Creating empowering meaning: an interactive process of promoting health with chronically ill older Canadians

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SUMMARY
Many health promotion approaches afford education about disease prevention and enhancement of one’s health status. But strategies for enabling older people with chronic illness to better mobilize their resources for everyday living still require development. This practical action research study explored the experiences of 13 purposefully selected older persons who participated in a health promotion intervention premised on the adult education theory of perspective transformation. Findings illuminate health promotion through a holistic interactive process in which professional and chronically ill older person together evolved a caring relationship and enhanced conscious awareness of life and health experiences. Five health-promoting strategies were identified: building trust and meaning; connecting; caring; mutual knowing; and mutual creating. Researchers suggest several important directions to refine professional practice approaches and health care delivery systems in order to promote the health of older persons with chronic conditions.

Key words: chronic illness; health promotion; seniors’ health

INTRODUCTION
Individuals aged 65 years and over have twice as many admissions to hospital and over double the average length of stay as do those who are 45–64 years (Statistics Canada, 1983/1984, 1984/1985). This experience with the acute care system often undermines chronically ill older persons’ self-confidence, and interest in and ability to participate in their own care (McWilliam, 1991; McWilliam et al., 1994). The result is often a vicious circle of reliance on institutionalized care.

While quality of life is a major issue, the cost of institutionalizing older persons with chronic conditions creates even greater pressure on health professionals to develop better approaches to care in the home. Providing the appropriate home care for elderly patients may reduce hospital readmission (Hendriksen et al., 1984; Mor et al., 1985; Townsend et al., 1988; Weinberger et al., 1988; Van Rossum et al., 1993), lengths of stay in hospital (Townsend et al., 1988; Weinberger et al., 1988), admission to nursing homes (Hendriksen et al., 1984; Carpenter and Demopoulos, 1990), and mortality rates (Vetter et al., 1990).

Yet interventions specific to the needs of individuals in this group have still to be developed. While there have been pleas for health promotion programs (Maynard, 1990; Teague et al., 1990), the concept of health promotion as ‘the process of enabling individuals . . . to increase control over the determinants of health, thereby improving their health’ [Epp, 1986; World Health
Organization (WHO), 1986], in particular for people with chronic illness, is still in its infancy (Kickbusch, 1992).

The purpose of this study was to evolve and test a health promotion intervention for older individuals with chronic medical problems and repeated admissions to acute care institutions for conditions which might have been managed at home. The overall aim of the intervention was to enable frail older persons to manage better at home and, thereby, to decrease their need for rehospitalization and traditional home care services. To complement the large randomized controlled trial, the qualitative component of the study reported herein explored chronically ill older persons’ experience of the health promotion intervention.

LITERATURE REVIEW

Previous research suggests the importance of perceived health status (Speake et al., 1989), health locus of control (Speake et al., 1989) and self-motivation (Pender et al., 1988; Kelly et al., 1991) as predictors of healthy lifestyles (Speake et al., 1989), lifestyle change (Kelly et al., 1991) and health-promoting behaviour (Pender et al., 1988). Many unlinked quantitative studies have identified positive correlations of perceived self-esteem (Cohen et al., 1985) with adaptation (Lowenthal and Haven, 1968), health maintenance (Cohen et al., 1985), (Lowenthal and Haven, 1968), mental health (Thompson and Heller, 1990), and morale (Thompson and Heller, 1990). A sense of goal-directed determination or ‘agency’ and a sense of ability to find ways to meet goals have also been found to be significant predictors of less psychological impairment and depression in individuals who had suffered physical losses through disabling trauma (Elliott et al., 1991).

Such findings have led researchers to study primarily group-oriented interventions (Zimpfer, 1987; Kaplun, 1992) for older chronically ill persons. For non-institutionalized individuals, the goals of these interventions have been to: impart information and skills related to physical care (Benson et al., 1989; Higgens, 1989); promote self-actualization and personal growth (Lieberman and Gourash, 1979; Milinsky, 1987); enhance social relationships, life satisfaction and work productivity (Moss, 1976); develop mutual support groups (Toseland et al., 1981); improve morale (Zgliczynski, 1982); establish confidante relationships (Heller et al., 1991); resolve grief (Hauser and Feinberg, 1976; Yalom and Vinogradov, 1988); and to increase personal power (Wynd, 1990). The combined results of these studies have not afforded clear direction (Zimpfer, 1987).

Results of interventions aimed at helping individuals to mobilize their personal resources for everyday living have been more encouraging. Interventions designed to improve the individuals’ mindfulness, or conscious cognitive awareness, have achieved significant improvements in initiative, activity levels, vigour, and sociability in residents of nursing homes (Langer and Rodin, 1976, 1977), suggesting the potential of an individualized intervention to enable older persons to manage better with their chronic conditions. Home-based health promotion to address individual needs (health care, substance use, exercise, nutrition, stress management, emotional and social functioning, housing, finances, and transportation) through assessment, goal-setting, skill development, referral, and support has also been found to reduce the need for institutionalization in long-term care facilities over a 21-month follow-up period (Hall et al., 1989).

To date, however, the literature reveals limited attention to the individual’s frame of mind in efforts to promote health. Experts suggest the importance of the care recipient’s: unique history and needs (Rook, 1991); interest in, need for, and belief in the type of intervention offered (Wills, 1991); perception of care and the meaningfulness of participating in one’s care (Wills, 1991); unwillingness or inability to take advantage of support people (Vaux, 1991), personal values, resourcefulness, determination, self-confidence, motivation to improve, and hope for a better future (Lord and Hutchison, 1993).

THE INTERVENTION

The intervention tested in this study was premised upon the adult education theory of perspective transformation (Mezirow, 1991; Mezirow et al., 1991). Through participation in reflective dialogue guided by the professional, the individual is intended to acquire an understanding which adds to, extends, or changes expectations, beliefs, values, and perceptions; hence, the meaning that experience has in one’s life and, therefore, one’s emotional reaction to it. Through the individualized process, the learner may rede-
fine needs and action priorities, and thereby consciously choose to modify his or her everyday living (Mezirow et al., 1991).

The steps of perspective transformation vary with the topic, and in this study reflected a therapeutic application (Gould, 1990) over the course of 12–16 home visits approximately 1 h in length. The aims were to: (i) enable older persons to participate as partners in their own care; (ii) foster a self-help philosophy; (iii) enhance active decision-making; and (iv) improve morale, self-esteem, self-care agency, interpersonal dependency, locus of authority and desire for information. The ultimate goal was to reduce hospitalization rates of chronically ill older persons.

The theoretical basis of the intervention has parallels with the work of other theorists interested in health. Newman (1986, p. 14) describes the process of health as one of discovery of ‘the meaning of life and health and what those of us in the health professionals can do about it’ through expanding consciousness. Similarly, Carlson (1988) identifies ‘meaning-making’ as a therapeutic approach to transformative adult development, and Bruner (1990) describes meaning-construction as the process of creating self.

**METHODOLOGY**

In the practical action research design (Lewin, 1952; Grundy, 1982; Whyte, 1991) of this study, a research nurse and each study participant worked together to assess, plan, enact and evaluate critical reflection on the individual’s life and health, and on the meaning of these reflections. The process focused on evolving the individual’s life and health, with due consideration of needs, motives, expectations, values, personal and other resources and the costs, barriers, benefits and trade-offs of potential options. Taped intervention sessions constituted phenomenological data on the experience of health promotion.

**SAMPLE**

Inclusion criteria limited the overall study sample to individuals who were: >65 years of age; cognitively intact; hospitalized two or more times in the past 1 year; discharged from hospital within the past 1 week, and in receipt of professional home care to manage their chronic illness. Chronic illness was defined in keeping with the US National Centre for Health Statistics definition, as any illness of ≥3 months duration (Stedman, 1990).

The intervention sessions of all consenting study participants (102/107) were audiotaped for review and purposeful selection of the qualitative sample. Purposeful sampling led to the selection of 13 information-rich cases, with maximum variation of chronic illness (Patton, 1990). The sample had a mean age of 77.6 years (range 68–86 years), mean intervention hours of 13.92 (range = 8.5–22.5 h), and a mean number of intervention visits of 13.8 (range = 10–16). All qualitative research participants were English-speaking Caucasians. Their chronic conditions included: chronic obstructive lung disease; coronary artery disease; congestive heart failure; diabetes; chronic renal disease; renal failure; arthritis; chronic back pain; haemorrhagic bowel; and cancer.

**METHODS**

Audiotapes of all visits to the 13 participants selected for the qualitative study were transcribed verbatim, and together constituted 181 h of interview data. Additional secondary data included nurses’ fieldnotes about these visits and 40 h of audiotaped and transcribed team analysis sessions in which the two intervention nurses and the principal investigator explored the nurses’ experience of the health promotion process.

Each intervention nurse and the principal investigator independently made a preliminary analysis of the transcribed data, using the immersion and crystallization interpretive analysis technique (Lincoln and Guba, 1985). Team analysis further clarified themes and patterns (Lincoln and Guba, 1985). Ultimately, the principal investigator prepared a synthesized interpretation which was finalized through subsequent team analysis.

Techniques to promote credibility of the findings included tape-recording and verbatim transcription of interviews and team analysis sessions to ensure accuracy of the data (Lincoln and Guba, 1985). Member-checking (Lincoln and Guba, 1985; Kuzel and Like, 1991) occurred with study participants at each subsequent visit, and with a select group, at final visits, when nurses presented the preliminary interpretation of findings to confirm and further refine themes.
and patterns of participants’ experiences. To promote applicability of findings to others having similar experiences, co-investigators did several peer reviews during the course of the one and one-half years spent collecting and analyzing the data. Credibility was further enhanced by triangulation of both methods and sources (Patton, 1990), and by a variety of health professionals who received preliminary presentations of the findings, and provided assessments on the cogency, coherence, and relevance of the findings to their experience of health promotion.

FINDINGS

The process of using perspective transformation to promote health illuminated two inextricably linked components of health promotion: (a) evolving a therapeutic relationship and (b) enhancing conscious awareness of life and health experiences and the potential one has for evolving life and health in a positive direction. Five themes captured the holistic experience of the health promoting process, in which nurse and participant interactively contributed to: (i) building trust and meaning; (ii) connecting; (iii) caring; (iv) mutual knowing; and (v) mutual creating. These process elements did not occur in discrete linear phases, but built upon each other in a manner which enhanced personal health. This complex process facilitated the individual’s conscious attention to deliberate, diligent, creative pursuit of the fulfilment of human potential experienced as health (McWilliam et al., 1996b).

The following sections use the paradigm case of ‘Mrs X’ to illustrate how the actual process of promoting health unfolded.

Building trust and meaning

During this fundamental process, the individual participant’s role was telling one’s story. The nurse’s role was facilitating both her own and the participant’s understanding of the individual’s situation and situatedness (Benner and Wrubel, 1989). Much of this process occurred during the first two or three visits, but story-telling threads reappeared in all interviews.

In the paradigm case, the nurse listened as she and Mrs X together explored Mrs X’s situation within the framework of her larger life context. Mrs X was an 84-year-old widow with congestive heart failure which severely limited her mobility and necessitated oxygen by nasal cannula, on occasion. Confined 24 h a day to a recliner chair in the living room of her seventh floor apartment, she used the walker with her son’s assistance only for getting to the washroom. Otherwise, she sat, ate, and slept in her chair. She had only three windows on the outside world: her television; her 50-year-old unemployed son of limited intelligence; the sliding glass door to her apartment balcony which, because of a 4-ft solid safety railing, limited her view to the sky, the clouds, and the occasional bird which flew that high. Mrs X might have ventured further, but identified limited fiscal resources and no automobile as barriers. As her story unfolded, Mrs X revealed some sense of control from having her limited social circle come to her. She therefore remained ensconced in her recliner, which, after all, was her most valued and apparently most valuable possession, a gift from her son.

Mrs X had experienced a hard life: put out to work in a factory at age 16 to help her working-class parents make ends meet; married to a poor immigrant farmer whose elderly live-in parents she had cared for right through their dying days; widowed mother of a son who did not have the capacity to support himself and therefore shared her meagre old age pension. Yet Mrs X’s story portrayed a life pattern of mustering the resources for everyday living with an unmistakable hardiness until her heart failed her. Understandably, this loss of physical stamina severely undermined Mrs X’s self-confidence. As difficult breathing, edema, skin breakdown and other complications of the congestive heart failure escalated, Mrs X told of how she feared loss of ability to manage living on her own with her son. The possibility of institutionalization in a nursing home, or worse, the possibility of death, was unthinkable to her, for what would happen to her son? As she said,

I have had one wonderful son. That is why I don’t want to go to a nursing home . . . what we [she and son] can get together, we are trying hard to stay out of a nursing home . . . we look after each other.

Thus, whenever the least sign of a further threat to her physical health appeared, Mrs X ‘panicked’. As a consequence, she had visited the local hospital’s emergency department an average of two or three times per month in the past year, and had called the local home care program for help two or three times a day. Understandably, this pattern of apparent over-dependence on the health care system had invited the disrespect of
health professionals. From her perspective, doctors had begun to pressure Mrs X to make a decision to move to a nursing home, thereby only worsening her ‘panic attacks’.

The intervention was begun at this point, subsequent to Mrs X’s having been sent home once again from the hospital’s emergency department with the admonition that she was abusing health care services and that it was perhaps time for ‘the nursing home’. Obviously, for Mrs X, this constituted a disorienting dilemma which led to self-examination, feelings of guilt and shame, and a readiness to critically assess her own assumptions (Mezirow, 1991). The importance of having the nurse understand her situation and situatedness became apparent only toward the end of the intervention, and is revealed indirectly in the excerpts portraying the other components of the health promoting process.

Connecting and caring

As the health promoting process continued, nurse and participant connected with one another. The participant’s role evolved to ventilating struggles with life and health, while the nurse’s role was one of active listening and presencing (Benner and Wrubel, 1989), using such communication techniques as prompts, reflection, and conveying understanding. Inextricably intertwined in this process was simultaneous effort toward the goal of enhancing conscious awareness of life and health experiences and the participant’s potential for their optimization.

For example, at the second visit, having previously described her general experience of life and health, Mrs X began talking about having been told she was abusing emergency room services. Quietly crying, she struggled to express her experience:

Mrs X: Talking about this, does things like this [crying]. . . . I am ashamed. . . . I’ve lost my confidence I don’t know if I’m doing the right thing. . . . Well, I will tell you what. First time [I went to emergency and they scolded me] I thought, —I was really afraid when I had that severe nose bleed. I said, ‘Oh my god, I think my brain has snapped.’ So it was quite a thing, what people have in mind!

Nurse: Yes.

Mrs X: Because I was really afraid, because I couldn’t get it stopped. But to go up to the hospital, and the nurse said, ‘Pinch your nose!’ ‘Why couldn’t I do that?’ she said. I never thought about such a thing.

Nurse: That is what they do.

Mrs X: All I used was this. [Mrs X waves a Kleenex.]

Nurse: Yes.

Mrs X: [I just] kept on dabbing—and the doctor says it is the worst thing you can do!

Illuminating a different solution enabled Mrs X to adopt a new problem-solving pattern.

Nurse: Yes. That’s right. You have to put pressure on it to stop it. It pinches off the vessels and allows the blood to clot so that it doesn’t seep out any more.

Mrs X: I know what to do now.

The nurse conveyed understanding and further illuminated Mrs X’s predicament. In response, Mrs X ventilated, unloaded negative feelings and recognized her own limitations.

Nurse: Yes. You just didn’t know what to do then. But it made you feel afraid, because you were afraid that something had snapped in your mind.

Mrs X: It is not funny, is it?

Nurse: No, it isn’t. . . . And the reason it isn’t funny is that you were afraid for your health, right? Afraid for your mind.

Mrs X: I didn’t know what was going to happen.

Nurse: You didn’t know what was going to happen, so it is fear of the unknown, really, isn’t it?

Two months later, in completing the intervention, Mrs X revealed the inextricable links between affective and cognitive components of the interaction. As well, her comments revealed the caring which evolved from the interaction of participant (who continued connecting by further unloading negatives, discovering strengths, and, ultimately feeling understood), and nurse (who provided positive regard and non-judgemental responsiveness):

Mrs X: Well I think I’ve learned a lot, and I appreciate your friendship, because, because, because you put your hand out to me and I’ve accepted it. . . . I was beginning to think that nobody cared about me anymore. . . . I’m all right now. I guess I’ll be all right.

Nurse: I think you will.

As is apparent in this text, both active listening and presencing, and providing positive regard and non-judgemental responsiveness facilitated Mrs X’s progression toward empowerment, and ultimately, toward being more healthy.

Mutual knowing

The continuity of the relationship between the nurse as caregiver and the study participant as care recipient, not the continuity of the care plan so commonly espoused by health professionals, was also a critical part of the health promotion process. Continuity of relationship led to mutual
knowledge of the individual’s patterns and strengths for life and health. In the first visit, Mrs X had revealed that she had in the past written short stories which she used in teaching Sunday School. Additionally, she had mentioned that letter writing was currently a major pastime. As Mrs X had difficulty in articulating her thoughts on the meaning of health and her health practices, the nurse had suggested that she try to write her thoughts on paper. Mrs X responded, providing the nurse with three short essays entitled, ‘Life’, ‘Health’, and ‘Friendship’ at the outset of the second visit. The nurse interviewer read them immediately. The following text reveals how the nurse’s knowing about Mrs X’s patterns related to writing prepared her for illuminating factors which promote health and enhanced Mrs X’s self-knowing. Mrs X’s developing conscious awareness of her own patterns and strengths empowered her to better mobilize personal resources for everyday living; that is, for being healthy:

Nurse: Actually, your stories are very good. How does this make you feel, writing stories?

The nurse’s question stimulated Mrs X to reflect critically on her own strengths.

Mrs X: I didn’t think I could do it. I didn’t think I was able to.

Nurse: You have done three really good ones.

Mrs X: I know [in the past] I have done little bits of devotion from the Bible, but that is a different thing.

Further illumination and reinforcement of Mrs X’s knowledge of herself followed. Self-esteem was also reinforced:

Nurse: It is. It takes a lot of thought. You have a lot of ability and a lot of understanding of yourself. . . . Your thoughts come very well when you put pen to paper. . . . Do you think your thoughts flow better when you put pen to paper?

Mrs X: I don’t know.

Nurse: I think they come very well; I am impressed. Not many people can do this you know.

Mrs X: They say when you get older, you can do more than when you were young.

Six weeks later, Mrs X revealed how her expanded knowledge of her own strengths afforded her a basis for reaching out to connect with potential social supports, thereby creating more potential for health, as is revealed in the following section.

Mutual creating

As nurse and participant built on their mutual knowledge of the individual, together they pursued the process of mutually creating the individual’s health by reframing ways of doing and being, and of seeing one’s self. The following excerpt from Visit 11 illustrates the process:

Mrs X: I think [writing stories]—it has [helped]. . . . It has brought something out in me that I thought I couldn’t do. . . . My niece and my nephew were here on Friday night. I said, ‘You didn’t know your Aunt had turned into an author.’ So I gave one copy I had left . . . to them to read. . . . I said, ‘Now you know what kind of an Aunt you’ve got!’ I enjoyed doing it. . . .

Nurse: So do you think you could still go on writing if I weren’t here?

Mrs X: I might be able to, if I had something to write about.

Nurse: Sure. Well you thought of all those topics yourself, didn’t you?

Mrs X: [reflectively] You know, I picked that word ‘Kindness’ [story title] up off the TV. . . .

Subsequently, Mrs X reflected aloud about how she might continue her writing:

Mrs X: I told him [son] . . . he had better bring me a new writing pad. Because those pages are really too big. I can’t imagine enough. . . .

Toward the end of this visit, the nurse asked Mrs X if she might write out her thoughts on how she was managing with her care in the home, as part of the preparation for the next visit. Two weeks later, the nurse returned, and the intervention proceeded:

Nurse: Do you remember the story we talked about?

Mrs X: [About] Home Care?

Nurse: Yes.

Mrs X: It’s in the City Times [local newspaper].

Mrs X provisionally tried out a new role, using personal resources to connect with the outside world. The nurse explored further, fostering conscious awareness of this new pattern:

Nurse: How do you feel about that?

Mrs X: Well I’m kind of pleased with myself.

At the final visit, the nurse facilitated evaluation of their health promotion effort:

Nurse: So how else have you changed since I started seeing you last October?

Mrs X: I don’t know really. I keep on writing. . . . I gave my nurse four pieces this morning. . . . she had a program [in a women’s church group] and she asked if I had anything I could give her, so I gave her two or three pieces.
Nurse: . . . So you’ve found a new niche in the world. Mrs X: [Laughter] Well . . . two pieces were in the City Times.

Over time, Mrs X published several other columns in the local newspaper. In keeping with the phases of perspective transformation, she had created competence and self-confidence in her new role and relationship with the outside world, reintegrating into her life a sense of being a valued and connected part of society. Her frequent visits to emergency and telephone calls to home care services stopped. Continuity of the relationship over time had permitted mutual knowing which evolved the client’s knowledge of herself, creating a greater conscious awareness of her own strengths and new images and expectations of her life. This self-knowledge, promoted and positively reinforced by the nurse, enhanced her self-esteem and facilitated mobilization of personal resources for everyday living, even

Fig. 1: The integrated model of the health promoting process.
though her physical experience of her chronic illness did not change. Empowerment and, ultimately, being healthy despite the chronic illness (McWilliam et al., 1996b) was the outcome.

THE HEALTH PROMOTING PROCESS

Figure 1 presents the integrated model of the health promoting process. Both nurse and chronically ill individual are depicted as entering the process with their own individual helices of dynamic, constantly evolving life patterns (Rogers, 1970). As both interactively engage in building the relationship and in illuminating factors which affect health, the individual ultimately acquires the self-esteem, self-confidence and self-insight needed to achieve fuller potential to make conscious choices. The process enhances the individual’s sense of control or autonomy and empowerment, allowing the individual to be more healthy (McWilliam et al., 1996b). The nurse, too, changes in the process (McWilliam et al., 1996a) and emerges a more evolved professional. Thus, the process is mutually shared.

DISCUSSION

While topics pursued through a critical-reflection approach to health promotion are unique to the individual participant, the process is common to all. Discovering the personal meaning of the individual’s current life and health in their larger life context is essential to the approach. Themes related to the content of health and health promotion as experienced by the chronically ill older participants in this study are reported elsewhere (McWilliam et al., 1996b). But professionals have perhaps the most to learn from the process themes which emerged.

The five health promoting processes (building trust and meaning; connecting; caring; mutual knowing; and mutual creating) together comprise two inextricably linked components of health promotion: evolving a caring relationship and enhancing conscious awareness of life and health experiences. Both are essential to promoting health.

Evolving a caring relationship

The professional’s focus on relationship is apparent in: understanding the individual’s situation and situatedness; active listening; unconditional positive regard; non-judgemental responsiveness; and continuity of relationship. These actions reflect: Benner and Wrubel’s (1989) caring model of nursing; Gaut and Boykin’s (1994) portrayal of caring as healing; Rogers’ (1961) therapeutic relationship; and Montgomery’s model of healing through communication.

If one views health as an ontological state of physical, mental, psychological and spiritual well-being (Eriksson, 1992), the importance of relationship-building as part of the process of promoting the health of chronically ill older persons is easily understood. Participants in this study all suffered from debilitating chronic illness. All were also aging. Both of these factors threaten self-image (Charmaz, 1983) in later life; hence, self-esteem, a feeling of love and belonging, and self-actualization are diminished. Evolving a caring relationship promotes self-esteem and a feeling of love and belonging, thereby empowering the individual to pursue self-actualization (Maslow, 1962). Thus the caring relationship also seems essential to the experience of ‘health as behavior’ (Eriksson, 1992), described as a process of searching for balance or harmony in the inner state and an effort to adapt and seek the fulfilment of needs.

Enhancing conscious awareness

Full enactment of health as behavior (Eriksson, 1992), and of ‘health as becoming’, or consciously striving to return to the original experienced state of wholeness (Eriksson, 1992), required not only relationship-building, but also the acquisition of greater conscious awareness of life and health experiences. This dimension of health promotion aligns closely with Antonovsky’s (1985) description of the health promotion process as the complex process of salutogenesis and Newman’s (1986) theory of health as consciousness-raising.

When participant and professional together engaged in illuminating factors which affect health, they moved beyond the ontological expression of health as behaviour and being, to health as becoming (Eriksson, 1992). A sense of wholeness (Newman, 1986), rebirth (Eriksson, 1985), re-creation (Eliade, 1968), or coherence (Antonovsky, 1985) emerged.

The experience of empowerment

Viewed holistically, the five health promoting processes combined to create the experience of empowerment through simultaneous relationship-building and consciousness-raising. The
empowerment did not come solely from the acquisition of self-understanding and personal growth, hence, personal power (Rogers, 1979). Nor did empowerment come solely from people working together in a relationship aimed at mobilizing resources (Katz, 1984). Rather, empowerment and, in turn, health (Jones and Meleis, 1993), or the ability to mobilize one's resources for everyday living, came through a holistic focus on the content and processes of conscious thought and relationship.

This finding is supported by several more current theoretical perspectives of empowerment. Rappaport (1987, p. 121) defined empowerment as 'enhance(ing) the possibilities for people to control their own lives' through a 'quality of the relationship between a person and his or her community, environment and something outside one's self'. Kieffer (1984, p. 9) viewed empowerment as a necessarily long-term process of adult learning and development and defined it as 'the continuing construction of a multi-dimensional participatory competence'. Surrey (1987, p. 164) defined psychological empowerment as: 'the motivation, freedom, and capacity to act purposefully, with the mobilization of the energies, resources, strengths, or powers of each person through a mutual, relational process'. She maintained that personal empowerment and the relational context through which this emerges must always be considered simultaneously (Surrey, 1987).

A few recent investigations of the phenomenon of empowerment also suggest that both relationships and, to a lesser degree, consciousness-raising comprise the process of empowerment. An exploratory study of the process of empowerment of adults with disabilities, (Lord and McKillop-Farlow, 1990) identified providing moral support, believing in the person, encouraging the person to take a new risk, giving the individual a break, and starting the person thinking in new ways, thereby increasing confidence and control, as important actions. Cancer patients' experience of empowerment/disempowerment in receipt of primary nursing care (Murdoch, 1995), portrayed empowerment as a mutually shared interaction of establishing/building trust, acquiring/providing comfort, building/inspiring positiveness, acquiring/providing information and acquiring/giving control, underscoring the importance of relationship.

Friere (1970, 1973) suggested that individuals become powerless through assuming the role of 'object' acted upon in the environment, (rather than 'subject' acting in and on the world), thereby becoming alienated from participation in the construction of social reality. Thus, older persons frequently hospitalized for treatment of chronic illness would be particularly vulnerable to disempowerment, and potential candidates for empowerment through strategies which foster adult learning and development through both relationship-building and consciousness-raising.

**Implications for practice and research**

All prolonged illness has the potential to create a loss of personal power through adoption of the sick role (Parsons, 1966; Dracup and Meleis, 1982; Kubsch and Wichowski, 1992). As well, the traditional health care approach of doing things to and for a patient to protect them from harm, may decrease personal power (Malin and Teasdale, 1991). Unwitting ageism often further exacerbates the problem (Coupland and Coupland, 1994; McWilliam et al., 1994). Thus, the health promotion process evolved through this study may have applicability in all chronic and rehabilitative care, and all care of older persons, including primary care.

The health promotion processes identified differ from those suggested by existing models of health promotion. Health education approaches premised on Green's Precede Model (Green et al., 1980) most frequently include assessment of learning needs, provision of information, and monitoring and evaluation of behaviour changes. In resource mobilization approaches to promoting health [for instance, in applications of Kolbe’s (1981) Decision-making Model], professionals most frequently focus on assessing, teaching, guiding, facilitating, and monitoring the individual's ability to mobilize resources for everyday living. Health promotion approaches intended to enhance self-efficacy (Parcel and Baranowski, 1981; Goldfried and Robins, 1982) emphasize the professional's role in assessing, supporting, encouraging and monitoring cognitive and behavioural changes. None of these more prominent models for health promotion captures relationship-building and heightening conscious awareness as significant components of health promotion. Thus findings of this study suggest new strategies for promoting the health of individuals.

Strategies for health promotion through relationship-building present particular challenges for practitioners. Most professionals have been...
socialized to maintain objectivity and professional distance from clients/patients, thereby avoiding over involvement (May, 1991). As well, some believe that pursuit of client/patient empowerment may undermine the individual’s needs for interconnectedness and interdependence (Clarke, 1989). Our findings, like those of others (Reiman, 1986; Benner and Wrubel, 1989; Montgomery, 1993), suggest that professionals must really come to know and connect with participants, or to use self therapeutically in building the relationship, if empowerment is to be achieved.

Pursuit of continuity of relationship between professional and health care recipient as a strategy to promote health also presents a challenge. Traditionally, health care delivery frequently is fragmented by professional specialization and work assignments. This challenge is not, however, insurmountable. Both the concept of ‘primary care provider’ and professional preparation for a variety of care contexts afford opportunities to cross institutional boundaries which divide those we serve into parts reflecting the medical model of illness care. The discipline of Family Medicine has traditionally espoused continuity of care in evolving its practice (McWhinney, 1982; Freeman et al., 1993).

Findings emphasizing the importance of heightening the individual’s conscious awareness of life and health, rather than illness, also have implications for professional practice. Health professionals need to be able to recognize when and to what degree to take this focus with people with chronic illnesses or medical problems that have led them to seek ‘health’ care. Taking the time to begin the professional encounter with an open-ended question about the individual’s life and health and taking time to listen are the most immediate requirements. While seemingly easily accomplished, these strategies challenge the current system’s demands for focus on illness care, efficiency and cure outcomes.

Furthermore, the collaborative adult learning process of illuminating factors which affect an individual’s life and health necessitates the artful practice of open-ended questioning to allow the learner to discover, rather than be told, the personal meaning of life experiences. The hegemony of the medical model of care, the pressures of time, tradition, and the system’s valuing of efficiency, and both societal and professional ‘outcomes’ orientations frequently shape the inclination to actively question, and thereby to make a ‘diagnosis’ of the individual’s needs. The professional therefore also has to experience consciousness-raising to unlearn engrained habits of interacting and being in control (McWilliam et al., 1996a).

Given these practice implications, education programs for all health disciplines may need to make several curricular changes to better prepare their practitioners to promote health. In particular, how educators act as role models through their relationships with students may require shifting to a more collaborative learning model and a more balanced distribution of power.

Most importantly, however, these findings raise several questions for future research. Further investigation is needed to identify whether or not the additional time spent in getting to know the person well enough to evolve health through critical reflection is cost-effective in the overall provision of care. Researchers might also ask: How do professionals and the recipients of their care create relationships? What is the individual’s experience of illumination? What does empowerment/disenfranchise mean in the context of everyday living? How do professionals experience the empowering process?

**CONCLUSION**

The actions discovered in this research to be part of the process of health promotion do not immediately suggest the need to master complex new skills. Rather, findings suggest that health might be promoted and, simultaneously, empowerment created, by an artistic application of the combined principles of several professional practice theorists (Rogers, 1961; Newman, 1986; Carlson, 1988; Dunst et al., 1988; Benner and Wrubel, 1989; Bruner, 1990; Mezirow, 1991). The individual components of the health promotion process seem simplistic. However, the real-life experience presented in this paper illustrates that creating an empowering relationship while facilitating critical reflection is a masterful art best acquired through experiential learning and reflection-on-practice (McWilliam et al., 1996a). Furthermore, findings illuminate the potential of this approach to health promotion.

If any ‘health’ profession is ever to be valued for its promotion of health, as currently defined, its approaches to promoting health merit consideration. Creating empowering meaning
through a process of critical reflection and relationship-building may be an important new direction in health promotion.

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Creating empowering meaning 123


