Prevalence and Factors Predicting Depression among LGBTQ+ Adolescents in Southern Thailand: A Cross-Sectional Study

Montha Saithanwanitkul, Wipawan Chaoum Pensuksan, Saifon Aekwarangkoon*

Abstract: Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and other (LGBTQ+) adolescents face a higher risk of depression than their heterosexual and cisgender peers, necessitating targeted mental health interventions. This study examined the prevalence of depression and its associated factors among LGBTQ+ adolescents in Southern Thailand, using the Minority Stress Model as a framework to explain how chronic stressors contribute to mental health disparities in this population. Specifically, it explored the association of distal stressors, such as bullying, discrimination, and family relationships, as well as proximal stressors including self-esteem and gender identity confidence, with depression. A cross-sectional study was conducted among 958 adolescents aged 13–18 who openly identified as LGBTQ+. Participants were recruited from four secondary schools through stratified random sampling from the Secondary Educational Service Area Office 11. Data were collected using the Patient Health Questionnaire for Adolescents, the Rosenberg's Self-Esteem Scale, the Experience of Discrimination Scale, and the Revised Olweus Bully/Victim Questionnaire. Analyses included descriptive statistics, Spearman's rank correlation test, and ordinal logistic regression.

Results showed that 84.8% of participants experienced depressive symptoms ranging from mild to severe. Low self-esteem emerged as a significant risk factor, while supportive family relationships served as a protective factor. These findings underscore the high prevalence of depression in this population and the need to strengthen self-esteem, promote family acceptance, and implement inclusive school and community policies. Culturally sensitive, trauma-informed nursing interventions can reduce mental health disparities and promote resilience among LGBTQ+ adolescents in Thailand and similar contexts by fostering self-esteem, strengthening family support, and promoting inclusivity.

Keywords: Cross-sectional study, Depression, Family relationships, LGBTQ+ adolescents, Mental health, Self-esteem

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Montha Saithanwanitkul*, RN, MNS, FHEA, Assistant Professor, Division of Psychiatric and Mental Health Nursing, Faculty of Nursing, Suratthani Rajabhat University, 84100 Thailand. E-mail: montha.sai@sru.ac.th*

Correspondence to: Wipawan Chaoum Pensuksan*,* RN, PhD, SFHEA, Associate Professor, Division of Psychiatric and Mental Health Nursing, Faculty of Nursing, Suratthani Rajabhat University, 84100 Thailand. E-mail: wipawan.pen@sru.ac.th*

Saifon Aekwarangkoon*, RN, PhD, SFHEA, Associate Professor, Division of Psychiatric and Mental Health Nursing, School of Nursing, Walailak University, 80160 Thailand; Excellence Center of Community Health Promotion, Walailak University, 80160, Thailand. E-mail: asaifon@wu.ac.th*

Author contributions

MS: Principal investigator, conceptualization, method and design, tool development and validation, and support for data collection and analysis

WCP: Support for conceptualization, support for data collection, data analysis and interpretation, drafting the manuscript, revising the manuscript, editing the manuscript, and final approval of the submitted version

SA: Support for conceptualization, support for method and design, and revising the manuscript

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Introduction

LGBTQ+ adolescents face disproportionately high rates of depression and suicidality compared to their heterosexual and cisgender peers, primarily due to stigma, discrimination, and minority stress.[1-2] Research indicates that LGBTQ+ adolescents are more than three times as likely to experience depressive symptoms and twice as likely to engage in self-harm compared to their non-LGBTQ+ peers.[3] These disparities are exacerbated by structural and cultural factors, including family rejection, bullying, and unmet healthcare needs, all of which are strongly linked to poor mental health outcomes.[4-5] While protective policies and mental health resources in some Western countries have helped mitigate these risks, LGBTQ+ adolescents in socially conservative regions, including parts of Asia, continue to face greater psychological distress and barriers to accessing care.[3-4] The lack of affirming environments further exacerbates feelings of isolation and distress, increasing their vulnerability to depression and suicidality.[3,4] These trends highlight the urgent need for interventions that address these disparities and improve access to LGBTQ+ youth-friendly mental health services.

Recent studies further underscore the mental health challenges faced by LGBTQ+ adolescents globally. The Trevor Project's 2022 National Survey on LGBTQ+ Youth Mental Health reported that 45% of LGBTQ+ adolescents and youth in the United States seriously considered attempting suicide in the past year, emphasizing the severity of these risks.[6] In Thailand, high rates of depression, anxiety, suicidal thoughts, and self-harm have been reported, particularly among transmasculine and bisexual/pansexual individuals.[7] The lack of inclusive mental health services further limits access to timely care, making LGBTQ+ adolescents more vulnerable to long-term mental health challenges.[3,7] Addressing these barriers is essential to reducing stigma, promoting mental well-being, and ensuring equitable access to mental health services at both national and global levels.

This study was conducted in Southern Thailand, where adolescent mental health disparities are particularly concerning. Health Region (HR) 11 (Upper Southern Thailand) ranks fourth out of 13 health regions in adolescent depression prevalence at 20.2%. This rate is comparable to the highest-ranked regions, including HR 5 (25.0%), HR 7 (24.0%), and HR 13 (23.9%), and exceeds HR 12 (Lower Southern Thailand, 18.7%).[8] Furthermore, the Surat Thani Provincial Health Office, HR 11, reported a non-fatal suicide attempt rate of 47.5 per 100,000 people in 2024, an increase from 33.2 in 2022 and 36.8 in 2023.[9] Adolescents aged 15-19 years accounted for the majority of cases, with depression, a history of self-harm, and childhood trauma identified as key contributing factors.[9] These trends indicate a worsening mental health crisis among this population in the region, necessitating further investigation into the underlying factors contributing to adolescent depression in HR 11. Understanding these regional disparities is crucial for developing targeted mental health interventions that address the unique challenges faced by adolescents in Southern Thailand.

Building on these concerns, this study applied the Minority Stress Model[10] to examine the prevalence and predictors of depression among LGBTQ+ adolescents in Southern Thailand. Given the high rates of mental health challenges in this region, this research investigated the role of distal stressors, including bullying, discrimination, and family relationships, alongside proximal stressors, such as self-esteem and gender identity confidence. By identifying these key predictive factors, the study aimed to generate data-driven recommendations for mental health policies and interventions that are responsive to Thailand's sociocultural context and address the specific needs of LGBTQ+ adolescents.

Literature Review and Conceptual Framework

The Minority Stress Model provides a foundational framework for understanding mental health disparities among LGBTQ+ individuals.[10] It conceptualizes stressors as distal (external), including discrimination, bullying, victimization, and negative family relationships, or proximal (internal), such as concealment, internalized stigma, fear of rejection, and confidence in gender identity.[11-13] Family relationships may function as either a distal stressor when involving external rejection,[11-12] or a proximal stressor when contributing to internalized expectations.[12-13] Both types of stressors arise from societal marginalization and contribute to adverse mental health outcomes.[10-11] Collectively, these stressors significantly increase the risk of depression, anxiety, and suicidality, particularly among adolescents, who experience heightened societal regulation of gender and sexual identity during a critical period of identity formation.[14-15]

LGBTQ+ adolescents face heightened social stress in hostile cultural environments, with reduced support, greater rejection, and unmet healthcare needs contributing to poorer mental health.[5] Young sexual minorities experience as much or more minority stressors than older peers, facing stigma and discrimination at an earlier, more vulnerable stage, increasing their risk of depression and anxiety.[13] Depression, a pervasive mental health condition, is characterized by persistent sadness, loss of interest or pleasure, and impaired functioning lasting at least two weeks.[16-17] Beyond transient mood changes, untreated depression profoundly affects social and academic functioning, increasing the risk of suicide in severe cases. Among LGBTQ+ adolescents, depression is a prevalent outcome of minority stress, driven by exposure to discrimination, internalized stigma, and lack of support.[17]

According to the Minority Stress Model, developed by Meyer,[10] explains that depression arises from the cumulative impact of distal and proximal stressors. These stressors interact with psychological and social determinants, exacerbating vulnerability to depressive symptoms.[2,10] While the model has been widely applied in Western contexts, its use among LGBTQ+ adolescents in Thailand is limited, suggesting a need for further culturally sensitive research. Complementing this, a biopsychosocial perspective emphasizes that depression is influenced by biological, psychological, and social factors.[18] Biological determinants include genetic predisposition, stress response dysregulation, and hypothalamic-pituitary-adrenal axis dysfunction.[18] Psychological determinants, such as low self-esteem, negative self-concept, and neuroticism, contribute to the onset and persistence of depression.[19] Social determinants, including discrimination, lack of social support, adverse childhood ex periences, and risk behaviors like substance use, further exacerbate depressive symptoms.[17-18]

Understanding risk and protective factors is crucial for addressing the psychological impact of minority stress on LGBTQ+ adolescents.[19] Risk factors increase vulnerability to adverse mental health outcomes, while protective factors buffer against these risks and promote resilience.[20] In the context of the Minority Stress Model, risk factors such as family rejection, parental conflict, substance use, discrimination, bullying, victimization, and identity concealment compound stress and contribute to negative mental health outcomes among LGBTQ+ youth.[2] Conversely, protective factors like strong family acceptance, school and peer support, and LGBTQ+ community belonging

mitigate minority stress, enhance emotional well-being, and foster resilience by providing safe spaces and reducing the impact of discrimination and victimization.[2,17]

This study emphasized the significance of identifying both distal and proximal risk factors alongside protective factors to address mental health disparities among LGBTQ+ adolescents comprehensively. Implementing targeted interventions, including affirming social environments, identity-positive mental health support, and culturally tailored programs, fosters resilience and well-being in this vulnerable population. For this study, adolescence is defined as between 12 and 18 years old, as this period encompasses the biological and social changes traditionally associated with the teenage years.[20]

Study Aim, Research Questions, and Hypotheses

This study aimed to determine the prevalence of depression among LGBTQ+ adolescents in Southern Thailand and identify the key risk and protective factors influencing their mental health. Specifically, we sought to examine whether depression rates are higher among LGBTQ+ adolescents compared to the general adolescent population and explore the factors contributing to these disparities. To address these objectives, the study investigated the following questions: 1) What is the prevalence of depression among LGBTQ+ adolescents in Southern Thailand? and 2) What are the key risk and protective factors associated with depression in this population?

This study hypothesizes that 1) low self-esteem and a lack of confidence in gender identity are significant risk factors for depression, and 2) supportive family relationships, the absence of discrimination, and the lack of bullying serve as protective factors. Findings from this study will help bridge knowledge gaps and inform targeted interventions to reduce depression and promote mental well-being in this population.

Methods

Design: This report employed a descriptive cross-sectional study, and writing this report followed the guidelines in the STROBE Statement Checklist for cross-sectional studies.

Sample and Setting: The study occurred in four secondary schools affiliated with the Secondary Educational Service Area Office 11 (SESAO 11), Thailand. The inclusion criteria were: adolescents aged 12-18 years, and 2) identified and openly disclosed as LGBTQ+. Exclusion criteria included 1) adolescents with mental disorders requiring psychological therapy and 2) individuals facing language barriers or communication challenges.

The sample size for this study was determined using G*Power software (version 3.1), a z-test, and a priori power analysis for logistic regression. A 95% confidence interval and 80% power were applied. Accounting for a hypothetical 5% refusal rate, the minimum required sample size was 160 LGBTQ+ adolescents.

A stratified random sampling method ensured representativeness. The SESAO 11 oversees 66 national secondary schools across two provinces (Province A: 44 schools, Province B: 22 schools). Province A was randomly selected, and its schools were categorized into three areas (Area 1: 14 schools, Area 2: 17 schools, Area 3: 13 schools). Four schools were randomly selected to maintain proportional representation: two from Area 1 (including one extra-large school), and one each from Areas 2 and 3. A total of 4,808 adolescents participated, with 958 self-identifying as LGBTQ+ and completing all questionnaire items. Figure 1 illustrates the sampling process.

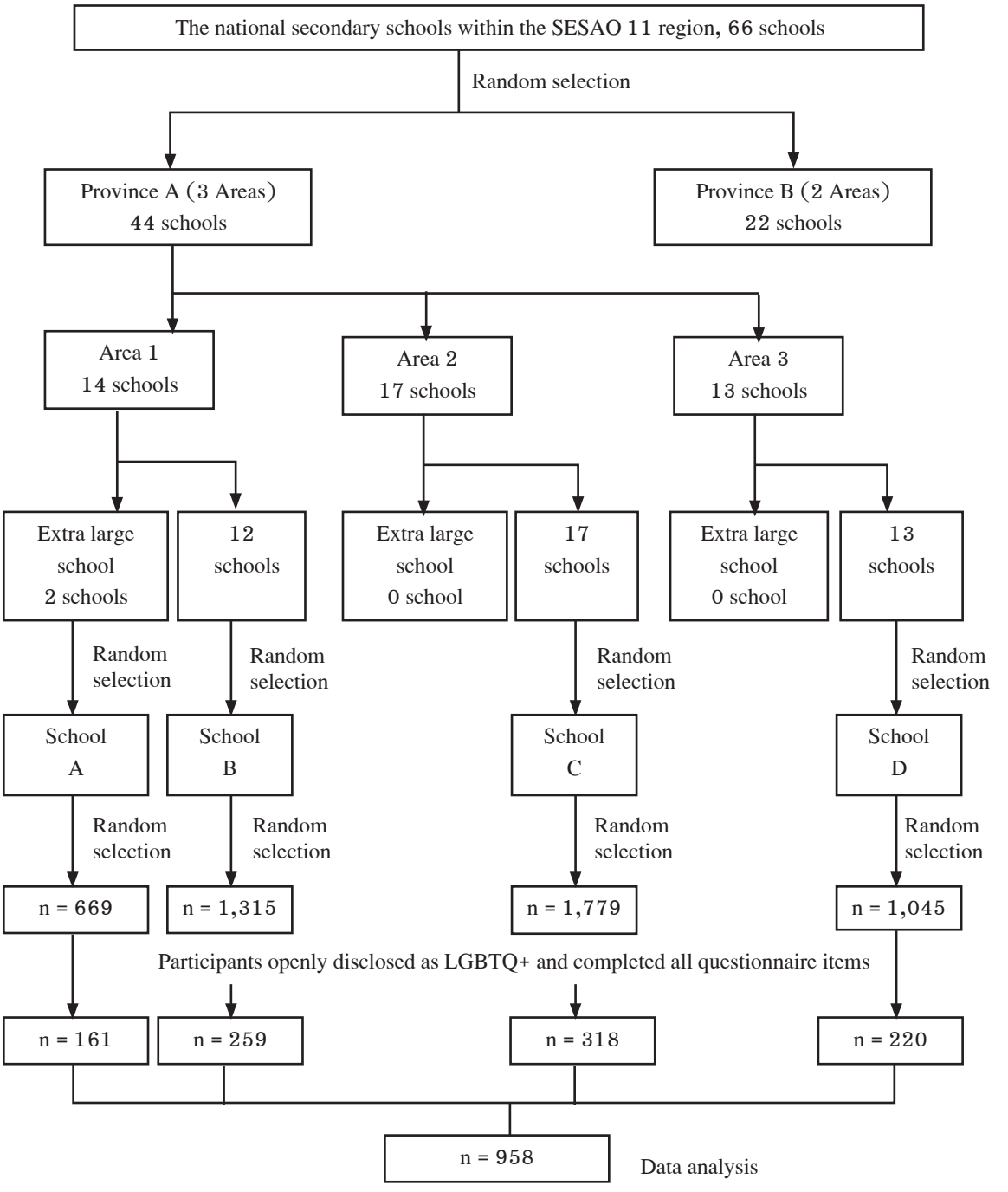

Figure 1. Stratified random sampling process for LGBTQ+ adolescents recruitment survey questionnaire

Ethical Considerations: This study adhered to ethical guidelines and received approval from the Human Research Ethics Committee (HREC) of Suratthani Rajabhat University following a Full Board Review (Approval No: SRU-EC2023/065), as it involved a vulnerable population—LGBTQ+ adolescents. Data collection was conducted among students in SESAO 11. All students were included, but only those who self-identified as LGBTQ+ in the personal data questionnaire were selected for analysis, as direct recruitment or interaction was restricted by the HREC for ethical reasons. Homeroom teachers informed participants and their parents about the study, and parents and teachers could contact the principal investigator (PI) directly with any questions. For participants under 18, parental consent was required. Informed consent was obtained through parent-teacher meetings, scheduled phone calls, and in-person discussions during student drop-offs and pickups. Parents provided written consent before their child's participation, while participants gave written assent before completing the questionnaire. This process ensured that parents and participants fully understood their rights and the study's purpose.

All data were anonymized to protect confidentiality, and no personally identifiable information was linked to participants' responses. Measures were in place to minimize potential risks, ensuring participants could engage in the study in a manner that respected their well-being. Additionally, information on available support resources was provided to participants should they require assistance after completing the study. Findings would be presented as a group report and used solely for academic purposes. Participation was voluntary, and students could withdraw at any time without explanation or consequences for their schooling.

The analysis was conducted in two parts: one on LGBTQ+ adolescents and the other on non-LGBTQ+ adolescents. This publication reports exclusively on data from LGBTQ+ adolescents. Titled Factors Predicting Depression Among LGBTQ+ Adolescents, this study aligns with the broader research project, while findings on non-LGBTQ+ adolescents would be presented separately.

Instruments: The data collection instruments were carefully selected to ensure thorough coverage of the key variables relevant to this study. They were organized into five parts, each designed to serve a specific purpose:

The Sociodemographic Data Questionnaire (Part I): The PI developed this to collect participants' essential personal and contextual information. It collected demographic information, including age, grade point average, confidence in gender identity, satisfaction with body image, family history of depression, quality of family relationships, quality of peer relationships, experiences of sexual abuse, substance use status, and history of suicide attempts.

The Patient Health Questionnaire for Adolescents (PHQ-A) (Part II): The Thai version of the PHQ-A, developed by Panyawong et al.,[21] is a validated self-report tool widely used to assess depression in adolescents aged 11 to 20 years.[8] The PHQ-A consists of nine items evaluating the frequency of experienced depressive symptoms over the past two weeks, with response options ranging from 0 (not at all) to 3 (nearly every day). For example, one item asks, "I feel down, irritable, or hopeless" to assess mood-related symptoms. Total scores range from 0 to 27, categorized into severity levels: minimal (0-4), mild (5-9), moderate (10-14), moderately severe (15-19), and severe (20-27).[21] The choice of the PHQ-A in this study was based on its extensive validation in adolescent populations and its reliability in the Thai context.[8,21] The tool enables standardized measurement of depression, facilitating comparisons across studies and enhancing the robustness of the findings. Panyawong et al. reported a Cronbach's alpha coefficient of 0.92,[21] indicating high internal consistency. In the pilot phase of this study, which included 30 LGBTQ+ adolescents with characteristics similar to the main sample, the PHQ-A demonstrated a Cronbach's alpha coefficient of 0.90. For the main study, the Cronbach's alpha coefficient was 0.88.

The Rosenberg's Self-Esteem Scale (RSES) (Part III): The RSES scale, developed by Rosenberg, is a widely validated instrument designed to measure self-esteem, particularly in adolescents.[22] For this study, the Thai version of the RSES, developed by Wongpakaran and Wongpakaran, was employed.[22] This 10-item scale includes statements such as "In general, I feel satisfied with myself" (positive) and "I often think that I am not good at all" (negative). Each item is rated on a 4-point Likert scale from 1 (strongly agree) to 4 (strongly disagree). Negative items are reverse-scored, with total scores ranging from 10 to 40; higher scores indicate better self-esteem. Self-esteem levels were categorized into three groups based on total scores: low (10–25), medium (26–29), and high (30–40).[22] These levels provide a standardized interpretation of self-esteem scores for individual response patterns. The RSES was chosen for its extensive validation and reliability across clinical and non-clinical populations, making it a robust tool for assessing self-esteem in this adolescent sample.[23] A prior study using the Thai version among high school students reported a Cronbach's alpha coefficient of 0.86.[23] In this study, the Thai version demonstrated internal consistency, with a Cronbach's alpha coefficient of 0.83 in the pilot study and 0.80 in the main study.

The Experience of Discrimination Scale (EOD) (Part IV): The Thai version of the 12-item EOD questionnaire, developed by Krieger et al.,[24] and adapted for the Thai context by Kittiteerasack et al.,[25] was employed to evaluate the discrimination experienced by LGBTQ+ individuals. The EOD measures discrimination across various settings, such as schools, workplaces, and public spaces. For example, one item asks, "Have you ever experienced discrimination in school settings?" Response options were 0 = No and 1 = Yes, with scores summed across all items. The total scores range from 0 to 12, with higher scores reflecting a greater number of situations in which the individual has experienced discrimination.[25] The EOD's inclusion in this study was based on its robust psychometric properties and relevance for understanding the impact of discrimination on mental health. The Thai version demonstrated internal consistency with a coefficient of 0.87 in validation studies.[25] Since the EOD questionnaire has no predefined cutoff point, the total score ranges from 0 to 12. For analysis purposes, the scores were categorized into two groups based on the score distribution: low (0–5) and high (6–12) experience of discrimination, with the mean score (M = 4.68) serving as a reference for the low category.[25] Additionally, continuous scores were presented to provide a more comprehensive understanding of the data. In the pilot phase, involving 30 LGBTQ+ adolescents from similar educational settings, the EOD demonstrated a Cronbach's alpha reliability coefficient of 0.88, reaching 0.90 in the main study.

The Revised Olweus Bully/Victim Questionnaire (OBVQ) (Part V), originally developed by Olweus[26] and adapted into Thai by Tapanya,[27] was employed in this study to assess bullying experiences among adolescents. The questionnaire consists of 39 items: 3 general questions, such as "Do you like your school?" and 36 items classified into two groups of bullying behavior patterns. The first group measures victimization behaviors (20 items), such as "I have been bullied by others." The second group assesses bullying behaviors (16 items), such as "I have used harmful words, called others names, or teased them in ways that caused pain or sadness."[27] This study focused solely on assessing victimization behaviors. A 5-point rating scale was used, with responses ranging from 1 (not happening for two months) to 5 (several times a week). This item has scores ranging from 0 to 5, with a score of 3 or more indicating that the respondent has experienced pure victim behavior.[28] In this study, the Thai version demonstrated internal consistency, with a Cronbach's alpha coefficient of 0.75 in the pilot study and 0.81 in the main study.

The content validity of all instruments in this study was assessed by three experts: a psychiatric nurse specializing in adolescent depression, a psychiatric nursing instructor specializing in adolescents, and

another psychiatric nursing instructor. The assessment yielded a Content Validity Index of 1.00 for all instruments. Permission to use these instruments was obtained through an official permission request letter from the Faculty of Nursing, Suratthani Rajabhat University.

Data Collection: Data were collected from September to October 2023. The principal investigator (PI) met with each school principal to explain the study's objectives, seek permission, and request cooperation for data collection. In accordance with the HREC's and school policies on adolescent gender identity, researchers were prohibited from directly interacting with students on this sensitive topic. At each school, a coordinating teacher, trained by the PI, collaborated with the PI and supported homeroom teachers, who were responsible for managing and supporting all students in a specific class throughout the academic year, in facilitating data collection during students' free time. Students completed self-administered questionnaires in their classrooms under the guidance of their homeroom teacher. Completing the questionnaires required approximately 30-45 minutes. Afterward, homeroom teachers reviewed the questionnaires for completeness and placed them in sealed envelopes for collection. Ultimately, 958 complete questionnaires were used for analysis.

Statistical Analysis: Descriptive statistics were used to summarize the demographic characteristics of the participants and key variables, with percentages calculated for each. Spearman's rank correlation coefficients were computed to assess relationships between all study variables and depression. All coefficients remained below 0.80, indicating no strong correlations that could suggest multicollinearity. Ordinal logistic regression analysis was conducted to identify factors predicting depression among LGBTQ+ adolescents. Associations were expressed as odds ratios (OR) with 95% confidence intervals (CI). An OR greater than 1 indicated increased odds of being classified at a higher level of depression, whereas an OR less than 1 indicated reduced odds. This regression approach does not assume a linear relationship between independent and dependent variables and does not require the dependent variable to meet assumptions of normality or homogeneity of variance.[29] All statistical analyses were performed using SPSS version 26, with statistical significance set at $p < 0.05$.

Results

A total of 958 LGBTQ+ adolescents who openly identified themselves participated in this study and completed the questionnaires collected from the coordinating teacher at each school.

Demographic characteristics of participants

As shown in **Table 1**, the study included 958 adolescents aged 13 to 18, with the majority (64.1%) in the 13-15 age group. Most participants had a grade point average of 3.00-4.00 and reported confidence in their gender identity (86.5%). Body image dissatisfaction was common (61.2%), and 95.0% had a family history of depression. Regarding social relationships, supportive family (75.4%) and peer relationships (80.4%) were common; however, 94.4% experienced sexual abuse. Substance use was also widespread, with 90.8% being former users. The mean discrimination experience score was relatively low, but 25.1% experienced high discrimination. Bullying victimization affected 98.2%, and 38.6% reported suicidal ideation or attempts. Self-esteem levels were low to moderate in 51.6% of participants. Depressive symptoms were highly prevalent, with 84.8% of participants experiencing at least mild depression, supporting the study's objective of examining its prevalence among LGBTQ+ adolescents. Mild depression was the most common category (35.3%), followed by moderate (29.1%) and moderately severe depression (12.7%). A smaller proportion (7.7%) reported severe depression, while 15.1% had minimal depression.

Table 1. Demographic characteristics of the participants and key variables (n = 958)

Demographic characteristics	Number	%
Age (years) Min = 13, Max = 18, Mean = 14.70, SD = 1.79		
Age groups		
13–15 years	614	64.1
16–18 years	344	35.9
Grade point average		
1.00–2.99	297	31.0
3.00–4.00	661	69.0
Gender identity confidence		
No	129	13.5
Yes	829	86.5
Body image satisfaction		
Satisfied	372	38.8
Not satisfied	586	61.2
Family depression history		
No	48	5.0
Yes	910	95.0
Family relationships		
Supportive	722	75.4
Abusive	76	7.9
Neglectful	103	10.8
Other (e.g., further diversity)	57	5.9
Peer relationships		
Supportive	770	80.4
Other (e.g., abusive, neglectful)	188	19.6
Sexual abuse experience		
Ever	904	94.4
Never	54	5.6
Substance use status		
Never used	77	8.0
Former user (stopped)	870	90.8
Current user	11	1.1
Discrimination experience (continuous) Min = 0, Max = 12, Mean = 3.94, SD = 3.50		
Discrimination experience category		
Low	718	74.9
High	240	25.1
Bullying experience		
Never	17	1.8
Ever (victim)	941	98.2
Suicide attempt history		
Never	589	61.5
Ever	82	8.6
Ever (ideation only, without active attempts)	287	30.0

Table 1. Demographic characteristics of the participants and key variables (n = 958) (Cont.)

Demographic characteristics	Number	%
Self-esteem		
Low	205	21.4
Moderate	289	30.2
High	464	48.4
Depression		
Minimal	145	15.1
Mild	338	35.3
Moderate	279	29.1
Moderately severe	122	12.7
Severe	74	7.7

Relationships among all variables

Table 2 presents the associations between depressive symptoms and independent variables. Non-supportive family relationships had a moderate positive correlation with higher depression scores, representing the strongest association among the variables. Satisfaction with body image had a small negative correlation with depression. Confidence in gender identity showed a very weak positive correlation with depression, while substance use status had a very weak negative association. Other variables, including age groups, grade point average, family history of depression, peer relationships, experiences of sexual abuse, discrimination, bullying, suicide attempt history, and self-esteem, showed no significant correlation with depression. Notably, all Spearman's rank correlation coefficients remained below 0.80, suggesting no strong correlations that might indicate multicollinearity among predictor variables.

Table 2. Correlations matrix of study variables (n = 958)

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13
1. Depression	1.00												
2. Age groups	-0.04	1.00											
3. Grade point average	0.02	0.01	1.00										
4. Gender identity confidence	0.09**	-0.07*	-0.04	1.00									
5. Body image satisfaction	-0.26**	0.07*	-0.02	-0.11**	1.00								
6. Family depression history	-0.03	-0.01	-0.01	-0.01	0.01	1.00							
7. Family relationships	0.36**	-0.08*	-0.03	0.09**	-0.71**	0.05	1.00						
8. Peer relationships	0.00	0.03	0.01	0.03	0.09**	0.01	-0.06	1.00					
9. Sexual abuse experience	0.05	-0.03	-0.07*	-0.02	0.04	-0.01	0.01	0.05	1.00				
10. Substance use status	-0.08*	0.03	0.04	-0.05	0.11**	0.01	-0.14**	0.04	-0.04	1.00			
11. Discrimination experience	-0.04	0.04	-0.06	-0.05	-0.03	0.01	0.04	-0.03	0.02	-0.04	1.00		
12. Bullying experience	-0.03	-0.05	0.03	-0.01	-0.01	-0.03	-0.01	-0.01	-0.00	-0.00	-0.23**	1.00	
13. Suicide attempt history	-0.04	0.05	-0.03	-0.11**	0.09**	-0.04	-0.08*	0.00	0.02	0.02	-0.02	0.01	1.00
14. Self-esteem	-0.04	-0.05	0.03	0.09**	-0.03	0.02	0.03	-0.15**	-0.10**	0.04	-0.02	0.05	-0.04

Note. *p < 0.05; **p < 0.01

Predictors of depressive symptoms: Ordinal logistic regression analysis

To further examine predictors of depression, an ordinal logistic regression analysis was conducted, using depression severity as the outcome variable (1 = minimal, 2 = mild, 3 = moderate, 4 = moderately severe, 5 = severe). Ordinal logistic regression was chosen due to the ordinal nature of depression severity levels. Preliminary assumption checks confirmed the model's appropriateness. The model demonstrated a significant fit ($\chi^2 = 170.92$, df = 13, $p < 0.001$), explaining 17.2% of the variance in depression among LGBTQ+ adolescents (Nagelkerke $R^2 = 0.172$). Goodness-of-fit tests, including the Pearson chi-square test ($\chi^2 = 599.95$, df = 607, $p = 0.573$) and the deviance test ($\chi^2 = 518.96$, df = 607, $p = 0.996$), were non-significant, confirming an adequate model fit. Additionally, the non-significant result of the test of parallel lines ($p = 0.470$) indicated that the proportional odds assumption was met.

As shown in **Table 3**, key predictors of depressive symptoms were identified: low self-esteem significantly increased the likelihood of depressive symptoms (OR = 1.39, $p < 0.05$). Additionally, supportive family relationships reduced the odds of depressive symptoms by 79% (OR = 0.21, $p < 0.001$). These findings highlight the importance of self-esteem and family support in influencing mental health outcomes among LGBTQ+ adolescents.

Table 3. Ordinal logistic regression model prediction depression (n = 958)

Factors	Depression	
	OR	95% CI
Discrimination experience (continuous)	2.45	[0.56, 1.23]
Gender identity confidence (Yes ref.)		
No	0.75	[-0.65, 0.06]
Body image satisfaction (Not satisfied ref.)		
Satisfied	0.97	[-0.38, 0.31]
Family relationships (Others ref.)		
Supportive	0.21**	[-2.12, -0.97]
Abusive	1.12	[-0.50, 0.73]
Neglectful	0.85	[-0.75, 0.42]
Suicide attempt history (Ever, ideation only, without active attempts ref.)		
Never	0.95	[-0.51, 0.40]
Ever	1.11	[-0.16, 0.38]
Substance use status (Current user ref.)		
Never used	1.05	[-1.11, 1.20]
Former user (stopped)	0.87	[-1.23, 0.95]
Bullying experience (Ever, victim ref.)		
Never	1.45	[-0.5, 1.25]
Self-esteem (High ref.)		
Low	1.39*	[0.03, 0.63]
Moderate	1.06	[-0.22, 0.32]

Note. *p < 0.05; **p < 0.001; ref. = reference group; CI = Confidence interval; OR = odds ratio

Discussion

This study confirms a high prevalence of depression among LGBTQ+ adolescents in Southern Thailand, with 84.8% experiencing at least mild depressive symptoms. This raises concerns about whether LGBTQ+ adolescents face higher depression rates compared to their non-LGBTQ+ peers. While

research on this population in Thailand is limited, an online survey of LGBTQ+ individuals aged 15–24 years reported a 71.1% prevalence of depression,[7] and 72.2% of general Thai adolescents aged 11–16 years experienced at least mild depression in the same year.[30] These findings indicate alarmingly high depression rates across Thai adolescents, suggesting that broader cultural and structural factors may contribute to mental health risks. In Southern Thailand, where religious and cultural beliefs strongly influence social norms, family expectations and school environments may further shape the mental health experiences of LGBTQ+ adolescents. Cultural differences also influence how depression is expressed and understood, with adolescents from different ethnocultural backgrounds displaying varying symptom presentations.[31] Additionally, despite increasing legal recognition, gender diversity remains socially unaccepted by many Thais, particularly within families and schools, contributing to minority stress and psychological distress.[32]

Building on the high prevalence of depression in this population, this study identifies low self-esteem as a significant risk factor for depression, reinforcing its role in amplifying psychological distress.[33-34] Within the framework of the Minority Stress Model, self-esteem is shaped by external stressors, including stigma, discrimination, and social rejection, which can undermine self-worth and increase vulnerability to depression.[2,11] However, resilience factors such as strong peer connections and social support may mitigate these effects, helping adolescents develop coping strategies that protect against psychological distress.[2,33] Although confidence in gender identity was associated with depression, it was not a significant predictor of depression. A previous study found that perceived and enacted gender stigma, rather than gender identity itself, significantly predicted suicidal ideation and attempts among LGBTQ+ individuals in Thailand, reinforcing the impact of minority stress on mental health disparities.[35] However, strong social support can mitigate these effects, reducing the risk of depression, suicidality, and emotional distress, highlighting the protective role of supportive environments for LGBTQ+ youth.[35]

Family support emerged as a key protective factor in this study, significantly reducing the likelihood of depressive symptoms. Adolescents with strong parental supervision had a lower risk of depression, reinforcing the role of family involvement in promoting well-being.[36] Parental support may provide a stable and nurturing environment, fostering emotional security and reducing psychological distress. Previous research highlights the importance of family acceptance in fostering identity development and resilience among LGBTQ+ youth, with initiatives such as the Family Acceptance Project emphasizing its role in improving long-term mental health outcomes.[37] However, family support in Southern Thailand is not uniform. While some families provide emotional acceptance, others may exert pressure on LGBTQ+ adolescents to conform to traditional gender norms, often due to cultural and religious expectations surrounding family honor. These contrasting experiences suggest that while family support is protective, its influence is shaped by the broader sociocultural context. Strengthening family-based interventions may help LGBTQ+ adolescents navigate self-acceptance and societal expectations, ultimately reducing psychological distress and fostering positive mental health outcomes.[32]

In addressing the research question, this study hypothesizes that supportive family relationships, absence of discrimination, and lack of bullying serve as protective factors against depression. However, findings indicate persistent school-based challenges, with 98.2% of participants reporting experiences of bullying and 25.1% experiencing high levels of discrimination. Despite these significant challenges, neither bullying victimization nor discrimination was found to be associated with or predictive of depression in this study. This contrasts with the fact that 80.4% of participants reported supportive peer relationships, suggesting that strong peer connections may buffer the negative psychological effects of bullying and discrimination. From the perspective of the Minority Stress Model,

LGBTQ+ adolescents face unique stressors—including stigma, discrimination, and victimization—that increase their vulnerability to mental health challenges.[11] However, resilience factors such as peer support may counteract the harmful effects of minority stress, fostering emotional security and a sense of belonging. Prior research indicates that high-quality friendships serve as a protective factor, mitigating the impact of peer victimization on mental health by reducing loneliness and enhancing self-worth.[38-39] In this study, the presence of supportive peer relationships may have acted as a crucial buffer against minority stress, helping LGBTQ+ adolescents maintain psychological well-being despite exposure to school-based stressors such as bullying and discrimination.

Limitations

This study provides a comprehensive analysis of factors predicting depressive symptoms among LGBTQ+ adolescents in Southern Thailand. However, several limitations should be acknowledged. First, the cross-sectional design precludes causal inferences, as it captures data at a single point in time. Future research should employ longitudinal designs to track changes over time and establish causality. Second, the reliance on self-reported data for sensitive topics such as depression, discrimination, and bullying may have introduced response bias, with participants potentially underreporting or overreporting experiences due to social desirability or recall issues. Incorporating qualitative or mixed-method approaches in future studies could enhance data accuracy and provide deeper insights.

Third, the findings are specific to LGBTQ+ adolescents in Southern Thailand, limiting generalizability to other regions or populations. Cultural and regional differences likely influence both the prevalence of depressive symptoms and their associated factors, warranting multi-site studies across diverse contexts to validate these results. Lastly, the predictive model accounted for only 17.2% of the variance in depression, suggesting that other influential factors were not included. Confounders such as socioeconomic status, family dynamics (e.g., quality of relationships and emotional support), peer dynamics (e.g., social interactions and group norms), and access to mental health services were not assessed despite their potential influence. Additionally, limitations in the assessment tools may have restricted the ability to capture the complexity of depression fully. Future research should address these gaps by incorporating additional predictors and refining assessment methods to enhance the understanding of depression in this population.

Conclusions and Implications for Nursing Practice

This study identified low self-esteem as a risk factor for depression among LGBTQ+ adolescents in Southern Thailand, while supportive family and social environments may serve as protective factors. Despite the Gender Equality Act B.E. 2558 (2015) prohibiting gender-based discrimination, policy enforcement and legal gender recognition challenges persist.[40] The lack of legal recognition for transgender individuals limits access to education, healthcare, and employment, contributing to minority stress. Future research should explore the impact of family acceptance, social support, and school policies on mental health and assess how legal barriers affect LGBTQ+ adolescents' well-being.

Nurses are key in promoting self-esteem, fostering family support, and advocating for inclusive environments. Trauma-informed care, including mental health screenings, early interventions, and culturally sensitive counseling, may help reduce distress. Strengthening peer support and family education can further enhance resilience. Additionally, awareness of legal barriers and policy advocacy for gender recognition and inclusive healthcare are essential to addressing mental health disparities. Integrating these strategies into nursing education, practice, and policy discussions

may help improve LGBTQ+ adolescent well-being in Thailand.

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ความชุกของภาวะซึมเศร้าและปัจจัยทำนายภาวะซึมเศร้าของเยาวชนที่มีความหลากหลายทางเพศในภาคใต้ ประเทศไทย : การศึกษาภาคตัดขวาง

มณฑา สายธารวาณิตร์กุล วิภาวรรณ ชะอุ่ม เพ็ญสุขสันต์ สายฝน เอกวรางกูร*

บทคัดย่อ: กลุ่มเยาวชนที่มีความหลากหลายทางเพศ เช่น เลสเบี้ยน เกย์ ไบเซ็กชวล คนข้ามเพศ เควียร์/ผู้กำลังค้นหาตนเอง และอื่น ๆ มีความเสี่ยงต่อการมีภาวะซึมเศร้าสูงกว่ากลุ่มเพศวิถีตามเพศกำเนิดทั่วไป ส่งผลให้มีความจำเป็นต้องได้รับการดูแลสุขภาพจิตอย่างเฉพาะเจาะจง การศึกษานี้มีวัตถุประสงค์เพื่อสำรวจความชุกของภาวะซึมเศร้าและปัจจัยที่เกี่ยวข้องกับภาวะซึมเศร้าของเยาวชนที่มีความหลากหลายทางเพศในภาคใต้ ประเทศไทย ใช้กรอบแนวคิดความเครียดของคนกลุ่มน้อย ซึ่งอธิบายความเครียดเรื้อรังส่งผลผลกระทบต่อสุขภาพจิตในประชากรกลุ่มนี้ การศึกษานี้มุ่งเน้นการวิเคราะห์ความเกี่ยวข้องระหว่างปัจจัยความเครียดภายนอก เช่น การถูกกลั่นแกล้ง ถูกเลือกปฏิบัติ และความสัมพันธ์ในครอบครัว และปัจจัยความเครียดภายใน เช่น ความมีคุณค่าในตนเอง และความมั่นใจในอัตลักษณ์ทางเพศ กับภาวะซึมเศร้า การศึกษานี้เป็นการศึกษาภาคตัดขวาง ในกลุ่มตัวอย่างเยาวชนที่มีความหลากหลายทางเพศ จำนวน 958 คน อายุ 13–18 ปี ที่เปิดเผยอัตลักษณ์ทางเพศของตนเอง จากโรงเรียนมัธยมศึกษาจำนวน 4 โรงเรียน ใช้วิธีการสุ่มตัวอย่างแบบชั้นภูมิจากสำนักงานเขตพื้นที่การศึกษามัธยมศึกษา เขต 11 เก็บรวบรวมข้อมูลโดยใช้แบบประเมินภาวะซึมเศร้าสำหรับวัยรุ่น แบบวัดความมีคุณค่าในตนเองของโรเซ็นเบิร์ก แบบวัดการถูกเลือกปฏิบัติ และแบบสอบถามการรังแกกันของโอลเวียสฉบับปรับปรุง วิเคราะห์ข้อมูลโดยใช้สถิติเชิงพรรณนา การทดสอบสหสัมพันธ์เชิงอันดับของสเปียร์แมน และสถิติถดถอยแบบโลจิสติกเชิงอันดับ

ผลการศึกษาพบว่า เยาวชนที่มีความหลากหลายทางเพศ ร้อยละ 84.8 มีภาวะซึมเศร้าตั้งแต่ระดับเล็กน้อยถึงรุนแรง ความมีคุณค่าในตนเองต่ำเป็นปัจจัยเสี่ยงสำคัญต่อภาวะซึมเศร้า ในขณะที่ความสัมพันธ์ในครอบครัวลักษณะให้การสนับสนุนเป็นปัจจัยป้องกันต่อภาวะซึมเศร้า ผลการศึกษาพบความชุกของภาวะซึมเศร้าสูงในกลุ่มประชากรนี้ และความสำคัญของการเสริมสร้างความมีคุณค่าในตนเอง ส่งเสริมการยอมรับจากครอบครัว และดำเนินนโยบายที่ครอบคลุมทั้งในโรงเรียนและชุมชน การพยาบาลที่ให้ความสำคัญกับความละเอียดอ่อนทางวัฒนธรรมและคำนึงถึงความบอบช้ำทางจิตใจสามารถลดความเหลื่อมล้ำด้านสุขภาพจิตและส่งเสริมความเข้มแข็งทางจิตใจในกลุ่มเยาวชนที่มีความหลากหลายทางเพศในประเทศไทยและบริบทที่มีความใกล้เคียง โดยการส่งเสริมความมีคุณค่าในตนเอง เสริมสร้างการสนับสนุนจากครอบครัว และส่งเสริมความไม่แบ่งแยกในสังคม

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คำสำคัญ: การศึกษาภาคตัดขวาง ภาวะซึมเศร้า ความสัมพันธ์ในครอบครัว เยาวชนที่มีความหลากหลายทางเพศ สุขภาพจิต ความมีคุณค่าในตนเอง

มณฑา สายธารวาณิตร์กุล *ผู้ช่วยศาสตราจารย์ สาขาการพยาบาลสุขภาพจิตและจิตเวช คณะพยาบาลศาสตร์ มหาวิทยาลัยราชภัฏสุราษฎร์ธานี*
E-mail: montha.sai@sru.ac.th
ติดต่อที่ : วิภาวรรณ ชะอุ่ม เพ็ญสุขสันต์ *รองศาสตราจารย์ สาขาการพยาบาลสุขภาพจิตและจิตเวช คณะพยาบาลศาสตร์ มหาวิทยาลัยราชภัฏสุราษฎร์ธานี*
E-mail: wipawan.pen@sru.ac.th
สายฝน เอกวรางกูร *รองศาสตราจารย์ สาขาการพยาบาลสุขภาพจิตและจิตเวช สำนักวิชาพยาบาลศาสตร์ มหาวิทยาลัยวลัยลักษณ์*
E-mail: asaifon@wu.ac.th