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A multidisciplinary concept analysis of empowerment : implications for nursing.

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Abstract: *According to the Institute of Medicine, nursing has failed to effectively shape the health care system and to advocate successfully for patients. Empowerment may be a potent tool to fulfill these responsibilities, yet nurses have not benefited from considering application of the concept to the continuum of health care advocacy in their communities, in their relationships with clients, and in their professional roles within health care organizations. This paper uses concept analysis to examine the attributes, characteristics, and uses of empowerment within diverse disciplines to clarify its meaning and explore its potential application to nursing's challenges that cross settings, disciplines, and time.*

Key Words: *Advocacy, empowerment, multidisciplinary, nursing profession, power*

A Multidisciplinary Concept Analysis of Empowerment: Implications for Nursing

Empowerment is a potent tool for nursing to influence patient safety, quality of care and equitable access to care (Beason, 2005; Busch, 2003; Dingle-Stewart & LaCoste, 2004). Public concern with these issues arose from a seminal report issued by the Institute of Medicine (IOM). *Keeping Patients Safe: Transforming the Work Environment of Nurses* (2004) identified nursing's failure to effectively shape the health care system and to advocate successfully for healthier communities, individuals, and for nurses themselves.

A clear understanding of empowerment is necessary for nurses to take advantage of this important tool. The concept of empowerment, however, is ambiguous and abstract and has been used in diverse disciplines with distinctly different meanings, dependent upon context and perspective. The authors employed methods of concept analysis derived from Walker & Avant (1995) to examine the attributes, characteristics and applications of empowerment in nursing and other disciplines. This analysis clarified the meaning of empowerment and its potential to influence the role of nurses in community advocacy, nursing care of individuals, and empowerment of nurses within health care organizations.

Seven formal concept analyses of empowerment have appeared in the nursing literature (Ellis-Stoll & Popkess-Vawter, 1998; Gibson, 1991; Hawks, 1992; Kuokkanen, 2000; Rodwell, 1996; Ryles, 1999; Skelton, 1994); however, this concept analysis is unique for two reasons. A *multidisciplinary perspective* enabled the authors to explore empowerment's influence across time, disciplines, and settings. Despite reluctance of earlier investigators to operationalize the concept, authors of this analysis provide clear evidence that empowerment *can be measured.*

Literature Review

A literature search of empowerment was conducted with keywords limited to *empower* and *empowerment* to minimize confusion with related but different concepts. Information was retrieved from an Ovid search of Medline (1950-2007), PsychINFO (1967-2007) and CINAHL (1987-2007), OVID Full Text Journals (n.d.-2007), and Your Journals @ OVID (n.d.-2007). The JStor database was searched to identify historical uses of the concept and online publishers EBSCOHost and PROQuest, active since the early 1990s, were accessed to retrieve literature from disciplines outside of health care. Online sites Google, Yahoo, MSN Live Search, Ask, About, MIVA, and LookSmart were searched to identify current popular uses of the term.

Literature from nursing, psychology, sociology, social work, community action, disability advocacy, organizational leadership, business management, and education was retrieved. The term *empowerment* originated in the 1920s, but little use of the term was identified prior to the mid-1970s. A marked increase after 1990, continuing to the present, was noted. In an OVID search, mapping terms for empowerment were used to identify three main categories: employment, patient care, and psychology, while results of other online search engines were classified as health care, business or organizational management, community advocacy and social justice, and government or international development. Seminal journal articles and books were identified through examination of reference lists. Tables 1-4 illustrate the exponential increase in use of the term and the distribution of varied meanings within specific contexts and disciplines, across the time period from the 1920s to the present.

The American Heritage Dictionary of the English Language (2000, online) defined *empower* as: "to invest with power, especially legal power or official authority; to equip or supply with an ability; to enable." Although the word originated in the mid-17th century, the modern usage of the concept was derived from the 20th century civil rights movement. Empowerment encompassed the term *power* which is itself derived from the Latin, *potere,* meaning "ability," the prefix *em* which constitutes "to cause to be" (*Merriam-Webster's Collegiate Dictionary,* 1993, p. 379) and the suffix *ment* which means "a result or product" (Hawks,1992, p. 610).

Framework for Analysis

Three classifications of empowerment were proposed in the literature, based on context and theoretical viewpoints: community empowerment, individuals' psychological empowerment, and organizational empowerment. These classifications provided a framework for this analysis (Kuokkanen, 2000; Rappaport, 1987). Each classification was explored to identify similarities and differences in the meaning and usage of empowerment, across time, disciplines, and settings, to understand the foundations and history of the concept. Non-nursing literature from the 1920s to the present was examined followed by an examination of the nursing literature for the same time period. The nurse's empowerment role for advocacy and health promotion in communities, both geographical and political, was explored first. Next, clinical

Table 1. Ovid Search Strategies and Results: Empowerment Citations over Time

OVID		J-STOR	
1900-1970	0	1900-1980	35
1970-1990	618	1980-1990	546
1990-1995	2700	1990-2000	4221
2001-2005	7700	2000-2007	1562
2006-2008	3300		

reports and studies on the individual and dyadic applications of psychological empowerment in the nurse-patient relationship were analyzed. Last, literature exploring empowerment of nurses within health care organizations, from individual employers to the system as a whole, was investigated. Following review of the literature, essential attributes, antecedents and consequences of empowerment were identified using the model for concept analysis described by Walker & Avant (1995).

Non-nursing Literature

The framework – community empowerment, individuals' psychological empowerment, and organizational empowerment

Table 2. Literature Search Strategies and Results: Mapping strategies employed in OVID Search

Mapping Term	Number of Citations Medline (1950-2007)	PsychINFO (1967-2007)	CINAHL (1987-2007)
Employment	49	49	42
Workplace	52	0	0
Health personnel attitudes	206	0	104
Organizational culture	143	87	191
Unduplicated Total	370	134	323
Nurse-patient relations	117	0	209
Consumer participation	249	0	280
Patient participation	263	35	280
Unduplicated Total	577	35	467
Social psychology	25	0	12
Power psychology	1134	0	0
Unduplicated Total	1142	0	1212
* No mapping terms available for OVID Full Text Journals and Your Journals @ Ovid			

Table 3. Literature Search Strategies and Results: Online Search

(Google, Yahoo, Microsoft Live Search, Ask, Dogpile, About, MIVA, LookSmart)	
Numbers of Citations in EbscoHost & PROQuest (In general, 1990 – present)	
Type of Publication	**Number of Citations**
Academic Journal	11,023
Magazine	4,693
Newspaper	2,258
Trade Publication	5,536
Company Reports	286
Dissertations PROQuest only	5186

Table 4. Literature Search Strategies and Results: Distribution of Citations in Academic Journals and Dissertations

Distribution of Citations in Academic Journals and Dissertations (N=300)	
Topic Area	**Percent**
Healthcare organizations	9 %
Nursing or patient care	8 %
Business or Organizational management	42 %
Community advocacy or Social justice	34 %
Government or International development	7 %

– was applied to an examination of the literature in diverse disciplines outside of nursing. Disciplines included community and political action; mental health and disability advocacy; psychology, sociology and social work; organizational leadership in manufacturing and business management, and education.

Community Empowerment

Social justice and advocacy were perhaps the earliest contemporary uses of the concept of empowerment, with access to resources identified as a repeated theme. Freire, a Brazilian educator working in the 1920s, was considered by many to have popularized the idea of empowerment resulting from consciousness-raising through education to achieve social justice and equal access to economic resources (Shor & Freire, 1987). Originating with the civil rights movement of the 1960s, the modern definition of empowerment was, "a process used to correct an imbalance of power by increasing access to resources such as communication and negotiating skills" (International Program on Intractable Conflict, nd.). In international development, the World Bank identified empowerment as a primary development assistance goal to reduce poverty and defined four core attributes of empowerment: a) a disadvantaged or powerless population; b) agency, i.e., empowerment must be claimed by the individual, not conferred by others; c) the ability to make decisions on one's own life and to take action to carry out those decisions; and d) empowerment as an ongoing process, not an end product (Malhotra, Schuler, & Boender, 2002; Mosedale, 2005; Williams, 2005).

Psychological Empowerment

Rappaport (1987) provided three contexts for empowerment in his definition, "a process by which people, organizations, and communities gain mastery over issues of concern to them" (Rappaport, 1987, p.122). While Rappaport and most others considered empowerment a *process*, at times it was used as an *outcome*

statement. *Empowered* referred to the results of empowerment including greater autonomy, decision-making power and freedom (Boggs, Carr, Fletcher, & Clarke, 2005), even though this usage was not fully established (American Heritage Dictionary, 2000). Zimmerman (1995) defined *psychological* empowerment at the level of the individual. He described psychological empowerment as the interface between a sense of personal control and efficacy and a willingness to change and take action, linking both internal cognitive factors and visible action or change.

Psychological empowerment was often associated with such constructs as self-esteem, self-efficacy, competency, and locus of control. It was correlated with four levels of cognition in a model used to describe the empowerment process in individuals: meaning, competence, self-determination, and ability to influence outcomes (Thomas and Velthouse, 1990). The nature of relationships employing empowerment was critically examined by Skelton (1994), emphasizing the vulnerability of individuals to manipulation by those in power and the potential for artificial or superficial activities referred to as empowerment, rather than substantive actions which would lead to significant change.

Organizational Empowerment

A large body of research on empowerment was identified in the field of organizational management. Kanter (1979) discussed empowerment as involving access to information, support, resources and opportunities to learn and grow in the work setting. Spreitzer (1995) discussed empowerment in terms of delegation, decision-making and hierarchies and used Thomas and Velthouse's (1990) levels of cognition to measure empowerment in nursing and social sciences (Spreitzer, 1995, p.1443).

In manufacturing and business, Deming (1986) conceptualized empowerment as a core value in his popular and widely implemented Total Quality Improvement Management theory (TQM). Empowerment in these settings proposed delegating authority and responsibility to lower levels of a hierarchy to improve productivity, with benefits intended for the organization rather than specific individuals. The nature and success of empowerment in this context varied widely. Boggs, Carr, Fletcher, & Clarke (2005) defined the results of empowerment as greater autonomy, decision-making power and freedom but cautioned against empowerment programs that failed to share authority, support autonomy, or provide access to resources because those people high in the hierarchy were unwilling to share what they perceived as a finite amount of power.

Murrell (1985) rejected the view of power as a finite commodity, and called for creation of *new power* which she termed *empowerment.* More complex than Zimmerman's (1995) model, Murrell's matrix was widely used in analysis of organizational empowerment. The five settings broadened Zimmerman's classifications to include "dyads, small groups, organizations, communities, and society" (Hawks, 1992, p. 610). Murrell (1985) identified six empowerment methods: "education, leading, mentoring/supporting, providing, structuring, and actualizing" (p. 610), and she rejected the notion of psychological empowerment as an internal process, strictly within an individual. According to Murrell (1985), empowerment was an inherently interactive process. Others said empowerment arose from the individual who behaved in an empowered manner rather than it being bestowed by people holding higher status in the hierarchy. This empowerment was independent of external factors, and did not necessarily require a public display of empowered action (Heathfield, 2005).

Nursing Literature

The three contexts for empowerment identified in the non-nursing literature were present in nursing literature as well: community empowerment, psychological empowerment and organizational empowerment (Kuokkanen, 2000; Rappaport, 1987). At the community level, literature was examined involving nurses' participation in facilitation of joint nurse/client advocacy efforts toward quality and access to health care resources in all types of communities, from neighborhoods to cities, at the national and international level (DuPlat-Jones, 1999; Gibson, 1991; Hildebrandt, 1996; Kuokkanen, 2000; Rodwell, 1996). Community empowerment included advocacy with and for groups to promote collective action aimed at increasing access to resources and social justice for individuals with mental illness and cognitive disabilities (Finfgeld, 2004; Moran, 2000; Ryles, 1999); physical challenges and limitations (Busch, 2003); gender issues (Meagher-Steward, 2001); AIDS (Fedor, 1991; Mackereth, 1993; McHaffie, 1994; Whipple, 1992); and socioeconomic, racial or age-related discrimination (Aroskar, Moldow, & Good, 2004; Barnes, Eribes, Juarbe, Nelson, Proctor, Sawyer, Shaul, et al., 1995; Falk-Rafael, 2005; Letty, 2003; Welchman & Griener, 2005; Whipple, 1992).

Empowerment Redefined

The World Health Organization's Alma Ata Declaration (1978) proposed empowerment as a method to enable people to increase control over and improve their own health (DuPlat-Jones, 1999; Gibson, 1991; Rodwell, 1996). Empowerment was described as a dynamic, positive, "democratic process" that "focuses more on solutions than on problems" (Gibson, 1991, p. 355) and recognized that an individual's lifestyle decisions were not the only influence on health. Blaming the victims overlooked the reality that many health outcomes were due to external factors over which individuals had no control, such as environmental conditions, access to care, and the safety and quality of care. Promoting and maintaining health through community education and collective advocacy, working together with individuals and communities, were necessary to effect change (Gibson, 1991). Gibson redefined empowerment for nursing as, "A social process of recognizing, promoting, and enhancing people's abilities to meet their own needs, solve their own problems and mobilize the necessary resources in order to feel in control of their own lives" (p. 359).

Community-based Empowerment

Kar, Pascual and Chickering (1999) identified seven methods of community empowerment for health promotion, using the acronym EMPOWER: "empowerment education and training, media use and advocacy, public education and participation, organizing associations and unions, work training and micro-enterprise, enabling services and support, and rights protection and promotion" (p. 1431). A community-based empowerment intervention in a black South African township illustrated the role of the nurse, transferring information and expertise to community members, facilitating people to overcome feelings of helplessness and hopelessness and to participate in information gathering, setting priorities, and selecting projects to produce solutions that ultimately increased people's access to health care and control over their health (Hildebrandt, 1996). Advocates of community-based empowerment realized that when outside experts determined a community's problems and decreed appropriate solutions, changes often lasted only as long as the experts remained. Without the outsiders, the community lacked the expertise and sense of ownership necessary to continue even the most successful programs.

Knowledge as power. Kuokkanen (2000) discussed the issue of power – including the power of nurses as health care experts. In social action especially, power is often interpreted in terms of "coercion and domination" and as a "negative, patriarchal and authoritarian concept" (p. 3 of 11, online), but knowledge is the real source of power. The nature of empowerment as a collective process increasing access to knowledge and resources for groups and communities was similar to the interactive process of nurses working with individual patients and their families, and involved some of the same potentials for conflict.

Expertise as power. Psychological empowerment of individual clients and families was employed within patient/nurse dyads to promote health, manage chronic illness, and achieve successful

aging. Conflict between the traditional value of caring and patient autonomy, integral to empowerment, was identified (Ellis-Stoll & Popkess-Vawter, 1998; Falk-Rafael, 2001; Rodwell, 1996). Issues involving the related concept of power were congruent with Skelton's (1994) concerns about nursing's reluctance to surrender the role of expert (Finfgeld, 2004; Ryles 1999).

Person-centered Empowerment

Dramatic changes have occurred in the health care system in the last 50 years, leading to fragmented care, limitations imposed by health maintenance organizations, insurance companies and government payers, and distance imposed by modern technology (Moss, 2005). An intervention involving a patient coping with cancer illustrated empowerment used to promote self-advocacy and ownership of the individual's own health care within this environment. Three empowerment strategies were described: assisting a patient to learn to obtain information, supporting the person in making choices, and facilitating effective communication and negotiation for insurance reimbursement (Busch, 2003).

The process of empowerment in the context of nursing practice was described as "evolving consciousness" in which increasing awareness, knowledge, and skills interacted with the client's active participation to move toward actualizing potential (Falk-Rafael, 2001, p.1) Nurses saw empowerment as a dynamic growth process rooted in each individual's values, beliefs and culture (Falk-Rafael, 2001). Active participation was an essential element of the process; nurses "could only facilitate, not create, empowerment" (Falk-Rafael, 2001, p. 4).

Shearer and Reed (2004) used Roger's (1992) view of person-environment to create a theoretical model of the contextual and relational factors contributing to development of true empowerment and called for a shift from empowerment given *to* clients *by* nurses, to empowerment as an integral part of the nurse/client relationship. The reciprocal nature of the relationship between power and responsibility, which was foundational to the interactive process of empowerment, consistently required mutuality, personal responsibility and capacity for growth on the part of patients and nurses (Finfgeld, 2004; Hawks, 1992; Kuokkanen, 2000; Ryles, 1999).

Nursing's Dichotomous Perspective

Nurses' struggles with patients' freedom of choice – when such choices did not value health and health-promoting practices – were repeatedly noted in the literature (Finfgeld, 2004; Rodwell, 1996; Ryles 1999). Ellis-Stoll & Popkess-Vawter (1998) advocated facilitating empowerment, encouraged patient autonomy, and supported the rights of patients to make their own choices and control their own health. However, Ellis-Stoll & Popkess-Vawter ultimately defined empowerment as, "A process designed to change unhealthy behaviors in clients" (1998, p. 64), exemplifying a significant dichotomy: Respect for a client's own values and choices conflicted with the nurse's traditional role as caregiver, utilizing the power of information expert and health care authority to promote compliance and in the process maintaining the nurse's power position (DuPlat-Jones, 1999; Finfgeld, 2004; Rodwell, 1996; Skelton, 1994). Skelton (1994) wrote of the origins of empowerment in its political context and critically analyzed its use in nursing, cautioning of the potential for nurses to undermine empowerment of patients rather than surrender the power inherent in the role of caregiver and expert health care provider.

Power conflict. Empowerment among individuals with chronic and severe illnesses, especially mental illnesses, illustrated this conflict. Seeing patients as competent to make their own decisions and take responsibility for outcomes and consequences was a necessary component of respectful, trusting relationships (Finfgeld, 2004; Ryles 1999). Relationships between nurse and patient consistently required respectful and trusting interaction and the nurse's willingness to relinquish power (Finfgeld, 2004; Hawks, 1992; Rodwell, 1996; Ryles 1999). This conflict in values inevitably involved issues with the related concept of power.

Shared power. The process of empowerment was seen as incomplete without a tangible shift in the balance of power (Rodwell, 1996; Ryles, 1999). A distinction between empowerment as a transfer of a finite amount of power from one person to another and the mutual sharing of continuously increasing amounts of power was discerned in the nursing literature (Ryles, 1999). Remarking on the tension between the concepts of caring and empowerment, Rodwell (1996) emphasized that nurses "cannot empower people, people can only empower themselves.... [The process of empowerment simply] "provides the resources, skills and opportunity to develop a sense of control" (p.310).

Nursing's Perceived Powerlessness

Issues of power arose from ambiguities in the traditional role of nurses and the power, or powerlessness, of the largely feminine nursing profession. These issues were explored by examining empowerment of nurses themselves within organizations, the third context in which empowerment operates. Empowerment of nurses themselves, as a step in professional and personal development, was identified as an appropriate and effective response to the perceived powerlessness of nurses in their roles within health care organizations and to failure of the profession as a whole to contribute effectively to health care restructuring (Gibson, 1991; Hawks, 1992). Empowerment as a method of obtaining core skills in communication, negotiation and conflict management was seen as essential to nurses' effective participation in shaping the health care system (Dingel-Stewart & LaCoste, 2004; DuPlat-Jones, 1999; Lewis & Urmston, 2000).

Compromising care. The IOM report, *Keeping Patients Safe: Transforming the Work Environment of Nurses* (2004) found that the health care environment in which nurses' work included multiple threats to patient safety and a level of care quality well below standards in other developed nations. The IOM laid responsibility for this on management practices, staffing issues, work design and organizational culture. The failure of nurses and the nursing profession to effectively influence the workplace contributed to breakdowns in safety and quality of care. The absence of nursing's voice in the larger political, economic and social environment lead to unsafe conditions, problems with health care access to care, and disparity in health care outcomes for disadvantaged groups and communities (DuPlat-Jones, 1999; Gibson, 1991; Ryles, 1999). DeMarco and Roberts (2000) noted that nurses had been unable to assert themselves collectively in the workplace.

Empowering themselves. Empowerment was proposed as a key process for nurses to gain the skills needed to participate in the health care arena (Lewis & Urmston (2000). The history of the concept was founded on action to change the conditions which oppress people and increase quality of life (Gibson, 1991; Ryles, 1999). The same methods and strategies employed by nurses with clients involved in community empowerment applied to nurses themselves. Development of such key skills as communication, negotiation and conflict resolution inherent to empowerment were critical for effective advocacy within health care organizations (Gordon, 2005; Moss, 2005).

Nursing's Obligation to Act

The lack of political stewardship left a void that was filled by rapidly changing market forces. Nurses' exclusive focus on bedside nursing and interaction with patients and families as well as their resistance to an awareness of the broader, economic, political and organizational aspects of health care systems prevented them from achieving the empowered status necessary to participate within today's health care organizations, both at the level of individual employer and within the larger political and economic environment of the health care system (Dingel-Stewart & LaCoste, 2004). "Unless nurses can learn to represent themselves, their interests and those of their clients more effectively, they will

continue to be a large body of professionals with a relatively small voice within the wider political, social and health-care arenas," intoned Du Plat-Jones (1999, p.8). She stated, "If nurses wish to gain power in their work environment and have a voice in national debates, they must raise their profile by actively representing their rights at all levels in society" (Du Plat-Jones, 1999, p.4).

Responding individually. Beason (2005) noted the IOM report arrived in the midst of a national nursing shortage made worse by a decreased respect for nursing, competition for nursing candidates with greatly increased career options, and a demographic in which large numbers of current nurses are approaching retirement age. The lack of empowerment was directly related to the worsening nursing shortage; deficits in accountability, commitment and productivity; low retention and high turnover rates, and serious issues with quality of care (Becker, 1994). The traditional hierarchical management structure created stress, particularly in nursing students and new nurses (Lewis & Urmston, 2000). Several studies of stress among nurses cited the role of empowerment as a preventative or curative response, leading to increased job satisfaction and retention. Laschinger and Finegan (2005) directly correlated empowerment strategies with the IOM's (2004) conclusion that leadership in nursing was insufficient. Specific actions for nurses, intended to increase empowerment and to set and achieve goals for their own and their patients' benefit, were identified and measured by Spreitzer (1995).

Acting collectively. Psychological empowerment cultivated within individual nurses as components of personal and professional development, rather than dependence on those people high in the health care hierarchy, was congruent with organizational theory (Simoni, Larrabee, Birkhimer, Mott, & Gladden, 2004). Despite the reality that nurses made up the largest group of health care providers, the power of collective action was infrequently exercised (DeMarco & Roberts, 2000; Gordon, 2005). The American Nurses Association as well as the American Colleges of Nursing, National League for Nursing, the American Organization of Nurse Executives and the American College of Nurse Practitioners were named as vehicles for nurses to participate in collective bargaining, but issues within the profession inhibited effective organization (Gordon, 2005).

Nursing's Persistent Passivity

Perhaps due to nursing's history as a predominantly female profession, nurses were seen as largely passive in the face of deteriorating work conditions and standards of care, avoiding the potential for tension and conflict inherent in empowerment efforts and collective power (Daiski, 2004; DuPlat-Jones, 1999; Gordon, 2005). Many nurses had negative associations with the issue of power. Discourse and behaviors of nurses were similar to those expected from members of oppressed groups, imposing the same negative aspects of control, power and disrespect on those lower in the hierarchy which nurses experienced from higher levels of the organization. This pattern of oppression significantly contributed to problems with retention of students and new nurses, increasing stress levels of nurses in general, and diminishing status of the nursing profession in the eyes of people in management and other disciplines (Daiski, 2004).

Nursing's Transformation

Empowerment activities proposed to effect change in nurses' attitudes toward conflict and power included collaboration and relationship building with other health care disciplines and among nurses themselves. Nurses can apply the same mutual respect and caring traditionally given to patients to peers and colleagues, raising consciousness through education, mentorship and transformational leadership strategies, and participating in decisions involving their own practice (Daiski, 2004). Collective action arising from empowerment of nurses within health care organizations appeared to exhibit the greatest potential to create change, not only for nurses themselves, but for their patients and families, their communities, and the profession as a whole (Gibson, 1991).

Defining Attributes of Empowerment

According to Walker and Avant (1995), defining attributes are characteristics which are inherent and essential to the meaning of a concept. Defining attributes of empowerment include a) reciprocal interaction, b) autonomy linked with accountability, c) shared or transferred power, and d) ultimately greater access to financial or intangible resources such as knowledge and influence. Though exceedingly abstract, empowerment is reported as inherently and essentially a positive concept (Gibson, 1991). It is regarded as both a process (Rappaport, 1987) and an outcome (Boggs, et al., 2005). The context in which empowerment occurs largely determines specific strategies for its use and resultant outcomes (Zimmerman, 1995). A working definition of empowerment, derived from these attributes and combined with ideas from earlier works, is proposed by the authors: *Empowerment is both a process and an outcome arising from reciprocal interactions among people, linking autonomy with accountability, involving shared or transferred power, and achieving the ultimate goal of greater access to financial resources or intangible benefits such as knowledge and influence.*

Empowerment must be part of a mutual and reciprocal interactive relationship (Hawks, 1992; Kuokkanen, 2000; Ryles, 1999), either on the level of individuals, organizations or communities. Nonetheless, an answer to the controversial question of whether empowerment originates with an external authority or whether it is a process initiated and pursued internally by empowered individuals remains elusive (Heathfield, 2005; Simoni, et al., 2004). The transfer or sharing of power is an integral part of the empowerment process, with power defined in nursing as a product of skill or knowledge as opposed to coercion or pressure (DuPlat-Jones, 1999; Kuokkanen, 2000; Ryles, 1999). Access to resources is the ultimate goal of empowerment (International Program on Intractable Conflict, nd.; Kanter, 1979). Inherent in the process of empowerment are accountability and responsibility; free choice is also reported as a necessary aspect of empowerment (DuPlat-Jones, 1999; Finfgeld, 2004; Hawks, 1992; Kuokkanen, 2000; Rodwell, 1996).

Antecedents of Empowerment

According to Walker and Avant's (1995) model, antecedents are those conditions which must exist before empowerment can occur. Antecedents to successful empowerment include respectful, trusting relationships and willingness to accept change (Hawks, 1992; Kuokkanen, 2000; Ryles, 1999). Communication, negotiating skills, and willingness to surrender or transfer power are reported as both antecedents and outcomes of empowerment (Ryles, 1999). Willingness to accept transferred or bestowed power necessarily precedes empowerment. According to Ryles, power is both a necessary antecedent and consequence of empowerment.

Trust and respect are foundational to the process of empowerment, with little potential for successful outcomes in their absence (Hawks, 1992; Kuokkanen, 2000). Self-esteem and confidence in both the abilities of nurses, and the worth or value of the nursing profession are vital to autonomous practice (DuPlat-Jones, 1999). Within a trusting and respectful patient/nurse interaction, the nurse's willingness to surrender the role of health expert and vital caregiver in favor of supporting the client's freedom of choice and right to self-determination is necessary for empowerment to occur (Ellis-Stoll & Popkess-Vawter, 1998; Finfgeld, 2004; Rodwell, 1996; Shearer & Reed, 2004). Personal capacity for growth and a desire for autonomy and self-determination are requirements underlying the process of empowerment for both patients and nurses. Willingness to accept the consequences of decisions and choices is also a necessary antecedent (Dingle-Stewart & LaCoste, 2004).

Consequences of Empowerment

Results of successful empowerment for nurses and the nursing profession are greater power and access to resources (DuPlat-Jones, 1999). Resources in non-nursing fields may be classified as economic, political or psychological, but resources in nursing predominantly include knowledge, autonomy and control of practice. Other consequences of nurses' empowerment are accountability, responsibility, willingness to see beyond the bedside, and the pursuit of effective advocacy skills for patients and for the profession (Simoni, et al., 2004).

For individual patients and their families, empowerment produces a trusting, respectful, and nurturing nurse-patient relationship that supplies support, encouragement and information, but patients and their families must accept responsibility for health care choices and behaviors (Ellis-Stoll & Popkess-Vawter, 1998; Finfgeld, 2004; Rodwell, 1996; Shearer & Reed, 2004). Conversely, the community and the nursing profession share ethical responsibility for the social, economic and political consequences of failing to confront coercive power and create change (DuPlat-Jones, 1999; Dingle-Stewart & LaCoste, 2004).

Positive rewards of empowerment include skills in communication, negotiation and political action; decreased stress; improved job satisfaction for nurses, and increased retention and recruitment, which address cyclical nursing shortages (Becker, 1994). As a profession, nursing benefits from increased status and influence yielded by the rights and responsibilities gained through participation in the empowerment process (Simoni, et al., 2004).

Related Concepts

Related concepts are those which are integrally connected with the concept under analysis (Walker and Avant, 1995). Primary among related concepts in the analysis of empowerment is the concept of power, which itself could be related to dominance and coercion or conversely to the more benign ability to access resources and effect change (Murrell, 1985; Ryles, 1999). The concepts of authority and control are closely related to power. Authority is related to dominance and coercion (Murrell, 1985; Ryles, 1999). Control, often used interchangeably with power, implies effective management of external situations or events, as well as individuals' control of their own behavior (Lewis & Urmston, 2000).

The identity and traditions of nursing are also related factors. Nursing's traditionally female composition contributes to the frequency with which many women in nursing decline to confront authority or seek control because they perceive these as negative or inappropriate qualities (Ryles, 1999). Oppressed-group behaviors within the nursing profession result in powerlessness; these behaviors are a consequence of the traditional caregiving role of nurses (Daiski, 2004; Kanter 1979).

Related to the concept of empowerment, accountability and responsibility lead to increased autonomy and control of nursing practice (Finfgeld, 2004; Hawks, 1992; Kuokkanen, 2000; Rodwell, 1996). The concept of enabling is also related to empowerment. Although often understood as permitting or encouraging a negative behavior, enabling may be understood as lending strength, developing abilities, or giving control, which is well matched with nursing (Ellis-Stoll & Popkess-Vawter, 1998). Caring is integral to nursing's identity, but it is linked to conflict in situations involving empowerment of patients. The contradiction between nursing's traditional caring role and the surrender of responsibility for the health and wellness of patients is a dichotomy needing further examination. This dichotomous perspective on caring and empowerment may require a change in the definition of nursing (Finfgeld, 2004; Ellis-Stoll & Popkess-Vawter, 1998; Kuokkanen, 2000; Ryles, 1999).

Empirical Referents of Empowerment

Although Walker and Avant (1995) called for reporting empirical referents or methods for measuring a concept, authors of previous concept analyses of empowerment declined to cite specific referents. Gibson (1991) and Rodwell (1996) argued against any attempt to do so, due to the ambiguous and abstract nature of the concept. They were joined in this argument by Zimmerman (1995). Rappaport (1984) reported that only indirect measurements of the concept, producing qualitative data, were possible. Watkins & Golembiewski (1995) stated neither independent variables, with empowerment as an intervention, nor outcome variables could be measured due to an inability to sufficiently control for confounding factors. Brown (2004) argued that operationalizing the concept of empowerment was value-oriented and subject to researcher bias because researchers choose the indirect variables which are to be measured.

Specifying referents. Reluctance of some researchers to specify empirical referents of empowerment did not discourage others. Several researchers advocated strategies for indirect measurement of related psychological or behavioral factors using observation, focus groups, surveys, and interviews as methods to derive data on empowerment. Spreitzer (1995) created an instrument commonly used in nursing research, a 7-item Likert scale measuring the relationships between four dimensions of empowerment derived from Thomas and Velthouse (1990): a sense of meaning, competence, self-determination, and impact, and three key outcomes: effectiveness, work satisfaction, and strain.

Obtaining evidence. Itzhaky & York (2000) utilized a 7-item Likert scale created by Zimmerman, Israel, Schulz and Checkoway (1992) for control of decisions, and a 34-item Family Empowerment Scale (Man, Lam, & Bard, 2003) was created for use with families and adolescents. Segal, Silverman, and Temkin (1995) created a complex of three scales: personal empowerment, organizational empowerment and extra-organizational empowerment. Wolf, Parkman, and Gawith (2000) produced a concept-mapping process, using a 5-point Likert scale and clustering responses from focus groups, followed by computer analysis which yielded an item-matrix. Reininger, Martin, Ross, Sinicrope & Dinh-Zarr (1999-2000) used grounded theory and qualitative research methods to generate a framework for subsequent quantitative analysis. Reininger et al. proposed ten process variables to increase empowerment and eight outcome variables as an effective way to institute control.

Measuring empowerment. Despite concerns with controlling for variable contexts in the measurement of empowerment, a number of instruments have exhibited validity. It appears safe to conclude that methods to measure empowerment are problematic but may be used with careful attention to their inherent limitations.

Conclusions

Because of its multidisciplinary focus and specification of empirical referents, this concept analysis contributes an expanded view of empowerment not found elsewhere in the nursing literature. Empowerment, as practiced and nurtured by nurses, has the potential to address issues of safety, quality and access to health care (IOM, 2004). Three classifications of empowerment – community advocacy, patient care, and empowerment of nurses themselves – offer a significant tool to improve patient care and foster ongoing development of the nursing profession. The IOM (2004) made clear the choices facing the nursing profession. Empowerment is not dependent on management initiatives; rather, it is a mutual process of learning, becoming politically and collectively active, and accepting the burdens of autonomy and responsibility. Nurses across the continuum of care must look beyond the bedside to the larger social, political and economic environment and gain the skills in communication, negotiation and conflict management necessary to effectively advocate for and with clients, families, communities, and themselves. The voices of empowered nurses are crucial for negotiating the rapidly changing health care environment, influencing political and organizational policies, and meeting challenges the IOM issued to the nursing profession.

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