Toxic Interaction Theory: One reason why African Caribbean people are over-represented in psychiatric services and potential solutions

Abstract

Purpose – To provide a conceptual framework for understanding how, even in the absence of identifiable racist behaviours by white people and predominantly white institutions, African Caribbean people can suffer detriment to their mental health due to toxicity in interactions.

Design / methodology / approach – This paper was developed through a desktop review of literature that analyses the factors that cause the sustained variation in experience and outcome in mental health for people from African Caribbean backgrounds.

Findings – Prior experiences of personalised racism (interpersonal and institutional) and an awareness of non-personalised racism in society creates conditions which mean that African Caribbean people experience toxicity in their dealings with white people and white institutions, including mental health services. This is detrimental to service user outcomes.

Originality / value – This paper provides a language for the process that leads to negative outcomes for African Caribbean people in mental health services resulting from interactions with white people or white institutions even in the absence of racism or racist events directed them.

Keywords – Race, Mental Health, Ethnicity, Toxic Interactions, BME groups

Paper type - Conceptual

Introduction

Toxic Interaction Theory provides a terminology for articulating the fact that the reactions of African Caribbean to white people and white institutions, in response to racism (i.e. the non-personalised but evident racism) creates a dynamic which is present even in the absence of racist events within present encounters. Toxic interactions are to do with relationships or exchanges which leave both parties feeling bruised or psychologically affected in the absence of a specific racist event.

Toxic Interaction Theory was first described as "*the damaging effect specific to the collision emotions and presentations arising from black people's experiences, with the fears and anxieties of white people*" (Sewell 2009a, pg 35).

Toxic Interaction Theory

Research indicates that racism can have adverse effects on people of African Caribbean backgrounds in terms of physical and mental health and that this arises from different manifestations of racism (interpersonal and institutional) and different reactions to it as a result of age, personality, social class (Karlsen and Nazroo 2002). Overwhelmingly arguments explaining the higher than average use of inpatient, forensic and community mental health services by African Caribbean people in the United Kingdom fall into three camps: a) those from antiracist schools such as Fernando (2003) who consider what they see as over-representation as a result of various manifestations of racism; b) those who ascribe causal factors to family arrangements and lifestyle choices in the African Caribbean community, e.g. Julian Leff (Guardian 2009) or c) those who link higher use of inpatient services to socioeconomic factors (Cooper et al 2008).

Racism is manifest in various forms but can be grouped mainly as interpersonal racism (between individuals) and systemic or institutional racism (the cumulative effect of less tangible but pernicious actions and decisions which are detrimental to people of black and minority ethnic groups (Bhui 2002; Fernando 2010). Confusion sometimes arises in discussions about racism and the impact on mental health. Singh and Burns (2006) challenge the assertion that the high use of services by black people is caused by institutional racism and fail to appropriately acknowledge the damaging effect of racism that operates throughout systems and processes in society, including in mental health services. The research by Karlsen and Nazroo (2002) highlights the psychological harm that arises when people are aware of racism that may not be directed at them but nonetheless creates a sense of risk or threat. The pervasiveness of racism and the sense of risk can create an alertness to indications of racism by black and Asian people, which can create *false positives* in the interpretations of the behaviours of white people and white institutions. In addition to the psychological harm to black and Asian people to which Karlsen and Nazroo (2002) refer, there is the potential for white people feel wrongly accused.

The concept of Toxic Interactions gives emphasis to the interplay between African Caribbean identities (individual and group) and a racist society and systems. Researchers such as Bhui (2002), Jones et al (2007) and Karlsen and Nazroo (2002) discuss the variability of the impact of racism depending on a person's reaction to it. The *Breaking the Circles of Fear* qualitative study (Sainsbury Centre for Mental Health 2002) was unusual in focusing specifically on the content of the interaction between African Caribbean service users and mental health services. Despite the fact that staff teams are sometimes predominantly from minority ethnic backgrounds the Breaking the Circles of Fear report (Sainsbury Centre for Mental Health 2002) highlights that the system itself (i.e. the technologies, policies and approaches) are imbued with racism and perceived as racist. Fernando (2003; 2010) illustrates ways in which racism has contaminated psychiatry and the psychiatric system, making the point regularly that there are racist white systems within which black and Asian

people may work. It is clear that it is possible for black people to perceive and experience racism from psychiatric services even where there are large numbers of black and Asian staff.

Understanding Toxicity

Psychological processes arising from racism and racist events: Exposure to repeated episodes of racist insults and affronts (described as micro-aggressions by Piece et al (1978) has a grinding down effect (Alleyne 2009) and a consequence is an increased tendency to interpret actions and behaviours as being a result of racism (Bhui 2002). The raised sensitivity increases the sense of threat. This is toxic, as illustrated in the research by Karlsen and Nazroo (2002) which showed the resultant poorer health. Additionally Karlsen and Nazroo (2002) highlight the toxicity arising from living in an environment where racism is evident even when it is non-personalised.

Socioeconomic processes as racism: Recent studies have identified that when all other factors such as class and inward migration are controlled for, urbanicity has a detrimental impact on mental health (Krabbendam and van Os 2005). Precisely what it is about urbanicity that is toxic to mental health is not known but suggestions include tension, pressure of a more stressful lifestyle, lack of green and open spaces (Friedli et al 2007 & Morgan, Mckenzie and Fearon 2008;). Reviews of inequalities in Britain by the Cabinet Office and the Equalities and Human Rights Commission highlight findings of particularly negative outcomes for African Caribbean people, drawing their findings from a significant body of research in fields such as education, employment, housing, mental health and the criminal justice system (Cabinet Office 2007; Equality and Human Rights Commission 2011). Racism in systems and processes places African Caribbean people in social circumstances where they are exposed to toxicity related to class and social disadvantage. Because of the psychological processes described earlier in relation to racism and racist events, the experience of toxicity will be compounded by a sense of racial injustice in relation to social disadvantage.

Relativity and toxicity: There is evidence that difference and an awareness of inequality and stereotypes has a pernicious psychological impact. In *Bounce,* Syed (2010) gives an example of how white athletes' performance in a test that was initially on a par with Black athletes declined when they were told that it was a test of natural athletic ability. The fact that they thought that their natural ability was inferior to that of black athletes led to their actual performance declining and conforming to this belief. Wilkinson and Pickett (2007) give several examples of where attainment levels of pupils decline when caste or ethnic differences became known or where the tests were identified as a test of ability. Pickett, James and Wilkinson (2006) demonstrated that common and serious mental health problems were more prevalent in unequal societies. In Britain, African Caribbean people have higher than average rates of mental health problems (Cooper et al 2008) but strikingly these are more pronounced in areas that are more ethnically mixed (Bentall 2009). It appears from these sources that seeing oneself as belonging to a disadvantaged group has a toxic

effect. This concurs with findings of Bhui (2002); Fanon (2008) Fernando 2003) all of whom describe the internalising effect of facing racism.

Toxic Interaction Theory and Mental Health Services

Given the evidence that interactions between African Caribbean people and white systems as well as white people trigger toxicity, even in the absence of malevolence or racist events, it is important to understand the implications in relation to mental health services.

Singh et al (2007) highlight the fact that the proportion of black people increases with each cohort of repeat admission to psychiatric hospital. Mental health professionals are aware that black people enter services (i.e. at first admission) with a greater degree of complexity (Cooper et al 2008). Black people feature more highly in figures for repeat admission indicating that the higher representation at the point of entry to the system becomes even worse over time (Singh et al 2007). One explanation offered by Singh et al for the worsening position is the poor service/ service user *interaction*. Repeat admissions are likely to mean that community services are working with people who break down and the evidence from Singh et al (2007) suggests that these teams are more effective at keeping white people out of hospital than they are black people.

The Breaking the Circles of Fear report (Sainsbury Centre for Mental Health 2002) also refers to the *interaction* between African Caribbean service users and services which leads to poorer outcomes. It can be concluded therefore that services have a degree of culpability. As Bhui (2002) points out, interpersonal racism and institutional racism in *mental health services* may be explanations but do not serve well as the default explanations without considering the effects of disadvantage in wider society. This view is endorsed also by Karlsen and Nazroo (2002). Toxic Interaction Theory therefore provides an explanation for the apparent detrimental interactions described by Singh et al (2007) and Sainsbury Centre for Mental Health (2002) in the absence of a default explanation of racism.

Toward Solutions

Toxic Interaction Theory is a short hand for the way in which white people and white systems are not just interacting with the person in a microcosm of time but rather within the context of their wider experiences and personal and social histories. Sewell (2012) highlights the need for professionals to acknowledge the role of histories (e.g. of disadvantage), racism and power in an attempt to improve relationships with black service users. The relationship between the service user and the trained professional provides the context for interventions in the caring professions (Loussada 2000; Ruch, Turney and Ward 2010) and these relationships can be maximised to acknowledge and tackle the impact of histories, racism and power.

The acknowledgement of service users' personal histories of racism by mental health workers is important in changing the dynamic of the relationship. This is relevant, regardless of the ethnicity of the worker because it demonstrates that negative (and toxic) influences on African Caribbean peoples' lives are being taken account of in treatment and care.

Workers need to demonstrate that they are aware of the intertwining of the histories of psychiatry and racism set out clearly by Fernando (2003; 2010). Workers must also acknowledge that the psychological side of mental health services is also tainted, for example "*nowhere in Freudian or classical psychoanalytic literature has there been an acknowledgement the 'race' might play a seminal role in ego development*" (Hickling 2007, pg 184). Again, irrespective of the ethnicity of the worker, the interventions and systems used in mental health still carry a racial bias (Fernando 2010). Exploring African Caribbean people's personal meanings of mental health problems, and their interpretations of causation, can effectively be done using explanatory models (Bhui and Bhugra 2002; Kleinman 1988). Simply put, explanatory models and narrative approaches (Epston and White 1992) allow people to set their stories alongside the professional assessment to create a more pertinent understanding of the presenting problems. Further, they allow for a focus on strengths and factors that develop and maintain resilience. Robertson-Hickling (2011) demonstrated that black service users who had seemed stuck in the UK mental health system were able to make significant strides in their recovery once they began receive treatment and care in an environment where their racialised identity was positively incorporated into care plans and where hope and belief in their capabilities was central to the work.

Knowledge and skills development is essential to ensure that frontline workers are equipped with the capacity for self reflection and competence in speaking with black service users about their experiences of disadvantage.

This paper suggests that Toxic Interaction Theory is just one of the paradigms for understanding the reasons why the outcomes for people from African Caribbean backgrounds continue to be poor in mental health. The focus here has been on relationships. More systemic approaches have been recommended in chapter 5 of the report *Completing the Revolution* (Centre for Social Justice 2011). This publication looks at the ways in which solutions are sought and recommends a focus on a number of essential elements within the mental health system, based on the "Locked Hexagon" model first presented in Sewell (2009b).

Conclusion

A review of research and literature points to a toxicity for African Caribbean people that emerges from relationships with white people and white institution. This is largely because personal histories and experiences of racism and racist events and an awareness of non personalised racism in society

influences African Caribbean people to towards caution and a sense of risk, which is toxic. Studies suggest that this toxicity plays a negative role in driving the above-average rates of service utilisation by black African Caribbean people and their poorer outcomes in relation to repeat admissions. A critical solution appears to be investment in the relationship between mental health workers and African Caribbean service users, with specific attention being paid to the impact of race in people's lives and the potential for negative outcomes as a result of experiences resulting from a racialised identity.

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