The Tonsil Party and a Career in Pediatric Psychology

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Precursors
When I reached age 5, our family pediatrician, who made house calls, told my parents that my tonsils should come out. The deed would be done by my pediatrician and an otolaryngologist in the kitchen of my family’s apartment in Cambridge, Massachusetts, saving the expense and hazards of a hospital stay during the polio epidemic of the 1950s. I was told that, “We’re going to have a tonsil party. They give you medicine to make you sleep, take them out, and when you wake up you can have all the ice cream and Popsicles you want.” The after-party experience was unpleasant. That set of events may well have triggered (via post-traumatic reaction formation) the origin of my subsequent interest in honest supportive communications with sick children, a generally skeptical and sarcastic personality, or both.

My parents were first-generation Americans, and neither they nor any of my extended family (13 aunts and uncles, their spouses, and their children) had attended college. Although my two brothers and I occasionally helped out with my father’s plumbing business, our parents placed a high value on education and expected us to attend college. At Cambridge High and Latin School, I won science fairs and a prize for having the best science grades during my 4 years there. Chemistry was my favorite, and I won a scholarship to Boston University (BU) that allowed me to afford enrolling at BU in September 1964 as a commuter student from my parent’s home in Cambridge.

Polymer chemistry seemed my career of choice until an unpleasant undergraduate experience with a “P-Chem” professor (i.e., physical chemistry) at BU convinced me to switch majors. I had worked as a summer camp counselor for many years and enjoyed working with children, almost as much as organic chemistry. The psychology department at BU had many excellent and engaging faculty, although the predominant theoretical approach of the department promoted psychodynamic theory as the answer to understanding and resolving most human behavior problems.

I consider myself fortunate to have had three outstanding faculty mentors during those years. The first, Robert “Bob” Chin, was a social psychologist and social activist—important to an idealistic anti-war college student in the 60s. He agreed to take me on as a wayward ex-Chem major and told me as a sophomore that I should be thinking about graduate school. Abnormal psychology came alive in classes with Murray Cohen, who spiked his lectures with research findings and anecdotes from his work with sex offenders at a corrections department mental health facility. Murray had earned a masters in clinical psychology at the University of Missouri, before coming back to Boston for a doctorate—more about that later. My mentor in developmental psychology, Freda Rebelsky, had once worked for Bruno Bettelheim at the Orthogenic School in Chicago, and spoke glowingly of her work there. Freda was an ideal faculty member from the students’ perspective. At BU, where a small class meant 150 students, she went out of her way to know each of us and remained a close personal friend until her death in 2009.

Graduate School
During my senior year (1967–68), career options seemed to crystallize: go directly to graduate school or work in the family plumbing business and await the Vietnam era draft to call my number. I chose to apply to some graduate programs in interesting locations and others where faculty I admired had done their doctorates, making sure that all were far away enough from Cambridge that I would have a good reason for not filling in at the plumbing shop during winter freeze-up emergencies. Site visits and interviews were not part of the process in those days. I accepted an offer from the clinical psychology program at University of
Missouri (aka: Mizzou). The brochures looked nice and they had a real green campus, as opposed to the urban concrete campus of BU. Out-of-state tuition and fees amounted to an affordable $360 and they offered an assistantship. Murray Cohen, who had taught my abnormal psychology course at BU, had gone there for his master’s degree, and Bob Chin touted their excellent social psychology faculty.

Leaving Cambridge, Massachusetts, for Columbia, Missouri, provided a significant culture shock personally and academically. During the spring of my senior year, Martin Luther King (a BU doctoral alum) and Robert Kennedy were assassinated. I had been an anti-war campus activist and worked for the presidential candidacy of Eugene McCarthy. My members of Congress had been John F. Kennedy and Thomas P. O’Neill. I had spent my entire life in a large politically liberal urban center and had never attended a college football game. The congressman from Columbia, Missouri, was Richard Ichord, who served as the last chairman of the House of Representatives Un-American Activities Committee. The town doubled in population on football Saturdays, and the primary political question on campus involved whether the athletic teams from Kansas were more sinister than those from Oklahoma or Nebraska. The psychological disconnects were similarly challenging. The one course in psychodynamic psychology was taught in alternate years, and was not offered during my 3 years on campus, as no faculty member wanted to teach it. Still, the psychology department provided a superb learning experience, free of the political travails of rural Missouri and the world beyond.

Fred McKinney was assigned as my advisor (see obituary by Robert S. Daniel, 1983). In an interesting parallel, he had also been Murray Cohen’s thesis adviser. Fred was a special mentor to me in fostering my teaching, my research, and by setting a superb example. He had completed his PhD at the University of Chicago at age 23 in 1931 and described himself as a “Chicago functionalist.” He started teaching at the University of Missouri later that year and had set up a “Personality Clinic” in the student health service by 1934. Most of what we know as “clinical psychology” evolved after he completed his doctoral work, yet when I entered the graduate program, he was totally current in his knowledge of the field and remained an active professional until his death from a heart attack in 1981.

Although I had a history of working with children, I was offered a paid clinical externship at State Hospital #1 in Fulton, Missouri. I was assigned to the maximum security unit housing male offenders deemed potentially unfit to stand trial or adjudicated “not guilty by reason of mental disease or defect.” At “Fulton State” (informal motto: “they don’t call us #1 for nothing”), I began to learn about forensic assessment, participating in competency and criminal responsibility assessments. One day toward the end of my first year there, an inmate tried to strangle me at work.

Along with another trainee, I had organized a therapy group for sex offenders. The composition of the group was driven more by functional level than diagnosis. In general, the serial sex offenders in the population had higher levels of cognitive functioning, were less likely to have hallucinations, and took lower doses of phenothiazines than the other patients confined under maximum security—thus enabling more productive verbal treatment. I had agreed to also allow one non-sex offender into the group because he seemed desperate for some sort of therapeutically oriented conversation. The medical record indicated that he was 34 years old and that his name was “Tommy.” He told anyone who would listen that he was the reincarnation of the Prophet and asked that everyone call him Mohamed. I had fallen into the routine of greeting him on the ward with his preferred “Salam aleikum.” Having Mohamed on my side paid off.

During one of the group sessions, a patient became agitated and began pacing as he talked about “doing his business” in St. Louis. This referred to his practice of seeking out sexual encounters with businessmen and strangling them with their own neck ties. He impulsively decided that a demonstration was in order, walked behind me, grabbed my neck tie, and pulled tightly. I managed to get a few
fingers between my neck and the tie and recall shouting for help while my co-therapist sat stunned, mouth agape, several feet away. In a flash, Mohamed jumped up, grabbed the perpetrator by the throat, and said, “You let go of my friend!” I began wearing clip-on bow ties to work after that, and also thinking that working with children would pose fewer workplace hazards.

My work on an idea for a master’s thesis began in a somewhat backward fashion. I had a job waiting for me back in the Boston area for the summer of 1969, working as program director of the YMCA summer camp where I had served as a nature counselor. I knew I would have access to a ready population of campers. I had a longstanding interest in the writings of Robert White on competence motivation (1959, 1960) that began when we used his textbook (White, 1964) in Murray Cohen’s abnormal psychology course at BU. In that context, it occurred to me that learning to swim presented a discrete competence marking event that might generate a boost in self-esteem. When asked, “Can you swim?” most people give a binary answer (i.e., yes or no). At the summer camp where I worked, all campers were given a swimming test (i.e., asked to swim 50 yards) on the day they arrived. Many children who could not pass on the first day, accomplished the feat during their 2-week stay at camp, marking a distinctive achievement and point of pride for those who “learned to swim.”

When I shared the idea with Fred McKinney, he got excited and introduced me to one of his mentors, Robert Bills, who had developed an interesting measure of self-esteem (Bills, Vance, & McLean, 1951). The study was quickly approved toward the end of my first year at Mizzou, carried out over the summer, written up in the fall, and approved by an MA degree in January 1970.

The Department of Psychology at Mizzou encouraged us to write our theses and dissertations in APA Publication Manual style, and Fred McKinney suggested that I ought to submit what I had done for publication. Not knowing enough to feel daunted by high rejections rates or journal prestige, I submitted the manuscript to the Journal of Personality and Social Psychology and in so doing learned a great lesson about generous mentoring. The editor handling the manuscript was Walter Mischel. The reviewers liked the study, but had lots of criticism about the write-up. Mischel gave freely of his time via postal and telephone contacts, guiding me through two revisions and ultimately my first peer-reviewed publication (Koocher, 1971).

Near the end of my second year at Mizzou, I had an opportunity to do child psychotherapy through the departmental clinic under the supervision of Professor June Chance. June was the only “clinical child” person in the department and taught developmental psychology and child psychopathology. Under her supervision, I treated a 5-year-old named Helen, who had been refusing to go to sleep in her bed (or any bed) for a few weeks. During a play therapy session with toy telephones, Helen re-enacted one side of a telephone conversation she had overheard. It involved a neighbor who, “Had a heart attack, fell out of bed, and died.” Helen was not sure about what a heart attack was, but she knew that if you die, “You can’t see your family anymore.” A bit of education about heart attacks, and some in vivo desensitization of practice falling out of bed, solved the problem quickly. Helen left me thinking about how children understand death and loss. I went searching through Psychological Abstracts (pre-digital paper versions), but could only find two published studies. Both had been done during or immediately after World War II, with children who had certainly been exposed to wartime travail. I had found my dissertation idea!

The study I designed used a Piagetian developmental framework to study children’s self-concepts and perceptions of death. All five of the faculty members I invited to serve on my doctoral committee told me that, “I really don’t know anything about the topic, but it sounds interesting.” I smiled inwardly when I heard that, knowing that they would not likely want to tweak my study or embarrass themselves by admitting to the rest of the committee that they knew little about the relevant literature. I passed my 3-day written and oral comprehensive exams, wrote the proposal, collected my data, and ran statistical analyses before leaving Missouri permanently in June 1971, 3 years after arriving. I headed back to Boston to begin my internship at Children’s Hospital and Harvard Medical School. I would be able to live at my family’s home and commute to work, thus surviving of the munificent stipend of $3600.

Becoming a Truly Pediatric Psychologist

The Psychiatry Department at Boston Children’s Hospital (then known as Children’s Hospital Medical Center) had been founded by George Gardner, a physician with a PhD in psychology. By the time I arrived, he had been succeeded as Psychiatrist-in-Chief by Julius Richmond, a pediatrician who had helped to found Project Head Start. The Chief of Psychology was Joseph P. (Joe) Lord, who had completed his PhD at Harvard studying “enuresis in latency age boys.” The training program collaborated with the internship at the Judge Baker Guidance Center across the street, where psychology was led by Joe’s Harvard classmate Bessie M. Sperry. The predominant training mode was long-term psychodynamic therapy, and trainees were
told that they should sign up for a personal analysis if they were serious about a career in psychotherapy. No one called the program “pediatric,” but rather, referred to it as clinical-child psychology, even though based at a medical school teaching hospital. Family therapy and behavior therapy were considered interesting novelties. The most respected members of the staff were the “child analysts.” When I inquired about using behavioral approaches learned in Missouri to treat enuresis, I was told in a patronizing tone that doing so would only result in “symptom substitution” without “a corrective emotional experience.”

The contrast in transitioning from a graduate program with a strong cognitive–behavioral bent to an equally strong psychodynamic internship program forced me to think more eclectically. I ultimately came to understand that many therapists who seemed to do effective therapeutic work with children would engage in similar practices, but rationalize their actions in different theoretical terms. What a psychodynamic supervisor called creating a corrective emotional experience for a child, a behavioral colleague might refer to as providing positive reinforcement for a child’s behavior.

I immersed myself in clinical work and finished writing up my dissertation, traveling back to Missouri to defend it in March 1972. I ultimately published four papers based on different aspects of the study (Koocher, 1973, 1974a,b, 1975). Because the topic of my research dealt with children’s conceptions of death, I was asked to take on some consultations with terminally ill children, and continued that work while doing a post-doctoral fellowship jointly with the Judge Baker Center. About the same time, I joined APA, the Division of Clinical Psychology, and its sections on clinical child and adolescent psychology and pediatric psychology (that ultimately became Divisions 53 and 54). Each section had a newsletter that ultimately built into a journal. It became possible to network readily with the rapidly growing number of psychologists working in medical centers. Traditional psychoanalytic approaches did not lend themselves to the needs of medically ill children and their families, who faced stresses and challenges not borne of psychopathology.

One fringe benefit of my work in pediatric psychology: finding Robin, my wife of 40 years. I met her thanks to an angry 5-year-old named Tammy, who delighted in provocative acting-out. While I worked with Tammy in psychotherapy, a social work student counseled her mother. Robin, also a social work student, shared an office with my co-therapist, and Tammy gave me ample excuse to stop by the office looking for my co-therapist. Thank you, Tammy.

As the trajectory of knowledge in pediatric psychology expanded exponentially, psychologists increasingly found themselves called in to work on projects involving research components for which traditional psychiatrists had no training. In 1975, I got an invitation from the head of the psychiatry consultation service, John E. O’Malley, and a pediatric oncologist, Norman Jaffee, to join them in setting up the first study of long-term survivors of pediatric cancer through the Dana Farber Cancer Institute. The 5-year project resulted in many papers, culminating in *The Damocles Syndrome: Psychological Consequences of Surviving Childhood Cancer* (Koocher & O’Malley, 1981). Along the way, we established the pediatric psychosocial unit at Children’s Hospital and Dana Farber, and began a robust program of research on ways to promote coping in chronic childhood illness.

In 1983, I became Director of Training in Psychology, and in 1988, Chief of Psychology at both Children’s Hospital and Judge Baker for the next 13 years. This work overlapped with service as editor of the *Journal of Pediatric Psychology* (1982–1987). This period saw a rapid advance into behavioral medicine, and newer
models of treatment incorporating cognitive, behavioral, and family approaches. These efforts included research on coping with painful procedures and chronic medical conditions, survivorship in the context of life-threatening illness, medical nonadherence and disease management in pediatric populations, symptom control, and quality of life. The concept of behavioral medicine and relatively brief focal interventions rapidly overtook older traditional psychodynamic strategies in hospital-based pediatric treatment. During the 1980s, family engagement also took center stage in the treatment process as pediatric hospitals saw the wisdom of allowing parents to room-in with their children as a way to reduce anxiety and prepare parents to better care for their children postdischarge. During the 1980s and 1990s, pediatricians and specialists in pediatric medicine increasingly came to see psychological care as a necessity for their patients and increasingly sought to include pediatric psychologists on treatment teams and in research projects.

Looking back on the 30 years I spent as a full-time employee at Boston Children’s Hospital (1971–2001), I see it was a remarkably productive and largely pleasant time. I had the opportunity to work with wonderful colleagues and make creative contributions to an emerging field. I had the opportunity to work as a real scientist practitioner, taking care of patients, conducting research aimed at improving care, and publishing on all of this. I seemed to naturally get involved in patient advocacy, leading me to edit a book on children’s rights (Koocher, 1976). That led to a term on the American Psychological Association’s ethics committee, where I was the youngest person ever to hold such a position and where I met Patricia Keith-Spiegel, who has become a wonderful research and writing collaborator for nearly forty years. My engagement in professional activities also grew, ultimately leading to the presidency of the APA in 2006, where my theme for the year focused on children and families.

The era of “managed care” often complicated the work of pediatric psychologists, requiring us to repeatedly seek authorization for services in cases where the chronicity and severity of a child’s medical circumstances seemed to make the need for our services obvious. Frustrations associated with those challenges and in dealing with hospital administrators tempted me to consider a career change, and in 2001, I accepted an appointment as the health sciences dean at Simmons College, located just two blocks from Boston Children’s Hospital; I continued teaching and supervising psychology trainees at the hospital while overseeing graduate and undergraduate programs in nursing, nutrition, physical therapy, and health care administration.

The college president who first hired me as a dean asked what I would miss most about my hospital-based work if I accepted the deanship.

I replied, “I’ll miss the day to day work with sick children,” thinking of the rewards of seeing improvements in their care.

He responded, “Have you met the undergraduate faculty yet?”

My career of interprofessional work in health care and as a scientist practitioner translated well to the skills needed as a dean. One must observe, gather and validate data, forge working alliances, and develop interventions based on those data and relationships. Whether engaging in such activities as a therapist, on a systems level in hospital administration, in educational settings, or when advocating for children, training as a psychologist has served me well.

In April 2013, I accepted a position as dean at the College of Science and Health at DePaul University in Chicago with a mission that integrates psychology and other science and mathematics departments and health programs in a single academic unit with new articulation mandates to integrate educational and research programs at two major medical centers. With a bit of luck, I hope to
continue advancing the integration of behavioral science and health care for several more years.

Lessons Learned
The Importance of Colleagues
A key element in my professional development involved collegial connections, both in Boston and in the wider professional community. Because we work with highly vulnerable children and families who often find themselves in stressful medical situations, I think that pediatric psychologists often tend to develop a pragmatic orientation toward finding creative solutions that work and sharing these rapidly and broadly. I have found this professional community an invaluable force in advancing my own skills and improving my work with patients. Some of the most meaningful work happens quietly in one-on-one interactions, but we must be prepared to engage with parents, siblings, other health care providers, teachers, and other people critical in the lives of the children we care for.

I found many kindred spirits and good friends with similar scientific and professional values. The temptation to name names is great, and at the risk of offending some by accidental omission, I would particularly cite Dennis D. Drotar, Lizette Peterson-Homer, Annette M. LaGreca, Phyllis Magrab, Michael C. Roberts, Dennis C. Russo, Lee Salk, Carolyn S. Schroeder, John J. Spinetta, C. Sue White, and Diane J. Willis. In the pre-Internet era, such connections provided key links to the latest work long before it appeared in print and considerable personal support over great distances.

Despite the wonderful colleagues, the most intimate influences on my career development were my patients and trainees. I have a box in my desk that contains what might look like trash to the casual observer: a faded college graduation photo from a former patient, a religious medallion given to me by the parent of a patient, a desiccated “8” made of Play Doh made by a patient celebrating her 8th and final birthday, and other such talismans heavy with private meaning for me. I also have significant relationships with >300 colleagues whose training I have participated in. I recall powerful learning experiences I had engaging with many of them, but feel confident that I learned some things from all of them.

The Future of Pediatric Psychology and Need for Nimbleness in a Changing World
Although many psychologists still train alongside psychiatrists, their profession is in decline. Residency slots in psychiatry go unfilled, while we lack sufficient internships for our doctoral students. A significant percentage of psychiatry residency slots go to so-called Overseas Medical Graduates (can you believe it, OMG!), betokening that specialty’s popularity among the least rigorously prepared young physicians. Most prescriptions for psychoactive drugs are written by primary care physicians or nonphysician prescribers (including psychologists). Leaders in psychiatry bemoan the disinterest of psychiatry residents in learning psychotherapy (Gabbard, 2005), as the brightest physicians interested in brain functioning pursue MD/PhD programs in the neurosciences.

Psychology has provided an ample supply of skilled professionally committed scientist–practitioners ready to apply evidence-based techniques. I doubt that any of us would recommend preparing a child for surgery with a description of a “tonsil party.” We stand ready to address patient symptoms and provide front-line assistance in care management that primary and specialty care physicians demand, but cannot get from psychiatry. We also stand well-positioned to engage in the integrated care models that will be demanded in the rapidly evolving health care payment system. In many ways, we are far ahead of our clinical colleagues wanting to engage with adult patients. The evolving health care system will demand good
outcomes and quality indicators, that psychologists have
long trained to develop, refine, and evaluate.

We do need to improve in one important area: attention
to developing payment systems and professional ad-
vocacy. We need to stand toe-to-toe with our medical
colleagues in studying, revising, and advocating for reason-
able systems of care and payment that serve our patients
and do not disadvantage our service providers and stu-
dents. In years past, our profession shunned advocacy,
and tended to overregulate ourselves. For example, in
many states, psychology remains the only health care pro-
fession that requires a year of supervision beyond the ter-
minal degree to obtain a license. These are some of the
reasons that I advocated for revising the APA model licensing
law (adopted in 2006), and now adopted in several
states.

It is no longer good enough to feel satisfied with our
cutting-edge behavioral science accomplishments. That is
one reason why I have focused the last decade of my career
on education in the health professions and interprofes-
sional practice. The key to our future success will involve
continued partnerships with nonpsychiatric physicians in
both specialty and primary care and allied health col-
leagues. Working together, we can prevent many health
care problems, demonstrate solid beneficial outcomes, im-
prove quality of life, and reduce the debilitating effects of
chronic childhood diseases. We must think and act differ-
ently than our predecessors did, but that is how pediatric
psychology began.

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