
1 Conceptual, Theoretical, and Research Issues Related to Empowerment Practice

I am convinced . . . that the nature of . . . (empowerment) theory must be ecological.

—J. Rappaport (1987:134)

The purpose of this practice text is twofold: to identify the components and process of empowerment practice in substance abuse services and to clarify important aspects of the complex multilevel environment outside a program's setting that influences client empowerment and service outcomes. Such an undertaking is fraught with problems, however, due to the tendency of helping professionals and researchers to overuse the concept of empowerment and not to clearly define it. Wasserman (1991) notes that, "Admittedly, it (empowerment) has compelling resonance; but like other catchy slogans, it may go out with the wind, unless we are willing to understand what we actually mean by the term" (235).

Clarifying what is meant by "empowerment" and its theoretical underpinnings may help to provide answers to some important questions: Is it possible to identify and observe an empowerment and/or disempowerment experience? Is what a professional identifies as empowerment consistent with what a client might identify? What effects does the environment or ecology have on whether and how empowerment occurs? Are there primary components that make up an empowerment approach, and if there are, how do they influence each other? And how does empowerment contribute to effective outcomes in substance abuse services—for example, in mandatory rehabilitation and in prevention programs focused on systemic change?

The field's inability to answer these and other key questions has limited effective practice in several ways. First, few components of effective empowerment practice have been documented. Service providers often fail to ask

clients what they have learned from their addiction experiences or from prevention of addiction. Clients' undiscovered wisdom, resiliency, and strengths from those experiences could be applied effectively during rehab and prevention services, and then throughout the life span (Miller 1994). For instance, a seventy-two-year-old man was admitted to a rehab program in a large metropolitan area. He had been addicted to alcohol and heroin for fifty years. Staff in the program developed a comprehensive drug and social history, which indicated one failed attempt at recovery many years before and a referral to the current program from a minister. Staff failed to ask other key questions, however, such as how this client had survived fifty years of drug addiction and what factors (strengths and problems) had led to his current decision to enter rehab. Answers to these questions could potentially facilitate his initial commitment to rehab, his maintenance in recovery, his hope for change, and his self-empowerment.

Second, many programs do not give key actors, especially the clients, more active roles in service delivery and in assessing the outcomes of services. Thus, opportunities may be missed for helping clients to develop skills and self- or group efficacy. In one in-service training session, staff from a substance abuse prevention program decided to collaborate in developing criteria for distinguishing among low, moderate, and high-risk middle school youths. The trainer suggested youths currently in the program could be consulted about this issue and about effective prevention strategies. Staff insisted the idea of risk criteria was too complex for these clients, ignoring the contradiction between their conclusion and the program's goals of empowerment and self-development for youths.

A related limitation is the failure of service providers and policy makers to identify and address structural barriers to helping individuals stop abusing, selling, and importing drugs (Rappaport 1981). Instead, the main focus of some policies is on pathology and blaming individuals without also clarifying how their empowerment and disempowerment experiences may be rooted in both their immediate and larger environments (in the family, community, and larger social systems or social policy). Yeich and Levine (1992) state that these roots, the structural causes of problems, must be changed for real empowerment to take place.

As a consequence of these limitations, the addictions field has not been able to apply empowerment concepts to some of the most intractable problems of service delivery, including reducing the high rates of recidivism during and after rehab ends (Freeman 1993). Additional efforts are needed

to increase the effectiveness of primary prevention with nonusers and secondary prevention with nonaddicted problem users by addressing the total environment (Chang 1993).

This chapter examines how well the conceptual literature on empowerment addresses the total ecological environment in defining and applying concepts to different populations. An analysis of the research literature on empowerment is included to highlight the process and outcomes of empowerment practice in substance abuse services, along with an analysis of my research findings in this area. These two sources are then used to develop a set of criteria and a conceptual framework for analyzing and understanding empowerment practice in substance abuse prevention, intervention, and rehabilitation from a number of theoretical perspectives.

Empowerment Definitions, Theories, and Concepts

The term “empowerment” has been defined in various ways in the conceptual literature, sometimes very narrowly and at other times more broadly to include different aspects of the ecological environment. A common aspect of the different definitions is the assumption that a person does not achieve empowerment for all time; rather, empowerment is a continuous process of growth and change throughout the life cycle. The definitions differ somewhat in whether they focus on empowerment as a characteristic of a unit or system, a process, a practice or research strategy, an outcome, or a combination of two or more of these elements. The definitions differ too in terms of their implicit or explicit theoretical assumptions.

Empowerment as a Characteristic or Quality of Systems

Some authors and researchers have defined empowerment as a quality related to a system or to a mechanism, structure, context, value, or philosophy of a system. An underlying assumption of this category of definitions is that empowerment is an existing precondition in a system or an opportunity that develops in a given situation for people to gain control over some aspect of their lives. Rappaport (1987), for example, indicates empowerment is a mechanism by which people, organizations, and communities gain mastery over their affairs. Similarly, Zimmerman (1991) notes that an empow-

ering organization is one whose structure encourages participatory decision making and shared rather than centralized power. Yeich and Levine (1992) define an empowered group as one that characteristically exhibits group cohesion. Other authors define empowerment as a value, belief, or philosophy, emphasizing that people should have the power to influence their personal and social lives (Freire 1970; Freire and Macedo 1987; Wallerstein and Bernstein 1988). This definition implies that having such a value or belief in the power to change is a precondition for successfully acting on or altering one's environment.

Health promotion and wellness theories, among others, provide conceptual support for these definitions. A lack of control over one's life and disempowerment experiences are thought to be risk factors (pre-existing conditions) that can lead to physical disease and debilitating psychological conditions (Syme 1986). In comparison, gaining control over a life situation and experiencing empowerment (qualities of certain person-in-environment transactions) can serve as health promotion strategies (Wallerstein and Bernstein 1988). Other theories are also consistent with such definitions of empowerment. For instance, the knowledge is power theory assumes that power is an implicit quality of knowledge and that therefore, one gains power through developing common knowledge (about the connections between personal problems and the social structure) (Freire 1970). Related to this assumption, social conflict theory is based on the belief that forced changes in the structure or in the social, economic, and political context are necessary for oppressed people to gain power (Yeich and Levine 1992).

Empowerment as a Process

A second category of definitions conceptualizes empowerment as a process. Some of these definitions imply a unilevel process while others view it as multilevel. Even authors who define empowerment based on an individually focused analysis of problems assume there are effects at other levels. For instance, Zimmerman (1992) defines psychological empowerment as those intrapsychic, behavioral, and interactional components related to a person's efforts to control decision making that affects their life. While his definition of the psychological level is distinguished from other levels, Zimmerman notes that this process may be influenced by organizational and community empowerment; however, he does not address the environment more directly.

Interpersonal definitions of empowerment have also failed to address the environment adequately in terms of the process. Much of the organizational literature, for example, discusses how leaders can and should delegate power to subordinates and likens empowerment to team building as a process for improving organizational effectiveness (Auerbach and Wallerstein 1987; Farley 1987). Similarly, definitions of empowerment based on concepts of social support are limited. Israel (1985) cautions that some communities have been defined as empowered because they have improved their mutual-helping process. But many of these communities may still not have the power to impact environmental stressors that are controlled by the social structure outside the community.

Multilevel definitions of empowerment are more explicit about interactional and sociopolitical effects related to the environment. Wallerstein and Bernstein (1988) define the concept as “A social action process that promotes participation of people, organizations, and communities in gaining control over their lives in their community and larger society” (380). Yeich and Levine (1992) state that empowerment is a process for mobilizing individuals and groups in order to cause changes in society that give oppressed people more power over their lives. These authors emphasize that the target of change is the existing social structure rather than individuals’ ways of coping with that structure.

The focus on empowerment as a multilevel process is based on social change, social influence, systems, and ecological theories. With social change and social influence theories, the emphasis is on group- and society-level power analyses to examine how economic dominance and unequal distribution of resources are creating barriers to the empowerment process (Brown and Tandon 1983). Systems and ecological theories require a similar analysis of larger systems and their social structure to determine who benefits from maintaining existing power disparities and what specific aspects of the system’s process block avenues to empowerment. These theories emphasize the importance of examining multiple sources of empowerment and disempowerment in the ecological environment in order to understand these dynamic, interactional processes.

Empowerment as a Practice or Research Strategy

A number of authors have defined empowerment as a strategy in education, community development, and other fields, either as a method of

service delivery or as a method for studying the empowerment process. Freire's (1970) seminal definition of empowerment involves the combined strategies of research (investigation of structural sources of problems), education (transfer of knowledge about political and advocacy strategies for addressing those sources), and social action (alleviating oppressive conditions in order to increase economic and political power). Wallerstein and Bernstein (1988) adapt and expand Freire's definition by developing specific ways to structure the problem, posing dialogue about key issues among the participants during the education phase. Their strategy validates and highlights common disempowerment experiences and "moves discussion from the personal to the social analysis and action level" (383).

More comprehensive definitions of empowerment as a practice strategy have been provided by helping professionals, including one by Solomon (1987): "A method by which helping professionals attempt to deal with the power blocks experienced by negatively valued individuals and families" (80). Gutiérrez (1990) defines empowerment as a strategy for increasing self-efficacy, developing group consciousness, reducing self-blame, and assuming personal responsibility. Gitterman's (1994) definition includes helpers in the target of change: "Empowerment practice is viewed as the process and outcome of social work practitioners, supervisors, and administrators helping clients and staff to increase their personal, interpersonal, and political power so that they can gain greater respective control and influence in their personal and professional lives" (personal correspondence 1994).

Other authors have developed comprehensive practical guidelines that help to define and clarify empowerment as a practice strategy (Lee 1994; Mattaini and Kirk 1991; Pinderhughes 1989; Gutiérrez 1990; Geetz 1983). For instance, Simon (1994) identifies nine guidelines for social work practice within an empowerment mode: 1) Shape programs in response to the expressed preferences and demonstrated needs of clients and community members; 2) Make certain that programs and services are maximally convenient for and accessible to one's clients and their communities; 3) Ask as much from one's clients as from oneself; 4) Call and build upon the strengths of clients and communities; 5) Devise and revise interventions in response to the unique configuration of requests, issues, and needs that a client or client group presents. Resist becoming wedded to a favored intervention method; 6) Make leadership development a constant priority of practice and policy development; 7) Be patient, since empowerment takes substantial amounts of time and continuity of effort; 8) Take ongoing

stock of social workers' own powerlessness and power at work; and 9) Use "local knowledge" to contribute to the general good (30). These definitions of empowerment as a practice strategy, including social justice issues, are consistent with the process definitions in the previous section because they focus on multilevel environmental factors that affect people's power (Lee 1994; Simon 1995).

Another set of interesting definitions are focused on empowerment as a research strategy or method. For instance, Yeich and Levine (1992) define participatory research as a strategy for involving oppressed people in the study of and solutions to social problems in order to empower them. This method is assumed to result in empowerment because it recognizes and supports the ordinary knowledge of people as valid and useful, in contrast to other research methods, which lead to the monopolization of knowledge by experts (the powerful few) (Brown and Tandon 1983). Rapp, Shera, and Kisthardt (1993) define empowerment research as that which amplifies "the voice of the consumer by attending to the context of research, the vantage point, the process of formulating research questions, the selection of interventions to be tested, the selection of outcomes and measures, and the dissemination of research results" (727).

Other definitions emphasize the building of partnerships in which community members work directly with researchers throughout the research and community action process. Consumer participation, rather than simple involvement, begins during the initial planning and conceptualization phase and continues through data collection, analysis, and interpretation and dissemination and application of results (Minkler and Roe 1993; Minkler 1994; Woodhouse and Livingood 1991; Turnbull and Friesen 1998). Finally, Yeich and Levine (1992) note that an empowerment research strategy is one that provides an examination and understanding of empowerment in action.

Conceptually, what Dunst et al. (1992) call promotion theories are most consistent with definitions of empowerment as a practice or research strategy. These theories have a mastery and optimization orientation that supports capacity building, self-sufficiency, resiliency, strengths, proactive rather than reactive coping patterns by individuals and groups, and social action and systems change. Although authors such as Dunst et al. (1992) and Cowen (1985) distinguish between promotion and paternalistic theories in terms of empowerment, they have not identified the former theories more specifically.

Empowerment as an Outcome

Definitions of empowerment as an outcome focus on various knowledge areas and skills that are strengthened as a result of enabling opportunities. For instance, Bandura (1986) refers to empowerment as an array of observable behavioral abilities that lead to a sense of control. Many authors have identified some of these abilities and qualities in their definitions: a sense of efficacy, a sense of community, flexibility, critical awareness, collective action and responsibility, initiation of network resource exchanges, knowledge about and skills in conducting power analyses, an enhanced cultural/ethnic identity, and competence (Dunst, Trivette, Gordon, and Pletcher 1989; Gutiérrez 1990; Lewis and Ford 1991; Simon 1995; Thomas and Velthouse 1990; Whitmore and Kerans 1988; Yeich and Levine 1992).

In spite of the range of empowerment outcomes that has been identified, the literature in this area lacks specificity in describing or operationalizing behaviors that indicate empowerment. For example, many authors fail to define what they mean by “competence,” “mastery,” and “social action skills.” Some authors have concluded that this gap is not surprising since manifestation of empowerment outcomes varies across different people and different social contexts as well as in the same person over time (Dunst et al. 1992; Rappaport 1984; Zimmerman 1990).

Social learning, group, and social support theories provide a conceptual basis for definitions of empowerment as an outcome. Social learning theory explains how environmental stimuli help individuals to gain control over situations and develop observable behaviors and skills that are evidence of empowerment outcomes (Bandura 1986). Group and social support theories assume that group process can encourage the group consciousness raising and cohesion that lead to collective empowerment (Freeman, Logan, and Gowdy 1992) and that mutual help activities and a sense of community are indicators of empowered social support networks (Germain and Gitterman 1996; Lewis and Ford 1991).

Summary of Efforts to Define Empowerment

What can be concluded from this analysis of empowerment definitions and theory? First, very little of the literature addresses addiction problems or service delivery in that area. The substance abuse field has traditionally

used encounter and confrontational practice approaches and cognitively oriented prevention approaches. This emphasis on deficit models and education may have delayed exploration of more consumer-oriented, empowerment approaches. Miller (1994) believes that many authors mistakenly assume these newer approaches might reinforce the denial and resistance that substance abusers typically exhibit before and during early phases of rehabilitation and prevention.

What then is the focus of this empowerment literature? Most of it addresses the fields of public education, health education, community development, health care and allied health professions, family and child welfare, mental health, and action or stakeholder research. Many different vulnerable populations have been discussed, including women, the aged, the poor, people of color, children and youths, those with chronic or acute health problems, and those with disabilities (e.g., chronic mental illness).

There is much disagreement in the literature about how empowerment should be defined and conceptualized. Some of the definitions conflict by focusing only on personal aspects of empowerment rather than multiple factors, including the environment. Other conflicts seem to result from authors emphasizing one part of the empowerment paradigm, such as outcomes, rather than viewing the construct more holistically. Recently, some authors have taken a more integrated perspective, making it possible to combine key factors from the different definitions in the previous section (Zimmerman 1990; Rappaport and Hess 1984). For example, Dunst, Trivette, and LaPointe (1992) define empowerment in terms of six interrelated aspects: philosophy, paradigm, process, partnership, performance, and perception.

With this type of integrated approach, empowerment can be defined as a lifelong, dynamic process that involves certain power-sharing qualities of systems, practice or research strategies, beliefs and values, and outcomes that provide opportunities for individual or collective control over personal, interpersonal, and political aspects of life situations (Freeman 1995). Such a definition focuses simultaneously on process, conditions or strategies that influence the process, beliefs about the process, collaborative relationships and collective action, and the outcomes or observable indicators of empowerment or disempowerment.

Theoretically, more integrated approaches to the concept can provide “a unified framework for defining the meaning and key elements of empowerment” (Dunst et al. 1992:111), including developmental, systems, orga-

nizational, community development, and cross-cultural theories. However, developing more clarity and consensus about the definition of empowerment and some of its theoretical implications is only one step in the right direction. Equally important is researchers' documentation of individual empowerment and disempowerment experiences under empirical conditions, along with factors that influence those events.

Empowerment and Disempowerment Research

Overview of Current Research

The discussion in the previous section helped to clarify what "empowerment" means theoretically and conceptually (how it is defined), while the discussion in this section describes how the concept has been operationalized in research (how it works under certain empirical conditions). A combination of interacting factors is assumed to influence empowerment and disempowerment experiences in service delivery. Some factors are related to the individual (previous mastery experiences), interpersonal relationships or systems (availability of recovering or abstinent social support networks), and social systems (policies that support community self-sufficiency or program factors that require active consumer involvement).

Research is beginning to document program factors in substance abuse services that can influence empowerment processes and outcomes, although such information is still very sparse at this time. Toubouron and Hamilton (1993) define program factors as any aspects of treatment that can be manipulated or readily altered by a program. Some examples, as documented by the research literature, are summarized across various types of programs in table 1.1. This table also contains aspects of intrapersonal, interpersonal, and social systems that may either influence empowerment or disempowerment experiences and/or be changed by these processes.

Gaps and Limitations in This Research

Most of the literature on empowerment practice documents only a few of the program factors included in table 1.1. Some factors, such as the planning and implementation of social action strategies, use of mutual support

activities, opportunities to link personal problems with community/societal conditions, and the validation of common knowledge were frequently identified across the different studies. Other studies, however, clarified unique factors that were population-specific in terms of clients' ages and stages of development, ethnicity and life circumstances, or gender, and the longevity or severity of their substance abuse problems. Overall, although the focus of research on empowerment practice with different populations includes substance abuse prevention and rehab services, most research addresses rehabilitation services and recovery. (For a more detailed, in-depth discussion of research on empowerment practice with specific population groups, see the epilogue, which summarizes that information in relation to future empowerment practice).

A Systemic Study of Empowerment Practice

Considering the limitations and gaps identified in the previous discussion of research on empowerment practice, I conducted a four-component study of substance abuse services between 1994 and 1997 focused on multiple systems that affect service delivery. The perspectives of clients and staff at different system levels were the central focus of this research since, as documented by current and past literature, their voices have been largely ignored by researchers, policy makers, and program developers in exploring empowerment practice. Their ordinary knowledge (Freire 1983) and "lived experiences" (Gulati and Guest 1990) related to abstinence or nonproblem use, problem use, and addiction and recovery are essential for operationalizing an empowerment paradigm and for validating their wisdom and strengths. Qualitative research seemed the most appropriate method for focusing on these key actors because of its attention to the unique perspectives and meanings people derive from their experiences (Jacob 1988).

This qualitative study included the following research components, each of which focused on one of four interrelated systems: 1) rehabilitation and prevention programs across the country that use empowerment methods and approaches; 2) the immediate communities in which these programs are located and the impact of their strengths, barriers, and other factors on the programs' empowerment approaches; 3) state policy and organizational variables relevant to empowerment practice in the identified programs; and 4) federal agencies' policy and funding patterns for substance abuse services

TABLE 1.1 Examples of Program Factors Related to Effective Empowerment Practice in Substance Abuse Services in the Literature
(T = treatment program; P = prevention program)

Major Themes		
Focus	Professional Services	Peer-Led Services
<i>Personal (individual clients)</i>	(T) Groups for youths are focused on ethnic and age-related issues regarding addiction and recovery (Freeman 1990)	(P) Older peer leaders are reinforced and empowered by conducting drug abuse prevention activities with younger students (Porter et al. 1986)
	(T) Individualized treatment and teaching skills of daily living are provided to homeless dually diagnosed clients and perinatal women (Blankertz and Cnaan 1994; Galanter et al. 1993)	
<i>Interpersonal (peers, family members, social networks, co-workers)</i>	(T) Reentry phase involves client preparation for assuming social roles without drugs (Toumbouron and Hamilton 1993)	(T) Peer-led orientation, counseling, and twelve-step groups are used to counter powerlessness in homeless dually diagnosed clients (Galanter et al. 1993)
	(P) Older Hispanic youths develop critical consciousness and knowledge of common powerlessness, and plan for social action to change university structure (Gutiérrez and Ortega 1991)	(T) Results from clients' analyzing mental health research literature presented to peers in regular group meetings (Pratt and Gill 1990)
		<i>Professional/Client Collaboration</i>
		(P) Youth participants provide feedback/help revise alcohol and drug programs and policies regularly (Wallerstein and Bernstein 1988)
		(T) Clients and staff determine treatment plan (initial and ongoing) (Toumbouron and Hamilton 1993)
		(T) Clients and staff participate in research study group to increase mental health knowledge and in program evaluation committee to revise service and evaluation strategies (Pratt and Gill 1990)

(T) Social supports (family members or friends) used to help addicted women seek and continue treatment (Robinson 1984)	(P) Teens use information from their interviews of adults in drug treatment and jails to design and conduct education sessions with younger peers (Malekoff 1994)	(P) Youth research and leadership skill development are the main focus of drug policy changes in a youth/social workers collaborative social action program (personal influence and program planning) (Malekoff 1994)
<i>Political (service program, community, social systems, public policy)</i>	(P) Focus on changing community norms through citizen participation in community action program targeting multiple indicators of social disorder, including drug abuse (Perkins et al. 1990)	(T) A percentage of program graduates serves on governing board to make and revise policy (Gulati and Guest 1990)
	(P) Peer-led social action activities to reduce drug abuse/trafficking and powerlessness (drug hotlines, crime stoppers, neighborhood watch projects) (Rosenbaum et al. 1989)	(P) Community members develop and conduct multiple political action strategies re drugs (mobile citizen patrols, police reports, legislative lobbying to change policies/community disorder) (Largio and Davis 1992)
	(P) Youths are taught media and policy analysis and dissemination skills that they apply in drug and alcohol town campaigns to reduce consumption/availability (policy impact) (Wallerstein and Bernstein 1988)	
	(P) Action research and political action to change or transfer power involving community members and professionals (Yeich and Levine 1992)	(P) Community members are involved in solution-focused needs assessments and program development to increase their ownership of process and reduce alcohol consumption by youths (Wheeler 1992)

that can influence empowerment practice. Table 1.2 illustrates these four components of the research and the types of substance abuse programs that were included in the study.

Research Methodology

The program, community, state, and national phases of this ethnographic qualitative study overlapped, with the initial work focused on the selected programs and their surrounding community and state environments. In this chapter, however, only the methodology and some of the findings related to the identified service programs are reported. The methodology and findings for the other three research components are included in chapters 3–5 on the general multisystem empowerment process and in chapters 13–16 on specific empowerment programs in the sample and the effects of the multi-level system on those programs. This discussion of methodology includes the research questions, the subjects and settings, the study design, research protocols and data collection, and the data analysis.

The Research Questions. A set of questions was developed to guide phases 1–3 of the study and then modified as needed to be consistent with the population/type of program under study at a given time. The questions helped to identify individuals and organizations that should be included because of their unique knowledge and perspectives about the multiple systems under study.

The common generic questions were as follows:

1. What is the typical process of rehab and prevention service delivery in the identified program, and what criteria are used for program decisions (e.g., for deciding what services are provided to clients, during what phases of helping, and consisting of what particular components)?
2. Which conditions and services (including empowerment experiences) in each program and within the surrounding community are identified by clients and staff as most important for effective recovery and prevention, and what is the basis for their identifications?
3. How are successful program outcomes defined by clients and staff

TABLE 1.2 Research on Substance Abuse Empowerment Programs

Organizational Sample (N = 17)	Organizational Subsample (N = 6)
<p><i>Research Design:</i> prospective/retrospective, qualitative, time series, organizational</p>	<p><i>New Alternatives:</i> serves ethnically diverse population of adolescents from 12 to 19 years of age, residential services; period of service from 9 to 18 months; uses positive peer culture approach, peer mentors, and clients as part of the treatment team (chapter 13)</p>
<p><i>Sampling Strategy:</i> reputational convenience sample, key informant snowball strategy</p>	<p><i>Restore and Repair:</i> serves women of color primarily along with white clients, 18 to 45 years of age, day treatment; services range from 18 to 24 months; provides gender-specific rehab services for the clients and their infants and children (chapter 14)</p>
<p><i>The Sample:</i> 12 rehabilitation and 5 prevention programs (rehab programs: 8 coed and 4 women-only; 9 adult and 3 adolescent)</p>	<p><i>Recovery Works:</i> serves dually diagnosed homeless adults (mentally ill substance abusers) from 18 to 65 years of age, integrated day treatment and outpatient services; range from 6 months to 2 years; emphasis on client-driven rehab services for this ethnically diverse client population (chapter 15)</p>
<p><i>Research Procedures and Protocols:</i> participant observation (observation data collection form); focus groups: planning and member checking (focus group topic guide); ethnographic interviews: staff and clients (semistructured interview guide); narrative inquiry (narrative sections: interview guide); review of key documents (document data collection form); stakeholder surveys (client/staff survey instruments)</p>	<p><i>Dareisa:</i> serves African American adults primarily, using an Africentric approach with clients from 18 to 75 years of age; includes cultural healing, recovery, social advocacy, and residential services ranging from 18 to 24 months (chapter 16)</p>
	<p><i>Better Life:</i> serves ethnically diverse group of adults; traditional rehab services include short-term residential and outpatient components (14 to 28 days) and a one-year aftercare phase</p>
	<p><i>Grassroots:</i> serves middle and high school youths and their families; community-centered prevention approach; parent and youth peers facilitate the eight-session program, including policy and systems change components</p>

- based on the client group's special needs (e.g., gender-oriented needs), and what is the rationale for their definitions?
4. In what ways are clients involved actively in the services provided, and what are their conclusions about these experiences? What are the effects of their involvement on how they view themselves, the services provided, and their nonuse or recovery?
 5. How do clients who complete programs successfully differ in their backgrounds and other characteristics from those who drop out prior to program completion?
 6. To what extent are the values, philosophies, and conceptual frameworks of key actors in national and state substance abuse funding agencies, community leadership roles, and in-service programs consistent with an empowerment approach?
 7. How do the values, philosophies, and conceptual frameworks of these key actors influence empowerment practice and other important service aspects in the study programs?

The Subjects and Settings. A key informant, snowball strategy was used to develop a reputational sample of programs engaged in empowerment practice (Gutiérrez et al. 1995). I used a comprehensive literature review and contacts at national, state, and local levels to identify potential key informants, then contacted those individuals to identify examples of programs that were using empowerment approaches. Using data from the key informants, I compiled a list of thirty programs to be contacted for possible inclusion in the sample. The list was reduced to seventeen based on organizational and conceptual issues identified through telephone contacts (e.g., a program was in a financial crisis and did not want to participate in the study or defined itself in terms of a conflicting paradigm). Among the seventeen remaining programs, six were identified as target programs whose clients represented certain special populations or the general population of people needing services. (Information obtained from all seventeen programs is included in some of the general discussions about empowerment practice in other sections of the book.)

Subjects were included in each of the six client samples based on convenience sampling; that is, each sample included from 50 to 100 percent of the clients being served by the identified programs at the time of the study. Clients were excluded due to absence, failure to volunteer to participate in the study, redundant themes and patterns showing in the study (indicating

that a sufficient number of clients had been sampled in a particular treatment phase), or time limitations that dictated only a certain number could be interviewed.

Table 1.2 summarizes information about the subjects and settings: the population groups served by each of the six programs and the types of programs included in the study. The treatment programs included one primarily for women of color and their drug-involved infants and children; a dual diagnosis program for an ethnically diverse group of chemically addicted, homeless, mentally ill adults; an adolescent program for an ethnically diverse population; a culturally specific program for African American adult males and females; and a traditional mainstream program serving an ethnically diverse group of adults. A community-centered, multicultural prevention program that serves youths, families, and individuals was also included in the subsample. As can be seen from this table, the age range across the samples was from thirteen to seventy-five years; participants included males and females with one exception (the women's perinatal program); participants tended to be ethnically diverse except in the women's and culturally specific programs; participants were primarily poor but also included some middle-income clients; and geographically they represented the East Coast, West Coast, South, and Midwest areas of the country. More detailed information about each sample and setting can be found in chapters 13–16, each of which is focused on one of the four programs.

The Study Design. This research involved the use of a combined retrospective and prospective time series design. Some retrospective data were collected, for example, information about how clients no longer in a program responded to treatment, experiences of current clients that influenced them to seek out and remain in treatment, and the sources of individual and collective power drawn upon by community residents to cope with or change conditions related to drug abuse and other problems. Current or prospective data were also collected, including clients' and community members' current empowerment and disempowerment experiences. The research period for each program varied from one to three weeks, with the research on the women's program also including a secondary, more in-depth substudy over several months.

Research Protocols and Data Collection Procedures. Table 1.2 includes the research protocols that were developed for the program compo-

ment of the research, as well as for the other three components: individual client interview guides and focus group guides; a critical incident direct observation form for treatment sessions, staffings, twelve-step sessions, and other meetings; and various document coding forms for analyzing the programs' written policy and procedures manuals. The fifty-item client and forty-item staff interview guides were organized into a semistructured format and included items about factors that influence treatment and prevention effectiveness, clients' and community members' involvement in the service process, and detailed information about clients' empowerment and disempowerment experiences related to alcohol/drug use or nonuse and addiction/recovery.

Therefore, a combination of data collection procedures was utilized in each setting, including: relevant written treatment or prevention policy, procedures, and program description materials; selected closed records for the past year representing each program's successful and unsuccessful cases/experiences; direct observation of client treatment/prevention sessions and other key events; and ethnographic interviews and focus groups with clients and staff. The interviews and focus groups were audiotaped. Directly observed sessions and events were recorded on the observation forms as soon as possible afterward. The written program materials were coded onto forms developed for that purpose during the actual process of reviewing each document.

Data Analysis Procedures. Written transcriptions of the taped interviews and focus groups as well as the forms for direct observations and written program materials were reviewed informally to identify common and unique themes and patterns for each data set. This information was used to develop separate data coding forms for each of the four data sets (interviews, focus groups, observed events, and written materials). The forms were pilot tested by using them to code several items for each data set (e.g., five written transcripts of individual interviews were coded by the researcher and a research assistant independently). Each of the four forms was revised based on feedback from the pilot testing process.

Then the information from each data set was coded onto the forms and was subsequently analyzed in terms of major themes/patterns unique to each data set and program and those common to all. Inter-rater reliability was achieved by randomly selecting items from each data set (e.g., four written transcriptions of focus groups) and having a third person who was not in-

volved in the research code those items. Comparisons were made between the interviews coded by the researcher or the research assistant and the same ones coded by the third person. The discussions and eventual agreement among the three coders on items used for reliability helped to improve the overall consistency and clarity of the coding process. The themes and patterns across data sets and programs are reported in the next section, highlighting program factors that were identified as key influences on the process and outcomes of substance abuse empowerment practice in the six programs.

Study Findings and Discussion

As noted previously, although this study focused on the seven research questions listed on page 00, the findings reported in this section focus more narrowly on program factors relevant to empowerment practice (questions 1–4). Data related to these four questions are reported utilizing Gutiérrez and Ortega's (1990) tri-level empowerment paradigm consisting of personal, interpersonal, and political aspects of power.

Personal Power in Rehab and Prevention Services. The findings are consistent with Gutiérrez and Ortega's (1990) assumption that having power at this level is a foundation for the availability and use of power at the other two levels. The focus of the present research on substance abuse treatment and prevention has, however, helped to clarify more of the complexities involved in attaining personal power. The sources of personal power for the clients in this study were strongly integrated into the structure of the programs, allowing staff to serve as the arteries through which empowerment opportunities flowed and were implemented. Table 1.3 illustrates examples of empowerment-related program structures or factors that can be compared with the examples of similar factors identified in the literature and summarized in table 1.1.

The main themes or sources of personal power across the six study programs were professional, peer-led, and staff-client collaborative supports. These same three sources of power were used to organize data from the literature summarized in table 1.1. This common organization method enhances a comparison of the literature findings and findings from my research. The examples in table 1.3 suggest that program factors for helping

TABLE 1.3 Examples of Program Factors Related to Effective Empowerment Practice in Substance Abuse Services from Freeman (1997) (T = treatment program; P = prevention program)

Focus	Professional Services	Peer-Led Services	Professional/Client Collaboration
<i>Personal (individual clients)</i>	<p>(T) Clients set own recovery goals (personal goal contract)</p> <p>(T) Client-centered, culture-specific groups re gender, age, dual diagnosis, ethnicity</p> <p>(T) Engagement phase of several weeks allows client to “try out” program and assess commitment to treatment</p> <p>(T) Clients develop and present a Heritage Book on their background/identity, sources of power by interviewing key informants</p>	<p>(T) Client expeditors or escorts help orient new clients to routines and remind old clients of appointments/treatment sessions</p>	<p>(T) Any discharge from treatment (client- or staff-initiated) requires mutual chart review of progress and a reentry plan</p> <p>(T) Clients and staff collaborate and agree on recovery treatment plan development/revisions in case staffing where staff are not viewed as the only experts</p> <p>(P) Initial planning contacts allow community members to “test” their power to disagree with professional staff or consultants in a program</p> <p>(T) Clients give feedback to other clients about their progress/lack of progress (“pull-ups”) in collaboration with staff to shift those who are stuck at certain points in recovery</p>
<i>Interpersonal (peers, family members, social networks, co-workers)</i>	<p>(T) Family groups can involve anyone the client identifies as in a “family” relationship</p> <p>(T) Client amnesty meeting can be called by staff to allow clients to reveal their mistakes and negative risks and discuss the impact on peers’ recovery without censure</p>	<p>(T) Client buddy system, positive telephone-calling network, graduates mentor current clients, current clients write/call recent graduates to support their recovery</p> <p>(T) Daily peer counseling groups, periodic peer-led phase meetings to determine if individual clients have met criteria for next phase</p>	

<p>(T) Clients are involved in supported work outside the program during later phases of treatment or on in-program work crews involving collaboration/cooperation</p>	<p>(P) Community members develop informal self-help groups relevant to drug abuse prevention, e.g., parents of children killed by gang violence, Tough Love</p>	<p>(T) Family members and staff collaborate in confronting clients who deny treatment is needed, is working, or requires more effort on their part</p>
<p>(T) Individual/family/group treatment revised every four months to accommodate clients' phases of recovery/special needs/interests (client-accepted treatment)</p>	<p>(P) Peer-directed coalitions are formed among community residents to reduce alcohol and drug availability and accessibility (liquor stores, drug houses, billboards)</p>	<p>(P) Clients and community members are represented on program advisory board</p>
<p>(T) Regular community meetings are held to ask clients what is working or not and address new issues, unresolved issues, needed changes</p>	<p>(T) Clients participate in peer-determined social action/environmental impact activities related to drug abuse and other social risk indicators while in treatment (housing inadequacies, violence, transportation problems)</p>	<p>(P) Youths help plan and implement prevention activities: conferences, education sessions, program evaluation, task forces on demand reduction</p>
<p>(T) Clients are expected to do volunteer work to improve some aspect of the community in later phases of treatment (step work)</p>	<p>(P) Trained community leaders teach substance abuse social action/prevention skills to other community members (proposal writing, program evaluation, policy analysis and reform, systems change, community mobilization)</p>	
<p>(T) Staff complete a specific reunification plan, including client tasks and advocacy strategies for impacting the court and protective service systems, when client's children have been removed prior to/during drug treatment</p>		
<p>(P) Alcohol and drug seminars are provided for community members in various stages of recovery to prevent relapse</p>		

Political (service programs, community, social systems, public policy)

an individual to “become a client” can often lead to initial empowerment experiences in treatment (e.g., “Professional Services/ Personal Focus”: “Engagement phase of several weeks allows client to ‘try out’ program and assess commitment to treatment.”). These types of events are empowering because, as noted by many respondents, they mark a discernible transition in the individual’s status from observer to client in a treatment program, or the point at which some of the initial game-playing ends. A similar transition sometimes occurs in prevention programs that require consensus between community residents and staff or consultants as part of an initial commitment to the work (see table 1.3, “Professional/Client Collaboration: Personal Focus”).

Other themes helped to identify additional professional or staff services that influence empowerment and recovery at the personal level. Those themes included clients’ input being solicited and considered (having clients develop personal goal contracts), and being regarded as unique and special (providing client-centered treatment or prevention services or having clients interview significant others about their unique cultural/ethnic backgrounds). The focus on uniqueness emphasizes that the individual is of value and thus brings something valuable to the service process. The process of discovering the uniqueness is empowering because it is acknowledged by the client and contributes to a staff-client bond when both integrate the discovery/empowerment process as a shared experience. Chandler (1992) notes that these activities convey trust, respect, and recognition of the individual’s value through interaction.

Themes related to peer-led services and staff-client collaboration at the personal level were also evident in the findings. Being viewed as responsible (escorting other clients or doing program maintenance tasks) and collaborating in decision making (mutually developing and revising the treatment plan in an open meeting involving all staff) are also consistent with Chandler’s (1992) findings about empowerment in the health field. The theme of collaborative tasks was identified as more important to empowerment because these tasks provide a “public” venue for recognizing the value of the client. In contrast, respondents indicated professional service themes relate more to “private” acts of empowerment, for example, developing a personal goal contract at the direction of the primary counselor.

In addition, collaborative tasks demonstrate the staff’s commitment to support mutual decisions about each client’s treatment or the use of a certain prevention strategy, even if they do not fully agree with those decisions.

Another example of this theme is when discharge is not an automatic consequence if a client relapses. In some programs, a meeting is held with the client to mutually determine the reasons or conditions that led to the relapse, the consequences, and what should be done about it. Some programs require clients who want to leave against medical advice to petition for a meeting where they present their request to leave and the reasons, negotiating/collaborating with staff on whether and the conditions under which they should leave. Other programs require the client and his or her primary counselor to complete a mutual chart review of the client's progress and develop a reentry plan for when and under what circumstances the client will be ready to return for services (See table 1.3, "Professional/Client Collaboration: Personal Focus.") The common aspect of these themes is the client's active involvement in decision making as an empowerment strategy. This involvement counteracts his or her previous denial and/or avoidance of issues needing to be addressed during the addiction or the inability of community members to control drug activities in their communities. Those denial and avoidance reactions were identified by respondents as a major source of their feelings of shame and guilt (their disempowerment).

Interpersonal Power and Substance Abuse Services. As noted by Gutiérrez and Ortega (1990), sources for this level of power are related to clients' abilities to influence others. My findings regarding this theme indicate that empowerment during treatment and prevention develops from opportunities for discovering and using that power. With professional support, the focus is on helping clients to develop a family or community. Empowerment occurs from defining who the family consists of, who should participate in treatment or prevention, and the interdependence between self and other community members or other clients in recovery (for example, see table 1.3, "Professional Services: Interpersonal Focus," i.e., amnesty meetings). The peer-led theme of interpersonal power includes program factors that allow clients to assume leadership roles in facilitating the recovery of other clients (leading peer counseling groups) or conducting prevention activities with other community members (developing and leading a self-help or mutual-support group).

In contrast, the professional/client collaborative theme refers to clients and staff working together to provide needed feedback to other clients. Respondents noted that a type of reciprocal empowerment occurs for the targets of the feedback, during an intervention, for example. Those in denial about

the need for treatment or those who are “stuck” in a certain phase of recovery, as well as family members or other clients who provide the feedback, may experience empowerment during interventions. Again, study participants concluded that it is the public venue made possible by the collaboration that leads to a greater sense of group efficacy and empowerment.

Substance Abuse Services and Political Power. The most recurring and important overall theme related to this level of power was the respondents’ ability to change the service delivery system. This common theme was evident for prevention *and* treatment services, as seen in examples included in table 1.3, for instance, keeping flexible and modifying client-determined treatment and clients/community members’ service on prevention program policy boards. In comparison, the examples of political power from the literature primarily focused on prevention programs (see table 1.1). Themes related to political sources of power in the current research, however, involved other large systems as well as the respondents’ substance abuse programs.

For instance, the professional support theme tended to emphasize the efficacy of impacting particular systems such as protective services or the courts when addiction has led to out-of-home placements for a client’s children. Another source of power is integrating formal treatment with twelve-step work, i.e., helping to improve some aspect of community life by doing community service (the atonement or giving back step) (see table 1.3, “Professional Services: Political Focus”). On the other hand, the peer-led and professional-client collaboration themes identified multiple sources of political power and collective empowerment, including more dramatic and radical transfers of power than the professional support theme, according to study respondents (see table 1.3, “Peer-Led Services and Professional/Client Collaboration: Political Focus”). Overall, the findings from this research provide a useful set of implications, or a framework, for analyzing empowerment practice across various substance abuse programs.

An Empowerment-Oriented Conceptual Framework

Table 1.4 illustrates some of the implications of empowerment practice that have been inferred from the previous literature review and from the author’s research findings in the preceding section. These implications have

been organized into a framework for analyzing and understanding practice with different populations of nondrug users, nonproblem users, and addicted individuals. The discussion includes the sources or levels of empowerment and the types of theories that are consistent with these levels, and three categories of empowerment programs that apply to different aspects of this paradigm.

Empowerment Levels and Relevant Theories

The levels of empowerment listed in table 1.4 indicate how power at each level is interrelated with the other levels, consistent with Gutiérrez and Ortega's (1990) assumptions and my research findings. Conceptually, those findings showed that within each power level, the degree of reciprocity and public observation of empowerment experiences increases in the shift from professional to peer-led to professional/client collaborative supports. This finding implies that a balance may be needed at each empowerment level based on the stage of treatment/prevention involved, a client's past power-related strengths or deficits, and current issues.

Gutiérrez and Ortega (1990) imply that at the personal level, the client develops an understanding of his or her disempowerment experiences in terms of social conditions without necessarily taking any action. But my findings indicated that across all three empowerment levels, empowerment of the study participants required lesser to greater degrees of action (from the personal to the political levels) leading to change from the individual to the collective level. Possibly, addicted individuals and community members who have lost control of their communities to drugs have become so disempowered that some form of direct action is necessary for them to become empowered, even at the personal level (see table 1.3).

The types of theories that support this view of empowerment, therefore, are those that assume a close interdependence between the individual and the environment. This is important, conceptually and in practice, because consumers who are served by substance abuse programs need multiple sources of power from various parts of the ecological system (Germain and Gitterman 1980; Freeman and O'Dell 1993). At the same time, these different parts of the system may involve barriers to empowerment and recovery or prevention that need to be addressed at the personal, interpersonal, and political levels. Examples of relevant theories in table 1.4 include cognitive

TABLE 1.4 Conceptual Framework: Empowerment Practice in Substance Abuse Programs

Empowerment Levels	Definition of Empowerment	Relevant Theories/Domains	Three Types of Empowerment Programs		
			Empowering	Microcosm	Empowered
Personal Level (foundation for other levels)	Development of individual feelings of personal power and self-efficacy	Psychological or personal change (critical consciousness) Ego psychology and cognitive-behavioral theory	Program factors help to construct new social reality of self as powerful and capable recovering person through individualized treatment, resocialization, accepting/giving feedback from/to peers, personal inventory activities, step work, obtaining basic resources and a social network	Program factors exist for clients selecting own work assignments, engagement phase, culture-specific treatment with client input	Program factors exist for involvement within program and community by individual clients (e.g., feedback to staff about program barriers and supports and involvement in self-selected community service projects)

<p><i>Interpersonal Level</i> (<i>simultaneous development of interpersonal and political skills</i>)</p>	<p>Development of skills for influencing others (e.g., problem solving, assertiveness, power analysis, social action, education) resulting in competence and a sense of group efficacy</p>	<p><i>Interpersonal/ intragroup change</i> (increasing resources for self and others) Family systems and mutual aid theories</p>	<p>Program factors help to construct new social reality of self as powerful and capable recovering person through individualized treatment, resocialization, accepting/giving feedback from/to peers, personal inventory activities, step work, obtaining basic resources and a social network</p>	<p>Program factors exist that require self-defined family involvement, peer mentoring and counseling, staff and client collaborative treatment planning, collective and structured feedback to staff</p>	<p>Program factors exist for within-program and peer-led environmental impact activities related to common issues (e.g., impacting protective services by women with children in out-of-home placements)</p>
<p><i>Political Level</i> (<i>based on achieving personal and interpersonal empowerment</i>)</p>	<p>Transfer of power between groups in society leading to a sense of collective and self-efficacy, and effective systems/structural change</p>	<p><i>Social action and social change</i> (structural and institutional change) General systems, social influence, organizational, and community development theories</p>	<p>Program factors help to construct new social reality of self as powerful and capable recovering person through individualized treatment, resocialization, accepting/giving feedback from/to peers, personal inventory activities, step work, obtaining basic resources and a social network</p>	<p>Program factors exist for transferring power from the program system to clients (e.g., for changing client-directed treatment regularly, service on program policy-making committees)</p>	<p>Program factors exist that impact or redistribute power from multiple social institutions to the clients and other community members (e.g., service by staff and clients on community planning boards, ad hoc task forces, public hearings re policies, antiviolenace campaigns, public school drug prevention sessions, community action programs)</p>

behavioral theory (personal power), mutual aid theory (interpersonal power), and systems change theory (political power), which are explored more fully in chapter 2 (Barth 1994; Freeman 1992; Freeman 1996; Hawkins and Catalano 1992).

Types of Empowerment Programs

In addition to illustrating the empowerment process using the three levels of power (and the necessary theory base), this framework helps to conceptualize the empowerment themes summarized in table 1.3 in different program categories. The substance abuse field is just beginning to explore the use of empowerment paradigms, so this framework is an initial effort to specify how they are being applied. Programs are applying empowerment concepts in at least three ways currently, and often not very explicitly, according to the literature and my research findings.

The first category includes programs that are applying the empowerment paradigm to the general process of recovery or prevention, but very narrowly. Their focus includes some aspects of the personal and interpersonal levels of empowerment, but only in terms of the professional theme area (see table 1.3). Clients are encouraged to develop a positive self-identity, to take a personal inventory and improve certain personal and interpersonal qualities important for successfully completing the program, and to give feedback to peers in these same areas based on what they have learned themselves.

Program factors such as a requirement for journaling and the use of “the hot seat” for confronting a peer about unacknowledged barriers to recovery support this process of self-reflection and growth. But there is no focus on the environment except in helping clients to procure basic tangible resources such as housing, health care, and employment or intangible resources such as a recovery support network. These programs enhance the confidence, personal competence, and empowerment of individual clients. They are what Florin and Wandersman (1990) describe as empowering organizations.

A second category of programs within this framework includes those with mechanisms that require clients to affect the service program structure and its political dynamics as part of the process of recovery or prevention. These microcosm programs tend to focus, therefore, on many aspects of the personal, interpersonal, and political levels of power within the program as well

as professional, peer-led, and collaborative supports for impacting the program (Freeman 1994). The active and respected involvement of clients makes these programs a microcosm of “the real world”; power is transferred from the system to clients (Gutiérrez and Ortega 1990) in a process of consciousness raising and collective empowerment.

Microcosm programs go beyond the individual growth and limited self-empowerment focus of empowering programs, which strengthen clients’ personal power or internal lives. Microcosm programs focus on personal empowerment as well as on collective empowerment via a systems change process within the programs, strengthening clients’ internal and external lives (Freeman 1994). By doing so, these programs fit between Florin and Wandersman’s (1990) definitions of empowering organizations and empowered organizations. Those authors define the latter as programs that influence the environment or community by helping to redistribute power and decision making ability within the community.

Thus, empowered organizations, the third category of programs within this framework, contain factors that help clients to change social systems in the larger environment external to the service program *and* the personal, interpersonal, and political environment within it. These more ecologically focused programs have a stronger concentration of politically oriented factors, social action, and environmental impact activities for changing external structural barriers. Table 1.4 has examples of these factors under “Empowered Programs: Political Level,” such as a requirement to do volunteer community service, participate in antiviolence campaigns, or help to plan and implement prevention programs (also see table 1.3 under “Political Focus”). Empowered organizations involve the same themes of professional, peer-led, and collaborative supports found in the other two types of organizations, in order to achieve the required transfer of political and social power.

Conclusion

This discussion on the strengths of empowered organizations points out the unique contribution the empowerment paradigm can make to services for special populations. The poor, women, and ethnic groups of color often experience strong barriers to their empowerment and recovery in the immediate and larger environments (Freeman 1992). Therefore, prevention and rehab programs that include an empowerment orientation can better

facilitate effective outcomes with those population groups as well as with other consumers and community members. Additional research is needed to illuminate what these individuals understand and can contribute to knowledge about what works or does not work from an empowerment perspective. Qualitative research and the use of ethnographic and narrative approaches can facilitate a collaborative and respectful client/researcher exploration of these issues (Yeich and Levine 1992).

There may be a danger, however, in assuming that an empowerment perspective is what's needed to create effective substance abuse programs. Empowerment paradigms should be only part of the response for achieving improved effectiveness, since there cannot be one answer or approach to addressing any problem. A more fruitful strategy is to explore what empowerment can add to a more holistic and ecological approach that considers multiple issues and methods with regard to program effectiveness. At best, an empowerment framework can only help to organize our thinking about the role of power issues in substance abuse rehab and prevention. And this framework can inform our attitudes about multiple sources of disempowerment as well, as a new way of thinking about how addictions develop: the focus of chapter 2 in this book.