‘You may say I’m a dreamer…’

Michele Birtel looks at using psychotherapeutic techniques to fight prejudice and stigma

How can we learn to love again? To act with empathy instead of anger? To change unpleasant or even hateful feelings towards persons who may be viewed as outgroups? For example, people from black and ethnic minorities, older people, those who are gay or lesbian, or people with mental illness? How can we learn to approach these people with compassion instead of avoiding them or discriminating against them?

No one is born hating another person because of the color of his skin, or his background, or his religion. People must learn to hate, and if they can learn to hate, they can be taught to love, for love comes more naturally to the human heart than its opposite. (Nelson Mandela, 1995)

W e are shaped by our thoughts; we become what we think’, the Buddha once said. If no one is born with prejudice, and if negative thoughts and feelings towards other people are learnt, then a way to nurture more positive attitudes could be by changing negative thoughts. How can we do this?

The answer may be found from a surprising source: clinical psychotherapy. For example, patients with anxiety disorder or depression show a vicious cycle of negative thoughts, feelings, physical sensations and behaviours related to their problem. Cognitive behavioural therapy (CBT) is an established clinical therapy for tackling such mental health disorders, and is used to stop this negative spiral. So if CBT can change people’s thoughts, feelings and behaviours in a clinical context, could it also be helpful in a social context? I believe that joining the forces of clinical and social psychologists, of methods from psychotherapy and prejudice interventions, could be fruitful in designing interventions to fight prejudice and stigma.

Before I start discussing the benefits of integrating clinical and social research, let me answer a key question first: Why do we actually need to reduce prejudice?

Growing dynamic of diversity

Wouldn’t a simple solution be to just avoid the people or situations that make us feel uncomfortable? This solution is neither desirable nor possible in daily life. The world is experiencing a growing dynamic of diversity. For example, if we look at the United Kingdom, research by the University of Manchester’s Centre on Dynamics of Ethnicity (CoDE) shows that plural cities (i.e. a city in which no ethnic group is in the majority) outside London are emerging in England (CoDE, 2012, 2013). Ethnic diversity has grown since 1991 and 20 per cent of England’s population is non-white British (CoDE, 2012, 2013). The 2011 census shows a great development from segregation to more mixing in the past 10 years. Ethnic minority groups (e.g. Pakistani, Bangladeshi, ...
African) have grown and become more evenly spread across England since 2001 (CoDE, 2012). For example, Manchester, whose population consists of 59 per cent British and 41 per cent of other ethnic groups, is close to becoming a plural city (CoDE, 2013).

Multiculturalism is a challenge for modern societies. Politicians are constantly debating the influence of multiculturalism: some believe ethnic diversity could be enriching, while others suggest it may be destructive for society. Both David Cameron and Angela Merkel have declared multiculturalism as failed. David Cameron suggests that strengthening the UK's national identity will help tackle interethnic conflict, and Angela Merkel emphasises that integration is key to a multicultural society. Barack Obama stresses the importance of tackling society's 'empathy deficit'.

As you go on in life, cultivating this quality of empathy will become harder, not easier (...) You'll be free to live in neighborhoods with people who are exactly like yourself, and send your kids to the same schools, and narrow your concerns to what's going on in your own little circle. (Obama, 2006)

His speech reflects how today's world is becoming more and more ethnically diverse, and in which developing empathy towards different cultures is made more difficult by actively avoiding people with different backgrounds, for example by choosing to live in a segregated area. Cultivating more empathy, i.e. putting yourself into someone else's shoes and seeing the world through their eyes, is important in a multicultural society. Diversity is often blamed for violent and non-violent conflict between groups, whether on the basis of ethnicity, religion, age, sexual orientation or other dimensions, is effective in reducing prejudice, compared to merely living side-by-side. In fact, Allport's (1954) intergroup contact theory is regarded as the most influential for improving intergroup prejudice.

Department of Health (2011). No health without mental health. A cross-government mental health outcomes strategy for people of all ages. Available at tinyurl.com/ptpkpsx


Gallup (2011). Fewer report depression in Germany than in U.S., UK. Available at tinyurl.com/p6aaa83


Holmes, E.A., Lang, T.J. & Shah, D.M. (2009). Developing interpretation bias modification as a ‘cognitive vaccine’ for depressed mood: Imagining positive events makes you feel better than thinking about them verbally. Journal of Abnormal Psychology, 118,
relations between conflicting groups. It has been supported by Pettigrew and Tropp’s (2006) meta-analysis of over 500 studies, which found that social contact between conflicting groups has a robust effect in reducing prejudice across different target groups, age groups, contact settings, and geographical areas.

Research has shed light on how and when contact reduces prejudice. Contact reduces prejudice by building affective ties, e.g., by reducing intergroup anxiety and enhancing empathy (Brown & Hewstone, 2003; Pettigrew & Tropp, 2008) or through cognitive processes such as creating common social identities emphasising shared membership (Gaertner & Dovidio, 2000). The idea that people do not necessarily have to experience personal contact with people from other groups but can rely on indirect contact experiences (e.g., plain knowledge that ingroup members have outgroup friends) has received significant support (Dovidio et al., 2011). Social contact has even been picked up by stigma campaigns to reduce mental health discrimination, for example Time to Change. So, is social contact the cure for prejudice and stigma?

What happens if individuals do not have the opportunity for social contact? Unfortunately, because prejudice goes many situations in which establishing meaningful contact between communities may be difficult, for example Catholic and Protestant communities in Belfast, South Asian and white people in Bradford, the Green Line in Cyprus or the West Bank in Israel. How can policymakers reap the prejudice-reducing benefits of contact in situations where contact is going to be difficult, unlikely, or impossible to establish?

The power of mental simulation
When reducing prejudice is difficult because opportunities or willingness for social contact are low, we can take a step back towards mentally simulated contact. Mental imagery has been targeted in interventions in clinical psychology when treating depression or emotional disorders (e.g., Foa et al., 1991; Lang et al., 2012), but recently also in social psychology to reduce prejudice or enhance general performance (for a review see Crisp et al., 2011).

There is extensive evidence that mental imagery is beneficial in various areas, such as health and personality psychology, consumer research, clinical therapy, and sports. Imagery improves attitudes, intentions, self-efficacy and behaviours. Recent research has shown that the benefits of mental imagery can be extended to the domain of prejudice. Crisp and Turner (2012) proposed that mentally simulating a positive social interaction with a person from another group capitalises on the extended psychological benefits of the contact concept (imagined contact hypothesis). Mentally simulating positive social contact has established positive effects on attitudes, intentions, self-efficacy and behaviour toward various target groups in terms of ethnicity, religion, sexual orientation, age or mental health. My work has shown that mental simulation of social contact could be especially useful for people high in intergroup anxiety (Birtel & Crisp, 2012a), building upon established evidence that it is effective in reducing intergroup anxiety (e.g., Turner et al., 2007).

Researchers have developed various versions of the contact simulation task: (a) elaboration, (b) perceptual focus, (c) perspective taken, (d) typicality, and (e) CBT-approach. Elaborating on the content of the simulated interaction, closing one’s eyes, taking a third-person perspective, and simulating an interaction with a person typical for their group all made the contact simulation more effective in reducing prejudice (for a review see Crisp & Turner, 2012). Together with my colleague, I have developed a short form of CBT. This CBT-approach of simulated social contact changed negative perceptions of stigmatised groups (Birtel & Crisp, 2012b). Before I introduce this new technique based on CBT, I discuss the similarities and analogy of clinical and social psychology in terms of anxiety.

Special link between imagery and emotion
A common, disorder-maintaining symptom in anxiety disorders is negative imagery. Research in clinical and

76–88.
Home Office (2012). Hate crime, cyber security and the experience of crime among children: Findings from the 2010 to 2011 British crime survey. Available at tinyurl.com/q2uxhqs
Obama, B. (2016). Obama challenges graduates to address ‘empathy deficit’. Available at www.northwestern.edu/observer/issues/2016/06/22/obama.h
The problems that people with social anxiety experience are essentially negative thoughts and feelings associated with social interactions. These thoughts include the belief that one will make mistakes, that others will evaluate negatively, and that others will notice and comment on any mistakes. The result of these thoughts is that people with social anxiety try to avoid social situations in order to avoid the negative consequences. However, this avoidance reinforces the belief that one will make mistakes and that the consequences will be negative. It is not unlikely that people who have an anxious personality may also have an anxious disposition that is not caused by social anxiety. However, it is clear that social anxiety is a problem that can be treated by cognitive-behavioural therapy.

The results showed that compared to purely positive interventions, negative contact, just prior to positive contact, resulted in the greatest reduction in prejudice. Similar to exposure therapy, the fear structure is activated through a negative mental imagery, but not a positive mental imagery, and therefore is more effective in reducing prejudice when replaced by a positive mental imagery afterwards. Furthermore, reduced anxiety uniquely derived from the psychotherapy-inspired imagery task accounted for enhanced intentions to engage positively with the previously stigmatised group in the future. These results support the benefits of incorporating insights from CBT into prejudice-reduction interventions.

**Conclusion**

Taking an established social psychological concept – social contact – and reconceptualising it in a way that it unites the field with another discipline within psychology, namely the large literature on cognitive behavioural therapy, could open new possibilities and opportunities in reducing social conflict. I hope to have shown that we may reap rewards by taking this integrative perspective. I discussed preliminary evidence for the counter-intuitive hypothesis that a little dose of negativity improves the impact of prejudice-reduction techniques. These findings are directly derived from an integration of methods in the literatures on clinical exposure therapy and intergroup contact theory. This work demonstrates the value in integrating insights from other areas, like clinical psychology, in the pursuit of solutions to the problem of prejudice.

As this CBT-approach is fairly new, key questions remain that are yet unanswered: Is a CBT-based prejudice intervention feasible and acceptable in real conflict settings? To which intergroup contexts can a CBT-based prejudice intervention be applied to? How does a CBT-based prejudice intervention need to be designed to be feasible and acceptable in various contexts, types of prejudice or stigma, and groups involved? What are the risks of using a CBT approach? These are questions which only future research can answer.