

The Black Mask of Humanity: Racial/Ethnic Discrimination and Post-Traumatic Stress Disorder

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Knowledge of the impact of racism on the psyches of African-Americans is limited by the following considerations: the tendency among European-Americans to deny, minimize, and rationalize the existence of racism; the tendency among European-Americans to ascribe inferior status to African-Americans; the application of many stereotypes and myths to African-Americans that serve to have them viewed as nonresponsive to human influences; and finally, an African-American tradition “which teaches one to deflect racial provocation and to master and contain pain” (Ref. 1, p 25).

It is not surprising that, given this disregard of African-Americans, responses to racial discrimination by African-Americans are often not viewed as severe enough to indicate that these blacks may have post-traumatic stress disorder (PTSD). Even in those instances in which African-Americans are objects of discrimination and describe symptoms consistent with PTSD, their symptoms may be dismissed or trivialized because of the view that the stressors are not catastrophic enough, according to the Diagnostic and Statistical Manual of Mental Disorders (DSM), to warrant a diagnosis of PTSD.

The tendency on the part of some European-Americans to define casually the reality of African-Americans’ experience may be problematic in view of the lack of knowledge about the “Black Experience” displayed by so many European-Americans. This

tendency led Ralph Ellison to write: “Thus when the white American says, ‘This is American reality’, the Negro tends to answer . . . ‘perhaps, but you’ve left out this and this, and this. And most of all what you’d have the world accept as me isn’t even human’ ” (Ref. 2, p 111).

There are intriguing psychodynamics implicit in the refusal by European-Americans to acknowledge and accept that the African-American response to racial discrimination should be viewed as potentially clinically symptomatic. First, there is a lack of sophistication regarding the adaptive nature of the formation of symptoms and that a symptom simultaneously represents a mechanism of constructive adaptation to the effects of stressors as well as (in the extreme) a maladaptive response to the effect of stressors. Thus, there is a great deal to be learned about formation of symptoms as African-Americans react to traumatic acts of discrimination and then define and expand their self-definition in response to these traumatic acts. Second, failure to characterize as serious trauma the symptoms that African-Americans report as responses to discrimination tends to further the emotional gulf between African-Americans and European-Americans.

During four decades of psychiatric and psychoanalytic practice, the author has treated thousands of African-American individuals, many of whom have described various types of racial trauma. Most of the African-American patients evaluated and treated by the author have described multiple personal experiences of racial and ethnic discrimination. Considering the ubiquity of racism, it is not surprising that

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instances of discrimination are as frequent as reported; but the devastating emotional responses to the racist acts are unsettling. The range and intensity of emotional responses varies from mild to overwhelming, and the duration of such responses varies from days to months or years. With a fair degree of frequency, black individuals who experience racial discrimination report symptoms consistent with a diagnosis of PTSD, even though the DSM-IV requires, for the diagnosis, that the symptoms follow exposure to extreme traumatic stress.

The essential feature of Posttraumatic Stress Disorder is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experiences of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate. . . . Traumatic events that are experienced directly include, but are not limited to, military combat, violent personal assault (sexual assault, physical attack, robbery, mugging), being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war or in a concentration camp, natural or manmade disasters, severe automobile accidents, or being diagnosed with a life-threatening illness [Ref. 3, p 463–4].

It is my premise that the clinicians who formulated the DSM have used an extremely narrow focus in citing the traumas that may be causative of PTSD. It is my view that racial/ethnic discrimination experienced by African-Americans frequently results in symptomatology consistent with a diagnosis of PTSD. Further, it will be argued herein that the subjective experiences and symptoms experienced by those African-Americans are often extreme and catastrophic, requiring active psychotherapeutic and psychopharmacologic care. Recognition of this notion should make it easier for blacks who have experienced intentional discrimination to bring claims that they have suffered psychological harm.

A Review of Selected Literature

Several behavioral scientists have sought to expand the view held by the DSM's authors as to the nature of trauma. Charles Brenner states:

What is traumatic is the subjective experience of the traumatized individual. It is what the event meant to the individual. It is the impact of the external stimuli, how they heightened fears,

intensified sexual and aggressive wishes, resonated with feelings of guilt and remorse [Ref. 4, p 196].

Jacob Arlow in a 1984 article notes:

What constitutes trauma is not inherent in the actual event, but rather in the individual's response to a disorganizing disruptive combination of impulse and fears integrated into a set of unconscious fantasies. The traumatic event itself has not been at issue, only the reaction that it evokes in the survivor [Ref. 5, p 521].

Pitman and Orr, in describing the illusory objectivity of the stressor, write:

The assumption that there exists a "range of usual human experience" is dubious from a cross-cultural perspective. For example, gang related shootings may be rare in rural Minnesota but all too common in urban Los Angeles. A recent study found that at some time in their lives, 39 percent of the middle-class Detroit population was exposed to traumatic events potentially capable of causing PTSD, and 25 percent of exposed persons went on to develop the disorder. Another study reported that stressors falling within the range of usual human experience are sometimes capable of resulting in the PTSD syndrome [Ref. 6, p 37].

Pitman and Orr add:

The examples presented in DSM III-R of stressors that may cause PTSD raise as many questions as they settle. Does the "sudden destruction of one's home" include losing one's summer house in a fire? Of all the examples provided in DSM III-R "serious threat to one's life or physical integrity" appears the most straightforward. However, not all experts would accept the sudden denuding of a litigant's scalp by a faulty hair rinse as a stressor sufficient to cause PTSD. The illusion of an "objective" stressor is further evidenced by the consideration that the victim's appraisal constitutes a necessary link in the causal chain from event to stress response. An identical event may not be experienced the same way by two people. Pilowsky has coined the term "cryptotrauma" for a situation in which a stressor that appears innocuous to an observer may be perceived by the victim as life-threatening. Retrospective discovery that the appraisal was incorrect doesn't erase the distress associated with the original experience [Ref. 6, p 38].

Butts⁷⁻¹⁰ and Butts and Butts,¹¹ offer cases documenting the appearance of PTSD symptoms in a series of African-Americans who experienced racial and housing discrimination. Each of the patients described symptoms consistent with a diagnosis of PTSD. Each was given the diagnosis and in several cases, expert testimony at the time of civil trial resulted in findings for the plaintiffs and awards for damages or settlements out of court.

Racial Discrimination and Post-Traumatic Stress Disorder

Unconscious racism as a socio-psycho-cultural phenomenon is ubiquitous in American society and affects the lives of all African-Americans and European-Americans. The behavioral manifestations of racism span a spectrum from subtle to extreme. The genesis of racism resides in the institution of black slavery, myths, stereotypes regarding Africans and African-Americans, and pathological thoughts and feelings of European-Americans that use pro-white, anti-black projective mechanisms.

Discriminatory behavior by European-Americans directed toward African-Americans represents trauma and engenders symptoms (which are for the most part subjective), that may be categorized in different ways and that may evoke multiple forms of behavioral responses. Increasing clinical evidence has shown that discriminatory behavior can and does cause not only psychiatric symptoms in African-Americans, but organic changes such as hypertension.

Case Presentation I

The patient, an African-American man in his thirties, was referred to the author after experiencing a denial of housing that he categorized as housing and racial discrimination. He had answered a newspaper advertisement for an apartment in New York City. After several failed attempts to view the apartment, he had asked a white coworker to make a request. She was allowed to see the apartment and encouraged to make application. After the alleged discrimination, the man sought legal representation, and it was suggested that he have a psychiatric evaluation.

His initial reaction to denial of the apartment was shock and confusion, which were rapidly replaced by obsessive rumination in which he thought repeatedly about what had occurred. Within the first week, he became depressed and sleepless. He had repeated nightmares (example: "I was searching for an apartment and being chased out"). He slowed down on the job because of his depression, became anorexic, and lost 25 pounds over a six-month period. He also exhibited gastrointestinal symptoms consisting of abdominal pain and discomfort. He sought medical attention, underwent gastroscopy, and received a diagnosis of duodenal ulcer. A treatment regimen was instituted. He had never experienced ulcer symptoms prior to the discrimination experience. Later,

he began to experience severe headaches, and migraine was diagnosed.

On mental status examination, the aforementioned symptoms were elicited. In addition, he continued to be depressed and anxious and to exhibit diminished ability to concentrate. Nightmares continued, as well as hypervigilance. He experienced flashbacks of the incident.

The diagnoses were: Axis I, Major Depressive Disorder, PTSD; Axis II, Dependent Personality Disorder; Axis III, duodenal ulcer and migraine; Axis IV, severe housing/racial discrimination. Axis V, Global Assessment of Functioning score of 80.

The patient was referred for individual psychotherapy. The legal matter was settled out of court in favor of the plaintiff.

Case Presentation II

A light-skinned Hispanic male was treated courteously when he made application for an apartment in New York City. However, when he returned with his African-American wife, the renting agent became aloof and informed them that the apartment was rented.

In response to the denial of the apartment, the wife immediately became depressed, insomniac, and hypervigilant. She interpreted every sound during the night as someone attempting to break into their apartment. She had repeated nightmares. At the time of the alleged discrimination, she noticed that her hair had begun to fall out, that her skin was dry, and that she was constipated. Although there were no hallucinations, delusions, or ideas of reference, there was a mild paranoid trend. There was no clinical or laboratory evidence of hypothyroidism. All of her symptoms were causally related to the alleged discrimination. Her anxiety had spread, and she experienced excessive fears about the welfare of her infant daughter. She became so distraught that on several occasions she considered abandoning the marriage and returning to her Caribbean homeland.

Her diagnoses were: Axis I, Major Depressive Disorder, PTSD. Both she and her husband were referred for psychotherapy.

Conclusions

Racial and ethnic discrimination produce psychic trauma, and African-Americans subjected to discrimination frequently respond with symptoms consistent with a diagnosis of PTSD. The symptoms

described fall into three categories: (1) reexperiencing criteria, such as distressing dreams and flashbacks; (2) avoidance criteria, such as affective restriction and the avoidance of thoughts and feelings associated with the trauma; and (3) arousal criteria, such as insomnia, hypervigilance, and startle reactions. The symptoms reported by African-Americans in the wake of discriminatory acts are subjectively perceived and may be felt as extreme and as annihilative, and described in catastrophic terms. Thus, it is surprising that racial discriminatory acts are not included among the stressors cited as causative of PTSD in the DSM of the American Psychiatric Association. One can only conclude that the formulators of the DSM lacked clinical familiarity with the experiences of African-Americans and therefore erroneously concluded that racial discrimination should be excluded from the list of stressors leading to PTSD. This is a serious omission, however, because it runs counter to the clinical experience of many African-American psychiatrists, who can document numerous instances of discrimination resulting in PTSD. It constitutes a gross oversight that the DSM has disregarded these valuable clinical and social data. These omissions may also make it difficult for African-Americans who experience such discrimination to succeed as plaintiffs in civil suits.

There is a paucity of accurate epidemiological data on the incidence and distribution of PTSD. Knowledge of defense mechanisms and symptom formation make it apparent that not all individuals exposed to traumas experience PTSD. Further, the personality organization of traumatized individuals is a significant parameter in the development of PTSD. With respect to African-Americans, there are no epidemiological data on either incidence or distribution of PTSD. Nor are there data on exposure to trauma and the occurrence of PTSD. As with the population at large, it seems reasonable to assume that not all African-Americans exposed to the trauma of discrimination will develop PTSD.

The following research initiatives are recommended:

1. What is the incidence and prevalence of PTSD among African-Americans exposed to racial/ethnic discrimination?

2. What proportion of African-Americans exposed to racial/ethnic discrimination do not experience PTSD? What is the psychodynamic explanation for this?

3. Is there any correlation among African-Americans between preexisting personality organization, exposure to racial/ethnic discrimination, and the development of PTSD?

4. What is the recovery rate among African-Americans who develop PTSD following exposure to racial/ethnic discrimination? What factors influence the recovery rate?

5. Are there differences between the incidence of PTSD in European-Americans and African-Americans? If differences exist, to what are they attributable?

It is important that other behavioral scientists share their clinical experiences with respect to racial discrimination and PTSD to develop a substantial, creditable body of literature in the area. Such information will also be useful to professionals participating in discrimination tort claims.

References

1. Ellison RW: Twentieth-century fiction and the black mask of humanity, in *Shadow and Act*. New York: Vintage Books, 1972, p 25
2. Ellison RW: The world and the jug, in *Shadow and Act*. New York: Vintage Books, 1972, p 111
3. Diagnostic and Statistical Manual of Mental Disorders (ed 4, text revision). Washington, DC: American Psychiatric Association, 2000, pp 463–8
4. Brenner C: The Reconstruction of Trauma: Its Significance in Clinical Work. Madison, CT: International Universities Press, 1986, pp 195–204
5. Arlow J: The concept of psychic reality and related problems. *J Am Psychoanal Assoc* 33:521–35, 1984
6. Pitman RK, Orr SP: Psychologic testing for posttraumatic stress disorder: forensic psychiatric applications. *Bull Am Acad Psychiatry Law* 21:37–52, 1993
7. Butts HF: Racism's link to posttraumatic stress. *The Medical Herald*. July 2001, p 23
8. Butts HF: Racism can spur posttraumatic stress. *The Medical Herald*. August 2001, p 23
9. Butts HF: Racism sparked posttraumatic stress. *The Medical Herald*. September 2001, p 21
10. Butts HF: Housing bias takes heavy psychiatric toll. *The Medical Herald*. September 1995, p 17
11. Butts H, Butts HM: Housing bias and posttraumatic stress disorder. *Mind Hum Interact* 8:261–5, 1997