EDITORIAL

ADULT PSYCHIATRY AS A SUBSPECIALTY OF GENERAL DEVELOPMENTAL CHILD PSYCHIATRY

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Rene Dubos begins an article entitled "Biological Freudianism—Lasting Effects of Early Environmental Influences (1966) with a quote from John Milton's *Paradise Regained.* In this epic poem, Milton says " . . . the childhood shews the man—as morning shews the day . . . ." Dubos clearly and definitively delineates previous physical and emotional events which impact later development.

In his title, Dr. Dubos makes a plea for looking at biological characteristics in the adult as Sigmund Freud explicated in developing psychoanalytic theory and practice. This developmental framework in appreciating adult behaviors is incorporated in our teaching of any and all psychological methodologies. It gives substance to the concept that "the child is the father of man" in that we explain that a person is what she/he is today because of the myriad of experiences and the interpretations placed upon these experiences that the person had before.

Webster (1955) defines the word *general* as "1. Of or pertaining to the whole, not local . . . 2. Pertaining to, affecting or applicable to, each and all of a class, kind, or order. . . ." Therefore, as we talk of "general psychiatry" we must by definition include in our thinking all classes and kinds of people *irrespective of age.* The Committee on Certification in Child Psychiatry of the American Boards of Psychiatry and Neurology has ruled that an accredited program in child psychiatry training

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0363-1907/78/1500-0143$00.95

must demonstrate a close and working relationship with a program in general (adult) psychiatry. Is there anything in the regulations of the American Boards of Psychiatry and Neurology that states that a general (adult) psychiatric training program must demonstrate a close and working relationship with accredited child psychiatry training programs? My reading is rather that the programs in general psychiatry require an "orientation" in child psychiatry, and in this sense it is my contention that the term "general" is a misnomer to describe these programs since graduates are unable to understand or treat that whole class of individuals we call minors. It is clear that Tarjan's paper "Orientation or Training: An Urgent Issue for Child Psychiatry" (1968) could be reintitled "Orientation or Training: An Urgent Issue for General Psychiatry."

It was in this brief 1968 communication that Tarjan noted that there were more than 70 million people below 18 years of age in the United States, and at the time of his writing this paper, there were 500 Board-certified child psychiatrists for this population. This represented one child psychiatrist per 140,000 children and adolescents. At that time, there was a ratio of one "general" psychiatrist to 16,000 adults. The comparative figures are still the same and if, as Tarjan facetiously suggested, children presented one-tenth of the problems of adults, these ratios might prove adequate. But it was clear to Tarjan that this differential in need is fallacious and incorrect, and therefore the population of psychiatric caretakers for children must be advanced at least tenfold.

I am postulating that the term "general" as applied to psychiatric residency should be able to care for the "general" problems of the "general" population. As it currently appears, the generalist in psychiatry really is able to diagnose and treat only a part—the adult portion—of the population and therefore in my estimation cannot be constituted as a true generalist. This concept was magnificently sponsored by Westman who saw that the only general psychiatrist was the person trained in child and adult psychiatry, and thus able to care for the entire age range of the population in the United States.

It is my belief that the majority of psychiatrists do not deal with children because the direct exposure to the impact of children's feelings and conflicts is too likely to stimulate old partially settled similar states in the psychiatrist. It is easier to handle the feelings of adults who have partially conquered infantile conflicts by repression, intellectualization, isolation, etc. It is easier to spend a professional lifetime reconstructing the effects of early life traumata behind the bulwark of a couch and the temporizing passage of years. It appears easier and more likely that a resident in psychiatry will have exposure

to the peculiarities of thinking of psychotic adults that direct contact with children in distress. Being placed in the vortex of the child's fantasies and behaviors, the family entanglements, the school, and other social pressures is too much of a regressive threat to most psychiatrists.

Yet, if this is not done during the training period, the psychiatrist dealing mainly with adults will engage in sterile, intellectual exercises in appreciating the contribution of past feelings and experiences. If exposure to children is not an active component of training, all theories remain unreal, as they have not been seen or participated in actively and directly, but only through hearsay filtered through the distortions of time. I submit that developmental child psychiatry must resonate continuously throughout the training to permit the evolution of a true generalist in psychiatry.

As it currently occurs, adult psychiatry can only be seen as a division of general psychiatry represented by the training process required to become a child psychiatrist. Those residents who want only to work with adults should be permitted to take two years in adult psychiatry and one year in child psychiatry. They would be Board qualified only in adult psychiatry. Those residents who want to work with children should be permitted to take two years in child psychiatry and one year in adult psychiatry. They would be Board qualified only in child psychiatry. I propose that residents taking two or three years in adult psychiatry and two years in child psychiatry be examined for dual Boarding in adult and child psychiatry—the true generalist in the frame of reference of Dubos and Webster. It is my contention that whatever the psychiatrist's theoretical framework reflects, and no matter what the age of the patient, we must prepare practitioners to know that when emotional and behavioral problems occur, we are always talking to the child within.

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