4  Liberating the Narratives of BIPOC Neuropsychologists

Unpacking Microaggressions through Lived Experiences

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I remember, as a child, before we would go into a store, my mother would say, “Don’t get in here and embarrass me in front of these White people.” That has been ingrained in me and I bring that into the room with me in these predominantly White spaces.

(Neuropsychology postdoctoral fellow)

I started cleaning houses on Saturday mornings when I was twelve and remember how people looked at me … through me. And now I have a Ph.D., and I’m board certified. But there are times when I feel like I am right back to cleaning houses … allowed to work hard but required to stay quiet and compliant. All that education and yet to some colleagues, patients and administrators I’m a “domestic” … an academic domestic.

(Neurophysiologist)

As neuropsychologists, we are unified by our passion for brain-behavior relationships, service of clinical populations, and dedication to scholarship. Embedded in our collective mission are assumptions of academic integrity, enlightenment, and equity. Yet, many Black, Indigenous, and People of Color (BIPOC) neuropsychologists encounter professional experiences incongruent with the equitable values and honorable missions of our field and institutions. The convergence of colorblind attitudes, neoliberal values, and assumptions of ahistorical scientific neutrality has significantly impacted academic, institutional, programmatic, and administrative aspects of medicine and healthcare. Similar inequities are likely experienced by BIPOC neuropsychologists, although the frequency, scale, and impact are relatively unexamined and remain unclear.

Systemic and institutional inequities, frequently obvious to BIPOC neuropsychologists, are often mystifying to their dominant culture colleagues. These discrepant perspectives may be due, in part, to the decline of blatant acts of workplace discrimination. Although racism persists, blatant discriminatory acts have been replaced by more covert and ambiguous manifestations of discrimination, such as microaggressions, which are more reflective of the fluid and evolving consciousness of society. This is perhaps more evident in sophisticated social contexts, such as academia.

Although studies are emerging regarding BIPOC discrimination and outcomes related to academics, there is increasing literature indicating that systemic racism significantly contributes to occupational health disparities. Workplace injustices have been associated with three outcomes including psychological (e.g., anxiety and depression) and physical health (e.g., increased blood pressure, headaches and sleep disturbance), health behavior (increased alcohol intake and smoking) and job outcomes (e.g., increased absence from work and restriction of information or services related to advancement). Workplace bullying and sexual harassment were associated with posttraumatic stress disorder (PTSD). While these studies

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reveal broad workplace injustices and health disparities, studies targeting various levels of education and expertise within specific careers are needed.

Despite increasing recognition of structural racism in psychology, academia and academic medicine,2,7,8 there has been a lack of scientific inquiry into the experience of systemic racism and inequity within the field of neuropsychology. This chapter aims to amplify the voices of BIPOC neuropsychologists and neuropsychology trainees, illuminating the inequitable, oppressive, intolerant, discriminatory, and often systemic practices that maintain power and privilege imbalances.

We used semi-structured interviews to collect data regarding personal experiences of identity-based discrimination and systemic racism. We hope that this chapter will inspire meaningful conversations that advance the implementation of policies that specifically address the gendered and racialized experiences of BIPOC in our field.

History and Terminology

“I can’t breathe.” “Say her name.” These collective mantras forged from the murders of George Floyd and Breonna Taylor reflect a 21st-century racism, long-integrated (and thriving) within public systems created and funded for community welfare in the United States. Marches, rallies, social media, live news feeds, smartphone video and body cam footage jolted us individually and collectively into a deeper awareness of systemic racism woven into 21st-century American government, law enforcement, healthcare, and academia, including medicine and neuropsychology. Scientific methods and classifications not only reflected racist views but were used by dominant culture scientists, some of whom directly influenced the field of neuropsychology.9

As national shock turns to reflection, individual (e.g., “What is my role?”) and collective (e.g., “What can we do?”) questions have emerged. For the neuropsychological community, as academicians, diagnosticians, and custodians of mental health, we recognize that effective intervention within our spheres of institutional and clinical influence first requires an appreciation for the etiology of systemic and institutional racism infiltrating our field.

While addressing race and race-related disparities are more “en vogue,” within the context of psychological scientific inquiry, the denial of disparities and inequities within academic and healthcare institutions persists.1,5,6 To rise among the ranks of dominant culture academia, BIPOC professionals must often assimilate, simultaneously minimizing or denying the occurrence and impact of identity-based discrimination. Within this context, the academic success of BIPOC professionals engenders an adaptive dissociation of experience or individual epistemology of unknowing.2 Relevant to this point is the substantial body of research implicating dissociation as a long-term consequence of traumatic stress and an important factor in the development of trauma-related disorders.1,2

Microaggressions

Lukianoff10 characterized microaggressions as the catastrophization of being offended, implying that BIPOC is somehow responsible for the acts of racism they experience or are characterologically flawed (e.g., overly sensitive) if they are offended by the act. Other scholars have questioned the conceptual clarity of microaggressions and argued that research on the topic is not yet mature enough to draw conclusions.11

However, we take Sue’s view3 that microaggressions are: (a) constant and continual in the lives of BIPOC, (b) cumulative, representing a lifelong burden of stress, (c) continuous reminders of second-class status in society, and (d) symbolic of systemic injustices at the bedrock of dominant culture values (e.g., freedom) and institutions (e.g., government and education) (p. 130). As such,
“micro” acts of discrimination are often experienced as “macro” acts of discrimination impacting career trajectory, professionalism, productivity, personal and professional development, physical and mental health, identity and well-being. As a result, the use of the term “micro” is meant to refer to “everyday or frequent” acts of discrimination rather than implying that these behaviors are insignificant or minor.

**Racial microaggressions** are defined as brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile derogatory or negative racial slights and insults toward people of color. Microaggressions include microvalidations (e.g., forms of discrimination perceived by the dominant culture as subtle but effectively continue the subjugation of BIPOC individuals), microinsults (e.g., ambiguous insults), and microassaults (e.g., personal attacks that fit with conceptualizations of traditional racism).

In short, microaggressions are not isolated negative events or hardships, but each microaggression adds to a lifelong pattern of marginalized or denied personal agency. The target is under constant demands to assert mental toughness and to re-assert and re-claim personal dignity. For many, the threat is unpredictable and can be experienced within any context, including professional and personal relationships previously experienced as equitable, further adding to the stress, psychological exhaustion and placing BIPOC professionals’ health at risk.

Borrowing from Liberation Psychology, which seeks to obtain and disseminate the narratives of oppressed and marginalized communities, the aim of this chapter is to use the personal narratives of BIPOC neuropsychologists and neuropsychology trainees to begin to “unrepress” the silenced voices of academic neuropsychology through a tone of inquiry. By normalizing diverse narratives, the goal is to forge alternative perspectives of scholarship, professionalism, practice and achievement, which informs future policy, healthcare, and power allocation.

**Lived Experiences of BIPOC**

We recruited neuropsychologists and neuropsychology trainees (i.e., graduate students, predoctoral interns, and postdoctoral fellows) from Listservs for professional organizations (e.g., American Academy of Clinical Neuropsychology (AACN-List), American Board of Clinical Neuropsychology (ABCN), Asian American Psychological Association (AAPA), Asian Neuropsychological Association (ANA), Hispanic Neuropsychological Society (HNS), International Mail List for Pediatrics Neuropsychology (PEDS-NPSY), Massachusetts Neuropsychological Society (MNS), National Academy of Neuropsychology (NAN), Society for Black Neuropsychology (SBN), and Society for Clinical Neuropsychology (ANST). Eligibility included age 18 and older and English speaking. Respondents provided verbal consent to participate in an interview.

Semi-structured qualitative interviews were conducted via virtual face-to-face technologies (e.g., Zoom) and phone calls. The growing body of research on microaggressions, racism, color blindness, discrimination in the workforce, and disparities in academic medicine provided a lens through which the interview was developed. More specifically, the interview included questions from the Racism and Life Experiences Scale-Brief (RALES-B), the Racial and Ethnic Microaggression Scale (REMS), the Assessment of Racial Microaggressions in Academic Settings Scale (ARMAS), and the work of Sue and colleagues. Interviews took approximately 60 to 120 minutes to complete. Respondents were instructed to indicate the number of times that a microaggression occurred throughout their career as a neuropsychologist or neuropsychological trainee. Questions were shaped by respondents’ responses, such that respondents reporting microaggressions were asked to provide additional detail about their experiences in order to gain insight on how they experienced acts of discrimination, racism, and microaggressions throughout their training and career.
Of respondents (n = 12), the majority self-identified as female (n = 11, 91.6%), with ages ranging from 26 to 46 years (M = 36.78, SD = 6.01). The sample was ethnically/racially diverse, with 44.4% Black or African American, 33.3% Asian, 11.1% Hispanic or Latino, and 11.1% Biracial. The sample was also diverse with regard to career stages, with 66.7% early-career, 11.1% mid-career, 11.1% predoctoral student, and 11.1% postdoctoral fellow or resident. With respect to work settings, 77.8% of the respondents reported working in an academic/university hospital, 11.1% in a VA or government facility, 22.2% in private practice, and 11.1% in a corporate setting. There was the option to select as many settings as applicable. A large proportion (77.8%) reported that their institution consisted of 2–5 neuropsychologists and 22.2% reported working with 10+ neuropsychologists at their institution.

Forms of Microaggression

Respondents were interviewed regarding types of microaggressions experienced in the workplace, including microassaults, microinsults, and microinvalidations.

To date, our interviews have yielded rich quantitative and qualitative data. Most respondents reported experiencing microaggressions (78%), with microinsults and microinvalidations reported more frequently (67% and 89%, respectively) than microassaults (33.3%). Qualitatively, the career stage emerged as a prominent factor with respect to microassaults only, such that respondents reported being the target of microassaults from academicians most often during their training, whereas microassaults experienced in subsequent career stages most often occurred during patient interactions. Nevertheless, in both cases, respondents reported feeling powerless in holding the offender responsible for their actions.

The following includes verbatim excerpts from interviews.

**Microassaults** are blatant statements or actions with clear intent.

I remember having an A+ on a report and when the professor ... called out my name and I went to grab the report, he said, “Oh! You’re not X.” I said yes and he said, “Oh, I didn’t know you were Black.” On the second instance, I remember getting a C ... I went back to the same professor and asked about some clarification ... he told me, “I can’t have a Black person having the highest grades in my class.”

### Themes and subthemes

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<th>Interview quotes related to microassaults</th>
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<td><strong>Race-based assumptions</strong></td>
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<td>Attack on intellect</td>
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<td>Assumptions of inferior status</td>
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<td>Assumptions about family structure</td>
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Assumptions about citizenship status
• It feels like I’m an outsider and I don’t belong … more subtle events, like people asking me and no one else about citizenship status. Without knowing if I’m a permanent citizen or permanent resident or not … people will bring this up, like, … to do a postdoc, you need to, like, apply for a green card … and start to explain this line of information to me, which is not something I asked.

Microinsults are actions that convey insensitivity or rudeness or directly demean a person’s racioethnic heritage, such as mistaking a person of color for a service worker.23 Though regarded as a “subtle” form of discrimination, microinsults are also potentially damaging to the target, posing a threat to mental well-being.1,24

One of the biggest things I have had to face is this assumption that I don’t deserve to be where I am. There are comments about affirmative action or how things are more lenient. This has actually been the main driving force for pursuing board certification … board certification was the one thing people can’t take away from me. There is no quota. The standards are the same for everyone. There are objective guidelines … I needed to get boarded for myself. I needed to know that I belong and I wasn’t just handed my position or degree.

Themes and subthemes Interview quotes related to microinsults

Denounced, devalued, and insulted
Disparaging remarks • One Saturday, my White supervisor told me and another practicum student, also a Black woman, that we should have stopped at our bachelor’s degrees because we were “not going to get very far.” It felt very intentional. Ironically enough, his daughter was also in our PsyD program – earning her second doctorate. When we brought that up, he was like, “She’ll be fine.” My body knew it was racially charged, but my mind was still trying to make sense of it.

Backhanded “compliments” • I recently started directing a neuropsych program in a new hospital division, and one of the lead nurses came up to me in the clinic to tell me that the Chief really liked me and how surprised he was that I was so smart. Her wide smile told me that I was supposed to take this as a compliment.

Accusations of unprofessional behavior • I was working as a psychometrist at a private practice … the patient, a White woman, arrived and she walked in the room and said I smelled like weed. [She] said to me, “this country is the way it is because of people like you.” [She] told me that she didn’t want to move forward with the testing … [My supervisor] told me, “We really need to get this testing done. What I would like for you to do is just apologize to her- just say you apologize to her for anything you could have possibly done to offend her.” Even during testing, the patient threw papers at me and made other comments and it felt horrible. I cried the entire way home.

Microinvalidations include behaviors that minimize or marginalize the competence of BIPOC professionals while often denying the importance of race and of personal racism (e.g., the myth of societal meritocracy).1 Of note, our findings suggest that BIPOC neuropsychologists are more likely to experience microinvalidations compared to microinsults in the workplace.

When sharing my personal racism experience in the field with a colleague, there was minimalization of my experiences – it can’t just be your name why clients aren’t calling you from the list – they probably lived closer. Or you look young that’s why they give your trainees more eye contact than you – don’t worry about this little stuff too much.
Narratives of BIPOC Neuropsychologists

Themes and subthemes

Interview quotes related to microinvalidations

Professional development and perceived competence

Inadequate mentorship • I always felt like I had to fight for what I had. I had to really make an effort to network. I made contacts on my own and was not given contacts, yet I noticed that some of my White colleagues were. I was fortunate to secure great training, but I felt like it was from my own doing.

Credentials disregarded • I once had parents in inpatient refuse to call me Doctor. One of the Caucasian psychologists went into the patient’s room right before me and was called doctor without issue. When I came in, I was asked if I had an MD. I was then told that I shouldn’t be allowed to call myself doctor, even though the psychologist who went in before me also had a PhD. After I did the feedback, the father finally called me “doctor.” Almost emphasizing it. It was like I had to prove my expertise. Once he saw that I actually knew what I was talking about, he was willing to call me doctor.

Overtly disturbing and cruel, the racist undertones of microassaults are obvious to the target. In contrast, microinsults and invalidations are ambiguous, socially subtle forms of microaggressions. As Offerman et al. point out, in some ways, microinsults and microinvalidations are more severe in that they: (a) often go unaddressed, despite often causing the target emotional/physiological distress; (b) are minimized/normalized given that they are more likely to be viewed as a misunderstanding or personal matter; (c) occur more frequently than microassaults; (d) are experienced by the target as racism, yet the lack of recognition and support by dominant culture observers triggers self-doubt and self-criticism within the target. Cumulatively or in isolation, each of these factors undermines or erodes professional performance, well-being, and morale, as well as personal identity and self-competence.

Microalienations. Interestingly, a new theme emerged from the interview data, which we have tentatively termed as microalienation. Unlike the existing microaggression subtypes, microalienations are acts of omission (e.g., failing to provide trainees of color with opportunities for research engagement) that are seemingly more difficult to quantify, but by respondents’ reports, no less frequent, relevant or harmful to BIPOC neuropsychologists and neuropsychology trainees. Indeed, respondents reported that microalienations impacted their professional and personal development and well-being.

Themes and subthemes

Interview quotes related to microalienations

Thwarted belongingness and employment

Underrepresentation and isolation • Yes, feels like I’m an outsider and I don’t belong. Never included.

Inequity in opportunities • I always felt like I had to fight for what I had. I had to really make an effort to network. I made contacts on my own and was not given contacts, yet I noticed that some of my White colleagues were.

• I was initially denied a position but was subsequently hired after one of the neurologists fought to open up the position for me. He questioned why a different neuropsychologist was selected over me when that person had less experience with neurological syndromes. I think the prevailing response in those situations was that selection is based on “fit,” but what does that mean exactly?

Sexism, Racism, and Intersectionality

Intersectionality acknowledges how unique aspects of gender, race, class, and even physical appearance create different modes of discrimination and privilege. In reference to intersectionality,
Kimberlé Crenshaw states, “All inequality is not created equal.”25 This statement highlights that overlapping identities can compound experiences of discrimination. For example, poor mental health and work outcomes among female employees are associated with combined experiences of sexist and racist discrimination, including harassment and microaggressions.1,18,26 As such, it is important to recognize concurrent forms of oppression to understand the depth of inequities and associated contexts.

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**Themes and subthemes**  
**Interview quotes**

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<thead>
<tr>
<th>Sexual harassment, unsupportive work environments, and power imbalances</th>
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<tr>
<td><strong>Stalking and sexual misconduct</strong></td>
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<td>• As a trainee, I was being sexually harassed ... I was a practicum student, and he was an intern. And when I reported it to my supervisor at the program, they told me that I should consult with other women in the field because they would know how to deal with it. And then when I told the director of the program at the practicum site ... the woman literally told me to come in and shut the door and told me to keep my mouth shut, and I would need to learn how to live with this to get by. I documented everything, and I even had text messages that he had sent to me. I had multiple witnesses who observed it. He was coming up and trying to rub my back. A lot of vulgar comments ... even my grad program, when I reported it, was very dismissive until I actually had to threaten legal action and all they did was move me to a different site. But they allowed him to finish and become a psychologist.</td>
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| Intersectionality of identities                                                                                                                                                          |
| **Intersection of race and gender**                                                                                                                                                        |
| • A supervisor once said, “You look great in that skirt, do you run a lot?” I just froze. He got embarrassed and rarely talked to me again socially, and became really critical of my work. Looking back ... I realized that this dynamic was different for me as a woman of color. My White female colleagues were allowed to ignore or reject a proposition from a White male supervisor without consequences. When I did, I was treated with passive aggression, and in two cases, transferred. Of course, I would never get a letter of recommendation. I figured out by the end of my doctoral program that ... it was easier to be the unattractive, nerdy Latinx trainee and get by than risk insulting them and jeopardizing my career. |

| Intersection of race, sex, and ability                                                                                                                                                     |
| • I was diagnosed with a chronic illness three months after starting postdoc. The faculty informed me that my contract would not be renewed for a second year because the intersection between my medical treatment and COVID-19 made the task of training me “insurmountable.” My treating physician wrote a letter, which I provided to the faculty. The letter noted that even in the context of COVID-19, my medical treatment did not preclude me from performing the essential functions of my job. Only then did the faculty offer me a second-year contract. It taught me that being a female ethnic minority with a disability is three strikes. I left the contract and my dreams of becoming a neuropsychologist behind. |

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**Personal Impact and Coping**

Gaining insight into how respondents were affected by or coped with microaggressions was a particularly relevant area of interest given the profession of our sample. Our preliminary results revealed that microaggressions have a negative impact on health, with respondents reporting elevated mental health difficulties (50%), disruption to well-being (67%), adverse impact on personal...
relationships (78%), and negative work outcomes (33%) as consequences of microaggressions. Additionally, respondents expressed feelings of exhaustion as the respondent below:

They've made me exhausted honestly. I just feel tired. Sometimes I feel like I can’t keep fighting this fight, but I also don’t see any way out of it because the fight isn’t over. I do feel a responsibility, particularly to women of color coming up behind me, to keep making the argument, to keep showing up, to keep pointing out instances of systemic racism, both obvious and subtle. But I do feel very tired.

Most respondents reported that they sought treatment (67%), such as psychotherapy, psychiatry, or chaplaincy, because of their microaggression experiences. Additionally, several participants reported efforts to overcompensate by working longer hours and taking on additional responsibilities. Respondents often noted that this attempt to fend off stereotypes through workaholism further compounded the negative impact on their professional and personal lives (e.g., lack of sleep, burnout, and poorer relationship quality with partners and children). Respondents’ reported patterns of coping varied in both strategy (e.g., problem-focused and avoidance-oriented coping strategies) and formality (e.g., seeking support from friends and/or relatives to psychopharmacology and psychotherapy). Of note, supportive dominant culture allies and minority-based institutional resources were noted to serve as important resources for managing microaggression-related distress and concerns.

Currently, I am involved in a mentorship program that my hospital has for Black doctors. I’m so fortunate to have this outlet. It gives me a space to discuss my feelings, barriers, and develop strategies with a senior physician. She doesn’t understand the field of neuropsychology, but she gets the impact of prejudice/discrimination. It also helps to talk to family and friends about what I am going through.

In some cases, participants reported that discussing and reliving their experiences of microaggressions during the semi-structured interview unearthed specific internalized feelings that have gone unaddressed and untreated.

**Protective Factors**

Of the few protective factors identified by respondents, the only male participant emphasized the impact of sex.

Being a male gave me privilege…especially on units where they know me, (and) gave me advantage which a female would not be able to enjoy.

This same respondent and others noted the importance of dominant culture allies and supervisors, particularly males, as well as affiliations with well-renowned clinicians, researchers, or institutions in mediating experiences of microaggressions. While powerful, dominant culture allies are uniquely positioned to provide support to BIPOC colleagues, this dynamic also illustrates the power of implicit systemic bias in which the BIPOC professional is somewhat dependent on dominant culture colleagues for career credibility. As such, the power differential between BIPOC neuropsychologists and neuropsychological trainees can be further intensified. Additionally, pressure to assimilate and accommodate (e.g., not challenge, or speak up about microaggressions) to the needs of a dominant culture or more senior colleague is likely greater as well. The implication is
that while affiliations with dominant culture allies may be a protective factor, within some contexts, the professional development and career trajectory of BIPOC neuropsychologists and neuropsychology trainees may also depend on the power of an alliance with a dominant culture colleague, rather than experience and/or expertise.

Given the vulnerability of BIPOC neuropsychologists and neuropsychological trainees, the role of the dominant culture colleague as a protective factor is two-fold. First, it is important for dominant culture colleagues to validate (e.g., provide microaffirmations) the BIPOC professional’s experiences of microaggression. To do so, dominant culture colleagues may have to pursue more psychoeducation and be willing to expand their points of view, perhaps even their worldview.

Within the professional community and institution, dominant culture colleagues, particularly males, are uniquely and strategically positioned to advocate for BIPOC colleagues, ensuring that their appropriate experience and expertise are attributed to their BIPOC colleagues. The latter will be particularly challenging, particularly if, by doing so, the dominant culture colleague may have to resign an aspect of professional power.

Several respondents cited institutional protective factors, including having a group of colleagues (e.g., mentorship programs and diversity-related committees or organizations) that validate their experiences of discrimination. Respondents reported that receiving validation from their colleagues positively influenced their mood and sense of belonging. In addition, to support within professional settings, several respondents cited the support of their relatives and friends as a protective factor.

While the need for microinterventions\(^3\) was reported by nearly all respondents, the importance of context in the development of microintervention frameworks is paramount in determining effectiveness and outcomes. In short, how microinterventions are implemented is likely as important, if not more important, than what type of microinterventions is used. To make the invisible visible, microinterventions will need to be context-driven, fluid, adaptive, and administered by individuals and institutions that value emotional intelligence, reward collaboration over hierarchy, and appreciate the intersectional complexity of microaggressions to enhance institutional equity.

**Conclusions and Future Directions**

Our preliminary findings, which are consistent with previous research examining microaggressions among medical professionals, provide compelling evidence that microaggressions pervade the workplace of BIPOC neuropsychologists and neuropsychology trainees, placing these individuals at risk for adverse health, work, and relationship outcomes.

Results revealed that microaggressions are commonly experienced by neuropsychologists and neuropsychology trainees and that microinvalidations and microinsults are more frequent than microassaults. The prevalence of vague and subtle microaggressions highlights Sue et al., views that the strategic goal of the microintervention is to make the “invisible visible”\(^3\) (p. 134). While many of our respondents reported enduring microinsults and microinvalidations in isolation and often without any recognition of offense, microintervention frameworks\(^3\) emphasize the need for acknowledging and disarming the microaggression in “real time” (e.g., validation, microaffirmations) and educating the offender. Individual microinterventions will need to be supported by institutional leadership and policies to ensure BIPOC career development and advancement. While frameworks for addressing microaggressions have been proposed,\(^3\) as the literature and our findings attest, more work is needed in this area.

Regardless of microintervention, an understanding of context is critical to outcomes. Factors that need to be considered are the following: How is the offender addressed (e.g., publicly or privately)? Is this an isolated event, a pattern of behavior, or part of systemic institution culture? and Can the target’s professional relationship with the offender place them at risk for negative outcomes?
Unfortunately, there is always the potential risk that microinterventions can be met with negative consequences or passive retaliation (immediately or in the future) that can jeopardize career development, opportunities, health and welfare. Notably, microaggression intervention strategies should give serious consideration to the effects of interlocking identities and the physical and mental health impact on BIPOC in processing their experiences, coping, and seeking out support.

Additionally, our findings suggest that intersectionality is an important lens through which BIPOC neuropsychologists and neuropsychology trainees attempt to understand and make meaning of microaggressions. This aspirational level of active coping might be one of the driving forces behind treatment seeking, as most respondents reported that they sought treatment to address their microaggression-related distress and concerns. Taken together, these findings beg the question of whether and how intersectionality is addressed within the therapeutic context. Researchers have emphasized the therapeutic utility of discussing therapist/client intersectionality in the context of treatment, noting that intersectionality may have a significant impact on the therapeutic alliance depending on the way in which it is addressed or avoided. Discussions about intersectionality might be particularly salient for clients presenting with discrimination-related distress or concerns. We refer interested readers to the corresponding reference for more in-depth information, including recommendations on how to structure conversations about intersectionality with clients.

A limitation of this study is selection bias, as individuals who had more significant or frequent experiences microaggressions may have been more likely to self-select to participate. Of note, however, our female to male ratio (11 females; 1 male) is consistent with previous findings suggesting that female-identifying individuals are more vulnerable to the impact of institutional racism and intersectional inequities. Generalizability is also a limitation of the current study. Although inequity is experienced globally, our respondents are highly educated professionals residing in North America. As such, their inequitable experiences reflect a narrow institutional context and may not generalize to other countries or careers. Recruitment and analysis of interview data is ongoing. Although our investigation is centered on collecting the narratives of BIPOC neuropsychologists and neuropsychology trainees at risk of repression, our goal is to expand our sample to include dominant culture neuropsychologists and neuropsychology trainees to investigate how they identify with and respond to witnessed microaggressions and the impact such experiences might have on their personal and professional development.

We hope this undertaking will steer us toward a comprehensive understanding of the impact discrimination has on our field, aiding in the development of micro- and macrointerventions that aim to reduce interpersonal and institutional discrimination. These efforts potentially help to safeguard and ensure the professional development of BIPOC neuropsychologists as we move the discipline toward a more equitable future. Success will be measured not only as BIPOC neuropsychologists become leaders among their BIPOC peers but leaders in the field of neuropsychology at large. This will provide a more representative reflection of the populations we serve as well as the underrepresented populations in need of our services.

**Glossary**

This section will define terms used in throughout the chapter. For more detailed information, readers are referred to the cited literature.

**Assimilate.** To make similar; to give up one’s native ethnic beliefs and adopt those of the host culture.

**Colorblind.** An ideal in which skin color is considered insignificant.

**Discriminatory.** Showing an unfair or prejudicial distinction, especially when bias is related to age, color, national origin, religion, sex, etc.
Equity. The quality of being fair and impartial.
Inequity/inequitable. Lack of fairness; injustice.
Intersectionality. Acknowledges how unique aspects of gender, race, class, and physical appearance create different modes of discrimination and privilege, with compounded experiences of discrimination.25
Intolerant. Unable or unwilling to endure others’ views, beliefs, or behaviors.
Meritocracy. Social system in which success and status in life depend primarily on an individual’s talents, abilities, and effort.
Microaffirmations. Small acts or tiny acts of opening doors that can be public or private, often unconscious but effective in offering gestures of inclusion, success, or care.
Microaggressions. Everyday verbal, nonverbal, and environmental slights or insults, whether intentional or unintentional, which communicate hostile, derogatory, or negative messages to a target person(s) based solely upon their marginalized group membership.1,12,23
Microalienation. Form of discrimination by the dominant culture that actively, overtly and/or subtly excludes, omits, or isolates an individual.
Microassaults. Acts of discrimination that are overtly disturbing and cruel to the recipient.1,12
Microinsults. Actions that convey insensitivity or rudeness or directly demean a person’s racioethnic heritage.1,24
Microinterventions. Everyday words or deeds, whether intentional or unintentional, that communicates to targets of microaggression messages of validation, value, affirmation, support, encouragement, and reassurance.3
Microinvalidations. Subtle form of discrimination that excludes, negates, or nullifies the experiential reality of a person from a marginalization group.1
Oppressive. Unjust or cruel exercise of authority or power.
Racial microaggression. Brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional that communicate hostile derogatory or negative racial slights and insults toward people of color.12
Structural racism. Macro-level conditions, such as residential segregation and institutional policies, that limit opportunities, resources, power, and well-being of individuals and populations based on race/ethnicity and other statuses, included but not limited to gender, sexual orientation, gender identity, ability status, religion, physical characteristics, health conditions, or English proficiency.7,8
Systemic racism (also known as institutional racism). Form of racism that is embedded as normal practice, such as rules, practices, and customs that are rooted in laws, society, or an organization.

References