Professional Psychology: Research and Practice
1998, Vol. 29, No. 3, 293-299

Copyright 1998 by the American Psychological Association, Inc.
0735-7028/98/$3.00

A Model for Training Psychologists to Provide Services for Children and Adolescents

Michael C. Roberts
University of Kansas

Cindy I. Carlson
University of Texas at Austin

Marilyn T. Erickson
Virginia Commonwealth University

Robert M. Friedman
Florida Mental Health Institute

Annette M. La Greca
University of Miami

Kathleen L. Lemanek
University of Kansas

Sandra W. Russ
Case Western Reserve University

Carolyn S. Schroeder
University of Kansas

Luis A. Vargas
University of New Mexico Health Sciences Center

Paul F. Wohlford
Center for Mental Health Services

Background and rationale for a comprehensive model of training for psychologists to provide services to children and adolescents are outlined. Eleven integrated aspects of training are described with respect to training topics, justification for the training, and ways to implement the training. The model described addresses the need for guidance in training specialists in psychologically based mental health services for children, adolescents, and their families. Practitioners can use this model to assess their own backgrounds, knowledge, and skills in working with these populations.

Children, adolescents, and their families represent a large segment of the population whose mental health needs are underserved (Markel-Fox & Stiles, 1996; Saxe, Cross, & Silverman, 1988). The relative lack of psychologists adequately trained to provide assessment, treatment, and prevention services to these groups poses a major obstacle to providing more and better services. Over many years, professionals have increasingly recognized the need for an updated, comprehensive, and integrated outline of training components in the area of psychologically based mental health services for the unique needs of children, adolescents, and families.

A number of previous reports have articulated the didactic and practical experiences thought to be necessary for psychology trainees preparing to work with children, adolescents, and families. For example, Carboy and Curley (1976) outlined a training model for a professional child psychologist from a school psy-

THE GENESIS OF THIS MODEL came through a 1992 initiative of the National Institute of Mental Health (later the Center for Mental Health Services) with the formation of a task group to improve quality services for children, adolescents, and their families through refinement of training (Wohlford, Myers, & Callan, 1993). The authors of this article represent a subcommittee of the task force that convened during a writing conference in Lawrence, KS, in 1993 in which a draft document was prepared. Revised versions were distributed for comments and action to groups with corollary interests. Over a period of 4 years, helpful input was received from a number of sources, and significant changes were made in the document. It was revised to meet the American Psychological Association's (APA's) *Criteria for Guideline Development and Review,* adopted by the Council of Representatives during its February 17–18, 1995 meeting.

PUBLICATION OF THIS MODEL should not be construed as the official position of the APA because the document was not considered or approved by its Council of Representatives.

AFTER MICHAEL C. ROBERTS, the order of authorship is alphabetical. Paul F. Wohlford's contribution was made as a private individual, not as a representative of the Substance Abuse and Mental Health Administration.

THE CONTRIBUTIONS of various groups and responding individuals for those groups are acknowledged as having strengthened the model outlined in this article. The financial support of the Section on Clinical Child Psychology (Section I of the Division of Clinical Psychology, APA), the APA Division of Psychotherapy, and the University of Kansas is gratefully acknowledged. Early contributions were made by Kari Ramos, Laura Giusti, Susan Milla, Michael Luxem, Lisa Buckloh, Katherine Katsens, Rodney McNeal, and Sarah Trane. We wish to thank Tammie Zordel for her assistance throughout the development of this model.

CORRESPONDENCE CONCERNING THIS ARTICLE should be addressed to Michael C. Roberts, Clinical Child Psychology Program, Department of Human Development and Family Life and Department of Psychology, University of Kansas, Lawrence, Kansas 66045. Electronic mail may be sent to MROBERTS@ukans.edu.

chology tradition. The Task Force on Training of the Division of Child, Youth, and Family Services of the American Psychological Association (APA) developed recommendations for training psychologists to work with children, youths, and families (Roberts, Erickson, & Tuma, 1985), which were endorsed by the National Conference on Training Clinical Child Psychologists (Tuma, 1985). Later, the National Institute of Mental Health held a series of conferences on mental health training, including one on children with serious emotional disorders (Magrab & Wohlford, 1990). However, for both aspiring professional child psychologists and trainers of this specialty, there has been no integration of these various recommendations to provide direction. Furthermore, the products of these activities appear to have had only moderate impact at best on actual courses and experiences in programs purporting to train psychologists to work with children and adolescents.

The flexibility in the new APA accreditation guidelines, principles, and procedures (APA, 1996) allows for innovative and constructive changes in training in applied psychology. These new accreditation guidelines open opportunities through the ability of a program to declare its own model of training. A program must make explicit its identified model of training, not just by claiming a specific title, such as "scientist–practitioner" or "clinical psychology," for example, but by articulating what the chosen model means. This element of the new accreditation guidelines may challenge some programs that currently use an implicit assumption in their course offerings and training sequences that adult training is basic for all clinical psychology students and that child training is supplementary, if studied at all. For example, many programs currently offer psychopathology and psychotherapy courses that neglect developmental and child–family aspects. It will be important that the curriculum and its components be accurately labeled because the accreditation criteria require a training program to justify what it does, thereby providing greater truth in advertising. Thus, a training program should indicate clearly to prospective trainees the degree of training it will provide.

The new criteria may allow an increased recognition that child training is a necessarily separate sequence of training distinct from adult training (and, correspondingly, that the child training is fundamental and that any adult experiences are supplementary). The potential for allowing even more specialty training in research and services for children and families is important because of the need for more and improved services for this particular underserved and complex population. Thus, in this article we outline a model of training to accommodate the new accreditation guidelines and to help direct predoctoral, internship, and postdoctoral programs that provide specialty training in psychological services for children, adolescents, and their families.

This model outlines what are considered to be important training experiences for psychologists working in this specialty because training is ultimately related to the quality of intervention and prevention practices. All branches of psychology that train professional psychologists to work with children and families will find this model useful. This model represents aspirational goals for trainers and trainees to enhance quality services to this special population. For students who intend to provide psychological services to children and adolescents in their professional careers, this model will help direct them to select training programs to meet their interests and to select appropriate experiences during their training. Clinical practitioners who work with children, adolescents, and families or who are considering such applied activities can use this model to assess their own background, knowledge, and skills in this area. In topics where they find themselves deficient, they could avail themselves of formal courses, continuing education workshops, and supervision to attain the necessary training. This model can also help those who employ psychologists in child and family service settings—as well as those serving on state licensing and credentialing boards—in evaluating applicants' training backgrounds. Of foremost importance, this model is intended to protect children, adolescents, and their families by outlining the fundamentals of quality training that are necessary to serve them.

This model was prepared to allow flexibility of implementation accommodating the expertise and resources of training programs, projected career paths of trainees, and future changes in professional psychology. In all training levels (predoctoral program, internship program, and postdoctoral experiences), faculty resources should be adequate to provide the didactic and practical experiences outlined in this model. Although a training program can be, and should be, flexible in how the child- and family-oriented curriculum is organized, topical content areas described in this model should be evident in both didactic courses and clinical practicums. However, this outline should not be viewed as a list of courses per se. The child- and family-oriented training program should demonstrate integration of these topical areas throughout the curriculum, including formal seminars, practicums, and other applied and research experiences.

There is no explicit enforcement mechanism for this model. As an aspirational outline of important training components, this model can facilitate development of programs to better meet the training needs of this specialty. Of course, in the APA accreditation process, the use of this model in a program's definition of itself can be evaluated by the site visitors and the APA Committee on Accreditation.

The following sections provide detail on topical areas, content, justification, and implementation. Training necessarily implies a sequence of learning, from a relative lack of knowledge to increasing degrees of sophistication and competence. The implementation sections of each topical area rely on the following model and definitions:

- Exposure: introduction to the topical area in a didactic seminar or through observation in an applied or research setting;
- Experience: the practice of the topical area or activity (e.g., in a therapy or assessment case, a practicum or elective rotation, or research project); and
- Expertise: course work and extensive experience in the topical area at a level of competence at which a psychologist can practice independently.

This model recognizes differing interests and abilities in attaining expertise in all dimensions of professional psychology in services to children, adolescents, and families. Nonetheless, in all work, the "Ethical Principles of Psychologists and Code of Conduct" (APA, 1992) applies:

> Principle A: Competence. Psychologists strive to maintain high standards of competence in their work. They recognize the boundaries of their particular competencies and the limitations of their expertise. They provide only those services and use only those techniques for which they are qualified by education, training, or experience. (p. 1599)

The present model for training psychologists to provide services to children, adolescents, and their families includes the structure to assist trainees to achieve exposure in all areas, experience in many areas, and expertise in at least some areas through the three levels of psychology training: graduate, internship, and postdoctoral training. The goal of training is to develop a professional capable of competent practice with independence and autonomy.

Topics and Rationale

Life Span Developmental Psychology

Life span development includes infants, preschool-age children, school-age children, adolescents, adults, and elderly persons within their ecological (family, school, community, and cultural) contexts. This topic should cover theoretical and practical aspects of social, cognitive, emotional, behavioral, and physical development. Children, adolescents, and their families present unique problems that require an understanding of developmental variables. Knowledge is required of developmental processes and their impact on assessment and diagnosis as well as treatment and outcome. The role of families in the developmental process must be recognized. In this aspect, families include those persons involved in the psychological development of the child or adolescent in complex manifestations, including nuclear, extended, adoptive, and gay or lesbian families, for example.

Justification. Developmental processes are critical in psychological considerations of children, adolescents, and families. Knowledge of normal development and behavior is essential for understanding children and their contexts, determining the presence of abnormal development and behavior, and designing effective treatments.

Implementation. Information should be presented in the form of didactic course work early in the training program to provide exposure to all graduate students. Experience in this topic should be continued throughout the training sequence and integrated in other work for students specializing in the delivery of services for children, adolescents, and families.

Life Span Developmental Psychopathology

This area should include mental, emotional, behavioral, developmental, and learning disorders occurring from infancy through old age. Serious emotional disorders, substance abuse, and dual diagnoses should also be included.

Justification. Psychopathology and abnormal development should be viewed within the context of developmental and sociocultural processes. A life span and developmental orientation is necessary for a complete understanding of the etiology of disorders and to form the basis for conducting appropriate assessment, developing relevant diagnoses, and providing therapy.

Implementation. This information should be presented in the form of didactic course work early in the training program to provide exposure to all graduate students. Experience and expertise in childhood disorders should be gained throughout training for the specialty student.

Child, Adolescent, and Family Assessment Methods

Assessment approaches should cover (a) intellectual, personality, and behavioral assessment of the child and adolescent; (b) family assessment; and (c) assessment of the sociocultural context (e.g., social support, school environment, community resources, cultural influences, and peer relationships). Assessment should be viewed as a problem-solving, hypotheses-generating process that requires psychological understanding of the child and adolescent and the systems (e.g., family, school, community) affecting them.

1. Trainees should be familiar with assessment methods for children of different ages (birth–21 years).
2. Trainees should be familiar with multiple and varied methods of assessment and their empirical foundations (e.g., interview procedures, self-report inventories, intelligence and achievement tests, objective tests, projective tests, behavioral observation techniques, rating scales, developmental screening, testing of cognitive processing, and measures of adaptive functioning). Trainees should become aware that information obtained from various sources is important and may vary as a function of the developmental status of the child or adolescent and the type of problem.
3. Trainees should develop an appreciation of the special considerations involved with assessing children and adolescents—especially those of ethnic minority backgrounds or of varying cultures—and with a variety of physical and sensory disabilities. Trainees should understand the limitations of assessment instruments and recognize the need for alternative assessment approaches. They should acquire a thorough understanding and appreciation of psychometric theory to enable them to evaluate existing assessment instruments and new measures that are developed.
4. Trainees should develop an awareness of the systems within which the child or adolescent functions and how these systems interact with the assessment process (e.g., sensitivity in terms of what information to obtain about a child and with whom the information may be shared). Trainees should be instructed in the proper communication of the results of their assessments through training in report writing. Training should impart an awareness of the impact assessment reports have on various persons and systems.

Justification. Psychological assessment involves a wide array of approaches and techniques. This complexity of assessment does not permit assumptions of easy or competent transfer to instruments in which a trainee is not specifically trained. Accurate assessment requires special training to determine what instruments and approaches are appropriate for different problems, situations, and developmental levels.

Implementation. Exposure to all methods, experience with several, and expertise with some is appropriate at the graduate level. At a minimum, the equivalent of two semesters of didactic course work and associated practicums is recommended. At the

internship and postdoctoral level, efforts should be made to develop expertise in all domains.

Intervention Strategies

Training in a variety of theoretical perspectives and related intervention methods directed to the child and adolescent and relevant social contexts is expected. Critical examination of research on the effectiveness of various interventions should be integrated into course work. Knowledge of the special considerations in working with children, adolescents, and families of culturally and economically diverse populations should be provided. Familiarity with interventions and their respective empirical foundations is recommended in the following areas:

1. Child–adolescent interventions (including individual psychotherapy, group psychotherapy, play therapy, behavioral and cognitive–behavioral interventions, skills training, and psychopharmacology);
2. Parent interventions (including consultation and education-training);
3. Family interventions (including family therapy and systems, family empowerment–support); and
4. School and community interventions (including consultation with social services, the legal system, and medical settings).

Justification. Professional psychology for children, adolescents, and families requires specialized interventions accounting for developmental processes and the unique characteristics of their circumstances. Therefore, specialized training in these intervention techniques is required for determining the relevance of particular interventions for specific disorders and for appropriate implementation. Most important, education about these therapies should examine those that are empirically based as well as those that have not yet been subjected to validation.

Implementation. At the graduate level, exposure through didactic courses and practicums to most of these approaches is expected; experience and expertise in several approaches is also expected. Internship and postdoctoral training should provide both breadth and depth in some of these approaches, resulting in expertise.

Research Methods and Systems Evaluation

In order to maintain an empirical base for treatment and prevention work and because professionals working with children, adolescents, and families need to be able to critically evaluate the quality of research in the field, an empirical orientation should be integrated throughout all aspects of professional training. Course work and clinical experiences should highlight empirical findings that pertain to the etiology, assessment, treatment, and sociocultural context of child, adolescent, and family problems. Whenever possible, practicums should adopt an approach of empirical validation to assessment and treatment cases, including the use of empirical methods to evaluate treatment cases. Specific didactic work in research methodology and data analytic procedures as well as independent research experiences with children, adolescents, and families are viewed as essential and integral aspects of professional training.

This content area includes knowledge of modifications in existing research methodologies that are necessary—as well as familiarity with special problems that arise—when designing and conducting research with children, adolescents, families, and related service systems (e.g., schools, medical settings, and so forth). In addition to single-subject and group designs, which are typically covered in many research methodology courses, attention to the following areas is also important: family-based research, longitudinal and prospective research designs, program evaluation, prevention research, and methodologies used within service systems. These content areas should be integrated through course work, research, and practicum experiences at all levels of training.

Justification. Because unique conceptual and methodological problems are encountered when conducting research with children, adolescents, and families and because professionals working with these populations must maintain an empirical base to their work, special attention should be devoted to relevant research methods and data analytic procedures.

Implementation. Exposure to all these methods through didactic course work and experience with several through research experiences is appropriate at the graduate level. Conducting research with children and families would be a minimum experience. Predoctoral training and internship training should provide continued opportunities to refine clinical research skills through evaluation of treatment outcome. Furthermore, an empirical approach to individual case evaluation should be trained to the expertise level by completion of the internship.

Professional, Ethical, and Legal Issues Pertaining to Children, Adolescents, and Families

The range of relevant issues especially important to psychological practices with children, adolescents, and families should be covered in course work and field experiences, including, but not restricted to, the following: child abuse reporting, custody evaluations, confidentiality of child and parent reports, a child's potential right to agree to or refuse treatment, informed consent or assent (child, adolescent, parent), limits of privileged communication, duty to protect, best interest of the child, and civil commitment. Psychologists' roles should include attempting to normalize the experiences of children with disabilities with regard to their educational, interpersonal, and vocational realms. Within these areas, as applicable, professional training should include familiarity with pertinent state and federal laws (e.g., mandatory reporting of suspected child abuse, licensing-credentialing criteria and procedures, knowledge of the Americans With Disabilities Act).

Justification. In order to ensure adequate safeguards to children, adolescents, and families, professionals need to gain familiarity with a wide array of professional, ethical, and legal issues that specifically pertain to these populations.

Implementation. The content area just mentioned should be integrated through course work, research, and practicum experiences at every level of training. Exposure levels are necessary in early stages of training; experience levels are required on completion of predoctoral training; and expertise is required in at least some areas, depending on postdoctoral positions and settings.

Issues of Diversity

Psychologists working with children and families need to provide services within appropriate cultural and ethnic contexts for their patients. To do otherwise may well result in an ineffective or inappropriate intervention. Thus, training should examine the role of ethnicity and culture (broadly defined)—along with related beliefs and value systems—in development and mental health in order to prepare students to provide appropriate and effective psychological services. Psychologists need to appreciate the broad sociocultural perspectives with regard to diversity of beliefs, values, expectations, and social status of the child and family as they relate to the following: cultural norms in the determination of psychopathology, interactions between the provider and the patient and his or her family, the match between the child's and the family's view of the problem and the provider's treatment theory and methods, service delivery systems and agencies, acculturation for the patient and psychologist, and the development of ethnic identity. The trainee should be prepared to meet the "Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations" (APA, 1993). Particular attention should be given to differences in sexual orientation, gender roles, disability, socioeconomic status, religious preferences, and family type as important issues of diversity.

Justification. The proportion of children and families from ethnic and cultural minorities is increasing. This diversity yields a wide range of perspectives on the nature of health and mental health in children and families. Ethnic minority children and families are disproportionately more frequently affected by economic and socioenvironmental stressors (e.g., poverty, violence, prejudice, unemployment, and limited and substandard education).These groups have historically had less access to mental health care and have been underserved. Psychologists are socialized within particular, usually dominant, cultures during training. Psychological practice is thus shaped by this socialization. As a first step toward a multicultural orientation, one needs to be aware of one's own culture and background and its subtle yet potent impact on therapy and research. Furthermore, cultural diversity for psychologists and their patients and families clearly relate to sexual orientation, gender roles, disability, socioeconomic status, religious preferences, and family organization.

Implementation. These topics should be integrated in course work, research, and practicum experiences at every level of training. A seminar on treatment and assessment of multicultural populations is one avenue of ensuring some breadth and depth of coverage of relevant issues but would not be sufficient. A predoctoral program needs to demonstrate integration of multicultural issues and a sociocultural perspective in its course work (e.g., developmental psychology, developmental psychopathology, psychological assessment, and research methodology), research experiences, and clinical practicums in order for sufficient exposure to exist. The program should facilitate its trainees' development from awareness and appreciation of their own culturally based beliefs and attitudes to demonstration of skills to implement culturally responsive services. Exposure and experience should be achieved in predoctoral work; expertise should be gained during internship and postdoctoral experiences. During training at all levels, direct contact with patients' families from different ethnic groups, both clinical and nonclinical in nature, and culturally responsive supervision are important.

The Role of Multiple Disciplines and Service Delivery Systems

In recent years, mental health services for children have changed to become more integrated, family-centered, individualized, and inclusive of families as participants in services planning and delivery. Interprofessional, interagency, and family–professional collaboration are increasingly being recognized as necessary for effective delivery of mental health services to children and families. Children, adolescents, and families have needs that often require several professional disciplines and service systems. In order to develop and implement optimal interventions, the trainee should gain an understanding of the roles and responsibilities of these service systems and disciplines. At the basic level, all trainees should receive an emphasis on the educational, medical, and public mental health systems and on how family members are partners. In addition, as skill development advances, the trainee may engage important systems for training (e.g., child welfare systems, social service agencies, substance abuse programs, developmental disabilities services, or juvenile justice systems). Recognition of the benefits of the interdisciplinary team decision-making process should be emphasized. The trainee might profitably gain exposure to and appreciation for the contributions of other disciplines, such as education, special education, pediatrics and family practice, psychiatry, social work, nursing, public health and epidemiology, law, public administration, and applied anthropology. Equally important for the trainee is to understand the role of family perspectives on the services the families receive and to learn skills in promoting family–professional collaboration.

These experiences should be taught through a combination of field work and didactic interdisciplinary presentations. In particular, there should be supervised work in community and home settings at the earliest level of training. Other settings, such as medical settings, educational settings, juvenile justice settings, psychiatric settings, residential treatment centers, foster homes, shelters for the homeless, and so forth, should also be part of the experience. Students should have opportunities for positive interactions with families during their training and develop confidence in their ability to build relationships and empathize with them.

Justification. The educational process should prepare the professional psychologist to better serve children, adolescents, and families; to contribute to multidisciplinary and multi-agency teams; to provide programmatic and systematic consultation; to work in partnership with families; to recognize and understand the contributions of their disciplines; and to act as agents of positive change in service systems. Training should be an organized progression of didactic and clinical work that includes information, observations, and participation with different service systems and disciplines. The goal is to introduce the student to the realities of the complex interactions of systems and disciplines with one another and with children and families in their own contexts.

Implementation. Exposure should be provided through didactic course work and observation of various systems and set-

tings, disciplines, teams, and functions. The predoctoral trainee should gain experience through supervised work in service delivery systems and with other disciplines. Expertise should be achieved in some settings during internship training and maximized in postdoctoral experiences through increasing independence, involvement in interdisciplinary teams, and autonomy in carrying out interventions in a number of service delivery systems. Exposure, experience, and expertise in working with families as allies can be developed through partnership with parents in developing curricula, teaching, observing, and consulting.

Prevention, Family Support, and Health Promotion

Professional psychologists working with children, adolescents, and families should have the ability to provide different levels of intervention, not just with individuals and not just with already well-entrenched problems. Prevention, health promotion, and family support represent psychological interventions fundamental to improving quality of life and avoiding serious problems before they arise. Training in this topical area should include, for example, enhancing social and problem-solving skills, promoting positive attachments, increasing successful experiences, teaching safety and health practices, and increasing the responsiveness of the community and service systems to the needs of children, adolescents, and families.

Justification. Given the human and economic cost of emotional and behavioral disorders, it is essential to reduce their incidence and prevalence by strengthening the protective variables, reducing the risk variables, and supporting families in their development.

Implementation. Graduate training should provide exposure through didactic course work and observation of prevention-promotion and family support programs. Experience may be gained at the graduate level but is necessary at the internship level through supervised experience in service delivery systems with other disciplines. Expertise should be approached during internship training and achieved during postdoctoral training for increasing independence and autonomy in carrying out interventions in a number of service delivery systems.

Social Issues Affecting Children, Adolescents, and Families

Trainees should be trained to recognize, understand, and work with the multitude of social circumstances affecting the psychological well-being of children, adolescents, and their families. In particular, training at all levels should focus on the unique role of the psychologist in clarifying the impact of traumatic events and their consequences. The psychologist should be prepared to minimize traumatic impact by working with the child, his or her family, and natural support systems as well as formal service delivery systems.

Justification. Children are exposed to natural and human-made disasters, abuse and neglect, and war and violence, which may result in psychological difficulties or physical disabilities. They are also exposed to separation, loss, family disruption, poverty, discrimination, and failure of service delivery systems. These circumstances are not only potentially immediately traumatic for children, but also represent an increased risk for development of psychological disorders or deterioration in functioning. The psychologist should focus on helping children, families, and communities build on their strengths to diminish potential negative effects associated with these events.

Implementation. The exposure level of training can be reached through didactic course work integrated into one or several courses and through observation and participation in community settings. Experience should be the goal of doctoral-level training, augmented during the internship year through supervised activity in service delivery systems and with other professional disciplines. Expertise may be achieved during internship training and during postdoctoral activities through increasing independence and autonomy in carrying out interventions in a number of service delivery systems relevant to a range of social issues.

Specialized Applied Experiences in Assessment, Intervention, and Consultation

During the training sequence, applied experiences with children, adolescents, and families should provide a variety of clinical problems, a broad spectrum of patient demographic characteristics, and use of diverse assessment and intervention methods. The training experiences need to be conducted in a number of different settings, such as schools, psychiatric inpatient settings, child residential centers, psychological service centers, rehabilitation centers for children with disabilities, child guidance clinics, community mental health centers, pediatric–medical hospitals, and office practices. Close supervision by qualified specialty psychologists must be ensured in these settings. In addition, interaction with professionals from a variety of disciplines should be encouraged (e.g., social work, psychiatry, physical therapy, occupational therapy, speech and language therapy, education, and pediatrics). Public-sector mental health agencies, in particular, should receive special attention in providing training.

Justification. Psychologists working with children, adolescents, and their families, by virtue of their patients and their presenting problems, need to be able to relate beyond the confines of the discipline and practice setting. Trainees need careful supervision as they develop their abilities to address various problems, settings, disciplines, and techniques. Service delivery in the future demands an ability to adapt. Training focused solely on a single approach, setting, or discipline is too limited to promote adaptability. Programs may emphasize one or another type of experience, but future patients and trainees will be best served by multiple and varied experiences. Training for the professional psychologist needs to be specialized to develop proper competence in conceptualization, tools, and implementation needed for child and family work. A downward extension of adult-oriented training is insufficient: A professional psychologist cannot competently function with child and family patients without having received specialized training to develop competence.

Implementation. There is no exposure level for this topic. At the graduate level, to achieve experience, a practicum experience should, at the minimum, include intensive work with children, adolescents, and their families in at least two different settings. Practicums should be designed to complement didactic

course work in assessment–diagnosis and treatment–intervention. At the internship level, clinical activity should involve more breadth and depth as well as more autonomy to begin to attain expertise. At a minimum, the internship experience should include at least one-half time with children, adolescents, and families. At the postdoctoral level, the training experience should allow for more autonomy and specialization to complete training for expertise.

Exit Criteria

At the conclusion of graduate training, the trainee should have had integrated exposure and experiences in the major areas of research, psychopathology, assessment, intervention, and prevention for a variety of patient, family, and system characteristics. At the conclusion of internship training, the trainee should have attained exposure to all topics, gained experience in most areas, and approach a level of expertise in at least a few areas. At the conclusion of postdoctoral training, the professional psychologist working with children, adolescents, and families should be able to demonstrate expertise such that the professional can carry out competent assessments and interventions with independence and autonomy for a variety of presenting problems, populations, and settings.

References

American Psychological Association. (1992). Ethical principles of psychologists and code of conduct. *American Psychologist, 47,* 1597–1611.

American Psychological Association. (1993). Guidelines for providers of psychological services to ethnic, linguistic, and culturally diverse populations. *American Psychologist, 48,* 45–48.

American Psychological Association. (1996). *Guidelines and principles for accreditation of programs in professional psychology and accreditation operating procedures.* Washington, DC: Author.

Carboy, J. J., & Curley, J. F. (1976). A new training model: Professional child psychology. *Psychology in the Schools, 13,* 153–156.

Magrab, P. R., & Wohlford, P. (Eds.). (1990). *Improving psychological services for children and adolescents with severe mental disorders: Clinical training in psychology.* Washington, DC: American Psychological Association.

Markel-Fox, S., & Stiles, P. G. (1996). State mental health policy: Effect on outcomes for priority populations. *Administration and Policy in Mental Health, 24,* 25–38.

Roberts, M. C., Erickson, M. T., & Tuma, J. M. (1985). Addressing the needs: Guidelines for training psychologists to work with children, youth, and families. *Journal of Clinical Child Psychology, 14,* 70–79.

Saxe, L., Cross, T., & Silverman, N. (1988). Children's mental health: The gap between what we know and what we do. *American Psychologist, 43,* 800–807.

Tuma, J. M. (Ed.). (1985). *Proceedings: Conference on training clinical child psychologists.* Baton Rouge, LA: Section on Clinical Child Psychology.

Wohlford, P., Myers, H. F., & Callan, J. E. (1993). *Serving the seriously mentally ill: Public–academic linkages in services, research, and training.* Washington, DC: American Psychological Association.

Received September 17, 1996
Revision received May 13, 1997
Accepted December 19, 1997 ■