

WHEN THE PUNISHMENT FITS NO CRIME: GENESIS AND TREATMENT OF A "SOCIAL PHOBIA"

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Current social policies encouraging severe punishment of crime fall disproportionately on ethnic minority groups, particularly African-Americans. This can provoke psychological reactions which can eventually lead to symptom formations in the members of these groups. The connection between the clinical presentation and the social experience of the minority group member is not always obvious. Especially when the therapist is of a different racial background than his or her client, it is important to be attuned to how current social pressures affect the client's experience. We report a case where inappropriate punishment of an African-American male in the absence of any crime led to the client developing a circumscribed phobia that he had contracted AIDS, and discuss the implications for treatment.

For several years newspaper polls, politicians, and television news shows have been trumpeting the prevalence of crime. Even a cursory viewing of television reveals that society favors a story line featuring clearly identifiable "good guys" and "bad guys" with little interest in the social causes of crime. Not surprisingly, then, there is a strong push to "treat" the problem of crime not through prevention, but by severely punishing individual offenders. Mandatory sentencing, of which "three strikes you're out" is but an extreme example, enjoys wide support among the population and has been enacted as law in numerous regions in the United States.

There is a substantial body of research which indicates the ineffectiveness of such punishment (National Council on Crime and Delinquency, 1993) and nu-

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merous groups, including the American Psychological Association, have indicated the necessity for attending to the underlying social causes of crime. Nevertheless, the main social emphasis is currently on law enforcement and punishment rather than prevention. Such punitive attitudes tend to fall disproportionately hard on minority populations, especially the African-American community. For example, according to a recent study,

More than 40 percent of African-American males age 18–35 who reside in the District of Columbia (D.C.) were either incarcerated, on probation or parole, out on bond awaiting disposition of criminal charges, or being sought on an arrest warrant.... The lifetime risk of arrest of a black D.C. male approaches 90 percent. (National Council on Crime and Delinquency, 1993, p. 16)

The above statistics clearly suggest a certain degree of racism inherent in our judicial system, and in our society in general. It is not surprising in such a context that many young African-American males often feel they cannot walk down a street, especially in a white neighborhood, without being at risk for arrest. This in turn inevitably affects the narratives African-Americans use to organize their experience. As long ago as the early 1950s, in landmark studies that were influential in the Supreme Court's striking down of the "separate but equal" doctrine, Clark (1950) demonstrated that in certain circumstances African-Americans, like other minorities who grow up in a context of institutionalized racism, may be prone to internalize the negative images the dominant culture has about them. While there is no empirical data regarding the impact of racism on actual stress levels or coping strategies, there is a significant body of anecdotal literature that addresses possible/likely effects of racism on multiple levels of adjustment including psychological, behavioral, physiological, and social (Billingsley, 1992; Cose, 1993; Grier & Cobbs, 1968).

Outlaw (1993) proposed a model to conceptualize the impact of institutionalized racism on African-Americans. This model (based on Lazarus and Folkman's [1984] phenomenological approach to cognitive appraisal in the context of stressful situations) suggests that African-Americans are likely to assess situations as harmful (constituting loss) or threatening because of their history of exposure to racism. Further, such cognitive appraisals are likely to be coupled with behavioral reactions such as avoidance, hypervigilance, and other compensatory behaviors. This model is consistent with the findings of Barnes and Ephross (1994). They studied the impact of hate violence on subjects, including acts stemming from prejudice based on racism and ethnicity. The most commonly reported emotional response was anger at the perpetrator (68%), followed by fear of injury (51%), followed by sadness (36%). Behavioral responses were also common (33.9%) including avoidance (e.g., relocation, withdrawal), and compensatory behaviors (e.g., increasing security, possession of weapons). The deleterious effects of racism appear to be further supported by evidence that

African-Americans suffer disproportionately from stress-related diseases including hypertension, cardiovascular disease, stroke, and chemical dependency (Billingsley, 1992; Foard, 1991).

While a complete assessment of the social costs of institutionalized racism is beyond the scope of this paper, it is important for clinicians to factor in the effect that living in such an environment has on the psychological functioning of individuals they see in psychotherapy. The following is a case in point which illustrates how an African-American male can, in response to events, live out a story which results in what looks like a "meaningless" psychological symptom. It highlights the importance for the clinician of being sensitive to social factors and, incidentally, illustrates the value of single-session therapy in situations where further treatment can result in inappropriately centering the locus of pathology in the affected individual.

Case Material

A 22-year-old African-American man, Jim, came to the Psychiatry clinic referred by his internist because of his phobia of contracting AIDS. Jim had been tested twice at appropriate intervals and was HIV-negative, but continued to fear infection with the AIDS virus, despite the fact that he had not been engaging in any high-risk behaviors. Jim described feeling captive to his fears. He had begun feeling concerned about AIDS when he had been innocently caught in a "sting" operation six months before (described in more detail below); he had been sentenced to a mandatory education course on AIDS as part of his probation. The course had sensitized him to AIDS issues; although he knew from the information he acquired in the course, and from his negative HIV test results, that it was extremely unlikely he could have acquired the AIDS virus, he could not put the fears out of his mind.

While Jim readily discussed his fears of AIDS, he was not particularly forthcoming about the rest of his life; he talked in vague generalities. The therapist, who was White, felt the client was reluctant to trust him enough to describe his situation fully. He felt it would not be helpful to attempt to get details of the client's sexual behavior which might be contributing to his fears without first developing an alliance (Rosenbaum, 1994), so proceeded cautiously: he tried to engage Jim using relative influence questioning (White, 1988), inquiring both into how much his fears were affecting his life, and attempting to find instances where Jim had influence over his fears. Jim reported he had stopped going out socially, he had discontinued most of his pleasurable activities, and spent most of his time when he was not working at home, worrying or sleeping. He was sleeping 12 hours a day. He complained of depression, and whenever he experienced any mild physical symptoms—swollen glands or constipation—he would become fearful again that he had AIDS, contact the medical center, and come in

for a complete workup. He felt the medical center was tiring of his concerns and giving him a run-around.

Jim mentioned that he had stopped visiting his young son and his girlfriend. Jim was engaged in a long-term relationship with a woman he wanted to marry, but he did not have enough money at this point, so his girlfriend and child lived with her parents, while Jim lived with his mother. He was hoping, despite economic hardship, to marry his girlfriend in the Spring. He had obtained a warehouse job shortly after his arrest in the sting operation, and while it was not the kind of work he wanted, he was grateful to have any job at all.

Strategic therapists know the value of paying attention to client strengths, and routinely emphasize these to help clients who are facing difficult obstacles combat dispirited withdrawal and discouragement. In this particular case, though, the therapist did not find himself thinking of "solution-oriented" techniques, but of the grim realities confronting people in Jim's position. Knowing the unemployment rate for African-American males of Jim's age group was currently around 60% in the region, and considerably higher for men living in the projects where Jim currently resided, the therapist felt impressed by Jim's ability to obtain work. The therapist commented on the difficult economic conditions, and noted how Jim must have had considerable drive and motivation to obtain a job against such obstacles.

Jim began to noticeably warm up at this point, and described some of the significant obstacles in his life. Most of his friends were doing drugs, unemployed, and just lounging around. Jim, though, maintained his own philosophy of personal responsibility and not giving up. When the therapist asked what kinds of things Jim did to keep his energy and hope up, Jim described how he was an expert kite maker; he loved flying kites and watching them soar. He also wanted to be a big-rig driver.

This, however, turned out to be his downfall. He had driven to a part of town with which he was unfamiliar, one populated mostly by whites, in search of a shop he thought sold a particular big-rig magazine. As he was searching for the shop, he passed by a place which turned out to be a house of prostitution, just as a sting operation was being triggered. He was arrested and pled guilty.

The therapist clarified that Jim had just been walking by the place. Jim said yes. Why, then, had he chosen to plead guilty? Jim felt he did not stand a chance in a courtroom since he'd had a previous conviction.

The therapist hesitated. Much of this felt flimsy and unbelievable. Could you really get arrested just for being near the wrong place at the wrong time? What was this previous conviction? Was Jim sociopathic, or engaging in denial? The therapist considered asking for more details and obtaining more information, to judge the veracity of the incident. Then he recalled some of the statistical data he had read about the high arrest rates of young African-American males, and thought of a recent incident an African-American friend of his had related: her 20-year-old son had been picked up by the police while walking in a white

neighborhood at night. The son had not been doing anything special; a middle-class African-American, he was on his way to visit a friend in the neighborhood when the police arrested him for no other apparent reason than that he was a young black man who apparently did not "belong" there.

The son had been incensed and had seriously considered dropping out of college as a rebellion against "the system." The therapist had been surprised by how matter-of-fact his mother had been about it: "yes," she said to her son, "this kind of injustice exists all the time. So? How do you live with it? Do you cut off your nose to spite your face?" She left the decision to her son, but while she acknowledged the injustice, she did not join him in what she felt would be a futile gesture.

Remembering this, the therapist turned to Jim and simply said, "It's so unfair, isn't it? Here you are just trying to find something you feel might open up some doors for yourself, and you get caught in something and get screwed."¹

At this point Jim began to talk volubly. He described not only his frustration in the incident, but his previous conviction. His older sister was getting a divorce, and he had been concerned about her. He knew she was impulsive, knew she had a gun in her house, and feared she might use it. He drove to her house, talked with her, and took the gun for safe-keeping. On his way back home, he was stopped by police, who arrested him for carrying a concealed weapon without a license. He fought that arrest in court, but lost because he felt the arresting officer perjured himself during the trial. He was shocked and amazed, and felt helpless.

Shortly after that, he discovered his girlfriend had been having an affair with another man. Upset, he allowed himself to be seduced by a woman who had been pursuing him for some time. This was the only unprotected sexual contact he had, and it took a form which involved virtually no risk of infection by the HIV virus. Within a few weeks he had reconciled with his girlfriend, and he now felt guilty about this episode. It was a few months after that the incident with the sting operation, the mandatory AIDS course, and the ensuing phobia occurred.

At this point the AIDS phobia could be re-narrated in a very different context. The remainder of the session was spent on exploring how the phobia represented all the dangers of social contact in a system which consistently treated him unfairly. It did not matter that objectively the tests told him he "shouldn't" have AIDS; he also "shouldn't" have been arrested and "shouldn't" have been betrayed by (or betrayed) his girlfriend.

Jim now told in some detail, and with considerable emotion, how he felt the odds in life had been stacked against him. Besides the material detailed above, Jim talked of how he had been blessed by having a caring, responsible father,

¹The colloquial term "screwed" was deliberately used to speak to the client's experience of being unfairly treated by institutionalized racism, and to connect that to his subsequent phobia regarding sexual contact and sexually transmitted diseases.

but his father had died while Jim was still in Junior High School. His father "shouldn't" have died—it was unexpected and unfair.

Many clients come to therapy complaining of the unfairness of life in ways which sometimes leave them stuck in an aggrieved but immovable stance toward their problems. In contrast, the more Jim told the therapist about his life, the more the therapist felt that Jim's situation was one of someone who, in the face of very real racial injustice and difficult life circumstances, had refused to complain, opting instead to take whatever actions he could to make the best of his situation. The therapist had the impression Jim had never before verbalized his feelings of being treated unfairly. Perhaps if Jim had the habit of complaining, he might not have developed symptoms: as it was, his irrational conviction that he had contracted AIDS seemed a metaphor for his unexpressed feelings that he lived endangered by life-destroying forces which could invade him if he made any slip, and might attack him even when he was innocent.

It was important for Jim to have an opportunity to acknowledge the social unfairness he had experienced and was likely, as an African-American, to continue to have to confront. It was also important for Jim to figure out a way to not feel defeated, but to get on with his life. The therapist acknowledged to Jim: yes, he had suffered from prejudice and injustice. The therapist also suggested that his current fears and depression were a response to this; his lack of energy and withdrawal indicated he was tired of dealing with hostile social forces, and he was in temporary retreat. He mentioned that in any battle, it was necessary to retreat at times, to regroup and marshal your forces. This served to validate Jim's situation, but also reframe it not as a disease, but as an opportunity for a choice. Once Jim had rested and fortified himself, though, the social issues would remain. Ultimately, the therapist said, the question was: how would Jim decide to live with the unfairness of life and society? What would he do, when he was ready?

Jim responded by saying that even though life might be unfair, he still had to take responsibility for his life and do what he could. It took bravery, but it was better than acting like a victim. He talked about how many of his friends and acquaintances had given up, blaming it all on institutionalized racism. Jim just didn't believe in blaming it all on others, and felt you had to do what you could with your own life. Sure, all African-Americans had been oppressed and were being oppressed, but they weren't slaves any longer. He spoke touchingly about how recently, for the first time in his life, a white man had befriended him, and even invited him to his home for dinner. He talked about how just a few days ago he had gone kite flying with this new friend, and how he planned to take his young son out soon.

At this point in the session, it no longer felt like Jim was an injured, sick man submissively seeking help from a doctor in a dominant social position. Instead there was a feeling of "connectedness," of energy, and of comradeship. The conversation turned rather naturally to specific strategies for countering his

phobic fears, with the therapist working as a consultant strategizing with Jim, allied together against his difficulties. Jim said he couldn't know what life held for him, but he couldn't give up, either.

The therapist underlined some things Jim was doing already so that they became more explicit. Jim decided to say to himself, when fears and difficulties came up, "it's not fair. But life's not fair, and I can choose between some options." This, he felt, would give him the energy and courage to fight against "the slings and arrows of outrageous fortune." Utilizing one of Jim's preferred enjoyable activities in a variation of DeShazer's "read/write/burn" technique for unwanted intrusive thoughts (DeShazer, 1985), the therapist suggested that Jim knew how to take advantage of strong forces and could turn to them to help him get over his difficulties. Since Jim knew the pleasures of harnessing the winds; if need be he could make a kite, write his fears on it, fly it up and let go of it, releasing any fears to be carried off by the winds.

At this point the session was drawing to a close. Jim seemed considerably different from the defeated, passive, somaticizing patient who had entered the session. The therapist asked him whether he felt he had enough to work with, or would like to set up another session, or would like to try and see how things went and call as necessary. Jim replied he felt he knew what he had to do, and wanted to work on things on his own for a while, but that he'd like to call the therapist in a few weeks to check in. This was agreed upon. In the follow-up phone call, Jim was no longer depressed, he was not obsessed with AIDS, was back to his normal activities, and felt considerably more hope and energy.

Comment

In this case, Jim's fear of AIDS was emblematic of a wider fear of a society which could and did treat him capriciously and unfairly. While the genesis of the phobia had individual grounds, in Jim's reactions to his father's premature death and his girlfriend's unfaithfulness, the immediate triggers and form for the phobia came through his interactions with an oppressive criminal justice system. Jim's life story up to that point had been of a man who had tried to do everything right: be a responsible father, a loyal boyfriend, a reliable employee, a helpful brother. He did this, however, in the context of a social structure which makes it difficult for young African-American men to obtain jobs of their choice, escape economic bondage, and maintain stable relationships. When some of the most visible symbols of the larger social structure—the police—interacted with him, he perceived an unpalatable choice: identify with rebellious strands in his own culture, which he perceived as self-defeating, or comply with an overtly oppressive and capricious social structure. Where there is punishment in the absence of crime, it is easy to cause an individual to become intrapunitive, to seek something he has done wrong which could account for the unjust consequence. Jim chose a fear which would prevent him from interacting

socially: fear of a "social disease" (i.e., AIDS) which invisibly enslaved and corrupted, capriciously infecting a person who dared to not toe the line by engaging in even a single impulsive act. His fear of AIDS was a true social phobia: a fear of engaging in a society which invisibly, cruelly, and capriciously could punish attempts at individual expression or initiative.

In such a situation, engaging a client in lengthy psychotherapy can be counterproductive if such psychotherapy engenders the idea that somehow the problem is "in" the client. Society provides more than enough messages of this sort. It is important to recognize the reality of the client's experience of his social setting, validate it, and then reinforce the client's ability to find creative pathways. Single-session therapies offer one such method (Rosenbaum, Hoyt, & Talmon, 1990; Rosenbaum, 1994).

While single session therapy is often the treatment of choice in such cases because of its reduced risk of pathologizing the client, there are of course many instances when more sessions are indicated. For example, clients who present as devastated by routine acts of racism (e.g., being the target of a racial epithet), and those who present with a history of immobilization (and/or underachievement) often benefit from longer therapy.

Clients who appear to be devastated by routine acts of racism frequently lack necessary defenses to cope with racism. Failure to develop adequate defenses may be related to a number of circumstances. For example, clients reared in certain "protected" environments may be shielded from more overt (i.e., personalized) aspects of racism, thereby reducing the need/opportunity to develop functional defenses. Such circumstances may include being reared in ethnically homogeneous areas (e.g., exclusively African-American) or in particularly affluent environments. Clients who "cope" with racism by denying its impact/significance as a means of distancing themselves from the pain and anger of disenfranchisement are also likely to demonstrate inadequate coping mechanisms. Hence, when confronted with more overt acts of racism, these clients frequently find themselves ill equipped to cope with such insults, and may experience symptoms of withdrawal and depression. In such cases, treatment focusing on increased awareness of one's level of ethnic identity integration (e.g., the patient's beliefs about racism, and the impact of their beliefs on their expectations and behavior) coupled with continued social involvement is recommended. Such interventions would provide clients with both the opportunity to better understand the role of their beliefs in the presenting problem, and to learn more effective coping skills through continued exposure.

Clients who present with a history of immobilization may also require more than one session. These clients often use racism in a defensive fashion, attributing all personal failures and, more importantly, lack of effort solely to racist conditions. It is important that therapeutic interventions emphasize balancing (integrating) the reality of racism with the client's development of personal responsibility and empowerment. This would include acknowledgment of the

limitations imposed by institutionalized racism (such as dearth of opportunities), and clarification of empowering resources (e.g., education, social/political supports, increased awareness of one's own passivity). Such an emphasis is supported by Outlaw (1994) who highlighted mechanisms to minimize learned helplessness associated with institutionalized racism. Specifically, Outlaw suggests that interventions focus on changing one's tendency to perceive harm or loss in any given encounter to recognition of the potential challenge. This shift would facilitate one's efforts to cope with difficult situations (via implementation of resources), thereby decreasing vulnerability to the deleterious effects of institutionalized racism (e.g., learned helplessness, avoidance, and stress-related diseases).

In order for a therapist to form a working alliance and join the client empathically, it is not enough to relate the personal family history of the client. The personal family history is always embedded in a larger social context, and it is precisely the larger societal forces therapists can lose sight of when they come from a different cultural background than the client. For white therapists, racism may be an offensive abstraction; for African-American clients, it has daily practical consequences. In the current political climate, it is all too easy, when a client has had more than one arrest, to construct a story which treats the client as either a sociopathic scoundrel or a helpless victim.

In the present case the client was able to construct a different story for himself, replacing a fantasy of a contaminating social disease with a realistic acknowledgment of his social and racial circumstances. By confronting the real difficulties of life in this way, a client always has an opportunity to create a story in which he is neither victim nor scoundrel, but rather, a hero. Being a hero does not mean being either naive or victorious; it simply acknowledges the perils of the route a client has traveled and the efforts a client makes. On a hero's route there is neither crime nor punishment, but simply the despair and exhilaration that come from confronting the risks of life itself.

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