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ADDRESSING diversity, equity, inclusion and belonging (DEIB) in mentorship relationships

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ABSTRACT

The growing racial, ethnic, and cultural diversity within the United States underscores the importance of neuropsychologists developing cultural competence to improve patient care and support increased practitioner diversity. APA has recognized the importance of expanding the field's diversity, equity, inclusion, and belonging (DEIB) efforts to promote the retention of historically underrepresented practitioners and culturally competent practices. Supervisors and mentors are particularly well suited and ethically required to support DEIB-related professional development in their trainees. However, current literature suggests that a lack of time and perceived lack of competence in initiating and facilitating these conversations remain barriers to DEIB efforts. This paper aims to increase a supervisor's/mentor's self-efficacy in facilitating these efforts. We offer adapted theoretical models of cultural competence and provide a "tool kit" of experiential activities adapted for neuropsychologists that can be utilized to support the initiation, maintenance, and quality of DEIB-focused discussions within these relationships.

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Introduction

The growing racial/ethnic, cultural, and linguistic diversity of the United States population and the increasing diversity of graduate students in the neuropsychology field underscores the importance of addressing cultural factors in professional development training. Pew Research Center's population demographic predictions indicate that by 2050, one in five Americans will be an immigrant, and white individuals will represent only 46% of the US population (Passel & Cohn, 2020). Between 2007 and 2016, the percentage of racial/ethnic minorities represented in the overall psychology workforce increased from 9% to 16% (American Psychological Association, 2020). However, the overall psychology workforce remains less diverse than the US population.

In 2021, the overall US demographics are 76.3% white (U.S. Census Bureau, 2021), 26% of individuals identify as having a disability (Center for Disease Control, 2020), and 12.2% of the population identify as LGBTQIA+ (U.S. Census Bureau, 2021). The psychology workforce in 2019 was predominantly made up of white, non-disabled women (American Psychological Association, 2020). The insufficient racial, ethnic, cultural, and linguistic diversity within the field of neuropsychology at the training and practicing level has previously been identified as a barrier to increased cultural competence and diverse representation within the field (Briggs et al., 2005; Mindt et al., 2010, 2010). Of the 874 respondents to the AACN's 2020 COVID-19 Student Affairs Committee Survey of Neuropsychology Trainees (Guidotti Breting et al., 2020), 71.8% identified as white, with approximately 28.2% of total respondents identifying as nonwhite, suggesting that (when compared to overall US demographics) efforts to recruit more diverse trainees have seemingly been somewhat successful. Regarding efforts focused on retention of diverse neuropsychologists in the field, (Sweet et al., 2021) practicing neuropsychologists' "Salary Survey" reported that 84.5% of the 1677 respondents identified as white and 15.5% as racial/ethnic minorities, suggesting an 8.4% increase in self-reported racial/ethnic minority representation as compared to those who completed the survey in 2005 (Sweet et al., 2021). While our improvements in racial and ethnic diversity are promising, the representation of racially and ethnically diverse individuals within the field remains below that of the U.S. population, suggesting there is ongoing work to be done. Furthermore, the representation of practicing neuropsychologists regarding other diverse characteristics such as disability, age, cultural background, languages spoken, socio-economic status,

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religious affiliation, political stance, and indigenous identity remains unclear. Previous research has identified several barriers to ongoing retention of ethnically diverse neuropsychologists, such as: "limited social support networks, mediocre didactic and experiential training in diversity issues, educational environments where diversity issues within the training program receive inadequate attention, lack of ethnic diversity among the faculty, and limited research opportunities on projects relevant to minority communities" (Byrd et al., 2010). These barriers highlight the need for ongoing efforts that promote diversity, equity, inclusion, and belonging (DEIB) in the recruitment and retention of diverse neuropsychologists.

Research has identified early and individualized mentoring as one of the most effective recruitment and retention tools for racially and ethnically diverse psychologists (Rogers & Molina, 2006). Our own experiences were reflective of this finding. This speaks to the need for culturally competent mentors who can guide and support minority and non-minority trainees in developing cultural competence. Nevertheless, most neuropsychologists identify as white and many completed their training prior to the formal integration and development of cultural considerations. As such, they may lack the necessary tools to effectively facilitate the development of cultural competence in their trainees (Mindt et al., 2010). Inherent systemic differences in privilege and access can mean that a white neuropsychologist's world views and lived experiences may differ from those of mentees with marginalized identity characteristics. A goal of this paper is to provide resources to address this possible discrepancy.

This knowledge and resource gap within the field of neuropsychology is a critical one. Psychology supervisors have a professional and ethical duty to address multicultural issues and identities with supervisees (American Psychological Association, 2017). Multicultural discussions initiated, integrated, and revisited throughout clinical psychology supervision are associated with experiences of DEIB such as increased supervisory satisfaction and enjoyment, enhanced supervisee self-efficacy, increased research productivity, and reduced role conflict (Fickling et al., 2019; Hird et al., 2001). They have also been associated with improved patient outcomes and satisfaction (Hollingsworth & Fassinger, 2002; Phillips et al., 2017). Conversely, a supervisor's lack of awareness and/or unwillingness to address multicultural considerations is found to have a deleterious effect on supervision and patient outcomes (Falender & Shafranske, 2017; Falender et al., 2014). Supervisory psychologists in studies examining the perceived barriers to multicultural discussions endorsed lack of comfort and lack of opportunity/time as significant barriers to discussing multicultural issues with trainees (White-Davis et al., 2016). The inherent power dynamics within supervisory relationships place the onus on the supervisor to initiate discussions surrounding multicultural issues to normalize and model this work for their trainees. Despite this critical need, there is a paucity of resources that offer practical guidance and resources for neuropsychology mentors/supervisors.

To do this, this paper addresses common concerns raised by supervisors regarding the initiation of multicultural discussions in mentoring relationships and provides recommendations for establishing a "brave space" for these discussions. Next, we describe a theoretical framework for the development of compassionate cultural competence within a healthcare setting. Finally, we provide several curated and adapted tools and resources for multicultural competency development that can be incorporated into individual or group settings. We have adapted these tools to target neuropsychology-specific considerations, though we believe our tools can be utilized across a range of specialties. Additionally, we offer modifications for a virtual platform. We also created a Cultural Competency Measure to support neuropsychology supervisors and their trainees in self-assessment and reflection of their developing cultural competence. For each resource, we provide a rationale for its inclusion, instructions for implementation, and important considerations for their use. We include a suggested schedule for those desiring greater structure.

Notes to reader

While supervisors and mentors can carry distinct roles in an individual's training and professional development, the former often being more task-oriented (i.e., overseeing a trainee's patient care) and the latter more focused on personal development, both relationships offer a unique and intimate platform for multicultural discussions (Bernard & Goodyear, 2018). In this paper, the two terms will be used interchangeably as we believe increasing cultural competence is critical in each of these roles. We also use the term mentee/trainee interchangeably throughout the manuscript. Moreover, while many of the examples we provide are clinical in nature, the essence and foundation of these examples can be readily applied to mentorship relationships with other focuses (e.g., research, professional).

We believe all individuals can benefit from increasing their personal and professional cultural competence. According to APA's Multicultural Guidelines (American Psychological Association, 2017), culture is

" . . . the embodiment of a worldview through learned and transmitted beliefs, values, and practices, including religious and spiritual traditions. It also encompasses a way of living informed by the historical, economic, ecological, and political forces on a group." Therefore, we believe everyone has a cultural identity and can benefit from engagement in the following activities. We will use the term "biopsychosocial-cultural" (as adapted by Mindt et al., 2010 from; Engel, 1977). The use of this terminology is purposeful as the field of neuropsychology has long emphasized the biomedical and psychosocial aspects of illness, with relatively little focus on the influence of sociocultural factors on our patients and ourselves (Mindt et al., 2010). We re-assert the critical role of culture in all aspects of neuropsychology practice and care.

We recognize that mentees come to their mentorship relationships at various developmental stages in their training. Specific adaptations to multicultural discussions based on the supervisee's developmental stage are outlined in the Multicultural Integrated Supervision Model (MISM; Mitchell & Butler, 2021). We encourage readers to familiarize themselves with this framework for a comprehensive understanding of how the needs and motivations of supervisees change as their developmental level evolves (Stoltenberg, 1997).

It is important to recognize that many tools aimed at teaching DEIB concepts do so through a "deficit" lens. In other words, they require individuals with marginalized identity characteristics to display the challenges they have faced for the learning of others. This unfortunately places the onus on marginalized individuals to be responsible for the learning and development of those with more privilege. While we sought to reduce this onus to the extent possible in our activities, the recognition of this is important. We understand the injustice of such an expectation, and we hope that most of our exercises differ by acknowledging that each person has likely experienced some form of discrimination (racial, ethnic, religious, age, gender, sexual, political, physical, financial, etc.) and has contributed consciously or unconsciously to the discrimination of others. The degree of impact can be variable for each individual, though the opportunity for learning from one another remains a valuable endeavor. We encourage facilitators to be mindful of the deficit-lens of other activities they select and to discuss this with their mentees. For further reading on this topic see, (Shupp-Singh et al., 2019).

Finally, while we refer throughout our paper to "multicultural discussions" we want to emphasize that the work being encouraged extends beyond a conversation. These discussions are intended to catalyze and promote further DEIB efforts by expanding individual perspectives and shining a light on the ongoing gaps within our field. We hope such discussions will encourage meaningful action that create a space of inclusion and belonging within our field for all individuals. We also hope that this article will help to reduce the professional burden placed on current minority neuropsychologists to educate colleagues by offering a centralized resource and toolkit.

Supervisor-perceived barriers to engagement in multicultural discussions

Supervisors have reported a lack of competence and time as primary barriers to engaging in multicultural discussions (Soheilian et al., 2014). They reported being unsure about how to approach discussions of ethnicity, race, and culture and feared negatively impacting the supervisory working alliance (Estrada et al., 2004; Jang et al., 2019). Supervisors expressed worries regarding inappropriate assumptions, violating supervisee privacy, and abusing the inherent power differential (Bernard & Goodyear, 2018; Herd et al., 2009; Schen & Greenlee, 2018). Supervisory relationships carry an inherent power differential and cultural differences often exist. Acknowledgment and discussion of these cultural differences and power differences were associated with perceptions of stronger working alliances and greater supervisory satisfaction for both the supervisor and supervisee, (Herd et al., 2009; Inman, 2006; Soheilian et al., 2014). Alternatively, a "culture-blind" approach (i.e., ignoring these differences) can potentially lead to intentional or unintentional microaggressions (verbal, behavioral, or environmental indignities that communicate negative or denigrating messages toward marginalized groups; Sue et al., 2007) and have negative effects on the supervisory relationship and patient outcomes (Burkard et al., 2016; Chang et al., 2003).

Our prior mentors often worried that a lack of shared identity factors between mentor and mentee would present a barrier to meaningful multicultural discussions. There is a paucity of research assessing the influence of cultural matching within a supervisory relationship on cultural competence within the field of neuropsychology. However, evidence from the counseling psychology literature has revealed that supervisor humility, acknowledgment of intersecting identities, and increased opportunities to discuss culture were more predictive of supervisory alliance and cultural competence than racial pairing in supervisory dyads (King et al., 2020; Mitchell & Butler, 2021; Popejoy et al., 2019). Supervisees did not report feeling less supported or less satisfied with multicultural discussions that occurred with supervisors of a different race (Green & Dekkers, 2010; Hilton et al.,

1995). Rather, research asking trainees to rate demographic and interpersonal characteristics of supervisors alongside the quality of multicultural supervision found that higher levels of trainee-reported supervisor self-awareness, self-disclosure, support, and validation were most strongly associated with the perceived quality of multicultural discussions. Conversely, supervisor defensiveness and lack of self-disclosure regarding gaps in their knowledge were correlated with reduced cultural responsivity and perceived supervisor cultural competence (Christiansen et al., 2011; Inman & Ladany, 2014; Lawless et al., 2001). Although shared identity characteristics have not been shown to impact the quality of multicultural discussions, these characteristics may impact their frequency. Specifically, multicultural discussions are least likely to occur when both the supervisor and supervisee identify as white and least likely to occur, regardless of the racial match between supervisor and supervisee, when the patient was white (Hess et al., 2008). It is important to note that while racial identification is a data point often available to us, race is only one identifying characteristic that an individual carries. As such, it is important to recognize that many biopsychosocial-cultural underpinnings should be considered in addition to race.

Creating a brave space for multicultural discussions

A critical first step in initiating multicultural discussions is creating a **brave space** for these discussions to occur (Arao & Clemens, 2013; Figure 1). To do this, supervisors are strongly encouraged to acknowledge there will be missteps and that this is a shared learning process (Brazill, 2020). A brave space requires both the supervisor and trainee(s) to commit to providing honest feedback, accept accountability, and reflect on feedback non-defensively. It is critical for a mentor to engage in personal reflection before engaging with their mentees in multicultural discussions, including consideration of their own implicit biases and ensuring their positive stance toward multiculturalism and diversity (Mindt et al., 2010). Before engaging in multicultural discussions in which sensitive personal topics may arise, it is strongly recommended that a mentor consider the following questions and explicitly communicate the answers to their trainee(s). The following represents considerations noted by Brazill (2020), in their paper on pedagogical strategies for creating brave multicultural learning environments for adult learners, in addition to questions we retrospectively wished our supervisors had answered for us.

- Will engagement in these discussions be reflected in a trainee's evaluation?
  - If so, what criteria is the trainee being assessed on?
  - Will the trainee's evaluation be discussed before it is submitted?
- How will the supervisor create time and space for the trainee to provide feedback regarding these discussions?
  - We encourage scheduling specific times throughout the mentorship relationship that will be dedicated to feedback.
- Who is the identified individual (ombudsman, training director, dean) that a trainee should approach should concerns arise regarding their mentor? The contact information of this individual should be provided to the trainee and their role in supporting the trainee should be described. Of note, although the goal is that the supervisor creates an environment that allows a mentee to feel comfortable expressing concerns directly with their mentor, the mentee must have access to resources for support if this is not the case.
- How will confidentiality, particularly regarding sensitive information disclosed by the trainee/supervisor, be maintained? What are the scope and limits of this confidentiality?
- How may the different cultural identity factors between supervisor and supervisee impact the mentorship relationship?

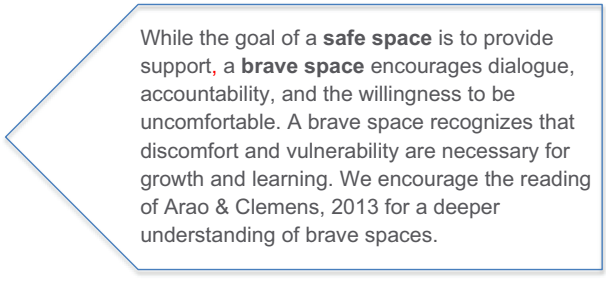

Figure 1. A Brave Space vs. A Safe Space

A conceptual model for the development of cultural competence

To provide mentors with a conceptual understanding of the development of cultural competence, we adapted the Papadoupolous, Tilki, and Taylor model (PTT Model; Papadopoulos et al., 2016) to address cultural competence development within the neuropsychology context. Originally developed in 2014 to provide a structure for transcultural nursing education, the PTT Model is based on educational principles of intercultural education as described in the UNESCO Education Position Paper

"Protection and Promotion of Diversity in Cultural Expressions" (Dasli, 2018; Papadopoulos et al., 2016). Intercultural education is predicated on respect for the cultural identity of the learner and the provision of a brave environment and resources that enhance cultural knowledge, attitudes, and skills necessary to respect, understand, advocate, and support those of diverse backgrounds (Dasli, 2018). This two-pronged approach to understanding oneself and one's context, as well as the patient and their context, is well-suited for neuropsychology given the interpersonal nature of our work. The emphasis on increasing practical knowledge while processing the intuitive and affective responses of our learning, positions us to better understand and support the functioning of our patients. This model incorporates K.D. Neff's (2003; 2011) work on self-compassion, which highlights the importance of treating ourselves with kindness and care when reflecting on past mistakes and gaps in our cultural knowledge and skills. Using this framework, we provide suggestions for the specific roles a neuropsychology mentor plays in guiding their mentee-(s) through each domain. While a mentor should introduce and be the primary facilitator (see, Martinez-Cola, 2020 for further reading), we recognize that certain mentees may have higher levels of comfort and competence with DEIB efforts than their mentors. As such, while the onus remains on the mentor to normalize and model this work for their trainee, collaboration throughout each domain is strongly encouraged and will enrich the learning of both parties.

The PTT model includes four domains that we work through and must experience to develop "cultural competence" (Papadopoulos et al., 2016). Cultural competence itself is a domain and the other three domains theorized to contribute to cultural competence include "cultural awareness," "cultural knowledge," and 'cultural sensitivity (Papadopoulos et al., 2016). Please refer to Purnell and Paulanka (2008, page 20) for comprehensive definitions of each domain. We provide a summary of each domain below.

Cultural awareness

Cultural awareness focuses on an examination of one's values and beliefs, as well as their influence on our health beliefs and practices. Papadopoulos et al. (2008) emphasize the importance of recognizing that our values and beliefs guide our decisions and judgments and are the lens through which we see the world. They discuss that we must first be able to understand our cultural identity and treat ourselves with compassion before we can do the same for our patients.

Cultural knowledge

Cultural knowledge is the gaining of knowledge regarding a specific culture that can be derived from multiple disciplines (e.g., anthropology, biology, history, arts), as well as meaningful contact with people from different ethnic groups (Papadopoulos et al., 2016). The accumulation of this knowledge is believed to further an understanding of the health beliefs, behaviors, and problems faced by a particular cultural group (Gopalkrishnan, 2019).

Cultural sensitivity

Cultural sensitivity is the crucial development of appropriate interpersonal relationships with patients that emphasize trust and communication (Papadopoulos et al., 2016). Papadopoulos et al. (2016) discuss that once cultural knowledge regarding a specific patient is developed, we then have to integrate that knowledge into forming a meaningful connection that allows for effective communication between people from two different cultures. While the PTT model emphasizes only the patient-provider relationship in a health care setting (Papadopoulos et al., 2016), we believe that developing appropriate interpersonal relationships and communication within a mentorship relationship is also critical.

Cultural competence

Cultural competence requires synthesizing and applying previously gained awareness, knowledge, and sensitivity into practical skills. This includes recognizing and challenging discriminatory and oppressive care practices and advocacy for patient and trainee needs (Papadopoulos et al., 2016).

While the PTT model presents each domain as something we work through to achieve cultural competence (Papadopoulos et al., 2016), we believe that cultural competence is not necessarily achieved in a binary sense and is also, culture-specific (i.e., an individual can be culturally competent with one culture but not others). As such, we continue to cycle through these domains as we are met with information and experiences that allow us to integrate and refine our cultural knowledge and skills. We encourage mentors to model and frame cultural competence as a lifelong endeavor for themselves and their mentees and to adopt a collaborative approach to the learning process.

Supporting mentees through developmental domains of cultural competence (Figure 2)

We will now summarize what we believe to be the most relevant factors of each domain in the context of

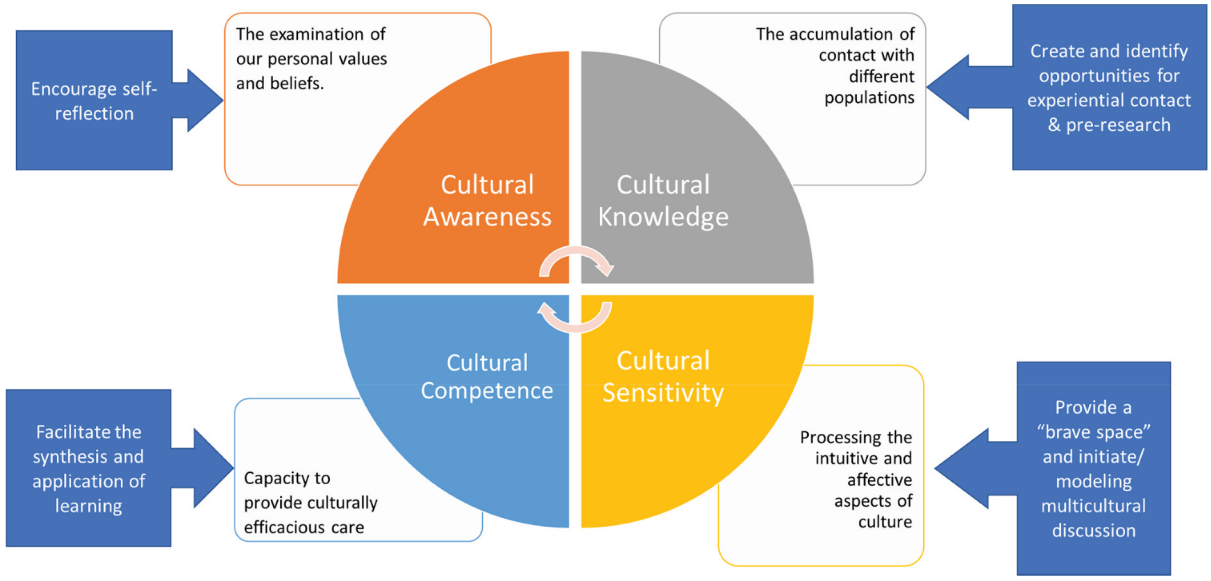

Figure 2. Summary of Cultural Competence Domains & Mentor Roles

a mentorship relationship and note the specific steps that a mentor can take to support the movement of their trainee(s) through each domain. Within the PTT model, we find it simplest to think of cultural awareness and cultural knowledge as *intellectual* pursuits adopted by a mentee that a mentor is supporting. Cultural sensitivity as the stage where a mentor facilitates a mentee's processing of the intuitive and emotional aspects of cultural interactions. With cultural competence as the stage where mentors actively aid trainees with integrating the awareness, knowledge, and sensitivity they have gained regarding a particular cultural identity into compassionate and culturally competent practices.

Cultural awareness

The purpose of this stage is to not only reflect on the building blocks of one's own cultural identity but to consider how our identity influences our patients' health-related beliefs, our clinical work, and how we practice (Papadopoulos et al., 2016). The goal is to promote honesty, humility, and vulnerability rather than judgment or shame.

Mentee role. Engage in reflective practices that enhance self-awareness and self-examination. Reflect on the strengths offered by one's personal experiences and the areas of growth one carries both in beliefs and practices regarding DEIB.

Mentor role. In this stage of development, a mentor's role is simply to encourage reflection through active listening, gentle questioning, and supporting their mentee(s) with appropriate tools to support the practice of self-awareness and self-reflection. We encourage mentors to model these behaviors within the context of the mentorship relationship. A mentor may wish to use the following tools personally and/or with their trainee(s).

- The Cultural Competency Measure (Appendix F; described in detail below)
- The Self-Identity Wheel (Runell, 2010): Various adaptations of this tool are available online. We recommend the version provided by the University of Michigan Learning Services Center at: https://sites.lsa.umich.edu/inclusive-teaching/social-identity-wheel/
- The ADDRESSING self-reflection worksheet (Winer et al., 2018; *Note*: The ADDRESSING model is described in detail below)

Cultural knowledge

Cultural knowledge is the accumulation of contact with different cultural populations. Meaningful contact with people from different cultural and ethnic groups enhances our knowledge about the diversity of health beliefs and behaviors that may occur with specific cultural practices. Cultural knowledge contributes to the awareness of the limitations of assessments and normative data that is primarily based on highly educated, white, monolingual individuals (American Psychological Association, APA Task Force on Race and Ethnicity Guidelines in Psychology, 2019; Medina et al., 2021; Mindt et al., 2010). Cultural knowledge also enhances a neuropsychologist's ability to discriminate between normal and impaired neurocognitive functioning and

behavior within the context of an individual's specific cultural practices (Cagigas & Manly, 2014).

Mentee role. To seek out experiential contact with unfamiliar populations. A mentee can "pre-research" known identity characteristics of specific patients through consultation and personal research. For example, a neuropsychology trainee working with a Sikh identifying patient(s) may wish to familiarize themselves with the three core tenets of the Sikh religion and the relevant cultural norms (e.g., regarding emotional expression, language, cognition). Also, the mentee may wish to visit a Gurdwara or a place of worship for Sikh individuals to increase familiarity with religious and cultural practices. While visiting cultural spaces is encouraged, one must ensure that we are welcome and respectful of the inhabitants of the space visited. One must familiarize oneself with the customs and practices of the spaces they plan to visit such as attendance requirements, attire, behavioral expectations, and if a chaperone is required.

Mentor role. In this domain, a mentor's role is to create or inform their mentee of opportunities for experiential contact with different cultural populations (such as events or establishments within the community). The mentor can also facilitate observation and discourse with providers of different backgrounds and medical specialties who have competencies and expertise with specific cultural groups. Working with diverse providers in different specialties allows for a deeper understanding of the various health beliefs and challenges faced by providers and patients outside of our field. The mentor should facilitate learning about the patient's cultural identities and support the mentee in gathering data through research, experiential contact, and consultation. The mentor should also work to develop familiarity with their trainee(s)' cultural identity and their patients' identity factors (Figure 3).

Cultural knowledge is primarily developed through research and meaningful contact with other cultures. All the tools provided allow for meaningful contact with the cultural characteristics of those engaged in the activity. Specific tools and other resources that may be helpful with this domain include:

- ADDRESSING Framework Applied to Clinical Cases [Appendix B]
- Fujii's (2018) ECLECTIC Model
- "Bridging Cultural Differences" TedTalk Playlist (Ted Talk Playlists, link in references)

Cultural sensitivity

Cultural sensitivity develops through the awareness and discussion of emotional reactions arising from cultural experiences that allow for the processing of intuitive and affective aspects of culture (Lee et al., 2014; Papadopoulos & Pezzella, 2015).

Mentee role. The mentee's role is to engage in reflective and self-examining processes regarding their emotional reactions to cultural experiences and how this can impact their work with patients and colleagues. Mentees are encouraged to consider their strengths, personal biases, stereotypes, and how personal experiences with certain identity groups may unconsciously or consciously inform their perceptions.

Mentor role. A mentor is tasked with identifying critical incidents (specific events and experiences that lend themselves to cultural discussions) and initiating discussions about them in supervision. The mentor should model openness and share personal experiences if relevant to the event. A mentor is further tasked with the provision of a brave rather than safe space for these discussions to occur (Arao & Clemens, 2013; see

Tip 1: Remember you as a mentor can offer your mentee experiential contact with your cultural characteristics and vice versa. A mentee may come in with greater competence in an area than a mentor carries. This should be acknowledged and explored.

Tip 2: Be mindful of generalizing from one individual to another. Rather, think of previous experiences as the outline of a jigsaw puzzle with an incomplete center. The center details will be filled by the specific individual in front of you.

Figure 3. Mentor Tips for Building Cultural Knowledge

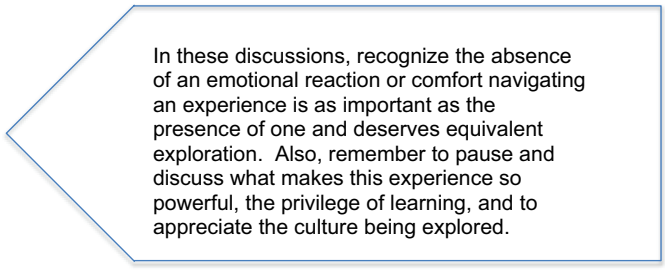

Figure 4. Mentor Tips for Building Cultural Sensitivity

Figure 1). In a brave space, a mentor is tasked with not only supporting but also challenging and holding their mentee accountable. They should encourage their mentee to do the same for them. The mentor should create regular space for these discussions. For example, by asking at each supervision, "What are the ADDRESSING factors in this case that we should discuss and consider? (Figure 4)."

Tools to support the development of Cultural Sensitivity include:

- Target and Non-Target Journey [Appendix E; described in detail below]
- Privilege for Sale [Appendix D; described in detail below]
- The Color of Fear Movie (1994). See, Lee (1994) for a discussion guide.

Cultural competence

Cultural competence requires the synthesis and application of previously gained awareness, knowledge, and sensitivity into practical skills (Papadopolous, 2016). We characterize this stage as taking the awareness, knowledge, and sensitivity one has gained and applying it to the work one is doing. We think of this stage as the "now what?" domain in which all of one's learning is translated into specific practical skills.

Mentee role. A mentee's role in this domain is to take all the information they have (e.g., limitations of normative data, the evidence base for intervention approaches for a certain population, the idiosyncrasies of their specific patient[s]) and determine how to meaningfully integrate and apply this information toward their clinical work. This includes maintaining awareness of their own cultural lens, identifying personal strengths, attuning to one's emotional experience, and acknowledging knowledge gaps. Following this, the mentee should take actionable such as, seeking supervision, reviewing the literature, adapting their practices, and consulting with appropriate individuals. The mentee should seek to convey neuropsychological test findings to patients, families, and medical providers through a bio-psycho-social-cultural lens and educate others on the importance of these factors. Recommendations made should take into consideration specific cultural and social factors relevant to the patient. For example, does the patient reside in a multigenerational home? If so, what roles will various family members play in the patient's care?

Mentor role. The mentor's role is to encourage, prompt, and direct the consideration of specific cultural characteristics in the neuropsychology work, and to support the mentee in the synthesis and application of cultural awareness, sensitivity, and knowledge within a particular neuropsychological activity. For example, the mentor may:

- Direct the mentee to further limitations of the data set they have collected.
- Help identify limitations of assessments or interventions for a specific patient and provide suggestions for alternative assessments/interventions.
- Model the communication of assessment findings in a culturally sensitive manner to the patient, their loved ones, and medical providers.
- Support appropriate documentation and/or navigating the policy and procedural barriers to culturally competent work (e.g., socio-economic limitations to accessing quality care; absence of culturally/linguistically appropriate assessment tools, etc.).
- Support the mentee in conveying neuropsychological assessment findings from a biopsychosocial-cultural perspective when giving feedback to medical providers.
- Support the identification of culturally appropriate referrals and resources.
- Encourage trainees to expand DEIB efforts in our field by sharing existing resources, such as this paper, and exploring continued gaps in knowledge and resources that trainees may address in their own work.

Tools that may support this domain include:

- Cultural Competency Measure [Appendix F; described in detail below]
- ADDRESSING Framework Applied to Clinical Cases [Appendix B; described in detail below]
- Fujii (2018) ECLECTIC Model

Tools & resources

This section offers a list of tools and experiential activities that can be incorporated as indicated to facilitate the development of cultural competency throughout a mentorship relationship. Because some exercises require greater levels of vulnerability than others, we believe it is important to consider the timing of each exercise. In our experience, when there is a greater level of rapport and comfort in the mentorship relationship, participants may feel more willing to express vulnerability and engage in more intimate self-reflection. Thus, we outline a suggested schedule for mentors who desire more guidance [See Appendix G and H]. For example, if a trainee appears particularly uncomfortable with self-disclosure, a mentor may wish to first begin with the Name Story Exercise, given the reduced self-disclosure requirement as compared to other activities.

ADDRESSING framework activity (adapted from Hays, 2008)

Hays's (2008) ADDRESSING framework provides psychologists with a non-exhaustive list of cultural characteristics that aid in contextualizing and integrating various cultural identities within an individual. Hays summarizes these identities through the acronym ADDRESSING which includes "age and generational influences, disability status (developmental), disability status (acquired physical/cognitive/psychological), religious orientation and spirituality, ethnicity, socioeconomic status, sexual orientation, indigenous heritage, national origin, gender" (Hays, 2016, p. 4). Hays emphasizes the cultural differences and social privileges experienced within each of these identities. In response to the current socio-political climate and the potential impact of divergent beliefs between neuropsychology mentors, mentees, and patients (e.g, COVID-19 vaccinations, the Black Lives Matter movement and increasing violence and discrimination against ethnically diverse communities) we added the consideration of political views (Appendix A). Additionally, we added a "!" domain to identify any other identifying characteristics not captured within the model (e.g., microcultures and third cultures) and to acknowledge the potentially dynamic nature of identifying characteristics.

We have created an activity utilizing this modified ADDRESSING framework (Appendix A) to facilitate the development of self-awareness and as a foundation for initiating and maintaining multicultural discussions. In this activity, the mentor and mentee each select two characteristics from the ADDRESSING framework and respond to the questions, "How do I identify?" and "How may this identity influence our mentorship relationship or my clinical/research/teaching/service work?" This activity also aims to develop rapport and trust within the mentor-mentee relationship. The activity allows for a mentor to model vulnerability, reinforces a brave space, and encourages self-reflection in accordance with the first domain of Self-Awareness in the PTT conceptual model (Papadopoulos et al., 2016).

Furthermore, completing this activity early on allows trainees a structured and organic way to share biopsychosocial-cultural characteristics that may influence their clinical work. For example, a trainee who will be fasting for the month of Ramadan may wish to share this information with their supervisor but be unsure of how to do so. Providing a trainee with the framework ahead of time and the expectation that they only select two characteristics allows them to determine what they are comfortable disclosing. Given the innate power differential and to model vulnerability and safety, the mentor should always go first. Mentors are encouraged to express any genuine feelings of discomfort they are experiencing to normalize such experiences for trainees. The phrase "ADDRESSING factors" can later become an umbrella term for multicultural factors during discussions (e.g., "What ADDRESSING factors do we need to consider with this patient?").

ADDRESSING framework applied to clinical cases

Clinical work with diverse patients and colleagues represents an excellent opportunity to discuss the potential impact of biopsychosocial-cultural factors on neuropsychological functioning. Each of these interactions would be considered a critical incident that should be utilized by the mentor to further a trainee's cultural competence. For example, a patient with a spinal cord injury may report they do not need to self-catheterize as in their multi-generational home a family member will always be available to manage their bladder needs. This represents a critical incident with the opportunity to discuss differing cultural values of interdependence and independence. We provide a list of questions to support the discussion of multicultural components

across PTT domains as they relate to neuropsychological care and critical incidences [Appendix B].

Name story exercise (adapted from name story exercise (2021). University of Michigan college of literature, science and arts; appendix C)

The purpose of this tool is to deepen each mentee's cultural awareness and to highlight the diversity of identity characteristics brought to supervision by each trainee and the supervisor. Also, this tool aims to promote group cohesion and connection with one another by broadening our understanding of each trainee's and supervisor's background and/or life experiences. We encourage mentors and mentees to participate in this exercise and suggest that the mentor introduce the exercise ahead of time to allow participants ample time to reflect on and/or explore their name story. The mentor should model this exercise by going first. Each individual is encouraged to share their "name story" with the option to share their first, middle, last, nickname, chosen name, or any name that has relevance within their personal history. Mentors should allow flexibility with this exercise, particularly for the consideration of individuals whose name stories may have traumatic or painful underpinnings. This promotes autonomy and safety as individuals can select the name shared.

Thus, the prompts provided in the appendix are simply suggestions or starting points. While participants are encouraged to consider the significance, history, meaning of the name, and personal reaction/experience with this name, they may also reflect on other aspects of their name experience for this exercise.

Privilege for sale (adapted from the university of North Carolina Greensboro division of student affairs intercultural engagement. n.d.; appendix D)

We selected this adaptation of the Privilege Walk as the activity in its original form promotes a "deficit lens" and perpetuates an "us vs. them" attitude. We believe Privilege for Sale allows for the same examination of privilege while reducing the onus on marginalized individuals. The purpose of this exercise is to help mentees develop an awareness of privilege and to explore how different types of privileges (social, financial, legal, health, etc.) variably impact an individual. For example, how can financial privilege influence access to education? How may this interact with one's social privilege? How important is this and why? It also aims to support peer relationships and facilitate a deeper understanding of one another in as participants can share which privileges are important to them and why their values may differ from others. Our main objective is to highlight how privilege and oppressive systems have and continue to promote the marginalization of certain identities. This limits access to important resources such as education, wealth, physical spaces, social status, safety, job opportunities, etc. In highlighting these oppressive systems, we hope each member can further develop sensitivity to different identity experiences and advocate for equity in neuropsychology. In our experience, this improves participants' ability to understand the various ways in which privilege has impacted their path in neuropsychology. For this exercise, we have included neuropsychology-focused privilege statements.

Target and non-target journey (adapted from Cornish et al., 2010; *appendix E)*

The purpose of the Target Journey exercise is to recognize how one has experienced oppression as a member of a marginalized or "Target" group (non-privileged) (Figure 5). We believe that the sharing of an individual's Target Journey allows for self-reflection and increased cultural awareness (e.g., how our identity characteristics interact with the world around us). Furthermore, hearing about others' Target Journeys allows for exposure to the cultural experiences of others.

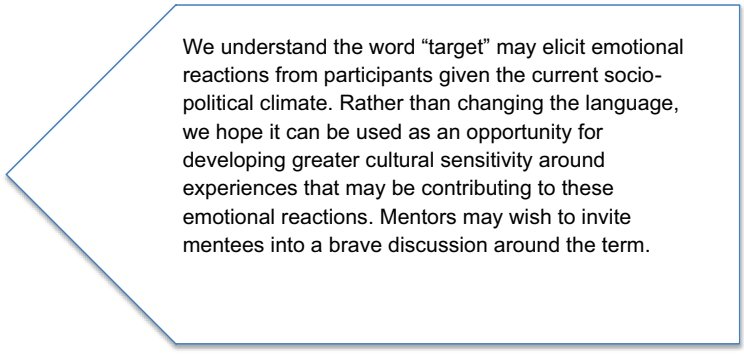

Figure 5. Target Journey Consideration

Building cultural knowledge and increasing cultural sensitivity. For example, a 55-year-old mentee who is a non-native English speaker may choose to share challenging experiences that have arisen from their older age as compared to their peers and/or experiences related to how others have perceived their accent. Conversely, the purpose of the Non-Target Journey is to recognize how we have participated in the marginalization or oppression of others as a member of a "Non-Target" (privileged) group. We view the sharing of these journeys as an opportunity to reflect on how one may inadvertently contribute to the challenging experiences of another individual. Non-Target Journeys do not and should not always have a positive conclusion. For example, a hearing mentee may reflect on the assumption that the measures they administered could be translated into the sign language of their patient.

The purpose of sharing Non-Target Journeys is to encourage thoughtful consideration and self-awareness regarding the particular advantages and challenges that have arisen from an individual's identity characteristics. The sharing of these journeys often highlights the influence of invisible diversity factors (e.g., medical health concerns, learning disabilities) on an individual's life. We have often found the sharing of these journeys to illuminate the significant impact our words and actions can have on others. This promotes the affective experiences necessary for cultural sensitivity development (Papadopoulos et al., 2016) and encourages actionable changes in how an individual interacts with their environment (i.e., cultural competence). It is important to remember that these conversations are inherently uncomfortable. As a brave space, the goal is to support supervisees in navigating uncomfortable conversations rather than avoiding discomfort. Finally, we provide shorter and expanded adaptations. The shorter adaptation accounts for the time limitations in a mentorship relationship as compared to a didactic training course. In the expanded version, we suggest allowing each participant twenty minutes per journey and the post-reflection may be expanded to ten to fifteen minutes.

Cultural competency measure (appendix F)

This measure, created by the authors, is intended to help trainees and supervisors reflect on the development of cultural awareness, sensitivity, knowledge, and competency. We propose offering this tool as a benchmark throughout the mentorship relationship, with the first administration occurring as early as possible. The measure is grounded in the PTT model and incorporates realizations we had as we progressed through our training. For example, the awareness that our lived experiences influenced our personal health beliefs and in turn, our treatment approaches. This experience is self-reflective and therefore requires some vulnerability. Consequently, we do not suggest requiring mentees to share responses to each question. Instead, supervisors may normalize and encourage any type of reflection, such as discussing professional goals, exploring growth/strength areas, or describing affect experiences during the exercise.

Suggested timeline for toolkit (appendix G and appendix H)

We provide a suggested schedule for working with an individual or a group (e.g., group supervision, a department) for mentors seeking further structure and guidance [Appendix G (Individual); Appendix H (Group)].

Discussion

As the US population becomes more diverse, increasing the cultural competence of neuropsychologists has become an urgent priority. We assert that to enhance cultural competence, multicultural discussions must be initiated and integrated throughout a neuropsychologist's training. We argue that the integration of these discussions allows for the advancement of diversity, equity, inclusion, and belonging (DEIB) within our field. While other psychological specialties have multicultural guidelines and practices, there are limited practical resources that support and promote multicultural supervision within the field of neuropsychology (Cohen et al., 2019). The present paper seeks to address this need through the presentation of a conceptual model for the development of cultural competence and the curation and adaptation of a set of activities and resources. These resources can be used to integrate cultural discussions into the mentoring relationship to support the growth of cultural awareness, sensitivity, and competence in neuropsychology mentees and mentors.

Quantitative evidence regarding the efficacy of this toolkit has yet to be obtained and warrants a future research endeavor. Furthermore, while our personal experiences in using these tools have helped to cultivate awareness, knowledge, sensitivity, and competency, we recognize that experiences may differ depending on the varying environments in which resources are used.

Our work has identified several areas of needed growth regarding culturally competent supervision within the field of neuropsychology. The field of

neuropsychology would benefit from increasing data regarding various identity characteristics of practicing neuropsychologists and trainees to assess the effectiveness of current recruitment and retention efforts. Increasing the collection and monitoring of this data may help to broaden the scope and understanding of the value and impact of diversity in patient care and our field. We would benefit from researching the effectiveness of cultural competence curriculums and tools developed by other specialties (e.g., counseling psychology, social work, medical physicians) when applied to neuropsychology. Additionally, it would be useful for future research endeavors to explore the specific challenges and needs of neuropsychologists mentoring trainees during a transitional period in the field. We have only recently acknowledged the limitations of our assessments, normative data, and research and have begun to recognize and address the impact of these limitations on culturally and linguistically diverse patients and practitioners (AACN Position on Race Norms, 2019; Medina et al., 2021; Mindt et al., 2010).

Further development of a definition and behavioral indicators of cultural competence in neuropsychology represents another important step for the field. The Minnesota 2022 Update Conference being hosted by the Education and Training in Clinical Neuropsychology planning commission states a goal of the conference is to "provide curricular and experiential resources that facilitate multicultural competencies within all training experiences and realms of neuropsychology practice, education, training, and research." We look forward to the published findings and conclusions provided by the planning commission following this conference and encourage readers to access the publication as a supplement to this paper.

A call to advocacy

Our intention in offering this set of resources for mentors and supervisors is not only to provide a method that can facilitate multicultural learning in the field of neuropsychology but also to highlight the importance of increasing our understanding and empathy for the lived experiences and perspectives of marginalized individuals. We hope to highlight not only the struggles and challenges faced but also the perseverance, persistence, and power such experiences provide. Neuropsychologists are required to demonstrate competency in a wide variety of domains, such as expert knowledge about psychological diagnoses, clinically relevant brain-behavioral relationships, competence in the diversity and cultural influences on clinical presentations, neuropsychological assessment, and psychological intervention (Hessen et al., 2018). We assert that cultural competence is critical for each of these domains. Furthermore, our field is set up in such a way that the acquisition of neuropsychology competencies highly favors individuals who are non-disabled (e.g., able to administer measures in standardized ways and sustain the pace necessary to be successful in our field), higher in socio-economic status (who can afford the education, time, and resources necessary to acquire this knowledge and who were exposed to the very existence of the field early on in life), and who are white (as this allows for greater comfort navigating the predominantly white educational and training spaces available to neuropsychology trainees). To recruit and retain individuals of diverse backgrounds and serve our increasingly diverse patients, our field will need to address these inequities.

Improving the quality and the method by which we encourage conversation, reflection, and guide supervision can prove tremendously helpful for identity development, clinical work, research, service, and teaching in neuropsychology. We believe that the resources we offer here will contribute to DEIB efforts focused on the creation of more inclusive and culturally sensitive training environments, retention of marginalized neuropsychology trainees, and further the cultural competence of our field overall.

We advocate for several actions that are needed to continue to improve the integration of multicultural awareness, sensitivity, knowledge, and competency into neuropsychology practice:

- Create new funding sources at the institutional and organizational (e.g., INS, NAN, and AACN) levels to support research and training in DEIB, multicultural awareness, sensitivity, knowledge, and competence at all career levels (from undergraduate to senior career).
- Provide safe environments for individuals within an institution or academic training site with diverse backgrounds to:
  - Celebrate one another's achievements and success.
  - Gather and discuss experiences of oppression and/or obstacles they are facing.
  - Connect mentors and mentees.
  - To share resources to combat these obstacles.

For example, A weekly process group for students and faculty of color to discuss their experiences with access to institutional leadership to address and implement institutional changes based upon these experiences.

- Establish diversity mentors within institutions who can mentor and guide individuals of diverse backgrounds.
- Create procedures, protocols, and resources for personal or professional hardship arising from issues of diversity (religion, immigration, finances).

- Create institutional requirements for neuropsychology mentors, supervisors, and members of selection or hiring committees to demonstrate annual engagement in cultural competency professional development.
- Create and strengthen pathways for marginalized individuals to access neuropsychology training, positions, and leadership through:
  - Early education programs targeting marginalized communities to educate and bring awareness to careers in neuropsychology.
  - Appointing an individual who is primarily focused on recruiting and networking with potential hires with diverse racial, ethnic, cultural, and linguistic backgrounds.
  - Recognize and value cultural competencies in admissions and hiring decisions.
  - Implement policies and structures that allow for paid undergraduate research and clinical practicum experiences (rather than expecting engagement in unpaid experiences).
  - Provide resources and implement policies that address trainee/clinician burn-out and reduce the burden of personal and professional hardships.
  - Develop alternative timelines and programs that support individuals with non-traditional neuropsychology background or who would benefit from program modifications (e.g., extended fellowship programs, partnerships with graduate schools, online support communities that share resources and knowledge).
  - Increase graduate school scholarships, GRE waivers, and technology fund assistance for undergraduate students who are majoring in psychology and related fields from underserved or historically marginalized communities.
- Get involved with APA's Society for Psychological Study of Culture, Ethnicity and Race (Division 45) to remain updated on social initiatives, research, and current cultural competence guidelines (e.g, surrounding language, test limitations, etc.)

Improving cultural competence within the field of neuropsychology is an urgent priority. We believe that increasing the frequency and quality of multicultural discussions will allow neuropsychologists to better serve their patients, improve collaboration, support professional identity development, and help meet the needs of an increasingly diverse population. We also believe that this work will strengthen the culture and sensitivity of neuropsychology training environments that will enhance DEIB efforts overall. We envision that these discussions will also facilitate the identification of knowledge gaps and needs at the individual level and as a field, and hope that this will motivate the next generation of neuropsychologists to address and meet these needs.

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Appendix A: ADDRESSING Model for Supervision

Note: The following should be provided to your trainee in advance of your meeting to allow for time for reflection. This list of cultural characteristics is intended to encourage consideration and reflective thought. However, it is not exhaustive. The person in the position of power (i.e., mentor or supervisor) should first model the exercise.

Instructions: Consider each of the following identity factors and any others you may think of. Pick two characteristics and respond to the questions:

(1) How do I identify?
(2) How might this influence my clinical, research, teaching, and service work? Supervisory relationships?
(3) What are some assets that this identity factor brings to my clinical, research, teaching, service work, and supervisory relationships?

*Content adapted from the ADDRESSING Framework (*Hays, 2008)

Cultural Characteristic	Definition & Examples
Age/Generation	A person's age and the certain periods they live through can influence their thoughts, feelings, and behaviors. E.g., Completion of training during the covid-19 pandemic; Completing graduate school with a majority of younger or older peers; Comfort with technology.
Disability/Diagnosis	Personal physical and mental health factors can be reasonably expected to impact individuals and their work. E.g., Past/current physical illness; Ongoing disabilities; ADHD; Depression; Panic attacks.
Diversity in Political Views	Conflicting political views between individuals, their families, and professional communities. E.g., Personal beliefs regarding vaccination; Access to medical care; Freedom of speech; The impact of socio-political movements in their childhood, graduate training etc.
Religion/Spiritual Orientation	Religious identification and/or spiritual practices. E.g, Views regarding suffering and death; comfort with various religions
Ethnicity/Race	Racial presentation and ethnic identification. E.g., Racial influences on daily experiences and assumptions regarding ethnicity made by others.
Socioeconomic Status	Current or past socioeconomic experiences that either provided or limited access. E.g., Parental presence; Personal work experiences; Ability to afford resources.
Sexual Orientation	Sexual identity and orientation.
Indigenous/Heritage	This is intended to refer to an individual's ancestral background. E.g., Familial values, expectations, and practices.
National Origin & Language	This is intended to identify differences in cultures one identifies with, the languages used in different spaces, and the challenges of adapting to each of these things. E.g., Experiences of acculturative stress; A "third culture" individual; and different languages being used at home and work.
Gender	Gender identity.
!	Participants may choose to share any aspect of their identity.

Appendix B: ADDRESSING Framework Applied to Clinical Cases

The following are examples of questions that can be asked to encourage ongoing consideration and discussion of multicultural components across PTT domains in relation to clinical care.

To encourage or support:

- Cultural Awareness – What ADDRESSING factors may be contributing to greater comfort or discomfort for you within this setting, stage of training, or clinical work?
- Cultural Knowledge -What ADDRESSING factors may be influencing this patient's presentation?
- Cultural Sensitivity – How did your cultural experience and the other individuals intersect within this interaction? What was your emotional reaction to their story, behavior, and actions?
- Cultural Competence – What did you learn from this case? What is a way in which you approached a cultural factor that you wish to continue, change, or learn more about?

Appendix C: Name Story Exercise

Adapted from The Name Story Exercise (2021). *University of Michigan College of Literature, Science and Arts. https://sites.lsa.umich.edu/inclusive-teaching/name-story/ Retrieved on 18 March 2022.*

Mentors should introduce this activity in advance to participants to allow time to reflect, ask questions, and prepare. The prompts provided are simply suggestions to facilitate a reflective process, but a participant can and are encouraged to share any aspect of their name story they feel comfortable disclosing. For example, a transgender participant may not feel comfortable discussing/disclosing a name given at birth and may prefer to explore a nickname.

(The same instructions can be used in a dyadic supervision setting)

Structure	Time	Instructions
Introduction	3–5 minutes	Introduce the goals and framework of the activity: Supervisees will learn more about their peers and supervisor by hearing stories related to names.
Name Game Prompts (read aloud) and Preparation	5–10 minutes	The following prompts/example questions can be displayed or distributed while participants prepare their responses. Participants can choose to respond to any of these prompts or select other aspects of their name to share: (1) Who are you named after and why? (2) Where does your name originate from? (3) Who named you and what was the significance? (4) Does this name hold special meaning in your family or from your cultural background? (5) Do you have any special memories associated with this name? (6) Do you like this name/what sort of experiences have you had with this name in the world? (7) If you chose this name for yourself, why did you choose it? (8) Share your favorite nickname and how it came about. Provide a few minutes for participants to jot down ideas and thoughts.
Name Game Story Exercise	5–10 minutes per individual	Come back together as a group. The supervisor should model the activity by going first. Have students present name stories following the model. Supervisees can share affective responses to their peers' name stories and the presenter can share the emotional response they had to sharing their name story.

Appendix D: Privilege For Sale

*Based on Peggy McIntosh's concept of White Privilege (*McIntosh, 2003*) and adapted from* the *University of North Carolina Greensboro Division of Student Affairs Intercultural Engagement. (n.d).*

Note: While richer in a group setting, this activity can be done in a dyadic supervision with instructions provided below.

Group Format Instructions:

On sheets of paper, write down random hundred-dollar amounts between $300-$700. These are the "privilege budgets." Randomly assign participants into groups of at least 3 and assign each group a "privilege budget." Provide each group with a list of the privilege statements below and as a group, have them discuss which privileges they would purchase with their "privilege budget." Each privilege costs $100. Participants are asked to buy as many privileges as their budget allows and the assumption is that each group starts with none of the listed privileges. Mentors should encourage participants to engage in discussion regarding differing views on the importance of certain privileges. Sharing personal experiences is also encouraged though optional. Once the groups have completed the task, bring them back and engage in a whole group discussion of their experiences.

Dyadic Supervision Instructions:

Have each participant select a limited number of privileges (e.g., 3) and discuss the relative importance of that privilege for the mentee and mentor. If time allows, read through each statement, and consider the implications it may carry.

Privileges for Purchase

- Your academic or training institution's staff is mostly represented by individuals who share your identifying characteristics (e.g., race, ethnicity, religion, gender, disability status, and/or sexual orientation).
- There are members of leadership and mentor who share your background and/or identifying characteristics.
- You do not feel the need to change your appearance, mannerisms, or behavior to "fit in" at your institution.
- There are no physical barriers to you comfortably accessing entrances, hallways, rooms, restrooms, or seating in your institution.
- Patients interact with you without making assumptions about your background or abilities based on your appearance.
- Persons in positions of power do not make discriminatory statements about an identifying characteristic you carry.
- You never have to miss class or training opportunities due to a disability or illness.
- Your institution offers accommodations and modifications that support your learning needs.
- Your graduate courses or training experiences are offered in your native language.
- You can move through your community without fear of sexual assault or harassment.
- You have the access and knowledge needed to easily navigate the technological requirements of your institution.
- The illness or disability of you or a loved one is never a barrier to pursuing your professional or personal goals.
- Your family supports your personal and professional identities/goals.
- Your institution offers financial resources and support that make your tuition affordable.
- You do not have to speak for or represent your cultural group in a professional context.
- You never have to rely on public transportation.
- You can pursue unpaid research or clinical training opportunities without concern.
- Your visa/immigration status does not impact your access to research or clinical training opportunities.
- Your program or your training institution is supportive of time off to address mental health needs, burnout, or overall wellness.
- Your supervisors and leaders provide consistent and constructive feedback.

Example questions for facilitation of post-activity discussion:

- Did you feel uncomfortable if a privilege applied to you or equally so if it did not?
- What emotions did you notice arise? Pride, shame, hesitancy, guilt, fear, anger, etc.
- What experiences have you had that may contribute to these feelings?
- How has the field of neuropsychology contributed to these issues?
- What can we do as a field to address these issues?
- What can we do ourselves to change the systems that have created these issues?
- How can my mentor address these issues?
- What trends, if any, did you notice about groups with more "budget"? What was it like for those groups with less "budget" to select which privileges were more important?
- How many varying degrees of privilege impact your relationships with each other? With me? (Supervisor) What about with your patients?
- Would anyone like to share a privilege statement that hasn't been discussed?

A link to statements for the traditional privilege walk can be found in the references under "Privilege Walk Exercise (n.d.) *Penn State Universit*y)

Appendix E: Target and Non-Target Journey

*Adapted from The Handbook of Multicultural Competencies (*Cornish et al., 2010)

Target and Non-Target Journey Exercise for Group Use:

(a) Introduce the task during one session and determine the order of presenters (approx. 10 minutes per journey including journey and group reflection). The following prompt can be used to introduce the exercise: *"Please describe and reflect on how you have been part of a target group (i.e., marginalized or historically oppressed) group. How has your membership in this group impacted you? You may share an example of an experience if you wish or describe how it impacts you more generally. You are also invited to share any impact on your life, including how your membership in this target group has positively impacted you*." The supervisor should model this experience by going first.
(b) Once every member has shared their target journey, each member will then cycle through their Non-Target journey, using the following prompt: "How has your membership in a Non-Target group (majority or privileged group) contributed to the discrimination, marginalization, or oppression of target groups (directly or indirectly)? When have your actions intentionally or unintentionally contributed to the oppression of a marginalized group? Do you or your loved ones hold prejudices and biases regarding other groups that have likely influenced your decisions and perceptions of others?" Again, the supervisor should first model this.
(c) Suggest to members to prepare notes or an outline before sharing with the group regarding the experiences and topics they would like to discuss.
(d) Require members to set up chairs in a circle so that all individuals are facing one another during the exercise.
(e) Members who are scheduled to share on this day will be given approximately 5 minutes to share their journeys. Encourage these members to discuss any feelings or reactions they may be having as they share their journey.
(f) After the participant finishes with Target and Non-Target Journey, their peers are encouraged to provide reflections, ask questions, or share reactions to the journey (5 minutes). Encourage that the focus remains on the trainee who has shared their experiences.

Adaptations for virtual use: Make sure that each member's screen is in "gallery" view so that all members are visible during the journeys. Members shall be required to keep cameras on during this exercise and remain on mute while individuals are sharing their journeys. During the reflection period, members can unmute themselves to respond to a journey. Everyone is encouraged to be actively listening and engaged (discourage the use of phones, chat functions, and internet surfing during this period).

Adaption for dyadic supervision: The same instructions are viable for dyadic supervision. We suggest that supervisors share their Target and Non-Target journey first.

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Appendix F: Cultural Competency Measure

Goal: To assess current comfort with cultural awareness, sensitivity, knowledge, and competency as it applies to the field of neuropsychology. While this is a "scaled" exercise, we do not provide, nor do we encourage numerical cutoffs to interpret one's competency level. Rather, we suggest this be used as a descriptive and reflective activity to encourage supervisees to assess how their comfort with awareness, sensitivity, knowledge, and competency may impact their clinical

work. As noted, cultural competency is a fluid and ongoing process, and we consider learning in these domains to be a lifelong learning process.

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
Cultural Awareness					
I am aware of my biases and prejudices and *how* they influence my health beliefs, my assessment, treatment approach, and my perception of patient experiences.	1	2	3	4	5
I engage in ongoing self-reflection to further my understanding of how my cultural factors influence my work.	1	2	3	4	5
I am aware of the ways and extent to which patients of different backgrounds face specific challenges regarding medical diagnosis and treatment.	1	2	3	4	5
Cultural Knowledge					
I consider the cultural factors that may be influencing my patient's presentation.	1	2	3	4	5
I understand the specific barriers and privileges awarded to those of different cultural backgrounds within our healthcare system.	1	2	3	4	5
I am aware of my cultural knowledge gaps and work to improve them.	1	2	3	4	5
Cultural Sensitivity					
I am comfortable exploring the affective and emotional experiences that arise during interactions with those of different backgrounds in a healthcare setting.	1	2	3	4	5
I am comfortable reflecting on my own affective and emotional experiences in multicultural interactions.	1	2	3	4	5
Cultural Competence					
I am comfortable exploring how race, ethnicity, age, religion, sexuality, disability status, gender identity, and socioeconomic status may affect my patients' experiences in the world.	1	2	3	4	5
I am comfortable exploring how race, ethnicity, age, religion, sexuality, disability status, gender identity, and socioeconomic status may affect my relationship and clinical work with my patient.	1	2	3	4	5
I am capable of interpreting neuropsychological assessment findings from a biopsychosocial-cultural perspective when giving feedback to my patients.	1	2	3	4	5
I am capable of interpreting neuropsychological assessment findings from a biopsychosocial-cultural perspective when giving feedback to referring providers, multidisciplinary care team members, and/or other colleagues.	1	2	3	4	5

Appendix G: Suggested Timeline for Toolkit in Dyadic Settings

Session	Tool/Agenda
1	Introductions, Brave Space discussion, and Cultural Competency Measure.
2	Name Game.
3	ADDRESSING Model identification exercise for supervisor and supervisees.
4	Privilege for Sale Activity. Introduce Target and Non-Target Journey exercise.
5–6	Target and Non-Target Journey exercise (depending on group size, this portion may vary in time needed. The suggested time for the supervisee is ~10 minutes).
7	Reflect on the experience of the Target Journey exercise.
8	Re-administer Cultural Competency Measure, explore differences from first outcome measure, learned information, impact on identity as a clinician and future clinical work.
9–10	Reflection (Discussion of experiences in totality and the impact on professional and personal identity development).

Appendix H: Suggested Timeline for Toolkit in a Group Setting

Session	Tool/Agenda
1	Introductions, Brave Space discussion, and Cultural Competency Measure
2	Name Game
3	ADDRESSING model identification exercise for supervisor and supervisees
4	Privilege for Sale Activity. Introduce Target and Non-Target Journey exercise
5–7	Target and Non-Target Journey exercise (depending on group size, this portion may vary in time needed. Suggested time per supervisee is ~10 minutes).
8	Reflect on the experience of the Target Journey exercise
9	Re-administer Cultural Competency Measure, explore differences from first outcome measure, learned information, impact on identity as a clinician and future clinical work.
10	Reflection (Discussion of experiences in totality and the impact on professional and personal identity development)