real” with child behavior and development. *Teaching of Psychology.*


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**Essential Tension: Specialization With Broad and General Training in Psychology**

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The practice fields of psychology develop through specialization in training and education. The recognized specialties play a major role in developing new opportunities for professional psychology and providing quality services for the public. The essential tension comes from the balance of innovation and tradition and, in professional psychology, from the balance of fragmentation and unification. As an example, specialization in clinical child psychology is integrated within the broad and general traditions. The greater degree of focused science and practice in a specialty is the logical consequence of advances of the discipline and profession of psychology.

**Keywords:** education and training, specialization, clinical child psychology, clinical psychology

What a psychologist is and what constitutes proper training for a psychologist are questions that have been around since psychology emerged in Wilhelm Wundt’s era. Commentary over the history of psychology reveals a range of suggestions and recommendations, requirements and demands, scoldings and praises for the directions the discipline and profession have taken and/or should be taking. Everybody, it seems, has an opinion about the proper education and training of psychologists. One of the enduring issues, in various forms, has been how specialized training should be at various levels of the educational preparation process. This discussion (even vociferous debate) has been muddled by differing terminology, misperceptions, and ignorance about what constitutes (a) the basic core for a training curriculum in psychology (attention to a presumed broader and more general set of knowledge, methodologies, and applications) and (b) specialization (a narrower or more focused attention building from the basic core).

**Essential Tension**

Thomas Kuhn (1977) wrote about the *essential tension* between tradition and innovation in science. This concept has current application in professional psychology as well. This tension derives from differences in what is thought to be good for individual psychologists, the discipline, the profession, and (most important) the public being served. To parallel Kuhn’s construction of science, the field of professional psychology progresses only by avoiding falls into either the fragmentation trap or the unification trap. In the fragmentation trap, the fields of study divide further and further into isolated bits or parcels of psychology. In the unification trap, the field unnecessarily requires a “one” psychology, with a cookie-cutter approach to education and training.

Adapting Kuhn’s (1977) model of essential tension, progress in science and professional psychology demands balancing “exploitation” of training programs and their content as they have existed for a number of years and the “exploration” of new ways and contents of training. Similarly, Roediger (2003) described narrow mentoring, resulting in narrow specialization in which psychologists “know little about many aspects of the field” (p. 5). At the other extreme are graduate programs that seek broad training and cover the breadth of psychology but whose graduates “do
not become experts in one area of the field” (Roediger, 2003, p. 5). Roediger (2003) noted that “most graduate programs try to steer between Scylla of narrow mentoring and Charybdis of a vacuous general program” (p. 5). This is an essential tension that is ongoing within programs and the field; this steering and veering is occurring within the discipline of its own accord and on its own initiative.

As noted in the historical roots of the Commission for the Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP) of the American Psychological Association (APA), almost from the inception of organized psychology in America, the differentiation of elements within the discipline has been debated:

Historically, there has been a tension of sorts between those who regard psychology as a unitary profession (the generalists) and those who view the profession as having a common core of knowledge but from which quite different professional practices are derived (the specialists). (Nelson, 1999)

Although some people may not like one or another innovative trend (or may have created their own model of innovation that they want others to emulate), the creative tension of old and new ideas is essential to the vibrancy of a discipline and its applied profession. In the Kuhnian sense, a dynamic and vibrant discipline should always be challenged from within itself so that it does not become stagnant and irrelevant. The essential tension between a generalist model and a specialist model is the focus of the present article, in which I describe the broad and general orientation and then provide the basis of specialization before specifically noting the clinical child versus clinical (adult) tension. Other examples could be drawn from other specialties such as clinical health psychology, clinical neuropsychology, and the rising clinical geropsychology.

Specialization is an inevitable and necessary product of developmental processes in a discipline and profession. The increases in knowledge and practice opportunities that provide improved services to the public require specialization and enhanced focus on necessary differences in training when commonalities and generalizations no longer apply. However, specialization and generalized training are not incompatible. The assertion seems to be made that any specialization at the predoctoral level is overspecialization and, thus, too narrow. Many of the specialties, such as clinical child psychology and clinical health psychology, actually may be more broad and general than a generalized program of study.

Broad and General Training as Preparation for Professional Psychology

Although some people decry the “proliferation of specialties” (e.g., Sobell, 2005, p. 1), there is little agreement on what constitute the broad and general aspects of psychology (Peterson, 2005). Of course, the Guidelines and Principles of the Committee on Accreditation (CoA) of the APA outline some basic areas for coverage in the curriculum, indicating that a trainee in a program has received an education in the “breadth of scientific psychology, its history of thought and development, its research methods, and its application” in social, cognitive-affective, and biological aspects of behavior (Committee on Accreditation, 2005, p. 7). Not clearly defined are how these areas are to be covered or what should be the content of the didactic courses. There is wide room for interpretation and implementation.

Peterson and Ober (2006) suggested that a standardized curriculum of survey courses is appropriate. Collins (2006), in contrast, argued that the content or knowledge of facts generated by a broad and general core area is not as important as is learning the approaches, methodologies, and ways of thinking of the subdisciplines as taught by faculty who are active in the particular areas. Many training programs fulfill these core requirements not with general survey courses (similar to an advanced undergraduate course) but with more advanced seminars with some specificity, fulfilling Collins’s goals for these topics.

In addition to the Guidelines and Principles of the APA CoA, a number of commentators have outlined broad and general concepts, or a common core, across psychology (Drum & Blom, 2001; Nelson, 2005). Matarazzo (1987), in particular, titled an article “There Is Only One Psychology, No Specialties, but Many Applications,” indicating his thesis that there is an enduring commonality. Although broad and general core areas of professional psychology are not well-defined, they are required for program accreditation and individual licensure. Similarly, there have been no widely accepted articulations of what clinical psychology is or of what the basic or core requirements for training are in the traditional practice field since the “Shakow Report” (Committee on Training in Clinical Psychology of the American Psychological Association, 1947) and the Boulder Conference in 1950 (Raimy, 1950). There has not been a recent training conference defining clinical psychology and outlining its unifying core. When one wants to know what clinical psychology is, where should one turn?

Psychologists in specialty areas such as health psychology, clinical child psychology, and clinical neuropsychology have held more recent training conferences and have written extensively about the content of training so as to define themselves (Hannay et al., 1998; Roberts et al., 1998; Stone, 1983; Tuma, 1985). A training conference for clinical geropsychology was held in summer 2006, and the case was made for this field to develop more fully as a specialty (e.g., Lichtenberg, 2005; Meyers, 2006).

Unfortunately, despite the lip service paid to the broad and the general, current clinical psychology training often fails to reach a true level of broad and general. While possibly aspiring to broad professional training, typical training programs face inherent limitations in faculty size and
in their ability to cover and/or interest in covering all topics in a comprehensive way, which is reflected in a broad approach to course titles. Consequently, courses can become, for some, surveys of a professor’s individual proclivities (which may not be bad, in the view of Collins, 2006, if approaches are covered as much as facts). Drum and Blom (2001) noted that programs have to make “compromises in either breadth or depth” (p. 515). Over time, these compromises in many clinical psychology programs have usually resulted in the sacrifice of child-oriented content. The focus is simply not recognized. However, the field needs to recognize that the situation has changed dramatically on several fronts from when there was something closer to a “one psychology” and when the content of knowledge was less well developed than it is now.

Even in broad courses on cognitive, social, and biological aspects of behavior, the subject focus of the research covered is often primarily adult (or at least generated from college-student participants). Thus, an adult bias extends to the broad and general topical areas. In the clinical core courses (for the CoA’s coverage of the substantive area of professional psychology), most APA-accredited clinical training programs require a basic course in psychopathology and a basic course in psychotherapy. An examination of the Web sites of those programs reveals that most of these courses cover issues of etiology, diagnosis, and treatment of adults’ mental health problems. If there were no inherent focus on clinical adult aspects, then one should see general psychopathology and general psychotherapy courses that take a life span developmental approach—or at least cover both child and adult etiologies, manifestations, and treatments—as well as an equal number of courses at the advanced level (for specialization in adult or in child psychology; e.g., advanced adult psychopathology, child and adolescent psychopathology). A survey of program Web sites does not reveal many adult versions, indicating adult topics are already covered in “general” courses.

Clinical psychology has become a de facto clinical (adult) psychology in many ways (Roberts, 2005; Roberts & Sobel, 1999). In contrast, a course in social development or cognitive development might have a life span orientation (and a more balanced presentation) but might be naively assumed to be only child-focused. Similarly, a developmental psychopathology or developmental psychotherapy course might actually have much more breadth than the typical adult-oriented course. But, of course, the acknowledgement of an adult orientation by the delimiter of Adult Psychopathology or Adult Psychotherapy is rarely seen, whereas Child Psychopathology and Child Psychotherapy are frequently used in course titles. Thus, what is construed as breadth in many programs is usually a restricted and narrow range of coverage from young adult to older adult, with attention given minimally, if at all, to children and adolescents (Roberts & Sobel, 1999). Given that the core courses in clinical psychology have come, de facto, to emphasize the adult end of the developmental spectrum, child and adolescent training has invariably become an add-on and a “subspecialty.” As Roberts (2005) asserted, “the lack of consensus over the broad as well as the specific content in psychology and the specialties in clinical and counseling only serves to perpetuate the status quo” (p. 1078).

Ross (1985) noted that the Boulder Conference participants “agreed on a broad rather than specialized training, and while they felt that people should be trained to work at many age levels, they considered ‘narrow’ specialization to be unwise” (p. 32). There have been many positive and enduring results from the Boulder Conference; however, the ever-present caveat against narrow specialization has outlived its applicability. Specifically, Raimy (1950) declared that the distinction between child work and adult work was dubious in 1950. Whatever reasons existed then are no longer valid. The participants at the Boulder Conference would be impressed with the substance of clinical child psychology today. Although the Boulder model is important for many enduring historical truths, most professional psychology programs no longer fulfill most aspects of the original training model as outlined in the 1950s. The field has adapted and progressed.

It is important to remember that professional psychology training is primarily about preparation for practice and service delivery. The field is trying to determine how best to provide services to help people—not any other mission, not any other ideology. The goal of training is to train providers and researchers to improve understanding and therapeutic services. The competent service provider will be the best trained professional who has mastered the basic and advanced content and the applications of the field. The more specific and comprehensive preparation of specialty training helps the psychologist in the making of appropriate diagnoses and treatment decisions and the implementation of services. There is so much information to be integrated to provide quality services, it would be difficult to accomplish only at an internship or postdoctoral level. Adequate training in clinical child psychology at the university program level provides both didactics and clinical experiences with child and adolescent populations to the level of proficiency, which cannot be attained through one or two courses or a handful of clinical contacts. Ethical psychologists should practice within the bounds of their competence; professional competence comes from didactic, experiential, and supervised experience. Improperly trained psychologists should not be practicing in the clinical child specialty. Child, adolescent, and family consumers deserve better.
Specialization in General

It is ironic that specialization and most specialties are more comprehensively defined in contrast to definitions of broad and general training (and of the traditional practice area of clinical psychology). Of course, within most frameworks, the traditional areas of clinical, school, and counseling psychology are considered specialties. The CRSPPP of the APA has been assigned the responsibility for reviewing and identifying specialties. The definition of a specialty includes the following:

A specialty is a defined area of psychological practice which requires advanced knowledge and skills acquired through an organized sequence of education and training. The advanced knowledge and skills specific to a specialty are obtained subsequent to the acquisition of core scientific and professional foundations in psychology.

Although the specific dimensions of specialty programs may vary in their emphases and in available resources, every defined specialty in professional psychology will contain: (a) core scientific foundations in psychology; (b) a basic professional foundation; (c) advanced scientific and theoretical knowledge germane to the specialty; and (d) advanced professional applications of this knowledge to selected problems and populations in particular settings, through use of procedures and techniques validated on the same. (Joint Interim Committee for the Identification and Recognition of Specialties and Proficiencies, 1995)

Currently, there are 12 specialties (including the traditional three of clinical, school, and counseling psychology) recognized by APA through the CRSPPP process and with synarchies represented on the Council of Specialties in Professional Psychology (these include theory-based and population-based specialties).

In January 2004, the Council of Credentialing Organizations in Professional Psychology (CCOPP) articulated “A Conceptual Framework for Specialization in the Health Service Domain of Professional Psychology.” In its definitions, a specialty was defined as

an area of professional practice requiring didactic and experiential preparation that provides the basis for competent services with respect to the distinctive patterns of the following essential parameters of practice: (a) populations served; (b) psychological, biological, and social problems targeted; and (c) procedures and techniques used. (Council of Credentialing Organizations in Professional Psychology, 2004)

The Canadian Psychological Association has implemented a specialty designation system (Service et al., 1994). Common to these definitions and organizational documents is the acknowledgement of a core foundation, distinctive applications, and applicability of training at all levels, beginning with predoctoral training.

Clinical Child Psychology as a Specialty

The specialty of clinical child psychology illustrates the issues being raised here. Simeonsson and Rosenthal (2001) outlined the defining elements of why a separate practice specialty relying on developmental theories and knowledge is necessary:

Age usually is not a central issue in the provision of psychological services to adults. However, every facet of clinical work with children is influenced by developmental factors. Presenting problems, the nature of assessment, types of diagnoses, and the implementation of interventions will vary significantly if the client is an infant, a school-age child, or an adolescent. . . . For a comprehensive approach to the clinical activities of assessment, diagnosis, and intervention, it is essential that appropriate consideration is given to the child’s age and stage of development . . . a model of development is useful to frame the clinician’s understanding of etiology and guide implementation of treatment. Furthermore, developmental factors continue to be important in accounting for individual differences of the child in which interactions over time may result in different outcomes for children with similar etiologies. (pp. 20–21)

For these reasons, comprehensive and targeted training is required for those who are going to serve children, adolescents, and their families.

A few years ago, Roberts and Sobel (1999) wrote about why the need for a clinical child specialty is imperative. Their primary thesis was that times had changed and the general clinical psychology field had been unable to keep up (or had been so focused on its adult interests as to be disinterested in child and adolescent developments). Advances in knowledge with specific research and clinical applications in clinical child psychology and related fields have expanded immensely. These advances must be mastered by the trainees of today if they are to be adequate professional psychologists serving the public. In comparison with the first clinical training cases of bedwetting from 30 years ago, the first training cases of students in the Clinical Child Psychology Program at the University of Kansas (Roberts, 1998) reflect more the types of cases seen by active practitioners, often a child or adolescent with multiple problems needing ecological involvement with the family, school, the juvenile justice system, peers, and pediatric–medical personnel. Indeed, the psychological problems of children, adolescents, and families of today are more severe and intense than they were in the past, are multiply determined, and require assessment and intervention at multiple levels. Today, a dilettante’s preparation is insufficient to serve the public or to make contributions to the scientific and professional literature.

The advancements in the field should be an advantage. The success of clinical researchers has contributed to the need for specialized training. The changes over the years in the number and severity of clinical problems, advance-
ments in assessment and intervention, and increasing so-
phistication in research methodology and data analysis all
require both focused and broadened attention. The content
of the field has changed over time, necessitating enhanced
learning by the trainee. The need remains strong for skilled
clinicians and scientists addressing issues of children, ado-
lescents, and their families.

In 2004, the petition for renewed recognition of clinical
child psychology as a specialty by the CRSPPP (approved
in 2005 by the APA Council of Representatives) stated the
following:

During the past 25 to 30 years . . . the area of clinical child
and adolescent psychology has become a well developed and legiti-
mate area of specialization, characterized by the development of
an ever increasing body of specialized knowledge and a vibrant,
diverse and specialized area of practice. (Society of Clinical
Child and Adolescent Psychology and the American Board of
Clinical Child and Adolescent Psychology, 2004, p. 1)

The specialty of clinical child psychology is defined by the
archival description of the specialty provided to the
CRSPPP:

Clinical Child Psychology is a specialty of professional psy-
chology which brings together the basic tenets of clinical psy-
chology with a thorough background in child, adolescent and
family development and developmental psychopathology.
Clinical child and adolescent psychologists conduct scientific
research and provide psychological services to infants, tod-
ddlers, children, and adolescents. The research and practices of
Clinical Child Psychology are focused on understanding, pre-
venting, diagnosing, and treating psychological, cognitive,
emotional, developmental, behavioral, and family problems of
children. Of particular importance to clinical child and adoles-
cent psychologists is a scientific understanding of the basic
psychological needs of children and adolescents and how the
family and other social contexts influence socio-emotional
adjustment, cognitive development, behavioral adaptation, and
health status of children and adolescents. There is an essential
emphasis on a strong empirical research base recognizing the
need for the documentation and further development of evi-
dence-based assessments and treatments in clinical child and
adolescent psychology. (Commission for the Recognition of
Specialties and Proficiencies in Professional Psychology, 2005)

The clinical child psychology petition for recognition as a
specialty by the APA CRSPPP described a field that is dis-
tinctive (or “narrow”) enough to be a specialty and require
intensive and focused training from predoctoral through
postdoctoral levels yet broad enough in relationship to the founda-
tions of psychology and broad enough to permit the pursuit
of a range of activities.

**Education and Training in Clinical Child Psychology**

In 1983, the Executive Committee of the Division of
Child, Youth, and Family Services of the APA approved
the recommendations for training psychologists to work
with children, youth, and families developed by its Task
Force on Training (Roberts, Erickson, & Tuma, 1985). These
guidelines were essentially endorsed by the Hilton Head
Conference on Training Clinical Child Psychologists
and sponsored by the Section on Clinical Child Psychology
(Tuma, 1985). As Roberts et al. (1998) noted, “the products
of these activities appear to have had only moderate
impact at best on actual courses and experiences in pro-
grams purporting to train psychologists to work with chil-
dren and adolescents” (p. 294).

On the basis of another training conference and task
force initially organized by the National Institute of Mental
Health and sponsored by the Section on Clinical Child
Psychology, Roberts et al. (1998) described a model of
training with attention to the three levels of psychology
professional training (graduate, internship, and postdoc-
toral) in terms of increasing degrees of sophistication and
competence. Eleven topical categories were described in
the model, with a rationale for the inclusion of each in
training psychologists to provide services to children, ado-
lescents, and their families. These training recommenda-
tions encouraged educators to develop their training pro-
grams to more fully provide specialty training in a
comprehensive, integrated, and focused manner. A task
force sponsored by the Society of Pediatric Psychology
adapted these training recommendations more specifically
for that area (Spirito et al., 2003). Even in the time since
the recommendations were written, further advances in
conceptualization, scientific literature, and practice patterns
have emerged that should compel updates to the training
curriculum in the clinical child psychology specialty.

**Breadth and Specialization in Clinical Child Psychology**

At the 1980 APA convention, Roberts (1980) presented a
paper with the assigned topic of “Clinical Child Training:
The Dangers of Too Narrow A View” (although the
printed title in the program became “Breadth of Specialty
Training”). The presentation argued against overspecializa-
tion such that the specialist would have no grounding in
the broad foundations of the field. This is still a defensible
view. What has changed in the field has been the even
greater narrowing of a definition of clinical psychology to
an even more intense focus on adults in clinical psychol-
yogy. Thus, broad and general concepts are important, but
they must be true breadth that is applied uniformly through
a principled approach. Both breadth (the “broadness” issue)
and depth (leading to “narrowness”) of training have been
emphasized in the conceptual models of specialty training
in clinical child psychology articulated through the years
(Roberts et al., 1998). Competence in clinical child psy-
chology inherently seems to require a broader perspective
and greater facility to interact in interdisciplinary ways
than does competence in traditional clinical (adult) psy-
chology (Roberts et al., 1998; Wohlford, 1978).
Many clinical child and pediatric psychologists are oriented toward working with the community and interacting with the various systems in which children, adolescents, and families are found. Perhaps more so than clinical and applied research work in clinical (adult) psychology, most work in clinical child psychology requires exposure to and interaction with the numerous institutions, settings, and personnel in which the clientèle (children and adolescents) are served (e.g., hospitals, schools, juvenile justice facilities, day care centers, mental health centers, sports teams, scouting troops, after-school programs). Other specialties, such as clinical health psychology and clinical geropsychology, have similar ranges of breadth while focusing on their specific domains. Specialization, if properly implemented and integrated in doctoral programs, should provide more breadth than does a traditional doctoral program.

Challenges to Clinical Child Psychology Specialization

Many of the reactions and challenges to clinical child specialization are made during conversations and confrontations at meetings. Sometimes, when the specialty of clinical child gets questioned, clinical (adult) psychologists will say mockingly, “That’s overspecialization,” and “Don’t those children have parents? What about them? They’re adults; your graduates need to treat them.” The answer is yes, children do have many significant adults in their lives—parents, grandparents, teachers, coaches, ministers, and so forth. And, yes indeed, specialty students need to learn how to work with them (and that complexity is a good reason for specialized training). However, the University of Kansas Clinical Child Psychology Program (CCPP) and other programs with a strong focus in clinical child psychology also instruct students that they should not treat both the child and the parent concurrently for their individual mental health problems. Specialty students are instructed to make appropriate referrals for the parent’s psychological therapy. One would also hope that the general clinical training programs train their students similarly to avoid this ethical trap. CCPP students receive required training in family systems—something most general clinical (adult) programs do not require, even though most adult clients have families.

Many traditional clinical programs, oriented by a training model that is dictated by adult work (often within strictly clinical–office settings), do not offer training opportunities for students to see clients in all domains. As a result, the broader perspective exemplified by the clinical child training espoused in Roberts et al. (1998) is not as likely to be found in general clinical programs. This unfortunate neglect may also be true for clinical child tracks in which child courses and practicums are “added-on” to the basic clinical (adult) courses taken by all students. La Greca and Hughes (1999) stated that “training models that add on a little bit of child work to primarily adult-oriented clinical training are inadequate for preparing practitioners and researchers who can effectively address the needs of children, youth, and families” (p. 442).

Many people fear overspecialization of students too early in their education and training as professional psychologists. Over specialization should be limited. Far too many of the students in “general” clinical psychology programs have chosen—and their programs have been designed to accommodate this preference—to specialize in clinical (adult) psychology. The profession has lost, over time (and lamentably), a sufficient coverage of a truly encompassing clinical psychology. And it was not lost by child- and adolescent-oriented psychologists. Indeed, the move to specialization was triggered by clinical (adult) psychology, not by clinical child psychology. How is it that clinical child psychology is an “overspecialization” but clinical (adult) psychology is not?

Of course, overspecialization depends on the perspective of the commentator. Unfortunately, the dominant forces in clinical (adult) psychology simply do not recognize how they have altered the meaning of clinical psychology. This is power-privilege blindness. In education and training in professional psychology, it is the equivalent of the monocultural ethnocentrism described by Sue, Bingham, Porche-Burke, and Vasquez (1999). The person in privilege—power does not recognize that they are interpreting the world any differently from others; they are not compelled to recognize that there are any differences. This monospecialty adultcentrism may be why clinical (adult) psychologists do not recognize that they are insufficiently sensitive to child and adolescent issues. They do not see that they are focusing on adults, whereas they view a program that focuses on children as a problem because it is too narrow or too targeting or not broad and general. Similarly, they may create even more sharply delimited foci in their own training programs or laboratories while decrying the looming dangers of overspecialization.

Here is one example of such adultcentrism. On a comment Web site for the CoA, there appeared this statement arguing against more specialization:

At the . . . VAMC [Veterans Affairs Medical Center], we have a generalist training program with a number of emphasis areas. Although a student can focus on a specific area via rotation selection, on each rotation we emphasize training in good clinical skills. We view all interns here as receiving training in a “clinical” program. We are concerned about the further compartmentalization of psychology, particularly at the intern level. As stated above, we firmly believe that all interns need to have good general clinical skills.

This is a strong assertion, but the program’s Web site revealed the statement: “Our male and female veterans range in age from young adults to the elderly” (Department of Veterans Affairs Eastern Colorado Health Care System, 2006). A focus on adults is a narrowed or focused training experience.
In contrast, an illuminating statement is posted on the Web site of the University of Denver Child Clinical Psychology Program, one that has a strong clinical child emphasis, that the program does not “neglect” training in working with adults (University of Denver Department of Psychology, 2006). However, an examination of programs known to have very focused adult emphases did not turn up any indication that they “do not neglect children.” That is monospecialty adultcentrism.

In the University of Kansas CCPP, even though there is a developmental perspective throughout—one that includes the breadth of core courses and adult clinical experiences—the faculty feels compelled to offer a workshop on clinical adult psychology taught by a U.S. Department of Veterans Affairs psychologist for the clinical child students so as to appease critics on the CoA. One can hope that the CoA similarly imposed clinical child training on the clinical (adult) psychology programs. Another example of monospecialty adultcentrism came when the Council of University Directors of Clinical Psychology did its annual survey of training directors; the questionnaire asked directors if their programs offered a “clinical child specialty.” When queried as to why they did not ask if a program offered a “clinical adult specialty,” the survey authors reported their surprise and indicated that they assumed that adult clinical training is basic to any other specialization.

Why has specialization become a boogeyman to be feared? As one training director intimated when the CCPP was started at the University of Kansas (Roberts, 1998; Roberts & Steele, 2003), other training directors who offer less focused training may fear that they will have to compete with a true specialty program and will have to do things differently to be able to claim that they offer clinical child psychology training. Additionally, the innovation-limiting conservative forces of the status quo (and CoA; see Peterson, 2005) and inertia, coupled with the pervasive monospecialty adultcentrism, have erected obstacles against the development of adequate training models in specialties other than the dominant clinical (adult) psychology, which is presumed to be general. Of course, for some, any difference from what they do is unacceptable and is narrow or overly focused. As Peterson (2005) noted, “one group’s innovations are another group’s anathema” (p. 1124).

Concluding Comments

Most specialized training is not the “overspecialization” that many decry. The immense mental health needs of children, adolescents, and families can be better served by competent clinical child psychologists (Roberts et al., 1998; Steele & Roberts, 2005). The scientific and professional literature has sufficiently developed to the point that clinical child psychology is a substantive area in its own right with regard to research and practice in developmental psychopathology and empirical support for methods of assessment and intervention. The specialized body of knowledge, skills, and competencies defining clinical child psychology is strongly integrated with the foundations of the discipline and fields of psychology.

Specialty development has invigorated rather than diminished the profession. The profession has not seen a willy-nilly proliferation of specialties—there has been a progression of development in a limited number of domains with distinctive content areas, knowledge bases, and spheres of practice. The specialties have many commonalities with all of professional psychology, but each of the ones now being recognized has distinctiveness. In the case of clinical child psychology, the development was a long-term progression. For years, the specialty developed itself with many publication outlets for research and with some training programs providing quality training at university, internship, and postdoctoral levels. Practice opportunities arose to meet the psychological needs of children, adolescents, and families. The clinical psychology field itself, including the limited number of related specialties, came about as adaptation to changes in science and practice of psychology, the immense demand for the knowledge and services of psychologists, the increased opportunities for education and training, and development of a range of settings in which specialty psychologists were needed to conduct their work.

The essential tension of specialization versus broad and general training is likely balanced best with integration. Because specialization can be integrated into a broad core, the tension of unification versus fragmentation, or stagnation versus innovation, can be balanced carefully. The process of developing and recognizing specialties has been a slow, meticulous, and conservative one. The greater degree of focused science and practice in a specialty is the logical consequence of advances of the discipline and profession of psychology.

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