Empowerment: Notes on Professional and Community Dimensions

Ronald Labonté
Community Health Consultant
Toronto, Ontario

Abstract

"Empowerment" figures prominently in the vocabularies of health and social service workers, their employing agencies, and government officials. The concept, however, remains somewhat murky, vacillating between politically conservative models of self-empowerment and social action models of political change. An integrating "Empowerment Continuum" is provided as a means of locating this intrapersonal-structural dialectic of empowerment within a professional practice. The Continuum is built from the collective experiences of health and social service workers in Australia and Canada. It represents an organizational imperative, that is, its five nodes of personal empowerment, small group development, community organization, coalition advocacy and political action require support and resources from organizations rather than individual professionals. Skills, issues and contradictions emanating from each of these nodes are discussed, and examples from practice provided.

Introduction

This article explores the concept of empowerment within the professional possibilities of government and community agency work. It is written specifically from the experience of public health work.[1] In the early 1970s, public health shifted from a strictly clinical practice (immunization, pre-/post-natal programs, sanitation and food inspection) to a "lifestyle" orientation (health education, social marketing). Health behavours are important determinants of illness. There have been significant changes in these behaviours, some of which can be attributed to public health endeavours. Much of this change, however, occurred among the better educated, more privileged members of Canadian society. Healthier lifestyles are lower priorities for people living in high risk conditions such as poverty, unemployment or low-paying, oppressive jobs. Moreover, the individualistic nature of health campaigns and education programs tended to "victim-blame" both directly in their content (e.g., "There are no bad foods, only bad eating habits ...") and indirectly by their failure to recognize the social and environmental contexts in which personal behaviours exist.

By the early 1980s health thinking began another shift towards a structural analysis of disease causation and prevention. This shift followed three professional trends. First, there was frustration with the failure of the social marketing approach to reach the poorer half of Canadian society. Second, many social movements grew and matured during the late 1970s, specifically, feminism, the anti-poverty movement, the "green" movement, the union struggle for safer workplaces, and the peace movement. (Recognition of racism and ethnocultural concerns is a recent addition to this panoply of social movements.) These movements challenged narrow biomedical and individual lifestyle models of health. Third, the activist cohort of the 1960s and 1970s moved into professional jobs, bringing with them more explicitly stated concerns for social justice and environmental sustainability.

Concepts of public health and health promotion changed accordingly. Health promotion has become "the process of enabling (empowering) people to increase control over, and improve, their health," the prerequisites to which are no less than peace, shelter, education, food, income, a stable ecosystem, social justice and equity (World Health Organization, 1986).[2] The public health sector has adopted income distribution, housing, social support, environmental pollution and other "structural" issues as priority concerns. The public health sector is also attempting to operationalize (within government constraints) empowerment and community development. It is towards that end that this article is prepared.

Defining Empowerment

Empower is both a transitive and an intransitive verb. Used transitively, it means bestowing power on others. There is another use of empower, meaning "to gain or assume power" (*Compact Edition of the Oxford English Dictionary*, 1971:855)[3] Empower used in this sense is reflexive; it takes no object. Rather, the subject is the object. This is important not so much for grammar as for what we might do to further an empowering process. If we talk about "empowering" others (transitive sense) we are the ones who control the process. We are the subject of the action, defining the terms of interaction; those who are getting done to remain our objects. Subjects act; objects are acted upon.

Empowerment exists at 3 levels: intrapersonally, it is the experience of a potent sense of self, enhancing self-esteem and self-efficacy; interpersonally, it is the construction of knowledge and social analysis based

upon personal and shared experiences; and, within communities, it is the cultivation of resources and strategies for personal and socio-political gains (Health Promotion Directorate, II, 1989:10).

At the heart of empowerment is power. Power means "the ability or capacity to act or perform effectively, to exercise control" (*American Heritage Dictionary*, 1973) In day-to-day life, power exists principally in our social relationships as "asymmetrical patterns of dependency whereby one person ... becomes dependent on another in an unbalanced way" and as the "ability to define the reality of others in ways that lead them to perceive and enact relations that one desires" (Morgan, 1986:185). These attributes, the dependency of "clienthood" and the power to define other peoples' problems, permeate the work of helping professionals. Can those with power over others act in ways that are empowering to those same people? This question captures the dynamic tension between the transitive and reflexive meanings of empower.

Two Models of Empowerment

Two empowerment models reflect this ambiguity by linking processes of individual change with social change. Freire's model of "conscientisation" and his method of "popular education" (Freire, 1968) is being espoused by public health professionals as a particularly empowering form of group learning. It begins with the personal experiences of learners, builds towards a "critical consciousness" of the deeper structural levels of inequalities these experiences illustrate, and promotes collective action as an outcome of a process of reflection action further reflection.

There are problems in directly translating Freire's ideas to a North American context. The more universally experienced oppression of many Latin Americans makes identification and action fairly simple to articulate. This is not necessarily the case in North America, where the exercise of power is more multiple, hidden and subtle, and where individualism and classlessness remain dominant cultural myths. Popular education in North America, rather than immediately building towards collective action, offers instead the opportunity for relatively alienated "individuals" to redevelop a sense of collectivity. This sense of collectivity, in turn, is viewed as an essential step in the re-creation of communal values.

Lerner offers a second model of empowerment, based upon his concept of "surplus powerlessness." Surplus powerlessness is the process by which,

> ... people make themselves more powerless than they need to be. The way people interpret their own real powerlessness helps create a surplus powerlessness so that they don't even engage in activities that meet their real needs. (Lerner, 1986)[4]

The task of the facilitator/community organizer is to pierce this "false consciousness" through a structured group-learning process which, fully developed, becomes what Lerner calls "compassion groups."

Lerner tested his ideas with groups of industrial workers in California who were experiencing extreme stress due to disempowering aspects of their jobs. He developed a group training program that combined elements of personal growth and development, knowledge about stress, and a critical analysis of the blatant and more insidious elements of dominance and powerlessness that exist in most jobs. Because these sessions were organized through unions, the potential to redress some of the structural conditions of powerlessness existed. Lerner, however, was more interested in determining if the very process of sharing experiences, developing a critical analysis and learning how to give and receive support, would independently remove the "surplus" powerlessness of internalized self-blame. Although the trial was fairly small, Lerner demonstrated that such groups not only lowered self-blame while increasing perceived power; they also improved social support, lowered depression and apathy, improved perceived health, and decreased absenteeism.

The role of the professional in these two models embodies empowering transitively (doing something for the group) and intrasitively (ensuring that the process allows participants to discover and exercise their own power). Both of these models, and particularly Lerner's, posit that social change requires interpersonal as well as collective strategies. Developing empathic skills through small group processes immediately benefits the well-being of participants, and may be a necessary step in building stronger collectivities amongst the relatively powerless so that effective political actions can be undertaken.

Empowerment and Professionalism

To the extent that professionalism represents control over people (creating "clienthood") and problem definition and solution (shaping the reality of others); and to the extent that it reinforces an institutional *status quo* to protect professional privilege, it disempowers others. This has led to a climate of "anti-professionalism," and not simply amongst those in the community with whom we work. There is an ironic antipathy towards "professionalism" expressed by many professionals themselves as if, in recognizing the disempowering elements of professionalism, they try to shun their own identities and become "professional anti-professionalists." We need to separate what is wrong with professionalism from the notion of being a professional. Our tendency

to deny or simplistically to critique our professional selves represents an internalization of negative stereotypes no less disempowering to us than agist, sexist, racist and classist stereotypes may be to those with whom we work. It is how we create a surplus powerlessness for ourselves.

We must actively deconstruct the barriers between "them" in the community at large as the recipients of our largesse, and "us" as professional elites or the managers of social change. This cleavage creates an artificial divide between the narrower concerns we might have in relating to the specifics of our work, and the larger concerns over social equity, social decency and a sustainable environment that we experience when we return home from work.

Table 1
Criterial for Empowerment

- improved status, self-esteem and cultural identity
- the ability to reflect critically and solve problems
- the ability to make choices
- increased access to resources
- increased collective bargaining power
- the legitimation of people's demands by officials
- self-discipline and the ability to work with others

Source: Adapted from S. Kindervatter, *Nonformal education as an empowering process*, Centre for International Education, 1979.

Preface to an Empowering Practice

Table 1 identifies some of the things one might expect to see if individuals or groups experience empowerment.

An empowering practice supports individuals and community actions that realize these criteria. Such a practice embraces the professional (personal), organizational (interpersonal) and community levels of interaction, that is, empowerment is not something that happens only "out there." We often espouse an organizational rhetoric of community empowerment while treating our own "community" of professionals in very disempowering ways. How can we expect to be involved with individuals and community groups in their empowerment if we are denied that opportunity ourselves? Thus, the criteria for empowerment exist as much for professionals as for the communities and individuals with whom they work. Table 2 provides a simple matrix of the key dynamics of empowerment by level and locus.

Table 2
Empowerment by Level and Locus

Empowerment	Professional	Organizational	Community
Intrapersonal	work choices	workplace democracy	overcoming isolation, surplus powerlessness
Interpersonal	peer/social support	team-building	community organizing
Community	deconstruction "them/us"	support, resources to community organizing	coalition-building

An empowering practice begins with an assessment of the capacities of the professional, organization, and community levels to undertake actions around power and its distribution and exercise.

Professionals assess their ability to function within a professional practice which assumes a critical analysis of the social distribution of power. This implies a willingness and a capacity to work with community groups on issues deemed important by those groups, in other words, a community development orientation to programs and services.

Organizations must be prepared to support their workers in developing an empowering practice. This requires a willingness to take risks (an empowering practice is intrinsically more politicized and advocacy-oriented than most conventional approaches to direct service) and to re-define job descriptions for agency workers. Most helping professionals have mandated responsibilities that do not relate, and may even be antithetical, to client empowerment. This is particularly so for middle-managers in bureaucratic organizations, who often are held accountable for ensuring that some centrally or abstractly defined "goal" is achieved through a series of complex rules and regulations, while having little actual authority over the interpretation in which workers work and communities function. They experience the dissonance between the hierarchical, rational, positivist form of bureaucracy, and the heterarchal, ambiguous and interactive reality of organizations within, and as part of, a larger social environment.

Communities are complex networks of social interaction. Communities are not always healthy or empowering in their organization or interaction, and have been unduly idealized by many professionals

frustrated by the disempowering "power over" tendencies of bureaucracies. Nonetheless, an empowering practice rests upon a principle of community self-determination of problems and solutions. This immediately challenges professionals and their organizations to assess which community problems they feel are worthy of assisting, which community solutions they feel capable of assisting, and with which community groups they feel comfortable working (Health Promotion Directorate, II, 1989).

The Empowerment Continuum

A useful way to model professional, organizational and community activities into an empowering practice is a continuum (Table 3) (*Health Promotion Directorate,* II, 1989).[5]

No one helping professional necessarily possesses the skills or time to work at each of the five nodes. Rather, the continuum represents an imperative for community agencies as a whole.

Table 3
An Empowerment Continuum

personal empowerment	small group development	community organization	coalition advocacy	political action

Personal Empowerment

This node on the continuum is the locus of direct service. An empowering practice challenges us to think about our own role not so much as service providers (doing unto others) but as resources essentially allowing people to do unto themselves. This represents a shift in our notion of empower from its transitive meaning (power we give up so that others can take it) to empower as something persons can only do for themselves. A resource is something that is used by a subject; a service is something that is delivered to an object. An empowering practice requires that we begin viewing "clients" as fellow community members, as subjects capable of, and responsible for, their own empowerment.

But we must also be wary of the risks of empowerment jingoism, which may throw the baby out with the bathwater (e.g., voluntary self-help supplanting state-provided professional services) or unintentionally denigrate our own community of helping professionals and reinforce the "them/us" polarity. For example, there is an unhealthy tension in many community health agencies between direct-service delivery and health promotion. The latter, focusing on groups and communities, is considered more "empowering" than the former, which is "medical," "band-aid," or too "professional." Community development is counterposed to case-management; community workers segregate from service providers.

Yet services can be very empowering, and powerless communities often first organize around the lack of services, or around more democratic and humanistic forms of delivering them.[6] The two pillars that allow service delivery to be empowering are, first, that they are offered in a non-judgmental or non-controlling way (empower in its transitive sense of sharing power) and, second, that they are not the limit of the services and resources offered by the agency (that is, resources are available for self-empowerment).

The combination of these two has been referred to as "developmental casework" (Jackson, *et.al.,* 1988). In contrast to more traditional forms of case-management,

> "developmental casework has the explicit goal the development (empowerment) of the individual receiving the support, and the creation of links between these individuals."

This approach builds towards community organizing, coalition advocacy and political action while recognizing

> "that low income people have the right, here and now, to support in the face of difficulties ... and that our credibility in working with disempowered groups rests to a large extent on whether or not these groups find community workers to be of practical usefulness."

Unless we become comfortable thinking simultaneously in both personal and structural ways, we risk losing sight of the simultaneous reality of both. If we focus only on the individual, and only on crisis management or service delivery, we risk "privatizing" (rendering personal) the social and economic underpinnings to poverty and powerlessness. But if we only focus on the structural issues, we mystify the plight of the powerless and people in crisis.

Creating a developmental casework is not a simple process. Much of our work (particularly that of statutory welfare) embodies the legacy of "lesser eligibility," that there are deserving and undeserving poor (Social Assistance Review Committee, 1988:70-76). This leads to the classic stigma of undeservedness that increases welfare recipients' disempowerment and, as the Ontario Child Health study found, their risk of physical and psychological stress relative to equally low-income working ("deserved") poor (Offord, *et.al.,* 1987). More importantly, the structure of mandated programs and services, coupled in the welfare sector with continued discretionary powers over

determination of eligibility, forces many helping professionals into a "power over" role that reinforces this hierarchy of deservedness.

This was graphically captured in workshops with community health and social service workers on the topic of poverty and health, conducted in Toronto in the mid-1980s by the city's health department (Labonté, 1986:341-351). Many participants drew pictures of themselves with eyes half-shut and ears half-closed to the minor problems and reportable "violations" they encountered. They realized that these stemmed not from an intent to abuse the system, so much as from the necessity to survive. Workshop participants struggled to keep themselves "blind" to what they saw, to avoid their own role conflict between helping and controlling.

This struggle represents a major source of professional disempowerment. The extent to which we persist in holding power over our "clients" may also reflect our own feelings of relative powerlessness within our jobs or our organization. This underscores the need for agencies to embrace a range of empowering strategies, as much for those who work in the agency as for those whom the agency putatively services.

Small Group Development

The first objective of developmental casework is to overcome isolation and the surplus powerlessness it creates by providing opportunities for individuals to come together in groups. (This applies to professional empowerment as much as it does to those with whom professionals work.) Isolation and its corollary of self-blame are potent killers. People who are isolated, who lack social networks and support, have over twice the risk of dying at any adult age, independent of any other risk factor that we know could cause death (*Health Promotion Directorate*, I, 1988).

Self-help groups, therapy groups, educational groups and informal social support networks are all aspects of small group development. Self-help and therapy groups differ because the former are able to define their own objectives and the role of the helping professional. Informal social support networks usually exist for the intuitively experienced rewards of support, esteem, reflected love and other attributes of "belonging" now being copiously documented in the social support literature. Experience in small group development indicates that many people who come together for educational or self-help reasons often continue to meet and network well beyond the "course" time-lines for the experienced rewards of group participation. Of particular importance are skills related to making the transition from agency-sponsored to self-help groups, which requires that the role of the professional shift from that of group facilitator/leader to that of group resource. This is the first point at which an agency will have to deal with its own inherent drive to "manage" programs and projects. An agency-sponsored education group can be managed, but not a self-help group.

This transition is not easy. A study of empowerment among small groups of poor women found that professional led groups were less successful in transferring authority to group members and enhancing the perceived and actual power of group participants (Killian, 1989:117-122). Professionals had more difficulty freeing themselves from a directive, pedagogic approach, and often continued to refer to group members as "clients" incapable of assuming responsibility for the projects' endeavours. This is a reflection of both the ingrained "them/us" mentality and the bureaucratic imperative to manage or control a social change process.

Small groups, of course, are often fraught with their own internal issues of power and cohesion. When issues become difficult or painful, or when conflict arises, many groups try to "organize" their way out of the pain, becoming what Peck describes as a "pseudo-community" or pseudo-group" (Peck, 1987:104). Rather than focus on "community-building" (allowing participants an opportunity to experience the development of a group identity through the sometimes painful and deliberate process of conflict resolution) groups move too swiftly to problem-solving, but our participation in, and facilitation of, small groups must look as well to how we deal with interpersonal power and community-building within the group if the group is to deal effectively with the conflict and position-taking that characterizes empowerment within communities.

In the support we give to small group development we must also recognize the tension between intrapersonal empowerment needs, and empowerment as a process of changing oppressive socio-economic conditions. For example, in the early years of a project in which sole support mothers organized around poverty and food access issues, the organizing group was split on the importance of a community garden it had created.[7] Some saw it as a metaphor, an organizing point for sole support mothers who, as their group strength grew, would be better able to do the "important" work of protest and lobbying for social assistance reform. Others saw the garden as the end in itself; empowerment existed in the act of planting, tending and harvesting tomatoes. Clearly, empowerment exists and must be supported at both levels. Often the process of small group development or community organizing fails to recog-

nize that these two levels, the intrapersonal and the political, are not contradictory, but necessarily complementary.

What is fundamentally empowering about small groups, and particularly self-help groups, is that they normalize people's experiences of powerlessness. This simplifies living problems and develops immediate solutions. Professional led groups often "problemize" group members' experiences by locating them within their more complex institutional frame of reference. Yet, to the extent that self-help groups deal only with individuals and individual problems, the deeper structural causes of powerlessness remain as obscured and unaddressed as they often do with professional-led groups.

Social action community groups do exist. But we tend to view such groups as "special interest" rather than "self-help," the latter being bureaucratically acceptable, the former smacking of political trouble. If we are to be significant resources to empowerment within communities, we must recognize that self-help can be both "defensive" (dealing with personal problems or illnesses), and "offensive" (dealing with the social causes and context in which these problems or illnesses arise).

Moreover, many defensive self-help groups explicitly reject a social analysis of their experienced problems in an attempt to establish inclusivity. AA, by adopting a disease model of addiction, deliberately avoids conflict within the group and political issues related to individual members' life experiences. The first step of AA and other twelve step groups admits to powerlessness over (fill in the problem). Acknowledging such powerlessness may be a necessary starting point in a recovery or empowerment process, but critics of the model maintain that it is presented as a permanent aspect of individual members' reality. Not only is the social context of experience not addressed; it is actively denied.

Despite AA's phenomenal growth, specialists in dependency counselling argue that it has been no more successful in maintaining sobriety than other personal or group methods. This raises an important ethical dilemma for professionals trying to develop an empowering practice: Do they passively accept, and resource, all defensive self-help groups and accept the problem definitions and parameters set by the group and its members, or do they challenge some of these definitions in a more interactive way?[8]

Community Organization

Small group development organizes people around issues or problems that are unique to group members. Community organization organizes people around problems or issues that are larger than group members' own immediate concerns. Organizationally, support for community organizing is a tonic for the contradictions inherent in defensive self-help groups. Given the often politicized nature of community organizing, community organizing as an activity may be better undertaken by a government supported but arm's length agency or organization, than by a direct government service.[9]

Community organization as a node on the continuum also implies choice on the part of professionals and their agencies or departments over which community to work with. Except in cases of relatively isolated and small communities, the notion of the community, or even a community, is mythical. All of us belong to several commuities at the same time. Every neighbourhood or geographic entity involves dozens of communities, not all of which should be supported to accrue more power (e.g., a residents' association betraying its ignorance or prejudice by attempting to prevent a group home or affordable housing from being established in its neighbourhood). There is growing acceptance within the community health sector of an "advocacy" framework of action, explicitly recognizing that priority communities are those whose income, educational, occupational and general social class positioning place them low within the hierarchy of political and economic power (Watt and Rodmell, 1988:359-368).

While community organizing as an empowerment strategy strives for inclusivity in community-building, for agreement amongst as broad a collective of communities as possible, relatively powerless communities usually seek to change their conditions by limiting the power of other communities over them. Conflict within and between communities is a fact of life. Many relatively powerless groups only create their identity as a community in opposition to or conflict with those groups or communities that are more powerful than themselves. This dynamic has been at the base of all Alinsky-style organizing efforts, and has been successfully used to create communities from the seemingly intractable conditions of isolation and apathy (Ward, 1987:18-21). It also challenges the simplistic rhetoric of "win-win" scenarios, now overwhelming organizational and political discourse.

For example, many community workers in the health sector believe that it is necessary to create novel linkages between those who have decision-making power over what the prerequisites to health (i.e., peace, shelter, income, employment, food, a sustainable environment, and social justice) and those who lack these prerequisites.[10] In the case of affordable housing, the impetus is to provide some type of consensus-building forum in which developers,

politicians, housing advocates and the homeless or housing-poor can all meet to develop new ideas and policies to overcome the affordable housing crisis. However, rarely would the homeless and housing-poor be as conversant or self-confident in engaging in such a process as the other players, whose power, in engaging in such a process as the other players, whose power, status and prior experiences render them more comfortable in discussion and the jargon of planning and policy. It may well be that, only with the support of a community group in opposition to current developers and planners and their policies, can representatives of the homeless or housing-poor feel sufficiently powerful and empowered to participate in such a forum.

Another point we have to be careful of when talking about community organizing is to distinguish between community development and community-based programming.[11] Many helping professionals think that if they can get a group in a community to accept responsibility for a certain problem, that is community development.

For example, many health agencies have developed or are developing comprehensive smoking prevention or "heart health" programs. Central to these programs is the notion of community involvement and, ultimately, "community ownership." The task of the professional is to convince the community of the importance of the issue and, eventually, to have the community take "ownership" for the program. While this entire process is usually called community development, it is not. It is an attempt at community-based programming, taking the agenda of government to local community groups. This may be an important activity, though it does raise the spectre of using community resources primarily as free or cheaper forms of service delivery in which community participation is tokenistic, at best, and co-opted at worst.

Community development implies that problem definition flows in the opposite direction, from community groups to government, bureaucrats and local politicians. Sometimes these problems may be entirely consistent with the program agendas of government, as is the current case with community actions to stem drug abuse, particularly in lower-income housing projects. Other times the problems, and the strategy groups propose to solve them, may be quite removed from the day to day mandates of social service or health agencies.

This community development principle of community self-determination of a problem or issue, however, should not be taken as an absolute. Rather, it is a principle that only exists in critical interaction between the professional, agency and community individuals or groups. There is no such thing as an agenda-free interaction between health and social service providers and community groups. Professionals often have knowledge and experience about what works, and what doesn't; it is an abrogration of responsibility not to share this, just as it is disempowering to impose it as a truth or superior knowledge. Thus, a superficial paradox exists: community self-determination and self-definition of the problem or issue (self-government), and a professional responsibility to critically engage in that defining process (empower as a transitive, sharing experience).

This paradox resolves when we cease thinking of communities as external to our professional practice, and professionals as external to communities.

Even when agencies or departments support new community initiatives that fall outside their conventional mandate, they may unintentionally sap the political vitality of community leaders. One health educator, for example, was able to extract "permission" from her senior managers to involve local activists on a housing and health committee, but after a year little progress had been made. She had been involving community activists in her bureaucratic process of committee meetings, reports and senior management approvals, rather than assisting the activists in directly lobbying decision-makers

Professionals nonetheless can play a potent supporting role in the process of communities exercising their own power and influence. The process of policy change can be likened to a nutcracker: we on the inside create reports and data-driven analyses that essentially tell politicians and the public that, as examples, there is a crisis in affordable housing, foodbanks represent a return to private charity, and there is a shortage in care options for the elderly. These form the legitimizing "inside arm" of the nutcracker, translating community anger (conflict) into the "neutral" language of government institutions. When community groups bring these concerns to their local leaders, applying that external nutcracker arm of lobbying and participatory democracy, there is less room for decision-makers to squirm. They come full against our "inside arm" of data and analysis and, hopefully, the policy nut begins to crack. To be effective, our inside policy initiatives must be simultaneously linked with outside lobbying. Otherwise our reports gather dust, or may not reflect a constituency; conversely, lobby groups may lack inside support and so diminish their effectiveness.

Decentralized decision-making is another facet of community organizing that requires critical reflection. To many community organizers, direct

decision-making and control by community members over programs and resources is the acid test of empowerment. Local decision-making is also regarded as more efficient and effective, and a vital countervailing to the disempowering aspects of state-centralism. Decentralized decision-making does allow for programs unique to community groups and their perceived needs, but the concept must be tempered with recognition that most economic and local policy is national and transnational in nature. Local decision-making at present can only be within narrow parameters at best, and is unlikely to include substantial control over economic resources. As Lester Brown of the Worldwatch Institute commented in his 1989 State of the World report, "small may be beautiful, but it may also be insignificant" (Brown, *et.al.*, 1989). Unless we append a strong advocacy component for macro-level policy changes to our drive for decentralized decision-making and community development, we may again unwittingly "privatize" (this time rendering local) what are much broader issues, mystifying the actual exercise of political and economic power. We may also inadvertently support growing social inequities by failing to defend social programs against fiscal restraint or regressive tax reform.

In very simple terms, political power must exist at the level at which economic power exists. Until our economy decentralizes, political power must continue to have central, as well as decentralized, aspects. There is legitimate concern that current government rhetoric supporting decentralized decision-making is a fobbing off of macro-level problems onto micro-level communities, in effect, an abrogation of political responsibility by those with power.

Finally, the fact both "community" and "empowerment" have entered political and bureaucratic vocabularies devoid of any analytical framework of power renders the words almost fatuous. Community empowerment can mean whatever a particular politician or power-broker wants it to mean and, in the case of people who do hold meaningful power, their interpretation usually defends the power that they have. This is an important, if subtle, point. Our language of community has taken us away from the individualistic victim-blaming of the past two decades. Most helping professionals no longer look to personal deficits to explain the "culture of poverty." We now talk openly of the relative structural disadvantages faced by most poor individuals, families and communities. Yet unless we extend our analysis to national and international trends our romanticization of community and our moves to decentralize decision-making may cease victimizing powerless individuals only to victimize powerless communities.

Coalition Advocacy

This is why advocacy is an important adjunct to community organizing and action. Advocacy has a narrow legalistic meaning (giving someone the power to represent oneself) and a broader sense of "taking a position on an issue," that is, initiating actions in a deliberate attempt to influence the choices made by those whose relative power (public or private) renders them "decision-makers." Helping professionals have been far too reluctant to take strong, vocal positions on the broader issues of social welfare reform, housing needs or affordability, employment policies or any other concerns that may be expressed by individual clients or, more likely, by community groups of clients. This reluctance reflects fears of stepping beyond professional boundaries (the inherent limitations of accepting the label of a "discipline"), of losing professional "stature" and, more palpably, of losing one's livelihood. Yet we can no longer afford the security of professional silence.

Institutions play a powerful role in shaping and defining what is important in political discourse through the implicit and explicit statements made by the types of services they offer, and the policies they create and make public. If they do not offer support for community organizing they are implying that this is not an important issue. If they do not discuss labour market issues in conjunction with social welfare reform, they are implying that macro-level economic considerations are unimportant factors. If they fail to speak out about the contradictory role of food banks, they tacitly endorse the reprivatization of public welfare.

One of the important functions organizations can play in advocacy is endorsing or commenting upon the public policy concerns of less powerful groups. This may not be a function of the organizations themselves, but of their governing boards or councils, which usually have the political independence to make independent political comment. In this instance, organizations and professional staff can play a role in setting the policy agenda for these boards simply by identifying and bringing forward the concerns of the groups with whom they work, or by assisting the groups in directly bringing their concerns to the board or council. Professionals can aid community groups in their own advocacy (self-empowerment) by offering knowledge, analytical skills, information on how the political and bureaucratic structures function and so on.

There are numerous examples of the potency of institutional legitimation of previously fringe issues.

Over the past decade, Toronto's health board took positions on concerns ranging from herbicide spraying in Nova Scotia, dioxin emissions at the Commissioner Street incinerator and soil-lead contamination in South Riverdale, to affordable housing as a health issue, the health implications of welfare reform and the deleterious economic effect of changing federal drug patent legislation in favour of multinational drug companies. The board's position on these issues invariably started by an expressed community group concern, either through staff or directly to the board or city council, and often received significant media attention. Both the board's position and its public prominence became useful strategic items in the more politicized and longer term advocacy work of the groups concerned about the particular issues. In this sense, policy legitimation is a strategy, part of an institution's contribution to the process of social change.

It is important to distinguish between an organizaton's capacities and roles in supporting coalition advocacy (up to and including participation in a coalition) from the increasing emphasis organizations place on creating coalitions amongst themselves. Usually, institution-created coalitions are an extension of community-based programming, and reflect the desire to improve inter-organizational coordination of services, to avoid service duplication and to better integrate (for both humanistic and cost-efficiency reasons) new services. This type of coalition or coordinating function is important insofar as it may lead to better resource provision at the personal empowerment and small group development nodes of the continuum. But rarely are such organizational coalitions concerned about the deeper structures of power and powerlessness.[12] Similarly, while the existence of multiple entry points into the political decision-making process (e.g., various committees, consultations, government levels, special taskforces, etc.) can enhance the effectiveness of coalition advocacy by providing more than one means to lobby or participate, the process of community consultation now in political vogue has more to do with dissipating comunity activist energies than with creating meaningful political participation.

Unlike the blurred line between small groups and community organizations, the division between a community organization and a coalition is a sharp one. In simple terms, many small community groups identify one or more overarching community issues that are shared by a range of other groups, and collectively initiate lobbying and advocacy activities to achieve specified changes in public policy. Because coalitions usually represent a direct politicization of an issue, member groups have to learn to set aside both the complexities of their concerns, and the differences in priorities and political analyses that often exist between them.

Coalitions also represent (at least potentially) a return to empowerment at the small group level, since it will be necessary for the individual representatives of member groups to support each other in achieving the coalition's goals. (One of the limitations of many coalitions is that they often fail to undergo a process of exploring power and consensus amongst themselves in their goal-driven pursuit of the immediate issue.) Coalitions represent not only a broadening of public concern and momentun for social change, but also the level of action at which the contradiction between conflict (the Alinsky model of community organizing) and consensus (the win-win or social policy approach to community organizing) can resolve.

Consensus models of social change now predominate bureaucratic and political discourse, in conservative as well as radical circles.[13] Unfortunately, this discourse rarely distinguishes between the space/time dimensions of social change. For example, conflict in community organizing is often a necessary strategy over a brief time and/or a limited space. But as the level of change broadens to cities, provinces, nations or transnational fora, the usefulness of conflict diminishes. Similarly, longer-term solutions usually can be defined in "win-win" terms (e.g., environmental sustainability as a prerequisite to sustained economic activity) while immediate actions often engender conflict (community groups demanding stricter emission or waste disposal regulations that may cost more than a company is willing to pay). It may now be imperative that community action groups seek to move through their locality/short-term conflicts to broader/long-term consensus approaches to coalition advocacy, if they are to develop large enough popular bases (social movements) to significantly influence political decision-making at all levels.[14] This presumes that a plurality in the approaches of individual coalition members can be maintained; if all local community action groups engaged in "win'win" discussions, none would remain to directly challenge the existing power skew within our political and economic systems. Recognizing, and becoming resources to, these two vital but quite different political processes (locality conflict, coalition consensus) represents one of the most difficult aspects of an empowering professional practice.

While professionals should support advocacy in their jobs, and influence the "legitimating" (empowering) agendas of their agency's decision-making boards, their most potent personal contribu-

tion to advocacy may come through alternative vehicles. I am particularly intrigued with the policy advocacy potential of organizations of professionals, rather than organizations employing professionals. For example, the Ontario Public Health Association (OPHA), of which I am currently president, is a voluntary group of around 3,000 public and community health professionals. The OPHA is a completely independent and autonomous Association, driven by volunteer members, governed by an elected board, and advocating for public policy changes on the basis of resolutions and position papers adopted by our general membership

Over the past three years the OPHA has increased dramatically its activism in "setting the policy agenda." Our advocacy has ranged from coalition participation, briefs and deputations to various ministers and government committees and press releases to participation in public demonstrations. Of particular significance, our framing of Ontario's welfare reform debate (i.e., the recommendations of the 1987 Social Assistance Review Committee) in terms of health, and in terms of a social investment in health, was critical in gaining all party support from the province's Standing Committee on Finance and Economic Affairs. The Association also actively resists the simplicity of developing a cadre of a dozen or so knowledgeable lobbyists. While this approach may be effective in recasting public policy debates, and is used by most lobbying groups, it does not fundamentally alter power relations. Rather, a new grouping of a select few become policy brokers. The Association's intent, instead, is to use itself as an organizing, educational and advocacy venue for its entire membership, to encourage and support professionals unfamiliar with lobbying to develop and practice those skills as their democratic right. In this sense, the Association links professional empowerment with client/community empowerment.

Workers in the helping professions represent an untapped political voice that may be crucial in moving us towards more just and sustainable forms of social organization. It is we who see the human costs of current economic and political practice, we who have access to the knowledge and information on how the governing system works, and we who have a degree of professional credibility in our statements. Empowerment for professionals, then, is both recognizing and claiming the power we already hold, not "over" others, but in relation to how governments currently enact programs and policies.

To summarize the implications of the Empowerment Continuum to this point: individual case-management is an important aspect of personal empowerment. However, individual case-management (personal empowerment) must be linked with the four other major community development-related strategies. Individuals should be encouraged and provided with opportunities to participate in small groups, which help to normalize individual problems and reduce isolation and self-blame. Small groups should be encouraged and provided with opportunities to link with community organizations dealing with social and environmental conditions of inequality. Community organizations should be encouraged and provided with opportunities to build coalitions, or advocate for their concerns, up to and including political action.

Political Action: By Way of a Conclusion

The final node on the continuum represents a further political intensification of coalition advocacy, including actions that may be partisan and non-partisan, representative and participatory, strictly legal or civilly disobedient. I do not intend to comment upon the various forms of action that might fall under this broad rubric; suffice it to note that it is unlikely that professionals will engage in political action in their employed capacity. The social change imperative that inheres in the Empowerment Continuum nonetheless demands a broader professional responsibility to support political action through the community groups with which professionals work, and as community members themselves.

One of the most disempowering aspects of social or health service delivery is that its organizational demands blind us to the larger playing fields upon which our relatively small plays are made. Indeed, we often exhaust ourselves in efforts to define and put boundaries around our work, partly to remain sane and somewhat productive in our jobs, and partly to retain what power our professional or organization status affords us. Yet an empowering professional practice is predicated on a commitment to fundamental social transformations which, with respect to ensuring human health or social welfare, can be typified as:

- equitable access to the means of production and physical livelihood
- enhanced acquisition and application of productive personal and social skills
- support for creative, educational and caring activities
- supportive and well-defined matrix of social relationships, allowing cohesive social identities to be formed
- decentralized economic and political decision-making that enhances communal values

- sustainable use of natural capital
- broad acceptance of responsibility and involvement in collective decision-making.[15]

These are fundamental requisites to a sustainable social system; they have also been, and remain, the goals of many social movements. Indeed, the whole node of political action might be considered the point at which the community and professional roles of helping professionals (the "them/us" dichotomy) fully merge in an individual commitment to ongoing social transformation. Without this commitment, and the social support of others so committed, professionals are unlikely to sustain an empowering practice for themselves and, hence, for those with whom they work.

This commitment is also the core of democracy, the important exercise of which is not what happens at election-time, but what transpires between elections. It is that stream of democracy usually called "participatory." The relatively powerful, make use of participatory democracy all the time; they are the ones who hold public office, head government commissions or regulatory tribunals, dine with politicians, are invited to make special comment on public policy, and manage the economy in the boardrooms of public and private corporations alike (Kane, 1980). Part of the exercise of democracy is to ensure that the relatively powerless become more powerful in their capacity to exercise choice, not only for themselves, but for their communities, for their preferred futures, and for ours. Unless the social capacities for choice are made more equitable, we cannot justifiably argue that we are creating democracy.

We are now living in a period of fairly fundamental social transformation which has characteristics of both revolution and reform. Our challenge, personally and professionally, is to ensure that this transformation moves us towards greater equity in power within and between natons and to a time when our obsession with power and empowerment no longer dominates our social discourse. For, as a Benedictine scholar once noted

> If we idolise wealth, then we create poverty;
> If we idolise success, then we create the inadequate;
> If we idolise power, then we create powerlessness.
>
> Thomas Cullinan, OSB

Endnotes

1. The public/community health sector is comprised of public health units (most of which are municipally based), community health centres (primarily in Ontario, and providing primary health care, health education, community development and case manage services) and CLSCs (the large and well-established network of local community centres in Quebec). This article does not directly reflect the Quebec experience, which has been well documented elsewhere (see, for example, Lamoureux, 1989). The important distinction between the public/community health sector and the much larger and richer "health-care" sector is that the former has always been concerned with disease prevention rather than disease treatment. As such, it is more comfortable with social rather than biomedical models of health.
2. Health comprises one of three major social policy fields, the other two being education and social welfare. At the risk of simplification, education provided a focus for analyses of power relationships during the 1960s and 1970s; social welfare did the same during the 1970s and 1980s; and community health is doing so during the 1980s and perhaps through to the 1990s.
3. Curiously, and perhaps a reflection of ideological differences, two American dictionaries—the *Heritage dictionary* and the *Unabridged Random House Dictionary—make no reference to the reflexive use of empower.*
4. Surplus powerlessness is evocative of Seligman's early animal studies of "learned helplessness," which are now being replicated at the cellular, i.e., cells exposed to a toxin will respond to a placebo as if it were the toxin, after the toxin is removed. At the cellular, "primitive" biological and "complex" social levels of organization, human functioning is completely dependent upon learned interactions with the environment, be it biochemical or social.
5. This Continuum was first developed in workshops with health and social service workers (front-line and management) in Australia in 1988. The Continuum is presented in a linear form because there is often progressive movement. However, movement can flow in both directions. In a left to right direction, the Continuum presents an ever broadening social definition of personal experience/power, and a steadily increasing politicization of action and solution. While this captured the experiences of most 1988 workshop participants, a minority felt strongly that the Continuum should be conceived of as a series of overlapping circles, somewhat like a flower.
6. Relatively powerless communities often organize over democratizing consumption-related issues—welfare reforms, housing affordability, improved social and health services—and one challenge we face as professionals may be to assist community groups in recasting these concerns within a framework of production, that is, more egalitarian models of economic development, such as community economic development, cooperative work structures, food and housing cooperatives, etc. This is particularly true regarding health-care expenditures, which now consume one-third of government spending, have not yielded any improvement in population health, and may divert expenditures from more urgent health-creating areas such as affordable housing, daycare subsidies, negative income taxes, environmental protection, and so on. Yet, many community groups and labour activists continue to demand more health-care spending on the presumptions that it creates health and/or enhances social equity because it represents a universally disbursed social benefit.
7. This project has been documented in several places, including Labonté (1986, 1988).
8. For a journalistic discussion of this issue, see the articles by Herman, Bufe, Perrin and Coleman, Fingarette, Collett and Schaef in Utne Reader (November/December) 1988:52-77
9. Critiquing the base literature on the pros and cons of government involvement in community organizing is beyond the scope of this article. I accept as a given an increasing role in government rhetoric for and bureaucratic intrusion into community organizing, both for fiscal reasons (off-loading program responsibilities) and for social change management. I am wary of the disempowering potential of these two motivations. At the same time, government workers represent a sizeable minority of many communities, and bureaucratic intrusion into community organizing, both for fiscal reasons (off-loading program responsibilities) and for social change management. I am wary of the disempowering potential of these two motivations. At the same time, government workers represent a sizeable minority of many communities, and bureaucratic organizations will continue to figure prominently in social change processes. I, therefore, remain sanguine of the possibility for humanizing smaller-scale, local level government bureaucracies. One at-

tempt to model this style of change is the Canadian Healthy Communities Project, in which local municipalities commit themselves to a modest program of increasing active citizen involvement in decision-making on issues that effect the community's health. (These can range from "safe" topics such as workplace smoking bans to more complex issues such as employment equity and industrial pollution.)

10. There is a worldwide "Healthy Cities" initiative currently developing under the auspices of the European Office of the World Health Organization, similar in intent to the Canadian Healthy Communities Project. While this initiative has many positive attributes (e.g., bridging sectors and disciplines, building larger professional collectivities for political action) there are also concerns that it may bury local conflicts within safe, "parenthood" types of actions that do not seriously challenge pathological economic and social forms of organization.
11. I acknowledge Michael Felix, Program Officer with the Kaiser Foundation in California, for drawing the distinction between the two processes.
12. A good discusion of different modes of organizational coordination (including coalitions) can be found in Goering and Rogers (1986).
13. See, for example, Gray (1989).
14. On a related theme, coalitions usually maintain themselves only by individual representatives putting aside their intergroup differences in favour of the winnable, simple policy question. One group with relative power over another group may sit as coalition members on a given issue, much as medical associations, government agencies, non-governmental health organizations, health activist groups and public health associations might join together in a coalition on tobacco issues, even though, at deeper levels of analyzing health, economics and medicine, these groups may fundamentally disagree. But if coalition members submit themselves to a process of small group empowerment even as they collectively strategize on the simple policy question, some of their deeper-level differences may surface and lead to a more profound understanding of radical social change.
15. Adapted from Blake (1990).

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