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On Stop Telling Women They Have Imposter Syndrome

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I first learned of "imposter syndrome" as junior in high school. I was in my 3rd year at the primarily white and extremely privileged Phillips Academy, and had been selected as a 2020 "Cand MD Scholar." This award tasked me with a summer research project of my choosing that I would ultimately present to support the campus' Community and Multicultural Development. I asked one of a handful of women of color in the faculty to act as my advisor. I had set up a meeting with her to discuss summer deadlines, but it quickly became a much more personal conversation. It began with me airing my grievances: my peers were either geniuses, filthy rich, or both, and I was just miserable. The conversation concluded with a diagnosis, so I scheduled sessions with the school counseling center.

This article, *Stop Telling Women They Have Imposter Syndrome,* defines the condition to be "loosely defined as doubting your abilities and feeling like a fraud." It also highlights that this condition is more common in high-achievers, and it was originally developed by psychologists studying high-achieving (white) women. As a concept, imposter syndrome defines the experience of high-achieving women to be rooted in internal conflict. It is an innate inability of even the most successful and respected (like Michelle Obama) to accept their success and move past a debilitating self-doubt to truly thrive in their work.

I found similar background information when I looked the term after talking to my advisor. It resonated with me greatly. As a student on full financial aid, I knew I didn't belong among the next generation of the 1%; knowing this only emphasized the gap between my upbringing and all of my peers' resources. I believed that my token acceptance was simply a component of the school's cultural competency curriculum – that my matriculation was not legitimate. I felt like an imposter. I found comfort in knowing most women struggled with similar feelings, and this motivated me to overcome it. I now understand this feeling to be a lack of confidence. I turned to counseling where a medical

professional confirmed that I needed help with my mental health and further legitimized the idea that my imposter syndrome was inhibiting me from thriving in school.

I wonder how things would have changed if I had read this article back then, because as empowering as it was to finally have my experience validated, imposter syndrome pathologized my experience of marginalization so that it was my fault – and my burden. I remember the emotional labor of scheduling counseling sessions and making time for various subsequent appointments – I still felt like an imposter, and I was even more tired than usual. I was aware of my social positioning as a minority on campus and the intricacies of my navigating of privileged spaces, but imposter syndrome taught me that the issue was *me*. Emphasized was my delusion rather than the lack of support for the intentional diversity the school boasted in its admission statistics. This article points out this exact problem by questioning the biases behind imposter syndrome and how it has become a tool for corporations to blame marginalized employees instead of accommodating for a truly multicultural workplace.

The article analyzes the term "imposter syndrome" itself to showcase both (1) the criminality coded in the word "imposter" and (2) how "syndrome" carries historical undertones of sexist conditions like "female hysteria." Women in the workplace are being told that they collectively suffer from this condition due to their gender. Any feelings of marginalization or disillusionment that are normalized (not pathologized) in their male coworkers and tied to microaggressions constantly undercutting their performance is understood to be monocausal, based in their crippling self-doubt. Here, corporate workplaces love to step in to acknowledge these feelings and affirm that they are a direct consequence of imposter syndrome by providing various resources to "support women who suffer the condition."

As the article shows, questioning the role of employers in encouraging women to manage their imposter syndrome reveals that it is much simpler to tell women they are the problem than to dismantle the various biases constantly diminishing them. The workplace holds the same ideals as the rest of society: a white, cis-gendered, heterosexual man. Standards coded with white supremacy and patriarchy present in various ways, but the concept of "confidence" is centered in this article: "The same systems that reward confidence in male leaders, even if they're incompetent, punish white women for lacking

confidence, women of color for showing too much of it, and all women for demonstrating it in a way that's deemed unacceptable" (Tulshyan, 111). Displayed here is the valuing of white male confidence as synonymous to competence as well as the maintained social perception of women as inferior to men and naturally so.

Living in an oppressive society is affecting women's performance, livelihoods, and health. Not only are they are being blamed for the marginalization they feel, but in diagnosing them with "imposter syndrome," society veils how it has fallen short of achieving the inclusive diversity it "strives for" today. The workplace is still centering the same historical values that have always oppressed marginalized populations. Women, especially women of color, are not in workplaces built for them or in spaces cognizant of the multitudes of their personhood. They are not set up to succeed in the same way white men are and are also targets of discrimination. Their experience is then met with paternalistic diagnosis of "imposter syndrome" where they are essentially told to stop doubting themselves and to pull themselves up by their bootstraps. Once again, society is recognizing oppression but not holding the oppressive systems accountable.

In the context of our textbook, the phenomenon of imposter syndrome firstly ties into the epidemiological transition. As a society marked with great improvements in infrastructure and diplomacy (among other things), we have moved from shorter lives ended by acute illness to aging, chronically ill populations (Weitz, 11-13). Imposter syndrome or discussion of how it relates to overlying power structures would not be possible or prioritized in the past. Today, this article is pointing out how this condition exacerbates structural violence that has always been inflicted upon marginalized populations (Weitz, 88-90).

Looking at the story of Talissa Lavarry that introduces the article, one can see how stressful it is to be a woman in the workplace. The allostatic load of existing as a woman of color is huge and detrimental to one's health. This racialized and gendered impact of stress mirrors how acute illnesses once rampaged more vulnerable populations made up of women, people of color, and the poor (Weitz, 142-144). Someone like Talissa Lavarry does not have to fear influenza because of poor living conditions, but

imposter syndrome and the factors that encourage it caused her mental health to plummet and even triggered suicidal thoughts. The chronic stress she faced is sure to have lasting impacts on her health.

Drawing parallels between Lavarry's experience and Christina Crosby's writing displays the importance of a sociological perspective in combatting the tunnel vision induced by a medical model of illness/disability. Crosby's memoir, "A Body Undone," places her personal experiences within interrogations of the social construction of disability. She writes, "Disability is created by building codes and education policy, subway elevators that don't work and school buses that don't arrive, and all the marginalization, exploitation, demeaning acts, and active exclusions that deny full access and equality to 'the disabled'." (Crosby, 6). Crosby became a quadriplegic after trauma sustained in her biking accident, but that does not make her disabled. What she is arguing is that in a society where quadriplegia is normalized in infrastructure and education, she would not be considered disabled. In her own book, "Confessions from Your Token Black Colleague," Lavarry reflects on her experience with imposter syndrome to realize that it was repeatedly facing systemic racism and bias rather than lacking self-confidence that limited her. In both cases, complete acceptance of socially constructed labels of disability or imposter syndrome veils bigger things like ableism and racism at play. Demonstrated again is the efficacy of imposter syndrome at shifting focus from oppressive systems to problematically individualize a social problem.

Unlike other examples of medicalization based on racist, sexist, and capitalist agendas, there are no clear ties between imposter syndrome and the drug industry, or a specific prescription for treatment. I was directed to my high school's counseling center, which shows the level of privilege I have – such access to mental health services is not common in communities of color and/or lower socioeconomic status. This lack of a market for medical intervention, however, speaks volumes about the issues of power and biases involved.

Returning to Lavarry, her diminished productivity and accompanying demotion did not ring any alarms even though it was in stark contrast with the competent employee she had already proved herself to be. The coworkers who bullied her had no qualms about doing so and bystanders did not have a

problem with them targeting the only Black woman on the team either. This proves that the demotion of women of color is seen as natural while their competence is seen as a threat. Beneath this active oppression of women (of color) in the workplace is a general disregard for women and their potential on a greater scale.

If there was truly belief that women could be as competent as men, then there would be more outrage at the number of women debilitated by imposter syndrome. There would be a market for miracle drugs and institutional investment like there is for erectile dysfunction, but there isn't. If women were truly valued as employees, workplaces would be motivated to foster their success for company profit. If women of color were truly valued as leaders, their leadership and competence would not be treated as a threat. The diagnosis of imposter syndrome allows companies what they view as a cost-effective means of supporting women in the workplace. It isn't a real solution for the underlying oppressive systems because society believes more in current hegemonies than in women and women of color.

In "The Cancer Journals," Audrey Lorde posits the very compelling question, "what would happen if an army of one-breasted women descended upon Congress and demanded that the use of carcinogenic, fat-stored hormones in beef-feed be outlawed?" (Lorde, 16). The context here is Lorde's personal decision to not wear a prosthesis after her right mastectomy, a decision for which she faced much social backlash. What Lorde identified in the social pressure to hide her mastectomy was the perpetuation of risk societies sacrificed for the economic gain of carcinogen-dependent industries. The widespread health risk of producing such beef manifests in cancer only to ultimately disappear with survivors shamed into cosmetic surgery.

Just as the health and life of Lorde was easily disregarded to cut costs, Lavarry's career was always disposable. Just as medical intervention for single-breastedness utilized a visual standard of womanhood to protect the economic gain of an industry, the label of imposter syndrome uses the pretense of cultural competency to gaslight women into accepting social devaluing of their potential. Both mechanisms individualize these experiences as private or internal matters, preventing the momentum of public outrage and blurring the influence of oppressive systems that are more visible in the public sphere.

Considering this article in the context of our Sociology of Health, Medicine, and Society course has made clear that regardless of any good intentions behind telling women they have imposter syndrome; the diagnosis is working against the interest of women and society as a whole – or at least it is without proper interrogation of biases in the workplace. Currently maintained in this phenomenon is a disregard for women and women of color that provides no motivation for those in power to truly accommodate multitudes of identity in the workplace.

Yet, there is still something hopeful about both the initial empowerment I personally felt in finally finding the language to describe my experience as well as the critical discussion that the phenomenon is now sparking. Imposter syndrome is as real and as false as any other social construction, but as someone that once strongly identified with it, it's hard to completely reject it the way this article calls for. This is a place for something like the political/relational model of disability that Alison Kafer offers to frame her book "Feminist, Queer, Crip."

Kafer offers this model as an alternative to the depoliticizing individual and medical models and the social model's erasure of the lived experience of disability. The benefit of the political/relational model is that it (1) centers the politics involved in the construction of disability to call for collective reimagining without sacrificing (2) the acknowledgement of heterogeneous experiences of disability and anyone who does seek medical treatment for their condition (Kafer, 4-10). This model is attractive in maintaining the critical thinking allowed by a sociological perspective while humanizing the various lived experiences of disability.

Being able to apply this duality of both a broader outlook and compassion for individual decisions to something like imposter syndrome could significantly change the experiences of women in the workplace. There is something powerful in allowing women to decide for themselves whether imposter syndrome speaks to them and making room for various perspectives on the condition, especially when considering the limited autonomy women hold. The relational component of such a model also accounts for intersectionality and the compounding of oppression for women of color. This ensures that their unique experiences with imposter syndrome are not marginalized in favor of white feminism. The

political component adds on by clearly naming the undeniable reproduction of systemic oppressions so that identifying with imposter syndrome no longer shifts the blame away from biased workplaces. Allowing women to examine and compare their experiences with imposter syndrome as a vehicle for the critical thinking this article grapples with empowers them to interrogate workplace biases themselves without rejecting the possible benefits of identifying with a diagnosis.

Thus, such applications of Kafer's political/relational model holds great potential in the context of imposter syndrome and the critique offered by this article. If executed properly, adapting the medicalization of imposter syndrome to this model can disrupt this diminishing of the health and careers of women in the workplace by allowing them to both react to and question their experiences.

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