

Between power and powerlessness – discourses in the individual plan processes, a Norwegian dilemma

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The purpose of this article is to explore what may cause tensions in the work with IP processes and discuss this in the light of power and powerlessness. The project is designed as a multi-case study. Qualitative data were collected through semi-structured individual interviews and observations from group meetings. Quantitative data were collected through a questionnaire focusing on activities of daily living, as well as from documents such as the available individual plan itself and official minutes of the meetings. The analysis of the material is based on a sociological discourse analysis. The three power discourses disclosed were *power of knowledge*, *power of language*, and *power of definition*. *Power of knowledge* refers to the clients' expert knowledge of themselves as well as the professionals' knowledge whereas the informants experienced *power of language*, as a physical, psychological, and social instrument to present the client's case. The holder of power of knowledge and power of language possesses *the power of definition* regarding the individual plan process, but the study revealed nuances in this relationship. More attention and self-awareness should be paid to the relationship between the trust professionals are given by the clients and the position of power this entails when collaborating in IP processes.

Keywords: individual plan; power; powerlessness; qualitative method; discourse analysis

Introduction

In order to deal with a challenge described as a dilemma between standardized solutions and lack of individual help in rehabilitation (Storting White Paper no. 25 1996–97), the Norwegian Parliament approved an act on the statutory right to have an Individual Plan (IP) drawn up. Clients who are users of long-term, coordinated health and/or social services are entitled to an IP. This is regulated in Health Care Act of 1999 and in Social Work Act of 2003 (Kjellevoid 2005). An IP is a tool for cooperation between the client and the public services and between the different service providers, sometimes also the relatives. Strengthening this interaction is meant to ensure that clients' needs for assistance are met, whether it is assistance

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from the health services, the social services, the Norwegian Labour and Welfare Organization (NAV) or educational assistance.

The individual plan should be voluntary and based on informed consent. Informed consent in this context implies that the client should be informed about exchange of information between different professionals included in the planning process, what information is exchanged, and also the client's right to refuse such exchange. The individual plan process gives the client the right to ethically acceptable actions executed with respect for the client (Kjellefold 2005). An IP is a personal plan and will contain an outline of the client's objectives, his/her resources, and the services required. The IP takes precedence over other plans. Other plans, such as an Individual Educational Plan or a Treatment Plan should be coordinated with the IP. The clients have the right to participate throughout the planning process. They are the best judges of their own situation, and professional personnel know which solutions and assistance are available to them (Health and Care Department 2004).

To our knowledge 'Individual Plan' is a Norwegian concept. The guidelines for the individual plan were introduced to secure the client a comprehensive, coordinated, and individually adapted service. However, the implementation may cause communication problems, and result in inappropriate interventions. This process could be experienced as meaningless from the client's point of view and can sabotage the collaboration between the helper and the person in need of help (Thommesen, Normann, and Sandvin 2003; Thommesen 2004).

Furthermore, the medical focus on rehabilitation versus the social expectation of participation in society may cause a dilemma for the client (Helgøy, Ravneberg, and Solvang 2003; Ladd 2003; Moser 2003).

The professionals claim to focus on client-centred practice. Despite this statement, people with impairments often perceive this relationship as asymmetrical and to a certain extent hierarchical (Barnes and Mercer 2003). This asymmetrical relationship tends to reinforce the professional's power and increase the powerlessness that people with impairments might experience (Barnes and Mercer 2003). Mike Oliver argues that the central problems within rehabilitation are the failure to address the issue of power and to acknowledge the existence of ideology (Oliver 1996, 104).

The main purpose of this article is to explore what may cause tensions in the work with IP processes and discuss this in the light of power and powerlessness.

Theoretical framework

The discourses of power and powerlessness will be discussed in the light of social and medical theories on power. In the book, *The healer's power*, Brody (1992) tries to shed light on responsible use of power. In professionals there is an asymmetric power relationship towards the clients and this is part of the mandate of the professionals from society. He claims that responsible use of power implies three general perspectives: *owned power*, *aimed power*, and *shared power*. This is deduced from Ladd (1980) who suggests three components of responsible exercise of power. The components are: (1) *Realism* which implies to be aware of the consequences of one's actions; (2) *Accountability* which is to give explanation of one's use of power in order to include others into the decisional process; and (3) *Purposiveness* where the intention of the action is made explicit and conscious when using power instead of

just drifting along and not knowing what this particular use of power will lead to (Brody 1992, 42).

In addition, Brody (1992, 16–7) refers to three kinds of power in health care settings: (1) *Aesculapian power* refers to the power the professionals own by virtue of their professional training and by the knowledge and practical skills she or he possesses as a professional; (2) *Charismatic power* is part of a personal trait and personal qualities which both the health care professionals and the client may possess; and (3) *Social power* which arises from the social status the professional may have. This includes cultural power. Social power is part of the authority health care professionals are given by the society (Brody 1992). This power can explain how health care professionals are given the power to define the context and situation within health care. They may define who is sick, who is entitled to an individual plan, and who should be allocated resources for rehabilitation, and so forth.

Perspectives on how trust can serve as a context in which power is exercised contribute to a theoretical framework for analysing the social conditions for establishing, maintaining, and eroding relations of trust (Grimen 2001, 2009). Trust has a transactional side. It involves transferring decisional power from one person to another. The relation between the health professionals and the patients/clients are founded on mutual trust. This trust gives the professionals room for action but also power to act. Power used to the client's advantage is described as 'beneficial power', but trust also creates structural conditions for power which need not be beneficial (Grimen 2009). 'It is trust that allows beneficial power to exist' (Hall and Berenson 1998, in Grimen 2009). In an article on how institutions may establish relationships of trust in an environment of unequal power, Oskarsson, Svensson, and Öberg (2009) found that if the institutions have fair rules and formal conflict resolution procedures, distrust may be reduced even in situations with power asymmetries. Power can have different forms, dependent on the tasks of the professionals and the institutional settings in which the interaction takes place (Grimen 2009).

Power can be exercised by health professionals through their function as supervisors of beneficial services that a patient's needs (Grimen 2001, 2009). The health professionals often have a double position, described as 'gatekeepers' (Grimen 2009). Gatekeepers have to consider different wishes and demands based on medical, social, economical, and administrative conditions. Professionals, in their role as gatekeepers may face different demands, and can also be motivated by own interests (Grimen 2001). Descriptions on how individuals function in social life can be described as 'interactive concepts' or 'indifferent concepts' (Hacking 2001). The understanding of an interactive concept is that it can affect our understanding of social life, whereas an indifferent concept cannot. Power is an example of an interactive concept. How we understand the concept of power has practical, social, and political consequences for what we see as power, how we behave in power relations, or what instruments we consider legitimate in acquiring, exercising, and maintaining power (Grimen 2001, 2009). Research shows that power mediates ways of moral thinking (Lammers and Stapel 2009). Unlike a person with power who tends to have a more duty-based and deontological way of reasoning, a person who experiences powerlessness will have a more consequence-based reasoning (Lammers and Stapel 2009).

Material and method

Design

The design is a multi-case study. In this study, a case is defined as a group of people involved in working with an individual plan. The group includes clients, relatives, and professional service providers. A case study implies following a case using multiple sources such as interviews, observations, and reading relevant documents (Andersen 1997; Yin 2003).

Sample

The inclusion criteria were clients over 18 years, eligible for an 'individual plan' for their rehabilitation processes. The individual plan was voluntary for the client. The relatives and the professionals that were included were selected by the clients themselves. We gave directions to those who provided us with informants that we were looking for in ordinary cases, not obvious conflict cases or cases with a lot of tensions. Inclusion was closed when saturation was achieved.

A total of 13 clients which represents five women and eight men were interviewed. Each client selected one of their relatives and one of their service providers to be interviewed. Seven relatives and 10 professionals were interviewed after the clients had given their permissions. This gave a total of 30 informants. Six relatives and three service providers were not interviewed due to lack of permission from the clients. All the professionals who were interviewed were coordinators of the IP group. The professions represented were physiotherapists, occupational therapists, registered nurses, and social workers. Both sexes were represented in the cases but women were predominantly represented. The clients were between 20 and 73 years, with a mean age of 42. They had different kinds of challenges causing the need for an individual plan, such as traumatic brain injuries, spinal cord lesions, and neurological conditions including stroke and Parkinson's disease, psychiatric conditions, drug addiction, and rare syndromes affecting sight (see Table 1).

The time span between onset of the clients' problems/illnesses and the introduction of the individual plan varied. For 10 of the clients the individual plan was implemented after they had been living several years with the need for coordinated services. Two clients started working with their IP after a few months of illness and one client had recently been injured, when his IP was introduced.

Most of the clients had short experience with the individual plan when interviewed, four clients were in the initial phase of the IP process, and seven clients had had their plans for a few months. Only two clients were experienced users and had had their plans for several years. The interviews were mainly performed in the clients home (n = 6), at the client's workplace (n = 1), in a health or social institution (n = 4) or in the office of the interviewer (n = 2).

Ethical consideration

The study is approved by the Regional Ethical Committee; South-East, and was authorized by the privacy protection ombudsman of NSD (Norwegian Social Science Data Services). The recruiting process included acceptance from hospital and community service offices.

Table 1. Descriptive information of holders of the individual plan and time perspectives, perceived purpose and initiator of t.

Participants	Gender	Age	Diagnosis	Participants main purpose with the individual plan	Experience IP	In need of services/ rehab	Initiator IP
1	Male	47	Bipolar condition	Organize services and life	4 years	8 years	Health services
2	Female	48	Bipolar condition	Structure life	new	1.5 years	Health services
3	Female	33	Burned out syndrome/ anxiety	Administration of all services involved	6 months	2 years	Social services
4	Female	24	Anxiety/ heart disease	Follow-up services	1 year	5 years	Health services
5	Male	72	Parkinson, stroke	Training and assistance	3 years	3 years	Health services
6	Male	22	Rare syndrome, involving gradual loss of sight – nearly blind	Structure work situation	2 years	15 years	Family and himself
7	Male	47	Rare syndrome, involving gradual loss of sight. Blind	Social integration	new	40 years	Health services
8	Male	20	CP	Plan life: education, living conditions	Had IP from childhood until 18 years. Now restarted	Up to 18 and now	Health services
9	Female	37	Tetraplegic	Administrative document to organize practical help	2 years	2 years	Health services
10	Female	48	Encephalitis	Administration of all services involved	6 years	9 years	Patient
11	Male	72	Tetraplegic	Practical administration of help services	6 months	2 months	Health services
12	Male	49	Stroke	Practical administration of help services	1 year	3 months	Health services
13	Female	31	Bipolar condition	Framework for the future and how to avoid becoming ill	1.5 years	15 years	Health services

Method

An inter-professional group of six health and social researchers collected the data. Qualitative data were collected by semi-structured individual interviews and observations from group meetings with the clients and the professionals. Quantitative data were collected by a questionnaire focusing on personal and instrumental activities of daily living (ADL) as well as documents such as the available individual plan itself and official minutes from the meetings.

Analysis

The analysis of the material is based on a sociological discourse analysis. In sociology, discourse is seen as an institutional way of thinking. It is a social framework which defines what is allowed to be said and how people talk about given issues in a social context. The dominant discourses will have consequences in the social context and for the participants. At the same time a focus on discourses shows how we might understand the world in a different way if other discourses were dominant (Jørgensen and Phillips 1999).

The focus of the analysis is how clients, relatives, and professionals talk about individual plan processes. Both the transcriptions from the in-depth interviews, the field notes, and the content of the clients' 'individual plan' formed the text that was analysed. A discourse analytic approach allowed the researchers to move beyond the intentions behind delivery of social services and to identify what meaning and consequences the discourses have in different contexts.

The analysis was conducted according to Parker's analytic process. This process consists of a number of analytic steps (Parker 1999). The analysis was inductive and the focus was on how the informants talked about the content of the plan and on how they perceived the IP process. The first step of the analysis consisted of a thorough reading with free associations to the text to grasp the meaning as a whole. Then we looked for variations related to tensions in the planning processes. Next, categories in the text were itemized systematically to highlight different issues of power and powerlessness within the individual plan process. The variations of tensions related to power and powerlessness were categorized. In the final analysis three different main discourses related to power were explored: *power of knowledge*, *power of language*, and *power of definition*. Further, culture and different opinions were discussed and the discourses were seen in relation to each other.

Findings

The findings disclosed three main discourses in the work with the individual plan: Knowledge is power; Language is power; and Power of definition. The power of definition seems to be a result of the knowledge possessed by the client and the coordinator, and how this knowledge is expressed through language and communication.

Knowledge is power

The client will often be an expert on his own conditions and his own life and will have his own opinion on how best to deal with it. The interviews reveal that the clients'

knowledge about their condition is mandatory to enable them to cope. On the one hand, the more experienced clients consciously use their expert knowledge in selecting how much and what kind of information they want to share with the different professionals in different situations. One example is a young client who expressed that in order to release benefits; he had to use his expert knowledge focusing mainly on all the negative aspects of his situation. The feeling of distrust and the need of negative exposure lead to a feeling of powerlessness. On the other hand, another client who was a novice in the health system chose to hand over more of the responsibilities and leave the decisions to the professional experts as to what kind of help he would need to have at home:

In principle, I must say that it is appropriate that the experts are those who handle my rehabilitation. If necessary we can provide input when things do not work. I cannot see how I am in a position to dictate those who are experienced professionals.

This client seemed to have full confidence in the helpers and their decisions, and trusted their expertise and ethical behaviour. At the same time he participated actively in the discussion, giving his opinion and expressing his needs. Another client emphasizes the importance of having an IP, but stresses that she deliberately hands over the power to define the contents to the coordinator. She does so in the assumption that the coordinator 'knows best', that is, has knowledge of the client's condition and needs, and can explain these better for relevant others.

Similarly, the helpers emphasize that knowledge is power. They focus on their own knowledge of the health system and their own capacity to manoeuvre in the same. The individual plan should ideally include actions and rights for the clients, but sometimes key-persons in the system fail to follow up and/or the clients do not get what they are entitled to. In these situations the coordinator may need to take 'short cuts' in order to reach the goals stated in the individual plan. Using his or her knowledge of the health and social systems, the pro-active coordinator takes informal contact with 'the right person' in order to speed up the process or solve the problem.

Language is power

Being eloquent

One client with a bipolar illness was well formulated regarding his own condition and life-situation. In this way, he was in control of the process of his own IP. His main concern was his economical situation in that he had lost his house and his business. He was well aware of the connection between his illness and his economical disaster. He was able to communicate this to his professionals in the IP group and together they came up with a strategy where his brother was appointed economical legal guardian with the IP team as supporting team. His rhetorical skills among others have helped him to regain control of his economy, and of his life.

Another example shows that rhetorical skills can make discrepancies more visible; an example from an IP meeting illustrates this. The client was a young man who had just begun a program of adapted work. The discussion in the IP meeting focused on how he enjoyed and managed the work. The client was very eloquent and self-confident when describing his experiences; expressing confidence and feeling of success. His mentor, on the other hand, was of a different opinion; expressing

concern regarding his client's social interactions and his ability to handle stressful situations.

The informants were different with different problems. One client showed little interest in the IP and the process as such, and considered the plan a sole remedy for the professionals. She did not experience the plan as a tool for her own personal use in the planning of her everyday life. The client had difficulties in articulating her problems, wishes, and needs. Another example was a man with a newly diagnosed brain injury who expressed his needs and wishes in the IP plan process with eloquence, but seemingly unrealistic goals. He was severely injured physically and had reduced cognitive function. He had lost his driving license and argued for regaining it. The arguments were presented in an eloquent manner, and justified with practical and reasonable arguments.

Loss of speech

With a loss of speech a spokesman needs to be appointed in the process of the IP. Often this is a close relative. The material shows how this can lead to situations where the relative speaks for the client. A wife who spoke for her husband had professional knowledge and experience related to similar situations. Having known his values throughout a long life, she spoke of her husband and his needs with respect for his wishes and integrity. In situations where it seemed that the two had intersecting interests; the wife's priorities seemed to take precedence. This was more likely to happen when the situation demanded a lot of her energy.

Bureaucratic language as power

Inaccessible language is also a reason for feeling powerless. When receiving written decisions regarding rights to public support, the informants described problems in understanding the terms, with references to laws and acts. Even professionals expressed difficulties in understanding the contents of letters from the public authorities describing the decisions made on behalf of the clients. A coordinator that knows the public system well, and is capable of clarifying the meaning and consequences of decisions made, reduces the feeling of powerlessness.

Power of definition

The material shows how clients' and professionals' self-understanding and understanding of the world will reflect how they understand or define a situation. The first example illustrates the cooperative process between the client and the professionals in her IP group and is related to the client's obligations to mutual agreements. This client, with a psychiatric condition, shows a more or less unpredictable behaviour as to when she chooses to attend previously agreed meetings with her IP group. Instead of involving herself in discussions with the IP group, where she would have had the opportunity to signal approvals and disagreement, she chooses a strategy of non-attendance. When encountering problems, she chooses an ad hoc solution, by contacting individual helpers.

Other clients describe the feeling of being distrusted when discussing their needs in IP group meetings. Even though the purpose of an IP is to highlight and focus the clients own goals, based on his resources and needs of assistance, professionals may

be the ones in power of defining the client's needs, as this client's experience shows: A young client in his early twenties, with a syndrome gradually leading to blindness, experienced suspicion from the professionals as to how functionally impaired he was. Despite describing himself as being functionally blind, he experienced being denied necessary measures to function as independently as possible. His mother describes the situation as a paradox:

We have tried to make him as self-reliant as possible throughout his life, and this strategy has worked well for him. And then, when we ask for help needed to continue to keep him as self-reliant as possible, they question his needs.

In order to be heard the client and his mother feel they have to conceal his resources and highlight his problems. The feeling of having to paint a desperate picture in order to have support and assistance released, makes them feel discouraged and disillusioned. The IP meetings disclosed a discrepancy between the professionals and the informants in so that the professionals attributed a greater functional capacity to him than the client experienced himself.

Yet another client expresses his own power to define his situation and goals in the IP plan: '(...) I am in control and I am the person who makes the decisions and decides the goals'.

Discussion

Two of the three power discourses disclosed in relation to individual plan processes were *power of knowledge*, that is, the client's expert knowledge of his/her own life on the one side and the professionals' knowledge on the other side, and *power of language*, as a physical, psychological, and social instrument. The holder of power of knowledge and power of language seems also to have the third power, which is the *power of definition* regarding the individual plan, but the study revealed nuances in this relationship.

The use and knowledge of the individual plan are based on explicit knowledge; however, the implementation of the same plan relies on both explicit and tacit knowledge. The concept of tacit knowledge refers to knowledge which is only known by the individual and which is difficult to communicate. The process of transforming tacit knowledge into explicit knowledge is known as codification or articulation, and can be interpreted as the interaction between knowledge and language.

The explicit knowledge in regard to the individual plan can be viewed as the knowledge of how the health and social system works. The tacit knowledge refers to cultures, psychology, and social rules in different 'communities' within these systems, but also with regard to individuals and this interpretation will have an influence on how the individual plan will be implemented. Explicit and tacit knowledge may lead to the fact that information is, consciously or unconsciously, withheld or manipulated and this, in turn, may lead to different power constructions between client and helper. Both the clients and the health care personnel were aware of the power they possessed by having knowledge of the situation, be it the clients' knowledge about their own disease and needs for coping or the health care personnel's knowledge of the possibilities in the system. The knowledge of how the injury or illness affects the body and influences life gives important information to the client how to cope with the situation (Brody 1992, 127). Brody (1992) discusses

the power to control information. In our study the informants described situations where they used their expert knowledge in order to get relevant help from the health care system by controlling what they shared with the professionals, either by withholding or elaborating information. The lack of openness when withholding information led to a feeling of powerlessness.

Withholding or manipulating information, consciously or unconsciously, can be seen as a moral dilemma due to lack of responsible exercise of power (Ladd 1980). There were difficulties in exercising the power of knowledge responsibly both in accordance to realism, accountability, and purposiveness (Ladd 1980). Realism was threatened by problems with knowing the exact consequences of one's actions and accountability was weakened by not including the other part in the decisional process. Brody (1992) discusses these forms of responsible use of power as *owned*, *aimed*, and *shared power*. The clients in our study often did not experience themselves as having power, even though they had knowledge. Exposing knowledge such as stating needs to enhance coping when suffering debilitating injuries, may lead to unwanted consequences, as for example, the loss of health care benefits like treatment in rehabilitation institutions. It is mandatory that the health care personnel explore how the situation in fact appears for the clients, how they cope with their life situation and how the health care personnel can recognize and improve this coping rather than mistrust the clients (Slettebø et al. 2009). It is the health and social care personnel who primarily possess the power of knowledge and who should aim the power at the clients as well as sharing the knowledge with them in order to provide a more equal situation between the client and the health care and social service system. Both Lammers and Stapel (2009) and Oskarsson, Svensson, and Öberg (2009) mention power as a factor which implies ways of moral thinking. When power is being exercised in an asymmetric power relation, there is a need for fair rules (Oskarsson, Svensson, and Öberg 2009).

Speech mirrors social reality but it also creates the same social reality. Inaccessible language or bureaucratic language creates distances between laymen and professionals and can be an effective way of exercising instrumental and Aesculapian power.

Bureaucratic language can reinforce the health and social systems' instrumental power giving little or no access to shared power, without a 'translator' or understanding helper.

In some spheres of social activity, both instrumental and influential power may be present at the same time, as for example, in the case of an individual plan.

The use of language would then reflect to what extent the general perspectives: owned power, aimed power, and shared power are exercised in a certain setting (Brody 1992). Language and communication are also preconditions for thoughts, emotions, and behaviour, and a result of the same thoughts, emotions, and behaviour. One obvious feature of how language operates in social interactions is its relationship with power, both influential and instrumental. Influential power inclines us or makes us want to behave in certain ways or adopt opinions or attitudes, without obvious force.

The rhetorical client may be eloquent in form and content. This client type uses speech in a highly proficient way and in combination with profound knowledge about the consequences of the disease and his/her social rights. This proficiency and knowledge could be referred to as charismatic power which enables the client to exercise influential and social power in the setting with the professionals. The

rhetorical client is an equal partner in regard to access to shared power with the professionals, as described by Brody. He achieves aimed power to a greater extent and could be said to own power in the individual plan work (Brody 1992).

However, the material reveals another rhetorical client, equally eloquent in form but less so in content. Clients with reduced intellectual capacity after a brain injury, reduced insight due to cognitive deficits or immaturity because of young age and little experience with adjusting to norms and rules, do not access the same shared power, despite eloquent speech. They possess less aimed and owned power, due to less charismatic and influential power. Despite technically proficient and rhetorical speech, the clients did not challenge the professionals' Aesculapian power by pure argumentation, influential power, and charismatic power. The power of the professionals owned by virtue of their professional training overruled the technical eloquence of the clients. The individual plan, as a document in itself is the responsibility of the healthcare and/or social system, which may be an unconscious implication of social power, arising from the mere social status of the professional (Brody 1992). This implies that the power of effectuation is in the hands of these professionals. This kind of power may also be referred to as the Aesculapian power (Brody 1992). Through the expertise of the professionals and their tacit knowledge of medical and social aspects, and of how the health and social system works, the individual plan is decoded and articulated. However, the client may have influential power through his or her way of communicating, also referred to as charismatic power (Brody 1992). The clients may use implicit techniques to gain charismatic power; by using their skills as communicators or communicating in a way that renders sympathy.

Patients with loss of speech are disadvantaged by their indirect communication although there are examples of traits of charismatic power communicated through other channels than by speech. Loss of speech could diminish a person's influential power, both in the short-term- and long-term rehabilitation setting, and in that way reduces the charismatic power (Brody 1992). Furthermore, if a person needs to communicate through another person or with the help of speech aids, this may in some cases reduce the participation of the client both physically and psychologically which will seriously damage owned, aimed, and shared power in the work with the individual plan.

A person's self-understanding and his/her understanding of the world will reflect how he/she defines the concept and thereby have practical effects (Grimen 2009, 26): 'Humans should care about the self-understanding and worldviews of other humans, especially if they depend on these other humans'. Professionals should be aware of how power and trust concern relations to those in need of their assistance, and how relations can be affected by how they understand them (Grimen 2009). People with reduced capacity, for example, cognitive, emotional or linguistic capacity are vulnerable, especially with regards to the danger of being manipulated in interaction with professionals. Health and social professionals should show utmost awareness of how power is distributed and exercised towards these groups (Grimen 2009).

Power of definition can be described as the power to get approval/impact of one's version of reality (Wikipedia). Different versions of reality, as experienced by the client and seen by the professionals, must be acknowledged when defining the client's need in order to have support and assistance released. The client who felt the professionals distrusted him is an example of a distorted relationship of trust.

One person's trust can become another person's power base (Grimen 2009). The connection between trust and power is found in all interaction between laypeople and professionals. As researchers we cannot judge whether it is the client, the relative or the coordinator who has the 'right' version of the client's need of assistance. We can point out that there are different experiences and different opinions, and that those who are empowered to define the situation possess the power. Health care professionals are often unaware of the gap between their own personal views of the world, their opinions and judgements and those of their clients (Grimen 2009, 21). In addition, there is a danger that due to a feeling of having power in the situation the professional sticks closely to the rules. However, the consequences of a decision may be an important factor for the client with less power. When the health care personnel sticks to duty-based thinking and rules the health care personnel pays less attention to the consequences (Lammers and Stapel 2009).

Another important issue is the question of who possesses the power to define what is good enough to fulfil the client's goals. In deciding what is best for the client, professionals are often faced with different demands, such as challenges between the client's medical and/or social needs and economical or administrative considerations. This puts them in a gatekeeper position (Grimen 2009). A position where the professional has a control function gives the professionals the power of definition. Gatekeepers can have mixed interests and motives, spoken or unspoken, and not all of these are necessarily in accordance with the client's interests. If the professional (coordinator) figure is seen as a helper with variable interests and mixed motives, the client will find it difficult to see what decisive factors his IP are based on. Patients and clients are vulnerable to mixed motives on the side of those whom they trust (Grimen 2009, 21). Trust is challenged if doubt arises as to whether the helper acts unbiased or not (Grimen 2001). The awareness of the position of gate keeping is neglected among health professionals as they are socialized to see themselves as beneficial helpers and not as powerful gatekeepers (Grimen 2009).

Health and social care contain a set of asymmetric relations where patients are in a structurally inferior position vis-à-vis the professionals. This structural imbalance is hard to combat, irrespective of good intentions. On the one side you have the people who need benefits and support and on the other side you have the professionals that can provide it. These people are the gatekeepers for the ones in need, who have 'less to offer' in return. There is also a knowledge differential between the parties, in that the professional party 'knows the road' and the other party has to trust that the professionals make the right decisions, without being able to challenge their choices (Grimen 2009). This asymmetric power-relation shows the importance of having institutional rules that are fair. This may lead to confidence in the professionals distributing benefits in a fair way (Oskarsson, Svensson, and Öberg 2009). There is a need for the professionals to share the power with their clients so that power discussions are reflected in actions and not only on the paper where the Individual Plan is written.

It may be better to opt for more self-consciousness among professionals about power and find more humane institutional forms of this nexus, not its abolition. Public discussions about power-where health professionals participate – are then crucial. (Grimen 2009, 17)

Methodological reflections

This study has some limitations and strengths in establishing trustworthiness. Lincoln and Guba (1985) discuss four criteria for trustworthiness: credibility, dependability, confirmability, and transferability. According to Polit and Beck (2010, 492) these criteria represent parallels to the positivists' criteria of internal validity, reliability, objectivity, and external validity, respectively. Regarding credibility we have aspired to describe our process as precisely as possible and in the process we have followed steps in qualitative analysis methods to ensure quality of data. Six researchers were all conducting interviews. The semi-structured interview guide was developed jointly and the researchers had discussions in advance on how to conduct the interviews and how to understand the interviewing process. The number of researchers may be both a weakness and strength for the interviewing and analysis processes. All researchers had their own style and different professional backgrounds but all were experienced in performing research interviews. This enhances the credibility and the confirmability of the study as several independent researchers have developed congruence between the accuracy, relevance, and meaning of the data, both in the interviewing and the analysis process. Another limitation may be the recruiting process. Our clients are a convenient sample where the professionals in the clinics choose which clients to interview. This may have caused that only satisfied clients were chosen. However, the data show that clients told different stories and there were both negative as well as positive experiences from the clients, the relatives, and the professionals. There are interviews from different facilities in Norway such as community health services, hospitals, and the social welfare system. Even though the researchers had some difficulties recruiting from some of these facilities, we succeeded and they are all represented in the data material. The findings are discussed with other professionals and are to a great extent transferable to other facilities in Norway. However, it is discussable whether these findings are transferable outside the Norwegian context due to the special organization of Individual Plans in Norway.

Conclusion

The three power discourses disclosed in relation to the individual plan processes were *power of knowledge*, that is the client's expert knowledge of his/her own life and the professionals' knowledge of medical and social aspects and how to manoeuvre in the system. In addition, the informants experienced *power of language*, as a physical, psychological, and social instrument to preceding the client's case. The holder of power of knowledge and power of language possesses *the power of definition* regarding the individual plan process, but the study revealed nuances in this relationship. Health and social care personnel have the knowledge to allocate help and support to their clients. Health and social care personnel also have the language, understanding, and skills in how to communicate within the health and social system when allocating help to the clients. This implies power, and professionals need to be conscious about the power they possess in order to define the situation for the clients, when collaborating in IP processes.

Implications for practice

The coordinators must be aware of their position and power in the individual plan processes. They must acknowledge the knowledge the client and relatives have related to the client's situation regarding resources and challenges. It is important that the coordinators share the power and respect the client's right to deny the definition the system imposes on him or her in the individual plan process. The clients should be empowered to speak for themselves and to be a genuine part when defining the situation and defining the needs in the individual plan in an ongoing process. More attention and self-consciousness should be paid to the relationship between the trust professionals are given by the clients and the position of power this entails when collaborating in IP processes.

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