European Journal of Clinical Nutrition (2005) 59, Suppl 1, S10–S16
 0954-3007/05 $30.00
www.nature.com/ejcn

ORIGINAL COMMUNICATION

Making healthy choices easy choices: the role of empowerment

MA Koelen[1]* and B Lindström[2]

[1]*Wageningen University, Sub-department Communication Science, Wageningen, The Netherlands; and* [2]*Nordic School of Public Health, Gotenborg, Sweden*

An important goal of health promotion is to make it easier for people to make healthy choices. However, this may be difficult if people do not feel control over their environment and their personal circumstances. An important concept in relation to this is empowerment. Health professionals are expected to facilitate and enable people moving towards empowerment. In this paper, we address the question what is meant by individual empowerment. In an attempt to provide a theoretical framework, we discuss individual empowerment from a salutogenic perspective. This perspective introduces two fundamental concepts: the general resistance resources, and the sense of coherence. In addition, in order to further clarify and operationalise the concept, some factors influencing individual empowerment are identified, that is, locus of control, learned helplessness, self-efficacy and outcome expectations. These concepts find common ground in feelings of (lack of) control, but they differ in stability and changeability. We provide some suggestions how these factors can be influenced, and we discuss the meaning of the identified factors for empowering interactions between professionals and their clients. Health professionals can facilitate people to see a correspondence between their efforts and the outcomes thereof, improve and facilitate health literacy, in a relationship which can be characterised as partnership.
European Journal of Clinical Nutrition (2005) **59,** Suppl 1, S10–S16. doi:10.1038/sj.ejcn.1602168

Keywords: health promotion; empowering interactions between professionals and clients

Introduction

One of the innovations of Public Health at the end of the 20th Century is the Health Promotion Movement. Health promotion focuses on the mobilisation and development of population health resources, enabling people to live a good life. The principles of health promotion were concentrated in the Ottawa Charter—the 'genetic code' of the movement (WHO, 1986). Health promotion can be defined as the process, which enables people to gain control over their health determinants, in order to improve their health and thereby being able to live an active and productive life (WHO, 1986). This definition contains three important components. Firstly, it recognises the determinants of health, that is, biological factors (endogenous determinants), the physical and social environment and lifestyle (exogenous determinants) and the system of health care. Secondly, it sets an objective, that is, to lead an active productive life. Thirdly, it refers to the activity—the enabling process—where the determinants of health are used to reach the objective in a dialectic relationship between people, the setting and the enablers. At the heart of the process is the respect of people as active participating subjects.

An important goal of health promotion is to make it easier for people to make healthy choices. Several barriers, both within individuals and within their physical and social environment, can hamper the possibilities to make such healthy choices. Health promotion therefore works on improving the capacities of individuals, but also on improving the social and economic conditions and the physical environments in which people live (Nutbeam, 1998). This latter is also referred to as 'creating supportive environments'. The role of professionals is to enable people to make sound choices. Health workers, including general practitioners, are expected to act as a catalyst, for example, by providing information on health and by facilitating skills development. However, even if environments are supportive, making healthy choices will be rather difficult if people do not feel in control over their environment and over their personal circumstances. An important concept in relation to

***Correspondence: MA Koelen, Wageningen University, sub-department Communication Science, Hollandseweg 1, KN Wageningen NL-6706 , The Netherlands.**
E-mails: bengt@nvh.se, maria.koelen@wur.nl

this is empowerment, a concept that since the Ottawa Charter (WHO, 1986) became a topical issue in health promotion literature. Yet, the concept still lacks a theoretical underpinning, and it remains difficult to make the concept operational and measurable.

In this paper, we address the question what is meant by empowerment. In an attempt to provide some clarity to the concept, we provide a possible theoretical framework. Subsequently, we discuss factors that influence empowerment. Finally, since health professionals are expected to play an important role in enabling individuals towards empowerment, we discuss the meaning of the identified factors for empowering interactions between professionals and their clients.

The concept empowerment

Much of the theoretical underpinnings of empowerment are based on the work of Paulo Freire (1973) who developed his ideas in literacy programmes in slums in Brazil, under the title 'the pedagogy of the oppressed'. Since then, the concept 'empowerment' has been examined in diverse academic and professional disciplines, among others in sociology and educational sciences. In health promotion, empowerment is considered to be the process through which people gain greater control over decisions and actions affecting their health (Nutbeam, 1998). Empowerment is often linked with social systems, communities, and social change (cf. Bracht *et al*, 1999; Laverack & Wallerstein, 2001; Koelen & van den Ban, 2004). Yet, in spite of extensive research and several programmes that aim at empowerment, there are many interpretations of the concept, and there is no unequivocal operationalisation. Rappaport (1985, 1987) argues that it is difficult to define empowerment in terms of its outcomes, because it includes psychological and political components, and it will look different in its manifest content for different people, organisations and settings. Several authors have argued that empowerment is easy to recognise when it happens, but the absence is also easy to recognise. They use terms like powerlessness, learned helplessness and alienation to reflect the absence of empowerment (cf. Wallerstein, 1992; Zimmerman, 2000).

Rissel (1994) proposes to make a distinction between empowerment at the level of the individual and empowerment at the level of communities. *Community empowerment* refers to a state of communities or subgroups within communities (cf. Wallerstein, 1992; Israel *et al*, 1994; Laverack & Wallerstein, 2001). This is reflected in Wallerstein's (1992) definition of community empowerment, that is, a social action process that promotes participation of people, organisations, and communities towards the goals of increased individual and community control, political efficacy, improved quality of community life, and social justice.

In this paper, we will not further discuss community empowerment, but focus on individual empowerment, firstly because it is important to all other levels of empowerment, and secondly since this is the one most applicable to the relation between general practitioner and patients.

Individual empowerment

Individual empowerment is also referred to as psychological empowerment. Several definitions of psychological empowerment can be found in literature (cf. Rappaport, 1985; Rissel, 1994; Perkins & Zimmerman, 1995; Nutbeam, 1998; Mechanic, 1999; Zimmerman, 2000). Rappaport (1985) provides a definition still widely used today. According to this author, empowerment is a sense of control over one's life in personality, cognition and motivation. It expresses itself at the level of feelings, in ideas about self-worth, and in feeling able to make a difference in the world around us.

Since empowerment is more of a principle than a solid theory, it has been suggested that the salutogenic approach of Antonovsky (1979, 1987) could form a theoretical framework for empowerment (Eriksson & Lindström, 2005). The salutogenic perspective focuses attention on health generation as compared to a pathogenesis focus on disease generation. The perspective introduces two fundamental concepts: the *general resistance resources (GRRs)* and the *sense of coherence (SOC)*. The GRRs are biological, material and psychosocial factors that make it easier for people to perceive their lives as consistent, structured, and understandable. They help people to move in the direction of positive health. Typical GRRs are money, knowledge, experience, self-esteem, social support, culture, intelligence, traditions, and ideologies. If people have such resources at their disposal or available in their immediate surroundings there is a better chance for them to deal with the challenges of life. GRRs open up the possibility for people to construct coherent life experiences. More important than the resources themselves, however, is *the ability to use* these resources. This is the meaning of the second and more generally known salutogenic key concept: the SOC. The SOC is described by Antonovsky (1979) as the extent to which one has a pervasive, enduring, though dynamic feeling of confidence that one's internal and external environment is predictable and that there is a high probability that things will work out as well as can be reasonably expected. Thus, SOC refers to a person's capability to see that one can manage any situation, independent of whatever is happening in life. The general resistance resources assist the individual in developing a strong sense of coherence.

Within psychology and in coping and stress management theories, which have adopted the salutogenic thinking, related concepts are used, such as resilience (Werner & Smith, 1982) and hardiness (Kobasa, 1982). *Resilience* is the capability of individuals and systems to cope successfully in the face of significant adversity or risk. Hardiness is a concept used to describe a person's ability to deal with stressful aspects of life. According to Kobasa (1982, 1993), hardiness

incorporates three key elements: control, commitment, and challenge. Control refers to the tendency to believe and act as if one can influence the course of events. Commitment refers to the ability to believe in the importance and interest value of what one is doing. Challenge refers to the belief that change rather than stability is the norm.

The concepts discussed above all focus on (the availability of) resources and on the (learned) ability to deal with and use those resources. Based on these elements of salutogenic thinking, we define individual empowerment as: a process by which people gain mastery (control) over their lives, by which they learn to see a closer correspondence between their goals and a sense of how to achieve these goals, and by which people learn to see a relationship between their efforts and the outcomes thereof.

Factors influencing individual empowerment

Concepts that can help to further understand individual empowerment and which can contribute to operationalisation originate from, among others, attribution theories (Rotter, 1966; Kelly & Michela, 1980; Weiner, 1986), control theory (Carver & Schreier, 1998), social learning theory (Bandura, 1982, 1986), and self-determination theory (Deci & Ryan, 2000).

The first concept we want to address is that of *locus of control*, which is defined as a generalised expectation of the correspondence between an individuals acts and the outcomes (Rotter, 1966). People who see outcomes (the things that happen to them) as a result of their own behaviour are considered to be internals. People who see things that happen to them as a result from external forces are considered to be externals. This phenomenon is also referred to as a general causality orientation. Related to health, we refer to *health locus of control*. Internals feel that they can influence their own health by changing their 'risky' behaviours into more healthy ones. Externals on the other hand, have the idea that their own behaviour does not affect their health. Their health status is destined by some outside forces, such as 'the will of God' or 'it is in the hand of doctors'. Locus of control is considered to be a *personality trait*, which means that it is relatively stable over time and situations. It is generally assumed that people with an internal health locus of control have better health habits, are more likely to perform health promoting behaviours (eg Wallston & Wallston, 1982), and consequently have better health status (eg Marshall, 1991), than people with an external locus of control.

A second, related concept, is that of *learned helplessness* (Seligman, 1975). Learned helplessness refers to a general lowered state of functioning, stemming from experiences with uncontrollability. If people find themselves in a situation in which there is no good connection between the behaviour and the results of that behaviour, they feel a lack of control. Consider someone who tries to loose weight and follows a diet but does not succeed either to lose weight or to keep up the diet. If this happens once, it may not be a problem: just try harder next time. However, if this result is repeated, it will be accompanied with a so-called giving up response. So, people trying to loose weight or trying to stop smoking become prone to 'stop changing' or to 'stop stopping'. Learned helplessness may have consequences for other behaviours as well. 'If I did not succeed to stop smoking I also will probably not succeed in loosing weight'. Learned helplessness somehow is comparable to external locus of control, but here it is not a personality trait but a *'state'*. This is an important difference, because personality traits are relatively unchangeable. States though, however difficult it may be, are more vulnerable to change (eg Brewin, 1982, 1985).

A third and again related concept is that of *perceived self-efficacy* (Bandura, 1977, 1982) or *perceived behavioural control* (Ajzen & Madden, 1986). Self-efficacy is defined as people's belief in their capability to organise and execute the course of action required to deal with prospective situations (Bandura, 1977). It refers to the perception of individuals about how easy or difficult it is to perform a specific behaviour, and their perception about whether they are able to perform the required behaviour or not. Feelings of efficacy are primarily based in what we call performance history. Consistent success experiences lead to high perceived self-efficacy, consistent failure leads to low perceived self-efficacy. Self-efficacy thus also is a state, as is learned helplessness, but generally it is behaviour specific. Someone who fails to stop smoking may still feel capable to reduce weight.

A fourth aspect, which can influence feelings of empowerment, is that of *outcome expectations* (Bandura, 1977) also called *response efficacy* (cf. Rogers, 1983). Outcome expectations refer to a person's estimate that a given behaviour indeed will lead to the expected outcomes (Bandura, 1977). So, for example, if I change my diet will it indeed lead to reduced weight? And will it indeed increase my physical condition? Outcome expectations are not necessarily based in direct personal experience. If the outcome expectation is low, individuals are less willing to put the effort in performing the behaviour. Outcome expectations do not have an overall negative effect. For different behaviours and even in different situations, the expectation may be either high or low.

Control as the core concept

The concepts described above have a common ground in feelings of control. If people experience a correspondence between a particular cause of action and its outcomes (ie a positive effort-results relation; success experience) they feel in control. People who do not experience such a positive relation (eg 'I put a lot of effort, but it does not lead to the expected outcome') are faced with failure and experience loss of control. Low outcome expectations, low self-efficacy, and learned helplessness all are based on consistent failure

experiences, whereas their counterparts are based on successive success experiences. Generally, a lack of control negatively influences feelings of empowerment, whereas feelings of being in control positively influence feelings of empowerment, which in turn affects both people's mental and physical well being.

An important difference between the concepts is their stability, and more specifically, the extent to which they are changeable over time. The stronger they are based on *consistent* success or failure experiences, the more stable they are. For health professionals the challenge is in influencing the negative expressions of the concepts. Low outcome expectation may be based on a single negative experience, or it may be just an idea, and it is relatively easy to change. To influence outcome expectations, health professionals first and foremost have to make very clear that the advised behaviour is effective (cf. Sutton, 1982). Low perceived self-efficacy mostly is behaviour specific, and primarily based on a longer standing negative performance history. It is therefore more difficult to change, but providing clear instructions about how to perform the advised behaviour can influence it. Several studies show that higher levels of perceived efficacy lead to better compliance to treatment and to choices for healthier behaviours than lower levels of perceived self-efficacy (cf. De Vries *et al*, 1995; Schaalma, 1995; Hausenblas *et al*, 1998; Oei *et al*, 1998).

Learned helplessness and locus of control are more generalised feelings of lack of control. They are rather stable and discourage people from taking any action because they feel it is out of their own control. This is not to say that nothing can be done. Much experience in this regard is gathered in the so-called reattribution programmes, which aim to help people regain confidence and feelings of control. A step-by-step approach is common in reattribution programmes, initially setting targets that are easy to reach. For example, an obese person may have to lose up to 30 kg of weight. This is a high target, and usually one will not succeed. Therefore, it would be more helpful to have targets set that are easier to reach, for example, an initial weight loss of 5 kg. This increases the chance of success, which increases the motivation to continue, especially if successes are followed by additional successes. The most important thing is that individuals feel that certain outcomes are under their personal control, thereby increasing the chance that one will persist in that behaviour. Reattribution programmes have successfully been applied in a variety of settings: for example, in the field of clinical psychology (eg Försterling, 1986), psychiatry (eg Brewin, 1985), school performances (Siero, 1987); smoking (cf. Eiser & Van Der Pligt, 1986) and weight management (*cf*. Haish *et al*, 1985).

Conclusions and discussion: consequences for interaction between professionals and clients

Although the concept of empowerment stems from sociology and educational science it has rapidly gained popularity in public health and health care research and practice. There are several reasons for this. One is the paradigm shift towards health promotion where health is no longer seen as an end, but as a resource on both individual and societal levels. Another reason certainly is the contemporary focus on the capability of individuals to deal with their own problems. Empowerment is the concept used in relation to this. However, the concept has proved to be difficult to define, and often is considered more as a principle than a defined theoretical framework. As with many concepts it is important to define its meaning, not only for academic reasons but also to make it operational and applicable in practice. We have therefore discussed empowerment from the perspective of Antonovsky's salutogenic framework and propose the key concepts of the salutogenesis. GRRs and SOC could 'empower empowerment' in a scientific sense, and give it a theoretical base and a clear structure. This has also given us the opportunity to introduce some of the less known frameworks of salutogenic thinking such as hardiness and resilience. Moreover, it gave the opportunity to unravel some of the factors influencing individual empowerment, that is, locus of control, learned helplessness, self-efficacy and outcome expectations. We provided some suggestions as to how these factors can be influenced. Strategies for change in fact refer to the availability of resources and the (learned) ability to use them.

In health promotion, professionals are expected to play an important role in enabling individuals towards empower>ment. Ideally, professionals and their clients are mutually engaged in an empowering process. The role of the professional is to support and provide options that enable people to make sound choices, to point to the key determinants of health, to make people aware of them and enable people to use them. In this enabling process it is important to help people to see a correspondence between their efforts and the outcomes thereof. It includes guiding clients through change processes in a successful way, that positively influences feelings of control.

In addition, health professionals can facilitate their clients' skills to cope with difficult or challenging situations and their ability to use the general resistance resources. In fact, this last aspect is also referred to as *health literacy*. Health literacy is assumed to be critical to empowerment. It represents the cognitive and social skills which determine the motivation and ability of people to gain access to information, and to understand and critically use this information in ways which promote and maintain good health (Nutbeam, 1998). By improving peoples' access to health information and their capacity to use it—and to use it in a critical way—health professionals can facilitate successes and thereby the process of empowerment.

We are aware that 'enabling clients towards empowerment' may be more easily said than done as well. There are at least two complicating factors. Firstly, as Pease (2002) argues, there seems to be a paradox in being a professional and being committed to empowerment. An essential part of

a profession is the profession-specific knowledge base. Professionals are supposed to be experts, a patient goes to see a doctor because the doctor is the expert, the doctor can find out what exactly the health problem is and the doctor can prescribe a medicine or a therapy to cure. By using their 'power of expertise' however, the GP can dis-empower the patient, and thus subvert his/her actual goal of empowering.

A second complicating aspect is that, in order to empower patients or clients, professionals themselves have to be empowered. In fact, all the aspects influencing empowerment are applicable to professionals as well. In research of, for example, Hiddink *et al* (1997) and Van Dillen *et al* (2004), GP's expressed difficulties with unmotivated patients, patients who are not really willing to change their behaviour. At the same time general practitioners experience a lack of personal skills to turn such 'un-motivation' into positive motivations. The chances are that these expressions of the GP's are based on failure experiences: 'Whatever I say to my patients, it does not help'. So past failure experience with motivating patients may increase feelings of low perceived self-efficacy and even learned helplessness, leading the doctor to return to the one thing he or she is trained in: to diagnose and prescribe.

Interesting in this regard is the work of Tronto (1993) and Niehof (2004) about care-relations. According to them, care knows four integrated aspects: caring about, taking care of, care giving and care receiving. For care to be effective, all these aspects have to be integrated. This means that provided care, no matter how accurate it may be from a medical point of view, will never be effective if the patient is not responsive to this care. It is in this interaction between GP and patients where empowerment comes in, both for the patient and the general practitioner. If the patient is not responsive to the provided care, the GP experiences at least some form of 'failure', increasing his or her feelings of low self-efficacy. To facilitate the empowerment process, the relation between professionals and lay people must be seen as a partnership, rather than as the traditional hierarchical health care provider—health care receiver relationship. Empowered relations between professionals and clients, doctors and patients, can best help to make the healthy choices the easy choices.

References

Ajzen I & Madden TJ (1986): Prediction of goal directed behaviour: attitudes, intentions and perceived behavioural control. *J. Exp. Soc. Psychol.* **22**, 453–474.

Antonovsky A (1979): *Health, Stress and Coping*. London: Jossey Bass.

Antonovsky A (1987): *Unraveling the Mystery of Health: how People Manage Stress and Stay Well*. San Francisco, CA: Jossey-Bass.

Bandura A (1977): Self-efficacy: toward a unifying theory of behavior change. *Psychol. Rev.* **84**, 191–215.

Bandura A (1982): Self-efficacy mechanism in human agency. *Am. Psychol.* **37**, 122–147.

Bandura A (1986): *Social Foundations of Thought and Action; a Social Cognitive Theory.* Englewood Cliffs, New York: Prentice-Hall.

Bracht N, Kingsbury L & Rissel C (1999): A five-stage community organization model for health promotion: empowerment and partnership strategies. In: *Health Promotion at the Community Level: New Advances*, ed. N Bracht, pp 83–104, 2nd Edition. London: Sage Publications.

Brewin CR (1982): Adaptive aspects of self-blame in coping with accidental injury. In: *Attributions and Psychological Change*, eds C Antaki & CR Brewin, pp 119–134. London: Academic Press.

Brewin CR (1985): Depression and causal attributions: what is their relation? *Psychol. Bull.* **2**, 297–309.

Carver CS & Schreier MF (1998): *On the Self-regulation of Behaviour.* New York: Cambridge University Press.

De Vries H, Backbier E, Kok G & Dijkstra M (1995): The impact of social influence in the context of attitude, self-efficacy, intention, and previous behaviour as predictors of smoking onset. *J. Appl. Soc. Psychol.* **25**, 237–257.

Deci EL & Ryan M (2000): The 'What' and 'Why' of goal persuits: human needs and self-determinantion of behaviour. *Psychol. Inq.* **11**, 227–268.

Eiser JR & Van Der Pligt J (1986): Smoking cessation and smokers' perceptions of their addiction. *J. Soc. Clin. Psychol.* **4**, 60–70.

Eriksson M & Lindström B (2005): The reliability and validity of Antonovskys Sense of Coherence Scale, Accepted for publication. *J. Ep. Com. Health* **59**, 460–466.

Försterling F (1986): Attributional conceptions in clinical psychology. *Am. Psychol.* **41**, 275–285.

Freire P (1973): *Education for Critical Consciousness*. New York: Seabury Press.

Haish J, Ruch G & Haisch I (1985): Längerfristige Effecte attributionstherapeutiser Massnahmen bei Übergewichtigen: Auswirkungen eines Attributionestrainings auf Abnehmerfolg und Abbrecherquote bei einem 23 wöchigen Gewichtsreductions-Programm. *Psychother. Med. Psychol.* **35**, 133–140.

Hausenblas HA, Carron AV & Mack DE (1998): Application of the theories of reasoned action and planned behaviour to exercise behaviour: a meta-analysis. *J. Sport Exerc. Psychol.* **19**, 36–51.

Hiddink GJ, Hautvast JGAJ, Van Woerkum CMJ, Fieren CJ & Van't Hof MA (1997): Information sources and strategies of nutrition guidance used by primary care physicians. *Am. J. Clin. Nutr.* **65** (Suppl), S1996–S2003.

Israel BA, Checkowa BN, Schulz A & Zimmerman M (1994): Health education and community empowerment: conceptualizing and measuring perceptions of individual, organizational, and community control. *Health Ed. Quart.* **21**, 149–170.

Kelly HH & Michela JL (1980): Attribution theory and research. *Annu. Rev. Psychol.* **31**, 457–501.

Kobasa S (1982): The hardy personality: toward a social psychology of stress and health. In: *Social Psychology of Health and Illness*, eds GS Sanders & J Suls, pp 3–32. Hillsdale NJ: Erlbaum.

Kobasa SC (1993): Inquiries into hardiness. In: *Handbook of Stress: Theoretical and Clinical Aspects*, eds L Goldberger & S Brenznitz, pp 77–100. New York: Free Press.

Koelen MA & Van Den Ban AW (2004): *Health Education and Health Promotion*. Wageningen: Wageningen Academic Publishers.

Laverack G & Wallerstein N (2001): Measuring community empowerment: a fresh look at organizational domains. *Health Promot. Int.* **16**, 179–185.

Marshall G (1991): A multidimensional analysis of internal health locus of control beliefs: separating the wheat from the chaff. *J. Pers. Soc. Psychol.* **61**, 483–491.

Mechanic D (1999): Issues in promoting health. *Soc. Sci. Med.* **48**, 711–718.

Niehof A (2004): A micro-ecological approach to home care for AIDS Patients. *Med. Antroplogie.* **16**, 245–265.

Nutbeam D (1998): *Health Promotion Glossary.* WHO/HPR/HEP/98.1. Geneva: World Health Organisation.

Oei TPS, Ferguson S & Lee NK (1998): The differential role of alcohol expectancies and drinking refusal self-efficacy in problem and non-problem drinkers. *J. Stud. Alcohol.* **59**, 704–711.

Pease B (2002): Rethinking empowerment: a postmodern reappraisal for emancipatory pratice. *Sociale Interventie*. **3**, 29–45.
Perkins DD & Zimmerman MA (1995): Empowerment theory, research, and application. *Am. J. Community. Psychol*. **23**, 569–579.
Rappaport J (1985): The power of empowerment language. *Soc. Policy.* **16**, 15–21.
Rappaport J (1987): Terms of empowerment; examplars of prevention: toward a theory for community psychology. *Am. J. Community Psychol.* **15**, 121–148.
Rissel C (1994): Empowerment: the holy grail of health promotion? *Health Promot. Int.* **9**, 39–47.
Rogers RW (1983): Cognitive and physiological processes in fear appeals and atitude change: a revised theory of protection motivation. In: *Social Psychology: a Source Book*, eds JT Cacioppo & RE Petty, pp 153–176. New York: Guilford Press.
Rotter J (1966): Generalized expectancies for internal *versus* external control of reinforcement. *Psychol. Monogr.* **80** (1), 1–28.
Schaalma HP (1995): *Planned development and evaluation of school-based AIDS/STD education*. Doctoral Dissertation. Maastricht: Maastricht University.
Seligman MEP (1975): *Helplessness: on depression, development and death*. San Francisco: Freeman.
Siero FW (1987): *Feedback en motivatie in de klas*. Doctoral Dissertation. Groningen: State University Groningen.
Sutton SR (1982): Fear-arrousing communications: a critical examination of theory and research. In: *Social Psychology and Behavioral Medicine*, ed. JR Eiser. Chichester: John Wiley and Sons.
Tronto JC (1993): *Moral Boundaries: a Political Argument for an Ethic of Care*. New York, London: Routledge.
Van Dillen SME, Hiddink GJ, Koelen MA, De Graaf C & Van Woerkum CJM (2004): Identification of nutrition communication styles and strategies: a qualitative study among Dutch GPs, submitted.
Wallerstein N (1992): Powerlessness, empowerment, and health: implications for health promotion programs. *Am. J. Health Promot.* **6**, 197–205.
Wallston KA & Wallston BS (1982): Who is responsible for your health? The construct of health locus of control. In: *Social Psychology of Health and Illness*, eds G Sanders & J Suls. Hillsdale, NJ: Erlbaum.
Weiner B (1986): *An Attributional Theory of Motivation and Emotion*. New York: Springer Verlag.
Werner EE & Smith RS (1982): *Vulnerable but Invincible: a Longitudinal Study of Resilient Children and Youth*. New York: McGraw-Hill.
World Health Organisation (1986): *Ottawa Charter of health promotion*. Copenhagen: WHO.
Zimmerman MA (2000): Empowerment theory: psychological, organizational and community levels of analysis. In: *Handbook of Community Psychology* eds J Rappaport & E Seidman. New York: Kluwer Academic/Plenum Publishers.

Abbreviated Discussion after Koelen

Rosser: In family practice, and probably in medicine at large, there is a concept that what happens between the physician and the patient is described as a partnership, where the physician is the expert, but the patient brings his own knowledge of his life; his beliefs, his values. So both partners have a set of knowledge. And you have to bring the two together to get empowerment ….

Koelen: The patient is the expert of his own beliefs.

Rosser: That is correct. The physician or health care worker does not have that expertise. If they ignore that piece of the two things having to come together then it will not be very effective.

Koelen: In the recent UK white paper, for instance 'Making healthy choices easy choices', the first thing is that it is the individual who is responsible for his own health and behaviour. At the same time, the individual cannot be held responsible for something that is out of his control.

Kok: You said in your talk that through interaction and communication the situation may be improved. Could you be a little bit more specific?

Koelen: I said this about partnerships. It's about taking each other seriously…. Not only being diagnostic and prescribing something. But talk with the patient more broadly about their situation. For example, doctors seem to have trouble with motivating patients to lose weight. For a doctor it may be very helpful to know why this is.

Green: In my experience the word *empowerment* does not travel so well in certain circles. The term *self-efficacy* communicates about the same thing. What in your mind is the essential difference?

Koelen: Empowerment is something more enduring. Self-efficacy is a part of empowerment. So empowered people will have higher levels of self-efficacy. Self-efficacy is more related to a certain type of experience or behaviour. I can feel very effective in changing my diet but not in my ability to take up physical exercise. A lot of success experience can lead to higher feelings of self-efficacy and to the opposite of learned helplessness, and that is learned hopefulness.

Truswell: There is a relation between someone's position in society and his feelings of empowerment. There must be a lot of people in our societies who have no control over their own lives, while others have a lot of control.

Koelen: That is true, and this affects the learned helplessness.

Helman: Whether the concept of learned helplessness applies to the family physician needs to be explored. In my experience they are quite willing to refer the patient to the dietician, who seems to be quite optimistic on their possibility to help the patient lose weight. Perhaps they don't observe the obstacles so much. Can we do something to change the attitude of family physicians?

Koelen: General physicians are people. So everything we say about patients will also apply to GPs. So, we could learn a lot from social science.

Rosser: A colleague of mine wrote an article in the Canadian Family Physician that family physicians suffer from learned helplessness professionally; not just in diet counselling, but basically that they were conditioned in medical school that specialists were the ones to look after most conditions, and therefore they should refer everybody that had anything more than a minor condition, and also that they do not really need to research or understand what they do, because it's all done by somebody else. This is something to remember when empowering family physicians to take on health promotion.

Van Weel: Do you think people who feel empowered have a more healthy life? Our government strongly believes that if you make patients responsible for their own health you will reduce health costs.

Koelen: People who are more empowered do not necessarily behave more healthily….. People who are more empowered can take better control over their own life. But this can be in a more healthy way or in a less healthy way.