Concept Analysis of Empowerment in Old People with Chronic Diseases Using a Hybrid Model

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SUMMARY

Purpose: The purpose of this study was to clarify the meaning and the nature of empowerment concept in some Iranian old people suffering from chronic diseases.

Methods: Concept analysis was undertaken according to the hybrid model, which consists of three phases: an initial theoretical phase, a fieldwork phase and a final analytical phase. After an extensive review of the literature in order to describe the characteristics and definition of the concept, a fieldwork phase followed in order to empirically elucidate the empowerment concept in the Iranian old people with chronic diseases. In the third phase, attributes of empowerment were extracted from the first and second phases. Purposive sampling was done for 13 participants consisted of 7 old people with chronic diseases, 3 family caregivers of elderly adult with chronic disease and 3 health care providers with experience of care with elderly patients with chronic disease.

Results: The review of literature in theoretical phase determined the attributes of the concept, including “active participation”, “informed change”, “knowledge to problem solve”, “self-care responsibility”, “presence of client competency”, and “control of health or life”. Fieldwork phase determined attributes such as “awareness promotion”, “sense of control”, “the development of personal abilities”, “autonomy”, and “coping”. In the final analytical phase, the critical attributes of old people with chronic diseases were investigated. They included “social participation”, “informed change”, “awareness promotion to problem solve”, “presence of client competency”, and “control of health or life”, “autonomy”, “coping” and “the development of personal abilities”.

Conclusion: The concept analysis of empowerment showed some of the required conditions for the empowerment of older people with chronic diseases in nursing care, which have not been mentioned in the literature.

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Introduction

The concept of “empowerment” has become a popular terminology extensively used in the health services (Hage & Lorensen, 2005). The emergence of the concept of empowerment is when societies encountered health cost enhancement and then the government worked to reduce these costs through the transition from hospital to home care for patients and vulnerable people (Bandura, 1994). Old people with chronic diseases, as one of the vulnerable groups due to reduced power induced by aging, need empowering for promoting health-related quality of life (QOL), and decreasing hospitalization and health costs (Shearer, Fleury, & Belyea, 2010). Empowerment of the old people with chronic obstructive pulmonary disease (COPD) is a mutual process in which human beings and their environment generate an ongoing and innovative change (Shearer, 2009).

In spite of the extensive use of the empowerment concept in aging, its applicability has been limited by the continuous ambiguity in its concept; this concept has different attributes from the different researchers’ viewpoints in different disciplines (Keiffer,
Iran is one of the countries where the elderly population is growing: the population of the elderly is projected to reach 10 million by year 2019 (Annually Country Statistics, 2003). They more than any other age groups are at risk of chronic diseases and health problems; aging also affects older adults' abilities and makes them feel disabled (Ravanipour, Salehi, Taleghani, & Abedi, 2009). Evidence shows increasing prevalence rates of chronic disease among Iranian old people. It causes health problems such as the increase in hospitalization costs, hospital complications such as nosocomial infections. For this reason, the ability to obtain needed health care is a necessity for them (Fotoukian, Mohammadi-Shahboulaghi, & Fallahi Khoshknab, 2013). On the other hand it is difficult for health care providers to meet old people's health care needs due to the increasing population of elderly patients. In Iran, health care services have been provided based on a professionalized model with paternalistic approach. In this condition patients are considered as passive agents in their own self-care, whereas in today's world, health system reforms emphasize the shifting of care responsibility from health care providers to the patients themselves. One of the solutions that could be effective is the empowerment approach.

Although there is evidence related to the empowerment interventions for old people (Joakar, Mohammadi Shahboulaghi, Khahe & Tafti, 2012; Rabiei, Mostafavi, Masoudi, & Hassanzadeh, 2013; Tol et al., 2013), little is known about the nature of empowerment, especially in the Iranian elderly population. For this reason, empowerment of old people with chronic disease is needed. However, despite the importance of this concept, there are vague definitions of “empowerment” by nurses and health care providers; this shows that the knowledge of empowerment for the elderly is not well developed. For example, Ravanipour in a qualitative study on “power” among Iranian old people extracted “awareness of personal changes”, “adaptation”, “independence”, “satisfaction attainment”, “control of life” and “self-management” as the nature of empowerment (Ravanipour, Salehi, Taleghani, & Abedi, 2008). In another study reported by Ravanipour et al. (2009), other words such as “power” were used instead of empowerment. In the study conducted by Nasiripour, Siadati, Maleki, and Nikbakht-Nasrabadi (2011), patients, on their current empowerment situation, reported “sense of competence”, “sense of meaning”, “feeling of self-determination”, “feeling of impact” and “overall ability of patients”. More studies in relation to empowerment interventions have been conducted as elderly patient education by using a quantitative method in social and cultural context of Iranian old people with chronic disease (Joakar et al., 2012; Rabiei et al., 2013; Tol et al.). Noting the consequences of empowerment (self-efficacy, well-being, and QOL promotion) for old people with chronic diseases, and considering that lack of clarification and true understanding of the empowerment concept may affect care, we conducted this study to clarify the concept of empowerment, which would give not only a better understanding of this concept, but also through distinguishing the concept's attributes, serve as a basis for developing and testing the measurement tools (Isokaanta & Johansson, 2006).

### Purpose

Our main purpose in this work was to achieve an in-depth understanding of the concept of empowerment in the social and cultural context of Iranian old people with chronic diseases.

### Methods

#### Study design

Concept analysis is a useful method for clarifying the concepts that have multiple applications and vague meanings. Considering that the empowerment concept emerged from clinical care, here we analyzed it with a hybrid model (Salsali, Mohammad-Pour, & Fakhr-Movahhedi, 2006), consisted of three phases: an initial theoretical phase, a fieldwork phase and a final analytical phase (Rodgers & Knafli, 2000). For a theoretical exploration of empowerment, the literature was reviewed by integrative review. An integrative review is a specific review method that summarizes past empirical or theoretical literature to provide a more comprehensive understanding of a particular phenomenon or healthcare problem. Well-done integrative reviews contribute to theory development, and have direct applicability to practice (Whittomore & Knafli, 2005). For finding the related articles, the databases of ScienceDirect, Elsevier, Proquest, Ovid, and Pubmed were searched using the following search terms: "empowerment and old people", "empowerment model", "empowerment program", "health empowerment", "old people" and "aging". As a result of the search, 620 citations (from 1974 until 2012) were found. As a result, 150 reviewed studies were retrieved. After reviewing, 60 articles were selected and used for the purpose of this work. In analyzing the concept of empowerment, the researchers sorted and reviewed the concept-related studies.

After an extensive review of the literature, a fieldwork phase was followed in order to empirically elucidate and explore the empowerment concept in Iranian old people with chronic diseases. Exploring in this phase involved empirical validation of the concept using a qualitative research method with a content analysis approach (Rodgers & Knafli, 2000). This phase was necessary for the concept evolution, and the qualitative data obtained from the participants' observations and in-depth interviews would help the development of cognition and insight toward the nature of the concept (Rafi, Soleimani, & Seyyed-Fatem, 2010). In the analytic phase, data from the fieldwork phase are compared with the findings from the theoretical phase to produce a refined definition of the concept that is supported by both the literature and the participants' perspectives (Seomun, Chang, Lee, Lee, & Shin, 2006).

#### Setting and sample

Thirteen participants were recruited from one university hospital, located in Ramsar, a small-sized city in north Iran. Considering that empowerment is an interactional phenomenon (Ajourlat, Marcolongo, Bonadiman, & Deccache, 2008), the old people with chronic diseases, their family caregivers and health care providers were interviewed. Therefore, the participants consisted of seven old people (3 with chronic obstructive pulmonary disease [COPD], 1 with chronic heart failure [CHF] 1 with diabetes mellitus, 2 with osteoarthritis), three members of the family caregivers with the experience of living with the patients and three health care providers with a minimum experience of 5 years working with old people (1 head nurse, 1 nurse, 1 nursing instructor). The old people (4 women & 3 men) were 60 years of age and over, with disease history of over 5 years, and also in various stages of diagnosis to rehabilitation. Kinship of family caregivers is as follows: wife (1 person), and daughters (2 people).

#### Ethical consideration

Permission to carry out this study was given by the head of the department and the ethics committee of University of Social...
Welfare and Rehabilitation Sciences. Written and informed consent was obtained from all participants in accordance with the Declaration of Helsinki that participation was voluntary and that they could withdraw at any time.

Data collection

For collecting the required clinical data, interviewing the individuals with experience of the concept of empowerment, and also field notes were used. Fieldwork phase started with clinical data gathering from old people with chronic diseases. However, given the role of family caregivers and the health care providers in empowerment, interviews were conducted with them. Purposive sampling was done for 13 participants. The participants were encouraged to talk freely and to add other reflections. A semi-structured interview guide was designed based on the literature review. The interview questions were designed regarding the participants’ definitions of empowerment concept, the role of old people with chronic diseases in self-empowerment, and factors affecting empowerment. The interview began with an open question based on the main question of the study. The following questions were given to the participants: (a) Please share with me your empowerment experiences if there are any? (b) Would you describe your feeling, perspective, and thinking as you experienced them? (c) What kind of changes did you go through while having an empowerment experience? (d) What are the characteristics of empowerment in older people with chronic diseases?

Then, based on the analysis of data, more probing and follow-up questions were asked with respect to the daily experiences of empowerment. Each interview lasted for about 40 minutes. The interviews were conducted face-to-face in a private setting and audio-taped. Based on data saturation in qualitative studies, a total of 13 interviews were conducted with 13 individuals. No new themes, statements or remarks emerged during the last two interviews. Therefore, the interviewer had a clear sense of data saturation after 13 individual interviews. With their consent and also for their comfort, the majority of the interviews were conducted by participants’ bedside, some at their workplace and some at their homes. The main researcher (PhD nursing student) conducted all of the interviews. The audio-taped interviews and field observations were transcribed verbatim, and the transcripts were content analyzed to identify and classify the categories within the data in relation to the research questions. Each transcript was read many times to enable the researchers to immerse. When all the data had been coded and the categories condensed, each category was assessed to determine saturation of data.

Data analysis

Research was conducted in Iranian language. The first author in conjunction with native English-language professionals translated the categories, subcategories and quotations from the participants’ interviews from Persian into English. Lastly, the translation was edited by professional English editors. The data obtained from participants’ descriptions and observations underwent qualitative concept analysis. Therefore, meaning units related to the aim of the study were condensed and interpreted. The codes were identified and grouped into subcategories. In the final stage, the subcategories were transformed into categories. Credibility was enhanced through the validation of emerging codes and categories in the subsequent interviews and debriefing with the project supervisors. Using member checking, peer checking and the maximum variation of sampling all attested to the conformability of the findings (Holloway & Wheeler, 2002). An independent analyst (experienced in qualitative research) reviewed a random selection of the transcripts to distinguish the themes from the data. Differences were contested through discussion, and consensus was reached.

Results

Review of literature: Theoretical phase

Characteristics and definition of concept

Dissection of the term “empowerment” reveals that it can be defined in many ways, depending on the context of its use, which can be at an individual, organizational or community level (Tveiten & Meyer, 2009). Empowerment has its roots in the black power movement of the 1960s, and the gays’ and women’s rights movements of the 1970s and 1980s. Since the early 1990s increased attention has been given to the concept of empowerment. The Random House Webster’s Dictionary defines “empower” as “to give official or legal power or authority to endow with the ability or to enable” (Guralnik, 2010). Interest in and attraction to the concept of empowerment can also be seen from the health-care sciences and nursing perspective, apparently stimulated by the World Health Organization’s mid-1980s definition of health promotion as a process of enabling people to increase control over and improve their own skills and specialization in enabling and empowering people for self care and to maintain health (Hermansson & Martensson, 2011). In nursing, empowerment can be defined as “an interpersonal process between the nurse and the patient intended to facilitate healthy behaviors” (Isokaanta & Johansson, 2006). Hermansson and Martensson attempted to redefine and describe the process of empowerment in the midwifery context, resulting in a modification of Isokaanta and Johansson’s definition. In that study (Hermansson & Martensson), empowerment was defined as an ongoing dynamic and social process of acting, creating, confirming, facilitating, listening and negotiating between the midwife and the couple, in which they develop a trustful relationship based on mutual respect and integrity. Compared to the definition of the word empowerment between nursing and other professions, Lord and Hutchison (1993), narrating from Keiffer (1984), labels the empowerment of social organizations as a developmental process, which includes four stages: entry, advancement, incorporation, and commitment. The entry stage starts with the participant’s experience, referred to as an act of “provocation”. The advancement stage includes three major aspects, which are important for the continuation of the empowerment process: a mentoring relationship, supportive peer relationship with a collective organization, and the development of a more critical understanding of social and political relations. The central focus of the incorporation stage is the development of consciousness. Commitment is the final stage, in which the participants apply a new participatory competence in the areas of their lives (Lord & Hutchison). From the viewpoint of Lewin and Piper (2007), empowerment is defined as “the enhancement of self-control on life”. It is a positive and dynamic process that focuses on people’s strengths and capabilities (Wahlin, Ek, & Ildvall, 2006).

Empowerment is a pattern of welfare and well-being through which old people with chronic diseases in order to control on their life, promote their abilities by communicating with the medical team (Shearer & Reed, 2004). The role of older people with chronic diseases is informed and active participation in self care. The roles of medical teams are education and support for access to objectives, reduction of barriers, and attainment of self-care capacity (Kapella, Larson, Patel, Covey, & Berry, 2006). Despite vulnerabilities, older adults also have strengths that can be built upon to promote well-being (Shearer, 2009). Then, empowerment for old people with chronic diseases means as purposefully participating in this “process of changing oneself” and one’s environment, recognizing
Empowerment is a process that people gain more control on the diverse aspects of life. It involves a process of purposefully participating in health change, which is evidenced in the concepts such as asserting personal control, feeling more powerful, self-esteem and self-worth, inner-confidence, well-being and self-capacity. The empowerment process occurs based on group dynamic. It involves the participants in problem formulation, decision making and action.

The attributes from the review of the literature can be summarized as follows: “active participation”, “informed change”, “knowledge to problem solving”, “self-care responsibility”, “presence of client competency”, and “control of health or life”, which emerged as critical attributes from the synthesis of frequently repeated characteristics encountered in the literature (Table 1).

The first attribute “active participation” is considered essential for empowerment. The one being empowered must be willing to assume responsibility and participate in goal-setting and decision-making. However, health care professionals can find it challenging when patients participate too much, especially if patients’ choices clash with practitioners’ preferences (Tveiten & Meyer, 2009). The second attribute is drawn from the work of (a) Keiffer as “a process of becoming”, (b) Tones as “committed to change”, and (c) Shearer as “a process of purposefully participating in health change” (Keiffer, 1984; Shearer, 2007; Tones, 2001). The third attribute is “knowledge to problem solving”. Thus it is not surprising that empowerment is related to knowledge. Tveiten and Meyer’s study equates the empowerment process to the learning process. The fourth attribute of empowerment is “self-care responsibility”. The person to be empowered must be willing to assume responsibility, and accept behaviors that encourage empowerment (Tveiten & Meyer). While some old people are also experts on the management of their disease, others may not wish to become experts (Gibson, 1991; "To be empowered, individuals living with a chronic illness must be able to communicate effectively, have knowledge to problem-solve and actively participate in their care.

The fifth attribute “presence of client competency” strongly suggests that the individual has competencies to be empowered or these competencies are possible (Gibson, 1991). This focuses on helping the clients identify what is normal for them so that they can identify when they are becoming unwell and know what to do, which will effectively manage their symptoms. The sixth attribute “control of health or life” suggests that the client should be allowed to “control what degree he/she will be able to participate in the decision making” (Mok, 2001).

Consequences of empowerment

The empowerment process helps old people with chronic diseases with the development of a sense of inner strength through connection with the health care professionals. Old people also feel “personal satisfaction, self-efficacy, a sense of mastery and control, a sense of connectedness, self-development, and a sense of hope” (Gibson, 1991). In conclusion, health promotion (Shearer et al., 2010), positive self-esteem, goal attainment ability, control of life (Tengland, 2007), self-efficacy (Hsueh & Yeh, 2006), well-being attainment (Shearer et al., 2010), decreased health care costs (Clark et al., 2011), empowerment attainment (Clark et al.; Dickinson & Gregor, 2006; Kapella, et al., 2006; Shearer, 2007; Shearer et al., 2010; Walsh & Oshea, 2008), autonomy attainment and change of performance (Hsueh & Yeh) are about the outcomes of empowerment that have been confirmed in different studies. Table 2 shows a summary of the literature review and the meaning of the concept of empowerment with its attributes, antecedents and consequences.

Working definition

The definition of empowerment in old people with chronic diseases based on these critical attributes is the following:

A personal process in which old people with chronic diseases actively develop and employ the necessary knowledge, competence and confidence, also feel positive self-concept, personal satisfaction, self-efficacy, a sense of mastery, self-development, and hope for control of life and health promotion.

The process of empowerment allows the elderly patient to actively participate in his/her own treatment and plan, access vital information, and make a decision.

Fieldwork phase

The attributes of empowerment concept in old people with chronic diseases were extracted as the following: “awareness promotion”, “sense of control”, “development of personal abilities”, “autonomy” and “coping” (Table 3). Factors (antecedents) that influenced empowerment were “social participation”, “support” and “interactions with professional team members” (Table 4).

Awareness promotion

Getting old is accompanied by several changes in individuals, which influence their capabilities and abilities in various dimensions. Since there is a direct relationship between decreased health level and decreased sense of empowerment, if old people with chronic disease are aware of these changes and behave accordingly, they will become empowered via an optimal use of their abilities (Boot et al., 2005)—this is a fact mentioned by the participants of the present study. For example, an old woman with

Table 1  Attributes of Empowerment Concept in Older People with Chronic Disease

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<th>Attributes of empowerment concept</th>
<th>Cases of literature review</th>
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<tr>
<td>1. Active participation that values self &amp; others</td>
<td>Hsueh &amp; Yeh (2006): “The empowerment process occurs based on group dynamic.” Shearer et al. (2010): “The empowerment process has been focused on relationships with others and on liberation, emancipation, energy and sharing power.” Rodwell (1996): “Mutual partnership and commitment is necessary for empowering.”</td>
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<td>2. Knowledge to problem solve</td>
<td>Tengland (2007): “Empowerment is not only a goal, it can also be described as a process or an approach. In a fundamental way, it involves the participants in problem formulation, decision making and action.”</td>
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<td>4. Informed change</td>
<td>Shearer &amp; Reed (2004): “Empowerment is a mutual process in human beings and their environment that generates an ongoing and innovative change.”</td>
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<tr>
<td>6. Control on health &amp; life</td>
<td>Lord &amp; Hutchison (1993): “Empowerment is a process that people gain more control on the diverse aspects of life.”</td>
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patterns, and engaging inner resources for well-being (Shearer & Reed).

The attributes from the review of the literature can be summarized as follows: “active participation”, “informed change”, “knowledge to problem solving”, “self-care responsibility”, “presence of client competency”, and “control of health or life”, which emerged as critical attributes from the synthesis of frequently repeated characteristics encountered in the literature (Table 1).
diabetes stated, “Some nurses think that since we are old, we don’t understand anything. As a result, they don’t teach us anything in the hospital. They don’t tell us what to eat or not to eat.” Based on her own experience, a nursing instructor said the following: “When an old guy asks a nurse a question about his/her problem, the nurse answers: ‘You ask too many [questions], then the patient is no longer encouraged to ask questions.’ From the perspective of an internal ward nurse, empowerment in the field of awareness and knowledge promotion is administrable in different ways and the society can empower old people through the administration of check-up and instructional courses of their diseases in medical centers. In discussing their relationship with clinical caregivers, a woman with COPD remarked: “They solve my problems, and I tell them my problems.”

**Sense of control**

The definition of “control” is the ability or authority to manage something or to direct something in circumstances beyond our control. Control refers to maintaining, manage, have power, be in command, overcome, and handle (Encarta World English Dictionary, 2008). Usually, old people with chronic diseases lose their control more often than others do, which harms freedom in medical decisions to promote their well being and empowerment (Zimmerman, 1995). For example, an old woman with arthritis said, “When you are forced and you don’t have any help, you yourself do your work.” A woman with CHF stated, “I love my friends, neighbors and the nurses working in this ward. They love me too.” The daughter of an old woman with CHF said, “If I am on a trip, and absent for several days, mommy can manage it by herself. She knows what is good and what is bad for her and she will encounter no problem.” Having control over oneself to pursue desired goals until achieving them was very important, according to many elderly participating in the present work. They also tried to keep their general information updated. An old man with diabetes mellitus said, “I try to keep my presence in the society by being informed about the latest news. So, when the others are talking about some events, I will be able to state appropriate ideas.”

**Development of personal abilities**

Getting old is along with many changes in the individuals, which influence their capacity and ability in various dimensions. Since there is a direct relationship between decreased health and

<table>
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<th>Table 2 Some of Studies Conducted on Meaning of Empowerment</th>
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<td><strong>Author</strong></td>
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<td>Clark et al. (2011)</td>
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<td>Dickinson &amp; Gregor (2006)</td>
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concept provides a psychological construct that includes behavioral and cognitive events; it also permits a prescription for learning by the patient, and helps to distinguish successful from unsuccessful patients (Seonun et al., 2006). The more adapted the elderly patients were in their new situation, the more control they had in their empowerment process. Then they would apply some coping mechanisms in order to modify their surrounding, and adjust to the new conditions. An old man with COPD said, “It is obvious that an older person is not able to change the environment to become like the environment of his/her young age; so they should be content to the existing situation.” The informants used different strategies to adapt to situations resulting from aging and disease, and all reached a more or less psychological balance with the results of their self-efficacy in coping and handling the situations.

Features derived from the review of the literature and fieldwork

“Social participation”, “informed change”, “awareness promotion in problem solving”, “self-care responsibility”, “presence of client competency”, “control of health or life”, “autonomy”, “coping” and “development of personal abilities” are the attributes/themes derived from the concept of empowerment in old people with chronic diseases.

Practical definition

The definition of empowerment in old people with chronic diseases based on these critical attributes is having informed changes together with awareness promotion related to self-care activities, coping, and having the ability and competency of disease management independently in order to feel in control over one’s life.

Discussion

Because of the importance of empowerment in old people with chronic diseases, the concept analysis approach was used in this work to clarify and elucidate the concept of empowerment. Data analysis revealed five attributes for empowerment, “awareness promotion”, “sense of control on life”, “development of personal abilities”, “autonomy”, and “coping”.

One of the attributes of the empowerment was “awareness promotion”, which was put forward as a theme by most of the participants. In other words, in defining the concept of empowerment and the techniques of becoming empowered, the participants introduced appropriate and fundamental instructions essential for achieving empowerment, and considered awareness as equivalent to empowerment. Older people with chronic diseases require self-awareness to engage in the empowerment process (Dowling et al., 2011). This attribute is the same as “knowledge to problem solve” extracted from other studies (Tengland, 2007). Accordingly, King and Calasanti (2006) suggested that valid and suitable instruction on appropriate lifestyle helps the promotion of physical and spiritual empowerment in old people. In the same field the reported results of investigations conducted by Nasiripour et al. (2011) showed providing the needed resources for the patient, responding to patients’ questions, and training in self care were the most useful empowerment strategies for patients in the Iranian hospital. Health empowerment emphasizes facilitating one’s awareness of the ability to participate knowingly in health and health care decisions (Shearer, 2009).

Data analysis also showed that some of the attributes achieved in the fieldwork phase are compatible with those of the theoretical phase and another study conducted in Iranian elders. (Ravanipour et al., 2009) include the following: “sense of control on life” and “self-care responsibility”. Usually, old people with chronic diseases lose their control of life more often than others do, which harms
freedom in medical decisions to promote their well-being and empowerment. In a study conducted on Iranian elderly, Ravanipour et al. (2009) reported that the main structure of empowerment is “the perceived sense of control in life and satisfaction”, consistent with our findings. Meanwhile in the study conducted by Rodwell (1996), “self-care responsibility” as an attribute and “control over one’s life” as a consequence of empowerment was identified. A review of the literature suggests that a prerequisite of control of life is to be able to take care of self. Therefore, if old people have an adequate understanding of self-care abilities and a sense of possession, they will have a higher sense of empowerment. Shearer (2007) pointed out that empowerment is a process that provides mutual participation between old person and the society in order to achieve control on health, self-care acceptance, self-efficacy and the promotion of life quality. It is fundamental to the self-management of any chronic disease in the elderly. It shapes how those living with a chronic disease view their illness and approach their involvement in self-care (Dowling et al., 2011).

The patient’s willingness and tendency also play an important role in empowerment, which is influenced by his/her abilities; this research uses the attribute of "development of personal abilities", while in some studies, these abilities have been interpreted as "personal resources" (Dickinson & Gregor, 2006), including "physical, economic, spiritual and mental abilities". In the present study, given the extracted codes, it seems that the attribute of "development of personal abilities" is more appropriate. Personal abilities incorporate all human dimensions and include physical, social, mental, economic and spiritual abilities. In the studies that introduce personal ability as an empowerment instrument, personal ability is regarded as equal to self-competence, that is, one can be empowered by becoming self-competent. In this regard, Kinch and Jakucbic (2004) believed that dependence resulting from physical weakness leads to the lack of cognition and to care reliance, and can have negative effects on empowerment in older people. Moreover, religion and religious beliefs reinforce the old patient relationship with the society (Kinch & Jakucbic). In the study conducted by Ravanipour et al. (2009), the satisfaction of spiritual needs, attendance in society helps to allow greater social participation. In the present study, a number of older people also said that increased tendency to spirituality, especially to worship and prayers, conveys to them a sense of empowerment.

One of the other extracted attributes in this study was "autonomy". Since most of the participants in this study emphasized the ability of autonomous performance of jobs, this theme was created. For example, an old woman with arthritis said, “My hands ache; that’s why I can’t do my chores by my own”. Some informants found themselves incapable of solving their problems, and tried to get help from other people till the situations are resolved. In today’s world, it is suggested that patients should have autonomy to make rational decisions on their treatment; they should also take responsibility for their own care and know that they need autonomy to control the disease and to live with it. This finding is compatible with the results of Tengland (2007), who introduced autonomy as a feature of empowerment. In a study by Ravanipour et al. (2009), the main categories that emerged from empowerment in Iranian old people, included the following: independence, coping, perceived self ability, role playing, and mastery/owning. The results of a study by Nasiripour et al. (2011) showed that empowerment provides an opportunity for the Iranian patients to increase their independence and have more participation in the care for themselves. Ben Natan (2008) believed that, the incidence of chronic diseases limits old people's activities with aging. In order to prevent dependence, empowerment programs are needed.

Another attribute was “coping”. This finding is harmonious with the results of Ravanipour et al. (2009), who introduced coping as a feature of empowerment. In other studies, coping was considered as the consequence of empowerment programs (Shearer et al., 2012). In the current study, it was extracted as the attribute of empowerment. In some contexts it could also be seen as representing an appropriate adaptation to a way of life. For example, in a study conducted by Pinnock et al. (2011), “acceptance of COPD as ‘a way of life’” was extracted. It was a sense of acceptance and coping in the face of severe disease and social difficulties.

“Active participation” was another attribute derived from the review of the literature. In this study, however, the analysis of open codes did not reveal this feature. Therefore, this feature should be considered in the empowerment programs for old people with chronic diseases with respect to the fact that, in the review of the literature, choosing correctly and autonomous decision-making are the features of empowerment. The one being empowered must be willing to assume responsibility and participate in goal-setting and decision-making (Dickinson & Gregor, 2006; Tengland, 2007). Noting the difference between cultures, and considering this study was done in the context of Iranian old people, autonomous decision making was not extracted from the participants’ experiences. But this finding is not compatible with the investigation conducted by Nasiripour et al. (2011), which demonstrated that nurses provided the needed resources for the Iranian patients’ participation in their self-care process.

“Informed change” is another theme extracted from the literature review. This theme was not extracted from our data. In a study developed by Ravanipour et al. (2009), “being aware of personal changes” emerged from the results. Shearer (2007) described the empowerment process as the following: "Empowerment is a mutual process in human beings and their environment that generates an ongoing and innovative change". Hseuh and Yeh (2006) stated the following: "Empowerment outcome is a change of patient's performance.” Older people see themselves as having an important role in changing their life (The Audit Commission and National Health Service in England and Wales, 2004).

“Presence of client competency” was another attribute derived from the review of the literature. The reported results of investigations conducted by Nasiripour showed that patients in Iranian social security organization hospitals are highly competent in their self-care and feeling of meaning, in spite of that declaration; they considered their empowerment status to be at a moderate level (Nasiripour et al., 2011). This finding confirms the result of our study. Empowerment strongly suggests that "the individual has conditions to be empowered". To be empowered, the elderly living with a chronic disease must be able to communicate effectively, have knowledge to problem-solve, and actively participate in their care. Empowerment will focus on helping older people identify what is normal for them so that they can identify when they are becoming unwell and know what to do in order to effectively manage their symptoms (Dowling et al., 2011). Furthermore, in the clinical work phase, it was found that, despite the fact that some older patients had a background of a 5-year diabetes, they did not have any information on the disease or its nature and treatment so that if they were asked about the disease, they did not know its main causes. For example, an old man with COPD explained his hospitalization as for having a cold and a lung infection. In a case of an old man with COPD explained his hospitalization as for having a cold and a lung infection. In a case of a 5-year diabetes, they did not have any information on the disease or its nature and treatment so that if they were asked about the disease, they did not know its main causes. For example, an old man with COPD explained his hospitalization as for having a cold and a lung infection. In a case of a 5-year diabetes, they did not have any information on the disease or its nature and treatment so that if they were asked about the disease, they did not know its main causes. For example, an old man with COPD explained his hospitalization as for having a cold and a lung infection. In a case of a 5-year diabetes, they did not have any information on the disease or its nature and treatment so that if they were asked about the disease, they did not know its main causes.
Factors (antecedents) influencing empowerment include social participation, support, and interactions with professional team members. (Table 4)

Social participation

One antecedent emerged from the data analysis was “social participation”, which incorporates the subcategories of “interaction with friends and relatives”, “participation in recreational and cultural programs”, and “interaction with peers”. Dickinson and Gregor (2006) stated that the process of empowerment concentrates on communication with others. According to Hsueh and Yeh (2006), the process of empowerment is administered on the basis of group dynamics in group activities, which results in more vivid cooperation of people with one another. For example, an old woman with diabetes said, “I’d like to communicate with my old friends and relatives; this is the peace of my soul.” Also, one essential competency for empowerment is the ability to communicate effectively. The process of empowerment takes place in a context, which includes interactions with others. Positive interactions with others are encouraging, strengthening and edifying. For example, the daughter of an old patient with CHF believed that to become empowered, it is necessary that the elderly patients with chronic disease have social participation: “When I take my mother to a party or to the beach, she feels that she is in the heavens, or when she communicates with her friends, she learns new things from their words”.

Support

This antecedent is raised by most of the participants because of old people’s needs for family and supportive organizations, and it included the two subcategories, “organizational support” and “family support” based on the extracted code. Supporting systems is very important in old age (Ravanipour, Salehi, Taleghani, & Abedi, 2008). In this regard, the chief of nurses in the internal ward said the following: “I believe that associations play an important role.” For the participants of this study, family and organizational support played an important role in the empowerment of older people. “Family support” played an important part in the empowerment of the elderly with chronic diseases. Among the most important needs expressed by the participants, emphasis should be put on the need for respect, love and the presence of a partner. As an older individual with CHF stated, “May God bless my husband. If he were alive, everything would be better now.” In other studies, family and cultural groups were considered as the instruments to access medical services for empowerment. For example, a nurse said, “It happened very often that we told the patients how to use the spray or how to inject the insulin. They said, “We don’t know”, and evaded learning. Then they told me to tell their company to do that for them upon their arrival; I want to say that empowerment of old people is not possible without the presence of the family.

In acknowledging support from others, all of the participants spoke of the role of their families. They talked about both the tangible aid their families gave to them as well as the emotional support offered through their frequent telephone conversations with the family members, especially with their daughters. The daughter of an old patient with CHF stated, “If her daughter-in law, her daughter-in law, grandchildren or son show disrespect for her, it will have a negative influence on my mother’s spirits. On the contrary, respect and even a phone call to her will make her forget her disease.” Family support in Iranian elders with chronic diseases is an important subject; in a study titled, “The effect of family-based intervention on empowerment of the elders” indicated that family-based empowerment model significantly increased QOL in the elders (Rabiei et al., 2013).

Organizational support is one of the other influencing factors in empowerment, which is noted in the findings of others (e.g., Ravanipour, Salehi, Taleghani, Abedi, & Schuurmans, 2008). Shearer et al. (2010) says, “Social resources help with the promotion of health related empowerment by providing support and constant accessibility.” Capabilities of support resources include, “information provision”, “promotion of knowledge”, and “encouragement for the expression of feelings” (Shearer et al., 2010). Although for the participants of this study, the support of family and cultural groups also played an important role in the empowerment of older people, family support contributed more importantly than cultural groups did in empowerment. The difference between this study and other studies is attributed to the research community and cultural differences because old people with chronic diseases, especially in the Iranian society, are dependent on family and many of their problems can be resolved with family support.

Interactions with professional team members

Inappropriate interaction between the medical team and old people with chronic diseases was considered a barrier to the empowerment of the patients. The reason was stated by the participants to be the age difference between the treatment team, especially the nurses, and patients. A nursing instructor said, “The first one to encounter the patients is the physician; he/she has to tell the patients about the disease, the foods they should or should not take, the kind and amount of activities permitted or not permitted, and the dangers of smoking. Unfortunately, the physicians do not allocate enough time for the patients. Now, nursing shifts are mostly full of young nurses who neither communicate with older patients nor allocate any time for them”. This finding is not in line with the results of from Nasiripour et al. (2011), in which nurses use six strategies to empower Iranian patients. One of these strategies was “good communication”. Therefore, good communication between nurses and the elder patients is essentially considered a type of partnership (Paterson, 2001) which can provide the elderly patient with the right to choose the type of treatment according to their effectiveness in the treatment process.

In empowerment process, nurturing trust and reciprocity between the nurse and old people is essential (Dowling et al., 2011). However, the findings reported by Tveiten and Meyer (2009) revealed that health care professionals may have difficulties in acknowledging old patients as experts in view of interesting factors such as old patients’ mental and physical conditions, and previous experience. The nurses need the competence in listening to the older patient and to be willing to respect his or her experiences, values, and interests as well as the experiences of the disabilities if the nurses want to facilitate the empowerment of older patients (Hage & Lorensen, 2005).

Limitations

This study was conducted to clarify the meaning and the nature of empowerment concept in Iranian old people suffering from chronic diseases. In the meantime, this is a complex concept within the context of nursing care, which requires further study within the social and cultural contexts of the health care of old people with chronic diseases. In addition, the contexts of the interview focused on old women with chronic disease. Because quotes of interest were expressed by the old women, we have used more of their quotes. Because old women with chronic disease did not
adequately represent the whole elderly population, this is seen as a limitation of the study.

Implications

Empowerment is fundamental to the self-management of any chronic disease, and is important for both the nurses and the elderly. Both nurses and older people require skills and self-awareness to engage in the empowerment process. The nurses need to communicate effectively and focus on the old people’s goals. The elderly need a willingness to engage in change and actively engage with the empowerment process. The elderly also need to have adequate knowledge and problem-solving skills. Perhaps, the first step in the empowerment process in older people with chronic diseases is the allocation of sufficient time for the older patient and his/her family, and the surrendering of control of the medical team. To surrender control, nurses must remember that the elderly with chronic diseases are experts who know how the disease affects them and how they live within the limitations imposed by their condition. Nevertheless, with self-awareness of any power over the elderly, nurses can attempt to relinquish this power in their efforts to assume a relationship of equality with their elderly clients.

Conclusions

The attributes of the concept of empowerment in old people with chronic diseases were identified in the research findings. This provided for the evaluation and the use of this concept in the health care of older people with chronic diseases. Moreover, identification of preventive and facilitating factors in the concept of empowerment helps the medical team and the authorities properly actualize empowerment with an insight based on scientific findings. These findings can be a baseline for future research in developing effective health interventions such as developing a nursing model for increasing empowerment in the elderly in Iran. Such a model can provide a strong basis for nursing care. This study aimed to achieve a deeper understanding of the concept of empowerment in Iranian elderly with chronic disease so that one can develop health care strategies for empowerment that is culturally appropriate.

Conflict of interest

The authors declare no conflicts of interest.

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