

Teaching Activities and Philosophy

Throughout my career my educational efforts have focused on clinical training, mentoring, development of community-based clinical training opportunities, didactic instruction and guest classroom lecturing. I have served on four dissertation committees and one honors thesis committee. My effort devoted to educational activities has varied over the years, from approximately 50% to about 10% as it is now (see below).

Since 1995 I have supervised 24 post-doctoral fellows completing two-year fellowships and 36 clinical psychology interns completing rotations in Pediatric Neuropsychology (University of Minnesota Medical School Clinical Psychology Internship is housed in Pediatrics). The process of supervising trainees is quite demanding. Assessments require that the trainee spend six to eight hours with the child and parent over two days to complete testing, interviewing, and family feedback. Trainees receive real time supervision on test administration, scoring, interviewing, case conceptualization, and family feedback technique. Trainees review extensive school and medical records and often interview teachers. They spend five to ten hours writing a four to twelve page report geared for parents and schools and the supervisor spends about two hours editing each report. I typically supervised three or four cases per week.

I have served as mentor to five post-doctoral fellows in community-based research, grantsmanship, clinical skill development, community-based clinical program development, and job seeking. As part of my mentoring work, I collaborated with mentees to design two community-based clinical training experiences. One was at Minneapolis Crawford School, which serves predominantly lower socioeconomic class students of color classified as Emotionally and Behaviorally Disordered. At Crawford we worked closely with the principal and school nurse to design a neuropsychological assessment service to augment the school's scarce mental health services. We created a mutually beneficial two year relationship that provided the school with desperately needed diagnostic services and recommendations and my mentee and me with an opportunity for both "real world" clinical training and a site for data collection for a research project on the neuropsychological and neurophysiological correlates of aggression. We ended this program in 2001 when the principal and school nurse left the school and my mentee completed his fellowship. The second experience was at Anderson Elementary, a Phillips Neighborhood school which serves predominantly inner city children of color whose families are non-English speaking. The goal in this experience was to create a Coordinated School Health Care model through the integration of School Psychology and Pediatric Neuropsychology trainees into the school-based health team. We worked closely with the school social worker and implemented this program for about one semester before I moved to my administrative position.

As the full-time Director of the Children, Youth and Family Consortium, I do not engage in clinical training, mentoring, or program development activities. I continue to teach clinical psychology intern didactics three times per year as I have in the past, focused on cultural diversity, environmental health, and grantwriting. I continue to guest lecture on community partnerships in Medical School (i.e. InMd 7521 Health Activism) and School

of Public Health (i.e. PubH5742 Research Ethics; PubH6606 Building Communities, Increasing Health: Preparing for Community Work; and PubH5661: Community Organizing for Public Health Workers) classes. Since taking my administrative position, I have developed a relationship with General Pediatrics and Adolescent Health (we are co-located in McNamara Alumni Center) and have begun to guest lecture for their fellows.

My teaching philosophy, or more appropriately my training philosophy, is grounded in three principles. First, I *have high expectations* for trainees and myself. I assume that trainees are self-motivated, independent and critical thinking junior colleagues and I treat them as such. Therefore, I strive to create a forum for them to develop their clinical skills, academic interests, and professional identities through; 1) asking questions that encourage application of course-based knowledge to clinical care; 2) encouraging integration of multiple data sources to create sophisticated and ecologically valid case conceptualizations; 3) encouraging trainees to coordinate all aspects of clinical cases; and 4) emphasizing the value of high quality work and professional responsibility. For myself, I expect that I will serve as a role model, displaying highly developed clinical skills, excellent communication, interpersonal and teamwork skills, and consistently ethical and professional behavior. I serve my trainees, rather than expecting them to serve me. I view my role as facilitating their academic and professional development rather than expecting them to support my clinical work. I provide frequent constructive feedback. I don't rewrite trainee reports or simply make corrections. I explain why I think changes are necessary and I encourage trainees to challenge my suggestions if they disagree.

Second, I believe that trainees learn most effectively through *participatory learning*. Clinical training is learning through doing with support, supervision, and constructive feedback. As described above, I have taken participatory learning farther, by creating innovative, community-based training opportunities to allow trainees to experience the complex clinical and ethical situations that arise "in the wild."

Third, I view my teaching and training as *complementary to my research and community engagement interests*. As the above-mentioned community-based training opportunities illustrate, I bring my passion for community collaboration into the clinical training situation. I also integrate research into my clinical training activities when possible, as demonstrated by my aggression study conducted in collaboration with Crawford School. I invite students to co-present at conferences and co-author manuscripts (I have noted these in my vita). My guest lectures in Medical School and School of Public Health courses are devoted to the mutual benefits of community-based participatory research and other forms of community-engaged scholarship. Integration of clinical training, teaching, research and community collaboration allows me to bring examples from my own research and community engagement into the classroom and supervisory relationship, as well as to further my own thinking through discussions with trainees and students. I view myself as a co-learner with students in their academic journeys.

I plan to continue teaching clinical psychology internship didactics and lecturing in Academic Health Center courses. I am particularly interested in increasing my participation in the Division of General Pediatrics and Adolescent Health fellows program.