Social cohesion and intrapersonal empowerment: gender as moderator

N. Andrew Peterson¹,³ and Joseph Hughey²

Abstract

Health educators have embraced empowerment as an alternative to traditional frameworks that place greater emphasis on individual health behaviors than socio-political factors that promote or constrain life-style choices. A critical element of empowerment theory for health educators is the participatory process in which people might engage to improve quality of life. As a piece of participatory process, social cohesion is an emerging construct that links community participation with notions of trust, shared emotional commitment and reciprocity. This study builds on prior research by exploring whether gender interacts with social cohesion to predict intrapersonal empowerment. Data were collected from interviews with randomly selected community residents. Extending previous studies, the findings showed that the effects of social cohesion on intrapersonal empowerment were different for females and males. Implications for community interventions and directions for future research are discussed.

Introduction

Empowerment is a ‘social action process by which individuals, communities, and organizations gain mastery over their lives in the context of changing their social and political environment to improve equity and quality of life’ [(Minkler and Wallerstein 1998), p. 40]. Health educators view empowerment as a vital target for intervention, usually treating it as a mediating variable between the implementation of health programs and the achievement of critical health outcomes (McLeroy et al., 1988; Freudenberg et al., 1995; Minkler et al., 2001). The approach is widely applied. Examples include the involvement of urban residents in community problem solving (Schulz et al., 1995), a collaborative partnership addressing youth antisocial behavior (Randall et al., 1999), promotion of patient–nurse discussions regarding concerns about impending surgery (Kettunen et al., 2001), a life-skills education program for elderly people (Heathcote, 2000), an HIV prevention program for Latina immigrants (Gomez et al., 1999), implementation and evaluation of an HIV/AIDS prevention project for Mexican gay men (Zimmerman et al., 1997), organization of community consortia addressing infant mortality among African Americans (Minkler et al., 2001), and formation of a heart disease prevention program for inner-city public high schools (Altman et al., 1998).

A crucial element of empowerment theory for health educators is the participatory process through which people work to improve health. More research is needed, however, on variables that affect the relationship between participation and empowerment in community contexts (Rissel, 1994; Wallerstein and Bernstein, 1994; Zimmerman, 2000). Could it be that participatory processes intended to optimally promote empowerment might function differently for women and men? Although
some work has scrutinized the complex ties between community participation and empowerment, clearly this relationship is not thoroughly understood, particularly as it relates to gender (Itzhaky and York, 2000).

Our study focuses on the intrapersonal component of psychological empowerment. Zimmerman and colleagues have contributed much of the theoretical work on empowerment (Israel et al., 1994; Schulz et al., 1995; Zimmerman, 1995, 2000; Zimmerman and Warschausky, 1998; Zimmerman and Zahniser, 1991). Individual-level empowerment may be labeled psychological empowerment (PE) (Zimmerman, 1990; 2000; Zimmerman and Rappaport, 1988). Zimmerman (Zimmerman, 1995) and others [e.g. (Parsons, 1998; Speer et al., 2001)] conceptualize qualities of PE as comprised of intrapersonal, interactional and behavioral components. The intrapersonal component includes self-perceptions concerning ‘domain-specific perceived control and self-efficacy, motivation to control, perceived competence, and mastery’ [(Zimmerman, 1995), p. 588]. The interactional component refers to critical awareness and understanding of the socio-political environment. The behavioral component includes actions intended to directly affect outcomes. Although empowerment is often described as a multi-level construct including psychological, organizational and community levels, PE has been identified as a primary goal of intervention. Most investigators of empowerment have focused on the intrapersonal component of PE. Therefore, to link our research to that of others, we operationalized empowerment as intrapersonal PE.

The literature on community participation and empowerment generally holds that participation is a precursor to empowerment. Building on earlier statements of empowerment (Rappaport, 1987), Zimmerman (Zimmerman, 1990) and Zimmerman and Zahniser (Zimmerman and Zahniser, 1991) tested the community participation–empowerment link, finding that participation predicted empowerment across three different samples that varied by age, life style and geographic location. Although using somewhat different conceptions of community participation and empowerment, and methods of study, others have confirmed the overall relationship between the two (Bond and Keys, 1993; Rich et al., 1995; Schulz et al., 1995; Saegert and Winkel, 1996; Speer et al., 2001). There are meaningful caveats, however, that highlight the complicated route from participation to empowerment (Itzhaky and Schwartz, 1998). Others have suggested moderating variables (Itzhaky and York, 2000; Speer et al., 2001) or the potential reciprocal or developmental relationship of participation and empowerment (Kieffer, 1984; Speer and Hughey, 1995). In sum, there seems to be an important association between community participation and empowerment, and there are strong indications that other variables may influence this relationship. Studying some of these nuanced effects would, therefore, advance understanding of empowerment processes. Of particular importance to health interventions are possible influences of gender or relational variables. Many public health interventions separately target women or men, and processes that ignore or fail to leverage gender or relational differences may miss the mark and thereby risk being ineffective.

Itzhaky and York (Itzhaky and York, 2000) asked if gender moderated the relationship between community participation and empowerment. In a sample of community activists in Israel, they found that gender interacted with participation to significantly predict empowerment. Women with higher empowerment scores tended to participate more inside organizations and were more likely to participate in organizational decision-making processes, whereas men with higher empowerment scores were more likely to participate in the community as representatives of other residents. Their study suggested that women and men may differ in the ways they achieve empowerment.

Another way to further understand the participation–gender–empowerment bond was suggested by Speer et al. (Speer et al., 2001). Their research examined community participation and empowerment through the lens of social cohesion—a construct that considers participation in the context...
of relational notions such as trust, shared emotional commitment and reciprocity among community members (Kawachi and Kennedy, 1997; Robertson and Minkler, 1994; Wilkinson, 1996). Speer et al.’s study combined community participation and sense of community to examine four conceptually distinct social cohesion categories, including (1) unconnected non-participants (i.e. individuals below the median on both sense of community and participation in community groups and activities), (2) unconnected participants (i.e. individuals below the median on sense of community, but above the median on participation), (3) connected non-participants (i.e. individuals above the median on sense of community, but below the median on participation) and (4) connected participants (i.e. individuals above the median on both sense of community and participation). Speer et al. found important differences between individuals in these categories on measures of empowerment. Overall, unconnected non-participants were found to be lower on empowerment than both unconnected participants and connected participants, suggesting that the relational aspect of participatory experience (i.e. connectedness) may be a critical element in understanding the mechanisms of empowerment. They did not include gender in their analyses; however, if connectedness were to inform the relationship between participation, gender and empowerment, it might help to unveil different participatory pathways to empowerment for women and men. Although there is a growing literature on gender issues in empowerment, most of this work has studied empowerment experiences within only one gender [e.g. (Swift et al., 2000)] rather than processes and outcomes among diverse samples of females and males. Investigating this question, using a diverse sample, may be useful to empowerment researchers and practitioners as they begin to articulate the role of gender and relational variables in empowerment-based participatory processes. If some forms of participatory experience were found to be more likely to lead to empowerment for females and others for males, interventions could be designed to better fit these subpopulations.

Method

Sample
A total of 661 randomly selected community residents participated in the survey (response rate = 59%). The sample was 57% female, 54% white, 20% Hispanic, 12% African-American and 8% Asian. Fourteen percent were age 18–24, 47% were 25–44, 24% were 45–64 and 15% were 65 or older. Thirty-five percent reported annual income of less than $30,000, 15% reported income between $30,000 and $39,999, and 50% reported income of $40,000 or more. Educationally, 6% had less than high school, 30% had completed high school, 24% had some college, 24% had a college degree and 15% had a graduate degree.

Measures
As shown in Figure 1, community participation was the predictor, gender and connectedness were moderators, and political efficacy and perceived leadership competence were the criterion variables. Scale scores for the predictor, connectedness and the criterion variables represented the mean of items for each measure. Consistent with Speer et al. (Speer et al., 2001), we used four measures—three representing community participation (i.e. civic participation, organizational membership and organizational involvement) and a measure of connectedness (i.e. sense of community) to allow for analysis of social cohesion categories based on participation and connectedness.

Community participation
The measure of civic participation included eight items asking respondents to indicate the frequency of involvement in community action activities (e.g. signed a petition, written a letter to influence local policies, attended a public meeting to pressure for a policy change) over a 3-month period. Respondents answered using a four-point Likert-type scale ranging from ‘not at all’ to ‘5 times or more’. Cronbach’s α for the participation scale was 0.81 (M = 1.67, SD = 0.62). Organizational membership was measured by an item asking respondents to indicate whether they were members of community
groups such as school/parent groups, civic/community organizations or faith organizations \((M = 1.14, SD = 0.91)\). Organizational participation was assessed by asking respondents to indicate (four-point Likert-type scale) how often they participated in community organizations during the past 3 months \((M = 1.84, SD = 0.79)\).

**Connectedness**

The measure of connectedness was a 12-item sense of community scale widely used in previous research (McMillan and Chavis, 1986). Items measured shared emotional connection, reinforcement of needs, membership and influence (five-point Likert-type scale). Support for the measure’s construct validity has come from several studies [e.g. (Perkins et al., 1990; Pretty and McCarthy, 1991)]. Perkins et al. (Perkins et al., 1990) reported a Cronbach’s \(\alpha\) of 0.80; reliability of the measure for the present study was 0.78 \((M = 2.81, SD = 0.58)\).

**Intrapersonal empowerment**

The abbreviated version of the Sociopolitical Control Scale (Zimmerman and Rappaport, 1988; Zimmerman, 1990; Zimmerman and Zahniser, 1991) was used to assess intrapersonal empowerment. Four items measured beliefs about political efficacy and four items measured perceived leadership competence. Similar to other studies, Cronbach’s \(\alpha\)s were 0.67 and 0.64 for political efficacy \((M = 3.41, SD = 0.94)\) and perceived leadership competence \((M = 3.44, SD = 1.01)\), respectively.

**Procedures**

Data were collected as part of a larger study evaluating a substance abuse prevention intervention in the northeastern US. Using a household telephone directory in electronic format, all residences with phone numbers in the study area were selected as the sampling frame. A simple random sample was then selected. The survey was administered by eight trained surveyors through telephone interviews typically lasting between 20 and 30 min.

**Results**

Analyses examined effects of community participation, connectedness and gender on two criterion measures representing intrapersonal empowerment. Consistent with Speer et al. (Speer et al., 2001), median splits of overall community participation (computed as the mean of the three participation subscales) and connectedness (computed as the mean of the sense of community items) were used to analyze social cohesion categories. In addition, we included gender. A three-way multivariate analysis of covariance (MANCOVA) was performed to examine how females and males in social cohesion categories varied on measures of intrapersonal empowerment. We included as covariates other demographic variables, i.e. age, race, education and income, which may be considered proxies for social position and expected to predict individual-level empowerment (Schulz et al., 1995).
To align our analyses with previous research, we examined main effects. MANCOVA results indicated statistically significant main effects for participation [Wilks’ \( \lambda = 0.93; F(2, 507) = 18.29, P < 0.001 \)], connectedness [Wilks’ \( \lambda = 0.94; F(2, 507) = 17.63, P < 0.001 \)] and gender [Wilks’ \( \lambda = 0.97; F(2, 507) = 9.16, P < 0.001 \)]. The main effect of participation was significant for political efficacy, \( F(1, 508) = 10.55, P < 0.01 \), with participants (\( M = 3.31 \)) scoring higher than non-participants (\( M = 3.16 \)), as well as perceived leadership competence, \( F(1, 508) = 33.27, P < 0.001 \), again with participants (\( M = 3.73 \)) scoring higher than non-participants (\( M = 3.22 \)). The main effect of connectedness was significant only for political efficacy, \( F(1, 508) = 34.90, P < 0.001 \), with connected respondents (\( M = 3.68 \)) scoring higher than unconnected respondents (\( M = 3.21 \)). The main effect of gender was significant only for perceived leadership competence, \( F(1, 508) = 14.35, P < 0.001 \), with males (\( M = 3.64 \)) scoring higher than females (\( M = 3.31 \)).

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More important for this study than main effects, a three-way interaction between gender, participation, and connectedness was significant, Wilks’ \( \lambda = 0.98; F(2, 507) = 4.70, P < 0.05 \), such that this interaction was significant only for perceived leadership competence, \( F(1, 508) = 5.23, P < 0.05 \). Table I presents mean empowerment scores for females and males in social cohesion categories. Figure 2 graphically illustrates the nature of the interaction. The data showed that among connected males, non-participants and participants did not significantly differ in their empowerment. Among unconnected males, however, the difference on empowerment between non-participants and participants was significant. Conversely, among unconnected females, non-participants and participants did not significantly differ on empowerment, while the difference between connected female non-participants and participants was significant. These data indicated that community participation predicted empowerment but only for unconnected males and connected females. Community participation did not predict empowerment for connected males or unconnected females.

### Discussion

This study examined the role of gender in community processes considered critical for the development of empowerment. Results showed that participation was more strongly associated with empowerment for unconnected males and connected females. These findings pinpoint a crucial
intersection for women and men between participatory processes and empowerment. Although previous researchers have adopted a gender perspective to study empowerment [e.g. (Saegert, 1989; Gutiérrez, 1990; Yoder and Kahn, 1992; Dixon, 1993; Riger, 1993; Browne, 1995; Abrahams, 1996; Swift et al., 2000; Valaitis, 2002)], most have focused on describing experiences within only one gender rather than examining empowerment processes and outcomes among substantial numbers of females and males. Adding to the one other closely related study that examined the effect of gender on the relationship between community participation and empowerment [i.e. (Itzhaky and York, 2000)], our study showed that gender may affect empowerment because of different participatory experiences related to connectedness. We found that the effect of participation on empowerment was different for women and men, but only when connectedness was taken into account. This implies that a key element to understanding gender differences in empowerment appears to be the relational aspect of participatory experiences.

A complicating feature of the empowerment construct is the fit between individual characteristics, e.g. gender, and empowerment processes for empowerment outcomes (Zimmerman, 2000). Our findings reinforce the contention that empowerment processes are complicated, multifaceted and may manifest differently for women and men. While Itzhaky and York’s (Itzhaky and York, 2000) research implied that women activists were less concerned with external representation than men and more concerned with internal organizational action, our sample of community residents yielded data showing that women were more empowered than men by participatory processes coupled with connection to community. This suggests that empowerment for women may be more effectively enhanced through participation in community groups and activities in which relational processes are emphasized. Empowerment for men, on the other hand, may be optimized by participatory processes emphasizing action. One explanation for our findings concerns the inequities in the distribution of power and resources between women and men in American society. Women have historically had less power than men in the US, which is manifested through less representation in government and media as well as less access to top-paying jobs. As is widely noted [e.g. (Saegert, et al., 2001)], women are disproportionately affected by disadvantage and are therefore more available to populate settings that may be empowering. These conditions may require women to develop an understanding of the importance of interpersonal
relationships in maneuvering through complex socio-political situations. Conversely, men’s historically privileged status may lead them to perceive their own empowerment as due to individual actions rather than investment in a network of complex relationships.

Our findings have important implications for health education research and practice. A key implication of our study is that health education researchers should attend to the fit between gender and relational features (e.g., opportunities for connectedness) of the community settings and activities in which they are promoting citizen participation. Much of the empirical work on this topic has focused on demonstrating the link between participation and empowerment (Le Bosse et al., 1999). Others have argued [e.g., (Zimmerman, 2000; Peterson and Hughey, 2002)], however, that more research is needed to understand the ecological context of empowerment. Studies that recognize the intersection of individual characteristics and relational qualities of activities that affect citizen participation could assist health educators in fostering empowerment and improving health. Our findings also have implications for theory by suggesting that ecological specificity is important for developing empowerment. Maton and Salem (Maton and Salem, 1995) introduced a critical conceptual distinction between ecological commonality (i.e., the extent to which setting characteristics are commonly important across settings) and ecological specificity (i.e., the extent to which setting characteristics are uniquely important for empowerment within specific contexts). Applied to this study, ecological specificity directs attention to the interaction between individual and relational variables for empowerment. Studying person-in-environment phenomena requires analysis of complex interactions, as in this study. Bronfenbrenner [(Bronfenbrenner, 1977), p. 518] put it thusly, ‘to corrupt, only slightly, the terminology of experimental design: In ecological research, the principal main effects are likely to be interactions’.

As a stressor negatively affecting health, disempowerment is a condition that health education practitioners continue to address through interventions (Israel et al., 1994). Our findings add to the knowledge base by further elucidating participatory experiences that lead to empowerment. First, our results showing a main effect of participation on both elements of intrapersonal empowerment, i.e., political efficacy and perceived leadership competence, add to the confidence with which health educators can facilitate empowerment by promoting community participation for individuals. For practitioners, strategies that cultivate opportunities for citizens to become participants in community organizations and activities represent empowering interventions. Previous research identified four setting characteristics that facilitate participation and empowerment for individuals: development of active leadership, opportunities to take on multiple roles, social support and a shared set of beliefs which provides a rationale for the group’s actions (Maton and Salem, 1995; Minkler et al., 2001).

Focusing on the nuances of participation within community health contexts allows not only opportunities to enhance empowerment, but also to support connections between individuals so that a collective sense of trust, commitment and action can be developed. In her influential discussion of empowerment and power, Riger (Riger, 1993) emphasized the inherent weakness of individualizing the notion of empowerment by emphasizing psychological change. It seems to us that when practitioners attempt to navigate the participation–gender–empowerment dynamic, it would be tempting to steer toward participatory behavior as a prime force for empowerment. Emphasizing behavior without attending to relational issues, however, may risk falling short. Instead, those interested in development of health promotion settings that yield empowerment might do well to tailor role structures (Maton and Salem, 1995; Minkler et al., 2001) with a variety of niches, some emphasizing community actions that involve interpersonal connections and others that entail action less imbued with interpersonal bonding. Together with previous research, the present findings clearly indicate that a one-size-fits-all approach to empowerment for females and males will maximize empowerment for neither. Considered with the work of Itzhaky and York...
(Itzhaky and York, 2000), research now appears to indicate that participation can best foster empowerment in women when it emphasizes relational bonds (e.g. trust and emotional commitment), rather than activities that may entail lower levels of social connectedness. This does not imply that participation for women should be restricted to internal relations (Abrahams, 1996). Nor does this imply that empowering participation for men be restricted to external bargaining. Rather, our findings suggest that women may be more likely to achieve empowerment from participation based on connectedness. We see it as equally imperative to understand the needs of individual women and men. Intentionally formed processes for listening to participants, integrated with carefully designed organizational structures that take external action and evaluate the action for both internal and external effects, is recommended (Speer and Hughey, 1995).

Our data suggest the need for strength-based role structures that promote gender-sensitive, meaningful niches that are mutually supportive of the strengths of each gender. These structures could be stimulated by creating multiple behavioral niches within organizations to accommodate women and men. As applied to health educators working on, say, Type II diabetes, this would entail structuring the organization so as to encourage women to develop a network of supportive social connections within the group prior to developing actions, such as strategies to reduce sweetened beverage consumption. One specific tactic to create opportunities for social connectedness might include frequent and periodic re-telling of life stories that highlight conditions of struggle or economic disadvantage (Rappaport, 1995). This tactic could also be used for men. For men, our research recommends a series of research or monitoring activities aimed at identifying settings likely to encourage unhealthy consumption or discourage exercise. Stories of these action-oriented experiences could then be told. Addressing cardiovascular disease in men, health educators might organize groups so that agendas lean toward concrete actions focused on, for example, creating environments that make healthy choices easy choices. For women, a stronger investment might be made in resources for relation-based group processes prior to action. Recognizing and valuing the stories of both women and men may facilitate trust, interdependence and develop a sense of community that sets a firm stage for joint action. From these different bases, joint consideration could then be more profitably given to strategies for change. The end result is that community organizations may become more empowered (e.g. able to influence public policy and practice) because they are able to leverage the diverse strengths of women and men.

While recognizing the potential value of gender-tailored empowerment processes, we also emphasize avoiding gender-stereotyped processes. One qualifier and implication of our findings is that mean values can mask important intragroup variance, i.e. some women may achieve empowerment through participation involving less connectivity and some men may need participation with highly connective experiences to achieve their empowerment. So, a deep understanding of individuals and their needs is recommended. This approach, however, may expose barriers to recommended strategies. Riger’s work with feminist movement organizations (Riger, 1984) showed that efforts to focus on shared leadership and decision making were undermined by demands for accountability by funders. These demands discouraged reliance on time-consuming processes that facilitated interpersonal understanding and emotional bonding, and failed to recognize the potential power in that kind of intimacy. Our findings imply that health education practitioners should incorporate specific strategies that facilitate opportunities for both women and men to assume a variety of roles in their quest for empowerment. These strategies can enhance empowerment, thus potentially limiting exposure to risk factors, improving coping responses and, consequently, attenuating the deleterious effects of stress on health.

Several limitations to this study should be recognized. First, telephone survey methodology has traditionally been criticized as biased against those without phones and unreliable when asking complicated or sensitive issues. The low response
rate of many telephone surveys is a potential limitation, although the achieved response rate in this study seemed respectable. Second, this study was also limited in its focus on one facet of empowerment theory—intrapersonal empowerment. Other variables, such as alienation and inter-actional empowerment, could be used. Finally, the present cross-sectional design limits causal interpretation of the data. These limitations require careful consideration, especially when generalizing findings to other settings or populations.

These limitations were balanced, however, by inclusion of probability sampling, multiple measures of participation, and the emphasis on the role of gender and connectedness in empowerment processes. The limitations are also offset by the consistency of these findings with previous research showing a relationship between community participation and empowerment (Zimmerman and Rapaport, 1988; Zimmerman, 1989; 1990; Zimmerman and Zahniser, 1991; Zimmerman et al., 1992; Bond and Keys, 1993; Rich et al., 1995; Schulz et al., 1995; Saegert and Winkel, 1996; Speer et al., 2001), and the relevance of gender (Itzhaky and York, 2000) and connectedness (Speer et al., 2001) in the participation—empowerment bond. Finally, our most compelling conclusion with implications for empowerment theory is that gender and the relational quality of participatory experience should be more carefully considered when promoting empowerment. Future research should examine other dimensions of empowerment, and the moderating effects of other variables on the relationship between community participation, empowerment and health.

References


