Commentary for Pioneers in Pediatric Psychology: Thirty-Seven Years of Research, Training, and Clinical Practice in Pediatric Psychology

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I have spent a substantial portion of my career working in a hospital with pediatric inpatients and outpatients and, except for a recent 5-year interval mostly devoted to research, have generally spent half of my working time involved in clinical care. Consistent with that background, the theme I hope to address in this essay primarily involves what it was like to develop a clinical service early in the history of the field of pediatric psychology and how that service has evolved to the present day. To provide some context for understanding how far we have come in training pediatric psychologists, I will also discuss what the climate was like for trainees and early career clinicians in the 1970s. Finally, I will comment on the research climate then and how it has evolved, as well as how clinical work and research can inform one another over the course of a career.

Figure 1. John V. Lavigne, PhD, ABPP.

The Climate Surrounding Clinical Psychology and Clinical Training, Then and Now

I completed my undergraduate degree in psychology at Loyola University of Chicago in 1970 and immediately entered graduate school in clinical psychology at the University of Texas at Austin. The 1960s and early 1970s marked a transition in our society, a period of time that included the free speech, Civil Rights, and women’s liberation movements; assassinations of three major societal figures; the unpopular Vietnam War and the society-wide protests it spawned; and the removal of President Nixon from office. Less monumental, but real nonetheless, were changes occurring in clinical psychology. Experimental psychology, developmental psychology, and social psychology were well-established areas and research in those specialty areas continued apace. Similarly, research on adult and child psychopathological conditions was active and progressing.

Major transitions, however, were occurring in the areas of clinical psychology that involved patient care. Psychodynamically oriented treatment approaches dominated (I recall, during my internship at Duke University Medical School, being taught that treatment was not complete until you adequately addressed the Oedipus Complex. Duke has changed over the years), but its reign as the treatment gold standard was being encroached upon. Therapists working with adults were experimenting with experiential approaches such as Gestalt Therapy and Albert Ellis’s “cognitive therapy.” In child and adolescent therapy, the early pioneering work of Minuchin, Haley, Bell, and others was attracting interest.

Perhaps, most importantly, the field of behavior therapy was still in a nascent state, new enough that it was not
clear if the term “behavior therapy” or “behavior modification” would eventually dominate. In the early 1970s, the principles of learning had been under intense study for several decades. Core principles of classical conditioning and operant conditioning were well established. Key studies in social learning theory had been done, but Bandura’s classic Principles of Behavior Modification (Bandura, 1969), which summarized much of the social learning literature, was only a year old when I entered graduate school, and the journal, Behavior Therapy, was first published that year. Cognitive behavior therapy (CBT) is now so well established that pediatricians will refer patients for “CBT” and one can occasionally see or hear about CBT in the media, but the term did not exist when I entered graduate school. My first encounter with that term came in 1972 when my dissertation advisor brought back a copy of a handout that Donald Meichenbaum had given at a conference when he presented on “cognitive behavior modification.” Don Routh (Routh, 2000) noted the sense of rebellion that students interested in behavior therapy felt during that era as they challenged the established psychodynamic school of thought. I shared that sense, but it was not my predominant feeling as a young clinician. I recall the challenges involved in trying to apply learning principles to a clinical situation when I could not find any reports related to what I was dealing with in the literature. Furthermore, I was engaged in doing a form of treatment that my superiors, and many colleagues within and across disciplines, thought was inferior to the psychodynamic treatment approach. But the desire to pursue a behavioral approach to treatment was strong because the patients I was treating using a more psychodynamic approach just were not getting better.

After completion of internship training at Duke in 1974, I spent a year working at the Duke University’s Durham Child Guidance Clinic, where I saw patients, supervised interns, and taught a graduate course in the Educational Psychology program. During that time, my wife, Victoria, was an intern and postdoctoral fellow down the road at UNC Chapel Hill where she worked with a number of outstanding supervisors, including Don Routh and, particularly, Carolyn Schroeder. Don and Carolyn were indeed among the founders of pediatric psychology. As eager young interns, dinners were often discussions of what we had learned that day, and my introduction to pediatric psychology came from stories about what Carolyn et al. were doing.

The quality of formal clinical training that I—and most of the clinicians I know who trained in that period—received did not approach the quality of training now. I had seen fewer than half as many patients before starting internship than the present graduate students from Northwestern University’s Feinberg School of Medicine whom I supervise, and the applicants to our internship program whose folders I review, have seen at the same point in training. Without a doubt, I would not have been a contender for a place in our APA-approved internship at Children’s Memorial Hospital (now the Ann & Robert H. Lurie Children’s Hospital of Chicago). In addition, virtually all trainees now do a postdoctoral fellowship after internship, but that was not required for licensure and was relatively uncommon back then. By the time a graduate student’s training is complete in 2012, trainees have probably seen twice as many patients than most of us had seen at a comparable point of training in the mid-1970s. Of course, most of us completed training in 4 or 5 years, while that is virtually unheard of now. That probably means better patient care is provided by new staff psychologists in the present era than occurred 30–40 years ago when much of that generation first began their working careers. Back then, the learning curve was probably steeper for young staff clinicians, however, and most likely we were all at about the same place in developing clinical acumen at comparable chronological ages.

The Evolution of a Clinical Service

That was the background I brought to Children’s Memorial Hospital (CMH) in Chicago when, at the age of 26 years, I arrived there in 1975. CMH was an established institution in Chicago that had begun as a small charity hospital about 80 years earlier. In the early 1970s, the department chairman and his staff threw their energy and resources into establishing an inpatient psychiatry unit, and new staff who were hired were more interested in what we now think of as child psychiatry and clinical child psychology rather than pediatric psychology or consultation-liaison psychiatry. In doing so, services to the hospitalized pediatric patients dwindled. It became time to add new staff to meet the needs for consultations on pediatric inpatients and to follow those patients and others on the pediatric services as outpatients. The initial plan, made prior to my arrival, was to hire three child psychiatrists to do that work. But the times just were not right to do this. During the heyday of long-term, psychoanalytically oriented play therapy, at a time when the psychopharmacology armamentarium was limited in scope and utility, few self-respecting child psychiatrists wanted to do short-term work (it was hard to deal with Oedipal issues in a brief consultation). Soon, it became clear that doctoral-level psychologists would be needed to do this work, and three of us were
hired. My job was to be the “generalist” who would work with patients referred from the outpatient service where pediatric residents learned to provide outpatient office care. We were to share the responsibility of dealing with all consults that came in through the hospital and to supervise psychology interns. The hospital was beginning to pay closer attention to fiscal responsibility for each of the services, and we each had a quota of patients that we had to meet on a weekly basis. As a new service, we were scrutinized particularly closely. What we did not know, until the day we arrived, is that we had one year to demonstrate that we could break even financially. Fortunately, we were able to do so.

This was an era in which psychologists were not necessarily widely accepted in hospital settings. Our first call for a consultation on an inpatient came from a surgical resident. I took the call and dutifully contacted the attending surgeon, a senior member of the faculty, to discuss the case. After I explained why I called, he curtly informed me that he would never ask a psychologist to see one of his patients. True to his word, that did not happen again for a long time. When we first started, we wore suits in the hospital rather than the long, gray lab coats worn by the attending physicians. By mid-year, we became aware that this visible marker of a status difference might not be wise and we obtained approval to wear lab coats as attending psychologists. Not long after that, we began receiving consults from the same physician who was not originally interested in our assistance. Had we worked our way into his confidence with our professional efforts, or was it that “clothes make the man”?

Many other physicians were far more receptive to our efforts, and we developed excellent working relationships with many—and eventually with most—of the attending physicians. I think there were a few aspects of the way we worked that served us well. Perhaps first and foremost, physicians are problem solvers, trained to focus on a problem, assess it, and resolve it as quickly as possible. Treatment approaches that were more analytical, where the focus was on breaking down defenses and long-term personality rebuilding, may have been effective in many instances, but they did not mesh well with the problem focus of the typical pediatrician. A behavioral approach involving a behavioral assessment and treatment plan, often emphasizing short-term care, seemed to get results more quickly and meshed well with the strong problem-focused orientation of the pediatricians. This approach helped us gain the respect of our medical colleagues and went far toward helping us build the service.

Our pediatric psychology service (at the time of the initiation of the service, the term “Medical Psychology” was used and we have not relinquished that name) was organized as a service within the Department of Child and Adolescent Psychiatry. However, the service functioned without any input from child psychiatrists on patient-related matters. Differences in orientation to psychosocial aspects of care and working styles made such a division desirable. On those occasions when a consultation to consider psychopharmacologic treatment was desired, a consult from one of the Department’s psychiatrists would be made. This changed in the early 1990s when the Department Chair retired and a new chairperson, Dr. Mina Dulcan, arrived. New leadership in a department can signal the beginning of needed, welcome changes, or it can be a recipe for disaster. Fortunately, Mina’s arrival fell into the first category. Soon, several new child psychiatrists arrived, all with four important characteristics: (1) they were well versed in child psychopharmacology at a time when the range of medications and what they could do for pediatric patients had expanded dramatically; (2) they were far more problem oriented and short-term focused than most of their predecessors; (3) while appreciative of the psychosocial aspects of their patients, their professional identities were not tied to long-term psychotherapy; and (4) they recognized that their psychology colleagues had their own set of competencies that complemented, rather than competed, with their own, setting the stage for effective collaborative work. Given that orientation, the process of combining the psychologist-only Medical Psychology Service into a multidisciplinary operation seemed appropriate.

Presently, the service functions as a joint pediatric psychology/child psychiatry service including attendings and trainees from both professions. We believe that patients benefit from better-integrated care, but perhaps the greatest benefits come to the trainees. Clinical psychology interns and postdoctoral fellows continue to be supervised by the pediatric psychologists as before, but they are also supervised by the child psychiatrists, and cases are reviewed at rounds attended by faculty from both professions. For the psychology trainees, this leads to greater exposure to issues involved in medication management decisions and, because the service staffs consult to the Emergency Department, increased opportunities for crisis management training. Child psychiatry fellows, in turn, get greater exposure to family therapy and cognitive behavior therapy as treatment modalities. To us, the advantages of this multidisciplinary approach to patient care and training were clear, and continue to be the model that guides our work.
Thirty-Seven Years of Research in Pediatric Psychology: Integrating Clinical and Research Activities

When I arrived at Children’s Memorial Hospital in 1975, my training still had primarily been with “general” clinical problems of children and adolescents, and I did not have a lot of experience with children who were dealing with chronic illnesses or “psychosomatic” problems. Duly trained in the scientist–practitioner model, I decided to immerse myself in the literature on psychological aspects of children’s physical disorders. Of course, these were days when computers were the size of whole rooms (usually placed in basements to prevent overheating), there were no electronic databases, and using Psychological Abstracts involved wending one’s way through multiple volumes of references. Plowing ahead, I tried to get a handle on the field. While there were hundreds of relevant papers, the vast majority was case reports or case series that would list descriptive statistics about frequencies of psychiatric problems among the participants without attending to such niceties as including comparison groups. There were, of course, some well-designed studies, but their number was small. Even fewer studies were concerned with the psychological impact of a child’s illness on their parents or siblings. As a clinician, it was disappointing that there was not more literature that could be helpful. As a novice researcher, however, it was equally clear that contributions could be made in this area. This led me to begin studying whether there was an increase in the prevalence of psychological problems among the siblings of children with chronic illness as well as among the children themselves. We were able to establish that the siblings were at increased risk for psychological problems in some relatively small-scale studies (Lavigne & Ryan, 1979; Lavigne, Traisman, Marr, & Chasnoff, 1982). We could not, however, move beyond that level to examine carefully what the processes were that led to this effect. Then recent work (Lamb & Sutton-Smith, 1982) on sibling influences had illustrated the role of birth order and, perhaps more importantly, that patterns of gender distribution within the sibship had to be accounted for. It soon became apparent that accounting for these factors (a boy with a chronic illness with one younger sister, another with one older sister, etc.) exceeded the recruitment capacity of a single 250-bed hospital with 100,000 visits a year, so we moved on.

Similarly, it became clear that a really careful look at whether children with chronic physical disorders were at increased risk for behavior problems needed to move beyond conducting single studies of specific disorders at a single location, and we discontinued working on that issue for several years. By the late 1980s, however, we became aware of the important work that Gene Glass and others were doing in developing the statistical procedures involved in meta-analyses. After reading extensively about how to conduct a meta-analysis, I reviewed 700 or so studies (first alone, then with graduate student Joan Faier-Routman) and published a meta-analyses on prevalence increases and risk factors associated with chronic illness published in 1992–1993 (Lavigne & Faier-Routman, 1992, 1993). Now, 20 years later, I am often the associate editor of the Journal of Pediatric Psychology who manages systematic reviews, and it has been interesting to work on several recently published meta-analyses on these topics. The level of sophistication of well-conducted meta-analyses is vastly greater than what it was in the 1980s and early 1990s, a trend that is apparent for all types of research in clinical child and pediatric psychology over the decades.

Three things can be illustrated by looking at the evolution of studies of children with physical disorders published between the 1970s and now. The first has to do with change in the quality of the research database that is available to both clinicians and researchers. The quality of that database is far better now than it was then, characterized by more and better studies, more interest in underlying mechanisms (mediators, moderators), and much greater sophistication in statistical procedures to study various phenomena. The field of pediatric psychology is much stronger as a result of the collective work of researchers over the last 30 years, and shows promise of continuing to develop along those lines.

The second point has to do with the process of integrating clinical and research work. Being a mediocre clinician is not difficult, but being an excellent clinician is both difficult and challenging, and being a full-time clinician can be very rewarding as a career. Being a full-time researcher is at least as demanding and certainly has its own rewards. Combining a clinical and research career may involve more work than focusing solely on clinical work (because one must keep up on a wider range of topics to be successful), and often means being less productive research wise than one could be doing research full time. Nonetheless, a career combining research and practice provides the opportunity for one’s clinical work to inform one’s research, and vice versa.

In graduate school, it became clear to me that I did not have the right cognitive style to be the kind of professor I saw in departments of psychology. The best of these researchers seemed able to immerse themselves in theoretical and empirical papers and deductively arrive at ideas for research to advance their fields. I, however, needed to
immerse myself in the clinical problems that I was facing at the hospital to grasp what was worth studying and decide on a research idea. In that way, clinical work informed my research, and probably serves the same purpose for other clinician researchers. Clinical experiences led me to be interested in the psychological aspects of children’s physical disorders, to be involved in randomized clinical trials, and to study how the behavior problems of young children develop longitudinally.

Moving in the other direction—using research to inform practice—is perhaps a greater challenge. Psychology and medicine have not always been successful in this regard. The gap between discovering something new that has potential clinical significance and actually applying it clinically is wide, and “translational” research, that is, “translating research into practice,” has become a national priority. To a small degree, my own work illustrates how that process can be addressed, as well as some of the problems and limitations involved.

Intervention studies, particularly randomized clinical trials, provide a greater opportunity to begin to translate research into practice. There is, however, even a continuum of the applicability of such studies to practice settings. Efficacy studies tend to be highly controlled RCTs that emphasize internal validity of design, often at the expense of establishing the generalizability of results (Hoagwood, Hibbs, Brent, & Jensen, 1995). A study of the treatment of depression in children with epilepsy, for example, might choose to exclude children with any psychiatric comorbidities and provide treatment by therapists who have a reduced case load. Such a study has emphasized internal validity by the choices made about who to treat and who to do the treatment. A study emphasizing effectiveness, in contrast, would not exclude participants on the basis of comorbidity and would use therapists who have to deal with the competing demands faced by heavy case loads. There is, of course, a continuum from efficacy to effectiveness (Hoagwood, Hibbs, Brent, & Jensen, 1995).

By mid-career, I was increasingly interested in intervention research and was fortunate enough to work on two multisite studies as one of the designers of psychosocial interventions for cholesterol reduction (Lavigne et al., 1999) and treatment of asthma comorbidity (Weil et al., 1999). My own clinical work had led me to collaborate closely with primary care pediatricians. I knew well how talented and caring they were, how many psychological problems their patients posed, and how limited their time (and training) was to deal with such problems. In recent years, we have designed two studies that fall on the effectiveness end of the spectrum. We became aware of how often pediatricians are asked by parents for guidance in treating difficult-to-manage preschoolers. The first study examined the treatment of Oppositional Defiant Disorder by nurses (an office practice model) and psychologists (a referral model) seen in primary care settings (Lavigne et al., 2008). The second (Lavigne et al., 2011) study arose from our awareness that pediatricians provide most of the medication management of ADHD and that it was often managed suboptimally. That led us to develop a computer-assisted monitoring program for the pharmacological management of ADHD that makes it easier to use parent and teacher ADHD scales administered during treatment and provides guidance on what the ideal dose of medication is for each particular child. The latter was done with “real” pediatricians in the course of their day-to-day practice, and the software is available at no cost on the Children’s Memorial Hospital website. In both instances, these studies involve research that, we hope, informs day-to-day practice.

It has been very rewarding over the years to work with a great many colleagues—at Children’s, Northwestern, and nationally—who have enriched my life. Watching the field of pediatric psychology mature, and playing a small part in that process has been extremely satisfying. The trajectory of growth in the profession keeps accelerating, and I hope this continues to be an exciting profession for many, many years to come.

Conflicts of interest: None declared.

References


