

# The Professional Adolescence of Clinical Child and Adolescent Psychology and Pediatric Psychology: Grown Up and Striving for Autonomy

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**We review the present and future of the specialty field of clinical child and pediatric psychology. The progress in education and training, science, practice, and organizational developments in this specialty is described with attention to the special issues of the developing field. Clinical child and pediatric psychology are well positioned for continued healthy development.**

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A century ago, one might have predicted that the predominant focus of clinical psychology would be the study and treatment of psychopathology among youth. Lightner Witmer, often credited as the founder of clinical psychology, envisioned a scientist–practitioner field with a focus on children and adolescents in particular (Routh, 1996). Following World War II, however, attention within the field of clinical psychology shifted radically toward understanding and treating psychopathology in adulthood, particularly among war veterans. Within a decade postwar, a taxonomy of predominantly adulthood psychiatric symptoms was introduced (*DSM-I*; American Psychiatric Association, 1952), and federal funding was directed toward the now named Department of Veteran

Affairs and to the National Institute of Mental Health to subsidize training, research, and practice opportunities in adult psychopathology. Published research during this same era offered an impetus for the development of more efficacious treatment of adult psychopathology, and applications of novel theoretical models (e.g., behavioral) began to receive attention as possible alternatives for psychotherapy in adulthood.

Today we bear witness to at least two enduring effects of these postwar developments. First, modern clinical psychology per se remains largely focused on the study and treatment of psychopathology among individuals between 18 and 65 years of age (Roberts, 2005). Second, clinical child and adolescent psychology (CCAP) and pediatric (i.e., child health) psychology (PedP), now impressively thriving and productive fields of their own, continue to wrestle with their historical identities as subspecialties of general (adult-oriented) clinical psychology versus unique areas with discrete training needs, scientific traditions, a developing knowledge base, and public service goals. The accomplishments of CCAP and PedP, often despite the emphases on clinical (adult) psychology over the past 50 years, have been remarkably significant. As noted in the petition for recognition of clinical child psychology as a specialty: “During the past 25 to 30 years . . . the area of clinical child and adolescent psychology has become a well developed and legitimate area of specialization, characterized by the development of an ever increasing body of specialized knowledge and a vibrant, diverse and specialized area of practice” (Commission for Recognition of Specialties and Proficiencies in

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Professional Psychology, 1998, p. 2). In light of these accomplishments, future goals in training, science and practice, and organizational domains likely will reflect the emerging identity struggle of CCAP and PedP as the offspring of clinical (adult) psychology or matured disciplines capable of prospering autonomously.

## **TRAINING**

It might be argued that the future of CCAP and PedP ultimately will be reflected in the areas' approaches to training future psychologists. Two training issues prevail, and will require prompt attention in the field to ensure the continued development of these areas. A primary and long-standing issue pertains to the training of CCAP and PedP as subspecialty areas within clinical (adult) psychology. It has long been recognized that the study and treatment of mental health among youth requires a fundamentally different approach toward clinical psychology, including, but not limited to, the conceptualization of psychopathology as a developmental construct, the consideration of multiple person-context transactions (e.g., within families, schools, and communities) that may contribute to, and be affected by, psychological symptoms, the unique manner in which identified clients may be capable of participating in treatment, and the reliance on external informants to assess psychopathology and treatment progress. Importantly, this approach does not merely represent a modification of theories and practices of clinical (adult) psychology, but rather an ideological shift in the nature of the discipline. Thus, training in CCAP and PedP requires a comprehensive training approach, rather than child experiences added on as an adjunct to a primary clinical (adult) approach (Roberts & Sobel, 1999). Indeed, La Greca and Hughes (1999) asserted that "...training models that add on a little bit of child work to primarily adult-oriented clinical training are inadequate for preparing practitioners and researchers who can effectively address the needs of children, youth, and families" (p. 442).

The need to document the unique and comprehensive training needs that are required to competently work with children, youth, and families initially was recognized in the late 1970s; they were later codified by a Task Force of the APA Division of Children, Youth, and Families and at the National Conference on Training Clinical Child Psychologists in Hilton Head, South

Carolina (Roberts, Erikson, & Tuma, 1985; Tuma, 1985), and were more recently reformulated and revised at a Kansas-based training conference (Roberts et al., 1998). These training recommendations also were adapted more specifically for pediatric psychology (Spirito et al., 2003). Several common themes are evident in each of these sets of training models and recommendations, including (a) the incorporation of lifespan developmental and developmental psychopathology perspectives throughout training; (b) the presence of a cadre of training faculty with expertise in psychological work with children and adolescents; (c) training experiences in a variety of research and practice delivery settings, reflecting the unique roles of clinical child and adolescent, and pediatric psychologists; and (d) specialty training in the fundamental areas of clinical psychology (i.e., psychopathology, assessment, treatment, research methods, ethics, etc.) with a predominant emphasis on children and adolescents. Progress in adhering to these training recommendations has been somewhat mixed, however.

Several indices suggest substantial progress in CCAP training. In 1982, Roberts reported that CCAP doctoral training occurred largely in the context of general clinical (adult) psychology programs wherein students acquired experience with children and adolescents as a supplement to predominantly adult-focused training. At that time, 10 of the 15 identified U.S. doctoral psychology programs offering training in CCAP fit this training model, two programs offered a specialized training degree in CCAP specifically, and the remainder of programs offered CCAP training as part of a different program of study (i.e., developmental or school psychology; Roberts, 1982). Today, at least 30 U.S. clinical psychology PhD programs offer formal training in CCAP as a specialty track, concentration, or emphasis, at least three offer a specialized training program in CCAP specifically, and at least three programs now also offer a specialty track in PedP.

### **"How Much" Child Training Is Sufficient?**

Thus, the good news is that training opportunities in CCAP and PedP are becoming more abundant. Unfortunately, this growth in training opportunities has been accompanied by increased variability in the types of experiences that are considered to be "formal training" in CCAP. Even among programs that identify a training track, concentration, or emphasis in CCAP, there is a

substantial range in the proportion of training faculty available with expertise in CCAP or PedP, as well as the number of didactic courses and practica experiences in CCAP or PedP available to students. To the extent that the quantity of training experiences or faculty affects the quality of CCAP or PedP training, this issue has numerous potential implications. For example, one implication pertains to the enforcement of the first principle of the APA Ethical Principles of Psychologists and Code of Conduct stating the importance of practicing within the bounds of competence (American Psychological Association, 2002). A second implication pertains to “truth in advertising” when recruiting applicants to doctoral programs in psychology. Students who enroll in a doctoral program purporting to offer CCAP and PedP training currently are not guaranteed that their experiences will afford them competence in working with children, adolescents, and families.

A resolution to this dilemma may be simply to enforce standards for minimum training experiences in CCAP and PedP at different levels of training. This solution could prove particularly complex, however, and likely will require CCAP/PedP first to adopt a more uniform stance on the doctoral training model most appropriate and feasible for advancing these respective fields. A central issue will be to develop some consensus as to (a) whether adequate training in CCAP and PedP can continue to occur within the context of general clinical (adult) psychology as a subspecialty area (i.e., without lengthening doctoral training prohibitively), and if so, whether minimal subspecialty guidelines are required; (b) whether a preferred CCAP and PedP training model will involve clinical psychology specialty programs that include a more formalized emphasis on child and adolescent issues throughout training; or (c) whether all clinical psychology programs might be required to adopt a lifespan training perspective, thus reversing the now default adult emphasis that characterizes modern clinical psychology, and allowing for more generalist training with subspecialty in either clinical adult or in child and adolescent psychology.

Importantly, the current training environment offers no official opportunities to ensure that what is advertised and offered as graduate training in CCAP or PedP meets at least minimum requirements in these areas, or that individuals who claim expertise in CCAP or PedP

demonstrate minimal competence. The internship application process offers an informal gateway for ensuring some quality control among students wishing to obtain specialty experience in CCAP or PedP. This training stage perhaps has been the most effective at professional regulation; the increasing competitiveness of internship admission has allowed programs to demand greater depth of training (i.e., within CCAP or PedP, for instance) at the doctoral level.

At the postdoctoral level, two recent opportunities for ensuring minimal CCAP or PedP competence are available. Formal postdoctoral programs may apply for specialty accreditation in clinical child psychology. Professional certification (i.e., American Board of Professional Psychology)—an elective process—also offers documentation of at least minimal expertise. Certification in CCAP was established in 2003 by the creation of the American Board of Clinical Child and Adolescent Psychology and the American Academy of Clinical Child and Adolescent Psychology following recognition in 1998 as a specialty by the APA Council of Representatives and the Commission for the Recognition of the Specialties and Proficiencies in Professional Psychology (renewed in 2005). Currently, state and provincial licensure do not occur at the specialty level, however.

The APA Committee on Accreditation typically serves a regulatory function for doctoral training in professional psychology programs generally. However, APA does not accredit areas other than clinical, school, and counseling psychology at the doctoral level. Thus, accreditation guidelines generally reflect a contemporary conceptualization of clinical (adult) psychology with numerous areas of competence (i.e., breadth of psychology) required for successful accreditation. Training in CCAP and PedP presently might be accredited by demonstrating that a program exclusively specialized in these areas still meets the requirements for general clinical psychology accreditation, or by integrating CCAP and PedP training experiences as a track, concentration, or emphasis area added onto a clinical (adult) psychology program. The former model is an option only for an institution with the resources and commitment to establish a specialized doctoral program. The latter model is the most commonly employed model for current CCAP and PedP training; however, training guidelines, such as those reviewed above, have not been formally adopted, either by the

field of clinical (adult) psychology, or by the APA Council of Representatives, or the Committee on Accreditation. Thus, the regulation of CCAP and PedP training remains less well enforced than training in clinical (adult) psychology. Relatively recent innovations in the creation of developmental psychopathology doctoral programs offer promising new directions for the creation of a better integrated lifespan training approach.

#### **What Are We Training for?**

A second training issue relevant to the future of CCAP and PedP, perhaps even more so than for clinical (adult) psychology, will involve a possible reconsideration of training goals. The products of CCAP and PedP in the marketplace arguably never have been more needed and valued than today. Children's mental health issues have received an unprecedented level of national attention in recent years, evidenced by the declaration of a national crisis in children's mental health by the Surgeon General (Department of Health and Human Services [DHHS], 1999) and a similarly themed White House conference in the same year. Over 13 million children (nearly one-fifth) of all U.S. youth are in need of mental health treatment, yet only one-third of youth with psychiatric diagnoses receive treatment (DHHS, 1999). Research and practice guidelines developed by clinical child and adolescent, and pediatric psychologists have had substantial implications for policy, program development, and mental healthcare provision and reimbursement over the past decade, illustrating the vast influence of CCAP and PedP in recent years.

As the mental health needs for children and adolescents have become more evident, the roles of clinical child and adolescent, and pediatric psychologists also have evolved. This soon may have important training implications. Although the scientist-practitioner (i.e., Boulder Model) training emphasis remains the most common model for training in clinical (adult) psychology programs, and by extension many CCAP and PedP programs nested within, growing numbers of PhD clinical child and adolescent, and pediatric psychologists are acquiring positions of employment that involve neither traditional science- or practice-oriented responsibilities. Recent graduates are more likely than their predecessors to obtain jobs outside of academia, in new settings (e.g., schools, primary care, and corporate firms), and

involving new roles (e.g., consulting, policy, program evaluation, supervision of nonpsychology healthcare professionals) (Barker & Kohout, 2003). These employment opportunities often do not match the types of experiences or skills that comprised the focus of graduate training (Snyder & Elliott, 2005), yet the addition of graduate training experiences to meet these new professional needs remains practically infeasible without significantly increasing the length of doctoral programs (Roberts, 2005). Continued attention to professional development training, perhaps at the postdoctoral or continuing education levels, will be needed to prepare graduates for new employment opportunities (Prinstein & Patterson, 2003).

#### **SCIENCE AND PRACTICE**

For many years, scientific endeavors in both clinical (adult) psychology and CCAP/PedP have been motivated by interests derived within the field; findings from this research then have been used to help direct priorities within the broader healthcare community, to guide policy, and to evaluate mental health-related programs. Since the era of managed care reform, scientific inquiry has been guided more dramatically by external needs, such as the responsibility to demonstrate the efficacy and effectiveness of psychological treatment most notably, as well as needs guided by changing federal funding priorities, educational initiatives, and primary-care practices. CCAP and PedP are in unique positions to capitalize on these changing dynamics in science. Perhaps more so than clinical (adult) psychology, the CCAP and PedP fields have had more integrated traditions of science and practice, without as many of the battles. These fields also have established collaborations with systems outside of the traditional scientific contexts of clinical (adult) psychology, including school systems, community settings (e.g., after-school care), and primary health clinics. An important future direction for CCAP/PedP will be to bear its considerable expertise and knowledge on the examination of these systems and their effectiveness, and to establish models for consistently integrating mental health practices into multiple youth settings (Roberts, 2005).

As with clinical (adult) psychology, it will also be essential for CCAP and PedP to continue to demonstrate the utility of psychological treatment in response to a

variety of presenting concerns, among a broad range of populations and settings, and to examine the multifinality of treatments or preventions on many types of outcomes, in addition to symptom reduction (Spirito & Kazak, 2006; Weersing & Weisz, 2002). A maximally efficient way to achieve this goal may be to continue a concentration on elucidating the mechanisms underlying efficacious/effective psychological interventions and prevention programs with hopes toward dissemination of active treatment mechanisms that then can be packaged in different forms based on the specific population, clinical presentation, or setting in question (Weersing & Weisz, 2002). Such translational issues between the science and practice of CCAP and PedP ultimately will prove crucial for the dissemination of evidence-based treatment and may help to address the barriers of resistance that currently impede dissemination progress.

Interestingly, a possible, but relatively underutilized, ally for promoting both the consideration of mental health services across youth contexts, and the dissemination of evidence-based treatments, may be the public itself. It is important to note that many members of the public that our field is meant to serve continue to have considerable difficulty differentiating the mission and practice of clinical psychology from related disciplines (psychiatry, social work), clinical psychologists with different training credentials (master's licensure, PhD, PsyD), or substantive areas within psychology (e.g., school, counseling). Despite the growing number of practicing clinical psychologists in recent decades, there remains remarkable difficulty identifying appropriate treatment providers meeting basic educational qualifications or specialty expertise for psychological services. Many members of the public also remain relatively un- or misinformed regarding the activities traditionally involved in psychosocial treatment, and few question the conclusions and recommendations of their treatment provider (i.e., "a second opinion") as is routinely sought for matters of physical health.

As the stigma of psychopathology and psychological treatment wanes, however, parents, educators, physicians, and youth themselves have more actively sought accurate information and effective treatment options for a range of psychopathological diagnoses, perhaps with more zeal and activism for some childhood diagnoses (e.g., pervasive developmental disorders, attention deficit/hyperactivity disorder) than is seen typically for psychopathology in

adulthood. Adults also commonly exhibit greater reluctance to rely exclusively on psychotropic medications for the treatment of psychological symptoms among youth (e.g., depression) than for themselves. The consumers of our psychological services increasingly demand safe, quick, effective treatment options for youth; the role of CCAP and PedP will be to educate the public regarding the supply of possible services, and increase the availability of these services in the coming decades. Public education may become an important component of the missions of CCAP and PedP, and a skill required of individual practitioners in these fields.

#### **ORGANIZATIONAL DEVELOPMENTS FOR CCAP AND PEDP**

A set of vibrant professional organizations and a growing scientific literature also reflect the level of maturity of CCAP and PedP development, and suggest that a growing segment of psychologists identify specifically with the study and treatment of youth. In 2000, both the Society of Clinical Child and Adolescent Psychology and the Society of Pediatric Psychology, previously specialty sections of the Society of Clinical Psychology, became separate divisions within APA (Divisions 53 and 54, respectively). The memberships of each society, and their flagship journals' impact factors (*Journal of Clinical Child and Adolescent Psychology* and *Journal of Pediatric Psychology*, respectively; both publishing for over 30 years) also have risen considerably in the past several years. Several additional organizations (e.g., International Society for Research on Child and Adolescent Psychopathology) and premier publication outlets (e.g., *Development and Psychopathology*, *Journal of Abnormal Child Psychology*, *Journal of Child Psychology and Psychiatry*) also reflect the growing identities and bodies of work in these areas. As noted above, board certification (i.e., ABPP) also is a major development in achieving the age of maturity for CCAP.

Although the emphases of clinical psychology have deviated notably from Lightner Witmer's initial vision for the field, the past century has yielded outstanding progress for CCAP and PedP. These fields have grown from specialty applications of general principles in clinical (adult) psychology to rich and unique disciplines. The growing needs among the populations served by these fields, the development of innovative cross-disciplinary scientific methods, the involvement of new and innovative treatment modalities and settings, the strength of related

professional associations in promoting science and policy relevant to youth, and the development of strong education and training opportunities all suggest that CCAP and PedP are well positioned for a healthy development over the next century to come.

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