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The Worldview Genogram: A Process Model for Enhancing Diversity Responsiveness and Competence in Education, Training, and Clinical Supervision

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Diversity responsiveness and competence is an imperative in current graduate psychology training and few, if any, will debate this. However, what has been and still remains frustrating to most practicum and internship clinical supervisors and graduate school instructors is a dearth of safe and practical tools to enhance this process, particularly in terms of the awareness domain. The authors of this article present a process model, the Worldview Genogram (WVG), that has been developed and implemented in clinical field placements and classroom settings over the last 22 years with significant success. The WVG, anchored by a three-generational family-of-origin genogram, is a depiction of individual and cultural diversity constructs that impact a person's identity formation. A rationale for the model and specific, practical steps in implementing it in academic and clinical settings are described. The model's uniqueness lies in the fact that it is nonpathologizing, strengths-based, trainee driven, and predicated on instructor or supervisor modeling.

Impact Statement
The Worldview Genogram model presented here is a vital practical tool for assisting supervisors, supervisees, and instructors in clinical and academic settings to train as well as model integrating diversity conversations in their work. We argue that doing so allows for culturally responsive supervision, clinical work, and general training. The model's versatility allows for broad implementation across settings and situations including public mental health centers, academia, and other clinical settings

Keywords: Worldview Genogram, practical training tool/model, diversity competency/responsiveness in classrooms, field placements and clinical supervision

Cultivating diversity responsiveness and competence throughout graduate training in classroom and clinical settings are imperatives today. As the U.S. population has continued to diversify, so have the fields of psychology and counseling at the training and practice levels (Ponterotto et al., 1995; Vasquez et al., 2006). As such, graduates from current clinical programs will and are increasingly serving more and more diverse clients, perhaps most significant of which may include immigrant populations (Iwamasa et al., 2002; Lim & Nakamoto, 2008; Lopez & Bursztyn, 2013; The APA Presidential Task Force on Immigration, 2013; Yznaga, 2008). Further, trainees and clinicians, including supervisors and academic instructors, must examine intersectional diversity in their work (Anders et al., 2021; Kivlighan et al., 2019; Lee & Kealy, 2018). However, it is challenging to practically implement culturally responsive training at practicum, doctoral, and postdoctoral levels (Benuto et al., 2019; Boysen, 2011; Keiley et al., 2002), and the Worldview Genogram (WVG) attempts to address this need.

Cultural competence training has long been comprised of addressing knowledge, attitude, and skill (Sue et al., 2022). This means gaining *knowledge* of cultural groups, examining one's *attitudes* toward them, and acquiring clinical *skills* to meet the unique needs of the group(s). Involving an exploration of personal biases and enhancing self-awareness—the *attitude* component—was found to result in most optimal outcomes in cultural competence training (Benuto et al., 2019; Patallo, 2019). A major limitation of diversity training is that it focuses more on the knowledge aspect of cultural responsiveness and thus has a tendency to oversimplify cultural information about individuals and cultural groups, potentially increasing stereotyping (Benuto et al., 2019; Owen et al., 2016; Patallo, 2019).

Implementing a practical way of training to enhance the self-awareness component of diversity responsiveness and competency in graduate classroom dialogs and clinical supervision is difficult and challenging (Beitin et al., 2008; Boysen, 2011; Chege & Fu, 2013; Sue et al., 2022). Increasingly, supervisory and treatment

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arrangements in clinical training involve dyadic and group matches of varying diversity configurations (Falendar & Shafranske, 2012, 2013; Falendar et al., 2014). Supervision has been shown to be the most ideal forum for implementing diversity training due to its correlation with satisfaction in training as whole (Benuto et al., 2019; Hooley, 2019; Ramírez Stege et al., 2020). However, the dearth of beneficent and practical ways to integrate training in diversity responsiveness, especially in supervision, remains troubling. It is also common to encounter situations where trainees have had more training in and exposure to the diversity literature and training than their supervisors and instructors (Somerville et al., 2019) or for trainees to experience the necessity for engaging in these conversations being devalued (Upshaw et al., 2020). This is particularly astounding given that at the heart of solid clinical training is robust clinical supervision (Hooley, 2019), a vehicle for modeling and inculcating cultural responsiveness as a central value in budding practitioners (Crockett & Hays, 2015; Hooley, 2019). During the authors' many combined years of training and supervision, they have encountered numerous trainees and supervisors frustrated with consistent calls for culturally responsive training while having few, if any, effective tools to engage in the process (Chege & Fu, 2013).

This article is an attempt to practically address these areas of concern in academic and clinical training settings. Personal experiences with using the WVG as a process model over the last 22 years in a variety of settings will be shared. Before describing the WVG, it is important to first identify other models that have been used. The WVG process will then be detailed, including how it is differentiated from other models based upon its strengths-based, nonpathologizing approach. Finally, practical suggestions for implementing the WVG in classroom and clinical training settings will be given in an effort to address the elusive but important goal of enhancing diversity responsiveness in education, training, and clinical supervision.

Current Genogram Based Models of Teaching Cultural Competency

There have been various attempts to use genograms to enhance clinical competency. The benefits of doing so within a multicultural context include providing a clinician with a better understanding of family members and their dynamics and allowing for more effective treatment interventions (Estrada & Haney, 1998; McCullough-Chavis & Waites, 2004). In order for us to consider the need for an additional genogram-based model, it may first be beneficial to explore existing models and what they currently offer our field. Others have proposed using cultural genograms as tools in teaching and practice; however, a comparison of what they have to offer and what limitations are present is an important framework for this discussion (Aniciete & Soloski, 2011; Hardy & Laszloffy, 1995; Kosutic et al., 2009; Shellenberger et al., 2007; Thomas, 1998).

Aniciete and Soloski (2011) propose a variation of the cultural genogram called the Intrarelationship Diversity Genogram, which focuses on interracial couples in relation to their external environment. The genogram's strengths include the fact that this tool can be used with same-sex and opposite-sex couples and allows couples in clinical settings to assess their differences in marital expectations. Couples who have used this tool may reach an understanding that their challenges may be a result of their external environment. A potential limitation is that the tool is specifically designed to assess for relationship discrepancies among interracial couples and does not easily avail itself to use in classroom or clinical training settings as a tool to enhance diversity competency.

Kosutic et al. (2009) promoted a tool they coined the "Critical Genogram," a process that was designed by students in a family assessment course to promote critical consciousness. The Critical Genogram is created by producing a basic genogram, and then by constructing systems of oppression that are salient in the students' lives. Reflective questions are used to further explore their genograms. It appears to be an effective tool to examine who the person is in relation to systems of oppression. A potential limitation of this tool is that it is specifically designed to examine power and privilege and is thus not as inclusive of other aspects of individual and cultural diversity or adaptations explicit to supervision or classroom use.

Thomas (1998) encourages mental health providers to consider culture outside of race and ethnicity and builds a case for counselors to learn to be sensitive to beliefs and values, in addition to gathering information regarding race/ethnicity, immigration, social class, gender, and spirituality/religion. Thomas (1998) argues that the potential limitation of only exploring race or ethnicity is to risk not obtaining information also affecting the individual and their family system (e.g., war trauma, poverty, or converting from one religion to another).

Hardy and Laszloffy (1995) promoted a cultural genogram that emphasized sources of shame and pride associated with culture and ethnicity. At the time, this was considered a fairly new concept. Keiley et al. (2002) and Warde (2012) have made some adaptations of this model in some aspects of training marriage and family therapists, as well as social work students. A potential limitation of the model is that its process is steeped in family therapy and family-of-origin aspects that might heighten discomfort. Lack of adequate safety constraints, particularly in group, classroom, and dyadic supervisory configurations, may, at times, make this model problematic.

Shellenberger et al. (2007) also described a cultural genogram, extending beyond the traditional genogram by integrating prompts related to health beliefs and behaviors, as well as health maintenance and disease prevention practices. Their model was originally designed to encourage medical students and residents to examine cultural practices related to health across generations and may be limited in its applicability to the broader training in diversity responsiveness.

Limb and Hodge (2010) are proponents of using spiritual genograms specifically as tools for helping child welfare workers improve their work with Native American children and their families. The model involves an examination of spirituality over three generations. Although this model is likely adaptable to other racial–ethnic groups, it seems limited by its strict focus on spirituality, which is additionally a very personal aspect of identity.

Other genogram models have been devoted to clinical work with specific client populations. For example, Lim and Nakamoto (2008) and Yznaga (2008) draw on Asian families with diverse cultural heritages. An obvious limitation of these models is that they are focused on clinical work with specific populations and are not necessarily readily adaptable to training and supervision in general.

Most educators, mental health practitioners, and therapists in training are familiar with the traditional genograms constructed by McGoldrick et al. (2005) and Shellenberger et al. (2007). Both models have been used largely in the training and practice of family

therapy. Naturally, these genograms have been easily adapted to cultural explorations and incorporated as tools for training in diversity competency. They are commonly referred to as cultural genograms (Hardy & Laszloffy, 1995; Shellenberger et al., 2007). The current effort builds on these two foundational considerations, extending them beyond family-of-origin and cultural considerations to a worldview focus, which is viewed and presented as more encompassing and inclusive of a wider range of diversity factors (Johnson et al., 2011; Koltko-Rivera, 2004).

Understanding and Defining the Concept of Worldview

In order to provide a structural framework for the WVG, it is important to first define the concept of a worldview. In developing the model being discussed, the concept of a worldview was determined to provide breadth and scope that would enable educators, supervisors, trainees, and practitioners to examine issues that would deepen a self-exploration of biases, assumptions, beliefs, and attitudes. Using the worldview, construct also potentially expands avenues for more nuanced intersectional diversity explorations and, by extension, the ability to apply the concept to various dimensions of practice. Baruth and Manning (2007) state that a worldview is, "One's individual experiences and social, moral, religious, educational, economic, or political inputs shared with other members of one's reference group, such as culture group, racial, or ethnic group, family, state, or country" (p. 8). Pedersen et al. (2008) aptly surmise that:

> A person's worldview encompasses a wider range of topics, including morality, appropriate social behavior, political stances, ethics, and even the nature of the universe. A person's worldview, which he or she has overlearned by being socialized and enculturated in a specific culture for many or most of his or her formative years, is the main source of his or her intimate contact with the assumptions about the world. (p. 40)

Johnson et al. (2011) have identified six elements of worldview: ontology (existential believes), epistemology (what can be known and how one should reason), semiotics (language and symbols used to describe the world), axiology (proximate values, goals, and morals), teleology (ultimate goals and afterlife consequences of action), and praxeology (proscriptions and prescriptions for behavior). In the WVG process, we draw from this broad understanding and definition of the construct of a worldview in coming up with a wide range of questions and prompts which help participants delve into extensive explorations.

The WVG

The idea of a WVG was born out of a struggle by the lead author and several fellow trainers working at a large community-based behavioral and mental health agency in the Los Angeles area serving diverse populations in 1999 (Chege & Fu, 2013). The group coined the phrase with the idea of transcending the limitations encountered by the traditional genogram models discussed earlier and because of their clinical experience with family-of-origin diversity focused explorations emphasizing psychopathology. The goal was to systematize a process that would create enough freedom and safety for supervisory dyads and groups to examine the influences of their worldviews on their respective roles without the trappings of the traditional genograms, which typically have a heavier focus on psychopathology (McGoldrick et al., 2005). The authors have since expanded the use of the WVG to graduate classroom settings. The WVG de-emphasizes psychopathology and focuses on the overarching general and organizing principles of worldview and culture. However, because it is anchored in a three-generational family-of-origin genogram like most other genogram models (Hardy & Laszloffy, 1995; McCullough-Chavis & Waites, 2004), it is still possible to examine crucial family and generational influences that have shaped one's worldview. Indeed, as, will be discussed in more detail later, familial and generational information, including its influence(s) on one's worldview, can still be incorporated into the process by deriving critical themes without veering into uncomfortable and unsafe pathology laden aspects that have tended to limit other approaches during classroom and supervision discussions.

Basic Tenets of the WVG

There are five basic tenets to the WVG process. First, the WVG emphasizes adaptation, resilience, and strengths. Second, the process of constructing the WVG is predicated on a philosophy of modeling, in that it requires educators and supervisors, in an established environment of respect and appreciation of each other's background, to first offer their own WVG to their student(s) or supervisee(s). Third, the model adopts an inclusive and comprehensive definition of culture and diversity by relying on one's worldview as defined broadly earlier. Fourth, the WVG process invites the participants to intentionally note how their worldview influences their roles as clinicians, supervisees, and supervisors (current or aspiring), and also assists them in elucidating motivations for joining the field of psychology. Fifth, although its target is primarily the self-awareness (attitudes, assumptions, biases) domain, because of its practical nature, the model also directly impacts diversity competency in the domains of knowledge and skills. Transference and countertransference influences (ethnocultural or otherwise) are accessed, and their examination has great potential to impact all three benchmarks of diversity competency—attitudes, awareness, and skill.

As authors, we are guided by some fundamental convictions in regard to how to make these tenets central to the WVG process. Primary to us, and perhaps the biggest asset and contribution of this model, is the centrality of modeling by having supervisors and instructors present first. Much more is learned and "caught" by the students through the supervisor modeling the WVG process than what is taught through the didactic content. Many of our students and supervisees give feedback that it is very helpful to have the trainer/supervisor present first (Chege & Fu, 2013). Doctoral interns and practicum students in their anonymous end of training supervisor evaluations, and graduate students in their end of term course evaluations, have profusely cited this as the most compelling tenet of the model.

Modeling the process for the supervisees (Crockett & Hays, 2015; Peters, 2017) and students is an important initial step, but without having first established an environment of respect and compassion, is not sufficient. There are minimally three aspects of our profession that work against students, faculty, supervisees, and supervisors being able to realistically observe and then acknowledge values and beliefs. The first is the very real power differential between students and faculty, and supervisees and supervisors. It is important to acknowledge and respect the power differential

(Hooley, 2019; Ochoa & Pineda, 2008; Proctor & Rogers, 2013), to be transparent about evaluative elements, and to be consistent and strengths-based in giving feedback to supervisees in an effort to establish an environment of trust and safety within the relationship. Many students have never voiced their family values to anyone, let alone to a supervisor with evaluatory power. Falendar and Shafranske (2013) state that a strong supervisory alliance is critical to enhancing supervisee development and self-disclosure in supervision, particularly in terms of reactivity/countertransference reactions. The second aspect is that while we are all biased, acknowledging bias, even if one is not from a dominant cultural group, is generally not well received and is often thought of as evidence of prejudice. Sue et al. (2022) identify this inhibitory reaction by noting our moral biases and suggest that no one wants to either act or think in a prejudicial way, nor be thought of as prejudiced. This can be a particular problem for trainees who identify as White. White identified trainees often struggle with guilt and shame when engaging in multicultural self-explorations, and these affects often impede their growth and clinical development (Parker & Schwartz, 2002). Creating an environment where acknowledging bias is seen as a helpful and constructive path of change and growth is vital to the implementation of the WVG exercise.

Third, potentially, there is power within the WVG model to combat the stigma against mental illness that exists at systematic levels of society (Adams et al., 2010; Servais & Saunders, 2007). The bias toward and disidentification of individuals with mental illness may limit a supervisor or supervisee/student from benefiting the most from the exercise. Supervisees doing the exercise the first time have often reported to us that they learned through the preparation phase that a close relative had a serious mental illness that was never spoken about in their families of origin. The injustice of mental illness stigma resounds in many of the stories found as a result of the WVG. Acknowledging the stigma, and creating safety among supervisees and supervisors to consider internalized aspects of the stigma, is a very powerful aspect of the exercise. It is important to note that ethical considerations of informed consent related to self-disclosure, emotional discomfort, vulnerability are addressed prior to engaging in the exercise (Cutri & Whiting, 2015; Deal & Hyde, 2004). All the settings where the authors practice have full disclosure in their publicity material about the nature and scope of these expectations during their training.

General Structure of the WVG Process

We now turn to the practical aspects and steps of the model.

Step 1: Research and Preparation Phase—Information Gathering

The goal of the preparation phase is to clearly gather and distill sufficient information to enable one to identify the implications of one's worldview on role functionality as a clinician, supervisee, and supervisor. It is important to begin by constructing at least a three-generation family-of-origin genogram. This appears to be the standard in most genogram exercises (Hardy & Laszloffy, 1995; McCullough-Chavis & Waites, 2004) and is the anchor of the process. One can, but does not have to, use technology programs such as Genopro or Ancestry.com to assist in gathering and organizing the information, and then follow the standard genogram symbols referenced in McGoldrick et al. (2008). There is flexibility in how this is done. Freehand drawing is permitted, too.

Instructions include telling participants to obtain as much information on their history, familial background, and all other possible worldview influences using questions as prompts. These prompts can vary in detail, nature, and scope depending on the setting and length of time available. It may be important to interview as many family members from various generations as possible, and to reference charts on generational and cohort influences, incorporating the Age and generational influcence, Developmetnal disability, Disability acquired later in life, Religion and spirituality, Ethnic and racial identity, Social economic status/social class, Sexual orientation, Indigenous heritage, National origin & Gender (ADDRESSING), framework (Hays, 2008), as a structured process for obtaining information covered under each domain. Any other means to generate the most detailed information on as many worldview variables is welcome. There is flexibility, and Hays (2008) framework is suggested because of its conciseness and thoroughness. Other frameworks which provide an intersectional approach to diversity are encouraged. Everyone is encouraged to generate as much insight and awareness as possible. The goal of the preparation phase is to identify implications of the past.

Step 2: Integration—Critical Examination, Analysis, and Synthesis

The goal of step two is to critically examine the insights and awareness generated in step one. The value of investment and engagement in the process itself is often as important or more important than the end product. Although the WVG de-emphasizes psychopathology, it is a good practice to attune oneself to these dynamics. A student or supervisee is not required to share anything that they are uncomfortable with, but are certainly encouraged to spend time exploring the implications of the dynamics uncovered. It is helpful to attempt to derive themes that may be safe to share in group or individual contexts and reflect on their impact in the various roles occupied.

The next step in this phase is to exhaustively and integratively assess how one's unique worldview impacts or may impact role functionality as a clinician, supervisee, and as supervisor. As pride and shame are critical motivators of behavior pertinent to diversity (Hardy & Laszloffy, 1995; Parker & Schwartz, 2002), it is helpful to identify at least two areas of culturally related or derived pride and at least two areas of culturally related or derived shame from one's background. Additionally, it is important to elucidate worldview influences instrumental in leading one to the field of psychology, and we recommend identifying at least three. We have learned that examining motivations for choosing the field of psychology as a healing profession are very often deeply intertwined with one's identity and worldview influences. Using the WVG to make these connections is illuminating, empowering, and clarifying. This has been our experience during numerous presentations in individual and group supervision as well as graduate school classrooms. Clinical trainees and students doing the WVG in their diversity course have reflected the same in their respective anonymous supervision and course evaluations.

Step 3: Presentation Phase—Setting or Situation Specific

The WVG is very adaptable to various instructional and training settings. Supervisors and instructors have latitude in determining

how they structure their presentation as long as they cover the required areas. Supervisors and instructors first model the process by presenting their own WVG. Minimally, all presenters discuss implications for clinical work, supervision, transference, and countertransference. Individuals determine levels of self-disclosure, with no adverse consequences (Chege & Fu, 2013). The goal of the presentation phase is that each presenter and the participant/audience are able to integratively examine the influences of their worldview background. The last step in this phase is interaction with the audience based on the setting and, in the case of individual supervision, between the two members of the dyad. We have found this to be very enriching and affirming as participants and presenter discuss their observations in strengths-based ways.

General Implementation Across Settings

These following instructions are designed to be adapted for use in academic, supervisory, and group or dyadic settings. The authors have implemented the WVG in all these settings many times over. The facilitator's first and most critical job is to work on establishing a climate of respect, safety, and trust (Ramírez Stege et al., 2020) and to design exercises to enhance this process so that these dynamics are established fairly quickly. For example, in academic settings, two of the authors find it helpful to have students visit the Museum of Tolerance in Los Angeles as an immersive experience in order to promote insight and lower defensiveness or other inhibitions. Second, as stated previously, the facilitator should present their WVG first. In addition to this, it has also proven to be extremely helpful to have a previous participant (e.g., a student from a cohort that has already participated in the exercise) who had a good experience with the process return. It is important to prepare the guest participant well in advance. At a field-based training, we recommend that the director of training present first, followed by respective supervisors. This two-level modeling process is powerful in helping to enhance comfort with the process. Using PowerPoint is recommended, especially in classroom and group settings.

Third, in group presentations and classrooms, ask for volunteers for the first several presentations and open sign-ups for the rest of the time. This way, those who are confident continue the modeling and normalize the process for the rest. In the meantime, safety, trust, and cohesiveness dynamics are evolving as the process continues, with the facilitator monitoring the process and addressing concerns (Thakral et al., 2016; Tinto, 1997) in a transparent manner. Fourth, allow adequate time for the interactions, questions, and sharing insights after each presentation. Many participants are naturally curious about the personal details of the presenter, so clarify the focus of the exercise, but leave room for the presenter to address anything else they feel comfortable with. The facilitator moderates the overall process and, as necessary, sets the tone for discussions without domineering or stifling acceptable inquiries by participant(s).

Fifth, a debriefing mechanism is often helpful and varies by setting. For example, in academic settings, the instructor may provide immediate written feedback using a standard rubric formatted after the presentation prompts. The presenter may write a brief reaction article focusing on their experience of presenting. One of the authors has had a more elaborate follow-up process article turned in a week after the class presentation wherein students integrate their insights and apply them to current practicum experience. If it is necessary to grade this part of the project, the focus should be more on engagement of the presenter to the process, and less emphasis should be placed on the mechanics of the presentation itself. For group and dyadic supervision, debriefing ought to occur shortly after the process is completed.

Last, since the goal of this exercise is to increase diversity competency and responsiveness in awareness, knowledge, and skills, it is recommended that the follow-up discussion and debriefing sessions be contextualized to the setting and roles of the facilitators and participants. It is often useful to relate this to ongoing practical or other clinical work and ask supervisees and students to reflect on what they have learned from the exercise that informs their roles as supervisees, clinicians, colleagues/peers in training. In individual and group supervision, we recommend this happening immediately after the presentation are over. Other areas included in this examination are ethnocultural considerations and other transference and countertransference issues. Further, one of the authors asks students to examine, by way of a separate article, how they noticed their unique worldview impacting how they engaged, assessed, evaluated, and diagnosed clients, as well as how they went about treatment planning and termination. There is plenty of room for creativity and flexibility with the assignments that can be designed around this process.

Example

The following actual account (used with permission by student) is from an article written after a recent in-class WVG presentation with one of the authors.

> In unpacking my worldview influences, it has become evident that I have been afforded many privileges. I determined I am privileged in 9 out of 10 of these areas of ADDRESSING framework (Hays, 2008). However, one could make this 7/10 due to my religious identification and indigenous heritage. It is my personal opinion that other aspects of my framework, namely my socioeconomic status and ethnic identification, shielded me from other areas of potential disadvantage. I also attribute my hesitancy to lower my score to feelings of extreme guilt and shame surrounding my socioeconomic standing and experience of White privilege.

It is also important to highlight my hesitancy in my ethnic identification. Although I identify as Caucasian, my ethnic makeup is that of mixed heritage. My mother, who is ethnically Mexican/Italian, has an olive complexion and black hair. Although I outwardly appeared Caucasian and was told by larger society that I was White, I felt dissonance and confusion around this identification, due to the fact that my appearance was markedly different from those to whom I was most closely related. During my in-class presentation I was asked why I do not consider myself to be multiracial. My response to this question is not dissimilar to my reasoning behind scoring myself a 9/10. Although there are aspects of my Mexican/Italian culture that I can identify as having shaped my upbringing, I cannot bring myself to openly identify with these cultures out of guilt and shame surrounding my socioeconomic standing and countless instances of being afforded white privilege throughout my life due to my outward appearance.

In-depth examination of my personal ADDRESSING framework and how the interplay of these diversity factors inform my worldview, provides great insight into the challenges I have faced as a burgeoning clinician. Due to the inherently sensitive nature of working with survivors of sexual trauma, the impact of my personal

history on these clinical factors is all the more relevant to my goal of becoming a culturally responsive clinician.

The student used the ADDRESSING framework in addition to other guiding questions to gather information and generate insights and awareness. Engaging in the WVG process, including class feedback, writing a brief integration paper in a week's time as well as a more elaborate process paper at the end of the semester enabled her to deeply examine how many of her worldview influences impacted how she was working with survivors of sexual abuse at her concurrent practicum.

In individual supervision, a student let her supervisor—one of the authors of this article-know that had they not shared their WVGs, she'd not have shared how the loss of her father just before internship started made it hard for her to connect with clients. "You humanized yourself by sharing your WVG and modeling it for me. Now I know I can share without feeling like I am talking to a stranger. I also saw many commonalities between us and our backgrounds despite being racially different, and that makes supervision a safe space for me." During the debrief process after all interns had presented their WVG in group supervision, another one stated "I had never made the connection between my maternal grandmother's struggle with bipolar disorder and me deciding to pursue clinical psychology until we engaged in the WVG process. I know it impacted my family, especially my mom, and how she parented us. I feel motivated more than ever to work with parents who have a major mental illness so they can parent their children better and prevent further perpetuation of psychological problems in the family system intergenerationally."

Overall Lessons Learned

Almost without exception, the most common feedback heard at the conclusion of the WVG presentation process in classrooms and clinical supervision is that group cohesion has been enhanced. In one graduate school setting, cohorts have reported experiencing significant reduction in intracohort conflicts and splits that was acknowledged by both cohort members and administration. In group supervision formats, a common refrain is, "Wow, now I know my cohort members in a much more meaningful way." In dyadic clinical supervision, we commonly hear, "Now I understand where my supervisor/supervisee is coming from and why they tend to … and, I wish we had done this earlier." Further research on the impact of the WVG will shed light into how much of this is directly attributable to participating in the exercise.

Second, regardless of the setting, there is no substitute for modeling by the lead professional. Although this may seem intimidating for instructors and supervisors, the rewards are immeasurable, and the freedom built into the WVG process makes even beginners less intimidated. Third, due to the humanizing factor of the process, the authors have noted over and over again that the WVG creates freedom for ongoing, broad-based diversity conversations by supervisors and instructors with their trainees. Everyone somewhat becomes de-mystified and made more relatable. From anonymous feedback obtained through various means of evaluating supervision and academic courses, we have noted that there are clear ways showing that this translates into better care for clients in clinical settings, richer diversity dialogs in academia, and improved relationships between supervisors and supervisees.

Fourth, although the three diversity competency aspects (knowledge, awareness, and skills) are all enhanced by this process, the self-awareness domain, which in our opinion and experience is the most difficult to develop practically, is the biggest area enhanced by the WVG process. This is largely due to the discomfort a lot of people have in exploring certain aspects of their backgrounds and worldview experiences (Parker & Schwartz, 2002; Sue et al., 2022) Fifth, increased self-awareness gained from the process appears to free trainees from the terror of the unspoken, un-examined, unprocessed, and often, unacknowledged privileges and oppressive dynamics. Needless to say, the gains from this process have the potential to permeate multiple aspects of professional identity and practice.

Limitations, Caveats, and Cautions

In academic settings, large classes can present logistical and safety challenges, and ought to be factored in when engaging in the WVG process, particularly in terms of scheduling. When possible and depending on class size, it is helpful to split the class into two sections and have two separate instructors. It is important that participants have sufficient, structured time to present their WVG's. Generally, in small groups, setting aside 1 hr for each presentation allows enough time for the presentation as well as comments from the cohort and the instructor. We have done 20-min classroom presentations with fair amount of success.

Processing one's worldview can be especially difficult for trainees, students and supervisors who come from cultures where there are strict taboos against talking about one's generational issues outside the family. It is important to create a facilitative environment so that stigma about certain issues does not impede the process (Lund et al., 2020). The difficulty can be exacerbated when one's family-of-origin genogram is not traditional or contains significant historical trauma and loss. It is often helpful to reiterate the need to focus on strengths and values rather than the psychopathology that is typical of traditional genogram presentations. The WVG process can be painful; however, it involves understanding the impact of privilege or recognizing the stigma and discomfort with mental illness inherent in most families of origin. It is important that the faculty and supervisors be skilled at navigating diversity conflicts and facilitating strengths-based discussions (Peters, 2017; Tinto, 1997).

Finally, caution is urged if a presenter elects to use the ADDRESSING framework (Hays, 2008) as their primary presentation structure, especially in regard to sexual orientation, so that no one feels the pressure to come out prematurely to any audience. Having said that, it is also important to note that presenters have, at times, found their supervisors, peer supervisees, or classmates are the best people to first come out to. Those who choose to do so within the WVG presentation process are aware from the beginning that no such requirement is made. One of the strengths of the model is absolute freedom to determine levels of disclosure and content to share. Second, the model does not dictate the format of content presentation, so no one is required to follow the ADDRESSING framework (Hays, 2008) format. The veracity of these self-reports on the benefits of the experience of participating in the WVG exercise will be examined when data on the same is gathered and analyzed in the near future.

Conclusion and Future Directions

We have found the WVG to be an excellent and respectful process to fulfill a critical gap in enhancing diversity competency training and conversations in academic, internship, and practicum training

settings, as well as in group and individual clinical supervision. The authors' combined experience of many years and over 800 WVG presentations attest to the versatility of this tool and its strengths-based tenets. Our next plan is to collect qualitative data in academic and clinical field placements in order to demonstrate the efficacy of this experientially powerful model.

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