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Mental Health's Blind Spot

Decades of research on the effects of racial bias on mental illness have systematically ignored antiwhite hatred.

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In recent years, mental health in America has been a growing concern. But even as awareness has grown, many practitioners overlook important issues. Much of this is related to the field's political bias, which leads researchers and therapists to ignore entire clinical populations. One example involves race. Left-leaning researchers have spent decades focusing on racial bias as a contributing factor to mental illness, but their research has ignored bias and belligerence directed toward whites.

Our culture is uncomfortable talking about antiwhite aggression. Some of this is understandable. In the public mind, concerns about anti-white hate are linked with white nationalism and other forms of extremism. But all forms of racial hatred are abhorrent, and confronting anti-white hate doesn't imply hostility toward any other racial group.

Antiwhite behavior manifests in many ways—violent attacks (including assault and rape) motivated by racial animus, bullying at school, insults, harassment, discrimination, and racially demeaning trainings at the workplace. Other examples include university courses that malign whites, and sometimes the news media's rush to judge white people accused of racism, without sufficient evidence.

My experience as a therapist tells me that these are not isolated anecdotes. A few years ago, I provided therapy for a young heterosexual white man that focused on anxiety, anger, and relationship issues. We talked about his family history and his current life. Then, more than a year into the treatment, he told me that he had experienced pervasive racially charged bullying at both his elementary school and his high school. The bullying included insults, harassment, and some fights. Much of it was explicitly racial, including comments like "white faggot" and "white bitch." It's unclear why no one at the schools did anything. He said that he had held back from telling me about it in part because he worried that I would frame him as privileged or "just not get it"—reactions he had experienced in the past from his friends.

An avalanche of feelings emerged. He had grown so used to keeping this experience buried that he became numb to it. Over time, it also became clear that he was in some ways more upset at the current cultural attitudes about race than about the bullying he had endured. He saw traces of his experience with bullying in current cultural dynamics: the racially insulting language like "toxic whiteness," and the inability of the

culture to express concern for white people who were attacked. As we talked, he started to formulate his experience and find his voice. I could see him become more relaxed, more reflective, more open, authentic, and assertive.

Other victims aren't so lucky. In response to attacks, some people develop PTSD. Others repress their experiences, leading to alcoholism, depression, paranoia, or anxiety. Some lose faith in racial equality and become radicalized; others internalize the hatred and take on a fanatical devotion to DEI ideology.

Unfortunately, DEI ideology provides a rationale for antiwhite hatred (and for ignoring it), with its insistence that racial aggression directed at white people "isn't racism." This leaves targets of these attacks unsupported and isolated. Like my client, many fear talking about their experience because they assume others will invalidate their concerns or side with their attackers.

Our knowledge of the problem is, admittedly, limited. Research into the psychological damage caused by racial aggression toward other groups is extensive. But there's almost no empirical literature—case studies, treatment modules, theoretical papers, and so forth—that empathically explores aggression against white Americans. I am aware of no trainings about this topic, and I know of no therapists or clinics specializing in it.

Most researchers seem to insist that antiwhite hate matters less than other forms of racial aggression. They argue that the victims of these attacks "have privilege," so their suffering is less important. Some privilege: an inability to get support and a widespread refusal to acknowledge their experience or address the dynamics that created it.

In my clinical work, I've found that targets of antiwhite hate seem to lack a kind of psychological immune system to respond effectively. Because white people were a large majority in the U.S. for so long, they don't have cultural tools and frameworks to respond to attacks. It can take them a long time to understand what happened, contextualize it, and learn to stand up for themselves assertively and non-hatefully.

Often, they do this alone. Victims of these attacks have nowhere to go. Friends, coworkers, employers, and teachers often minimize their experiences or frame them, again, as "privileged." Even family members can respond poorly: making demands that victims prematurely forgive unrepentant attackers, speaking about it approvingly as racial comeuppance, or just ignoring it. Institutions like the media systematically disregard it.

On top of this, too many therapists have become DEI-style activists, eager to accuse their clients of racism and sexism. Many believe that politicizing therapy sessions is a moral imperative. These therapists are probably more likely to work at clinics that focus on hate crimes or racial justice. If they aren't careful, clients who have experienced antiwhite aggression could end up seeing a therapist with these views.

How bad is the bias against addressing this issue? Look at the Racial Trauma Scale, published in an American Psychological Association journal in 2022. It's a questionnaire for assessing racial trauma, designed explicitly for nonwhite victims. Item 38 of the questionnaire asks participants how much they are "avoiding white people" in response to their attack. This question seems to presuppose that the attacker is always white. The ideology in academia is thick. Even worse, when therapists are trained at universities where DEI is pervasive, there's a high probability that they will misunderstand, judge, avoid, or shut down aspects of these client's thoughts and feelings—material central to the therapeutic process.

Granted, few people make explicit arguments that antiwhite racial aggression is acceptable. Many psychologists are aware of the problem but resist speaking out. Some have told me that they worry about being harassed, fired, or blacklisted.

Mental-health professionals' abandonment of these clients is a scandal. If universities and the mental-health establishment refuse to address this problem, we need new organizations that will do so. Research, training for professionals, and clinical services are a good place to start. Over the long term, these issues need to be addressed at a broader institutional and sociocultural level.

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