



## **A concept analysis of empowerment in chronic illness from the perspective of the nurse and the client living with chronic obstructive pulmonary disease**

Title	A concept analysis of empowerment in chronic illness from the perspective of the nurse and the client living with chronic obstructive pulmonary disease
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**Aims:** To explicate a model of empowerment appropriate to clients living with a chronic illness, in particular Chronic Obstructive Pulmonary Disease (COPD).

**Background:** Empowerment is a concept central to nursing practice and is viewed from a variety of perspectives in nursing literature. Empowerment shapes how those living with a chronic illness view their illness and approach their involvement in self-care. This concept analysis was conducted as part of the literature review to inform the development of the PRINCE trial (Pulmonary Rehabilitation in Nurse-led Community Environments).

**Design:** Review of the literature on empowerment, with particular focus on empowerment in chronic illness.

**Methods:** A search of electronic databases to March 2010 for literature related to 'empowerment' was conducted. Papers included in the review had reference to 'empowerment' in the abstract. The literature was then organised following guidance on the structure for concept analysis proposed by Norris (1982) and Rodgers (1989)

**Results:** Empowerment in chronic illness not only in COPD is a process with both the nurse and client contributing to its evolution. The nurse must feel empowered, communicate effectively and surrender control in the empowerment process. The client must be motivated to change and possess specific competencies in order to engage in the empowerment process. Both the nurse and client experience a transformation when empowered.

**Conclusion:** Despite identification of the characteristics, antecedents and consequences of empowerment in chronic illness, empowerment remains an evolving concept, with evident immaturity revealed in its competing definitions.

**Key words:** Concept analysis, chronic illness, Chronic Obstructive Pulmonary Disease

## **Aim**

The aim of this concept analysis was to explicate a model of empowerment appropriate to clients living with a chronic illness, in particular Chronic Obstructive Airways Disease (COPD).

## **Background**

This concept analysis was conducted as part of the planning phase of the PRINCE study (Pulmonary Rehabilitation in Nurse-led Community Environments). The aim of the PRINCE study is to develop and evaluate the effectiveness of a Structured Education Pulmonary Rehabilitation Programme (SEPRP) on the health status of people with Chronic Obstructive Pulmonary Disease (COPD) delivered at the level of the general practice compared with usual care.

Structured education programmes aim to empower, inform and support self-management skills. NICE (2003) identify five key criteria for high quality structured education programmes as follows: these programmes should have a structured written curriculum, a patient centred philosophy, be delivered by trained educators, be quality assured and audited.

This concept analysis of empowerment in chronic illness was therefore undertaken at the beginning of the study to inform the development of the SEPRP. The SEPRP developed for the PRINCE study and delivered by practice nurses, will focus on improving the self-management skills of persons with COPD by empowering them.

## **Method**

The aim of this concept analysis was to explicate a model of empowerment appropriate to clients living with Chronic Obstructive Airways Disease (COPD). The Norris method of concept clarification (Norris 1982) and aspects of Rodgers' (1989) evolutionary view of concept analysis were utilised to guide the analysis process.

There are five steps outlined in Norris's (1982) method. These steps are as follows:

- Identification of the concept of interest from within the discipline as well as from the viewpoint of other disciplines;
- Observation of the concept and repeated descriptions of the concept in order to provide a systematised description of the concept (look for patterns and sequences);
- Deciding on an operational definition of the concept;
- Development of a model, which illustrates the concept;
- Formulation of hypotheses.

The final stage has not been adopted in this analysis. The aim of the concept analysis was to develop a model that would inform the development of the SEPRP and not to exclusively develop hypotheses to inform further investigation of the concept.

Norris's framework has also been utilised by others, and in conjunction with other frameworks for concept analysis. For instance, Gibson (1991), in a concept analysis of empowerment, utilised Norris's method, synthesising it with the frameworks of Rodgers (1989), Schwartz-Barcott and Kim (1986), and Walker and Avant (1988). More recently, the Norris method has been used in conjunction with the Wilson method by Sachse (2007) in a concept analysis of hope.

The following two sections (i.e. 'Identification of empowerment' and 'Descriptions of empowerment') represent the findings from the first two steps of Norris's (1982) method. The subsequent sections describing antecedents and consequences (Rodgers 1989) for both the nurse and client related to empowerment, add further clarity to the concept. The discussion attempting to explicate an operational definition of empowerment and the model of empowerment presented represent steps three and four of Norris's (1982) method.

## **Identification of empowerment**

### ***What are the origins of empowerment?***

Views on the origins of the concept of empowerment are varied. There are many varied philosophical views on its origin. A popular view is that pragmatism underpins

empowerment because “action is critical to empowerment” (Hawks 1992, p. 613). Some authors (e.g. Connor *et al.* 1990) adopt the principles of the Brazilian educator, Paulo Freire in discussions on the genesis of empowerment. However, Powers (2003) clarifies that Freire, did not popularise the term through his writings. In fact, in an interview, Freire expressed the following view “...it is interesting to me how people in the United States are so preoccupied in using this word and concept, ‘empowerment’.” (Shor & Freire 1987, cited in Powers, 2003, p. 228). Freire’s reference to the United States in this aforementioned quote is interesting and probably reflects the view of the United States being forerunners in promoting empowerment in healthcare. The work of Carl Rogers is also associated with empowerment, with his emphasis on a humanistic approach to nursing practice (Ryles 1999). The Etymological Dictionary (Partridge 1966) traces the genesis of the term empowerment to power. Moreover, Skelton (1994) argues that the origins of ‘empowerment’ have arisen from the political interpretation of the “relationship between the individual (client/patient) and authority (p. 416).

Some argue that empowerment was taken away from lay people during the 18<sup>th</sup> century when power was shifted to physicians who were established as experts during the early 1900s (Loft, *et al.* 2003). Gibson (1991) traces the inspiration of empowerment to self-help perspectives of the 1970s. Similarly, Rodwell (1996) traces the use of the concept in mental health, women’s health and feminism, children, students, single parenting, community, and AIDS. Finally, Fullam *et al.* (1998), discussing the importance of the empowered nurse, argue that empowerment evolved from the business world. The origins of empowerment are therefore varied with many influencing philosophical perspectives.

### **Descriptions of empowerment**

Empowerment is a concept with many facets. Moreover, these facets pervade literature on education, organisational theory, management and psychology (Rodwell 1996, Mok 2001). Empowerment is also a term used among social workers, commentators on organisational behaviour and politicians (Skelton 1994). However, the descriptions to follow pertain to its uses in healthcare.

Dissection of the term 'empowerment' reveals that it can be defined in many ways, depending on the context of its use, which can be at an individual, organisational or community level (Tveiten & Severinsson 2005). Moreover, Malin and Teasdale (1991) make a distinction between 'micro' and 'macro' levels of empowerment.

Because of the diverse nature of empowerment, it may be viewed theoretically from many vantage points. These viewpoints are outlined by Kuokkanen and Leino-Kilpi (2000), who discuss critical social theory, organisational and management theories and social psychological theories in the context of empowerment. The latter viewpoint is most relevant to this concept clarification. Within this latter viewpoint, empowerment is seen as a development process, where power is not only surrendered but also liberated (Kuokkanen & Leino-Kilpi 2000).

What is agreed upon is that empowerment is a process (Wallerstein & Bernstein 1988, Lord & McKillop-Farlow 1990, Gibson 1991, Fullam *et al.* 1998, Mok 2001, Shearer and Reed 2004). The process of empowerment is described simply as "mutual participation, active listening and individualised knowledge acquisition by the nurse-client dyad" (Ellis-Stoll & Popkess-Vawter 1998, p. 65). This description of empowerment reflects the essential elements of empowerment, and fits with empowerment in the context of chronic illness.

The concept of empowerment fits "comfortably with nursing's developing discourse" (Chambers & Thompson 2009, p. 132). However, views of empowerment in nursing are described as "varied" and "imprecise" (Skelton 1994, p. 415). In addition, nursing is accused of adopting empowerment based on "abstract theoretical concepts, which were adopted with only a basic understanding of their meaning" (Chambers & Thompson 2009, p. 132).

To add to the lack of clarity, related terms to empowerment are the concepts of coping, support systems, participation, personal efficacy, competence, self-sufficiency and self-esteem (Kieffer 1984). Moreover, empowerment is viewed as not only a process but also an outcome (Wallerstein & Bernstein 1988, Gibson 1991).

Some of the complexity surrounding empowerment is revealed in more recent discussions where it is argued that empowerment is actually power (Powers 2003), and is “a coercive strategy that is justified by its outcomes” (Powers 2003, p. 227). The nurse is often viewed as the expert in a paternalistic role (Tveiten & Severinsson 2005). Moreover, Powers (2003) argues that patients are only considered empowered “if and only if they make that correct choices as defined by the health care provider” (p. 227). Powers (2003) also argues that empowerment is often a strategy employed by one person over another in an effort to produce outcomes that are prescribed by the person initiating the empowerment strategies. This claim is also made by Skelton (1994) who argues that behind the notion of empowerment “lurks an older view that ‘the professional knows best’ (p. 417), and prescribes in advance what behaviours are needed to change.

These aforementioned jaundiced views present a less positive aspect of empowerment, but are worth raising, because such views raise awareness of the possible coercive aspects of empowerment and through awareness this may be avoided.

The PRINCE study embraces the view of the patient as expert. Viewing the patient as the expert fits comfortably with empowerment, because it is a “positive concept” (Gibson 1991, p. 355), which refers to solutions as opposed to problems (Koukkanen & Leino-Kilpi 2000).

Gibson (1991) argues that some empowerment is “situationally determined” (p. 359) and that in order to understand empowerment, “it is critical to clarify the condition from which it evolves” (p.358). Therefore, in view of the aim of this concept analysis, empowerment from the standpoint of both the nurse and client with a chronic disease, i.e. COPD, is discussed.

Figure 2 presents a model of empowerment representing both the antecedents and consequences of empowerment from client and nurse perspective and also the context which promotes empowerment.

## **Nurse antecedents**

### ***Feel empowered***

In order to empower clients, nurses must themselves feel empowered. Self empowered nurses successfully perform professionally (Kuokkanen & Leino-Kilpi 2001), and empower others (Chavasse 1992, Skelton 1994, Rodwell 1996). Moreover, the empowerer must be willing to allow choices to the person being empowered (Hawks 1992). This is reflected in a study reported by Fulton (1997) where nurses felt their autonomy was limited, and therefore their freedom and empowerment was also limited.

### ***Communicate effectively***

Nurses need to be effective communicators to empower clients. Gibson (1991) argues that nurses need to communicate effectively with patients in the empowerment process. The establishment and maintenance of “good communications” with clients is also stressed by Todd and Ladon (1998, p.1), for the effective management of chronic illness. Moreover, Hawks (1992) stresses the need for “honest, openness and genuineness” (p. 611) for trust to evolve in the empowerment process. Linked to this is the finding that GPs who show empathy towards patients, whose health concerns are similar to them, empower patients with such a response (Fox *et al.* 2009).

In the process of empowerment, more recent literature emphasises the need for health care professionals to engage in reciprocal communication with clients. Rodwell (1996) argues in a concept analysis of empowerment that “practitioners appear to value the interpersonal process element of empowerment” (p. 307). The “interactive process” of empowerment is also stressed by Hawks (1992, p. 610). This view mirrors that of other literature on nurse-patient communication where reciprocity is viewed by nurses as essential to effective nurse-patient communication (Dowling 2008). Indeed, empowerment is considered a “transactional concept because the process involves a relationship with others” (Gibson 1991, p. 355).

Geoffrey (1998) also discusses the potential of the communication process in facilitating empowerment, with superficial talk on one end and information giving at the other. This latter view illustrates the continuum of the communication process in



facilitating empowerment. At one end is superficial talk, or 'chit chat' which involves a naïve attitude and a welcoming demeanour and helps put the client at ease (Kleiman (2004). This use of 'everyday' nursing language is used by nurses to resist what Hamilton and Manias (2006) term "dominant discourses" (p.87) which can alienate patients. This superficial talk also contributes to patients' "experience of emotional comfort" (Williams & Irurita 2004, p. 812). However, engaging in 'empowering dialogues' with clients is not always easy; practitioners admit that "old communication habits" can complicate collaborative efforts with clients (Tveiten & Meyer 2009, p.808). Therefore, practitioners need self-awareness and a raised consciousness regarding their communication styles with clients (Tveiten & Meyer 2009). Finally, effective communication lays the foundation for nurses' information giving to clients .

### ***Surrender of control***

The antecedent of effective communication is inextricably linked to the need for health care professionals to surrender control; "empowerment of consumers means corresponding relinquishment of power by providers" (Kane 2009, p.302). However, Gibson (1991) also asserts that "leadership skills are definitely needed to help the client" address their issues (p. 360). This latter view suggests that the health care professional must take the lead initially in order for clients to feel comfortable in their exchanges with nurses. Following which, the client is helped realise that their views are central to the process of empowerment. This leadership role is evident in the third stage of change, labelled preparation, where the client is fairly sure that he/she wants change, but lacks specific plans (Prochaska 1996). This also reflects a transformative approach in the empowerment process, which "includes provision of the proper resources, tools and environment necessary for empowerment" (Hawks 1992, p. 615).

The surrender of control is probably the most central nurse antecedent to empowerment, and clients must be "active, equal, and collaborative participants" in the empowerment process (Mok 2001, p.69). The need for the health care professional to "surrender" control is an antecedent to empowerment, which involves the nurse engaging in "a shift in thinking" (Gibson 1991, p. 357). Similarly, Skelton (1994, p. 419) argues that nurses need to "devolve more power to the patient, if that is what the

patients wants”. To do this however, requires self-awareness on the part of the nurse to identify his/her views of the patient as expert and any barriers present to such views. This self-awareness is vital. Patterson (2001) highlights that although practitioners may “assume the language of empowerment”, they may at the same time behave “in a manner that implies professional dominance” (p. 575).

Surrendering control implies a wish to relinquish power and a desire to assume a relationship of equality with the client. This is a shift away from the psychological model as proposed by Carl Rogers, because this model supports the status quo and existing power relationships in nursing (Ryles 1999).

Inherent in this view also is one of the client as expert (Rappaport 1987, Biley 2002). Self-management and empowerment are inextricably linked in chronic illness (Murphy et al 2010). Hawks (1992) argues that for empowerment to succeed, “both the one who empowers and those who are empowered must share a common purpose and/or vision” (p. 611). Similarly, Shearer (2007) argues that there needs to be “mutuality” between the client and those providing support in the health change (p.42), and Rodwell (1996) proposes that empowerment “places the patient in a partnership relationship with the nurse” (p. 306). Moreover, mutual participation is viewed as a defining attribute of empowerment, which facilitates learning (Ellis-Stoll & Popkess-Vawter 1998). These views are represented in Murrell-Armstrong’s empowerment matrix which argues that power can be shared or created but not controlled by others (Murrell 1985).

Many authors view empowerment from the stance of power (e.g. Stuart 1986, Kjervik 1990, Hawks 1992, Taylor et al 1992, O’Neill 1992, Rodwell 1996, Ryles 1999,) and enablement (Hawks 1992, Rodwell 1996). Similarly, Gallant *et al.* (2002) argue that “Power-with” is a positive force which “sustains and propels a relationship forward” (p. 154). Such a view is not surprising because empowerment is thought easier to understand if viewed from its absence, i.e. powerlessness (Gibson 1991), or disempowerment (Biley 2002). Moreover, Hawks (1992) argues that “the lines distinguishing the empowerer and the empowered are blurred” (p.611) in the empowering process. This aspect of empowerment is similar to the second stage of empowerment proposed by Gibson (1991) labelled the ‘era of advancement’, where

“opportunities for collaboration and mutually supportive problem-solving” exist (p. 356).

Closer examination of the view that equality in the health professional and client relationship is a dominant antecedent in empowerment, reveals a feminist view of power (Gibson 1991). The feminist movement generally associates empowerment with power (Kuokkanen & Leino-Kilpi 2000). Moreover, inherent in empowerment is a need for health care professionals to recognise the individual’s “right to self-determination (status)” and a recognition of the “interdependence of decision-making (authority)” (Loft *et al.* 2003, p.43). Clark (1987) also argues that recognising the individual’s right to self-determination is central to empowerment. Moreover, Gibson (1991) argues that when considering empowerment, it is essential to consider “not only how the ‘powerless’ attempt to take power but also how the ‘powerful’ release power” (p.355). Skinner (2010) sums this point up succinctly: “Giving patients more freedom to direct all aspects of care means not that providers should deny or underestimate their power but that, in their quest to provide high-quality care, they should never forget the depth of their powers or the mark they will leave on their patients' lives” (p. 182).

Tveiten and Severinsson (2005), however, question how mutuality in the nurse-client relationship can be achieved when the nurse has more knowledge than the client does. Furthermore, the need for equal levels of knowledge and status between the patient and the caregiver in order for empowerment to develop is also argued by Loft *et al.* (2003). However, this concept clarification proposes that if the equality between the health care professional and the client is viewed as one of reciprocity, it is a real possibility. The idea of reciprocity in the nurse-client relationship in the process of empowerment is also argued by Geoffrey (1998).

### ***Focus on goals***

Gibson (1991, p. 357) argues that nurses help people to empower themselves by using “resources that will promote or foster a sense of control and self-efficacy”. Self-efficacy and empowerment relate to psychological functioning in self-management with chronic disease (Swendeman *et al.* 2009). This focus of drawing on the patient’s own resources is also evident in the views of Todd and Ladon (1983) who argue that

health professionals “focus, focus, focus – less on problems and more on goals, successes, strengths and possibilities” ( p. 3), when helping clients self manage with chronic illness. Patterson (2001) also calls for further research on “the overt and covert ways in which practitioners may impede participatory decision making” (p. 579).

### **Client antecedents**

#### ***Motivation to change (Transition phase)***

Empowerment is likened to a process of becoming (Kieffer 1984). Moreover, to feel empowered, individuals must believe that they can influence their own futures (Tones 2001). It is argued that clients must be “committed to change” (Mok 2001, p.69), and many consider the client’s desire to change as central to the empowerment process (Shearer and Reed 2004, Ellis-Stoll and Popkess-Vawter 1998, Todd and Ladon 1998). Moreover, the person to be empowered “must be willing to assume responsibility, participate in goal-setting and decision-making, and accept behaviours that encourage empowerment” (Hawks 1992, p. 612). Therefore the practice nurses facilitating the SEPRP in the PRINCE study will facilitate clients to identify their commitment and desire to change, and will encourage clients to set goals in relation to making a lifestyle change. However, Skelton (1994) argues that many clients may not wish to be empowered and proposes that, “all patients are disadvantaged by virtue of their lay status in respect to the service provider and by their illness, and yet the majority may not wish to be empowered” (p.421). Self-determination and commitment are therefore also needed in the empowerment process (Mok 2001).

Shearer (2007) identifies the “essential structure” (p.43) of health empowerment as “a process of purposefully participating in health change”. This means that the individual has awareness of and engages with purposeful participation in change (Shearer 2007). The importance of change to the empowerment process is revealed in a phenomenological study involving fourteen homebound older women, which reveals that “recognizing potential to change emerged as a beam of strength guiding the women’s ability to change, improve, and eventually participate in their health” (Shearer 2007, p.41). Shearer (2007) compares her findings with Reed’s (1991) transformational process of self-transcendence. Inherent in this process is an openness to change, reflected in the view of Koukkanen and Leino-Kilpi (2000) who argue that individual empowerment requires the person to engage in critical introspection and

then change their patterns of activity as needed. “Interpretation of personal significance to the behaviour change needed” is also considered an antecedent of empowerment (Ellis-Stoll & Popkess-Vawter 1998, p.65). Similarly, Mok (2001) argues that clients must be “aware” (p.69) in order to be committed to change. Gibson (1991) also suggests that “empowerment entails a process of helping individuals develop a critical awareness of the root causes of their problems and a readiness to act on this awareness” (p. 356). Throughout the eight-week SEPRP programme, practice nurses will therefore work with clients facilitating them to identify the facilitators and potential barriers to making a lifestyle change but ultimately allowing clients to take responsibility in identifying the solutions to these barriers. The practice nurse’s role will therefore focus on supporting client’s commitment to change. However, it is argued that the individual must experience a threat to mobilise their intent to participation (Kieffer 1984).

This stage of the change process is called contemplation and is where the client is aware of possible benefits, but is not sure if he/she is ready to change and needs more information and encouragement to undertake the change (Prochaska 1996). This aspect of the process of motivation to change is similar to Gibson’s (1991) first stage of empowerment is the ‘era of entry’ where the individual’s participation is “exploratory” (p. 356) while they gain understanding on authority power structures. ‘Transition’ in this context is “the ways people incorporate the consequences of illness into their lives” (Kralik *et al.* 1997).

This stage also represents clients leaving behind feelings of ‘waiting’ and signifies active attempts to feel empowered. “Waiting” is defined as “a stationary, dynamic, yet unspecified time-frame phenomenon in which manifestations of uncertainty regarding personal outcomes remain suspended for a limited time” (Irvin 2001, p.132). Consequences of waiting include increased anxiety, uncertainty, loss of control, vulnerability, powerlessness and the potential for failure of normal adaptation and coping mechanism (Irvin 2001). Practice nurses will therefore be made aware that participants will need to be particularly supported on entry into the programme as they are likely to experience these latter feelings.

### *Presence of client competency*

Empowerment strongly suggests that the individual has competencies to be empowered or these competencies are possible (Gibson 1991). In order to be empowered, individuals living with a chronic illness must be able to communicate effectively, have knowledge to problem solve and actively participate in their care. The SEPRP will therefore focus on providing clients with information and knowledge on COPD. This will focus on helping clients identify what is normal for them so that they can identify when they are becoming unwell and know what to do which will effectively manage their symptoms. To this end, a Plan of Action Booklet will be developed with each client.

### *Ability to communicate effectively*

One essential competency for empowerment is the ability to communicate effectively. Shearer (2007) argues that skills to communicate effectively are necessary for the client to “connect” (p.44) with health care professionals. Shattell (2005) provide some interesting evidence to support such a conclusion and reports that patients are aware of how their response to the nurse affects the response they receive. The materials used in the SEPRP will therefore be reviewed to ensure that the language used is appropriate and at the correct educational level for COPD clients. In addition, it will be highlighted to practice nurses that their responses to clients influences whether a good nurse client relationship is established.

### *Knowledge to problem solve*

It is argued that clients need knowledge (Clark 1987) and an ability to problem solve for the process of empowerment to evolve (Ellis-Stoll & Popkess-Vawter 1998). This is further revealed in a qualitative study by Shearer (2007) where older homebound women expressed their acute awareness of their need to stay positive through self-talk.

The word empowerment arises from the Latin word ‘potere’ – meaning to be able (Gibson 1991). It is not surprising therefore that empowerment is related to knowledge. Gibson (1991) argues that in the second stage of the process of empowerment, “the individual develops mechanisms for action” (p. 356). Indeed, Tveiten and Severinsson (2005) equate the empowerment process to the learning process. Clients must be equipped with the knowledge, skills and self belief of

efficacy to alter aspects of their lives (Bandura 1986). Similarly, Funnell *et al.* (1991) argue that patients are empowered when they have the knowledge, skills and attitudes and self awareness to exert influence on their lives in order to improve their quality of life. Knowledge is also reported as central to participants' self-management of diabetes. Murphy *et al* (2010) report on their study which focused on the factors that impact on diabetic clients' self-management skills. They found that five factors influenced participants' self-management of their diabetes. These were: knowledge, support, motivation, relationship shift and empowerment. Empowerment is therefore an integral part of self-management of a chronic disease (Murphy *et al* 2010).

Knowledge has also been identified by a number of researchers as a pre requisite for positive adjustment to chronic illness and better self-care and control (Turk 1979; Brown 1990; De Weerdts *et al.* 1990). Preliminary pilot work for the PRINCE study revealed that COPD is a term that clients with this condition were not familiar with or understood. A central element of the SEPRP will therefore focus on reducing this knowledge deficit and thereby establish a key requirement for empowerment.

### ***Active participation***

Client participation is considered essential for empowerment (Mitcheson & Cowley 2003, Tveiten & Severinsson 2005). "The one being empowered must be willing to assume responsibility and participate in goal-setting and decision-making" (Hawks, 1992, p. 611). However, health care professionals can find it challenging when "patients participate too much", especially if patients' choices clash with practitioners' preferences (Tveiten & Meyer 2009, p. 810). Therefore, practice nurses facilitating the PRINCE study will be encouraged to accept the client's decision to prioritise lifestyle goals even when they might not agree with the client's identified priorities.

### **Context Antecedent**

The process of empowerment requires time, especially for those living with chronic illness (Patterson 2001). Similarly, Mok (2001) argues that it takes time to develop a client's empowerment and healthcare professionals achieve this by taking time to talk to patients, "answering questions, offering helpful information and listening" (Mok

2001, p. 72). Adequate time also facilitates the nurse-client relationship to develop. Within the SEPRP therefore, each week specific time will be allocated to answering clients' queries and concerns.

Moreover, there has to be choice entrenched in the empowerment process (Rodwell 1996). However, this choice must be meaningful and not mere tokenism. Trust in the context of a creation of dialogue is also necessary for the empowerment process to succeed (Hawks, 1992, Hurty 1984). This trust was revealed in a study describing public health nurses' understanding of client supervision and how they perform it through an analysis of twenty three dialogues between the nurses and their clients (parents of children) (Tveiten & Severinsson 2005). In addition, the PRINCE pilot study revealed that COPD clients have a high level of trust in their practice nurse; this foundation of trust will be further built upon to enhance the empowerment process.

A "nurturing and caring environment" is also needed for the empowerment process (Hawks 1992, p. 611). In addition, the client should be allowed "control what degree he or she will be able to participate in the decision making" (Mok 2001, p. 72).

### **Client Consequences**

The empowerment process results in patients developing "a sense of inner strength through connection with ... health care professionals. It is also a process of transformation through which they actively develop new perspectives by reframing and reinterpreting their illness" (Mok 2001, p.69). Furthermore, clients experience a sense of control (Mok 2001) that their decisions matter and are acted on.

Patients also feel a "positive self-concept, personal satisfaction, self-efficacy, a sense of mastery, a sense of control, a sense of connectedness, self-development, a sense of hope" (Gibson 1991). The change to patients' self esteem as a result of the empowerment process is also argued by other (Hawks 1992, Abbot *et al.* 1997); the latter arguing that empowered individuals are "generally satisfied, motivated, and independent" (Abbott *et al.* 1997, p. 270). The PRINCE study will therefore measure clients' self efficacy pre and post the PRINCE intervention and in this way hope to capture changes in empowerment. Connor *et al.* (1999) report that participants



experience themselves change, feeling successful, “helping create respectful, equal interactions with health care providers and peers” and “defining health from an internal frame of reference” and “determining actions that will improve one’s own or others’ health status and pursuing those actions” (p. 371).

### **Nurse Consequences**

It is argued that the nurse experiences a transformation of consciousness whereby the boundaries of the client’s self and the nurse’s self undergo exchange (Wallerstein & Bernstein 1988). This type of relationship also suggests some reciprocity and a “professionally satisfying type of relationship” (Gallant *et al.* 2002, p. 155). Therefore, practice nurses’ perceptions of and experience of facilitating the SEPRP and working in an empowering way, will be captured to identify any changes to their relationship with their COPD clients. However, reciprocity between the client and nurse needs to be considered in the context of the client’s needs. While not a study about nurses but GPs, the findings reported by Fox *et al.* (2009) are relevant to this latter point. Fox *et al.* (2009) conclude that GPs need to weight up the costs and benefits of self-disclosure with patients who are living with a chronic illness. Moreover, some GPs in this study shared the view that by sharing their own experiences of illness with clients, they could be potentially abusing their power.

## **Discussion**

### ***Defining Empowerment***

This concept analysis of empowerment in chronic illness reveals the difficulties in defining what empowerment is. This difficulty is further compounded by virtue of empowerment being viewed not only as a process but also an outcome (Wallerstein & Bernstein 1988, Gibson 1991). Gibson (1991) argues that because empowerment is a process, “it is difficult to operationalise and no single measure can capture it adequately” (p. 360). Nevertheless, Gibson (1991) adds that “each measurement, intervention and description in a particular context adds to the understanding of the construct” (p. 260). The particular context of empowerment being discussed here is in chronic illness, specifically COPD. An operational definition for empowerment in this

context therefore emphasises equality in the relationship between the health care professional and the client, with the client viewed as an expert.

### ***Model of Empowerment***

Stage four of Norris's concept clarification involves development of a model of the concept that includes all its component parts. The model developed here has similarities to the model proposed by Gibson (1991) (Figure 1). Interestingly, Gibson's (1991) model of the nursing domain is curiously like Orem's (1991) view of nursing helping roles. Interesting also is that the nurse domains are similar to the six categories of empowering methods proposed in the Murrell-Armstrong Empowerment Matrix (Murrell 1985), which are: education, leading, mentoring/supporting, providing, structuring and actualizing. Indeed, Chandler (1991) reports that interactions that involve counselling, supporting and comforting assist the empowerment process. The nurse-client relationship is also evident in Gibson's model. However, the model proposed here (Figure 2) makes explicit the centrality of mutuality in the nurse-patient relationship.

### ***Using Norris's and Rodgers' models***

Evaluating a concept for its maturity is a necessary early aspect of the research process (Morse *et al.* 1996). This concept analysis has mapped the concept of empowerment with particular focus on its role in chronic illness, specifically COPD. The outcome of the analysis adds to the concept analysis on empowerment presented by Gibson (1991), by its focus on chronic illness.

Norris's (1982) framework was chosen because the steps inherent in the method outlined are focused on concept clarification. A clarification of what empowerment means from client and nurse perspectives was an essential prerequisite to the development of SEPRP. Moreover, developing a model of the concept of empowerment in chronic illness, as outlined by Norris (1982), provided clarity to the concept.

On reflecting on the process of undertaking this concept clarification, utilisation of two approaches was useful. Rodgers' (1989) framework added structure and labelling to the analysis process. However, Rodgers (1989) outlines that a 'model case' is a real life example of the concept that illustrates all its attributes, and that a model case is best identified in the literature rather than constructed. A model case illustrating all the attributes of a concept suggests a mature concept, which empowerment in chronic illness is not. Morse *et al.* (1996) argue that a mature concept reflects "consensus and consistency with its use among theoreticians, researchers and practitioners" (p. 387). This concept clarification does not reflect this view, and empowerment in chronic illness and in particular COPD, is revealed as an evolving concept, with some immaturity still evident. Although its characteristics, preconditions and outcomes are evident, competing definitions of empowerment are evident in the concept analysis. This is somewhat surprising considering the extensive literature that addresses this concept.

Finally, while both approaches to concept analysis used here appear different, they are both influenced by Wilson's method; a point criticised by Beckwith *et al.* (2008) who accuse both Norris and Rodgers of naïve adaptation of the Wilsonian method.

## **Conclusion**

The purpose of this concept analysis was to clarify the concept of empowerment in chronic illness, and explicate a model of empowerment appropriate to clients living with COPD. While client and nurse antecedents and consequences were identified, the concept of empowerment as it pertains in chronic illness lacks clarity. Nonetheless, this concept analysis highlights that if empowerment is to be a central component of the PRINCE SEPRP programme it will need to combine the delivery of a curriculum with a client-centred approach to priority setting and problem solving. It will also need to be cognisant of self-efficacy and clients' motivation to make lifestyle changes. In addition, the need to capture practice nurses' experiences of facilitating SEPRP was highlighted so that any changes in the nurse client relationship from the nurse's perspective as well as from the client's can be explored, in particular to identify any transformation of consciousness in relation to empowerment.

### **Relevance to practice**

Empowerment is fundamental to the self-management of any chronic illness, not just COPD and is important for both nurses and clients. Both nurse and client require skills and self-awareness to engage in the empowerment process. The nurse needs to feel empowered, surrender control, communicate effectively and focus on the client's goals. The client needs a willingness to engage in change and actively engage with the empowerment process. The client also needs the ability to communicate effectively, have adequate knowledge (through effective communication and information giving from nurses) and problem solving skills. In addition, central to the empowerment process in chronic illness is a clinical context, which nurtures trust and reciprocity between the nurse and client and sufficient time to allow this.

Perhaps the first step in the empowerment process in chronic illness is the surrendering of control by nurses. To surrender control, nurses must remember that the COPD client is an expert who knows how their illness affects them and how they live within the limitations imposed by their condition. Nurses also need to remember that while some clients are also experts on the management of their illness, others may not wish to become experts and may choose to defer to the expertise of health care professionals. However, the findings reported by Tveiten and Meyer (2009) reveal that health care professionals may have difficulties acknowledging the patient as expert in view of interfering factors such as the patient's mental and physical condition, the presence of pain and previous experience. Nevertheless, with self awareness of any power over clients, nurses can attempt to relinquish this power in their efforts to assume a relationship of equality with their COPD clients.

In conclusion, this concept analysis of empowerment undertaken as part of the planning phase of the PRINCE study therefore reveals that any SEPRP for COPD clients needs to be cognisant of self efficacy and clients' motivation to change. Moreover, the programme must also educate nurses to facilitate the delivery of a curriculum with a client-centred approach to the setting of goals and problem solving.

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**Study design:** KM, DC, AC, MD. **Analysis of literature:** MD. **Manuscript preparation:** MD, AC, KM, DC.

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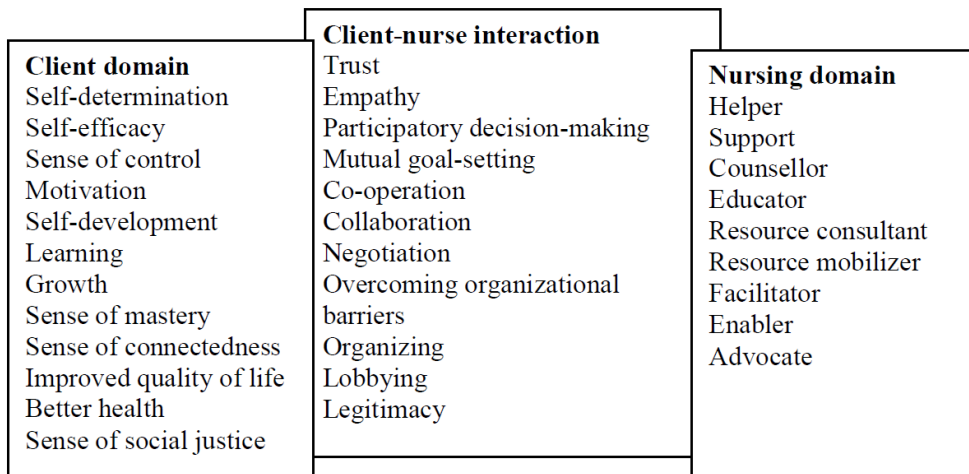
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**Figure 1: Gibson's (1991) model for empowerment**



**Figure 2: Model of empowerment in chronic illness for PRINCE study.**

