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Presidential Address

The Future of Pediatric Psychology[1]

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In this address I would like to take a look at where we have been and then make some comments about where we appear to be headed in the future. The projections for the future are based on a study that was conducted by two of our postdoctoral fellows and myself approximately a year ago. But first, let me briefly trace the history of pediatric psychology from its inception to the present.

HISTORY OF PEDIATRIC PSYCHOLOGY

Lightner Witmer, who at the University of Pennsylvania in 1896 established the first psychological clinic in the United States, is credited variously with being the father of clinical psychology, clinical child psychology, and professional psychology (McReynolds, 1987). It is interesting to note that, if one examines the kind of cases that Dr. Witmer saw and the way he handled them, the seeds of pediatric psychology also are found in his work and he might legitimately be referred to as the father of pediatric psychology. Witmer dealt with all of the common behavioral and learning problems of children of his day and worked very closely with physicians, schoolteachers, and others involved in the care of those children (Witmer, 1907, 1908, 1925). While the seeds of pediatric psychology may have been present in his concepts, the field did not really get started until much later.

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A landmark along the way was the address by John Anderson given in 1930 at the Convention of the American Medical Association in which he discussed the benefits of collaboration between pediatricians and child psychologists. This address was part of a symposium presented to the Section on Diseases of Children. Anderson, a psychologist, was Director of the Institute of Child Welfare at the University of Minnesota. He discussed the contributions of psychology in terms of basic research in such areas as intelligence testing, child development, and child training. Interestingly, there are hints in Anderson's paper of applications that would today be called behavioral medicine. Thirty-five years later, in 1965, psychologist Jerome Kagan described a new marriage between pediatrics and psychology. In this important paper he outlined the ways in which pediatricians and psychologists might work together and described the benefits to children of such a union. At this time, many child psychologists around the country who were employed in medical school had begun to find that they had much in common with pediatricians. As a result, they developed close liaisons with pediatric physicians in research, clinical work, and training. Out of this developed professional experiences which were seen to be mutually beneficial. At first, most of these psychologists thought that their situation was unique and that they were alone. However, it became apparent that other people throughout the country were having a similar relationship with pediatricians and finding it filled with exciting prospects.

In 1967, George Albee, then president of the Division of Clinical Psychology (Division 12 of the American Psychological Association: APA), appointed a committee to look into this development and to make suggestions regarding the current status of such efforts (Elkins, 1986). Logan Wright served as chairperson of that committee. Also on the Committee were Lee Salk and Dorothea Ross. This Committee initiated correspondence with pediatric departments in medical schools across the nation in order to identify psychologists in such settings. During 1968–1969, the Society of Pediatric Psychology was formed and affiliated with the Section on Clinical Child Psychology of Division 12 (Elkins, 1986). The newsletter began publication in March of 1969 with Gail Gardner as the first editor. The first business meeting of the Society of Pediatric Psychology was held in the Fall of 1969 at the APA Annual Convention in Washington, DC. The following September, the bylaws of the Association were adopted. Between the years of 1969 and 1975, the newsletter of the Society was entitled *Pediatric Psychology*, and appeared approximately 3 or 4 times per year. In 1976, the newsletter became the *Journal of Pediatric Psychology* with Donald Routh as Editor and Gary Mesibov as Associate Editor (Elkins, 1986). This provided a significant and important outlet for the research activities of pediatric psychologists. An informal newsletter for the Society was continued as a means of communication among the members of the Society. In 1980, the Society of

Pediatric Psychology officially became Section 5 of Division 12. Currently, there are approximately 1,000 members in the Society of Pediatric Psychology and subscriptions to the *Journal of Pediatric Psychology* total 1,500. The Society has had considerable influence on the field through research publications, professional activities, task forces, study groups, conferences, and similar activities.

FUTURE TRENDS IN PEDIATRIC PSYCHOLOGY

Approximately 2 years ago, two postdoctoral fellows in Pediatric Psychology at the University of Oklahoma Health Sciences Center, Dr. Keith Kaufman and Dr. Wayne Holden, approached me with the idea of doing a study of future trends in pediatric psychology. They suggested that we use the Delphi procedure (Linstone & Turroff, 1975) which has been used effectively in a number of other areas. The idea was certainly appealing to me and it seemed an opportune time in the history of the Society to conduct such a study. We were able to obtain a small grant from the Psychiatry and Behavioral Sciences Department of the University of Oklahoma Health Sciences Center to pursue this project. The project involved a series of two surveys (Kaufman, Holden, & Walker, 1987). The first survey was an open-ended questionnaire in which experts were solicited for their opinions regarding issues of importance for the future in three key domains: research, training, and clinical service. As designed, the study included professionals in the area of clinical child psychology as well as pediatric psychology. We were particularly interested in exploring the differences between the two, since this has often been debated. In the present address, however, I primarily discuss pediatric psychology.

The original group of experts to whom our questionnaire was mailed were identified by virtue of their serving on the editorial boards of the *Journal of Pediatric Psychology* or the *Journal of Clinical Child Psychology* or because they served as directors of pediatric or clinical training programs.[3] For this questionnaire, a 69% return rate was achieved which provided us with 80 completed questionnaires from experts in the field of either pediatric or clinical child psychology. Of course, 53 respondents identified themselves as having a primary emphasis in clinical child psychology while the remaining 27 ascribed to a pediatric psychology orientation. The areas listed by these experts were collated separately for the two disciplines.

[3]The editorial board lists were obtained from the masthead of the 1985 volume of the *Journal of Pediatric Psychology* and the *Journal of Clinical Child Psychology*. Directors of programs were obtained from the 1984-1985 edition of the *Directory of Internship Programs in Clinical Child and Pediatric Psychology*, edited by June Tuma.

A second questionnaire was then prepared for each group, listing the topics that had been suggested by the respondents to the first questionnaire. For pediatric psychologists, the second questionnaire was composed of 22 items considered important for the future of research in pediatric psychology, 14 for training, and 17 for clinical service, making a total of 53 items. The appropriate questionnaire was then sent to the earlier respondents who had identified themselves as pediatric psychologists or clinical child psychologists. They were asked to rank order the 10 most important issues for the future in each of the three areas (research, training, and service). Individuals who did not respond to the first questionnaire were sent both questionnaires and asked to pick one to complete based on their current perception of their orientation. There was a 72% rate of return for this second questionnaire which resulted in 53 responses from clinical child psychologists and 36 from pediatric psychology experts.

The demographic characteristics of the two groups are presented in Table I. In terms of the years of experience, it is obvious that both groups are similar. Examining the amount of time spent in various activities indicates that pediatric psychologists appear to spend slightly more time in research and administration and less time in clinical service than do clinical child psychologists, though these differences were not statistically significant. It is clear from the theoretical orientations identified by the participants that a behavioral approach is the predominant one in pediatric psychology. This was a statistically significant difference between the two groups. Clinical child

Table I. Demographic Data for Pediatric and Clinical Child Psychologist Respondents[a]

	Pediatric $N = 36$	Clinical child $N = 53$
Years of professional experience		
Mean	12.9 years	13.0 years
SD	1.59	7.75
Time spent in		
Research	26%	21%
Administration	22%	16%
Training	23%	25%
Clinical service	29%	36%
Therapeutic orientation		
Behavioral	63%	36%
Eclectic	25%	30%
Psychodynamic	0%	16%
Psychoanalytic	3%	4%
Family systems	0%	12%
Other	9%	2%

[a]Data are based on survey conducted by Kaufman et al. (1987).

Table II. Topical Clusters of Research Areas Considered Important by Pediatric Psychology Experts[a]

Rank order	Research area
(1)	Chronic illness
(5)	Medical compliance
(6)	Neuropsychology
(2)	Prevention
(7)	Parenting issues
(8)	Early intervention with children at risk
(10)	Child abuse and neglect
(3)	Cost/benefit of interventions
(4)	Treatment effectiveness
(9)	Research strategies

[a]Numbers in parentheses indicate final rank order position for each item. This analysis is based on results from Kaufman et al. (1987).

psychology shows a greater range of theoretical orientations, particularly including more psychodynamic and family systems orientations.

Table II presents the pediatric psychology rankings for research. The actual rank of each item is indicated in parentheses. For ease of discussion, I have grouped similar items together. These groupings represent clusters that strike me as having some similarity, but they are not empirically derived from the data. In the first cluster, I have put chronic illness, medical compliance, and neuropsychology. There is clearly an interest in medically related issues in pediatric psychology. In support of this conclusion, Pauline Elkins, a graduate student completing her dissertation under the direction of Michael C. Roberts analyzed the content of the *Journal of Pediatric Psychology* from 1976 to 1985 (Elkins, 1986; Elkins & Roberts, 1988). Her analysis indicated that during this time 58.5% of the senior author for articles in this journal were affiliated with medical schools. Further, 43.8% of the published articles were relevant to medical populations. The experts in the Kaufman et al. (1987) study saw this medical emphasis as being of continuing interest for research in pediatric psychology.

The next cluster that I have identified includes prevention, parenting issues, early intervention with children at risk, and child abuse and neglect. This may look like a strange combination, but I think there is a central theme of prevention that runs through these items. It has often been noted that no disease or problem of a medical nature was ever eliminated by treating all of the sick people (e.g., Roberts & Peterson, 1984). The major diseases that have been brought under control have been dealt with by prevention such as better sanitation, inoculation, and so forth. It is becoming increasingly apparent that prevention and early intervention are the keys to fur-

thering the overall health and development of children. One of the major ways of accomplishing this is through working with the parents.

Due to factors within our culture, I think it is fair to say that we are currently in the midst of a crisis in parenting. When one considers the number of divorces, single-parent families, and two-career families, with the lack of parental involvement and supervision that often comes with these, one must have considerable concern about the quality of parenting that our children are receiving. I personally experience serious discomfort and concern for the emotional health of future generations.

Child abuse and neglect illustrate this problem. Over the years, I have worked extensively with children who were enuretic, encopretic, hyperactive, or who had behavioral problems. It is enjoyable to work with them clinically and to see them progress and overcome their problems. I had occasionally thought that preventive efforts would be worthwhile and that some problems might have been avoided by early intervention or parent training. However, it was when I began to devote a significant amount of my time to abused and neglected children that I recognized the need for prevention to be imperative (Walker, Bonner, & Kaufman, 1988). It simply is not an acceptable strategy to treat the child after abuse has occurred and to attempt to prosecute the adults responsible. The solution to this problem must be prevention. Anything short of that is totally inadequate and inappropriate. In reality, the same holds true for most problems of children. It is encouraging to see that the experts in the field of pediatric psychology are concerned with these issues and rank them highly.

The next cluster includes cost–benefit of interventions and treatment effectiveness. These no doubt reflect the considerable concern that is expressed nationally with respect to cost containment for medical care. Psychologists suffer in this area due to their lack of a medical degree, their late arrival on the scene as health care providers, and the view that somehow the services they provide are a luxury or an extra. If we are to continue to make our services available to children, and I believe that our services are essential to the welfare of children, we must demonstrate the effectiveness of what we do and present convincing evidence of a favorable cost–benefit ratio for our efforts. If we fail to do that, changes in the policies regarding third-party payment could mean the virtual end of our clinical practice as psychologists. This is a highly important area for research in the next decade.

Finally, we see that there is interest in developing more effective research strategies for the populations and problems with which we deal. With respect to the latter, pediatric psychologists have been innovative and creative, but there is still much room for further development. In particular, it is time for those of us who deal with children to take the lead in developing new research strategies (as we have done in the field of behavioral medicine) rather than continually adapt research and ideas developed on adults to children.

Table III. Topical Clusters of Clinical Service Areas Considered Important by Pediatric Psychology Experts[a]

Rank order	Clinical service area
(1)	Pediatric behavioral medicine
(2)	Effective treatment protocols from common problems
(4)	Chronic illness
(6)	Medical compliance
(7)	Neuropsychology
(3)	Role in medical setting
(9)	Educating other health professionals
(5)	Insurance reimbursement
(8)	Insurance alternatives (e.g., HMO, PPO)
(10)	Prevention

[a]Numbers in parentheses indicate final rank order position for each item. This analysis is based on results from Kaufman et al. (1987).

Table III presents the 10 items ranked most highly by pediatric psychologists for future development in the area of clinical service. As with Table II, the actual ranks are indicated in parentheses and the items have been grouped in clusters for purpose of discussion. Again, we have a cluster which includes pediatric behavioral medicine, chronic illness, medical compliance, and neuropsychology. In this particular cluster I have also chosen to include effective treatment protocols for common problems. These items all have to do with providing services that are needed in a medical setting.

The second cluster has to do with our role in the medical setting and educating other health professionals. The definition and role of pediatric psychology has been one of considerable debate over the years. In 1967, Logan Wright described the pediatric psychologist as "any psychologist who finds himself dealing primarily with children in a medical setting which is nonpsychiatric in nature." In 1979 I attempted to further delineate the uniqueness of the pediatric psychologist by noting that the pediatric psychologist differs from the traditional clinical child psychologist first in conceptualization (Walker, 1979). That is, pediatric psychology may be viewed as a speciality within behavioral medicine that deals with the behavioral and developmental problems of children while the clinical child psychologist is more aligned with mental health and psychiatric models. Second, the pediatric psychologist differs from the clinical child psychologist in terms of the point of intervention (pediatric clinics rather than mental health centers). And finally, the pediatric psychologist differs in terms of the nature of intervention (short-

term and consultation vs. long-term treatment). Ideally the pediatric psychologist attempts to do for the behavioral/emotional health of the child what the pediatrician does for physical health. That is, the pediatric psychologist follows the child from birth to maturity providing anticipatory guidance regarding proper care as well as assessing problems when they occur and either providing treatment or referring to other specialists while retaining the role of care coordinator and child advocate.

It has been pointed out that pediatric psychologists were practicing child behavioral medicine before the general field of behavioral medicine developed (Carter, Bendell, & Matarazzo, 1985). To the present, the role of the pediatric psychologist has been largely in medical school and university settings, with medical school settings predominating. Psychologists in these settings have conducted basic research on children's problems, particularly those with a medical emphasis, consulting with pediatricians, and participated in the training of physicians. Thus, it would be fair to say that historically the paradigm for the pediatric psychologist has been a scientist-professional working in a medical school and collaborating with pediatricians in performing their duties (Roberts, 1986).

However, I think the trend in the next few years is going to be for more and more pediatric psychologists to be in private practice and to work in clinics or hospitals that are multispecialty centers for health care. A major trend in the provision of health care is for the solo practitioner to disappear and be replaced, on the one hand by major multidisciplinary clinics where a wide range of medical specialists are present, and on the other hand with drop-in clinics where one can be seen immediately, without an appointment, for minor and emergency care. It is interesting to think of this, by analogy, to the trends that have taken place with respect to grocery stores. The old "Mom and Pop grocery" is virtually nonexistent. In its place, we have, on one hand, supermarkets with departments that, in addition to groceries, sell everything from hardware and auto parts to toys and clothing. On the other hand, there are small convenience markets where one can stop and buy a few items at odd items of the day or night. Pediatric psychologists can readily fit into the multidisciplinary clinic model provided they are able to present evidence that they have effective treatment protocols and that they are cost effective. They should be available, on call, to minor and emergency care centers. It is essential that we begin training our students for this kind of career. Due to the fact that the field of pediatric psychology itself is young, the majority of faculty in the medical schools are young. It will not be long before medical school faculties will be saturated with academic pediatric psychologists. The next wave of graduates will have to go into private patient care arenas where they will be confronted with the trends noted above. Educating other professionals as to who pediatric psychologists are and what they can offer will be crucial in their acceptance in the market place.

The next cluster is insurance reimbursement and insurance alternatives. I have already commented on this under research and it is obvious that much of what I said regarding the previous cluster having to do with our role in the medical setting is appropriate in this context also. One additional comment that I think important is that, as psychologists, we must become much more aggressive and adept at influencing legislation. The major shaping of the health professions is going to be provided by Congress through legislation and by private companies following the lead of Congress in their policy determinations. We must mobilize and become aggressive at making legislators aware of the contributions we make. If they are unaware of us, we will not be included in legislation and if we are not included, we will essentially cease to exist.

Finally, prevention is again listed as an area of importance in clinical practice for the future. It is interesting to note that, with respect to clinical services, prevention is ranked 10th. This is no doubt due to the fact that it is very difficult to obtain reimbursement for prevention activities. Federally funded projects attempt to correct that difficulty, but it is difficult to get people to pay to prevent a problem. The motivation to act generally does not reach a critical level until people are actually faced with the problem. This is one of the major obstacles to producing effective prevention. Unfortunately, prevention is also not as personally rewarding to the service provider as is individual psychotherapy. I have never had anyone come by my office or write me a letter thanking me for doing something that prevented children from developing problems. Yet, patients that I have treated personally frequently do so.

Table IV presents the 10 most highly ranked items having to do with training in pediatric psychology (actual ranks are in parentheses, clusters are

Table IV. Tropical Clusters of Training Areas Considered Important by Pediatric Psychology Experts[a]

Rank order	Training area
(1)	Brief treatment techniques
(8)	Consultation and liaison
(2)	Residency model
(4)	Specialty model
(6)	Standard curriculum
(3)	Biological and medical issues
(5)	Chronic illness
(9)	Neuropsychology
(7)	Funding
(10)	Prevention

[a]Numbers in parentheses indicates final rank order position for each item. This analysis is based on results from Kaufman et al. (1987).

to facilitate discussion). I have grouped brief treatment techniques and consultation–liaison together. One of the major roles of the pediatric psychologist is brief intervention, assessment, and consultation and liaison with other professionals (Walker, 1979; Walker, Miller, & Smith, 1985). Thus, this must be a focus of training in pediatric psychology. Helping compulsive graduate students and interns learn to use brief techniques is no easy task. Training students in focused interviewing, the ability to make quick decisions, and to implement interventions promptly should be a major goal of training.

The second cluster I have identified has to do with the model and curriculum for training in pediatric psychology. There is certainly much debate in this area. Over the years there have been a number of issues within this debate. For example, there has been the issue as to whether pediatric psychology is a subspecialty of clinical child psychology or whether it is sufficiently different to constitute an entirely separate discipline. Most would agree that it is a subspecialty under clinical child psychology that emphasizes behavioral medicine (e.g., Roberts, Maddux, Wurtele, & Wright, 1982). Also, there has been the question of the level at which pediatric psychologists should be trained. Currently, there are no universities that offer a PhD in pediatric psychology. However, there are an increasing number of graduate schools that offer a course or two in this area along with practicum training and which have individuals on the faculty who are identified as pediatric psychologists in terms of their primary orientation.

Should there be increasing training at the graduate level and should there be degrees specifically in pediatric psychology? Most pediatric psychologists develop their orientation during an internship or postdoctoral experience in a medical setting working with pediatric psychologists and pediatricians. This has led to the suggestion that the field of pediatric psychology might be modeled after the medical residency system in which the individual would spend a year in internship followed by another year or two or more in residence in order to continue study and development in the area of pediatric psychology. This is an intriguing possibility and might be very appropriate for pediatric psychology. However, the item in the list having to do with funding would be a problem. Funding such elaborate and advanced training would be difficult and it will become increasingly difficult as cost containment efforts and budget constraints increase in the future.

The specialty model and standard curriculum appear to relate to the possibility that was explored at the Hilton Head Conference. In 1985, a conference was held at Hilton Head (Tuma, 1985) in which leading pediatric psychologists and clinical child psychologists from around the country met to determine whether it would be possible to identify specific courses and experiences that would be necessary and sufficient to produce a clinical child specialist who could be so identified and would be uniquely trained for such a role. In this conference, no such specialty prototype emerged. However,

this is a continuing area of interest and will likely become a reality in the future. It is an intriguing question as to where pediatric psychology will be included in this. Will it be an additional specialty under clinical child psychology or will it have its own status? Exactly what will be required for pediatric psychology and how will these experiences differ from other areas of training for work with children?

The next cluster has to do with biological and medical issues, chronic illness, and neuropsychology. I have put these items together because they suggest that a reasonable foundation in medicine and biological psychology are required for effective training in pediatric psychology. Adequate training for the practice of pediatric psychology requires a basic knowledge of psychological research and theory, in-depth exposure to child development, knowledge of child assessment and intervention strategies, principles of behavioral medicine, and the biological bases of illness and health. The latter, biological bases of illness and health, is the area in which most training programs are deficient. We attempt to accomplish this training by assigning readings to students and by having them attend lectures or have private conversations with physicians who can familiarize them with a disease process that is present in one of their patients. However, the time has come to provide a much more systematic and comprehensive coverage of this material for the student of pediatric psychology. This might be a good project for the Society of Pediatric Psychology to pursue with some group such as the American Academy of Pediatrics. It should be possible to prepare a series of study guides along with videotapes and other instructional aids that could be used as a training program for the pediatric psychologist. Trainees might be exposed to this program in the first few weeks of their internship or postdoctoral fellowship.

Finally, we have the remaining items of funding and prevention. I have already said a considerable amount about prevention and it should certainly not be overlooked in the training of pediatric psychologists. In fact, if anything is to be done in terms of research or practice in prevention there must be an increased emphasis on this in training.

Funding will be an increasingly difficult problem. Many internships and fellowships have gone out of existence as funds ceased to be available. It is essential that we seek more effective and creative ways of providing stipends for our students. The quality of a training program depends greatly on the level of stipend support available for the students. Nevertheless, in spite of all efforts, we may well be headed for a situation where there will be available more unfunded internships and fellowships as well as increasing pressures upon trainees to generate, through patient care, sufficient income to pay for the stipends that are provided. If we do find ourselves in that position, it is essential that we strive to maintain excellence and quality in the educational aspects of the experience in spite of the clinical demands,

rather than simply yielding to the clinical demands and allowing the trainee to provide menial labor for a year or two following which they receive certification as competent to practice.

CONCLUSIONS

One thing is clear. We are living in the midst of considerable changes taking place in universities, hospitals, communities, and social agencies. There are also dramatic changes taking place in families and in our culture. The role we play as pediatric psychologists in the future will largely depend on decisions we make now. I think the present data provide us with very useful information regarding the important areas to consider and I trust we will ponder these in order to take effective proactive stances rather than reacting with too little, too late.

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