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Mentoring the Mentors of Underrepresented Racial/Ethnic Minorities Who are Conducting HIV Research: Beyond Cultural Competency

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Abstract

The majority of literature on mentoring focuses on mentee training needs, with significantly less guidance for the mentors. Moreover, many mentoring the mentor models assume generic (i.e. White) mentees with little attention to the concerns of underrepresented racial/ethnic minorities (UREM). This has led to calls for increased attention to diversity in research training programs, especially in the field of HIV where racial/ethnic disparities are striking. Diversity training tends to address the mentees' cultural competency in conducting research with diverse populations, and often neglects the training needs of mentors in working with diverse mentees. In this article, we critique the framing of diversity as the problem (rather than the lack of mentor consciousness and skills), highlight the need to extend mentor training beyond aspirations of cultural competency toward cultural humility and cultural safety, and consider challenges to effective mentoring of UREM, both for White and UREM mentors.

Keywords

Cultural humility; Cultural competency; Cultural safety; Mentoring; Diversity; UREM

Ending racial/ethnic disparities in HIV will require the development and nurturing of a culturally diverse research workforce. Yet racial/ethnic minorities remain significantly underrepresented in higher education, accounting for only 12 % of all doctorates and fewer than 3 % of medical school professors in the United States (U.S.); [1–3]. Barriers to the retention of underrepresented racial/ethnic minority (UREM) researchers in the research pipeline are well documented and include a history of discrimination toward UREM in

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educational, research, and health settings [4, 5]. Although the importance of mentorship has been identified as a critical factor to UREM academic and scientific success [5], there are only a handful of formal "mentoring-the-mentors" training programs in the U.S. [6–8]. Among these, few fully address the knowledge and skills needed to successfully mentor UREM. There is growing appreciation of these skills, however. In the "Mentoring the Mentors" workshop described in another article in this issue, for example, "addressing diversity" is included as one of the six domains of mentoring competencies [8]. Additionally, Pfund et al. (also in this issue) include "culturally responsive/diversity" as one of the key attributes for effective mentoring relationships [9]. In this article, we critique the depiction of diversity itself as the problem, highlight the need to extend mentor training beyond aspirations for cultural competency, and consider barriers to effectively mentoring UREM, both for White and UREM mentors.

The Culture of Health Research and Training and The "Problem" of Diversity

One factor that is seldom addressed in cultural diversity trainings for mentors is the culture in which they operate—the Western culture of the health research world. Richardson (2004) noted the Western acceptance of the "individualistic and mechanistic Cartesian worldview" stands in sharp contrast to the more collective, holistic and interrelated worldviews of other cultures [10]. In fact, as Hammell [10] noted, the "transmission of cultural values and beliefs is often so effective that these appear to be normal, natural, and commonsense," (p. 225) creating an institutional environment infused with "normative Whiteness" [11]. The Western perspective dominating health research environments is accepted as superior, the standard to which all trainees should aspire and by which they should be evaluated. This worldview is presumed to be the only legitimate approach to research and identifying solutions to pressing HIV prevention and treatment needs. Richardson further noted that the health care training environment tends to foster a paternalism that assumes the dissemination of its norms will unquestionably benefit the UREM trainee [10].

The internalization of Western imperatives by both mentor and UREM trainee is apparent when diversity itself is treated as the problem [12]. Mentors are often encouraged to "accommodate" diversity in the laboratory [13], nurture awareness and "appreciation" of differences, and "be aware" of challenges that race can present to the trainee's career development [14]. The race of the UREM trainee is presented as an "issue" to be managed—rather than providing strategies for addressing structural and interpersonal aspects of discriminatory practices that perpetuate inequities. For example, medical student trainees in one study attributed their "awkward, difficult clinical situations" to the "diversity issues of patients," framing diversity itself as the cause of their problems instead of their own inadequacy in addressing it [[12], pp. 387–388].

Given that we are all racialized beings, implicit bias and norms typically are expressed through racially coded behavior and languages, permeating social scripts and affecting the social environment for both White and UREM researchers. DiAngelo [15] noted that White people in the U.S. "move through a wholly racialized world with an unracialized identity

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(e.g. white people can represent all of humanity, people of color can only represent their racial selves).” Academic environments in North America not only provide unacknowledged privilege based on light skin color, but also protect and insulate White researchers from race-based “stress,” buttress their expectations for racial comfort (i.e. experiencing their world as neutral/natural), and lower their tolerance for any experience of racial discomfort that arises when acknowledging racialized experiences [16]. White racial privilege sets the foundation for “*White fragility*” [16], a condition in which even the smallest amount of racial discomfort will be experienced as intolerable, triggering defensive moves and intense emotions when conversations about race arise–including minimization, anger, fear, guilt, tears and outright flight. For example, when one of the present authors respectfully and appropriately questioned a White colleague's assumptions that were tinged with an unexamined racial bias, the White colleague abruptly withdrew from all connection to the project. In a mentoring situation, these defensive maneuvers may serve to restore racial equilibrium for White mentors, but they can be damaging to the UREM mentee as well as the mentoring relationship. Focusing efforts on anticipating or addressing White fragility helps to shift the analysis from “diversity problems” to one of addressing privilege.

Mentor Training: Beyond Cultural Competence

A number of models and approaches to cultural competency training have been proposed (see Nazar [12], for comprehensive overview), including those emphasizing cultural humility, but these are limited.

Cultural competence training approaches tend to assume that culture is static and can be learned or even mastered by those outside it [17]. Such approaches also tend to downplay the rich diversity within cultural groups. The lack of clarity over what cultural competence means has led some mentors to overestimate their sense of competency, assuming a priori “cultural” knowledge of their mentees irrespective of the mentee's own input or unique experience [18]. Critics of this approach contend that it reinforces a key facet of imperialism, namely the belief that “the colonized possess a series of knowable characteristics and can be studied, known and managed accordingly by the colonizers whose own complicity remains unmasked” (Razack, 1988, cited by [12] p. 10). Indeed, some mentors believe they have more cultural knowledge than mentees who are a part of their communities. For example, one White researcher working outside her cultural group resented the placement of community members on a human subjects panel reviewing her research because she felt she knew the cultural issues involved better than they did. Hammell [10] noted that while there are more insightful and nuanced contemporary models of culturally competent teaching and mentorship, these still overemphasize the skill development of the mentor while ignoring the power differentials in the relationship, thereby unintentionally accentuating power inequities [17].

Tervalon and Murray-Garcia [17] advocated for a focus instead on *cultural humility*, a process “in which individuals continually engage in self-reflection and self-critique” (p. 118). Hammell [17] extended this to include an appreciation of social positioning—or one's location along the dimensions of race, class, gender, age, etc. This approach recognizes that the mentor–mentee relationship is the starting point for working across differences and

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stresses self-awareness but also action and the ability to acknowledge ignorance [18]. The cultural humility model also recognizes the uniqueness of each individual within cultural contexts, thus acknowledging the importance of tailoring cultural understanding to each individual and relational interaction [12]. Finally, as a first step in building a positive working alliance, this model requires the mentor to relinquish the role of cultural expert to the trainee, as the UREM trainee is seen as the expert. A successful interaction requires the mentor's critical self-awareness of the power, privilege, and inequities within themselves and the training encounter [19]. Notably, critics contend that the locus of power in a cultural humility approach remains primarily with the mentor.

The concept of *cultural safety—Kawa Whakaruruhau*-emerged from Maori nurse practitioners and researchers in Aotearoa/New Zealand in the 1980s [19, 20] in response to problematic health provider–Maori patient relationships. Proponents noted that when the colonial context of the relationship is not acknowledged, dominant values, worldviews, and practices may haunt the relationship and create culturally harmful (i.e. unsafe) encounters between provider and patient. The task then is to create a relational space in the encounter that is culturally safe (or "safer" as it may be impossible to achieve complete safety given the colonization context) so that the mentorship relationship becomes culturally effective and produces mutually desired outcomes. Webby (2001) noted that cultural safety is as much a tool or approach as a philosophy. Non-UREM mentors in social positions of power have the choice of either perpetuating oppressive practices or interrupting such practices; the recognition of this is a central feature of this model [10]. In sum, a critical difference among the cultural competence, cultural humility, and cultural safety perspectives on mentor training is that, for the first two, the focus is on the development of the mentor's self-awareness whereas cultural safety focuses on the trainee's power to define the experience [10] and the need for continuous, bidirectional learning between mentee and mentor.

Barriers to Effective Mentoring

Color-Blind Racial Ideology

Color-blind racial ideology (CBRI) is a manifestation of racism that is reflected in the individual and collective investment to ignore race and the salience of race-related social processes [20]. Empirical research has demonstrated that CBRI leads to increases in prejudicial attitudes and behaviors [21], less effective communicative styles and avoidance of eye contact with UREM [22], as well as attitudes that reinforce stereotypes under conditions of stress.

Two expressions of CBRI may be especially detrimental to developing healthy mentoring relationships [23]. First is the *color-evasion strategy*, which minimizes or denies differences by emphasizing "sameness" with the mentee (e.g. "I don't see you as (*insert race*)" or "We are all human") or over-identification with the mentee along another status (e.g. "As a woman, I am oppressed, too"). Second is the *power-evasion strategy*, in which there is a minimization of interpersonal racism (e.g. "Race is not an issue in this relationship"); of institutional racism (e.g. "It's not that bad anymore, especially not here"), and of racial privilege ("Whites have disadvantages, too"). Among White populations, studies indicate that CBRI is related to racial and gender intolerance, belief in a just world [23], a social

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dominance orientation [24], lower cultural appreciation [25], victim-blaming ideology, fear of people of color or "White fear" [26] and lack of ethno-cultural empathy [27]. Among UREM populations, studies indicate that CBRI is related to internalized racism and denial or minimization of institutional racism and the role of White privilege [28, 29]. Though not explicitly studied, evidence suggests that those who endorse CBRI may have a negative impact on UREMs when they evidence colorblind behaviors [19].

Neville and colleagues [23] suggested the adoption of a "color-conscious outlook" and taking action to reduce racial injustice in the mentoring relationship and the workplace. One approach incorporates "privilege checking" which begins with a commitment to multi-directional learning with mentees. As socially constructed beings, we can engage in ongoing self-reflection of our own internalized superiority and can commit to clearly seeing our advantage. We can ask mentees and colleagues to gently point out ways that privilege might be interfering with real connection. We can begin by opening to the racial discomfort associated with discussions of race and privilege; pledging to empathize with the negative racial realities of people of color through authentic interaction, witnessing and listening; and taking action to address racism as we find it in ourselves, our colleagues, and our institutions.

Microaggressions

A CBRI limits awareness of one's privilege and of the dynamics of oppression for UREM and can lead to microaggressions. Microaggressions are the covert and overt verbal, non-verbal, and environmental messages that serve to denigrate, demean, or invalidate the identity or experience of a group or its members [4, 21, 23, 30]. They are commonplace and, though some might be considered "slights," their cumulative effect–including anticipation of them–over time is considerable. As Hepshiba [22] explained: "Think of it as a sort of space dust: It's not a huge meteor that will smash your space ship to pieces; it's tiny fragments of sand and rock that will, at the speed of life, fatigue and erode even the hardest of metals." For example, a person who endorses CBRI may promote microaggressions by ignoring or denying a UREM person's experience of racism, claiming that the perpetrators do not see race. Through asserting White privilege, the perpetrator attempts to define the UREM and their ability to define themselves as a racial being. Over time, these slights compound and can adversely affect the UREM person and the relationship. Although not all microaggressions relate to CBRI or White privilege, both serve as prime proponents for microaggressions.

The burden of addressing microaggressions typically falls upon the recipients, who must determine if their perceptions are accurate, weigh the intentionality of the perpetrator (who may be an otherwise esteemed mentor), and decide whether they should broach their concerns. When confronted, perpetrators often outright deny, dismiss (e.g. "lighten up"), mystify (e.g. "it's all in your head"), elicit concern for their own privileged guilt, or respond with hostility and retribution. Expressions of CBRI (discussed above) may well be experienced as microaggressions by UREM mentees. Studies have demonstrated that microaggressions negatively impact interpersonal relationships in supervision and among faculty members [24, 25]. Hence, mentors need to be attuned to any microaggressions they

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perpetrate, assume responsibility and take corrective action to repair and build trust in the mentoring alliance. Mentors should also have an understanding of the types of microaggressions their mentees may face across health care and academic settings. Effective mentoring can involve explicitly inviting mentees to point out instances of microaggressions —if mentors can respond non-defensively.

Gandhi et al. [31] reported that both UREM and non-UREM mentors identified exposure to microaggressions as a major barrier to effective mentoring. They compared microaggressions to the weight of "a ton of feathers" to illustrate how internalization of these sometimes subtle, insidious messages can lead to increased self-doubt and diminished confidence and sense of belongingness. Walters and Simoni [4] advised supporting UREM mentees by helping them to identify when microaggressions trigger internalized oppression and to label it as such so that it can be externalized, examined, and transformed. The mentor with a critical consciousness can strategize with the mentee on how to address microaggressions in the institutional environment.

Challenges to White Mentors

Research has shown that White mentors may withhold support from UREM trainees until they prove themselves worthy of investment [14] while White trainees are given support based on their perceived potential. In addition, White mentors may encourage UREM mentees to adopt behaviors that have been successful for non-UREM in academic settings without first considering how these strategies may work for UREM. For example, an African American participant in one study recounted how his White mentor encouraged him to adopt the mentor's more aggressive style, which lead to his being labeled "an angry black man" [14].

The challenge to building a positive alliance among White mentors and UREM mentees is often affected by the "protective hesitation" phenomenon, in which both parties avoid or refrain from raising issues around diversity [14]. This may be defensive for UREM, whereas for non-UREM it may serve as a way to inhibit their own racist slips or microaggressions, a way to protect their "White fragility." In both cases, this may work to some degree, but ultimately, as with CBRI, it diminishes the opportunity for corrective action and can lead to situations where racist attitudes or assumptions play out in the mentoring relationship. Thomas [14] found that UREM advance more rapidly in their careers when they have mentors who understand and openly acknowledge how race (both in terms of privilege and oppression) can be a major factor in the trainees' institutional environment as well as in their mentoring relationship. White mentors can, for example, openly acknowledge the normative Whiteness that permeates the halls of academe and then engage in an ongoing dialogue with UREM mentees about how they can navigate this setting in a way that allows them to sustain their racial and cultural integrity. It can be helpful to simply broach the subject of race, letting the UREM mentee know race and racism are legitimate topics for discussion. In response to hearing about a UREM trainee's difficult experience in class or a contentious relationship with another faculty mentor, a White mentor might ask, "Did race play a role?", "Did the White students have a different experience?", or "Is there a cultural difference in how you and others are approaching this or in what is expected as an outcome?" UREM

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mentees often commit to a career in HIV research because of the chance to address the racial disparities in the epidemiology of the disease. Mentors can reinforce this passion and should avoid questioning mentee's objectivity when this is seldom done with White mentees following their personal interests.

Challenges to UREM Mentors

UREM mentors can be an invaluable resource to UREM early-stage investigators; research suggests that having UREM mentors positively impacts UREM mentees' professional development and increases the retention of UREM as researchers [26, 27]. Yet, there are unique challenges associated with being one of few ethnic minority leaders in HIV, a field involving considerable racial/ethnic health disparities.

Whereas shared experiences as UREM may provide mentors with additional insight into mentee's perspectives and needs, they can result in mentors overidentifying with their mentee. Race or ethnicity is a salient, but not the only component, of a UREM mentee's identity. Focusing mainly on shared racial/ethnic experiences can lead mentors to have an incomplete or inaccurate understanding of their mentees' perspectives, interests and goals, resulting in a failure to provide good mentoring. For example, an UREM mentor from an upper-middle class background may not understand why his or her UREM mentee raised in a disadvantaged community chooses to focus on community-based participatory HIV research, rather than the more common researcher-driven approach to studying HIV prevention. As a result, the mentor may fail to support the mentee in developing the skills and experiences necessary to conduct participatory work. The intersection between race and class, in this example, can lead to important differences in researchers' interests and goals despite their shared racial/ethnic experiences as UREM.

Effective UREM mentors remain mindful of intersectional identities, beyond the ones they share with mentees. They are aware of the ways in which their mentees' experiences and perspectives converge and diverge from their own, and are actively engaged in understanding and assisting with the range of challenges mentees face, including those in which they may not be personally experienced. An additional challenge for UREM mentors has to do with recognizing that the ways they have dealt with discrimination to become leaders in their field is just one example of navigating a predominantly White research environment and that they must assist mentees in identifying their own pathways to success.

Whereas some UREM have successfully navigated discriminatory environments by “keeping their heads down” and putting all of their energies into focusing on becoming more productive, other UREM have found relying on a community of UREM peers to provide both strategic and emotional support crucial to navigate predominantly White research environments. An UREM mentor who understands that such differences exist will be less likely to disparage alternative ways used by their mentee to overcome discrimination and more likely to suggest their mentee explore diverse ways of navigating discriminatory environments.

In addition to helping UREM trainees navigate institutional discrimination, UREM mentors must pay attention to their own and mentee's internalized oppression regarding UREM skills

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and abilities. For example, UREM often report having to work twice as hard to be viewed as equal in ability as their White peers [26, 28]. This constant pressure to prove that one is qualified adds additional stress and may contribute to the imposter syndrome or stereotype threat, and negatively impact performance [29]. This requires mentors to work against any internalized oppression, and develop balanced expectations and standards for their mentees (i.e. neither lowering nor raising the bar to prove UREM mentees are intellectually capable to be researchers). Finally, to be effective, UREM mentors must be mindful of the power imbalance and recognize that despite shared experiences and perspectives with their UREM mentees, mentees may be uncomfortable processing experiences of internalized oppression or interpersonal discrimination with them. It is essential that mentors balance assisting UREM trainees in navigating barriers while maintaining an appropriate level of distance and respecting mentees' autonomy and privacy.

Conclusion

In order to address HIV health disparities, there is an urgent need to diversify the research workforce. Mentoring programs for UREM researchers play a critical role in working towards this goal. While health research training programs for UREM have increased in number, they have historically focused on addressing the cultural competency of mentees conducting research or socializing them to align with the mentors' worldviews rather than addressing the diversity training needs of mentors themselves. It is imperative that all research training programs include a mentor training component particularly in relation to fostering mentor consciousness of their own power and racial privilege as well as institutional discrimination and microaggressions faced by UREM mentees. These critical domains of mentoring should be assessed and their impact evaluated in future research (see the article of PFund et al. in this issue on metrics for assessing and improving mentoring relationship [9]). Mentor training models should also move beyond the traditional focus on cultural competency–which may actually be detrimental to the mentoring relationship and serve to undermine UREM mentees. Instead, we encourage mentors to foster a stance of cultural humility and a focus on cultural safety in the mentoring relationship. Finally, while we know that UREM mentors may be particularly effective with UREM mentees, mentor training models often implicitly assume that mentors are White. Mentoring training programs must be expanded to embrace UREM mentors and reflect their unique training needs in becoming an effective mentor (e.g. overidentification with mentees). Ultimately, we cannot nurture UREM mentees and future mentors if we continue to frame diversity as a "problem." Embracing diversity in the research workforce training environment is not a problem, but is an opportunity to advance healthful and helpful research environments. Mentees from UREM backgrounds have the potential to challenge the underlying assumptions of the field, identify innovative solutions to major HIV prevention challenges, build a representative HIV research workforce, and ultimately strengthen the HIV research enterprise for all.

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