DOCUMENT RESUME

ED 225 036 CG 016 382

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TITLE A Clinical Psychology Training Program Interfaces with the Schools.
PUB DATE Aug 82
NOTE 11p.; Paper presented at the Annual Convention of the American Psychological Association (90th, Washington, DC, August 23-27, 1982).
PUB TYPE Reports - Descriptive (141) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Child Psychology; *Clinical Psychology; Consultation Programs; Counselor Training; *Graduate Study; Higher Education; Learning Experience; *Pediatrics; Program Descriptions; Psychological Evaluation; *Psychologists; Referral; Student Evaluation; Training Objectives
IDENTIFIERS *University of Massachusetts

ABSTRACT

This paper describes how clinical child psychologists are trained in a pediatric psychology program and emphasizes their interface with the school. The need for clinical child psychology training is stressed, and training programs for pediatric psychologists and clinical child psychologists are compared. The collaborative pediatric psychology training program by the Baystate Medical Center Pediatrics Department and the University of Massachusetts Psychology Department is described in detail, including areas of training; i.e., clinical, developmental, and psychosomatic theory in both academic and supervised clinical experiences and academic components. A description of the response to school referrals, involving a collaborative team model of consultation characterized by an interdisciplinary approach to evaluation is also provided. A case study is presented to illustrate the collaborative team model of student assessment in the schools. Benefits of the model are discussed. (JAC)

A CLINICAL PSYCHOLOGY TRAINING PROGRAM INTERFACES WITH THE SCHOOLS

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INTRODUCTION

The clinical psychology training program at the University of Massachusetts, has, as is characteristic of clinical psychology programs across the country, moved away from offering training in clinical child psychology. Tuma (1982) reports on the current status of child psychology training: "Psychologists who have interests in assessing children's needs have had very few options for obtaining training designed to address their future professional functioning. The small number of doctoral programs in clinical child psychology point to a possible preponderance of reliance on informal educational pursuits. Because of the variability of intensity and depth, such informal pursuits permit, the quality of that preparation is variable" (p. 324).

The continuing need for psychologists trained in child clinical psychology is currently reflected in the development of the pediatric psychology specialty area within clinical psychology. Because of the continued expansion and development of this specialty the present paper reports on how clinical-child psychologists are trained in a pediatric psychology program with an emphasis on their interface with the school. In order to understand this new direction in the training of clinical child psychologist it is necessary to ask the question; how do pediatric psychologists differ from clinical child psychologists? Routh (1977) has provided data that the basic doctoral training in pediatric psychology is primarily in developmental and clinical psychology. Psychosomatic theory provides an additional conceptual approach that distinguishes pediatric psychology from clinical child programs. We are concerned here with that aspect of the theory that deals with the two major differences. First training in pediatric psychology places a major emphasis on normal development while

child clinical places its' major emphasis on pathology. Second, pediatric psychology has a theoretical basis in psychosomatic theory. Current psychosomatic theory is concerned with the effects of stress on the individual and his/her adaptive responses. Such common stressors as disturbed family interaction, school and work conditions and sensory and informational over loads are relevant to understanding childrens maladaptive behaviors. Practitioners find this theory useful for identifying conditions, in a child's life, whose occurence increases the likelihood of maladaptive behaviors. Finally, adherence to this theory has significant consequences for both training and practice, namely, that the focus of both has been broadened to include prevention as well as assessment, intervention and consultation.

The University of Massachusetts Program

Baystate Medical Center the site of the pediatric psychology training program is a 1000 bed general hospital. The Pediatric Department has sixty-nine inpatient beds, and an outpatient section, ambulatory pediatrics, which has reported approximately 26,000 patient visits over the past two years. Ambulatory pediatrics is staffed by three staff pediatricians, fifteen pediatric residents, two pediatric nurse practitioners, and three specialty clinic pediatric physicians. The University of Massachusetts psychology department has fifty-seven full time faculty and offers doctorates in psychology, with specialty areas of clinical, developmental, biopsychology, educational, social and cognitive. The University of Massachusetts, through the Psychology Department is under contract to provide pediatric psychology services. Two program areas, clinical and developmental, in the Psychology Department have collaborated to field the pediatric psychology program. The clinical part of the program is administratively related to the Psychological Service Center, which is a training clinic sponsored by the Psychology Department.

AREAS OF TRAINING

The program offers academic and supervised clinical experiences for both pediatric residents and pediatric psychology students, the goals of which are: 1) to apply theories and research of normal child development to pediatrics; 2) to foster the learning of child clinical psychology, family evaluation and developmental assessment skills in a pediatric setting; 3) to develop a design for consultation to the schools and other community agencies. The program is transdisciplinary in nature, and combines both clinical, developmental and psychosomatic theory in a unique integrative approach to the practice of psychology with children.

CLINICAL COMPONENT OF THE PROGRAM

The clinical components of the program include: 1) participation in the Developmental Evaluation and Brief Intervention Clinic (D.E.B.I.C.), an outpatient clinic aimed at the assessment, and short-term treatment of children and adolescents with combined medical, developmental and psychological probelms; 2) consultation with schools and other community agencies.

During the past two years, the Developmental Evaluation and Brief Intervention Clinic has processed forty-five children and their families. Demographic data revela that ninety percent are from lower socioeconomic status, forty percent are Black, thirty-seven percent Hispanic and twenty-three percent Caucasian. Referrals to the clinic are made by schools, social agenices, courts, pediatric staff and local private practitioners, both medical and psychological.

Patients represent a wide range of problems including behavior disorders, anorexia nervosa, failure to thrive, language and hearing problems, genetic disorders, child abuse (physical and sexual), developmental delays, attention disorders and hyperactivity. Methods of assessment include the Brazelton, the Peabody, the Bender-Gestalt, the Kinetic Family Drawing, the Winnicott

Squiggle Game, doll play, the Wechsler Intelligence Test, the C.A.T., the Rorschach, the McCarthy, The Denver Developmental Screening Test, the Bayley, and child and family interviews. Visits range from one to six times with three the modal number

ACADEMIC COMPONENT

The academic components of the program for both pediatric residents and pediatric psychologists include: 1) an advanced course in normal child development, covering such topics as social, emotional and cognitive development of infants, children and adolescents, Piagetian theory, psychoanalytic theory, transactional developmental models, cross-cultural perspectives on parenting, and Winnicott's view of pediatric developmental psychology; 2) a course on perinatal medicine, taught by pediatric house staff, covering such topics as the well-child examination, selected topics in neurology and endocrinology; chronic and infectious diseases of childhood, encopresis and enuresis, seizure disorders, psychiatric diagnoses of children; 3) a series of workshops and lectures on family internviewing techniques, object relations theory, and infant and child assessment techniques; 4) research meetings on questions related to the pediatric setting; 5) medical educators, pediatric residents and pediatric psychologists present and integrate medical and psychological findings at a disposition staff meeting. The pediatric psychologist may then see the child and/or the family for brief psychotherapy, discuss management objectives with parents and/or teach management skills.

THE RESPONSE TO SCHOOL REFERRALS

The program offered service to 43 patients during the year 1981-82. School referrals accounted for 15 or 35 percent of the cases referred. There were 13 referrals from grades K through eight and 2 referrals from grades nine through twelve. School referrals were divided into two categories, behavorial problems and poor school performance. Each referral was assessed by a pediatric

resident for physical problems and a pediatric psychologist. The pediatric psychologist provided information on developmental delay, personality problems and family and community stresses that were affecting the child. Medical and psychosocial findings were discussed at a general staff conference and a number of recommendations were agreed upon. The role of the pedicatric psychologist was to provide direct consultation to the school. These consultations sometimes included presentations at planning and evaluation sessions held in the school, more often they provided for direct contacts with teachers, adjustment counselors and other appropriate school personnel. In all cases the model of consultation stressed by the program, the collaborative team model, represented the psychologists approach to consultation. This model is characterized by the sharing of imformation, problems and recommendations, each professional contributing his/her own unique perspective and competence in an effort to arrive at the best educational plan for the student.

An Illustrative Case

C.K. was referred to DEBIC by a member of the Valley Educational Collaborative for a complete psychological and physical evaluation to determine her readiness for first grade. A previous evaluation done a year earlier had revealed both cognitive and emotional difficulties. Her kindergarten teachers doubted C.K.'s readiness saying she evidenced agressive behavior, inadequate attention spanand a problem in language processing. There was disagreement on the part of the school staff whether C.K.'s problems were emotional, a position held by her teacher, or the result of a language processing problem. The latter position was held by the speech pathologist. Her parents felt that she was ready for first grade and were anxious to have their belief collaborated by the diagnostic study.

The initial referral question framed by C.K.'s teacher was as follows:

> She demonstrates bizarre behavior in the classroom. She is aggressive to other children and extremely aggressive in her play. She verbalized fantasies about killing and extreme hatred which she has difficult controlling. The staff are very concerned about a placement for next year, and would appreciate some appropriate program recommendations.

Initial interviews with her mother and her nursery school teacher, who accompanied her to the first clinic visit revealed further relevant information.

-- Courtney displays inappropriate behaviors, laughs when children are hurt

-- she responds inappropriately to questions. What is her favorite thing to do? Red.

-- she exhibits severe startle reactions

-- spontaneous conversational speech is markedly better than her responses to questions or directions.

-- she has a difficult time following directions, often seeming to hear only part of what is said.

In the context of the above information a multidisciplinary team was prepared to carry out a developmental assessment, psychosocial and family assessment, a medical evaluation and an emotional-affective evaluation. The assessment involved three separate visits with the child, the kindergarten teacher and the child's parents. The outcome of the assessment was that C.K. does suffer from developmental delays and language processing problems. These, however, seem to be emotional in nature and the result of stress placed on her development by familial problems. The family was constantly stressed by a dominant maternal grandmother who assumed the mothers role while C.K.'s mother was devalued and treated like an older child. C.K, within this family context had great difficulty controlling her own agression.

The clinic recommended to the family that they seek family therapy to obtain a rebalance of relationships within the family. They recommended to

the school that if the parents did engage in family treatment, C.K. should be permitted to enter the first grade and that her problem which was primarily emotional would become considerably less troublesome as the family dealt with their issues. The benefit to the school personnel was an understanding of C.K. and a reasonable decision about her next year. The advantage to the child was first to help her to be understood, to avoid her having to spend another year in hopes of preparing her better for entry into first grade, and to free her from unnatural family stress so that she could fulfill the developmental task of mastering her aggression.

CONCLUSION

Only about 10 percent of American children and adolescents in need of care or treatment are served by the present mental health system. Service availability and methods of service delivery are significant factors accounting for this underservice; however, a severe shortage of appropriately trained psychologists further contributes to this underservice. The number of programs offering training in clinical child psychology remains small in spite of the well documented need for service to this population. This paper has presented a new kind of training program in applied child psychology, the pediatric psychology program. Such programs have been developed in the past decade. This paper focuses attention on the program at the University of Massachusetts with specific attention to the relationship of the training of pediatric psychologists in school consultation. The pediatric psychologist is well trained to act as a consultant to the schools where the child's problem is either a developmental delay or a school adjustment problem. First because the conceptual basis for the practice of pediatric psychology is much broader than that of traditional child clinical psychology; second the pediatric psychologist is trained as a consultant who works

in a collaborative model with other professionals; and third since slightly over a third of the psychology students cases are based upon school referrals they have substantial experience in working with schools and school personnel.

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