Scandinavian Journal of Child and Adolescent Psychiatry and Psychology
Vol. 4(2):44-45 (2016)

Editorial **Open Access**

The Swedish Patient

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There is a ghost in the house of academic child and adolescent psychiatry in Sweden that harbors an inconvenient truth that has been ignored for far too long: there is currently a dramatic shortage of domestic child and adolescent psychiatrists who are qualified for university professorships, and there is a serious risk for the extinction of several chairs in this field. About 450 child and adolescent psychiatrists are registered in Sweden; 150 of these are in Stockholm County alone, which represents one of the highest—if not *the* highest—density of practitioners of this profession in the world. Child and Adolescent Psychiatry Stockholm has 900 employees and serves an area with a population of 2.2 million, which makes it one of the largest single child and adolescent psychiatry organizations worldwide. Nevertheless, among all child and adolescent psychiatrists in Sweden, the proportion with PhDs is low, and the number of senior researchers with track records that make them eligible for professorships and that demonstrate international competitiveness is humble.

In Sweden, there are six university child and adolescent psychiatry departments: Lund, Gothenburg, Linköping, Stockholm, Uppsala, and Umeå. In Uppsala and Umeå, the chairs have been formally vacant for several years, having only been kept alive by the former and now retired chairs taking continuous responsibility. Fortunately, in Uppsala, it seems that a valuable new recruit is within reach. Lund, Gothenburg, and Linköping are facing the emeritus statuses of their chairs in the not too distant future. In Stockholm, the traditional child and adolescent psychiatry chair has not been continued, and it is likely to be terminated completely after the current senior professor's final retirement. Instead, two new professors have been recruited for the area of child and adolescent psychiatric science, particularly to address neurodevelopmental disorders as well as obsessive-compulsive disorders and related conditions. However, these individuals are clinical psychologists rather than child and adolescent psychiatrists. It may be considered a positive move that academia and child and adolescent psychiatry have opened themselves up to psychologists and acknowledged their pivotal role in clinical child and adolescent psychiatry and that the field is prioritizing scientific excellence, irrespective of profession. Still, one of the major reasons that child and adolescent psychiatrists were not recruited for these positions was simply the lack of availability. For example, for the professorship on neurodevelopmental disorders, Karolinska Institutet and Child and Adolescent Psychiatry Stockholm had searched Sweden for eligible candidates who were child and adolescent psychiatrists for several years, without success. It is also worth noting that the two psychologists recruited for the chairs came from abroad. Although it is vital for Swedish psychiatry to diversify by incorporating international perspectives, the inability to employ domestic experts raises additional questions about the availability of sufficiently academically qualified senior researchers in this field in Sweden as a whole.

What are the reasons for this problematic situation, and what can be done to improve it? Most of my academic and clinical colleagues in Sweden agree that the negative developments in this area began during the 1980s as a result of the politics associated with the decisions made in many counties to separate the academics and clinical practice of child and adolescent psychiatry as much as possible. This generated gaps between research, education, and practice, and it made it hard for clinicians to combine their clinical and scientific work. It diminished the inclusion of research and education as natural parts of an active clinician's working life, and it excluded the use of any clinical resources for research, development, and education. Consequently, academic skills were no longer considered necessary or beneficial to standard child and adolescent services. In many of today's child and adolescent

psychiatry departments, even the leaders lack scientific qualification. For child and adolescent psychiatrists who may wish to start scientific careers, a particular challenge related to the dissociation of academia from practice is compensation. Salaries for physicians are high as compared with other professions in clinical psychiatry; such salaries are very unusual for junior researchers or simply impossible for universities to afford. Most physicians, for understandable reasons, do not feel that they can tolerate large salary cuts to conduct science. In addition, for some areas of psychiatric research, medical expertise is not mandatory, so employing young gifted researchers from other professions can be equally meaningful. As compared with the examinations that must be passed in the field of psychology, an explicit scientific education in medicine is limited, which is another disadvantage for physicians who may want to begin performing research.

Are there other explanations for the shortage of highly merited academic senior child and adolescent psychiatrists? I am afraid that there are at least two additional aspects of significance. First, research is still not valued highly enough in the field of clinical child and adolescent psychiatry in Sweden, and evidence-based clinical practice is a goal that is far from being achieved. There are still many anti-scientific practices and traditions that are tolerated by health care authorities and influential in many clinical organizations. There is also a widespread, subliminally shared belief that research does not really contribute to clinical practice and thus that practice can do well without science. Guidelines for the diagnosis and treatment of mental disorders do not exist, are not evidence based, or are not sufficiently followed. Regrettably, these circumstances—which contribute to academic child and adolescent psychiatry being threatened with extinction—are not taken very seriously or are not even recognized by many. Second, despite the bad odds described previously, academic child and adolescent psychiatry frankly must blame itself for not having made a better effort to bring up the next generation of senior child and adolescent psychiatrists to lead the profession in this country's universities.

Although the situation appears to be critical, there are also some positive developments to report. In 2004, the Swedish Association for Child and Adolescent Psychiatry started a child and adolescent psychiatry academy with the objective of connecting all academic child and adolescent psychiatry chairs and senior researchers to coordinate and strengthen the field and to develop an adequate academic curriculum. The Child and Adolescent Psychiatry Research Center in Stockholm[1] (Karolinska Institutet & Stockholm County Council) was also established to unite three strong clinical research centers (Center of Neurodevelopmental Disorders at Karolinska Institutet [KIND][2], Child and Adolescent Psychiatry Stockholm (BUP) Obsessive Compulsive Disorders and related disorders [BUP OCD], and BUP Center for Psychiatry Research [BUP-CPF] at one location, thereby integrating clinical services, education, and research and development. I am keeping my fingers crossed for more such developments, and I sincerely promise to increase my own engagement with these issues so that the Swedish patient can recover.

The *Scandinavian Journal of Child and Adolescent Psychiatry and Psychology* assists in addressing these matters by offering timely and high-quality reviews to child and adolescent psychiatrists at all stages of their careers and by providing open access to its findings to the scientific community at large.

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[1]www.bup.se/sv/Om-BUP/Forskning/Barn--och-ungdomspsykiatriskt--forskningscentrum/

[2]www.ki.se/kind