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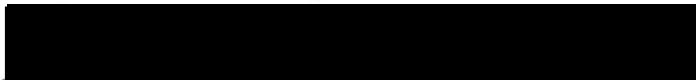
School of Nursing
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THE RELATIONSHIP OF
SEX ROLE SELF CONCEPT AND ROLE CONFLICT
IN FEMALE NURSING ADMINISTRATORS

A thesis submitted in partial fulfillment of the
requirements for the degree of Master of Science
at Virginia Commonwealth University.

by

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TABLE OF CONTENTS

	Page
LIST OF TABLES.....	vi
LIST OF FIGURES.....	vii
LIST OF ABBREVIATIONS.....	viii
ABSTRACT.....	x
CHAPTER	
1. INTRODUCTION.....	1
The Problem.....	4
Definition of Terms.....	4
Hypotheses.....	6
Assumptions.....	7
Limitations.....	8
Delimitations.....	9
Methodology Overview.....	9
2. SELECTED REVIEW OF THE LITERATURE.....	11
Introduction.....	11
Conceptual Framework.....	11
Role Conflict.....	11
Perceived Role.....	15
Self Concept.....	15
Sex Role.....	15
Female Role Socialization.....	16
Nurses and Nursing.....	16
Leaders.....	18
Interrelationships of Concepts.....	19
Literature Review.....	21
Role Conflict.....	21
Perceived Role.....	28
Sex Role, Self Concept, Female.....	28
Nurses and Nursing.....	33
Leader.....	38
Summary.....	42
3. METHODOLOGY.....	46
Introduction.....	46
Design.....	46
Subjects.....	47
Setting.....	47
Procedure.....	48
Instrumentation.....	49

Chapter 3.

Bem Sex Role Inventory	49
Reliability	51
Validity	52
Hoelzel Role Conflict Inventory	53
Authority Figures	54
Assertive Role.....	54
Multiple Roles	54
Test Construction.....	55
Reliability and Validity	56
Demographic Data	57
4. DATA ANALYSIS	58
Introduction.....	58
Results.....	58
Description of the Sample.....	58
Testing of Hypotheses.....	63
Hypothesis 1	63
Hypothesis 2	64
Hypothesis 3	65
Hypothesis 4	65
Hypothesis 5	66
Hypothesis 6	67
Hypothesis 7	67
Relationships Between Variables	68
Interpretation of Results	72
5. SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS.....	78
Summary	78
Conclusion	79
Recommendations	85
SELECTED BIBLIOGRAPHY	86
APPENDICES	
A. Bem Sex Role Inventory.....	96
B. Hoelzel Role Conflict Inventory.....	98
C. Introductory Letter to Participants	100
D. Questionnaire Instructions.....	101
E. Demographic Data	102
F. Mean BSRI and HRCI Scores for Demographic Groups of Female Administrators.....	104
VITA.....	106

LIST OF TABLES

Table	Page
1. Characteristics of the Sample: Age and Basic Nursing Education	59
2. Characteristics of the Sample: Basic Nursing Education and Highest Educational Degree	60
3. Characteristics of the Sample: Highest Educational Degree and Size of Hospital	61
4. Pearson Correlation Coefficients for BSRI and HRCI	63
5. Spearman Correlation Coefficients for Age, Education, Experience and BSRI and HRCI Ranks	65
6. Two Way ANOVA of BSRI Score, Basic Schooling and Size	69
7. Two Way ANOVA of BSRI Score, Highest Education and Size...	70
8. Two Way ANOVA of HRCI Score, Highest Education and Size...	71
9. Two Way ANOVA of HRCI Score, Sex Role Self Concept and Size.....	72
10. Mean BSRI and HRCI Scores for Demographic Groups of Female Administrators.....	104

LIST OF FIGURES

Figure	Page
1. Variables Influencing Role Conflict	77

LIST OF ABBREVIATIONS

AD.....	Associate Degree in Nursing
AD/Dip.....	Associate Degree and Diploma combined
A/DIP.....	Associate Degree and Diploma combined
ADM	Administrative title
BACC	Baccalaureate degree, i.e., BSN or BSO
BSN.....	Bachelor of Science in Nursing
BSO.....	Bachelor of Science not in Nursing
BSRI.....	Bem Sex Role Inventory
DEPT.....	Department head title
df.....	Degrees of Freedom
DIP	Diploma in Nursing
EDUC	Education
EXPER	Experience
F.....	F-ratio in analysis of variance
FEM/Fem ...	Feminine
GRAD	Graduate degree, i.e., MSN, MSO, PhD.
HOSP.....	Hospital organization membership
HRCI.....	Hoelzel Role Conflict Inventory
M/PHD	Masters and Doctoral degrees, combined, e.g., MSN, PhD.
MASC/Masc.	Masculine
MAST.....	Masters degree, i.e., MSN, MSO
ms	Mean of Squares
MSN.....	Masters of Science in Nursing
MSO.....	Masters of Science not in Nursing
N	Number

NSG.....Nursing organization membership

p.....Probability value

PHD.....Doctoral Degree in Nursing

r.....Correlation coefficient

sd.....Standard Deviation

ss.....Sum of Squares

UNDERGR..Undergraduate degree, i.e., AD, DIP, BSN, BSO

\bar{X}Arithmetic mean

Abstract

THE RELATIONSHIP OF SEX ROLE SELF CONCEPT AND ROLE CONFLICT IN FEMALE NURSING ADMINISTRATORS

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Medical College of Virginia - Virginia Commonwealth University, 1983.

Major Director: Dr. Sarah S. Strauss

This study investigated the relationship between the sex role self concept of female nursing administrators and the role conflict they experienced. The correlation of age, education and experience with sex role self concept and role conflict was examined. This was a descriptive survey with a purposive probability sample of 126 subjects from three mid-Atlantic states. A mail survey resulted in a useful return of 88 questionnaires, including 81 females.

The Bem Sex Role Inventory was utilized to measure sex role self concept; masculinity and femininity are viewed as two independent dimensions present in every individual. Role conflict was measured by an investigator developed tool designed to examine internal role conflict associated with socialization as a female and nurse while occupying an administrative position.

Masculine self concept, not feminine, had a significant relationship to role conflict. Education was significantly correlated with sex role self concept and role conflict, while age and experience were not. Education had a positive relationship with masculine self concept which was inversely related to role conflict. Size of hospital had a significant inverse relationship with role conflict.

Chapter 1

INTRODUCTION

With no apology to the two percent of men involved, nursing is a woman's profession. From early history, women have been expected to provide care and nurturing to the sick. Nursing continues to be viewed as most appropriate for females, and society's perceptions of nursing are closely associated with their perceptions of women. Women and nurses are considered to be less independent, less capable of initiative and less creative than men and physicians, and in need of masculine guidance (Ashley 1976).

According to results of a survey conducted in 1977 by the American Society for Nursing Service Administrators, ninety-four percent of nursing administration positions were held by women. The female nursing administrator has been socialized as a woman and as a nurse. The managerial role, however, requires abilities such as assertiveness, self reliance, and achievement orientation, traits often associated with men (Krueger 1980). Female nurses in managerial positions requiring male managerial traits may experience role conflict.

"Conflict faces the would-be career woman, for the core of attributes found in most professional and occupational roles is considered to be masculine" (Epstein 1970:22). Management and

psychological research clearly indicates that stereotyped female sex role characteristics and leadership characteristics are not congruent (O'Leary 1974; Schein 1973, 1975).

Sex-roles are culturally determined and influence all aspects of life. For example, little girls receive dolls to play with and are expected to help with household duties, while little boys receive balls and bats and are expected to mow the lawn. When the child enters school, sex role stereotypes are generally reinforced. Women in textbooks have been generally portrayed as timid, inactive, not ambitious, and intellectually inferior to men (Weitzman 1982). Guidance counselors often channel girls into more "feminine" subjects while encouraging boys to pursue the sciences and mathematics. High school girls often feel they have to conceal their intelligence in order to be popular with boys. Weitzman (1982) reports that peer influences in college continue to support sex role stereotypes. The effects of sex role perceptions often operate on a subconscious level and persons may not be aware that the basis for actions or reactions are a subconscious sex role stereotype.

Stereotypes are easy classification systems held in common by members of a group that represent an oversimplified opinion or uncritical judgment. Women are stereotyped as passive, dependent and emotional, and men are stereotyped as active, aggressive, and instrumental (Weitzman 1982). In addition, lower self esteem is associated with women who have a traditional female role concept rather than a nontraditional concept (Lasky 1982). Society has not valued

female characteristics to the same degree as male characteristics and therefore women have been afforded a second-class status.

Nursing literature has identified the critical need for highly skilled and influential nursing leaders and administrators (Kinsella 1977; Krueger 1980; Leininger 1974). LeRoux (1976) suggested that a possible explanation for the lack of influential women in the health care system as a whole stemmed from the structural barriers of sex role stereotyping. Given the need for influential nursing leaders, one wonders if women socialized to traditional female sex roles can fill this need.

If the self concept of the female nursing administrator includes female and nursing stereotypes (e.g., submissive and dependent) and does not include masculine leadership stereotypes (e.g., assertive and independent), the self concept may create a barrier to the woman's success in administration. If the social expectations for sex-appropriate behavior are in opposition to professional expectations for leader-appropriate behavior, role conflict may also present a barrier to success. The extent of this sense of conflict between one's sex role and the managerial-role needs to be examined. Research has not addressed the sex role self concept of the female nursing administrator and its relationship to role conflict. As LeRoux (1976) says, "we must consider how much stereotyping has affected our motivation to achieve and our initial credibility in leadership positions." Therefore, this study investigated the sex role self concept of nursing administrators and the degree of role conflict they experienced.

The Problem

The research questions posed in this study were:

Is there a relationship between the nursing administrator's sex role self concept and the degree of role conflict experienced as a nursing administrator? Is the relationship between sex role self concept and extent of role conflict influenced by age, education or length of administrative experience?

Definitions of Terms

For the purpose of this study, the following terms were defined:

1. Sex-role Self Concept. Rogers (1951) states that self concept is composed of the individual's own perceptions of her/his characteristics and abilities and these perceptions and concepts in relation to others and to the environment. The sex role consists of behaviors and characteristics society considers appropriate for males and females (Heilbrun 1981). The sex role self concept would include the individual's perceptions of the appropriate behavior, characteristics, and abilities for their biological sex. Sex-role self concept was measured by a self administered adjective rating scale designed to treat femininity and masculinity as two independent dimensions (Appendix A). The Bem Sex Role Inventory allowed subjects to receive both masculine and feminine scores and did not preclude the

possibility of a concurrent high-level endorsement of feminine characteristics and masculine characteristics. Subjects' raw scores could be categorized as androgynous (high scores on both feminine and masculine dimensions), undifferentiated (low scores on both feminine and masculine dimensions), feminine (high score on the feminine and low score on the masculine dimension) or masculine (low score on the feminine and high score on the masculine dimension). Standardized score differences were utilized to indicate if subjects were sex typed or sex reversed. Scores above neutral indicated femininity and scores below neutral indicated masculinity (Bem, 1981).

2. Role Conflict. Katz and Kahn (1978) define role conflict as the simultaneous occurrence of two or more role expectations such that compliance with one would make compliance with the other(s) more difficult. Role conflict was measured by an investigator-designed questionnaire which attempted to measure internal psychological role conflict associated with socialization as a female and nurse while occupying an administrative role.

3. Nursing Administrator. The nursing administrator is traditionally responsible for planning, organizing, directing, coordinating, and evaluating the activities of the nursing staff and department. For the purpose of this study, the nursing administrator was the one registered nurse in a hospital employed on a full-time basis, responsible for the management of the nursing department and accountable to the chief executive officer or Board of Trustees.

4. Age. On the questionnaire, chronological age in years was classified into mutually exclusive ten-year periods, e.g., 20 to less than 30, etc.

5. Education. Education was considered the highest level of formal education attained according to the following divisions: associate degree in nursing, diploma in nursing, bachelors degree (specify in what field), masters degree (specify in what field), or doctorate (specify in what field).

6. Length of Administrative Experience. The total number of years in the nursing administrators role was grouped into mutually exclusive five-year periods, e.g., less than 5, 5 to less than 10, etc.

Hypotheses

The following hypotheses were tested:

1. Female nursing administrators with a feminine sex role self concept will experience more role conflict than female nursing administrators whose sex role self concept is less feminine.

2. There will be an inverse relationship between age and degree of femininity as measured by the Bem Sex Role Inventory.

3. There will be an inverse relationship between age and degree of role conflict as measured by the Role Conflict Inventory.

4. There will be an inverse relationship between education and degree of femininity as measured by the Bem Sex Role Inventory.

5. There will be an inverse relationship between education and degree of role conflict as measured by the Role Conflict Inventory.

6. There will be an inverse relationship between administrative experience and degree of femininity as measured by the Bem Sex Role Inventory.

7. There will be an inverse relationship between administrative experience and degree of role conflict as measured by the Role Conflict Inventory.

Assumptions

The basic assumptions underlying this study were as follows:

1. Nursing administrators were honest in completing the test instruments.

2. Nursing administrators completed the test instruments for themselves.

3. The nursing administrator role was a managerial role which required masculine characteristics and behavior.

4. Subjects did not communicate with each other about the test instruments.

Limitations

The investigator acknowledges the following limitations of this study:

1. There was no possibility of establishing a causal relationship between sex role self concept and role conflict.

2. There was no control for the effect of variables which may have affected the subjects' responses on the test instruments, such as life experiences, home-life situations, or personality characteristics.

3. There was no control over who returned the survey, therefore, it was possible that a certain group or type of respondent was more likely to reply, resulting in a selection bias. This limited the generalizability of the study.

4. There was no control for low return of mailed survey questionnaires; a small sample size limited generalizability.

5. There was no control for extraneous variables such as when the survey was completed or where it was completed.

6. There was no reliability and validity established for the Role Conflict Inventory.

Delimitations

1. Subjects were selected by a purposive probability sample. Systematic sampling was used to select the nursing administrator from every third hospital in Maryland, Virginia, and North Carolina listed in the 1982 American Hospital Association Hospital Guide, for a total of 126 subjects.

2. Extraneous variables such as age, education, and length of administrative experience were incorporated as independent variables.

3. Subjects were exposed to the same instructions and introduction to the instruments. These were pilot-tested before use.

4. The surveys were all mailed at the same time, ensuring that all subjects received the questionnaire at approximately the same time.

5. Subjects were assured anonymity, thereby increasing the likelihood of participation.

Methodology Overview

The study was a descriptive survey with a purposive probability sample of 126 subjects. Self administered questionnaires were collected from November, 1982 to January, 1983 from nursing administrators in hospitals in three mid-Atlantic states. The questionnaire included demographic data, the Bem Sex Role Inventory and the Role Conflict Inventory.

Data gathered from the returned questionnaires were summarized into descriptive and inferential statistics. Means or medians for age, educational level, length of experience, and scores of the Bem Sex Role Inventory and Role Conflict Inventory were computed.

The Pearson product moment correlation coefficient was used to test the relationship between the feminine scale scores on the Bem Sex Role Inventory for female nursing administrators and their Role Conflict Inventory scores. The Spearman rank correlation coefficient was used to test the significance between age, education, experience, and the feminine scale scores on the Bem Sex Role Inventory. This same procedure was used to test the relationship between the Role Conflict Inventory score and age, education, and experience.

Chapter 2

SELECTED REVIEW OF THE LITERATURE

Introduction

The framework for this study included the following concepts: role conflict, perceived role, self concept, sex-role, female, nurse, and leader. Each concept was developed and interrelationships examined. After a discussion of this conceptual framework, a review of selected literature relevant to the research problem is presented.

Conceptual Framework

Role Conflict

Role conflict has been defined by Katz and Kahn (1978) as occurring when two or more role expectations transpire so that compliance with one makes compliance with the other(s) more difficult. Clarification of several terms is necessary to establish the dimensions of role conflict. Role includes both the expected and actual behavior and attributes associated with a position (Hardy 1978, Hunt 1976). Role expectations are the "position-specific norms that identify the attitudes, behaviors, and cognitions that are required and anticipated for a role occupant" (Hardy 1978:76). Individuals associated with the person or position under consideration, and who have role expectations

about the person or position comprise the role set (Hardy 1978 , Kahn et al 1981). Role expectations are in the minds of members of the role set. These expectations do not remain there, but are communicated to the focal person. The sent role is the expected role activity communicated by the members of the role set to the focal person (Kahn et al 1981). The focal person's perceptions and cognitions of the sent role are the received role (Kahn et al 1981). Role pressures are the various influence attempts directed at the focal person and "intended to bring about conformity with the expectations of the senders" (Kahn et al 1981:15).

The position of nursing administrator interacts with various groups within the hospital situation, and each group has their expectations concerning the behavior of the person in the position. For the nursing administrator, the role set might include employees and colleagues in the nursing department, management colleagues in other departments, administrative personnel, physicians, patients, family and close friends. Each member of the role set has expectations for the nursing administrator. For example, the nursing staff may expect the nursing administrator to negotiate assertively for higher wages for nurses while administration may expect the nursing administrator to accept passively a set budget and convince the nurses to accept their current wage rate. Both groups communicate their expectations to the nursing administrator along with the message that they anticipate their expectations will be met. Because both expectations can not be complied with at the same time, the nursing administrator experiences role conflict.

There are several types of role conflict: 1) intra-sender, 2) inter-sender, 3) inter-role, and 4) person-role conflict. Intra-sender conflict results when conflicting expectations are sent from a single member of the role set (Kahn et al 1981). For instance, the hospital administrator may expect a department manager to be a strong and assertive leader while also expecting female behavior to be passive and submissive. If the head of the nursing department is female, the expectations from the hospital administrator may be conflicting.

The second type of role conflict, inter-sender conflict, occurs when the focal person is sent opposing pressures from two or more members of the role set (Kahn et al 1981). An example of inter-sender conflict occurs when a hospital administrator expects the nursing administrator to exert close supervision over subordinates and the subordinates pressure the nursing administrator for looser supervision.

Inter-role conflict, the third type of conflict, results when the focal person is a member of two groups that exert conflicting pressures (Kahn et al 1981). Inter-role conflict for the nursing administrator might occur when the demands for overtime and take-home work conflict with demands at home to devote attention to family affairs.

The final type of conflict presented is a combination of sent pressures and psychological forces. This fourth type is called person-role conflict (Kahn et al 1981) and exists when there is a conflict between the needs and values of a person and the demands of the role set. An example of person-role conflict would be when the needs of

a female nurse to excel as a nursing administrator leads to behavior which is unacceptable to members of her role set who expect her to behave as a stereotypic female. This is similar to role incongruity (Hardy 1978) which is defined as occurring when expectations for role performance run counter to the person's self perception, disposition, attitudes, and values. For instance, role incongruity occurs when a nurse considers herself to be altruistic while filling an administrative position that focuses on budget, coordinating activities of others, and record keeping (Hardy 1978).

All of these types of role conflict are similar in that in each, members of the role set exert pressure to change the behavior of a focal person. Various members of the role set may hold conflicting expectations for the focal position. These expectations are sent to the focal person and pressures are exerted for conformity to these expectations.

The individual to whom the role pressures are sent, has her/his own self-sent role expectations and perception of the sent role (received role). The focal person experiences role forces created by the role pressures associated with the sent role, self-sent role, and received role. Role conflict will be experienced when any of these role forces oppose one another. The intensity of a person's role conflict will depend on the strength of the role forces in action. The more nearly equal in strength the two conflicting role forces, the greater the conflict.

Role conflict can emanate from the environment of the focal person as external pressures and/or in her/his psychological life as internal forces (Kahn et al 1981). Although the types or sources of role conflict may differ, the critical ingredient is always present: the focal person is met with role expectations that are mutually exclusive and therefore are unachievable.

Perceived Role

Self-concept. A person's self concept is made up of

"perceptions of one's characteristics and abilities; the percepts and concepts of the self in relation to others and to the environment, the value qualities which are perceived as associated with experiences and objects; and goals and ideals which are perceived as having positive and negative valence" (Rogers 1951:136).

The knowledge of self begins with the interaction between the infant and the mothering figure and continues to grow and change throughout the various stages of childhood and adult life. The self is forever changing and responding to interactions with people and the environment. Self-concept becomes the most significant determinant of response to the environment (Rogers 1951). Each individual has a unique self concept.

Sex-role. A person's sex has a major influence on her/his self concept (Burns 1979). Sex roles developed by society communicate what behavior is expected and acceptable for males and females (Heilbrun 1981). Sex role stereotypes for females include characteristics such as yielding, warm, tender, shy, sensitive and gullible; while masculine traits include aggressive, ambitious, analytical, competitive and forceful (Bem 1974).

Female Role Socialization. Women are raised to fill the roles society's stereotyped images have fashioned for them. Socialization begins at birth and even newborn babies are given reinforcement for appropriate behavior (Weitzman 1982). The differential treatment afforded males and females leads to the development of females that are dependent, affiliative, love and approval-oriented, who underestimate their own skills and abilities (Lasky 1982). These stereotyped sex roles are learned and they are difficult to unlearn. They are still accepted by most of our society even in this age of equality (Bem and Bem 1971, Lasky 1982).

"The ideology has become nonconscious. We remain unaware of it because alternative beliefs and attitudes about women go unimagined. We are like the fish who is unaware that his environment is wet" (Bem and Bem 1971:85).

Females grow up being told that they are socio-emotional submissive beings, opposite of males, and that male traits are more socially desirable (LeRoux 1976).

Nurses and Nursing. Nursing as a female profession is often characterized with the same terms used to describe women (Muff 1982). Women have always taken care of the sick; women filled the nurturing role in society, therefore it was considered natural that they take care of the sick. The profession of modern nursing started during Victorian times and the ideas and biases of those times played a decisive role in shaping the education of nurses and the role of the nurse (Ashley 1976). The socialization process for the nurse has emphasized characteristics that society considered appropriate for women and, therefore, nurses (Lowery-Palmer 1982).

The role of nurse is typically thought of in terms of the female in the home. The hospital is conceptualized as a household and nurses are expected to manage and coordinate the activity so that all needs of the different members of the hospital family (doctors and patients) are met (Ashley 1976). Nursing administrators often take "wifelike" actions and attitudes toward male hospital administrators such as acquiescing to the head of the hospital on fiscal matters, much as the housewife asking for household money to replace the refrigerator (Cleland 1971).

Not only are nurses thought of and expected to play a feminine role, but the educational experience of nurses often stresses the same stereotypically feminine characteristics. The learning process for nurses was first organized around an apprenticeship model. Apprentice nurses were socialized to be obedient and docile and to expect discipline (Ashley 1976, Lowery-Palmer 1982). The educational environment today retains elements of the apprentice programs. Teaching methods often emphasize course content and memorization of facts rather than the nursing process which emphasizes problem solving and the nature of interpersonal relationships (Lowery-Palmer 1982). In the work situation, nurses are more often rewarded for performing tasks in accordance with policies and procedures, than for innovative and creative problem solving (Lowery-Palmer 1982). The result of all these influences is that the self concept of a nurse is composed of messages which say that it is most appropriate to be caring, tender, warm, dependent, loyal, obedient, and yielding. These are not adjectives which best describe the characteristics of managers or leaders.

Leaders. There are many definitions of leader; sometimes "leader" and "manager" are considered interchangeable (Cribbin 1981), other times they are considered separate concepts (Zaleznik 1977). Leaders are expected to be autonomous, independent risk-takers with the ability to communicate, make decisions and organize effectively (Ruiz 1982). Managers plan and organize, direct and coordinate, control and review; they "lead their people so as to stimulate them to do willingly" and in an acceptable manner the work of the organization (Cribbin 1981). Zaleznik (1977) considered the question of difference in managers and leaders, and concluded that managers and leaders are different kinds of people with different motivations, personal histories, and processes of thinking and acting. He stated that managers are problem solvers, persistent, tough minded, intelligent, and organizationally goal directed. Leaders develop fresh approaches to problems and are disposed to seek out risk and danger. Leaders feel separate from their environment and although they may work in organizations, they never belong to them (Zaleznik 1977).

Hersey and Blanchard (1977) considered the role of leader to be broader than that of manager. A leader attempts to influence behavior of an individual or group whereas a manager attempts to influence so as to accomplish organizational goals. While the concepts are considered to be separate, one individual may be both a manager and a leader. The Situational Leadership Theory developed by Hersey and Blanchard (1977) suggests that different leadership styles are needed depending on the maturity of the followers. Effective leaders carrying out managerial duties must adjust their leadership style to fit the maturity level of

their followers. Hersey and Blanchard (1977) suggest that leadership style is composed of two behavior styles, relationship behavior and task behavior. A leader who adopts relationship behaviors would be more concerned with person related issues, would have a more supportive, considerate, emotional style. With a task behavior emphasis, the leader would be more goal directed, work related and instrumental in style.

Even with different leadership styles and behavioral emphasis, certain characteristics are universally accepted as appropriate for a leader/manager. Leader/managers are expected to be independent, able to take charge, make decisions, plan effectively, and take disciplinary action. These characteristics of the leader/manager are compatible with male traits but not with female traits.

Interrelationships of Concepts

A female nurse in the role of nursing administrator is confronted with conflict situations. According to Rogers' (1951) Self-Theory, when social expectations are not compatible with personal values, the potential for conflict is created. This type of conflict corresponds to the concept of person-role conflict (Kahn et al 1981) where there is a discrepancy between the needs and values of a person and the expectations of the role set.

The stereotyped image of the female nurse is composed of traits such as shy, submissive, and a tender socio-emotional being, while

expectations for persons in a leader/manager position include competent, aggressive, tough, forceful and ambitious. Role conflict would result when these conflicting expectations come together in and around the person of a female nurse in a leader/manager position.

The type of conflict would depend upon how much the stereotyped image of female nurse and leader/manager is accepted by the female nurse administrator and members of her role set. The degree to which stereotypes are accepted and how much the administrative position required leader/manager behavior would influence the amount of conflict experienced by the nursing administrator.

Other variables that could modify the degree of role conflict include age, education, and length of experience. With age, an individual has time to evaluate the truth and applicability of learned stereotypes. Education exposes individuals to new ideas and knowledge with which to question stereotypic concepts. Length of experience also allows the individual more time and opportunity to examine the acceptance of stereotypes. Therefore any, or a combination of these variables could influence the nursing administrator's sex role self concept and her degree of role conflict.

Literature Review

Role Conflict

In any complex social system involving interdependent and interrelated positions, where people occupy many roles at the same time, there is a high probability for confusion and conflict. People have expectations for themselves and others, often these expectations are not compatible and role conflicts result.

The first of three studies in this section on role conflict illustrates that sex role self concepts are associated with role conflicts (Deutsch and Gilbert 1976, Gordon and Hall 1974, Holahan and Gilbert 1979). The studies by Brief et al (1979) and Arndt and Laeger (1970A &B) indicate that role conflicts are experienced within nursing and by nursing administrators. The last two studies (Bedeian and Armenakis 1981, Powell and Reznikoff 1976) demonstrate the personal and organizational consequences of role conflict.

The relationships of self-image, satisfaction and happiness to role conflicts and coping behavior were studied by Gordon and Hall (1974). The subjects, married women with a college education (N=229), rated their own self-image, their image of a feminine woman, and what they perceived to be the average man's image of a feminine woman. There was no significant correlation between sex role self-image and the existence or non-existence of conflict as such. The item most commonly associated with conflict was the woman's perception of the male's image of a

feminine woman. If a woman believed men felt women should be less assertive and independent and more emotional, then she experienced more conflict in the home versus nonhome role. About one-fourth of the sample reported no conflict, but when conflict was identified, it was usually between home role and a nonhome role. The most common source of pressure was the home role.

In Gordon's and Hall's sample, women who worked perceived a greater discrepancy between their own image of a feminine woman and their perception of a man's ideal woman than women who did not work outside of the home. Working women attributed men with a traditional stereotype of women. Gordon and Hall said that the "findings suggest that in more male dominated environments outside the home, the man's standards of femininity may create difficulties for women" (Gordon and Hall 1974:243). Considering the fact that hospital administrators and physicians are predominantly male, the female nursing administrator may be subject to the same difficulties.

Adjustment and sex role perceptions were examined in a study by Deutsch and Gilbert (1976). A group of male (N=64) and female (N=64) college students identified perceptions about real self, ideal self, ideal other sex and belief about the other sex's "ideal other sex." Adjustment was measured in terms of submissiveness and emotionality.

Results for females showed a slightly feminine real self, an androgynous ideal self, an androgynous ideal other sex, and a highly feminine belief about the other sex's "ideal other sex." Males reported

a slightly masculine real self and ideal self, a slightly feminine ideal other sex, and a slightly masculine belief about the other sex's "ideal other sex." There was no significant difference between the males' belief (slightly masculine) and the females' ideal other sex (androgynous), but there was a large significant difference between the females' belief (highly feminine) and the males' ideal other sex (slightly feminine). The scores within each sex showed women's sex role concepts of real self, ideal self, and their belief of the other sex ideal were highly dissimilar, while the males' sex role concepts were highly similar.

Results of the Deutsch and Gilbert (1976) study concerning adjustment and sex typing indicated females had a significantly poorer adjustment score than males on both scales used. Among females, those with androgynous scores had better adjustment scores than females with highly feminine scores. Among males, subjects with highly masculine scores showed higher adjustment scores than the androgynous males. This finding was contrary to the hypothesis of the Deutsch and Gilbert study. It was suggested that in a male oriented culture, men are more comfortable with being masculine, but have difficulty incorporating characteristics that are considered feminine. Women, on the other hand, are more comfortable adopting masculine characteristics as shown by the higher adjustment scores for androgynous women.

The discrepancies illustrated between the woman's real self, ideal self and belief about what the other sex desires, suggests a source for role conflict similar to Kahn's (et al 1981) person-role conflict. It

also lends some support to the suggestion by Gordon and Hall (1974) that the male standard of femininity may pose problems for women. In a male oriented environment, the female who adopts masculine traits to succeed might experience conflict if she believed males wanted her to be more feminine.

A study of inter-role conflict by Holahan and Gilbert (1979) supported the Gordon and Hall (1974) findings concerning conflict and home roles. Four major life roles: worker, spouse, parent, and self as a self actualizing person, were examined in a group of married college graduate mothers (N=41) engaged in career and noncareer "just a job" employment. The noncareer group experienced more role conflict than the career group, and especially in the roles of parent and spouse. The career group had significantly greater commitment to work than the noncareer group, and also received more emotional support from their spouses. Results suggest that spouse support may be critical to the reduction of role conflict in the career working married woman (Holahan and Gilbert 1979). The career group in the sample reported significantly greater life satisfaction from both work and self than the noncareer group. These findings suggest that when married female nursing administrators are committed to their careers and do not consider their position "just a job", role conflicts may be offset by a greater sense of personal fulfillment and satisfaction from work.

Role conflict experienced by registered nurses (N=117) employed by hospitals in staff nurse positions was studied by Brief et al (1979). It was hypothesized that role stress would vary according to type of

basic nursing education. It was also predicted that staff nurses experiencing role stress would also show less job satisfaction. Results indicated that task activity did not vary by education, but role stress did vary significantly. Baccalaureate nurses showed more conflict and ambiguity than nurses from diploma or associate degree programs. Role conflict and ambiguity both had a significantly negative relationship with satisfaction. Length of tenure did not moderate the effects of role stress. The findings of this study suggested that if educational socialization was incongruent with the role requirements as defined by the employing organization, then role stress occurred and was not improved over time (Brief et al 1979). These results raise the question that if educational programs affect stress on the staff nurse level, will it also be present when these nurses are in administrative positions.

In a study of hospital directors of nursing service (N=47), Arndt and Laeger (1970A & B) examined the nursing administrator position to determine if it constituted a diversified role set and to look at the position's relationship to role strain. A diversified role set was defined as a position that required maintenance of relationships with a number of diverse role-senders groups. Strain was subdivided and measured as role conflict and role ambiguity.

The results of the study indicated that the directors position was indeed a diversified role set. The position was influenced by and required interaction with four major classes of role senders: 1) administrative superiors, 2) colleagues (other department heads),

3) nursing colleagues and supervisors, and 4) significant others (doctors, patients, families, etc.).

The data indicated no statistically significant correlation between role strain and age or educational level of the director. Although the relationship was not significant, the authors said there was an indication that directors of large hospitals (over 250 beds) experienced more job strain than directors of smaller hospitals (Arndt and Laeger 1970A). The authors said there was a "slight trend" which suggested that those directors 40-49 years of age experienced less strain. Again, even though not statistically significant, there was some suggestion that the longer a director worked in a particular hospital the less strain was experienced (Arndt and Laeger 1970A).

In scrutinizing the types of strain experienced by directors in this study results showed that nearly all subjects were confronted with inter-sender conflicts. Conflicts between job and family roles were experienced by nearly 70% of the sample. Role overload was another type of conflict reported by almost all respondents and person-role conflicts were described by about 80% of the subjects. The role conflicts experienced by the directors are of concern because common reactions to conflicts and its associated tensions and strain are often dysfunctional to the hospital organization and self-defeating for the person in the long run (Arndt and Laeger 1970B).

Powell and Reznikoff (1976) conducted a study of role conflict and symptoms of psychological distress such as nervousness, insomnia,

feelings of impending nervous breakdown, or psychiatric hospitalization. The subjects for the study were two groups of women college graduates (N=136 and 132) from classes separated by 15 years. Overall, the recent graduates had significantly higher numbers of symptoms, a higher need for achievement, and a contemporary rather than a traditional orientation.

Results indicated that women with a contemporary orientation exhibited significantly higher symptom scores than those subjects with a traditional orientation. The increased number of symptoms experienced by women with contemporary orientation suggests that stress and its associated symptoms accompany conflict between personal needs and cultural role expectations. This is similar to the type of conflict described as person-role conflict by Kahn et al (1981).

When looking at doctorally prepared women of the earlier class, there was no significant difference in symptoms between those employed doctoral-level women and other employed women. However, in the younger class group, the doctorally prepared women employed full time had significantly higher symptom scores than other full time employed women of that class. This may suggest that stresses associated with establishing oneself in a professional career while dealing with family responsibilities continue to be problematic in a society that views the role of women to belong in the home and not in following a career (Powell and Reznikoff 1976).

Another study investigating the consequences of role conflict and ambiguity was conducted by Bedeian and Armenakis (1981). The subjects (N=202) were nursing department employees in a large hospital, and 57% were female. Each subject was assessed for role conflict and role ambiguity, tension, propensity to leave the organization and satisfaction. Results showed that conflict and ambiguity both have high levels of association with job induced tension, and are directly related to low levels of job satisfaction. Results confirmed the importance of job satisfaction on the propensity to leave the organization. Based on these results, it appeared that reduced job ambiguity and job conflict reduced tension, increased job satisfaction and decreased an employee's propensity to leave (Bedeian and Armenakis 1981).

These previous two studies of role conflict indicate that the negative consequences of conflict can be person related in the form of psychological symptoms, or job related through dysfunctions such as dissatisfaction, tension, and propensity to leave the organization. If similar negative consequences operate when nursing administrators experience role conflict, this suggests that role conflict may be a barrier to effective job performance.

Perceived Role

Sex Role, Self Concept, Female. Society, through the socialization process, specifies certain behaviors as acceptable and expected. Sex roles are the "constellation of qualities an individual understands to characterize males and females in his culture" (Block 1973:512).

The development of a sex role identity is influenced by anatomy, history, and personality, and this identity has considerable influence on the individual's behavior and self-evaluation (Block 1973). Women are "trained to model themselves after the accepted image" and to fulfill the expectations held by society for women (Freeman 1971:124). It is expected that women will behave differently from men. In order to understand why women behave the way they do, one must understand how women have been socialized. In order to understand how women have been socialized, one must understand how they see themselves and how they perceive that others see them. The process is self-perpetuating. A nonconscious ideology (Bem and Bem, 1971) in which alternative behaviors are inconceivable, becomes the standard for acceptable behavior and socialization.

Women, in comparison with men, were described as submissive, less independent, less adventurous, more easily influenced, less aggressive, less competitive, more excitable in minor crises, having their feelings more easily hurt, being more emotional, more conceited about their appearance, less objective and disliking math and science (Broverman et al 1970). These were the characteristics identified by male and female clinical psychologists, psychiatrists, and social workers (N=79) when asked to describe a mature, healthy, socially competent adult woman!

The characteristics identified as a healthy adult male and a healthy adult were not significantly different, whereas a marked difference did exist between concepts of health for adults and females. The male and female clinicians identified masculine traits (aggressive,

independent, objective, dominant, competitive, logical, and a leader) as more socially desirable than female traits. These results confirmed data obtained earlier from college students that characteristics of a healthy adult are strongly related to characteristics of social desirability. The study concluded that

"for a woman to be healthy from an adjustment viewpoint, she must adjust to and accept the behavioral norms for her sex, even though these behaviors are generally less socially desirable and considered to be less healthy for the generalized competent mature adult" (Broverman et al 1970:6).

In the light of the growth of the women's liberation movement, Kravetz (1976) investigated sex role self concept of women. Using a questionnaire consisting of items used in the Broverman study, women were asked to describe a healthy adult man, healthy adult woman, and themselves. The subjects (N=150) were members of social and political groups at a university, and half considered themselves to be active members of the women's liberation movement. In this study descriptions of women and men by both women's liberation members and non-members did not conform to sex role stereotypes, and traits that were socially desirable were used most frequently to describe both sexes. The traits that represented healthy men and women in this study corresponded to traits identified as healthy and as socially desirable in the Broverman et al (1970) study. The sample of women belonging to the women's liberation movement identified a healthy adult woman as more masculine than did women not members of the liberation movement. But generally, women of both groups did not accept the stereotyped view of women; the ideal woman was seen in more masculine terms.

In the two studies cited, the tool to measure sex role concept assumed that masculinity and femininity represent a single bipolar dimension. There is no evidence presented as to the accuracy of this assumption.

In order to counteract the assumption of a bipolar male-female dimension, Bem (1974) developed a sex role inventory that treated masculinity and femininity as two independent dimensions. This enabled the person to be both assertive and passive, both analytical and emotional, depending on the situation (Bem 1974). In a later study (N=54), Bem demonstrated that androgynous subjects of both sexes displayed more sex role adaptability across situations (Bem 1975). In another study (N=84) (Bem et al 1976) it was shown that masculine males were lower in nurturance than androgynous or feminine males. For women, the same patterns appear, androgynous women are high in independence and nurturance; feminine women were low in independence and masculine women were low in nurturance. The results from this study indicate that for both men and women, sex typing perceptions appear to restrict behavior in the instrumental or the expressive domain (Bem et al 1976).

A longitudinal study of sex role attitudes of women (N=1161) conducted from 1962 to 1977 showed tremendous shifts toward more egalitarian sex role attitudes (Thornton and Freedman 1979). Results showed the shift was more apparent for global items concerning role segregation and division of authority within the home, than for more specific aspects of role specialization, such as sharing housework or legitimacy of nonhome activities. Women with more education, who were

younger, had better educated husbands and who were working in 1962 were more likely to adopt egalitarian sex role attitudes. Women with large families who were fundamentalist Protestants tended to retain traditional sex role attitudes. This study, along with the evidence from the Kravetz (1976) study, suggests that sex role attitudes may be changing.

A study (N=185) conducted by Dreyer (et al 1981) to validate a tool to measure women's sex role orientation, found that education and employment experience were significant determinants of sex role attitudes. Age and age at first marriage also appeared to be influential in an indirect sense. The critical influence of education in sex role attitudes reported in this study supported the Thornton and Freedman (1979) study.

The relationship of sex-oriented occupations to personnel selection decisions was investigated by Cohen and Bunker (1975). Male job recruiters (N=150) evaluated applicants for positions which were considered to be sex linked occupations. Application blanks and interview transcripts contained identical information except for the first name of the applicant which varied by sex. Results showed that females were considered significantly more acceptable for female oriented jobs than for male oriented jobs, and males were considered more acceptable for male oriented jobs than female oriented jobs. This study suggests that sex discrimination may occur at the initial stages of job selection process (Cohen and Bunker 1975).

In a similar study (N=100), Zikmund et al (1978) found evidence supporting the findings of Cohen and Bunker (1975) that sex discrimination for employment still exists in traditionally male occupations. If a female and male are applying for an administrative position, and if the recruiter perceives the administrative position as masculine, these two studies suggest that females may experience discrimination in the selection process. It has not been demonstrated if selection discrimination occurs in nursing. Nursing is perceived as a feminine occupation, but the top management position may be perceived as a masculine position. Evidence which might support the occurrence of leadership selection discrimination in nursing is the over representation of men in supervisory and administrative positions (Flanagan 1982).

Nurses and Nursing. Nurses as females have been socialized to accept feminine behaviors and characteristics. From the evidence of the Kravetz (1976) and Thornton and Freedman (1979) studies, there is an indication that sex role self concepts of women may be changing to include more masculine socially valued traits and more egalitarian sex role attitudes. Whether this trend will continue or spread is not known.

The self concept of nurses has often been examined through studies of nursing students. Stromborg (1976) examined the relationship between the sex role identity of nursing students and their image of nursing. In this study, the image of nursing was defined as the image advanced by nursing as an organized profession: the image that sets the pace for

standards of practice and of education. Female senior nursing students (N=430) representing baccalaureate, associate and diploma programs were surveyed.

Results of the Stromborg (1976) study showed a positive relationship between a masculine sex role identity and a more professional image of nursing. Seniors in associate degree and baccalaureate programs had significantly more masculine scores and higher image of nursing scores than seniors in diploma programs. As a possible explanation for the difference between the professional image of nursing and the traditional feminine image, Stromborg suggests that women with more career commitments self-select into the leadership role and hold a more professional image of nursing as opposed to those who work, but have committed to the role of wife and mother. Stromborg suggests that nursing educators become more aware that "the prevalent conforming orientation of the female precludes the acquisition of those traits which are valued by the profession" (Stromborg 1976:368). Stromborg (1976) cited the need for more research to investigate ways to reduce the stresses created by the difference in sex role stereotype held by many nurses and their professional commitments.

In a study of the sex role stereotype views of nurse faculty members, Acuff (1977) concluded that the sample (N=117) studied did not appear to expect male and female nursing students to display the traditional culturally accepted sex role stereotypes. The faculty subjects expected the female student to be more independent, less excitable in minor crises, more capable of decision making, more

interested in their own appearance, and neater than male students. The faculty also "seemed prejudiced" against male students and expected them to be effeminate and exhibit to a lesser degree than females the socially desirable characteristics of females (Acuff 1977:138). Because of the disagreement between faculty and cultural expectations, the potential of role strain, role contradiction, and role conflict appears to exist (Acuff 1977). The faculty responses in this study lend support to Stromborg's (1976) contention that the professional image of nursing is not a feminine image.

Both of the previous studies measured sex role identity on a bipolar scale. As was pointed out earlier, Bem (1974) felt that masculinity and femininity were two independent dimensions and developed a tool to measure sex role identities as independent concepts. Vandever (1978) used the Bem tool to measure the sex role identity of nursing students in a university setting (N=122). Results indicated that the subjects were stereotypically feminine and statistically different from the female sample of other university students. The results supported the concerns expressed by nurse faculty that students lacked aggressiveness, assertiveness, leadership, and risk taking behaviors (Vandever 1978).

In another study of the relationship between sex role identity and image of nursing, Till (1980) used the two dimensional Bem tool to measure sex role identity. The subjects were female baccalaureate nursing students (N=91) at entry and exit levels. Image of nursing was measured with the same tool used by Stromborg (1976). A significant

difference in sex role identity was identified between the total nurse sample and a normative group of college females.

Examination of scores on the masculine and then the feminine scale revealed that exit level nursing students had higher masculine scores than entry level nursing students, as did the normative college group. There was a significant positive correlation between education and masculinity scores. A significant difference on feminine scores was found between exit level nursing students and the normative group, with the nursing students having a significantly higher feminine score. These results lend support to Vandever's (1978) findings that nursing students are often highly feminine.

In the Till (1980) sample, both levels of students displayed an image of nursing significantly less professional than the professional image; although the exit level students' image was closer to the professional image. Results showed that a higher masculine score was positively related to a professional image of nursing, whereas the feminine score showed little effect. This result confirms and further clarifies Stromborg's (1976) finding that a masculine sex role identity was associated with a professional image of nursing.

Meleis and Dagenais (1981) investigated sex role identification and type of nursing program (baccalaureate, associate degree, or diploma) of female graduating students (N=91, 23, 49) in relation to descriptions of themselves. The purpose was to investigate if differences in self descriptions were the result of sex role identity or educational program. Sex role identity was measured on a unidimensional scale.

The measure of self-description did have a significant relationship with nursing program type. The associate and baccalaureate students had higher self image scores than diploma students. Diploma students used less positive descriptions of their abilities than did associate or baccalaureate students. Results showed that self descriptions were significantly related to type of nursing program but not related to sex role identity. There were no significant differences in the sex role identity among the three types of nursing programs or between the nursing students and the normative group of female college students. This lack of difference between the students of the three types of nursing programs is in contrast to the Stromborg study (1976).

An investigation of the relationship between sex role identity and self esteem in female graduate nursing students (N=96) was conducted by Gauthier and Kjervik (1982). Sex role identity was measured by the Bem tool. Results indicated that highest self esteem was found in students with high masculine scores. Age, year of graduation and doctoral plans revealed no statistical significance when examined in relation to self esteem or sex role categories. In this study, 55% of the students had high masculine scores and rated themselves as ambitious, independent, assertive, aggressive, and self-reliant. An explanation for this may be that students who choose to attend graduate school see themselves in more masculine terms and have higher self esteem. Another explanation may be the influence of attending graduate school. The sex role identity of graduate nursing students in this study contrasts the highly feminine sex role identity of undergraduate nursing students reported by Vandever (1978) and Till (1980).

In the studies about undergraduate students, even though most were stereotypically feminine, Associate Degree and Baccalaureate students had more masculine self concepts and greater self esteem than Diploma students (Meleis and Dagenais 1981, Stromborg 1976). This suggests graduates of AD and BSN programs may experience less role conflict than Diploma graduates when occupying positions requiring more masculine characteristics. Graduate nursing students whose self concept incorporated more masculine characteristics (Gauthier and Kjervik 1982), exposed to a faculty of nursing professionals who view nursing in more masculine terms (Acuff 1977, Stromborg 1976, Till 1980) would be even less likely to experience role conflict when called upon to fill a masculine position such as leader/manager. Higher education may be one way to assist nursing administrators in adopting more masculine self concepts, and thereby experience less role conflict.

Leader. The concept of leader/manager is composed of characteristics and behaviors consistent with the male stereotype: dominant, independent, competitive and logical. In literature, managers are generally portrayed as males. Women are not expected to behave as leaders (LeRoux 1976).

In two studies, Schein (1973, 1975) asked male (N=300) (1973) and female (N=167) (1975) managers to identify characteristics of women in general, men in general, and successful middle managers. Results from both female and male subjects showed a large and significant correlation between the ratings of the characteristics of men and managers. Among the male manager subjects, there was a nonsignificant resemblance

between the ratings of the characteristics of women and managers. In ratings by female subjects, there was a significant relationship between the ratings of the characteristics of women and managers. However, female subjects rated male and manager characteristics as significantly more similar than female and manager characteristics. As the results of these two studies show,

"association between sex role stereotypes and requisite management characteristics fosters a view of women as being less qualified than men for managerial positions, the results imply female managers are as likely as male managers to make selection, promotion, and placement decisions in favor of men" (Schein 1975:343).

Several studies examined the way sex role stereotypes influenced evaluation of male and female managerial behavior; there was clear evidence that sex role stereotypes had an important impact on expectations regarding appropriate supervisory behavior (Rosen and Jerdee 1973, 1974; Bartol and Butterfield 1976; Haccoun et al 1978; Mai-Dalton et al 1979).

In these studies, subjects evaluated stories depicting different leadership styles, each with a male and female version. It appears that when information is limited, traditional concepts of male and female behavior - stereotypes - are utilized to generalize and categorize behavior. Generally, these studies suggest that female managers were expected to behave in a manner consistent with feminine characteristics, such as friendly, considerate, emotional, and family centered. Rosen and Jerdee (1974) indicated that organizations apparently expect women to change to satisfy the organization's expectations rather than organizations accepting any responsibility to adapt or to change.

In another study concerning evaluation of leaders, Garland and Price (1977) found that attitudes toward women in management were unaffected by descriptions of success or failure. Results of the study indicated that a bias against women in management operated at the beginning of the female's career when there was no performance data as well as when she was established in a career and had an excellent performance record. This study adds to the evidence indicating that there is a male sex stereotype for managers.

Powell and Butterfield (1980) found that perceptions about and evaluation of leaders are situation-specific and dependent on the amount of information given, including group performance. Results showed that when group performance outcome was included in the situation information, responses (N=256) reflected evaluation based on performance of the group and not on sex roles. This study may indicate that sex role perceptions of leaders are not as influential on evaluations as they once were thought to be.

In light of the influence of sex discrimination legislation and the women's liberation movement, studies were conducted to see if there had been a shift away from sex typing of the manager's role (Rosen and Jerdee 1978; Powell and Butterfield 1979). A national sample of male managers found that "virtually every perceived difference between male and female employees was unfavorable to women aspiring to higher level occupations" (Rosen and Jerdee 1978:843). This sample of men perceived women to be home oriented rather than job oriented and to enjoy doing routine tasks. Women were also seen as being too emotional, sensitive,

and timid and to put family matters ahead of the job. It can be surmised that if this sample of male managers were responsible for the promotion of employees into a managerial role, they would not be inclined to select a female. It also seems likely that a male manager from this sample might not be willing to delegate responsibility and authority to a female manager because of his negative perceptions of her abilities, motivations, temperament, and attitudes.

In an effort to determine if the perceptions of a "good" manager had expanded to include androgynous characteristics, Powell and Butterfield (1979) compared a group of undergraduate business students (N=574) with part-time (evening) MBA students (N=110), most of whom held full time jobs. Each subject completed the Bem Sex Role Inventory for a "good" manager and for her/himself. Results showed an overwhelming preference for a masculine manager for both groups of students in this study. There was no significant difference between the good manager description of males and females in either group, confirming Schein's (1975) proposal that both sexes perceive management characteristics in similar terms. In their self-image scores, undergraduate men and women were typically masculine and feminine. Graduate men and women, though, did not differ greatly on masculinity and femininity. Graduate women saw themselves as more masculine than feminine. This suggests a change in sex role self concept, but may be self selection. Preparing to enter a masculine oriented environment, these graduate women may have taken on characteristics they believed necessary to survive and advance (Powell and Butterfield 1979). If these women adopted masculine characteristics in order to survive and not as a result of a changed sex role self

concept, it can be predicted that they would experience person-role conflict. The female nursing administrator with feminine self concepts who adopts masculine role characteristics because of the pressures and expectations of others can be expected to experience role conflict.

If adopting masculine characteristics to survive and advance in a masculine oriented leader role is considered appropriate, Wheelan (1978) demonstrated that assertive training was effective in increasing acceptance of masculine characteristics. Using the Bem Sex Role Inventory as a pre- and post-test, Wheelan noted a significant increase in masculine scores for the assertive training subjects (N=70).

Summary

The sex role self concept of an individual has a major influence on that person's manner of handling and reacting to life events. Job aspirations and performance behaviors are affected as well as personal motives and private conduct. Society's sex role stereotypes are often internalized and adapted to form a nonconscious ideology (Bem and Bem 1971). The characteristics of women are perceived to be different from men (Broverman et al 1970, Bem 1974, Cohen and Bunker 1975, Zikmund et al 1978). Nurses appear to adopt more feminine characteristics than normative female groups (Till 1980, Vandever 1978) and are perceived by society as feminine. Managerial characteristics are seen as similar to masculine characteristics (Powell and Butterfield 1979, Rosen and Jerdee 1978, Schein 1973, 1975) but dissimilar to the feminine characteristics.

Role conflicts occur when an individual experiences role expectations that are mutually exclusive and therefore not achievable. Female nurses with a feminine self concept may refrain from seeking an administrative role because of the conflict between the feminine/nurse and managerial characteristics. Other female nurses with a feminine self concept may accept an administrative role and adopt masculine characteristics in order to survive and succeed in this "male" role. Role conflict may be predicted for these nurses because of the differences between self concept and role behavior.

Another group of female nurses may believe that they have the potential and ability to be managers and actively seek such an administrative role. However, social pressures may convince these women that they are unfeminine and deviant if they pursue a managerial role. Because of conflicting pressures these nursing administrators may experience role conflict. Women with divergent views of their real self and ideal self may experience role conflict (Deutsch and Gilbert 1976). Literature has documented the dysfunctional behavior associated with role conflict, including anxiety, propensity to leave the organization, and impending nervous breakdown (Bedeian and Armenakis 1981, Brief et al 1979, Powell and Reznikoff 1976).

Gordon and Hall (1974) suggested that male standards of femininity may create conflict for women. Support for this is suggested by the findings that a woman whose spouse supports her career experiences less conflict than women without this support (Holahan and Gilbert 1979). The evidence of job selection discrimination against women (Cohen and

Bunker 1975, Zikmund et al 1978) and the bias against women when evaluating their management behavior (Bartol and Butterfield 1976, Garland and Price 1977, Haccoun et al 1978, Mai-Dalton et al 1981, Rosen and Jerdee 1973, 1974, 1978) suggest that through sent role expectations and pressures, men may critically influence the attitudes and values and thereby the internal conflicts of women. Whether this occurs with female nursing administrators and male physicians and hospital administrators has not been demonstrated.

In the studies concerning role conflict, there is evidence that for working women there is considerable conflict between the home role and the job role (Arndt and Laeger 1970, Gordon and Hall 1974, Holahan and Gilbert 1979, Powell and Reznikoff 1976). Younger women with younger children may experience more conflict because society continues to expect the mother to be more involved in the child rearing process (Powell and Reznikoff 1976).

Several of the studies reviewed indicated that education may impact sex role self concept (Dreyer et al 1981, Powell and Butterfield 1979, Thornton and Freedman 1979). In the studies about nurses, there also appeared to be evidence of a link between education and sex role self concept (Gauthier and Kjervik 1982, Stromborg 1976, Till 1980) although the study by Meleis and Dagenais (1981) showed no such relationship.

Several of the studies in the literature review used undergraduate college students as sample subjects. The validity of using results from students to generalize to the population as a whole must be questioned.

There is a need for more research to address the sex role self concept of females, nurses, and managers in their natural settings.

In addition, the studies cited examined relationships between variables, and lacked the experimental controls to infer cause and effect. Even if causal inferences could have been drawn, one may question their applicability to current situations. In even the most recently published report the data were gathered in the mid-70's. The effect of the women's liberation movement may make perceptions in the 80's different.

If, as some studies indicate (Meleis and Dagenais 1981, Stromborg 1976), graduates of associate and baccalaureate nursing programs think of themselves differently than diploma graduates and with the growing percentage of associate and baccalaureate nursing graduates, then self concept of nurses may be changing. Further research is needed to indicate if changes have occurred. There is also a need to document the nursing administrator's sex role self concept and any role conflict associated with sex role self concept. Research can assist the nursing administrator in understanding if her role concepts are contributing to role conflict.

It is the belief of this investigator that the female nursing administrator must become aware of how her social conditioning has molded her behavior in order to successfully cope with the demands of her leadership position. It is for these reasons that this study has been conducted.

Chapter 3

METHODOLOGY

Introduction

It is suggested that in order for the female nursing administrator to be a successful manager, she must have a self concept that enables her to be comfortable in and successful with the various situations and expectations that are a part of the managerial role. As a first step in this process, the individual must become aware of her self concept, and the effect sex role has on self concept. The purpose of this study was to examine the sex role self concept of nursing administrators and to determine if there was a relationship between sex role self concept and role conflict.

Design

This study was a descriptive survey. Polit and Hungler (1978) define survey research as gathering information from the groups of interest in order to describe the group as it is. This study examined sex role self concept and role conflict of nursing administrators and their relationship to age, education, and length of experience. Survey data do not permit the establishment of cause and effect relationships, therefore responses were used to describe, and explore relationships between variables. Data were gathered at one point in time by a mailed questionnaire. This made the study cross-sectional in time.

Subjects

The target population for this study was hospital nursing administrators. The accessible population consisted of those nursing administrators working in hospitals listed in the 1982 American Hospital Association's Hospital Guide. The investigator used a purposive probability sample. Three states were purposely selected because of proximity to the investigator's location and also to provide a wider variety of respondents. Systematic sampling was used to select every third hospital in the three state area, for a total of 126 hospitals. In an effort to make the sample representative of the population, no limitations were used as to size of hospital, classification as acute or long term, or location, such as urban or rural. The one nursing administrator of each of these 126 hospitals was asked to participate in this study by a mailed survey. Responses were received from 91 (72.22%) nursing administrators, and of these responses, 88 (69.8%) were usable.

Setting

The three states used in this study were in the mid-Atlantic region. The 1982 AHA Guide listed 85 hospitals in Maryland, 136 in Virginia and 159 in North Carolina. Included in the sample were 28 hospitals in Maryland, 45 in Virginia and 53 in North Carolina. Returns from subjects included 11 which were not identifiable for state, 17 from Maryland (60.7%), 31 from Virginia (68.9%) and 32 from North Carolina (60.4%).

Procedure

The nursing administrator from every third hospital from the three state area was selected to be included in the sample (N=126). Using information from the Virginia Hospital Association and the American Society for Nursing Service Administrators, names of the nursing administrators at 51% of the hospitals were obtained (Maryland 39%, Virginia 87%, and North Carolina 28%). In hospitals where the name of the nursing administrator was not known, envelopes were addressed to the "Director of Nursing Service" and letters addressed to "Dear Colleague".

A questionnaire packet was prepared for each subject, consisting of introductory letter (Appendix C), instructions (Appendix D), Bem Inventory (Appendix A), HRC Inventory (Appendix B), demographic data (Appendix E), self addressed return envelope, and self addressed post card. The post card allowed the investigator to know which questionnaires had been returned while protecting the subjects' anonymity.

Strict protection of the individual's anonymity was provided. The participants were not requested to sign a consent form. There was no foreseeable risk to the respondents' emotional, mental, or physical well being. The subjects were at liberty to choose not to participate in the study. The act of completing and returning the questionnaire was their means of consenting to participate.

Six weeks after the first mailing, 62% (N=78) of the questionnaires and 56% (N=71) of the postcards had been returned. A follow up mailing resulted in the return of 13 additional questionnaires for a total response rate of 72.22%.

The only information available for non-respondents was size and type (acute vs long stay) of hospital, so respondents and non-respondents were compared using the chi-square goodness of fit test. Results gave chi-square values of 2.83 (2 df, $p < .25$) for size of hospital and 5.49 (1 df, $p < .02$) for type of hospital. Therefore, the respondents did not differ from non-respondents on size of hospital they represented, but were different for type of hospital. Nursing administrators in acute care hospitals chose to participate more often than nursing administrators in long stay hospitals.

Instrumentation

Bem Sex Role Inventory

The Bem Sex Role Inventory (BSRI) was used to measure the sex role self concept (Appendix A). This adjective rating scale consists of sixty adjectives rated on a seven point scale. There are twenty stereotypically feminine, twenty stereotypically masculine, and twenty filler characteristics. In the BSRI, masculinity and femininity are treated as two independent dimensions rather than two end points of a single dimension. This concept enables an individual to score high on

both dimensions (androgynous), low on both dimensions (undifferentiated), or high on one dimension, but low on the other (either feminine or masculine). The difference between the standardized scores on the feminine and masculine scale is utilized to indicate whether the individual tends toward a more feminine or more masculine self concept.

One of the basic assumptions of the BSRI is that a traditionally sex typed person accepts culturally defined sex appropriate behavior and utilizes such definitions as criteria by which to judge her or his own behavior. Based on this assumption, the traditionally sex typed individuals seek to keep their behavior in line with the stereotyped view (Bem 1981).

The items of the instrument were developed from a list of 400 personality characteristics. The final items were judged by college students as significantly more culturally desirable for a woman than for a man, or more for a man than a woman, or no more desirable for one sex than for the other. Half of the filler neutral items are positive and half negative. The validity of using female and male college students as judges for a tool to be used with the general population may be questioned.

To determine the femininity score, the mean of the self ratings on the twenty feminine items is computed. The same procedure is utilized to compute the masculine score. From these raw scores, a standard score is determined using a table provided in the scoring manual. The

standard scores are adjusted so that females and males are equally represented. Next, the standard masculine score is subtracted from the feminine standard score. High scores above neutral indicate the individual is strongly feminine, and low scores below neutral indicate the individual is strongly masculine in self concept.

The median split method classifies individuals whose femininity and masculinity raw scores are both above the normative median as androgynous; those with both scores below the median are classified as undifferentiated. Individuals with the feminine raw score above the normative median and the masculine raw score below are classified as feminine, while the opposite raw scoring indicates a masculine classification.

Reliability. Test-retest reliabilities of the BSRI were established using a group of twenty-eight males and twenty-eight females from the college student normative sample tested four weeks apart. Results were: femininity = 0.90, masculinity = 0.90, and androgyny = 0.93 (Bem 1974). Two groups of college students (n = 723 and 194) were utilized to estimate internal consistency. The coefficient alpha results for the two groups respectively were: masculinity = 0.86 and 0.86; femininity = 0.80 and 0.82; and androgyny = 0.85 and 0.86 (Bem 1974). Another estimate of internal reliability using 400 females and 171 males resulted in alpha coefficients of 0.79 and 0.77 for femininity and 0.89 and 0.89 for masculinity (Beere 1979).

Validity. In two groups of college students ($n = 723$ and 194) the mean scores for males were significantly higher ($\bar{X} = 4.97$ and 4.96) than for females ($\bar{X} = 4.57$ and 4.55) on the masculinity scale ($p < .001$), and the females were significantly higher ($\bar{X} = 5.01$ and 5.08) than males ($\bar{X} = 4.44$ and 4.62) on the femininity scale ($p < .001$), which indicated that sex differences were reflected in the two scales (Bem 1974).

Correlations between the PRF ANDRO masculinity and femininity scales and the BSRI scales were 0.68 and 0.61 for the combined sexes (Beere 1979). Correlation between BSRI and the Personal Attribute questionnaire were 0.75 for males and 0.73 for females on masculinity and 0.59 for males and 0.59 for females on the femininity scale (Beere 1979). A factor analysis of the BSRI adjectives, sex of respondent, femininity score, masculinity score and androgyny score yielded four factors: femininity, masculinity, sex of subject and neutral maturity (Beere 1979).

The BSRI was chosen for the following reasons: 1) masculinity and femininity are conceptualized as independent traits present in varying degrees in every individual; 2) construction was based upon the assumption that sex typed persons internalized society's sex role stereotypes and utilized these stereotypes to judge their own and others' behavior; and 3) availability of reliability and validity information and extensive use of the tool in a number of studies examining women and sex role self concept.

Hoelzel Role Conflict Inventory

The Hoelzel Role Conflict Inventory (HRCI) was developed by the investigator. A search of the literature for an instrument to measure internal psychological role conflict associated with sex roles proved disappointing. A questionnaire developed by Rizzo et al (1970), to measure role ambiguity and role conflict, looked at role conflict in terms of organizational demands and tasks, but did not include conflict associated with multiple authority or professional values such as a nursing administrator might experience. A similar questionnaire designed to measure relative role strain derived from common problems on the job was developed by Kahn et al (1981). Again, this instrument did not appear to address internal psychological role conflict that may be experienced as a result of being socialized as a female and as a nurse while occupying a position requiring behavior characterized as masculine.

Therefore, given the hypothesized influence of sex role self concept on role conflict of female nursing administrators, and given the lack of a suitable tool to measure these conflicts, a need existed to develop such an instrument. From a review of the literature and from the personal experience of the investigator and her professional advisors, it was felt that role conflict associated with sex role self concept might cluster around three factors: 1) interaction with authority figures, 2) assertive behavior, and 3) occupying multiple roles.

Authority Figures. Most individuals are raised in the nuclear family. In that situation, the parents, especially the fathers, have the authority and the children are supposed to respect and obey that authority. Little girls are especially socialized to defer to authority. "Dominance and independence are associated with the masculine roles; submissiveness, passivity, and nurturance, with the feminine" (Bass 1981:494). These stereotypic views have been internalized and accepted as norms (O'Leary 1974). Women entering nursing receive the message that the male - physician is dominant and superior and the female - nurse is the submissive helper (Ashley 1976). Female nursing administrators who have internalized these sex role stereotypes might be expected to experience role conflict when they feel called upon by their managerial role to respond to an authority figure in other than a submissive and passive way.

Assertive Role. Good managers are described in terms of masculine traits (Powell and Butterfield 1979). Managers are expected to take charge, make decisions, take disciplinary action, and protect other members of the group (Miner 1978). Women who have internalized the feminine stereotyped sex role may be expected to experience role conflict when their job roles prescribe assertive behavior that is not congruent with their sex roles.

Multiple Roles. American society has said that the woman's place is in the home, but if women choose to or must work outside the home, the most acceptable jobs are those associated with the role of wife and mother (Epstein 1970). Women have internalized the societal norm that

in order to be feminine, they must stay in their designated roles. Role conflict can be expected when this female occupies a role that has been characterized as masculine, such as the managerial role. This woman would also experience conflict to the extent that she felt she possessed the masculine attributes necessary for a management position and also interests in marriage and family which society considers appropriately feminine.

Test Construction. The test pool items were written to include statements of behaviors or feelings associated with the three constructs thought to represent areas of probable conflict. A total of 67 items were written following procedures for the construction of attitude scale items (Polit and Hungler 1978). Each item consisted of a declarative "I" statement for which there were five response alternatives (Likert scale) ranging from never or almost never true (value 1) to always or almost always true (value 5). Some of the statements were negative and were therefore reverse-scored. Responses for all items were totaled and divided by the number of items answered, therefore possible total scores ranged from 1-5, with 1 indicating high role conflict and 5 indicating low role conflict. Nursing administrators with a high score should have experienced less role conflict because of the agreement between their personal beliefs and values and personal role expectations and the expectations of others for the administrative role.

The preliminary questionnaire was pilot tested by nursing administrators (N=7) in Assistant Director positions in a large university hospital to ascertain if the instructions and the statements

were clear and unambiguous. It was reasoned that the duties, responsibilities, conflict situations, and reactions of these assistants were typical of the target population. In order to choose statements for the final scale, average scores, standard deviations, and relative standard deviations were computed for each of the test items. Relative standard deviations denoted the range of response to the items, with larger percentage numbers indicating a greater variability in response. Statements were selected which indicated variability in response, so as to discriminate among individuals on the basis of their attitudes. Thirty statements were selected for the HRCI, which included ten items in each of the three concept groups. There were thirteen negative and seventeen positive statements so that response patterns could be discouraged.

Reliability and Validity. The small number of respondents participating in the preliminary questionnaire test prevented any measurement of internal reliability. Time constraints interfered with testing of reliability over time. The lack of reliability measurements is an acknowledged weakness of the HRCI.

In an effort to establish internal reliability for the HRCI, results from the 88 respondents were submitted to the split-half (odd-even) reliability test. The correlation coefficient was 0.44. The Spearman-Brown formula was utilized to estimate reliability for the entire test and the resulting value, 0.61, indicates a modest amount of internal consistency in the sample studied. The individual items of the HRCI were developed around specific constructs and are addressed to

behaviors or feelings that might arise in those situations. The items of the test appear to measure aspects of role conflict, giving the HRCI face validity. The test items were developed through a relevant literature review and in consultation with nursing experts. Because of the lack of evidence of reliability and validity of the HRCI, results of the present study must be interpreted with caution.

Demographic Data

The last part of the questionnaire consisted of items necessary to construct a demographic profile of the study subjects (Appendix E). Information gathered related to the subjects' sex, age, education, experience, hospital data and professional organizations. In an effort to simplify data gathering for the respondents, data as to age, education, experience and hospital size were grouped into categories. It would have been preferable to gather actual age, length of experience and hospital size so that more powerful statistical analyses could have been performed. Marital status was not included in the demographic data questionnaire; as an intervening variable, it may have provided some interesting results.

Chapter 4

DATA ANALYSIS

Introduction

The purpose of this study was to examine the relationship of sex role self concept and role conflict in female nursing administrators. Data compiled from results of the survey were utilized to provide a profile of the subjects. Hypotheses were tested using the Pearson product moment correlation coefficient or Spearman rank correlation coefficient. The effect of certain variables (basic nursing education, highest education, and size of hospital) and their interaction on the mean Bem Sex Role Inventory (BSRI) scores was tested for statistical significance using two way analysis of variance. Two way analysis of variance was also utilized to test the significant effect of highest education, hospital size, BSRI score and their interaction on mean Hoelzel Role Conflict Inventory (HRCI) scores. The significance level of $p \leq .05$ was accepted for testing hypotheses.

Results

Description of the Sample

Questionnaires were sent to 126 nursing administrators; 91 questionnaires (72.22%) were returned. After three incomplete questionnaires were eliminated, there was a useful return rate of 69.8% (N=88).

Females comprised 92.0% (N=81) of the sample, males 6.8% (N=6); one questionnaire did not indicate sex. The percentage of males in this sample was close to the 6% of nursing administrators found to be male in the 1977 American Society for Nursing Service Administrators survey. Therefore, this sample of nursing administrators was similar to the population of nursing administrators with respect to gender.

In the survey sample 40.9% of the respondents were in the 40 to 49 age group and 30.7% of the respondents were in the 50-59 age group. In the 30 to 39 age group, were 22.7% of the respondents (Table 1).

TABLE 1

Characteristics of the Sample: Age and Basic Nursing Education (N=88)

Basic Educ	Age				
	20-29 N=3	30-39 N=20	40-49 N=36	50-59 N=27	60-69 N=2
AD N=4	1	2	1	0	0
DIP N=53	0	3	22	26	2
BSN N=31	2	15	13	1	0

Most nursing administrators age 40 and over completed their basic education in diploma schools (76.9%), while 21.5% received baccalaureate degrees and 1.5% attended associate degree programs. For the group under 40, 73.9% were educated in baccalaureate programs, with 13% each in diploma and associate degree programs.

Of the total respondents, 60.2% received their basic nursing education in a diploma school. Graduates of baccalaureate schools of nursing comprised 35.2% of the sample. Only 4.6% of the sample received their basic nursing education in an associate degree program (Table 2).

TABLE 2

Characteristics of the Sample: Basic Nursing Education and Highest Educational Degree (N=88)

Highest Education							
Basic School	AD N=1	DIP N=23	BSN N=12	BSO N=4	MSN N=31	MSO N=15	PHD N=2
AD N=4	1	0	1	1	1	0	0
DIP N=53	0	23	3	3	12	11	1
BSN N=31	0	0	8	0	18	4	1

When questioned about highest educational level achieved, two respondents (2.3%) had earned a Ph.D. Over half of the sample (52.3%) had completed masters degrees, 31 in nursing and 15 in other disciplines. Of those with baccalaureate degrees as the highest degree obtained (18.2%), 12 had a BS in Nursing and 4 in other disciplines. Eight (9.1%) of the BSN respondents had not attained a higher degree, while 26.1% of the diploma graduates had not attained a higher degree, and one subject continued with an associate degree (Table 2).

In the 1977 American Society for Nursing Service Administrators survey, 45.9% listed the diploma as the highest degree held, 27.5% held a masters, 23.6% a baccalaureate, 2.5% an associate degree, and 0.5% held a doctorate. The sample in this present study held more graduate degrees. Whether this sample is different or more nursing administrators are now getting graduate degrees is not known.

Of the respondents, 72.7% were in hospitals of less than 250 beds. The modal size hospital was 100 to 249 beds, with 44.3% of the respondents in this group. Most of the remaining (29.5%, N=26) came from hospitals of less than 100 beds; 22.7% of the nursing administrators were at hospitals with 250-499 beds. Nursing administrators from hospitals with 500-749 beds were 2.3% of the sample and 2.3% from hospitals of 750-999 beds (Table 3).

TABLE 3

Characteristics of the Sample:
Highest Educational Degree and Size of Hospital (N=88)

Highest Educ	Size of Hospital				
	<100 N=26	100-249 N=38	250-499 N=20	500-749 N=2	750-999 N=2
A/DIP N=24	13	9	2	0	0
BACC N=16	7	9	0	0	0
M/PHD N=48	6	20	18	2	2

A large percentage (88.6%, N=78) of the respondents came from acute care, short stay hospitals. Only 9.1% (N=8) were from chronic, long stay hospitals. There was no response to this question from two subjects.

Of the respondents, three fourths had administrative experience of less than 10 years; 40.9% with less than 5 years and 34.1% with 5 to 9 years experience. Eleven respondents had 10 to 14 years experience, four had 15 to 19 years, one with 20 to 24 years and six with over 25 years experience.

Nursing administrators reported various titles which were classified into department head titles (Director of Nursing; Chief of Nursing) or administrative titles (Assistant Administrator, Nursing; Vice President, Nursing). Department head titles were used for 63.6% of the sample, while administrative titles were used for 34.1%. Two respondents did not answer this question. In the 1977 American Society for Nursing Service Administrators survey, 81.7% of the respondents had the title of Director of Nursing or Chief of Nursing.

The subjects were also asked to rank professional organization membership in order of commitment of time and effort. The investigator felt that commitment to professional organizations might indicate the nursing administrator's basic allegiance to the nursing profession or to the hospital organization. For instance, role conflict might increase if the respondent was committed to nursing while the administrative position required an obligation to the hospital. Of the responses,

80.7% ranked nursing organizations first, suggesting that for the sample studied, nearly all of the nursing administrators were more committed to the nursing profession than to the hospital organization. Only five respondents ranked hospital organizations first, and twelve subjects did not respond to the question.

Testing of Hypotheses

Hypothesis 1. The first hypothesis, that female nursing administrators with a feminine sex role self concept will experience more role conflict than female nursing administrators whose sex role self concept is less feminine, was tested by examining the relationship between the BSRI scores on the feminine scale and the HRCI scores. The Pearson product-moment correlation coefficient for the sample (N=81) was -0.151, which was not significant; therefore a relationship between sex role self concept and role conflict did not exist as hypothesized. Hypothesis 1 was not supported.

TABLE 4

Pearson Correlation Coefficients for BSRI and HRCI (N=81)

	Feminine scale	Masculine scale	HRCI score	BSRI score
Feminine scale	1.00			
Masculine scale	-0.005	1.00		
HRCI total score	-0.151	0.594*	1.00	
BSRI total score	0.717*	-0.699*	-0.518*	1.00

* $p \leq .05$

When the HRCI scores were correlated with the masculine scale on the BSRI, the correlation coefficient was significant ($r=0.594$ $p<.05$). In this sample of female nursing administrators, as masculine self concept increased, role conflict decreased (higher HRCI scores). From this evidence it appears that masculine self concept, not feminine self concept, is inversely related to role conflict. These results support the idea that leader/managers with self concepts that include masculine characteristics such as competent, independent and assertive experience less role conflict. Nursing administrators with sex role self concepts that were compatible with culturally expected role behaviors of managers experienced less role conflict. It was not the feminine self concept as hypothesized, but the masculine self concept that influenced role conflict.

Hypothesis 2. The second hypothesis, there will be an inverse relationship between age and degree of femininity as measured by the Bem Sex Role Inventory, was examined by ranking BSRI scores on the femininity scale and age. The relationship between age and degree of femininity as measured by the BSRI was tested using the Spearman rank correlation coefficient. The correlation coefficient, $+0.181$, was not significant for alpha $\leq .05$. The calculated critical value for the Spearman rho for a 1-tail test was 0.186 . Therefore, hypothesis 2 was not supported (Table 5).

TABLE 5

Spearman Correlation Coefficients for Age, Education, Experience and BSRI and HRCI Ranks (N=81)

	Age	Educ	Exper	Fem. rank	Masc. rank	BSRI rank	HRCI rank
Age	1.00						
Education	-0.178	1.00					
Experience	0.568*	-0.096	1.00				
Fem. rank	0.181	-0.217*	0.177	1.00			
Masc. rank	-0.038	0.361*	-0.116	0.037	1.00		
BSRI rank	0.145	-0.425*	0.232*	0.706*	-0.631*	1.00	
HRCI rank	0.054	0.315*	-0.055	-0.126	0.528*	-0.430*	1.00

* $p \leq .05$

Hypothesis 3. The third hypothesis, that there will be an inverse relationship between age and degree of role conflict as measured by the Role Conflict Inventory, was tested using the Spearman rank correlation coefficient. The correlation coefficient was +0.054 (N=81) (Table 5). Hypothesis 3 was not supported. Younger women were just as likely to experience role conflict as measured by the HRCI as older women in the sample.

Hypothesis 4. The fourth hypothesis, there will be in inverse relationship between education and degree of femininity as measured by the Bem Sex Role Inventory, was tested using the Spearman rank correlation coefficient. The correlation coefficient was significant at -0.217 ($p \leq .05$, N=81) (Table 5). Therefore hypothesis 4 was supported; an inverse relationship was demonstrated between amount of education and

sex role self concept as measured by the BSRI. Female nursing administrators with more education had a lower femininity score on the BSRI than did those with less education.

When BSRI scores on the masculine scale were ranked and correlated with education, the relationship was positive and significant ($r=0.361$) (Table 5). For the sample studied, female nursing administrators with increased education also had a more masculine sex role self concept. Both of these results support the findings in the literature that education and sex role self concept are related (Dreyer et al 1981, Gauthier and Kjervik 1982, Powell and Butterfield 1979, Thornton and Freedman 1979, Till 1980). It may be that the motivations to seek higher educational degrees are similar to and reflected in the masculine scale of the BSRI. Another possibility could be that the educational process increases masculine sex role self concepts and decreases feminine sex role self concepts.

Hypothesis 5. The fifth hypothesis, there will be an inverse relationship between education and degree of role conflict as measured by the Role Conflict Inventory, was tested using the Spearman rank correlation coefficient. The correlation coefficient was $+0.315$ ($N=81$), which was significant at $p<.05$ (Table 5). Scoring of the HRCI was such that high scores represented less role conflict; therefore hypothesis 5 was supported. In the sample studied, as female nursing administrators attained higher educational degrees, their degree of role conflict decreased as measured by the HRCI. It may be that the educational

process supplies the nursing administrator with more tools to alleviate role conflict, or the nursing administrator who chooses to pursue higher education has characteristics that lead to less role conflict. In addition, education may expose the nursing administrator to ideas and knowledge which lead her to discard stereotypic sex role concepts and adopt self concepts appropriate to the role she occupies and therefore experience less role conflict.

Hypothesis 6. The sixth hypothesis stated that there will be an inverse relationship between administrative experience and degree of femininity as measured by the Bem Sex Role Inventory. To test this hypothesis, BSRI scores on the femininity scale and experience were ranked, and the relationship was tested using the Spearman rank correlation coefficient. The correlation coefficient was +0.177 (N=81) (Table 5), and was not significant therefore hypothesis 6 was not supported. Female nursing administrators with less experience were just as likely to have a more feminine sex role self concept as those with more experience.

Hypothesis 7. The seventh hypothesis, there will be an inverse relationship between administrative experience and degree of role conflict as measured by the Role Conflict Inventory, was tested using the Spearman rank correlation coefficient. The correlation coefficient was -0.055 (N=81) which was not significant (Table 5). Hypothesis 7 was not supported from the evidence of this sample. Role conflict was just as likely to occur for female nursing administrators with short periods of experience as for those with longer periods of experience.

Relationships Between Variables

The mean scores and standard deviations on the BSRI and the HRCI among different demographic groups (age, experience, basic schooling, highest education, hospital size and type, title and membership) are presented in Appendix F.

In an effort to explain which variable, basic nursing school, size, highest education, had more influence on BSRI scores, two-way analyses of variance were calculated. The first two variables to be compared with BSRI scores were basic schooling and size. In order to perform the statistical tests, cells had to be combined so there would be no empty cell, therefore, basic schooling was divided into two groups, associate degree and diploma graduates in the first cell and baccalaureate graduates in the second cell. Size of hospitals was grouped into those with less than 100 beds and those with more than 100 beds. Size of hospitals was split at the 100-bed level because nursing administrators of hospitals over 100 beds had a masculine self concept (scores below 50) and those nursing administrators in hospitals of less than 100 beds had feminine self concepts (scores above 50).

TABLE 6

Two Way ANOVA of BSRI Score, Basic
Schooling and Size (N=81)

	AD/DIP <100	AD/DIP >100	BSN <100	BSN >100	
N=	19	34	6	22	
\bar{X}	51.7	48.5	50.0	43.3	
sd	10.5	6.5	4.5	5.7	
SOURCE	df	ss	ms	F	p
School	1	162.7	162.7	3.02	.086
Size	1	334.4	334.4	6.21	.015
Interaction	1	40.3	40.3	.75	.390
Error	77	4148.9	4148.9		

The effect of size on BSRI scores was significant ($F=6.21$, $p<.015$). The effect of the variable, schooling, on BSRI scores was not significant. There was no significant interaction between these variables.

Highest educational group was combined into those who had completed graduate school and those who had not. Results of a two-way ANOVA with highest education and size as the independent variables (Table 7) indicated that only highest education had a significant effect ($F=4.55$, $p=.036$) on BSRI score. No significant main effects were found for the variable of size, and no significant interactions were found between the variables of size and highest education.

TABLE 7

Two Way ANOVA of BSRI Score, Highest Education and Size (N=81)

	UNDERGR <100	UNDERGR >100	GRAD <100	GRAD >100	
N=	20	19	5	37	
\bar{X}	52.3	49.2	47.4	45.1	
sd	8.7	6.5	12.0	6.3	
SOURCE	df	ss	ms	F	p
Education	1	248.8	248.8	4.55	.0361
Size	1	89.6	89.6	1.64	.204
Interaction	1	1.7	1.7	.03	.86
Error	77	4208.5	4208.5		

In the sample studied, significant differences between schooling, size and educational groups on BSRI scores was explained by the effect of education. Female nursing administrators with graduate degrees had BSRI scores which indicated more masculine sex role self concepts; most nursing administrators with graduate degrees worked in hospitals with more than 100 beds.

In an effort to explore the effect hospital size and highest education had on role conflict, a two way analysis of variance was performed. When hypothesis 5 was tested by Spearman rank correlation, there was a significant relationship between education and role conflict ($r=.315$, $N=81$, $p<.05$). Results of two-way analysis of variance (Table 8) indicated that size exerted a significant main effect ($F=8.99$,

$p < .004$) on HRCI scores. The influence of education was not significant, and no significant interaction was found.

TABLE 8
Two Way ANOVA of HRCI Score, Highest
Education and Size (N=81)

	UNDERGR <100	UNDERGR >100	GRAD <100	GRAD >100	
N=	20	19	5	37	
\bar{X}	3.33	3.43	3.19	3.60	
sd	.30	.31	.62	.22	
SOURCE	df	ss	ms	F	p
Education	1	.004	.004	.05	.83
Size	1	.78	.78	8.99	.004
Interaction	1	.3	.3	3.49	.066
Error	77	6.64	6.64		

Considering that sex role self concepts were significantly influenced by highest education (Table 7) and role conflict scores were significantly influenced by size (Table 8), a two-way analysis of variance for size and sex role self concept on HRCI score was carried out. Sex role self concept was divided into those respondents with a masculine self concept and feminine self concept.

TABLE 9

Two Way ANOVA of HRCI Score, Sex Role
Self Concept and Size (N=81)

	MASC <100	MASC >100	FEM <100	FEM >100	
N=	11	41	14	15	
\bar{X}	3.47	3.59	3.18	3.42	
sd	.22	.25	.42	.26	
SOURCE	df	ss	ms	F	p
BSRI	1	.84	.84	10.35	.0019
Size	1	.52	.52	6.45	.013
Interaction	1	.06	.06	.73	.396
Error	77	6.26	.08		

The results of the two-way analysis of variance (Table 9) indicated that sex role self concept had a significant ($F=10.35$, $p<.0019$) effect on role conflict. The effect of size also significantly influenced role conflict, but the effect of interaction of the two variables was not significant. These results suggest that role conflict as hypothesized may be linked to sex role self concept.

Interpretation of Results

In the sample studied, the average nursing administrator was female, between the ages of 40 and 49, whose basic nursing education was in a diploma school of nursing. This average nursing administrator now had a bachelors degree, had worked between 5 and 9 years as a nursing

administrator in an acute care hospital with 100 to 249 beds. The average nursing administrator had a department head title, and if she chose between joining a nursing or a hospital professional organization, she chose a nursing organization.

The average female nursing administrator had a BSRI feminine score of 5.02 and a masculine score of 5.46. The normative score (Bem 1981) for feminine and masculine scales are 4.90 and 4.95, respectively. This indicated that the sample in the present study on the average, was androgynous. The mean BSRI score for female nursing administrators (N=81) was 47.96 with a standard deviation of 7.85. The scores ranged from a maximum of 81 to a minimum of 33. The mean HRCI score for female nursing administrators (N=81) was 3.47 with a standard deviation of 0.32. The scores ranged from a low of 2.33 to a high of 4.13.

For the female nursing administrators studied, the relationship between sex role self concept and role conflict appeared to depend on the masculine self concept, not the feminine self concept as hypothesized. The female nursing administrator who was able to incorporate into her self concept characteristics that are stereotypically masculine and considered appropriate to her position, experienced less role conflict. This result is compatible with Rogers' (1951) Self Theory which suggests that the potential for conflict is created when personal values are not compatible with social expectations. It is also related to person-role conflict (Kahn et al 1981) which exists when the needs and values of a person conflict with the demands of the role set, and is similar to role incongruity (Hardy

1978) which occurs when expectations for role performance disagree with the person's self perception, attitudes, and values. These results support the findings of Deutsch and Gilbert (1976), Gordon and Hall (1974) and Holahan and Gilbert (1979) that sex role self concepts are associated with role conflicts.

A significant relationship between age and sex role self concept or role conflict was not demonstrated in this study. There also was no significant relationship between experience and sex role self concept or role conflict. The suggestion that with age and experience, an individual has more opportunities to examine and reject stereotyped views was not supported by the findings of this study. These results support the finding of Arndt and Laeger (1970A) which found no correlation between age or experience and role conflict and role ambiguity in nursing administrators.

There was a significant inverse relationship between feminine self concept and education, as well as a positive correlation between masculine self concept and education. These findings of a significant relationship between education and sex role self concept support the results reported in the literature (Dreyer et al 1981, Gauthier and Kjervik 1982, Powell and Butterfield 1979, Thornton and Freedman 1979, Till 1980). In this study, as female nursing administrators attained higher educational degrees, they had a decreased feminine self concept and an increased masculine self concept. This result in the present study is consistent with the evidence in the literature.

The results concerning education and role conflict, in this study, were mixed. When role conflict was correlated with education, there was a significant inverse relationship. As the female nursing administrator attained higher educational status, she experienced less role conflict. However, two-way analysis of variance of education, size, and role conflict produced no significant effect for education on role conflict. There is very little in the literature concerning the relationship between education and role conflict, but the findings of Brief et al (1979) suggest a positive relationship between these two variables. Education may influence role conflict through its effect on sex role self concept. In this present study, education was correlated positively with masculine self concept and inversely with feminine self concept. It may be that nursing administrators with more masculine self concepts pursue more education and experience less role conflict because of their self concepts.

There was evidence that as size of hospital increased, role conflict experienced by nursing administrators decreased ($r=0.383$, $p<.05$) (high role conflict scores indicate less role conflict). This does not support the findings in the Arndt and Laeger (1970A) study that nursing administrators of large hospitals (over 250 beds) experienced more role conflict and role ambiguity. An explanation could be that the type of role conflict measured in the Arndt and Laeger (1970A) and Brief et al (1979) study was a different type of role conflict than that examined in the present study. The decrease in role conflict of nursing administrators in larger hospitals in this study may be explained by the influence of sex role self concept. The female nursing administrator

with more masculine self concepts worked in larger hospitals. It may be the masculine self concept of the nursing administrator that decreases role conflict.

When the relationship between size of hospital and title was examined, the evidence indicated ($r=0.287$, $p \leq .05$) that as size of hospital increased, the nursing administrator's title implied an administrative position rather than that of a department head. This suggests that the organizational structure in larger hospitals places the nursing administrator in an executive management position or at least gives her an executive title. In this study, smaller hospitals tended to title the nursing administrator with a department head designation. As indicated, female nursing administrators in larger hospitals had more education and a more masculine self concept as well as administrative titles. Perhaps the competitive and assertive nursing administrator negotiated for an executive management position and title, or the hospital recognized these types of administrators with an appropriate title. Results may also indicate that titles in larger hospitals realistically indicated the executive management position most nursing administrators already occupy, while smaller hospitals utilized the nursing administrator in the same way but the title did not reflect this.

Considering the results of this study, the following model is offered as a possible explanation of the effect certain variables have on role conflict.

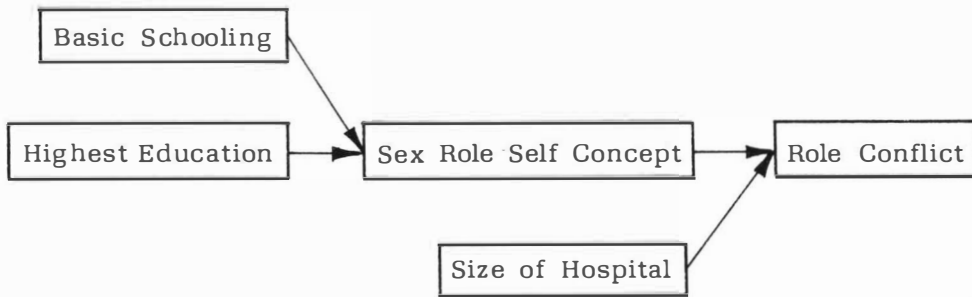


Figure 1

Variables Influencing Role Conflict

Chapter 5

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

The purpose of this descriptive survey was to investigate the relationship between the sex role self concept of female nursing administrators and the degree of role conflict experienced as a nursing administrator. The relationships between age, education and length of administrative experience and sex role self concept and role conflict respectively were also examined. A purposive probability sample of 126 subjects from three mid-Atlantic states was contacted by a mailed survey, with a useful return rate of 69.8% (N=88). Of the respondents, 81 were female and 54.5% had Masters or Doctoral degrees.

Sex role self concept was measured by the Bem Sex Role Inventory (BSRI). The BSRI treats masculinity and femininity as two independent dimensions present in varying degrees in every individual, and assumes that culturally defined sex appropriate behavior is adopted by individuals as criteria for acceptable behavior.

Role conflict was measured by an investigator-developed tool designed to look at internal psychological role conflict that may be experienced as a result of being socialized as a female and as a nurse while occupying a position requiring behavior characterized as

masculine. Based on a literature review, role conflict was conceptualized as clustering around three factors: 1) interaction with authority figures, 2) assertive behavior, and 3) occupying multiple roles. This tool possessed face validity, but no pre-established reliability or concurrent or construct validity. High scores on the HRCI indicated less role conflict.

In the sample studied, the masculine sex role self concept and not the feminine self concept, had a significant relationship ($r=.594$) to role conflict score. Education also correlated significantly with feminine sex role self concept ($r=-.217$) and role conflict score ($r=.315$). No significant relationship existed between age and experience and sex role self concept and role conflict. In the sample, education had a significant positive relationship with masculine sex role self concept ($r=.361$) which in turn had a significant inverse relationship with role conflict ($r=.528$). Higher scores of the HRCI indicated less role conflict. Size of hospital also had a significant inverse correlation with role conflict ($r=.351$).

Conclusion

In interpretation of results it should be remembered that because of the regional nature of the sample, no generalization of conclusions can be drawn to the national hospital nursing administrator population. Interpretation of results must also be guarded due to the limitations of the investigator-developed role conflict tool. The data did not support the first hypothesis that there would be a positive relationship between

feminine self concept and role conflict. An inverse relationship between masculine self concept and role conflict was found. These results suggest that in this study feminine self concepts were not related to female nursing administrators' role conflict. Female nursing administrators who had masculine self concepts, however, did experience less role conflict.

The reviewed literature supported a relationship between sex role self concept and role conflict (Deutsch and Gilbert 1976, Gordon and Hall 1974, Holahan and Gilbert 1979). Deutsch and Gilbert (1976) found that androgynous females were better adjusted than highly feminine women. If better adjustment and less role conflict are similar, support is offered for the results of this study that females who incorporate masculine traits in their self concepts experience less role conflict. What is demonstrated by this present study is that those nursing administrators who have included masculine characteristics such as assertiveness, independence, ambition and forcefulness experienced less role conflict in the administrative position, regardless of their feminine self concept. What is suggested is that female nursing administrators do not have to give up warm, caring feelings, but instead should add to their feminine self concept characteristics that have heretofore been considered masculine. These results agree with the assertion in the conceptual framework that nursing administrators in leader/manager positions whose self concept includes masculine managerial traits would experience less role conflict.

From the results of this study, age (Hypotheses 2 and 3) and length of experience (Hypotheses 6 and 7) did not have a significant relationship to sex role self concept or to role conflict. The evidence in the literature was mixed on the effect of these two variables, and the hypothesized relationship was not supported by the results of the study, so for age and length of experience the framework put forth must be questioned.

It was hypothesized that there would be an inverse relationship between age and sex role self concept and role conflict and between experience and sex role self concept and role conflict. The conceptual framework suggested that with age and time, individuals would have the opportunity to examine and evaluate the truth and applicability of learned stereotypes. Several of the reviewed studies supported the age relationship (Dreyer et al 1981, Powell and Reznikoff 1976, Thornton and Freedman 1979) and Dreyer et al (1981) suggested employment experience was related to sex role attitudes. Reports that showed no relationship with age were Arndt and Laeger (1970A) and Gauthier and Kjervik (1982). It may be that age and administrative experience do not affect sex role self concept as measured by the BSRI, or that this sample of female nursing administrators was different. Further research would have to be conducted to determine the likely explanation.

According to the results of this study, education is inversely related to feminine self concept, supporting Hypothesis 4, and inversely related to role conflict, supporting Hypothesis 5. Correlations also indicated that education is positively related to masculine self concept

and as stated earlier, masculine self concept is inversely related to role conflict. Whether these results were because of higher education, or whether the subjects with more masculine and less feminine self concepts chose to pursue higher education can not be answered by this study.

One could speculate that the inverse relationship between higher education and role conflict may be explained by the educational experience which exposes the nursing administrator to effective methods to lessen role conflict. Another explanation might be that individuals who pursue higher education have characteristics that lessen role conflict. The investigator suggests that the nursing administrator with more masculine self concepts pursues higher education and that it is this masculine self concept that operates to decrease role conflict. The investigator also believes that individuals with more masculine self concepts pursue higher education and that this experience affirms the masculine self concept.

Size of hospital was another variable which showed a significant relationship with sex role self concept (inverse to feminine self concept and positive to masculine self concept). When the relationship of sex role self concept, education and size was examined by two way analysis of variance, results indicated that it was education and not size or interaction of size and education that had the main effect on sex role self concept.

Size of hospital had an inverse relationship to role conflict as did highest educational level. A two way analysis of variance was performed which showed that size, not education or the interaction of size and education, influenced role conflict. The inverse relationship of size and role conflict was contrary to expectations, which raises the question of whether large hospitals provide more means to successfully cope with role conflict, or whether nursing administrators in larger hospitals are different. A two way analysis of variance of size, sex role self concept and role conflict indicated that sex role self concept and size both had significant effects on role conflict. The interaction effect was not significant. In other words, the sex role self concept of the female nursing administrator along with the size of the hospital influenced her role conflict; and as stated earlier, the female nursing administrator who had a more masculine self concept experienced less role conflict.

If, as suggested in the literature review, role conflict can be detrimental to an individuals' personal well being and counterproductive to organizational goals (Bedeian and Armenakis 1981, Powell and Reznikoff 1976), it would seem that nursing administrators as individuals and as a part of hospital administration would be interested in reducing role conflict. If sex role self concepts present barriers to female nurses in pursuing and being effective in managerial or leadership positions, it would seem the members of the nursing profession would be interested in addressing the situation. From the results of the current study, higher education for nursing administrators may be one way to address this. Another possible avenue

to explore may be raising masculine self concept by assertiveness training.

If the results of this present study are supported by further research, it would appear to be advantageous to the nursing profession to more actively support and encourage graduate education for all those nurses in administrative positions. If the nursing leader with graduate education has or adopts a sex role self concept more appropriate to the position, then she is more likely to be an effective and powerful role occupant. With more effective and powerful nursing leaders, the nursing profession may be able to provide more leadership in the health care system.

It would also appear that to ensure a future supply of nursing leaders, the thrust of nursing education must change to encourage the independent assertive problem solver. The hospital nursing administrator must also encourage the development of leadership qualities of these professional nurses. Expectations of male physicians and hospital administrators will also have to adjust, as nursing leaders with more masculine characteristics in their self concepts come into positions of influence in the health care system.

Recommendations

As a result of this study, the investigator proposed the following recommendations for further research:

1) Establish acceptable reliability and validity for the HRCI.

2) Replicate the study using a larger, more representative sample with the revised HRCI, including other pertinent demographic variables, for instance, marital status.

3) Conduct a quasi-experimental time-series study of nursing administrators without graduate degrees to investigate if assertiveness training increases masculine sex role self concept and organizational management education decreases role conflict.

4) Examine the effects of role conflict in nursing administrators. One of the assumptions in the present study was the negative consequences of role conflict. Determine if poor physical health, low job satisfaction, and propensity to leave the organization are associated with increased role conflict as measured by the revised HRCI.

5) Conduct a prospective study to examine the sex role self concept of basic nursing school graduates to determine if those with more masculine self concepts pursue higher education more frequently than those with feminine self concepts.

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APPENDIX A

BEM SEX ROLE INVENTORY

BEM INVENTORY

Developed by Sandra L. Bem, Ph.D.

Name _____ Age _____ Sex _____

Phone No. or Address _____

Date _____ 19 ____ . _____

If a student: School _____ Yr. in School _____

If not a student: Occupation _____

DIRECTIONS

On the opposite side of this sheet, you will find listed a number of personality characteristics. We would like you to use those characteristics to describe yourself, that is, we would like you to indicate, on a scale from 1 to 7, how true of you each of these characteristics is. Please do not leave any characteristic unmarked.

Example: sly

Write a 1 if it is never or almost never true that you are sly.

Write a 2 if it is usually not true that you are sly.

Write a 3 if it is sometimes but infrequently true that you are sly.

Write a 4 if it is occasionally true that you are sly.

Write a 5 if it is often true that you are sly.

Write a 6 if it is usually true that you are sly.

Write a 7 if it is always or almost always true that you are sly.

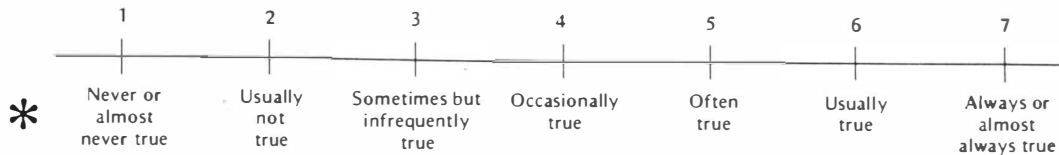
Thus, if you feel it is sometimes but infrequently true that you are "sly," never or almost never true that you are "malicious," always or almost always true that you are "irresponsible," and often true that you are "carefree," then you would rate these characteristics as follows:

Sly	3	Irresponsible	7
Malicious	1	Carefree	5

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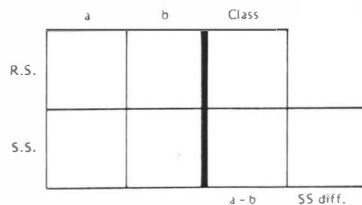
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Defend my own beliefs	
Affectionate	
Conscientious	
Independent	
Sympathetic	
Moody	
Assertive	
Sensitive to needs of others	
Reliable	
Strong personality	
Understanding	
Jealous	
Forceful	
Compassionate	
Truthful	
Have leadership abilities	
Eager to soothe hurt feelings	
Secretive	
Willing to take risks	
Warm	

Adaptable	
Dominant	
Tender	
Conceited	
Willing to take a stand	
Love children	
Tactful	
Aggressive	
Gentle	
Conventional	
Self-reliant	
Yielding	
Helpful	
Athletic	
Cheerful	
Unsystematic	
Analytical	
Shy	
Inefficient	
Make decisions easily	

Flatterable	
Theatrical	
Self-sufficient	
Loyal	
Happy	
Individualistic	
Soft-spoken	
Unpredictable	
Masculine	
Gullible	
Solemn	
Competitive	
Childlike	
Likable	
Ambitious	
Do not use harsh language	
Sincere	
Act as a leader	
Feminine	
Friendly	



APPENDIX B

HOELZEL ROLE CONFLICT INVENTORY

THE HRC INVENTORY

1	2	3	4	5
never or almost never true	sometimes but infrequently true	occasionally true	often or usually true	always or almost always true
<input type="checkbox"/>				
I have difficulty expressing my viewpoint about conflicts and misunderstandings to the hospital administrator.				
<input type="checkbox"/>				
I call a physician by his/her first name when he/she calls me by my first name, no matter where we are.				
<input type="checkbox"/>				
I experience conflict between responsibilities of my job and my personal life.				
<input type="checkbox"/>				
I like to keep the peace in a conflict situation.				
<input type="checkbox"/>				
I agree, "Above all to thine ownself be true."				
<input type="checkbox"/>				
I feel the needs of the nursing staff and hospital administration are compatible.				
<input type="checkbox"/>				
I negotiate with the hospital administrator the criteria which are used to rate my performance.				
<input type="checkbox"/>				
I handle conflict with those with a higher rank well.				
<input type="checkbox"/>				
I let the hospital purchasing agent pursue complaints with suppliers of defective hospital products.				
<input type="checkbox"/>				
I would rather the results of my accomplishments speak for themselves.				
<input type="checkbox"/>				
I agree with the statement, "When in Rome, do as the Romans do."				
<input type="checkbox"/>				
I have family members who share in home responsibilities thereby freeing my energies for job responsibilities.				
<input type="checkbox"/>				
I initiate discussion about management of patient care with physicians and hospital administrators at least once a week.				
<input type="checkbox"/>				
I follow strictly the rules and regulations in employee disciplinary situations.				

- ___ I am unable to participate in community activities because of job responsibilities.
- ___ I am too tired to do a good job at work because of the many roles I must fill.
- ___ I find it stimulating and challenging to fill several roles at once.
- ___ I put off making decisions when I anticipate conflict with the nursing staff.
- ___ I like to hold up my end of an argument.
- ___ I participate in as many community activities as I choose.
- ___ I engage in collegial relationships with the medical staff.
- ___ I try to soothe the hospital administrators' feelings when we disagree in order to preserve our relationship.
- ___ I overlook small problems because small problems often resolve themselves.
- ___ I have difficulty meeting the expectations of the nursing staff because of my commitment to hospital administration.
- ___ I try to show the hospital administrator the logic and benefits of my position.
- ___ I avoid taking positions with physicians which would create controversy.
- ___ I become actively involved with those of a higher rank when serving on policy and planning committees.
- ___ I primarily think of myself as a nursing administrator.
- ___ I say "No" to a request as often as I say "Yes."
- ___ I find it easy to balance the different roles I fill.

1	2	3	4	5
never or almost never true	sometimes but infrequently true	occasionally true	often or usually true	always or almost always true

APPENDIX C

INTRODUCTORY LETTER TO PARTICIPANTS


Richmond, Va. 23236

Dear

I am a graduate student in the Masters' program in Nursing administration at the Medical College of Virginia of Virginia Commonwealth University in Richmond, Virginia. For my thesis, I am looking at the relationship between the sex-role self-concept of nursing administrators and the role expectations of the administrative position. In order to assist me in examining this relationship, I ask you to take about 30-45 minutes of your time to complete the enclosed questionnaire. Specific instructions are included with the questionnaire.

You were chosen to receive the questionnaire by a random selection procedure among hospitals in Maryland, Virginia, and North Carolina. Your complete anonymity and that of your hospital is assured; the questionnaires are neither marked or coded. By completing and returning the questionnaire you will indicate your informed consent to participate in this study. If you are interested in results from the completed study, please feel free to contact me at the above address.

Your contribution to this research is greatly appreciated and I thank you for taking your time to complete and return the questionnaire.

Sincerely,

Charlotte B. Hoelzel, R.N.

APPENDIX D

QUESTIONNAIRE INSTRUCTIONS

Instructions

1. To be completed by the one R.N. employed on a full time basis, responsible for the management of the nursing department and accountable to the chief executive officer or Board of Trustees of the hospital.
2. Please do not review the questionnaire until you are ready to complete it so that your responses are not based on prior consideration of an item.

The questionnaire consists of three parts, the Bem Inventory, the HRC Inventory and demographic data.

3. On the Bem Inventory, rate yourself on a seven-point scale ranging from 1 (never or almost never true) to 7 (always or almost always true).
4. On the HRC Inventory, rate yourself on a five-point scale ranging from 1 (never or almost never true) to 5 (always or almost always true).
5. On the third part of the questionnaire complete questions concerning demographic data.
6. After completing each item of the questionnaire, place the three parts of the questionnaire in the self-addressed, stamped envelope.
7. Complete and sign the self-addressed post card. This post card provides me knowledge of who has returned the questionnaire while protecting your anonymity.
8. Mail both the post card and sealed envelope containing the questionnaire.
9. Please consider the importance of completing every item on the questionnaire and mailing both the post card and the questionnaire.

Again let me thank you for your participation. I very much appreciate the time and effort you have taken to assist me.

APPENDIX E

DEMOGRAPHIC DATA INVENTORY

Demographic Data

1. Age
 20-29 30-39 40-49
 50-59 60-69 70+
2. Sex
 Female Male
3. Basic Educational Program
 Associate Degree Diploma
 B.S. in Nursing Other _____
(please specify)
4. Highest Level of Education Completed
 Associate Degree in Nursing
 Diploma in Nursing
 Bachelors' Degree in Nursing
 Bachelors' Degree in _____
(please specify)
 Masters' Degree in Nursing
 Masters' Degree in _____
(please specify)
 Doctoral Degree in Nursing
 Doctoral Degree in _____
(please specify)
5. Total number of years of administrative experience (total years of experience in the position of the one registered nurse, employed on a full time basis, responsible for the management of the Nursing Department and accountable to the Chief Executive Officer or Board of Trustees of the hospital)
 less than 5 years 5 but less than 10 years
 10 but less than 15 years 15 but less than 20 years
 20 but less than 25 years 25+ years
6. Title of position (e.g., Director of Nursing Service)

(please turn over)

7. Hospital Size (number of beds)

less than 100 100 to 249 250-499
 500 to 749 750 to 999 1000+

8. Hospital Length of Stay:

Acute care, short stay Chronic care, long stay

9. Professional organizations (please rank in order of commitment of time and effort; 1=highest)

<input type="checkbox"/> American Nurses' Association	<input type="checkbox"/> State level of ANA
<input type="checkbox"/> National League of Nursing	<input type="checkbox"/> State level of NLN
<input type="checkbox"/> American Hospital Association	<input type="checkbox"/> State level of AHA
<input type="checkbox"/> Amer. Soc. for Nursing Serv. Adm.	<input type="checkbox"/> State level of ASNSA

APPENDIX F

MEAN BEM SEX ROLE INVENTORY AND
HOELZEL ROLE CONFLICT INVENTORY
SCORES FOR THE DEMOGRAPHIC GROUPS
OF FEMALE ADMINISTRATORS

TABLE 10

MEAN BSRI AND HRCI SCORES FOR FEMALE
ADMINISTRATORS FOR THE DEMOGRAPHIC GROUPS
OF FEMALE ADMINISTRATORS

		AGE					BASIC SCHOOLING		
		20-29	30-39	40-49	50-59	60-69	AD	DIP	BSN
N		2	17	32	27	2	3	50	28
BSRI	\bar{X}	45.0	46.8	47.8	48.7	54.0	46.7	49.8	44.8
	sd	8.7	5.8	7.1	9.9	1.4	4.9	8.3	6.1
HRCI	\bar{X}	3.0	3.5	3.5	3.5	3.4	3.3	3.4	3.6
	sd	.27	.23	.33	.33	.16	.22	.32	.30

		EXPERIENCE						HIGHEST EDUCATION				
		<5	5-9	10-14	15-20	20-25	25+	AD	DIP	BACC	MAST	PHD
N		34	26	11	4	1	5	1	23	15	40	2
BSRI	\bar{X}	47.1	47.4	49.8	47.8	51.0	52.2	50.0	52.0	48.9	45.6	40.5
	sd	7.4	9.3	7.9	6.6	-	3.7	-	8.4	6.8	7.2	.7
HRCI	\bar{X}	3.4	3.5	3.5	3.4	3.6	3.3	3.1	3.4	3.4	3.5	3.6
	sd	.34	.33	.28	.40	-	.12	-	.30	.32	.32	.05

TABLE 10
(continued)

		SIZE OF HOSPITAL					HOSPITAL TYPE	
		<100	100-249	250-499	500-749	750-999	SHORT	LONG
N		25	34	18	2	2	72	7
B S R I	\bar{X}	51.3	47.1	47.1	44.0	34.0	48.0	49.1
	sd	9.4	6.4	6.5	5.7	1.4	7.8	9.7
H R C I	\bar{X}	3.3	3.5	3.6	3.7	3.8	3.5	3.4
	sd	.37	.29	.17	.09	.02	.30	.48

		TITLE		MEMBERSHIP	
		DEPT	ADM	NSG	HOSP
N		53	26	66	4
B S R I	\bar{X}	48.8	47.2	47.7	43.5
	sd	7.9	7.4	7.1	6.0
H R C I	\bar{X}	3.4	3.5	3.5	3.4
	sd	.35	.25	.29	.43

VITAE

