

Research Proposal –

Can cooperative intergroup contact (CIC) interventions reduce transgender prejudice in healthcare providers?

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Introduction

Stark health disparities exist between transgender people and the general population. Many transgender people report that they avoid healthcare services due to the experience of or fear of being stigmatized (Rani and Samuel 2019; Whitehead et al. 2016). Most research on prejudice against sexual and gender minorities either ignores transgender people or include them in aggregate with the rest of the LGBT population, which limits the generalizability of findings to transgender people's unique needs and experiences (Worthen 2012). Reducing healthcare provider prejudice against transgender people could make healthcare more accessible for transgender people and reduce healthcare disparities for this vulnerable population.

Allport's theory of intergroup contact has been used to durably reduce other types of prejudice and offers one way to address transphobia. Interpersonal contact is a strong predictor of sexual stigma and prejudice, and healthcare providers may not naturally encounter transgender people very often, which makes an intergroup contact intervention a promising avenue for attitudinal change (Walch 2012).

Allport theorized that interpersonal contact can reduce prejudice when it occurs within equal-status groups, with the support of authorities, where the groups have common goals and cooperative contact (Dovidio, Gaertner, Kawakami 2003). This type of contact reduces intergroup anxiety, which facilitates several cognitive and affective mechanisms for attitudinal change (Dovidio, Gaertner, Kawakami 2003). Pettigrew (1998) notes that both cognitive and affective mechanisms are essential and identifies four mediators – learning about the out-group, behavioral modification, creating affective ties between groups, and in-group reappraisal. The cognitive process of learning about the out-group lays the groundwork for affective mechanisms. The cooperative environment sanctioned by authority figures sets an expectation for behavior, what Pettigrew (1998) calls a “benign form of behavior modification.” The cooperative environment creates positive affective ties between group members which can help soothe some of the natural anxiety and tension that arises when interacting with an “out-group.” Participants experience attitude shifts about their own group (“in-group”) as well as the out-group, as they are exposed to new experiences and interactions.

Out of the research on intergroup contact theory, few studies focus on transgender people, and of those even fewer are methodologically sound (Walch 2012). Although Pettigrew (1998) suggests that longitudinal designs provide a stronger case for causality and that repeated treatments may be needed to see an effect, Dubin et al. (2018) found that most transgender education is provided to healthcare providers as a one-time intervention, which provides short-term effects but does not substantially improve healthcare long-term. Out of the studies reviewed for this proposal, none focused on reducing transphobia within the healthcare community. This research proposal aims to identify effective, longitudinal prejudice reduction interventions for healthcare providers.

Literature Review

Despite the large body of work surrounding Allport's intergroup contact theory, few studies focus on prejudice against sexual and gender minorities, and even fewer deal specifically with transphobia. Out of the studies reviewed for this proposal, all used surveys to operationalize their dependent variable (changes in attitudes) and only one employed a longitudinal design.

Gu et al. (2016) used a randomized experiment to test whether intergroup contact generated more positive attitudes between rural and rural-urban Chinese school children. The children participated in one intergroup contact session and were surveyed twice – once immediately after the session and again 10 months later. The study found that children in the treatment group had more positive attitudes towards the out-group immediately after the treatment, but that the effect disappeared by the 10-month follow up, which aligns with Pettigrew's (1998) assertion that repeated contacts may be required to see an effect.

Krahé and Altwasser (2006) examined attitudes towards physically disabled persons through a randomized experiment which compared a cognitive-only intervention, cognitive and behavioural intervention, and a no-treatment group. Like Gu et al., they used students as their unit of analysis and included an immediate post-test survey as well as a follow-up survey three months later. They controlled for prior exposure to physically disabled persons and included a social desirability scale in their survey to control for social desirability bias. The intervention included two sessions for each of the groups. They found that only the cognitive and behavioral intervention group showed any statistically significant changes in attitudes and that the treatment effect was still statistically significant at the three-month follow-up, although it had degraded over time. Due to the design of the experiment, it is hard to determine causality. Since treatment combined cognitive and behavioral interventions, it is unclear whether it was the behavioral component that caused the treatment effect or whether it was an interaction effect. Further, since only the cognitive and behavioral group participated in hands-on activities, it is possible that the activities themselves that contributed to the treatment effect, not the intergroup contact.

Scacco, Alexandra, and Warren (2018) examined religious prejudice through a field experiment in a Nigerian community. Out of the experiments reviewed for this proposal, this is the only study that used multi-week intervention that involved more than a few points of contact between groups. This was also the only study to assess change in attitudes through both a survey and behavioral games. Like Krahé and Altwasser, this study controlled for prior out-group exposure. The study randomly assigned individuals to either homogenous or mixed groups and to either a treatment or control group. The study found that intergroup contact in the heterogeneous treatment group reduced discriminatory behavior but did not appear to have an effect on attitudes.

Rani and Samuel (2019) studied the effect of direct and indirect intergroup contact on transphobia, using a sample of undergraduate students at an Indian university. Using a two group pre- and post-test design, the direct contact group attended a panel discussion led by transgender women while the indirect contact group watched a half hour talk by a transgender man. Attitudes were assessed through a survey before the treatment, immediately after, and one month after. The study found that while both the indirect and direct contact groups had a statistically

significant reduction in transphobia immediately after the intervention, the direct contact group showed a larger effect and the effect persisted through the one-month follow-up, while the indirect contact group's effect did not persist.

Most of these experiments use a single point of contact as the basis for the experiment and struggle to show that treatment effects persist over time. Most use a sample of students, which limits the generalizability of the findings. In order to develop programs to reduce transphobia in high-impact areas like healthcare, studies need to establish that intergroup contact is effective in healthcare settings and determine an appropriate “dose” of treatment to create long-term effects.

Methodology

Transphobia in the healthcare profession harms transgender people and increases healthcare disparities that this already vulnerable population faces. This study will test whether cooperative intergroup contact (CIC) interventions can reduce transgender prejudice among healthcare providers.

H_0 : CIC interventions do not reduce transgender prejudice in healthcare providers.

H_A : CIC interventions do reduce transgender prejudice in healthcare providers.

The independent variable (CIC) would be operationalized as a 12-week training series provided to medical professionals at DFW hospitals, where the treatment group would have transgender instructors and the control group would have cisgender instructors. To meet Allport's criteria for optimal contact, the trainers would be fellow doctors (equal-status), the training would be introduced by a statement from a department head (support of authorities), and the training would involve interactive activities with the trainers, where the trainees and trainers share the common goal of learning better patient care techniques and cooperate in completing the exercises.

The study will utilize a randomized two-group post-test design with a follow-up test three months after the intervention. The dependent variable, transgender prejudice, would be assessed through a survey scale. The questionnaire would be completed anonymously by participants to decrease the threat of social desirability bias and would include within it a scale to assess prior exposure to transgender individuals. The survey will also assess prior contact with transgender individuals so this confounding factor can be controlled for in the analysis.

To increase external validity, participant selection would be limited to healthcare providers who treat patients on a regular basis, such as doctors, nurses, and physician assistants. Using currently practicing healthcare providers will increase the generalizability of results to our population of interest (healthcare providers), as opposed to using samples of students. The survey results will be analyzed using the individual healthcare providers as the unit of analysis. In prejudice reduction interventions, self-selection is a prominent threat, so the training sessions would be advertised as “patient care” trainings, which includes a component on transgender patient care, rather than being advertised as an LGBT training. This should decrease the likelihood that individuals who opt into the program will differ from other healthcare providers in terms of their attitudes towards transgender individuals.

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