International Encyclopedia of Rehabilitation

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Empowerment

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Empowerment is a central and recurring theme in rehabilitation. For example, in commemorating the 70th anniversary of the Vocational Rehabilitation Act in the US, former Rehabilitation Services Administration Commissioner Nell Carney emphasized that the "vocational rehabilitation program spans seven decades providing hope, training, employment, opportunity, independence, and *empowerment* for millions of Americans with disabilities" [italics added](1990, p. 6). Similarly, a fundamental purpose of the VR Act-funded Independent Living Program is described as to "maximize the leadership, *empowerment*, independence, and productivity of people with disabilities" [italics added] (US Department of Education 2007, p. 43).

The *American Heritage Dictionary of the English Language* (2000) defines the noun empowerment as "to invest with power." The usage note in the *American Heritage Dictionary* (2000) states the following with regard to the word *empower:*

> Although it is a contemporary buzzword, the word empower is not new, having arisen in the mid-17th century with the legalistic meaning "to invest with authority, authorize." Shortly thereafter it began to be used with an infinitive in a more general way meaning "to enable or permit." Both of these uses survive today but have been overpowered by the word's use in politics and pop psychology. Its modern use originated in the civil rights movement, which sought political empowerment for its followers. The word was then taken up by the women's movement, and its appeal has not flagged. Since people of all political persuasions have a need for a word that makes their constituents feel that they are or are about to become more in control of their destinies, empower has been adopted by conservatives as well as social reformers. It has even migrated out of the political arena into other fields. (pp. 586-587).

This 'modern use' of the term empower referred to by the Usage Panel of the *American Heritage Dictionary* refers to the word's meaning as to *invest with power*. That usage is prevalent in academic disciplines aligned with social movements, perhaps most noticeably the fields of disability studies, community psychology, and social welfare. Julian Rappaport, a founder of the discipline of community psychology, wrote in 1981 with regard to the focus of this new discipline:

> To be committed to an empowerment social agenda and to be consistent with that agenda in one's approach to social science theory, research, and action is to be committed to identifying, facilitating, or creating contexts in which heretofore silent and isolated people, those who are "outsiders" in various settings, organizations, and communities, gain understanding, voice and influence over decisions that affect their lives (Rappaport 1981, p. 52).

Writing more recently, Michigan State University psychologist John F. Kosciulek, who introduced the Consumer-Directed Theory of Empowerment to the field of rehabilitation, defined empowerment as:

> … the process by which people who have been rendered powerless or marginalized develop the skills to take control of their lives and their environment (Kosciulek 1999, p. 197).

At its most basic intent within the disability movement, the notion of empowerment is rooted in issues pertaining to obtaining greater power and control over their lives. Again, Kosciulek noted:

> … a growing belief has emerged in recent years that consumers of rehabilitation services should gain power over the services they receive and, in the process, gain or regain control over their lives (Kosciulek 1999, p. 198).

Within the disability movement, empowerment has been used to reflect a changed understanding of the self and one's place in society, a focus facilitated by the fact that science and society are, albeit gradually, adopting ways of understanding disability itself that emphasizes the role of environment and context in conceptualizing what is meant by disability. For much of history, disability has been understood in negative terms; as pathology, aberration, and something atypical. People with disabilities themselves were viewed as, in some way, diseased, broken, or needing to be fixed. Toward the end of the 20th Century, these conceptualizations began to be replaced by ways of thinking about disability that focused on disability as a function of the interaction or fit between personal capacity and the context in which people with disabilities lived, learned, worked, and played. The most visible of these functional models of disability, the World Health Organization's *International Classification of Functioning, Disability, and Health* (ICF), is a biopsychosocial model of disability in which disability and functioning are viewed as outcomes of interactions between health conditions (diseases, disorders, and injuries) and contextual factors. These contextual factors include environmental and personal factors. The ICF proposes three levels of human functioning upon which these health conditions and contextual factors act: Body Functions and Structures, referring to the physiological functions of body systems and the anatomical parts of bodies, including organs and limbs; Activities, or the execution of tasks or actions by the person, and Participation, pertaining to involvement in life situations. The impact of health conditions and contextual factors on body functions and structures might result in impairments, defined as problems in body function or structure, while the impact on activity and participation factors may result in activity limitations or participation restrictions. The key element of the ICF is the notion that disability is a function of the relationship or the fit between the person, his or her health condition, and the social context.

By defining *disability* as a function of the reciprocal interaction between the environment and the person's functional limitations, as the ICF does, the focus of the 'problem' shifts from being a deficit within the person to being the relationship between the person's functioning and the environment and, subsequently, to the identification and design of supports to address the person's functioning within that context. An empowerment focus, therefore, becomes more relevant as the onus for change to promote optimal functioning shifts from being somehow the

sole or primary responsibility of the person to change to a greater emphasis on changing the environment or context in which that person must function. This is achieved through policy and legislative initiatives, modifications to tasks and the environment to ensure access, the use of technology to mitigate the limitations introduced by a disability, and so forth.

Adopting an empowerment approach creates a Catch-22 for many professionals in rehabilitation. That problem is that any understanding of empowerment as meaning 'to invest with power' implies, essentially, that one person holds the power and is at liberty (or not) to 'invest' another with that power. When one has the power to invest someone else with power or control, one also has the power, presumably, to withhold granting that power. Power and control remain, fundamentally, with the granter in that circumstance (Wehmeyer 2004). A second meaning of the word empowerment offered by the *American Heritage Dictionary*, "to enable or permit," provides, perhaps, a direction for understanding empowerment that circumvents the difficulties of the 'granting power' problem and that captures the understanding of the construct as understood in the disability self-help movement. The first part of that definition, the notion of permitting, has the same problems inherent in the 'investing power' definition. It is the second meaning, the notion of enabling or enablement, that provides a means for rehabilitation professionals to approach the delivery of services and supports with a true empowerment focus. Enable means "to supply with the means, knowledge, or opportunity; to make feasible or possible" (*American Heritage Dictionary*).

The way out of the 'granting power' conundrum, then, is through efforts to *enable* people with disabilities to exert control in their lives and, as a function of such actions, to become empowered to do so to a greater extent. As professionals in rehabilitation, the route to "enablement" is through providing opportunities and supports that promote and enhance the self-determination of people with disabilities, which emphasize choice and control, and that place people with disability in the role of causal agent in their lives (Wehmeyer 2005). (More information about self-determination can be found in the Self-Determination article in the International Encyclopedia of Rehabilitation.)

Drawing from the work of Emener (1991), Kosciulek identified four "philosophical tenets" as necessary for an empowerment approach to rehabilitation:

1. Each individual is of great worth and dignity.
2. Every person should have equal opportunity to maximize his or her potential and is deserving of societal help in attempting to do so.
3. People by and large strive to grow and change in positive directions.
4. Individuals should be free to make their own decisions about the management of their lives.

The themes that drive an empowerment approach to rehabilitation involve consumer direction and control, involvement in habilitation planning and decision making, choice opportunities, an emphasis on personal preferences, and the implementation of self-regulation and self-management strategies. In the US examples of the operationalization of these themes include efforts to increase consumer control in individualized planning leading to plans for employment (Wehmeyer et al. 2003), consumer-controlled funding for rehabilitation outcomes (Hardina

2003), and the inclusion of language pertaining to choice and self-determination in iterative reauthorizations to the rehabilitation act. For example, the 1992 reauthorization stated in the findings of Congress [Section 2 (29 USC. 701)]:

1) millions of Americans have one or more physical or mental disability and the number of Americans with disabilities is increasing;
2) individuals with disabilities constitute one of the most disadvantaged groups in society;
3) disability is a natural part of the human experience and in no way diminishes the right of individuals to:
    a) live independently;
    b) enjoy self-determination;
    c) make choices;
    d) contribute to society
    e) pursue meaningful careers; and
    f) enjoy full inclusion and integration in the economic, political, social, cultural and educational mainstream of American society;

and

6) the goals of the nation properly include the goal of providing individuals with disabilities the tools necessary to:
    a) make informed choices and decisions; and achieve equality of opportunity, full inclusion and integration into society, employment, independent living and economic and social self-sufficiency, for such individuals.

The 1998 amendments to the State Vocational Rehabilitation Services Program Act further strengthened and emphasized the centrality of informed choice in the rehabilitation process.

The Consumer-Directed Theory of Empowerment (CDTE) (Kosciulek 1999, 2005; Kosciulek and Merz 2001) attempts to model these themes in a way that captures the variables leading to empowerment and, beyond empowerment, to an enhanced quality of life. CDTE is predicated on the proposition that "greater consumer direction in disability policy formulation and rehabilitation service delivery will lead to increased community integration, empowerment, and QOL among people with disabilities" (Kosciulek 2005, p. 41). The structural model of CDTE, evaluated several times (Kosciulek 2005; Kosciulek and Merz 2001), proposes that consumer direction (e.g., consumer controlled and directed services, a variety of service options, adequate information and support, and active participation in policymaking) leads to enhanced community integration (home/family, social/leisure, productive activity/work), and both consumer direction and community integration lead to empowerment, which in turn leads to an enhanced quality of life.

Notably, Kosciulek views empowerment within two frames: an internal or psychological frame and a situational or social frame. Psychological elements include feelings of competence, confidence, responsibility, a willingness to participate in interactions with others as necessary to achieve chosen goals, and an internal locus of control. An interest in planning for the future, the ability and skills to make adaptations as needed, the initiative to take charge of making plans and carrying them out, and a willingness to use adaptive technology when appropriate are also

important. Situational elements of empowerment include the person's possession of skills to effectively interact with others, to organize, plan, make decisions and exercise control over resources, or the opportunity to learn such skills. In addition, environmental elements such as the mobility to interact with the community, access to information, acceptable living conditions, social support and a respected social status are important to empowerment. Requisite skills can be acquired by the person with a disability, but social and living conditions are not entirely within the control of the person with a disability, and may require action by the person with the disability to create change. As such, perhaps the most important "skills" a person can acquire relate to their capcity to be a catalyst for change in society, environment, or the context in which one must function.

Self-help and self-advocacy groups which are run by people with disabilities for the purpose of helping them achieve personal and group goals often enhance empowerment on the individual and collective level. The situational aspect of empowerment is improved for many people with disabilities by legislation such as the Americans with Disabilities Act (ADA) and similar civil rights laws, which provide broad protection to individuals with disabilities across education, employment, public services, public accommodations, transportation, and telecommunications; prohibit discrimination in all programs, activities, and services of state and local governments.

The Role of Rehabilitation in Empowerment

The role of rehabilitation has been, historically, linked to efforts to restore skills and abilities to a person who, as a result of injury or disease, has lost those functions, and to enable that person to return to greater levels of self-sufficiency. In fact, the etymological root of the word rehabilitation or rehabilitate is the Latin word *habilitare*, which means to "make fit" and, thus, *rehabilitare* meaning to make fit again (American Heritage Dictionary 2000). Of course, for some people with disability, the needed supports do not attempt to restore skills so much as to provide such skills in the first place (e.g., habilitation). Either way, the primary focus for the rehabilitation professional is one of skills and abilities development and enhancement and the provision of supports to augment those skills and abilities.

For the person with a disability, however, empowerment is not just acquiring or reacquiring skills, but the application of those skills to achieve the change needed to assume greater control and power and, ultimately, to improve one's quality of life. Thus, it is important that models within rehabilitation ensure supports that emphasize and support an understanding of one's self as capable and competent along *with* the possession of skills and abilities.

As such, it is important that rehabilitation professionals approach the process of rehabilitation with models that emphasize self-determination and consumer control and direction. As discussed elsewhere (see Self-Determination entry), there are existing strategies that support professionals to achieve the objective of promoting self-determination and consumer control, including:

- *Promote active involvement in problem solving and decision making activities*. If necessary teach skills to enable more effective problem solving and decision making skills, and use activities such as involvement in habilitation planning to practice and reinforce those skills.

- *Engage youth and adults in self-directed learning and self-management strategies*. There is a host of research documenting that learning and using self-management and self-regulated learning strategies—such as antecedent cue regulation strategies, self-instruction, self-monitoring, self-evaluation, and self-reinforcement—can enable greater independence in tasks across multiple domains, including employment, and enhances self-determination.

- *Participation in Rehabilitation Goal Setting and Planning.* Self-determined behavior is goal directed. Support youth and adults to participate in goal setting linked to educational and rehabilitation planning, including supporting/teaching them to: (a) identify and define a goal clearly and concretely, (b) develop a series of objectives or tasks to achieve the goal, and (c) specify the actions necessary to achieve the desired outcome.

Empowerment evaluation

Like any other widely available (and, generally, federal or state funded) support, rehabilitation professionals are increasingly accountable for outcomes related to the provision of supports and services, and thus program evaluation becomes an important component of the rehabilitation process. Unfortunately, gains made in the provision of rehabilitation services and supports within an empowerment framework can easily be dismantled or diluted by an evaluation process that does not take a similar philosophical approach. Program evaluation refers, quite simply, to efforts to evaluate the efficacy and utility of a given program.

Traditional program evaluation has, by and large, been a top-down affair conducted by experts in evaluation design, data collection, analysis and reporting. Agencies engaged in a wide array of programmatic activities, from drug treatment to providing youth sports, have often had to hire an "expert" external evaluator to evaluate their program. Traditional program evaluation has usually identified a single person as 'the evaluator,' and that person is typically an expert in evaluation and external to the agency itself.

While there is often some benefit to having someone who is, at least theoretically, external to the agency to evaluate the program's efficacy, there is also a cost to reliance on external experts. First, with regard to the issue of objectivity, it is worth noting that while external evaluators may be more objective than someone internal to the agency, that is not to say they are completely objective. Beyond simply the question of evaluator objectivity, however, there is a growing concern in disability services, particularly within the realm of rehabilitation services, that the emphasis on objectivity and measurability in program evaluation and accountability systems has not, in fact, resulted in benefits in the lives of people supported in these programs. Fetterman (1996) and colleagues proposed, as an alterative to traditional program evaluation, a model of evaluation called Empowerment Evalution. Empowerment Evaluation is:

> the use of evaluation concepts, techniques, and findings to foster improvement and self-determination. It employs both qualitative and quantitative methodologies. Although is can be applied to individuals, organizations, communities, and societies or cultures, the focus is on programs. It is attentive to empowering processes and outcomes (Fetterman 1996, p. 4).

The empowerment evaluation framework has been used widely across program and policy spectrums, including being used to evaluate programs in substance abuse prevention, welfare reform, HIV prevention, school reform and crime prevention (Fetterman 1996). Moreover, the empowerment evaluation approach is well grounded in evaluation theory and practice, having been "institutionalized within the American Evaluation Association" (Fetterman 1996, p. 3) and embodying the spirit of standards developed by the Joint Committee on Standards for Educational Evaluation (Fetterman 1996). Unlike traditional program evaluation, the empowerment evaluation process has:

> an unambiguous value orientation – it is designed to help people help themselves and improve their programs using a form of self-evaluation and reflection. Program participants conduct their own evaluations and typically act as facilitators; an outside evaluator often serves as a coach or additional facilitator depending on the internal program capabilities (Fetterman, 1996, p. 5).

Fetterman (1996) continues, stating that empowerment evaluation is, by necessity, "a collaborative group activity, not an individual pursuit," and noting that "an evaluator does not and cannot empower anyone; people empower themselves, often with assistance and coaching" (p 5). Fetterman further contends that because of the democratic nature of the empowerment evaluation process, the intent or purpose of the process changes. Traditional program evaluation emphasizes and results in an evaluation of the program's value and utility. That judgment is the endpoint of the program evaluation process. In empowerment evaluation, however, the determination of a program's utility becomes an indicator upon which to improve the program. Fetterman (1996) stated:

> Program participants learn to continually assess their progress toward self-determined goals and to reshape their plans and strategies according to this assessment. In the process, self-determination is fostered, illumination generated, and liberation actualized (p. 6).

Fetterman and colleagues identified several steps of the empowerment evaluation process:

> *Step 1: Taking Stock*. The first step in the empowerment evaluation process involves having program participants, those served and those providing the supports/services rate the program on a scale of 1 to 10, with 10 indicating the highest level of quality and satisfaction. The importance of this step is tied not specifically to the rating assigned itself, but to the establishment of baseline information and the opportunity this process provides to allow each participant to express his or her perception of the quality of the program. Fetterman also notes that this process often illustrates or reinforces the necessity of collecting data to either support or refute some of the perceptions.
>
> *Step 2: Setting Goals.* The second step of the process is to have program participants indicate how highly they would like to rate their program in the future, and to set goals that will lead them to that rating. This goal setting activity

is at the level of improving the program, not specifically related to setting specific habilitation goals.

Step 3: Developing Strategies. As a third step, program participants are responsible for developing strategies to achieve overall program objectives. At the level of the rehabilitation planning process, this is the determination of the appropriate supports and related goals.

Step 4: Documenting Progress. In this step, program participants are asked what types of documentation is needed to provide evidence of progress at two levels; progress on the system goals identified in step 2 and progress on the specific content or programmatic goals and strategies identified in step 3.

Summary

Empowerment is a broad concept that affects the individual, groups, and all aspects of community and political life. Responsibility falls on professionals to enable empowerment by promoting self-determination, consumer control and direction; and on society to provide contexts and environments in which all people, including people with disabilities, can function optimally and improve their quality of life and life satisfaction.

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