The Effect of Common Ingroup Identity on Doctor-Patient Competitive Victimhood and Its Mechanisms

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Abstract

Based on the common ingroup identity model, this study examined the influence and mechanism of common ingroup identity on competitive victimhood between doctors and patients, with medical staff and patients and their families as research subjects. A pilot study demonstrated through questionnaire surveys that competitive victimhood exists between doctor-patient groups. Experiment 1 adopted the operational paradigm of common ingroup identity and found that common ingroup identity can effectively reduce competitive victimhood among both doctors and patients. Experiment 2A further discovered that power need mediates between common ingroup identity and competitive victimhood in both medical staff and patients, while the mediating effect of moral need was not significant. Experiment 2B adopted a recategorization paradigm that more closely approximates real-world social contexts. Results showed that the main effect of common ingroup identity was not significant, but its interaction with group identity was significant, and only the mediating pathway of power need in medical staff was established. This study reveals that common ingroup identity can not only directly reduce competitive victimhood among both doctors and patients, but also further reduce competitive victimhood by decreasing power need, thereby providing a new intergroup perspective for alleviating tension in doctor-patient relationships.

Full Text

The Influence and Mechanisms of Common Ingroup Identity on Competitive Victimhood in Doctor-Patient Relationships

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Abstract: Based on the Common Ingroup Identity Model, this study examined the influence and mechanisms of common ingroup identity on competitive victimhood between medical staff and patients and their families. A preliminary survey confirmed the existence of competitive victimhood between doctor and patient groups. Experiment 1, employing a common ingroup identity manipulation paradigm, demonstrated that common ingroup identity effectively reduced competitive victimhood among both parties. Experiment 2A further revealed that power need mediated the relationship between common ingroup identity and competitive victimhood for both doctors and patients, whereas moral need did not show a significant mediating effect. Experiment 2B, using a recategorization paradigm closer to real-world social situations, found that the main effect of common ingroup identity was not significant, but its interaction with group identity was significant, with only the mediation path through power need for the doctor group being established. This study reveals that common ingroup identity not only directly reduces competitive victimhood between doctors and patients but also further decreases it by reducing power need, offering a new intergroup perspective for alleviating tensions in doctor-patient relationships.

Keywords: doctor-patient relationship, competitive victimhood, common ingroup identity, power need, moral need

A harmonious doctor-patient relationship is fundamental to ensuring smooth medical practice and constitutes an important component of building a harmonious society. However, as medical reform policies continue to advance and the medical environment and standards gradually improve, the doctor-patient relationship in China has become increasingly tense, with incidents of doctor-patient conflict triggered by poor relationships occurring frequently [**?**, **?**]. How to strengthen mutual identification between doctors and patients, alleviate contradictions, and promote the development and establishment of harmonious doctor-patient relationships has become a focus of attention across society. Some researchers argue that both parties in doctor-patient conflicts develop competitive victimhood \cite{艾娟, 2018}, a phenomenon where group members believe their own group is the primary victim in a conflict and strategically emphasize their suffering to prove their victim status, thereby gaining sympathy and support from third parties while reducing their own responsibility in intergroup conflict [**?**, **?**]. However, rigorous empirical research examining competitive victimhood between doctors and patients and its potential influencing factors and mechanisms remains lacking.

1.1 Competitive Victimhood

Competitive victimhood is a psychological phenomenon pervasive in intergroup conflict situations [?, ?]. Once conflict arises between groups, members perceive that their ingroup has suffered greater hardship than the outgroup and strive to prove their ingroup is the primary victim, showing reluctance to engage with the outgroup or attempt forgiveness and reconciliation. This phenomenon can be transmitted across generations and become part of group culture [?, ?, ?, ?]. Its emergence rests on two foundations: first, social resource inequality between groups creates competitive tendencies; second, perception of victim identity in conflict events [?, ?, ?]. Competitive victimhood is thus built upon subjective cognition and experience rather than the objective severity of suffering, emphasizing societal recognition of victim status [?, ?].

Currently, no empirical research has specifically examined competitive victimhood between doctors and patients, though scholars have noted that doctor-patient conflicts generate competitive victimhood in both parties. Medical staff may emphasize the harm and psychological pressure caused by patients during conflicts \cite{降海蕊等，2022}, thereby perceiving group victim status \cite{汪新建等，2016}. Conversely, as disease bearers, patients may emphasize unequal access to medical resources, inappropriate medical behaviors, and cold attitudes from medical staff, also engaging in victim competition [?, ?]. Competitive victimhood leads both parties to develop negative stereotypes about each other, and even without personal experience of doctor-patient conflict, they may worry about being harmed during interactions, undermining doctor-patient trust.

Therefore, it is necessary to explore effective interventions to reduce competitive victimhood between doctors and patients, promote communication, and facilitate reconciliation over past conflicts, thereby reducing doctor-patient conflict and improving relationships. Some scholars have addressed this issue: [?] proposed that increased intergroup contact can effectively reduce competitive victimhood, and even vicarious indirect contact (such as imagined contact) has similar effects \cite{王珊珊，2016}. [?] found that using inclusive narrative approaches in reporting can effectively reduce competitive victimhood. Additionally, enhancing intergroup empathy and understanding and establishing a common identity are effective measures for reducing competitive victimhood [?, ?]. In Chinese medical practice, similar attempts to establish common ingroup identity have been made. For example, \cite{罗佳等人（2016）} had nurses who had recovered from breast cancer participate in preoperative counseling for breast cancer patients, significantly improving patients' psychological states through establishing doctor-patient dual identity empathy. This suggests that common ingroup identity interventions are applicable to Chinese doctor-patient groups. However, this method requires medical staff to share the same condition as patients, making it difficult to generalize. Therefore, more feasible methods for establishing common group identity between doctors and patients need to be explored.

1.2 Common Ingroup Identity and Competitive Victimhood

The Common Ingroup Identity Model (CIIM) proposes that by reconstructing social identity and changing perceptions of group boundaries, members of conflicting groups can construct a common superordinate identity, shifting classification from "us" versus "them" to a more inclusive "us" and developing a new common ingroup identity. Due to ingroup preference, group members' positive emotions and preferences toward their own group may extend to the common ingroup, reducing focus on current subgroup conflicts and improving attitudes toward outgroups [**?**, **?**]. This helps reduce negative stereotypes and intergroup prejudice [**?**, **?**], as well as anger arising from intergroup conflict [**?**, **?**], making intergroup relationships more harmonious. Activation of common ingroup identity primarily involves constructing a common superordinate group identity. For example, when Jews were encouraged to view themselves and Germans as part of a superordinate group (humankind), they were more willing to forgive Germans [**?**, **?**]. When African Americans and Latino Americans activated a superordinate identity (Americans), their anger toward outgroups decreased [**?**, **?**]. Similarly, [**?**] found that when African Americans and whites activated a superordinate identity (Americans), negative stereotypes and intergroup anxiety decreased.

According to the CIIM model, establishing common ingroup identity helps alleviate intergroup attitudes and eliminate competitive victimhood. For instance, [**?**] found that activating a common superordinate identity between Jews and Palestinians simultaneously met both parties' spiritual needs, thereby increasing contact, reducing competitive victimhood, and achieving reconciliation. [**?**] found that Serbs and Kosovars could reduce competitive victimhood through increased contact and establishing common ingroup identity, a process achieved by increasing perspective-taking and trust toward outgroups. Although these studies focused on war and ethnic conflicts, they provide inspiration: if competitive victimhood in such intense conflicts can be reduced through establishing common superordinate identity, might this strategy also be effective for Chinese doctor-patient groups? Compared to war and ethnic conflicts, most doctor-patient conflicts are triggered by mutual misunderstanding and psychological pressures from work or illness, and reconciliation may not require substantial concessions but may respond well to psychological interventions. In other words, reducing competitive victimhood between doctors and patients may be significant for improving doctor-patient relationships. Moreover, Chinese culture advocates harmony and universal brotherhood, making common ingroup identity strategies potentially more acceptable to Chinese doctor-patient groups. In summary, this study explores the effect of activating common ingroup identity on competitive victimhood between doctors and patients. After activating a common superordinate identity—where both parties unite as humans fighting disease together [**?**, **?**], competitive victimhood may decrease. Therefore, we propose Hypothesis 1: Common ingroup identity can reduce competitive victimhood among both doctors and patients.

1.3 The Mediating Role of Power and Moral Needs

Based on the need-based model (The Need-Based Model) [?, ?], [?] proposed that power need and moral need are basic needs driving both parties in a conflict to engage in victim competition. Disadvantaged groups lose status and receive fewer resources in intergroup conflict, and by highlighting victim status may gain social compensation and empowerment, thus showing greater power need [?, ?, ?]. Conversely, advantaged groups often show greater moral need. People hold stereotypes that advantaged groups are immoral, corrupt, or cold [?, ?], while disadvantaged groups are innocent and highly moral [?, ?]. Therefore, advantaged groups hope to restore their moral image through competing for victim status, gaining social recognition and third-party sympathy and support, and providing justification for violent policies against hostile groups [?, ?, ?, ?].

This theory can also be applied to doctor-patient situations, where both parties have dual status with both advantages and disadvantages. From the patient' s perspective, medical staff have more convenient access to medical resources, placing patients at a disadvantage. Disadvantaged groups desire power to improve their status [?, ?], and when their power need is satisfied, patients have more positive emotional experiences \cite{徐简, 2020}. Therefore, patients have motivation to gain more power during diagnosis and treatment. Meanwhile, in news reports, patients often appear as "medical attackers" [?, ?, ?], creating a need to restore their moral image to gain sympathy and social support. Surveys also show that medical staff are dissatisfied with their current power status and pessimistic about doctor-patient power interactions \cite{全鹏, 刘瑞明, 2016}. Increased power need from patients threatens medical staff' s power and weakens their dominant position during consultations, so medical staff also have motivation to maintain treatment authority. Additionally, the public has formed stereotypes of medical staff as technically inadequate, providing excessive treatment, and having cold attitudes, and doubts their moral level, creating a need for medical staff to restore their moral image \cite{吕小康等, 2019}. Therefore, it is necessary to simultaneously examine the roles of power and moral needs in generating competitive victimhood for both parties.

Furthermore, research shows that common ingroup identity can also reduce power and moral needs in both groups [?, ?, ?]. After establishing common ingroup identity, doctors and patients can more clearly recognize that both are essential components in fighting disease, with disease being the common enemy. Both parties hope to restore patients to health and defeat disease, which facilitates equal cooperation. On one hand, common ingroup identity leads doctor-patient groups to respect each other, acknowledge each other' s influence and autonomy in medical care, thereby reducing both parties' need for medical power. On the other hand, common ingroup identity implies intergroup reconciliation, and both parties will reduce denigration of each other' s moral image, correspondingly reducing moral need [?, ?, ?]. In summary, we propose Hypothesis 2: Power need and moral need mediate the effect of common ingroup identity on competitive victimhood.

This study used medical staff and patients as research subjects and tested hypotheses through three experiments following a preliminary study. The preliminary study distributed competitive victimhood questionnaires to medical staff and patients and their families at three hospitals in Shanghai and Sichuan to explore whether competitive victimhood exists between doctors and patients. Experiment 1 examined the direct effect of common ingroup identity on competitive victimhood between doctors and patients. Experiments 2A and 2B further explored whether power need and moral need mediate the effect of common ingroup identity on competitive victimhood for both parties.

Preliminary Study: The Existence of Competitive Victimhood Between Doctors and Patients

Purpose

Currently, no research has directly examined competitive victimhood in doctor-patient groups. Therefore, this preliminary study used the competitive victimhood questionnaire developed by [**?**] to measure whether both doctors and patients experience competitive victimhood and whether differences exist between them.

Methods

Participants This preliminary study recruited 265 participants, including 127 medical staff (52 male, 75 female, mean age = 36.23 $\pm$ 9.65) from three hospitals in Shanghai and Sichuan as the doctor group, and 138 patients and their family members (65 male, 73 female, mean age = 37.36 $\pm$ 13.91) as the patient group. Due to pandemic restrictions preventing access to inpatient departments, all participants were recruited from outpatient departments. Patients and family members completed paper questionnaires in outpatient halls and waiting areas, while medical staff completed them in consultation rooms and lounges. Participation was voluntary, and small gifts were provided after completion as appreciation.

Materials **Competitive Victimhood Questionnaire**: Adapted from [**?**] for the doctor-patient context, consisting of 5 items with wording adjusted based on participants' group membership (e.g., "In doctor-patient conflicts, patients and their families suffer more than medical staff," "In doctor-patient conflicts, medical staff's suffering does not receive due attention compared to patients and their families"). Items were rated on a 7-point scale from 1 (strongly disagree) to 7 (strongly agree). The mean of the 5 items served as the competitive victimhood score, with higher scores indicating stronger competitive victimhood. Scores above the midpoint (4) indicated presence of competitive victimhood [**?**, **?**]. Cronbach' s α for this questionnaire in the preliminary study was 0.69.

Results

One-sample t-tests examined whether competitive victimhood scores differed from the midpoint (4). Results showed that the doctor group' s competitive victimhood (M = 5.60, SD = 1.00) was significantly higher than the midpoint, t(126) = 18.02, p < 0.001. The patient group' s competitive victimhood (M = 4.61, SD = 0.94) was also significantly higher than the midpoint, t(137) = 7.66, p < 0.001. These results indicate that both doctors and patients experience competitive victimhood. Independent samples t-tests examined differences between groups, revealing that the doctor group' s competitive victimhood was significantly higher than the patient group' s, t(263) = 8.26, p < 0.001, Cohen' s d = 1.02.

Discussion

The preliminary study confirmed the existence of competitive victimhood between doctors and patients, validating its presence in this context. The following experiments discuss how to reduce competitive victimhood between doctors and patients and its psychological mechanisms. According to the Common Ingroup Identity Model, when conflicting groups establish a common ingroup identity related to their conflict identity, competitive victimhood can be reduced [**?**, **?**]. Therefore, Experiment 1 examined the effect of common ingroup identity on competitive victimhood between doctors and patients.

Experiment 1: The Effect of Common Ingroup Identity on Competitive Victimhood

Purpose

Based on the preliminary study' s finding that both doctors and patients experience competitive victimhood, Experiment 1 investigated the effect of common ingroup identity on competitive victimhood for both parties.

Methods

Participants Using G*Power 3.1, we calculated the required sample size. With a 2 (group identity: doctors vs. patients) × 2 (group identity activation: common ingroup identity vs. control) between-subjects ANOVA, setting parameters at medium effect size f = 0.35, significance level $\alpha = 0.05$, and statistical power 1-$\beta = 0.85$, the calculation indicated a minimum total sample of 105 participants (27 per group). We ultimately recruited 176 participants.

We selected 90 medical staff from three hospitals in Shanghai and Sichuan as the doctor group and 86 patients and their family members as the patient group. Within each group, participants were randomly assigned to either the common ingroup identity condition or the control condition. The doctor common ingroup identity group included 45 participants (25 male, 20 female, mean age = 31.93 ± 8.87). The patient common ingroup identity group included 45 participants (21

male, 24 female, mean age = 35.38 ± 9.96). The doctor control group included 45 participants (24 male, 21 female, mean age = 33.16 ± 7.12). The patient control group included 41 participants (20 male, 21 female, mean age = 32.61 ± 10.05).

Materials and Procedure **Competitive Victimhood Questionnaire**: Same as in the preliminary study. Cronbach' s α in this experiment was 0.68.

Common Ingroup Identity Activation: Adapted from [**?**], participants in the common ingroup identity condition read a text describing doctors and patients as a common group fighting disease together, both being indispensable forces in combating illness. Control condition participants read a popular science text unrelated to doctor-patient conflict or identity. Both texts were approximately 200 words. After development, medical experts evaluated the materials' rationality and accuracy, and 11 psychology graduate students rated them, showing no significant differences in familiarity, arousal, or valence between the two materials.

Procedure: Using a 2 (group identity: doctors vs. patients) × 2 (group identity activation: common ingroup identity vs. control) between-subjects design with competitive victimhood questionnaire scores as the dependent variable, participants were randomly assigned to conditions and read the corresponding text. To check activation effectiveness, participants completed two items adapted from [**?**] 's common ingroup identity questionnaire: "Doctors and patients together constitute a group fighting disease. I also belong to this group" and "Belonging to the group fighting disease, I feel proud of this." Items were rated on a 7-point scale, and the mean served as the common ingroup identity score. Participants then completed the competitive victimhood questionnaire. After the experiment, all participants received small gifts, and to avoid negative effects from conflict materials, they were informed of the materials' fictional nature.

Results

Manipulation Check for Common Ingroup Identity Independent samples t-tests examined differences in common ingroup identity between experimental and control groups. For the doctor group, common ingroup identity scores were significantly higher in the experimental group (M = 6.51, SD = 0.62) than in the control group (M = 5.52, SD = 1.60), $t(88) = 3.86$, $p < 0.001$, Cohen' s d = 0.82. For the patient group, experimental group scores (M = 6.47, SD = 0.63) were also significantly higher than control group scores (M = 5.89, SD = 1.15), $t(84) = 2.92$, $p = 0.005$, Cohen' s d = 0.63. These results indicate successful activation of common ingroup identity for both groups.

Effect of Common Ingroup Identity on Doctor-Patient Competitive Victimhood A 2 (group identity: doctors vs. patients) × 2 (group identity activation: common ingroup identity vs. control) ANOVA on competitive victimhood revealed a significant main effect of group identity, $F(1, 172) = 5.89$,

$p = 0.016$, $p^2 = 0.033$, with doctors' competitive victimhood ($M = 5.03$, $SD = 0.82$) significantly higher than patients' ($M = 4.67$, $SD = 1.11$), $p = 0.004$, 95% CI = [0.18, 0.96]. The main effect of common ingroup identity was also significant, $F(1, 172) = 16.58$, $p < 0.001$, $p^2 = 0.088$, with the common ingroup identity group' s competitive victimhood ($M = 4.58$, $SE = 0.93$) significantly lower than the control group' s ($M = 5.15$, $SD = 0.96$), $p < 0.001$, 95% CI = [0.45, 1.20]. The interaction between group identity and common ingroup identity was not significant, $F(1, 172) = 2.66$, $p = 0.105$.

Discussion

Experiment 1 measured competitive victimhood after activating common ingroup identity and found that the common ingroup identity group' s competitive victimhood was significantly lower than the control group' s, indicating that common ingroup identity can effectively reduce competitive victimhood for both doctors and patients. The need-based model proposes that power need and moral need are the foundations of competitive victimhood, with higher needs leading to stronger competitive victimhood [**?**, **?**]. Therefore, Experiment 2A further examined these mechanisms by testing whether power need and moral need mediate the effect of common ingroup identity on competitive victimhood.

Experiment 2A: The Mediating Role of Power and Moral Needs

Methods

Participants Using G*Power 3.1 with the same parameters as Experiment 1, we calculated a minimum required sample of 105 participants (27 per group) and ultimately recruited 147 participants. We selected 71 medical staff from three hospitals in Shanghai and Sichuan as the doctor group and 76 patients and their family members as the patient group. After removing 3 outliers with scores exceeding $±$3 standard deviations from the mean in the patient group, 73 participants remained. Within each group, participants were randomly assigned to conditions: doctor common ingroup identity group (n = 36, 14 male, 22 female, mean age = 30.58 ± 5.39), patient common ingroup identity group (n = 37, 18 male, 19 female, mean age = 31.00 ± 7.24), doctor control group (n = 35, 14 male, 21 female, mean age = 29.57 ± 4.71), and patient control group (n = 36, 18 male, 18 female, mean age = 33.83 ± 7.97).

Materials and Procedure **Competitive Victimhood Questionnaire**: Same as in the preliminary study. Cronbach' s α in this experiment was 0.62.

Power Need Questionnaire: Adapted from [**?**] for the doctor-patient context, consisting of 4 items measuring power need (e.g., "I hope patients/medical staff can have more influence over the consultation process"). Items were rated on a 7-point scale from 1 (strongly disagree) to 7 (strongly agree), with the mean of the 4 items as the score. Cronbach' s α was 0.78.

Moral Need Questionnaire: Adapted from [**?**] for the doctor-patient context, consisting of 4 items measuring moral need (e.g., "I hope medical staff/patients know my behavior is not without reason"). Items were rated on a 7-point scale from 1 (strongly disagree) to 7 (strongly agree), with the mean of the 4 items as the score. Cronbach' s α was 0.84.

The procedure was essentially the same as Experiment 1. After completing the common ingroup identity activation or control condition, participants completed the power need questionnaire, moral need questionnaire, and competitive victimhood questionnaire in sequence.

Results

Manipulation Check for Common Ingroup Identity Independent samples t-tests examined differences in common ingroup identity between experimental and control groups. For the doctor group, experimental group scores (M = 6.71, SD = 0.50) were significantly higher than control group scores (M = 5.20, SD = 1.48), t(69) = 5.80, p < 0.001, Cohen' s d = 1.37. For the patient group, experimental group scores (M = 6.05, SD = 1.03) were also significantly higher than control group scores (M = 4.96, SD = 1.29), t(71) = 4.01, p < 0.001, Cohen' s d = 0.93. These results indicate successful activation of common ingroup identity for both groups.

ANOVA Results for Competitive Victimhood, Power Need, and Moral Need A 2 (group identity: doctors vs. patients) × 2 (group identity activation: common ingroup identity vs. control) ANOVA on competitive victimhood revealed a significant main effect of group identity, F(1, 140) = 7.96, p = 0.005, p^2 = 0.054, with doctors' competitive victimhood (M = 5.12, SD = 1.04) significantly higher than patients' (M = 4.67, SD = 0.98), p = 0.016, 95% CI = [-1.00, -0.10]. The main effect of common ingroup identity was significant, F(1, 140) = 13.54, p < 0.001, p^2 = 0.088, with the common ingroup identity group' s competitive victimhood (M = 4.60, SE = 0.92) significantly lower than the control group' s (M = 5.19, SD = 1.06), p = 0.032, 95% CI = [0.04, 0.95]. The interaction was not significant, F(1, 140) = 0.36, p = 0.552.

A 2 (group identity) × 2 (activation) ANOVA on power need revealed a significant main effect of group identity, F(1, 140) = 12.80, p < 0.001, p^2 = 0.084, with doctors' power need (M = 5.54, SD = 0.95) significantly higher than patients' (M = 4.06, SD = 1.04), p = 0.022, 95% CI = [-0.97, -0.08]. The main effect of common ingroup identity was significant, F(1, 140) = 11.89, p = 0.001, p^2 = 0.078, with the common ingroup identity group' s power need (M = 4.97, SD = 1.00) significantly lower than the control group' s (M = 5.52, SD = 0.99), p = 0.009, 95% CI = [0.15, 1.06]. The interaction was not significant, F(1, 140) = 0.11, p = 0.738.

A 2 (group identity) × 2 (activation) ANOVA on moral need revealed a signif-

icant main effect of group identity, F(1, 140) = 39.05, p < 0.001, p^2 = 0.218, with doctors' moral need (M = 5.15, SD = 0.87) significantly higher than patients' (M = 4.34, SD = 0.87), p < 0.001, 95% CI = [-1.19, -0.47]. The main effect of common ingroup identity was not significant, F(1, 140) = 0.03, p = 0.853, nor was the interaction, F(1, 140) = 0.01, p = 0.919.

These results indicate that compared to the control condition, common ingroup identity effectively reduced competitive victimhood and power need for both doctors and patients, but had no significant effect on moral need.

Mediating Effects of Power and Moral Needs Correlation Analysis: Correlations among variables for both groups are shown in Table 3 . Significant correlations were found between common ingroup identity, power need, and competitive victimhood for both groups, while common ingroup identity was not significantly correlated with moral need. Therefore, we examined the mediating effect of power need between common ingroup identity and competitive victimhood [**?**, **?**, **?**]. For more rigorous hypothesis testing, we included moral need in a double mediation analysis.

Double Mediation Analysis: Using PROCESS Model 4 [**?**, **?**], we examined the mediating roles of power need and moral need in the relationship between common ingroup identity and competitive victimhood. Common ingroup identity manipulation (common ingroup identity group = 1, control group = 0) was the independent variable.

For the doctor group (Figure 1 [Figure 1: see original paper]), the indirect effect of power need was significant, estimate = -0.23, 95% CI = [-0.52, -0.06], while the indirect effect of moral need was not significant, estimate = 0.006, 95% CI = [-0.05, 0.08]. Common ingroup identity significantly predicted power need, β = -0.64, p = 0.006. Common ingroup identity significantly predicted competitive victimhood, β = -0.48, p = 0.042, and power need significantly predicted competitive victimhood, β = 0.36, p = 0.003. When both power and moral needs were included in the regression, common ingroup identity no longer significantly predicted competitive victimhood, β = -0.26, p = 0.273, indicating that power need mediates the relationship between common ingroup identity and competitive victimhood for doctors.

For the patient group (path coefficients in parentheses in Figure 1 [Figure 1: see original paper]), the indirect effect of power need was significant, estimate = -0.25, 95% CI = [-0.55, -0.01], while the indirect effect of moral need was not significant, estimate = 0.002, 95% CI = [-0.10, 0.10]. Common ingroup identity significantly predicted power need, β = -0.48, p = 0.040. Common ingroup identity significantly predicted competitive victimhood, β = -0.70, p = 0.002, and power need significantly predicted competitive victimhood, β = 0.52, p < 0.001. When both needs were included, common ingroup identity still significantly predicted competitive victimhood, β = -0.46, p = 0.014, indicating that power need mediates the relationship between common ingroup identity

and competitive victimhood for patients.

Cross-Group Comparison of Mediation Models: Using AMOS for multigroup path analysis, we tested differences in path coefficients between doctor and patient groups. Results showed that absolute values of critical ratios for differences in all path parameters were less than 1.96, indicating that group identity does not moderate the mediation model. Table 4 shows the comparison of path coefficients between doctor and patient groups.

Discussion

Experiment 2A examined the mediating roles of power need and moral need in the effect of common ingroup identity on competitive victimhood. Results showed that common ingroup identity effectively reduced competitive victimhood for both doctors and patients, consistent with Experiment 1. Power need mediated the relationship between common ingroup identity and competitive victimhood for both groups, revealing that reduced power need may be the underlying mechanism linking common ingroup identity to reduced competitive victimhood. Reduced power need and common ingroup identity both decreased competitive victimhood, and common ingroup identity reduced power need while decreasing competitive victimhood, echoing previous theoretical models [**?**, **?**, **?**]. However, moral need did not show a significant mediating effect.

Experiment 2B: Testing the Model with a Recategorization Paradigm

Experiment 2A showed that establishing common ingroup identity can reduce competitive victimhood by reducing power need for both groups. However, it is necessary to retest this mechanism using different methods. Therefore, Experiment 2B used a recategorization paradigm closer to real-world social situations, allowing direct communication between doctor and patient groups to activate common ingroup identity and test the robustness of the mediation model.

Methods

Participants Using G*Power 3.1 with the same parameters as Experiment 2A, we calculated a minimum required sample of 105 participants. We ultimately selected 108 participants (27 per condition). The experiment was conducted online via Tencent Meeting. Medical or nursing students with hospital internship experience from two Shanghai universities served as the doctor group, and non-medical students with medical treatment experience in the past six months served as the patient group. Within each group, participants were randomly assigned to conditions: doctor common ingroup identity group (n = 27, 6 male, 21 female, mean age = 22.56 $\pm$ 1.22), patient common ingroup identity group (n = 27, 7 male, 20 female, mean age = 22.70 $\pm$ 2.69), doctor control group (n = 27, 7 male, 20 female, mean age = 22.70 $\pm$ 1.17), and patient control group (n = 27, 6 male, 21 female, mean age = 20.63 $\pm$ 1.71).

Materials and Procedure Competitive Victimhood Questionnaire: Same as in the preliminary study. Cronbach' s α was 0.72.

Power Need Questionnaire: Same as in Experiment 2A. Cronbach' s α was 0.80.

Moral Need Questionnaire: Same as in Experiment 2A. Cronbach' s α was 0.84.

Common Ingroup Identity Activation: Following the recategorization paradigm used by [**?**] to activate common ingroup identity among different ethnic groups, two groups discussed winter wilderness survival problems. Common ingroup identity was manipulated by controlling discussion format, group names, and virtual background images.

Procedure: Twelve experienced psychology graduate students participated in a pilot study, and their suggestions were used to adjust the online experiment' s organization and 流程. In the formal experiment, doctor and patient participants were randomly assigned to 36 groups of 3 same-identity members each. Each experimental session involved one 3-person doctor group and one 3-person patient group (6 participants total).

Group Formation Stage: Using Tencent Meeting' s breakout room function, each group first discussed within their own group with cameras and microphones on, using assigned virtual backgrounds (doctors: "starry sky," patients: "dewdrops"). Before discussion, groups chose representative names and changed their display names to "group name + nickname." In the first 7-minute discussion, common ingroup identity groups freely expressed views on the survival story, while control groups completed ranking 12 survival items by importance. Afterward, participants were informed they would interact with another group and were introduced to that group' s name and identity as doctors or patients.

Recategorization Stage: Both groups returned to the main meeting room. In the common ingroup identity condition, the experimenter told all 6 participants, "After escaping the crash site, you met other survivors. To survive, you decided to travel together. Please choose a new representative name for your 6-person survival team." Participants then changed their display names again and were told, "Now, Group 1 (original name) and Group 2 (original name) have reformed into New Group (name). To create a survival atmosphere, please change your virtual background to 'wilderness' uniformly." They then reached consensus on ranking the 12 items within 7 minutes. In the control condition, groups did not unify names or backgrounds; each group sent one representative to report their first-round ranking results and reasoning to the other group, with the other two members supplementing. During this period, group members only reported to each other without discussion.

Participants then completed manipulation check items: "During problem-solving, the two groups felt like one team" and "During problem-solving, the two groups felt like two independent teams," rated on a 7-point scale from

1 (not at all) to 7 (very much). Finally, participants completed the power need questionnaire, moral need questionnaire, and competitive victimhood questionnaire. They were informed of the materials' fictional nature and received compensation.

Results

Manipulation Check for Common Ingroup Identity Independent samples t-tests examined differences in common ingroup identity between experimental and control groups. For the doctor group, experimental group scores ($M = 4.94$, $SD = 1.49$) were significantly higher than control group scores ($M = 4.04$, $SD = 1.75$), $t(52) = 2.05$, $p = 0.045$, Cohen' s $d = 0.55$. For the patient group, experimental group scores ($M = 5.06$, $SD = 1.48$) were also significantly higher than control group scores ($M = 4.02$, $SD = 1.48$), $t(52) = 2.57$, $p = 0.013$, Cohen' s $d = 0.70$. These results indicate successful activation of common ingroup identity for both groups.

ANOVA Results for Competitive Victimhood, Power Need, and Moral Need A 2 (group identity: doctors vs. patients) × 2 (group identity activation: common ingroup identity vs. control) ANOVA on competitive victimhood revealed a significant main effect of group identity, $F(1, 104) = 26.52$, $p < 0.001$, $p^2 = 0.203$, with doctors' competitive victimhood ($M = 4.99$, $SD = 1.00$) significantly higher than patients' ($M = 4.11$, $SD = 0.83$), $p < 0.001$, 95% CI = [0.87, 1.83]. The main effect of common ingroup identity was not significant, $F(1, 104) = 1.58$, $p = 0.212$, $p^2 = 0.015$. However, the interaction between group identity and common ingroup identity was significant, $F(1, 104) = 7.43$, $p = 0.008$, $p^2 = 0.067$. Simple effects analysis showed that for the doctor group, experimental group competitive victimhood ($M = 4.65$, $SD = 1.05$) was significantly lower than control group ($M = 5.33$, $SD = 0.83$), $p = 0.006$, while for the patient group, experimental group competitive victimhood ($M = 4.24$, $SD = 0.96$) did not differ significantly from control group ($M = 3.99$, $SD = 0.66$), $p = 0.301$.

A 2 × 2 ANOVA on power need revealed a significant main effect of group identity, $F(1, 104) = 24.48$, $p < 0.001$, $p^2 = 0.191$, with doctors' power need ($M = 5.47$, $SD = 0.97$) significantly higher than patients' ($M = 4.52$, $SD = 1.06$), $p < 0.001$, 95% CI = [0.79, 1.86]. The main effect of common ingroup identity was not significant, $F(1, 104) = 1.64$, $p = 0.204$, $p^2 = 0.015$. The interaction was marginally significant, $F(1, 104) = 3.82$, $p = 0.053$, $p^2 = 0.035$. Simple effects analysis showed that for the doctor group, experimental group power need ($M = 5.16$, $SD = 1.18$) was significantly lower than control group ($M = 5.78$, $SD = 0.56$), $p = 0.024$, while for the patient group, experimental group power need ($M = 4.58$, $SD = 1.05$) did not differ from control group ($M = 4.45$, $SD = 1.09$), $p = 0.634$.

A 2 × 2 ANOVA on moral need revealed no significant main effects or interactions (all $ps > 0.170$).

These results indicate that for the doctor group, common ingroup identity effectively reduced competitive victimhood and power need, but this effect was not significant for the patient group. Moral need showed no significant differences between groups or conditions.

Mediating Effects of Power and Moral Needs Correlation Analysis: Correlation results are shown in Table 5 . For more rigorous hypothesis testing, we included all variables in a double mediation model.

Double Mediation Analysis: Using PROCESS Model 4 [**?**, **?**] with the same parameters as Experiment 2A, we conducted the analysis.

For the doctor group (Figure 2 [Figure 2: see original paper]), the indirect effect of power need was significant, estimate = -0.12, 95% CI = [0.06, 0.26], while the indirect effect of moral need was not significant, estimate = 0.001, 95% CI = [-0.07, 0.07]. Common ingroup identity significantly predicted power need, β = -0.32, p = 0.017. Common ingroup identity significantly predicted competitive victimhood, β = -0.34, p = 0.011, and power need significantly predicted competitive victimhood, β = 0.36, p = 0.009. When both needs were included, common ingroup identity no longer significantly predicted competitive victimhood, β = -0.23, p = 0.10, indicating that power need mediates the relationship between common ingroup identity and competitive victimhood for doctors.

For the patient group (path coefficients in parentheses), the indirect effect of power need was not significant, estimate = -0.02, 95% CI = [-0.14, 0.09], and the indirect effect of moral need was not significant, estimate = 0.001, 95% CI = [-0.03, 0.06]. Therefore, the mediation model was not established for the patient group.

Discussion

Experiment 2B used a recategorization paradigm to activate competitive victimhood in doctor-patient groups. Results differed from Experiment 2A: the main effect of common ingroup identity was not significant, but it interacted significantly with group identity. For the doctor group, power need mediated the relationship between common ingroup identity and competitive victimhood, but the patient group mediation model was not established. This may be because the college student patient participants in this experiment differed from the outpatient patient participants in previous experiments. This issue will be discussed in more detail in the general discussion.

General Discussion

Competitive Victimhood in Doctor-Patient Relationships

The preliminary study found that both doctors and patients experience competitive victimhood. Doctors and patients should be a community of shared

interests with the common superordinate goal of defeating disease and restoring health, requiring both excellent medical skills and active patient cooperation. However, medical system reforms combined with negative media portrayals of doctor-patient conflicts have made relationships increasingly tense, placing both parties in opposition and leading each to believe they are the primary victims in doctor-patient conflicts.

Second, the preliminary study found that doctors' competitive victimhood was higher than patients' , a result replicated in Experiments 1 and 2. Compared to patients, medical staff have more frequent doctor-patient interactions and experience conflicts more often. Data from the Chinese Medical Doctor Association show that 66% of physicians have experienced varying degrees of doctor-patient conflict [**?**, **?**]. The China Social Mentality Research Report also indicates that tense doctor-patient relationships cause more negative emotions for medical staff than for patients [**?**, **?**]. Therefore, medical staff may be more likely to view themselves as the disadvantaged party in tense doctor-patient relationships, experiencing higher competitive victimhood. However, due to sample size limitations, this conclusion is not representative and requires more comprehensive systematic research for verification.

Effects of Common Ingroup Identity on Doctor-Patient Competitive Victimhood

When doctor and patient members construct a common superordinate identity and develop common ingroup identity, competitive victimhood can be effectively reduced, consistent with previous findings [**?**, **?**, **?**]. Common ingroup identity makes both parties realize they share the common goal of fighting disease. According to superordinate goal theory, when two opposing groups face a common goal requiring joint effort, the need to achieve the superordinate goal becomes more important than intergroup hostility, leading groups to shift from opposition to cooperation and easing tense intergroup relationships during cooperation [**?**, **?**]. Simultaneously, this common ingroup identity blurs group boundaries, extends the ingroup to a superordinate common group, and extends positive ingroup emotions to the common group. Group members focus less on current subgroup conflicts, pay more attention to the other group' s experiences, reduce negative stereotypes and prejudice [**?**, **?**], increase perceived similarity, enhance interpersonal attraction [**?**, **?**], promote psychological fusion [**?**, **?**], and reduce hostility, thereby lowering competitive victimhood.

These findings provide empirical support and practical basis for applying common ingroup identity strategies to Chinese doctor-patient relationships. Experiment 2A' s results indicate that power need mediates the relationship between common ingroup identity and competitive victimhood for both doctors and patients. Compared to the control group, common ingroup identity reduced both power need and competitive victimhood, and reduced power need further decreased competitive victimhood.

For medical staff, the effect of common ingroup identity on competitive victimhood depends on the mediating role of power need. According to Foucault' s "power-knowledge" theory, medical staff' s professional knowledge is an important source of power [**?**, **?**]. With the rapid development of the internet, patients have increased access to medical knowledge, threatening medical staff' s power. According to the need-based model, medical staff may engage in victim competition to maintain power [**?**, **?**, **?**]. The common goal of fighting disease transforms the relationship from hostile to cooperative, granting patients some autonomy while ensuring medical staff' s treatment authority, shifting the focus from power inequality to jointly fighting disease, reducing both parties' pursuit of power during interactions, and thereby lowering competitive victimhood. For patients, activating common ingroup identity implies a resource-sharing and cooperative interaction model, satisfying their power need [**?**, **?**], reducing negative emotions, and increasing positive impressions of medical staff [**?**, **?**, **?**], which also helps reduce competitive victimhood.

Experiment 2A also found that common ingroup identity was not significantly correlated with moral need, and moral need did not mediate the relationship. This may be because, compared to intractable ethnic conflicts and structural inequality in previous research, doctor-patient conflicts, though long-term tense, are relatively brief, occasional, temporary, and personal, with interactions often being one-time. Due to social desirability, people in social interactions hope to establish good moral images and leave positive impressions, including in doctor-patient interactions. This social desirability, as a personality trait, is relatively stable and difficult to change [**?**, **?**]. Therefore, common ingroup identity may not necessarily reduce both parties' need for a good moral image. Additionally, since both parties view themselves as disadvantaged in the conflict, and disadvantaged groups engage in competitive victimhood mainly to restore status and gain resources through power need, their need to establish a good moral image is not high [**?**, **?**].

Experiment 2B, using a recategorization paradigm closer to real-world situations, further demonstrated the robustness of the doctor group mediation model. However, the patient group' s common ingroup identity effect and mediation mechanism were not established, which differs partially from Experiment 2A but provides new insights. Data show that patient group competitive victimhood in Experiment 2B' s control condition ($M = 3.99$, $SD = 0.66$) was significantly lower than in Experiment 2A' s patient control group ($M = 5.02$, $SD = 1.03$), $p < 0.001$. The difference lies in that although the former had recent medical experience, they were no longer in the hospital environment, while the latter completed the experiment in an outpatient setting. This suggests that being in a hospital environment may affect patients' competitive victimhood. When patients are in hospitals, anxiety about illness or frustration from waiting may increase competitive victimhood, which decreases after leaving the hospital. This may explain why patient group baseline competitive victimhood was lower in Experiment 2B, making it difficult for experimental results to differ significantly. For medical staff, whose work and learning environments are closely related to

hospitals and whose social circles are mostly colleagues, competitive victimhood in control groups did not decrease when away from the hospital environment. In summary, the hospital environment may have a unique effect on patient group competitive victimhood, which could be reduced through measures such as optimizing registration processes and improving waiting experiences.

Contributions and Limitations

This study innovatively applied previous research on intergroup conflict and reconciliation to the doctor-patient field, exploring the effects of common ingroup identity on competitive victimhood and the mediating role of power need, providing new ideas and methods for improving today' s tense doctor-patient relationships. This study enriches and develops CIIM model theory in three ways: First, it is the first to demonstrate the significant effect of common ingroup identity on competitive victimhood in doctor-patient groups, extending the CIIM model' s applicability from ethnic groups to doctor-patient groups. Second, it confirms the generalizability of the CIIM model in Chinese cultural contexts, providing a practical foundation for localizing common ingroup identity interventions. Finally, Experiments 2A and 2B demonstrated the effectiveness of both text-based activation and recategorization paradigms, enriching the CIIM model' s activation methods.

This study offers positive practical implications for promoting good doctor-patient relationships. Establishing a common superordinate group identity is an effective intervention for doctor-patient relationships and can be applied in real medical environments. For example, a Shandong hospital implemented warm culture services, including "family-like care" and "doctor-patient public welfare symposiums," which can be seen as operations for establishing common ingroup identity [**?**, **?**]. A Nanjing doctor spontaneously organized patient hiking clubs during rest time, establishing a friend superordinate identity beyond the doctor-patient relationship. Second, given the mediating role of power need, it is necessary to respect and protect both parties' basic power. On one hand, medical staff' s treatment authority should be ensured, and medical knowledge should be promoted \cite{吕小康等，2019} to prevent patient misunderstandings such as excessive treatment. On the other hand, patients should be granted some autonomy, such as choosing treatment options within reasonable ranges and sharing medical information.

This study has several limitations. First, participants were only selected from three hospitals in Shanghai and Sichuan, and the degree of competitive victimhood may be influenced by regional and hospital type factors. Future research should expand sample sources and increase sample size, strengthening studies on doctors and patients in different city levels and hospital grades. Additionally, since conflict experiences trigger more negative emotions and damage doctor-patient relationships [**?**, **?**], future research could consider participants' past medical experiences and examine differential effects of conflict experiences on competitive victimhood and the intervention effects of common ingroup identity.

Second, this study used text-based activation and recategorization paradigms, common methods for activating common ingroup identity. Future research could use more diverse activation methods, such as explicit [**?**, **?**] and implicit activation methods, to further test and enhance the reliability and validity of results. Third, this study' s measurement of power and moral needs was primarily based on existing scales. Future research could explore the psychological structure of power and moral needs in Chinese doctor-patient groups, develop more comprehensive measurement tools, and attempt to develop more effective experimental paradigms to directly manipulate power and moral needs to further test mediation models. Additionally, this study only examined the mediating roles of power and moral needs. Future research should examine other variables such as perceived intergroup threat [**?**, **?**, **?**], group trust, and group empathy [**?**, **?**, **?**] in the relationship between common ingroup identity and competitive victimhood.

Conclusion

Based on the preliminary study and three experiments, this study explored the influence and mechanisms of common ingroup identity on competitive victimhood in doctor-patient relationships, reaching the following conclusions: (1) Common ingroup identity can significantly reduce competitive victimhood between doctors and patients; (2) Power need mediates the relationship between common ingroup identity and competitive victimhood for both parties; (3) The recategorization paradigm verified the robustness of the mediation model for the doctor group.

References

[**?**, **?**, **?**, **?**, **?**, **?**, **?**, **?**, **?**, **?**, **?**, **?**]

\cite{Ai, J. (2018). Intergroup competitive victimhood and its countermeasures in doctor-patient conflicts. Chinese Social Psychological Review, 14(1), 63-73.}

\cite{Alves, H., Koch, A., & Unkelbach, C. (2016). My friends are all alike—the relation between liking and perceived similarity in person perception. Journal of Experimental Social Psychology, 62, 103-117.}

\cite{Andrighetto, L., Mari, S., Volpato, C., & Behluli, B. (2012). Reducing competitive victimhood in Kosovo: The role of extended contact and common ingroup identity. Political Psychology, 33(4), 513-529.}

\cite{Bar-Tal, D., Chernyak-Hai, L., Schori, N., & Gundar, A. (2009). A sense of self-perceived collective victimhood in intractable conflicts. International Review of the Red Cross, 91(874), 229-258.}

\cite{Belavadi, S., & Hogg, M. A. (2018). We are victims! How observers evaluate a group' s claim of collective victimhood. Journal of Applied Social Psychology, 48(12), 651-660.}

\cite{Branscombe, N. R., Warner, R. H., Klar, Y., & Fernández, S. (2015). Historical group victimization entails moral obligations for descendants. Journal of Experimental Social Psychology, 59, 118-129.}

[?, ?, ?, ?, ?, ?, ?, ?, ?]

[?]

\cite{de Guissmé, L., & Licata, L. (2017). Competition over collective victimhood recognition: When perceived lack of recognition for past victimization is associated with negative attitudes towards another victimized group. European Journal of Social Psychology, 47(2), 148-166.}

\cite{Demirda, A., & Hasta, D. (2019). Threat perception and perspective taking as mediators between competitive victimhood and evaluations of collective action: the gezi park protests. Political Psychology, 40(5), 953-971.}

\cite{Dovidio, J. F., Gaertner, S. L., Ufkes, E. G., Saguy, T., & Pearson, A. R. (2016). Included but invisible? Subtle bias, common identity, and the darker side of "we" . Social Issues & Policy Review, 10(1), 6-46.}

\cite{Fiske, S. T., Cuddy, A. J., Glick, P., & Xu, J. (2002). A Model of (often mixed) stereotype content: Competence and warmth respectively follow from perceived status and competition. Journal of Personality and Social Psychology, 82(6), 878-902.}

\cite{Gaertner, S. L., & Dovidio, J. F. (2009). A Common Ingroup Identity: A categorization-based approach for reducing intergroup bias. In T. Nelson (Ed.), Handbook of prejudice(pp.489-506). Psychology Press.}

\cite{Glasforda, D. E., & Dovidio, J. F. (2011). E pluribus unum: Dual identity and minority group members' motivation to engage in contact, as well as social change. Journal of Experimental Social Psychology, 47(5), 1021-1024.}

[?, ?, ?, ?]

\cite{He, J., & Zhang, B. (2020). The influence of doctor-patient conflict on patients' negative emotions: The moderating effect of doctor-patient communication quality. Chinese Journal of Clinical Psychology, 28(4), 803-808.}

\cite{Jiang, H. R., Yu, X. H., Gao, S., Shang, P. P., Cao, P., & Qiang, B. Y. Z. (2022). Influence of doctor-patient relationship on perceived stress of grassroots medical staff in Jilin province. Medicine and Society, 35(08), 105-109.}

\cite{Kahalon, R., Shnabel, N., Halabi, S., & SimanTov-Nachlieli, I. (2019). Power matters: The role of power and morality needs in competitive victimhood among advantaged and disadvantaged groups. The British journal of social psychology, 58, 452-472.}

[?, ?]

\cite{Liang, M. F., Xiao, Z. L., Bao. Y., & Fang, Y. (2020). The promotion effect and mechanism of common ingroup identity on psychological compatibility.

Journal of Psychological Science, 43(5), 1147–1153.}

\cite{Liu, T. Y., & Wang, P. (2020). Influences of information consistence and decision-making power on the expression of doctors' stereotypes. Chinese Journal of Clinical Psychology, 28(2), 413–417.}

\cite{Luo, J., Yu, L., Yang, Y., & Wu, H. Y. (2016). Psychological influence of doctor-patient dual identity empathy pre-visit on breast cancer patients. Medical Information, 29(24), 117–118.}

\cite{Lupu, N., & Peisakhin, L. (2017). The legacy of political violence across generations. American Journal of Political Science, 61(4), 836–851.}

\cite{Lyu, X. K., Fu, C.Y., & Wang, X.J. (2019). Effect and underlying mechanism of refutation texts on the trust and moral judgment of patients. Acta Psychologica Sinica, 51(10), 1171–1186.}

\cite{Nadler, A., & Shnabel, N. (2015) Intergroup reconciliation: Instrumental and socio-emotional processes and the needs-based model. European Review of Social Psychology, 26(1), 93–125.}

\cite{Noor, M., Brown, R., & Prentice, G. (2008). Prospects for intergroup reconciliation: Social psychological predictors of intergroup forgiveness and reparation in Northern Ireland and Chile. In A. Nadler, T. Malloy & J. D. Fisher (Eds.), The social psychology of intergroup reconciliation (pp. 97–114). Oxford University Press.}

\cite{Noor, M., Shnabel, N., Halabi, S., & Nadler, A. (2012). When suffering begets suffering: The psychology of competitive victimhood between adversarial groups in violent conflicts. Personality and Social Psychology Review, 16(4), 351–374.}

\cite{Quan, P., & Liu, R.M. (2016). Self-cognition analysis of the current situation and prospects of doctors' power. Chinese Hospital, 20(8), 67–69.}

\cite{Riek, B., Mania, E., Gaertner, S. L., McDonald, S., & Lamoreaux, M. (2010). Does a common identity reduce intergroup threat? Group Processes & Intergroup Relations, 13(4), 403–423.}

\cite{Robinson, J. D., & Heritage, J. (2016). How patients understand physicians' solicitations of additional concerns: Implications for up-front agenda setting in primary care. Health Communication, 31(4), 434–444.}

[?, ?, ?, ?, ?, ?, ?, ?, ?, ?, ?]

\cite{Shnabel, N., Halabi, S., & Noor, M. (2013). Overcoming competitive victimhood and facilitating forgiveness through re-categorization into a common victim or perpetrator identity. Journal of Experimental Social Psychology, 49(5), 867–877.}

\cite{Shnabel, N., & Nadler, A. (2008). A needs-based model of reconciliation: Satisfying the differential emotional needs of victim and perpetrator as a key to

promoting reconciliation. Journal of Personality and Social Psychology, 94(1), 116–132.}

\cite{SimanTov-Nachlieli, I., Shnabel, N., & Nadler, A. (2013). Individuals' and groups' motivation to restore their impaired identity dimensions following conflicts. Social Psychology, 44(2), 129–130}

\cite{Smith, D. B., & Ellingson, J. E. (2002). Substance versus style: A new look at social desirability in motivating contexts. Journal of Applied Psychology, 87(2), 211–219.}

\cite{Solomon, J., & Martin, A. (2019). Competitive victimhood as a lens to reconciliation: An analysis of the black lives matter and blue lives matter movements. Conflict Resolution Quarterly, 37(1), 7–31.}

\cite{Ufkes, E., Calcagno, J., Glasford, D., & Dovidio, J. F. (2016). Understanding how common ingroup identity undermines collective action among disadvantaged-group members. Journal of Experimental Social Psychology, 63, 26–35.}

\cite{Vollhardt, J. R., & Bilali, R. (2015). The role of inclusive and exclusive victim consciousness in predicting intergroup attitudes: Findings from Rwanda, Burundi, and DRC. Political Psychology, 36(5), 489–506.}

[**?**, **?**]

[**?**, **?**]

\cite{Wang, X. J., Chai, M. Q., & Zhao, W. J. (2016). The effect of perceived group victimhood on collective guilt of medical workers. Journal of Northwest Normal University (Social Sciences), 53(01), 125–132.}

\cite{Wen, Z. L., & Ye, B. J. (2014). Analyses of mediating effects: The development of methods and models. Advances in Psychological Science, 22(05), 731–745.}

\cite{Wohl, M., & Branscombe, N. R. (2005). Forgiveness and collective guilt assignment to historical perpetrator groups depend on level of social category inclusiveness. Journal of Personality & Social Psychology, 88(2), 288–303.}

[**?**, **?**]

\cite{Yao, B. Y., Fu, H., & Chen, Q. J. (2021). Thoughts on the construction of doctor-patient destiny community in COVID-19. Chinese Medical Ethics, 34(04), 489–491.}

\cite{Yin, L., Zeng, R. H., Gao, X., & Gu, J. D. (2019). Analysis on the status-quo and influencing factors of medical disputes in the IIIA hospitals—based on the perspective of doctors, patients and family members. Health Economics Research, 36(12), 67–70+74.}

\cite{Young, I. F., & Sullivan, D. (2016). Competitive victimhood: A review of the theoretical and empirical literature. Current Opinion in Psychology, 11,

30–34.}

\cite{Yuan, X. (2014). The application of foucault' s philosophy: Analysis on micro-power in doctor-patient relationship. Medicine & Philosophy, 35(502), 58–60.}

Note: Figure translations are in progress. See original paper for figures.