

FIRST AMENDMENT TELEVISION

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THE UNNAMED INJURY

Race-Based Traumatic Stress and the Case for a Public Record

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“Not everything that is faced can be changed, but nothing can be changed until it is faced.”

— James Baldwin

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About the Civic & Editorial Research Series

The First Amendment Television Civic & Editorial Research Series publishes evidence-based monographs examining issues of public importance through the standards of responsible journalism. Each publication distinguishes documented findings from areas of ongoing debate and is intended to contribute to the historical record rather than advocate predetermined policy outcomes.

Executive Summary

Throughout history, societies have struggled to recognize injuries before they possessed the language to describe them. Medical science has repeatedly demonstrated that an injury may exist long before it is fully understood, formally classified, or widely accepted. Tuberculosis existed before the discovery of the bacteria that caused it. Alzheimer’s disease affected patients long before researchers understood its pathology. Psychological injuries followed a similar path. Soldiers returned home carrying invisible wounds long before medicine developed the diagnosis now known as post-traumatic stress disorder (PTSD).

Recognition followed evidence.

The purpose of this publication is to examine another area of continuing clinical research and public discussion: race-based traumatic stress.

During the past several decades, psychologists, psychiatrists, neuroscientists, and public health

researchers have increasingly examined whether repeated exposure to racial discrimination can, under certain circumstances, produce measurable psychological injuries resembling recognized trauma responses. This work did not emerge from political advocacy but from clinical observation, patient experience, and empirical research.

In 2001, the United States Surgeon General's landmark report on mental health concluded that racial and ethnic disparities in mental health outcomes were closely associated with the lived experience of racism and discrimination rather than inherent differences among populations.¹ Building upon that foundation, psychologist Dr. Robert T. Carter developed one of the first comprehensive clinical frameworks describing race-based traumatic stress, arguing that repeated experiences of racial discrimination may produce trauma symptoms comparable to those observed following other psychologically overwhelming events.²

Subsequent meta-analyses reviewing nearly ninety independent studies have consistently reported statistically significant associations between experiences of racial discrimination and increased symptoms of anxiety, depression, psychological distress, and traumatic stress.³ That body of evidence has since been situated within a broader public health literature documenting how discrimination contributes to racial disparities in health outcomes generally.⁷ The existence of a substantial body of peer-reviewed research on this question is no longer in dispute — though how that research should be interpreted, classified, and applied clinically remains an active scientific debate, as the chapters that follow describe.

This publication does not argue that every unpleasant encounter constitutes trauma. It does not suggest that every individual who experiences discrimination develops lasting psychological injury. Human beings respond differently to adversity, and resilience varies widely among individuals.

Instead, this publication asks a narrower and more important question: what does the current body of scientific evidence tell us about the relationship between repeated racial discrimination and psychological trauma?

The answer carries implications extending well beyond psychology. If repeated racial discrimination contributes to measurable trauma responses, understanding those effects becomes relevant to medicine, education, public health, employment, journalism, law, and public policy. The consequences affect not only those who experience the injury but also the institutions responsible for serving them.

The purpose of this publication is therefore educational rather than ideological. Its objective is to examine the available evidence, explain complex clinical concepts in language accessible to the general public, distinguish established findings from areas of continuing debate, and encourage thoughtful discussion grounded in documented research rather than assumption or rhetoric.

Scientific understanding evolves through evidence. Journalism serves the public by documenting that evolution accurately, fairly, and without exaggeration. This publication is offered in that spirit.

Introduction

Why This Publication Exists

Every society preserves a public record. Governments preserve laws. Courts preserve testimony. Universities preserve scholarship. Hospitals preserve medical knowledge. Museums preserve artifacts. Journalists preserve events. Collectively, these records become history.

History records more than what people did. It records what people understood. As scientific knowledge advances, the public record must advance with it.

History demonstrates that many conditions now recognized as legitimate medical diagnoses were once misunderstood, dismissed, or attributed to personal weakness. Medicine evolves by observing evidence, questioning assumptions, testing hypotheses, and refining its understanding as new information becomes available. Psychological science is no exception.

For generations, physicians struggled to explain the invisible injuries carried home by military veterans. Depending upon the era, these conditions were described as “soldier’s heart,” “shell shock,” “battle fatigue,” or “combat exhaustion.” Although the terminology changed, the underlying suffering remained remarkably consistent. Only after decades of clinical observation and scientific investigation did modern psychiatry establish what is now recognized as post-traumatic stress disorder.

The injury existed before the diagnosis.

The evidence accumulated before the terminology matured.

Recognition followed research.

The discussion surrounding race-based traumatic stress follows a similar pattern of scientific inquiry. Researchers are not asking whether racism exists or whether discrimination can be emotionally painful. Those observations require little debate. The more precise question is whether repeated exposure to racial discrimination may, under certain circumstances, produce measurable psychological responses that resemble trauma already recognized elsewhere in clinical psychology.

That question deserves careful examination because it concerns more than academic theory. If repeated discrimination contributes to chronic psychological injury, its effects may influence physical health, educational achievement, workplace performance, family relationships, community trust, and confidence in public institutions. Understanding those relationships is therefore relevant not only to clinicians but also to educators, employers, journalists, policymakers, and citizens.

The responsibility of journalism extends beyond reporting immediate events. It includes documenting the development of knowledge itself. As research advances and society’s understanding deepens, the public record should reflect that progress accurately, distinguishing established evidence from continuing scientific debate.

This publication does not ask readers to accept any conclusion on faith. It asks only that documented research receive the same thoughtful consideration afforded to any other area of scientific inquiry. Where evidence is strong, it should be presented honestly. Where uncertainty remains, it should be acknowledged openly. Where legitimate disagreement exists, it should be described fairly.

An informed public conversation begins not with ideology but with evidence. The chapters that follow examine that evidence, explore its implications, and consider why emerging forms of psychological injury deserve careful documentation as part of the historical record.

II. The Clinical Record

The research referenced above deserves to be stated plainly and in full, rather than gestured at from a distance.

The Surgeon General’s 2001 report was the first major federal acknowledgment that racial and ethnic disparities in mental health outcomes were connected to lived experience rather than biology.¹ That finding opened the door for a generation of clinical researchers to ask a more specific question: what, exactly, does repeated racial discrimination do to the mind of the person experiencing it?

Robert T. Carter, a professor of psychology and education at Columbia University’s Teachers College, spent much of the following two decades answering that question. Carter’s model — developed with colleagues including Alex Pieterse and Silvia Mazzula — describes race-based traumatic stress as the response to a racial encounter that is sudden, uncontrollable, and emotionally severe enough to overwhelm an individual’s ordinary capacity to cope.² Carter and later researchers built assessment tools, including the Race-Based Traumatic Stress Symptoms Scale, to measure these responses with the same rigor clinicians apply to other trauma diagnoses.

The evidence behind the model is not limited to a single study or a single research team. A 2012 meta-analysis by Pieterse, Todd, Neville, and Carter reviewed 66 independent studies examining the relationship between racism and the mental health of Black Americans.³ A separate set of meta-analyses by Lee and Ahn reviewed 23 more studies on the same question.⁴ Combined, these reviews cover nearly ninety independent bodies of research, and they point toward the same conclusion: exposure to racial discrimination is measurably associated with anxiety, depression, and traumatic stress symptoms, independent of other risk factors.

A note on scope: this chapter presents the foundational research base. A fuller clinical treatment — including symptom presentation, physiological research, and public health implications — is planned for a future expanded edition of this monograph.

III. The Limits of Current Diagnostic Frameworks

The purpose of this chapter is not to criticize the Diagnostic and Statistical Manual of Mental Disorders (DSM), nor to suggest that contemporary psychiatry has failed to recognize trauma. The DSM remains the principal diagnostic reference used by mental health professionals throughout the United States and many other countries. It provides a common clinical language, promotes diagnostic consistency, guides treatment planning, and supports research across institutions.

The question examined here is narrower: does the current diagnostic framework fully account for the psychological consequences of repeated racial discrimination?

That question has become an increasingly important subject of discussion within clinical psychology, psychiatry, counseling, and public health. While no universal consensus has yet emerged, a growing body of scholarly literature argues that existing trauma classifications may not completely capture the cumulative nature of race-related psychological injury.^{2,6}

Trauma as Traditionally Defined

Modern PTSD is largely organized around what clinicians describe as a Criterion A traumatic event under the DSM-5-TR. Such events generally involve actual or threatened death, serious injury, or sexual violence, experienced directly, witnessed, or learned about under specified circumstances.⁵

This framework reflects decades of research involving combat veterans, survivors of violent assault, serious accidents, terrorism, natural disasters, and other catastrophic events.

For many individuals, this framework is entirely appropriate. A discrete traumatic event can often be identified, symptoms emerge afterward, and clinicians are able to evaluate whether the diagnostic criteria have been met.

The model works well when trauma can reasonably be connected to a specific event occurring at a particular point in time.

A Different Pattern of Exposure

Researchers studying race-based traumatic stress have suggested that many experiences involving racial discrimination follow a substantially different pattern.

Rather than arising from one overwhelming event, psychological injury may develop through repeated exposure to racial insults, exclusion, humiliation, intimidation, unequal treatment, or institutional discrimination occurring over many years.²

No single encounter may appear sufficiently severe to satisfy the traditional threshold associated with PTSD. Yet the cumulative burden of repeated exposure may nevertheless produce symptoms resembling those observed following recognized forms of trauma.

Clinical researchers have therefore proposed that the mechanism of injury may differ from that described in traditional PTSD models, even when important psychological consequences overlap.

Repeated vigilance, anticipation of discrimination, chronic physiological stress activation, and

repeated vigilance, anticipation of discrimination, chronic physiological stress activation, and recurring emotionally significant encounters may gradually affect emotional regulation, sleep, concentration, mood, interpersonal relationships, and overall psychological well-being.^{2,6}

The Problem of Cumulative Trauma

One of the principal challenges identified in the literature is that cumulative injury is often more difficult to recognize than acute injury.

A patient arriving in an emergency department after an automobile collision can identify the moment the injury occurred.

Individuals experiencing chronic racial stress frequently cannot.

Instead, they may describe years — or decades — of recurring experiences that, taken individually, might appear relatively minor but collectively become psychologically overwhelming.

Researchers have compared this process to other forms of cumulative or chronic stress injury in which repeated exposure, rather than a single catastrophic event, contributes to clinically meaningful impairment.²

The distinction is important because clinical diagnosis often depends not only upon symptoms but also upon the conceptual framework used to understand how those symptoms developed.

An Active Scientific Debate

The existence of this discussion should not be confused with scientific consensus.

Researchers continue to disagree about the most appropriate diagnostic approach.

Some investigators have argued that race-based traumatic stress should eventually receive formal recognition as a distinct diagnosis.

Others have suggested expanding existing trauma diagnoses through additional specifiers or clinical guidance rather than creating an entirely new category.

Still others believe that existing DSM diagnoses — including PTSD, Adjustment Disorder, Anxiety Disorders, Major Depressive Disorder, or other trauma-related conditions — already provide sufficient flexibility when applied carefully by experienced clinicians.⁶

Each position reflects legitimate scientific reasoning.

The debate therefore concerns classification, not whether psychological suffering associated with racial discrimination can occur.

Why Classification Matters

Diagnostic language is more than academic terminology.

It influences clinical assessment, treatment planning, insurance reimbursement, epidemiological research, professional education, and the allocation of public health resources.

Conditions lacking widely accepted diagnostic language may receive less systematic study, fewer specialized treatment protocols, and less consistent recognition across institutions.

For patients, the consequences may be equally significant.

The ability to describe an injury using language recognized by clinicians often affects whether that injury is understood, documented, researched, and treated consistently.

History provides numerous examples in which scientific understanding advanced only after medicine developed terminology capable of describing observations clinicians had been making for years.

The diagnosis did not create the injury.

The diagnosis created a common language through which the injury could be systematically investigated.

Evidence Before Certainty

The current state of research therefore supports several conclusions with greater confidence than others.

Researchers have consistently documented statistically significant associations between experiences of racial discrimination and adverse mental health outcomes, including anxiety, depression, psychological distress, and trauma-related symptoms.^{3,4,7}

Researchers have also developed clinical models and assessment instruments specifically designed to evaluate race-based traumatic stress.²

What remains unresolved is whether those findings ultimately justify recognition of a separate diagnostic category, modification of existing trauma diagnoses, or continued use of race-based traumatic stress primarily as a clinical framework rather than a formal DSM diagnosis.

Those questions will be answered by future research rather than advocacy.

Science advances by refining evidence, testing competing explanations, and revising conclusions when warranted.

The responsibility of journalism is different.

Journalism documents where the evidence presently stands, distinguishes established findings from continuing debate, and resists the temptation to claim certainty where none yet exists.

That distinction is especially important in emerging areas of clinical research, where careful reporting serves both scientific integrity and the public interest.

Whether race-based traumatic stress ultimately becomes a distinct diagnosis is not the central question of this publication. Scientific classifications evolve as evidence accumulates. What matters for purposes of the public record is that a substantial body of peer-reviewed research has identified a phenomenon worthy of serious clinical attention. Responsible journalism need not predict where future editions of the DSM will arrive. It need only report, accurately and fairly, where the evidence stands today.

IV. Why This Belongs in the Public Record

First Amendment Television's founding principle holds that the record is the resistance. An injury that has no name is an injury the record cannot hold — it cannot be measured, funded, treated, or defended in court, because the language to describe it plainly has not reached the people living it or the institutions meant to serve them.

Making race-based traumatic stress part of the public conversation is not an act of grievance. It is an act of documentation — the same discipline First Amendment Television applies to every subject it puts in front of a camera. Evidence before imagery. Accuracy before speed. The clinical literature exists. The Surgeon General's report exists. Decades of peer-reviewed research exist. What has been missing is a public record willing to say so plainly, in language people without a clinical background can use.

Why Journalism Documents Evidence Before Consensus

A common objection to publishing on an unsettled scientific question is that journalism should wait until the science is settled. That standard, if applied consistently, would silence responsible reporting on almost every emerging area of medicine. Consensus is the end product of scientific inquiry, not a precondition for reporting on it. Journalism's obligation is to document the evidence as it stands, attribute claims to their sources, and distinguish what has been established from what remains contested — not to wait for a final verdict that may take decades to arrive, if it arrives at all.

This publication has followed that standard throughout. It has not asserted that race-based

This publication has followed that standard throughout. It has not asserted that race-based traumatic stress is a recognized diagnosis. It has reported that a substantial and growing body of peer-reviewed research exists, that clinical assessment tools have been developed and tested, and that serious researchers disagree about how that evidence should ultimately be classified. Reporting the existence and weight of that evidence is not premature. Waiting until every academic question is resolved before acknowledging that the evidence exists would not be caution — it would be a failure to keep the public record current with what researchers already know.

The Public Record Is Not Advocacy

It is worth stating plainly what this publication is not. It is not a policy proposal. It is not a legal argument. It is not a demand that any institution adopt a particular diagnosis, position, or program. Advocacy argues for a specific outcome. The public record does something narrower and, in the long run, more durable: it preserves an accurate account of what was observed, what was studied, and what remained in dispute at a given moment in time, so that later readers — clinicians, journalists, historians, policymakers — can evaluate the question with the same evidence available today, rather than reconstructing it from fragments.

This distinction matters because it determines what kind of scrutiny the publication should invite. A policy argument is judged by whether its proposed outcome is wise. A public record is judged by whether it is accurate, fairly sourced, and honest about the limits of what is currently known. This monograph asks to be judged by the second standard.

Precedent: Journalism and Emerging Medical Science

The pattern described in this monograph's Introduction — recognition following evidence, sometimes by decades — is not unique to race-based traumatic stress, and journalism has documented that pattern before. Reporters wrote about the invisible wounds carried home by combat veterans long before post-traumatic stress disorder entered the DSM, using the imperfect language available at the time: shell shock, battle fatigue, soldier's heart. That reporting did not wait for a diagnostic category to exist. It described what clinicians and families were already observing, and the diagnostic language caught up later.

A similar pattern has recurred whenever medicine has needed time to formally classify a condition that patients and frontline clinicians were already describing consistently. In 1962, a team of physicians led by C. Henry Kempe published findings on what they termed "battered child syndrome," giving a clinical name to a pattern of injury radiologists and pediatricians had been observing, and in many cases hesitating to report, for years before the term existed.⁸ In each case, the responsible journalistic choice was the same: report what the evidence shows, attribute uncertainty honestly, and let the classification debate proceed on its own timeline. This publication follows that precedent rather than departing from it.

Who Inherits the Record

A public record is written for readers who are not yet part of the conversation. Clinicians training years from now will want to know what the evidence looked like before a diagnostic question was resolved, not only after. Policymakers evaluating funding for research or treatment will want a documented account of when the evidence base became substantial enough to warrant attention. Historians examining how institutions responded to emerging science will want a contemporaneous account rather than a retrospective one written after the outcome was already known.

This is the audience this monograph is written for, as much as any reader encountering it today. Its purpose is not to resolve the diagnostic debate on race-based traumatic stress. Its purpose is to ensure that whoever resolves it — and whenever that resolution comes — inherits an accurate account of what was known, what was uncertain, and why the questions mattered in the first place.

V. Closing Statement

This publication does not ask anyone to accept a claim on faith. It asks that a documented body of clinical research be treated with the same seriousness afforded any other form of trauma —

and that the people carrying this injury be given a name for it, because a name is often the first tool anyone has for healing, for legal standing, or simply for being believed.

History repeatedly demonstrates that societies make their greatest progress not when difficult questions disappear, but when they are examined honestly. Whether future research ultimately expands, revises, or redefines today's understanding of race-based traumatic stress will be determined by evidence. The responsibility of journalism is different. Journalism preserves the questions, documents the evidence as it exists, and ensures that future generations inherit an accurate record of what was known, what remained uncertain, and why those questions mattered.

Every generation inherits injuries that previous generations struggled to name. Whether race-based traumatic stress ultimately becomes a distinct diagnosis or remains a clinical framework will be decided by future evidence. What should not remain unnamed is the body of research documenting that repeated racial discrimination can, under certain circumstances, produce measurable psychological injury. The public record begins by acknowledging what the evidence already shows.

The record is the resistance. A name is where the record begins.

First Amendment Television LLC · Pilsen, Chicago

Editorial Methodology

This publication relies exclusively on publicly available scholarly and governmental sources, cited in the Notes that follow. Statements describing empirical findings are attributed to the research that produced them. Where researchers disagree, or where a question remains under active scientific debate, that disagreement is identified as such rather than resolved by assertion.

This publication does not constitute medical or legal advice, and nothing in it should be read as establishing clinical consensus where none yet exists. Its purpose is documentary: to describe, as accurately and fairly as the current evidence allows, what researchers have found, what they continue to debate, and why that distinction matters to the public record.

Notes

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