To the Graduate Council:

I am submitting herewith a thesis written by Rebecca Davidson entitled "The Relationship Between Cohesion and Power in Staff Nurses in An Acute Care Hospital." I have examined the final copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Science in Nursing.

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THE RELATIONSHIP BETWEEN COHESION AND POWER IN STAFF NURSES IN AN ACUTE CARE HOSPITAL

A Thesis

Presented for the

Master of Science

Degree

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Rebecca Davidson

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ABSTRACT

In the past, nurses felt powerless and functioned in a subservient role in health care institutions, minimally participated in working to advance the profession, and as a rule, did not become active in influencing health policies. A sense of powerlessness prevailed as a result of nursing being a predominantly female profession (Martin, 1991). Few, if any, traditions of power within nursing have existed. The concept of power did not emerge in nursing literature until the 1960s. Although issues and papers presented at the National Student Nurses' Association convention in 1968 provided unprecedented momentum to nurses' concerns about power in nursing professional literature, not until the 1980s did a majority of nurses begin to view power as a positive and necessary trait (Dennis, 1983; Schmieding, 1993). Nursing leaders are calling for registered nurses to recognize and exercise their potential power to elevate the status of nursing to a professional level and to work to influence national health policy in relation to health promotion and disease prevention (Cohen, 1992). Some nurses are beginning to use their potential power in health care institutions and in the political arena, while others have yet to realize their potential power. In the organizational pattern of shared governance, nurses come together as cohesive groups to collectively have the opportunity to gain power and to shape the health care system in which they practice. Cohesion has been said to be a way for all nurses to gain power, but research into the relationship of cohesion and power is lacking.

This study examined the relationship between cohesion and power in staff nurses in an acute care hospital. This was a cross-sectional correlational survey of a convenience sample of female registered nurses employed as staff nurses in the general medical-surgical units and intensive care units in a large southeastern teaching hospital. The Pearson's Product Moment Correlation was performed to examine relationships among cohesion and power and demographic characteristics of the nurse, and to examine the nature of power in the nurse.

The correlations between cohesion and power and cohesion and the sub-scales of power were not statistically significant. For demographic characteristics of the nurse, the only significant relationship found was an inverse statistical relationship for number of years in practice at $r = -.23$ and $p = .03$ for power, and $r = -.22$ and $p = .03$ for cohesion, which indicates as the number of years in practice increases, perceived power and cohesion in the nurse decreases.

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CHAPTER I

INTRODUCTION

Overview of the Problem

A number of years ago, nursing leaders issued the call for registered nurses employed by hospitals to exercise their potential power, to elevate the status of nursing to a professional level, and to participate in the political arena to influence national health policy with relation to health promotion and disease prevention (Betts, 1993; Cohen, 1992; Stevens, 1980). More recently, the nursing profession has also "been given a mandate from society to use its resources, knowledge and skills to facilitate the achievement of the goal of health for all by the year 2000" (Watts, 1990, p. 40). However, hospital nurses have been labeled powerless in the health care system by some (Cohen, 1992; Palmer, 1988; Ruiz, 1988; Wynd, 1985). Investigators who have identified the powerless orientation in nurses say that the roots of the problem lie in nursing's long history of inadequate education, economic exploitation, and sexual discrimination (Ashley, 1976; Kalisch & Kalisch, 1982; Lerner, 1985; Muzio, 1985; Porter, 1991; Schmieding, 1993). The issues of powerlessness in nursing, a predominantly female profession, parallels the status of women in the American society (Clifford, 1992; Porter, 1991). In the past, women were socialized to be subordinate and held a mystical view of power; men used power to dominate and control women (Janeway, 1980).

According to Janeway (1980), women have held a mystical view of power. Women were socialized not to like power, not to want to use it, not to want to think or talk about power. Women felt weak, inadequate, and puzzled. Their excruciating despair over their powerlessness led them to feel worthless without validity. They felt that their actions would be ineffective. They adjusted to life as subordinates. She said that the root of the problem was the faulty definition of power.

Today, 80% of the more than two million nurses are actively employed, two thirds of them employed by hospitals (Aiken, 1990). Until more recent times, hospital nurses remained totally dominated by physicians and hospital administrators (Sweeney, 1990). According to Ashley (1976), from the advent of America's first hospital in 1751, physicians have actively and knowingly suppressed the realization by nurses that they possess both knowledge and skill. Historically, nurses devoted themselves totally to the hospital, physicians, and patients. They accepted long hours, poor working conditions, and stringent discipline without question. Obedience to authority was the rule; subservience remained an unquestioned state. A majority of nurses merely reacted either positively or negatively to the decisions made for them by more dominant groups and did not involve themselves in influencing the decisions regarding the health care system and the nursing profession (Chandler, 1991; Cohen, 1992; Stevens, 1980).

Some progress has been made by a small percentage of nurses who understand and exercise power to shape and mold the future for practicing nurses.

Nurses' salaries, benefits, working conditions, and professional image have improved. Nurses, themselves, as well as the public and other health care professionals question the subservient role. These changes came as a result of the women's movement in the 1960s, a product of the civil rights movement. With this movement, a positive perception of power developed in some women, including nurses (Galligan, 1985; Sweeney, 1990). With the 1970s feminist movement, changes continued and evolved into organized political interest groups on the national, state, and local levels by and for women (Costain, 1988). In cohesive groups, women acted on behalf of women and achieved major developments for the advancement of women. Women began to view power positively and exercise its use for women. However, not until the 1980s did a large number of nurses start to view power as an essential characteristic for nurses (Dennis, 1983; Schmieding, 1993). One reason for the changing view of power was an increase in academic education and graduate education for nurses (Dennis, 1983). Today an even larger percentage of nurses have obtained graduate education. Nursing leaders, educators, researchers, and entrepreneurs and others committed to advancing the profession have worked to help other nurses to realize their power. However, the arena where nurses manifest powerlessness the most is the hospital (Manthey, 1991).

Unfortunately, most of the million plus nurses employed by hospitals do not fully understand or exercise their power to influence national health policy or advance the profession. Some nurses exhibit low self-esteem, lack of

self-determination, and lack of commitment to the profession (Jenny, 1990). Advancement of the profession is a goal; therefore a need to study power in nurses employed by hospitals exists. Research on power in nurses remains very limited.

Most studies of power in nurses have used research instruments developed in other disciplines and based on their discipline's definition of power. Barrett (1983) proposed a theory of power derived from Martha Rogers' Nursing Science of Unitary Human Beings. Barrett's theory, that human beings have the capacity to knowingly participate in change provides a knowledge of power for nurses. This view of power differs from the traditional definition associated with domination and control over others. Barrett defines power as the way one relates to the environment to actualize some potentials rather than other potentials; it is a knowing participation in change. Knowing participation in change would allow nurses to participate in the political arena and efforts to advance the profession. Today the positive view of power emerging within nursing and a theory of power for nurses serves as an impetus for change in the profession. Investigators from nursing and other disciplines have proposed possible solutions to the problem of powerlessness in nurses including academic preparation, better working conditions, respect, and recognition of the value of their work by others (Chandler, 1991; Cohen, 1992). Nurses have proposed that cohesion among nurses and commitment to the profession will contribute to making nursing a powerful profession (Bankston, 1992; Boyle, 1984; Hayes, 1992; Honeycutt, 1989; Kalisch & Kalisch,

1982; Manthey, 1990; Neff, 1992; Porter-O'Grady, 1989; Rosenfeld, 1986; Wynd, 1985). An investigation of the relationship of cohesion and power in nurses will provide knowledge for nurse leaders who desire to facilitate cohesion in nurses to enhance power.

Statement of the Problem

The manifestations of power in nurses employed by hospitals must be understood to develop solutions to the age-old problem of a feeling in nurses that they are unable to use power, and feel powerless. Many nurse leaders, nurse researchers and nurse educators have proclaimed that nurses must unite to support each other for power to be enhanced, understood, and exercised on a daily basis. Unity will promote advancement of the profession and allow nurses to participate in the political arena and in the formulation of the health care system for the future (Ballard, 1988; Bankston, 1992; Boyle, 1984; Porter-O'Grady, 1986; Wynd, 1985).

As the largest group of health care professionals in the country, nurses are in a position to shape the health care delivery system at large (Aurilo, 1985; Boyle, 1984; Cohen, 1992; Ferguson, 1985; Jones, 1985; Kalisch & Kalisch, 1982; Smith, 1985; Wynd, 1985) and determine the way nursing is practiced to ensure that humanization remains a part of patient care (Coile, 1988; Collins & Henderson, 1991; Scearse, 1989; Wynd, 1985). Louis W. Sullivan (Sharp, 1991), [former] Secretary of the Department of Health and Human Services, commented that

nurses have the pivotal role and greatest potential for improving the health status of the people of this nation; nurses focusing their energies on disease prevention and health promotion are the means to achieving this goal for the people of this nation. Nurses' knowing participation in change or power, as defined by Barrett (1983), can influence the health of the nation. However, all nurses, community and hospital based, must first understand their role in the future of health care, health promotion, and disease prevention, and then take an active role in shaping the future in the health care of the nation.

Statement of the Purpose

The purpose of this study was to examine the relationship of cohesion and power in female registered nurses employed as staff nurses in hospitals and to examine the nature of power in the nurse. In addition, cohesion and power were examined in relation to selected demographic characteristics of the nurse. This research was guided by Martha Rogers' Science of Unitary Human Beings (1970) and Barrett's (1983) theory of power as "knowing participation in change."

Hypothesis

The following is offered as hypothesis for the study: **There is a positive relationship between cohesion and power as perceived by registered nurses employed by hospitals.**

Subsidiary Questions

1. What is the relationship of the age of the nurse to power?
2. What is the relationship of the age of the nurse to cohesion?
3. What is the relationship of the educational level of the nurse to power?
4. What is the relationship of the educational level of the nurse to cohesion?
5. What is the relationship of previous management experience of the nurse to power?
6. What is the relationship of previous management experience of the nurse to cohesion?
7. What is the relationship of work in a general unit versus intensive care unit to power?
8. What is the relationship of work in a general unit versus intensive care unit to cohesion?
9. What is the relationship of the number of years in nursing practice to power?
10. What is the relationship of the number of years in nursing practice to cohesion?
11. What is the relationship of membership in a professional nursing organization to power?
12. What is the relationship of membership in a professional nursing organization to cohesion?
13. What is the nature of power in the female registered nurses?

Definitions

Power: "The capacity to participate knowingly in change characterizing the continuous repatterning of the human and environmental fields" as measured by the Barrett Power as Knowing Participation in Change Tool (Barrett PKPCT, VII) (Barrett, 1983, p. 4). The nature of power is defined as the subscales of power that are freedom to act intentionally, involvement in creating change, awareness, and choices as measured by the Barrett Power as Knowing Participation in Change Tool (Barrett PKPCT, VII) (Barrett, 1983).

Cohesion: A state characterized by the nurses' perception of the degree of productivity, efficiency, morale, feelings of belongingness, personal feelings about the group, and enjoyment of working with co-workers on their own unit as measured by the Group Cohesion Scale (GCS) (Byrne, 1961).

Nurse: Any female registered nurse working in a staff nurse position on one of the general surgical and intensive care units in the hospital in which the survey took place.

Limitations/Delimitations

The major limitation of this study is that it cannot be generalized to nurses working at other hospitals and to the nursing population at large. With the convenience sample of female registered nurses, no steps were taken to ensure a random sample. The study has useful implications for nurse managers and

educators as they provide leadership to restructure the environment in which nurses work and reinforce the potential power of nurses.

Assumptions

1. Power is a desirable trait.
2. Female registered staff nurses possess potential power.
3. Nurses employed by hospitals are unable to exercise their potential power.
4. Nurses must unite to support each other for power to be enhanced, understood, and exercised on a daily basis.
5. Cohesion in nurses will promote advancement of the profession and allow nurses to participate in the political arena.
6. Power and cohesion, a neglected issue in nursing research must be maximized for nurses to assume roles to shape the future of the profession and the future of the health care for the nation.
7. A systematic investigation of power in nurses based on nursing science will contribute to the knowledge of power possessed by nurses and help the profession maximize its potential power.

Theoretical Framework

Martha Rogers' Science of Unitary Human Beings guided the development of this research project. Rogers' (1992) four concepts of openness, energy field,

pattern, and pandimensionality describe the nature of human beings and their environment. Energy fields are "the fundamental units of the living and the non-living" (p. 29). In Rogers' system, "energy signifies the dynamism of the human and environmental fields. Fields are infinite, in continuous motion, and always changing mutually; in essence, they are without boundaries" (Lutjens, 1991, p. 6). Pattern is "the distinguishing characteristic of an energy field perceived as a single wave" (Rogers, 1992, p. 29). Pandimensionality is a "nonlinear domain without spatial or temporal attributes" (Rogers, 1992, p. 29). Openness means we live in a "universe of open systems"; energy fields are continuously open and of an infinite nature, and without causality (Rogers, 1992, p. 29).

Rogers' (1992) three principles of homeodynamics (resonancy, helicy, and integrality) explain the way change occurs. Helicy is the "continuous innovative, unpredictable, increasing diversity of human and environmental field patterns" (p. 31). Resonancy is the "continuous change from lower to higher frequency wave patterns in human environmental fields" (p. 31). Integrality is the "continuous mutual human and environmental field process" (p. 31). Integrality as defined by Rogers states the nurse, the environment, and other nurses are infinite, irreducible, "unified wholes" distinguished only by pattern. The principle of integrality guides the development of this research project.

According to Rogers (1970), humans and the environment mutually and continually share energy and participate with one another either knowingly or unknowingly. A nurse is an energy field always in mutual process with the

environment (everything external to the nurse). Within Rogers' system the staff nurse, the nurses' co-workers, and the nurse manager on one unit are regarded as an energy field or unified whole and anything external to and interacting with their unit is their environment (Rogers, 1990). Also, the entire nursing department of the hospital can be considered an energy field in mutual process with the entire health care delivery system in the institution. Each behavior, emotion, and word is an energy that flows in mutual process with someone else. An individual knowingly or unknowingly influences someone else with his or her flow of energy. Strategies can be implemented to influence the mutual process of one nurse, one unit, or entire nursing department as an energy field.

It is proposed that cohesion according to Rogers' system is a pattern manifestation of the human and environmental field. Although Rogers does not mention cohesion, cohesion can be linked to her writings in the following manner. Cohesion means "the act or state of sticking together tightly" (Webster, 1993). In this investigation, cohesion is defined as a state characterized by the nurses' perception of the degree of productivity, efficiency, morale, feelings of belongingness, personal feelings about the group, and enjoyment of working with co-workers on their own unit as measured by the Group Cohesion Scale (GCS) (Byrne, 1961). According to the Rogerian framework, cohesion manifests as a pattern out of the integral nature of people and their environment. The principle of integrality relates to cohesion. In Rogers' system, relationships flow from integrality, not cause and effect.

Rogers' system does not discuss power, but Barrett (1983), using Rogers' principle of helicy, proposed a theory of power. According to Barrett (1983), power is a unity that cannot be analyzed; it is understood in terms of its nature or its manifestations. Each manifestation has a synergistic relationship to the whole. She defined power as "the capacity to participate knowingly in the nature of change characterizing the continuous patterning of the human and environmental fields as manifested by awareness, choices, freedom to act intentionally, and involvement in creating changes" (Barrett, 1990, p. 159). In any context, knowing participation is "being aware of what one is choosing to do, feeling free to do it, and doing it intentionally" (Barrett, 1983, p. 1). Power is the capacity of humans to participate in the nature of their development; it is a field manifestation that emerges out of the human-environment interaction, a mutual process. Barrett supports her subscales of power which she terms the nature of power by related literature.

1. Awareness is an "innate attending to one's surroundings," one's perception of events that allows for conscious choices and response patterns (Ford & Urban, 1963, p. 186).

2. Awareness is a subjective full experience of the unitary person (C. Rogers, 1977).

3. Freedom is irreversible (C. Rogers, 1977, p. 186).

4. Freedom provides a selection in our evolving development and provides for independence in our motives for making choices. It allows a focusing on

conscious experiences, willful acts, value judgments, and anticipation of the future (Dubos, 1972).

5. Intentionality is our knowing and forming reality; the imaginative choosing in events of our lives. It is an "assertive response of the person" to their world and creates one's uniqueness (May, 1969, p. 233).

According to Barrett (1983), awareness and freedom to act intentionally may be the knowing that guides one's participation in making choices and in involvement in creating changes in the mutual process of the human and environmental field. Change is an ongoing process in human evolution. Depending upon the choices that one makes, change occurs to actualize some potentials rather than others. We create our own reality for ourselves and our environment from the choices we make. Depending upon the way the nurse knowingly participates in change, some potentials are actualized rather than others. An active involvement and dynamic flow of human field integral with environmental field leads to one's development; as development proceeds so does the capacity to participate knowingly in change. Barrett's (1990) Power As Knowing Participation in Change tool (PKPCT, VII) measures perceived power and subscales of power that are awareness, choices, freedom to act intentionally, and involvement in creating change; these four subscales of power are the field manifestations of power, or the nature of power.

The nurse is a unitary human being in continuous mutual process with the environment, continuously changing, with infinite possibilities. The nursing

profession has been influenced by the masculine principles related to power that continue today. Rogers' conceptual system explains the powerless orientation that characterizes the majority of nurses employed by hospitals. Historically, males have comprised less than 5% of the nursing population. Reflecting the socialization of women in our society, the literature details the male domination that has patterned female submissiveness and subservience in nurses (Ashley, 1976; Janeway, 1980; Kalisch & Kalisch, 1982).

Barrett intended her "power instrument to serve as an assessment planning and interventive tool" (p. 12). Once the manifestations of power of individuals or groups are identified by the tool, plans for mutually patterning with individuals and groups can be initiated. After the nurse, unit, or nursing department manifestations of power are identified, nurse leaders and managers can exercise their power as knowing participation in change to develop strategies for meaningful participation and patterning of staff nurses. Staff nurses using power or knowing participation in change can meaningfully likewise participate in mutually patterning the health care they deliver and the health care system at large for society. Using Barrett's definition of power and Rogers' principle of integrality, the belief that cohesion leads to manifestations of power by the nurse was explored in this investigation. To say that one can enhance the power of another or pattern power does not imply a causal phenomenon; it is a noncausal phenomenon, a mutual process of energy flow between human and environment (Barrett, 1983).

CHAPTER II

REVIEW OF THE LITERATURE

The need for united decision-making in nursing has been clear for some time. However, there is a lack of a unified understanding that powerlessness in nursing prevents the profession from manifesting its potential power. This powerlessness must be understood for power enactment to occur (Clifford, 1992; Schmieding, 1993). The literature review discusses powerlessness in nursing, gives common definitions of power that have been adopted in nursing, traces how power has been acquired by nurses, and traces the need for cohesion and power in the profession.

Results of Powerlessness

Kieffer (1984) views powerlessness as an interaction between a person and his or her environment that fosters an attitude of self blame, a generalized sense of distrust and alienation as well as a feeling of vulnerability and hopelessness. The core issue, hopelessness dominates the life process of the person. Powerlessness imparts a sense of being a victim. Staff nurses have experienced these feelings in varying degrees. The majority of nurses employed by hospitals continue to feel powerless (Chandler, 1991; Clifford, 1992; Kieffer, 1984; Schmieding, 1993).

Brown and Schultz (1991) discuss the results of nurses being powerless entities in the health care system. Feelings of powerlessness induce negative personal health outcomes, painful emotional feelings, and other stressors on the individual. Powerless persons cannot enjoy their work and many times become unable to be creative or contribute to the goals of the organization. The powerless cannot reach their full potential for the organization, because their energies are spent coping with the powerless state. As a result, their sense of self becomes diminished. A feeling of independent problem-solving pervades the powerless; they do not seek out others for consultation with problem-solving. This view of powerlessness explains the past lack of cohesion and united decision-making within the profession.

Mason, Nickitas, Scanlan, and Magnuson (1991) state powerlessness exists in the nursing profession because nurses have minimal roles in decision-making. In general, the profession lacks authority and power in health care institutions. Nurses are frustrated in their day-to-day efforts to bring about change in the way they practice nursing. Some feel intimidated by physicians and other health care providers, and demonstrate nonassertive behaviors. Some do not confront their problems directly, nor consult with other nurses to help in decision-making and problem-solving. Some lack confidence in their own decision-making abilities.

Pinderhughes (1983) states the victims of oppression and powerlessness exist in the midst of a circular system of the larger society or environment that fails to provide them with the needed means to overcome the dilemma. Similarly,

the majority of nurses function within the larger society of the hospital or institution. Nurse leaders and mangers must take responsibility to create an environment to help nurses overcome the cycle of powerlessness within the hospital system (Scearse, 1989).

Freire (1972) stated that the oppressed cannot sense themselves as being oppressed because the oppression is their environment; for the oppressed to overcome their oppressors, their leaders had to "unveil the world of oppression" and "commit themselves to its transformation" (p. 40). He proposed that the oppressed possess a magical view of the oppressor. When the oppressed see a contrary view of the oppressor, the oppressed begin to believe in themselves. Similarly, nurses must begin to believe in themselves and come to realize their power. This requires serious reflection. Freire said that leaders must begin a dialogue at a level in which the oppressed perceive reality to begin to believe in themselves. A leader's dedication to uniting the oppressed achieves liberation and humanization for the oppressed. He called this dialogue and action a mutual process. The mutual process allows one to come to know the "why" and "how" of his or her reality. In oppression, one is prevented from "being."

Witt (1992), in her study of nursing education, cited Freire's writings on the characteristics of oppressed people. He observed that the oppressed identify with the oppressor, incorporating a "negative view of themselves and a positive view of the oppressor" (p. 150). Similarly, nurses value physicians (predominantly males), and do not value themselves or their peers. As a result of lack of self-respect and

low self-esteem, nurses lack an affiliation with other nurses and have "a propensity to project negative traits on other nurses" (p. 150). Freire (1972) called this "horizontal violence" (p. 150); some hospital nurses experience and exhibit this on a daily basis. Witt (1992) states nurses' lack of affiliation with other nurses prevents many nurses from collectively realizing and using their power. This powerless orientation prevents cohesion within the profession.

Roberts (1983) examined models of oppression and characterized nursing as an oppressed group. Nurses possess values of both medicine and nursing, and some cannot become assimilated completely in either profession. In this context, some nurse managers not able to assimilate become marginalized, behaving more like the field of medicine adopting the masculine principles related to power. Some managers remain marginalized and reinforce nurses' subordination to medicine.

Clifford (1992) proposes that all nurse managers acknowledge nursing's roots in subordination and take actions to redefine power for the profession. She recommends managers exemplify pride as a nurse and visibility of their identification with nurses to overcome the powerless orientation. Engaging in dialogue with nurses about nursing's history and the power of caring enhances power.

Various forces influenced the difficulty nursing has experienced with regard to being recognized as a profession. Nursing leaders have devoted considerable effort to dialogue with nurses to lead them to an objective view of reality. An

examination of definitions of power will provide an objective view of nursing's current reality.

Definitions of Power

A review of the nursing literature with regard to power led to definitions of power from other disciplines used by nurses (Claus & Bailey, 1977; Dennis, 1983; Hersey, Blanchard & Natemeyer, 1979; Kennedy, 1984).

1. **Reward power**--based on the recipient's perception that those in power wield rewards such as pay raises, grades, and promotions (French & Raven, 1959).

2. **Coercive Power**--based on the recipient's perception that those in power wield punishments such as reprimands and undesirable work assignments (French & Raven, 1959).

3. **Legitimate Power** (French & Raven, 1954) or **Positional Power** (Dennis, 1983)--based on the recipient's perception that those in power possess the right to prescribe based on the authority given to a specific position or social structure emanating from a formal position.

4. **Referent Power**--based on a recipient's identification with the power agent. One has referent power when he/she is respected, liked, and admired. It can be based on identification with a group (French & Raven, 1959).

5. **Expert Power**--based on a recipient's perception that those in power possess special knowledge and skill emanating from superior knowledge (French & Raven, 1959).

6. **Informational Power**--based on a recipient's perception that those in power possess information or access to information that is valuable to others (Raven & Krauglanski, 1975).

7. **Connection Power** (Hersey, Blanchard, & Natemeyer, 1979), **Alliance Power** (Kennedy, 1984), or **Interpersonal-Social Power** (Claus & Bailey, 1977)--based on the recipient's perception that those in power possess connections with influential important people. To remain a part of the powerful connection, others comply with this type of leader. It is based on effective interactions with others.

8. **Vertical power**--based on a relationship between superior-subordinate relationships (Dennis, 1983).

9. **Personal power**--based on a strong self-concept and a heightened self-esteem, this type of power can be enhanced when leaders take responsibility for personal growth in the nurse (Claus & Bailey, 1977).

10. **Organizational power**--based on structural and environmental characteristics of an organization (Claus & Bailey, 1977).

Dennis (1983) wrote extensively about power in nursing and defined power as having impact and said that the educational credentials of the nurses equated with the power or impact of the nurse. Positional and knowledge power have provided nurses with their knowledge about power. Nursing knowledge gives nurses the power to practice. In positional, legitimate, or organizational power, the official's position leads others to be obedient or loyal. A nurse in an official position has the right to wield rewards or coercive power over others not on the

same positional level. Dennis (1983) also states that some nurses cannot use positional or expert power for various reasons, and that some of these nurses have found power in numbers or collective action. She implies that collective action (cohesive action) must be advocated until nurses understand or use the other potential power sources. Further, she states that vertical power between superior-subordinate relationships has been extensively investigated, but lateral or horizontal power in nursing that occurs among colleagues on the same level has not. She stated that lateral power must be validated to define power in nursing, otherwise the powerlessness and ineffectiveness of nurses will continue.

Kalisch and Kalisch (1982) note that power requires learning; it is inevitable and a part of all forms of human interactions and people. They, as do social scientists, define power not as a commodity to accumulate but "a relationship among people" (p. 3). This view supports mutual process.

Kennedy (1984) defined personal power as influence. Power used to influence, not to command, is true power. Power inherent in a position is not enough; personal power that builds and maintains relationships and influences is true power. Power a neutral trait, neither good nor bad, is assumed in all individuals. One has to observe power in action to believe it exists. If one does not observe the outcome of power, one perceives the other lacks power. Power also requires regular maintenance in keeping one's alliances. Maintaining an alliance requires time and energy. This view of power supports cohesion as a way to acquire power. Nurses in the institution can influence the work environment, patient

care, and national health policy. In summary, power is characterized by: (a) neutrality (neither good nor bad); (b) visibility only when used; (c) requiring maintenance; (d) requiring time and energy. This view of power without the traditional negative connotation characterized by domination and control over others can be adopted by nurses.

According to Claus and Bailey (1977), for staff nurses to exercise power, nurse leaders must be aware of the work environment and know how power occurs. Power, "the ability and will to act" (p. 43), occurs when people cooperate and co-create it by collaboration. These authors state that there is a tripartite nature to power: (1) strength based on a strong self-concept and an awareness of reality; (2) energy based on characteristics inherent in individuals that influence the activities of others; and (3) action based on performance of acts to motivate others. Their view supports integrality. Nurse leaders and staff nurses who understand the nature of power can work to enhance power in other nurses. Nurses with strong self-concepts and heightened awareness of the current reality of the nursing profession and professional goals who possess energy for political action and action directed toward influencing patient care delivery could work to influence the advancement of the profession and national health policy. Cohesion in nursing fostered by nurse leaders and managers could pattern this reality for the staff nurses employed in hospitals.

The strength of the profession depends upon cohesion of members for goal-setting and taking action to achieve the goals. As stated by Janeway (1980),

shared goals are worth more and are worth fighting for; a unified group begins to realize they have a changeable future. Nursing has been characterized as being resistant to change (Ruiz, 1988). Cohesion and power could change this characteristic to one of creating and actively participating in change for the health of the nation. Power would give the profession the needed resources for change.

According to Rogers (1990), nursing is both an art and a science. The science is knowledge, a noun. The art of nursing is the application of the knowledge into practice. Some nurses employed in hospitals exercise their power daily by putting their knowledge to work delivering the art of nursing. Nurses possess knowledge power and operationalize it to deliver nursing care. However, some nurses do not exercise alliance power, personal power, and interpersonal-social power to advance the profession and influence health policy because of the powerlessness they feel (Ballard, 1988). Nursing's power in sheer numbers should allow nurses to make change, but first, nurses must unite to use their resources of power. Power can no longer be viewed by nurses as a negative trait. Power as knowing participation in change is a must for the nursing profession. To further support Rogers' framework and Barrett's theory of power as knowing participation in change relevant nursing literature on power acquisition will be presented next.

Power Acquisition

Mason, Nickitas, Scanlan, and Magnuson (1991) cite nurse managers as responsible for free and open communication. Nurses must listen to and respect

each other. Nurses must value each others' perceptions, knowledge, and experience. Nurse managers must foster discussions of personal accomplishments and successes to support and develop nurses. Nurses must transcend oppressed ways of relating to each other. Nurses must hear and respect the dissenting voices in nurses; a respect of nurses for all nurses can work to bring unity and power acquisition. A nurse must be proud to be identified as a nurse.

According to Lutz, Petrovic, and Miller (1991), nurses must learn to nurture and trust each other to acquire power collectively and individually. In their study, they found that self-disclosure episodes and a desire to seek dialogue with other nurses about their professional experiences fostered professional power. Dialogue among nurses ends the constraints that hinder creative problem-solving and promotes implementation of solutions in the patient care arena.

According to Moccia (1988), nurses must assume a role in influencing the problems of health care for the nation. A lack of cohesion in the profession must be solved before nurses can influence the larger societal problems in health care. Since the majority of nurses are employed in hospitals, the development of power there could mobilize the profession. Moccia (1988) viewed power residing in numbers and unity for the profession. Kalisch and Kalisch (1982) stated that cohesion was the essence of political mobilization; all groups that achieved status did so by cohesive political action.

Shared governance, an organizational model that emerged in the 1980s, brings workers together in cohesive groups for power sharing (Porter-O'Grady,

1989). Traditionally, hospital management has not solicited nurses' input on personnel and patient care issues, and totally omitted the nurse from the decision-making processes (McDonagh, Rhodes, Sharkey, & Goodroe, 1989). A powerless position created by a lack of participation in decision-making perpetuates a powerless environment for the nurse. However, various forms of shared governance now commonly bring staff nurses together in groups and committees concerned with quality assurance, policies, procedures, forms and guidelines, and in some institutions committees for wages, salaries, and benefits (Pinkerton, et al., 1989). These groups possess the power to discuss and formulate independent solutions to problems in patient care and management for enactment (Boissoneau & Schwahn, 1989; Caramanica & Rosenbecker, 1991; Dugger, 1991; McDonagh et al., 1989; Pinkerton, et al., 1989; Shidler, Pencak, & McFolling, 1989). Shared governance, develops the power base of individual nurses by promoting networking, coalition building, and negotiating with other nurses.

Shidler, Pencak, and McFolling (1989) emphasize that participating in and implementing change allows nurses working under a shared governance model to control the work environment and delivery of patient care. Nurses gain autonomy and change the reality of their powerlessness. They learn creative problem-solving skills and that their ideas and opinions are important and respected. When a nurse participates in decision-making, he/she develops increased self-esteem and self-confidence, greater job satisfaction, and increased commitment to the organization as a whole. Jenkins (1991) suggests that in institutions without shared

governance, managers should daily seek staff opinions on patient care, management, and personnel issues to increase their involvement in decision-making and create situations to foster collaborative decision-making and relationships.

Chandler's (1992) study using interviews found nurses employed in hospitals felt powerless. These feelings resulted from negative nurse-physician interactions, families not being appreciative of the care given by nurses, short-staffing, and autocratic and ineffective management. She defined power as interaction among colleagues, connection with patients, physicians, and co-workers. Her results suggested managers should work directly with staff to help them gain support and power from their nurse colleagues.

Cohesion

According to Beeber and Schmitt (1986), cohesiveness in groups has a variety of definitions. In this study, cohesion is defined as morale, high productivity, strong feelings of belongingness, high efficiency, personal feelings, and working together (Byrne, 1961). Creegan's (1989) study defined group cohesion as the degree to which a group coheres or hangs together and has friends in their immediate work group. Hintze's (1989) study defined group cohesion as a sense of bonding with or being linked to other group members. She found that "the more cohesive the group, the better the member's self-esteem, hope, coping, participation, goal attainment, and healthy relationship-building will improve" (p. vi). Cohesive groups increase their risk-taking, self-worth, self-esteem, personal

satisfaction, growth, job satisfaction and attainment of goals (Beeber & Schmitt, 1986; Byrne, 1961; Creegan, 1989; Good, & Nelson, 1973; Hintze, 1989).

Nurses have collective power (Boyle, 1984). Nurses gain power by sharing with other nurses and by working collaboratively. Nurses who seek out other nurses for consultation and support have more power than nurses that work independently. Fragmentation, common among nurses, contributes to individual and collective powerlessness. Nurses need to cooperate with one another to identify the goals of nursing practice and work collectively to meet them.

Honeycutt (1989) states a sense of belonging and connectedness in the work place increases self-esteem and allows for creative expression, motivation, productivity, commitment, and power. Interpersonal trust and acceptance of others are nothing more than an extension of our basic emotional needs. Cohesion in the work place brought about by trust and open communication should be fostered by management in all levels of the organization as work place unity encourages maximum productivity of the worker.

According to Casey (1989), the role of a nurse manager is to foster cohesiveness in nurses and to work to take care of staff so that the nurses in turn can effectively care for patients. When the basic emotional need to belong to a group is met, one can grow both personally and professionally. Cohesion, the fundamental principle of group dynamics, allows the group to accomplish goals (Hayes, 1992). When a person feels a sense of belonging to a group, he or she does not

fear repercussions from discussing their concerns about patient care issues and problems; they confront problems and derive creative solutions together.

Hayes (1992), in an observational study, worked with a unit of nurses and nursing assistants who lacked cohesiveness and felt powerless. Patient care on the unit suffered. Nurses, taught the characteristics of cohesive groups and how cohesive groups operate by using group dynamics theory and strategies, developed awareness of cohesiveness, became cohesive, and gained power through peer relationships; ultimately patient care improved.

Kramer and Schmalenberg (1991) commented that a supportive and cohesive environment within the culture of the hospital and unit pave the way for nurses to have power, autonomy, and freedom to act on their knowledge. Trust and confidence in each other and their managers enhanced job satisfaction and productivity. The managers fostered cohesiveness.

Senghaus, Brennan, and Mackay (1990) describe the process developing cohesion. Listening to each other while discussing issues of practice produced an initial sense of belonging. The discussions used simultaneous translations from one's beliefs about practice to the others' beliefs about practice. Trust developed in the translation talks and a sense of cohesion evolved. For cohesion to develop, they stress that nurses must engage in the translation talk, discuss diverse definitions and opinions on practice, negotiate and express individual meanings, and develop a sense of trust in each other as individuals.

A lack of cohesion threatens the life of the group, as well as type of care given to the patient (Manthey, 1990). Cohesion, a fundamental principle of group dynamics, allows the group to accomplish goals (Hayes, 1992). Management must support unity and cohesion to build team spirit and morale. Morale, "a function of how staff members treat one another, translates into the type of care the patients receive" (Manthey, 1990, p. 20). Cohesion and power at the unit level determine the care patients receive.

The failure of some nurses to unite on issues has had apparent negative consequences that continue today, including but not limited to: a lack of autonomy in the profession (Collins & Henderson, 1991; Prescott & Dennis, 1985; Reverby, 1987; Scearse, 1989); low salaries compared to other professionals (Ballard, 1988; Lovell, 1981; Martin, 1991); continued dispute over educational entry level into practice (Alm, 1991; Dennis, 1983; Martin, 1991; Reverby, 1987; Smith, 1990); and a failure to support professional organizations (Berney, 1991; Jenny, 1990). A lack of cohesion in nursing has left nursing in a continuing struggle for autonomy and professionalization.

However, cohesion has proven to be a dramatic power force in the political arena on more than one occasion, namely: (1) the victory over the registered care technologist proposal by the American Medical Association (Kinney, 1988; MacPhail, 1989) and (2) preservation of the Board of Nursing that was meant to be abolished by the Sunset Law (Kinney, 1989). Nurses also united when they

presented Congress with the Nurse Training Act, third party reimbursement for nurses, and a National Center for Nursing Research (Smith, 1990).

Power and energy were generated when nurses united in the political arena. Themes of cohesion are more prevalent in this decade than ever before. This is "an era of nursing moving forward" (MacPhail, 1989, p. 4). She says cohesive nurses who can creatively solve the health care issues that confront our nation today should be the message given to all nurses and concentrated at the staff nurse level where "power in numbers" occurs. She discusses power in numbers and power in creativity expressed through membership in a variety of professional organizations.

The belief that nursing organizations enhance voice and power nursing is abundant in the literature (Berney, 1991; Betts, 1993; Jenny, 1990; Neff, 1992; Smith, 1990). Lucille A. Joel, former president of ANA, stated, "Without organization, there is no voice . . . no power"; " Unity among nurses today is not an isolated phenomena" (Neff, 1992, p. 174). However, some nurses still decline membership in a professional association, thus isolating themselves from the knowledge of nursing's real accomplishments which perpetuates powerlessness (Neff, 1992).

From the literature, some nurses still do not realize and exercise their potential power. Powerlessness in nursing prevents some nurses from manifesting their potential power. Beginning at the staff nurse level where power resides in numbers, power could shape the future of the nursing profession and influence

health care policy. A knowledge of power for nursing is necessary. This study tested the hypothesis that there will be a positive relationship between cohesion and power in staff nurses employed by hospitals.

CHAPTER III

RESEARCH DESIGN

The design of this study was a cross-sectional correlational study. The purpose was to investigate the relationship between cohesion and power in female registered nurses employed by hospitals. Power and the nature of power, the subscales of power, were measured by the Barrett Power as Knowing Participation in Change Tool (PKPCT VII) (Barrett, 1990). Cohesion was measured by the Group Cohesion Scale (GCS), a modified version of the Byrne Interpersonal Judgment Scale (Byrne, 1961). Demographic characteristics of the nurse were collected by an investigator developed Demographic Data Sheet.

Subjects

A convenience sample was drawn from a population of 257 female registered nurses employed as staff nurses in medical, surgical and intensive care units in a large southeastern medical center used for this study. All female registered nurses employed as staff nurses, regardless of educational level, employment status (part-time or full-time and shift of work), position, specialty, and age were invited to participate in the study. Participation was voluntary. Only nurses in non-management positions were invited to participate in the study to exclude differences in power that may result from positional power. One hundred fifty questionnaires were distributed; 110 were returned for a survey response rate of 73%,

and population response rate of 43%. Of the 110 returned, 5 lacked completion and 14 were completed by nurses currently employed in assistant head nurse positions. These questionnaires were not included in data analysis. A total of 91 surveys were used in the data analysis for a population response rate of 35%, and adjusted total usable sample response rate of 61% (n = 91).

Demographic Characteristics of Sample

Table 1 presents an overview of the demographics. As can be seen, approximately one-third of the subjects were between the ages 30 to 39. For data analysis, ages 50-59 and 60-69 were collapsed since the 60-69 group contained only one subject.

Greater than two-thirds of the subjects held an associate degree as their basic level of education in nursing. The literature attributes acceptance of a positive view of power to academic and graduate education for nurses (Dennis, 1983; Neff, 1992). In the sample of female registered nurses, in addition to their basic level of nursing education, 5 held non-nursing bachelors' degrees, 2 non-nursing Master's degrees, and one non-nursing Doctorate. These additional non-nursing degrees were not considered in this data analysis due to a low number of subjects. For educational level, nurses holding a BSN and MSN were grouped together since the MSN group contained only two subjects.

Table 1. Demographic Characteristics of Sample (n = 91).

	N	Percent
Age		
20-29	18	19.8
30-39	35	38.5
40-49	24	26.4
50-59	13	14.3
60-69	1	1.1
Greater than 70	0	0.0
Basic Educational Preparation in Nursing		
Diploma	24	26.4
AD	39	42.9
BSN	26	28.6
MSN	2	2.2
PhD	0	0.0
Number of Years in Nursing Practice		
Less than 3	17	18.7
3 to 6	20	22.0
7 to 10	17	18.7
11 to 14	14	15.4
More than 15	23	25.3
Current Specialty		
General Medical Surgical Unit	54	59.3
Intensive Care Unit	37	40.7
Previous Management Experience		
Yes	24	26.4
No	67	73.6
Current Employment Status		
Full-time	88	96.7
Part-time	3	3.3
PRN	0	0.0
Shift Currently Working		
Day Shift	59	64.8
Evening Shift	4	4.4
Night Shift	27	29.7
Rotate Day/Evening or Day/Night	1	1.1
Membership in Professional Organization		
Yes	24	26.4
No	67	73.6

Twenty-four nurses had previous management experience. Twenty-four nurses belonged to professional organizations: 17 belonged to one professional organization, 5 belonged to 2 professional organizations, 2 belonged to 3 organizations. Four nurses worked the evening shift, a low number because the majority worked 12 hour shifts which eliminates the late afternoon or evening shift.

Procedure

After approval from the Institutional Review Boards of the medical center and university, a conference was held with the nursing liaison to the institutional review board at the hospital to define the purpose of the study. The investigator presented information to the clinical nursing directors and head nurses of each of the nursing units to define the research protocol, the purpose of the study, and proposed benefits to the nursing profession.

A cover letter with an invitation to participate in the survey was attached to the questionnaires (See Appendix A). The cover letter explained the survey and the methods to ensure anonymity. The questionnaires were placed in large manila envelopes marked "Questionnaires" on the designated units for the two-week data collection period. Completion of the questionnaire indicated voluntary participation in the study. Code numbers on the questionnaires were used to correlate demographic data to the Group Cohesion Scale and the Barrett PKPCT, VII during data analysis. After completing the questionnaire, subjects were requested to

separate the demographic section from the GCS and Barrett PKPCT, VII and seal it in a letter-sized envelope provided by the investigator to maintain their anonymity. Subjects were requested to place the sealed envelope containing the demographic section in a large manila envelope labeled "Confidential" and place the GCS and the Barrett PKPCT, VII in a second large manila envelope labeled "Survey." The investigator provided additional questionnaires (not in excess of the original 150) to the units with high levels of participation. The data collection occurred over a period of two weeks.

Instruments

The investigator developed questionnaire elicited demographic characteristics of the sample: (a) age, (b) educational preparation, (c) number of years in practice, (d) current specialty, (e) previous management experience, (f) employment status (part-time or full-time and shift of work), and (g) professional organization membership (see Appendix B).

The Group-Cohesion Scale, a modified version of the Byrne Interpersonal Judgment Scale (Byrne, 1961), consists of six items on a 7-point rating scale. (See Appendix C.) Subjects are asked to rate the items based on their opinions. Respondents rate items dealing with beliefs on productivity, efficiency, morale, and feelings of belongingness, on a 7-point scale ranging from "very much above average" to "very much below average." The item dealing with personal feelings about the group is rated from "like it very much" to "dislike it very much." The

item dealing with enjoyment of working together in the group is rated from "enjoy it very much" to "dislike it very much." Each of the six questions was scored 1 to 7 and summed for the Total Cohesion score. Possible scores could range from 6 to 42.

Hinshaw and Atwood (1985) distributed the GCS to 1,597 nursing staff members (63% RNs, 37% LPNs and nursing assistants) in 15 urban and rural hospitals throughout Arizona with a response rate of 96%. Construct validity was estimated using principal components for factor analysis and predictive modeling. Factor coefficients ranged from .49 to .81, with all six items clearly loading on one factor which explained 52.5% of the variance. Internal consistency reliability was estimated at alpha = .81.

The GCS scale has been used in nursing to test job satisfaction related to group cohesion of colleagues and anticipated turnover of nursing staff (Hinshaw, Atwood, Gerber, & Erickson, 1985), and to measure cohesiveness in nurses when a unit was staffed with all registered nurses (Hinshaw, Scofield, & Atwood, 1981). Lucas, Atwood, and Hagaman (1993) used the GCS to measure cohesiveness in 385 nurses in a replication study as a predictor of turnover. Their study found the nurses were a cohesive group with a mean of 5.0 and standard deviation of 1.15. This investigation also found the nurses to be a cohesive group, with a mean of 5.5 and standard deviation of 1.1 for cohesion. Chronbach's alpha = .88 was found for the GCS total scores in this study.

The Barrett (1990) Power As Knowing Participation in Change Tool (PKPCT, VII) (see Appendix D), is a semantic differential scale to measure perceived power and the nature of power that consists of freedom to act intentionally, involvement in creating change, and feelings about awareness and choices. The "instrument contains instructions to check the space on the 7-point semantic differential scale that best reflects the meaning that concept has for the subject" (p. 167). Each space on the continuum of bipolar adjective pairs is assigned a number 1 to 7. The scores were summed for each of the four subscales; the four subscales were then summed to give a total power score. The scores for each of the four subscales indicate the nature of power in the subjects. Scores for the subscales can range from a low score of 12 to a high score of 84. The thirteenth item on each of the 4 subscales is a retest item and is not included in the summed sub-scale scores. Scores for the total power measure can range from a low score of 48 to a high score of 336. Lower total scores indicate lower power and higher scores indicate higher power.

The Power as Knowing Participation in Change Tool (PKPCT) (Barrett, 1983) was modified. Version II, the Barrett PKPCT, VII, was validated on a sample of 625 men and women with congruence coefficients of .99, which indicated that power measures were reliable across the contexts. On the revised tool, the means for each of the four subscale power scores ranged from 5.06 to 6.07. Standard deviations ranged from 1.00 to 1.35. Barrett (1990) cites Trangenstein's 1988 study that tested the instrument with 326 registered nurses and "reported the

following estimates of reliability using Cronbach's alpha: awareness .86, choices .88, freedom to act intentionally .89, involvement in creating changes .92, and total power (four concepts considered together) .96" (p. 171-172).

The means found in this investigation ranged from 4.8 to 5.0 and standard deviations from 1.1 to 1.54. Chronbach's alpha = .94 was found for the power score in this investigation.

Data Analysis

The statistical analysis was performed on the VMS-VAX clusters computer at The University of Tennessee, Knoxville Computer Center using SAS, the Statistical Application Program.

To address the hypothesis that there is a positive relationship between cohesion and power in hospital staff nurses, the Pearson's Product Moment Correlation was used to test a linear relationship among the variables (Ferguson & Takane, 1989). The level of significance selected was $p = .05$. To address the subsidiary questions, what is the nature of power in the nurses and what is the relationship of selected demographic characteristics of the nurse: age, educational level, previous management experience, work in general unit versus intensive care unit, number of years in practice, and membership in a professional organization to power, and to cohesion, the Pearson's Product Moment Correlation was also used. The level of significance was $p = .05$.

CHAPTER IV

FINDINGS

This study investigated the relationship between cohesion and power in female registered nurses employed by a hospital. Participants completed the Barrett PKPCT, VII, the Power as Knowing Participation in Change Test, the GCS, the Group Cohesion Scale, and the Demographic Data Sheet. The subscales of power in the Barrett PKPCT, VII were examined to show the nature of the power in the registered nurse in relation to cohesion. The demographic characteristics of the nurses were age, educational level, previous management experience, type of specialty (general unit versus intensive care unit), number of years in nursing practice, previous management experience, employment status (part-time or full-time and shift of work), hours of work, and membership in professional organizations. The relationship of employment status (part-time or full-time and shift of work) to cohesion and power were not analyzed.

Measurement Findings

The means (5.06 to 6.07) found by Barrett (1990) in the validation study for the PKPCT, VII were high. The means (4.8 to 5.0) for perceived power and the subscales of power found in this investigation were also high. According to Barrett (1990), the PKPCT, VII may have an "inherent bias toward the high-frequency descriptors" (p. 167). Alternatively the subjects in this investigation may

perceive themselves to have higher power as indicated by their scores on the instrument. Cronbach's alpha = .94 was found for the power scores in this investigation; therefore, the subjects' responses are considered highly reliable. Table 2 shows the means, standard deviations and ranges found for the total scores on the Barrett PKPCT, VII, and cohesion score.

Table 2. Measures of Central Tendency and Variability for Power Score, Subscale Scores, and Cohesion Score

Variable	Mean	Standard Deviation	Minimum	Maximum	Median	Mode
Total Power Score	235.90	30.10	157.0	336.0	233.5	228
Awareness	59.52	7.83	43.0	84.0	59.0	56
Choices	59.91	7.78	42.0	84.0	60.0	60
Freedom to Act Intentionally	59.74	8.29	39.0	84.0	60.0	60
Involvement in Creating Change	57.20	10.80	32.0	84.0	58.0	72
Total Cohesion Score	32.92	6.34	12.0	36.0	34.0	34.0

Test of Hypothesis

A correlational design was used to investigate the relationship of cohesion and power in female registered nurses employed in a hospital. The Pearson's Product Moment correlation test was done to ascertain the relationship between

the variables, with selected confidence level at $p = .05$. The correlation between the total measure of power (Barrett PKPCT, VII) and cohesion (GCS) was not statistically significant at $r = .15$ and $p = .16$.

Subsidiary Questions

A correlational design was used to investigate the relationship of cohesion and of power to the demographic characteristics of the nurse using the Pearson's Product Moment Correlation Coefficient with a confidence level of $p = .05$. Table 3 shows Correlation Coefficients and probability for cohesion and power in relation to the demographic characteristics of the nurse.

As can be seen from Table 3, significant statistical inverse relationships were found between number of years in practice to power and cohesion. An $r = -0.23$ and $p = .03$ for power and number of years in practice indicates that as number of years in practice increases, nurses perceive they have less power. An $r = -0.22$ and $p = .03$ for cohesion and number of years in practice indicates that as number of years in practice increases, nurses perceive themselves as being less cohesive.

The Nature of Power in the Female Registered Nurse

To determine the nature of power in the female registered nurse, a correlational design was used. The Pearson's Product Moment Correlation with a $p = .05$ was used. The subscales of the Barrett PKPCT, VII which are awareness,

Table 3. Pearson's Correlation Coefficients and Probability for Demographic Characteristics of the Nurses in Relation to the Total Power and Total Cohesion Scores.

	Power		Cohesion	
Variable	**r**	**p**	**r**	**p**
Age of the Nurse	-.04	.68	0.01	0.91
Basic Nursing Educational Level	.12	.27	0.03	0.77
Years in Practice	-.22	.03*	-0.22	0.03*
Unit of Specialty	-.15	.15	-0.05	0.63
Previous Management Experience	-.04	.65	-0.19	0.06
Membership in Professional Organizations	-.01	.93	-0.07	0.49

choices, freedom to act intentionally, and involvement in creating change indicate the nature of power in the subject in relation to cohesion.

Table 4 displays the correlation coefficients and probability for the total power score and power subscales in relation to the total cohesion score. As can be seen from Table 4, there were no statistically significant relationships found between cohesion and power or the subscales of power, which would indicate the nature of power in the nurses in this investigation.

Table 4. Pearson's Product Moment Correlation and Probability for the Barrett PKPCT, VII Sub-units and Total Scores in Relation to the Total Cohesion Score.

Variable	Cohesion	
	r	p
Awareness	.19	.06
Choices	.13	.20
Freedom to Act Intentionally	.19	.06
Involvement in Creating Change	.02	.84
Total Power Score	.15	.16

CHAPTER V

DISCUSSION

The purpose of this study was to investigate the relationship of cohesion and power in female registered nurses employed in a hospital. The study also investigated relationships of demographic characteristics of the nurse to cohesion and power. In addition, the subscales of power which indicate the nature of power were investigated in relation to cohesion. The theoretical basis of this study was Rogers' (1990) nursing model and Barrett's (1983) theory of power as knowing participation in change. Barrett (1983) stated that the interrelationship of awareness, choices, freedom to act intentionally, and involvement in creating change constitutes power; nurses have suggested that cohesion is a way for the nurse to gain power (Ballard, 1988; Bankston, 1992; Boyle, 1984; Porter-O'Grady, 1986); cohesion and power were hypothesized to be correlated constructs.

Hypothesis

It was hypothesized that there would be a positive relationship between cohesion and power in female registered nurses. This study focused on female registered nurses working in adult general and intensive care medical surgical units of the hospital. The hypothesis, to determine if a positive relationship existed between cohesion and power was not supported at $r = .15$ and $p = .16$. The study was underpowered because of the small sample size (Polit & Hungler, 1991;

Polit & Sherman, 1990). To achieve true statistical power in a study where the probability of committing a Type II error is 20%, and the probability of committing a Type I error is 5%, and a low effect size of r = .20, the sample size should be 197 (Polit & Hungler, p. 487). The adjusted sample in this study was n = 91. Perhaps with a larger sample of nurses the r value in this investigation would have approached statistical significance.

Subsidiary Questions

There was no statistical significance found for the subsidiary question that addressed the nature of power in the female registered nurse, as can be seen from Table 4. For the subsidiary questions relating to power and cohesion in relation to demographic characteristics of the nurse, no statistically significant relationships were found for age of the nurse, educational level, previous management experience, practice in general versus intensive care unit, and membership in a professional organization. There was, however, a statistically significant inverse relationship for number of years in practice to the total power score, and to the total cohesion score.

For the question, what is the relationship of number of years in nursing practice to power at $p = .03$ and a correlation coefficient of -0.23, the inverse relationship means that as the number of years in practice increases, perceived power in the nurse decreases. For the question, what is the relationship of number of years in practice to cohesion at $p = .03$ and a correlation coefficient of

-0.22, the inverse relationship means that as the number of years in nursing practice increases, perceived cohesion in the nurse decreases. However, the effect size is low at approximately r = .20 (Polit & Sherman, 1990).

The inverse relationship may be explained by the outcomes of powerlessness that some nurses feel. Staff nurses feel powerlessness in varying degrees. Brown and Schultz (1991) and Mason, Nickitas, Scanlan and Magnuson (1991) suggest the environment in which nurses practice fosters a sense of frustration and an inability to exercise power which may lead to a lack of affiliation with one's co-workers. Another possible explanation could be the way nursing leadership evolved under a system of masculine principles related to power (Chally, 1992; Lowery-Palmer, 1988; Roberts, 1983). Roberts (1983) states past and some present leaders in nursing have characteristics and beliefs modeled from masculine beliefs about power. Some leaders tend to be controlling, coercive and rigid with their leadership styles. In the past, some nursing leaders were promoted due to their allegiance to maintenance of the status quo in nursing which was subordination to the field of medicine. Perhaps past leadership has led to a perceived lack of cohesion and power in the nurses who have been in practice for a number of years. This finding provides knowledge for implementation of strategies by today's leaders in nursing to increase power and cohesion in nurses who have been in practice for a number of years.

The inverse relationship found between number of years in practice to perceived power and cohesion may also be explained by the number of nurses

included in the study with past management experience (n = 24). Individual reasons for the nurses stepping down (voluntarily or by demotion) to a staff nurse position were not known. Perhaps they experienced burnout and frustration in their management positions as a reason for returning to a staff nurse position. Therefore, their participation may have contaminated the results in this investigation.

This study supports the characterization of staff nurses as being resistant to change (Ruiz, 1988). For involvement in creating change, the mean was 57.19, the median was 58, the mode was 72. The large standard deviation (Table 2, page 41) indicates the area of greatest variability in responses from the subjects was for involvement in creating change. The above measures of central tendency would indicate that some nurses in this study did not perceive themselves to possess power to be involved in creating change.

Perceived power in the area of choices, awareness, and freedom to act intentionally were not statistically significant. Nurse managers could increase the awareness of nurses to their potential power, as they perceive they have power as indicated by the higher power scores found in this investigation. This strategy, along with the strategy to involve each nurse in unit decision-making (choices) and in creating changes for improved patient care and unit management, would allow for greater manifestations of power and feelings of being free to act intentionally.

Limitations of the Study

The small sample size n = 91 limited the power of the study. With a small sample size there is greater chance of statistical error (Polit & Sherman, 1990). The findings are less generalizable to the population from which the sample was taken due to the small sample size. A very small sample of nurses belonged to professional organizations, n = 24. With a very small sample, it was not evident that nurses belonging to a professional organization had more power than nurses not belonging to a professional organization. Perhaps a larger sample size would have made that evident as the review of literature associates power with membership in professional organizations (Betts, 1993; Neff, 1992). From the conceptual phase of this investigation, this investigator was interested in a possible "carryover" effect of the organizational or positional power. Therefore, nurses in current management positions were excluded from this investigation. As stated previously, the reasons some subjects with previous management experience returned to staff nurse positions were not identified. The nurses with previous management experience may have contaminated the results of this study.

Suggestions for Future Research

This study should be repeated with a randomized sample of female registered nurses employed in more than one institution. Randomization in more than one institution would allow for generalization of findings to larger segments of the nursing profession so that plans to maximize power could be made. Future

studies should plan for statistical power and estimate needed sample size to obtain statistical power in the results.

This investigator plans to exclude the nurses with previous management experience n = 24 in a future statistical analysis to determine if these study results were contaminated. Future studies should exclude staff nurses with previous management experience.

Readiness for power is a variable in one's manifestations of power. Future studies should focus on determination of readiness for power enactment in the staff nurse and on readiness for assuming management positions by staff nurses.

A question that has emerged in this study is, does the style of leadership influence perceptions of cohesion and power in the nurse? The manager and staff nurse are always in mutual process with one another. Leadership style of the manager influences the practice environment for the nurse (Scearse, 1991). Therefore, the leadership style of the immediate manager of the staff nurse should also be investigated in relation to perceptions of cohesion and power.

Finally, research is needed to further refine the Barrett PKPCT, VII to make it more valid and reliable as Barrett (1990) stated the tool appears to have "an inherent bias toward the high-frequency descriptors" (p. 167). Knowledge about the relationship of cohesion and power is a must for the profession. Studies about the relationship of cohesion and power in nurses should be examined by other instruments.

Conclusion

This descriptive study explored the relationship of cohesion and power in female registered nurses employed as staff nurses in an acute care hospital. This study was a beginning exploration of cohesion and power in the profession. The nursing literature strongly associates cohesion with power although empirical evidence linking the two is lacking. There was no statistically significant relationship found for cohesion and power in this study. The subjects' responses were highly reliable in the study. However, the sample was not large enough to achieve an r of .20 (the average r found in nursing studies) or control for statistical error with hypothesis testing (Polit & Sherman, 1990).

From the findings of this study, the investigator suggests that nurses perceive themselves to possess power as indicated by their higher scores for power. Nurses in this study were cohesive as indicated by their higher cohesion scores.

Nurses with increasing number of years in practice perceived themselves to possess less cohesion and power. The statistical correlations were low at r = approximately .20. Reasons for this finding were suggested. The investigations into cohesion and power in staff nurses must continue. Interventions to increase power in the profession are necessary for nurses to assume their role in influencing the health of the nation and their role in the advancement of the profession.

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APPENDIXES

SAMPLING DEVICES

APPENDIX A

COVER LETTER

Dear Registered Nurse:

I am pleased to invite you to participate in a research study. As a registered nurse with many years of hospital experience; I value your opinions and perceptions about your working with other nurses in the hospital setting as it relates to the decisions that you make on a day to day basis. To this end, I ask you to complete the attached surveys. The research project is to fulfill requirements for the masters of science degree in nursing at the University of Tennessee, Knoxville. The survey requires 20 to 30 minutes to complete. The information that you give will be vital in planning for the future of registered nurses.

There are no risks to the subject. Completion of the questionnaire gives consent to participate, no names are required. Participation is voluntary; refusal to participate will involve no penalty. You may withdraw from the study at any time. No personal benefits will be obtained from your participation, however, the information you give will serve to advance the science of nursing related to hospital nursing practice, specifically nursing decision making. Participation is completely anonymous and information will be kept confidential. It is essential that you complete every item on the survey. After you complete the Demographic data sheet separate it from the Group Cohesion Scale and the Barrett PKPCT, VII and place it in the letter size envelope provided by the researcher and insert it into the large manila envelope marked "**confidential**" that has been placed on your unit. Place the Group Cohesion Scale and the Barrett PKPCT, VII in the second large manila envelope marked "**surveys.**" The code numbers on the survey will serve to correlate the surveys with the appropriate demographic data when data analysis begins. Completed forms will be collected daily by the researcher in the two week data collection period. The data will be reviewed by the researcher, project director and co-director only. All data will be kept in a locked file in the researcher's home.

Thank you for taking time to complete the questionnaire. Your opinion is important, and your cooperation is appreciated. If you have any questions regarding the study, notify Rebecca Davidson at the following address:

University of Tennessee
College of Nursing
1200 Volunteer Blvd.
Knoxville, TN 37920
(615) 974-4151

Upon completion of the study I will present my findings to the nursing research group in your institution. I invite you to attend.

APPENDIX B

DEMOGRAPHIC DATA SHEET

Code # _____

Demographic Data Sheet

Please complete each question by placing a check mark in the appropriate blank space or writing in the answer.

1. Age (in years)
   20-29 ____ 50-59 ____
   30-39 ____ 60-69 ____
   40-49 ____ 70 > ____ .

2. Education preparation (check all that apply)
   ___ 1. Diploma ___ 6. non-nursing Baccalaureate (specify) _____
   ___ 2. AD ___ 7. non-nursing masters (specify) _____
   ___ 3. BSN ___ 8. non-nursing doctorate (specify) _____
   ___ 4. MSN
   ___ 5. PhD

3. Number of years in nursing practice?
   ___ less than 3
   ___ 3 to 6
   ___ 7 to 10
   ___ 11 to 14
   ___ > 15

4. What is your current specialty _____

5. Have you ever worked as an assistant head nurse or head nurse?
   _____ Yes _____ No

   If so in what capacity. _____ How many years _____
   How long ago? _____

6. Employment status
   ___ 1. full-time
   ___ 2. part-time
   ___ 3. prn

7. Shift you are presently working
   ___ 1. day shift ___ 2. evening shift 3. __night shift
   ___ 4. rotate day-evening ___ 5. rotate day-night

8. Are you a member of a professional organization? _____
   Specify organization(s)

   _____
   _____
   _____
   _____

APPENDIX C

GROUP COHESION SCALE

Code # _____

Group Cohesion Scale

The following six items ask for your opinion about your coworkers (nurses) with whom you work on your particular unit/floor or department.

1. I believe the productivity of this group is: (mark one)

   VA AA SA A SD BA VB

   VA = Very Much Above Average
   AA = Above Average
   SA = Slightly Above Average
   A = Average
   SB = Slightly Below Average
   BA = Below Average
   VB = Very Much Below Average

2. I believe the efficiency of this group is: (mark one)

   VA AA SA A SD BA VB

   VA = Very Much Above Average
   AA = Above Average
   SA = Slightly Above Average
   A = Average
   SB = Slightly Below Average
   BA = Below Average
   VB = Very Much Below Average

3. I believe the morale of this group is: (mark one)

   VA AA SA A SB BA VB

   VA = Very Much Above Average
   AA = Above Average
   SA = Slightly Above Average
   A = Average
   SB = Slightly Below Average
   BA = Below Average
   VB = Very Much Below Average

Code # _____

4. I believe the feelings of belongingness in this group are: (mark one)

VA AA SA A SD BA VB

VA = Very Much Above Average
AA = Above Average
SA = Slightly Above Average
A = Average
SB = Slightly Below Average
BA = Below Average
VB = Very Much Below Average

5. In terms of personal feelings about this group. I feel I: (mark one)

LV L LS N DS D DV

LV = Like it very much
L = Like it
LS = Like it slightly
N = Neither Particularly Like or Dislike it
DS = Dislike it Slightly
D = Dislike it
DV = Dislike it Very Much

6. In terms of working together on this unit with this group. I believe I (mark one)

LV L LS N DS D DV

LV = Like it very much
L = Like it
LS = Like it slightly
N = Neither Particularly Like or Dislike it
DS = Dislike it Slightly
D = Dislike it
DV = Dislike it Very Much

APPENDIX D

BARRETT PKPCT, VII

Code # _____

BARRETT PKPCT, VII

Check the spaces below that best reflect your feelings about your AWARENESS. Make one check for each bipolar set of words.

My AWARENESS is

profound						superficial
avoiding						seeking
valuable						worthless
unintentional						intentional
timid						assertive
leading						following
chaotic						orderly
expanding						shrinking
pleasant						unpleasant
uninformed						informed
free						constrained
unimportant						important
unpleasant						pleasant

Check the spaces below that best reflect your feelings about your CHOICES. Make one check for each bipolar set of words.

My CHOICES ARE

shrinking						expanding
seeking						avoiding
assertive						timid
important						unimportant
orderly						chaotic
intentional						unintentional
unpleasant						pleasant
constrained						free
worthless						valuable
following						leading
superficial						profound
informed						uninformed
timid						assertive

(PLEASE TURN OVER AND CONTINUE)

Code # _____

BARRETT PKPCT, VII PART 2

Check the spaces below that best reflect your feelings about your Freedom To Act Intentionally. Make one check for each bipolar set of words.

My FREEDOM TO ACT INTENTIONALLY is

timid						assertive
uninformed						informed
leading						following
profound						superficial
expanding						shrinking
unimportant						important
valuable						worthless
chaotic						orderly
avoiding						seeking
free						constrained
unintentional						intentional
pleasant						unpleasant
orderly						chaotic

Check the spaces below that best reflect your feelings about your INVOLVEMENT IN CREATING CHANGE. Make one check for each bipolar set of words.

My INVOLVEMENT IN CREATING CHANGE is

unintentional						intentional
expanding						shrinking
profound						superficial
chaotic						orderly
free						constrained
valuable						worthless
uninformed						informed
avoiding						seeking
leading						following
unimportant						important
timid						assertive
pleasant						unpleasant
superficial						profound

THANK YOU

APPENDIX E

APPROVAL FROM CLINICAL RESEARCH COMMITTEE

THE UNIVERSITY OF TENNESSEE
MEDICAL CENTER AT KNOXVILLE

• *University Memorial Hospital*
• *Graduate School of Medicine*

Office of Institutional Review Board
1924 Alcoa Highway
Knoxville 37920-6999
(615) 544-9781

August 5, 1993

Ms. Rebecca Davidson
115 Royal Heights Drive
Knoxville, Tennessee 37920

RE: **Protocol #0389 "Relationship Between Cohesion and Power in Staff Nurses in an Acute Care Hospital"**

Dear Ms. Davidson:

Your above referenced research study has been administratively reviewed and approved with the provision that an office address and telephone number be used on the questionnaire rather than a home address.

Your research application will be reviewed in one year, and you are reminded that you have individual responsibility for reporting to the committee in the event of any adverse reactions of the study.

We appreciate your informing us of this project.

Sincerely,

Joseph E. Fuhr, Ph.D.
Chairman, Institutional Review Board

JEF/tll

VITA

Rebecca M. Davidson was born in Knoxville, Tennessee on December 9, 1955. She was graduated with a Diploma in Nursing in 1979 from Fort Sanders Hospital School of Nursing. She was graduated from The University of Tennessee, Knoxville with a Bachelor of Science in Nursing degree in 1982.

Miss Davidson held various clinical positions in nursing including neonatal intensive care, psychiatric, oncology, and pediatric settings. She has held positions as staff nurse, assistant head nurse and nursing coordinator. In August 1994, she completed requirements for the Master of Science in Nursing at The University of Tennessee, Knoxville. She is a member of Sigma Theta Tau International Honor Society of Nursing.