Commentary: The Trauma of Insidious Racism

Glenn H. Miller, MD

Race-based traumatic stress assessments are difficult because of the insidious nature of racism, the lack of scientific research, and the disregard of the nondominant cultural experience. Although there is a large body of scientific literature about the harmful psychological effects of racism, most of that literature is not directly applicable to individual assessment. Carter and Forsyth begin to correct that deficiency. Implicit in their attempt is the beginnings of defining a race-based traumatic stress syndrome. At present, the psychiatric expert can be useful to the court through a psychological description of the evaluee within a racial-cultural context.

J Am Acad Psychiatry Law 37:41–4, 2009

Carter and Forsyth[1] describe their article as a guide for the assessment of race-based trauma. It is more than a guide. It is a comprehensive review of the psychological-legal assessment of racism. It discusses legal obstacles, the lack of scientific literature, racial identity, the inadequacies of diagnosis, the need for a racial-cultural assessment, and the disguised forms of racism. The paper transcends its topic: it is an invitation to the reader to explore the importance of cultural bias in all forensic evaluations.

The major problem facing these authors—or anyone trying to set up a method for forensic assessment related to racism—is the lack of decisive measures for evaluating a person despite a variety of data. It is hard to establish that the psychological trauma experienced by a nondominant group member was caused by a race-based stressor. It is difficult because racial discrimination is today "insidious, pervasive, and ubiquitous" (Ref. 2, p 269).

Case Study

The authors present a case study of A.Y., who sued his employer over alleged racial discrimination. A.Y. claimed that he was demeaned by his manager, was given menial jobs, and was forced to track African-American customers for fear of their stealing. He reported symptoms suggesting depression, anxiety, and post-traumatic stress disorder (PTSD), both on the job and after he was fired. Five employees supported many of his allegations.

Based on the information presented, A.Y.'s claims are credible. But it would not have been difficult for the employer to counter his allegations, regardless of whether they were founded. The manager surely denied that he had forced A.Y. to track black customers since that would be *prima facie* evidence of racism. The manager probably also argued that any disparate treatment, such as the assignment to menial jobs or firing, was a result of A.Y.'s poor performance, not his race. Or, since he had a history of depression, A.Y. could have had a relapse. Or he developed the symptoms because of the firing.

Racism Stressors

The evidence is clear in large group studies that race-based discrimination is ubiquitous, resulting in injustices such as a greater chance of incarceration, less chance of being hired, and poorer health care, among others. However, when it comes down to an individual situation, as in whether a particular employer has harassed an employee, it is frequently impossible to make a determination unless there is collateral evidence.

The authors cite a large number of studies related to the effects of racial discrimination. These studies demonstrate the effect on persons who have suffered discrimination, but the research is almost always suggestive rather than decisive. Even the most careful studies are limited in their application for individual cases. For example, the careful study by McCord and

Dr. Miller is Clinical Professor of Psychiatry, George Washington University Medical Center, Washington, DC, and Adjunct Professor of Law, Georgetown University Law School, Washington, DC. Address correspondence to: Glenn H. Miller, MD, 8213 Tomlinson Avenue, Bethesda, MD 20817. E-mail: gmmd123@gmail.com

Ensminger[3] found that discrimination increased the probability of violent crimes. But this was based on self-report, so the study could not distinguish the actual experience from the report of the experience. "Audit studies" where black and white individuals ("auditors") apply for the same purpose (e.g., a black man and a white man apply separately for the same job) are compelling, but there may be enough individual nonracial variation or a bias among the auditors that alternative outcomes are defensible.

In an elegantly simple study, Bertrand and Mullainathan,[4] responded to help-wanted ads by sending out 5,000 fictitious resumés. Half the resumés had black-sounding names like Latoya and Kareem; the other half had white-sounding names like Allison and Brett. The white-sounding resumés received 50 percent more invitations for interviews than the black-sounding resumés. But, as the authors point out, race was suggested but not explicit, and it could not be proven that the employer noticed the name.

Thus, although there are many compelling studies documenting racism, in individual cases, an employer can almost always defend an alternative explanation unless the discrimination is overt, serious, and documented. That must be one major reason why so few race-based claims are won.[1] If A.Y.'s employer or the prospective employers in the resumé experiment were confronted, they would say anything except that they had been discriminatory.

Post-traumatic Stress Versus Race-Based Traumatic Stress

A.Y. presented with a mixture of general symptoms of anxiety and depression. Although there were also some symptoms suggestive of PTSD, the authors did not make a PTSD diagnosis, apparently because of the absence of a devastating stressor and perhaps because of the indefiniteness of his symptoms. Instead, he is described as appearing to suffer from a race-based traumatic stress injury.

Nor would it be a surprise, if the racist stressor were confirmed, that this was not a case of PTSD. Classic PTSD involves a singular, unexpected event of catastrophic magnitude. For African-Americans, racism is never a single act. It is expectable and persistent. Racist acts today rarely include a stressor that involves the possibility of death, serious injury, or damage to physical integrity. As a result, a race-based traumatic stress reaction does not fulfill the stressor criterion (Criterion A) of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR).[5]. Racism is mostly subtle, ambiguous, "statistical," or unconscious.

Nor is a race-based traumatic stress reaction a complex PTSD (C-PTSD), involving repetitive traumas of great magnitude over a long time.[6] Like C-PTSD, race-based traumatic disorders alter the character of the person because of the chronic and noxious element present. But a key difference is that in C-PTSD the stressor is overt and severe (e.g., continuous physical abuse of a child), whereas in most race-based disorders, the stressor is subtle or disguised.

Overt and catastrophic cases of racist action easily satisfy Criterion A, and therefore should be diagnosed as PTSD. However, it seems more likely that the traumatic results of the insidious racism of today produce a different symptom complex and should be classified separately rather than as a subtype of PTSD.

It remains to define a race-based traumatic stress disorder. We already have a general idea of symptoms that appear as a result of a race-based traumatic stress—for example, feelings of fear, anger, worthlessness, and humiliation. What is required is to confirm those features and to outline specific and well-defined symptoms characteristic of the syndrome. In that way, reliability can be assured.

Psychological instruments also are valuable. There are now several psychometric scales designed to measure various aspects of racism,[2] although there is not yet an instrument accurate enough for courtroom use.

The Problem of Diagnosis

One of the important contributions of the article is its description of the hazards of diagnosis. The authors are, I believe, quite right in asserting that diagnosis is often irrelevant, inadequate, or misleading when used in legal proceedings.

Two fundamental purposes of diagnosis, communication and comprehension, are rarely served by introducing diagnoses in the courtroom.[7] Diagnosis is valuable as a communication between doctors, but ironically, use of diagnosis in legal proceedings endangers communication, since the principals in court do not know what a given diagnosis means. All that a diagnosis entails can be expressed without the label and without then giving the impression that there is something mysteriously more than what constitutes the diagnosis. If a diagnosis suggests some etiology to the expert, that must be explained too—stating the

diagnosis alone does not enhance the jury's comprehension of the disorder. Diagnosis is no shortcut, nor is it explanatory in the courtroom.

Diagnosis has been center stage for psychiatry for over 25 years. (As *The New Yorker*[8] and other popular publications[9,10] regularly report, Robert Spitzer is a leading candidate for the most influential psychiatrist since Freud.) The DSM was not intended for legal purposes, of course, but the authority of the DSM has extended to law. It is a necessity, now, that psychiatric experts include an official diagnosis, often with all axes and all the codes, in their reports to the court. The criticisms of diagnosis in the courtroom have long been made,[11–14] and they have been gaining favor over time.[15] The DSM has taken note of the change over successive editions. It has expanded both its caution about nonmedical misuse and has expanded its introductory paragraph on forensic misuse.

Carter and Forsyth point out that a PTSD diagnosis covers only a small portion of the psychiatric symptoms that result after being traumatized by a race-based stressor. There is currently no named syndrome that encompasses the variety of reactions to racist actions. The DSM is silent on racial stressors. In an assessment of racial traumatic injury, in which the person has psychiatric symptoms but does not fit into either of the two stress disorder categories of DSM-IV-TR, the examiner may fit the symptoms into a variety of diagnoses: anxiety disorder, NOS; dysthymia; or adjustment disorder, to name a few.

A DSM-IV-TR diagnosis implies an official acceptance of a disorder. If a person is suffering but there is not a standard diagnosis, there is a temptation to believe that the symptoms the person is experiencing have no psychiatric importance. In the most crass formulation, a person does not have an emotional problem unless he has a DSM diagnosis.

Diagnosis encourages the study of disease without reference to culture. Prior to DSM-IV's publication, a cultural psychiatry work group attempted to secure a larger representation for cultural concerns in the manual.[16] As a result, DSM-IV incorporated several of the group's suggestions. However, "proposals that challenged universalistic nosological assumptions and argued for the contextualization of illness, diagnosis, and care were minimally incorporated and marginally placed" (Ref. 16, p 457).

Diagnosis itself decontextualizes culture; in the courtroom, emphasis on diagnosis results in the neglect of cultural aspects relevant to the case. This neglect can unwittingly contribute to the kind of unjust result that Griffith[17] has assailed.

One of the reasons, it seems, that racial claims so seldom are successful is because ". . .courts only find in favor of plaintiffs who have been exposed to particularly severe and overt racial discrimination or harassment (Ref. 1 p 30). In turn, this suggests that courts implicitly adopt a view consistent with a PTSD model where a stressor must be catastrophic to count. A plaintiff's case is helped by a stressor of great magnitude and a label, even if it is true that subtle discrimination can cause a syndrome without a name.

Not only race-based traumatic stress disorders but also many other disorders that result in great pain are not included in the DSM. One of the most widespread emotional disorders is the unnamed syndrome that occurs in children and adults after divorce. This is often the most painful time of a person's life, and the pain and dysfunction may last for years. Like a race-based disorder, it meets the criteria of disability and distress, which are fundamental criteria for inclusion in DSM-IV-TR. However, neither is included.

Carter wishes to de-emphasize the pathology of the victim following a racist attack: ". . .it might be more clinically effective to consider the effects of racism as a type of psychological injury rather than as mental disorder, since the effects of racism arise from environmental stressors rather than from an abnormality of the target" (Ref. 1, p 37). Such a change emphasizes the effect of a stressor on the "target." But the affected person is more than a target; he is a reactive human, from a nondominant culture, whose response is necessarily unique.

The Task of the Forensic Assessment

Carter and Forsyth state, "Forensic evaluators are not called on to determine the truth of the legal claims of racial discrimination or harassment . . . [but] to address questions of psychological damage or injury, based on the available information" (Ref. 1, p 38). In race-based traumatic stress cases, the examiner makes a particular effort toward understanding the complex meaning of the stressor to a member of a nondominant culture, and to recognize that diagnostic categories are generally inadequate to the demands of assessment.

The examiner's job in all forensic cases is to tell the truth in the sense that Appelbaum[18,19] has developed in his theory of ethics: the notion that the whole truth entails more than the psychiatrist's examining a person, reporting accurately what has been observed, and formulating an opinion. The whole truth requires, in a race-based traumatic stress case, that the expert be conversant with the professional literature concerning racial stress. The expert is sensitive to the particular conditions of the person's being in a nondominant culture, is aware of the complex transference and countertransference distortions and tries to correct his responses. In making a report, the experts must state whether their opinions are based on personal experience, anecdotal reports, or scientific studies, and whether their opinions are mainstream or idiosyncratic. Examiners report not only what supports their opinions but also what limits their opinions.

These matters are very complex and there is a lamentable lack of scientific knowledge about the forensic assessment of race-based traumatic stress disorders. The expert may cite many studies that bear on evaluation of the individual. The list that Carter and Forsyth examined is long, and just a fraction of the available research, but the authors note that although there are many studies documenting the emotional harm of racism, they found only four articles in psychiatric journals to aid psychiatrists in addressing the trauma of racism.[1] Our literature base consists of small samples, conflicting results, anecdotes, or sophisticated studies that are very limited in application.

What is left for the examiner to do? Ironically, these limitations make the job of the expert less complicated. With such uncertain scientific findings, there is little to present from an evidenced-based perspective. In assessments, the evaluators are not required to go beyond telling the whole truth; indeed, they are forbidden to do so. Unfortunately, the expert can offer little beyond clinical description with any degree of certainty. The results are not as devastating as Stone claimed when he said: ". . .even when [forensic psychiatrists] pursue the standard [i.e., Appelbaum's] approach. . . , [their] testimony rests on inadequate scientific foundation.[20] But that does not mean that an expert's testimony is useless. Testifying about the psychological make-up of the plaintiff alone informs the court and provides information that the court may use in determining its decision.

References

1. Carter RT, Forsyth JM: A guide to the forensic assessment of race-based traumatic stress reactions. J Am Acad Psychiatry Law 37:28–40, 2009
2. Utsey SO: Assessing the stressful effects of racism: a review of instrumentation. J Black Psychol 24:269–88, 1998
3. McCord J, Ensminger ME: Racial discrimination and violence: a longitudinal perspective, in Violent Crime: Assessing Racial and Ethnic Differences. Edited by Hawkins DF, New York: Cambridge University Press, 2003, pp 319–30
4. Bertrand M, Mullainathan S: Are Emily and Greg more employable than Lakisha and Jamal?—A field experiment on labor market discrimination. Am Econ Rev 94:991–1013, 2004. Available at http://www.economics.harvard.edu/faculty/mullainathan/files/emilygreg.pdf. Accessed December 27, 2008
5. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington, DC: American Psychiatric Association, 2000
6. Herman JL: Trauma and Recovery: the Aftermath of Violence From Domestic Abuse to Political Terror. New York: Basic Books, 1997
7. Miller GH: Prohibiting psychiatric diagnosis in insanity trials, with special reference to John W. Hinckley Jr. Psychiatry 49:131–43, 1986
8. Spiegel A: The dictionary of disorder: how one man revolutionized psychiatry. New Yorker January 3, 2005. Available at http://www.newyorker.com/archive/2005/01/03/050103fa_fact, Accessed December 30, 2008
9. Grossman R: DSM psychiatry manual's secrecy criticized. Los Angeles Times, December 29, 2008. Available at http://www.latimes.com/news/nationworld/nation/la-na-mental-disorders29–2008dec29,0,3418306.story. Accessed December 30, 2008
10. Lane C: Shyness. New Haven, CT: Yale University, 2007
11. Miller GH: Criminal responsibility: an action language approach. Psychiatry 42:121–30, 1979 May.
12. Morse SJ: Crazy behavior, morals, and science: an analysis of mental health law. S Cal Law Rev 51:527–654, 1978
13. Morse SJ: Failed explanations and criminal responsibility: experts and the unconscious. Va Law Rev 68:973–1084, 1982
14. Morse SJ: The ethics of forensic practice: reclaiming the wasteland. J Am Acad Psychiatry Law 36:206–17, 2008
15. Greenberg SA, Shuman DW, Meyer RG: Unmasking forensic diagnosis. Int J Law Psychiatry 27:1–15, 2004
16. Mezzich JE, Kirmayer LJ, Kleinman A *et al*: The place of culture in DSM-IV. J Nerv Ment Dis 187:457–64, 1999
17. Griffith EEH: Ethics in forensic psychiatry: a cultural response to Stone and Appelbaum. J Am Acad Psychiatry Law 26:171–84, 1998
18. Appelbaum PS: A theory of ethics for forensic psychiatry. J Am Acad Psychiatry Law 25:233–47, 1997
19. Appelbaum PS: Ethics and forensic psychiatry: translating principles into practice. J Am Acad Psychiatry Law 36:195–200, 2008
20. Stone AA: Ethics in forensic psychiatry: re-imagining the wasteland after 25 years. Presented at the 38th Annual Meeting of the American Academy of Psychiatry and the Law. October 19, 2007