Mental Health and Quality of Life among Thai Psychiatrists

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Objective: *To survey the mental health and quality of life among Thai psychiatrists.*
Material and Method: *This cross-sectional descriptive study included all Thai psychiatrists. The postal survey was mailed out to all psychiatrists. The questionnaires consisted of three parts: demographic data, the WHO Quality of Life-BREF-Thai version and the Symptom Checklist 90-Revised-Thai edition. Correlation analysis was set up at 95% confident interval and $p<0.05$.*
Results: *Response rate was 28% from all 650 psychiatrists. The respondents described normal state of mental health but female psychiatrists had tended more to suppress the psychological symptoms than male psychiatrists. The mental problem that might most disturb male psychiatrists under stress condition was obsessive-compulsive symptoms. Female psychiatrists tended to be disturbed when distressed by (1) anxiety, (2) somatization, (3) phobia, (4) depression, and (5) paranoia, respectively. The quality of life (QOL) of most psychiatrists was in the average level (77.5%). The older (>40 years old) psychiatrists had higher QOL than younger psychiatrists significantly ($p = 0.027$). QOL correlated significantly with not getting enough support from work place ($p = 0.007$), colleagues ($p = 0.026$), lack of consultancy ($p = 0.011$) and low job satisfaction ($p = 0.007$). Better life quality in psychiatrists' group had better QOL in social relationships and satisfaction with the environment.*
Conclusion: *Thai psychiatrists had mental health status within normal range. Male psychiatrists had obsessive-compulsive traits in stress response, but female psychiatrists had anxiety and somatization traits. Thai psychiatrists' quality of life was on the average level and most of them satisfied with their QOL.*

Keywords: *Mental health, Quality of life, Psychiatrist*

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The mental health of psychiatrists in Thailand has never been surveyed before[1-3]. Most among a few international researchers focused on the surveying psychiatrists' burnout more than mental health or quality of life. Society expects Psychiatrists to have good mental health because they have to serve the mentally ill. However, studies in Thailand[1,3] found that the main cause of psychiatrists' suicide was the inability to deal with problems in their own lives.

The prevalence rate of abnormal mental health of Thai Physicians in 2004 was 7.4 percent. It was also determined that there was significant negative association between the mental health and their career satisfaction and sedative use in the past 6 months[1]. Most of Thai Physicians did not drink alcohol or drank occasionally; only 9.0% of them drank regularly. The percentage of physicians who had smoked since they were medical students was 2.7. 15% of them committed suicide, which was the second cause of death after an accident[2]. The study focused on 18 Thai doctors who had committed suicide before January 2002, composed of 17 males and one female. Two of them were psychiatrists; which means that the psychiatrist's rate would be more prevalent than other kinds of specialists when compared with the number of psychiatrist in Thailand[3]. Another interesting study was Balon R's[4] which showed that the attitude of 830 psychiatrists in Michigan who treated their own depression, 43% of the respondents themselves, determined to treat and dispense medicine if depression symptoms were mild or moderate and 7% of the respondents still insisted treating themselves even if their depression symptoms were severe. In addition, even if they had suicidal thoughts, the number of psychiatrists who chose to treat themselves was up to 50%. David H. Rosen's study in 1973[5] found that psychiatrists had a rate of suicide of 58 to 65/100,000 which was higher than the general population (11/100,000) and commented that suicide rate was reported lower than reality.

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Schernhammer ES [6] studied the physician's suicide rate via meta-analysis and systematic quality assessment by gathering information from research since BC 1960. He found the male suicide rate was 1.41 times higher than the general population at a confidence of 95%, and 2.27 times higher than the general population at a confidence of 95% in females. Schernhammer ES[7] also found that drug abuse was related to a doctor's expertise especially psychiatrists, anesthesiologists and emergency internists.

The quality of life of psychiatrists in Thailand has never before been surveyed.

Material and Method

The present study has been approved by Human Ethics Research Committee of Faculty of Medicine, Thammasat University No. MTU-PS-9-CR004-004/53.

Study design and Participants

A cross-sectional descriptive study was designed to survey the mental health and quality of life (QOL) among Thai psychiatrists. The population was 650 psychiatrists who are members of the Royal College of Psychiatrists of Thailand.

Data collection

The questionnaires were first mailed out to all 650 psychiatrists in the country. Three weeks after they were sent, the same 650 questionaires were sent it again. The participants were informed not to reply to the second one if they had already answered and returned the first one.

Measures

There were three parts in the questionnaires which were: demographic data, the Symptom Checklist 90-Revised-Thai edition (SCL-90-R-Thai edition)[9] and the WHO Quality of Life-BREF-Thai version (WHOQOL-BREF-THAI)[12].

The SCL-90-R Thai edition was interpreted and validated[9] from the Symptom Checklist-90-R (SCL-90-R). The reasons for selecting this instrument were Thai Psychiatrist were not familiar with the test questions; besides, the test is one of the most widely used measures of psychological distress in clinical practice and research. A relatively brief self-report psychometric questionnaire was designed to evaluate a broad range of psychological problems and symptoms of psychopathology. It is aimed on individuals 13 years and older. It consists of 90 items and takes 12-15 minutes to administer, yielding nine scores along primary symptom dimensions and three scores among global distress indices. Each score was calculated by using T score formula. The primary symptoms,which were assessed first, were somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, psychoticism. The "additional items" category helped the researcher to assess other aspects of the symptoms (e.g. item 19, "poor appetite"). The three indices were global wellness indices, hardiness, and free symptom[10]. The SCL-90-R Thai edition has expert face validity and a satisfactory overall internal reliability with co-efficiency of 0.98 (0.97 for the psychiatric patients and 0.96 for the non-patients)[9].

WHOQOL-BREF-THAI is the QOL assessment in Thai. The participants completed it themselves and sent it back within 2 weeks. The questions consisted of two types of perceived objective and subjective reports. This instrument was interpreted and validated from the WHOQOL instruments that were developed with the collaboration with a number of centers worldwide, and have been widely field-tested[10]. The information of the QOL had been collected and considered in 4 aspects, which were (1) physical domain, (2) psychological domain, (3) social relationships and (4) environment. Then, it was interpreted in three scoring ranges, which were well, mid and low life quality compared with the general population[11]. WHOQOL-BREF-THAI has reliability score of 0.65 ($p<0.01$)[12].

Statistical analysis

The researchers used SPSS version 16.0 to perform the descriptive statistics analysis, which included frequency, percentage, mean, standard deviation and 95% confident interval (95%CI) and statistical significance were set at $p<0.05$. An independent t-test was used to determine the difference in quality of QOL and each other demographic factor and work attitude. One way ANOVA used to analyze the differences between QOL and work data. The correlation between QOL and workload was analyzed by using Pearson correlation. Pearson's Chi-squared test was used to determine the relationship between subdomain of QOL and psychiatrist group in difference level of QOL.

Results

Demographic data

The ratio of Thai responding psychiatrists to

the total was 182: 650 or 28%, of which there were males 48.4 % and females 51.6%; general psychiatrist 81.3% and child and adolescence psychiatrist 18.7%. Their age range was 28-80 years old with the average age was 41.7 years old ±12.1 SD (Table 1). 183 psychiatrists returned questionnaires, but one female psychiatrist replied by returning only SCL-90-R Thai edition.

Work data

Data about workplace, experience, workload, work description is showen in Table 1.

Mental health status

183 psychiatrists of 650 returned form SCL-90-R Thai edition questionnaires (28.2%). The respondents' symptom profile reveals a pattern and magnitude to be considered in the Adult's non-clinical range. The study found that the distribution of the pathological scores was in all nine traits in both sexes and the scores were at normal levels. The GSI scores in both male and female psychiatrists were negative-negative. Mean of t-score of global sensitivity index (TGSI) in male and female psychiatrists were 37.99 and

Table 1. Demographic characteristics and work information of respondents

Demographic variables (n = 182)	No. (%)
Sex	
Male	88 (48.4)
Female	94 (51.6)
Age (year)	
0-40	98 (53.8)
>40	84 (46.2)
Marital status	
Single	72 (39.6)
Married	105 (57.7)
Separate/divorce	5 (2.7)
Specialties	
General psychiatrist	148 (81.3)
Child & adolescent psychiatrist	34 (18.7)
Work organization	Mean No. of psychiatrists (%)
Government	
Mental health institute/hospital	58 (31.9)
General hospital	45 (24.7)
Medical school hospital	42 (23.1)
Private	
Mental hospital/clinic	37 (20.3)
Experience: work as	Mean (years) (SD)
GP before psychiatric training	2.3 (2.5)
Psychiatrist	12.2 (11.0)
Workload	Mean (hours/week) (SD)
Full-time working in official time	34.0 (11.8)
Duty hours	22.0 (38.4)
Part-time working hours	7.1 (8.6)
Work description	Mean (hours/week) (SD)
OPD	14.9 (1.2)
Teaching	3.5 (4.5)
Research	1.4 (2.6)
Executive	4.4 (7.1)
Average of amount of outpatients in full-time working hour (patients/week)	79.8 persons/week (68.5 SD)
Work about took care of severe patients in inpatient department (IPD)	Mean No. of psychiatrists (%)
No. of psychiatrist who had attempted suicide patient within last 1 year	101 (55.5)
No. of psychiatrist who had committed suicide patient within last 1 year	39 (21.4)
No. of psychiatrist who had violence patient within last 1 year	32 (17.6)

33.97, respectively. There is no clinically significant evidence of psychiatric problem in clinical ranges presented in psychiatrist respondents' protocol (Table 2).

Quality of life (QOL)

The majority of Thai psychiatrists had a subjective view that they had good QOL (57.7%) whereas the results from WHOQOL-BREF-THAI indicated that the majority of Thai psychiatrists had middle level in overview of QOL when compared with the general population (77.5%). Psychiatrists' group which had better QOL than general population, had better QOL in social relationship and satisfaction with the environment domain than psychiatrists' group which had average QOL at $\chi^2 = 214.01$, $p = 0.000$ (Table 3).

Statistics analysis the difference between demographic and work data with QOL

Study found that psychiatrists who were 40 years old and older had better QOL than younger psychiatrists, significantly at $p<0.05$, but there were no differences in QOL in sex, marital status and specialty. The result showed no significant differences between QOL and work organization ($p<0.227$). There were no significant correlations in the QOL and workload (Table 4).

Quality of life and the work attitude (Table 5)

The results showed that psychiatrists who felt that they got enough support from their workplaces had a significantly better QOL than those who did not get enough support.

Psychiatrists did not get support enough from their workplaces or colleagues had significantly lower average score in overall QOL than those who had enough support at $p = 0.007$, t = -2.714 and $p = 0.026$, t = -2.245 respectively.

Psychiatrists who did not have any consultant when they had problems in their work had significantly lower average score in overall QOL than those who had some advisors at $p = 0.011$, t = -2.584.

Psychiatrists who were dissatisfied/very dissatisfied with their work had lower average scores in overall QOL than those who are satisfied with the statistical significance at $p = 0.007$, t = -2.726.

However, there is no difference in overall QOL in both psychiatrists who thought and not thought to stop working as a psychiatrist with the statistical significance ($p = 0.880$, t = -0.151).

Discussion

The mental health of Thai psychiatrists

The study found that both Thai male and female psychiatrists had normal mental health.

T-scores of the global sensitivity index (TGSI)

Table 2. Nine primary symptom dimentions and three indices in Thai psychiatrists

Variables	Mean of T score (T) (SD)	
	Male psychiatrists (n = 88)	Female psychiatrists (n = 95)
SCL-90-R scales		
Somatization (SOM)	46.82 (8.24)	45.82 (7.79)*
Obsessive-compulsive (OC)	52.78 (8.07)*	51.48 (8.15)
Interpersonal sensitivity (IS)	50.88 (8.43)	49.06 (7.96)
Depression (DEP)	48.82 (8.67)	46.31 (8.67)*
Anxiety (ANX)	47.08 (7.33)	44.57 (7.53)*
Hostility (HOS)	50.13 (8.27)	48.73 (7.49)
Phobic anxiety (PHOB)	48.60 (4.86)	46.12 (4.91)*
Paranoid ideation (PAR)	48.35 (7.91)	46.92 (7.37)*
Psychotism (PSY)	49.91 (8.29)	49.21 (7.85)
Three indices		
Global sentivity index (GSI)	37.99 (4.73)	33.93 (5.07)
Positive symptom distress index (PSDI)	40.00 (0.00)	37.00 (0.00)
Positive symptom total (PST)	48.72 (1.04)	45.88 (1.03)

* Out of normal range of T score range

Table 3. Quality of life (QOL) in overview and each subdomain in Thai psychiatrist

Attitude questions	Level of quality of life (%)				
Subjective view in their own quality of life (mean 4.0, SD 0.7)	Very poor	Poor	Middle	Good	Very good
	0 (0)	1 (0.5)	34 (18.7)	105 (57.7)	42 (23.1)
Satisfaction with their health (mean 3.64, SD 0.9)	Very dissatisfied	Dissatisfied	Neutral	Satisfied	Very satisfied
	4 (2.2)	9 (4.9)	58 (31.9)	87 (47.8)	24 (13.2)

WHOQOL-BREF-THAI	Poorer than general population (PGP) n (%)	Equal general population (EGP) n (%)	Better than general population (BGP) n (%)
QOL, physical domain (mean 23.1, SD 2.6)	0 (0)	165 (90.7)	17 (9.3)
QOL, psychological domain (mean 21.9, SD 2.8)	1 (0.5)	100 (54.9)	81 (44.5)
QOL, social relationship domain (mean 12.1, SD 1.8)	1 (0.5)	57 (31.3)	124 (68.1)
QOL, satisfaction with the environment domain (mean 31.0, SD 3.9)	0 (0)	57 (31.3)	125 (68.7)
QOL, overview (mean 88.2, SD 9.6)	1 (0.5)	141 (77.5)	40 (22.0)

Level of QOL	4 domains of QOL				χ^2	*p*-value
	Physical (n)	Psycho logical (n)	Social relationship (n)	Environ mental (n)		
Equal general population (EGP)	165	100	57	57	214.01	0.000
Better than general population (BGP)	17	81	124	125		
Total	182	181*	181*	182		

* A PGP psychiatrist group had poorer psychological and social relationship domain of QOL and that was too less to include in Pearson chi square

is the best single index score as an indicator of significant distress levels and hidden potential for mental health disorders.

The TGSI score in male psychiatrists was negative-negative, which referred to unclear presentation of a full-blown disorder or referring to their effort to hide the disorder even if it could slightly disturb their mental health. T-scores in obsessive-compulsive dimensions were the highest scores found in male psychiatrists. In distress condition, male psychiatrists tended to be disturbed by obsessive-compulsive symptoms (TOC = 52.78) that are found in obsessive-compulsive disorder. The symptoms, which might be found, were repetitive, intrusive or unwanted thoughts, impulses, actions and ego-alien.

The TGSI score in female psychiatrists was negative-negative as with male psychiatrists. However, the TGSI in female psychiatrists indicated that female psychiatrists tended to suppress more or hide the symptoms than male psychiatrists in a significant manner, at df = 181, t = 5.58, $p<0.001$, 95% CI; 2.62, 5.49.

The psychiatric problem that might most disturb female psychiatrists under stress condition were anxiety (TANX 44.56) features as founded in generalized anxiety disorder. The symptoms were nervousness, tension, panic attacks and trembling. The secondary problem was the somatization (TSOM 45.82) whose symptoms were perceptions of bodily dysfunction, autonomic nervous system and complaints focusing on cardiovascular, gastrointestinal,

Table 4. Relationship between quality of life, demographic data, work organization and workload

Demographic variables	n	Mean of QOL in overview (SD)	t	*p*-value
Sex				
Male	88	87.30 (9.6)	-1.1850	0.238
Female	94	88.90 (9.6)		
Age				
≤40 years old	98	86.70 (9.9)	-2.2310	0.027*
>40 years old	84	89.90 (9.0)		
Mental status				
Single/divorce/separate	76	87.10 (9.4)	-0.1518	0.131
Married	104	89.20 (9.6)		
Specialties				
General psychiatrist	147	16.15 (10.9)	-0.2390	0.811
Child & adolescent psychiatrist	34	16.65 (11.4)		

Work organization	n (persons)	Mean of QOL in overview (SD)	F	*p*-value
Medical school hospital	41	90.50 (9.7)	1.462	0.227
Mental health institute/hospital	57	86.80 (9.8)		
General hospital	45	87.60 (9.7)		
Private mental hospital/clinic	36	89.40 (8.6)		

Workload	QOL in overview	
	Correlation (r)	*p*-value
Work as psychiatrist	0.137	0.065
Teaching hours	0.128	0.085
Research hours	0.111	0.137
Executive working hours	0.059	0.430
Amount of violence patients	0.030	0.686
Amount of outpatients in full-time working hour	0.024	0.744
Amount of committed suicide patients	0.013	0.859
Duty hours	0.005	0.944
Part-time working hours	-0.015	0.841
Outpatient service working hours	-0.016	0.832
Full-time working in official time	-0.046	0.540
Amount of attempted suicide patients	-0.097	0.191

* $p<0.05$

respiratory, neurological and other systems including pain and discomfort of the gross musculature and other somatic equivalents of anxiety. The tertiary problem was a phobia syndrome (TPHOB 46.12) as in phobic disorders. The symptoms were the persistent fear response to a specific person, place, object or situation, which was disproportionate to any actual threat, and led to avoidance or escape behavior. The symptoms were the persistent fear response to a specific person, place, object or situation, which was disproportionate to any actual threat, and led to avoidance or escape behavior. The final problem was paranoid (TPAR 46.92) symptoms as featured founded as in a thinking disorder. The cardinal characteristics of this problem were projective thought, hostility, suspiciousness, grandiosity, centrality, fear of loss of autonomy and delusion. The quaternary problem was depression (TDEP 46.31) which might present a dysphoric mood, signs of withdrawal of life interest, lack of motivation, loss of vital energy, and hopelessness.

Table 5. The difference in quality of life and work attitude

Variables	n	Mean of QOL in overview	SD	t	*p*-value
Support from agency e.g. fund, fringe benefit, promotion, staffing					
Not enough	87	86.2	9.2	-2.714	0.007**
Enough	95	90.0	9.6		
Support from colleague					
Not enough	36	85.0	9.7	-2.245	0.026*
Enough	146	89.0	9.4		
Having advisor coach when face the problem					
Not enough	45	85.0	9.0	-2.584	0.011*
Enough	137	89.2	9.6		
Satisfaction of working					
Satisfied/very satisfied	34	84.2	9.5	-2.726	0.007**
Dissatisfied/very dissatisfied	148	89.1	9.4		
Thinking to stop working as psychiatrists within last 1 year					
No	154	88.1	9.7	-0.151	0.880
Yes	28	88.4	9.1		

* $p<0.05$, ** $p<0.01$

The present study corresponded to Jiongjiong Wang's study[13] which indicated that both male and female had different ways to respond to stress and this helped to explain the anxiety and depression in these genders. Male and female have different brain functioning when faced with a stressful situation. The male's response was "fight-or-flight" so the male chose to confront a stressor by either overcoming or fleeing it. The result of the increasing cortisol hormone in hypothalamic-pituitary-adrenal (HPA) axis caused the male's doing the wrong thing repeatedly. This behavior was also found to go along with the increasing cerebral blood flow around the right prefrontal cortex, but the cerebral blood flow was decreasing around the left orbitofrontal cortex-part of the brain which was concerned with a obsessive-compulsive tendency. For the female, the temporal profiles were more than the male's so the female's response was "tend-and-befriend". They preferred to nurture an offspring and to affiliate with social groups. It also found that the function of the limbic system was more stimulated. The female's brain response was stronger than male's because the female's brain was going to respond to stress longer than the male's[13]. Correspondingly, female psychiatrists displayed a rate of anxiety and depression which exceeded male psychiatrists, 2:1. The psychiatric problems found when the female psychiatrists were under stress were anxiety, phobia, depression, and somatization.

However, the present study of the mental status aspect of Thai psychiatrists found that there were only 27.8% of the psychiatrists who replied to the questionnaires so that it could not be the best sample of all psychiatrists in the country. Moreover, the title of the study aimed at mental health might have caused responders to have some bias in answering the questions or they did not honestly answer their real mental health status. The psychiatrists who had a major psychiatric disorder might not be comfortable in answering the questionnaire. However, it was assumed that those who responded were the psychiatrists who worked as mental health professionals.

The SCL-90-R instrument has high accuracy in indicating current symptoms, this study showed that Thai psychiatrists' mental health was normal; however. It could not predict from the overall images of the past or future images that respondents could/would have a mental problem or not. Therefore, if the psychiatrists, who answered the questionnaires, were in the implicit psychiatric symptom period they could not identify the disorders. Therefore, this specific study and with regard to the disorders found in psychiatrists were for example anxiety, obsessive- compulsive, phobia, depression, and somatization. It also included adding

some questions about the experience of each psychiatrist who was diagnosed with a psychiatric disorder or took psycho-pharmaceutical medications by themselves or through other mental health professionals. This would give more precise mental status to psychiatrists.

Life quality and other factors concerning with Thai psychiatrists

The evaluation of WHOQOL-BREF-THAI questionnaire showed that the life quality level, all 4 aspects, of Thai psychiatrists compared with Thai people was at the moderate level (77.5%). This result was similar to the previous study about QOL of Thai female physicians[8] that found that most female physicians had fair to good QOL scores.

However, the subjective questions for Thai psychiatrists mostly determined by themselves that they had a good life quality (57.7%) which was higher than the actual figure, which was analyzed by WHOQOL-BREF-THAI. This attitude toward life might affect positively on their lifestyle and lessen their mental health problems.

Even though the evaluation of their life quality in physical health was in the moderate level (90.7%), only 47.8% of all psychiatrists were satisfied with their health. Their health satisfaction level was scored from "much dissatisfied" to "the most dissatisfied" only 7.1%; the WHOQOL-BREF-THAI evaluation did not find any Thai psychiatrists who had bad physical problems (0%). Possibly Thai psychiatrists paid more attention to their physical health than the general public.

The study found that the most psychiatrists (54.9%) displayed a life quality with regard to mental health aspects very similar to that of the general Thai public, 44.5% of psychiatrists displayed this aspect to be better than others. Only 0.5% psychiatrists had bad mental quality.

When analyzing the relationship of overall life quality of Thai psychiatrists with demographic data factors, it showed that those who were 40 years old or younger had a worse life quality than those who were older than 40.

The study results found that the views of psychiatrists-who felt that they were not getting support from their institutes or colleagues including the feeling of having no advisor when they had working problems or were dissatisfied-could cause their overall life quality to be significantly worse than the opposite group.

Better life quality in psychiatrists' group had better QOL in social relationship and satisfaction with the environment than psychiatrists' group who had QOL equal to the general population. The present study indicated that social relationship and satisfaction with the environment were important factors, which affected psychiatrists' QOL more than physical and psychological health. Satisfaction with the environment means financial resources, freedom, physical safety and security, health and social care, home environment, opportunities for acquiring new information and skills, participation in and opportunities for recreation/leisure activities, physical environment (pollution/noise/traffic/climate) and transportation. The result of this study may provide the data for the next development of the psychiatrists' life quality by adapting the social relationship and environment. However, this research found that psychiatrists' life quality was not related to their work organizations, which were located in difference regions and various inconvenient environments. However, QOL related to social relationship and their feeling that they were not getting support from their institutes or colleagues. The author hypothesized that convenience and a safe work place's environment were not probable reasons that psychiatrists chose to work; whereas social relationship in the work place might carry more influence.

Conclusion

There was no clinically significant evidence of psychiatric symptoms presented in both male and female psychiatrist respondents. Male psychiatrists revealed little evidence of psychological distress associated with obsessive-compulsive symptoms whereas female psychiatrists revealed evidences of psychological distress associated with anxiety, somatization, phobia, depression and paranoid. The majority of Thai psychiatrist respondents had a middle class quality of life.

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Potential conflicts of interest

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ภาวะสุขภาพจิตและคุณภาพชีวิตของจิตแพทย์ไทย

ลำพู โกศัลวิทย์

วัตถุประสงค์: *เพื่อสำรวจคุณภาพชีวิตและภาวะสุขภาพจิตของจิตแพทย์ไทย*

วัสดุและวิธีการ: *เป็นการศึกษาเชิงพรรณนาแบบภาคตัดขวางโดยเก็บข้อมูลด้วยการส่งแบบสอบถามไปทางไปรษณีย์ถึงจิตแพทย์ทุกคนในประเทศไทย โดยใช้แบบสอบถามข้อมูลทั่วไป แบบทดสอบวัดสุขภาพจิตซิมตอมเช็กลิสท์-90-รีไวซ์ ฉบับภาษาไทย และแบบประเมินคุณภาพชีวิตขององค์การอนามัยโลก ชุดย่อ ฉบับภาษาไทย (WHOQOL-BREF-THAI) แล้ววิเคราะห์ความสัมพันธ์ด้วยสถิติเชิงอนุมาน ณ ค่าความเชื่อมั่นที่ ร้อยละ 95 และระดับนัยสำคัญ <0.05*

ผลการศึกษา: *จำนวนผู้ตอบแบบสอบถามร้อยละ 28 จากจิตแพทย์ทั้งสิ้น 650 ราย พบจิตแพทย์ไทยมีภาวะสุขภาพจิตอยู่ในเกณฑ์ปกติ แต่จิตแพทย์หญิงมีแนวโน้มเก็บซ่อนปัญหาสุขภาพจิตมากกว่าจิตแพทย์ชาย โดยจิตแพทย์ชายมีแนวโน้มที่จะเก็บซ่อนปัญหาสุขภาพจิตที่เกิดจากอาการย้ำคิดย้ำทำ-obsessive compulsive มากที่สุด จิตแพทย์หญิงมีแนวโน้มเก็บซ่อนปัญหาสุขภาพจิตที่จะแสดงออกและรบกวนเมื่อมีความเครียด คือ ความวิตกกังวล-anxiety การเจ็บป่วยทางกายที่มาจากสาเหตุทางจิตใจ-somatization ความกลัว-phobia อารมณ์เศร้า-depression และ ความระแวง-paranoid ตามลำดับ ผลสำรวจคุณภาพชีวิตพบว่าจิตแพทย์ส่วนใหญ่มีคุณภาพชีวิตโดยรวมอยู่ในระดับกลาง (ร้อยละ 77.5) เมื่อเทียบกับประชากรทั่วไป จิตแพทย์ที่มีอายุ >40 ปีมีคุณภาพชีวิตโดยรวมดีกว่าจิตแพทย์ที่อายุน้อยกว่า ($p = 0.027$) คุณภาพชีวิตของจิตแพทย์มีความสัมพันธ์อย่างมีนัยสำคัญทางสถิติกับความรู้สึกว่าได้รับการสนับสนุนทั้งจากหน่วยงาน ($p = 0.007$) จากเพื่อนร่วมงาน ($p = 0.026$) การมีที่ปรึกษาเมื่อมีปัญหาในการทำงาน ($p = 0.011$) และความรู้สึกพึงพอใจต่องานที่ทำ ($p = 0.007$) กลุ่มของจิตแพทย์ที่มีคุณภาพชีวิตดีกว่าประชากรทั่วไป พบว่ามีคุณภาพชีวิตที่ดีกว่าในด้านความสัมพันธภาพทางสังคมและสิ่งแวดล้อม*

สรุป: *ภาวะสุขภาพของจิตแพทย์ไทยอยู่ในระดับปกติ หากมีความเครียดจิตแพทย์ชายมีแนวโน้มเกิดจากปัญหาของอาการการย้ำคิดย้ำทำ ส่วนจิตแพทย์หญิงมีแนวโน้มเกิดปัญหาในด้านความวิตกกังวลและการเจ็บป่วยทางกายที่มาจากสาเหตุทางจิตใจ คุณภาพชีวิตของจิตแพทย์ไทยส่วนใหญ่อยู่ในระดับเท่ากับประชากรทั่วไปและจิตแพทย์ไทย ส่วนใหญ่มีความพึงพอใจต่อคุณภาพชีวิตของตนเอง*