Black Girls Don't Cry

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Casey Shearer Memorial Award for Excellence in Creative Nonfiction, 1st Place

The following article contains mentions of self-harm, depression, and suicide.

I'm sitting in the living room, picking at the polish on my toes. My dad sits on my left, my mom on my right. The TV flashes soundlessly in front of us. It's one of my first days home for the summer after my sophomore year at Brown. We make small talk. They've missed me. I've been well. But we're still so quiet about the things that count.

It's as though they can't remember us sitting in this same position two years earlier—my mom, my dad, and me, in the volatile space between them—only then, the conversation wasn't about grades or friends or college, but about my latest suicide attempt, yet another plea for help. We don't talk about the times I couldn't even look my parents in the eyes, and so settled on staring at my wrists. They were often such furious shades of red, loud and hurt in ways I wasn't yet allowed to be.

Defining Depression

When I was 17, I was diagnosed with concurrent major depressive disorder and dysthymic disorder—a mental illness cocktail sometimes termed "double depression."

Major depressive disorder is characterized by episodes of depressed mood that impair everyday functioning. Episodes become diagnosable after they've lasted two weeks, and can be one-time occurrences or the first of many. Major depression makes conversations feel fatiguing,

like performances I give dozens of times a day, no breaks. Getting out of bed and facing a day of even minimal activity sometimes requires giving myself a mental lecture or rallying speech before I can imagine moving. Wanting to stop existing becomes as routine a thought as wondering what I'll eat for lunch.

Dysthymic disorder is a chronic, ongoing state of depression. Some people are happy or at least okay until something makes them unhappy; I'm sad until something makes me less sad. Even when I'm not Depressed, I'm depressed.

Both disorders feel like self-hatred. Futility. Falling out of love with everything I usually can't get enough of, leaving good books unfinished and delicious food untouched.

Depressive disorders have long been attached to stigma and skepticism in the United States. The National Institute of Mental Health (NIMH) finds that Black Americans in particular have reported drastically fewer diagnoses of depressive disorders than other racial groups nationwide—4.2 percent, compared to 6.2 percent of whites and 7.2 percent of Hispanics. When we take into account all of the cases that go unreported for a variety of reasons—fear of stigmatization, largely—we can guess that this isn't an accurate or even near-accurate reflection of how many individuals in Black communities actually experience these disorders, but a testament to the power of cultural stigma to keep Black sufferers silent.

A 2011 Center for Disease Control and Prevention report found that about three percent of adults in the US suffer from major depressive disorder, and about 10 percent suffer from at least one depressive disorder; these are some of the highest rates of depression in the world. Yet, even as overall diagnoses of depressive disorders increase, Black Americans remain relatively tight-lipped about mental illness in their communities. Sometimes these communities say outright that depression is a "white people problem." In her book on depression in Black

American communities, *Black Pain*, Terrie Williams quotes one Black sufferer as saying, "Depression is what white folks do … We [Black people] didn't have time to be depressed."

A popular perception of depressive disorders is that because common symptoms like insomnia, moodiness, and feelings of hopelessness are ostensibly matters of mindset, these disorders are outlooks that can be rectified at will. This view denies the significance of the biological aspects of depression. Certain hormone imbalances, such as higher rates of cortisol secretion and decreased serotonin production, have been shown to be reliable indicators of depression. These specific imbalances are often the result of sustained stress, which can occur in anyone. Hormonal factors can also work in tandem with hereditary predispositions and other genetic factors to set off this chemistry.

Another common perception of depression is that it can, apparently, be avoided all together, depending on one's race—more specifically, it's the idea that Black people don't get depressed. The 'white people problem' approach to depression, which focuses on how race interacts with the experience of this illness, gets one thing right, though: depression can be (and often is) experienced differently across racial backgrounds. Chemistry shapes the way our brains interpret events and stimuli, but our cultural contexts can also shape how we think, and can often determine what the final outward expression of a depressive disorder looks like. The physiology of depressive disorders is the foundation upon which cognition and culture build; it's the one commonality across all affected individuals. This means that although I have some biochemical aspects of depression in common with, say, a 65-year-old white man who also has a depressive disorder, we might express these chemical similarities in vastly different ways because of our cultural attitudes, influences, and—in the case of Black communities—restrictions on expressing certain emotions.

In other words, Black Americans do not have cultural permission to be depressed.

Permission Denied

To say that expressions of sadness are not "allowed" in many Black communities is to hint at the existence of certain cultural rules that govern such communities. Psychologist Paul Ekman coined the term "display rules" to describe the appropriate sociocultural contexts in which people can express certain emotions. To study these display rules, Ekman ran a series of experiments on American and Japanese subjects in the 1970s.

Imagine you're one of the subjects, walking wide-eyed and oblivious into Ekman's lab in either San Francisco or Tokyo. He sets you up in a chair in front of a screen. The lights dim, and a film starts. As time passes, the film gets progressively harder to watch. You see a man impaled by a piece of machinery, watch another lose his finger to a quick, serrated blade. These studies found that Americans watching the film reacted with facial expressions of horror and disgust, whether they watched alone or with someone else in the room. But the Japanese subjects, who reacted with the same sour looks as the Americans when watching the film alone, wore blank expressions while watching with an experimenter. Ekman's research team chalked this up to the fact that preserving social harmony—which, in this case, meant maintaining emotional calm in the presence of others—is more crucial to collectivist cultures like Japan's than it is to individualistic ones like the United States's.

Ekman concluded that people across cultures are capable of experiencing and expressing emotions in similar ways, and respond with comparable facial gymnastics to strong stimuli like the graphic films he'd screened. But in some cultures, strict display rules exist that dictate when

expressing emotions is appropriate, and when it would be better to keep your feelings to yourself.

I learned these lessons early on. When I cried as a child and there were no protruding bones, no missing skin or bloodstained clothes, my mother would tell me to "stop crying before I give you something to cry about." She would raise a hand and say, through clenched teeth, to "fix your face"—or she would fix it for me. These sayings and others like them are featured in "Shit Black Moms Say" videos all over YouTube, in blog posts and round-ups on Black parenting at *The Root*, *Slate*, *The Crunk Feminist Collective*, and more. My experiences are not isolated incidents. So many Black children in the US grow up in a culture where sadness cannot exist.

The mostly white American subjects in Ekman's experiment had no restraints on their emotions, no matter who was around. But for Black Americans, our display rules can mirror those of the Japanese subjects. We train ourselves to read as "neutral," even when we're in pain.

In order to understand this cultural stigma on sadness, it is important to consider the relentless history of violence and discrimination against Black communities in the US, the collective experiences that have shaped this culture into one known for its resilience and its suppression of weakness and vulnerability. Beginning in the era of Black slavery, continuing through to the Jim Crow era and into today's age of police brutality and institutionalized discrimination, the notion of Black resilience was used as a tool of justification for our mistreatment at the hands of white communities—the idea that Black people are strong, and can endure more suffering than others. The same narrative was also used as a tool of faith-based strength building within Black communities—the idea that Black people are strong, and we can overcome anything. In order to sustain themselves in the face of these hardships, Black

communities needed to project strength. Weakness from individual members could not be tolerated.

This mentality has persisted for centuries. We have bigger problems to face than mood swings and racing thoughts. As a survival tactic, perhaps resilience has served its purpose. But it remains a legacy we haven't found a way to exist outside of, a legacy that allows stigma to thrive and Black people with depressive disorders to effectively disappear.

'White People Problems'

Growing up, the word "depression" was worse than a slur in my house. In the eighth grade, when I first approached my parents about seeing a therapist—a concept I had read about on Internet forums—they turned me down on the grounds of what seeing a therapist would do to my 'record.'

For a Black child, the 'record' can become a source of constant paranoia. The idea is that we start out with one 'strike' against us—our Blackness. If you're born into poverty or the working class, add another strike. Any mistakes you make go into this record—the stolen candy from the drugstore becomes the reason you were shot down in cold blood. That time you smoked weed in your friend's basement becomes the reason you deserved it. If young Black people do have a chance at survival or success in this country, openly having a mental illness can only be another strike on the record, a virtual guarantee that we don't get to see that bright, fabled future.

Black communities' framing of mental illnesses, particularly depressive disorders, as 'white people problems' reveals an understanding, however problematic, of the relationship between privilege and emotional expression. Through this rhetoric, the expression of sadness

becomes synonymous with—and exclusive to—whites, who have not been denied the ability to express their emotions and receive empathy.

This is not to say that Black sufferers don't express their sadness: they just do so in more covert ways. Across all racial groups, Black women have the highest rate of self-harm and are among the most vulnerable communities for the development and exacerbation of mental illnesses. The lack of awareness that self-harm has been and continues to be prevalent in Black communities stems directly from dominant cultural myths that sadness and self-destruction are luxuries only white, wealthy people have the time for—and the privilege of disclosing. As a result, members of Black communities are less likely to be diagnosed with depressive disorders and, even if they are diagnosed, are less likely to seek treatment or counseling.

An NIMH survey published in 2012 finds that 73 percent of whites diagnosed with a depressive disorder received treatment compared to 60 percent of Black Americans. These diagnostic disparities arise partially from issues of access and bias in health care. Many Black communities, especially in densely populated cities and ghettos, do not have access to affordable and convenient health care or insurance. And for every Black American who does seek treatment, several do not receive it—the National Alliance on Mental Illness and other research groups find that non-Black health care professionals constantly misdiagnose or under-diagnose Black patients. For instance, doctors will wrongly name Black patients paranoid schizophrenics in 86 percent of cases before they accurately name us depressed. When looking at how social factors like race impact depressive disorders in ways that go beyond the symptoms, it becomes clearer why some cultures have restricted the expression of these disorders—why they refuse their children's requests for help, and deny their children permission to be sad. I would never have been able to get a diagnosis or counseling had I not left my city and the Black community I

was a part of there and been given access to Counseling and Psychological Services at a private university 200 miles away from home; no one should have to go to these lengths to find help.

And even now, I can count all the Black people I know on my campus who suffer from depressive disorders on just one hand. Because the public faces of depression have never been Black faces. We are still not allowed to fully own our sadness.

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I'm nearing the end of my fall semester, junior year. My depression has peaked, and I'm having thoughts of dying. I tell this to my new counselor, who listens attentively.

Her office is furnished with the requisite long, plushy couch and a floor lamp that provides warm lighting. Animal trinkets line an in-the-background bookshelf. I focus on them, not her, as I tell her how being Black and depressed means keeping secrets from my family, and how none of my friends seem to notice, care, or believe that I'm suffering.

That must be hard for you, she says. Or maybe, that must hurt you a lot. Whatever it is, it's such a simple remark that when I open my mouth to respond, I surprise myself with the tears that come to my eyes. I touch my face, to check that it really is wet. Nineteen years, and I've never allowed myself to cry in front of a stranger before.

My counselor reaches for the box of tissues on the end table beside the couch, and I wave my hands. "I'm fine." I want to laugh—this is absurd, after all, this is against the rules—but now I'm really sobbing.

"You know, it's okay to, if you want," my counselor says. She plucks out a few tissues, hands them to me, and I'm almost convinced when she tells me, "It's okay to cry."