

ORIGINAL ARTICLE

**PSYCHOTHERAPY PRACTICE AMONG CHILD AND  
ADOLESCENT PSYCHIATRISTS IN THAILAND**

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**Abstract**

**Objective:** To survey patterns of psychotherapy practice of child and adolescent psychiatrists in Thailand, including identifying obstacles to conduct psychotherapy. **Methods:** This was a cross-sectional descriptive study. A self-reported questionnaire was developed by the authors and sent to all child and adolescent psychiatrists in Thailand by mail. **Results:** The total number of child and adolescent psychiatrists in Thailand at the time of the survey was 176. There were 95 respondents (54.0 % response rate), with the average age of  $39.7 \pm 9.8$  years old. 67 (70.5%) respondents were female. Respondents endorsed conceptual frameworks used in case formulation and treatment planning as following: learning and cognitive theory (68.8 %), Eriksonian theory (41.3 %) and attachment theory (34.8%). Only 6.4 % of respondents reported that they provided psychotherapy to their patients “frequently” and “very frequently”. Instead, the majority of respondents provided just only counseling and parenting advice & guidance, parent management therapy (PMT). Respondents estimated that  $36.3 \pm 24.0$  % of their patients should be treated with psychotherapy but in real-life practice, they provided psychotherapy for  $5.1 \pm 8.6$  patients/ week in the past year. Psychotherapies that most children and adolescent psychiatrists used were behavioral therapy, supportive psychotherapy and cognitive-behavioral therapy (73.3 %, 71.8 %, and 56.5% of respondents reported to conduct “frequently” and “very frequently,” respectively). Main obstacles in performing psychotherapy were heavy workload, lack of readiness of patients and lack of confidence by child and adolescent psychiatrists. **Conclusion:** Although psychotherapy is considered an essential treatment in child and adolescent psychiatry practice, child and adolescent psychiatrists in Thailand provide psychotherapy to only a small number of patients. Behavioral therapy, supportive psychotherapy and cognitive-behavioral therapy were the most frequently used psychotherapies by Thai child and adolescent psychiatrists. Lack of time to engage in psychotherapy due to heavy workload was the most common obstacle in providing this treatment. *ASEAN Journal of Psychiatry, Vol. 17 (2): July – December 2016: XX XX.*

**Keywords:** Psychotherapy, Child, Adolescent, Psychiatrists, Thailand

## **Introduction**

Psychotherapy is a core competency in child and adolescent psychiatry practice. In 2014, the American Academy of Child and Adolescent Psychiatry (AACAP) launched a policy statement stating that "Psychotherapy is and must remain a core skill in the practice of child and adolescent psychiatry." [1]. Studies have shown that various types of psychotherapies are effective in treating various psychiatric illnesses in children and adolescents, including conditions classified as depressive disorders, anxiety disorders, post-traumatic stress disorder, obsessive-compulsive disorder, eating disorders, self-harm behavior and externalizing disorders [2-16]. The AACAP has integrated psychotherapy into practice parameters and treatment guidelines, and encourages child and adolescent psychiatrists to incorporate principles and techniques of psychotherapy in everyday practice [1].

Contemporary psychiatric practice has shifted from psychosocial interventions towards emphasis of the psychopharmacological approach, with polypharmacy becoming increasingly common [17-22]. In addition, non-psychiatrists physicians deliver over 50% the mental health care of children and adolescents in the USA by prescribing them medication [17]. In the USA, from 2007-2010, children and adolescents evaluated by psychiatrists received medication only five times more than in combination with or psychotherapy alone [17]. The availability and accessibility of medication, the managed care system and other economic indicators, and the adoption of DSM and ICD nosology are some factors presumably accountable for the change in the USA [23-25]. Even though medications have proven to be effective, and at times less time-consuming and as cost-effective as psychotherapy, the risk of iatrogenic adverse effects is unavoidable [26-30]. Moreover, there is evidence that the combination of treatments, medication and psychotherapy, provides a better outcome in some conditions, for example in the treatment of depressive disorder and attention deficit hyperactivity disorder (ADHD) [31, 32]. Studies have also found that psychological interventions are cost-effective in preventing

mental disorders in children and adolescents [33, 34].

According to Accreditation Council for Graduate Medical Education (ACGME), psychiatry residents must demonstrate competency in applying supportive, psychodynamic, and cognitive-behavioral psychotherapies to both brief and long-term patient encounters, as well as to ensuring exposure to family, couples, group, and other individual evidence-based psychotherapies [35]. Child and adolescent psychiatry fellows must demonstrate proficiency in brief and long-term individual therapy, family therapy, group therapy, crisis intervention, supportive psychotherapy, psychodynamic psychotherapy, cognitive-behavioral therapy, and pharmacotherapy [36]. The Royal College of Psychiatrists of Thailand (RCPT) also places emphasis on psychotherapy training, and incorporated psychotherapy competency in their core competencies for psychiatrists. All graduating children and adolescent residents in Thailand are required to exhibit proficiency in individual and group settings, performing various types of psychotherapies, including supportive psychotherapy, psychodynamic psychotherapy, family therapy, cognitive therapy and behavioral therapy [37].

A national survey of early career psychiatrists conducted in Thailand in 2010 by Chareemboon and Phanasathit, including early career child and adolescent psychiatrists, found that the respondents expressed a positive attitude when asked about their desire to conduct psychotherapy with patients. However, 69.6 % of the respondents were practicing psychotherapy for less than 4 hours/month. Heavy workload, lack of supervision and lack of confidence in performing psychotherapy were reported to be the main obstacles [38].

When examining how all psychiatric office visits in the USA changed from 1998 to 2007, psychopharmacology achieved greater prominence while psychotherapy took a secondary role. Among individuals receiving outpatient mental health care, use of psychotherapy without medication was 15.9% in 1998 and 10.5% in 2007. The use of psychotherapy and psychotropic medication

together declined from 40.0% to 32.1%, while the use of psychotropic medication without psychotherapy increased from 44.1% to 57.4% during the same period of time [25]. In view of these findings, we decided to investigate whether these trends also apply to psychotherapy practice in Thailand. To date, there is no previous research specifically examining psychotherapy practices of child and adolescent psychiatrists in Thailand. The authors of this study in Thailand collaborated with authors from the United States, who assisted in the design of a survey of practice patterns to co-investigate the state of psychotherapy practice among child and adolescent psychiatrists in Thailand [39].

## **Methods**

This was a cross-sectional descriptive study. A self-reported questionnaire was developed by the authors. It was composed of 3 sections: (i) Demographic data: age, gender, religion, region and workplace; (ii) Current workload and practice: Outpatient (OPD) hours/week, OPD patients/week, In-patient (IPD) hours/week, IPD patients/week, consultation hours/week, consultation patients/week, percentage of patients who were treated with psychotropic medications, percentage of patients who were treated with psychosocial interventions, types of psychosocial interventions used, and conceptual frameworks used in case formulation and treatment planning; (iii) Psychotherapy practiced experience: percentage of patients who should be treated with psychotherapy, number of psychotherapy patients/week, diagnoses of psychotherapy patients, and types of psychotherapies used and obstacles in providing psychotherapies to patients who would benefit from them.

The questionnaire included both numeric data and forced choice. There were brief descriptions for each frequency choice: “Never”, “Very rarely” = 1-20 % of patients,

“Rarely” = 21-40 % of patients, “Occasionally” = 41-60 % of patients, “Frequently” = 61-80 % of patients and “Very frequently” = 81-100 % of patients.

The questionnaires and the informed consent forms were mailed to all children and adolescent psychiatrists in Thailand by using a mailing address listed in the database of the Child and Adolescent Psychiatric Society of Thailand. The questionnaires were first mailed in October 2014 along with a letter from authors stating the purpose of the study, and a consent request form. The questionnaires were sent again to non-respondents of the first round in March 2015. The Institutional Review Board of Ramathibodi Hospital, Mahidol University, approved the study. All participants were requested to sign an informed consent form prior participation in the study. Data was analyzed by PASW Statistics for Windows, Version 18.0. Chicago: SPSS Inc. Categorical variables were computed by using frequencies and percentages. Continuous variables were computed by using means, standard deviations, minimum and maximum.

## **Results**

### *Demographic data*

The total number of child and adolescent psychiatrists in Thailand registered in the database of the Child and Adolescent Psychiatric Society of Thailand was 176. There were 95 respondents (54.0 % response rate), with the average age of  $39.7 \pm 9.8$  years old (range 28 - 77). 67 (70.5%) respondents were female and 87 (91.6 %) respondents were Buddhist. 45 (47.9 %) respondents were working in Bangkok and 66 (70.2 %) respondents were working in non-academic settings. The duration of child and adolescent psychiatry practice was  $7.5 \pm 7.0$  years (range 0.3 - 34). Demographic data is shown in Table 1.

**Table 1. Demographic data**

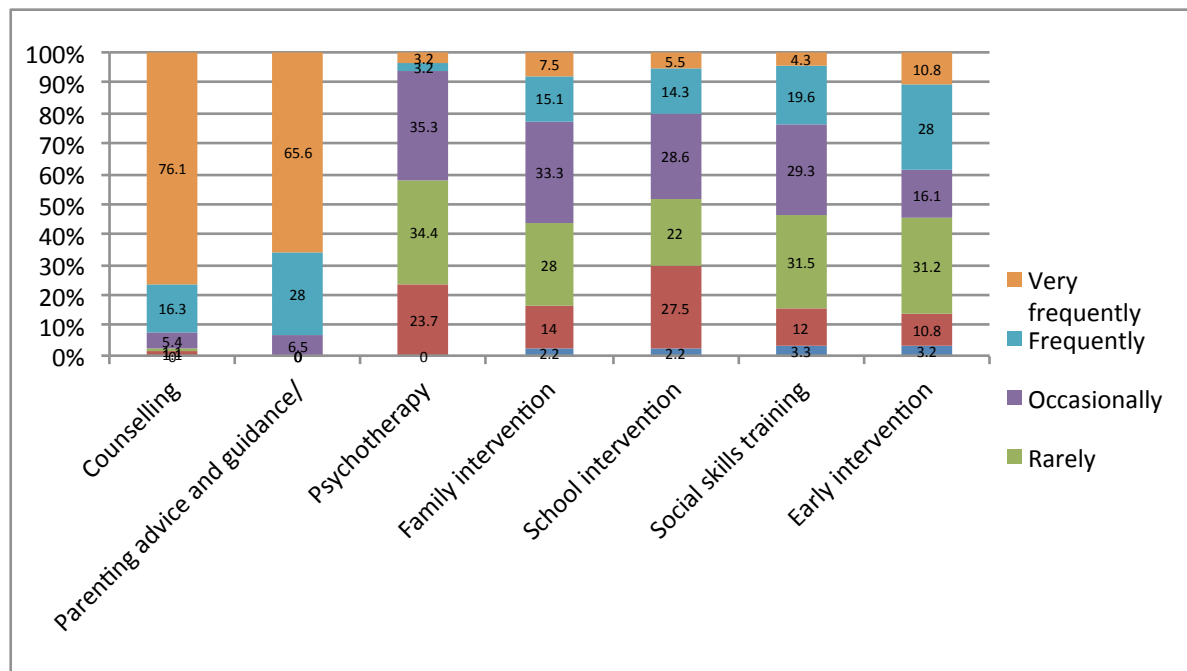
Variable	N (%)
Gender	
Male	28 (29.5)
Female	67 (70.5)
Religion	
Buddhism	87 (91.6)
Christianity	5 (5.3)
Islam	2 (2.1)
Hinduism	1 (1.1)
Region	
Bangkok	45 (47.9)
Other areas	49 (52.1)
Workplace	
Training hospital	28 (29.8)
Non-academic hospital	66 (70.2)

***Current workload and practice***

All respondents had workload in outpatient clinics with OPD hours of  $14.3 \pm 9.3$  hours/week ( $39.4 \pm 30.9$  patients /week). 54 respondents had workload in in-patient service with IPD hours of  $2.0 \pm 3.1$  hours/week ( $2.5 \pm 5.7$  patients /week). 62 respondents provided consultation-liaison to pediatric units with

consultation hours of  $5.58 \pm 9.4$  hours/week ( $2.3 \pm 3.5$  patients /week).

Psychotropic medications were prescribed in  $70.0 \pm 17.4$  % of patients while psychosocial interventions were provided in  $86.5 \pm 22.6$  % of patients. There were several types of psychosocial interventions provided as shown in Figure 1.

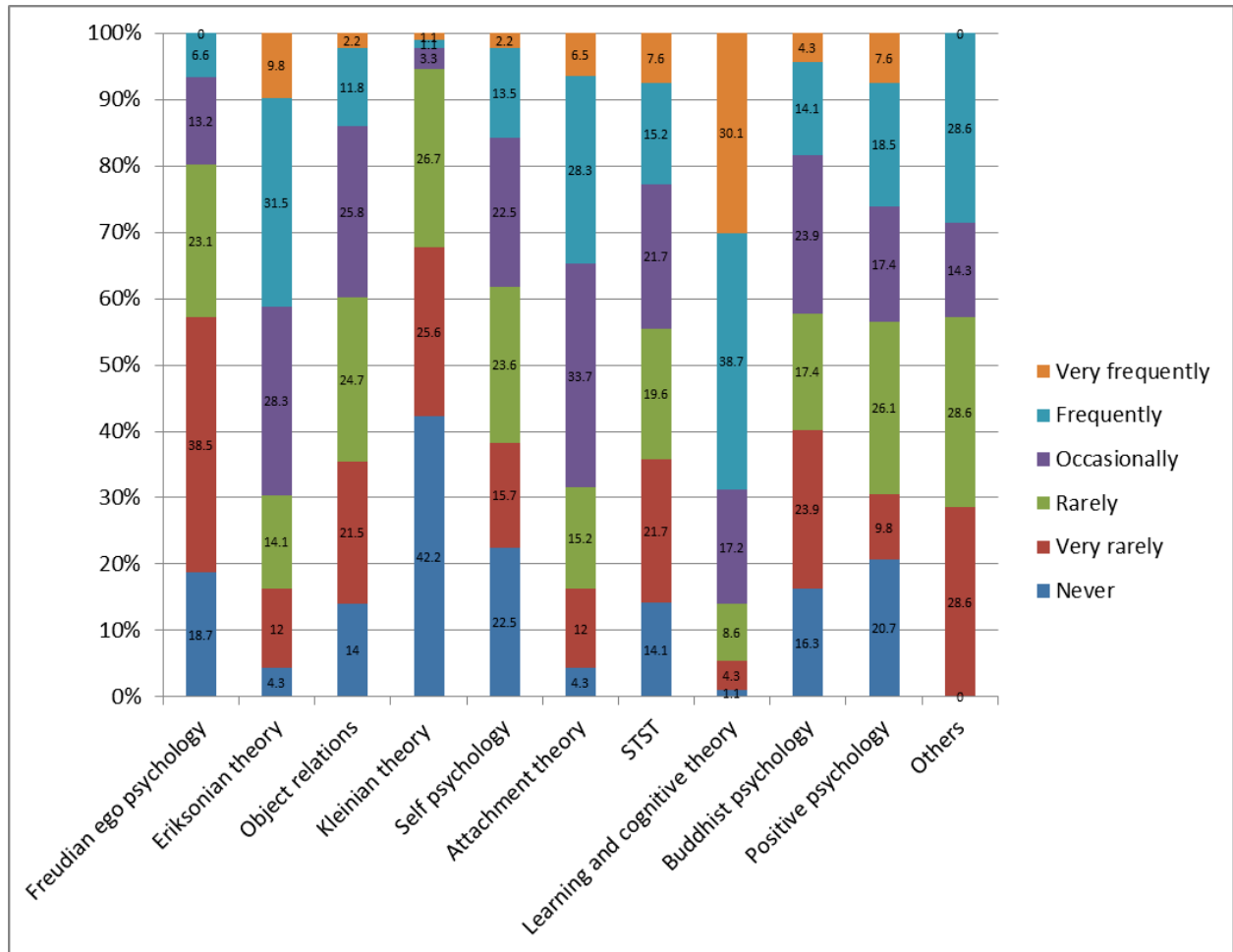


**Figure 1. Psychosocial interventions provided by child and adolescent psychiatrists**

Psychosocial interventions that most child and adolescent psychiatrists prescribed to their patients were parenting advice and guidance/parent management training and counselling (93.6 % and 92.4 % of respondents reported “frequently” and “very frequently” respectively). Only 6 (6.4 %) respondents reported that they provided psychotherapy to their patients “frequently” and “very

frequently”. Other interventions such as family intervention, school intervention and social-skill training were provided “very rarely” to “occasionally”.

When asked: “How often do you use these conceptual frameworks in case formulations and treatment planning?” Results are shown in Figure 2.



**Figure 2. Conceptual frameworks used by child and adolescent psychiatrists**

Learning and cognitive theory were the conceptual framework that most child and adolescent psychiatrists used in case formulations and treatment planning (68.8 % of respondents reported “frequently” and “very frequently”). Second and third conceptual frameworks commonly used were Eriksonian theory and Attachment theory, respectively. Other conceptual frameworks such as as object relations, self-psychology and Freudian ego psychology were rated as “never” to “rarely”,

used by 60.2%, 61.8% and 80.3 % of respondents respectively. The least favored basic conceptual framework was kleinian theory.

In Thailand, there are psychiatrists who have expertise in Satir transformational systemic therapy (STST) and Buddhist psychology. Therefore, these conceptual frameworks are encouraged by the RCPT to be incorporated in training. 44.5 % and 42.3% of respondents

reported that they used these conceptual frameworks “occasionally” to “very frequently”, respectively.

**Psychotherapy practice experience**

When asked: “In your opinion, what percentage of your patients should be treated with psychotherapy?” respondents estimated

that  $36.3 \pm 24.0$  % of their patients should be treated with psychotherapy but in real-life practice, they provided psychotherapy for  $5.1 \pm 8.6$  patients/ week in the past year.

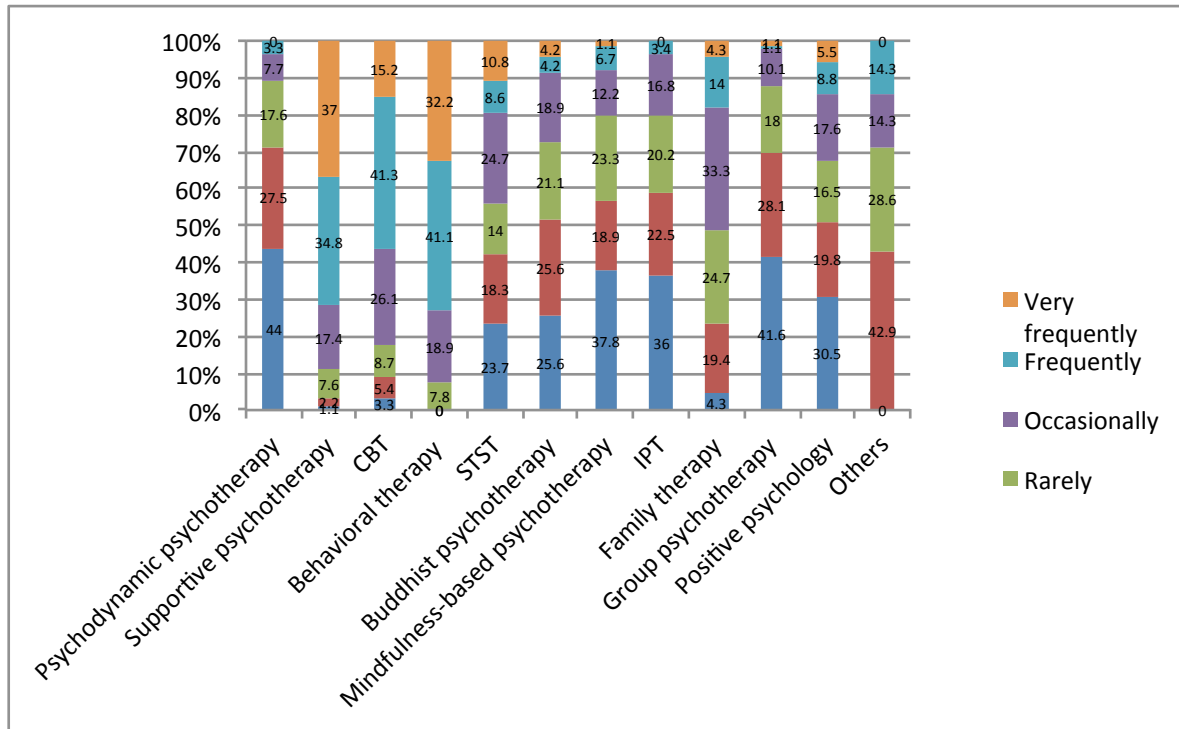
Diagnoses of patients who were treated with psychotherapy in the past year are summarized in Table 2.

**Table 2. Diagnoses of patients who were treated with psychotherapy in the past year**

Variable	N (%)
Depressive disorder	89 (95.7)
Anxiety disorder	83 (89.2)
OCD	57 (61.3)
Attention deficit hyperactivity disorder	41 (44.1)
ODD and CD	34 (36.6)
Somatic symptom disorder	32 (34.4)
Substance-related disorder	31 (33.3)
Specific learning disorder	28 (30.1)
Eating disorder	23 (24.7)
Autistic spectrum disorder	21 (22.6)
Bipolar disorder	17 (18.3)
Gender dysphoria	11 (11.8)
Psychotic disorder	8 (8.6)

Types of psychotherapies used and frequency of implementation of these therapies are shown in Figure 3. Psychotherapies that most children and adolescent psychiatrists used were Behavioral therapy, supportive psychotherapy and CBT (73.3 %, 71.8 %, and 56.5% of respondents reported to use “frequently” and “very frequently”, respectively). Group psychotherapy,

psychodynamic psychotherapy, interpersonal psychotherapy, mindfulness-based psychotherapy, positive psychology and family therapy were reported to be used “frequently” and “very frequently” by 2.2 %, 3.3%, 3.4%, 7.8 %, 14.3 % and 18.3 % of respondents respectively. 8.4% and 19.4 % of respondents reported that they used Buddhist psychotherapy and STST “frequently” and “very frequently” respectively.



**Figure 3. Types of psychotherapies used by child and adolescent psychiatrists**

Table 3 summarizes respondent responses to identifying obstacles in providing psychotherapies.

Variable	N (%)
Have to treat many patients and do not have time for psychotherapy	67 (72.8)
Have many other duties and responsibilities and do not have time for psychotherapy	63 (68.5)
Patients refuse psychotherapy	34 (37.0)
Not confident with psychotherapy skills	29 (31.5)
Psychotherapy is time-consuming and takes a long time to achieve therapeutic results in patients	19 (20.7)
Psychotherapy training experience during residency was not sufficient	18 (19.6)
Lack of psychotherapy supervisors	17 (18.5)
Being of the opinion that psychotherapy is less effective than medication	9 (9.8)
Being of the opinion that forming good therapeutic relationships is more important than performing specific types of psychotherapy	9 (9.8)
Not receiving payment for doing psychotherapy	7 (7.6)
Others	5 (6.0)

**Discussion**

Although psychotherapy is considered an essential treatment modality in child and adolescent psychiatry practice, child and

adolescent psychiatrists in Thailand provide psychotherapy to the only small number of patients, which is similar to other studies in the USA showing a decrease trend toward the provision of psychotherapy by psychiatrists

and a smaller proportion of psychotherapy visits when compared to psychotropic medication's visits [17, 24, 25, 40]. Child psychiatrists considered that  $36.3 \pm 24.0$  % of their patients would have benefited from psychotherapy, but they only provided psychotherapy for  $5.1 \pm 8.6$  patients/ week in the past year. Instead of psychotherapy, they provided mostly counseling and parenting advice and guidance/ PMT, which is less time-consuming.

The average OPD number of hours for child and adolescent psychiatrists who responded to this survey was  $14.3 \pm 9.3$  hours/week. Respondents also provided care for psychiatric in-patients with IPD hours of  $2.0 \pm 3.1$  hours/week. Some also provided consultation-liaison to pediatric units with consultation hours of  $5.58 \pm 9.4$  hours/week. When comparing the number of hours worked with a US study that found the average working hour of American early-career child and adolescent psychiatrists was 43.5 hours /week [40], one could argue that child and adolescent psychiatrists in Thailand work less clinical hours. However, due to the shortage of allied mental health professionals and lack of public understanding about mental illnesses in children and adolescents, child and adolescent psychiatrists often assume leadership public health roles in promoting mental health and preventing mental illnesses through other works such as liaison with school mental health systems and raising public awareness and policy-making in ways that are not captured by this study. In reality, a child and adolescent psychiatrist in Thailand typically spent six long working days a week doing a variety of tasks in addition to direct clinical care. Moreover, the present study surveyed all children and adolescent psychiatrists working in Thailand, including senior ones. This might explain in part the lower number of clinical hours reported since senior psychiatrists usually provide fewer clinical hours and are involved more with other responsibilities such as teaching, policy-making and conducting research.

Although there is no data determining the total amount of child and adolescent psychiatric patients, the number of children in Thailand under the age of 15 and between 15 -19 years old in 2014 was 11,699,299 and 4,669,627

respectively [41]. With only 176 child psychiatrists available, the service rate availability for the subspecialty is 1.08/100,000 children and adolescents. Under-service is aggravated by an uneven geographic distribution, with almost half of the child and adolescent psychiatrists in Thailand located in Bangkok. Heavy workload plus other non-clinical responsibilities are reported in the present study to be major obstacles in performing psychotherapy. This reflects not only the shortage of child and adolescent psychiatrists but also that of allied mental health professionals in Thailand, a situation faced by other Asian and African countries as well [42, 43].

It is reasonable to conclude that efficacy and availability of psychotropic medications might play a role on time spent with patients, shunting child psychiatrists away from performing psychotherapy because it is less time consuming. Other main obstacles in performing psychotherapy are lack of readiness of patients and lack of confidence by child and adolescent psychiatrists. The lack of readiness of patients might reflect the low public understanding about mental illnesses and benefits of psychotherapy, and the possible fear of stigmatization. [44-47]. One possible additional reason aggravating this scenario could be that there is no organization in Thailand that devotes efforts to promote psychotherapy to the general public. Moreover, the lack of confidence raised a question about the quality and adequacy of psychotherapy training in residency.

Our findings are partially different from what happens in the USA, where low financial incentive, insurance policy and managed care are thought to be possible causes of the decreased trend in performing psychotherapy by psychiatrists [16, 23]. Our results lead us to conclude that increasing the number of the child and adolescent psychiatrists and allied mental health professionals workforce, raising the appreciation of general public about psychotherapy, and improving standards of psychotherapy training can lead the way in enhancing the provision of psychotherapy in Thailand.

In terms of conceptual frameworks preferred for formulating cases, the three most



commonly used are learning and cognitive theory, Eriksonian theory and attachment theory. These are concordant with understanding child psychological development and provide familiar and useful ways to frame how child and adolescent psychiatrists to think about their patients.

In terms of types of psychotherapies, most child and adolescent psychiatrists in Thailand use behavioral therapy, supportive psychotherapy and cognitive-behavioral therapy. Our perception is that this occurs as a result of greater access to training of these particular modalities during residency as required by the RCPT [37]. Group psychotherapy, psychodynamic psychotherapy, interpersonal psychotherapy, mindfulness-based psychotherapy, positive psychology and family therapy were reported to be used less frequently than what the investigators expected.

This study is significant in that it is the first to reach out to all the child and adolescent psychiatrists at a national level examining psychotherapy practice in Thailand. Although the response rate is robust by some research standards, it was below what the Thai authors expected and should be considered a major limitation of this study. Generalizing findings from our study must be done cautiously due to the response rate, a questionnaire design that did not capture all nuances of practice patterns, and self-selection bias. We hope that the data provided by this research will begin a dialogue to help to identify the problems faced by the child and adolescent psychiatrists in Thailand, and help understand the obstacles preventing psychotherapy practices. We hope that our efforts will encourage more research in this area, locally in Thailand and in neighboring Southeast Asian countries, as well as in other underserved child and adolescent psychiatry communities.

## **Conclusions**

Child and adolescent psychiatrists in Thailand provide psychotherapy to the only small number of patients. Behavioral therapy, supportive psychotherapy and cognitive-behavioral therapy were the most frequently used psychotherapies by Thai child and adolescent psychiatrists. Lack of time due to

heavy workload was the most common obstacle in performing psychotherapy. We believe more studies on this area, especially in underserved communities are needed. Data from this study brings insights that can possibly help improve psychotherapy training. Additionally, our study reinforces the importance of having an adequate number of mental health professionals fulfill the mental health needs of Thailand.

## **Competing interests**

None of the authors have any competing interests.

## **Authors contributions**

NC and SH conceived the idea, designed the study, collected data, performed the statistical analysis and interpretation of data and drafted the manuscript. CA and SW assisted in the design of a survey and critically reviewed the manuscript. All authors contributed to writing, read and approved the final manuscript.

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