Commentary: A Call to Action to Secure the Future of Pediatric Psychology—Resonating to the Points of Rozensky and Janicke (2012)

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The field of pediatric psychology has adjusted and adapted to fit the changing environment of healthcare and needs of children and their families over its history (Aylward, Bender, Graves, & Roberts, 2009). Although initially considered to have an overly narrow focus, pediatric psychology became novel and innovative in the 1960s and 1970s and ultimately developed into a creatively vibrant and productive force in research and practice in healthcare psychology. Although the field has achieved great accomplishments, there is the potential of stagnating or even being left behind if practitioners and researchers continue to exclusively maintain the “status quo” without further innovation. Therefore, current and rising professionals will need to focus their incredible intelligence and energies to move out of what are now the established routines and ways of doing “things” to become once again novel and innovative, responding to changes in health care.

Rozensky and Janicke (2012) have contributed a significant vision for the future of pediatric psychology in a changing healthcare system. The significant points in this article are truly a call to action, a strategic plan as it were, for the field of practice and research in pediatric psychology. Rozensky and Janicke highlight several ripe and exciting opportunities for the field of pediatric psychology in terms of growth and expansion in light of current changes in the healthcare environment and in various other related fields and disciplines. In this commentary, we briefly attend to several of the issues raised by these visionaries as important areas for growth in the future of pediatric psychology. We have highlighted only a few of the major recommendations made by Rozensky and Janicke in order to provide the detailed discussion that each point warrants, and this selection should not be interpreted as an exhaustive list of the valuable points made in their discussion.

Interprofessional Practice and Integrated Care

“Interprofessionalism” may be a new term for many pediatric psychologists, who have been raised on the concepts of “multi-disciplinary” teams as fundamental to a field whose name synthesizes two disciplines: pediatrics and psychology. Indeed, multidisciplinary collaboration and consultation are nothing new for pediatric psychologists; in fact, these concepts were central to the initial conceptualization of a need for psychologists in pediatric settings and emphasized in the early formulations of the developing field (e.g., Drotar, 1995; Drotar, Benjamin, Chwast, Litt, & Vajner, 1982; Roberts, 1986; Roberts & Wright, 1982). These activities are practiced daily by pediatric psychologists in multiple settings. Multidisciplinary approaches have often involved different professionals communicating with each other, but basically each doing their own functions independently. The idea of interdisciplinary or interprofessional practice (and research) requires the additional step of greater integration among professionals to develop jointly determined interactions and functions in which professionals work together toward agreed upon goals. Rather than the mere action of multiple disciplines working together, individuals in different professions will generate what Rozensky and Janicke so appropriately term
a “coherent delivery system” creating interprofessional action to benefit healthcare consumers. Until working models have been established and evaluated, we predict some push-back and misperceptions from the field (and from our allied professionals). There may be those who resist sharing responsibility, desiring to emphasize individual contributions to patient care and maintaining professional identity. Furthermore, because interprofessional integrated care means a high degree of communication and agreement on goals, those who prefer autonomy of functioning may resist perceived subordination to the common purposes. However, this type of interprofessional and integrated care can exist very well in current practice, only without formal acknowledgment or documentation through publications. In the future, this form of integrated care will need more articulation and documentation in order to prove itself to pediatric psychologists and the larger spheres in which we function and work. Further definition and published exemplars will be needed of interprofessional functioning and integrated care concepts as manifested in pediatric psychology.

As previously mentioned, true “interprofessional” functioning will take a new way of thinking and doing beyond the current model of multidisciplinary work. Interprofessionalism will require health service professionals to take these efforts one step further by creating knowledge bases or practices across disciplines. While this approach to health care is different from a multidisciplinary perspective, the skills and knowledge that pediatric psychologist have in working with individuals of multiple disciplines will certainly assist in the transition to this type of care. In fact, many psychologists who receive graduate training in pediatric psychology learn skills of collaborating and understanding individuals of other disciplines as part of their education. Rozensky and Janicke provide an excellent road map for addressing these issues in student training in pediatric psychology, including the suggestion of forming a task force to update current recommendations for training. These ideas will no doubt foster further discussion in this area. However, the discussion by Rozensky and Janicke focuses solely on education on integrated care for a small subset of individuals (i.e., graduate students in pediatric psychology). Students trained in other disciplines, such as traditional clinical, school, and counseling psychology programs and professionals already practicing will also benefit from education on integrated care and should be incorporated in plans to develop such educational programming. We believe that professional development is a lifelong experience that extends far beyond graduate training.

Many of the changes that will come with changes in the healthcare system, such as integrated care and increased accountability, will present new challenges with which even seasoned professionals may not have experience. Integrated care concepts will require more elaboration and examples of implementation made available to pediatric psychology practitioners (and our clinical researchers will need to step up and change focus to the challenge of providing the necessary evidence base). It will be important to consider forums for practicing professionals to develop knowledge of the new changes in the healthcare forum, in addition to training graduate students and interns for the future.

As a related example, starting around 2000, our training program in Clinical Child Psychology Program engaged in a grant-funded training project to enhance “interprofessional leadership” in our trainees through didactic education and practicum experiences. Students took relevant courses on “interprofessional” functioning taught by leaders developing the concept in their own disciplines of education and social work (e.g., Lawson & Sailor, 2000) alongside students from these disciplines. Students then received field placements where they had roles in an interprofessional work model in educational and other pediatric settings (Roberts, Jacobs, Puddy, Nyre, & Vernberg, 2003). Although such training and experience allowed for development of valuable skills for future practice in clinical child psychology, students occasionally resisted interprofessional concepts because they struggled with the potential implications of changing their identities as psychologists at the very time they were seeking to develop themselves in the discipline. Many of them have since become active pediatric psychologists, and have offered reflective acknowledgment of benefits from this early exposure to interprofessional concepts and experiences. In this way, we imagine that interprofessionalism will influence trainees and pediatric psychology practitioners in the future.

Continuing education workshops at the national and regional conferences and online webinars may be other venues to provide training in the changes to the healthcare system that will affect the practice of pediatric psychology. Many pediatric psychologists now function in multidisciplinary, even “interprofessional,” teams in hospitals and clinics and, consequently, professional practice changes may not be dramatically different for all professionals; however, additional skill development and documentation will be essential for all. We will need resources and publication outlets dedicated to providing information relevant to these clinical practice developments.
Gerry (2002) provided an excellent conceptualization of a “true” model of interprofessionalism. He defined that: Integration demands that all services are personalized and caring. Where co-occurring needs are evident, service providers coordinate their efforts, and they treat individuals and families in need as partners. Working together, service providers tailor their services to fit what children, parents, and families want and need. (pp. 66–67)

Lawson and Sailor (2000) provided the interprofessional definition that:

Interprofessional collaboration occurs when two or more professions join forces and develop unity of purpose to improve results. It occurs when (and because) they depend on each other to achieve their goals and meet their accountability standards. When professionals truly collaborate, they do because they understand their interdependence; they view collaboration as part of enlightened self-interest; and they promote and reward reciprocity. (p.11)

Primary Care Practice and Related Focus on Early Intervention, Prevention, and Health Promotion

A second area noted by Rozensky and Janicke as an increased emphasis in the new healthcare environment will be practice in primary care in pediatrics (or in family medicine as another related healthcare specialty). Again, unfortunately, this area is not as well developed as earlier envisioned when Carolyn Schroeder’s psychological practice in a pediatric clinic was considered a model program for emulation (Schroeder, 1979, 1996, 2004). There is a set of complicated reasons that pediatric psychology has not devoted as much attention to primary care, worthy of a more complex analysis than this commentary. Suffice it to say that the field is not in the position where it needs to be—in terms of research and practice reports to understand what is being done and what can be done in primary care settings and in terms of positioning the field to respond affirmatively to healthcare changes. This is a lament that has been repeated over time (Stancin, 1999; Wildman & Stancin, 2004), but integrated primary care is going to be an even more important function that pediatric psychologists should be at the forefront of developing. A primary care orientation will turn attention to other topics, such as early intervention, prevention, and health promotion, which have been similarly neglected by the field in its overriding focus on chronic conditions (Roberts & Brown, 2004). It may be the case that many pediatric psychologists do operate in primary care settings; if this is so, we echo our earlier call for more documentation, published exemplars, and evidence of successes and failures.

Proving the Worth of Pediatric Psychology

Under the new healthcare system, each discipline and profession will be required to demonstrate the importance of their services and the role they play in providing children and families with integrated and quality health care. Rozensky and Janicke’s proposal for a database of evidence-based practices in pediatric psychology would promote greater use of procedures that can be clearly documented as beneficial and effective for families. In some sense, this push for accountability in the larger healthcare system is similar to recent trends in the entire discipline of psychology, as discussion of empirically supported treatments has increased recently in the last decade.

Finding support for demonstrating the needs for psychological services in pediatrics and demonstrating the effectiveness of such services will require development of a cohesive and conclusive body of research (e.g., Spirito & Kazak, 2006). A recent notable model may be found in the efforts of Division 53 of the American Psychological Association (APA), the Society for Clinical Child and Adolescent Psychology, which is undertaking several initiatives for web-based presentation of assessment and interventions for problems presenting in its domain. In our view, published illustrations and empirical analyses of practice implementation, as done in the 1970s and 1980s, are becoming increasingly rare. As the field starts its adaptation in the new healthcare environment, including both assimilation and accommodation (in Piagetian terms) of the new concepts and required activities, we will need similar types of illustrations. The field’s practitioners need encouragement to conduct local program descriptions and evaluation relevant to clinical practice and implementation of evidence-based assessment and treatment, both of these goals requiring identification of a publication venue for these types of reports. In addition to reaching pediatric psychologists with a diverse range of interests, expanding the scope of published work will also make significant strides in terms of including and working with our future collaborators and peers. If interprofessionalism is the future, it is only sensible to reflect this shift in our research and literature through efforts to conduct studies that will include services offered by
members of interprofessional teams. This will also likely increase the visibility and impact of our field. Articles on enhancing care and collaboration will be valuable to the field at all levels (trainees to professionals), but also for our fellow professionals who will be grappling with interprofessional activities in the new era of health care.

“Proving our worth” requires us to create a research foundation for implementing evidence-based practice in primary care and integrated care and utilizing interprofessional concepts in pediatrics. Similarly, the integration of medical home concepts into pediatric health care is going to increase dramatically over the coming years (e.g., Kleinsorge, Roberts, Roy, & Rapoff, 2010). Certainly, more numerous clinically based research reports on implementation of evidence-based practice, service delivery and organization, evaluation and quality improvement are needed with high degrees of clinical relevance to provide the foundation for a prominent presence in the emerging environment. Funding and opportunities will drive development of this research foundation.

Where medical cost-offset might be difficult to demonstrate in an integrated care concept, certainly measurement of “value added” of pediatric psychological services could be measured. For example, Bandstra, Crist, Napier-Phillips, and Flowerdew’s (2011) recently found that including a behavioral intervention in the treatment of children with feeding disorders decreased the frequency of pediatrician visits by these children over time (and, by extension, decreased the cost to the healthcare system). Studies like these certainly underscore the importance of conducting and empirically evaluating multidisciplinary treatment options for health conditions, and also serve as models for a feasible way to do so. We need measurement of health outcomes as well as psychological and process variables. With that said, “some” work in this area is not enough—we need more, and the time is now.

Accreditation and Board Certification

Representing the effectiveness and appropriateness of psychological services in a system of integrated care will not only require the prior mentioned efforts of documenting treatment effectiveness, but will also require focus on the skills and training of practitioners themselves. Rozensky and Janicke discuss that psychology may be the only discipline with only individuals from accredited training institutions receiving licensure will likely take a few generations. That is, many individuals are already licensed without such training (and are not necessarily providing poor services). A visionary field of pediatric psychology and psychology in general, however, should be finding ways to improve its services, not perpetuate what was not trained very well in the past and had to be learned on the job. Accreditation standards need to be flexible and responsive to developments in the field to meet emerging needs, but not just train professional psychologists to meet the needs of the last century (to avoid the cliché that psychology training programs are “buggy whip factories”).
The additional concern of specialization of training and service provision is discussed by Rozensky and Janicke, who support practitioners receiving board certification through the American Board of Clinical Child and Adolescent Psychology (under the auspices of the American Board of Professional Psychology, see www.abpp.org). This specialty board recognizes almost equal numbers of board certified pediatric psychologists and clinical child psychologists, meaning many pediatric psychologists have sought out this certification even with the lack of specific pediatric specialty. As noted earlier, training in the necessary competencies and demonstration of those competencies will be increasingly important in an accountable care environment.

**Conclusion**

Rozensky and Janicke have contributed a major service to the pediatric psychology field by highlighting these issues. We think we are doing okay, but as Robert Burns wrote, “Oh to see us as others see us” (1786, verse 8). We can and must do more than sitting our laurels. Significant investments of SPP efforts (group and individual efforts and financial support) would be very appropriate in areas outlined by Rozensky and Janicke, and we believe these efforts would be feasible within the resources of SPP. This article is a strategic plan, and the SPP leadership is well-advised to consider broad-based initiatives to fulfill the outlined points. Although we resonated to all of the points discussed by Rozensky and Janicke, we personally would give emphasis to the following:

a. Commission a more comprehensive work force analysis to meet our particular professional needs. Although the contribution of Opipari-Arrigan, Stark, and Drotar (2006) has been valuable, we will need to extend efforts beyond a survey methodology, possibly partnering with APA’s Center for Workforce Studies, but not waiting for that Center to develop itself, or expecting it to recognize the focus on the needs of pediatric psychology in the changing healthcare field.

b. Engender greater effort on prevention and health promotion for children and adolescents to serve our position as contributing players in this arena (this would not necessitate diminishing the exceptionally strong attention to chronic conditions) and incentivize greater recognition of prevention goals and mechanisms for fulfilling these.

c. Identify a publication outlet to publish what is already being done in these clinical application areas, but also to provide impetus to accomplish and document many of the newly emerging clinical functions in the changing healthcare arena; we know pediatric psychologists are engaging in these activities; we need documentation to share with ourselves and others and build upon those activities.

d. Update the pediatric psychology training recommendations (Spirito et al., 2003) to provide guidance on education and training of the concepts such as integrated care and primary care, interprofessional team functioning, and other concepts into an organized set of standards for accreditation and licensure so that the field has an evolving model of training responsive to positive changes and potential reversals over time. Sharing resources and developing modules of training for doctoral, internship, and postdoctoral levels on the key concepts and basic principles in pediatric psychology should be a function of a vibrant Society seeking to secure the future for the field. The identification of specific competencies at various levels of training may be particularly relevant and helpful here.

With great effort and adaptation over time to a continually changing environment, the SPP has developed into a strong organization; it has not been a “cottage” organization for many years, but needs to do more than maintain itself. In contrast to earlier times when board members got together at their own expense, and the journal expenses were paid out of board members’ pockets, SPP has the resources to do a great deal of good. We have the means and technology to fulfill the needs for the field outlined by Rozensky and Janicke as the healthcare field in which we are so involved boldly ventures into the new era. Individuals and teams of clinicians and researchers can embark on many efforts stimulated by the directions outlined by Rozensky and Janicke. SPP as the major organization for the field can accomplish, commission, or catalyze others to undertake many, if not all of the projects to secure its future if it has the leadership, vision, and will to invest its enormous resources and talents to benefit its members, benefit our patients, and benefit society.

**Conflicts of interest:** None declared.

**References**

Roberts, Canter, and Odar


