

Addressing Power Relations in Health Psychology Research: EHPS 2023 Roundtable Report

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This report provides insights from the roundtable “Addressing and Overcoming Power Relations in Health Psychology (Research): An Interactive Discussion” at the European Health Psychology Society conference 2023 in Bremen. The overarching goal of the roundtable was to take a collaborative perspective

on issues of power in health psychology: How do power relations affect our research? How can we move towards a more just and equitable health psychology?

The roundtable was grounded in the assumption that power relations have a pervasive influence on health and health research. Power refers to the influence of specific groups through the processes of persuasion, authority, and coercion, which leads to the creation and control of resources (Turner, 2005). In research, for example, we hold power to select our research questions and methods or encounter issues of power when working with marginalised groups. Overlooking such issues can lead to the reproduction of power in theories and methods, and eventually contribute to the reinforcement of health inequalities (Barrett, 2022). For example, if health prevention and intervention strategies are primarily designed based on the input from or to suit individuals with high social status who already have better health

on average, these efforts may only reach and benefit these groups (Western et al., 2021). This targeted approach can inadvertently reinforce existing health disparities, as it fails to address or even acknowledge the needs of those with less access to health resources. The roundtable provided an opportunity for a dialogue on issues of power in health psychology research and how to overcome them. To do so, the facilitators first shared their perspectives on power in health psychology research and then lead small groups to further discuss each perspective.

Perspective 1: Power in health behaviour theories

The ubiquity of power dynamics and their impact on health behaviour was introduced by Vica Tomberge. In her own work on women’s health behaviour, she explained how she drew from the sociological theory of gender to address socio-structural levels of power imbalances (Connell, 1987; Wingood et al., 2000). The Gender Division of Labor, for example, pertains to women in lower-paying or unpaid employment, for whom maintaining health behaviours is difficult due to financial and time constraints. Tomberge made the point that this power-sensitive perspective was critical to explain health behaviours among women with limited socio-structural resources.

In the discussion, the small group first took established health psychology models (e.g. Theory of Planned Behaviour) into focus. The group

identified a common issue: the tendency to aggregate aspects reflecting power imbalances into a single variable labelled "socio-structural factors/barriers". This variable may sometimes even simplistically include social support, potentially contributing to overlooking critical socio-structural power imbalances. The group also noted that many health psychology models focus on individual processes, which perpetuates stereotypes by attributing health behaviours to individual choices. Consequently, the group agreed that considering power in theories is important but also discussed that incorporating power into individual health psychology models might prove challenging. Instead, the term "theory shopping" was conceived spontaneously during the round table discussion and was advocated for. The term "theory shopping" was thought to capture the exploration of health behaviour through the lens of interdisciplinary theories, which account for power imbalances related to factors such as gender or disability. One example of such a theory may be the theory of gender and power as used to describe women's health behaviour in the roundtable contribution. Thereby we can enhance the contextualization of health behaviour and aid in preventing researchers from inadvertently excluding marginalised groups during intervention development.

Perspective 2: Positionality and reflexivity as tools to address power

Maria Blöchl raised the question whether reflexivity and positionality could contribute to address power relations in health psychology research. Reflexivity is the process of engaging in self-reflection about who we are as researchers and how our subjectivities and biases shape the

research we do (Wilkinson, 1988). Positionality describes one's worldview and the position one adopts about research and its content (Holmes, 2020). Both practices have a strong tradition in feminist critiques of research and have long been a hallmark of qualitative research, although their value in quantitative research is increasingly recognised (Jamieson et al., 2023; Lazard & McAvoy, 2020).

During the group discussion, consensus emerged that reflexivity and positionality are indeed beneficial in both qualitative and quantitative health psychology; they allow to actively and systematically consider power dynamics and transparently communicate how these issues influence the research process. For instance, the group noted how a researcher's description of their positionality in a study on *BRCA1* alterations (Warner & Groarke, 2022) demonstrated their conscious reflection of how their ingroup status shaped their data collection, thus making this information accessible to readers. Additional examples illustrated the complexities of reflexivity and positionality, such as which identities to disclose, defining "effective" reflexive practices, or the implications of conducting research as an "outsider" researcher. These issues underscore the need to integrate questions of identity and power in our research in a structured manner through positionality and reflexivity.

To facilitate the use of reflexivity and positionality in health psychology, important steps need to be taken. On the one hand, structural changes by journals and funders, which often act as gatekeepers, are needed to foster the recognition and support of reflexive practices. Moreover, many (quantitative) health psychologists receive little training in reflexivity and positionality. The group agreed that learning opportunities would be necessary to unfold the potential of these practises in health psychology

research as a whole. The discussion and roundtable served as an empowering moment for this endeavour as participants exchanged their questions and experiences.

Perspective 3: Power in the samples we do (not) study

Christine Emmer opened the dialogue on a subtle but persistent power dynamic in health research: selective sampling. Sampling methods are not just technical decisions; they are intrinsically tied to power dynamics, shaping who gets represented in research and whose experiences get marginalised. Using meta-analytic data on the consequences of discrimination as an example (Emmer et al., 2020, 2024), an overreliance on convenience sampling was demonstrated, resulting in rather privileged samples mostly from WEIRD-countries (see also Arnett, 2009). Importantly, selective sampling affects health research at large, comprising treatment efficacy and safety for specific subpopulations (e.g., Western et al., 2021). Overlooking certain populations can thus lead to an amplification of health disparities. But how can we do better?

During the group discussion, several challenges linked to selective sampling emerged – but also a set of potential solutions. To address issues related to the unsuitability of certain methodologies for diverse populations, the group proposed mixed-methods approaches, particularly when existing theoretical frameworks do not apply to all populations (see Mertens, 2023). Moreover, there is a clear need for diversity measures and thorough interpretation of research findings based on detailed sample descriptions (e.g., Diversity Minimal Item Set; Stadler et al., 2023). To address

participation barriers for marginalised groups, direct community engagement and participatory methods were deemed essential. Importantly, inclusive sampling methods come with higher costs and require advocating for increased resources. However, such additional efforts are important as they foster and ensure trust and acceptance, cultural appropriateness, and inclusivity. Lastly, collaboration and sharing both resources and insights can be transformative, driving a more comprehensive understanding of health. The group highlighted this roundtable as a strong example of enhancing visibility and starting collaborations within our research community to move towards health psychology research for all.

Perspective 4: Participatory research to share power

Finally, another example for power in research is the relation between researchers and research participants, which was introduced by Anna Levke Brütt. Though researchers often talk about participants, the word participation needs further explanation. Besides its origin in political discussions, participation became used in disability activism in the 1990s, established the slogan „nothing about us without us“, and has recently entered health research. Back in 1969, Sherry Arnstein described the „Ladder of participation“ (Arnstein, 1969), illustrating different levels of citizen participation in (political) decision-making processes. It differentiates between different forms of citizen participation and defines citizen power as partnership, delegated power and citizen control. Research funders and journal editors argue that research can profit from participation (Greenhalgh et al., 2019). In order to promote shifting power,

the roundtable discussion dealt with the questions when to share power in the research process, who to share power with and how do researchers feel with sharing power in the research process?

The group discussion revealed that sharing power can take place at all stages in the research process. It is important to be open to new perspectives at the start, when identifying research questions. Consequences of sharing power should be visible in conducting the research project when decisions are made together. Relevant stakeholders for active participation in health psychology research are patients, citizens, clinicians or health care professionals. There needs to be a motivation of researchers to share power with these members of the public who have expert knowledge, which can be biased due to personal interests. Sharing power and shaping the participation process reveals challenges: Firstly, researchers must be willing to share power. Additionally, it entails time, and resources – otherwise, it risks being tokenistic. In summary, round table participants emphasized that sharing power has the potential to incorporate the valuable perspectives of members of the public into research and yield results relevant to healthcare practice.

Reflection and the attendees' perspective

As facilitators, our goal was to create an interactive roundtable and space for mutual learning and in-depth discussion. One participant highlighted the value of our interactive and solution-oriented format:

"I really enjoyed the session, which included a good portion of self-reflection and working on possible solutions." (Michael Kilb)

Another participant furthermore noted that "the roundtable hosts even modelled power sharing by

facilitating small group discussions to elevate the voices of attendees", and summarises:

"I look forward to seeing how we, as health psychologists, can use our power and privilege to amplify less heard voices in health research in an ethical way. This roundtable was an important first step!" (Daniella Watson)

Take aways and how to move forward

Overall, the roundtable highlighted that power dynamics pervade health psychology: Power shapes our work, impacts the lives of those we study, and perpetuates health inequalities when left unaddressed. However, our roundtable demonstrated we can also take action (see call to action in Box 1). While our call is in no way exhaustive, it is a starting point to reflect and overcome issues of power in our everyday research practice and foster a more inclusive understanding of health. Collaboration is essential to achieve these goals and counteract power imbalances. With a vision of a sustained dialogue, we hope that the roundtable was a first step and can be carried forward in future EHPS activities.

Box 1: Call to action: Recommendations from the roundtable

Power and theories: Current theories should be more inclusive and sensitive to socio-structural power imbalances. We advocate to incorporate interdisciplinary theories that consider specific power imbalances, while utilizing individual health behaviour models.

Positionality and reflexivity: The process of understanding and counteracting power imbalances is possible through reflexivity and positionality. We urge the research community and journal editorial boards to recognize and integrate these practices, coupled with robust training modules for researchers.

Sampling practices: Selective sampling perpetuates power imbalances and can result in the exclusion of marginalized groups, thereby reinforcing health disparities. The path forward involves diversifying sampling techniques, adopting mixed-methods approaches, investing in participatory approaches, and advocating for increased resources to ensure comprehensive representation.

Participatory research: Sharing power with research participants can lead to more relevant and inclusive health psychology research. By involving patients, citizens, and professionals in all research stages, we can ensure a research outcome that resonates with diverse stakeholders. Invest willingness, time, and resources to make participatory research meaningful.

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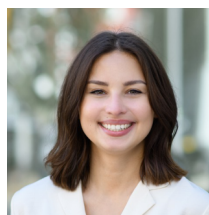
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