Choosing Child and Adolescent Psychiatry as a Career: The Top Ten Questions

Geri Fox, M.D.
Professor of Clinical Psychiatry
Director of Psychiatry Undergraduate Medical Education
University of Illinois at Chicago/Institute for Juvenile Research

If you are a medical student or general psychiatry resident considering subspecialty training in child and adolescent psychiatry ("CAP"), you probably have lots of questions. In this article, I will answer the questions that have been most commonly asked each year by students and residents at the University of Illinois. Please contact the training director at your institution if you need more information.

1) What does a child and adolescent psychiatrist actually do?

It's important to remember that, in order to be Board-certified in CAP, you must first be Board-certified in general psychiatry. First and foremost, then, child and adolescent psychiatrists are also qualified adult psychiatrists. Many residents are hesitant to consider subspecialization because they think they will have to "give up" seeing adult patients, which they enjoy. The reality is that most child and adolescent psychiatrists also see adults.

The degree to which an individual practitioner focuses on a particular age group is a matter of choice. For example, around half of my patients are adults. My patients range in age from infancy through their 80's. Many of my patients first come to me with a problem concerning their child. To address the problem, I may work with the child individually, or with his or her family. It may turn out that there are parental or marital issues. I may end up doing parent education, couples therapy, or treating a parent individually for depression, which ends up helping the child. Even if I see an adult individually and never see his or her

family, the patient usually views my extra expertise in working with children and families as a bonus, helping me to better understand past or current struggles with family members.

A developmental perspective is helpful with patients of all ages. Child and adolescent psychiatrists often like to refer to themselves as the true general psychiatrists, because they are trained to treat patients throughout the life cycle. And, as noted above, there is great flexibility in the choice and provision of treatment modalities. Child and adolescent psychiatrists are well-versed in individual, family, couples, and group psychotherapy. They are trained in long-term and short-term dynamic as well as cognitive-behavioral therapy, and are able to integrate pharmacotherapy into their work with patients of all ages. Child and adolescent psychiatrists have the opportunity to treat children in the context of their families, schools, and community. They are holistic in their approach, understanding and treating problems by integrating biomedical, psychological, and social perspectives.

Child and adolescent psychiatrists can choose from a wide variety of professional avenues. **Clinical opportunities** include private practice in solo or group settings; working as an employee in a managed care or government setting; or becoming a supervisor or administrator. Child and adolescent psychiatrists can select from a continuum of care settings in which to work, from inpatient to residential to partial hospitalization to outpatient. **Consultation opportunities** occur in schools, hospitals, or court settings, as well as consulting to agencies and professionals in other related fields. Some physicians become specialized experts in a particular age group (such as infants or adolescents), a particular diagnosis (such as obsessive-compulsive disorder, pediatric depression, or anxiety disorder), or a particular treatment modality (such as pediatric psychopharmacology or custody evaluations). There is a tremendous need for **academic psychiatrists**, both clinician-educators and researchers. The search for new knowledge and treatments for child and adolescent mental illness is crucial. In the public arena, child psychiatrists can become active in their community or government as **advocates** for child mental health. Through political action or by helping to develop wide ranging programs at both the treatment and prevention levels, they can help address such issues as sexual abuse, substance abuse, poverty, and teen pregnancy.

Finally, it is important to remember that you don't have to specialize in one area. Many child and adolescent psychiatrists enjoy combining a variety of professional activities and roles.

2) What are the job prospects and lifestyle?

The **demand** for child and adolescent psychiatrists far outstrips the supply.[i] There are currently only 7,418 child and adolescent psychiatrists practicing in the United States (AMA, 2009). A report by the U.S. Bureau of Health Professions (2000) projected a need in the year 2020 for 12,624 child and adolescent psychiatrists, but a supply of only 8,312. In its 1998 report, the Center for Mental Health Services estimated that 9-13% of 9- to 17-year-olds had serious emotional disturbances, and 5-9% had extreme functional impairments. However, in 1999, the Surgeon General reported that "there is a dearth of child psychiatrists." Only 20% of emotionally disturbed children and adolescents received any mental health treatment, a tiny percentage of which was performed by child and adolescent psychiatrists. Furthermore, the U.S. Bureau of Health Professions projected that the demand for child and adolescent psychiatry services would increase by 100% between 1995 and 2020.

The **job opportunities and lifestyle options** in child and adolescent psychiatry are excellent. According to a survey of all graduating residents and fellows in two states in 2000, child and adolescent psychiatry ranked first of 27 medical specialties in California, and second of 28 specialties in New York, in the average number of job offers per resident on graduation.[ii] Child and adolescent psychiatry also fared extremely well in graduates' ratings of diversity of practice options, work-life balance and flexibility.

Since there is such great demand, child and adolescent psychiatrists can select from multiple possible activities, and decide how many hours they want to work at different periods in their careers. Due to this flexibility, child and adolescent psychiatry careers can be particularly attractive for those who want to devote significant time to raising a family.

According to the 2008-2009 AAMC Summary Statistics on Medical School Faculty Compensation, the average salary nationwide for Assistant Professors in Child and Adolescent Psychiatry was $155,000. Most institutions and agencies pay a higher salary to psychiatrists who have completed CAP training. According to 2000 and 2001 combined survey data, the median starting income for child and adolescent psychiatrists was $141,600, compared to $109,100 for adult psychiatrists. Many insurance companies reimburse subspecialists at a higher rate.

3) Is it necessary to do a child and adolescent psychiatry residency if I only want to treat adolescents?

Some residents tell me that they only want to work with adolescents, not children. They therefore plan to do a PGY-4 elective working with teenagers, and avoid a child and adolescent psychiatry residency (also commonly referred to as

a "fellowship"). Adult psychiatrists do sometimes treat older adolescents without subspecialty training. However, there are a few points to consider.

First, the desire to work only with adolescents is often based on a discomfort when working with younger children. This discomfort is usually due to a lack of training in how to assess and treat children. It is common for a trainee to enter our CAP residency program planning to work primarily with adolescents. They insist, like W.C. Fields, that they can't stand little kids, only to graduate two years later with a whole new attitude, having developed new skills, comfort level and understanding. Limiting your scope to adolescents, rather than keeping your options open by doing a CAP residency, may be short-sighted. A resident's passion for adolescent work is frequently based on the relatively recent memories of one's own teenage experience. Your interests will likely change along with your phase of life. For example, it is common for residents to gain a whole new fascination with small children as they start their own families.

Second, adolescence occurs within the context of normal development and family/community systems. In order to truly understand what is going on with a teenager and how to treat the problem, the overall in-depth knowledge acquired in a CAP residency is inordinately useful. Understanding adolescents, particularly immature ones, often necessitates a deep understanding and appreciation of the impact of early childhood on development. Work with adolescents often involves family treatment, which may include younger siblings. When adolescents become teenage parents, CAP psychiatrists have the full range of necessary skills to help their patients and babies cope.

Third, I sometimes get requests from practitioners, 10 years out of adult psychiatry training, to come back and do a CAP residency. These clinicians are doing some work with adolescents, but desire to improve their knowledge base, or find that subspecialty credentialing is increasingly requested by employers and insurance companies.

4) What do I need for Board certification?

In order to be Board-eligible in general ("adult") psychiatry, you need to complete four years of post-graduate training. One year of this can be spent in the first year of a CAP residency, and this will count toward general psychiatry Board certification. Therefore, if you enter CAP training as a PGY-4, but decide after a year that it's not for you, and you decide not to do the second year of your CAP residency, you will still be able to take your general psychiatry Boards.

In order to be Board-eligible in child and adolescent psychiatry, you'll need to complete two years of child and adolescent psychiatry training, and be Board-

certified in general psychiatry. Residents entering their residency as PGY-4s usually take their general psychiatry Boards in their PGY-5 year (the second year of the CAP residency), and take their CAP Boards after they are out of training and have passed their general psychiatry Boards. However, residents can opt to wait to take any Board examination until all training is completed.

5) Should I do CAP residency training after my PGY-3 or PGY-4 year?

This question assumes that you are following the most frequent route of doing your general psychiatry training before your CAP training. (For other options, see question #6, below.) If you choose to, you can shorten your general psychiatry residency by one year, allowing you to become Board-eligible in both adult and child psychiatry within five years after medical school. Deciding between five and six years of training is a common dilemma for residents. There is no "right" answer, just what is right for you.

Common reasons for choosing the **"short" route** (entering CAP after the PGY-3 year and taking five years total to complete training) include: believing that five years of training is "enough already," wanting to move out of the student phase and into the professional phase of life, carrying a large debt load, having a family to support or wanting to start a family, being older, or having a relative dislike of general psychiatry training experiences coupled with a desire to move more quickly into experiences with children and adolescents. A rough estimate of the financial cost of choosing the long route would be $100,000 in lost income, since in that sixth year you might earn around $40,000 as a resident, versus approximately $140,000 starting out in practice.

Common reasons for choosing the **"long" route** (entering CAP after the PGY-4 year and taking six years total to complete training) include: wanting to be chief resident (although there is also an opportunity to be chief resident in CAP training programs), enjoying the student role and wanting to learn as much as possible in general psychiatry, having particular skill deficits to fill in before moving on to a subspecialty, or special training opportunities in the PGY-4 year that will supplement or complement subspecialty training in child and adolescent psychiatry. The PGY-4 year may provide an opportunity to consolidate skills and knowledge, particularly in psychotherapy.

Whether you choose the short or long route, the CAP training director will require a letter from your general psychiatry training director, certifying areas in which you have achieved competency, and areas still in need of completion. Be sure to check with your general psychiatry training director well in advance. You will need to be in good standing, projected to complete the requirements of your

given residency year, in order to enter CAP training. For example, if you choose the short route, at the time that you apply, you will need to be "on track" for successful completion of your PGY-3 requirements. However, a short route resident will not also be expected to have somehow completed the general psychiatry PGY-4 requirements as well.

I strongly advise taking USMLE Step 3 as soon as possible. Most CAP training programs prefer, and some require, that you pass USMLE Step 3 before applying. Some general psychiatry residency programs require that you pass USMLE Step 3 by a certain date in order to apply for CAP training. For example, our program states that you must have passed Step 3 by September 1 of PGY-3 in order to be allowed to take the short route.

6) What does child and adolescent psychiatry residency training involve?

Becoming a child and adolescent psychiatrist usually requires completion of an internship (which may include pediatrics and pediatric neurology), two to three years of general psychiatry residency, and two years of CAP specialty training.

There are multiple paths toward completing CAP training. According to the CAP Residency Review Committee ("RRC") requirements: "To achieve greater flexibility in the sequence of residency training and to assist in recruitment, the 2-year child and adolescent psychiatry training experience may be initiated immediately following, or at any point beyond, the PGY-1 level in the psychiatry residency sequence." Most commonly, CAP training follows adult psychiatry training (see question #5, above). It is also possible to do child and adolescent psychiatry training before general psychiatry training. (If you choose this route, check the general psychiatry training requirements to be sure you meet the expectations for continuity.) There are also "Triple Boards" programs that offer combined, extended training and Board-eligibility in psychiatry, child and adolescent psychiatry, and pediatrics. For graduating medical students who are sure they will pursue CAP training, some psychiatry residency programs have the flexibility to integrate child and adult training experiences over the five-to-six year training sequence. Interested medical students should inquire about this possibility when interviewing.
Several programs also provide an option for a Post-Pediatric Psychiatry Portal Program. This pilot project was approved by ACGME for pediatricians. The Portal Project provides a three-year training experience that meets requirements for Board Certification in both general psychiatry and child/adolescent psychiatry.

There are basic requirements that every CAP training program must meet in order to be accredited. These RRC requirements are available on-line at the Accreditation Council for Graduate Medical Education website: http://www.acgme.org/acWebsite/downloads/RRC_progReq/405pr1104.pdf . Beyond these requirements, however, there is a lot of room for individuality. Programs are delightfully varied in their content, according to the strengths and philosophy of each institution. You should compare and contrast programs.

In general, a CAP residency provides training in working with children from infancy through late adolescence. You learn how to work with the parents, extended families, schools, hospitals, courts, and communities where these kids live. Training is provided in different therapeutic modalities (group, individual, cognitive-behavioral, psychodynamic, psychopharmacologic, family systems) and treatment settings (inpatient, day hospital, outpatient, sometimes residential). You will learn how to be a teacher, a supervisor, and an administrative leader. You will be trained to work with interdisciplinary teams, as well as independently. You will receive training in pediatric neurology and in hospital consultation-liaison to pediatrics. You will participate in extensive classroom experience involving extended coursework in normal developmental theory throughout the life cycle, as well as the full range of clinical syndromes and their treatments. You will also be exposed to research methodology, with the level of expected research participation varying between programs.

7) What training programs are available?

There are over 120 accredited CAP training programs in the United States. The ACGME website maintains a complete listing of all the CAP training programs, and how to contact the training director for an application. Go to http://www.acgme.org/adspublic/ . Under "Reports—List of Programs by specialty," under "Psychiatry," select "Child and Adolescent Psychiatry." In addition, near the bottom of the list, you can select "Peds/Psych/Child-Adolescent Psych" to view the available Triple Boards programs. There are detailed descriptions of most programs on their university web pages. The American Academy of Child and Adolescent Psychiatry's website, http://www.aacap.org, provides further information about programs that provide specialty training in areas such as research and infant psychiatry.

8) When and how do I apply?

Applications are generally available after July 1 for entry the following July. For the short route, request applications starting in June of your PGY-2 year for CAP entry after your PGY-3 year. For the long route, request applications starting in June of your PGY-3 year for CAP entry after graduation. However, applications

are often requested as late as November for entry the following July. And if you make up your mind late, don't despair; just request an application anyway, as there may still be openings. One of the easiest ways to learn about programs is to request a variety of applications and compare them before choosing which ones to apply to. Medical students often request applications to learn more about the program they may be considering in general psychiatry.

9) Is there a Child and Adolescent Psychiatry Match, and is there an early decision process?

Since 1995, the vast majority of child and adolescent psychiatry programs have participated in the **National Residency Matching Program** (NRMP). Between July 1 and mid December of the year immediately preceding the desired entry, applicants have the opportunity to interview at as many programs as they wish without any pressure to make a decision between programs, and without fear that positions will be given away by programs. In mid-December, applicants and programs fill out rank order lists, and are notified in January of their matches. The majority of applicants currently match with their first choice program. Applicants need to contact the NRMP to register for the Match. Go to http://www.nrmp.org/fellow/match_name/index.html#CAPS for a schedule of dates, Match results statistics, list of participating programs in the previous match, and Match rules.

The Match is for residents applying after July 1 who plan to start CAP training the following July. Without violating the rules of the Match, it is possible to apply "**early decision**" (i.e., separate from the Match, before the Match begins for that year), as long as the contract is signed before July 1 of the year immediately prior to entry. However, this is the exception rather than the rule, as I will now explain.

Occasionally, trainees and programs may choose to commit to each other before the Match. This usually occurs in special circumstances, when a trainee is certain that they wish to attend a particular training program without interviewing elsewhere. Examples: A resident may be involved in a multi-year research project with a faculty member, and wishes the certainty of seeing it through to completion. A medical student may not wish to relocate to a different city, unless receiving a guarantee of being able to remain at the same program for both general psychiatry and CAP training. A resident may have strong clinical interests matching the particular faculty and program involvement at their university. It is expected, however, that most residents will wish to avail themselves of the opportunity afforded by the Match to consider a variety of programs, and are encouraged to go through the Match. If you are intending to

interview at a variety of places and select between them, you should NOT apply "early decision," but should go through the Match.

10) What are the advantages of a trainee membership in AACAP?

For **only $70 per year,** general psychiatry, pediatric, and CAP residents can become resident members. AACAP resident membership benefits include a free subscription to the Journal of the American Academy of Child & Adolescent Psychiatry and AACAP News, on-line access to the Child and Adolescent Psychiatric Clinics of North America for a year, discounts on AACAP publications and meeting registrations, AACAP award opportunities, and a variety of mentorship and networking opportunities. AACAP members also have access to the members' only section of the AACAP website, which contains the online membership directory, webinars, advocacy opportunities, and many other resources. **Medical student membership is free of charge!**

Membership also includes participation in the state branch of the Academy. For example, trainee membership in Illinois includes four dinners per year in a Chicago-area restaurant, with a guest speaker. These dinner meetings provide the opportunity to socialize with trainees and faculty from a variety of universities in the area, as well as local practitioners.

For more information about AACAP opportunities, you may contact the Department of Research, Training, and Education at training@aacap.org. The AACAP website has special sections for medical students and general psychiatry residents with lots of useful information, including links to the other organizations I have mentioned above.

Closing thoughts

Gaining an understanding of normal development and problems through the life cycle is fascinating and fun, and utilizing that framework in one's daily life and work is a pleasure. Children's psyches are still relatively flexible; it is satisfying to see their often quick response to our interventions. In addition to relying on our cognitive skills and medical knowledge, working with children and adolescents calls upon our creativity, our imagination, and our sense of humor. I hope that this article has addressed some of your questions about child and adolescent psychiatry as a career, and that you will investigate this area of practice further.

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[i] For a comprehensive review and references, see: Kim WJ, "Child and Adolescent Psychiatry Workforce: A Critical Shortage and National Challenge." Academic Psychiatry 2003; 27:277-282.

[ii] Center for Health Work Force Studies at SUNY, Albany (http://chws.albany.edu).