ARTICLE

'You may say I'm a dreamer…'

Michèle 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?

questions

What are the benefits of combining clinical and social psychological approaches to fight prejudice and stigma?

Could prejudice interventions based on psychotherapeutic principles be feasible and acceptable in real conflict settings?

resources

Centre on Dynamics of Ethnicity (CoDE): www.ethnicity.ac.uk
Understanding Prejudice: www.understandingprejudice.org
Mind Changers, BBC Radio 4: www.bbc.co.uk/programmes/b008cy1j
Time to Change: www.time-to-change.org.uk

> 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)

'We 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,

Barack Obama stresses the importance of tackling society's 'empathy deficit'

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African) have grown and become more evenly spread across England since 2001 (CoDE, 2012). For example, Manchester, whose population consists of 59 per cent white 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, mental health, weight or gender. Immigration, globalisation and regular conflicts (e.g. the August 2011 UK riots), vividly remind us how important the need to tackle this social problem is. Informed policies that encourage tolerance and cooperation are vital (Crisp et al., 2011).

What is the price of prejudice?

Social disharmony or conflict is not the only price we are paying for prejudice. Prejudice has extensive consequences. Discrimination leaves stigmatised people with poorer physical (e.g. cardiovascular disease, cancer) and mental health (e.g. enhanced life-stress, depression) (Major et al., 2013); and the economy with a considerable amount of direct and indirect costs. In other words, prejudice extorts major economic, social and health costs through antisocial behaviour, violence, and impacts on health and well-being.

To illustrate the severity of the problem, let me give some examples of prejudice and its costs in the UK. Over 43,000 hate crimes (e.g. regarding ethnicity, sexual orientation, disability) were recorded in England and Wales in 2011/12 (Home Office, 2012), and £9 billion is spent annually to fight antisocial behaviour and crime among 'troubled families' in England (Department for Communities and Local Government, 2013). The August 2011 UK riots cost the British taxpayer around £100 million (Hawkes et al., 2011). The UK's 'most segregated town', Oldham, has particularly suffered from ethnically motivated riots in the past.

In addition to the direct costs associated with prejudice, it is notable that almost 29 per cent of people aged 16 and over (especially pronounced among ethnic minorities) in Oldham experience mental health problems (e.g. depression) compared with 15 per cent in the UK (17 per cent in the US) as a whole (Gallup, 2011). Oldham therefore contributes significantly to the economic and social cost of mental health problems in the UK (e.g. direct costs of services, lost productivity at work and reduced quality of life), which is currently £105.2 billion (Department of Health, 2011). In fact, the largest cause of disability in the UK is mental illness (22.8 per cent), which is even greater than cancer (15.9 per cent) or cardiovascular disease (16.2 per cent).

Prejudice interventions based on social contact

Having demonstrated the pervasive need to fight prejudice and discrimination, I will now turn towards research that has tested prejudice-reduction interventions. People can feel anxious at the prospect of interacting with people from other groups (called 'intergroup anxiety': Stephan and Stephan, 1985). This is because they expect to be rejected or discriminated against, or because they fear to behave incompetently or offensively. Anxiety about potentially poor, embarrassing or difficult interactions with stigmatised group members inhibits interest in cross-group contact and can even lead to hostility or physiological threat (e.g. Blascovich et al., 2001; Stephan & Stephan, 1985). As mentioned earlier, intergroup anxiety plays a key role, and reduced anxiety is the primary mechanism through which actual or simulated social contact reduces prejudice (e.g. Crisp & Turner, 2012; Pettigrew & Tropp, 2008).

> "meaningful contact between members of groups with different backgrounds ...is effective in reducing prejudice"

Research programmes to develop interventions to reduce prejudice have correspondingly focused on combating anxiety about interacting with stigmatised groups. A great amount of research has shown that meaningful contact between members of groups with different backgrounds, whether on the basis of ethnicity, 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

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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, i.e. by reducing intergroup anxiety and enhancing empathy (Brown & Hewstone, 2005; 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 hand in hand with segregation, there are 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).

How can policymakers reap the prejudice-reducing benefits of contact in situations where contact is going to be difficult, unlikely, or impossible to establish?

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

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cognitive psychology proposes a special link between mental imagery and emotion, especially anxiety (Holmes & Mathews, 2005).

Surprisingly, imagery has a more powerful effect on emotions like anxiety than verbal processing, and even prevents negative mood more effectively than verbal thinking, acting as a 'cognitive vaccine' (Holmes et al., 2009). Mental imagery influences emotions in both positive and negative ways (Holmes & Mathews, 2010). For example, in Holmes and Mathews (2005) participants received descriptions of unpleasant scenarios. One half imagined these events, the other half thought about their verbal meaning. Participants in the imagery condition experienced a greater increase in anxiety compared to participants in the verbal condition.

Research on social phobia has stressed how negative imagery can be harmful for social interactions. People with social phobia fear interacting with other people and being negatively evaluated by them, especially in unfamiliar situations. As a result, they tend to avoid these situations. For example, when people with social anxiety had a negative self-imagery, they felt more anxious and the conversation was less fluent and interesting. However, when they created an imagery of being relaxed in the social situation, they felt less anxious and the conversation was of higher quality.

It seems that negative imagery plays a causal role in developing and maintaining social anxiety (Hirsch et al., 2004). How can cognitive-behavioural therapy be helpful for designing prejudice interventions?

Exposure therapy

There are a number of forms of CBT that draw upon the power of imagery in tackling anxiety disorders (e.g. social phobia) by modifying the persistent negative images that patients hold of the phobic stimulus (e.g. Foa et al., 1991). For example, exposure therapy confronts the patient with fear-evoking objects or situations within a safe environment, with patients instructed to actively visualise and describe the phobic stimulus. Similarly, in systematic desensitisation, therapists work with the client to form a graduated anxiety hierarchy and to tackle these with concomitant imaginal relaxation techniques, as these are antagonist to an anxious physiological state. How does exposure therapy work?

According to Foa and Kozak's (1986) emotional-processing theory, fear develops through a fear memory which is responsible for escape and avoidance reactions. Fear is represented in a network in one's memory. This fear structure contains stimulus information, responses to the stimulus and information about the meaning (threat or danger). Exposure therapy modifies this fear structure if two conditions are met: First, only if the fear memory is activated, can it be modified. Second, new information must be available to form a new memory structure that replaces the old, anxiety-provoking structure.

CBT-based prejudice intervention

We (Birtel & Crisp, 2012b) adapted these psychotherapeutic principles to develop a short form of 'exposure therapy' to 'treat' prejudice against stigmatised groups. We conceived of stigmatised groups as a type of 'phobic stimulus', and intergroup anxiety as a non-pathological 'fear structure'. If this analogy holds, then activating negative thoughts and feelings associated with the stimulus before introducing new positive thoughts should reduce negative perceptions of stigmatised groups.

We tested the hypothesis that mentally simulating positive social contact with a stigmatised group member would be more likely to promote positive perceptions when preceded by simulated negative contact. Previous research on mentally simulated social contact has shown that simulating contact can actually enhance prejudice when no instruction about a positive tone is given. For example, participants who simulated social contact with a person with schizophrenia, experienced greater anxiety because they simulated negative contact (West et al., 2011). Our intervention involved simulating contact with a member from a stigmatised group twice. In three experiments, featuring a range of stigmatised groups (adults with schizophrenia, gay men and Muslims), participants were asked to either simulate two positive contact experiences, or to simulate negative social contact and then positive social contact.

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.

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