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COMPREHENSIVE REVIEW

Whiteness hurts society: How whiteness shapes mental, physical, and social health outcomes

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Abstract

Confronting *whiteness* could complement and amplify the study of Critical Race Theory and enhance psychologists' capacity to effectively study and address health and social issues. Whiteness is a racialized social system and a set of beliefs that uphold White American social supremacy and the oppression of populations of color. We discuss how prior scholarship has addressed whiteness and we illustrate how whiteness can harm health and well-being among White Americans and broader society. By documenting the negative effects of whiteness, we encourage divestment from the construction of reality that inequitably produces power and privilege, and ultimately, threatens society. Understanding how whiteness operates will aid the development of interventions and policies that reduce the inequity that results from whiteness and the enduring nature of racism. Finally, we call on psychologists to actively divest from systems of whiteness within our field; otherwise, we are complicit in how whiteness hurts society.

INTRODUCTION

Rationale

Critical Race Theory (CRT) recognizes that racism is a systemic, enduring force that is embedded in every facet of society in the United States that differentially structures opportunities and

privileges that shape health and well-being across minoritized and majoritized racial groups (Bell, 1995; Crenshaw, 2011). Yet, traditional psychological and social science research consistently draws upon theories, research methods, and study designs that pathologize racially minoritized groups by focusing on individual-level attitudes and health behaviors that do not fully account for the systems of oppression and subordination that perpetuate inequities (Zuberi & Bonilla-Silva, 2008). Furthermore, the psychological and social sciences have traditionally overlooked how systemic social supremacy (e.g., white[1] supremacy) has affected the health of majoritized populations. In conjunction with research that examines the health effects of systemic oppression for minoritized groups, we contend that understanding how supremacy influences the health of the socially dominant group (e.g., non-Hispanic White people in the United States) is a critical component of deconstructing the nuanced ways that racism affects society. In this paper, we call attention to the construct of *whiteness* (see section "Whiteness as a System") to argue that addressing whiteness can support, complement, and amplify the study of CRT in psychology and the social sciences.

Our call to investigate whiteness is not meant to center whiteness in the way that it has historically been centered as the unnamed default, rather, we propose that deliberately investigating whiteness within the context of psychological research will help illuminate how to disrupt its deleterious effects. In this paper, we provide a brief overview of research on whiteness, discuss how whiteness has been addressed within the social sciences, and illustrate how whiteness harms health and well-being among White Americans and broader society. We conclude with recommendations for how psychologists can address whiteness within our own research and within our field.

Doing intersectionality and researcher positionality

First, we want to acknowledge that who we (the authors) are influences our research conceptualization and application. Overall, and consistent with methods and praxis for "doing intersectionality" (see Davis, 2008), we recognize the limitations that we, as researchers, have to make claims about the meanings associated with any construct, including the topic of whiteness. At the same time, in considering responsible stewardship for actualizing intersectionality in our research (see Cole, 2009), we intentionally engage in conversations amongst ourselves about our social identities and relative closeness, distance, and general proximities to positions of power and privilege throughout the writing and theorizing of this manuscript. While we all share at least three group identities (i.e., cisgender women, hold doctoral degrees, occupy positions at well-regarded U.S. universities), we come to this paper with varying levels of marginalization, sensitivities, and sensibilities regarding race and whiteness.

Regarding our own racial and ethnic identities, we are racialized as Black American (Versey), Black American and Mexican (Wilkins), and White American (Efird). We come to this paper both as researchers and as human beings who have been deeply affected by whiteness throughout our life course and in the present era. We navigated whiteness amidst our primary socialization in the United States, studied and applied CRT during our graduate training at predominately

[1] We capitalize the W in "white" only when we reference a group of people who are racialized as White (e.g., White Americans, White people) or the White racial category. This highlights that White people are a racialized group who should not be afforded the comfort or privilege of racial invisibility (see Painter, 2010, 2020). In solidarity with prior Critical Whiteness Studies scholarship (Matias & Boucher, 2021; Matias, 2022), we do not capitalize the W when we reference whiteness, white privilege, or white supremacy.

White institutions, and currently research and confront the negative effects of whiteness through our scholarship and lives. Our varied lived-experiences, academic expertise, and commitment to antiracist praxis inform our conceptualization and theorization of whiteness.

Whiteness as a system

We conceptualize whiteness as the racialized social system and a set of beliefs that uphold White American social supremacy and the oppression of populations of color (Bonilla-Silva, 1997; Efird & Lightfoot, 2020; Leonardo, 2004). As a tiered system that directly and indirectly affects both individual and group experiences (see Bronfenbrenner, 1979), whiteness socially, economically, and ideologically benefits people who have been racialized as White, and actively disadvantages people who have been racially minoritized (Bonilla-Silva, 1997, 2022; Efird & Lightfoot, 2020; Malat et al., 2018). Whiteness encompasses a broad set of experiences and socializations, including practices, behaviors, and ideologies that contribute to how whiteness is created and sustained. Consequently, whiteness is invisibly embedded within institutions, policies, culture, and everyday life in the United States (Bonilla-Silva, 2022), and is inextricably linked to other exploitative systems (e.g., capitalism). Whiteness scholars, such as Leonardo (2004), Helms (2017), and Matias (2022), remind us that it is critical to acknowledge the *supremacy* aspect of whiteness; that is, we must recognize that White Americans collectively possess more power, authority, and status because the U.S. society was intentionally designed to disproportionately benefit people who are racialized as White.

In the same way that global economies built upon capitalism are not race-neutral (see Robinson, 1983), whiteness does not exist in a vacuum. Whiteness and capitalism are complementary and interdependent (e.g., racial capitalism), working synergistically as systems that both reify whiteness and hierarchies of racial oppression globally (Harris, 1993; Melamed, 2015). Robinson (1983) first defined racial capitalism as a tendency "of European civilization…not to homogenize [groups of peoples] but to differentiate," (p. 26) for the purpose of exploitation, expropriation, and the establishment of racial hierarchies. The transatlantic slave trade exemplifies why racial hierarchies built upon economic exploitation were necessary to facilitate whiteness. Whiteness was established to exploit and oppress people of color—racially and economically, implicitly and explicitly—in ways that impact health and well-being (Laster Pirtle, 2020; McClure et al., 2020). As Gilmore (2020) states in an interview

> The relationship between slavery and race, race and unfreedom, unfreedom and labor, is one that we constantly try to untangle and at our peril we ignore it, but also at our peril we make it too simplistic. Because the complexity of it matters for what we do in the current moment….Capitalism requires inequality and racism ensures it.

Throughout this paper, we focus on whiteness for the sake of clarity, highlighting contemporary examples (e.g., gun ownership, suicide deaths, status threat) that support a link between whiteness and health. For example, on a microlevel, whiteness influences factors like prejudicial racial attitudes (Karras et al., 2021; Roediger, 2007) and religious beliefs (e.g., White Christian nationalism) (Butler, 2021; Whitehead et al., 2018). These individually held beliefs proliferate in contexts where whiteness is normalized, creating a macrolevel ethnoreligious culture that remains largely

unnamed—and invisible to many White people—thus, perpetuating the hegemonic nature of whiteness in society.

Origins of whiteness and racial stratification

One example of how whiteness operates as a system is evident in the ways it shapes laws and policies that replicate the oppression of populations of color and privilege for those who are racialized as White. Harris (1993) explains how property rights—access to land and housing—are essential privileges that have, and continue to be, largely afforded to groups racialized as White, contributing to the largest wealth gap in the U.S. history (Bailey et al., 2021). The right to own property is intertwined with the way whiteness evolved in this country. The categorization of who is considered "White" has shifted since the initial census was taken in 1790, primarily benefiting wealthy, White landowners (Lee, 1993). During the American colonial period, most laborers were European indentured servants who were gradually replaced with enslaved laborers from Africa. Skin color became a proxy for race since it was an easily identifiable feature, marking laborers as distinct from owners. At the same time, new laws made slavery permanent and inheritable for people racialized as Black, rather than "White," "Christian," or "Englishman" who began appearing in colonial statutes (Fredrickson, 1982). Therefore, in an early American context, hierarchies of social class and power became placeholders for race and the ability to access capital resources (i.e., racial capitalism).

Similarly, Haney-López (2006) argues that the historic (and present) legal construction of race in the United States perpetuates systemic White racial privilege. The United States restricted immigration on the basis of race until 1965, primarily through national origin quotas based on racial characteristics, essentially excluding people based on physical traits who were considered "non-White" (Haney-López, 2006). Furthermore, antimiscegenation laws throughout the U.S. history regulated sexual relations, interracial marriage, and segregation laws, perpetuating racial divisions in public and private sectors in ways that socially and economically benefitted people racialized as White (Haney-López, 2006). For example, in the United States (and contrary to British law), status was conferred based on matrilineal descent in which the offspring of Black–White unions were granted their mother's status, protecting White men who owned and raped enslaved Black women from being held accountable for their actions (Roberts, 2021). More recently, Vigil and Muñoz (2023) articulate how immigration law can reproduce racial privilege for White Americans and oppression for racially and ethnically minoritized people without explicitly naming race within the wording of the policy. For instance, the decision to rescind the Deferred Action for Childhood Action policy brought about immediate and long-term negative social and health effects for undocumented immigrants of color (Vigil & Muñoz, 2023). Additionally, Garnar et al. (2022) articulate how gun rights laws signal whiteness without using explicitly racialized language. In particular, Virginia's Second Amendment sanctuary resolutions provide elected officials the opportunity to tie whiteness to gun ownership via coded language that does not mention race. Through race-coded language that taps into fear and racism (e.g., dog whistling) (Schutten et al., 2021), lawmakers generate political support for progun policy by propagating the notion that White men are "law-abiding citizens" and "good guys with guns" who serve as armed guardians of America and deserve to be armed (Garnar et al., 2022). Thus, whiteness is invisibly embedded in colorblind laws and policies that entrench racial inequality into the U.S. society. Taken together, these examples show the social creation and evolution of whiteness as a system and race as a construct, comprised of ideology and structure that mutually reinforce one another. As noted by CRT scholars, racism and whiteness are permanent fixtures that maintain the social construction of

race and racial categorization (Bell, 1995; Delgado & Stefancic, 1992). Naming and drawing out these embedded features are important to understand why whiteness is critical to advancing CRT research in psychology and more broadly.

At a macrolevel, whiteness invisibly upholds societal and cultural norms that hurt society via ideologies that "reflect and produce racial domination" (Salter & Adams, 2013, p. 781). For instance, whiteness propagates the meritocratic illusion that all people have equitable opportunities to succeed and achieve the American Dream if they exert sufficient individual effort (Efird & Lightfoot, 2020; Malat et al., 2018). Yet, decades of empirical evidence reveal that marginalized and minoritized populations (especially those at the intersections of multiple marginalized identities) disproportionately bear the burden of adverse social outcomes and relatively poor health (Bailey et al., 2017; Darity et al., 2022; Geronimus et al., 2020; Kwate & Meyer, 2010; Pearson, 2008; Viruell-Fuentes et al., 2012; Williams et al., 2019), so much so that the Centers for Disease Control and Prevention (CDC) named racism a public health crisis (CDC, 2021b). However, novel research (which we detail below) suggests that there is variation in the ways that whiteness affects White Americans: whiteness benefits the most privileged, while simultaneously hurting less privileged White individuals and society at large. Therefore, we draw from complementary frameworks to build upon existing research, connecting social determinants of health to frame specific implications for psychology and mental health.

A brief history of research on whiteness

While whiteness is not new, its formulation as a topic of study and growing academic interest is relatively novel. Early scholars, such as W. E. B. Du Bois, James Baldwin, and others laid the foundation for what later labor historians, educators, and critical race theorists call Critical Whiteness Studies (CWS). One of the central reasons to study whiteness is to understand it, mark it as real, and illuminate how it operates as both a social system and identity category that forms the basis for opportunities, access to power, and lived experiences for individuals identified and racialized as White. Though not exhaustive, we briefly discuss engagement with the construct of whiteness in several fields, ending with further ideas and suggestions for the advancement of CWS (as a complement to CRT and intersectionality) in the field of psychology.

Whiteness in sociology, philosophy, and history

One of the earliest theorists of race in the United States, Du Bois (1935) undertakes and describes whiteness as a process of transformation. As mentioned above, during the early constructionist period, diverse European ethnic groups were assimilated into one category (White) for the purpose of marking skin color as difference, accumulating wealth and labor benefits, and gaining property ownership (Du Bois, 1935). Clearly, land and labor were essential tools in creating whiteness as an identity category that undergirded the nation's economic system (Roediger (2007). In this way, whiteness and capitalism are intertwined as racist and mutually reinforcing systems; creating hierarchies of resource accumulation and privileges that benefit an elite group to the exclusion of those deemed not White (Laster Pirtle, 2020; Melamed, 2015; Robinson, 1983). These interlocking systems, buoyed by continuing white supremacy and complementary oppressions, create a range of lived experiences and psychological responses. Prior historical and sociological analyses provide the necessary framing for establishing the central tenets of whiteness: (1)

whiteness is a modern invention, it varies by time and place; (2) whiteness is a socially constructed norm linked to indices of implicit and explicit privileges and advantages; and (3) whiteness constitutes a system that sustains and reproduces privileges and advantages over time for White-identified individuals and groups (Guess, 2006; Yancy, 2012). As other research in this volume illustrates (see Gonzalez & Plaut, 2024), whiteness and CRT go hand in hand. CRT draws attention to these enduring, linked structures by shedding light on them and studying them explicitly.

Whiteness has evolved over time as an unfixed, unstable, complex, and rather invisible construct concerning its boundaries—who is/was considered White (or not), and how these distinctions map onto larger systems of power, political significance, and social benefit (Lewis, 2004). From this perspective, it is unsurprising that the study of whiteness emerged in tandem and as a complement to CRT, and that it draws inspiration from Karl Marx, Cedric Robinson, and other paradigms that position race as "a consciously constructed political, epistemological, legal, cultural and economic system" used to define white supremacy (Engles, 2006, p. 10). Other scholars have expanded the idea of race as a creation through social constructionist theory, highlighting how concepts of race emerged during the Enlightenment and continue to shape institutions, political conflict, and ideology (Mills, 1997; Omi & Winant, 2014). Though race is a social construct, it remains a real and tangible social problem (Smedley & Smedley, 2005). It is a marker for a variety of experiences, exposures, and sensibilities that are important to consider for health and life outcomes.

At the same time, the formation of race as a social construct excludes whiteness in the sense that White people do not generally claim a White identity or a White race. Therein lies the artistry of how whiteness operates. Whiteness (as both a system and an identity) is normalized, ordinary, the default, the standard, and the comparison group. Given its ubiquity, whiteness becomes invisible, and race becomes a label reserved for those categorized as the "other" or different (Bonilla-Silva, 2022; Feagin, 2013; Johfre & Freese, 2021). This framing is most evident in health disparities and inequities scholarship, where the field commonly characterizes differences between minoritized racial groups and non-Hispanic White Americans to document group-level variation in health outcomes. In public health research, White people are consistently used as the default comparison group (Bediako & Griffith, 2007). Consistent with criticisms of this approach (Bediako & Griffith, 2007; Bowleg, 2023; Griffith et al., 2024; Johfre & Freese, 2021; McCall, 2005; Sabik & Versey, 2023), we suggest that research focused on health and psychological disparities and inequities may be better served by naming and addressing the structural actors and fundamental causes that create disparities and inequities in the first place.

Why whiteness hurts population health and psychological outcomes

Critical Race Theory and public health

In 2010, Ford and Airhihenbuwa issued a call to the public health community to seriously consider the role of race and racism on health, stating that a failure to eliminate racism is a central barrier to health equity. To understand how racialized health disparities and inequities emerge, researchers must "discuss complex racial concepts and challenge racial hierarchies" by utilizing Public Health Critical Race Praxis (PHCRP) (Ford & Airhihenbuwa, 2010, p. 530). PHCRP tailors CRT to the needs of health researchers and practitioners by providing a framework that exemplifies how to move beyond the simple documentation of health inequities and move toward research and practice that explains and challenges the power structures and hierarchies that perpetuate

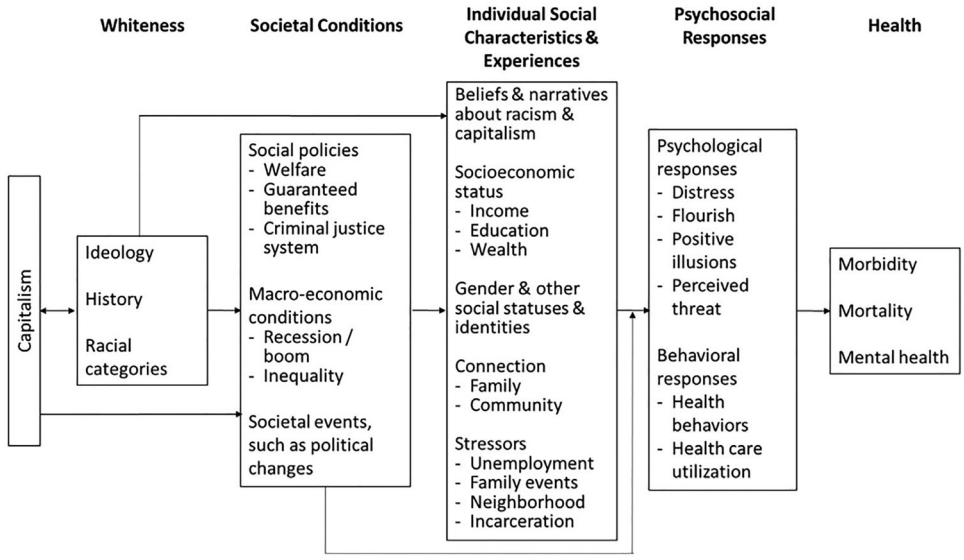

FIGURE 1 Malat et al. (2018) framework depicting how whiteness influences the health of White Americans. Reprinted from *Social Science & Medicine*, Vol 199, Jennifer Malat, Sarah Mayorga–Gallo, David R. Williams, The effects of whiteness on the health of Whites in the USA, p.150, Copyright 2018, with permission from *Elsevier*.

health inequity (Ford & Airhihenbuwa, 2010). Public health scholars and practitioners are now making widespread efforts to combat the wicked public health problem of racism (Came & Griffith, 2018; Ford et al., 2019; Jones, 2018), and additional research on whiteness would complement their endeavors.

Like the banality of racism, whiteness—if not named—becomes firmly entrenched as a feature of the social and cultural environment (Cogburn, 2019). Rather than solely investigating the effects of oppression and discrimination on marginalized populations, we contend that researchers should concurrently evaluate the mental, physical, and social health effects of supremacy and racial privilege for the socially dominant group (e.g., White Americans) and for society more broadly (e.g., the health of the democratic political system).

Whiteness and health framework

While it is widely established that whiteness and racism hurt the outcomes of minoritized populations, only recently have health scholars begun to acknowledge how whiteness hurts the mental and physical health of White people (Williams et al., 2019). To discuss whiteness as one racial concept that lacks attention in relation to health, Malat et al. (2018) developed a theoretical framework on the health effects of whiteness, examining how whiteness as a system has the potential to harm the health of White people. For example, for all the privileges afforded to White Americans, they experience lower life expectancies and poorer health compared to people in other rich nations (Woolf, 2023), suggesting that they are not as healthy as they could be. What explains this phenomenon? How can a system set up to benefit and privilege White Americans work against their health? In their conceptual framework (see Figure 1), Malat et al. (2018) detail a complex pathway

where whiteness yields disparate outcomes among Whites through beliefs and social policies that undermine Whites' health. The framework illuminates how whiteness can structure inequity at multiple levels: societal conditions, individual characteristics and social experiences, psychosocial responses, and ultimately, health outcomes (Malat et al., 2018).

Our paper expands on the whiteness and health framework, and research by others (e.g., Efird, 2021; Efird & Lightfoot, 2020; Ford & Sharif, 2020; Metzl, 2019; Versey et al., 2019), to further investigate the effects of whiteness on health and mental health among White Americans. Specifically, we highlight how the ideologies of whiteness can influence Whites' specific psychosocial responses (see Figure 1), and our unique contribution names how these ideologies can shape Whites' health, while simultaneously adversely affecting the health and function of society at large.

Whiteness and psychological responses

How whiteness impacts psychological states and mental health

Whiteness reconstitutes over time, shape-shifting to accommodate new dominant systems. Whiteness shapes ideology, a constellation of ideas and ideals that help explain and rationalize social order, through religion, nationalism, and scientific research (Bailey et al., 2021). As historians have shown, several groups who were immigrants when they entered this country (e.g., Irish, Italian, Eastern Europeans), became White Americans in subsequent generations in ways that Black Americans could not (Omi & Winant, 2014; Painter, 2010). The melding of a unitary White category serves dual purposes, allowing for both economic systems (e.g., capitalism) and racialized hierarchies to exist in tandem, depending on one another to flourish. According to one race scholar, "racism enshrines the inequalities that capitalism requires" (Melamed, 2015, p. 77).

The persistent quest for crafting boundaries of White citizenship and belonging infiltrates other systems of domination as well, such as religion. Gorski and Perry (2022), for instance, suggest that whiteness was constructed with and through religion. Early American Catholics were considered heathens and White Christians were championed for defending both the state and religious ideals against threats (typically racialized "others") (Gorski & Perry, 2022). Today, the intermingling of whiteness, religion, nationalism, and extremism is a clear example of the reproduction of whiteness through other ideologies that permeate national consciousness (Perry & Schleifer, 2022). And recent evidence suggests that the categories "White" and "Christian" are conceptualized by White Christians as overlapping (Al-Kire et al., in press). Therefore, as a system, whiteness traverses neat categorization (e.g., cultural, ethnic, religious, gendered) across the United States and globally.

Just as some scholars have maintained that race is a social construct, others claim that there are true biological differences between so-called racial groups. Quite simply, science has legitimized race, while simultaneously perpetuating whiteness through research. Our own field has a troubled history of defining intelligence, behaviors, and racial qualities according to skull measurements and other pseudoscientific theories, allowing scientific racism to flourish (Saini, 2019). Despite these histories, new opportunities for advancing critical perspectives where race, racism, and whiteness are examined are on the horizon (Ford et al., 2019; Homan et al., 2021; Neblett, 2023). Using several case examples, we interrogate how whiteness can influence psychological states and mental health among those who are racialized as White.

Case examples: Mechanisms of whiteness and the health of White people

Gun rights and suicide deaths

A critical examination of psychosocial responses to whiteness will expand our understanding of how White people also suffer under this inequitable system. For instance, gun ownership and gun rights are racialized in the U.S. society due to the system of whiteness. Throughout the U.S. history and in contemporary times, guns "have appeared as tools of White men's entitlement to use violence to protect the private sphere [and] to police the public sphere" (Garnar et al., 2022, p. 600). Racially resentful White Americans have a stronger tendency to associate guns with White (and not Black) people, and their support of gun rights fluctuates based on racial identity politics (Higginbotham et al., 2022). We must simultaneously recognize that white supremacist efforts to arm White Americans coexist with the reality that the majority (56.64%) of deaths by suicide in the United States are driven by firearms, and White men account for nearly 70% of all suicides in the nation (American Foundation for Suicide Prevention, 2022). Additionally, White men have the highest age-adjusted rate of firearm-related death by suicide in the nation at 15.8 per 100,000, while the overall age-adjusted rate of firearm-related death by suicide is 12.3 per 100,000 for men and 1.8 for women (CDC, 2021a). As such, whiteness amplifies racialized gun ideology and the concurrent crisis of gun-involved deaths by suicide among White Americans, and in particular, among White men.

Globalization and residential trends

A recognition of whiteness also allows us to see that racial demographic shifts that lead to a more diverse United States do not simply shape politics (Craig et al., 2018), they shape racial attitudes and can lead some White Americans to perceive that their social status is declining (Craig & Richeson, 2014; Parker, 2021). A perceived decline in relative racial group status is, in turn, associated with worsening mortality and increased deaths of despair among White Americans (Siddiqi et al., 2019). Moreover, a recent scoping review also reveals that perceived social status threat can harm White Americans' health in ways beyond mortality (Efird et al., 2023a). For example, some White Americans' self-rated health and mental health are adversely affected by perceived (or actual) threats involving societal conditions, interpersonal social experiences, and individual social standing (Efird et al., 2023a).

Kwate and Goodman (2014) present another way that whiteness yields negative implications for White people's health. They find that White people in the richest neighborhoods who believe that Black people are unwelcome experience worse health than their counterparts who perceive that Black people are welcome. Yet, in lower-income neighborhoods, Whites' perceptions of Black people as welcome does not confer health benefits and are associated with relatively worse self-rated health (Kwate & Goodman, 2014). Lower-income neighborhoods have relatively more Black residents than do the wealthiest neighborhoods; hence, perceiving Black people as welcome is concordant with local demographics. In this context, the authors posit that White people's perceptions of Black Americans as welcome may be related to poorer health because "the neighborhood environment upsets expected benefits stemming from whiteness" (Kwate & Goodman, 2014, p. 158). This study represents an example of how neighborhood or area-level effects provide additional, ecological (i.e., hierarchical) data that are important for measuring and assessing the effects of whiteness and related constructs (e.g., perceived discrimination) over and beyond traditional, individual measures (see Michaels et al., 2022).

Additionally, research on city- and regional-level gentrification indicates negative health impacts for lower-income residents *regardless of race*, suggesting that large-scale forces that contribute to gentrification (e.g., capitalism, austerity urbanism, globalization, neoliberalism, and income inequality) can harm lower-income White people as well (Anguelovski et al., 2021; Gillespie et al., 2021; Versey, 2022). As CRT scholar Harris explains (1993), "…whiteness does not confer immunity from disaster on all [W]hite bodies…poor and working-class [W]hites suffer greatly in all areas; the gap between them and wealthier [W]hites is profound, and, by all metrics, growing. "White," "poor," and "sick" are words that can and do converge" (p. 6). In other words, residential and economic racism against Black people can also hurt poor White people's health.

Social status discordance

Furthermore, racial ideologies intrinsic to whiteness and capitalism suggest that Whites ought to experience relative material and social success in comparison to racially minoritized groups, but this has the potential to harm White Americans' health when these expectations of privilege are unfulfilled (Efird & Lightfoot, 2020; Malat et al., 2018). Geronimus and colleagues' (2015) research on telomere length (an indicator of stress-mediated biological aging) among a racially and ethnically diverse sample reveals that poor Whites had shorter telomere length than non-poor Whites, yet this pattern was not present among Black Americans or Mexican Americans (Geronimus et al., 2015). For poor White Americans, economic disadvantage is contrary to the expectation of white privilege, and over time, these unmet expectations may translate to adverse health outcomes (Geronimus et al., 2015). Moreover, we contend that these harmful ways that whiteness affects White Americans' health can subsequently harm society and the democratic political system more broadly.

Whiteness and the health of society

We previously discussed how whiteness can compromise White people's health and psychological well-being. Here, we outline how ideologies rooted in whiteness can negatively affect the health and well-being of society at large.

Case examples: How whiteness impacts Whites' health-related beliefs, behaviors, and attitudes

COVID-19 pandemic

The COVID-19 pandemic has laid bare how illness can exacerbate social inequality (Thrasher, 2022), and in particular, how whiteness can hurt the health of society more broadly. For example, racist and xenophobic rhetoric—ideologies intrinsic to whiteness—about SARS-CoV-2 resulted in negative health and societal effects (Bonilla-Silva, 2020; Perry et al., 2020). Former President Trump's early references to "the China virus" and the subsequent increase in hate crimes against Asian, Asian American, and Pacific Islanders (AAPI) are well established, as are the negative health repercussions for the AAPI community (Daniels et al., 2021; Dai & Levine, 2022; Le et al., 2020) and other minoritized racial groups (Chae et al., 2021). Another emerging pandemic theme is how whiteness likely exacerbated the effects of the pandemic both in the United States and abroad.

Although COVID-19 is an airborne virus, many White Evangelicals in the United States were resistant to masking at the onset of the COVID-19 pandemic (DeMora et al., 2021). Furthermore, learning about the disproportionate negative impact of COVID-19 on racially minoritized groups reduced White Americans' support for safety precautions (Skinner-Dorkenoo et al., 2022). In fact, more negative racial attitudes (greater modern racism) among Whites predicted fewer health protective attitudes and behaviors in the United States and Brazil (Miller et al., 2023). In Brazil, perceiving racial disparities in COVID-19 also led to less support for public health measures (Miller et al., 2023). These findings are consistent with research revealing that increased racial diversity and increased mortality salience reduce support for equitable health policies (Jimenez et al., 2022). Together, this research suggests that prioritizing White lives leads to attitudes and behaviors that ultimately deprioritize health measures and likely exacerbate illness and death.

White Christian nationalism

Furthermore, we assert that the increasingly prominent ideology of White Christian nationalism is wrapped up in whiteness and has the potential to harm democracy, civic life, and health. Christian nationalism is described by Whitehead and Perry (2020) as a belief system that "includes assumptions of nativism, white supremacy, patriarchy and heteronormativity, along with divine sanction for authoritarian control and militarism. It is as ethnic and political as it is religious" (p.10). Christian nationalism is the belief that the United States is and ought to be a White Christian nation, and it is thus enmeshed with White racial identity and driven by white supremacist attitudes (Gorski & Perry, 2022). In fact, Christian nationalism is a stronger predictor of racist and xenophobic attitudes than is political orientation or is religious attendance (Whitehead & Perry, 2022), so we argue that Christian nationalism is driven by whiteness.

Christian nationalism has implications for social and democratic health. Its characteristic authoritarian drives are at odds with democracy, as is the interest in preserving power for the ingroup (e.g., White Americans, Christians, men) at the expense of outgroups (e.g., racially minoritized groups, non-Christians). This embrace of whiteness includes a perception that particular forms of violence are "righteous" if they are working toward the cause and may help explain why many White Evangelicals in the United States ironically describe themselves both as "pro-life" and as "progun" (Cromer & Bjork-James, 2020). Furthermore, Christian nationalism was a key ideology motivating the January 6th insurrection at the U.S. Capitol, where rioters attempted to overturn the 2020 presidential election results (Edsall, 2021). Christian nationalism is also associated with other antidemocratic values, such as the desire to restrict voting access (Gorski & Perry, 2022). Because free and fair elections are a hallmark of a healthy democracy, these examples demonstrate how whiteness hurts the health and social functioning of society more generally.

Thus far, we have explained how and why psychosocial responses and ideologies are related to whiteness, and subsequently, affect population health and well-being. Yet, psychological research has traditionally investigated White Americans' beliefs, attitudes, and behaviors without considering how these factors exist within the broader sociopolitical context of whiteness. To take the field further, and improve the health and well-being of society, more researchers must learn to discern how whiteness ultimately influences policy.

Case example: How whiteness interacts with health policy

In psychology, we recognize that health and development are shaped by the physical, social, and cultural dimensions of an individual's environment and personal attributes (e.g., behavior

patterns, psychology, and genetics) (Bronfenbrenner, 1979; Stokols, 1996). Stokols (1996) notes that the same social environment can have differential effects on health and well-being because of other factors like one's financial or material resources. From the social determinants of the health perspective, one's social environment encompasses the socioeconomic and political contexts (e.g., governance, macroeconomic policies, social policies, public policies, culture and societal values) that are present where people are born, live, work, worship, play, and age (Solar & Irwin, 2010). As such, we consider how the system of whiteness itself does not homogeneously distribute privileges and experiences among all White Americans within the same social environment. Below, we illustrate how particular subgroups of White Americans (e.g., high-income and low-income) can disparately experience a health policy (e.g., Medicaid expansion), even though they may exist within similar social environments.

Medicaid expansion

Let us consider how whiteness influences some White Americans' views and experiences related to Medicaid expansion. The Obama Administration's Patient Protection and Affordable Care Act of 2010 was intended to expand Medicaid coverage to all individuals whose income was below 138% of the federal poverty line, yet the U.S. Supreme Court ruled in 2012 that key decisions about the implementation of healthcare reform should be left in the hands of individual states (CMS, 2022; Jacobs & Callaghan, 2013; KFF, 2023). Since that time, many majority-Republican states have refrained from expanding Medicaid (Hertel-Fernandez et al., 2016; Shepherd, 2022). Research consistently demonstrates that White Americans associate needs-based social programs, such as Medicaid, with people of color (Efird, 2021; Gilens, 1996; Snowden & Graaf, 2019) and many White Americans remain avidly opposed to Medicaid expansion (Fiscella, 2016; Grogan & Park, 2017; Jardina, 2019; Metzl, 2019). Fueled by whiteness, hostility toward people of color "encourages Whites to reject policies designed to help the poor and reduce inequality" (Malat et al., 2018, p.151). Yet, expansion would likely benefit the White American collective, given that Whites comprise the majority of Medicaid users (KFF, 2022). Furthermore, White American opposition to health-promoting social programs is paradoxical, given that Whites in the United States generally have relatively worse health than Whites in wealthy nations where universal health care is available (Malat et al., 2018; Woolf, 2023).

Additionally, the same social environment (e.g., lack of Medicaid expansion within a state) is experienced differently for White Americans based on individual-level factors, such as their socioeconomic status, employment status, or overall health status. We posit that wealthier Whites are potentially unimpacted by some Republican-led states' decisions to snub Medicaid expansion (Fording & Patton, 2019), while lower-income Whites could experience negative health outcomes in nonexpansion states because they lack the financial or social resources needed to access and utilize healthcare services (Grogan & Park, 2017; Michener, 2021). Beyond income or socioeconomic status, Whites in these states may experience the effects of nonexpansion differently based on their gender identity or expression, sexual orientation, age, ability status, or geographic location. White people—like other socially constructed racial groups—are not a monolith, thus, White Americans do not uniformly experience the social context of living in a nonexpansion state.

As more psychologists recognize, name, and research whiteness as an underlying determinant of variations in White Americans' beliefs, attitudes, and behaviors, we will be able to target and address the specific ways that whiteness influences the psychosocial and behavioral responses that influence Whites' health and impact society and public policy.

Advancing psychological research on whiteness

There are two schools of thought about how to best address whiteness. Abolitionists propose abolishing (destroying) whiteness, rearticulating human histories, and reframing how Whites experience themselves and their relationships to a variety of contexts and spaces marked by the global majority (i.e., Black, Indigenous, and other people of color). Using the Irish in the United States as a case study, Singley (2002) and other race scholars describe how the Irish learned the norms associated with approximating whiteness in this country and adapted their behavior accordingly. Essentially, the Irish became White. On the other hand, Thandeka (2000) proposes a reconstructionist approach to unlearning whiteness, first by making whiteness visible, and second, by understanding how White people learn to be White. Evaluating how to undo whiteness becomes a critical point for intervention, consciousness raising, and additional theorizing of CRT in developmental psychology and identity studies generally, since most research in both areas lack serious attention to the development of a White identity, and what it means for establishing normative whiteness—practices, norms, cultures, and policies that center whiteness as the default. Though solution-driven approaches to addressing whiteness in our field are complicated, and likely messy, they are also necessary for addressing how whiteness shapes physical and mental health. We also presented examples that show how racial capitalism is linked to health and deaths of despair for the U.S. residents racialized as White, as other scholars have detailed (Hansen et al., 2023; Metzl, 2019; Siddiqi et al., 2019). To this end, we draw from emerging work in the field of public health as well as framings from psychology to move beyond describing whiteness, outlining how psychologists might become more attuned to whiteness, its impact, and how it affects health outcomes and harms all of society.

Psychologists are uniquely equipped to investigate the complex ways that whiteness shapes beliefs, attitudes, behaviors, and subsequent health outcomes of White Americans. Primarily, social psychology is grounded in the assumption that social forces influence individual behaviors (Bordens & Horowitz, 2001). Lewin (1935) demonstrated that behavior is a function of the interaction of any given social situation and an individual's characteristics. Thus, we must consider how the social situations created by whiteness can influence White Americans in potentially disparate ways, given specific individual characteristics (e.g., gender identity, class status, age, religion, political affiliation). In addition to our field's proficiency in the theoretical foundations of behavior, psychologists possess a robust history of measuring complex, social phenomena. We may not be able to fully abolish whiteness, but we can follow Powell's (2000) calls to "interrogat[e] the dominant discourse of the White gaze while challenging the material conditions that support it" (p. 464). Psychologists can advance the trajectory of research on whiteness, but we must also actively divest from the ways that whiteness operates within our field. While our recommendations are not exhaustive, below we offer suggestions for how to confront whiteness and conduct research that addresses and counters its deleterious effects.

Addressing whiteness in future psychological research

Scholars in decolonial psychology call for continual disruption and interrogation of assumptions of truth, objectivity, the construction of knowledge, and understanding of worldviews (Adams et al., 2015; Adams & Estrada-Villalta, 2017; Fanon, 2004; Fernández et al., 2021). We believe such an approach could be useful to frame future research on whiteness, racial stratification, and racism

in psychology. The overreliance and embeddedness of Eurocentric thinking and White-centered science in our field have resulted in a psychology that reflects the narrow interests of a privileged minority of people (mostly racialized as White) in the WEIRD (Western, Educated, Industrial, Rich, Democratic) world (Henrich, 2020; Henrich et al., 2010), while neglecting the lived experiences of the global majority (i.e., Black, Indigenous, and other people of color) (Gichane & Wallace, 2022). Moreover, psychological research, teaching, and training programs insist on perpetuating these trends, while work focused on understanding, uncovering, and dismantling racism (and whiteness) has been marginalized, disparaged, and delegitimized as "ideological" and "activism" (Roberts et al., 2020; Roberts & Mortenson, 2023). To advance our field and develop new ways of thinking that meet the challenge Fanon (2004) identified decades ago, psychologists must actively acknowledge whiteness, engage with it as a real construct, study, and measure it.

Fortunately, some efforts (including this special issue on CRT) are already underway. In non-WEIRD scholarly circles, for example, conferences, special convenings, edited volumes, and journal publications suggest a possible decolonial turn (Adams et al., 2008; Adams et al., 2015; Adams & Estrada-Villalta, 2017; Adams & Salter, 2019; Carolissen & Duckett, 2018; Dupree & Krause, 2022; Fernández et al., 2021; Malherbe et al., 2021; Montiel & Uyheng, 2022; Readsura Decolonial Editorial Collective, 2022). These efforts indicate a willingness to engage with the reality of whiteness and race in psychology and suggest that a paradigm shift focused on interrupting colonial legacies (vis-à-vis examining notions of whiteness) can strengthen our understanding of power and how disparate power relations create the psychological responses and inequities that we study. As psychologists, we contend that decoloniality is an essential epistemic and ontological process and practice for addressing whiteness.

Other scholars have offered suggestions for decolonizing the field of psychology (e.g., Adams et al., 2015). To these efforts, we would add the following areas for theoretical consideration and filling knowledge gaps about whiteness specifically: (1) naming whiteness; (2) prioritizing CRT-informed research methods; (3) implementing CRT-informed training; and (4) measuring components of whiteness.

Naming whiteness

From a psychological perspective, demarcations of difference (e.g., dominant and subordinate group status) can serve as a proxy for power and social privilege; if left unchecked, group characteristics become entrenched in persistent mental stereotypes and legitimizing myths (Pratto & Stewart, 2012; Roberts & Rizzo, 2021; Sidanius et al., 1992; Sidanius & Pratto, 1999). Yet somewhat paradoxically, much of this work has not been applied to the study of whiteness or racial hierarchies in psychological research specifically (for an exception, see Zou & Cheryan, 2017). Moreover, research by scholars studying whiteness and White identity has all but been erased or relegated to the margins of the field (Fox et al., 2009; Prilleltensky, 1989). For instance, Fanon (1952) frames whiteness, colonialism, and power as key drivers of anti-Black racism, yet his texts and writings are seldom mentioned in contemporary framings of race research in psychology.

The absence of a discussion of whiteness in our field is, in fact, a marker of its whiteness. As Farr (2004) puts it, "there is no White perspective but only the universal, impartial, disinterested view from nowhere.… Whiteness becomes visible in the very absence of a serious consideration of the problem of race" (p. 154). If psychologists continue to allow whiteness to flourish in our discipline without interrogating it, we are complicit with a psychology that embraces White ways of knowing, theorizing, evaluating, and teaching. While whiteness studies are growing, the

construct has not received significant attention by psychologists until recently (Coleman et al., 2021; Collins & Watson, 2021; Ferguson et al., 2022; Fine et al., 2004; Karras et al., 2021; Remedios, 2022; Salter & Adams, 2013; Teo, 2022; Tyler et al., 2022).

Naming structures and processes that contribute to discrimination and disparate outcomes is central to CRT studies. Legal scholars have shed light on interlocking systems of oppression by examining legal claims, identity categories, social movements, and engaging in critical scholarship (Collins & Bilge, 2016; Crenshaw, 2011; Delgado & Stefancic, 1992). Naming whiteness as a driving force behind psychosocial responses and health outcomes (particularly among Whites) will enable researchers to more clearly articulate the harms of whiteness and racism for society more broadly. Divesting from whiteness should be a central goal for psychological studies and academia generally; doing so facilitates research that pushes our field beyond the WEIRD world, the study of the intrapersonal (without social context), and recognizes how systemic forces shape outcomes for society at large. This work will also illuminate what we lose when we fail to empirically address whiteness, as current efforts in psychology to further antiracist pedagogies, research, and practice have largely stalled (Roberts & Rizzo, 2021).

Prioritizing CRT-informed research methods

Research designed with the intent of understanding any psychological phenomena expected to vary across diverse populations can and should be informed by CRT (Bowleg, 2017; Cole, 2009). Cole (2009) reminds us that *all* psychologists—not only those concerned about race—should reflect on our assumptions and the constructions of difference at each stage of the research process. The study of structural racism and intersectionality (via intersectional methods) remains a growing and fruitful area for future health equity research (Agénor et al., 2021; Bowleg, 2019; Del Río-González et al., 2021; Griffith et al., 2021; Landers & Bowleg, 2022; Richardson et al., 2021). While there is complexity concerning which research methods best capture intersectional phenomena, there are promising and pragmatic examples of how to effectively use intersectional and antiracist methods within this special issue (Carbajal et al., 2024; Sheppard et al., 2024; Vargas, 2024).

Futhermore, qualitative methods and mixed-methods show how attending to participant experiences and within-group heterogeneity can deconstruct assumptions about psychological phenomena, facilitate critical pedagogy, aid knowledge production, and complicate basic comparative research (Causadias et al., 2023; Cho et al., 2013; Cuádraz & Uttal, 1999; Reyes et al., 2022; Rosenthal, 2016). As Bediako and Griffith (2007) illustrate, "…assessing the health outcomes of racial minority groups by comparing them to a racial majority standard is valuable for identifying and monitoring health inequities, but may not be the most effective approach to identifying strategies that can be used to improve minority health outcomes" (p. 51). Moreover, we currently lack empirical evidence about *how* mechanisms that comprise whiteness disparately affect the mental and physical health of White Americans. We know that there are differences in the ways mental health is experienced for White Americans across class status (Cooley et al., 2020; Kwate & Goodman, 2014), gender (Bey et al., 2018), and geographic location (Efird et al., 2023b). Yet, data are lacking about the causal mechanisms that facilitate these differences. We must illustrate *how* these within-racial group variations map on to specific mental and physical health outcomes for White Americans, and psychologists are well-equipped to design and validate tools researchers need to systematically investigate the health and social effects of whiteness. While a critical race psychology is "not yet born" (Adams & Salter, 2019, p. 135), the future of a decolonized and equitable

psychological science lies in the potential leveraging of CRT methods (especially intersectionality) to elucidate social structures alongside psychological mechanisms that help uphold and perpetuate whiteness (Buchanan & Wiklund, 2020; Cole, 2009; Grzanka et al., 2020; Overstreet et al., 2020; Rosenthal, 2016).

Implementing CRT-informed training

The need to train future psychologists to recognize whiteness (e.g., incorporating whiteness theory and CRT within the standard psychology curriculum) is critical to ultimately deconstruct and decenter whiteness in the field (Fuentes et al., 2021). Institutional change is inherently slow; however, critical research praxis harnessing community resources, partnerships, and knowledge (e.g., Cook et al., 2022; Fleming et al, 2023) and antiracist pedagogical methods (e.g., intersectional teaching, decolonizing syllabi, and addressing positionality) combined with pressure from academicians can accelerate radical, transformative change (Adkins-Jackson et al., 2022; Grzanka, 2020; Merino, 2018; Overstreet et al., 2020; Sabik, 2021; Secules et al., 2021). Others (Starck et al., 2024; Trawalter et al., 2024) provide important reminders about CRT's tenets concerning interest convergence. According to Bell (1980), racial equity is unlikely if the interests of the minoritized group do not align with the interests of the majoritized group (i.e., the group who holds the power). In other words, our field must also acknowledge and address how White American psychologists (e.g., the majoritized group) play essential roles in promoting (or impending) efforts to deconstruct whiteness. Using more CRT-informed pedagogy within our training programs stands to promote the development of future psychologists (of all racial and ethnic backgrounds) who have a well-developed understanding of whiteness and how it operates. As such, an explicit recognition of whiteness—and its harmful effects on health and society—raises a number of important questions that the field of psychology is aptly suited to address.

Measuring components of whiteness

Psychology provides the unique ability to assess psychological processes to understand whiteness. We contend that more scholars in our field should evaluate the components of whiteness that create oppression and discrimination in the first place, as well as the impact of these tools for individuals and society (e.g., Byrd et al., 2021). First, we need a more comprehensive understanding of variations in White identity, and what motivates those differences. Interestingly, demographic differences (e.g., gender, friendships with people of color) among White Americans are associated with meaningful variations in Whites' racial attitudes (Parigoris et al., 2024). Therefore, it would be helpful to determine which social and demographic characteristics are most highly correlated with White identity. In particular, how do characteristics, such as religious affiliation, class status, gender identity or expression, place of residence, or political affiliation relate to White identity? While some of these issues have been explored (Efird, 2021; Jardina, 2019; Scott, 2022), scholars still lack knowledge regarding how these potential variations might be associated with White Americans' specific health outcomes.

Psychologists can create validated scales to systematically investigate *how* whiteness shapes White Americans' health. For example, we know that White Americans can exhibit a conservative shift in their political views when they perceive that their majoritized group status is threatened (Craig & Richeson, 2014), and this perceived threat can influence worsening morbidity and

mortality among White Americans (Siddiqi et al., 2019), but we do not have a comprehensive understanding of all of the components that precipitate this threat response (Efird et al., 2023a). Relatedly, we know that folk economic beliefs (e.g., whether one views the U.S. economy as a zero- or non-zero-sum system) can shape how White Americans respond to the potential "threat" of a majority-minority population shift (Perkins et al., 2020), but it is unclear which underlying factors (other than folk economic beliefs) facilitate perceptions of threat for some Whites, but not for others. Psychological concepts, such as social dominance orientation (Sidanius & Pratto, 1999) and loss aversion (Eibach & Keegan, 2006), may help clarify *why* social change is so terrifying to White Americans. Specifically, White people tend to see race relations as being in zero-sum competition, such that they interpret gains for Black people as losses for Whites (Norton & Sommers, 2011; Wilkins & Kaiser, 2014; Wilkins et al., 2015; Wilkins et al., 2016). Importantly, understanding these processes helps us consider how to intervene.

Furthermore, we do not know exactly how this misperception of losing majoritized or dominant group status influences individual-level mental and physical health for White Americans (Efird et al., 2023a). Developing more tools that quantify the components of whiteness would enable researchers to document the specific health effects of whiteness for White people. As experts on measuring perceptions, beliefs, and attitudes, psychologists should consider collaborations with other social scientists to systematically investigate how potential within-racial group variations among White Americans map on to specific mental and physical health outcomes. Ultimately, understanding the health effects of whiteness for White Americans could support interventions and policies that promote health equity for *all* people.

CONCLUSION

By cultivating a deeper understanding of whiteness within the field of psychology, we can conduct research that accounts for the nuanced ways that macrolevel systems affect White Americans' mental and physical health, beliefs, and attitudes, which ultimately impact the health and well-being of both White Americans and racially and ethnically minoritized populations. By documenting the negative effects of whiteness, we encourage divestment from the "constructions of reality" (Salter & Adams, 2013, p. 787) that yield inequitable distributions of power and privilege, and subsequently, harm the health and well-being of our society. Once psychologists recognize whiteness, we will be better equipped to confront it and develop effective interventions and policies that reduce the inequity that whiteness produces. Finally, psychologists must actively divest from systems of whiteness within our field, otherwise, we are complicit in the multitude of ways that whiteness hurts society.

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The authors declare no conflicts of interest.

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Caroline R. Efird is a Postdoctoral Fellow in Health Justice Research at the Racial Justice Institute at Georgetown University. Her interdisciplinary, community-based, and mixed-methods research investigates the health effects of whiteness. Dr. Efird completed her Ph.D. and MPH at the University of North Carolina at Chapel Hill Gillings School of Global Public Health in the Department of Health Behavior, and she also holds a B.S. in Elementary Education from Appalachian State University. As a White American woman and first-generation Ph.D. who was primarily socialized in the rural U.S. South, Dr. Efird has benefitted from sys-

temic white supremacy throughout her life course. To complement the important research that addresses the negative effects of structural racism for racially and ethnically minoritized populations, she is compelled to critically examine whiteness and the fundamental injustices and health inequities that are associated with racialized inequality. Overall, her research seeks to deconstruct the inequitable systems that replicate oppression and supremacy so that researchers, community members, and policymakers can effectively promote health equity.

Clara L. Wilkins is an Associate Professor and holds the Earl R. Carlson Endowed Professorship in the department of Psychology at the University of Washington. She completed her Ph.D. and M.S. at the University of Washington and her B.A. with honors at Stanford University. Dr. Wilkins' research examines prejudice, stereotyping, and the self. She explores how social change (e.g., racial and gender progress) affects high-status groups' perceptions of victimization. She also examines how within-group variation in racial and ethnic minorities' physical appearance shapes stereotyping and identification. The overarching goal of her work is to understand social inequity in order to minimize its negative effects on individuals, groups, and society. These interests are informed by Clara's experiences navigating both privileged and minoritized spaces. As the daughter of Black American father and Mexican immigrant mother, she became aware of how race, nationality, language, education, and other identities shape stereotyping and discrimination.

H. Shellae Versey is an Assistant Professor of Psychology at Fordham University, and leads several projects exploring the intersection between race/racism, gender, housing, and place. Within psychology, she examines lifespan development, aging, health, and intersectional-identity among Black women using a variety of mixed methods. Dr. Versey is a cisgender, able-bodied, second-generation college-educated Black woman from the American South. These identifications impact her view of the world, her "critical" approach within the academy, and relation to whiteness. Previously, Dr. Versey was a postdoctoral fellow at the Institute of Health, Health Care Policy and Aging Research, and she earned her Ph.D. from the Department of Psychology at the University of Michigan. She also holds degrees in Public Health and Epidemiology from Columbia University (MPH) and the University of Michigan (M.S.).