Pioneers in Pediatric Psychology: Between Two Professional Worlds: Personal Reflections on a Career in a Pediatric Setting

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The purpose of this article is to provide a brief personal account of the development of my career in pediatric psychology with a focus on influences and lessons learned. My hope is that readers will learn something and not be dissuaded by the potential narrowness of personal reflection.

Early Career Roots

My love of learning and scholarship came from my parents, both of whom had a life-long respect for learning and academic achievement. Their lives marked by the experiences of the Great Depression and World War II, my parents valued hard work and believed in the American Dream, that is, if you get an education and work hard, you will succeed, but their individual legacy to me differed. My mom, an athlete, captain of her basketball team, and second in her class in high school (I think she always wanted to be first), taught me standards of achievement and how to get things done. My dad, who left high school early to pursue a career as a merchant marine, was a dreamer, would-be author, and dedicated union man who taught me to value causes and to respect the power of writing and of personal values.

When I was eight years old, our small family was enriched by the birth of my sister Patty, and I became an older brother. Unfortunately, my sister’s life tragically ended at age 12, cut short by a sudden, mysterious illness, eventually diagnosed as acute renal failure secondary to lupus. Although she had hardly been sick a day in her life, she now was dead, which was a truly devastating loss for our entire family. In the process, I learned that one does not progress neatly through, or ever quite recover from, the so-called stages of grief, but simply tries to outlast them and create meaning wherever and whenever one can (albeit slowly). In retrospect, at some level my sister’s death may have helped to fuel...
my professional interest in things related to medicine and illness, as well as my unabiding concern with time and productivity. Patty’s spirit burned brightly during her short life, commanding my attention to a compelling question: what will you do with your life in the time you have?

Professional Training

Part of the answer to my question turned out to be the profession of psychology. But how did I choose a career in pediatric psychology? As it turned out, luck and coincidence played a role, along with extraordinary mentorship. I was initially interested in physical science and made it through one year as a chemistry major. Alas, the combination of my lack of excitement for inert compounds and lack of technical skills (I left a trail of broken test tubes in the lab) forced me to rethink my original career direction. I was interested in literature, philosophy, as well as science, but settled on psychology, based, in part, on the strength of the teaching of the psychology faculty at Rutgers. A very influential early career-forming experience was my first independent research with Dick Lanyon as a part of the Henry Rutgers Scholars Program. We collaborated on two research projects, one concerning response sets as personality concepts and the other on verbal conditioning, intelligence, and awareness, which were eventually published. My experiences in implementing research and helping to prepare manuscripts for publication under Dick’s supportive mentorship were critical in forging my interest in psychological research.

Graduate Training

I had several options for graduate school and chose the University of Iowa, partly because Lanyon had attended there and because it offered training in a new program involving research and practice with children’s medical and developmental problems. Although I had not completely settled on the idea of working with children, I always enjoyed my experiences working with children on playgrounds and as a baseball coach. As a consequence, a graduate program that would train me to work with children seemed to fit my interests. And so this New Jersey boy went off to Iowa, as it turned out a fortuitous move. But who knew at the time?

The training program at Iowa was the first to combine pediatrics and psychology in a systematic manner, even before the field had been defined (Routh, 1969). The brainchild of Leonard Eron, a noted researcher on aggression in children who was director of clinical training, and Gerald Solomons, a pediatrician and expert on cerebral palsy, this National Institute of Health-funded program featured an innovative fare. Courses in child development and an intensive clinical experience in an interdisciplinary child development clinic at the University of Iowa Hospital School were combined with clinical psychology taught in rigorous Iowa style. We were skeptical when we were told that this was a “unique opportunity.” But it was true. Among other experiences, the repeated opportunities to observe experienced psychologists working closely with pediatricians and other professionals were extraordinary and, as it turned out, a career-defining experience for me.

On the other hand, in the era of the Peace Corps and the Vietnam War, the atmosphere of the graduate program at the University of Iowa promoted a non-student-centered survival of the fittest ethic that I found distasteful. Many students were not (or did not feel) respected, and most of the department couldn’t seem to move beyond the narrow confines of Hull-Spence theory, which was still being touted as a revolutionary breakthrough, even though it had passed its time and prime. I learned there has to be a better way to train and acculturate students into the profession of psychology. I would eventually try my hand at creating such opportunities (Drotar, 1998).

Yet despite what I, and at least some of my peers, regarded as an intellectually oppressive atmosphere, my Iowa years were enriched by extraordinary research mentorship from Ira Semler and Don Routh and in clinical work from Bruce Cushna, Camille Hanlon, and Jane Anderson. Don, of course, deserves special mention, given his leadership status in the field of pediatric psychology (Routh, 2000). Arriving at Iowa fresh out of training, Don had a strenuous joint appointment in medical school and the department of psychology. Don’s personal work ethic, respect for students and his profession, and conscientious mentoring set high standards that I try to emulate to this day. For example, as a matter of course (there was no other way), Don always managed to provide an expedient and thoughtful critique of any work that I handed him. Consequently, progress in writing could be delayed only
by my hand, not his. When we worked together in the late 1960s, Don and I could not have known that each of us would play a role in the development of the field of pediatric psychology and that our admiration and respect for one another would grow over these many years.

**Early Clinical Training**

The more I learned about pediatric conditions and their impact on children and families in my work at Iowa, the more I wanted to learn ways to assess and help families manage these problems. Aided by Bruce Cushna’s guidance, my decision to pursue clinical training in an internship at Boston Children’s Hospital gave me experience with a subject that would turn out to be of life-long interest: consulting and collaborating with pediatricians. My experience and interest in this topic grew by leaps and bounds during a postdoctoral fellowship at the University of Colorado Medical Center which provided intensive training in pediatric psychology and school consultation. My supervisor in pediatric psychology, Gail Gardner, had just joined the faculty and had been trained in pediatric psychology by Lee Salk, one of the founders of this field. Gail was quite an action-oriented individual who taught me a lot about program development and clinical skills.

**Professional Life: First Job and Developing Interests**

By the end of my postdoctoral year, I was more convinced than ever that I wanted to pursue a career in pediatric psychology (community mental health was another option I entertained) and looked around for a job in a medical school setting that fit my interests. Although there weren’t a lot of job openings at the time, one that was, and turned out to be an ideal setting in which to begin a career, was at Rainbow Babies and Children’s Hospital in the Department of Pediatrics at Case Western Reserve University (CWRU). Some of the extraordinary pediatric colleagues whom I met on these initial job interviews and subsequently worked with as a new junior faculty member, such as John Kennell, have remained colleagues some 29 years later. As the first full-time psychologist in this setting, I threw myself into clinical service and program development, especially consultation on the inpatient service (Drotar, 1976). My initial total immersion in clinical experiences at Rainbow stimulated what eventually evolved into career interests in children with chronic illnesses, failure to thrive (FTT), consultation, and professional activities in the field of pediatric psychology.

**Children with Chronic Illness**

Much of my initial clinical work was with children, adolescents, and young adults with chronic, life-threatening illnesses, including cystic fibrosis and end-stage renal failure, who presented much as they do today with problems such as anxiety, depression and noncompliance with treatment. In the course of this work, I became intrigued (and still am) with the question of why some children have a negative psychological outcome associated with the experiences of a chronic illness whereas others remain remarkably resilient (Drotar, 1981).

**Children Who Fail to Thrive**

My introduction to a second compelling clinical population, children with failure to thrive (FTT), came in a series of trial by fire clinical consultations in which I was called in to provide an assessment of the child’s development and “do something” about difficult family problems. I learned from talking to the staff, as well as sometimes irate and highly threatened parents, that there was a need to design more effective methods of family intervention for this difficult problem. I was concerned with questions such as how could this (FTT) happen? What could be done to intervene? My interests in finding out the answers to these still unanswered questions eventually led to a research program concerning FTT, which continued (Drotar, 1985; Drotar & Robinson, 2000).

**Consultation and Collaborative Process**

One of the earliest and most important lessons I learned as a consultant and collaborator was that professional life in the pediatric hospital needed to involve interdisciplinary teamwork, even if the teams didn’t always work together so well. My work in the cauldron of interactions and relationships among children, families, physicians, nurses, and other staff in hospital settings sparked a career-long interest in learning more about collaborative rela-
tionships and the consultation process (Drotar, 1976, 1995).

**Professional Activities in Pediatric Psychology**

My involvement in clinical care and consultation also gave me an opportunity to participate in the development of the field of pediatric psychology through my work with the Society of Pediatric Psychology, which in its early days, prior to its more established status, had a hand-to-mouth existence but always excellent leadership. These experiences put me in contact with outstanding pediatric psychologists throughout the country and fostered valued relationships.

**Turning Points in My Career**

**Developing Collaborative Relationships With a Department of Psychology**

Although I did not fully realize it when I took the job at Rainbow, one of the most fortuitous features of the campus and professional environment at CWRU was the close physical proximity and availability of outstanding colleagues in the department of psychology. The support and intellectual grounding afforded by my collegial relationships with psychology faculty and eventually with students at CWRU eventually became a sustaining force in my career. This collaboration began modestly: to “share the wealth” of clinical experiences at Rainbow with students, I developed a year-long placement that involved students directly in clinical consultation in pediatric settings and also gave them opportunities to observe psychological consultation in action in various forms. Some of the first students who were interested in such training included some talented ones such as Barbara Boat, Henry Ireys, Susan McGrath, and Lynn Singer.

My involvement with and commitment to the development of graduate students have deepened as my interest in research and research mentorship blossomed. This work was facilitated by the availability of research populations at Rainbow, my pediatric colleagues’ interest in research, and strong support from departmental chairs, among them Irv Weiner, Herb Rie, Cleve Gilmore, Doug Detterman, Joe Fagan, and Sandy Russ, and faculty colleagues. In such a supportive context, I eventually learned to traverse two widely discrepant professional cultures, that of the pediatric setting and the academic department of psychology, including potentially lethal doses of multiple faculty meetings.

What have I learned from this immersion in these two professional worlds? Medical culture is one of action and initiative but at the same time potential professional vulnerability, given the necessity of independent generation of income from research and clinical care to sustain faculty positions in schools of medicine. Consequently, to succeed in a pediatric setting, one needs to be an entrepreneur-scholar. Whereas the greater job stability (assuming tenure) inherent in academic positions of psychology is much more conducive to promote scholarly activity for its own sake, academic cultures can be insular and isolated from important questions of practice and policy. Which is “best”? I have never been able to decide, but I retain my membership in both groups, hoping to broker what I see as the best of one to the other and vice versa. At times, this can be a nomadic existence because one’s true professional “home” does not exist in a setting so much as it does in the work. Sometimes I succeed in my role as a broker between these cultures; sometimes I don’t. Yet on the whole, my professional development has been enriched by collaboration with faculty in each group.

**Developing a Research Career**

I was some 5 years into my work at Rainbow. My clinical work load that varied from 25 to 40+ direct service hours per week threatened the development of what I now regard as my most precious professional activities: that of researcher and writer. My clinical work was gratifying, but it was not sufficient to sustain a professional career. The more patients I saw, the more I realized that clinical care alone would neither be an optimal source of professional satisfaction nor result in a sufficient contribution to the field. Nevertheless, as many pediatric psychologists can attest, it is much easier to think about research that needs to be done than it is to actually do it. This was certainly true for the kinds of research projects that interested me, which required significant grant funding, which I was not trained to do. I owe a significant debt of gratitude to Carl Doershuk, a pediatric pulmonologist, who helped to secure some initial funding for my research in cystic fibrosis, and most especially to Charlie Malone, then chief of child and adolescent psychiatry, who
provided support and mentorship to help me develop the funding for my research on FTT that would support a career transition. Our work gradually evolved from early studies that documented various clinical problems to a controlled study of family intervention for children with FTT, who were studied along with a cohort of physically healthy, normally growing infants recruited from similar socioeconomic circumstances.

My deepening involvement in research necessitated a great deal of time and learning and required some difficult choices. For example, my decision to focus my career increasingly on research was not exactly met with enthusiasm from a number of pediatric colleagues who had grown to depend on the services I provided directly or supervised. This underscored the wisdom of the adage “you can’t please everyone,” which in this instance included valued pediatric colleagues who did not understand or agree with the choice I made.

Managing Transitions in Pediatric Leadership: But Wait a Minute, I Thought I Was a Success

Although I had established good working relationships with colleagues and a reasonable level of early success, like pediatric psychologists in today’s hospitals, I was in no way immune to the impact of changes in administrative leadership and philosophy. In a relatively short 6-year period after I took the job, the hospital and its leadership changed dramatically from that of a patient-oriented community hospital atmosphere to one in which the financial bottom line had become king. These events occurred prior to the managed care revolution but presaged modern mandates to see ever increasing numbers of patients in order to fund salaries. In addition to these financial pressures, other forces conspired to make Rainbow an increasingly intolerable professional environment: financial pressures dictated policy to the point where patient care became less of a priority and much of the “value” of faculty was reduced to what money they could bring in. These pressures were “fair,” in that they were experienced by pediatricians and psychologists alike, but they were nonetheless troubling.

Psychologists in our setting were also plagued by a problematic administrative organization, then typical of the time, in which our major academic appointments were in one department, in this case psychiatry, but we functioned full-time in another, pediatrics. This arrangement added to the frustration experienced by pediatric leadership, who wondered what we did and why it was not more closely tied to pediatrics.

Partially in response to this atmosphere, a number of my pediatric and psychologist colleagues found themselves other jobs. In retrospect, I realize I stayed a little too long out of loyalty, guilt, and not knowing any better. However, I knew the writing was clearly on the wall when the department hired a person who looked like the man from Glad to follow us around and document what we did or didn’t do and report this information back to the administration. Clearly, trust had broken down.

Making a Change: The Metro Years

Because I had established roots in Cleveland and had developed many collaborative relationships that would have been hard to duplicate elsewhere, a local job search seemed my next logical step. A pediatric psychologist colleague of many years, Sue White, heard about my plight at a meeting and let me know that they had an open position in the Department of Psychiatry at Metro Health Medical Center, a teaching hospital in the same medical school, which turned out to be a very good opportunity. During my 10 years at Metro, I was able to devote increasing energies to develop the research training program in pediatric psychology at CWRU, which was funded for the first time, conducted research on the outcomes of children with HIV infection (Drotar et al., 1999), and wrote Consulting with Pediatricians (Drotar, 1995). Other professionally gratifying activities continued during this time, among others the privileges of serving as president of Division 37 (Children, Youth, and Families), working with colleagues in the Research Consortium in Childhood Chronic Illness, and serving a term as associate editor of the Journal of Pediatric Psychology, working with editor Annette LaGreca and fellow associate editors Anne Kazak and Kathy Lemanek.

Bringing It All Back Home: To Rainbow

When I had made the decision to leave Rainbow, I had no illusions that I would return. Nevertheless, in some ways I never left. All the while I maintained collaborative relationships with some members of the pediatric faculty through my own and students’
research projects. Eventually, pediatric leadership changed for the better, and opportunity knocked once again in this setting, this time in 1996. The new chair, Ellis Avner, wanted to develop an interdisciplinary division of behavioral pediatrics and psychology to build on the successful research programs established by Lynn Singer and Gerry Taylor and research, training, and clinical care programs developed by John Kennell and Karen Olness. The national search for a chief of this division eventually turned up, among others, yours truly. I was offered the position and accepted it but not without asking myself some difficult questions such as “What has really changed?” “Can I trust this new chair?” “What if I can’t do the job?” Fortunately, I learned that values had in fact returned to the institution, and I was back home, professionally speaking.

All those years that I had worked under various administrators I always thought I could do it better. I know now that such thinking falls into the category of “be careful what you think you can do.” Between managed care, which continually erodes our financial bottom line, and the challenges of academic and clinical program development, my own research, mentoring students and faculty, and putting out various administrative fires, my current position is clearly a stretch. Truth be told, I’m not always sure what I’m doing. Nevertheless, I have resolved to have some fun with this work anyway. My interactions with colleagues in my department and division, many of whom are very committed to the welfare of children and families, remain a source of support and inspiration.

My current vision of pediatric psychology and behavioral pediatrics involves the development of interdisciplinary research, teaching, and clinical care programs that are as closely integrated as possible with departmental initiatives. In this setting, training programs for graduate students and post-doctoral fellows has been taken to a new level by opportunities that can be created in close collaboration with pediatric faculty. My research has become increasingly focused on developing randomized controlled trials of interventions to enhance the clinical management and psychological adaptation of children with chronic illness. At the same time, I have become interested in developing interventions programs that link the department of pediatrics and the Cleveland community and have helped to develop a new early intervention program for children who have experienced violence, a clinical care coordination program for children who are failing to thrive, and an evaluation of a new home-based early intervention curriculum for parents of infants. My job also includes some clinical practice, so I still see children and families who present with a wide range of behavioral and developmental problems and, of course, attend far too many meetings.

Professional Lessons Learned: A Short List

So what is it all about? What lessons have I learned thus far from my professional odyssey? Here are a few.

The Opportunity to Help Others in the Service of Science and Practice Is a Privilege

Two of the primary reasons why I chose to spend my professional career in a medical setting included my attraction for real-life problems and my interest in helping people. At the same time, I developed an equally strong commitment to the values of science. At this point, I have a firm conviction that ultimately the best way to help people is to develop a knowledge base that accurately describes the nature and causes of clinical problems and then to design and implement empirically sound interventions based on this knowledge. The opportunity to work in a department of pediatrics in a school of medicine furthers these aims.

Pediatric Psychology Needs a Public Health Agenda

My experiences have led me to the belief that one cogent vision of the future of pediatric psychology lies in our building capacities to respond to human problems from a public health perspective that includes broader population-based approaches to research and clinical care and a focus on prevention. Others, such as Roberts (1986) have reached similar conclusions, but much sooner. To achieve this goal, the pediatric psychologists of the future will need to broaden their training to include developmental epidemiology (Ialongo, Kellam, & Poduska, 2000) and experience in the methods of randomized controlled trials.

Mentoring the Next Generation of Pediatric Psychologists Is a Critical Challenge

Perhaps reflecting my age and stage of development, my interest in mentoring the next generation
of pediatric psychologists has grown progressively stronger. Consequently, I regard the mentorship of the next generation of pediatric psychologists and pediatricians as a critical step in sustaining and developing our field. Fortunately, throughout its short history, the field of pediatric psychology has enjoyed a wealth of young talent attracted to this field. Such talent demands the best of mentors, many of whom are also present in this field.

**Colleagueship Is a Sustaining Force**

In looking back over my career, one of the most sustaining influences has been the opportunity to work with colleagues in pediatrics and psychology both at my own institution and elsewhere. This outstanding group of colleagues has helped to sustain me through some difficult professional times.

**It's Not What You Know; It's What You Can Learn**

In looking back, I thought I knew the most about pediatric psychology when I was starting out as a young and naive faculty member, armed with all the “right” training. This belief has faded with time and in the face of my need to scramble to learn new things in order to keep up with the challenges posed by the ever-changing science and practice of pediatric psychology. While the ratio between what I’d like to know and feel I do know seems to grow wider with time, I think I have learned to ask better questions and to cherish the moments of learning. My current definition of a good day: I learn something I didn’t know before or see something in a different way.

**Epilogue**

As I hope you have gathered by now, the business, practice, and science of professional life at the borders of pediatrics and psychology are by no means stress-free. At times in my career it has been difficult to straddle the professional demands of multiple settings and roles. The demands of work in a pediatric setting with their continuing refrain, “What have you done for me lately?,” can be downright annoying, if not frightening, especially if you are not sure that you have more to give. Consequently, even the most professionally focused among us requires a satisfying personal life. In this regard, my relationship with my wife Peggy has been the most sustaining and gratifying personal force in my life.

Although this historical account has emphasized the past, I believe (perhaps this is just the vain hope of an aging pioneer) that some of my best work still lies ahead of me. At this point in time, thanks to a great group of colleagues, students, and fellows, I am in the most stimulating and supportive professional environment that I have ever known. So I suppose I’ll continue to ride the wave so long as it lasts.

Is there one parting message to hand down? It could be the following, taught to me by the words and example of John Kennell: keep showing up and working; otherwise someone might take your office (after all it is a medical setting). I’m sure that there will come a time when I am no longer interested in showing up, when they can truly say that this author, like Elvis, has “left the building” and his office is now up for grabs. I’m not there yet. But if I have problems keeping up, I can only hope that my true friends and colleagues would plan “an intervention” to remove me before I reach the point where I am no longer able to recite the lyrics of pediatric psychology without slurring them or fit into my jump suit. I’m relying on you.

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