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# Baccalaureate-prepared women in nursing: Return to graduate education in nursing in midlife

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# BACCALAUREATE PREPARED WOMEN IN NURSING: RETURN TO GRADUATE EDUCATION IN NURSING IN MIDLIFE

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by

Barbara Ann Ritch-Brant

August 1995

BACCALAUREATE PREPARED WOMEN IN NURSING:

RETURN TO GRADUATE EDUCATION IN NURSING IN MIDLIFE

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## DEDICATION

I dedicate this dissertation to my mother, my special cheering section, whose unfailing love, encouragement, and will for me to succeed, and "meet the mark" did not fall on deaf ears. My one regret is that I was not able to complete this work before she was called Home.

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BACCALAUREATE PREPARED WOMEN IN NURSING:
RETURN TO GRADUATE EDUCATION IN NURSING IN MIDLIFE

## ABSTRACT

The purpose of this descriptive study was to investigate the return of mature women as nurses to graduate education in the midlife period; particularly: (a) factors that prompted their return during this period in their lives; (b) other variables that influenced their return; and (c) their perceptions of this experience in the educational arena. Both quantitative and qualitative methods were used. A 62% response rate was obtained from women in nursing in midlife (40-65+) who returned to NLN-approved graduate programs in nursing in six colleges and universities. The SAS program was employed for data entry and computation of descriptive statistical measures in the study. Multilevel sampling was used in the selection of six colleges and universities participating in the study and in the selection of nurse participants. Three standardized instrument, the Empowerment Instrument, the BSRI, the POI, and the Brant Survey of Returning Women, a researcher-developed survey tool were used in data collection. Based on instrument scores, two extremes of the study sample were identified and examined. In-depth telephone interviews were conducted with participants who comprised the two extreme groups. Each interview was synthesized into a case study and analyzed for common themes by the researcher. The findings from the study indicate that mature

women nurses in midlife returned to graduate eduction in nursing (a) to fulfill a personal goal, (b) to enhance their career opportunities, and (c) because of a desire to learn. Major challenges or obstacles in returning to graduate education as perceived by the subjects were family demands, work, school, time management, and finances. The study results from the three standardized instruments and the subset interviews further revealed that most mature women in the study sample perceived themselves as empowered to some degree, and moderately to highly self-actualized regardless of gender attribute. This study has implications for reassessing the educational milieu, refining the graduate curriculum, restructuring administrative procedures, and redesigning nursing education and practice to accommodate mature women as nurses and mature women, in general, who return to graduate education.

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# BACCALAUREATE PREPARED WOMEN IN NURSING:
# RETURN TO GRADUATE EDUCATION IN NURSING IN MIDLIFE

# CHAPTER 1

## Introduction

### Statement of the Problem

Historically, the male-oriented bias of the traditional university in the United States has been well documented in the educational literature (Bernard, 1988; Chickering, 1988; Kerr, 1975; Pearson, Shavlik, & Touchton, 1989; Solomon, 1985). Academia has been what Bernard (1988) terms a "male preserve" for centuries. There was no special invitation extended to women in the traditional academic setting prior to the 1960s, and as Bernard (1988) contends, "Accepting women on the college campus is not the same as warmly welcoming them into the 'outer space of the male world'" (p. 257). For generations, the education of women was thought to be useful only as it prepared them to become better wives and mothers (Chickering & Havighurst, 1988). College was usually reserved for the sons; learning was predominantly male-focused. An early study of the Carnegie Commission (Kerr, 1975) on women in higher education revealed the inequities and attitudes that have seriously hampered women in their efforts to achieve academic opportunity, equality, and success.

According to the early work of Bardwick (1980), the psychological thinking of that era tended to assume that the motive to achieve was a major determinant in striving for success. Data enabling the prediction of achievement behavior were derived from studies involving men; the sparse data regarding women were contradictory and inconsistent (Bardwick, 1980).

One of the most persistent and unresolved issues in research on need achievement was one of gender difference. It was frequently assumed that women tended to underachieve, particularly in the occupational fields such as nursing (Meleis, 1985; Meleis & Dagenais, 1980). The perceived lowering of self-esteem and a sense of competence were viewed as contributing factors in the social perception of the nursing profession (Mason, Backer, & George, 1991). Mason et al. (1991) support the notion that "many nurses are likely to be limited in their sense of competence, given their gender, society's inaccurate image of nurses and nursing, and their work in a system that fails to sufficiently value the rewards of nursing" (p. 54)

The limited data available on women in education may have been influenced by the Life Cycle Theory, a popular but controversial theory of the past few decades (Chickering, 1980, 1988; Cross, 1981; Erikson, 1959; Havighurst, 1972, 1988; Levinson, 1978; Lowenthal, Thurnher, & Chiriboga, 1975; Neugarten, 1968, 1970, 1973; Sheehy, 1976). Early life cycle theorists hypothesized that since the biological role of women was to bear and rear children, a woman would need to

> omit her education during the childbearing years and choose some form of post-secondary training that would prepare her for work before and after child-bearing, with flexible hours during which she could be home with the children while pursuing her education on a drop-in--drop-out basis (Chickering, 1988, p. 23).

Directly or indirectly, greater emphasis was centered on the feminine occupations of teaching, nursing, and office work as interim alternatives in

women's pursuit of education. Women were viewed as "more affective than cognitive; more humanistically oriented; more prone to apply rather than create knowledge; and to be fearful of success" (Meleis & Dagenais, 1980, p. 51). Nursing was depicted as an occupation whose characteristics were reflected as "predominantly feminine and nurturing--a profession that is often accorded second-class status by society" (Meleis & Dagenais, 1980, p. 52). As is evident in nursing, traditional roles serve as a means of social control. These controls restrain nurses' expectations for power, privilege, and access to self-determination (Mason et al., 1991, p. 75).

While change in higher education is said to come slowly, multiple changes have begun to impact the educational arena in the United States (Parnell, 1990). Among the factors contributing to change in the educational environment are the demographic characteristics of academic campuses; the influx of women to education; the variances which influence teaching, such as pedagogical thinking, andragogy, and scholarship; and an increasingly heterogeneous student body. Parnell (1990) explains that there is simply not a "typical college student today; and age and time are no longer reliable indicators of college behavior--they [students] are not acting their [traditional] age" (p. 197). Parnell (1990) further asserts, "The day is clearly over when colleges and universities exist in splendid monastic and scholarly isolation from the real world activities and problems" (p. 10).

The rising enrollment of women returning to higher education at both the undergraduate and graduate levels has presented one of the greatest singular changes. Women of all ages are projected to dominate higher education admissions well into the 21st century, and will influence greatly the composition of college and university students across the United States

(Pearson et al., 1989). Changes of this nature will continue to place increasing demands on the current educational system of the country.

To fully understand the trend toward rising enrollments which impact the educational system today, it is helpful to examine changes over time affecting reentry women, particularly mature women. Over the past two decades, the influx of adult women attending the nation's colleges and universities has increased threefold. Women 35 years and older have been the fastest growing group of college students, nearly tripling in size between 1972 and 1987 (Touchton & Davis, 1991, p. 57). Mature women will constitute more than 52% of all students enrolled on academic campuses (National League for Nursing [NLN], 1992a; Pearson et al., 1989; United States Bureau of Census, 1981). A new breed of college student, away from the educational system for many years, is entering the system once again to pursue self-identified goals. This developmental shift toward education should come as no surprise in light of the technologic advances which demand new career skills, the changing family structure of mature women, their personal search for identity and self-fulfillment, economic autonomy, and degree completion. Increased life expectancy, higher levels of education, and early retirement may also prompt mature women's reentry in graduate education.

The phenomenon of human capacity for progressive development across the life span (Giele, 1982) and its complementary phenomenon, "the greying of the college campus," reflects the influx of reentering or returning women to higher education. Midlife is a time for stock-taking (Levinson, 1978; Reinke, Ellicott, Harris, & Hancock, 1985), a time for considering life purpose outside the family (Neugarten, 1977), and a time of completion of roles and scripts mandated by society for women (Miller, 1976, 1986; Rubin, 1979).

Research related to women in "middlescence" (Neugarten, 1977) clearly indicates their diversity in terms of general characteristics, motives for returning to higher education, and special needs. Learning styles, skill capabilities, and goals of mature reentry women could greatly influence the teaching styles, course development, and curriculum in institutions of higher learning.

The reentering adult woman presents an interesting challenge. Not only was she socialized before the impact of the feminist movement of the 1960s, but she grew up in an age of unprecedented social and technological change (Christian & Wilson, 1985). While women returning to the student role are as diverse as any other adult population group, Datan, Dickinson, Larkey, and Jones (1986) found them to be highly motivated and likely to be successful achievers. This finding contradicts earlier thinking and studies (Bardwick, 1980).

General Characteristics of Returning Women

Touchton and Davis (1991) indicate in their Fact Book on Women in Education, that 76% of master's degree awarded to women in 1986 were in the health sciences. Interestingly, neither nurses nor nursing (the largest group of health professionals) were among the categories listed in the text, as one might expect, except as subsumed under the headings of "Medicine" or "Health Sciences" (p. 79).

A 1970s profile of adult women returning to the college campus revealed these characteristics: 25 years of age, white, middle-class, the mother of two children, and with some college education prior to reentry (Christian & Wilson, 1985: Roehl & Okun, 1984). Astin's (1976) seminal work with highly motivated women in continuing education programs supported this

emerging profile. He described the "typical" women in his study as 36 year-old, middle-class, white, mothers with several children. Astin further characterizes these women as "diverse in age and background; serious, determined and pragmatic about their goals; and definite in their plans to complete their degrees" (p. 60).

In contrast, the 1980s version of women returning to academe have their own profile. The characteristics of these women of the 1980's comprise a diverse and growing majority of middle-class and lower income Caucasian women and women of color, entering their midlife years, with several children nearly grown, in college themselves or on their own. The women were either married, divorced, or never married; employed or unemployed; and enrolled in part-time study (Clayton & Smith, 1987). This profile of returning women includes older women with low level jobs and latent aspirations; older single women already in a career, but seeking advancement, a career change, and/or a degree; and younger, single women in low level positions with high aspirations (Tittle & Denker, 1980).

The National Center of Education Statistics Report (NLN, 1992b, p. 5) for the 1990s indicated that women now comprise more than 54.5% of total enrollments, with the greatest enrollment growth in higher education between 1980 and 1990 "occurring among the 35 to 44 year old cohort" (p. 5). These findings tend to confirm a transition to larger expectations among all women students enrolled in the educational arena, whether they are entering fresh(wo)men or mature reentry women. A composite of these data are depicted in Table 1.

Table 1

Changing Trends of Women Returning to Academia

| Characteristics | 1970 | 1980 | 1990 |
|---|---|---|---|
| Age | 25-36 | 30-50+ | 35-55 |
| Marital status | Most married | Undeclared | Undeclared |
| Children | 2 or more | Nearly grown | Grown, some younger children |
| Employed | None to few | Working and/or home | Professional |
| Career change | No | Yes, to advance | Yes |
| Economic status | Middle income | Middle, lower income | Middle |
| Race | Caucasian | Racial mix | Diverse |
| In college | None to few | Part-time study | Part-time and full-time |
| Prior college | None to some | Some | Most |

Characteristics of Returning Nurses

At a time when nursing is stretching its expansion beyond traditional roles, renewed interest in nursing as a professional career comes at a most opportune time (Rosenfeld, 1992). According to Rosenfeld (1992), nursing has undergone changes parallel to those in higher education which have proved beneficial to maintaining and increasing nursing education enrollment. The median age of a 1990 nursing school graduate was 31; whereas the age of a typical nursing school graduate in the 1980s was 25 (NLN, 1992b). Social, health, and economic trends in higher education have had a rippling effect on all nursing enrollments including part-time enrollments which increased from 41% to 43% (Rosenfeld, 1992, p. 5).

Enrollments in graduate education in nursing at both the master's and doctoral levels expanded between 1991-1992. During this period, the number of doctoral degrees granted in nursing increased by 20% (Rosenfeld, 1992, p. 3). Various studies have examined the indicators of success in graduate nursing programs, but as Iava (1994) contends, "There is a definite lack of research concerning who attends these programs and why they do so" (p. 317).

A Synopsis of the Literature

As mature women return to institutions of higher learning, they tend to bring with them vast life experiences and a unique configuration of needs, goals, values, expectations, conflicts, and fears (Glass & Rose, 1987; Grottkau & Davis, 1987). Many women returning to colleges and universities to seek advanced degrees face numerous role conflicts. Research is needed to determine how mature reentry women can meet the challenges and opposing factors in their return to higher education, such as increasing demands of

school, family, and a rapidly changing society. Perry's (1987) study of nurses as "Supermoms" emphasized this need. Barnett and Baruch's (1978) earlier research recommended more quality and quantity in research and theory development concerned with the mental health of women in midlife who return to academia.

Striving for a new identity, mature reentry women returning to higher education often experience a lack of credibility; they want to be taken seriously and not be perceived as marginal persons (Saslaw, 1981). The literature points to the importance of differentiating among groups of women on the basis of their past roles and experiences (Holliday, 1985). A paucity of research exists, however, that refers to women's past roles and experiences as they influence their return to graduate education. According to Clayton and Smith (1987) graduate education and personal growth rather than vocational goals become the focus of women as they become older; but the authors contend little empirical research has been attempted. This lack may be the result of studies conducted in gerontological literature to date which focus on men or "the elderly." Except in specific areas of research and study, older women tend to be ignored or subsumed under the category, "the aging," or "the elderly," or "nongender," as many such terms in the gerontological literature tend to infer. Important contributions can be made to the body of knowledge in gerontology, in nursing, and in education as a whole from studies of mature women students reentering higher education.

Formal education is often the catalyst that provides adults with a support structure for responding to inner imperatives that will change their lives and their work (Weathersby, 1977). Further research is indicated in determining the underlying impetus or imperatives of mature women returning

to graduate education. Findings from this type of research can be expected to impact teaching methods, andragogy, "the art and science of helping adults learn" (Knowles, 1990, p. 38), counseling, and course and program scheduling in higher education.

## Purpose

The purpose of this study was to investigate the return of mature women as nurses to graduate education in nursing in the midlife period. The following research questions emphasize the foci of the study

## Research Questions

1. What influences mature women to return to graduate education in nursing during midlife?

2. What roles do inner imperatives play in this decision-making process?

3. Are there personal challenges or obstacles encountered in their reentry into graduate education in nursing?

## Definition of Terms

**Mature reenty women** refers to women students, ages 40 to 65+, reentering higher education after having left the academic system for 2 to 20 or more years (Roehl & Okun, 1984; Tittle & Denker, 1980).

**B.S. prepared female nurses**, as used for this research study, are those students who graduated from a generic bachelor of science (B.S.) program in nursing.

**Generic** refers to a common or universal program of general education and nursing studies for undergraduate students entering a baccalaureate program in nursing for the first time.

**Inner imperatives** are special needs and motives for learning (Weathersby, 1980). The term "imperative" can also denote power, agenetic competency (White, 1979), or authority, from the perspective of a compelling duty to achieve.

## Delimitations of the Study

In an attempt to achieve a clearer picture of the phenomenon to be studied, the descriptive study design may impose a bias related to sample selection, sample size, and access to a target population governed by the administrative protocols of some universities targeted for the study. Therefore, any conclusions and generalizations derived from this study may be applicable only to this particular population and sample. A second limitation is the lack of established reliability and validity in the use of the instruments developed or selected by the researcher for this study.

## CHAPTER 2

## Review of the Literature

### A Historical Overview on Educated Women

More than 25 years have elapsed since the resurgence of the Women's Movement and the unveiling of women's issues. From a societal perspective, women have been viewed characteristically as less aggressive, more emotional, and less independent (Miller, 1986; Rubin, 1979). The inability of women to "gain a voice" (Gilligan, 1982) reflects these stereotypes of powerlessness, subjugation, and inadequacy. A period of self-discovery occurred as women began to break out of these socially constricted stereotypes (Solomon, 1985, p. 203). Many women learned to demystify certain aspects of their lives and gain greater self-sufficiency, assertiveness, and self-knowledge.

Dramatic changes in values during the 1970s led to a redefining of women's roles. While men's lives remained relatively static, choices for women expanded rapidly, forcing them to address both modern and traditional lifestyle patterns in their decision-making roles. Ambiguity and persistent uncertainty often resulted from these conflicting norms and choices. To develop an independent self-identity, self-determination and a diminishing need for continuous approval requires empowerment to face the reality of a social foundation of power that continues to endorse traditional feminine values (Bernard, 1988). According to Mason et al. (1991), education is a power resource that many mature women have been unable to pursue because

of economic and domestic restrictions as well as socialization patterns and forms of discrimination that have discouraged participation in various educational programs. Harding (1983) labeled this the "politics of non-consideration." Solomon (1985) postulated that the most persistent educational concern in the late 20th century should be how to enlarge the coeducational environment and assure that women are taken as seriously as men. In Solomon's (1985) view, women are still the second sex in most of academia. Even though women have more collegiate options than their male counterparts in this historical reversal, males predominate in graduate education and professional schools (Solomon, 1985, p. 203). Their perspectives and values remain deeply embedded in the academic disciplines.

Modern women face significant challenges throughout the life course to "have it all"; yet the social changes necessary to allow for ample choices have still to be resolved. Needless to say, prevailing norms regarding femininity in society remain. This is also true of women in less traditional roles. Femininity is still, to a large extent, equated with passivity, dependency, and pleasing men (Bernard, 1980, 1988).

Women's identity has long been enmeshed in the "married state" and viewed as "necessary for mature integration of personality" (Evans, 1985). Women's lives were reduced to their reproductive or family life cycle, tending to underestimate other important aspects of their lives, their value systems, human potential, and world views (Evans, 1985). Although early studies focused primarily on men's development, the resulting theories were generalized to all adults (Bardwick, 1980; Reinke et al. ,1985) Women's development, seldom alluded to, was viewed narrowly and judged aberrant if

gender development did not conform to already established male patterns (Gelwick, 1985).

Declining fertility, extended longevity, new marital lifestyles, family formation, and involvement in the labor force have changed the lives of many women (O'Rand & Henretta, 1982). Many more women, however, are still "roughing it" (Snyder & Bunkers, 1994), often finding it difficult to make inroads in changing roles even in these last years of the 20th century.

The Psychology of Women: Bridges to Understanding

The concept of adult development for women has its moorings in early psychological developmental theories centering on childhood psychology and derived from a biological orientation. The model of human development espoused by Bardwick (1980) and Giele (1982) posits the notion that psychological growth and change are intertwined and never cease. The model assumes that human beings desire the sense of actualization which accompanies and requires psychological and realistic change. As Bardwick (1980) and Giele (1982) propose, one can seek creative approaches to self-discovery and self-development that emphasize individual quality and human potential.

Past approaches to the study of the development of women seem inappropriate. Many of these approaches fail to consider the varying roles a woman may occupy. From Gilligan's (1982) perspective, the line of development seemingly missing from current psychological accounts is the failure to "describe the progression of relationships toward a maturity of interdependence, or to trace the evolution of the capacity for responsible caring" (p. 90). Miller (1976, 1986) contends that because women's development may not conform to age, career achievement, or life

stage as meaningful conceptions of life, movement must occur in developing a new psychology of women.

At no other time in history has there been an urgency for knowledge about women in the middle years. But as Colaruso and Nemiroff (1987) assert, the study of women in midlife has been "the remotest outpost on the research frontier" (p. xxii). Because a paucity exists in available data, the middle years in the life course of women would be a rich resource for research, particularly for women in midlife who return to academia. The longevity of women has expanded, their numbers are continually increasing in the population, and they have an established track record of advancement and achievement in their new pursuits.

Midlife Perspectives: Women in Transition

The aim of the fully developed person is the integration of responsibility for self and for others (Gelwick, 1985). All too often, however, women view their roles as caring for others to the exclusion of themselves. Women must learn to like themselves, to be good to themselves, to take responsibility, to implement choices, and to promote a sense of well-being (Giele, 1982). While decision making is a critical aspect of responsibility that promotes increasing ownership of one's self, self-responsibility is a crucial element in the articulation and achievement of life goals (Bardwick, 1980; Gelwick, 1985).

Often in the process of achieving these goals, women in their mature years find that they prefer to engage in more egalitarian relationships with their spouses and to establish careers outside the home. While men may agree in principle to changes in traditional relationships and career pursuits of their spouses, conflict may arise due to the potential impact these changes may have on their own lives (Grambs, 1989; Suitor, 1987). Having reached the

pinnacle of their own careers or jobs, many men may view this change from traditionalism as a threat to "becoming one's own man" (Bardwick, 1980; Levinson, 1978).

Women's Reentry to Academia at Midlife

Many mature women are making a transition in their lives, entering a new setting (college), exploring new frontiers, and adapting to the new role of student well into midlife and later life. Life transitions such as job change, family maturity, and change in marital status can provide an incentive to return to higher education. Entering college affects the shape and direction of the adult woman's life and, at the same time, incurs greater demands and expectations. Caracelli's (1988) research suggests that beginning or returning to college may be one way in which women attempt to build a new identity structure that can serve current or emerging developmental tasks. Bardwick (1980) proposes that most mature capable women will successfully develop a new sense of self, increased autonomy, and freedom from unwanted responsibilities in a contemporary world more accepting of their venturing out.

The decision to return to school is what Datan et al. (1986) term "a violation of inertia'; that is, the traditional student is one who has taken the path of least resistance to obtain an education while the nontraditional student has had to make the extra effort to return to school. Research on the decision to return to school proposes several themes (Glass & Rose, 1987; Holliday, 1985; Tittle and Denker, 1980): (a) a reevaluation of one's self brought on by divorce or death of a spouse; (b) maturity of the family which frees up more time to devote to personal interests; (c) preparation for a career change; (d) increased desire for education; (e) need for intellectual stimulation and

realization of potential; (f) the need for self-identity; (g) a pressing need for self-worth; and (h) an acute awareness of time limitations, especially in late midlife.

The work of Reinke et al. (1985), Timing of Psychosocial Changes in Women's Lives, focused on the question of timetables for psychosocial experiences and whether regularities in timing existed. The authors found that women's lives were oriented around relationships and that many self-reported psychosocial changes were associated with specific phases of the family-cycle (e.g., crises; maturational occurrences).

Mohoney and Anderson's (1988) interviews with 38 college women, ages 25-46, revealed that timing for women returning to higher education was determined by their relationships and life events rather than by motivation. The key notion in the timing of events model is that adult development is not paced by crises or by the sense of the average expected life cycle phase, but as a manifestation of a lack of synchrony in the timing of life events (Rossi, 1980). This "social clock" theory, developed by Neugarten (1977), portrays time in middle life as "time running out" which may provide the impetus for getting on with one's life. Returning to college in midlife may be one way to "beat a ticking clock."

A study by Ross (1988) combined descriptive and qualitative research procedures to investigate the developmental forces influencing women's decisions to reenter or return to college after the age of 25. Results suggested that despite the ability of most respondents to report events that significantly influenced their reentry decision, the role of such events might be better interpreted within a more complete life cycle context.

Mature Women as Students

The research literature in adult developmental psychology and in gerontology suggests that older adults have a substantial learning potential and a special need for educational opportunities throughout the life span (Butler, 1991; Hartley, 1980; Long, 1983; Lowy, 1986; Robertson-Tchabo, Hausman, & Arenberg, 1982; Schaie, 1982). The "older adult learner," however, is a nongender term that encompasses both men and women in its definition. Research on the "older adult student" typically fails to distinguish between males and females, particularly with regard to motivational factors influencing educational preparation (Hooper & Traupmann, 1984). The newer focus of research on returning students tends toward women under 50, especially women in their 30s and 40s. The research, however, tends to ignore the "inner imperatives" that Weathersby (1980, p. 59) describes and the special needs and motivation of women at midlife. This may be in part due to a lack of understanding of the motivation of mature women who return to higher education (Hooper & Traupmann, 1984).

Hildreth, Dilworth-Anderson, and Rabe (1983) surveyed 81 women over age 50 enrolled in college. Their findings showed that older women entered college to receive a degree, to achieve independence, and for employment preparation. The majority of older women indicated positive support from their families and anticipated employment after graduation. In Hooper and Traupmann's (1983) study of older women, 106 middle-aged students (outwardly oriented) and nonstudents (home oriented) were compared on attitudes toward age, perceived happiness and satisfaction, perceived physical health, number and severity of depressing symptoms, self-esteem, and autonomy. The student group reported better health, fewer and less severe

depressive symptoms, and higher autonomy. These findings question the stereotype society retains of older women.

Many young women choose to express their identity in multiple roles by attending colleges and universities as traditional college-age students, but what of the persistence and attrition status for this group of women who enter higher education later in life? Findings from Pirnot's (1987) longitudinal study of 29 women volunteers in a private liberal arts college in the Midwest showed that broad life value preferences (i.e., search for knowledge, truth, honesty, practicality, and religion) remained consistent throughout the reentry process. Reentry women persisted in school at a rate far exceeding that of traditional age students. Following Gilligan's (1982) axiom that one include oneself in the group of people deserving of care, it would seem that "persisters" in Pirnot's (1987) study would view themselves as deserving of care. Another group of persisters are minority, low income women interested in career advancement (Holliday, 1985). These women are described by Holliday (1985) as enthusiastic, highly motivated, serious, self-determined, eager to learn, and academically successful. Further research on mature women as students is integrated in other studies throughout this review.

## Variables Influencing the Education of Reentering Women

Motivation/achievement. The educational motivation of 200 adult undergraduate college women, 30-55 years of age, in four different academic groups was studied by Der-Karabetian and Best (1984). Analysis of the data showed older students scored significantly higher on the motivational factor of cognitive interest that reflected an internal drive for knowledge. Scores were found to be lower in forming social relations and meeting external expectations

of another person or authority. The researchers concluded from their findings that adult women in college have realistic expectations of their education. Professional advancement appeared to be a motivator for students in the health and administrative services, while those in the liberal arts curriculum chose this route because of cognitive interest and learning enjoyment. Der-Karabetian and Best's (1984) findings indicated that a high cognitive interest in education is suggestive of self-directedness and a strong internal drive for learning in returning college-bound women.

Fear of success (FOS) research suggests that women are not living up to their intellectual potential because they fear the consequences of success. According to Frelino and Hummel (1985), "Achievement, usually defined as 'masculine,' is thought to lead to unpopularity, loss of femininity, and inability for marriage. . .hence fear of success" (p. 2). Early research using college-age students found a disproportionately high rate of FOS among this group (Tresemer, 1976; Waterman, 1982; Zuckerman & Wheeler, 1975). In Frelino and Hummel's (1985) study, concern was directed to whether mature college students exhibited significantly less FOS than younger college-age women. The study showed that while college-age students, in general, may feel threatened by achievement, mature college women seemed to be more secure in their achievement efforts and more likely to have obtained what the authors termed "femininity credentials," those roles and functions of women sanctioned by society. Frelino and Hummel's (1985) findings suggest that women's attitudes toward achievement may be related to age but, more specifically, to life experiences, particularly the development of intimacy concerns.

Relationships between environmental and psychological predictors of career achievement motivation in 162 married, female reentry college students

were examined by Farmer and Fyans (1983) as part of a larger exploratory study. Students were grouped according to first and second year in study and by sex type (androgynous or feminine). A discussion of the findings suggested that feminine sex-typed women may be highly achieving given adequate support; while androgynous women, a more field-independent group, may be more highly successful in diverse environments. Fear of success was shown to be highest in highly motivated women. The study further showed that persons who have high achievement motivation do not necessarily have high career motivation.

Various studies in education have focused on reentry women as adult learners and their motives for learning. Replicating an earlier study by Maslin (cited in Clayton & Smith, 1987), the research focus centered on motives which underlie specific reasons that women return to college and whether these motives took on a pattern. One hundred women students, between the ages of 20 and 60 years of age, voluntarily participated in Clayton and Smith's (1987) study. The authors found that motive patterns differed from the original study and that more than one motive type can be derived from these patterns. One interesting aspect of the study concerned those women returning to school labeled "empty nesters." Clayton and Smith (1987) cited 17% of the women in their study were over 45, and nearing the end of their childbearing years. This finding stimulates speculation as to whether the stereotype of older women returning to college primarily for reasons of fulfillment after their children have left the "nest" is currently applicable. Based on the findings of the two studies (Clayton & Smith, 1987; Maslin, cited in Clayton & Smith, 1987), it would seem that such motives as escape from boredom, career preparation, or self-fulfillment often given for reentry women's return to college

may be inaccurate and descriptive of only a small portion of the population of returning women. The needs of older women students may be more related to independence and identity (Sands & Richardson, 1984). Self-actualization and emotional well-being may be prominent considerations among mature lifelong learners returning to college. To enable more women to achieve academic equality, motivation for reentry should be more adequately assessed.

Professional/career development. Relatively little emphasis has been placed on the professional development of women in recent years. High success seems to be achieved primarily by those women who engage in work and education continuously. Various factors related to personal and professional development in mature (age 35 and older) reentry women graduates were investigated by Speer and Dorfman (1986). The authors found that support from classmates and desire for intellectual stimulation were equally good predictors of perceived personal development and that a desire for career identity was the only predictor of perceived professional development. The work of Slaney and associates (1981, 1983, 1985) found some measure of career indecision in mature reentry women who returned to academia.

Stress, coping, and mental health in midlife women. Women's development involves managing what one has to do, accepting compromises and ambivalence in every commitment, and engaging in the future as viable, autonomous, and valuable women (Bardwick, 1980). However, the risk of role strain increases with this freedom to add new behaviors. The accumulation of new roles increases individual demands, particularly if conflict exists between personal and societal roles. These changes may provoke role conflict for the returning student. To resolve the conflict, the individual must relinquish

roles that are not personally satisfying rather than adding new behaviors to old (Glazebrook, 1984)

Using Hall's conceptual model of coping relevant to college-educated women and role conflict, Beutell and Hare (1987) investigated coping strategies for dealing with role conflicts among a sample of 92 returning women students. A significant finding was that professional and nonprofessional women used different coping strategies for different conflicts. The study indicated that professional women experienced more intense conflict between roles as "employee" and "homemaker" and between "employee and parent" than did nonprofessional women.

Using a descriptive survey design, also based on Hall's coping model, Perry (1985) studied the coping responses of 157 "mature students" enrolled in the study of nursing in a baccalaureate completion program. In responding to vignettes involving stress, the nursing students overwhelmingly chose negotiation as a means of coping with significant others in order to reduce role conflict and limit demands. The study revealed that the category "doing it all, the Superwoman mentality," was analogous to no coping at all.

Additional research involving mature women students returning to higher education at midlife examined factors which contributed to satisfaction and stress among this population. Kirk and Dorfman (1983) found that the most significant correlates of satisfaction with the student role were psychological support from children and friends, helpfulness of counseling, and helpful attitudes of professors in the college setting, which was the strongest predictor of satisfaction. While no indication was given regarding professional gender, these findings tend to contradict the male-dominated attitudes and classroom behavior of many university professors (Bernard, 1980, 1988). In

contrast, the character of an individual teacher/professor, rather than gender, may be the key factor in the teacher's influence on students (Rice & Hemmings, 1988, p. 558). Negative life events and family social support had significant main and interactive effects on the mental health of reentering female students as found by Roehl and Okun (1984). Conversely, Jacobi's (1987) study of the relationships among demands, coping resources, stress, and well-being in 210 reentry women students, 26 to 66 years of age, compared to 102 traditional women, 18 to 29, found that although reentry women faced more demands and conflicts across life domains than did traditional women students, they did not show higher levels of stress or illness. Hooper and Traupmann (1984) and Sands and Richardson (1984) found similar results from their research related to stress and mental health in mature reentering women.

Golan (1986) theorized that in order to facilitate the bridging process to bring about change, certain psychosocial/affective transitional tasks must be resolved in order to cope in a healthy way and move forward. These mature tasks would include:

> (a) developing new standards of well-being, (b) agreeing to lessened gratification, (c) changing one's self-image, (d) raising the level of functioning to acceptable norms, (e) achieving a comfort level in the new situation or role, (f) coming to terms with the new reality, and (g) seeking different ways of gratification and enjoyment (p. 31).

In this manner, says Golan, constructive coping can be therapeutic in preserving mental health.

Challenges, Obstacles, or Barriers to Reentry

The challenges, obstacles, or barriers encountered by reentry women in Glass and Rose's (1987) study can be categorized as either internal, external, or, at times, both.

**Internal barriers** can include guilt; anxiety; lack of self-confidence; lack of organization, successful performance; coping effectively with changing image; juggling the many roles of adulthood; insecurity about study skills and testing situations; perceived inability to keep up; possible resistance, often passive and disruptive, from spouse and family; economic insecurity; and perceived racist attitudes (Christian & Wilson, 1985; Glass & Rose, 1987).

**External barriers** are often those which deal with institutional policies such as admissions, financial aid, and special services which can have discriminatory outcomes. These outcomes include curricula that do not adequately address women, cultural diversity, or aging issues; maintaining an attitude toward returning women that their only commitment is to "drop-in-drop out" on university campuses (Chickering, 1988); nonflexible class scheduling; and lack of child care services (Glass & Rose, 1987).

Cross's (1981) topology presents a three-pronged approach to defining **educational barriers**: (a) ***situational*** - those restrictions which arise because of circumstances within the individual's life situation; (b) ***dispositional/attitudinal*** - restrictions on activity and/or interest in engaging in educational pursuits; and (c) ***institutional*** - tendency of institutions to have operating procedures undeveloped with the mature student in mind. These categories help to focus on challenges/obstacles/barriers which may have implications for women in the future.

The Concept of Ego-Development and Reentry Women

Weathersby (1977, 1980) posits three basic conditions that are thought to foster ego development: (a) varied direct experiences and roles, (b) meaningful achievement, and (c) relative freedom from anxiety and pressure. According to Weathersby, an axiom of ego development proposes that if higher education induces major changes in students' cognitive style, changes in other aspects of the personality are likely to be induced. In Weathersby's view, if the changes are significantly widespread and irreversible, a new stage of development may be reached.

A hypothesis generated from Weathersby's (1977, 1980) work postulates that adults who return to educational institutions have progressed along these dimensions as a result of life choices and informal learning. Many reentry students, particularly mature women, return to college campuses in response to deeply felt "inner imperatives" which may incur a radical transformation or readiness to undergo such transformations (Weathersby, 1980, pp. 58-59). Although data tend to be sparse, the available literature suggests that individual differences in ego development may be related to choice of college and to educational outcomes. Assuming this is so, the concept of ego development may be employed to gain a greater understanding of mature women students' reasons for enrolling in educational programs and their personal meaning of the educational experience. Implicit in ego development is an increasing ability to understand and articulate one's own motivation. Mastery of the process which Weathersby (1980, p. 60) terms "learning how to learn," is, in her view, the hallmark of self-directed learners. A knowledge of one's own learning process, an increasing sense of personal agency, and effectiveness in learning are characteristic of one stage of ego

development, the "individualistic" stage. The concept of ego development is a promising area of investigation in the study of women in midlife transition returning to higher education.

Psychological Androgyny

Several theories of adult development suggest that the developmental tasks of midlife include increased individuation in one's identity (Jung, 1933, 1966). By mid-adulthood, awareness of elements within the self may emerge characteristic of those which have earlier been repressed (White, 1979, p. 296). White (1979) further suggests the integration of sex-role identity as a major developmental process. As Marecek (1979) has pointed out, major demographic trends (e.g., longevity, work, changes in marital status, and return to education) favored androgynous functioning, inducing women to develop competencies in both masculine and feminine spheres of behavior and to seek additional satisfaction outside traditional roles.

According to White (1979), competencies can be classified into two categories: (a) agenetic competencies (instrumental/masculine), and (b) communal competencies (expressive/feminine). Agenetic competencies encompass capabilities, such as determination, industriousness, independence, and decisiveness the self has to achieve a goal, but not necessarily in competition (p. 300). Communal or expressive competencies encompass the capabilities of warmth, receptivity, altruism, and nurturance which foster interrelationships (p. 300). By using competencies in this manner, androgynous orientations may be more currently suited to mature women, especially those who tend to be highly differentiated in their sex-role orientations.

The concept formulation of androgyny has been credited to the work of Carl Gustav Jung (1933, 1966), who postulated that men were not forever masculine (animus) nor were women forever feminine (anima) but began to develop these recessed traits into their aging. Jung defined the task of middle age (ages 35-65) as "using the opposite of one's personality, feminine or masculine, as a guide to wholeness" (p. 310). This schema would suggest that one task of adulthood is to become androgynous, thereby melding the masculine and feminine sides of one's personality. However, few attempts have been made to measure this process (White, 1979). More recently, androgyny researchers have argued that it is logically possible to be both masculine and feminine, and the existence of both in the same person has been labeled "androgyny" (Bem, 1974, 1979; Marsh, Antill, & Cunningham, 1987).

Concepts of masculinity and femininity have received increased attention since the 1970s. Prior to this time, researchers assumed a traditional view of bipolar sex-role identity. The psychological attributes of masculinity and femininity were presumed to evolve logically and smoothly from physiologic differences present at birth or before to fulfill their "genetic destiny" (Cook, 1987, p. 473). Traditional conceptions of masculinity and femininity as dichotomous, bipolar variables with masculine behaviors at one end of the continuum and feminine behaviors at the other, have since been challenged (Bem, 1974, 1975; Spence, Helmreich, & Stapp, 1975). Bem (1974) originally proposed that androgyny replace masculinity and femininity as the norm for men and women's behavior. Her thesis was that an androgynous individual integrates masculine and feminine characteristics in an adaptive manner. Given masculine and feminine behaviors from which to

choose, the individual increases his/her behavioral repertoire. The wider the repertoire of behavior, the greater the adaptability in dealing with new situations and a changing environment. With this wider range of adaptability, Bem believes that the androgynous person will be psychologically healthier (Bem, 1979). The presence of masculinity-femininity interactions would support Bem's "balance androgyny" hypothesis emphasizing the notion that the balance or imbalance between these two sex types, rather than the absolute magnitude of either, is important for mental health and that mental health standards should be "genderless" (Bem, 1993, p. 121; Zeldow, Clark, Daugherty, & Eckenfels, 1985).

Bem (1975) posited that for both men and women favorable psychological adjustment should be associated with psychological androgyny, rather than sex typing. Androgynous persons would be maximally flexible, free to respond appropriately to situations, regardless of whether they call for the traditional traits or behaviors of masculinity or femininity. In contrast, highly sex-typed persons would be strongly motivated to behave consistently with an internalized standard of sex-role appropriate behavior, regardless of situational requirements (Bem, 1975; Silvern & Ryan, 1979). Many men and women strive to keep their behavior consistent with existing stereotypes by suppressing those behaviors that would be considered inappropriate for their sex. As a result, traits belonging to the other sex are not developed and the individual's full potential is not realized (Glazebrook, 1984, p. 3).

Operationally, androgyny is measured by the difference between a person's femininity (F) score and masculinity (M) score. The smaller the difference between (F) and (M), the greater the degree of androgyny (Bem, 1975; Wakefield, Sasek, Friedman, & Bowden, 1976). Bem (1975) confirmed

this definition in reiterating that an androgynous sex role represents the equal endorsement of both masculine and feminine attributes (p. 636). Sex role, or gender role, encompasses the constellation of personality attributes, attitudes, preferences, and behaviors a person acquires and learns to value through the sex-typing process (White, 1979). Sex-role socialization is the process by which individuals learn the values, beliefs, and behaviors assigned to them by virtue of their gender.

Several instruments have been developed to measure the usefulness of the construct androgyny in conceptualizing sex roles. The Bem Sex-Role Inventory (BSRI) (Bem, 1974), and the Personal Attributes Questionnaire (PAQ), designed by Spence et al. (1974), have been used most frequently as the operational measures of the construct. The BSRI was originally developed to measure self-concepts in terms of separate masculinity and femininity dimensions. Spence et al. (1974) later reformulated four categorical sex-type groups based on Bem's research, operationally defining these categories as:
(a) **androgynous** - high masculinity and high femininity attributes;
(b) **masculine** - high masculinity and low femininity attributes;
(c) **femininity** - high femininity and low masculinity attributes; and
(d) **undifferentiated** - low masculinity and low femininity attributes.

The concept of androgyny has sparked renewed interest in research concerned with sex typing. Bem's (1979) research on androgyny represented a significant advancement in the conceptualization of sex roles. Much of the research into the consequences of biologically consistent sex typing has been conducted with college students as subjects. Little has been reported, however, about the circumstances and adjustment of conventionally sex-typed individuals beyond the traditional college years.

Women, Androgyny, and Self-Esteem

Throughout history, society has defined the place of women in its midst. Furthermore, traditional goals of women have not been valued as highly as those for men. Women's early training was to be nurturant, passive, dependent, and intuitive while men's early training was toward being aggressive, independent, productive, and rational beings. Whether implicit or explicit, women are susceptible to cultural definitions of how they ought to be, and sensitive to the social guidelines that tell them whether they are doing a good job of being a woman (Josselson, 1987). Self-concept is determined by an individual's perception of self, interactions with others, and the environment. Self-concept is undermined if a person is in conflict with society's demands and feels inadequate because of it.

Several studies (Bem, 1977; Spence et al., 1974) tend to support the notion that feminine women have significantly lower self-esteem than do androgynous and masculine women. Bem (1977) reported analyses which separated the effects of the BSRI masculinity and femininity scores. The findings indicated that among men only masculinity, not femininity, has a significant effect on self-esteem. Among women, there was a significant effect of femininity upon self-esteem, but weaker than the main effect of masculinity.

In studies of the relationship between sex roles and self-esteem, the majority have found a relationship between androgyny or masculinity and higher self-esteem. In Heilbrun's (1986) study of self-esteem among women, the highest levels of self-esteem were found among androgynous women. The authors also found that masculinity was a better predictor of self-esteem than was femininity. Long (1986) found in her study of female professionals, college students, clients, and victims of violence, that the masculine

component of androgyny was the best predictor of self-esteem in all groups. The study also found that masculinity was the best predictor of self-acceptance in all groups except professionals. Femininity was generally not relevant in all groups as a predictor of self-esteem or self-acceptance in women. Educational levels emerged in Long's (1986) study as a slightly better predictor of self-acceptance than masculinity in the professional group.

Hoffman and Fidell (1979) suggested that androgyny by itself cannot explain complex adjustment patterns of individuals; therefore, it becomes necessary to take into account the life circumstances of those individuals as well as their attitudes and values in order to gain a more complete understanding of their adjustment. Hoffman and Fidell (1979) also found greater importance of self-attribution of masculine traits for predicting life circumstances and satisfaction, personality characteristics, and attitudes. Few reliable differences were found in their study between undifferentiated and feminine women, and between masculine and androgynous women.

In more recent research related to women and androgyny, Cook (1987) found from her study that both men and women agreed that roles assigned on the basis of sex were more restricting. Traditional roles were being challenged and new roles that better suit the individual's inherent abilities and traits were being substituted. Josselson (1987) credits the women's movement as having made challenging sex-role norms more acceptable for women. In more recent years, women have begun to reject societal notions of how they are expected to behave, experimenting with new roles they tend to find more challenging.

In their paper, "The Androgyny of Later Life: For Women Only?," Datan et al. (1986) described androgyny as "the innate bisexual nature (masculinity

and femininity) of men and women as they age, and in the case of women, the aggressive and managerial potential" (p. 2). Datan et al. (1986) expanded this notion of the androgyny phenomenon to women in midlife who are living out what the authors term the "developmental potential," considering the struggles women must overcome in choosing their life course. Further studies to investigate the development of androgyny have been suggested by Christian and Wilson (1985).

Nurses, Health Professionals, and Androgyny

Stereotypes defined women as deficient in characteristics traditionally viewed as prerequisites for success in certain occupations. An assumption has also been made that these stereotypes played a significant role in explaining why women tended to choose the "less prestigious female-dominated professions," such as nursing. These professions are traditionally labeled as typically feminine in nature and perceived by the public as a woman's field (Clerc, 1985, p. 100; Meleis & Dagenais, 1980). Contrasting the expectations of Bem's (1979) themes, Culkin, Tricarico, and Cohen (1987) suggested that female nursing students exhibited a sex-typed feminine pattern. The authors further proposed that the androgynous person is less likely to perceive the world of work in terms of sex-stereotyped notions.

Contemporary nursing studies described androgyny as an important trait for nurses. In Kinney's (1985) research, the androgynous type seemed a requisite characteristic for the "ideal nurse." As reiterated by Lukken (1987), psychological androgyny has been shown to positively relate to some degree of behavioral flexibility, self-esteem, personal adjustment, assertive behavior, and leadership sharing. Levine, Wilson, and Guido's (1988) study of critical care nurses found that androgynous women as nurses possessed higher levels

of self-esteem and achievement. In contrast, the assumption that low self-concept, lowered self-esteem, and feminine sex-role stereotype may have a direct effect upon nurses' delivery of patient care was borne out by Joseph (1985), who found that many nurses ascribed to typically feminine role models. These nurses experienced a lowered self-esteem and are believed to value being feminine and being a helper. Decision making, problem solving, and assertiveness were not strong points in nurses in her study. Kalish and Kalish (1976, cited in Joseph, 1985, p. 32) make the point that "nurses are so caught in their present mind set with multiple roles of wife, mother, nurse, that assuming a more decisive and assertive posture professionally, presents a real or perceived dilemma."

Nevertheless, traditional femininity may no longer accurately reflect the type of personality found in the nursing profession. For example, Martha Rogers (1989, 1991) proposed in her chapter on "Nurses in Space" in Perspectives in Nursing that "the androgynous personality is deemed the most propitious choice [for a space shuttle crew member], combining the best of female and male stereotypes in one - more specifically, those who are goal seekers and sensitive" (p. 215). In Lukken's (1987) study, the author found that the nursing program in her study attracted more androgynous subjects than feminine subjects. Lukken's (1987) proposed that as the personalities of students enrolled in nursing programs become more androgynous, "the characterization of this profession may change, with nurses acquiring a different status within the health care system" (p. 56). It may be that nurses who are more androgynous, flexible, and adaptable will be better able to survive the dynamic health care environment of the future. Nurses' feelings regarding their own characteristics have the potential to influence the manner

in which they view nursing roles. The likelihood is greater when nurses are able to integrate multiple-role expectations they experience in contemporary health care and to develop a more positive perspective toward nursing as a profession.

As Bem (1979) and Olds and Shaver (1980) assert, when the human ideals of traits rather than a mix of masculine and feminine sex type is attained, the concept of androgyny will have been transcended. Gornick (1978) adds, "When one integrates appropriate traits, regardless of sex, self-possession is achieved" (p. 169).

Empowerment

Empowerment is often depicted as an elusive concept encumbered with multiple meanings. Empowerment has been defined as (a) increasing the capacity of people to function in their own behalf; (b) the process of helping others to take control of the decisions that affect their lives; and (c) a mechanism by which people gain mastery over their own lives (Rappaport, 1981).

The conceptualization of empowerment, as proposed by Gibson (1991), is one of a social process of recognizing, promoting, and enhancing people's abilities to solve their own problems, and to mobilize the necessary resources to maintain control of their own lives (p. 359). Gibson (1991), using Keiffer's model to develop the concept, described the first stage of the model as "the era of entry," where exploration is unknown and unsure, while at the same time the demystifying of power and authority structures is in progress. Stage two, termed "the era of advancement," is characterized by a mentoring relationship for collaboration and mutually supportive problem solving. The third stage of Keiffer's empowerment model, "the era of incorporation," focused on the

development of organized leadership and survival skills and confronting the permanence and painfulness of structural or institutional barriers to self-determination (p. 356). Gibson (1991) moved Keiffer's model to its last stage, "the era of commitment," whereby the individual integrated new personal knowledge and skills into the reality and structure of the every day world (p. 356).

Torre's (1992) research on empowerment takes a different approach to understanding the concept in creating an instrument that could measure it. The author's study reflected the degree to which her sample of oppressed Hispanic women felt empowered and how this elusive concept could be defined and measured. According to Torre, (a) positive self-worth and confidence appear central to the empowerment process; (b) implicit in the empowerment process is the assumption that, regardless of age, people continue to develop throughout life; (c) empowerment is facilitated through education designed to enhance people's ability to think critically about their position and the world around them; and (d) empowerment can only occur if individuals recognize that the knowledge and skills they have acquired throughout life are valid and useful in coping with their environment (p. 22).

Dickenson-Hazard (1994) similarly defined empowerment as (a) control and choice over life and actions given to individuals trusted to serve and act for the common good of the entity which empowers; (b) accountability for meeting responsibilities to serve the common good; and (c) enactment, which rests with the individual (p. 2). In Dickenson-Hazard's view, "It is simply a matter of choice, control and commitment to exercise the belief that the answer to being empowered scholars lies within each of us" (p. 2). These

characteristics of empowerment proposed by Dickenson-Hazard (1994) defined the nurse and nursing.

Describing the enabling process from the perspective of nursing and nurses as the professionhood, Styles (1982) defined power as the capacity to act and she takes the position that "in modern perspective, power to act is not based on trappings and accoutrements, but on clear goals and effective relationships within a highly political and fluid internal and external environment" (p. 17). An advocate for the professionhood, Styles (1982) proposed that "reformation for nursing is internalized, that the dominant figure in nursing is our own image, and that the progress of nursing is better served by internal beliefs than by external criteria about professions" (p. 18).

Hall (1992) embraces the identity empowerment theory which flows from her writing about women and empowerment through real life interviews and case studies. The premise of identity empowerment, as described by Hall (1992) is to heighten sensitivity awareness of women to the intended and unintended consequences of their decisions and actions. Hall defines empowerment as "the individual and collective strengthening of the negotiating position in relation to the negotiating position of other people; contributing to development, growth and maturation of real talents and aptitudes; and recognition and responsibility as an equal" (p. 121). The 10 concepts embedded in identity empowerment theory include: self, dyad, triad, family, religion, definition of the situation, reference group, class, culture, and society. These concepts are intended to neutralize some of the inhibitions and entrapments endemic to age, gender, and social class, according to Hall (1992, p. 3).

The education of nurses is contributory to the power and influence they derive from it. Empowerment should not be construed as a power which tends to control or dominate others, but rather a personal sense of power which enables individuals to exercise control over their lives and achieve a sense of mastery and increased autonomy (Gibson, 1991; Hall, 1992; Torre, 1992). The acquisition of an advanced education is a means of attaining expert power, legitimacy, and windows of opportunity for those who seek it.

Self-Actualization and Self-Esteem

Self-actualization and self-esteem are important tenets of Abraham Maslow's (1954) theory of human motivation. Self-esteem forms the foundation of psychosocial health (Taft, 1985), particularly as it reflects one's self-perception of worthiness, developed throughout life interaction with others. Maslow (1954) found that individuals have two categories of esteem needs, self-respect and esteem from other people. Persons with high self-esteem tend to be more confident, capable and productive, while persons with lowered self-esteem tend to exhibit feelings of inferiority, helplessness, and discouragement (Maslow, 1954; Taft, 1985).

Maslow's (1954) idealized view that what a (wo)man can be, s/he must be, has been posited as the basis for identifying the psychological need for growth, development, and the utilization of potential. According to Goble (1984), Maslow regarded self-actualization as an aspect of one's personality that generally emerges after the need for love and satisfaction are met (p. 35). Based on Maslow's theory that the need for self-actualization can be met in work as well as leisure time, Goble (1984) proposes that a major requisite for growth, self-actualization, and happiness is commitment to an important job and doing it well through hard work, discipline training, and often

postponement of pleasure (p. 37). In Goble's view, this description of a self-actualizing person "could almost be taken as a description of a professional!" (p. 38).

Self-actualization implies inner motivation (freedom to express one's self in unique ways) or inner convictions (absorbed in ideas and ideals than in people and things) (Ebersole & Hess, 1990, p. 681). A discussion of the traits of self-actualized persons contained in the Personality Orientation Instrument (Shostrom, 1963,1974) used in this study and defined by Shostrom are presented:

1. **Time competence** - living more fully in the present rather than the past or future, but with the capability of retaining meaningful ties to both.

2. **Inner directedness** - independent and self-supportive and dependent on internal forces not others to provide direction.

3. **Flexibility** - ability to react to situations without regard to adherence to values or principles.

4. **Sensitivity to self** - responsiveness to one's own feelings.

5. **Spontaneity** - freedom to express feelings behaviorally; willing to be one's self.

6. **Valuing self** - high self-value and self-worth; ability to see and accept one's strengths as a person.

7. **Self-acceptance** - approval of self despite weaknesses or deficiencies.

8. **Positive view of others** - ability to see both good and bad in others. Opposites are viewed as positive and balancing factors in people. Opposites are also viewed as resulting in people's essentially good and constructive nature.

9. **Positive views of life** - ability to view life in a positive manner and view the opposites of life as meaningfully related.

10. **Acceptance of aggressiveness** - ability to accept one's feelings of anger and aggressiveness as natural.

11. **Capable of intimate contact** - able to develop warm interpersonal relationships with others, without expectations or obligations (Ebersole & Hess, 1991, p. 680; EdITS, personal communication, January 19, 1994; Knapp, 1990; Shostrum, 1964,1973).

Maslow believed "self-actualization was not possible in younger persons because it required wisdom and maturity to face the realities of life and choosing to be fully oneself" (cited in Ebersole & Hess, 1991, p 681). From this perspective, self-actualization is presumed to begin in midlife at a time when persons begin to explore their inner world, become increasingly interested in their internal status and self-determined needs, while developing satisfaction and continuity as they do so. Self-actualization implies that social surroundings are no longer of greatest import to an individual, but rather an inner source of strength which allows one to rise or transcend external sources without dependence upon external affirmation (Ebersole & Hess, 1991).

## Summary

Women as a diverse group make up more than 52% of the enrollment in colleges and universities today, and it would appear the numbers will increase well into the 21st century. With this expansion comes the awareness that these women come with their own agenda as adult learners. Mature women want to be taken seriously; their needs are numerous; and their goals secure in knowledge. Personal growth, high achievement, role conflicts, struggle for self-esteem and self-identity in a rapidly changing society also brings with it

challenges of midlife. Midlife is a time for introspection, motivation, and making choices. Bem's work on androgyny brings with it new ways to view the old and traditional roles of women generally, and women as nurses particularly.

Contemporary nursing studies described androgyny as an important trait for nurses and a requisite trait for the ideal nurse. Traditional femininity may not accurately reflect the type of personality found in the nursing profession today. Rogers proposed that the androgynous personality combines the best of female and male attributes in one, in those who are goal seekers and sensitive. Through education, mature women as nurses can become empowered to achieve mastery and autonomy over their own lives, both personal and professional. The ability of a woman to be what she must be is the basis for identifying the psychological need for growth, development, and the utilization of human potential--toward what Maslow views as self-actualization.

# CHAPTER 3

## Methodology

This study employed a descriptive survey design to investigate the return of mature women as nurses to graduate education in nursing in the midlife period; in particular: (a) factors that prompted their return during this period in their lives; (b) other variables that influenced their return; and (c) personal challenges or obstacles encountered in their reentry experience.

### Sample

The target population for this study was mature women prepared at the bachelor's level in the profession of nursing who had completed or were completing a National League for Nursing (NLN) approved graduate level program in nursing. A stratified sampling of all colleges and universities listed in the Regional Colleges and Universities with National League for Nursing Approved Graduate Programs in Schools of Nursing publication (NLN, 1990-92) comprised the sample pool. A second level sampling refined the sample to 25 colleges and universities in close proximity (a 450-500 mile radius) to central Virginia, whose graduate programs in nursing are housed in these institutions. Letters of introduction, an abstract of the study, self-addressed, stamped response cards, and sample survey packets were mailed to deans, program directors, or chairs of schools and/or departments of nursing in the 25 colleges and universities in the Mid-Atlantic corridor of the East Coast, requesting their participation. Survey packets included samples of the consent

form, the demographic survey, and the three standardized instruments used in the study.

A nonprobability multisampling of mature women in the profession of nursing who completed or were completing a NLN-approved graduate level program in nursing (Appendix A) was obtained from the rosters of the six participating colleges and universities with nursing programs. Schools of Nursing in these six institutions shared their packets with students, research committees, and faculty to obtain and reaffirm approval of their participation. The sample size determined for the study was 100. In institutions with less than 17 graduate students (one university had three consenting students), all students listed on the roster were included in the sampling pool. For larger institutions with more than 100 graduate students, subjects were randomly selected.

An introductory letter explaining both phases of the study and an informed consent form (Appendix B) for signature and return in the self-addressed, stamped envelope were mailed to 164 students and graduates of the graduate nursing programs. Students who met the study criteria and signed the consent form for participation in both phases of the study were immediately mailed the survey packet (the Brant Survey Instrument; three pretested, standardized instruments; and a self-addressed, stamped envelope). Criteria for participation were defined as: 40-65 or more years of age, female, bachelor's preparation in nursing, and enrollment in or graduation from a NLN-approved graduate program in the colleges and universities participating in the study. Signed informed consent forms and instruments from each participant are kept in a confidential file by the researcher.

Instrumentation

The Brant Reentry Survey Instrument, a researcher-developed instrument designed to elicit demographic data on the return of mature women in nursing to graduate education, and three standardized research instruments: the Torre Empowerment, the Bem Sex Role Inventory (BSRI), and the Personality Orientation Inventory (POI) were employed in the survey. An elaboration of the self-administered instruments follows:

**The Brant Reentry Survey Instrument,** a color-specific and numerically coded instrument, contained items that yielded demographic data relative to the study. The instrument inclued two open-ended items related to (a) participant decisions to return, and (b) major challenges, obstacles, or barriers perceived in returning to graduate education in nursing. Participant responses to these two items were entered into the database for content analysis in the qualitative section of the study. The demographic information included such items as birth year, race/ethnic background, education, religious orientation, enrollment in graduate education, and type of employment. No age variable was included on the survey.

To establish content validity, six well-respected experts at the doctoral level in the health care field were asked to independently review and complete the survey instrument for relevance, appropriateness, and clarity. Eight students in the graduate nursing program of a large university were also asked to complete the instruments to be used in the study and indicate in writing each item's relevance, clarity, ease of responding, and time frame for completion. One student chose not to complete the entire packet of instruments. Based on student and expert responses, the Brant Reentry Survey Instrument was refined, submitted for review, and approved by the

dissertation Chair and the Chair of the Human Subjects Committee of the College of William and Mary prior to implementation in the study. Because no instruments were found to measure the variables of inner imperative directly, the BSRI, the Torre Empowerment Instrument, and the POI were selected as indirect measures of these variables.

The **Torre Empowerment Instrument** (1992) was designed to measure such variables as autonomy and freedom as facets of empowerment. Items in subscale A of the Torre Empowerment Instrument (pp. 259-260) related to individual empowerment, and items in subscale B (pp. 261-262) related to group empowerment were incorporated into the study. Items were both positively and negatively directed. Subjects rated their degree of agreement or disagreement with items on the instrument, using a 5-point Likert Scale (Appendix C). The data were scored by adding all weighted items, properly oriented, then tallying the final score. Sample items from subscale A and subscale B of the Torre Scale are provided:

**Scale: Strongly Agree to Strongly Disagree**

Subscale A - Individual

If I need help I know where I can get it

I do not have many freedoms in my life

Subscale B - Group

It is just as important to help others become fulfilled as it is to help oneself

To make it in this world, people must work alone and get what they can for themselves

Because Torre's research was related to instrument development, multiple tests of reliability and validity were established for this instrument. Convergent validity, using Spearman's Rank Correlation Coefficient was found to be $r = .43$, $p < .01$ (Torre, 1992, p. 169). Cronbach's test of internal consistency

resulted in an alpha of .77 for Scale A, the predominant scale in this study "designed to measure autonomy, confidence, self-worth and related issues" (Torre, 1992, p. 165).

The **Bem Sex Role Inventory (BSRI)** (1981) is a self-administered 60-item inventory which takes approximately 15 minutes to complete and can be administered in either the long form or the short form. The short form BSRI consists of 30 adjectives and phrases, while the long form used for this study, is inclusive of the entire battery of 60 adjectives and phrases. These specific adjectives and phrases were selected by Bem to "categorize individuals according to their sex role, as a function of the degree to which they identify with an array of gender-typed attribute" (Bem, 1979). Instructions included with the scoring guide were designed for hand scoring. The responses for this study were computer coded in data entry. Subjects indicated their response to each item using a 7-point Likert scale. These responses indicated how true each of these characteristics were as they applied to the respondent (Appendix C). A sample adjectives, phrases, and ratings are presented:

<u>Scale: Never of Almost True to Always or Almost Always True</u>

| ITEM | RATING |
|---|---|
| 1. I defend my own beliefs | 7 |
| 2. I am self-reliant | 4 |
| 3. I am conventional | 3 |
| 4. I make decisions easily | 6 |

Internal consistency for the long form of the BSRI was established by Bem (1976), using Coefficient Alpha for the F-Score. Reliability for Femininity and Masculinity was .78, respectively. The Coefficient Alpha for the M-Score on Femininity (.86) and Masculinity (.85) proved highly reliable. Test-retest

reliability for Masculinity and Femininity scores on the original form were .76 and .89 for males and .82 and .94 for females, respectively (Bem, 1981b, p. 15).

The **Personal Orientation Inventory (POI)** (Shostrom, 1964, 1973) measured values and behaviors important in the development of the actualizing person; e.g., time competence, inner directedness, self-actualizing value, self-regard, self-acceptance, among other values and behaviors operationally defined in Chapter 2. Time competence (TC) and Inner Directedness (I) were the major values measured, since all subvalues were subsumed under those two categories (EdITS, personal communication, January 19, 1995). The instrument contained bipolar item pairs of comparative values and behavior judgments from which to choose. Because of the nature of the scaled items used in the POI, Shostrom (1964,1973) clarified that the items were not forced choice items but rather paired opposites (Knapp, 1990). Raw data from the instruments were mailed to EdITS in California for processing the data from computerized forms to disk by the company's data analyst. The disk was returned by mail and data were entered into the Statistical Analysis System (SAS) database. Examples from the POI include:

1. (a) Sometimes I am irritable when I do not feel well.
   (b) I am hardly ever irritable.
2. (a) I fear failure.
   (b) I do not fear failure.
3. (a) Impressing others is most important.
   (b) Expressing myself is most important.
4. (a) I try to be sincere but sometimes I fail.
   (b) I try to be sincere and I am sincere.

The Inner Directedness (I) scale has been found to be highly stable and internally consistent in all studies. Test-retest coefficients for the scales of Time Competence (TC) and Inner Directedness (I) were .75 and .88, respectively (Knapp, 1990; Wise & Davis, 1978).

Procedure

A multilevel sample of 164 nurses was drawn from the roster of 410 female nurses enrolled in or graduated from graduate programs in nursing at the six colleges and universities participating in this study. An introductory cover letter; an abstract; a self-addressed, stamped envelope; and an informed consent document approved by the Humans Subjects Committee of The College of William and Mary in Virginia were sent to each individual in the sample. Survey packets containing an introductory cover letter; an informed consent document (Appendix B); a self-addressed, stamped envelope; the Brant Reentry Survey instrument; and the three standardized instruments (Appendix C) were mailed to each subject upon return of the signed consent document. All demographic instruments were color coded and numerically coded in accordance with the color and numerical codes assigned to each participating university. Each survey packet also contained a special blend of tea bagged in a matching color-coded envelope and attached to a card and verse. A professional business card was affixed to assure legitimacy of the investigator.

Because the survey packets were mailed during the spring 1994 semester of the school year, a 3-4 week return rate became the norm. Completed instruments and signed informed consent forms were sorted by batch, date, color, and matching numerical identification. Matching

color-coded cards were sent 3 weeks after the return date to nonresponders, eliciting their participation by returning the informed consent forms and completing the questionnaires. New survey packets were offered to participants who had misplaced or forgotten to complete them. Five subjects who had overlooked completion of the packet, or requested a new one, contacted the researcher either in writing or by telephone. Alumnae associations of the participating schools were contacted, requesting permission to insert an announcement of the study in their newsletters. No follow-up telephone calls were initiated to those who had not returned the instruments after the second mailing.

Coding Schema. Demographic data were coded as to numerical categories, frequency distributions were calculated, and participant comments were entered by computer using SAS. Using the BSRI Scoring Guide, which accompanied the instrument manual, responses to the BSRI, a three column instrument (Appendix C), were calculated across three distinct categories: masculine attributes (M), feminine attributes (F), and discrete adjectives. The raw scores of (F) and (M) were then divided; thus, the computed average of the (F) raw score (r) divided by 20 yielded the standard score. This procedure was followed consistently for each subject to obtain the average (F) and the (M) raw scores, then computerized in increments of 5/10ths. The standard scores of (F) and (M) were then changed into standard differences and then to a t-score for each participant, based on the BSRI scales.

Computerized data from the Bem Inventory were examined in two ways:

1. T-scores were compared to the BSRI Scoring Guide and computerized; then standard differences scores were translated into t-scores.

2. Data were classified into four categories or operational schemes: Masculine (M), Feminine (F), Androgynous (A), and Undifferentiated (U), as recommended by Bem (1981b) and Spence et al. (1975), using Feminine (F) and Masculine (M) total scores.

Schema were created in the following manner:

If F > 4.90 & M > 4.95 - then schema = Androgyneous
If F > 4.90 & M < 4.95 - then schema = Feminine
If F < 4.90 & M > 4.95 - then schema = Masculine
If F < 4.90 & M < 4.95 - then schema = Undifferentiated

Personal Orientation Inventory

Completed POI instruments were forwarded to the EdITS/Educational and Industrial Testing site in San Diego, California where POI instruments were scanned and raw scores were transferred to a computer disk. Turn around time for the return of the original instruments and raw data disk to this study's data entry system was 1 week. Raw data were categorized for computerization by item, by state, by cohort, and by aggregate. A printout of POI data by state accompanied the disk. Data were then collapsed into the two major scales: Time Competence (TC) and Inner Directedness (I). Three subcategories were created for computer input: (a) over-actualized (OA), (b) self-actualized (SA), and (c) under-actualized (A). Raw scores were translated to standard scores; then, using the profile sheet, standard scores were translated back into raw scores to determine OA, SA, and A. A standard score less than 20 indicated subjects were less actualized. A standard score greater than 60 indicated subjects were over-actualized:

Low 20_____ <standard score> _____ 60 High

Raw scores were hand-plotted on selected individual profile sheets to determine how each subject compared with scores of self-actualizing others (Shostrom, 1963,1974).

Phase Two - The Interview

The purpose of this phase of the study was to: (a) examine the two extremes in the study sample based on instrument data; (b) obtain perceptions leading to their decision to return to graduate education in midlife; and (c) construct personal histories for case study analysis of the data. Phase Two of the study was implemented between January 30 and March 20, 1995. An informed consent document (Appendix B) had been completed by each participant prior to data collection to participate in this phase of the study.

To complete the qualitative segment of the study, extremes of the study sample were computer-generated, based on the responses of the study sample to the BSRI, Torre Empowerment, and POI instruments used for data collection. The scores were compared, two distinct subsets were identified, and interviews were conducted based on these findings (Appendix D).

An unstructured telephone interview was arranged with each participant. Only four participants in the subset lived in close proximity to the researcher. Participants lived in Maryland, North Carolina, Pennsylvania, and Virginia. Participants verbally agreed to taping their session and to using a speaker telephone. Interviews lasted approximately 1 hour. A description of the participants and their educational experiences and perceptions were obtained. The interviews were conducted within 1 year of completion of the survey data collection in Phase One of the study. Case studies were constructed and analyzed by the researcher.

# CHAPTER 4

## Results and Discussion

Descriptive and statistical analyses of data from the research study are presented in this chapter. Both quantitative and qualitative data analysis methods were used in the study. Chapter 4 has been divided into three sections: Demographic Data, the Research Questions, and Qualitative Data. Quotations from the study sample and from the telephone interviews conducted with participants in each of the subset samples whose scores best met the upper and lower levels or extremes on the Bem Inventory (BSRI), the Torre Empowerment Instrument, and the Personality Orientation Inventory (POI), were used as illustrations in supporting the theses.

## Demographic Data

### The Study

Of the 25 schools of nursing drawn from the roster of colleges and universities from October 1993 to January 1994, 24% of the schools participated in the study; 28% expressed willingness but were constrained by academic policy; 12% chose not to participate; and 36% did not respond. Of the 164 survey packets mailed to the sample, 5% were returned with no forwarding address listed with the post office; 13% of the respondents did not meet the study criteria; 2% of the respondents gave informed consents but ultimately did not complete the survey instruments; and 31% of the sample did

not return the survey instruments. Reminder cards mailed to nonrespondents produced five additional responders, increasing the response rate to 62%. No further follow-up action was taken. Participants in the study sample attended, or had completed, graduate nursing education in colleges and universities in Maryland (24%), North Carolina (17%), Pennsylvania (30%), and Virginia (28%). Research data were collected from January 1994 through March 1995.

Demographic Findings

Individual, cohort, and aggregate data were entered into the Statistical Analysis System (SAS) during the summer and fall months of 1994. The term cohort was used in this study to denote persons born within a similar time period, but not necessarily studied over time (Ward, 1987). Using Ward's definition, two cohorts born (a) between 1926 and 1949, and (b) between 1950 and 1955, were established for the study.

The Before 1950 cohort. Most of the study sample (66%) fell in the Before 1950 cohort. Fifty-three percent of the participants in this cohort were born between 1945 and 1948. Of those participants born between 1945 and 1948, 19% were born in 1947. One percent of the study sample was born in 1936. In the birth order for the cohort, 40% of the participants were first born, 35% were second born, and 19% were third-born. Forty-seven percent of the participants were married; 43% assumed caregiving responsibility for children; 47% provided care for their spouses; 22% were caregivers for their parents; and 9% cared for grandchildren.

Both mother (97%) and father (95%) lived in the home while the participant was growing up; in some homes, so did the grandmother (19%) and/or grandfather (12%). More mothers (51%) remained at home with their

families than did mothers (49%) who went out to work. Of those mothers who went out to work, 46% worked continuously, while 54% worked intermittently.

The basic nursing education for the Before1950 cohort included graduation from diploma programs (38%), with the greatest number of participants graduating between 1964 and 1968. For those participants (19%) who graduated from an associate degree program, the greatest number of participants graduated between 1980-1981. The percentage of those who attended baccalaureate (BS) programs (3%) was much less than those who graduated from BSN programs (91%). The lower percentage of participants who graduated from BS programs may have been attributed to graduation from academic programs other than nursing. Sixty-eight percent of the participants in the Before 1950 cohort had enrolled in or graduated from master's degree programs, while 4% were enrolled in or graduated from doctoral programs. Thirty-three percent of those who completed a master's program graduated between 1993-1994. Of those currently enrolled, 72% were enrolled part-time. Forty-six percent enrolled between 1 and 4 years after graduation from BSN programs.

Of those participants currently employed, 68% were employed full-time while 29% were employed part-time. The predominant employment positions were found in education (18%), and staff nursing (18%), followed by administration (8%), research (7%), advanced practice (7%), and middle management (7%). No participant was engaged in private practice; one participant was actively seeking employment; and another had since retired.

Born 1950 and After cohort. The 1950 and After cohort comprised 34% of the study sample. Most of the participants in this cohort (84%) were born in

1952. In the birth order of participants, 30% were first born, while 46% were second born. Frequencies for the remaining years did not exceed 1.2%. Eighty-one percent of the participants were married; some (12% ) never married. Caregiving responsibilities included spouse (42%); children (72%) between the ages of 17-21; and parents (4%). None of the participants in this cohort were providing care for grandchildren. All but one participant (96%) grew up with both parents in the home during the "growing up" years. Grandmothers (12%) and grandfathers (8%) also lived in the family household. Sixty-two percent of the mothers worked outside the home. Of those mothers working outside the home, 62% were working in interrupted employment.

Basic nursing education was obtained through diploma programs (36%); associate degree programs (36%); BSN programs (88%); and other baccalureate programs (4%). More diploma graduates (44%) completed their nursing education in 1974, while more BSN graduates (18%) completed their education between 1993-1994. Of those nurse participants who enrolled in graduate education at the master's level, 56% enrolled in part-time study. Forty-four percent of the cohort had earned their master's degrees, 21% had graduated between 1992-1993, while 31% graduated in 1994. Seven percent of the cohort had either completed a doctoral program or were continuing in the program. Three percent of the cohort were awaiting acceptance in a doctoral program or recently conferred.

Fifty-six percent of those participants in the 1950 and After cohort were working full-time, while 24% were working part-time; 12% were students; and one participant was seeking employment at the time of the study. The positions held most frequently by this group were education (21%), middle management (17%), and staff nursing (17%). Other positions held were

administration, research, consultation, and advanced practice. None of the participants were retired. Aggregate data are summarized in Table 2.

## The Research Questions

Among mature women, as nurses, in the midlife years:

1. **What influences their decision to return to graduate education in nursing?**

Analysis of survey data show that the predominant decision-making influences centered around (a) personal goal fulfillment (40% of all responses), (b) career advancement and opportunities (37% of all responses), and (c) desire to learn (32% of all responses). Twenty-five percent of the sample cited one or more responses and all responses were counted. Four percent of the participants cited other factors which influenced their return to graduate education; for example, required in order to maintain their employment position; required by their state to teach at the master's level; employment benefits of vested retirement and tuition for children; nursing scholarships; and bodily injury.

Personal goal fulfillment. Nurses who perceived goal fulfillment as an influencing factor in their decision to return to gradute education supported this notion by citing their needs to: (a) fulfill a motivational desire, (b) achieve a personal goal, (c) prove to themselves that they could succeed--that they "could to it," (d) satisfy a personal challenge or an inherent need, (e) actualize a goal set in high school, (f) move forward, (g) achieve greater autonomy, (h) achieve the goal to get an advanced degree, (i) achieve the dream to earn an advanced degree at their Alma Mater, and (j) fulfill a personal need for competence, and (k) knowing it was time.

Table 2

Characteristics of Mature Women in Nursing Who Returned to Graduate Education in Nursing

| Characteristics | (N = 84) | Frequency | (%) |
|---|---|---|---|
| Birth Year | 1926-1935 | | |
| | 1936-1945 | | |
| | 1946-1955 | | |
| Birth Order | First child | 31 | 37 |
| | Second child | 32 | 39 |
| | Third child | 12 | 14 |
| Childhood | | | |
| Mother | In home | 81 | 96 |
| Father | In home | 80 | 95 |
| Grandmother | In home | 14 | 17 |
| Grandfather | In home | 9 | 11 |
| Significant Influences | Mother | 31 | 36 |
| | Father | 7 | 19 |
| | Parents equally | 18 | 20 |
| | Grandparents | 12 | 13 |
| | Others | 9 | 10 |
| Mother's Work | At home | 44 | |
| | Not home | 45 | 54 |
| | Continuous | 17 | 41 |
| | Interrupted | 25 | 59 |
| Adult Marital Status | Married | 63 | 75 |
| | Divorced | 9 | 11 |
| | Separated | 2 | 2 |
| | Widowed | 1 | 1 |
| | Single | 9 | 11 |
| Caregivers | Spouse | 38 | 46 |
| | Child | 44 | 52 |
| | Parents | 14 | 17 |
| | Grandchildren | 5 | 6 |
| Basic Nursing Education | Diploma | 31 | 37 |
| | AD | 20 | 24 |
| | BS | 3 | 4 |
| | BSN | 75 | 90 |

Table 2 (cont.)

| Characteristics | (N = 84) | Frequency | (%) |
|---|---|---|---|
| Graduate Education | Master's | 53 | 64 |
| | Doctoral | 3 | 4 |
| | Graduate Study | 58 | 69 |
| | Full-time | 17 | 29 |
| | Part-time | 41 | 70 |
| Entry Year | 1993-1994 | 35 | 42 |
| Year Completed | 1994-1995 | 15 | 27 |
| | 1990-1993 | 19 | 35 |
| | 1986-1989 | 10 | 18 |
| | 1984-1985 | --- | ----- |
| | 1980-1983 | 4 | 7 |
| | 1976-1979 | --- | ----- |
| | 1975-1978 | 7 | 13 |
| Current Employment Status | Full-time | 52 | 64 |
| | Part-time | 22 | 27 |
| | Seeking | 3 | 4 |
| | Student | 3 | 4 |
| | Retired | 1 | 1 |
| Current Positions Held | Educator | 21 | 26 |
| | Staff Nurse | 20 | 25 |
| | Middle Management | 10 | 13 |
| | Researcher | 9 | 11 |
| | Administration | 9 | 11 |
| | Consultant | 4 | 5 |
| | Advanced Practice | 8 | 10 |

Career advancement/opportunities. Reentry nurses who cited career advancement/opportunities as factors which influenced their decision making, supported their decision to: (a) become more marketable, (b) advance their nursing career, (c) gain more career ladder mobility, (d) seize the opportunity for investment, (e) expand career opportunities, (f) change their career path, (g) meet the changing role of nursing, (h) become promotion/tenure eligible, (i) advance to independent practice, (j) get the job they wanted, and (k) increase their autonomy.

Desire for learning. Nurses in the study cited the desire for learning as a decision-making factor in their return to graduate education to: (a) fulfill a desire to learn more, (b) satisfy the need for more advanced education to achieve their educational and personal goals, (c) take the necessary step to graduate education at the master's and doctoral levels, (d) learn new/ advanced skills, (e) enhance their critical thinking, (f) replace frustration with present knowledge base (g) broaden their clinical practice base, (h) become credentialed in their area of expertise, (i) become more knowledgeable in nursing theory and research, (j) use the opportunity "to do more" for their patients, and (k) satisfy a need to know what direction nursing is taking. Factors influencing the decision to return to graduate education are presented in Table 3.

2. **What roles do inner imperatives play in this decision-making process?**

For this study, inner imperatives are operationally defined as those variables of empowerment measured by the Torre Empowerment Instrument (Torre, 1992), gender attributes measured by the Bem (BSRI) (1979, 1981) Instrument, and Time Competence (TC) and Inner Directedness (I), the major

Table 3

Factors Influencing the Decisions of Mature Nurses

to Return to Graduate Education in Nursing

| | |
|---|---|
| **Personal Goal Fulfillment** | **40%*** |
| Personal desire to earn a Ph.D. | |
| Dream to complete education at Alma Mater | |
| A long-term desire to get my MSN | |
| Advance knowledge for personal goals | |
| Need for more education to achieve goal | |
| Motivational desire | |
| Personal goal | |
| It was time. . . | |
| Prove to myself that I could do it | |
| Goal set in high school | |
| **Career Opportunities** | **37%*** |
| Allow more options | |
| Need advanced degree for future goals | |
| Desire to advanced nursing career | |
| Career mobility | |
| Employment opportunities | |
| Benefits | |
| Increase autonomy | |
| Need to have advanced degree to teach | |
| Promotion | |
| **Desire to Learn** | **32%*** |
| Desire for increased knowledge | |
| Desire to be best prepared | |
| Enhance my abilities | |
| Love of learning | |
| Need to know directions nursing is taking | |
| Intent to pursue doctoral education | |
| Opportunity to do more for my patients | |
| Credentialed in area of expertise | |
| Desire for more education | |
| Frustration with present knowledge and lack of advancement | |

Note: *Percent of all responses counted.

scales of the Personal Orientation Inventory (Shostrom, 1963, 1974) which together measure traits of self-actualization.

Results of the Torre Empowerment Instrument

Analysis of the weighted and counterbalanced scores on the Torre Empowerment instrument revealed that all nurses in the study sample possessed characteristics of empowerment to a greater or lesser degree. Ninety-two percent of the nurses were found to be the more empowered of the study sample. Only 8% of the nurses were found to be less empowered than the majority of the sample. Both the minimum (63) and maximum (86) scores obtained from the Empowerment instrument used in this study were greater than those of Torre's pre-pilot test scores which yielded a minimum score of 35 and maximum score of 64. The difference in scores may be attributed to the composition of each sample regarding ethnic, cultural, and educational variations in the backgrounds of Torre's sample of Hispanic women and this larger group of mature professional nurses.

Results of the Bem (BSRI) Inventory

Analysis of the responses to the long form of the Bem instrument revealed that 48% of the study sample were identified as exhibiting the androgynous attribute; 23% the femininity attribute; 18% the masculinity attribute; and 9% were undifferentiated. The median raw scores for the Femininity scale (5.15) and the Masculinity scale (5.23) found in this study compared similarly to the median raw scores for the Femininity (5.10) and Masculinity (4.80) scales suggested by Bem (1981) for sample subjects who are more similar in composition; for example, a sample of women. In other words, more of the nurses in the sample were found to be androgynous (that

is, possessing a balance of both masculine and feminine traits) than feminine, masculine, or undifferentiated (that is, possessing less of the attributes of femininity and masculinity) on the Bem instrument (Spence et al., 1975).

Results of the Personal Orientation Inventory (POI)

Analysis of data from the POI Inner Directedness (I) scores found that most nurses in the sample were identified as either under-actualized (53%) or self-actualized (42%). Only 6% were over actualized as measured on the instrument. The raw scores of the over-actualizers fell between 101 to 112 on the Inner Directedness (I) trait referred by Knapp (1990) as the "intellectualized or pseudo-actualizing" range. The raw scores for the under-actualizers fell between 59 to 85, sometimes referred to as the "fake good" profile (Knapp, 1990). The raw scores of the self-actualizers fell between 86 and 100 referred to as the "actualizing" range by Knapp (1990).

On the POI Time Competence (TC) trait, 59% of the sample were found to be under-actualized, and 38% self-actualized. Only 3% were considered over-actualized as measured on the instrument. Raw scores for the over-actualizers fell between 30 and 23. Raw scores for the under-actualizers fell between 9 and 17. For the self-actualizers, raw scores fell between 18 and 20. A score of 20 may be indicative of either self-actualization or over-actualization on TC (Knapp, 1990).

These findings indicate that more nurses in the study perceived themselves as under-actualized than self-actualized on both the Inner Directedness and Time Competence scales. As Renee, a subset participant, reflected, "I may have gained power. . .through 26 years of knowledge, a lot of knowledge to draw from, but I don't particularly see it as a power force in my perception of myself." Nurses who perceived themselves to be

self-actualized as measured by both POI-TC and I would be considered more fully autonomous, inner directed, present-oriented, and self-fulfilled.

Results from Examining Two Extremes of
the Study Sample by Instrument

Two distinct subsets of the study sample, **Subset X and Subset Y**, were computer-generated to implement Phase Two of the study between January 30 and March 20, 1995. Criteria for Phase Two included the selection of five participants whose scores fell in the upper levels or extremes and five participants whose scores fell in the lower levels or extremes of the Torre Empowerment, the Bem (BSRI), and the POI instruments. The instrument scores of each subset were examined separately and scores were compared. Interviews were initiated based on these findings. The interviews and results of the data will be discussed in the Qualitative Data section to follow.

**Subset X.** Table 4 presents the scores at the upper levels or extremes for this subset on the three standardized instruments. The five participants who comprised this subset exhibited the androgynous attribute, scored between 18 and 21 on the POI-TC with a mean of 20, and between 92 and 97 with a mean of 95 on the POI-I. The scores for **Subset X** fell between 82 and 84 as measured by the Empowerment instrument with a mean of 83, the maximal scoring range for the instrument is noted by Torre (1990, p. 144). Participant E in this subset scored as androgynous on the Bem instrument, but scored lower on the raw scores of TC (12) and I (63), a finding that may be indicative of the participant's self-perception as under-actualized. The empowerment score for this participant was lower (68) than the overall scores of **Subset X**. The scores of Participant E were eliminated from the calculation of mean scores on the three instruments.

Table 4

Subset Scores and Norms for Gender Attribute

Androgyny, POI-TC, POI-I, and Empowerment

| Subset Respondent | Gender Attribute | POI-TC and Scores | POI-ID and Scores | Empowerment Scores |
|---|---|---|---|---|
| A | Androgyny | SA - 21 | SA - 96 | 82 |
| B | Androgyny | SA - 20 | SA - 93 | 84 |
| C | Androgyny | SA - 19 | SA - 92 | 82 |
| D | Androgyny | SA - 18 | SA - 97 | 84 |
| E* | Androgyny | LA - 12 | LA - 63 | 68 |
| Group Norms | All Subset Androgyny | 20 | 95 | 83 |

Note: SA = Self-Actualized
LA = Less Actualized
* = Outlier

**Subset Y**. Table 5 presents the scores at the lower limits or extremes for this subset on the instruments. The five participants who comprised this subset were undifferentiated. Their scores on the POI-TC fell between 15 and 20 with a mean score of 17, and between 83 and 89 on the POI-I, with a mean score of 87. The scores of **Subset Y** fell between 71 to 80 on the Empowerment instrument, with a mean score of 76, lower than the maximum scoring range cited by Torre (1990, p 144). Participant B scored as undifferentiated on the Bem instrument, self-actualized on both POI-TC (19) and I (98), approaching the over-actualizing raw score range. The Empowerment score (80) for Participant B was above the mean for the remaining participants in **Subset Y**. The scores of Participant B were eliminated from the calculation of the mean scores on the instruments. A comparison of Tables 4 and 5 shows that, while some variability exists in the comparative scores of the subsets, the variability tends not to be substantially wide.

## Qualitative Data

A discussion of the interview process with the two distinct subsets of nurses in the study and their experiential worlds ensues.

### An Overview of the Interview Process

Eighteen participants who met the criteria for this phase of the study were identified. Telephone calls to participants who lived in Maryland, North Carolina, Pennsylvania, and Virginia were attempted on three different occasions. These telephone calls resulted in responses from 12 participants. Five of the 12 participants who met the criteria for the upper levels or extremes as measured by the three instruments, and five of the remaining

Table 5

Subset Scores and Norms for Gender Attribute

Undifferentiated, POI-TC, POI-I, and Empowerment

| Subset Respondent | Gender Attribute | POI-TC and Scores | POI-ID and Scores | Empowerment Scores |
|---|---|---|---|---|
| A | Undifferentiated | SA - 20 | SA - 87 | 80 |
| B* | Undifferentiated | SA - 19 | SA - 98 | 80 |
| C | Undifferentiated | LA - 17 | LA - 89 | 74 |
| D | Undifferentiated | LA - 15 | LA - 87 | 71 |
| E | Undifferentiated | SA - 15 | SA - 83 | 79 |
| Group Norms | All Subset Undifferent | 17 | 87 | 76 |

Note:
SA = Self-Actualized
LA = Less Actualized
* = Outlier

participants who met the criteria for the lower levels or extremes of the instruments, agreed to be interviewed for the study. Interviews were conducted within 1 year of the initial survey. Personal information and participant signatures obtained earlier in the study and kep in confidential files were confirmed. Verbal agreement was obtained by telephone to tape the individual interviews and to log notes over a time period of 45 minutes to 1 hour. Due to a taping error, 2 of the 10 interviews were unrecorded, but notes of each interview were kept in the log. All interviews were voluntary and unstructured with the exception of occasional cues provided by the researcher.

Upon termination of each interview, data were immediately transcribed by the researcher to preserve the accuracy of the content, prevent loss of the data, and assure a best fit between what was recorded and what actually occurred during the interview (Boydan & Biklin, 1981). The data were then transposed to a case study format, analyzed for relevant themes, and categorized by the researcher. A fictitious name has been given to each case study to protect the privacy, confidentiality, and identity of each participant. Grammatical editing was employed for greater readability. All interviews, transcribed in their original form, remain in locked files accessible only to the researcher.

A Description of the Subsets of Mature Women

Two distinct subsets emerged from the study. Five androgynous women as measured by the Bem instrument, comprised **Subset X**. All of the women were identified as belonging to the Before 1950 cohort. All but one of the nurses were married, one nurse was divorced, and each of the nurses had at least one child, although the children were either finishing high school or in college. Megan and Virginia were pursuing post-master's degree nurse

practitioner education. Sheila completed her doctorate in May, 1995; Phyllis recently graduated from an accelerated master's program and was seeking a "job"; and Norma completed her master's education and was actively employed in nursing. The span of years between their first nursing program and their most recent graduate experience ranged from 5 to 19 years. All but one nurse in this subset was self-actualized in both POI-TC and I. All but one nurse in the subset scored above 80 on the Empowerment instrument indicating that this subset of nurses was the more empowered, inner directed, future oriented, and self-actualized.

The five women in **Subset Y**, also identified as belonging to the Before 1950 cohort, were undifferentiated as measured by the Bem instrument. Four nurses were married, one nurse was divorced and a single mother, and all had two or more children at home. Janine is currently a doctoral student; Lisa is preparing to enter doctoral education but not in nursing; Yvonne earned her master's degree in May, 1995; Renee graduated with a master's degree in 1994 and is employed as a clinical nurse specialist in a large hospital; Mary has a master's degree in education and is now a master's student in nursing after having taught nursing for more than 22 years in a BSN program. The intervening years between the nurses' early nursing education and their most recent graduate education ranged from 10 to 25 years. Two of the nurses in this subset were less-actualized on both the POI-TC and I; one nurse was under-actualized on POI-TC and self-actualized on POI-I, and two other nurses were self-actualized on both the POI-TC and I. All but one participant scored less than 80 on the Empowerment scale indicating that nurses in **Subset Y** were empowered and self-actualized or under-actualized to some degree, but to a lesser degree than were those nurses in **Subset X**. No recent

illnesses were identified in either subset, although one nurse in **Subset X** referred to herself as a "cancer survivor." Another nurse in **Subset Y** experienced the trauma of the death of her mother, a significant support figure in her life, during her master's education.

The Interviews: Themes and Perceptions of Nurses in the Subsets

As a collective, nurses in **Subset X** and **Subset Y** were found to be positive in their thinking, philosophical about life experiences and their meaning, and definite about the direction they wished to pursue. Each of these nurses could be considered "persisters," as one woman's university professor described them; "pioneers who forged their way" into graduate education in nursing in midlife not knowing what their future holds, and concerned about the direction nursing will take in the health care arena. During the interviews, nurses in each of the subsets indicated they knew what they wanted, knew how to obtain it, and wished to excel in their pursuit of a goal.

Specific themes emerged from the interviews of the women who comprised each subset. Themes and perceptions were merged and categorized as (a) support systems; (b) philosophic views; (c) education as empowerment; (d) mature women as nurses; (e) self-fulfillment; (f) personal future at midlife; and (g) a special category, views on nursing. The themes and perceptions identified from this research further support Research Question 2 that inner imperatives do play a role in the decision-making process of women as nurses who return to graduate education in nursing in midlife. The categorial synopses are described here.

**Support systems.** Support systems varied. By far, however, the primary support system was the family unit. While most husbands were described as very supportive, two women did not share this view. Family discord occurred, but as one participant described it, "All survived and were none the worse for wear for the experience." Other supporters included specific professors at the universities the women had attended, some nursing faculty, and occasionally a mentor or chaplain. Peers were not viewed as favorably in their experience.

**Philosophic viewpoints.** Philosophies of life and living tended to be on a higher plane, thoughtful and lived. Three persons described their relationship with a higher power and the strength of that relationship as involved and committed. The life goals for one participant had changed direction as a result of this "spiritual" relationship. All participants were firm in their beliefs that they had the ability to accomplish what they set out to do and believed that a person should do with one's life as much as one is able. Faith in self and a "belief in a being stronger than one's self," destined for something, and being directed in this manner were the views expressed by two or more women in the subsets. One participant added that her personal philosophy has always been "never burn bridges--keep all doors of communication open to everyone."

**Education as empowerment.** Education was viewed among the women in each subset as authority bestowed upon or assumed; as power through knowledge; as control; as security; a gift; and/or as empowerment. All of the women in the subsets agreed that education helped them to have more control and/or mastery of their personal and professional lives. Mature nurses in each subset told of the need to prove to themselves that they could succeed; to view the world through a broader lens. These nurses perceived themselves as

sufficiently empowered to empower others through their knowledge and skills. One nurse described the most empowering and challenging experience in her life of developing a phenomenological master's thesis, and defending her right, and "I did!" [her emphasis]. Only one woman was unable to cite empowerment as experienced in her life.

**Mature women as women and nurses.** Being a woman and a nurse was not foreign to the women in **Subsets X** and **Y**. There was no hesitation about expressing their views in this realm. Most of the women enjoyed being a woman and a nurse, and viewed womanhood in nursing as nurturant and caring. Most of the nurses considered this notion "nothing out of the ordinary--that is what nursing is all about." To some nurses, nursing was viewed as one's life work; a means of giving back what had been given them. To others, nursing was a commitment made early in life and not regretted. Three women commented, "I have always enjoyed being a woman and being a nurse." A strong emphasis was placed on the perception that "women can do anything they set out to do."

Four nurses referenced womanhood and nursing as still strongly influenced by the bureaucracy of the institution; still a patriarchal system, usually run by men; and influenced by the orientation and socialization of society. Two more women referred to nursing as "cannibalistic to its young" (Meissner, 1987). No direct reference was made to being "oppressed," "subservient," or "manipulated" in the profession. Most of the women interviewed advocated "ridding ourselves [nurses and nursing] of the stereotypes that permeate our thinking and get on with collaboration in the profession."

**Self-fulfillment**. Self-fulfillment and self-actualization were often interchanged in the discussion. All of the women perceived themselves as self-fulfilled and/or "self-actualized," but not necessarily to the same extent, however. Goble's (as cited in Fuszard, 1984, p. 37) description of self-actualization as Maslow (1954) had described it, fits this theme: "Without exception. . .self-actualizing people are dedicated to some work, task, duty or vocation which they perceive as important. Commitment to an important job and doing it well, is a major requirement for growth, self-actualization and happiness."

Most of the nurses in the two subsets viewed the educational experience as one of self-fulfillment; something you have in your imagination and experience subjectively; a "warm fuzzy." Self-fulfillment was a high priority early in one nurse's education because "other things must be put aside, not act on what other people tell you to do." Nurses in each of the subsets expressed the need to improve themselves in some personal way in order to feel fulfilled and satisfied.

**Personal future in midlife**. The personal views of the women in each subset were, except for two, futuristic. There was no concern evident in those women who viewed their future as "opportunity." One nurse expressed some concern that she was getting no younger and was not really sure what she was going to do. Another nurse described it this way, "I do not feel the need to be in the fast lane at this stage of my life. I feel the time clock is ticking." Still another did not think that she had enough energy to go through a doctoral program at this stage of her life, but, as she asserted, "If I cannot find anything else that satisfies me, I'll just go back for that doctorate." As indicated by

most of the nurses interviewed in the two subsets, their new degree, whether master's or doctorate, had prepared them for new challenges in their lives.

**Views on nursing.** The nurses in each of the subsets had something to say about nursing and their recommendations for the future based on their educational, professional, experiential, and personal perspectives. The concern for nursing's place in the future and the direction the profession will take were most evident in the responses of each subset and of the study sample as a whole. Additional responses related to nursing will be described in Chapter 5. Because the subset samples of X and Y represent less than 10% of the study sample, the results of the interviews should be interpreted judiciously.

3. **Are there personal challenges or obstacles which mature women encounter in their return to graduate education in nursing?**

Personal challenges or obstacles were encountered and existed for the mature women as nurses who returned to graduate education in nursing. Responses from nurses in each subset and from the study sample addressing this aspect were content analyzed by the researcher.
The results in support of Research Question 3 are presented in the following sections.

Challenges, Obstacles, or Barriers of Each Subset

To categorize and classify data related to major challenges or obstacles in returning to graduate education in nursing reported by nurses in **Subsets X** and **Y**, Cross's (1981) best-fit topology, a three category scheme for defining barriers, was used to distinguish specific responses of the nurses in each subset. These topologies are categorically defined below. More than one response was given for the survey item. All responses were counted.

**Situational barriers** are those restrictions which arise because of circumstances within the individual's life situation. Examples of situational barriers cited in the survey include: (a) a lack of understanding on the part of the spouse of the need (for the nurse) to earn another degree; (b) the many demands of children on an already full schedule; (c) assuming caretaking for elders in the family; (d) stress and fatigue resulting from "balancing family, work, and school"; and (e) needing financial assistance to complete one's education.

**Dispositional/attitudinal barriers** are those which place restrictions on activity and/or interest in engaging in educational pursuits and attitudes reflective of one's emotions. Examples cited in the survey which help to describe this category include: role confusion/conflict; guilt; "buying into" the "Super-mom phenomenon" (Perry, 1985), gratitude for remission from terminal illness; logistical or geographic constraints in attending a college of choice; and losses such as family members, possessions, esteem, and time for self.

**Institutional barriers** are reflective of the tendency of institutions to have few operating procedures developed with the mature student in mind (Cross, 1981). For example, this scenario described by a nurse participant reflects a confrontational experience in the work situation with an administrator who always seemed to be "one step ahead of me." The nurse inquired whether a position would be opening in that hospital for a clinical specialist. The man, in a controlling manner, responded "Absolutely not." The nurse left the job for another more satisfying position on a career level track. Other examples would include enrolling for courses that were poorly described in the university catalog; faculty; admission criteria more reflective of traditional students than mature adult learners.

Challenges, Obstacles, or Barriers of the Study Sample

The major challenges or obstacles reported by the study sample in returning to academia have been grouped under six common categories as synthesized in Table 6 in support of Research Question 3.

**Family demands.** (37% of times mentioned). Family was perceived as the primary priority, regardless of the desire to return to education or the demands placed upon the sample studied. Parenting; caregiving, the "sandwich generation phenomenon" of caring for elder parents, children and grandchildren; and psychologically giving themselves permission to return to graduate education without guilt were among the issues.

**Work.** (35% of times mentioned). Work was of pragmatic import because of tuition benefits for children, retirement credits, seniority, and accrual in vested rights. Many participants indicated they will likely return to the same work environment after completing their program. Full-time work was not viewed in a positive light by the faculty in master's and doctoral programs, as perceived by these women, because of its "negative influence" on student learning. Other women viewed "work" as a means of honing skills while reaping the benefits and enjoyment of their employment. One participant voiced her commitment to work after 22 years (of teaching).

**School.** (34% of times mentioned). Participants revealed that, in their view, organizing their school, work, and family responsibilities was stressful, even though returning to graduate education was a personal goal, a career opportunity, or a desire to learn. Learning expectations of the faculty, program, and the university were perceived by some as overwhelming. Advanced practice program offerings were not clearly represented (in their perception) to two women who enrolled in programs that were not reflective of

their goals or expected program outcomes. These nurses attributed their misguided reentry in graduate education to "inefficient advisement." One nurse described the stress of her personal decision to relocate to another state to obtain a quality education while maintaining a commuter marriage. Another nurse described the stress of relocating to her spouse's new job in a large metropolitan city during her last semester in graduate education. Still another nurse enrolled in graduate education wherever she and her family relocated (over a 10-year period) in order to achieve her goal of earning a master's degree.

**Time management**. (30% of times mentioned). Some families planned and strategized together to enable participants to return to academia. Others did not discuss their return, since they felt their families were accustomed to their "life long learning" habits. Being a single parent, having to work, planning for education, raising a family, and concerned about finances were the concerns of two or more participants. Getting used to "not being all things to all people" was seen as "very hard to adjust to." "There is just no time. . . ."

**Finances**. (22% of times mentioned). Getting a loan as a single parent, to complete education on a full-time basis; incurring financial loss; fear of failing financially; and working 12-hour shifts to earn money to pay taxes on a scholarship gift, were situations cited by the respondents. One participant, unable to afford babysitting expenses, turned to her parents-in-law for assistance. Another participant took a cut in pay in her position to return to academia. Feeling guilty about taking money away from the family to finance education was a singular issue. Finally, one participant sold her home to pay off her educational debts only to learn that she was still indebted to the federal government "for the next 10 years!" [her emphasis].

**Commuting.** (15% of times mentioned). Participants, some of whom lived in rural communities, found travel to and from the universities and the clinical experiences they were required to attend fatiguing and time wasteful; an interference in scheduled time; unsafe to drive home in the late hours; and an added expense. Parking on the academic campus after having driven a long distance to attend classes was a constant frustration for one participant. Driving time consumed 30 minutes to 4 hours for six or more participants. These data are found in Table 6.

Table 6

Challenges, Obstacles, Barriers Perceived by Mature Nurses Who Return to Graduate Education in Nursing[a]

| All Responses | Frequency of Times Mentioned | Percent of Times Mentioned |
|---|---|---|
| Family Demands | 31 | 37 |
| Work | 29 | 35 |
| School | 28 | 34 |
| Time Management | 25 | 30 |
| Finances | 18 | 22 |
| Commuting | 12 | 15 |
| Program/Faculty Expectations | 11 | 13 |
| Skills | 9 | 11 |
| Time for Me | 8 | 10 |
| Retain/Concentrate | 6 | 7 |
| Energy | 6 | 7 |

[a]Most participants identified more than one challenge, obstacle, or barrier in their statements

# CHAPTER 5

## Summary and Discussion

A summary of the study and the major findings are presented in this chapter. Limitations are stated and recommendations for future study are given.

### Summary of the Research

The purpose of this descriptive study was to investigate the return of mature women as nurses to graduate education in nursing in midlife; in particular (a) factors that prompted their return during this period in their lives; (b) other factors that influenced their return; and (c) personal challenges or obstacles encountered in their reentry experience. Both quantitative and qualitative analyses were used in the study. A composite profile of mature women as nurses in midlife (age 40-65+ years), returning to NLN-approved programs in graduate education in nursing, was constructed using the SAS for data entry and descriptive statistical manipulation.

A sample of six colleges and universities in the mid-Atlantic corridor participated in the study. Multilevel sampling was used in the selection of the sample. Data used in this study were collected between October 1993 and March 1995. Three standardized instruments, the Torre Empowerment Instrument (1986, 1992), the Bem Sex-Role Inventory (BSRI) (1975, 1981), the Personality Orientation Inventory (POI) (Shostrom, 1963, 1974), and a researcher-developed tool, the Brant Reentry Survey Instrument were used in

the data collection phase. Telephone interviews were conducted with two distinct subsets of mature nurses, five women who (a) scored at the upper levels or extremes, and (b) five women who scored at the lower level or extremes of the instruments. Interviews were synthesized into case studies and analyzed by the researcher to generate themes common to all who were interviewed. The major challenges or obstacles encountered in the educational experience of all mature nurses in the study were also synthesized into case studies and analyzed for common themes by the researcher (Appendix E). Responses from each subset and the study sample are integrated into the section on Research Questions as illustrative and supportive of those questions.

Research Questions

In an effort to expand the body of knowledge regarding reentry women in midlife, the following research questions were studied:

1. **What influences the decisions of mature women to return to graduate education in nursing?**

Three predominant influences were identified in the decision making of baccalaureate-prepared women in nursing to return to graduate education in nursing in midlife. Those influences were, in rank order: (a) fulfillment of personal goals, e.g., "I always wanted to get my master's degree"; (b) career opportunities and career advancement/opportunities, "I want to have my own independent practice and regain autonomy"; and, (c) desire to learn, e.g., "I returned to graduate education because of my love of learning."

An assumption may be made that because mature nurses are said to be in middlessence (Neugarten, 1977), they may have no interest in advanced

education; their interests lie in slowing down the pace. This research has shown that the majority of nurses in the study sample have actively demonstrated their interest in advancing their education and moving into the future with new expectations. These findings support Iava's (1994) findings regarding mature women in her study who return to master's education. This research also supports Hildreth et al. (1983) and Sands and Richardson's (1984) findings that the need to be creative, responsible, and knowledgeable does not decrease as women become older.

Sheila, Yvonne, and Norma, three of the many nurses in midlife who participated in this study reflect these findings in making their own decisions to return to graduate education.

**Sheila**, who recently completed her doctorate more than 20 years after her basic nursing program, attributed her decision to return to graduate school to "fulfilling my personal goals. I feel very self-actualized and very satisfied with where I am now. While it may not be for personal gain, I know I am destined for something and I am preparing in the best way I know how."

**Yvonne** attributed her return to graduate education to "looking for a way I could be credentialed so that I could obtain a job. I think I went into my graduate program not knowing what it was all about. I found that there were other exciting avenues to explore. I think my goals are getting out there and doing something with my education. I really know something now and I need to do it."

**Norma**, now a member of the faculty in the school of nursing in which she completed her master's degree, described her return to graduate education as "convoluted, but a good combination. An instructor contacted me personally and that made all the difference in the world to me. I didn't look

any further for another graduate program [to which to return]. I felt broadened in what I was able to do and that is what I wanted to get from my graduate education. Self-fulfillment has always been a high priority since my early education, because you have to put some other things aside; to not do what someone else wants you to do. I still feel fulfilled because I am older now, and I guess that speaks to your study. I now see that there are other things to learn." Norma's response is reflective of Weathersby's (1980) premise that learning how to learn is the hallmark of self-directed learners.

**Lisa** is another example of nurses in midlife in the study sample who reflects these findings: "Well, I have done everything in midlife. I feel I have more flexibility, more self-esteem, more choice, and I do have an inquiring mind. The drive to move on in education comes from within and you have to want it badly. It has to come from within. In my future, I see myself getting that doctorate."

The responses of these nurses support Der Karabetian and Best's (1984) study that high cognitive interest is suggestive of self-directedness and a strong internal drive for learning in returning to higher education. In applying the model of self-actualization, as Bardwick (1980) and Giele (1982) suggest, creative approaches to self-discovery and self-development could provide answers through theory development that emphasize individual quality and human potential.

2. **What roles do inner imperatives play in this decision-making process?**

Among baccalaureate-prepared women as nurses, inner imperatives played an active role in their decision making to return to graduate education in midlife. The constructs of inner imperatives identified as empowerment,

gender attributes, time competence, inner directedness, and self-actualization guided the study. The BSRI (Bem, 1981) is a self-administered, easily scored test designed to categorize individuals according to their sex role as a function of the degree to which they identify with an array of gender-typed attributes. The tool has demonstrated its usefulness empirically over the past 2 decades. This study was particularly interested in whether the androgynous attribute was an identifiable attribute in this study of mature nurses. Mature nurses in the study identified with the androgyny attribute to a greater degree than with the femininity, masculinity, or undifferentiated attribute. This finding supports Lukken's (1987) finding that nurses who perceive themselves as androgynous are generally more flexible, adapt readily to new situations, and can assert either masculine or feminine attributes as situations demand.

The Torre Empowerment Instrument (1990), one of a limited number of such instruments in the research field, is a measure of both individual and community empowerment. The tool, consisting of five sections, was originally designed to "evaluate the effectiveness of policies and programs which attempt to empower people" (p. 3) in order to gain a better understanding of the concept. Torre's instrument is a reliable and valid tool, but needs to be further tested empirically to strengthen its reliability and validity in research. This study employed only 2 of the 5 sections; those particularly related to individual empowerment, to ascertain the degree to which mature nurses in this study perceived themselves to be empowered. Based on the responses of the study sample, more nurses scored moderately to greatly empowered on the instrument. The nurses who were identified as androgynous, however, were not necessarily those who scored highest on the empowerment instrument. This finding is suggestive of Torre's (1992) assertion that

empowerment can only occur if individuals recognize the importance and validity of their own knowledge and experience (p. 23).

Shostrom's (1963, 1974) Personality Orientation Inventory (POI) is an instrument for measuring "personal self-fulfillment defined through concepts of self-actualizing, using a 'paired opposites' format" (Knapp, 1990, p. 1). The tool comprises two major scales which measure the traits of inner-directedness, time competence, and 10 subscales. Only the major scales were used in this study to measure the degree to which these nurses perceived themselves to be inner-directed and time competent. The tool has been extensively tested empirically in humanistic psychology and other fields such as nursing. Its use in nursing has been primarily with undergraduate nursing students. A greater percentage of nurses identified as androgynous were found to be self-actualized on both POI-TC and I, as compared to the gender attributes, masculinity, femininity, and undifferentiated.

In summary, the majority of nurses in the study sample were found to be androgynous in their responses on the Bem instrument, empowered to some degree on the Torre instrument, and moderately to highly actualized on the Personal Orientation Inventory, regardless of gender attribute. Perhaps, as Lott (1988) asserts, "Gender differences are better understood if related to learning antecedents and situational determinants than if based solely on gender" (p. 222). For nurses who scored lower, this outcome may have occurred because these women underestimated their self-perceptions; hence the self-selected choices would not be reflective of their true selves. The POI (Shostrom, 1963, 1974) in particular is highly agenetic (self-assertive) and the major scores consist mainly of endorsement of agenetic statements (White, 1979).

Of interest to the study was the written comment made by Pat, a study participant, that "the 'forced choice' statements on the various questionnaires [in the packet] were difficult [for me] to answer because they are such absolutes. In my life, I have found very little to be absolute." Lowered confidence and self-esteem may have also been influencing factors. When the variables of gender attribute, empowerment, and self-actualization (inner-directedness and time competence) were used to measure the extent to which women in the two subsets of the sample responded on these instruments, the scored comparisons of the subsets revealed both similarities and differences; however, the variations were not significantly different.

3. **Are there personal challenges or obstacles encountered in their return to graduate education in nursing?**

Personal challenges, obstacles, or barriers were identified on the survey instrument by the majority of mature nurses in the study sample. The most frequent challenges or obstacles as experienced by the study sample fell into the following categories: (a) family demands, (b) work, (c) school, (d) time management, (e) finances, and (f) commuting. These findings compare similarly with the findings of Hildreth et al. (1983) in their study of older women in college. Other interesting challenges or obstacles that were reported, but with less frequency and consistency by the study sample included: (a) illness of family and/or self; (b) caregiving of children and parents; (c) concentration and retention of material; (d) commitment to making sacrifices to continue education; (e) difficulty in establishing enduring relationships with other students; (e) incurring multiple losses--of family members due to death or divorce, and freedom, i.e., time for self, autonomy, and youthfulness. While the study findings tended to reflect a more negative view of the nurses'

return to graduate education, these personal challenges or obstacles described by Virginia, Janine, Sheila, Alice, and Bettye revealed positive influences expressed in the study sample.

**Virginia**: "I was a single parent when I returned to graduate education. I returned for purely personal reasons. I did not consult anyone when I returned to school--I just went! I am an intelligent person and I always thought of knowledge as power. The person with the knowledge has the power. I like to be boss because it gives me authority to make decisions. On the other hand, I was never satisfied with my sense of self. I have come to terms, not particularly with Virginia, but to be secure in who I am."

For **Janine**, the major challenge or obstacle for her personally was "being psychologically free to go back to school."

**Sheila's** challenges centered around "taking the GRE's and passing the math section. I had to get over that obstacle before moving on. I guess it was making the GRE experience less fearful--there is no doubt about it; it was fearful because I was out of school for so long. Once I got over that hurdle and began my first semester [in graduate school], I said, 'I can do this--this is for me.' It was then that I began to realize that only at that point was I open to what I could get out of my education, rather than whether I could meet the demands of what I was being asked to do."

**Alice** also found challenges in returning to graduate study: "Learning new skills, such as writing at the graduate level, becoming disciplined and organized in my studying, and tuition expenses incurred in my return. However, before I returned to my studies, I realized that I was experiencing 'burn out and was tired of fighting the windmills of change and the resistance to change.' Returning to grad school was the spark which reignited my

passion for nursing. Returning to grad school has also been an affirming of my experiences as a nurse and my evolved philosophy of nursing."

**Bettye** attributed her major challenge to return as "just getting started."

Issues and concerns identified as obstacles by study participants specific to the nursing discipline, centered around graduate program offerings, faculty/student relationships, program requirements, the future direction of nursing as an organized body, and the role of nurses and nursing in the health care arena. **Edith**, **Ellen**, **Evelyn**, **Ruth**, **Irene**, and **Marge's** concerns about nursing and nursing education are revealed here.

**Edith's** concern was that "there was no way to determine which adult students had experience and what we learned on our own by working in the profession." She continues, "I found myself feeling extremely distressed trying to meet my job and the school requirements. Also, there were yearly changes in the program which benefitted those who followed [us], but frustrated those of us who had already enrolled. I believe master's programs should offer some recognition of experience. Having worked in a university setting, it is more clear to me now that a degree is given more consideration than experience."

**Ellen**, a Ph.D. candidate, was concerned with faculty/student relationships. She described her experience as "rude and disrespectful treatment in my nursing program from some faculty whom I consider more my peers than 'superiors,' although I respect their knowledge and achievements. We are all about the same ages. I consider this treatment a form of 'pecking order' behavior. Another concern is program offerings that require full-time (9 hours) of coursework and sometimes expects an apprenticeship for $10.00

an hour! Most of us in this program work full time for the benefits of our employment."

**Evelyn's** challenge in being a graduate nursing student "at my age" was role conflict. She described her role conflict in this way: "At one point in time I am a professional nurse, an independent, self-sufficient adult, coping with the work setting, as well as life in general, and then the next moment I am a student being treated as though I were a helpless, dependent being with inadequate decision-making capabilities. Having taught for many years at two universities, it is very difficult to sit in a classroom of doctorally-prepared faculty members who, in my view, know little about teaching. I have always enjoyed learning and going to school, but I can honestly say that there has not been much enjoyment in this educational experience. It has taken its toll physically, emotionally, and financially. The question that haunts me most is, 'Will it all be worth it?'"

**Ruth**, who earned her doctorate 21 years after she completed undergraduate study, also echoes the experiences of **Ellen** and **Evelyn**. In her view, "The major challenges [or obstacles] in my nursing education, especially my doctoral education, were faculty members who spoke down to doctoral students even though some students were older than they and had equal, if not more, clinical experience. Referring to the students as 'kids' was inconsiderate, yet heard. There is a need to help some faculty to 'bend' a little more. Rigidity is not expected at the doctoral level. Also, faculty need to become critical thinkers so they, in turn, can help students better."

**Irene**, who assumed responsibility for her aging parents at home as well as for her children, saw the need for "more flexibility with school schedules and greater autonomy for the graduate student." She continues, "I went to

school full-time but I had to resign and resort to part-time employment for holidays and semester breaks. The school schedule was inflexible and demanding--some classes were scheduled during the day and others during the evening. I found my best hours for studying were from 10:00 p.m. to 2:00 a.m. Child care was unpredictable."

The major challenges of **Marge's** experience focused critically on the nursing educational process, in general. She relates, "After talking with other nurses and fellow students regarding the nursing educational process, I believe the academic experience is another example of 'how nurses eat their young.' The physician's experience is renowned for being demanding, challenging to more than the threshold of the individual's capacity, and expensive. The nursing academic experience is the best kept secret in the world." From an androgogical perspective, Knowles (1971,1990) admonishes educators that adults tend to resist learning under conditions that are incongruent with their self-concept as autonomous and unique human beings (p. 40).

These participants clearly described the challenges, obstacles, or barriers encountered in their reentry experience and it was evident in their comments. Views on the future direction of nursing, the role of nurses and nursing in the health care arena today and tomorrow were more the philosophical focus of the mature nurses in each of the subsets whose candid comments are reflected here.

**Roles.** "I do not see that the expanded educational role will necessarily influence nursing. I am in a post master's nurse practitioner program and I am not clear on where the nurse practitioner will be in the scheme of things. Nursing has been asked to expand the role but never did, until lately. Even 5

to 10 years ago, there was no strong voice for leadership in nursing. Nursing has had difficulty in uniting to speak in one voice and, in my view, will become an endangered species. If it comes to us [nurses'] or them [physicians and administrators], it will be 'them' who will win out."

A second nurse participant who also voiced concerns for the role related, "I have great concern for the status of clinical nurse specialists in nursing and their loss of positions in the hospital environment. These nurses are having a hard time. . .they [the hospitals] are letting them go [or making other educational demands] in order to fit in. It seems nursing is always the one to let staff go."

Said another participant of the nursing role: "Being a woman and a nurse at this particular time, when the demands and expectations are so different, is more the core of it. Being a woman and a nurse can be detrimental to the health care scene. To me, being a woman and a nurse conjures up all those things I grew up with and that women have been moving away from for years. You have to get beyond that to accept that you are simply a qualified individual acting in this environment and to do it in the bet way you know how, in the health care scene today. We have to get rid of those stereotypes, move away from thinking in those terms. Old stereotypes get in the way; you have to develop a certain mindset in nursing and believe what is really important. You really have to fight for autonomy in nursing."

The following responses from four other nurses in the study offer a contrasting view of their perceptions on nursing and nursing's future.

**Nursing and nursing's future.** "Being a woman is the reason I went into nursing. Nursing is a women's profession, not purposefully developed. Women as nurses have some skills that are innate and socialized, a natural

inclination, if you will, to be nurturant mothers and carers. Women and nursing are interconnected through orientation and socialization. Nursing is a relational activity; we have the ability to relate and establish rapport. I hope the future holds some promise for nursing in forming nursing and health policy, extending our research productivity as well known, and cultivating faculty in some way."

"Nursing's future, I pray, will be community-based, from what is coming out of Washington. I believe that nursing could certainly lead the way. We have the skills required to put it together for families, particularly kids that are at risk. We started out in this profession in the community, closer to where people actually live, in promoting health and preventing disease; I hope the shift in nursing will be in this direction. I would be even better if we were to be reimbursed."

"Where will nursing fit in all of this? I think nursing is sitting on a time bomb and we can go in any direction. I don't know in which direction we will go or in what capacity, but we will be there, no matter what. I see nursing going into the home, like it used to be, as opposed to a hospital since peopl are being discharged sicker and quicker. Then it becomes a concern as to who is skilled and competent to provide the necessary care when these people are discharged. What is nursing's future? Time will tell."

These views are succinctly summarized this respondent's perspective on nursing's future, nursing's role, and nurses in the health care arena today:

"I see three goals for nursing in the future. First, we must place more emphasis on education of nurses and nursing practice on primary prevention. Secondly, we must promote ourselves in our role. Lastly, we must look to

community-based care for the future because that is where it will be for nursing."

Limitations of the Study

Several study limitations are acknowledged. First, sample size was a notable limitation. Although in-depth data were gathered, generalizability of findings are confined to those participants in the sample, their particular universities and graduate program affiliations. Additionally, the sample may not be representative of the population.

Second, of the 25 colleges and universities invited to participate in the research, only 6 universities consented to participate. Administrative costs and policy constraints were limiting factors in accessing a larger student population that might have met the study criteria.

Third, the study of women as nurses raises an issue of limitation. A paucity of studies of reentry women in graduate education still exists. Published research on mature women, particularly mature women in graduate nursing education was sparse.

Conclusions

The results of the study indicate that mature, baccalaureate-prepared women as nurses were influenced in their decision making to return to graduate education in nursing, in midlife, for much the same reasons that other mature women return to academia--career advancement and opportunities (Iava, 1994). In this study, however, mature women as nurses were as much interested in achieving personal goals as Datan et al. (1986) projected, and meeting the desire to learn, as they were in career advancement or identity, a predictor of perceived professional development,

as Speer and Dorfman (1986) found. Most nurses in the study perceived themselves as empowered to some degree, and moderately to highly self-actualized, regardless of gender. This finding supports Lott's (1988) contention that women's behavior does not always fulfill cultural expectations of femininity and points up the role of experience in gender learning and variations among women (p. 255). Bem (1985, cited in Lott, 1988) takes this idea one step further, concluding that "human behaviors and personality attributes should no longer be linked with gender. . .and that society should dispense with artificial dualities" (p. 222).

The results of this study have further provided knowledge regarding mature women who return to graduate education in nursing and the learning environment. The nurses in the study waited from 5 to 29 years to return to the educational arena to advance their knowledge and skills, to seek further educational advancement, to improve competence, and to be the best prepared. They are knowledgeable, "have an inquiring mind," as two subset respondents asserted, and wish their experiences to be recognized, their work acknowledged, and their efforts considered (Saslaw, 1981). These nurses returned to nursing education to become more advanced in their roles, become better educated in order to teach and empower others, for self-fulfillment and the satisfaction of being successful, to engae in work that has life meaning (Bardwick, 1980, 1986), and to plan for the future.

This study supports earlier studies by Hildreth et al. (1983) and Kirk and Dorfman (1983) who found that the greater the support for returning women the more apt they are to return to higher education, remain in academia, and value the experience. Most of the women in this study credited their spouses and their children with supportive behavior throughout the educational

experience, a finding which compares to Farmer and Fryans' (1983) finding that spousal support is crucial factor in the woman's return to school, culminating in success. Only a few of the nurses credited others, e.g., their professors, who provided support. No participant identified mentors as support persons in their educational experience.

The need for expanding knowledge became increasingly urgent to those mature women nurses in the study who had a personal goal to succeed and to plan for the future. Nearly all of the participants had been active in nursing for 10 or more years and felt that in order to practice with more advanced level competencies, one needed to be prepared at the master's level. Because women are living longer, educational attainment and career preparation may become more important due to changing roles, lifestyles, or other socioeconomic factors that impact women as nurses in midlife.

## Implications

The results of this study have implications to reassessing the educational milieu, adapting the graduate curriculum, restructuring the administrative procedures for mature women as adult learners, and more specifically, redesigning nursing education and practice to accommodate mature women as nurses returning to graduate education. Longevity, role change, lifestyle changes among other socioeconomic factors, place greater emphasis on the need for current research about women in midlife. Studies of women in midlife will be needed to challenge the myths surrounding this phase of development (Hunter & Sundel, 1989) and to further enhance the knowledge of the psychology of women, the aging majority.

Research. A dearth of current research on women who return to nursing at the graduate level and to the educational arena has implications for

the direction of some research. Further research is needed in women's past roles, in their cultural expectations and experiences as they influence return to graduate education. Data tend to be scarce on mature women's return to higher education in response to what Weathersby (1977, 1980) refers to as deeply felt inner imperatives; therefore, expanding research in this significant and challenging area must be ongoing, as indicated by these study findings.

Findings from the studies of men have long been generalized to women; but these findings no longer seem to best fit the contemporary image of women on the college campuses, in the workplace, and at the bedside. Research on women in midlife is needed to support women and their development, explode the midlife myths regarding women and the stereotypes still fostered by society (Hunter & Sundel, 1989) and "rescue" research on women in midlife from the "remotest outposts on the midlife frontier" (Colaruso & Nemiroff, 1987, p. xxii).

Further study is needed in order to examine the indicators of success in mature women who return to graduate education in nursing and their impact on the profession, as Iava (1994) urges, and as the study findings imply.

Practice. Nursing has struggled for recognition, respect, and position in the health care arena for more than a century (Ashley, 1976; Melosh, 1982; Muff, 1982, 1989; Styles, 1982). Persons in the profession have worked diligently to raise its standards, focus on scholarship, and promote a teaching/learning environment for critical thinking, through what Freire (1970) refers to as "true communication" that occurs in dialogue between people (American Nurses Association [ANA], Scope and Standards of Practice, 1989). Some inconsistencies seem to prevail, however, in recognizing and heeding the wisdom of its colleagues for the creation of a richly supportive environment

for dialogue and exchange of ideas. Surely, learning from peers must be more than reinventing the "pecking order," as described by **Ellen**, **Phyllis**, **Irene**, and **Ruth**, who among others teach today's mature colleagues who return to graduate education. The greater majority of mature women as nurses in this study have demonstrated compassion and commitment to nursing. All of the women in the study chose nursing as their career opportunity for advancement. Will nursing continually be known, as **Marge** indicates, for "eating [cannabalizing] their young" (Mattera, 1991; Meissner, 1986) or older counterparts? Women in midlife in the roles of nurse and student need to believe that their contributions are valued and that they are knowledgeable beings.

Because participants cited faculty as obstacles in graduate education in nursing, establishing mentoring relationships for collaboration and mutually supportive problem solving, decision making, independent self-identity (Keiffer, 1991, as cited in Gibson, 1991), and leadership development in mature women returning to graduate education has significant implications for education and for research. Mentorship shapes leadership qualities, and as Madison (1994) asserts, all nurses, regardless of their roles, should consider including their professional code of ethics a responsibility to develop, nurture, and support colleagues. Mentorship as an intense relationship calls for a high degree of involvement between an expert and a less developed colleague to become acquainted with customs, resources, values, and scholarly endeavors. For mentorship to evolve, the right personal dynamics must exist (Madison, 1994; May, Meleis, & Winston-Frye, 1982).

Higher education. ***Nursing.*** In order that all mature women, as adult learners, derive the most out of the learning environment and in order to meet

the educational challenge of the future, educational institutions must analyze existing policies and procedures and adapt to accommodate women with diverse educational interests and backgrounds who will, in increasing numbers, impact these very institutions well into the 21st century. From the voices of the nurses in this study, it seemed apparent that they knew their needs and desires and strived to derive the most they could from the learning environment. For knowledge to be accessible to women, institutions must also plan for changes in curricula, provide for scholarships, and recognize the valuable contribution women can make to education and to nursing (Barnard, 1988; Pearson et al., 1988). The desire to engage in theory development and in research in the clinical area was clearly a stated goal by nearly 25% of mature nurses in the study, a major step in nursing toward broadening the knowledge base and strengthening the theoretical underpinnings of the profession. Many mature women in this study viewed knowledge as helping them become more expert, but tentative; therefore learning must be ongoing.

The many voices of mature nurses in this study have contributed to the body of knowledge regarding their colleagues in graduate nursing education and in nursing as a discipline. Through the interview process, nurses have shared some of their innermost thoughts, goals, and future plans. The profession of nursing, and society as a whole, needs to attend to these voices and futuristically redirect their thinking regarding women and nursing. These women as nurses are potential leaders for the organization. Strong leadership remains an essential ingredient in the profession of nursing. This study supports Madison's (1985) view that there is need for fully-developed nurse leaders within the clinical, educational, and administrative areas of nursing

who not only understand and realize their own potential, but who are also willing to share themselves with less developed nurses.

***Academia.*** The influx of women on the college campuses in the 21st century has been well documented (Bernard, 1988; Pearson et al., 1989; Touchton & Davis, 1991). To accommodate this influx, curriculas must include a coeducational focus where women can be assured equality. Because many mature women returning to graduate education in nursing and the college campus work part-time or full-time, course scheduling must also be a prime consideration. While full-time study in doctoral programs may be mandatory in some universities, this may not be the directional wave of the future for career women, as pointed out by the various participants; and, women's enrollment in schools, whose flexibility in this regard has not changed, may be affected. Further study is indicated to examine the indicators of success (Iava, 1994) in mature women who return to graduate education in nursing and their impact on the profession of nursing.

Recommendations

Research outcomes from this study indicate that a field study be implemented to further identify the influence of peer behavior on the learning behaviors of mature women returning to graduate education in the educational environments used by the discipline of nursing.

Secondly, in this era of cutbacks, shutdowns, and downsizing in nursing and other educational environments, a follow-up study of the successes of mature nurses who have recently completed graduate education in fulfilling goal expectations and achieving career opportunities may provide further data on midlife women and their place in the broader world.

Thirdly, in light of the findings of this study, it is highly recommended that educational administrators in universities and schools of nursing reevaluate the role of support services, admission policies and financial aid to enhance academic motivation of mature women. Institutions must make long-term commitments to self-examination. Reviewing policies and procedural materials, programs and curricula to accommodate mature women students on university campuses should become a periodic and an ongoing process.

As a final recommendation from the study, it would seem most advantageous to both advanced students and faculty to foster and nurture mutually supportive, collaborative relationships rather than the "one-upmanship" practices often encountered in the college classroom today.

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Barbara A. Brant, a nurse gerontologist, has been on the faculty of the School of Nursing, Virginia Commonwealth University, Richmond, Virginia since 1984. She has been the Nursing Education Specialist with the Virginia Geriatric Education Center since 1985. Professional membership includes Sigma Phi Omega Honor Society in Gerontology; Kappa Delta Pi Honor Society in Education, charter membership in Delta Tau Chapter; and an affiliate of Gamma Omega Chapter, Sigma Theta Tau Honor and Scholarship Society in Nursing. Ms. Brant, active in university, professional, and community affairs has presented professionally at the international, national, regional, state, and local levels; she is the author and co-author of numerous manuscripts and publications on aging. She was co-investigator on the first national study of suicide among the elderly in long-term care facilities, and

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