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Empowerment of Individuals With Enduring Mental Health Problems

Results From Concept Analyses and Qualitative Investigations

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Empowerment has been proposed to enhance the well-being of individuals with enduring mental health problems. Despite this apparent endorsement, critics charge that the concept of empowerment is poorly defined, and its actualization within mental health care is rare. Concept analyses and findings from qualitative research offer helpful insights into the process of empowerment and ways to promote it among individuals with long-term mental health problems. An empowerment model is proposed based on concept analyses, which are supported by qualitative findings. **Key words:** *concept analysis*, *empowerment*, *empowerment model*, *mental illness*, *power*

AMONG individuals with enduring mental health problems, well-being consists of more than simply bringing symptoms of psychiatric problems under control. Rather, it involves awakening parts of the self that have been idle and rediscovering personal strengths, meanings, and purposes within a reformulated self-identity.[1,2] Well-being means not allowing others to make all of one's decisions and rejecting a "living by proxy" lifestyle.[3(p6)] It is suggested that empowerment makes this reformulation of self possible.[2]

The notion of empowerment is rooted in the social action ideology of the 1960s and the self-help movement of the 1980s. During the 1990s, the idea of empowerment grew in popularity, since there was greater emphasis on individual responsibility and personal decision making.[4] Despite this history, critics charge that empowerment remains poorly defined[5] and largely a myth within mental health care.[6,7] In addition, a great deal of the literature related to empowerment is conceptual in nature and requires empirical support.[8]

Based on this critique, there was interest in analyzing existing concept analyses of empowerment among individuals with enduring mental health problems and examining how these conceptualizations are supported by research findings. Qualitative versus quantitative findings were selected for analysis based on several factors. First, definitions and frameworks of empowerment that currently exist have largely been developed using quantitative instruments that measure concepts such as self-esteem, locus of control, self-efficacy, internal political efficacy, hope, and alienation[8] rather than perceptions of empowerment that are grounded in the phenomenon. Second, the use of qualitative methods has been recommended in order to capture the richness of the concept.[8] Third, experts have urged scholars to aggregate qualitative findings to make them

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more accessible to clinicians, researchers, and policymakers.[8,9] Thus, the purpose of this project was to examine concept analyses related to empowerment, evaluate ways in which qualitative findings support these analyses, and propose a model based on this work.

METHODOLOGY

The key terms *empowerment* and *power* were used to search electronic databases such as CINAHL, MEDLINE, PsycINFO, and SocioFile. Searches were limited to English-language documents. Concept analyses of these constructs were culled along with qualitative research studies of empowerment and power among individuals with enduring mental health problems. Studies reflecting the viewpoints of clients as well as health care providers were selected.

Walker and Avant's work served as the initial organizing framework for this analysis,[10] and qualitative coding strategies were used thereafter.[11] Concept analyses were reviewed first, and findings from each were placed within a matrix that was organized according to antecedents, critical attributes, and consequences.[10] Next, results from qualitative investigations were placed within a similar matrix, and additional organizing categories (eg, barriers) emerged based on the richness of the findings. Development of the matrix continued in this manner until all findings were codified, and a process of empowerment could be identified based on apparent interactions among categories. Following are the results from these analyses and a discussion of how they add to the understanding of empowerment among individuals with enduring mental health problems.

CONCEPT ANALYSES OF EMPOWERMENT

Antecedents

A precursor to empowerment is the lack of power[12] or a maladaptation in the balance of power[13] such that oppression exists at the individual or societal level.[14] This results in a sense of outrage,[12] which serves as the motivation for change.[12,13]

Motivation alone does not guarantee a change in the balance of power. Rather, a complex assortment of intrapersonal and interpersonal elements must also coalesce. Foremost among these is the ability to acquire knowledge.[15] For example, individuals need to have some understanding of the social, political, and economic forces that influence how health care is delivered.[14] Thereafter, in order to make knowledge useful, the actual or potential ability to achieve objectives or goals is necessary.[15] This implies the capacity to problem solve, make decisions, and effectively communicate.

Empowerment is promoted by viewing all individuals as personally responsible and capable of growth and self-determination.[5,12,15,16] These perceptions are instilled when communication is carried out in a caring and respectful manner[5,15,16] such that one's personal value and worth are acknowledged.[5,16] Advocating for and supporting others also results in the development of resources that promote and maintain personal empowerment.[5,12]

A modicum of self-confidence or self-efficacy is important in order to become and remain empowered.[12,15] These attributes are based on an awareness of one's knowledge acquisition, problem-solving, and communication skills, as well as trust in interpersonal relationships and the sociocultural environment.[12,15,16] Trust in a perfect system is unrealistic and impractical; however, confidence in a beneficent power-sharing system is suggested to be a minimum requirement.

In order for individuals to become empowered, those with power must be willing to cooperate, compromise, and relinquish control.[12,14] This requires an intuitive understanding of the needs of others, empathy, tolerance, and flexibility.[14] It also necessitates risk taking and courage, which is grounded in a commitment to social justice.[12,14]

Critical attributes

Based on the concept analyses reviewed for this article, becoming empowered involves an interpersonal process that is characterized by active and equal participation of 2 or more individuals. Interactions are characterized by respectful mutuality, power sharing, and participatory decision making, which requires relinquishment of professional power, collaboration, and negotiation. All parties come with unique perceptions and knowledge, and everyone is placed in a position to learn from each other. Although professionals may bring expert teaching, counseling, or lobbying skills to the table, the mutual exchange of ideas is axiomatic to the empowerment process.[5,12,13,15,16]

Outcomes

Outcomes of empowerment are evident on 2 levels (personal and societal), both of which reflect an alteration in the power base and diminished oppression.[14] Individuals and groups of individuals become aware of increased autonomy,[5,16] power, control,[12,14,16] and self-efficacy,[12] and this leads to higher self-esteem,[16] self-determination,[5] greater satisfaction, and an improved self-concept.[12] Healthy behaviors are promoted[13] and, in turn, physical health improves as does one's overall quality of life.[12] Hope is enhanced,[12,16] and there is a greater sense of inter-connectedness without indebtedness to others,[12] expanding consciousness, and harmony.[5]

COMPARISON OF CONCEPT ANALYSES AND QUALITATIVE FINDINGS

Antecedents

Findings from qualitative investigations support results of concept analyses. They also help to further clarify the phenomenon among individuals with enduring mental illnesses. In particular, qualitative findings support that loss of power is a fundamental precursor to empowerment[17,18] and is characterized by stigmatization of individuals with long-term mental health problems[19–21] and an oppressive mental health care system. For instance, staff-client hierarchical relationships, the use of medications, and restrictive physical environments are disempowering.[19] Beyond these factors, bodily restraint is perceived to be severely disempowering and is accompanied by feelings of helplessness, fear, and vulnerability.[22]

In concordance with conceptual analyses, qualitative findings suggest that selective intrapersonal factors are necessary for empowerment to occur. First is the understanding that health care providers cannot empower others. Rather, clients are responsible for empowering themselves.[23,24] The caveat to this imperative is that individuals must possess intrapersonal resources such as the capacity to cognitively acquire and process information.[18] In addition, they must also have a minimum amount of self-confidence[25] and a sense that empowerment is possible.[20]

On an interpersonal level, qualitative findings substantiate that power exists and is exercised within a network of relationships.[22] Although it is perceived that patients must take an active role in empowering themselves, it is also thought that there must be an organizational commitment to empowerment.[18,24,26] Currently, it is perceived that a paradigm shift is necessary for empowerment of clients to take place within mental health care.[19] This would mean power sharing and a blurring of client and health care provider roles.[18,27]

Barriers to empowerment

Interestingly, stigma is seen as a barrier[20,21,28,29] as well as an antecedent to empowerment.[19–21] As such, stigma may not only stimulate the empowerment process, it may also impede it. Stigmatization results in stereotyping and failure to relate to patients as individuals rather than as diagnoses.[21,28] Consequences include societal devaluation,[20] discrimination,[20,21] social isolation,[20,21,28] decreased self-esteem,[21,30] and hopelessness.[21]

Limited financial resources[20,21,28,30] are common due to challenges encountered in securing stable employment, and individuals are subject to victimization and crime due to their vulnerable status.[28]

Selective client attributes are also seen as barriers to empowerment, especially by health care providers. These include impaired cognitive ability,[25,26,31] medication effects,[31] and lack of motivation.[25,26,31] It is acknowledged that the latter problem may relate, in part, to reluctance on behalf of family members[29,31] or legal guardians[26] to support patient empowerment. It is also likely, however, that lack of motivation is system-induced and attributable to a history of patient disempowerment, few consumer choices and resources,[25,26,31] the demands of routine treatment standards,[26] and organizational limitations.[25]

Organizational barriers include expectations imposed by external funding agencies. If empowerment is not a funding-agency priority, conflicts are likely to arise related to treatment goals, strategies, and outcomes. In the end, allegiances to funding agencies may take priority, and empowerment could rank second to maintaining an agreed-upon operating budget.[32]

Egalitarian ideologies are difficult to actualize in the presence of hierarchical staff positions and pay scales.[32] This is particularly true when health care providers are not allocated adequate time to invest in the empowerment process,[26,33] and staff are resistant to change. Fear of the unknown, paternalistic attitudes, unwillingness to listen and accept criticism,[25,26] and reluctance to share power[26] are all thought to be significant stumbling blocks to client empowerment.

Role of health care providers

Based on qualitative research findings, health care providers are encouraged to address power imbalances[31] by dismantling professional boundaries[19,27] and establishing more equitable relationships.[20] Nurses are also urged to avoid taking control[27] and to share responsibility with clients.[19] This requires change on the part of care providers as well as patients, and all parties must be open to learning new ways of functioning. Empowerment of clients involves open, authentic, artistic, and esthetic nursing practice such that intuitive mutuality between client and health care provider can be established.[27]

On a more perfunctory level, therapeutic communication skills are needed in order to share power and enter into equitable relationships with clients. These skills include listening, understanding, empathizing, and providing information in a respectful manner.[23–25,31] Communication needs of individuals with cognitive limitations must be accommodated, and meetings should be organized such that clients are adequately briefed, provided with frequent breaks, and given ample time to speak. Moreover, client suggestions must be acted upon such that empowerment is truly realized rather than merely an idealized abstraction.[25]

It is incumbent upon health care providers to enable empowerment by providing information in a manner that is understandable to the client[24,26,31] and that addresses issues such as how the mental health care system works, consumer rights, and mental health care legislation. In order to shift the balance of power, patients need to be trained in organizational and communication skills, public speaking, preparation of proposals and presentations,[25] and assertiveness.[24]

A critical element of the empowerment process involves providing clients with choices. This means truly allowing patients to take responsibility and make their own decisions[20,31] and, at the same time, accepting that their choices may not always coincide with recommended care. Health care providers are urged to accept the trial-and-error approach, provide meaningful feedback if needed,[18,25] and be prepared to rescue clients when necessary.[18,29] This attitude echoes Gibson's[12] and Ryles's[14] suggestion that empowerment of clients entails risk taking and courage on the part of nurses.

Stigmatization and oppression of individuals with enduring mental illnesses does not begin or end within the health care system; rather, disempowerment is prevalent throughout communities. It is the responsibility of mental health care providers to advocate for clients within society at large and to serve as a link between the community and the mental health care system.[21,25] That said, qualitative findings also suggest that maintaining patient anonymity within the community is important in order to minimize barriers to empowerment.[21,28]

Attributes

Results from qualitative research indicate that empowerment involves iterative movement from one level to another.[23] Four levels of empowerment have been proposed: participating, choosing, supporting, and negotiating. At the first level, individuals may simply participate in prescribed activities more often. As such, requisite cognitive capabilities,[18] self-confidence,[25] and a sense of personal responsibility[23] are inferred to exist.

At the second level, clients more assertively select among options, and demonstrate self-control and courage.[23] Again, this level suggests a growing sense of personal responsibility and self-confidence.[23,25] In addition, it implies an organizational commitment to power sharing, blurring of client-nurse roles,[18,19,27] and risk taking.[12,14]

At the third level of empowerment, clients see beyond their personal needs and take a greater interest in interpersonal relationships. There is a sense of responsibility to others as well as oneself, and individuals are thought to accept, support, and even coach others who are less empowered.[23] At this level, it is presumed that individuals would be ready to begin learning about service on institutional committees and activities related to social activism.[25] Thus, it would be incumbent upon staff to apply the teaching principles discussed earlier and diminish any barriers to learning that may exist.

The fourth level is characterized by greater equality between staff and patients such that negotiation is possible. Individuals are able to take a position, respectively cooperate, and work toward a mutually satisfactory solution. At this level, considerable sophistication is needed on the part of patients as well as health care providers, and successful negotiation may not always be possible. In this event, iterative movement through prior levels of the empowerment process may be necessary before negotiations are successful.[23]

Outcomes

In keeping with the cyclical nature of the empowerment process, positive outcomes echo antecedents. For instance, self-confidence, self-esteem, and personal competency are bolstered as empowerment increases[24,25,30,34] and one's health status improves.[18] Underlying these changes are enhanced social and communication skills,[25,34] community involvement, employment, and less isolation.[34]

Although positive results are hoped for, research findings suggest that negative outcomes are also possible. Feelings of inadequacy may result if empowerment efforts are not reciprocated. Moreover, even when empowerment efforts are mutual, frustration may ensue due to bureaucratic entanglements, slow decision-making processes, and unsuccessful attempts to secure power. Finally, empowerment efforts may result in distress due to increased demands on time, and conflicts with peers or health care providers.[34]

EMPOWERMENT MODEL

Based on results from concept analyses and qualitative research findings, an empowerment model can be articulated (see Fig 1). Antecedents of empowerment include loss of power, which is characterized by an oppressive health care system and stigmatization. Antecedent intrapersonal factors involve a willingness to assume personal responsibility,

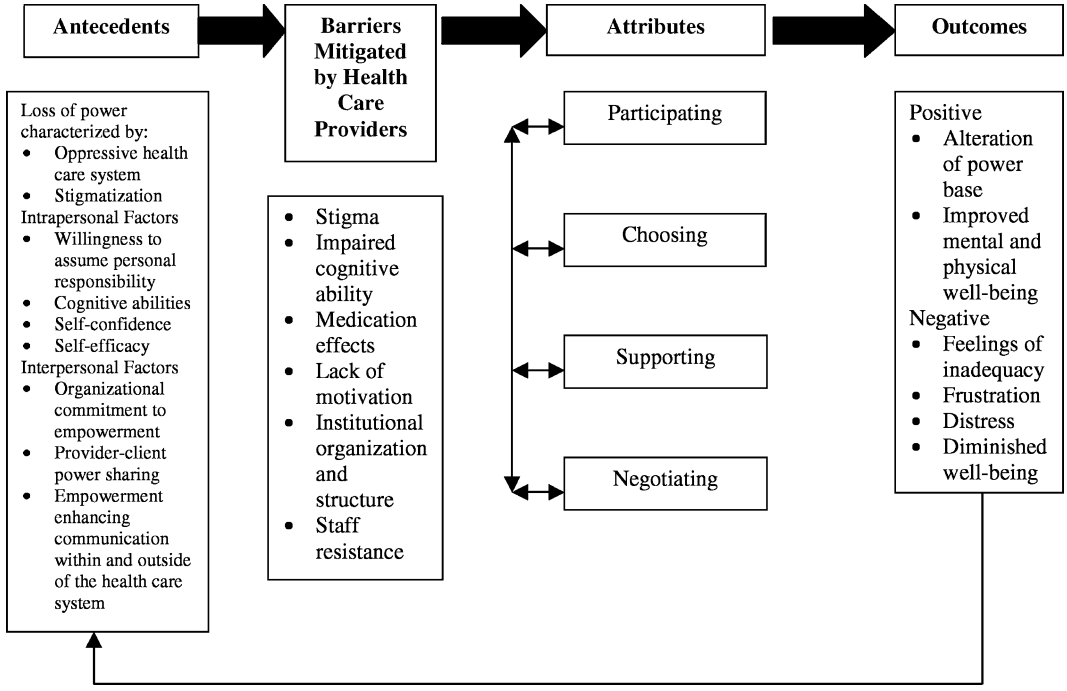

Figure 1. Process of empowerment among individuals with enduring mental illnesses.

cognitive abilities, self-confidence, and self-efficacy. Fundamental interpersonal elements consist of an organizational commitment to empowerment, provider-client power sharing, and empowerment enhancing communication within and outside of health care settings.

Barriers overlap with antecedents, since stigma and elements of the health care system are identified as motivating antecedents as well as barriers to moving forward. Other obviating elements include impaired cognitive abilities, medication effects, and lack of motivation. Nurses and other health care professionals are encouraged to assist in the mitigation of these barriers.

Attributes that make up the core process of empowerment consist of participating, choosing, supporting, and negotiating, and involve back and forth movement from one level to another. Ideally, there is gradual forward progression toward the level of negotiation. Although an alteration in the power base and improved mental and physical well-being are the hoped-for outcomes, empowerment efforts may also result in diminished well-being in the event that feelings of inadequacy, frustration, or distress emerge.

In keeping with the notion that empowerment comprises a process, outcomes are perceived to become part of the constantly evolving phenomenon. As such, positive and negative outcomes would be anticipated to influence antecedents. For example, willingness to assume personal responsibility could be enhanced by improved mental and physical well-being, whereas, the opposite might result from diminished well-being.

DISCUSSION

Qualitative findings relating to empowerment among individuals with enduring mental illnesses support concept analyses of empowerment. They fulfill an even greater role, however, in that they aid in understanding subconstructs of the concept, help to clarify

the cyclical and iterative nature of the empowerment process, and provide some guidance as to how health care providers can best promote empowerment among individuals with enduring mental health problems. In general, the role of nurses in this process appears to involve the mitigation of barriers at societal, institutional, and individual levels.

In light of the antecedents to empowerment, individuals should possess some degree of self-esteem and self-efficacy to become empowered. Providing these requisites are not in place, it is incumbent upon the nurse to foster their development by creating a milieu that will nurture a sense of self-confidence, personal integrity, and responsibility. Additional individual barriers include impaired cognitive ability, medication effects, and lack of motivation. To mitigate these factors, health care providers are encouraged to use medications to enhance cognition and, at the same time, minimize their side effects. They are also urged to share power with clients, interact using therapeutic communication skills, and allow patients to make their own decisions and offer suggestions.

As noted earlier, each person will present with a unique set of circumstances. Although reaching the fourth level of empowerment may be the hoped-for goal, nurses must recognize that innate personal limitations and desires may prevail. Part of the flexibility involved in cultivating empowerment will include understanding that not all individuals will function at level 4, and success will be evaluated on a case-by-case basis.

On an institutional level, funding agencies and care facilities should be better apprised of the benefits of patient empowerment such that treatment philosophies reflect more egalitarian ideologies. In turn, intervention strategies and outcome goals will ideally accommodate clients' strengths while providing assistance when setbacks occur. Institutions are encouraged to support frontline health care providers through this process, since relinquishing power may be challenging and staff resistance could occur.

From a societal standpoint, diminishment of stigma is an important requisite for the cultivation of empowerment. Efforts of this sort may involve the promotion of mental health care parity legislation and support for workers' rights. Members of the health care community as well as patients and their families are encouraged to strive toward these goals.

Nurses are urged to avoid being disenchanted by struggles that may be difficult to overcome throughout the empowerment process. Moreover, the temporal nature of this endeavor cannot be underestimated, since quantitative evidence suggests that instillation and stabilization of power can take 7 years or longer.[8]

Despite potential challenges, nurses appear well prepared to enhance empowerment among individuals with enduring mental health problems. Ironically, their expertise and insights into helping others may come, in part, from their own experience of being disempowered.[14,35] Nurses' familiarity with the current bureaucratic and hierarchical health care system could serve as a great asset in helping others to overcome challenges and understand the slow progress and setbacks that may occur along the way. Nurses are also well prepared to empower others on the basis of their understanding of chronic mental health problems and their well-honed communication skills.

In contrast, sharing power may be difficult for nurses, since they have not always possessed it, and they may find it difficult to relinquish.[35] Nurses may also have difficulty overcoming biases regarding the capacity of individuals with enduring mental health problems to take control and make decisions for themselves. Finally, nurses will need to remain cognizant of potential negative outcomes and adjust their expectations accordingly.

SUMMARY

Concept analyses, which are supported and augmented by qualitative findings, offer important insights regarding the

empowerment of individuals with enduring mental health problems. In an effort to promote empowerment, nurses are encouraged to enhance clients' self-esteem and self-efficacy and overcome limitations imposed by medication effects, cognitive limitations, and lack of motivation. Nurses are also urged to modify institutional and societal barriers such as staff resistance and stigma. Empowerment appears to emerge in iterative stages; thus, nonlinear and time-delayed movement through the process should be expected. Finally, not everyone will present with the same potential or aspirations to be empowered; thus, success should be evaluated on an individual basis.

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