Cultural Humility and Cultural Brokering in Professional Training: Insights from People of Color (POC) and Persons with Disabilities (PWD)

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Cultural Humility and Cultural Brokering in Professional Training: Insights from People of Color (POC) and/or Persons with Disabilities (PWD)

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Plain Language Summary

This paper explores the experiences of trainees and faculty who are people of color (POC), persons with a disability (PWD) or PWD-POC. It includes a positionality table that informs readers about the authors' backgrounds and potential biases. Using case vignettes, challenges of being a trainee and working with others, when both are POC, PWD, or PWD-POC are highlighted. Suggestions are offered for helping training programs to better support trainees are offered. These include embracing cultural humility and better understanding cultural brokering.

Abstract

This conceptual paper reflects the collaborative work of LEND trainees and faculty exploring the need to shift from "cultural competencies" to "cultural humility" in training programs. The authors draw on their lived experiences as members of racially/ethnically marginalized groups, members of the disability community, and advocates for equity in accessibility. Collectively, the authors highlight some of the challenges and opportunities in supporting diverse trainees in professional- and discipline-specific training programs and in the provision of services the trainees provide to care-recipients across a variety of fields. This paper includes a series of case vignettes in order to: examine individual authors' experiences working in health-related systems as representatives from marginalized communities who identify as people of color (POC), persons with a disability (PWD) or PWD-POC. Informed by literature in the field alongside lived experiences, this paper identifies problematic systemic, attitudinal, and cultural elements that can limit the benefit that trainees receive in training programs and offers suggestions for mediating these limiting factors to more successfully mentor trainees who are POC, PWD, or PWD-POC. Implications for training programs in addressing diversity, equity, and inclusion through the incorporation of cultural humility and cultural brokering are highlighted.

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Introduction

In this conceptual paper, we discuss two important elements of training future leaders to support individuals with neurodevelopmental and related disabilities—cultural humility and cultural brokering. We address these constructs from our perspectives as interprofessional fellows and faculty of a Leadership Education in Neurodevelopmental and related Disabilities (LEND) program (Smith et al., 2022). LEND programs and closely related University Centers of Excellence in Developmental Disability (UCEDDs) and Intellectual and Developmental Disabilities Research Centers (IDDRCs) were established during the Kennedy administration to "focus the expertise of the academic community" and address a serious dearth of knowledge in the field of intellectual and developmental disabilities (Fifield & Fifield, 2021, p. 5). LEND programs explicitly pursue and offer interdisciplinary training experiences to rising professionals from a wide variety of disciplines, family members of people with disabilities, and people with disabilities (PWD) themselves.

Even outside the highly specialized and targeted training experience of LEND, training programs across such sectors as medicine and nursing (Teixeira-Santos et al., 2021), psychology and social work (Jani et al., 2016; Pieterse et al., 2009), and education and law (Bustamante et al., 2016; Zawisza, 2015) have embraced the development of "cultural competencies." In the area of disability studies, policy, and advocacy, too, "[multi]cultural competencies" have been embraced. Aligning with the Developmental Disabilities Act of 2000, national programs, including the LEND programs and UCEDDs, have increasingly attended to the development of "multicultural competencies" in training future generations of leaders (Baumann & Cabassa, 2020).

At this juncture, the authors argue for the need to go beyond a focus on competencies to embrace training in cultural humility (Fisher-Borne et al., 2015; Foronda, 2020; Yan Li et al., 2022) and to inform training through the meaningful inclusion of trainees from diverse backgrounds. This paper reflects the collaborative work of LEND fellows and faculty who draw on their lived experiences—as members of racially/ethnically marginalized groups, members of the disability community, and advocates for equity in accessibility—to support training and delivery of services that contextualize current challenges/barriers faced by persons with disabilities from diverse backgrounds. Utilizing the dual lenses of cultural humility and cultural brokering (Lo & Nguyen, 2018; Mortier et al., 2021; Wyatt et al., 2017), this paper touches upon systemic barriers that contribute to discrimination and marginalization for persons with disabilities (PWD) who are Persons of Color (POC), or PWD-POC. Importantly, it also highlights the many benefits of inclusion of, and learning from, professionals/emerging professionals who are themselves POC.

Informed by literature in disability-related fields alongside lived experiences, this paper identifies systemic and attitudinal/cultural elements that sometimes hinder and sometimes help the effectiveness of trainees and professionals in working with PWD-POC. This paper includes a series of case vignettes that (1) examine individual authors' experiences working in health-related (or adjacent) systems as individuals who identify as POC or as a PWD; and (2) explore the role of cultural brokering by trainees/professionals who are PWD, POC, or PWD-POC. Implications are highlighted for training programs (including LEND programs, as well as discipline-specific

training programs) who wish to address diversity, equity, and inclusion, particularly through the embracing of cultural humility and cultural brokering.

Language Matters: Clarifying Terminology

The authors recognize that language has power, and that "labels" used to describe groups of people can be problematic, neutral, or empowering. Honoring an individual's preferred terminology when interacting with that person is strongly encouraged; however, in written form, some decisions about language use must be made for the sake of clarity or consistency. For example, the term "Latinx" to refer to both Latinos and Latinas is socially constructed by nonmembers of that group on the grounds that this term honors gender and sexuality diversity; yet "Latinx" is not a term utilized by those in that group to describe themselves (Salinas, 2020). Others support "Latine," suggesting this term is more appropriate given its phonological and lexical alignment with speakers of Spanish (Slemp, 2020).

The motivations of writers and speakers will influence the use of specific terminology across time and in different contexts. Along with their diverse backgrounds, the authors of the current paper bring to this work different ideas about terminology. Thus, the language used throughout this paper reflects compromise along with acknowledgement that selected terms may not align with the preferred terms of each reader. We respectfully request grace from the reader as we navigate this novel and interesting terrain.

A common term used in the U.S. to capture the experience of marginalized groups is BIPOC (Black, Indigenous, and People of Color), which places emphasis on persons who are Black and Indigenous who have historically experienced severe racial injustice (Pérez, 2021). However, this term places greater emphasis on a subset of individuals who experience racial/ethnic stigmatization and discrimination, which can also be experienced by other POC. Given the racial/ethnic backgrounds of the authors and the desire to understand the experiences of marginalized individuals more broadly, this paper will utilize POC.

Individuals or groups of individuals who benefit from services are known by various terms, including patients, clients, consumers, stakeholders, students, and trainees. Given that the authors of this paper hail from divergent educational backgrounds and interact with the public in different settings in their work-related roles (e.g., where "client" might be used by one author, and "patient" by another), for the purpose of this shared work we will refer to those benefiting from supports, services, or care as "care-recipients."

Key Constructs Guiding this Work

Racism

Racism, as a component of the social environment, is tied with power differentials resulting in inequitable access to quality education, appropriate medical facilities, safe housing, transportation, job opportunities, access to nutritious foods, access to physical activity opportunities, and access to clean air and water (Guess, 2006; National Academies Sciences

Engineering Medicine [NASEM] et al., 2020). In the public health literature, these differences in access, deemed the social determinants of health (SDOH) are organized and structured based on demographics such as race, ethnicity, disability, gender, socioeconomic status, immigration status, geography, etc. (NASEM et al., 2017, 2020; Nuriddin et al., 2020; Omi & Winant, 2014). These drivers of social and structural inequity encompass policy and law; they play a role in structuring history, politics, the economy, and the culture of the U.S. (NASEM et al., 2020; Omi & Winant, 2014). Based on all of the above, one could comfortably argue that Western ideology is rooted in a culture of inequality (Marmot & Wilkinson, 2001).

A construct related to racism is the zero-sum philosophy that "resources are finite. Gains on one side require losses by the other side such that the sum of gains and losses is always zero" (Flores & Sims, 2016, p. 210). This widely held belief can be used by those in power to argue against the granting of rights or freedoms to marginalized groups. Relatedly, the construct of the solidarity dividend emphasizes that the drivers of inequities not only impede those who are most marginalized, but rather impacts all those living, working, socializing, and residing in these systems (McGhee, 2021). An illustrative example of how discrimination against one group can lead to unintended negative consequences against the entire population is the way many Southern cities and towns reacted to the Civil Rights Movement—rather than integrating their public swimming pools, these municipalities drained them, thus depriving everyone of this public benefit (McGhee, 2021). As African Americans gained greater access to government programs during and following the Civil Rights Movement, drastic cuts and restrictions in services were undertaken in an effort to keep some groups from reaching the middle class (McGhee, 2021).The negative repercussions of these actions have reverberated through all sectors of society from education and housing to infrastructure and healthcare, including halting the progress being made toward establishing universal healthcare in the U.S. (Krugman, 2009; McGhee, 2021).

Social Determinants of Health

Its ethical mandate "to do no harm" notwithstanding, Western healthcare exists in a cultural ecology that encourages the integration of cultural, behavioral, and structural social inequalities (Eckersley, 2006; Singh-Manoux & Marmot, 2005). Worsening social, economic, and environmental circumstances are affecting health outcomes for all. While there continues to be dissonance between political systems and the available health information, there will continue to be disparities in health outcomes impacting all individuals. Indeed, marginalized families face greater barriers to accessing health, education, and social opportunities, leading to greater health disparities, and ultimately to poorer health outcomes when compared to their White counterparts (NASEM et al., 2017; Omi & Winant, 2014). However, it is important to note that growing research in the SDOH emphasizes that medical care alone is not a determining factor in health outcomes: SDOH accounts for nearly 80-90% of health outcomes with medical care accounting for only 10-20% (Braveman & Gottlieb, 2014; Hood et al., 2016). The notion that frontline healthcare might be a more mutable factor (relatively speaking) than "the other 80-90%" drives those who express a sense of optimism and urgency about attacking this critically important societal problem.

Cultural Humility

In the last two decades, there has been an increasing shift away from "cultural competence," which emphasizes cognitive understanding about cultures other than one's own (and the way that individuals from different cultures present in majority culture), to embracing "cultural humility" (Lekas et al., 2020). The key principles of cultural humility include, above all else, the understanding that one can never be "expert" in another person's culture, and that providing care (to anyone, but especially when that person comes from a different cultural/ racial/ethnic background) must entail a willingness to listen and learn. Care occurs in context, and helping professionals must be attuned to the circumstances, facilitators, and barriers surrounding their recommendations.

Cultural Brokering

Cultural brokers mediate between individuals or groups of people from differing cultural backgrounds and the systems they encounter, commonly striving to reduce barriers or conflicts (Mortier et al., 2021). Given their knowledge of diverse worldviews and systems, cultural brokers assist individuals or groups of people, often from marginalized communities, to access services and support, ranging from healthcare to business to education, more effectively (Wyatt et al., 2017). Beyond translating language, cultural brokers assist professionals and care-recipients to understand cultural symbols, including gestures, drawings, and pictures. Effective cultural brokers possess deep understanding of both the marginalized group and the majority group with respect to their goals, norms, and values.

In some contexts, cultural brokers are "brought in" to mediate and facilitate dialogue and understanding; in other contexts, cultural brokers work within systems to address the needs of various care-recipients as they arise. Although challenges can be inherent when cultural brokers are also institutional agents (Martinez-Cosio & Iannacone, 2007), the specific knowledge that they may possess about the systems in which they work can enhance the outcomes for care-recipients and for professionals (Mortier et al., 2021).

Contextualizing the Authors' Experiences

Our paper is not meant to be representative of any particular group or experience, and we have worked together as a team to identify and address any potential language or positions that may be biased or exclusive of other experiences. While our intention is to highlight the importance of cultural humility, we recognize that we all have assumptions, implicit biases, and areas for growth and learning that may be reflected in this paper. We acknowledge that embracing cultural humility is a lifelong journey, and we are committed to being open to learning from ourselves and others in order to continue this process. Toward this end, utilizing the recommendations of Bourke (2014) and Secules et al. (2021) the authors include a statement and table (Table 1) to explicitly communicate each author's positionality.

Table 1

Positionality Table

Author	Profession	LEND Trainee/ Faculty	Class[a]	Race	Ethnic-identity	Gender	Ability	Neurodiversity
Alisa Lin (Vignette 1)	Registered nurse	Trainee	Middle	Asian	Taiwanese	Cisgender female	Able-bodied	Neurotypical
Heather Mendez (Vignette 2)	Lawyer	Trainee	Middle	Mixed race	Latine	Cisgender female	Able-bodied	Neurotypical
Victoria Filingeri (Vignette 3)	Social worker	Trainee	Middle	White	Latine	Cisgender female	Able-bodied	Neurotypical
Gyasi Burks-Abbott (Vignette 4)	Writer/Public Speaker/Autism Self-Advocate	Faculty	Middle	Black	African American	Cisgender male	Disabled	Autistic
Amy Szarkowski	Psychologist/ Administrator	Faculty	Upper Middle	White	European American	Cisgender female	Able-bodied	Neurotypical
Jason Fogler	Psychologist/ Assistant Professor	Faculty	Upper Middle	White	Eastern European Jewish	Cisgender male	Able-bodied	Neurotypical

[a] Middle class is defined as households with an annual income between $45,802 and $137,406 per year, based on income thresholds established by the Pew Research Center, which defines middle class as households with an annual income that is two-thirds to double the national median household income (in 2021, this was $68,703). Upper middle class is defined as households with an annual income that is double the national median household income or more (i.e., $137,406 or more per year; Kochhar & Sechopoulos, 2022).

This paper was written from the experiences of six individuals, belonging to both Generation X and Generation Y, following the completion of the virtually held LEND fellowship program in the summer of 2022. This paper was written collectively, online, during the COVID-19 pandemic just as restrictions were beginning to be lifted. While the focus of this paper is not on the influence of COVID-19 on marginalized communities, the authors recognize the significant impact of the pandemic on health outcomes and social movements, particularly regarding exposing disparities faced by people of color and individuals with disabilities. The identities and intersecting identities of the authors, along with their privileges and lived experiences, have informed their positions and interpretations of the case vignettes presented in this study.

Additionally, the authors have each had the opportunity to work with disability communities in various capacities—whether through our professional roles or personal commitments. Our shared experiences of working with and being a part of disability communities have informed our approach to this work and have highlighted the importance of cultural humility, inclusivity, and respect for diverse perspectives. We recognize that our identities and experiences shape the way we view and understand the issues addressed in this paper, and we strive to be mindful of the potential biases and assumptions that may influence our perspectives.

We acknowledge that our experiences are not representative of all individuals, and we are committed to being inclusive and respectful of diverse viewpoints in our writing.

Case Vignettes

In our experience, when helping professionals are assigned to care-recipients based on shared race, ethnicity, or disability, those attributes are often (a) considered to be superordinate to the skillset or temperamental fit of the helping professional and/or (b) assumed ex ante to be a critical ingredient in effecting positive outcomes. We would argue that shared physical attributes may be an imperfect signal or proxy for shared experiences, but it is shared experience that will deepen an empathic bond and working alliance between helping professionals and care-recipients. Below, we enumerate the common struggles and burdens of POC that can form the basis of a shared understanding and stronger working alliance.

The vignettes that follow highlight critical issues that one should be mindful of when providing care generally, and for programs seeking to train culturally humble and attuned helping professionals in particular. We believe strongly in the reciprocal relationship between theory and practice—that academic theory should directly inform clinical work (inclusive of healthcare, education, and law), and the practical work should enrich evolving academic theory.

Case Vignette 1 - Alisa Lin

> A careworker from a multicultural background encounters a 20-year-old college student who immigrated from China 2 years ago. The student was diagnosed with anxiety and depression, resulting in frequent absences during the semester. His family members, namely his father and grandmother who raised him, were worried about him. Like many marginalized families, this family was experiencing additional psychosocial stressors, including parents' divorce, unwanted change of residence, and prolonged sense of loneliness that began to pile up and pervade everyday life. These stressors impacted both his mental health and adaptive capabilities at home, school, and in the community. His family tried to help him overcome the "maladjustment" through school counseling and other healthcare services. However, because of language barriers and the unspoken limitations of "cultural expectations" (i.e., the belief that cultural differences will place limitations on what one can accomplish during a treatment session), treatment had not affected meaningful progress. During the last office visit, he expressed that the medication (SSRI, escitalopram oxalate/Lexapro, 20mg per tablet) made him feel worse and that he was not taking it anymore. His grandmother sat by his side and was concerned, desperately asking for a solution for her grandson's overall feeling of "unwellness."

For professionals who are POC in a variety of settings—this clinician included—dealing with vulnerable and diverse populations presents a dizzying array of questions that can be summarized as follows: How can we apply the often collectivist wisdom of different cultural perspectives to the enterprise of alleviating human suffering in the fast-paced, time-sensitive, recipient-focused environment of the traditional Western clinic? Training regarding cultural

competency often teaches that Asians are perceived to be "humble," shy, or reserved; eliciting information from and building rapport with Asian patients may take longer than with other patients, related in part to their collectivistic culture (Sue & Sue, 2016). To apply this learning in such a defeatist or cynical way that we resign ourselves to "not having enough time" to connect with the depressed young man described above during the time of his brief inpatient stay, although unacceptable, is not uncommon. Trainees and emerging professionals can adopt a sort of "learned helplessness" in healthcare with minoritized groups that can be detrimental to care (Fogler et al., 2022). Instead, by embodying the role of cultural broker, a professional who is a POC working with a care-recipient who is a POC can be more attuned to the cultural influences influencing the care-recipient's presentation and garner a more nuanced sense of the challenges the individual is facing. This can provide greater authenticity to a co-created management or treatment plan.

Case Vignette 2 - Heather Mendez

> A Latinx mother of a child with Attention Deficit Hyperactivity Disorder (ADHD) reported that through meetings with her child's school to discuss his IEP, she felt she could not properly understand or convey her thoughts to her IEP (Individualized Education Plan) team even with the help of an interpreter. This was not a lack of interpreter proficiency that led to confusion and inconsistencies, rather the interpreter's inability to convey the cultural nuance surrounding the information being shared by this Latinx mother. The mother reported not understanding terms used during the meeting mostly because there was no "perfect" translation and because of the diction used by the interpreter. The use of jargon and acronyms in meetings without explaining key terms in everyday language is challenging for English speakers, and even more so for non-native English-speaking parents. The mother also reported that her general concerns and questions were at times dismissed as the interpreter was able to use their own judgment when interpreting what the mother wished to convey. After the IEP meeting ended and the parent was provided with a summary, she realized that the report failed to correctly discuss the specific issues she wanted to address at the meeting. Later requests for another interpreter were denied because the school held that it had complied with its legal obligation by providing an interpreter for the IEP meeting.

In the legal field, the structures that are held to provide relief, or are intended to work as an equalizer, can also lead to inequitable and generally unfavorable outcomes because of issues of practicality. On its face, some "rights" enumerated in the law aim to provide equity, although they may do more to undermine the populations they purport to serve. While the law, as written, is thought of as an equalizer, it often obscures access and deprives individuals of their ability to provide meaningful or realistic solutions. For example, although interpreters are required at IEP meetings (and other meetings with speakers of languages other than the majority language in a culture), the adequacy and accuracy of such communication is a constant source of frustration for parents (Nonacademic Settings, 2012). This barrier has been identified as a significant obstacle for meaningful parent participation at the IEP meetings (Park & Turnbull, 2001). Concerns like those presented in the case from non-native English-speaking parents are not novel. Non-English-speaking parents are consistently perceived as being disinterested or not fully

advocating for their children by their school administrators (Burke et al., 2021). Delays in administrative proceedings greatly impact families' access to needed services, making it impossible for some families to seek administrative remedies and affirmative rights. Without providing an explicit time frame, the law provides a de-facto method of further marginalizing vulnerable groups (New York City Department of Education, 2022). Operating under a veil of neutrality, the law aids in undermining the rights of parents and the children it claims to protect. A recent class action lawsuit was filed on behalf of New York City families to address this very problem (New York Legal Assistance Group, 2020). At a micro level, the ability for parents to effectively advocate for their child is undermined; at the macro level, systems and institutions often lag behind in providing accommodations required by law and, consequently, continue to marginalize certain populations.

In supporting the Latinx mother in navigating the IEP landscape, a Latinx professional in law occupies two worlds—that of advocate and of realist. In advocating for her client, there is an acute realization that the administrative appeals and processes intended to provide equity and access actually undermine the ability of a child to receive the education they are legally entitled to and prevents parents from the opportunity to properly advocate for their child. Moreover, families can suffer reputational harm and loss of credibility from a lack of adequate translation services when they are perceived by school staffers as disinterested or incapable of understanding the intricacies of care for their children. This leads to another equally striking problem—the provision and use of interpreters are reduced to a granular (verbatim) level, when in fact, there is much more nuance involved with communication. The treatment of certain groups and demographics as a monoculture prevents institutions such as schools and the law from looking at meaningful sub-populations, much less the individual, leading to displacement of the group as a whole and, in the aggregate, disenfranchising the most vulnerable whom the law purports to protect.

In responding to the health, cultural, and social needs of patients and families, trainees and professionals who are POC, PWD, or PWD-POC are challenged to navigate their own inequitable systems. Along with navigating their professional roles, in their roles as cultural brokers they must "translate culture" promoting care-recipients' understanding of Westernized constructions of how certain behaviors and social nuances are defined and structured. Further, trainees and professionals who are POC, PWD, or PWD-POC may be tasked with explaining the social and racial stratification that exists in the U.S. and how that hierarchical stratification can influence social opportunities (Gee & Ford, 2011; Irwin et al., 2016; Omi & Winant, 2014).

Case Vignette 3 – Victoria Filingeri

> A Spanish-speaking Latina mother learns of her daughter's medical complexity. While processing this information, the mother was also being told of the treatment plan for her daughter, age 2. The treatment plan included ongoing medical appointments, early intervention services, weekly outpatient physical therapy (PT), occupational therapy (OT), and speech/language therapy (SPL). Like any mother in this situation, she jumped into action and scheduled every appointment with the desire of doing everything possible to improve her daughter's developmental outcomes. However, while the intention was

there, the execution proved far more challenging than the mother had anticipated due to her personal, housing, and financial difficulties.

Although information related to the family's social situations seemed irrelevant to discuss in the medical setting, the family's social situations impeded access to healthcare services. While homeless, the child missed appointments and was unable to access early intervention because of restricted space available at the shelter. With the additional challenge of managing the care of her three children, a history of domestic violence, a new pregnancy, and three weekly outpatient appointments for her daughter, the mother missed medical appointments. Without context of the family's situation and the ongoing homelessness, the family was labeled as "noncompliant," and a report was filed with child protective services. The inability for the provider to connect with the family, resulted in the family feeling unheard, distrustful of the medical system, and stigmatized due to their social situation.

In this high-stakes situation, the role of translating behaviors, culture, and support assimilation for this POC caregiver became shared labor with the bicultural POC social worker. In her role as a cultural broker for this family, the POC trainee was required to: (1) navigate her own biases, (2) examine her assimilation and acculturation experiences, (3) consider the impact of intergenerational trauma, and (4) identify the SDOH and its effect on the child's health outcomes.

Through the lens of health inequity, the trainees'/professionals' goal is to establish safe access to public resources to support stabilization. Simultaneously, through the trauma-informed lens of safety, the goal is to provide trauma-informed services to foster an understanding of domestic violence in the U.S., assist care-recipients in identifying unsafe behaviors (which may be tied to cultural norms), and support care-recipients in navigating the larger systems that they engage with. In the provision of culturally appropriate services, as a cultural broker, the POC-bicultural social worker is positioned to help in a number of ways. The POC trainee/professional supporting care-recipients who are POC may aid families in understanding their own responses and the responses of "the systems" toward them and translate/interpret cultural understandings of health, disability, and safety in Western culture.

Additional support is enlisted through establishing relationships with community resources, which are pivotal in addressing SDOH and exposing barriers to care. For example, the term "noncompliance'' is used in the medical field as a label to identify patients and families who have disregarded recommendations from their medical providers (Sinkfield-Morey, 2018). However, noncompliant behaviors are often multifactorial and can include challenges in communication and lack of comprehension, cultural issues, psychological difficulties, and psychosocial stress, all of which are barriers to care (Kleinsinger, 2003). Thus, the utilization of the term denotes a failure in establishing rapport with patients and families, as providers may have struggled in establishing a therapeutic alliance to further understand the individualistic, cultural, and psychosocial narratives that influence patients' and families' behaviors and health priorities.

Case Vignette 4 - Gyasi Burks-Abbott

When the author was a LEND fellow, he observed the evaluation of an autistic child whose developmental history was remarkably similar to his own. When this author learned that the parent was in some denial about their child's autism, he was tempted to step from behind the observation mirror and reveal himself. But he held back, remembering that for the purpose of this particular clinic observation visit, he was there to see and not to be seen. The teaching moment came for this author when he reflected on the different responses to his (in)action. While one of his neighbors felt he should have stepped in, arguing that he would have been an inspiration to the parent, the author's LEND mentor (as well as one of the guest speakers) assured him that he was right to have exercised restraint. It also occurred to the author that he had no way of knowing how the parent would have responded had he made himself known—the well-intentioned plan could have completely backfired. This incident highlighted the importance of balancing the personal passion that drives one forward in one's work with the professional judgment that enables one to perform the work most effectively.

Trainees and professionals who are POC, PWD, or PWD-POC are uniquely positioned to understand how internal conflicts can easily lead to confusion and misunderstanding. Awareness of cultural differences sheds light on the unique and varied cultural approaches in channeling and dealing with frustration, depression, and emotions to build an internal relationship with self. However, this empathy brings with it another source of tension that emerges when advocates trying to create change become part of the same hierarchical structures that undermine minoritized groups' participation in "The System." Even though they are culturally and linguistically occupying the same spaces, there can be an invisible and silent divide of "otherness" between care-recipients and the trainees/professionals providing care. This silent divide of otherness, taken in consideration with other factors, creates acute relational difficulties that can potentially undermine the advocate's credibility and limit impactful advocacy. To use the language of music, the ability to strike a resonant or discordant "chord" with care-recipients depends on how well the trainee/professional can balance these dynamics in their work—neither erring overly on the side of "learned helplessness" (i.e., succumbing to the apathy, cynicism, and despair that can come from working in an imperfect system) nor indiscriminately "fighting the system" (and potentially jeopardizing one's place in it) without a sense of strategy or "greater good" for one's care-recipients. Below, we discuss and reconcile these important tensions.

Discussion

This conceptual paper argues for an increase in the number of professionals with different cultural backgrounds in disability-related fields yet suggests that the presence of a diverse workforce will not, in itself, be sufficient. Training programs need to be intentional about this inclusion and be open to input about how to improve support of trainees from a variety of backgrounds. It is necessary to consider both how training programs can support meaningful, respectful inclusion of trainees who are POC, PWD, and PWD-POC, as well as to support those trainees in providing services to care-recipients who also come from diverse backgrounds and may be POC, PWD, or PWD-POC.

Embracing Cultural Humility in Training Programs

Increasingly, training programs include trainees from diverse cultural backgrounds, developing expertise in their discipline. Trainees who are POC, PWD, or PWD-POC can play an important role in assisting training programs to understand the importance of, and perhaps embrace, cultural humility as a framework for addressing issues related to cultural differences. The authors encourage discipline- and disability-related training programs to shift their approach to addressing diversity, equity, and inclusion from a cultural competencies framework to one centered in cultural humility. Some discipline-specific training programs have already adopted a framework of cultural humility. In medical education, for example, cultural humility was introduced decades ago (Tervalon & Murray-García, 1998) and was conceptualized as a mechanism to address the physician-patient dynamic. Yet, across many fields, this shift has yet to occur or to be widely accepted.

Embracing cultural humility requires expansion of training from the discipline- or disability-specific lens to include race, gender, sexual orientation, and self-identity, and other manifestations of cultural differences. In addition to "learning about cultures," a cultural humility lens in training programs promotes self-questioning, active listening, bi-directional cultural immersion and exploration, as well as skill development in negotiating culturally influenced differences and misunderstandings (Chang et al., 2012).

Despite the promise of cultural humility as a principle, adopting and implementing cultural humility as a practice has proven more challenging (Solchanyk et al., 2021). For one, self-report of cultural attitudes does not seem to be linked to changes in ability to work with care-recipients from different backgrounds (Juarez et al., 2006). In contrast, self-questioning, self-critique, and self-evaluation of one's personal and professional strengths and limitations in working transculturally can transform the working relationship (Chang et al., 2012; Solchanyk et al., 2021). Participatory learning activities that incorporate self-reflection show promise for promoting cultural humility in training programs (Juarez et al., 2006). Trainees (and the professionals working with and teaching them in training programs) can be encouraged to: (1) self-reflect on their own culture, (2) explore the fluidity of cultures, (3) acknowledge that they have much to learn from individuals from other cultures directly, (4) examine their explicit and implicit assumptions regarding culture, and (5) address power differentials and institutional barriers with and on behalf of marginalized groups (Fisher-Borne et al., 2015; Foronda et al., 2016; Lekas et al., 2020).

Mechanisms of facilitating growth and increasing cultural humility in training programs include offering opportunities for trainees to learn directly about dissimilar cultures and the lived experiences of individuals with different backgrounds through guest presenters, panels, and experiential activities (Manis, 2012). Some scholars (Upshaw et al., 2020) have underscored the importance of offering process-oriented supervision that both creates a "safe space" for trainees and invites them to explore their experiences of being a POC, PWD, or PWD-POC and how that intersects with what is being addressed in the training curricula. Supervisors in training programs can further promote involvement of trainees who are POC, PWD, or PWD-POC by utilizing the "initiate-invite-instill" approach endorsed by Hook et al. (2013) whereby supervisors begin the

conversation, invite trainees to provide information about their intersectional experiences, and model for the cohort a foundation of cultural humility.

Embracing a stance of cultural humility reduces the demands for training faculty to be "experts" and opens further opportunities for authentic dialogue (Upshaw et al., 2020). When embedded into training programs, cultural humility has the potential to promote openness to feedback, curiosity, and self-awareness (Winkeljohn Black & Gold, 2019)—qualities that are valuable to the clinical supervision experience, adult learning in the classroom, and sustainable work with care-recipients of different backgrounds and abilities.

Mentoring Trainees in Professional Training Programs

Throughout much of the public health literature, there is an assumption that POC, PWD, and PWD-POC trainees and professionals are perfectly suited to provide care to those from marginalized populations and are able to serve as a bridge between two cultures (Lo & Nguyen, 2018). These trainees and professionals are often charged with being "sense-makers" for care-recipients in chaotic environments. However, beyond the broad training that includes "cultural competencies," emerging professionals who are POC, PWD, or PWD-POC have often not received guidance regarding their potential roles as both professionals working within systems and cultural brokers who are expected (implicitly and/or explicitly) to aid their care-recipients in navigating the very systems in which they work (Lo, 2010). Even the understanding of what it means to exude "professionalism" can vary by culture, yet there is a "social construct" that trainees and professionals in certain fields will act in accordance with cultural rules governing professionalism (Cruess et al., 2010).

Through their understanding of the inequitable distribution of resources and opportunities, driven by structural inequities that include racism, sexism, xenophobia, ableism, classism, homophobia, among others, trainees and professionals who are POC, PWD, or PWD-POC are prominently aware of the implications of these drivers in the systems in which they work (Lo & Nguyen, 2018; NASEM et al., 2017, 2020). They are further burdened with simultaneously addressing the disparities described above and navigating the paradoxical nature of their work; that is, as POC, PWD, or PWD-POC trainees or professionals, they may simultaneously serve as a role model and "part of the problem" to their care-recipients. Mentorship regarding these overlapping roles is often missing; this is an important area in which training programs could intentionally offer more guidance.

In their individual attempts to eradicate inequitable outcomes and address disparities, trainees and professionals who are POC, PWD, or PWD-POC willingly take on considerable cultural, emotional, professional, and personal labor. In carrying this labor, they are acutely aware of the ways that complex social and structural inequities influence the health outcomes of their care-recipients, individually and collectively (as families and communities; Beadle & Graham, 2011). The act of attempting to eradicate or "fix" disparities and inequities individually inherently runs counter to the culture, values, and beliefs of many of these trainees and professionals. Recognition and acknowledgement of this "additional labor" on the part of the faculty and facilitators of training programs is vitally important.

In responding to the health, cultural, and social needs of care-recipients and families, trainees who are POC, PWD, or PWD-POC are challenged to navigate their own inequitable systems, fulfill their professional roles, serve as a cultural broker, provide culturally responsive care and services, code-switch between their roles with their supervisors/other staff and the care-recipients they serve, and provide trauma-informed services. For bicultural trainees, who may share similar cultural histories or understanding of the challenges faced by patients and families, there may be an added level of responsibility in fostering a therapeutic alliance and facilitating services. As a result, they may need to navigate their own vicarious traumatization alongside care-recipients and their families. Pointing trainees to resources that can more optimally support them in addressing these systemic barriers and potential traumas, whether inside or outside of the training program itself, may be necessary.

Trainees can be supported to recognize that the care-recipient is the expert of their own experiences and prioritize care-recipients' narratives with the same sensitivity and respect as lab results or expert medical consultation (Tervalon & Murray-García, 1998). Although an advocate or clinician may possess a certain knowledge that their client may not, it is critical to have both collaboration and deference throughout their relationship. Equally important is the recognition that trainees themselves who are PWD-POC are not the "spokesperson" or "ambassadors" regarding a certain demographic, but instead provide insights towards how systems of power have worked to oppress various demographics while also navigating through their own journey of cultural humility. Mentoring for trainees to address these "additional layers" of cultural complexity is often needed and should be addressed by training programs.

For trainees who are POC, PWD, or PWD-POC working with marginalized care-recipients, additional tasks may be involved beyond the traditional scope of work, such as: (1) translating between systems (e.g., health, education, legal, other systems in the majority culture and those same systems in the care-recipients' cultural background); (2) bridging divergent views on relevant topics (e.g., addressing differences in how the majority culture and the care-recipient's culture perceive supports); (3) establishing longer-term relationships with care-recipients (e.g., understanding that reaching a decision to comply with or embrace recommendations offered by the professional may involve building trust); and (4) working with the care-recipients' relational networks (e.g., involving important others in the care-recipient's life in order to honor cultural/familial hierarchies; Lo, 2010). Mentors of these trainees can benefit from understanding these additional tasks, working with trainees to ensure that they are not overburdened by tasks, and to create space in supervision to discuss and work through them.

Conclusion

Much of the literature on cultural humility and cultural brokering focuses largely on cultural differences and working with care-recipients who are POC. There is a dearth of information about the incorporation of these topics in disability-related training programs. Yet there is significant relevance, particularly in light of the "nothing about us without us" narrative of disability rights activists (Charlton, 1998) and the striving in such programs for greater inclusion of disability self-advocates and family members of individuals who are PWD. As described by a

training program faculty member who identifies as PWD-POC:

> *Just as inequality and marginalization have become systemic, so too can equity and inclusion be institutionalized…by creating a learning environment that fosters cross-cultural and interdisciplinary collaboration. In addition to coming from traditional fields…, [trainees] also bring their lived experience into the classroom; indeed, the value of lived experience is codified in the slots designated for Family Fellows and Self-Advocate Fellows. And, oftentimes, Fellows inhabit more than one role. For instance, a Fellow pursuing a graduate degree in a particular field can also be a family member and/or a self-advocate. The personal and professional flow together almost seamlessly.*

Trainees' intersectional experiences, especially when channeled into forming deeply empathic working alliances with care-recipients who are POC, PWD, or PWD-POC and/or brokering better understanding of their care-recipients' needs and concerns with those who hold power and access to resources, offer tremendous opportunities for increased insight, skill development, and delivery of culturally informed care among their immediate colleagues and, through publication and social media, the wider field.

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