A Consumer-Constructed Scale to Measure Empowerment Among Users of Mental Health Services

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Objective: **A scale to measure the personal construct of empowerment as defined by consumers of mental health services was developed and field tested.** ***Methods:*** **After extensive development, pilot testing, and analyses, a 28-item scale to measure empowerment was tested on 271 members of six self-help programs in six states. Factor analyses were used to identify the underlying dimensions of empowerment. To establish the scale's reliability and validity, responses were factor analyzed, and other analyses were conducted.** ***Results:*** **Analyses revealed five factors: self-efficacy–self-esteem, power-powerlessness, community activism, righteous anger, and optimism–control over the future. Empowerment was related to quality of life and income but not to the demographic variables of age, gender, ethnicity, marital status, education level, or employment status. Empowerment was inversely related to use of traditional mental health services and positively related to community activism.** ***Conclusions:*** **The findings set a framework for a clearer understanding of the imprecise and overused concept of empowerment. The scale demonstrated adequate internal consistency and some evidence for validity. Further testing must be done to establish whether it has discriminant validity and is sensitive to change. (*Psychiatric Services* 48:1042–1047, 1997)**

Despite the burgeoning use of the term "empowerment" in the lexicon of mental health programs, few researchers or service providers have attempted to define, operationalize, or measure it (1,2). Early definitions of empowerment grew out of studies conducted by Rappaport (3,4), who defined psychological empowerment as "the connection between a sense of personal competence, a desire for and a willingness to take action in the public domain."

McLean (1) noted that empowerment is often defined as the action of those who are disempowered and acting to become empowered. Furthermore, Segal and his colleagues (2) described empowerment as a process of "gaining control over one's life and influencing the organizational and societal structure in which one lives." Staples (5) described empowerment as "a process by which power is developed, facilitated, or sanctioned [allowing] subordinate individuals to build capacities to act on their own behalf."

In the mental health literature, empowerment appears most prominently in relation to the function or mission of self-help programs (6–8) and to how mental health professionals or services can promote empowerment (9–11). Empowerment has been extensively discussed in several fields other than mental health, including social work, community psychology, and case management. It has been appropriated by so many other fields that it has been referred to as a "buzzword" with little meaning. Simon (12) stated that the roots of empowerment lie in the "self-help and mutual aid tradition of the United States" and that "not a single constituency or client population of the human services professions has failed to join the empowerment movement." Empowerment has also been studied in relation to family concerns (13–17) and to persons who are homeless and mentally ill (18–21).

Despite this growing emphasis on empowerment as the goal of mental health services and self-help involvement, few empirical studies of empowerment as a construct, a process, or an outcome have been done. One qualitative inquiry has been conducted to examine empowerment from the consumer's perspective (22). Rosenfield and her colleagues (23) have also attempted to define and study empowerment within the context of a psychosocial rehabilitation clubhouse program. Using a 21-item scale to measure empowerment, they found that it was associated with many aspects of quality of life but was

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unrelated to members' satisfaction with their employment or financial status. Similarly, Segal and associates (2) developed scales to measure the personal, organizational, and extra-organizational aspects of empowerment, which they tested on members of four client-run self-help agencies.

Although these studies have shed light on the construct of empowerment, more research is needed to develop a reliable and valid measure. The purpose of this study was to further define and operationalize the construct of personal empowerment from the perspective of consumers, survivors, and former patients and to construct and validate a scale that can be used in a variety of settings.

Attributes of empowerment developed by an advisory board of leaders of the self-help movement

Having decision-making power
Having access to information and resources
Having a range of options from which to make choices (not just yes-no and either-or)
Assertiveness
A feeling that one can make a difference (being hopeful)
Learning to think critically; unlearning the conditioning; seeing things differently. For example, learning to redefine who one is (speaking in one's own voice), learning to redefine what one can do, and learning to redefine one's relationships to institutionalized power
Learning about and expressing anger
Not feeling alone; feeling part of a group
Understanding that a person has rights
Effecting change in one's life and one's community
Learning skills (for example, communication) that one defines as important
Changing others' perceptions of one's competency and capacity to act
Coming out of the closet
Growth and change that is never-ending and self-initiated
Increasing one's positive self-image and overcoming stigma

Methods

The survey was designed with the assistance of a consumer research advisory board, under the direction of the second author. At the outset of the project, the second author selected for the board ten individuals who were leaders in the consumer-survivor movement, who were able to represent various factions of that movement, and who were diverse in gender, ideology, ethnicity, and the area of the country in which they resided. Three meetings were held with the board to design and plan the study. The use of such a board is encouraged by proponents of participatory action research (24,25), who assert that for evaluation to be meaningful and credible, constituents of that research must be involved.

Sample

Using various resources, the board developed a list of 200 self-help programs across the country, and letters were sent to each program requesting its participation. Based on the responses to the initial recruitment letter, final site selections were made. They included six self-help programs, one in each of six states: New Hampshire, New Jersey, Indiana, Arkansas, Washington, and California. Program selection was based on geographical and ethnic diversity; various types of consumer-run programs were chosen.

Each site identified an individual to act as a liaison. The second author visited all but one site to discuss the project further (the remaining site was contacted by telephone). On these visits she discussed the logistics of project implementation, met members, and secured the final agreement for participation.

Instruments

All instruments were developed using standard guidelines for paper-and-pencil surveys (26,27).

Empowerment Scale. The board delineated 15 attributes of empowerment based on its definition of psychological empowerment (see box). The need for this process became apparent when the board reviewed and then rejected several standard psychological instruments as measures of empowerment. The board felt that no existing instrument captured the dimensions of empowerment in relation to persons with mental illness. Furthermore, board members feared that study participants might find these instruments offensive.

We began the process of developing the scale by asking the board members to arrive at a consensus about a definition of empowerment that was relevant for persons with mental illness. Several dimensions of empowerment related to the definition, such as control over one's life, achievement of goals, self-esteem, and self-efficacy, were identified and agreed on.

Using these dimensions, items for the scale were modeled after the Rotter Internal-External Locus of Control Instrument (28), the Self-Efficacy Scale (29), and the Rosenberg Self-Esteem Scale (30). The initial scale consisted of 48 items, rated on a four-point Likert scale ranging from strongly agree to strongly disagree. It was tested on a sample of 100 subjects in two self-help programs in New Hampshire. Factor and reliability analyses were conducted, and 28 items having the highest factor loadings were retained.

The final items of the scale did not address all aspects of the board's original definition of empowerment; however, the board was satisfied that most aspects were addressed and that the items captured the essence of empowerment as they perceived and defined it.

Other instruments. In addition to the Empowerment Scale, seven brief instruments were developed for use in this study. They included a checklist of 22 traditional mental health services on which respondents indicated whether they had used each service in the past year; a five-item scale to assess the effect of self-help on social supports; an 11-item scale to assess the effect of self-help on quality of life; a five-item scale to assess the effect of self-help on self-esteem; a 19-item scale to assess participants' satisfaction with their self-

Table 1

Factors derived from the Empowerment Scale

Factor and scale item[1]	Loading
Factor 1: Self-esteem–self-efficacy[2]	
I generally accomplish what I set out to do	.79
I have a positive attitude about myself	.74
When I make plans, I am almost certain to make them work	.72
I am usually confident about the decisions I make	.70
I am often able to overcome barriers	.56
I feel I am a person of worth, at least on an equal basis with others	.47
I see myself as a capable person	.46
I am able to do things as well as most other people	.41
I feel I have a number of good qualities	.41
Factor 2: Power-powerlessness[3]	
I feel powerless most of the time	.69
Making waves never gets you anywhere[4]	.66
You can't fight city hall	.66
When I am unsure about something, I usually go along with the group	.66
Experts are in the best position to decide what people should do or learn	.63
Most of the misfortunes in my life were due to bad luck	.62
Usually, I feel alone	.60
People have no right to get angry just because they don't like something[4]	.43
Factor 3: Community activism and autonomy[5]	
People have a right to make their own decisions, even if they are bad ones	.68
People should try to live their lives the way they want to	.64
People working together can have an effect on their community	.62
People have more power if they join together as a group	.53
Working with others in my community can help to change things for the better	.52
Very often a problem can be solved by taking action[4]	.41
Factor 4: Optimism and control over the future[6]	
People are limited only by what they think possible	.78
I can pretty much determine what will happen in my life	.62
I am generally optimistic about the future	.58
Very often a problem can be solved by taking action[3]	.42
Factor 5: Righteous anger[7]	
Getting angry about something is often the first step toward changing it	.73
People have no right to get angry just because they don't like something[4]	.52
Getting angry about something never helps	.48
Making waves never gets you anywhere[4]	.40

[1] Items that are negatively worded were recoded for consistency before the factor analysis.
[2] Eigenvalue=6.85, variance explained=24.5 percent
[3] Eigenvalue=3.48, variance explained=12.4 percent
[4] This item loaded on more than one factor.
[5] Eigenvalue=2.13, variance explained=7.6 percent
[6] Eigenvalue=1.5, variance explained=5.4 percent
[7] Eigenvalue=1.12, variance explained=4 percent

help program; a 16-item community activity checklist; and a demographic questionnaire. The questionnaire asked respondents about the length of time they had been involved in self-help and how many hours on average they attended their program each week, as well requesting as their demographic characteristics, vocational and residential status, and psychiatric history.

The final version of the Empowerment Scale and other instruments used in this study were pilot tested with a local self-help program that did not participate in the study. (The instruments are available from the first author.)

Survey procedures and data analysis

Data were collected between March and August 1992. All instruments and procedures were approved by the institutional review board. Informed consent was obtained from all participants. The liaison at each program site was responsible for recruiting individual members at the program for participation, ensuring the anonymous handling of the instruments, and returning the instruments to the center. A total of 271 usable questionnaires were returned.

To examine the validity of the instrument, we used correlations, t tests, regressions, and descriptive statistics. We used analyses of variance to test for differences among programs and to examine differences in respondent characteristics. To examine the psychometric properties of the scale, we used factor analysis and statistics to examine internal consistency. Several demographic variables were dummy coded for the multiple regressions. They were marital status (single, not married, and married), housing status (independent housing, supervised housing, and homeless or other housing), and ethnic status (minority and nonminority).

Results

Empowerment Scale

The 28 items of the Empowerment Scale were summed and averaged to arrive at an overall empowerment score. Out of a possible score of 4, the mean±SD score was 2.94±.32 (range, 1.82 to 3.79). These results suggested that respondents scored somewhat above the middle range of the scale. Analysis of variance indicated that empowerment scores did not differ significantly between the six self-help programs. Mean scores at the six sites ranged from 2.75 to 3.02.

Cronbach's alpha suggested a high degree of internal consistency (alpha=.86, N=261). Results of a factor analysis using principal components analysis and oblique rotation suggested a somewhat satisfactory factor solution. Five factors were extracted, accounting for 54 percent of the variance in scores. Table 1 shows the items that loaded on each factor. The skree test and conceptual clarity of the factor solution were used to determine the final number of factors as well as the method of rotation.

Construct validity

Despite our prediction that self-help involvement and empowerment would be positively related, no significant correlations were found between the total Empowerment Scale score and hours spent in the self-help program per week or the total number of years of involvement in self-help. The mean±SD number of hours spent in the program was 15.34±15, and the mean number of years of involvement was 4.70±4.73.

We also examined the relationship between Empowerment Scale scores and the demographic characteristics of respondents. A t test indicated that males and females did not differ significantly in their feelings of empowerment. Analysis of variance suggested no significant differences by race (white, black, or other racial status) or by marital status (married; single; or divorced, widowed, or separated). No significant correlation was found between empowerment and educational level achieved or total number of previous psychiatric hospitalizations.

As might be expected, a small but statistically significant relationship was found between the number of community activities engaged in and empowerment ($r=.15$, $N=261$, $p=.02$). A small but statistically significant inverse correlation was found between use of traditional mental health services and empowerment ($r=-.14$, $N=256$, $p=.02$)

Respondents were categorized by whether they were working in a "regular" job (N=43); those who were doing sheltered or volunteer work or who were retired, in school, or unemployed were classified as not working (N=210). The mean Empowerment Scale score was 3.01 for the working respondents and 2.92 for the nonworking respondents, a nonsignificant difference. They were also categorized by whether they were engaged in any productive activity, that is, in a regular job, a sheltered workshop, volunteer work, or school (N=104) or not so engaged (N=149). No significant difference in empowerment scores was found between these groups.

Although no differences in empowerment were found between working and nonworking respondents, a significant relationship was noted between total monthly income and respondents' scores on the Empowerment Scale ($r=.24$, $N=234$, $p<.001$). Furthermore, among the respondents who were engaged in productive activity, a significant positive relationship was found between the number of hours engaged and empowerment ($r=.34$, $N=98$, $p=.001$).

In addition, we found significant positive correlations between empowerment and quality of life ($r=.36$, $N=254$, $p<.001$), social support ($r=.17$, $N=253$, $p=.002$), and self-esteem ($r=.51$, $N=258$, $p<.001$). The correlation with self-esteem may be explained, at least in part, by the fact that items explicitly tapping self-esteem were included in the Empowerment Scale. A significant positive correlation between empowerment and respondents' satisfaction with their self-help program was also found ($r=.28$, $N=255$, $p<.001$).

Predictors of empowerment

Two stepwise multiple regressions were conducted to determine the best predictors of empowerment. First used were respondents' characteristics, including age, gender, educational status, ethnicity, age at first psychiatric contact, work status, housing status, marital status, total monthly income, and total number of lifetime psychiatric hospitalizations. Only total monthly income emerged as a significant predictor of empowerment, explaining 5 percent of the variance in empowerment scores (adjusted $R^2=.048$, $F=14.71$, $df=1,271$, $p<.001$).

The second regression was conducted using several of the other measures, including quality of life, number of community activities engaged in, satisfaction with the self-help program, number of traditional mental health services received, and social support items. This multiple regression was considerably more successful in explaining the variability in empowerment scores, accounting for 22 percent of the variance (adjusted $R^2=.22$, $F=20.19$, $df=4,268$, $p<.001$). The most useful predictors were items measuring quality of life, number of traditional mental health services received, number of community activities engaged in, and overall life satisfaction. The items measuring satisfaction with the self-help program and satisfaction with social supports were not useful predictors of empowerment in this multivariate analysis.

Known-groups validity

The Empowerment Scale was administered to two other groups for additional validation. One group consisted of 56 patients hospitalized at a state facility (mean length of stay=4.3 years; range=three months to 22.6 years) (31), and the other of 200 college students (32). In the former group, the mean±SD scale score was 2.29±.24, and in the latter group, it was 3.16±.24. The first mean is approximately two standard deviations below the mean in this study, and the second is about two standard deviations above it. These results lend credence to the scale's ability to discriminate among groups of respondents whose feelings of empowerment are different from those of participants in self-help programs.

Discussion

Clarifying the construct of empowerment

Our attempt to develop and validate a scale measuring the construct of empowerment, as defined by consumers and former patients themselves, was successful. The scale has high internal consistency, and analyses produced a somewhat satisfactory five-factor solution.

Furthermore, the findings of this study set a framework for understanding the imprecise concept of empowerment. Using a tripod metaphor, there are three legs or supports that constitute empowerment. The first is self-esteem–self-efficacy and optimism and control over the future; it can be thought of as a sense of self-worth and a belief that one can control one's destiny and life events. The self-esteem–self-efficacy factor was one of the strongest and most consistent produced by the factor analysis. It is partly equivalent to the idea of internal locus of control as described by Rotter (33) and to other definitions and scales measuring self-efficacy and mastery.

The second leg of empowerment is actual power, another consistent factor in the scale. The remaining two factors of the scale constitute the third support. These factors are righteous anger and community activism. They imply the ability and willingness to harness anger into action and a sociopolitical component of empowerment that is evident in both community activism and righteous anger factors.

This framework of empowerment

was supported by the additional analyses conducted in this study. As predicted, a positive relationship was found between empowerment scores and the number of community activities engaged in (for example, writing to a public official and voting), which buttresses the idea of action as a component of empowerment. The inverse relationship between empowerment scores and use of traditional mental health services is somewhat difficult to tease out from a causal perspective given the ex post facto nature of this study.

A significant relationship was found between number of hours worked (among those working) and empowerment. Monthly income was also a predictor of empowerment, which differs from Rosenfield's finding (23). In this society, income and earning power are often linked to actual power, the second leg of empowerment; thus the relationship between income and empowerment seems reasonable.

Like Rosenfield, we found that empowerment was related to quality of life but unrelated to employment status. Although empowerment was related to income, when monthly income was combined with other variables such as quality of life and life satisfaction, it lost its predictive power. This finding suggests that income may play a mediating role in empowerment by increasing quality of life, which in turn affects feelings of empowerment.

The absence of a relationship between the total empowerment score and the host of demographic variables tested shows that empowerment is not limited to the privileged, the educated, the majority race, or the employed; it is an "equal opportunity" personal state.

Our initial hypothesis that empowerment would be positively related to the length and intensity of involvement with a self-help program was not borne out by the data. Empowerment was correlated with satisfaction with the self-help program when those variables were examined in a bivariate correlational analysis. However, satisfaction with the self-help program lost its predictive power in the multivariate analysis.

Conclusions

This study yielded a valid and reliable measure of empowerment that was developed from the perspective of consumer activists, and it further served to clarify the components of empowerment and its relationship to other factors. Results of this study suggest that programs wishing to promote empowerment among their members must focus on increasing self-esteem and self-efficacy, decreasing feelings of powerlessness, and increasing feelings of power especially by increasing financial resources. They must also focus on heightening sociopolitical consciousness and community activism.

It should be noted that the persons selected to construct this scale can be considered leaders of the self-help movement. As such, it may be argued that they represent a higher-functioning and more educated group than would a random selection of consumers of mental health services. Consequently, the empowerment scale constructed by this sample may look different from one constructed solely by users of mental health services. On the other hand, the persons who served on this advisory board are active in shaping policy and defining new directions in mental health services, so their voices deserve our attention.

The framework for empowerment developed by this study is consistent with the definitions offered by Rappaport (3), Staples (5), and McLean (1). Our results provide empirical support for at least part of the advisory board's initial definition of empowerment. Results of our study suggest that an empowered person is one who has a sense of self-worth, self-efficacy, and power. The empowered person recognizes use of anger as a motivating force to instigate social change and is optimistic about the ability to exert control over his or her life. He or she recognizes the importance of the group or community to effect change, but the empowered person also values autonomy.

Further testing of the empowerment scale will yield additional information about the psychometric properties of the scale and, in turn, the construct of empowerment. For example, evidence for known-groups validity could be strengthened by administering the scale to additional samples suspected of having lower or higher empowerment scores. It would also be useful to determine if the scale is both sensitive to change and stable over time. Administering the scale to new participants of a program thought to promote empowerment may yield evidence of its sensitivity (and indeed may suggest whether empowerment is a changeable trait), while additional studies examining test-retest reliability would yield evidence of its stability. In addition, it may be useful to administer the scale along with other standardized measures of psychological functioning to gather more evidence of the scale's convergent and divergent validity. Unfortunately, these assessments were beyond the scope of this initial study, and the results are correspondingly limited. ♦

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