

*Edited by Susan Shaw,
Ailsa Haxell and Terry Weblemoe*

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Power Relations

Ruth DeSouza

CHAPTER OVERVIEW

This chapter covers the following topics:

- + Oppression
- + Power
- + Critical social theory
- + Organisational and management theories
- + Social psychological theories
- + Post-structural theories
- + Empowerment.

KEY TERMS

Power
 'The state'
 Surveillance
 Oppression
 Critique
 Foucauldian
 Consumerism

Many practitioners see themselves as apolitical and powerless, particularly with regard to their relationships with the structures of medicine and management. However, in reality practitioners are powerful both as individuals and as members of the groups with which they identify. The structures and cultures within which most health and disability practitioners exist and work are based on beliefs and practices that constrain autonomy. These constraints are at work through a number of mechanisms, such as the market, the infusion of targets and performance measures and quality programmes (Newman & Vidler, 2006). In addition, the changing role of consumers or service users from passive recipients of care in the past to people who may be informed, empowered, articulate and 'demanding' poses a threat to the 'knowledge-power knot' on which professional power rests.

When practitioners view themselves as people who are doing good, they tend to lack awareness of their complicity and embeddedness in relations of **power** that structure inequality. Yet, power is embedded in everyday practices and interactions (Bradbury Jones, Sambrook & Irvine, 2008). Practitioners within the wider health and disability support sector contribute to social regulation through their roles as employees of **the state**. They enact government policies for the benefit of the health of the citizens of the state; so they are both governed and governing. Members of recognised professional groups are provided with a moral authority by their capacity to define problems and pose solutions, and their role in defining and evaluating good or normal behaviour and health practices through **surveillance** of the population and the criteria for interventions on behalf of the state (Gilbert, 2001, p. 201).

These ambivalent relationships with power that are evident among health practitioners require exploration. This can be done by considering the various ways in which power is conceptualised and the micro and macro definitions of empowerment. Some shifts in power have occurred in the last few decades, largely influenced by various social movements. Maternity and mental health are two particular examples of professional practice and service delivery in which power can be recognised and ideas of empowerment can be translated into meaningful engagement between service delivery and those who engage with the service.

Oppression

It can be difficult to understand, but in the process of doing good, people can contribute to **oppression**. For example, medicine has historically dominated health care, but in recent times it has come to be thought about and understood in terms of power and relationships between institutions (and the practitioners

Power The exercise of strength or control.

'The state' The politically organised leadership (or government) of groups of people or populations.

Surveillance The act of keeping watch over people and their actions.

Oppression The unfair or unjust exercising of power over others.

within them) and those who seek care and support (Broom, Nicholls & Deed, 2010). This **critique** of power has significantly eroded the traditional position and role of medicine within our society. This desire to rebalance power has challenged assumptions within the professions in relation to personal and professional culture.

For example, there is an assumption that being a member of a group that provides health care and disability support services automatically means individuals are neutral and egalitarian. However, such assumptions have been challenged and the oppressive capacity of these services, systems, institutions and groups has been exposed.

Critique Critical comment, appraisal or evaluation.

Foucauldian In the spirit of French philosopher Michel Foucault and therefore with an interest in critique of institutions and power.

Young (1990) conceptualises oppression in the **Foucauldian** sense as 'the disadvantage and injustice some people suffer not because a tyrannical power coerces them but because of the everyday practices of a well-intentioned liberal society' (Henderson & Waterstone, 2008). The suggestion is that the actions of many people who are going about their lives contribute to the maintenance and reproduction of oppression, but few of those people (such as health practitioners) would see themselves as agents of oppression (Young, 1990). Oppression, therefore, goes beyond a few people's choices or policies. Its causes are embedded in unquestioned norms, habits and symbols, in the assumptions underlying institutional rules and the collective consequences of following those rules (Young, 1990). It is structural and woven throughout the system. Seeing oppression as the practices of a well-intentioned group removes the focus from individual acts that might repress the actions of others. Instead the focus is on acknowledging that 'powerful norms and hierarchies of both privilege and injustice are built into our everyday practices', which call for structural rather than individual remedies (Young, 1990).

Power

Many practitioners hold empowerment as a central concept to their work with clients, patients and consumers/tangata whai ora. However, in order to empower others, it is important to know what power is. The concept of power has three central themes:

- 1 Ability—the ability to do something or act in a particular way: capacity, capability, potential, faculty and competence.
- 2 Control—having the capacity or ability to direct or influence the behaviour of others or the course of events: authority, influence, dominance, mastery, domination, dominion, sway, weight, leverage, clout and teeth.
- 3 Strength—the physical strength and force exerted by something or someone: powerfulness, might, force, forcefulness, vigour, energy, brawn, muscle, informal punch.

It could be argued that practitioners have all these attributes and are enabled and constrained in their roles and behaviour by the institutions they work for. Practitioners are in positions of political or social authority or control, and have delegated authority (Gilbert, 2001). However, there are different ways of understanding power. Four main theories of power are explored here:

- + critical social theory
- + organisational and management theories
- + social psychological theories
- + post-structural theories.

Critical social theory

Within a critical social theory or liberational framework, power is viewed as a possession and hierarchies are central to the imbalance of power. The group with control has more power and status than other groups in society, which are in a subordinated position. Critical theory is concerned with helping disenfranchised groups in society to overcome this domination. Power is obtained through the surrender of another's power, and empowerment is equated with liberation. In order for this transfer of power to happen, a struggle must occur as powerful people will not readily transfer resources, information or responsibility (Bradbury Jones, Sambrook & Irvine, 2008). Empowerment is collective and is about increasing the power and influence of oppressed groups (Kuokkanen & Leino Kilpi, 2000). However, power is not always repressive and this is a limitation of critical social theory.

Organisational and management theories

Where critical social theory is concerned with oppressed groups, organisational and management theories are concerned with how power is distributed in organisations. Hierarchies also come into play, especially the idea of top-down power (Bradbury Jones, Sambrook & Irvine, 2008). Within this framework, there is an acknowledgement of structural factors and their capacity to empower and disempower, rather than focusing on the individual. According to Kanter (1993), four conditions are necessary for empowerment to occur within organisations, with the degree of empowerment related to how many of the four conditions are present: opportunity for advancement, access to information, access to support and access to resources. Power is then framed as the

ability to get things done, and being empowered is having the opportunity to do things. However, the problem with this model and with critical social theory is that power is not only distributed in a top-down manner: it also operates from bottom to top and laterally (Foucault, 1977).

Social psychological theories

Social psychological theories contrast with organisational models of power in that they focus on the psychology or the point of view of the individual, rather than environmental factors. Power is framed as a personal attribute that can be nurtured, and personal growth leads to personal power and therefore empowerment (Bradbury Jones, Sambrook & Irvine, 2008; Masterson & Owen, 2006). However, it does not necessarily follow that individuals are empowered or able to assert their power in any given situation. It may be argued that individualistic empowerment deflects attention from socio-structural disempowerment, as well as social, cultural and structural factors that disempower (Masterson & Owen, 2006). Morrall (1996) challenges individual empowerment, saying that empowering the individual is like treating the symptoms of disempowerment rather than the cause. Other concerns are that an increase in self-confidence might result in an altered perception of power. This would then allow an individual to act or exert influence while power imbalances remain because there has not been an actual transfer of power.

Post-structuralist theories

A post-structural appreciation of power conceptualises it not as a thing (something that is possessed by individuals or organisations) but as a relation: something that is exercised (Foucault, 1977). Consequently, post-structuralism challenges the view that power can be relinquished in order to empower someone else (Bradbury Jones, Sambrook & Irvine, 2008). Michel Foucault (1926–1984) is a key theorist within post-structuralism. Foucault conceptualised power in a number of key ways that differ from the previous three theories: power is always shifting and moving; power is ubiquitous and omnipresent, coming from everywhere and moving in multiple directions and permeating like capillaries into every space and interaction; and power is productive. Within this framework, power is not a logical causal relationship where someone can take over or give up power. Power in this paradigm is about having an influence over thoughts, attitudes and social relationships (Kuokkanen & Leino Kilpi, 2000) and practitioners can be viewed as powerless in some circumstances, and powerful in others (Bradbury Jones, Sambrook & Irvine, 2008).

Empowerment

Empowerment is a central concept in recent approaches to health and health promotion, and acknowledges the importance of people having control or being able to participate in their own life and environment. Notions of 'patient empowerment' and participation in care can be identified throughout recent health-care policy and practice information and documents. Empowerment is almost universally viewed as a good thing. However, empowerment can be misapplied in such a way that a transfer of tasks away from formal care occurs without people and their families being resourced and supported. The risk is that traditional service providers and organisations can absolve themselves of the responsibility for supporting the health and well-being of the population by arguing that people should be taking care of themselves—without transferring the resources to the community for such support. The idea of empowerment can be operationalised in diverse ways in practice and differentially received by clients and families. There might be negative consequences for clients who do not value 'empowerment' as much as they trust professionals. For example, when someone does not want active involvement in certain decisions or tasks, promoting involvement can contribute to negative experiences, dissatisfaction, anxiety, fear and guilt.

Empowerment and recovery

Many people who have experiences of mental illness have been marginalised, experiencing social exclusion and the loss of their dignity, freedom, autonomy and rights. Collective action for empowerment by service users has produced many organisations in Aotearoa New Zealand, including Psychiatric Survivors and Mind and Body. These groups have been at the forefront of de-stigmatisation efforts, contesting negative perceptions of mental illness and exploring new ways of talking about mental health and illness (Masterson & Owen, 2006), particularly recovery. As a result of these efforts, the centrality of service users to New Zealand mental health services has been solidified through both legal and contractual frameworks and culture change, with service users employed within mental health services and playing a part operationally, strategically and nationally.

There is a growing expectation for service-user involvement at all levels of social service delivery, in part due to social and policy changes such as de-institutionalisation and community care.

These have led to a resistance to the supremacy of what has been considered the historically paternalist 'professional knows best' approach, a valuing of people's personal experiences of mental illness, and a growing ownership and pride among consumers. In New Zealand services, consumer participation has had impacts for consumers, health-care professionals and policymakers. Consumers are required to be involved in the planning, implementation and evaluation of service delivery at every level of mental health service provision. Transparent and clear processes that show this in service design and delivery are contractual requirements (Ministry of Health, 1995; Phillips, 2006).

Perhaps the most powerful impact has been on critiquing the normalising judgments of medico-psychiatric discourses that are also widespread in society, where labels of deviance such as 'psychiatric patient', 'schizophrenic' and 'mentally ill' have been accompanied by stigma and caused social exclusion and disadvantage (Masterson & Owen, 2006). The power of medico-psychiatric discourses has placed service users in a sick role, where they have been dependent on the knowledge and resources of professionals. Instead, advocacy, recognition of lay knowledge and personal experience of mental illness have resulted in the creation of alternative discourses, such as the recovery model, which have helped to reduce stigma and the power of health practitioners (Masterson & Owen, 2006).

The recovery model reconceptualises what has been typically called mental illness (Masterson & Owen, 2006), framing it as a natural phenomenon occurring along a spectrum of human experience, rather than long-term dysfunction. Prominent advocates of the recovery model include Deegan (1998), Copeland (1997), Jacobson and Curtis (2000) in the USA, and Campbell (1997), Barker and Buchanan-Barker (2005), and Repper and Perkins (2003) in the UK. In Aotearoa New Zealand, O'Hagan (2001) has developed recovery competencies for mental health workers.

The recovery model provides not only an alternative model but also a critique of professional dominance as seen in mental health policies and practices. Consumers charge that medico-psychiatric discourses obliterate hope, disempowering, stigmatising and removing choice from service users. By contrast, recovery advocates assert that regardless of claims about illness, chronicity and progress that are offered in medico-psychiatric discourses, all service users can achieve recovery. However, it is the

individual—rather than services or practitioners—who drives the recovery process and what recovery means to them. Therefore, the recovery project provides a mechanism for empowered action and legitimates the rights of service users, supporting autonomy and self-direction as well the creation of user-run services and reformation of existing mainstream mental health services (Masterson & Owen, 2006). While societal and service 'buy in' is critical (without appropriation and professionalisation), this is not without its challenges. Embracing a recovery perspective requires challenging and transforming some taken-for-granted practices and developing new kinds of relationships with service users. Strategies might include redistributing power in tangible ways (for example, contractually); making professionals dependent on service users for training, education or performance assessment; and renegotiating the professional functions of therapy and carers.

Models and discourses of empowerment

Individual level or micro-level strategies of empowerment include the psychological model and the consumerist model. The psychological model involves developing power from within, by avoiding 'power-over'. Information giving is highly regarded as an essential step towards genuine empowerment (Masterson & Owen, 2006). It is thought that collaborative partnerships between practitioners and service users—founded upon relationships of trust, support, equality, respect, genuineness, empathy and positive regard—facilitate this. However, consumers/clients can be reluctant to challenge decisions made about their care for fear of consequences such as being labelled and experiencing the withdrawal of care or the imposition of punitive care (Masterson & Owen, 2006). Despite the presence of codes of patient rights within nations or organisations, users might be unable to exert them. Professionals might appear to facilitate service user decision-making, but still exert control over their decisions where power might be exercised in terms of limiting the range of decisions and maintaining 'expert' authority.

By contrast, **consumerism** involves delegating or sharing formal power through structural change and where there is a transfer of top-down power within services (Masterson & Owen, 2006). Increasingly in fields such as mental health, policy directives have centralised the role of the consumer and their whānau in terms of being able to shape, participate and evaluate health services. In Aotearoa New Zealand, service users have been taught leadership skills to facilitate their ability to assert themselves in organisations. However, while consumerism can mean service-user participation in decision-making (ostensibly giving them influence

Consumerism
Viewing human interaction with an emphasis on access to goods and services.

and allowing professionals and managers to appear empowering), power is still being retained by professionals and managers who set the terms of engagement, incorporating consumerist ideals into existing power structures without changing them (Masterson & Owen, 2006).

A social or macro perspective of empowerment assumes that large-scale action, to meet people's common needs, changes the social and material circumstances of society. There are two general approaches: socio-structural change and grassroots communal action. Socio-structural change encompasses such strategies as creating equal opportunities through structural change and through legislation, policy, financial and organisational means to ensure the social inclusion of all—regardless of ability, age, gender, race, income, social class, sexual orientation or any other form of difference. Power is evident through the unequal distribution of resources between those who are poor and socially excluded and those who are not. By devolving responsibility to patients and their families, the concept of empowerment achieves the goals of improving perceived control and self-efficacy—which are thought to enhance well-being—while fitting in with neo-liberal political and economic imperatives of efficiency and cost (Funk, Stajduhar & Purkis, 2011).

Consumer involvement in health-care decision-making, planning and policy making (as individual consumers, potential service users, citizens and organised groups) is a feature of the contemporary health-care scene (Coney, 2004). The growing centrality of the consumer is part of many efforts to change health systems so that they are more responsive. However, the advent of 'consumerism' has posed a set of challenges to professional, occupational and organisational power (Newman & Vidler, 2006), not least by threatening the hegemony of the medical model of health, whereby the replacement of the machine model of the body with more holistic models has required more personally tailored responses. This holism has been accompanied by challenges to professional judgment in favour of consumer 'choice' (Newman & Vidler, 2006). Critics of the term argue that 'choice' is inappropriate if a person is an unwilling or involuntary user, or if alternative services are scarce (Newman & Vidler, 2006).

Consumers and birth

The New Zealand midwifery profession has struggled for autonomy in the face of threats from medicine, hospitals and nursing (Stojanovic, 2008). It has shaped itself into an autonomous feminist profession founded on partnership with women (Surtees, 2003), creating a point of difference emphasising 'normal' and 'natural' births and the capability of women to 'naturally' carry and deliver a baby without the surveillance and interventions of physicians in a hospital setting (Macdonald, 2006). Mutually beneficial political lobbying by

consumers and midwives in the late 1980s saw legislative changes occur that led to autonomous midwifery practice. Midwives wanted to differentiate their scope of practice from nurses and regain independent practice and autonomy, while maternity consumer activists viewed autonomous midwifery practice as a mechanism for gaining increased control over their own birthing (Pairman, 2006). The subsequent passing of the Nurses Amendment Act in 1990 heralded an era of choice in maternity care for Aotearoa New Zealand, allowing women to choose a caregiver (Lead Maternity Carer or LMC) who would either coordinate or personally provide the care they required from early pregnancy to six weeks post partum (Pairman, 2006). Direct access to government maternity funding means midwives can be self-employed, prescribe some pharmaceuticals, and access pathology and radiology services, hospitals and other birthing facilities. They can also consult with obstetricians or refer women to consultant obstetricians (Davis & Walker, 2010). In 2004, 75.3 per cent of New Zealand women were registered with a midwife to provide lead maternity care, demonstrating a high uptake of midwifery care (Ministry of Health, 2007).

Partnership

The concept of partnership between women and midwives in midwifery practice recognises the centrality of women as consumers in society and to the profession (Freeman, Timperley & Adair, 2004). Partnership was incorporated into the New Zealand College of Midwives' *Handbook for Practice* in 1993 (New Zealand College of Midwives Inc., 1993) and is named as the first of ten standards of midwifery practice: the midwife works in partnership with the woman and the twin forces of feminism and consumerism contributed to this ethic. The women's health movement in the 1970s and the Inquiry into the Treatment of Women for Cervical Cancer at National Women's Hospital (also known as the Cartwright inquiry) in the 1980s identified the omission of informed consent and choices in cervical cancer screening and treatment as evidence of the violation of women's rights (Surtees, 2003). This led to an emphasis on 'accountability, patient-centred care, self-determination and cultural sensitivity in the health service' (Surtees, 2003, p. 30). The centrality of the consumer role became instantiated in roles such as patient or consumer advocates in health services and consumer representation on committees.

The newly formed New Zealand College of Midwives, which had emerged from the New Zealand Nurses Association in August

1988, encouraged consumers as members and representatives in decision-making (Daellenbach & Thorpe, 2007). This partnership was a recognition of the value of the political and public support of midwifery, but also an acknowledgment that there was further collaborative work to be done. The midwifery autonomy regained in 1990 allowed for one-to-one working, and the partnership between the midwife and the woman came to underpin the midwifery model in New Zealand maternity services (Pairman, 2006). Partnership assumed equity between mother and midwife, and acknowledged that both parties were making equally valuable contributions. Midwives brought their knowledge, skills and experience, and the woman brought her knowledge of herself and her family, and her needs and wishes for her pregnancy and birth. Midwives argue that their point of difference from the more hierarchical professional models of medical, nursing and obstetric practice is the shift from authoritative models to partnership and collaboration, where women are empowered (Daellenbach & Thorpe, 2007). However, partnership rests on consumers who are informed and want to be informed (DeSouza, 2006).

Critics from within the midwifery profession challenge the model of partnership on two counts: first, because it assumes a white, middle-class subject; and second, because the relationship between midwives and clients is more akin to individualist contractualism, where individuals contract with each other but do not produce a participatory outcome (Skinner, 1999). Skinner's critique of contractualism contradicts the explicit claim by Guilliland and Pairman (1995) that the concept of partnership originates from their understanding of partnership as it is encapsulated in the Treaty of Waitangi. Instead, Skinner argues that the Treaty is a contract that only has a contemporary reading of partnership and that the demands for *tinorangiratanga* (self-determination), protection and equity remain absent in the midwifery partnership. Skinner (1999) concludes that partnership 'reflects a superficial analysis of society, neglecting to identify the dominant underlying right-wing philosophy of individualism, contractualism and patriarchy. It does not recognise inequalities in power or access to resources and is culturally elitist' (p. 16).

Choice

A second tenet of midwifery is the notion of choice and being an informed consumer. The assumption that choice is empowering is derived from the notion that women can be empowered by being

consulted and actively involved in processes that affect them. Informed choice emerged as a women-centred, feminist mode of health-care communication, which provided a contrast to more hierarchical and paternalistic modes associated with biomedical obstetrical contexts (Spoel, 2007). Informed choice became both an ideological principle implicit in midwifery models of care and a rhetorical practice of midwives exchanging information with women in order to facilitate decision-making (Spoel, 2007). This led to the advancement of empowered and choice-making subjects who were no longer passively recipient 'patients' but active 'consumers' of health care (Tully, Daellenbach & Guilliland, 1998, p. 248). This notion of the choice-making subject is arranged around discourses of neo-liberal subjectivity and relies on an individual who is rational and responsible within the discursive culture of midwifery. Choice is also constrained by a tension within contemporary liberalism, where respect for the autonomy and privacy of individuals is posited against the concern for the regulation of social and economic life, and where expert knowledges are a mechanism for regulating the choices of individuals within the limits of government, thereby constraining the choices that are made (Murphy, 2003).

Liberal feminists view increasing choice in childbirth as a mechanism for enhancing women's perception of control, but radical and social feminists argue that choice has led to the illusion of freedom in an oppressive context where the status quo remains unchanged (Leap & Edwards, 2006). Leap and Edwards outline the limitations of the concept of informed choice. First, the person who is doing the informing has a powerful influence on the decisions that are made. Being given information about a limited range of choices is not a guarantee of involvement in decision-making. Ultimately, the health practitioner is a gatekeeper who decides what information is relevant. However, if the mother disagrees with the health practitioner, she needs to have either the resources to find alternative support or the attributes that will allow her to challenge the decision—such as being articulate, assertive and knowledgeable (Leap & Edwards, 2006).

Schmidt's (2008) example of breastfeeding information provided by the Ministry of Health is emblematic of the neo-liberal paradox. Schmidt contends that what appears to be the provision of scientific information about the benefits of breastfeeding and risks of formula feeding frames breastfeeding as the only rational option and appropriate choice for a good modern parent to make. Schmidt contextualises contemporary breastfeeding discourses in the new

public health model, where neo-liberal ideals of individual informed choice are advanced in tandem with the narrowing of choices to those that advantage the state, such as those that reduce the costs of health care.

Natural childbirth

The legislative changes of 1990 that paved the way for greater midwifery autonomy in birthing also saw the advancement of natural childbirth as a philosophy that was strongly intertwined with partnership and informed choice. Central to this philosophy is the idea of being close to nature, and of returning women to the rewarding aspects of a labour.

However, natural childbirth discourses reflect class and race biases where control over birth and informed consumer choice are emphasised without the recognition that these require access to cultural and material resources that are available only to privileged women (Brubaker & Dillaway, 2009). The feminist notion of taking control of one's life and body is a very middle-class perspective (Lazarus, 1997). However, evidence is growing that alternative approaches to childbirth do not necessarily guarantee more fair or compassionate treatment, as seen by a growing body of work about the experiences of migrant and refugee birthing women (Bowler, 1993). Therefore, midwifery concepts of partnership, choice and natural childbirth derived from radical feminist critiques of medicalisation have been aligned to middle-class white subjectivity, but have not effectively changed the structures of biomedical dominance.

The emergence of the consumer movement in health occurred in the context of related social movements, including the civil rights, anti-racist and indigenous rights movements, the psychiatric survivors' movement and the women's movement. Groups coalesced around identity politics and demanded a larger say in health particularly in terms of policy, professional regulation and service planning (Coney, 2004). The women's health movement was the forerunner in challenging tenets of modern medicine and predated other consumer movements, such as patient's rights and disability movements. The emphasis on critiquing mainstream health care resulted in scrutiny of who held the power in the health sector: governments, health practitioners, health industries, the pharmaceutical industry, policymakers, researchers and funders.

Alongside these people-led developments came community development and public health approaches that advanced critiques of medical dominance and the desire for

community-based primary health-care models. These developments were supported by the Alma Ata Declaration (WHO, 2008) and the Ottawa Charter (WHO, 1986). In particular, indigenous Māori and mental health consumers have articulated the need for community-controlled services.

Public health as a field has broadened its scope from communicable disease to the recognition of the role of social inequalities as determinants of health. With the medical model failing to substantively improve the health of deprived populations, the need for models that address the social determinants of health have led to greater involvement of communities in shaping such services. This has led to the development of new and innovative service delivery models by, for example, Māori, Pacific refugee and Asian communities.

{ SUMMARY }

Power is a complex phenomenon in health care and disability support where many professionals assume that because they are doing good that oppression does not exist. However, the rise of consumer movements demanding the redistribution of power in these contexts has foregrounded the empowerment agenda. Therefore, in order to provide services and support that are empowering, professionals must first understand the part they play in power relations. This chapter has outlined the ways in which power is conceptualised through four main theories: critical social theories, organisational and management theories, social psychology theories and post-structural theories. These theories range from viewing power as a possession to seeing power as a relation. In response to the professional dominance of human experiences, such as having a baby and experiencing mental illness, the empowerment agenda has been advanced in a range of ways. In mental health, the recovery model challenges the dominance of professional knowledge in mental health policy and practice, and demands that service user involvement occurs at all levels of care. Importantly, the consumer drives his or her own process of recovery. In the patriarchal area of maternity services, the use of partnership, choice and natural childbirth are viewed as ways of redistributing power back to women. However, empowerment through the redistribution of responsibility to the consumer and their family can be problematic if the corresponding resources are not made available.

REFLECTION POINTS

13.1 Intention (motivation, message, meaning, emotion)

What motivates the consumer movement in health care and disability support services?

13.2 Reception (received message, response, feedback)

Who has more power when practitioners are giving information to consumers?

13.3 Perception (style, manner, impression, analysis)

Do consumers always understand what practitioners say?

QUESTIONS FOR REVIEW

- 1 Outline the different models of power and empowerment. Which definitions appeal and why?
- 2 Is there a risk that practitioners and professions can absolve themselves of responsibility when they emphasise the empowerment of service users?
- 3 What does being empowered mean to you in a health context?

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Culture

Denise Wilson, Ray Gates, Junior Sonny Samuela and Terry Weblemoe

CHAPTER OVERVIEW

This chapter covers the following topics:

- + Cultural difference
- + Cultural competence
- + Cultural safety.

KEY TERMS

Cultural difference	Interpersonal racism
Culture	Linguists
Ethnicity	Indigenous
Race	Stereotypes
Colonisation	Cultural blindness
Assimilation	Cultural imposition
Cultural domination	Institutional racism
Māori	Racism
Pacific People	Cultural competence
Aboriginal and Torres Strait Islanders	Cultural awareness
	Cultural safety