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Centrum Empowerment in Ouderenzorg

REPORT

EMPOWERMENT:VISION AND THEORETICAL FOUNDATION

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EFRO-project 655
Ondernemingsgerichte kennisontwikkeling
en valorisatie in West-Vlaanderen

West-Vlaanderen
Door mensen gedreven

CEMO

The ageing of the population is a fact: we are living longer and sooner or later are confronted with the need for care.

CEMO was founded in 2012 under the European Regional Development Fund (ERDF) project 655 as a centre of expertise within the domain of care competencies and facilities.

The VIVES expertise centre, Centre for Empowerment in Care for the Aged focuses on the position of the elderly in their care context and reflects on the position of carers and professionals within it.

Under the banner of "empowering care", CEMO wants to promote and encourage empowering care provision in (professional) care.

The label "empowering technology" encompasses the projects with which CEMO is examining the place of technology in health care that can strengthen the position of the elderly in their care context.

Finally, CEMO is working on a digital learning environment to learn to use tablet technology.

Looking to the future, CEMO will continue to focus on the preparation of supporting tools for empowering care and the testing and development of innovative empowering technological applications.

Introduction

In the context of population ageing, the policy has a certain vision of the place and the role of those needing care within its own care theme. To understand this task and role and place them in context, the role and function it is assigned in policy documents will be examined. The available policy documents are analysed according to the tripartite federal level - Flemish level - provincial level. At the federal level, the population ageing is seen as a challenge that is associated with an increase in the demand for care. Proposals are made to - in their own homes and in residential care - to provide additional support. At the Flemish level it can be concluded that there is more emphasis on the "personality" of the care recipient. Through the residential care decree there is also an explicit commitment to letting the dependent elderly keep living at home as long as possible. Finally, attention is also paid to primary health care.

At the provincial level, the main concern is home care that can offer an answer for stimulating self- and home care. The respective governments, ministers, officials, etc. formulate a number of suggestions or allowances that should encourage older people to stay at home longer. All of these allowances could be categorised under the general heading of "Customised care"[1] that was introduced by the Flemish Minister of Welfare, Health and Family; Jo Vandeurzen. This proves, however, to be an ambiguous concept that is interpreted by every care provider in a personal way.

CEMO chooses the emancipatory vision of the empowering concept for studying the elderly and their care context. Within the scientific literature, there is a great deal of ambiguity. According to Van Regenmortel (2002), the concept is applied at different levels, in different domains, to various target groups, within various disciplines and in a wide range of organisations and projects. A definition and clarification is urgently needed.

In this report, we first highlight the emancipatory vision of social inequality that lies at the basis of empowerment. The main focus of this report, however, lies on the identification of empowerment as a theoretical concept. We discuss the different levels of empowerment (individual, organisational and community level) and on the various definitions of empowerment as a process and as a product. Finally, we make the transfer to the context of the health care of patient empowerment.

[1] Originally, "customised care" is a translation of the concept of "tailored intervention" and must be understood mainly from a more economic view of care (Lennox et al., 2001). This view assumes that the provision of a standard care package exceeds the need for care of many care recipients. According to the principle of "customised care", a reduction or modification of the care leads to time and money savings in the provision of care. Customised care can be provided by splitting the standard care package into small steps.

1. Method

The focus of CEMO is in health care, so that searches were made in the scientific database Medline. In order to find valid and reliable documents, only peer-reviewed A1 journals were selected. First, reviews concerning empowerment were searched for, but none were found. Then a search was made for research articles using the search term "empowerment + health". The search produced 66 results. Based on the abstracts, 31 articles were selected from these.

When reading the articles, the primary focus was on the theoretical underpinning and the definition of the concept of empowerment. From the 31 selected articles, the definitions of empowerment used were listed. On the basis of this literature - following the snowball method - other literature was searched for and consulted.

2. Empowerment, an emancipatory vision of social inequality

Paulo Freire is seen as the godfather of empowerment (Wallerstein & Bernstein, 1988). Initially this concept was pedagogically inspired and strove towards an empowering education to enable individuals to intervene in reality themselves, to come to grips with their living environment and their living conditions (Freire, 1975).

Starting in the 1980's, the community psychologist Julian Rappaport in America introduced empowerment within the domain of "community psychology" (Van Regenmortel, 2002). Together with Zimmerman, Rappaport is seen as an authority on empowerment.

Empowerment was originally seen by Rappaport (1981) as a promising alternative to prevention in the context of the social movement. Unlike previous approaches to social problems in which the principle of "blaming the victim" was used, from an empowerment policy actions aimed at social change were dealt with in a positive and proactive way. From this approach, mainly positive aspects are emphasised or the focus is placed on powers. Rappaport (1981) thus described the purpose of empowerment as being "*to enhance the possibilities for people to control their own lives" (p.15)*.

In addition to the focus on the powers of an individual person, empowerment was also described by Rappaport (1981) as a *"sensible social policy"* (p. 19): attention should also be paid to the mediational structures within a community such as family, neighbourhood, voluntary organisations, etc. As a result, these structures and settings must be examined.

The attention to the broader context within a community is called the ecological nature of the empowerment theory (Rappaport, 1987). This perspective of the "*community embeddedness of persons and the nature of communities themselves"* (Trickett, 1984, p. 265) is the opposite of the approach that merely focuses on the person.

Menon (2002) indicates that the typical methodologies that are based solely on increasing individual autonomy lead to alienation instead of empowerment. The ecological nature of the empowerment theory also pays attention to the context, diversity, resources, costs and benefits of a particular approach (Rappaport, 1987).

Besides the focus of empowerment on the individual and the wider context, the diversity among individuals is stressed. From an empowering vision individuals can gain more control over their lives; even those who are less competent, have more needs or *apparently* can no longer function in today's society because the decreased ability to function is not seen as something that is determined by the individual, but rather as the result of a defect within the social structures or defective resources that make it impossible to function properly (Rappaport, 1981). Rappaport (1981) thus also indicates that everyone benefits from a vision that aims at more - instead of less - control over your own life.

Conclusion: the empowerment approach is based on both attention to every individual (as an elderly person needing care) and his/her strengths and positive aspects and attention to the context and the mediating structures of the community. These different principles are reflected in the concept of empowerment as a "multi-level construct".

3. Empowerment, a theoretical concept

3.1. Empowerment as a multi-level construct

Empowerment is seen by Rappaport (1987) seen as a "multi-level construct" that is equally applicable to individuals, organisations and communities. The definition of empowerment was therefore changed as follows (Rappaport, 1984): *"Empowerment is viewed as a process: the mechanism by which people, organizations, and communities gain mastery over their lives"* (p.43) . The interconnectedness of the three levels indicates the interactive nature of empowerment with a continuous focus on relationships between individuals and their environment; as well as the organisations and the community to which they belong.

Zimmerman (1995) also calls empowerment on the individual level psychological empowerment. On this first level, empowerment concerns perceptions of personal control, a proactive approach to life

and a critical understanding of the socio-political environment. The empowerment of organisations has to do with processes and structures that ensure that the members of the organisation are more effective so that they can have an effect on the community (Zimmerman, 1995). At the level of the community, empowerment refers to an organised cooperation between individuals so that life gets better and so that relationships can be established with organisations that can ensure that the quality of their life can be guaranteed (Zimmerman, 1995).

CEMO starts from the elderly persons themselves, whereby the focus is on empowerment on the individual level. In view of the relationship between the different levels it is important to briefly discuss the other two levels of empowerment. In this context, Israel, Checkoway, Schulz and Zimmerman (1994) indicate that - if, for example, attention is only paid to individual empowerment without including the context in which it is embedded - there is a good chance that the influence on the individual level will remain limited. Hence, to make empowerment a meaningful whole, the cultural, historical, social, economic and political context must be recognised (Israel et al., 1994).

3.1.1. Empowerment at individual level: psychological empowerment

Empowerment on the individual level consists, according to Israel et al. (1994) of the following three components "(1) personal efficacy and competence, (2) a sense of mastery and control, and (3) a process of participation to influence institutions and decisions" (p. 152). Before discussing individual or psychological empowerment further, three assumptions are made. First of all, psychological empowerment varies from person to person (Rappaport, 1984; Zimmerman, 1990). Many personal characteristics can affect the meaning of psychological empowerment. So, for example, Zimmerman (1995) indicates that the objectives of individual empowerment are different for a pregnant teenager in comparison to an unemployed worker. Secondly, empowerment also differs depending on the context (Zimmerman, 1995). Hence the skills, knowledge and actions that workers need to exercise control and influence in an organisation with a hierarchical structure are different to those in an organisation with more structures aimed at participation. This contextual dependence of individual empowerment can then be extended to the variation of psychological empowerment over domains of life (Zimmerman, 1995).

Finally, it is indicated that psychological empowerment is a dynamic variable that changes over time (Zimmerman, 1995). This means that every individual has the potential to experience empowering and disempowering processes and to feel empowered or not at various times.

A further unravelling of psychological empowerment brings Zimmerman (1995) to its subdivision into three components: an intrapersonal, an interactional and a behavioural component (Figure 1). With

the intrapersonal component, personal variables such as perceived control, self-efficacy, perceived competence, control, motivation to control, etc. can be considered. The interactional component refers to the extent to which individuals understand their community and associated socio-political issues. This component likewise refers to the awareness that individuals should have of the options and choices that they have to act towards the goals they set themselves. With the last component it concerns actions that one can take to influence results.

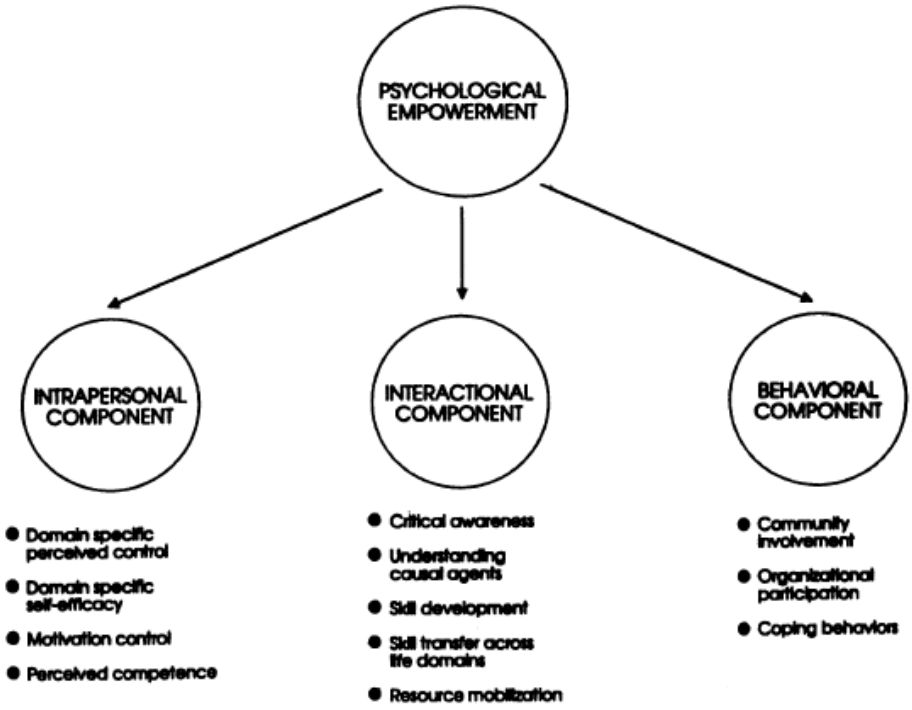

Figure 1: Nomological network for psychological empowerment (Zimmerman, 1995)

Conclusion: psychological empowerment arises when you believe that you have the capacity to influence a certain context - the intrapersonal component - if you understand how systems work within the given context - the interactional component - and if you are committed to engage in certain behaviour to gain control over the context - the behavioural component (Zimmerman, 1995).

It should be noted here that power or control is not the desired goal for all individuals or all populations in all contexts (Zimmerman, 1995); sometimes it is enough if you are informed, if you are more capable, if you are healthier, if you are more involved in a decision-making process, etc.

When the transfer is made to the target group of elderly people requiring care, psychological empowerment means that the elderly gain more purchase over their own care process and are motivated to actively participate in interactions within their care process (intrapersonal component). The elderly person should (interpersonal component) understand what (care) tasks are performed by

whom in their care situation and why, and what possibilities there are for pursuing certain choices. Finally (behavioural component), the elderly person should know the actions you take to influence the care. According to Zimmerman (1995) not every elderly person may strive for full control over their care situation, but can strive for other objectives such as being more involved in care decisions.

3.1.2. Empowerment at the level of organisation and community

Israel et al. (1994) argue that a too narrow focus on individual empowerment can result in aspects such as the social, structural and physical factors in the environment and the organisation (inadequate housing, unemployment, lack of training, lack of control or supporting relationships, the health care system, etc.) being ignored. These factors are, however, outside the individual ability to control and monitor them, hence collective action for social change is also desirable (Israel et al., 1994).

An empowering organization is democratically led. It can therefore be said that empowerment at the level of the organisation on the one hand concerns processes that ensure that individuals get greater control within the organisation, but on the other hand also that organisations, for their part, can also influence the policies and decisions of the wider community (Israel et al., 1994).

An empowering community is one in which individuals and organisations can use their skills to address their respective needs. In addition, such a community also has the possibility of making decisions and bringing about changes in a larger social system (Israel et al., 1994).

3.2. Empowerment as product and process

Empowerment is seen by some authors as a process and by others as a product. Israel et al. (1994) make the distinction between empowerment seen as a verb or as a noun. As a verb, empowerment refers to the process by which people gain influence and control over their lives. As a noun, it refers to the state in which individuals find themselves as a result of a process. Perkins and Zimmerman (1995) also state that actions, activities or structures can be empowering and that the result of such a process may result in *"a level of being empowered"* (p. 570).

3.2.1. Empowerment as product

Zimmerman (1995) indicates that empowerment as a result can be used to examine the effects of interventions - which were developed with the objective of empowering individuals. According to Perkins and Zimmerman (1995) these results can for an individual, for example, concern perceived control or ability to do something you want to do, for organisations this can be the establishment of organisation networks, the growth of the organisation or a way to influence the policy. For the community, empowerment can result in the emergence of multiple subsystems in one community, the existence of cooperating organisations and access to community resources.

3.2.2. Empowerment as process

Empowering processes are defined as follows (Cornell Empowerment Group, 1989; Zimmerman, 1990): *Processes (…) where people create or are given opportunities to control their own destiny and influence the decisions that affect their lives. They are a series of experiences in which individuals learn to see a closer correspondence between their goals and a sense of how to achieve them, gain greater access to and control over resources, and where people, organizations, and communities gain mastery over their lives*. (p. 583)

Zimmerman (1995) indicates that empowering processes can have the following characteristics: (a) involving people in developing, implementing and evaluating the processes, (b) developing an eco-identity in which professionals are part of the community, (c) seeing people outside the community as equal partners and working with them and (d) creating opportunities so that skills can be developed so that people do not become dependent on professionals. Perkins and Zimmerman (1995) also indicate that these processes or interventions oriented towards empowerment can have the following objectives: *"[to] enhance wellness while they also aim to ameliorate problems, provide opportunities for participants to develop knowledge and skills, and engage professionals as collaborators instead of authoritative experts"* (p. 570).

Empowering processes are specified by Perkins and Zimmerman (1995) at different levels. On an individual level, it concerns participation in organisations, at the organisation level, it involves making

collective decisions or shared leadership and finally, at community level, it concerns collective actions to gain access to community resources (e.g. media).

Israel et al. (1994) indicate that - although perceptions and subjective experiences are important - empowerment cannot occur if there are no changes in the objective level of control. This does, however, create restrictions on the use of self-reporting methods.

4. Empowerment as process: conditions for methodologies

Empowerment is a process of reinforcement by which individuals, organisations and communities get a grip on their situation and their environment through the acquisition of control, the sharpening of critical awareness and the encouragement of participation (Rappaport, 1984; Zimmerman, 2000).

A major caveat to the above definition is the fact that people cannot gain empowerment from someone else but must acquire it themselves (Steenssens & Van Regenmortel, 2007). Those who are more empowered do have the task of creating conditions to make empowerment possible for people who are less empowered. Steenssens and Van Regenmortel (2007) call this latter process "enablement".

Menon (2002) states that *"Empowerment interventions take on a variety of forms"* (p. 29). This is also indicated by Van Regenmortel (2002): empowerment is applied in a variety of domains, to different target groups, within various disciplines and in a variety of organisations and projects. Steenssens & Van Regenmortel (2007) propose six operating principles with conditions that an empowering methodology must ideally satisfy.

4.1. Six operating principles

When studying methodologies, it is important to pay attention to certain conditions that promote the process of empowerment. In their report "Empowerment Barometer, process evaluation of empowerment in neighbourhood-oriented activation projects", Steenssens and Van Regenmortel (2007) call these conditions the six operating principles of empowerment (see Figure 3). In general, it can be said that in an ideal process on the basis of the six operating principles there is still an interaction present.

On the one hand, the already existing powers are called upon and on the other hand the necessary assistance and support resources are made available (Steenssens & Van Regenmortel, 2007). Geenen (2009) emphasises this first process and a belief in individual potential as a starting point for empowering work.

Before explaining the six operating principles in more detail, it is important to indicate that the focus of the empowerment barometer is individual or psychological empowerment. Steenssens and Van Regenmortel (2007) define this as follows: *An awareness of the level of the individual, the psychological dimension, means seeking an activation of the parties that benefits their psychological well-being and their resilience. Those concerned should gain "psychological benefit" from the activation. Major components within this dimension include: confidence, control, critical awareness and involvement in the community. (p. 10)*

Following on from Jacobs, Braakman and Houweling (2005; in Steenssens & Van Regenmortel, 2009), Steenssens and Van Regenmortel (2007) indicate that participation is the vital core of the empowerment process. Without participation there can be no empowerment. Participatory work is thus also the first operating principle. With this operating principle it is assumed that participants take an active role where the breadth and depth of participation may vary (Steenssens & Van Regenmortel, 2007). The breadth of participation primarily relates to the aspects in which they participate. The depth on the other hand focuses on how the participation is done and what the impact is. According to Arnstein (1969), there are eight different levels of depth of participation and these are represented via a participation ladder (see Figure 2).

The bottom rungs of the ladder are "manipulation" and "therapy" (Arnstein, 1969); they describe levels of non-participation that are used by some as a substitute for genuine participation.

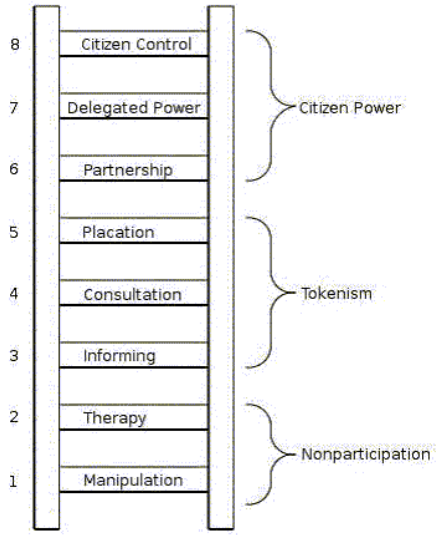

Figure 2: Eight rungs on the ladder of citizen participation (Arnstein, 1969)

The next two rungs refer to levels of participation in which people are heard or have a say; namely "informing" and "consultation" (Arnstein, 1969). However, it is still not a true form of participation. People are heard, but there is no guarantee that anything effective will be done with it. If participation remains limited to these levels, there is no chance of change. On the fifth rung "placation" you go to a higher level of tokenism because advice is given, but it is still other people who continue to have the

right to make decisions (Arnstein, 1969). Higher up the ladder there are three more levels with an increasing degree of influence that can be exercised. A "partnership" can be reached that ensures that there can be negotiation (Arnstein, 1969). Finally, "delegated power" and "citizen control" ensure that, respectively, most of the decisions can be made and there is full control over processes (Arnstein, 1969).

In addition to the breadth and depth of participation, attention is also paid to the scope of the participation. In the second operating principle: inclusive work; the question is asked as to who can and cannot participate. With empowerment methodologies, paying attention to reaching and involving different actors and also showing an openness towards them is important (Steenssens & Van Regenmortel, 2007).

To be able to achieve participation, attention should be given to positive work; the third operating principle. Steenssens and Van Regenmortel (2007) define this as a fundamental attitude of equality and respect for each other, a starting point to finding an entrance and connection with the target group(s). With an empowerment methodology, it is important that those concerned will also effectively dare, be able and be willing to express their concerns, comments, additions and questions.
The fourth operating principle, power-oriented work (Steenssens & Van Regenmortel, 2007) means that the attention of the empowerment methodology must firstly be aligned with the powers present and should look for positive issues. In this way, an attempt is made to improve the negative aspects of the situation.

In addition to the power-oriented work, integral work is also emphasised as the fifth operating principle. Following the example of Steenssens and Van Regenmortel (2007), Geenen (2009) states that attention must be paid to the total context of a person. Integral work therefore sets out to pay attention to the relationship between powers and/or problems in different life domains, dimensions and meaning contexts.

Finally, Steenssens and Van Regenmortel (2007) state that relationship-oriented work as the sixth operating principle places the focus on the creation of partnerships that provide win-win situations for all parties involved.
This means that work in a group deserves attention within empowerment methodologies and offers opportunities for gaining insight into problems raised and possible solutions for creating more involvement.
The schematic diagram (see Figure 3) shows the links between the six operating principles. At the centre is the principle of power-oriented work. The other five principles contribute to this and have power-oriented work as objective (Steenssens & Van Regenmortel, 2007).

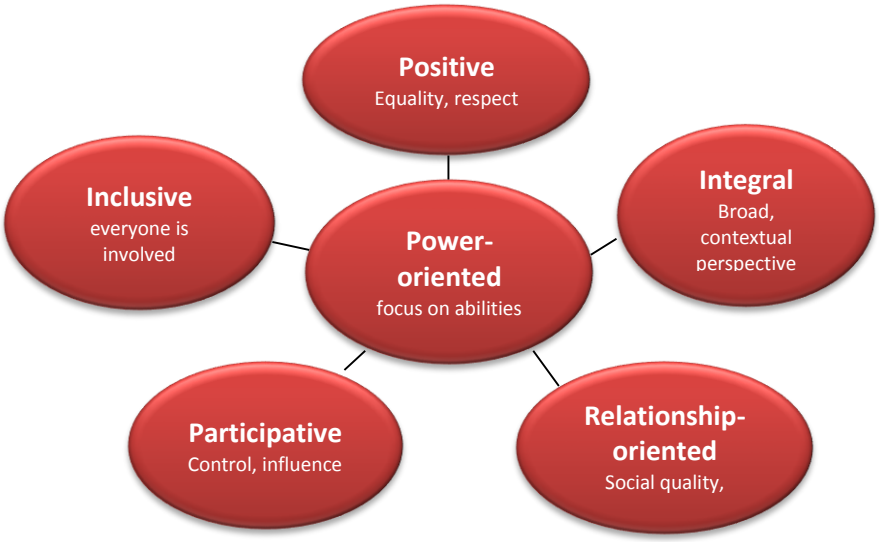

Figure 3: The six operating principles of empowerment (Steenssens & Van Regenmortel, 2007)

Exemplarily, it can be stated that inclusive and integral work contribute to there being a greater variety of powers being examined. In addition to the connectedness concerning power-oriented work, there are also other links between the operating principles. Hence, participative and relationship-oriented work both lead to more attention being paid to collaboration and group activity.

Conclusion: the operating principles can be seen as conditions for methodologies that promote empowerment: participative work, inclusive work, positive work, power-oriented work, integral work and relationship-oriented work. The interrelationships between the principles shows according to Steenssens and Van Regenmortel (2007) that attention must not be focused in an empowerment methodology on one or a few operating principles, but that the power of a methodology lies in the mutual interaction of the operating principles[2]. With a specific methodology, the extent to which the six operating principles occur and what their interconnectedness is can therefore always be examined.

[2] As Van Regenmortel (2011) states, the formulation of operating principles is not a finite process. In 2011, Van Regenmortel supplemented the principles with “coordinated working” and “structured working”.

5. Patient empowerment

At the beginning of the 1990's, Robert Anderson introduced the concept of "empowerment" within health care. Anderson and Funnell (2005) state that health care professionals often work on the principle of the "treatment of acute illnesses" in which the responsibility for solving the problem of the person requesting care lies with the person needing care. If patients do not follow the recommendations of the health care provider, this is considered to be problems with "compliance" or "adherence" and can lead to feelings of frustration on the part of the health care provider.

"Patient empowerment" is proposed as an alternative to "treatment of the acute illnesses" (Anderson & Funnell, 2005). Funnell et al. (1991) define this as helping patients improve their inner strength and using it to control their condition. The corresponding approach includes facilitating and supporting patients in reflecting on their experiences of living with the condition (Anderson & Funnell, 2010). The emphasis is thus on making changes yourself in order to be able to live a healthy life; partly because a chronic disease is something the patient has to live with on a daily basis (Feste & Anderson, 1995). Within this approach, the relationship between the health care provider and the person needing care is characterised by psychological security, warmth, cooperation and respect. This is the basis for self-directed positive changes in behaviour, emotions and attitudes, but also in the context (e.g. community organisations) that has an influence on the life of the patient (Anderson & Funnell, 2010). The purpose of an empowerment approach is to help patients to think critically and make informed decisions about their own care (Feste & Anderson, 1995; Anderson & Funnell, 2010) and to increase the autonomy and freedom of choice of the patient (Funnell, Arnold & Anderson, 1991).

Conclusion: the vision of Anderson is inspired by the vision of Paulo Freire (Anderson & Funnell, 2010), namely: *"a more appropriate and realistic purpose for diabetes patient education was to increase the learner's freedom/autonomy (i.e., one's capacity to make informed decisions) rather than increase the learner's conformity/compliance (i.e., one's willingness to follow the instructions of those in authority)."* (p. 278).

Following the example of the importance that Paulo Freire attaches to patient education in empowerment, Feste and Anderson (1995) also cite "education for empowerment" as a concept. On the one hand, it concerns health education where the objective is providing both knowledge, skills and an increased self awareness of values and needs, so that patients can define and reach their own goals (Feste & Anderson, 1995). On the other hand, it is stated that empowerment is largely accomplished by the individual him/herself, but this whole process can be facilitated by health care professionals (Feste & Anderson, 1995). Feste and Anderson (1995) give the following role to the professionals: *(…) doing an assessment of patients' psychosocial and spiritual health, providing appropriate interventions, and doing follow-up. When health risk assessments are done, they must go beyond the physical aspect and assess*

a number of things: patients' coping history, the efficacy of their coping skills, their social support, and their ability to mobilize the support on their behalf. Appraisal of health and health risks can also assess patients' level of hopefulness. When a problem surfaces, there must be appropriate interventions that people can use to facilitate their empowerment-strengthening the psychological, social, and spiritual aspects of their lives. (p.141)

5.1. Methodologies concerning patient empowerment

Feste and Anderson (1995) indicate that one specific methodology "*is by no means a panacea for successfully dealing with chronic disease. They are a piece of a larger puzzle.*" (p. 143). This would mean that more should be combined in order to strive for the desired result.

Although the operating principles of empowerment of Steenssens and Van Regenmortel (2007) have been developed for methodologies in the social sciences, they can also be used as guiding principles for methodologies in health care. In general, Feste and Anderson (1995) identify three different methodologies that health care providers can apply to facilitate patient empowerment. First of all, it is about asking questions so that those seeking care can further reflect on their life. From a philosophical point of view it can be stated that questions ensure that new insights can be obtained and that these insights can change. It is primarily concerned with questions that arise within the context of the life of the person needing care, namely the daily worries, the family, social life, etc. combines with their own reduced capabilities. A second technique that can be used is the use of an activating language as this can encourage people to take action and make choices. Finally, storytelling is also encouraged. The limitations of the person needing care mean that their joy of life can come under pressure. Storytelling facilitates the process of self discovery that is important in empowerment.

Conclusion

CEMO chooses the emancipatory vision of the empowering concept for studying the elderly and their care context. Within this emancipatory concept, CEMO focuses on empowerment as a process of which "getting a grip on one's own situation" is the central principle. CEMO primarily starts from the bottom up or from the individual or psychological empowerment.

This report should help to identify the theoretical empowerment concept and make it easier to understand. The report also outlines conditions for an empowering provision of care and methodologies are presented.

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