Recruitment of Child Psychiatry Residents From Pediatrics: Difficulties and Options

Michael Jellinek, M.D.

Pediatricians represent a potential source of high-quality recruits to child and adolescent psychiatry, although only about 120 physicians are board-certified in child psychiatry, adult psychiatry, and pediatrics. However, the growing need for pediatricians to understand and treat psychosocial and psychiatric symptoms may make them increasingly receptive to pursuing training in child and adolescent psychiatry. To capitalize on this opportunity, organized psychiatry and pediatrics must work together to tailor training programs for pediatrician-child psychiatrists that do not lengthen the period of training unreasonably. The current experimental program to train triple-board-eligible psychiatrists is discussed.

There is a serious, ongoing shortage of child and adolescent psychiatrists. The shortage is hard to correct quickly, since the length of residency training is five years, most programs are small (graduating two or three child psychiatrists a year), and many do not have the resources, faculty, or stipends necessary to expand. The shortage has profound long-term implications for the field, both for the livelihood of the guild and for its professional mission.

From a clinical perspective, child psychiatrists are among the most thoroughly trained mental health specialists for children and play a key role in leadership of programs, treatment of the most seriously disturbed, and child advocacy. Within medical centers they teach general psychiatry residents and pediatricians as well as their own residents. From a research perspective, child psychiatry has made gains in developing a scientific basis of practice. However, without adequate numbers of new child psychiatrists, clinical, academic, and research efforts will be markedly constrained; the lack of an adequate work force may cast the field into a minor or even trivial role in meeting the mental health needs of children.

Many steps will have to be taken to correct the clear need for more child and adolescent psychiatrists. These steps include taking political action that raises the level of federal funding to meet the emotional needs of children and negotiations at the medical school and departmental level to give child psychiatrists sufficient visibility to facilitate recruitment. One strategy for attracting highly qualified applicants to child and adolescent psychiatry is to encourage interested pediatricians to enter the field.

Dr. Jellinek is chief of the child psychiatry service at Massachusetts General Hospital and associate professor of psychiatry (pediatrics) at Harvard Medical School. Address correspondence to Dr. Jellinek at Child Psychiatry Service, Massachusetts General Hospital, 15 Parkman Street, ACC 725, Boston, Massachusetts 02114.

An earlier version of this paper was presented at the National Recruitment Conference on Child and Adolescent Psychiatry, held January 18–19, 1989, in San Diego.

Copyright © 1989 Academic Psychiatry.
Although recruiting "pediatrician-child psychiatrists" would make only a small numerical contribution to the shortage, it would add a group of uniquely skilled, potentially influential clinicians.

Hopefully many of these pediatrician-child psychiatrists would be valued by both departments of psychiatry and pediatrics and would assume leadership roles bridging the gap between pediatrics and child psychiatry. Being triple-boarded, they could facilitate communication, serve as role models to both child psychiatric and pediatric house staff, and enhance further recruitment efforts by encouraging medical students on pediatric rotations, pediatric interns, and board-eligible pediatricians to pursue child psychiatry training.

Within medical centers, pediatively trained child psychiatrists could enhance the "medical" image of psychiatry. Having triple-boarded faculty also helps meet the need for pediatric staff with expertise in psychosocial and developmental issues. Lastly, triple-boarded physicians may be able to make unique contributions to clinical research that requires integration of pediatric and psychiatric perspectives.

This paper discusses the increasing mental health needs of children and impediments to training pediatrician-child psychiatrists. It offers some recommendations to enhance the number of pediatrician-child psychiatrists.

SUPPLY OF PEDIATRICIAN-CHILD PSYCHIATRISTS

There is little precise information about how many of the approximately 40,000 pediatricians currently in residency or practice have been trained as pediatrician-child psychiatrists, although we know the number is too few. The hope of recruiting more pediatricians to child psychiatry and the current low number of pediatrician-child psychiatrists must be viewed in the context of the overall relationship between pediatrics and child psychiatry (1-4). Although one would expect the two specialties to be closely aligned, the relationship is frequently distant, despite the groups' mutually held goals and shared clinical concerns. Both fields care deeply for the well-being of children, treat their dysfunction, and recognize the rising prevalence of psychiatric and psychosocial disorders, yet they differ dramatically in culture. The professional distance—even coolness—between pediatrics and child psychiatry is hard to understand.

Given the epidemiology of pediatric practice, pediatricians are seeing many children with primary or secondary psychosocial disorders. This evolving pattern of practice is partially the result of medical progress. Vaccinations and antibiotics have reduced the burden of infectious disease, many more children are surviving the effects of chronic disease and disability, and there has been major progress in understanding children's developmental needs from birth, through school, and during adolescence.

In addition, pediatric practice has felt the impact of powerful societal forces that have complicated the life of the family and the development of children. The rise in the divorce rate over the past 30 years now results in approximately one million children each year enduring the divorce process; an estimated 10% continue to suffer ongoing difficulties. There has been a substantial rise in the adolescent suicide rate based on both better reporting and an absolute increase in prevalence. There is an increased recognition of substance abuse, eating disorders, psychosocial effects of chronic disease, and depression.

The prevalence of well-defined attention deficit hyperactivity disorder is probably 2% to 3%, and there is a growing recognition of learning disabilities. Recently emerging concerns include teenage pregnancy, prevention of accidents, which lead all other causes of death in adolescents by a factor of 10 to 1; physical and sexual abuse; AIDS; and the unknown effect (if any) of