Avoiding piecemeal research on participation in cervical cancer screening: the advantages of a social identity framework

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Abstract

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Background Cervical cancer screening research has predominantly focused on one type of participation, namely compliance with medical recommendations, and has largely ignored other types of participation. While there is some research that has taken a different approach, findings in this research area are not well integrated under a theoretical framework.

Objective The aim of this study is to show how consideration of a broader definition of participation and better integration of the theoretical conceptualization of participation in cervical cancer screening are both possible and desirable to enable a better understanding of women's experiences of cervical cancer screening specifically and to improve women's health generally.

Main Conclusion It is suggested that alternative types of participation in cervical cancer screening warrant further investigation and that a social identity theoretical approach offers one way of integrating such conceptualizations of participation. The paper also argues for more explicit consideration of the role of social processes and of the variables, such as power, social identity and relational justice, which are involved in participation in cervical cancer screening.

Participation has been conceptualized in various ways across interdisciplinary research in health, social and community psychology (See for example references:^{1–3}). However, such research is frequently plagued by poor definitions^{4–6} and there is room for greater specificity regarding the concept of participation and to better recognize that it can be multifaceted and complex, involving much more than simply seeking and receiving medical services (hereafter termed 'compliance participation'), as per the definition most commonly utilized in cervical cancer

screening literature.^{7–10} Exploring a broader conceptualization of participation than simple compliance with medical requests is important to our understanding of women's cervical cancer screening because other types of participation are associated with positive health outcomes such as increased patient satisfaction, heightened feelings of self-efficacy and more constructive dialogue between patients and health-care practitioners. This article not only reviews these various conceptualizations of participation and acknowledges prior critiques

of them, but also proposes that social identity theory offers one way of drawing together different conceptualizations and enables better integration of what often seems to be unrelated and disparate findings in this research area.

Major research findings regarding compliance participation

A lot is now known about the variables associated with increased 'compliance participation'. For example, greater rates of compliance participation in cervical cancer screening have been found among younger women, for example, those under 35 years,^{11,12} as well as among those with higher levels of education^{13,14} and among those with health insurance.^{15–17} Women with higher levels of knowledge about the risk factors associated with cervical cancer are also more likely to report this type of participation than women with lower levels of such knowledge.^{14,18,19} Compliance participation is also higher among women who are recommended by their physician for cervical cancer screening²⁰ and who have a regular physician^{20,21} and a female physician.^{10,20} Factors found to be negatively associated with compliance participation include fear, pain, embarrassment, anxiety and beliefs regarding who should be screened for cervical cancer, as well as cynicism regarding the medical profession.^{22–30}

Other variables found to be associated with compliance participation include perceived susceptibility to cancer,^{31,32} perceived benefits of screening such as relief and reassurance³² and perceived barriers to screening such as embarrassment, pain and anxiety.^{32,33} Implementation intentions (specifying where, when and how women would make an appointment to be screened), self-efficacy, perceived behavioural control (people's perceptions of their ability to perform a behaviour), message framing (e.g. emphasizing test accuracy) and perceived obligation to be screened have also been found to be positively associated with willingness to undergo screening.^{34–37}

Social relationships, including physician, family and friends, are also important. Aspects of the doctor–patient relationship, such as the level of

communication and the interpersonal skills of the physician, as well as the patient's level of trust in the physician, are associated with compliance participation.^{25,38–42} Social support has also been found to have a positive relationship to cervical cancer screening uptake.⁴³ Indeed, higher rates of compliance participation have been found to be associated with being married,^{13,44} having friends or family members who receive cervical cancer screening¹⁶ and having close friends with whom one can discuss health issues.⁴⁵

Issues with existing cervical cancer screening research

Despite the above-detailed evidence, the concept of 'participation' has frequently been left ill defined, and too often, the reader is left to infer a definition from the way in which 'participation' is operationalized (See for example references: 7, 43 and 46). Moreover, only a limited number of studies have explored alternative types of participation in relation to cervical cancer screening intervention programmes.^{47–49} Indeed, as noted earlier, most researchers have implicitly equated participation in cervical cancer screening in compliance with medical recommendations to undertake a test or to be screened for cervical cancer (See for example references: 20, 50–52), and most research in the field has had the underlying objective of increasing cervical cancer testing (See example references: 8, 10, 20, 36 and 53–58). Researchers have tended to take a fairly traditional 'biomedical model' approach to health and 'participation': that is, they have tended to make the assumption that medical or scientific knowledge is superior to other types of knowledge such as 'lay knowledge' and that the patient should be a passive recipient of medical care.⁵⁹ Indeed, as argued by researchers such as,^{60–62} 'compliance participation' in cervical cancer screening research is usually assumed to be a positive norm and is often presented as a 'morally neutral' health behaviour that is an unproblematic and rational response to health education regarding cancer prevention (For examples of such treatment, refer to references: 7, 8, 10, 54 and 57). In short, to date, there has been little explicit

consideration in this area of research of the best way to conceptualize participation or of the potential health implications associated with emphasizing one type of participation more than another.

Nonetheless, it is acknowledged that there is a smaller body of predominantly qualitative research that has highlighted women's subjective experiences of cervical cancer screening and emphasized alternative aspects of the cervical cancer screening process (See for example references: 61–63). These researchers tend not to ascribe to the more traditional biomedical model approach (See for example references: 60–62, 62, 64 and 65), but instead emphasize the importance of exploring the meaning that women ascribe to their screening experiences and examine how these experiences may be influenced by social processes such as 'power'.^{61–63,65,66}

However, even in research taking such an alternative approach to participation in cervical cancer screening there has still been a tendency to define participation in terms of compliance with medical requests (See for example references: 61, 62). Moreover, there has been little explicit consideration of conceptualizations of participation that do not entail undergoing cervical cancer screening tests or of how other notions of participation are related to processes such as social identity. In short, even though researchers such as Fross *et al.*, Howson, and Lovell *et al.*^{61–63} argue for greater consideration of the subjective experiences of women in cervical cancer screening, there still seems to be an opportunity for more in-depth discussion of the concept of 'participation' itself and for explicit consideration of other types of participation and the social psychological processes that might be involved and their implications for women's health outcomes.

Drawing on interdisciplinary research to extend the conceptualization of participation in cervical cancer screening

In other, interdisciplinary areas of research and in contrast to the above, 'participation' is represented as a much more complex and multidimensional concept: representing involvement in

decision making, having a say or as having certain perceptions of involvement. Given research suggesting that such forms of participation are associated with positive outcomes (detailed below) in health and other settings,^{2,67,68} it seems especially important to take these alternative approaches into consideration in cervical cancer screening research.

One type of participation, referred to hereafter as 'perceived voice opportunity', is an important concept in social justice research or the branch of social psychology concerned with individuals' perceptions of fairness.⁶⁹ Perceived voice opportunity is one element of procedural fairness (i.e. the perceived fairness of how decisions are made) and is defined as the extent to which an individual perceives that they have the opportunity to express their opinions or are consulted during decision making.^{2,70,71} This type of participation has usually been measured by asking individuals how much opportunity they feel they have to express their opinion in a specific decision-making situation (See for example references: 70, 72).

In relation to undertaking cervical cancer screening, it is important to women's health to explore the relevance of this form of participation given that it has been found to be associated with perceptions of satisfaction in decision-making contexts related to personal health care.² Patient satisfaction has been found to be associated with compliance with medical recommendations and positive health status.⁷³ Women value the opportunity to be listened to, to discuss problems, to ask questions and to convey their anxieties about the screening procedure to their physician.⁴¹ Such research findings suggest that extending existing cervical cancer screening research to explore social justice concepts such as perceived voice opportunity is important. Moreover, it would not only assist in drawing links between research in social justice and health psychology but would also be consistent with some of the calls made for increased consideration of social psychological concepts within health research.^{1,3,74}

Other forms of (what may be termed here as 'active') participation, as discussed in social psy-

chology, community psychology (i.e. 'community participation') and health psychology (i.e. 'patient participation'), may also be of considerable relevance to any efforts to extend cervical cancer screening research. For example, given that existing cervical cancer research suggests that women value conveying their opinions and discussing problems with their physician,^{41,42} it may be useful to incorporate the notion of participation discussed by van Vugt *et al.*,⁷⁵ whereby there is an acknowledgement that participation can include conveying opinions to others. Consideration of the concept of community participation discussed in some community psychology may also be extremely valuable for increasing our understanding of cervical cancer screening. This is the process by which individuals or groups become actively involved in issues regarding their own health care, including policy-making and the delivery of health services.^{1,68,76,77} Researchers have argued that this type of participation is positively associated with a sense of empowerment and perceptions of increased responsibility for one's health care.^{67,68} Moreover, Campbell and Jovchelovitch suggest that such participation is intimately related to social psychological processes such as power and social identification. To date, however, only a limited number of studies have considered this form of participation in community-based cervical cancer screening interventions,^{47-49,78} and additionally, there seems to be considerable scope for much more explicit consideration of how this research relates to other conceptualizations of participation.

Another related type of participation, termed patient participation, has been explored within the context of disease management and diagnostic screening.⁷⁹⁻⁸³ Patient participation during medical encounters means being involved in one's health care and includes behaviours such as seeking information, asking questions, expressing concerns, sharing opinions, being assertive and participating in decision making.^{6,79,83,84} Patient participation has been measured in various health contexts using self-reports,⁷⁹ by means of the coding of audiotaped physician-client encounters,⁸³ as well as combinations of these.⁸⁵ This type of participation has been found

to be associated with positive health outcomes such as heightened patient satisfaction with health care, personal self-efficacy and patient empowerment in a variety of health-care settings.^{79,83,84,86,87} Nonetheless, within this particular body of literature, participation is still often not explicitly defined. Indeed, the term patient participation is frequently used interchangeably with other terms such as 'patient involvement', 'empowerment' and 'collaboration', and the conceptualizations of patient participation across studies are often inconsistent.^{4,84,88} For example, some researchers have conceptualized participation as involving multiple active behaviours⁸³ or as having restricted opportunities to ask questions,⁸⁹ while other researchers have chosen to emphasize the importance of people's perceptions of patient participation.⁹⁰ Therefore, even within this particular body of literature, which seems highly relevant to cervical cancer screening, there is an opportunity for far greater specification, discussion and understanding of the concept of participation. There also seems to be an opportunity for greater consideration of how this form of participation differs from other types of participation and for investigation of what the implications for women's health outcomes might be of emphasizing one form of participation more than another in cervical cancer screening research.

At the very least, the above discussion of alternative conceptualizations of participation suggests that participation is a complex and multifaceted concept and that women's health could potentially benefit by considering forms of participation in health care other than agreeing to or receiving medical services. To our knowledge, there has been little consideration of many of the forms of participation in cervical cancer screening discussed above. Moreover, the construct validity (i.e. conceptual distinctiveness) of these different types of participation still awaits investigation.

Another topic for future research that arises from the above discussion is the effect of different variables on different types of participation as much as relationships between those different forms of participation. For example,

given in Dunst and Trivette's⁹⁰ argument that feelings of involvement could serve to enhance a person's perceived control over her life and capabilities and thereby influence her actions, it may be that there is a relationship between perceived voice opportunity and patient participation in relation to cervical cancer screening. That is, women who perceive that their physicians have consulted them (i.e. high perceived voice opportunity) could feel more involved, and capable of making decisions regarding their own health care, and may be more likely to actually engage in patient participation. Such participation may have health benefits.^{83,86,91} In contrast, when women perceive that they do not have high voice opportunity, they may be less likely to feel a sense of control over their own health and therefore may be found to be less likely to engage in patient participation and gain associated health outcomes.

Also, worthy of further consideration in this research area is the fact that social justice research suggests that perceived voice opportunity and relational justice are highly related concepts (See for example references: 92–94). Relational justice refers to the quality of interpersonal treatment during a decision-making process^{69,94} and includes an individual's perceptions of the extent to which they have been treated with honesty, consideration, neutrality, dignity and respect during a decision-making procedure.^{94,95} Like perceived voice opportunity, an individual's perceptions of relational justice are related to their perceptions of fairness and satisfaction.⁶⁹

Existing research suggests that providing people with the opportunity to be involved (i.e. voice opportunity) enhances their perceptions of relational justice in comparison with when they are not provided with voice opportunity.^{93,94,96} Research also suggests that relational justice is highly interrelated with group membership and social identity processes.^{96,97} Consistent with this interdisciplinary research, there is therefore an opportunity for researchers to explore the extent to which relational justice is related to participation and social identity processes in cervical cancer screening. For example, it is feasible that the positive relationships between relational justice,

perceived voice opportunity and social identity processes may be relevant to women's experiences of cervical cancer screening. Such relationships await empirical investigation, and it is noted that existing cervical cancer screening research actually seems to support the proposition that relational justice may be important to women's experiences of participation in cervical cancer screening (See example references: 25 and 38–42).

Consideration of the more specific underlying psychological mechanisms of participation in cervical cancer screening also awaits investigation. In particular, social identity theory^{98,99} and self-categorization theory¹⁰⁰ offer promising directions for future research because they suggest some reasons for the relationship between undergoing cervical cancer screening and variables such as relationship with physician and friends.^{16,42,43,45} A social identity framework is also potentially very useful for better understanding why women show greater patient participation when they have a pre-existing relationship with their physician.^{81,101,102}

Extending our understanding of social processes and participation in cervical cancer screening

Participation and social identity processes

Social identity is defined as 'that part of an individual's self-concept which derives from his (or her) knowledge of his (or her) membership of a social group (or groups) together with the value and emotional significance attached to that membership' (p. 255). Social identity processes can influence the extent to which we perceive ourselves as sharing similar qualities with others and can thus influence our feelings, attitudes and behaviours.¹⁰⁰

Social identity theorists Tajfel and Turner^{99,103,104} proposed that individuals use social groups to categorize themselves and others. Social identity theory suggests that an individual's behaviour during social interactions can be understood in terms of a bipolar continuum, with interaction at one pole determined by the individual's personal character and motivations

as an individual (i.e. more interpersonal behaviour) and interaction at the other pole determined by the individual's group membership (i.e. more intergroup behaviour).¹⁰³ However, Tajfel noted that the extreme poles were hypothetical only and that the interpersonal extreme was impossible because membership in social groups will always play some role in an individual's interaction with others.¹⁰⁴ Social identity theory also suggests that any category can form the basis of a group, including broad socio-demographic categories (e.g. ethnicity, gender) as well as smaller groups such as teams or clubs. Moreover, social identity theory suggests that individuals are motivated to derive positive self-esteem from their group memberships.^{99,105}

Self-categorization theory¹⁰⁶ was developed to extend¹⁰⁴ Tajfel's interpersonal/intergroup continuum by suggesting that an individual's self-concept could also be understood as a continuum, with *personal identity* (defined as the sense of self we derive from our individual, unique characteristics such as personal appearance, idiosyncrasies) at one end of the continuum and *social identity* (defined as the sense of self that we derive from our group memberships) at the other. Turner suggested that interpersonal behaviour is more highly associated with a salient personal identity and intergroup behaviour is more highly associated with a salient social identity.

Turner^{100,106} was especially interested in intragroup behaviour. He suggested that when a person's social or collective identity becomes salient, the distinction between the self and other members of the person's 'in-group' is not always clear, and people think about themselves in terms of their group memberships. Self-categorization theory¹⁰⁷ suggests that an individual's social identity becomes salient through the cognitive process of 'depersonalization'. When the process of depersonalization occurs, and an individual's social identity becomes more salient, they perceive the 'self' more in terms of the characteristics that they share with the other members of their group (i.e. their 'in-group') and less in terms of their personal, idiosyncratic characteristics.¹⁰⁷ As a result of these self-categorization processes, social identity can affect an individual's beliefs,

values and behaviours.¹⁰⁷ For example, when an individual's social identity becomes salient, perceptions of similarity between the self and other in-group members are heightened.¹⁰⁷ In turn, these perceptions of similarity enhance cohesiveness, group co-operation and conformity, and positive self-sentiments are extended to other in-group members in the form of mutual attraction and liking.¹⁰⁷

To date, social identity and self-categorization processes have not been explicitly or systematically explored in cervical cancer screening research. However, there is research indicating that social relationships with physicians, family or friends, as well as factors such as feelings of dependence, 'belongingness' and being understood by others, are important to cervical cancer screening.^{41-43,45} This suggests that more systematic exploration of social identity processes in cervical cancer screening is warranted. Indeed, exploring participation in cervical cancer screening from a social identity approach may be useful for identifying some of the underlying psychological mechanisms through which relationships with others, such as the physician and friends, influence women's experience of, and willingness to become involved in, cervical cancer screening (See for example references: 16, 42, 43 and 45). For example, are women more willing to undertake cervical cancer screening when they have a sense of group belonging with others? What sorts of intergroup relations affect cervical cancer screening? For example, can one's sense of group belonging vary across different health contexts and does that in turn affect women's willingness to undertake cervical cancer screening? In the long run, it seems highly possible that such research may actually serve to better integrate currently disparate cervical cancer screening research findings (e.g. the relationship of participation in screening and women's social relationships) and may go a long way in helping to understand how and why different types of participation in cervical cancer screening are related to one another.

Consistent with¹⁰⁴ Tajfel's original proposition that membership in social groups will always play some role in an individual's interaction with

others, it certainly seems feasible that in cervical cancer screening, the interaction between a woman and her health-care provider during a Pap smear consultation will be influenced by the woman's perceptions of social category membership. As described previously, both Tajfel and Turner^{100,103,106} argued that what defines a social group is not its structure, function or size but its social reality for group members. In cervical cancer screening, it seems possible that social categories such as 'women' or 'women concerned with women's health issues' may be salient social identities for many women when they are in a health screening context and could prompt women to view their physicians in terms of their membership of such groups. Certainly, existing cervical cancer screening research that highlights women's preferences for female practitioners seems consistent with this suggestion.^{41,42}

Having a shared social identity (or a shared group membership) can affect a person's perceptions of and behaviours towards others.^{98–100,105,107} Therefore, it seems plausible that social identity processes could influence a woman's perceptions of and behaviour towards her physician during her cervical cancer screening consultation. That is, when a woman perceives herself and her doctor as sharing a common social identity, it may be expected on the basis of social identity processes that there will be a heightened sense of similarity between them and that 'positive self-sentiments will be extended to other members of the in-group'.¹⁰⁸

It seems plausible that these perceptions of heightened similarity and positive sentiments (regarding 'we', or the woman and her physician as in-group members) may affect a woman's perceptions of being 'understood' by her physician and affect her 'feelings of involvement' (such as her 'perceived voice opportunity'),* as well as behaviour (e.g. 'patient participation') during the cervical cancer screening consultation. More specifically, it may help to explain

why research has found that women prefer female practitioners and consider them to be more considerate and understanding of their feelings and health needs.^{41,42} It also explains why there is a relationship between factors such as 'understanding' in the doctor–patient relationship, 'social support' and the ability to discuss health problems with others and willingness to undertake cervical cancer screening.^{43,45}

Social identity processes may even mediate the potential relationships between different types of participation. In the previous section, it was suggested that perceived voice opportunity and patient participation may be positively related in cervical cancer screening. Using a social identity approach to exploring participation in cervical cancer screening, it is further suggested that any positive association between patient participation and perceived voice opportunity may be heightened when a woman's identification with her physician is high as opposed to low. As described above, a social identity approach suggests that when a woman's identification with her physician is high (e.g. if she perceives both herself and her doctor as women who are concerned with women's health issues), she will perceive herself as being similar to the physician. This process of depersonalization can influence feelings, attitudes and behaviours, such as the extent to which a woman is willing to engage in patient participation in response to perceived voice opportunity. That is, it seems that when identification with the physician is high (and, in turn, her perceptions of similarity and positive self-sentiments, such as feelings of trust and being 'understood', are extended to her physician, a fellow in-group member), a woman may be more likely to engage in patient participation in response to perceived voice opportunity. This prediction as well as the general issue of how the level of social identification affects cervical cancer screening awaits empirical exploration.

Participation and power

In addition to the potential importance of social identity processes in cervical cancer screening, it also seems that there is an opportunity for

*This line of reasoning also seems consistent with some research in the field of social justice that emphasises the importance of social identity processes to people's perceptions of justice^{109–112}.

greater consideration of other social processes, such as 'power' and 'empowerment' in relation to different types of participation in cervical cancer screening. Interdisciplinary research suggests that participation is a dynamic and socially constructed event, which is intimately intertwined with social processes such as 'power' and 'empowerment'.^{1,3,6,113} Indeed, investigating such processes in cervical cancer screening is important given that increased feelings of 'empowerment' and 'power' are positively associated with certain types of participation in health care.^{5,67,68,113,114}

Just like the concept of participation, power has also been variously defined and conceptualized.^{64,115–118} Different assumptions are made regarding the extent to which power is related to other concepts such as participation. The concept of power is highly interrelated with participation in some theoretical frameworks of power,^{64,115,119} but not in others.^{120,121} For example, Foucault's approach to power highlights the relationships between power, knowledge (or 'discourses'), social control, subjectivity, agency and participation. Foucault proposed that power was above all relational and conceptualized it as the domination of some over others through the production of 'subjects', where the subordination and compliance of individuals ('subjects') leads to 'docile bodies'. In his approach to 'power, Foucault proposed that the concepts of participation and power are so highly interrelated that it is impossible to consider one without consideration of the other. For Foucault, power is present in every aspect of social life and operates 'through' people. Any action undertaken by an individual (e.g. participation in health screening) is therefore an example of power from a Foucauldian perspective.

To date, only a limited number of researchers^{62,63,66} have explicitly acknowledged the importance of concepts such as power, subjectivity and agency to participation in cervical cancer screening. The majority of researchers exploring participation in cervical cancer screening have failed to acknowledge the integral role of such processes and concepts in par-

ticipation. Neither has there been any explicit consideration of how processes of power may be related to different types of participation in cervical cancer screening. Therefore, there is an opportunity for greater exploration of power processes and their role in different types of participation in cervical cancer screening.

Conclusions and future research directions

In the cervical cancer screening literature, participation has been too often left ill defined, and there has been little consideration of the best way of conceptualizing participation, with its associated psychological mechanisms, and the health implications for clients of emphasizing one type of participation more than another. Although a limited number of studies have explored alternative types of participation in relation to cervical cancer screening intervention programmes,^{47–49} we call for far greater consideration of other types of participation in cervical cancer screening.

In this review, we have argued that if researchers broaden the possible ways in which participation in cervical cancer screening is conceptualized there may be important health implications for women, given that in other areas of disease management and diagnostic screening as well as community health, an association has been found between types of participation and positive health outcomes.^{2,79,83,86,122} We have also offered numerous suggestions for future research.

This article strongly endorses the calls by others^{61,63} for more explicit reflection on the conceptualization and theoretical framework used to understand participation in cervical cancer screening, which may take more account of the subjective experiences of women in health settings. We consider the research suggestions made in the article to be of considerable promise in not only integrating this disparate field but also assisting in providing some further impetus to the investigation of the variables and processes involved in cervical cancer screening. At the very least, the current review of participation in cervical cancer screening has offered the

argument that participation is a far more complex and dynamic process than simply 'taking a test' and that there may be positive health outcomes for women associated with extending research beyond such a conceptualization.

Conflict of Interest

The authors do not have any conflict of interest with this research.

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