STUDY REPORT

Mental Health and Well-being of Children and Youth with Diverse SOGIESC in Thailand

frl.
Save the Children

Authors

Timo T. Ojanen, Faculty of Learning Sciences and Education, Thammasat University, timotapaniojanen@gmail.com

Cody Freeman, Faculty of Learning Sciences and Education, Thammasat University, codyfreeman101@gmail.com

Priyoth Kittiteerasack, Faculty of Nursing, Thammasat University, priyoth_k@hotmail.com

Nanchatsan Sakunpong, Behavioral Science Research Institute, Srinakharinwirot University, nanchatsans@gmail.com

Sakol Sopitarchasak, Faculty of Learning Sciences and Education, Thammasat University, sakol@lsed.tu.ac.th

Kulvadee Thongpibul, Department of Psychology, Faculty of Liberal Arts, Thammasat University, a.kulvadee@gmail.com

Kawin Tiansuwan, School of Community and Regional Planning, The University of British Columbia & Faculty of Learning Sciences and Education, Thammasat University, desskaw@gmail.com

Peeranee (Ami) Suparak, Save the Children Thailand, ami.suparak@savethechildren.org

Artwork: Waewisa Na Songkla & Ruangtup Kaeokamechun, 2023

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Organization address: 518/5 Maneeya Centre Building, 14th Floor, Ploenchit Rd., Lumpini, Pathumwan, Bangkok 10330 Thailand

Email: info.thailand@savethechildren.org

Website: thailand.savethechildren.net

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Acronyms

9Q	9-Question Depression Inventory (name of a depression scale)
ANOVA	Analysis of variance (statistical test)
AOR	Adjusted odds ratio
APTN	Asia-Pacific Transgender Network
CI	Confidence intervals
EOD	Experience of Discrimination (name of a discrimination scale)
GAD-7	Generalized Anxiety Disorder-7 (name of an anxiety scale)
LGBT	Lesbian, gay, bisexual, and transgender
LGBTI	Lesbian, gay, bisexual, transgender, and intersex
LGBTIQ+	Lesbian, gay, bisexual, transgender, intersex, queer, and others
LGBTIQNA+	Lesbian, gay, bisexual, transgender, intersex, queer, non-binary, asexual/aromantic, and others
MSPSS	Multidimensional Scale of Perceived Social Support (name of a scale measuring social support)
NGO	Non-governmental organization
OI	Outness Inventory (name of a scale measuring outness)
RSES	Rosenberg Self-Esteem Scale
RQ	Resilience Quotient scale
SC	Save the Children
SOGIE	Sexual orientation, gender identity and expression
SOGIESC	Sexual orientation, gender identity and expression, and sex characteristics
UNDP	United Nations Development Programme

Executive Summary

Project Background

Save the Children's exploratory research report (Olivier, 2018) on LGBTIQ+ youth in Thailand highlighted mental health risks for LGBTIQ+ children and youth. Building on that initial research, the study described in this report collected and analyzed quantitative and qualitative primary data from children and youth (age 15-24 years) with diverse sexual orientation, gender identity and expression, or sex characteristics (SOGIESC) in all regions of Thailand in order to explore their mental health (e.g., psychological well-being, self-esteem, depression, anxiety, suicidality etc.) and factors influencing it (victimization, discrimination, self-stigma, sources of social support, coping mechanisms, positive and negative teaching around gender/sexual diversity, etc.), including resilience and its predictors as a protective factor.

Study Purpose and Key Questions

The purpose of the project was to conduct quantitative and qualitative research on mental health and well-being of children and youth (age 15-24 years) with diverse SOGIESC living in all regions of Thailand. The research aimed to identify factors affecting their mental health and well-being, as well as risks, protective factors, and predictors of resilience among them:

- Study Question #1: What are the risk factors/protective factors for mental health and wellbeing of children/youth with diverse SOGIESC?
- Study Question #2: How do risks and protective factors operate on different levels (child as an individual, families, community and society)? What do the interactions between children, families, and societies look like, and how does it affect mental health outcomes?
- Study Question #3: How are children developing resilience? What are the key supportive factors to create/develop resilience of the children?

Conclusions

- **Study Question #1 Conclusions**

Our survey indicated that most participants had symptoms of anxiety and depression (over 70% had at least mild symptoms and circa 20% had severe symptoms of either depression or anxiety) as well as suicidal thoughts (over 50%), attempts (circa 16%) and non-suicidal self-harm (25%). These rates were highest among transmasculine and bi/pansexual participants. Our interviews reflected how experiences of nonacceptance, discrimination and various forms of violence were linked with mental health problems, as were other kinds of adverse circumstances and stressful life situations. On the other hand, having access to supportive peers, families, online communities, and health professionals was helpful to our participants.

- **Study Question #2 Conclusions**

The first take-home message from our models conducted for this study question is that all kinds of violence (ridicule, physical violence, online and offline sexual harassment, as well as online bullying) had the strongest positive associations with mental health problems, including depression, anxiety, suicidality, self-harm, and alcohol use. In other words, the more experiences of violence they had, the higher the likelihood of having mental health problems was. Secondly, experiences of discrimination were associated with lower well-being scores and somewhat higher depression and anxiety levels as well as self-harm. Thirdly, participants who had

been forced to do something that was intended to change their SOGIE had somewhat higher anxiety and depression scores. Perhaps most importantly, resilience was the strongest protective factor for all types of mental health problems, and it was also a very strong predictor of psychological well-being. Social support was also an important predictor of psychological well-being.

- **Study Question #3 Conclusions**

First, our interviewees' accounts of resilience point at the importance of finding ways to shift one's perspective. Second, our findings highlight that having sufficient social support is paramount for psychological resilience. Third, being allowed to openly express one's gender identity and sexual orientation helps to build resilience. Finally, adverse life circumstances (such as poverty, violence, or being discriminated against) reduce resilience among children and youth of diverse SOGIESC. Recalling that resilience in turn was the strongest predictor of positive and negative mental health outcomes, the overall conclusion is that when children and youth of diverse SOGIESC are supported and live in circumstances free from discrimination, violence, and poverty, their mental health will be significantly better.

Recommendations for data use

The recommendations below are summarized highlights of our full recommendations contained in the end of the report.

Ministry of Education

1. Issue regulations and provide resources to educational institutions to design and implement a whole-school anti-bullying policy, strive for a gender-neutral approach, explicitly forbid discrimination in their regulations, and increase the capacity of staff to understand SOGIESC issues.
2. Increase contents in the core curriculum of basic education that are of relevance for children and youth of diverse SOGIESC.
3. Establish school-based mental health services and provide teaching to increase mental health awareness.

Educational institutions

1. Strive for a gender-neutral approach and create a culture that respects SOGIESC diversity.
2. Design and implement a whole-school anti-bullying policy.
3. Promote understanding of mental health issues and how to access appropriate support.

Ministry of Public Health, particularly the Department of Mental Health

1. Increase financial resources and skilled staff in existing mental health services.
2. Expand the geographic coverage and capacity of clinics providing holistic care for children and youth of diverse SOGIESC.
3. Provide mental health promotion activities and training that enhance resilience among children and youth.

Non-governmental organizations

1. Increase activities related to mental health awareness to address the specific mental health challenges among children and youth of diverse SOGIESC.
2. Facilitate opportunities for children and youth with intersectional characteristics to advocate for their needs and access additional support and activities relevant to their specific needs.

3. Provide training for children and youth to be aware of their rights, how to protect themselves from all forms of violence, and how to seek help.

Methodology and Limitations

This mixed-methods study collected data through an online survey (3,094 participants) and online interviews (38 participants) with 15-24 year-old children and youth of diverse SOGIESC throughout Thailand. The survey findings describe mental health outcomes, their predictors, and access to mental health services, whereas the interviews were conducted to give a clearer picture of the specific challenges experienced by various subgroups of this population. Our use of convenience sampling and the survey being in Thai only pose some limitations to the generalizability of the findings.

MENTAL HEALTH AND WELL-BEING OF CHILDREN AND YOUTH WITH DIVERSE SOGIESC IN THAILAND

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Study Questions

1. What risk and protective factors influence mental health?
2. How do these factors on various levels influence mental health?
3. How can resilience be developed?

Collected data from 15-24 year-old LGBTIQNA+ children and youth living in Thailand

Children and youth voluntarily participated in the research

3,094 answered the survey

Experiences of violence in the past year

LGBTIQNA+ children and youth faced

Being ridiculed **75%**

Physical violence **31%**

Sexual Harassment Online | Offline **53% | 58%**

Online bullying **36%**

Throughout their lives, many LGBTIQNA+ children and youth...

were forced to attempt changing their SOGIESC...

42%

.... by.....

Family members

School personnel

Community members

Impact on mental health

71% Depression

78% Anxiety

58% Thought of suicide

25% Self-harm

15% Attempted suicide

Transmasculine participants had highest rates of depression, anxiety, and suicidal thoughts

WARNING

The more types of violence, the higher the risk of mental health problems

Ridicule

Bullying

Physical violence

Discrimination

Sexual harassment

Pressure to change SOGIESC

Online harassment

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Access to mental health services

Problems & Obstacles

95% of those who accessed services said...

- ... the staff understood them
- ... the staff accepted their identity

→ Safe space

Social Support

Examples

Supportive actions

Resilience

LGBTIQNA+ children and youth want to let you know that

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Ministry of Education

Enact policies | Increase resources | Build capacity

- No bullying
- No discrimination
- Gender-neutral learning environments
- More contents on mental health

Educational institutions

- Build a culture that respects diversity
- Create a whole-school Anti-bullying policy
- Provide school-based mental health services & referrals

(Brief) Recommendations

Ministry of Public Health

- Increase budgets & personnel
- Increase coverage of clinics for LGBTIQNA+ children & youth
- Arrange activities & trainings to increase resilience

Civil society organizations (NGOs)

- Arrange activities to raise awareness
- Provide space for intersectional identities & arrange group-specific activities
- Provide education on child rights and staying safe from violence

NO | GO | TELL

Introduction & Project Background

Children and youth with diverse sexual orientation, gender identity, gender expression, and sex characteristics (SOGIESC) face stigma and discrimination that hinders their development and well-being. At the national level, Thailand has not legalised same-sex marriage and does not have a gender recognition law, which means that a citizen cannot request to be legally recognized as the gender they identify as (UNDP, 2019). These legal gaps partly mirror existing attitudes: A national survey conducted by UNDP (2019) found that 36.6% of the general population felt negatively towards having LGBT children in the family and 40.6% disagreed with the notion that students should be able to wear uniforms according to their gender identity.

Education in Thailand is currently not SOGIESC-inclusive in several respects. A large comprehensive sexuality education review (Ministry of Education et al., 2016) indicated that the coverage of sexual and gender diversity topics was patchy and many teachers' and students' attitudes on same-sex attraction were negative. A health education curriculum review (Wongwareethip, 2016) further revealed that gender and sexual diversity topics were being taught through the stigmatizing and outdated concept of "sexual deviation." Correspondingly, a secondary analysis of the comprehensive sexuality education review dataset indicated that even among LGBT-identified students, 35% had negative attitudes toward homosexuality, and students were more likely to hold negative attitudes if they had attended lessons related to sexual diversity, suggesting that existing teaching increased rather than reduced self-stigmatization (Shrestha et al., 2020). A civil society complaint on the discriminatory curriculum in health education led to a curriculum revision in 2019, but the changes may have been superficial and many aspects of gender and sexual diversity are not taught about (Lekkla, 2021).

Thai schools rarely have explicit bullying prevention policies, and ones that specifically refer to SOGIESC-based violence are even rarer (Mahidol University et al., 2014). The study by Mahidol University et al. (2014) found that 55.7% of self-identified LGBT students reported having been bullied in the month prior to the survey because they were LGBT. Nearly one third (30.9%) experienced physical abuse, 29.3% reported verbal abuse, 36.2% reported social abuse and 24.4% reported being victim of sexual harassment or abuse. Even among students who did not identify as LGBT, 24.5% reported having been bullied in some way in the past month because they were perceived to be transgender or attracted to the same sex.

Multiple layers of barriers often impact the mental health of children and youth with diverse SOGIESC. Findings from Mahidol University et al. (2014) showed that students who faced SOGIESC-based violence were more likely to be depressed or have attempted suicide compared to those who had not been bullied or had been bullied for other reasons. A secondary analysis of the same dataset indicated that sexual and gender minority youth (including those who self-identified with LGBT identity categories, and those who did not) had a higher burden of illicit drug use, which was associated with having symptoms of depression, suicidal ideation, and social victimization (Guadamuz et al., 2019). A more recent study on vocational school students in Bangkok similarly found that LGBT-identified students had a higher prevalence (20.2% vs. 9.8%) of poly-drug use than non-LGBT students (Kongjaroen et al., 2022).

In UNDP's (2019) national survey, findings demonstrated that almost half of Thai LGBT adults have contemplated suicide, and nearly one-sixth have attempted suicide. Additionally, 49% of LGBT respondents viewed mental health services as a high priority, while one in five people reported having difficulty accessing mental health services. Although the World Health Organization recommends national mental health plans for specific vulnerable populations, including LGBTIQ+ persons, Thailand still lacks such a plan and its implementation.

Mental health issues remain a major concern among LGBTIQNA+ population, including children and youth with diverse SOGIESC. According to the Mental Health Act, B.E. 2551, patients under 18 years old need to be accompanied by guardians to receive mental health treatment. In September 2020, an announcement from the Department of Mental Health (2020a) clarified that children under 18 years of age are understood to give consent to treatment by virtue of requesting the service in the first place, and parental consent is only required for high-risk treatment, hospitalization, or for patients who are incapable of giving consent themselves. Although accessibility of mental health services has been improved, a youth shared her experience in seeking mental health services during consultations conducted in 2020 that when she turned 18 and got to see a psychiatrist, she was told that changing her sexual orientation to heterosexual might be better for her mental health (Coalition of CSOs and INGOs for Children's SOGIESC Rights - Thailand, 2021). Given that any attempts to change sexual orientation or gender identity are ineffective and harmful (Bishop, 2019), such suggestions indicate a serious lack in the psychiatrist's knowledge of sexual and gender diversity.

This reality reflects broader gaps in practitioners' competence in providing service for LGBTIQ+ clients. A Delphi study of mental health practitioners and LGBTIQ+ service users in Thailand recommended that mental health practitioners should understand LGBTIQ+ identities and concepts, accept diverse SOGIESC, and reject stereotypes, among other facets of their LGBTIQ-related competencies (Ojanen et al., 2021).

In addition, specialist mental or gender health services for transgender and/or gender-non-conforming children and youth that may be needed when these youth transition are not covered under Thailand's public health insurance schemes (Juntrasook et al., 2020), which has led to children and youth buying hormonal pills without prescription, professional psychological support, or monitoring of hormone levels and side effects. Stigma also hampers access to mental health care. A secondary analysis of the UNDP national survey of LGBT adults in Thailand indicated that approximately 20% reported difficulties accessing mental health care and 27% actively concealed their gender expression to access care; both perceived and enacted stigma were associated with difficulties accessing mental health care (Moallef et al., 2022a).

The COVID-19 pandemic has compounded these barriers. Research from UNDP and APTN (2020) has shown that major impacts on the LGBTI community were the loss of income/job (47%), and unsafe living situations (36%), while 60% of respondents said that they have not received any assistance from the government. The research also found that the communities affected by isolation had increased loneliness, stress, and depression.

Meyer's (2003) minority stress theory is a predominant framework for explaining the mental health disparities observed among LGBTIQ+ groups. It recognizes the key importance of stress levels in explaining mental health problems; the additional stress caused by victimization, discrimination, anticipated rejection, self-stigmatization, and having to hide one's identity; as well as the protective roles of appropriate coping mechanisms and sources of social support. Seen in the light of this theory, the above findings suggest that the current situation of children and youth of diverse SOGIESC in Thailand systematically puts them at risk of developing mental health problems – over a half are victimized at school, school regulations discriminate against them, a third have attitudes indicating self-stigma, a significant proportion use illicit substances, and usual sources of social support (e.g., parents, peers, teachers) may not be accessible because these persons also hold stigmatizing attitudes. However, the available data on these issues in Thailand are fragmented across studies and do not permit systematic analysis. This is the gap that the study described in this report aims to fill.

Building on Save the Children's exploratory research report (Olivier, 2018) on LGBTIQ+ youth in Thailand that highlighted mental health risks for LGBTIQ+ children and youth, the research project described in this report was conducted between December 2021 and December 2022. Following up from the initial

exploratory research, this project collected and analyzed quantitative and qualitative primary data from children and youth (age range 15-24 years) with diverse SOGIESC in all regions of Thailand, in order to explore their mental health (e.g., psychological well-being, self-esteem, depression, anxiety, suicidality, etc.) and factors influencing it (victimization, discrimination, self-stigma, sources of social support, coping mechanisms, positive and negative teaching around gender/sexual diversity, etc.).

For this research, Save the Children collaborated with a research team based at Thammasat and Srinakharinwirot Universities to strengthen the evidence base for policy making around mental health, with the aim to improve mental health outcomes for children and youth with diverse SOGIESC in Thailand. Given the ongoing COVID-19 pandemic, the data collection took place entirely online, consisting of an online survey and online interviews.

Study Purpose & Scope

Study Purpose

The purpose of this study was to conduct quantitative and qualitative research on mental health and well-being of children and youth (age 15-24 years) with diverse SOGIESC living in all regions of Thailand. The research aimed to generate a substantive evidence base by identifying factors affecting mental health of children and youth with diverse SOGIESC. The overall objectives of this research were to:

- Understand factors that affect mental health and well-being of children and youth with diverse SOGIESC and analyse how risks and protective factors operate on the multiple levels (to identify what are the risks and protective factors, focus on children's development and explain interaction between children, families, communities, and society and the impact of those interactions to mental health outcomes: depression, suicidal ideation or attempts)
- Inform evidence-based prevention and protection programming strategies and advocacy focusing on children's empowerment and self-esteem, basic services that are safe, socially appropriate and protect dignity and mental wellbeing of children and youth with diverse SOGIESC, and in return, contributing to the prevention and resilience against SOGIESC-based violence

Study Questions

1. What are the risk factors/protective factors for mental health and wellbeing of children/youth with diverse SOGIESC?
    - Child:
        - Wellbeing and signs of negative mental health: depression, suicidal ideation or attempts
        - Ability to disclose or express their SOGIESC
        - Empowerment to speak up and advocate about their SOGIESC identity and experiences
        - Self-esteem and body-esteem
        - Internet use to obtain information and connection with other diverse SOGIESC; and experience of SOGIESC-based online bullying

- Family:
  - Perceived support from family and fostering healthy environment that accepts children's SOGIESC
- Community:
  - Children know and have access to mental health services and support, including mental health professional or access to desired transition services
  - Access to support services at schools or other units in the community
  - Peer support/acceptance (includes positive relationships with peers, support of friends)
  - School factors as per the introduction: anti-bullying policy, school curricula inclusive of LGBT identities, etc.
- Society:
  - Relevant systems and practices in regards to mental health support for children and youth with diverse SOGIESC
- Gender and power dynamics:
  - SOGIESC-specific factors, e.g., perceived acceptance from family, peers, teachers, discrimination or violence (trans and LGB specific factors)
- Impact of COVID-19

2. How do risks and protective factors operate on different levels (child as an individual, families, community and society)? What do the interactions between children, families, and societies look like, and how does it affect mental health outcomes?
3. How are children developing resilience? What are the key supportive factors to create/develop resilience of the children?

In reporting the findings, we adjusted these questions somewhat in cases where certain types of material made more sense to report in one place than another.

Methodology & Limitations

Study design

The study reported here was a convergent mixed methods study. This approach was adopted to collect a quantitative dataset to provide strong evidence to inform practices and policies, and a qualitative dataset to create a richer understanding on the topics of the study questions. The quantitative data were collected through an online survey to reach a high number of participants nationwide and allow for anonymous responding. The survey investigated key mental health outcomes and their possible antecedents among children and youth of diverse SOGIESC in Thailand, using Meyer's (2003) minority stress as its core framework. Save the Children's socio-ecological framework was used as an additional framework. The qualitative data were collected through online in-depth interviews. The interview guideline (Appendix 2) had a structure similar to the survey.

Sampling methods & sample size

Target population: Children and youth (age: 15-24) with diverse SOGIESC throughout Thailand

Online survey

Sampling and sample size

According to the National Statistical Office, there were 8,290,005 Thai children/youth in the age bracket 15-24 years in 2021 (National Statistical Office, 2021). Recent studies with Thai youth samples have reported that over 10% identified with one or another LGBTIQNA+ identity (Kongjaroen et al., 2022: 13.9%; Mahidol University et al., 2014: 11.9%; Ministry of Education et al., 2016: 14.0%), so the number of children and youth (age: 15-24 years) with diverse SOGIESC nationwide is likely to be around one million or more. With confidence level at 95%, margin of error at 5%, and variance of the population at 50% (Bartlett et al., 2001), the calculated sample size for the population was 384 (Taherdoost, 2017). Anticipating some invalid responses (e.g., missing data, responses from persons not eligible to participate), we chose the more conservative quota of 400 participants per group.

To be able to disaggregate the findings on the level of umbrella groups, we aimed to recruit at least 400 participants in the following subgroups: (1) gay or bisexual men (2) lesbian or bisexual women and (3) gender diverse individuals (e.g. transgender, non-binary, etc.). Children and youth with diverse SOGIESC who do not identify with one of these subgroups (e.g. intersex, asexual, aromantic, etc.) were also welcome to participate in the study, but anticipating challenges in recruiting participants from these groups, we did not set minimum target quotas for them.

Sample recruitment process

Survey participants were recruited via convenience sampling, because there was no feasible alternative for our intended sample. We incentivized participation by providing a lucky draw of 50 one-thousand baht cash prizes, payable by bank transfer. The call to participate was posted on multiple Facebook accounts and the post was boosted so that it was shown to a large audience on both Facebook and Instagram. Our 13 partner organizations, our Youth Advisory Board, and our Research Committee consisting of topic area experts (**Appendix 3**) also helped to share the post.

Online interviews

Sampling and sample size

Our purposive sampling for the interviews was guided by a 6x6 region by identity group grid, so our planned sample size was 36 interviewees. Columns in the grid represented regions: 1) Greater Bangkok (Bangkok and surrounding provinces), 2), Central (excluding Greater Bangkok), 3) North, 4) Northeast, 5) Deep South (Narathiwat, Pattani and Yala provinces), and 6) South other than Deep South. Rows represented broad identity groupings: 1) gay men, 2) lesbian women, 3) transgender women, 4) transgender men, 5) pan/bisexual men/women, and 6) intersex, non-binary, asexual, aromantic or other SOGIESC. Participants in identity categories 1), 2), and 5) could be cisgender or transgender, and participants in categories 3) and 4) could be of any sexual orientation. We also aimed to have at least one participant with intersectional characteristics (disability, neurodiversity, ethnicity, or statelessness) per region to represent these groups. It was not possible to find participants matching this scheme exactly (for details of the actual sample, see "Demographic data & respondent characteristics").

Sample recruitment process

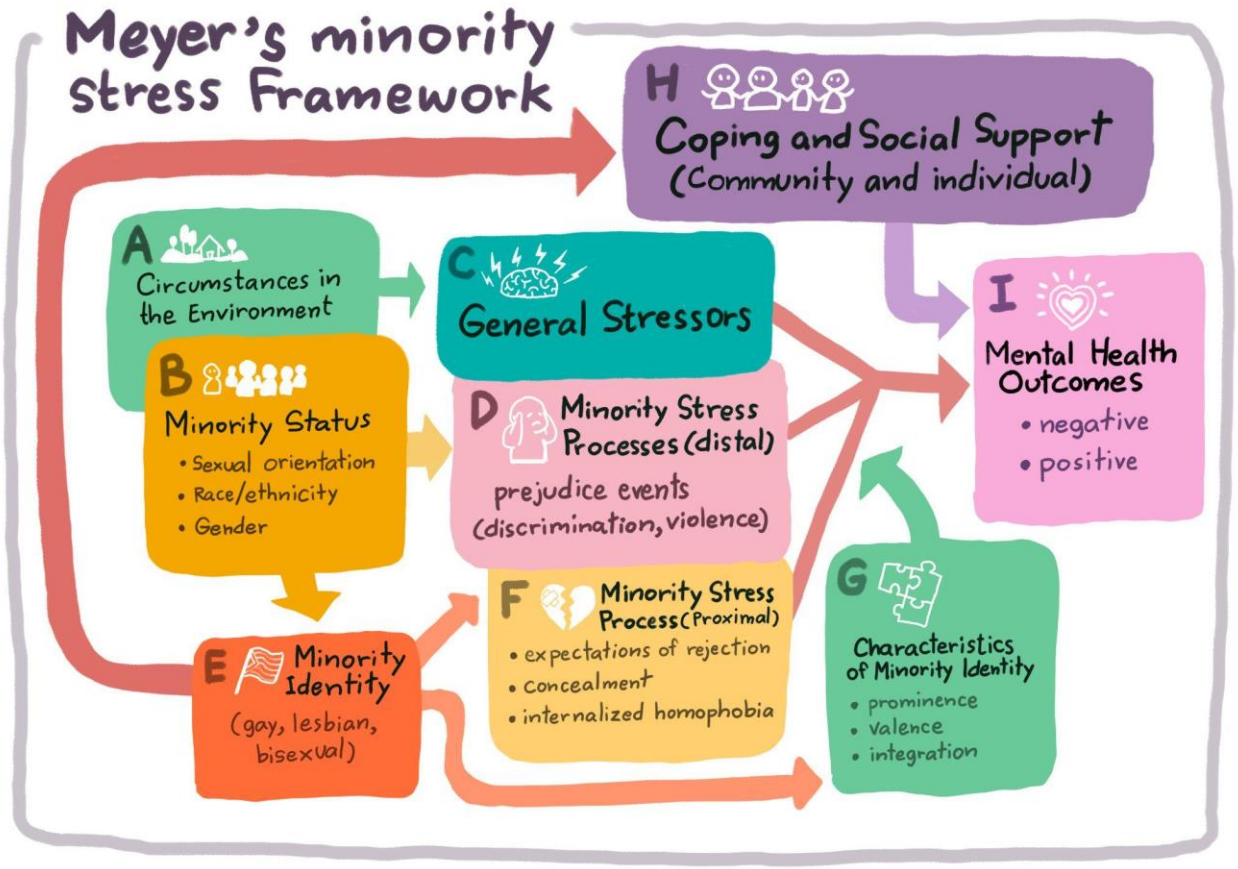
The research team recruited Interview participants via purposive sampling using the research team's existing networks and assistance from the Research Committee, the Youth Advisory Board, and our partner organizations **(Appendix 3)**.

Data sources

Online survey

The online survey was conducted using Google Forms, targeting children and youth (age: 15-24 years) with diverse SOGIESC nationwide in Thailand. Participants did not need to be Thai nationals, but given that the survey was in Thai, most participants were Thai nationals (15 indicated they were stateless). The survey was open from 24 June to 2 September, 2022.

Table 1. Meyer's minority stress framework



The survey was constructed with reference to Meyer's (2003) minority stress framework (**Table 1**) and Save the Children's socio-ecological framework (**Table 2**). The minority stress framework is based on the premise that stress increases mental health problems, and belonging to a minority group causes additional stress, which explains why minority groups have higher levels of mental health problems. More specifically, general circumstances in a person's environment (A) determine the extent of general stressors (C) that person has (e.g.,

insufficient income or stress from work, study, or the family), which in turn influences their mental health outcomes (I). A person who has one or more minority status (B) may also experience prejudice events (D), such as discrimination or violence, which also influence that person's mental health outcomes (I). Minority status may also result in having a minority identity (E), which may influence the coping mechanisms and social support available to that person (H), various psychological reactions to having a minority status (F), both of which may influence that person's mental health outcomes. Finally, persons with a minority identity may view their identity in different ways (G); the identity may be more or less important for them (prominence), they may view it positively or negatively (valence), and they may feel it is difficult or easy to reconcile their minority identity with their other identities (e.g. religious or ethnic identities). These characteristics may influence how much the general and minority stressors impact on that person's mental health outcomes (I). Save the Children's socio-ecological framework emphasizes focusing on all levels from the child to society, as well as gender and power dynamics on all levels. The survey incorporated several scales already validated in Thai, as well as newly designed elements for aspects where no pre-existing validated scales existed in Thai. The Youth Advisory Board and Research Committee provided feedback on the survey questions, and many adjustments were made based on them. Our partner organizations were asked to facilitate access to the survey and equipment to complete it.

Table 2. Save the Children's socio-ecological framework

Prior to starting the survey, participants were shown information about the study and their rights as participants, and then asked to tick a box to indicate their consent to participate. If they ticked yes, they could begin doing the survey; if no, the survey terminated. At the end of the survey, participants were shown information about sources of assistance they could use (Save the Children's and Department of Mental Health's hotlines as well as Lovecare Station), and shown a link to a separate form where they could insert their bank account details to participate in the lucky draw. Using this method, the participants' names and bank details were not included in the dataset itself, and those who wanted to participate totally anonymously were able to do so (2,387 participants chose to participate in the draw). Draw winners were picked by creating random numbers. Winners were notified using the contact information they gave.

Online interviews

Online in-depth interviews were conducted between June 28 and September 10 in 2022. The interviews used a semi-structured interview guideline **(Appendix 2),** based on Meyer's (2003) minority stress model **(Table 1)** and Save the Children's socio-ecological framework **(Table 2)**, exploring the same areas as the online survey, but from a qualitative, in-depth, and open-ended angle. The interview guideline had three broad sections: 1) Background characteristics; 2) stressors and characteristics of minority identity; and 3) social support and coping. Near the end of each interview, we asked all participants if they had any advice for other children and youth of diverse SOGIESC in Thailand, anything they wished the Thai state or NGOs would do, and if they had any final remarks for the research team or Save the Children Thailand.

Interviews were conducted via social media or online meeting platforms (Zoom, LINE, and Facebook Messenger), depending on each participant's convenience. Three interviews were conducted via text chat at the participant's request, and some participants sent additional comments via text chat or email, which were incorporated in those participants' interview transcripts. Most interviews were in Thai (two were in English). Two interviews used interpretation between Thai and Thai Sign Language. The interview guideline was created in corresponding Thai and English versions.

Before starting to record the online interviews, we briefed participants about the project and their rights as well as obtained their informed consent to participate and have their interview recorded. Interviews had cash incentives of 500 THB per interview, which were paid by bank transfer, to compensate for participants' time. Participants did not have to submit any paperwork in order to safeguard their privacy and confidentiality.

Data analysis

Quantitative data

The quantitative data were analyzed with statistical software (IBM SPSS) for both descriptive statistical analysis (means or percentages), disaggregated by gender identity category, sexual orientation, intersex status, region, and age group, and inferential analyses, consisting of linear and logistic multiple regression models for Study Question 2 and 3. The descriptive data tables in Appendix 1 have footnotes to indicate significant differences between groups; these analyses used Chi-Square for categorical data, independent t-test for continuous data from two groups, and one-way ANOVA for continuous data from more than two groups. The data analysis was informed by Meyer's (2003) minority stress model and Save the Children's socio-ecological framework, where applicable.

Qualitative data

The interview transcripts were analyzed using a modified version of thematic analysis (Braun & Clarke, 2006), using the study questions as the top-level structure and Google Docs as the platform. The audio-based interviews were transcribed in their original language by research assistants, who signed a confidentiality form. The quality of the transcription was then checked by the person who conducted the interview. To analyze the data, excerpts from the interview transcripts were coded by storing each excerpt under a particular study question (or one of additional categories for emerging data types) in a central coding Doc shared by the research team, with a brief note to summarize the essence of the excerpt. A content analysis of the summaries under each study question was conducted, and the key categories emerging from this analysis constituted the themes (sometimes with subthemes). Research team members worked in pairs during the content analysis and theme identification process to ensure a shared understanding of the material.

Findings validation and dissemination

The research team prepared a first draft of the report and participated in a findings dissemination session. Following feedback from Save the Children, edits were made as agreed on and the final version was prepared in English. The Thai version is a translation of the English version, except for direct quotes from original material that have been aligned with the original Thai wordings. The research team also plans to publish peer-reviewed journal articles from this project as well as participate in subsequent advocacy efforts in collaboration with Save the Children.

Ethics & accountability

Research ethics

Oversight and children/youth involvement

To ensure the scientific validity, ethicality, fit for purpose, and child and youth engagement of project, all research activities were reviewed by 1) Save the Children Thailand; 2) the Research Committee consisting of relevant experts (**Appendix 3)**; 3) the Youth Advisory Board (**Appendix 3)**; and 4) the Human Research Ethics Committee of Thammasat University (No. 2 Social Sciences). We supported the Youth Advisory Board by providing capacity building on research and advocacy methods as agreed with Save the Children, and carefully reviewed the research collection tools together with the Board, making adjustments when necessary. The study activities were designed to comply with SC Child Safeguarding Policies' basic requirements.

Ethics approval

The research proposal, data collection tools and participant information materials were reviewed and approved by the Human Research Ethics Committee of Thammasat University (No.2 Social Sciences, approval number 055/2565, 18 May 2022, amended 16 June 2022 to accommodate for technical limitations of Google Forms). The committee approved a waiver of parental consent for 15-17 year-old participants, given that many children of diverse SOGIESC are not out to their parents, and asking parents for permission to participate in a related study could expose children in this situation to harm.

Consent, confidentiality, risks, and mitigation

Our outsourced statistician and transcribers signed confidentiality forms. Data were kept in password protected systems.

In our anonymous online survey, participants were shown information about the study and their rights on the first page of the survey, and prompted to tick a box to proceed to the survey. Since the survey contained some

potentially triggering questions, participants were warned in advance and given the option to skip any questions. Contact information was given for services that could help the participant in case they felt upset after completing the survey.

Before starting online interviews, we briefed participants about the project and their rights, sent them the participant information sheet, and obtained their verbal consent to participate and record the interview. We also asked participants to choose a pseudonym and state their preferred pronouns to use in this report. The research team received training from Save the Children on child safeguarding and psychological first aid so as to be able to contact relevant authorities if a participant was in a dangerous situation or to provide immediate assistance if a participant became upset as a result of giving the interview. Given the risk of secondary traumatization through interview participation, we asked participants after the midpoint and end of the interview how they were feeling, and provided them the option to talk with professional counselors. Generally, participants said they felt relieved after having been able to share about difficult issues with someone who could understand them.

Participation from stakeholders including children and youth

The research project encouraged participation by children/youth and other stakeholders through three primary mechanisms: 1) the youth advisory board, 2) the research committee and 3) partner organizations **(Appendix 3)**. Each of these groups helped the research team in creating the data collection tools and process, disseminating the survey, recommending interview participants, and disseminating the findings.

Limitations

Online survey

The survey was only in Thai language, which excluded children and youth who could not read Thai from the study. This means that our findings do not fully represent highly marginalized populations (e.g., illiterate children and youth, foreign, ethnic minority, or migrant children and youth who were not sufficiently fluent in written Thai to complete the survey). Some deaf participants also shared with us that they found the language of the survey difficult to understand. Children and youth needed internet access to participate, although we requested our partner organizations to facilitate access to communication equipment where needed. To our knowledge, our survey dataset is nevertheless one of the largest quantitative datasets collected in Thailand specifically among children and youth of diverse SOGIESC.

Online interviews

The interviews were conducted in Thai, English, or Thai sign language (through interpretation). Each participant could choose one of the languages they preferred to participate in the interview. Although we were able to represent children and youth with many specific characteristics, the qualitative dataset nevertheless does not fully represent all groups of children and youth of diverse SOGIESC in Thailand. Children and youth needed communication equipment to participate, but given the ubiquity of smartphones among Thai children and youth, this was a minor limitation. In three cases, we could not find participants matching our region by SOGIESC category grid. Nevertheless, the interviews provide a rich perspective to the experiences of many kinds of children and youth with diverse SOGIESC living in Thailand.

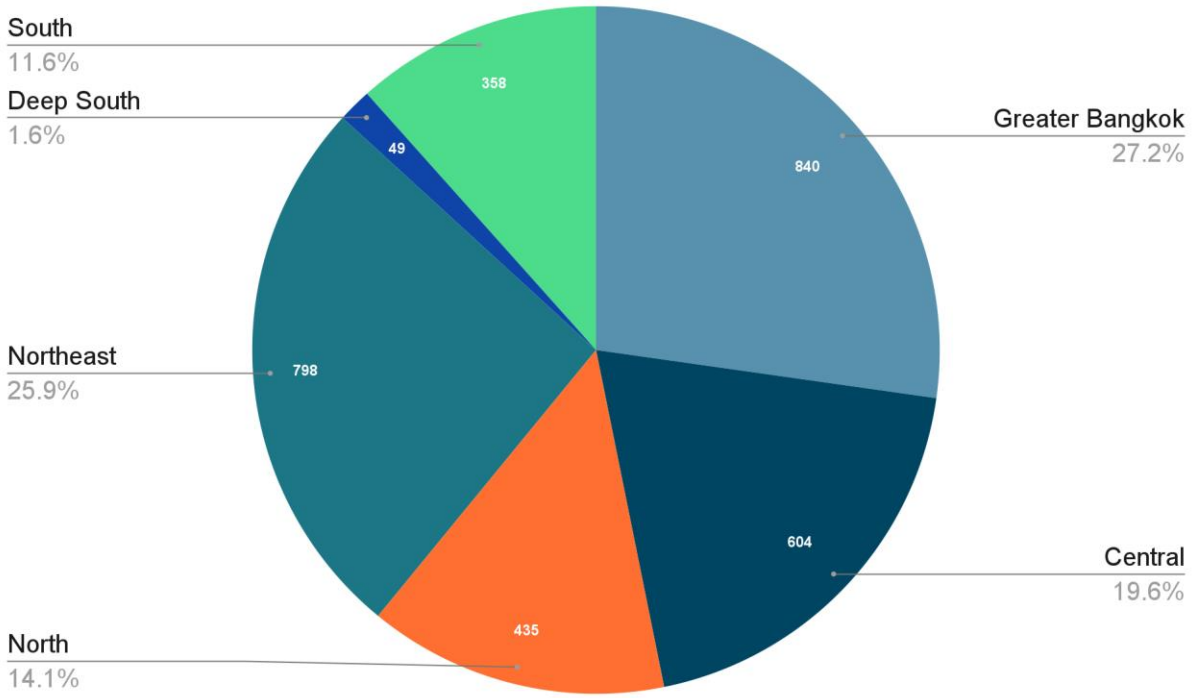
Findings

Demographic data & respondent characteristics

Online survey

In our survey, after removing invalid responses (i.e., those who were not LGBTIQNA+), the final sample size was 3,094. **Table 3** shows the number and percentage of participants in each region. In the Deep South, we were only able to get 49 participants, so the findings for this region may be less reliable than for other regions.

Table 3. Number and percentage of participants in each region



Participants' average age was 17.61 years (standard deviation: 2.07 years). Most (88.9%) were full-time students, and 71.9% were living with their parents. A quarter were living in the capital region, 19.3% lived in other urban areas, and 55.7% lived in rural areas. When asked if their or their family's income was sufficient for daily expenses in the past month, only 39.3% responded yes, 19% were unsure, and 41.7% stated their income was insufficient (the last two groups were combined in further analyses).

Given that the survey was in Thai only and limited to participants within Thailand, all but 17 participants indicated having Thai nationality and 96.9% reported having Thai ethnicity, although some participants mentioned other ethnicities. In terms of religion, 2288 (73.9%) stated they were Buddhist, 113 (3.7%) were Muslims, 96 (3.1%) were Christian and 530 (17.1%) stated they were not religious. Sixty-seven (2.2%) gave

some other response or skipped the question. The number of participants with disabilities was generally too low for meaningful disaggregation: 92.8% stated that they had no disabilities.

In terms of sex assigned at birth (Thai law only allowing male or female options), 2173 participants (70.2%) indicated they had been assigned female at birth, whereas 901 (29.1%) had been assigned male at birth (20 participants, or 0.6% did not answer this question). However, 174 participants (5.7%) indicated that they were in fact intersex (i.e., neither male nor female).

Categorizing the gender identity of the survey participants for further analysis was challenging, given that many participants had multiple overlapping and sometimes conflicting identities (**Appendix 4** has a glossary of Thai terms). To be able to present between-group comparisons, we needed to regroup the participants into non-overlapping categories. With regard to gender identity, we created "gender identity categories" in a multi-stage recoding based on participants' legal sex (currently unchangeable in Thailand and hence corresponding to sex assigned at birth) and identity terms. First, anyone who used the term non-binary (or similar others, such as genderfluid, bigender, agender or genderqueer) was coded as non-binary. Second, male participants were coded as transfeminine if they had not already been coded as non-binary, and their identity marker was "woman" or they stated any of the the relevant transfeminine Thai terms (*tut*, *kathoey*, *sao praphet song*, *phu ying kham phet*) or the English term "trans woman." Male participants only using the term "man" or masculine/unisex sexual identity terms (e.g., *chai rak chai*, *gay*, *bi*, queer) were coded as cisgender men. Third, female participants were coded as transmasculine if they had not already been coded as non-binary, and their self-descriptors included the term "man" or any of the relevant transmasculine Thai terms (*phu chai kham phet* or *tom*) or the English term "trans man." Female participants were coded as cisgender women if they only used the term "woman" or feminine sexual identity labels (e.g., *les*, *ying rak ying*, *dee*). Finally, anyone who could not be categorized, was recoded as other/unsure. With regard to sexual orientation, the process was more straightforward because there was a forced-choice question with the options asexual, heterosexual, gay/lesbian, bisexual/pansexual, other, and unsure, that we were able to keep for our reporting (we combined "other" and "unsure" to keep tables manageable).

Following our manual recoding, the survey had at least 438 gay or bisexual men (272 gay, 166 bi/pansexual, overall 14.1%), 1,045 lesbian or bisexual women (332 lesbian, 713 bi/pansexual, overall 33.8%), and 977 gender diverse participants (31.6%). The gender diverse participants consisted of 635 non-binary participants (20.5%), and an additional 238 (7.7%) transfeminine and 104 (3.4%) transmasculine ones who did not indicate non-binary or a similar gender identity marker, such as genderfluid or genderqueer. Many non-binary participants also had transmasculine or transfeminine identities, but we chose to categorize participants in this way to allow cross-group comparisons. In the detailed findings tables in **Appendix 1**, the key findings are disaggregated for gender identity category, sexual orientation, and intersex status separately, and the number of participants in each category is shown in brackets after the category's name. Given that some participants skipped some questions, the number of participants in each analysis is also shown separately in the table rows.

Online interviews

We conducted 38 interviews, 33 of which corresponded to our intended region by identity group grid, and 5 additional ones were conducted specifically to represent intersectional characteristics (disability, neurodiversity, ethnic minority, and statelessness). Interviewees represented the following six regions of Thailand: 1) Greater Bangkok (9 interviews), 2) Central (6 interviews), 3) North (8 interviews), 4) Northeast (6 interviews), 5) Deep South (Narathiwat, Pattani and Yala provinces; 5 interviews), and 6) South outside the Deep South (4 interviews). Interviewees included seven gay men, six lesbian women, seven trans women, four trans men, six bi/pansexual women, three bi/pansexual men (one of whom was trans), four non-binary

participants (one of whom also identified as *tut*), as well as one queer woman, one asexual woman, and one feminine male participant who was unsure about which identity word to use.

Interview participants' ages ranged from 15 to 24 years (average 19.7 years). In terms of religion, 27 identified as Buddhists, while an additional four said they were from Buddhist families but were now practically or fully nonreligious, and one said he was questioning in terms of religion. Four were Muslims, one was a Catholic Christian, one had recently converted to Judaism, and one said they also followed folk religion in addition to Buddhism. Nine were currently general secondary school students, while 15 studied at a university and four in vocational schools. Occupations among those who were working included creative/content writer, store employee, barber/makeup artist, factory employee, coffee shop employee, Grab driver, and others. Several were involved as various kinds of activists. Among our participants, four ethnolinguistic minorities (Karen, Shan, Lawa, Malay) were represented, while several others had some Chinese ancestry. One participant was stateless, two were deaf (interviews used a sign language interpreter), two were living with HIV, and one identified as neurodivergent.

Study Question #1: What are the risk factors/protective factors for mental health and wellbeing of children/youth with diverse SOGIESC?

Individual (child/youth) characteristics

Wellbeing, self-esteem, and signs of negative mental health

Perhaps the most concerning finding of the study was very high levels of depression, anxiety, suicidality, and self-harm among the survey participants. **Appendix 1: Tables 1-3** show the detailed findings disaggregated by gender identity category, sexual orientation, region, and age group, and below we describe the general pattern. Under Study Question 2, we examine what factors explain these outcomes.

Overall, 58.2% of participants indicated that they had thought of suicide in the past 12 months, and 15.6% had made at least one suicide attempt in the past 12 months. These figures were similar to the lifetime suicidality figures (ideation: 50.7%, attempts: 16.8%) obtained from LGBTIQ+ Thai adults in the nationwide UNDP (2019) survey, as reported by Moallef et al. (2022b). In our survey, exactly one in four had engaged in nonsuicidal self-harm, such as cutting, in the past 12 months. Suicidality and self-harm were particularly prevalent among transmasculine participants and least prevalent among cisgender boys and men. This finding differed from the Thai LGBTIQ+ adult findings, where suicide attempts were most common among transgender women and genderqueer/non-binary people (Moallef et al., 2022b). With regard to sexual orientation, bisexual or pansexual participants in our survey had highest rates of suicidality and self-harm, whereas those who were gay or lesbian had the lowest. With regard to region, thoughts of suicide and suicide attempts were most common in the Central region (excluding Greater Bangkok) and least common in the Deep South (which, however, had the highest rate of non-suicidal self-harm). Suicidality and self-harm were significantly higher among 15-18 year-olds than among 19-24 year-olds.

Overall 71.1% of the participants had at least mild symptoms of depression (measured with the 9Q questionnaire) and 78.2% had at least mild symptoms of anxiety (measured with GAD-7). Eighteen percent had severe symptoms of depression and 21.1% had severe symptoms of anxiety. Compared to previous general population findings, these prevalence estimates are very high. For example, a 2013 epidemiological survey of Thai adults found that just 4.0% of women and 2.4% of men had *any* mental disorders (mostly anxiety and depression, but not including substance use disorders) in the past 12 months (Kittirattanapaiboon et al., 2017, p. 9). In our survey, depression and anxiety scores disaggregated by gender identity category mirrored

the pattern of suicidality, with transmasculine participants reporting the highest scores (86.7% had at least mild anxiety and 85.4% had at least mild depression) and cisgender boys and men reporting the lowest (63.6% had at least mild anxiety and 52.8% had at least mild depression). When disaggregated by sexual orientation, asexual participants had the highest depression scores (80.3% had at least mild depression) and gay/lesbian participants had the lowest (60.8% had at least mild depression). Anxiety scores were highest among bi/pansexual participants (at least mild anxiety: 82.6%) and lowest among gay/lesbian ones (at least mild anxiety: 69.6%) . Depression and anxiety were significantly lower among 19-24 year-olds (at least mild anxiety: 71.9%; at least mild depression: 65.9%) than among 15-18 year-olds (at least mild anxiety: 80.2%; at least mild depression: 72.8%), but these differences were minor.

Psychological well-being scores were lowest among transmasculine (mean: 35.5 points) and highest among transfeminine participants (mean: 43.4 points). With regard to sexual orientation, gay/lesbian participants had the highest psychological well-being (mean: 40.1 points) and self-esteem (mean: 29.1 points) scores, while asexual participants had the lowest (psychological well-being mean: 36.4 points; self-esteem mean: 27.1 points), although these differences were minor. Self-esteem or psychological well-being scores did not differ significantly between regions, but both were higher among 19-24 year-olds (psychological well-being mean: 39.4 points; self-esteem mean: 28.7 points) than among 15-18 year-olds (psychological well-being mean: 38.3 points; self-esteem mean: 27.6 points).

Considering substance use (**Appendix 1: Tables 4-6**) as a mental health outcome, the only substance widely used by the participants in the past three months was alcohol; it had been consumed by 45% of the participants. Tobacco product use was reported by 13.4%, cannabis was used by 4.3%, the stimulant herb krathom was used by 2.7%, and only 0.8% reported having used other substances. Tobacco, alcohol and cannabis were most commonly used by transmasculine participants, while transfeminine participants and cisgender girls and women had the lowest rates of using these substances. Asexual participants had the lowest proportion of drinkers, whereas bi/pansexual ones had the highest. Alcohol use was notably low in the Muslim-majority Deep South (just 18.8% drank there), and most common in Greater Bangkok and the North. Alcohol, cannabis and other substances were significantly more commonly used by 19-24 year-old participants than 15-18 year-olds. Nevertheless, although the minimum age to drink alcohol legally in Thailand is 20 years, 41.7% of the 15-18 year-olds had used alcohol in the past three months.

Our interview participants' experiences mirrored the quantitative findings. Several participants described their experiences with stress, depression (either self-diagnosed or formally diagnosed and treated), and one or more suicide attempts (usually in that sequence). Some participants described other specific symptoms, such as panic, inability to sleep, social anxiety, or psychosomatic symptoms, or thought patterns underlying these problems, such as perfectionism. For example, Porsche, a 17-year-old gay man from the Northeast, described his experience in a message to the interviewer: "Having entered tenth grade, I was studying in a special program class. Mama was putting more and more pressure on me. When I was in Maths class, my chest started to feel tight and my head was hurting so badly that an ambulance had to be called. Time passed and my symptoms got so bad that I thought of [and tried] killing myself twice, but didn't succeed."

Ability to disclose or express one's SOGIESC and internalized stigma

The minority stress theory (Meyer, 2003) posits that the ability to disclose one's identity (in particular, sexual orientation) to significant others is associated with better mental health outcomes, because worrying about a secret identity being disclosed is inherently stressful. Our detailed quantitative findings on these two factors are listed under this heading in **Appendix 1: Tables 4-6.**

To measure internalized stigma, we modified an existing version of a validated Thai version of an Internalized Sexual Stigma Scale (Kittiteerasack et al., 2021). Specifically, items referring to same-sex attraction only were modified to represent being a person of gender or sexual diversity. Measured with this adapted scale, the average scores reflected a relatively high level of contentment about being LGBTIQNA+. There was only minor variation across gender identity categories, sexual orientations, and age groups (with older participants having slightly less internalized stigma), but the comparison across regions showed that participants in the Deep South had more internalized stigma than participants in other regions.

This finding corresponds to our Deep South interview participants' accounts of intense pressure against gender and sexual diversity in this region, linked to beliefs of same-sex sexuality and transgenderism being sinful. Nat, a 19-year-old bisexual Muslim woman described a classroom incident in which a male teacher first asked her if she had in fact been born male and if she was hiding a past sex reassignment operation from her friends. When Nat said that wasn't the case, the teacher then asked her in front of everyone "being like this, surely I already know that it's wrong, against religious principles, so why am I still like this? Don't I feel sorry for my parents? … He talked just like that … it was terrible, it brought tears to my eyes." At home, Nat had introduced a girlfriend to her parents who had afterwards also told her it was wrong, forced her to separate with the girlfriend, and forced Nat to change her hairstyle and the way she dressed to follow religious norms. So, although our interview participants in the Deep South seemed not to share others' opinion about their way of life being wrong, it is understandable if they or some of the survey participants at times did not feel particularly good about being LGBTIQNA+.

To measure the extent to which our participants could be open about their identity with others, we used a modified version of the Outness Inventory previously used in research with Thai LGBT adults (Kittiteerasack et al., 2020b). In the current version, we substituted the term "being a person of sexual/gender diversity" for the original "sexual orientation" to expand the scale's applicability to gender minority participants. Outness scores did not significantly differ between regions, but 19-24 year-old participants were significantly more open about their identity with others than 15-18 year-old participants were. Across gender identity categories, transfeminine participants were most open about their identity, and cisgender girls and women were least open. Across sexual orientation groups, gay/lesbian participants were most open about their identity, and asexual participants were least open.

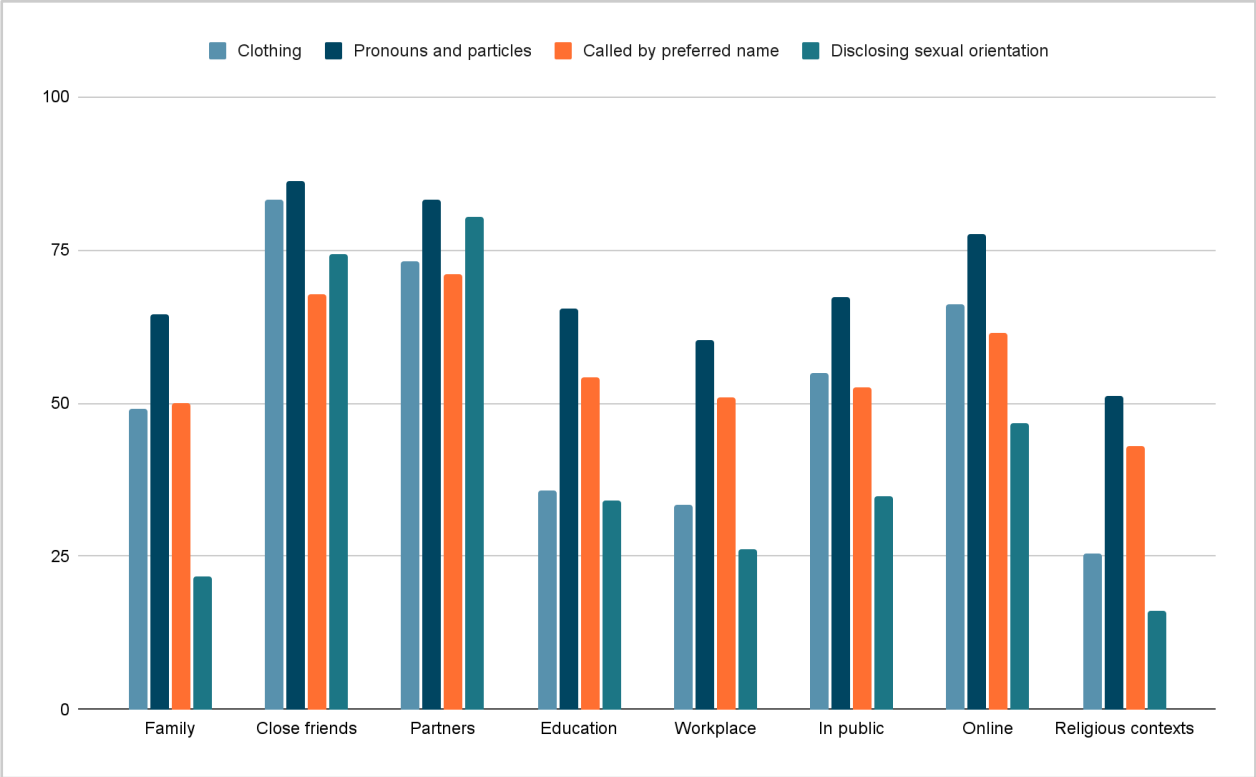
The experiences of Beth, a 21-year-old asexual university student whom we interviewed in the Central region, may explain these lower outness scores. She thought that while disclosure of same-sex attraction could incite stronger negative reactions than disclosure of asexuality, at least people had a concept of what it means to be attracted to the same sex, whereas in her case, telling people like her parents or grandparents might be pointless since they would probably not understand it. She tried to mention it to her parents, but felt that they did not get the message, based on their dismissive response: "I feel that it's not every issue that I can consult [my parents] on, like … they don't really even know what gender [*phet*] I am right now. It's like they've asked me before if I like guys or girls … and I told them I guess I like guys, but I don't really have any feelings toward guys, and I don't feel like I want kids, either … but they just said 'What's that?' Yea, it's like they said I'm not grown-up yet or something like that, I don't know myself well enough, I don't have enough experience, and so on."

We also examined specific ways in which our participants were or were not able to express their gender identity or sexual orientation in various contexts. First, we asked if they were able to wear clothing that corresponds to their gender identity. Second, we asked if they could use gendered first-person pronouns and politeness particles (e.g., *khrap*, *kha*) in Thai that correspond to their gender identity. Third, we asked if others called them by the name they wanted to be called. Finally, we asked if they were able to be open about their sexual orientation and relationships (e.g., hold hands in public with their partner, or talk about their partner

without having to change details about their gender). Each of these questions was asked for eight different contexts: 1) family, 2) close friends, 3) partners, 4) educational institutions, 5) workplaces, 6) in public, 7) online, and 8) in religious contexts. We simplified the responses of the participants by reporting just the percentage who are always able to express their identity in these ways (or be called by their preferred name) in each context, counting the percentage only among those participants who said they had some involvement in these life contexts.

Table 4 shows the detailed results of this analysis. On one hand, close friends and partners are (unsurprisingly) the kinds of people with whom our participants were most able to express their identity and have it respected by being called by their preferred name. On the other hand, even with these very close people, roughly a quarter were not always able to express themselves in some ways. In all other contexts, less than half of the participants were able to be always open about their sexual orientation or relationships. With their families, in their schools and workplaces, and in religious contexts, under a half were able to dress in a way that corresponds to their gender identity. These findings tangibly represent the pressure that many of our participants faced in their daily lives to present a sanitized representation of themselves to other people.

Table 4. Ability to express one's gender identity and sexual orientation in various life contexts



Overall, our interviews reflected the complicated nature of coming out. Participants described their decisions about telling or not telling family members, friends, teachers, doctors, colleagues, or others. Reasons for telling others included needing advice about one's sexuality, the perception that the people to be told appeared accepting, parents' encouragement for the participant to speak out, having a same-sex partner and wanting to

introduce them at home, rectifying an awkward atmosphere with classmates, having an independent income (so that even if things went wrong, one would still have a home), telling a doctor because it was necessary for hormone treatment, and telling a teacher so that the teacher could assist the participant (a trans man) to make an appeal to be allowed to switch to a male school uniform. As in the survey, many interview participants trusted friends to be most accepting. Some told others directly, some indirectly. Some asked a significant other if they already knew about their identity. Some expressed it through their clothing or accessories. Many talked about or indirectly expressed it on social media, for example by having a profile picture accurately reflecting one's identity. Bringing home a same-sex partner was one way.

The reactions interview participants got from those they told varied from positive to mixed and to outright negative. Positive consequences of telling others included reassurance from those told that it was fine, support in dealing with less accepting others, and being called in a way corresponding to one's gender identity. For example, Rick, a 22-year-old trans man in Bangkok, said that both his stepdad and biological father have adjusted to calling him son. Many participants said that those they told thought it was not a big deal, and many said they already knew.

Sometimes reactions were ambiguous, for example when others reassured the participant they were accepting but then started behaving in a somewhat awkward way. Rick had this experience with colleagues at a law firm internship placement after telling them he was a trans man: "they still respect me, but in a way they started treating me a bit differently, like you know, my male colleagues, they started to saying like–try to say more like weird masculine stuff like 'Hey bro, how you doing bro?' stuff like that. Before they didn't even say stuff like that, you know? They treated me like as a normal guy. But now they're really focusing on the male part, you know?" Many participants said their parents or relatives had responded with the cliché "it's okay as long as you're a good person;" some heard the more positive version: "it's okay because you're my child."

Negative reactions included disbelief and dismissal, becoming a subject of disrespectful jokes, still being called by one's old name even after telling others one wanted to be called by a new name (in case of transgender participants), and outright condemnation. Many parents expressed worries - what others would say, if hormone treatment was safe, and so on. Rick said that when he was around 15 or 16, he discussed transitioning into a man with his mother, and she said that if he did, he would "become like one of those monstrous things." Ter, another trans man, had a similarly hurtful reaction when telling his father: "it's like Dad didn't understand, … Dad told me to go see a psychiatrist. … After that, I didn't talk [about it] with anyone."

Reasons why some interview participants chose not to tell others included their belief that others already knew, that it was irrelevant, too personal or uncomfortable to talk about, or most importantly, because they anticipated that others would not understand or accept them. For example, B, a 16-year-old Muslim gay man from the Deep South said: "I can 't tell my parents, can't even talk about these things - every time there's LGBT+ related news, they talk about it very coarsely… I'm afraid that if I tell them there will be a violent argument to the point of them chasing me out of the house." And when Fa, an 18-year-old pansexual Shan woman in the North was asked what people in her community thought about gender and sexual diversity, she said: "I guess this is one of the reasons that I've not told my parents, or my family, because my family being Shan … in my area, it's not just my tribe, there are many tribes in that district and neighboring ones, and they still have ancient views on the topic, most people, that is, it's not that everyone who's tribal is nonaccepting, but most people still do have ancient views, haven't updated their views." Tao, another ethnic minority participant in the North, had told his family members that he liked men, and people in his Lawa village and family didn't really bother him about it, but they didn't really understand it, either; when asked to expand on this, he said they just can't understand why he wouldn't rather "get a wife." These experiences highlight how children and youth of diverse SOGIESC need to think carefully about what can be gained by telling others about their identity, and what could be lost if things go wrong.

Empowerment to speak up and advocate about one's SOGIESC identity and experiences

Interviewees' experiences of empowerment

Many interviewees talked about being empowered by activists and gender or sexual diversity related groups and organizations. Joining their activities was empowering because the participants who did so felt they gained a safe space, understood their often painful experiences in a new light, and in some cases were motivated to do similar work themselves. Some were already activists, and others planned to become activists in the future.

Two participants in the Deep South talked about activities that helped them to cope with or challenge the religious limitations of the area. Nat talked about how activities led by a human rights defender helped her overcome her sadness caused by the nonacceptance of gender and sexual diversity in her strictly religious family, school, and community: "At that time, I felt like I didn't want to live anymore … because I felt really bad … I think it's one older person (*phi*) who works on rights issues … my friend told me that they often had activities … they invited me to join those activities and it opened up my world, gave me another perspective, made me see the world in a better light. … I guess it's called venting, but with this group, I feel I can talk about anything, so that made it much softer." When asked what kinds of activities the group did, Nat replied: "Oh, lesbian [issues], um, playing football … providing a safe space." Rin, a 22-year-old questioning university student talked about how they were empowered to demand change at their university: "...since I joined *phi* Best's Young Pride [Club] in Chiang Mai and campaigned for gender equality and nondiscrimination among students, I brought [what I'd learned] to use at my university. I collected names of people who had faced gender-based discrimination at the campus, created a list of them (my university has five campuses) so I collaborated with my old high school friends at each campus, it's good I had that connection … and so I tried to present like, okay, [students at] the university have faced these kinds of discrimination, we don't have the *dao-duean-queen* [women's, men's and trans women's] contests for these reasons… and finally the university made the announcement that students of gender diversity can dress according to their gender or how they want to dress, and that there is to be no gender-based discrimination. It was like Heaven had mercy on me, had mercy on the things I'd done. Now I feel proud that I didn't stop there…"

Mali, a 19-year-old non-binary online activist and student in the Northeast, talked at length about how they had felt oppressed by Thai society's norms for women and had supported feminism for a long time. However, coming in contact with non-binary activists gave Mali a new identity, a new understanding of the oppression they had faced (i.e., it was not just oppression by patriarchy, but also oppression by the binary division of genders and gender norms), understanding friends, and - again, a safe space: "I got to watch the live video of two people who were also non-binary activists. One of them was a trans woman. She said: 'I'm a trans woman but I'm also non-binary' … For me, … from knowing about this trans woman, who said she likes to use she/her but is non-binary, it made me feel like, wait a minute, then I can be non-binary too! And so I started identifying as non-binary." When asked how finding this term affected Mali, they explained with excitement: "Oh, it was so good! Like, I don't have to be stuck in the frame that I've been pushed into from the beginning. It's like when I kept being a cisgender woman, it's like I had to strictly abide by those standards, or when I tried to break the frame, break those norms, I couldn't do it fully. I didn't feel like I wanted to fight all the time. … But being non-binary now, I feel that I can be myself, it's okay. … and I got to meet friends who are also non-binary … I feel they are so open-minded, it's like I found a safe space." Through these experiences, Mali was empowered to engage in leading similar activities online.

Two deaf participants, Po (22 years) and Golf (24 years), both living in Greater Bangkok, had attended a training workshop specifically for deaf youth of diverse SOGIESC, with contents on gender/sexual diversity and HIV prevention. Po had also participated in a beauty contest for deaf trans women. Although Po did not

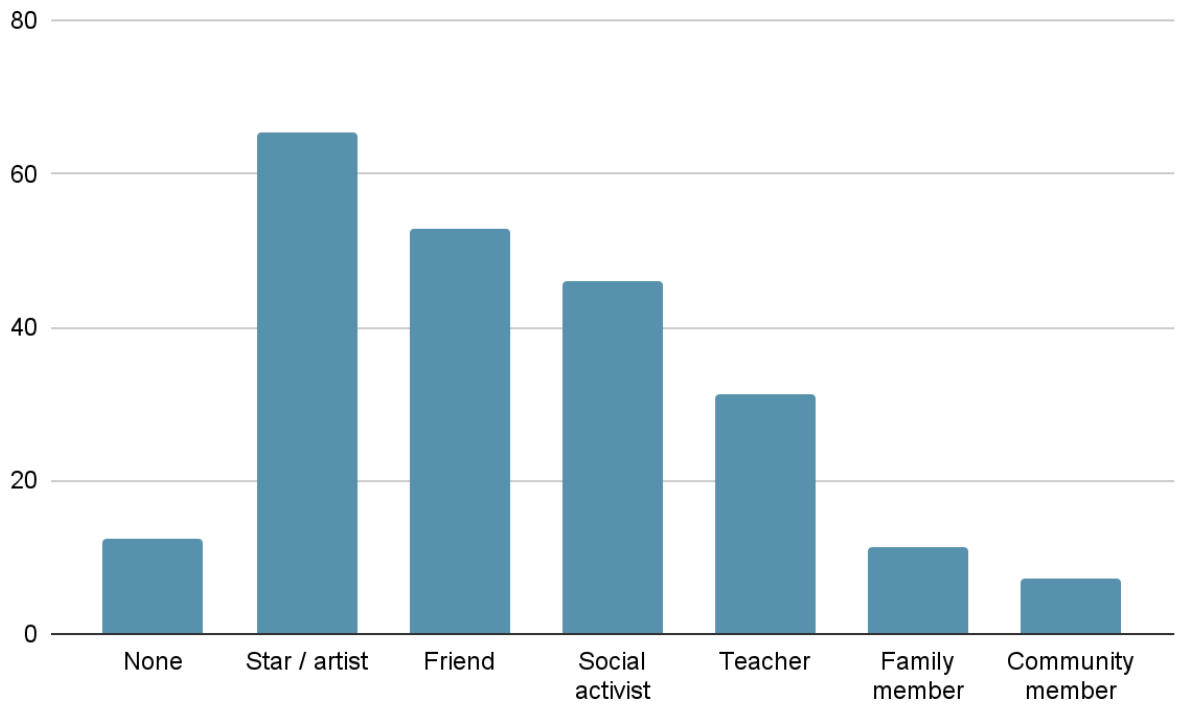
win, the existence of such contests provided her with the goal of winning the crown. She thought that winning the contest would enable her to feel equal to hearing people, including in terms of beauty, which currently was a pain point: "I don't have breasts, I don't have a [beautiful] nose, my face is not beautiful yet. But seeing hearing people, it's like they can do it all [i.e., beauty operations]. They have the eyes, the breasts, everything, complete. And they can win the prize. But deaf people like us - we lack role models, it's like we can only do 50%, 70% of it…" Golf identified as a gay man. His pain point was a traumatic memory of having faced sexual violence from other students in his former school. Having seen the example of the training in which he'd participated, he reflected on his trauma and how he wanted to protect others from victimization: "I didn't know how to take care of myself, how to protect myself. How should I do it? But having grown up, I now have the knowledge, and I think I can teach younger people on how they can protect themselves. I had this experience of victimization. I want the kids at school to know that this kind of thing should not happen [and] how they can protect themselves. It's like taking our story and using it to help others protect themselves."

For Fa, although she identified as pansexual, the circumstances of her life, namely statelessness and the problems it caused, were the driving force and the main focus of her activism. She was born in Burma, but her family had to flee the war there to Thailand when she was little. As a result, she and her family became stateless, and at the age of 18 years, she and her family were still stateless. She and her family needed to apply for a permit every time they needed to go outside their province, and the lack of documentation also limited the jobs they were able to take. In school, being the student council president had given her some experience in organizing. But it was the extreme difficulty with which she had been able to get her certificate at the end of her studies on each level that she thought was "the reason why I entered the [activist] 'circles', making demands related to our legal status, [ID] cards, that is, if you have the card, you have basic rights, right? But really, we're all born as human beings and we should get those basic rights automatically, without having to make any demands … but we don't! And that's the sad and oppressive fact. … I've been to so many forums, so many of them, but if you look at the big picture, most of them were on the legal status issue, followed by problems in the area that youth face there…" It says a lot about Fa's tenacity that she was doing all of this on top of being a vocational school student and juggling three part-time jobs to make ends meet.

Survey participants' LGBTIQNA+ role models

Another way of looking at empowerment is considering role models among our survey participants. The question was: "In your life, are there LGBTIQNA+ persons whom you consider role models?" Several options could be chosen. As shown in **Table 5**, just 12.5% of the survey participants could not think of any LGBTIQNA+ role models. The most commonly mentioned category consisted of stars and artists, followed by friends and social activists. Almost a third also mentioned a teacher, whereas family or community members were not as commonly mentioned. Although not shown on the graph, some 30-40 participants wrote additional fill-in answers. In these responses, YouTubers were commonly mentioned. Several mentioned fictional characters in cartoons, books, or other works of fiction. Some mentioned other kinds of people, such as politicians or religious leaders. Considering that nearly 90% had LGBTIQNA+ role models, these characters' role in their lives should not be overlooked, given that such figures can be important sources of encouragement and inspiration. In particular, openly LGBTIQNA+ stars/artists may be able to create much positive impact if they share their story to encourage and inspire their followers, given their high exposure and credibility as role models among children and youth.

Table 5. LGBTIQNA+ role models in survey participants' lives



Internet use to obtain information and connection with other diverse SOGIESC

As the experiences of Mali with encountering a non-binary community online suggest, online spaces were very important sources of information and support for our interview participants. Several participants who wanted to understand nuances of identities simply searched online for the name of the identity or identities they wanted to understand better.

For some, the information helped them understand themselves better, like Mali explained above. Beth also recognized herself in the information she found: "I found all the information on the Internet about what an asexual is, because that's something nobody taught me before … and then I compared that with myself, like how close a match it is, and it was pretty close! … at that point I could read English and understand it, so I went to the AVEN website … and read about the numerous shades of it, and I myself was in one of those shades of being asexual - those who could accept, like if you've got a partner, and you have sex with your partner, it's not because there's attraction between you, but it's more because of love … it's more likely to happen because you want the other party to be happy." Others found the diversity of identities and information online confusing, like Yu, a 21-year-old lesbian woman in Greater Bangkok, who explained that compared with what she knew previously, the information she found online was "...quite different. Because what I'd heard before, they'd just talk about *gay* … *kathoey* … *tom* or the like, that's all they'd talk about. But when I searched [online], it wasn't just these ones, there was much more, like people who are *bi* or can [love] both sexes, or *kathoeys* who might like women, or *toms* who like men, there were many kinds, more than what they'd talked about. Having done that search, I couldn't define myself."

Besides sexuality-dedicated websites, our interviewees talked about having used a range of sources, including various social media or video platforms (Instagram, Facebook, Twitter TikTok, YouTube, or social media in

general). Social media group admins were a source of support for some participants who had chatted with them before. Some read news about celebrities coming out. For some, videos created by people with the same identity were helpful. Eddie, an 18-year-old trans man and secondary student in the Central region, found a rationale for calling himself just a man (rather than a trans man) from watching a video posted by another trans man: "There was a time last year when I was still calling myself a trans man (*phu chai kham phet*). I guess I thought it was a word that would make others understand me best, for not having to use the word *tom*. But no! Whether you use *phu chai kham phet*, or *trans man* [in English], or whatever, for most people it just means a *tom*. I didn't know what to do, until I found a clip on an LGBT YouTube channel. This guy was gay, but his birth sex was female. He explained that his personal title was a woman, just like I just explained to you, so I took that part. See, his title was legally a woman, but most people understood that he was gay, or a man who likes men and is feminine. … so if I tell others like this, I feel more comfortable than saying I'm a trans man, because whatever my legal sex is, most people believe I was born as a guy with a willy." In other words, the information Eddie found in the video helped him to find a way to pass as a man, which made him feel more comfortable than before, when he was regularly told by others that he was a *tom*, which made him feel like others didn't acknowledge him as a man.

Family influences: Protective and risk factors

Protective factors

Based on our interviews, an important factor in explaining well-being among children and youth of diverse SOGIESC is that they know their family has at least one person who understands, respects, and validates their identity. Practical examples include taking their child to buy clothing that corresponds to the child's gender identity, allowing their child to use the kinds of pronouns and particles the child feels comfortable with, calling their child a son or daughter in keeping with the child's gender identity, and supporting transitioning costs if the child chooses to transition medically. The experiences of Tin, a 21-year-old trans man in the North reflect many of these ideal characteristics: "Dad is great, Dad gets it. Sometimes he even calls me son. So, I feel very happy about being a person of gender diversity with such understanding parents. I feel it's my good luck. … I told them I want to transition, get chest surgery and so on; they said they'll support the costs. I felt great!" Emmy, a 23-year-old trans woman in Central Thailand had similar good memories: "Mom told me to ask the teacher if I could have my hair, wear a fringe, and bought me a hair clip to wear on my hair. I could feel I was a woman. When I was little, Mom allowed me to wear a skirt. I dressed as a girl then, and came to live with Dad's relatives and wanted to buy a bra. 'Go for it!' They never blamed me. When I wanted to do my hair, get extensions, they'd always be like 'Go for it! But keep it within good taste, if you want to be a woman, you've got to wear it like this' … they supported me like this."

Parents providing encouragement and acting as an advocate for them when they faced discrimination, stigma, or violence, were also appreciated by our interviewees. Ice, a 19-year-old Muslim trans woman in the Deep South, had an ally in her mother, which helped her cope with her father, who was very much opposed to her being trans: "He said just like this: 'your kid's a *kathoey*, do you realize that?' He told Mom just like that. Mom said: 'Aw, yea, of course I know. Though she's a *kathoey*, she never does anything wrong.' She said I didn't do anything wrong, I wasn't that bad. Then he started again, 'we're Muslims, it's a sin in Islam.' And she hit back: 'How can you know it's a sin, sin, sin, maybe it's a sin but it's not a sin against you. It's up to Allah to judge, let her get her judgment from Allah. Don't you dare judge my kid like that.' ... Mom fights back with full force!"

Our participants' stories suggested that even families with less understanding about gender or sexual diversity or willingness to respect or validate their child's identity may be able to support the wellbeing of their child and to prevent mental health problems to some extent, if the family members are in good terms with each other, provide encouragement, communicate in a constructive manner, and enable their child feel that they have options in life. For example, while Mali was disappointed about their parents' rejection of Mali's *tom* partner that Mali had introduced at home, the family was nevertheless a source of warmth and strength: "I've never been so down as to grab a sharp object to cut my wrists, like I've seen so many of my friends do. I think I've never been so down. I think it might be because of the warmth my family have given me in bringing me up … it makes me think that though I didn't receive love from this person I liked, or was hated by that person, at the bottom of it I still have that love, my life is still full of love … so I keep on living and it's not hard for me to rediscover my strength."

Risk factors

Our interviewees also talked about various kinds of family adversity that constituted risk factors. Some were not connected to gender and sexual diversity, such as a family member's illness or death, financial problems, lack of understanding on mental health issues, fights between the parents, divorces characterized with strife, or in a few cases, forcing their child to study in a school or university program they did not like. Both Mali and Ter described how having been forced to study in a program not to their liking had caused their mental health to suffer (in Ter's case, to the point of attempting suicide), and both participants eventually dropped out of those programs and later enrolled in a program they felt more passionate about.

Several participants had faced verbal, psychological, physical, and even sexual violence in their families. In a couple of cases, violence was connected with fathers' excessive alcohol use. For example, Porsche explained about his experience: "but while I was growing up, I faced violence, whether physical or psychological. Papa slapped my mouth so badly it was covered in blood. Mama threw a stick at me, just because I tried to stop their fight. It's like this almost every time, going around the same loop to the point that I got used to it. Papa likes to drink a lot, with wine and liquor bottles of various brands casually lined up. Papa was drinking so much that Mama asked to divorce him, but Grandpa asked her not to … it's just getting more and more violent, more and more intense, from physical to psychological. I've been slapped or blamed a lot of times."

In many cases, risk factors were connected to a lack of knowledge, prejudice against gender and sexual diversity, and negative stereotypes related to LGBTIQNA+ groups. In Porsche's case, although the family was generally abusive, he explained that his parents did not like him being gay, either, and it was linked to their perception that being gay meant being weak (they were also scornful of his polite manners, for the same reason). Adherence to stigmatizing interpretations of religious scripture were also linked to parents' insistence that their child must not deviate from cisgender or heterosexual norms, especially in the Deep South. Parents' expectation that their child must perpetuate the family line were problematic for some, especially for those who were the only child, or the only male child in the family. B, a 16-year-old gay man in the Deep South who was not out to his parents, said: "I'm the youngest child, and the only male child. That puts pressure on me to get married." Conversely, Golf said that he did not face pressure to get married with a woman, because his brother was what he called "a real man".

In many families, patriarchal norms led family members, especially male ones, to think that it was acceptable to use violence against their offspring or to scrutinize their gender expression. Pet, a 16-year-old queer female

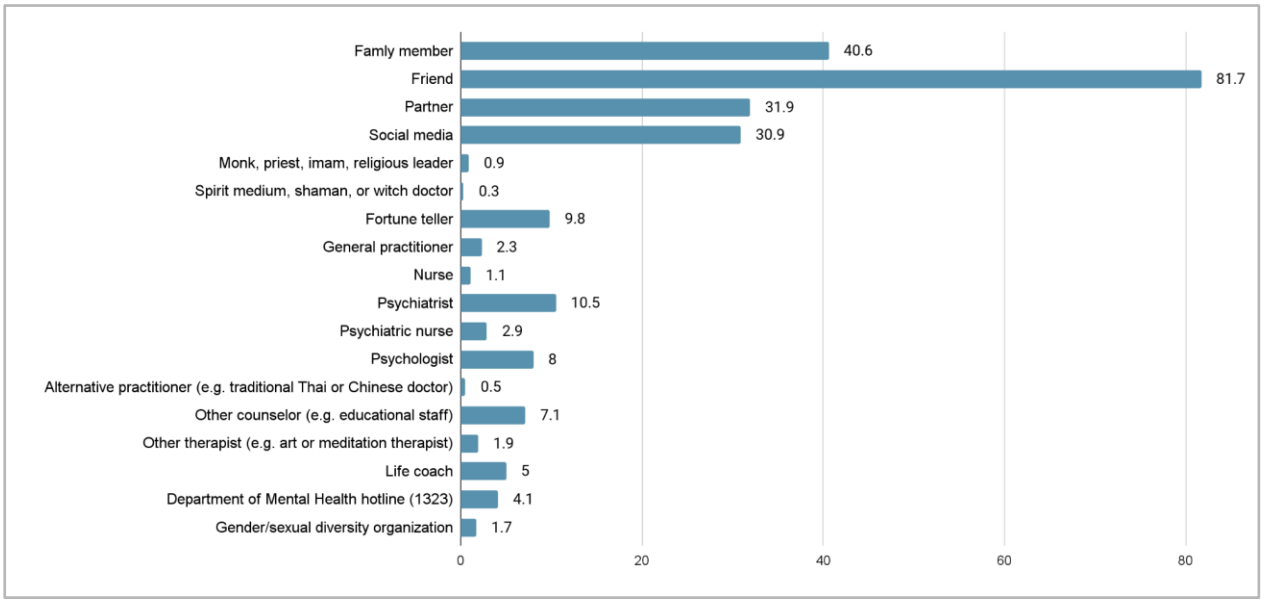
person in Greater Bangkok described her coming-out experience and its aftermath: "I told Dad and Mom: 'Dad, Mom, I don't like guys. I'm not a woman.' ... and really, they couldn't accept it. But the person who was the harshest was Dad. Dad said things like 'What? Nonsense!' and so on. And I said, 'no, I mean for real, I'm not kidding' like I'm not ... the way they think. And when they knew, what I faced from Dad and big brother was that whenever I'd do something, they'd say 'get back into being a woman, why do you do like that,' blaming me with their words, like, 'You're a woman, why do you have to go boxing, why do you do that? Why don't you behave like a woman for a change?'" Such experiences were experienced as oppressive and they were linked to our interviewees' mental health difficulties; for example, Pet said that she had symptoms of depression and panic disorder and attempted or came close to attempting suicide five times.

Community factors

Social support and mental health service use

As recognized by the minority stress model (Meyer, 2003), social support can be an important buffer against negative mental health outcomes. We measured both social support (using the validated Thai version of the Multidimensional Scale of Perceived Social Support; Sakunpong & Ritkumrop, 2021) and its sources. Looking at overall social support scores across gender identity categories, cisgender men had the highest (57.1) scores and those in the other/unsure category had the lowest (49.2). Across sexual orientations, asexual participants were the only group with social support scores (47.7) under 50. Social support scores did not differ significantly between regions or age groups.

Table 6. Sources of support accessed at times of stress, worry, or mental health problems in the past 12 months



Recognizing that children and youth may access support from numerous sources, our survey included a multiple checkboxes question with 18 response options (**Table 6**). The responses to this question highlight that the most common source of support to our participants were their friends, stated by 81.7% of the

participants. Family members, partners and social media were also common sources of support, mentioned by 30-40% of the participants. Sources of support outside the participant's immediate circle of people were each used by no more than about 10% of participants.

Thailand's mental health system is formally described as a pyramid with self-care at the base, followed by village health volunteers, then generalist nurses and physicians in primary care, then mental health services at community and general hospitals, and finally psychiatric hospitals at the tip of the pyramid (Pavasuthipaisit et al., 2016). The system attempts to leverage benefits from the large number of volunteers and generalist nurses and physicians, and accommodate the limitations due to the small number of trained mental health professionals. This structure was not reflected in our findings, where mental health specialists (especially psychiatrists and psychologists) were the most commonly mentioned formal service providers. Fewer participants received services from general practitioners, nurses, or educational staff, for example.

It has also been recognized that fortune-tellers are a popular source of support in Thailand, and there have been calls to integrate them more closely in the mental health system (Kubasova, 2021). This was reflected in our findings: A slightly larger proportion of survey participants consulted fortune-tellers than psychologists.

In the survey, just 1.7% indicated they sought help from gender/sexual diversity organizations. Our interviews clarified the role of such organizations, as seen in the section on empowerment above. This was particularly clear from the two participants who received both emotional and practical support in the context of testing HIV positive. Kla, a 24-year-old gay man from Central Thailand, described his experience of receiving assistance from the organization Pink Monkey: "Like with Pink Monkey, it's like a coincidence or my good or bad luck - I don't know. That is, someone added me on Facebook, and I checked out what kind of work they did. But I could not dream of needing to consult or ask them for advice … but they were among the first people that I realized I should go consult, because they work on these issues. I got a lot from them."

Our additional survey findings specifically on using mental health services (**Appendix 1: Tables 7-9)** highlighted gaps in accessing treatment, but also relative satisfaction when participants were able to use mental health services. Reflecting high rates of anxiety, depression, and suicidality among the participants, overall 57.3% stated they felt they had needed mental health services in the past 12 months. Across gender identity categories, this was highest among transmasculine participants (66.3%), who also reported the highest rates of mental health problems, and lowest among transfeminine participants (40.9%). Surprisingly, perceived need to use mental health services was lowest among bi/pansexual participants (46.8%), though they had relatively high rates of mental health problems, and highest among heterosexual participants (64.6%), most of whom were gender minority individuals. Across regions, Bangkok had the highest rate of perceived need (65.4%) and the Northeast had the lowest (52.5%). Age groups did not significantly differ in this regard.

Among the 57.3% who perceived they had the need for using mental health services in the past 12 months, only 21.3% actually did use mental health services. Using services when needed was most common among participants identifying as non-binary (26.4%) and least common among those whose identity could not be categorized (18.2%); there were no significant differences between sexual orientation groups. Service use rate among those with the need was the highest in the Deep South (32.1%) and lowest in other southern provinces (16.9%). Using mental health services when needed was significantly more common among 19-24 year-olds (29.1%) than 15-18 year-olds (18.6%). Overall, when asked to rate how difficult it was for them to access general and mental health services (from 1, easiest, to 7, hardest), our participants gave general health services an average rating of 3.5 and mental health services an average rating of 4.2, reflecting that mental health services were somewhat harder for them to access than general health services. A similar pattern was reported by Moallef et al. (2022a) for LGBTIQ+ adults in Thailand.

One piece of good news is that over two thirds (68.4%) of those who used mental health services perceived that their service use resulted in an improvement. This was most common among transmasculine participants (93.3%) and least common among non-binary (59.3%) and transfeminine (57.7%) participants; sexual orientation groups, different regions, or age groups did not have significant differences.

Another piece of good news is that the vast majority of participants who used mental health services (94.8%) felt that their service provider was respectful and understanding of their SOGIESC (94.8%), although there were some differences: nonbinary (89.9%) and transfeminine (88.5%) participants were less likely to feel understood and respected than participants belonging to the other gender identity categories, in particular cisgender women (99.3%), reflecting earlier research findings suggesting that transgender individuals are particularly likely to report having been discriminated against in healthcare contexts (UNDP, 2019; World Bank Group, 2018). While sexual orientation groups and participants in different regions did not significantly differ in this regard (perhaps due to small cell sizes), 19-24 year-old participants (90.1%) were significantly less likely to feel understood in and respected in terms of their SOGIESC than 15-18 year-olds (97.2%). We are unsure why this difference emerged between the age groups.

Our interviews offer a complementary picture of mental health service use among children and youth of diverse SOGIESC. From analyzing the interviews, we identified reasons why participants did or did not use mental health services, what kinds of services they knew of, were willing to use, why service providers were helpful or not so helpful, and how others reacted to the news of participants using these services.

The reasons why some of our participants chose to use mental health services included situations where they were experiencing symptoms of mental health problems. Two participants described situations in which they came to contact with mental health professionals after they had attempted suicide or when they recognized they were at immediate risk of hurting themselves. In both cases, participants met mental health professionals at a hospital's emergency department. In some cases, participants sought help in stressful life situations (e.g., death of a family member, pressure at school, difficult financial situation). Some reasons were SOGIESC-specific, such as having issues about one's identity, needing a prescription for hormones, or having to find a way to convince their parents that hormone treatment would be safe. Many said that they just searched online for the information and then went to a hospital on their own, with or without their parents' knowledge.

On the other hand, corresponding to the survey findings, there were many participants who talked about being in a situation where they might have used services, but in the end didn't. Some thought they could or should solve the situation on their own, weren't sure if their issues were "serious enough" to warrant using mental health services, or didn't feel ready to open up or raise their parents' suspicion about what was going on. Some were concerned they would be seen as a crazy person by others. One turned to religion instead. But there were also several participants who intended to use services and couldn't. In one case, a planned appointment was canceled because of the Covid-19 epidemic. In another, the participant's parents forbade the participant to use mental health services. In yet another, the parents tried this, but the participant used these services anyway. Two participants said they had tried to call the Department of Mental Health's helpline 1323, but the line was always busy, so they could not get through; a third participant did manage to get through and received appropriate help.

Participants described seeing a range of practitioners (e.g., a psychiatrist, a psychologist, or an endocrinologist) in diverse contexts such as private and public, general and psychiatric hospitals. A few used services online, and two received help from hotlines (1323 and the Samaritans). One mentioned having used the Gender Variation Clinic at Ramathibodi Hospital, and two mentioned using university-based services. Job, a 20-year-old gay man and a university student in the South, described how the counseling center at his university was designed to be welcoming and easy to use, and how this made him curious to try out the

services: "Actually, there was one time, they call it the (*name omitted*) Center of the (*name omitted*) University. This center is where students can go to talk … if they have any problems or something making them feel uncomfortable, they can talk about it, right? At that time, I liked to go to rest at the center because the … Center doesn't just have students receiving counseling … but they also have, like, a spot where students can go to relax. So I used to go to relax there, but having gone there every day with my friend, enjoying the air conditioning, every day we'd see this one room with a door and a chair and this person (*phi*) who would listen to students and is like a psychologist … so I, like, was curious, so I walked in and asked them like 'excuse me, if I wanted to use the services in this room, what do I need to do, and they told me … you can come in right away … so I walked in and brought my friend along, and then we talked about various problems, whether studies, society, family problems, or anything. It was … easy to access, like okay, 'there's no need to fill in your name … you open the door and you can sit right away.'" This experience is significant not only in being one of just two examples of participants accessing university-based services (in the other case, university student insurance paid for hospital-based services), but also reflecting how such services can be made easily accessible and welcoming.

Most reasons why participants described the services they used as helpful were related to the practitioner's characteristics, such as them being friendly, understanding, having enough time and appropriate experience to deal with the issue, or providing a safe space by listening nonjudgmentally. Some just said services were helpful because they got the medicine they needed, whereas others described more transformative experiences, such as a change in their mindset after talking with a service provider.

The practitioner being SOGIESC-sensitive was also appreciated. Rick tried summarizing in general terms what he considered helpful characteristics in mental health providers from a transgender person's point of view, reflecting many of the above points: "So, umm…firstly, they are understanding. So, they just listen to what you say and they just try to understand as much as they can. Even though, okay, they might not be familiar with, you know, LGBT terms or whatever, they try to listen and try to understand. Secondly, they respect your name and pronouns … And third one is like he tries to get the problems that I have with myself to, you know, explain it to me in a way that like you know, to make me understand myself more. And also, to explain to my parents that … it's not because I'm a bad person or anything. It's just, you know, like the chemicals in my head."

Services were seen as less helpful for diverse reasons. Some were structural issues, such as practitioners only having time for a quick chat followed by prescribing medicine, having very infrequent appointments, having to queue the entire day at the hospital, or having to travel cross-province to receive services not available in the participant's own locality. Others had to do with providers who failed to impress our participants because they were a bad listener, did not have the specific information needed, had unfriendly non-verbal communication, or spoke in a way that made the participant feel blamed. Rick felt that one provider rushed to brush aside a transgender-specific aspect of his problem: "I tell her the story like being trans and all the stuff but she doesn't really — she just seems to like skip that part and focus more on the you know the feeling empty, feeling sad part, you know? And like — you know, not really acknowledging that part of this problem is because I am going through like this identity thing as well." Porsche mentioned feeling uncomfortable with a psychologist who repeatedly teased him about his weight when measuring his blood pressure: "even though your weight is down, you still got these big arms," to the extent he did his best not to talk with that psychologist again.

When asked where they would use services if they absolutely had to, participants gave an equally varied range of answers from hotlines to online services, university-based services and hospitals. Several said they would either go to their local hospital or a psychiatric hospital simply because it was located nearby, but not all. Kla, for example, had considerable privacy concerns: "If I were to go, it would have to be somewhere where there aren't many people who know me. Like with my current [HIV] treatment, at first it was really serious for me, I was afraid of people's gaze and having the virus, but it's good it's not in my hometown, or the town where I was

born. If it were there, I might feel more stressed about it than now, because in the town where I work, hardly anyone knows me. … I think it would be similar if I had to consult with a psychiatrist, right? You have to find somewhere where not a lot of people know you." Some participants said they really had no idea. For example, when Golf, one of the deaf participants, was asked where he would go, the interpreter had to first clarify the concept of psychologists and psychiatrists. He then responded: "Where? I don't know. A psychiatrist, I could see one, but what are the steps needed, how does it work, and where? … I've never known about these things … I've just seen the name, but I didn't know what it is, nobody ever gave me training about what it is or where. If someone can advise me, I might go." Some talked about experiences of being unable to move their Universal Health Coverage insurance to a hospital that had the specific health services they needed, and consequently having to pay out of pocket at a nearby hospital that had the needed services, or having to spend a lot of time and money traveling to the hospital where they were registered.

Other people's reactions to participants using mental health services were also varied. In some cases, it was a significant other, like a parent or a friend, who took the participant to see a mental health provider in the first place. However, several participants talked about their parents or other relatives opposing their mental health service use, because they refused to believe that the participant needed such services. Porsche had perhaps the most extreme experiences in this respect: He said his mother threatened to disown him for having seen a social worker. On another occasion, his family members ganged up on him to throw away his existing medications: "I can still remember that day, all of them came, my uncle, aunt, big sister, Dad, Mom, Pa, Ma, they all came to take away my medicines and threw them away … They said: 'Why would you take those medicines? You're not crazy or anything.' … That night, I couldn't sleep a wink." He was also unfortunate enough to have peers in school, who publicly ridiculed him online for going to see a psychiatrist. Nevertheless, he did not lose his trust in mental health providers with whom he had a good experience, and hoped to become a psychologist in the future.

Peer support

As seen in the above sections, our survey findings indicated that (close) friends were the most important source of social support, the group of people with whom participants were most able to be themselves and express their identity, and the second most important category of role models.

Among our interviewees, friends were also mentioned as sources of support by roughly half of our participants. For example, Golf, who didn't have knowledge about formal mental health services, nevertheless had supportive friends who helped him feel better in times of stress: "Those two friends, I can consult them. The first one, suppose I'm stressed and confused. They'll take me somewhere to have fun, take me to go out and have a chat, or play games and so on. Those two friends will help, and if it's a secret, they will keep it." Similarly, when Tao was asked what helped him to come to terms with his HIV diagnosis, he said without hesitation: "Encouragement from friends. I have three close friends. … I told all of them. They'll take me to see the doctor … and they gave me encouragement from the beginning, from the time I found out … My close friends understand everything. Suppose I have an appointment with the doctor … I'll tell them 'can you take me to the hospital' and my friend will ask, 'What's wrong with you? Why?' and I'll say, like, I'll say 'my chronic illness, that's all' and they'll say 'Okay, sure, I can give you a lift.' And they, the encouragement from friends, with that I don't feel too troubled about it."

For many interviewees, it was important to have friends who were of the same identity, so that they would understand their identity and issues and offer support to each other. This was particularly clear in the school experience of Emmy, a 23-year-old transgender woman in Central Thailand: "it would be like, if we'd eat, we'd do it together, or if we'd go somewhere, we'd go together, gathered together … wherever a group of *kathoeys*

would be, they'd just be there, the whole set. … I think that back then, I felt that *kathoeys* had to be friends with *kathoeys*, it was that simple … because we couldn't go join the guy gang, they'd be playing football, teasing others, playing rough, having fistfights, we couldn't accept that, but there would be some groups of girls with whom we'd … we'd talk with most women, but we had our own exclusive friend group. If someone wanted to talk with us, they had to join our group, that was it. … It felt like we had power, we felt confident; I had my friends and they had me." Even as an adult, Emmy said that her closest friends were all LGBT, with similar interests.

A couple of participants said that they felt more comfortable with women in general. For example Jo, a 23-year-old bisexual man in the Northeast mentioned that he was somewhat girly. When asked if he had friends of a similar identity, he responded: "Umm, I don't, really, not at all, like, I have both men and women friends, and when I go with women, it's like [being] a boy among girls, but it's like when I go with men, it's like I don't fit in with them, they're nothing like me."

For a few participants, their partner was their most important source of support. For example, Eddie said that he had few friends and those he had were not very trustworthy. However, his girlfriend, who had moved in to live with Eddie and his grandparents, was his most important source of support, so he preferred to rely on her. Eddie considered her a family member, and they planned to study together at a university after graduating from secondary school. Tao also said that when he got his HIV diagnosis, his boyfriend at the time was very understanding, but their relationship ended later on for an unrelated reason.

School factors

As educational institutions are a place where most children and young people spend a considerable amount of their time, how schools manage issues related to gender and sexual diversity could have a big impact on the mental health and well-being of children and youth of diverse SOGIESC (Mahidol University et al., 2014). In our study, we were particularly interested in what kind of teaching, if any, children and youth received about gender and sexual diversity, what the atmosphere was like, if there was bullying or violence, and what schools did to prevent or manage these problems.

Since our participants were at least 15 years old, all of them should in principle have studied some gender and sexual diversity contents, because the national core curriculum mandates that these be covered in Health and Physical Education from Grade 7 (roughly age 12-13 years) onwards (Lekkla, 2021; Wongwareethip, 2016); until 2019 these contents were under the heading "sexual deviation." Positive teaching about gender and sexual diversity could be one form of social support, since it could help children and youth of diverse SOGIESC to understand themselves better and form a more positive view of themselves, as well as reduce bullying at the school by giving others a more positive view of their LGBTIQNA+ peers. In our survey, we asked participants: "Throughout your time as a student, have you ever studied contents related to gender/sexual diversity at your educational institution?" The response options were "No," "Yes, positive contents," "Yes, both positive and negative contents," and "Yes, negative contents." Overall, 19.3% of the participants indicated they had never studied any related contents. Positive contents only were reported by 20.1%, negative contents only were reported by 9.2%, and the majority (51.4%) reported having studied both positive and negative contents.

Given that the core curriculum was adjusted in 2019 to eliminate stigmatizing contents related to gender in general and gender and sexual diversity in particular (Lekkla, 2021), it should have resulted in younger participants having studied more positive contents. This was indeed the case: Only 7.7% of 15-18 year-olds

reported having studied negative contents only, compared to 13.5% among 19-24 year-olds. Correspondingly, 21.3% of the younger group and 16.6% of the older group indicated having studied only positive contents. These differences were statistically significant. Nevertheless, in both age groups, roughly a half had studied both positive and negative contents.

In **Appendix 1: Tables 7-9,** we report specifically the percentage who studied positive contents only. There were some significant differences between gender identity categories, with cisgender men and transmasculine participants having a higher percentage of students who reported having studied positive contents only. Since the teaching itself is unlikely to have differed much between participants in different gender identity categories, this might indicate that participants with a masculine gender identity were overall more satisfied with the teaching, corresponding to Wongwareethip's (2016) earlier analysis that core curriculum and textbook contents were particularly biased against women. Between sexual orientation groups, the differences were not statistically significant, but the highest percentage reporting only positive contents was among asexual participants and the lowest percentage in the other/unsure category. This might suggest that participants with less well-known sexual orientations could have found their teaching less satisfying. Between regions, the differences were again not statistically significant, but the percentage who reported only positive contents was strikingly low in the Deep South: just 8.2% compared to 18.9-23.3% in the other regions. This corresponds to our interview participants' experiences of many teachers in the region (although not all of them) being vehemently opposed to gender and sexual diversity.

Our interview participants' experiences of gender and sexuality related teaching mirrored the patterns in the survey, although the proportion who could remember having studied no related contents whatsoever was higher, around 15 out of 38. Just six participants talked about experiences of markedly positive teaching at some point. These experiences included teaching without discriminatory comments, a health/physical education class that encouraged equal treatment of LGBT people, secondary-school classes related to equal rights or the legal issues of civil partnership and same-sex marriage, as well as positive coverage of related contents in university-level classes on film or psychology. Champ, a 15-year-old bisexual woman in the South, was one of these participants, describing the teaching she received as follows: "It was quite okay, because they didn't teach us to discriminate, or teach us to, like, look down on anyone. They explained the characteristics of each preference and how open Thai society is nowadays, and there was no blaming or divisiveness. They gave us knowledge based on the LGBTQ+ basics." A further eight participants talked about teaching that they thought was appropriate but superficial or insufficient. The least amount of coverage was mentioned by Eddie, who noted that in upper secondary school teachers just mentioned that gender/sexual diversity exists in society, without elaborating. And Cent, a 17-year-old lesbian woman in the North, commented on the teaching that "There was not a lot. Like, they would just say, like, 'a lesbian means a woman who loves women, and gay means a man who loves men' but I'd like them to add about, like, the misunderstanding that people who are gay are prone to disease, so I'd like them to add that it's not like that."

Eight interview participants talked about teaching that was outright stigmatizing, for example teaching that homosexuality or transgenderism are sinful, wrong, abnormal, or deviant. The concept of sexual deviation (*biang-ben thang phet*) is linked to the earlier core curriculum, which endorsed using this term (Wongwareethip, 2016). Eddie, for example, remembered that this term was used in his primary school, and whenever it was mentioned, his peers in class pointed at him as an example. The concept of sinfulness seemed to be linked to specific religion classes or the teachers' own beliefs. Ice, for example, explained about her Islamic religion

classes: "They would teach about religion, teach about gender, like, you're a *kathoey*, it's wrong, it's a sin … you should change yourself more into a man, Ice." Tao remembered having been taught that anal sex poses risks for sexually transmitted infections because it's "dirty." As a gay person, he was offended by such teaching and felt it was as if the teacher was "judging on this matter - that the third gender (*phet thi sam*), or, like, having sex like this, is not good."

Our interviews were also informative on the topic of school policies and practices. Several participants studying at the university level said positive things about their university. In particular, being allowed to wear the type of gendered uniform and graduation gown they felt comfortable with was praised by several students, whether this was by policy or by administrators' tacit approval. Awareness campaigns related to gender and sexual diversity were also mentioned in some schools and universities, as were other specific activities, like flower arrangement or transgender beauty contests. While specific anti-bullying policies were not mentioned, some schools would give warnings or deduct behavior points from bullies. Several students felt grateful for having had accepting, understanding, and supportive instructors. For example, A, who was a 24-year-old trans woman in the South, remembered that when male students had ridiculed her or other trans girls in class, the teacher would intervene: "The teacher would say: 'whatever your friend is, let them be, and give your friend some respect' or the like, like blaming the guy … for going over the limit, that is, 'we're all equal,' the teacher would always teach like that."

On the side of negative experiences in schools and universities, participants talked about schools' anti-bullying measures being nonexistent or ineffective, and of teachers who spoke of homosexuality or transgenderism in a stigmatizing way. Mali observed how teachers at her former school socialized students in inflexible gender norms, for example by insisting that only boys help the teacher lift heavy objects, like chairs in the classroom. She encountered the term "sexual deviation" not only in health classes but also in the school intake form: "it's like a questionnaire, 'father's name, mother's name, names of close friends, does the student have sexually deviant behavior?' Like that, I was confused - what is 'sexually deviant behavior'? I expressed myself in a cisgender way at that time, but I didn't just like guys, I liked others too, had a [*tom*] partner, so do I need to tick this 'sexually deviant' box?"

Inflexible, birth-sex based uniform and hair regulations were a pain point for some transgender students. Eddie, a transgender man and still a secondary student at the time of interviewing, explained that he suffered from not being allowed to wear masculine hair and uniform to school from the beginning, as he had preferred boys' clothes from an early age. By the first year of upper secondary school, he found the courage to demand change: "When I was close to graduating from Grade 10, I decided to buy a boys' uniform. In Grade 11, I was taking hormones and consulted a Guidance teacher who was also LGBT and understanding. They helped to make an official request for me to be allowed to dress according to my gender, because my body was already changing. From around Grade 8-10, I'd bought hormones to take on my own, and my voice broke. At first, it was just my voice and shoulders that changed a bit, but when I took hormones from the doctor, it was body hair, mustache, voice, body shape, everything changed. [The teacher] sent the request to Student Affairs, and in the end they did not allow it, referring to personal titles being unchangeable, ministerial regulations, blah blah, and so the teacher said, 'never mind, just let him' and so I just started wearing [the boys' uniform]. … I forgot to mention, in my school *toms* also wear their hair short. It's not that there are no regulations, they're just lenient. There are only two administrative teachers [*khru pokkhrong:* school disciplinarians], but over 3000

students, there's no way they can monitor everyone." Eddie explained that students were also able to break other kinds of rules, as long as it was not blatant, so he also got away with it.

Some participants mentioned teachers doing nothing about bullying, and in some cases, being bullies themselves. For a clear example of this and how it affects students' mental health, Perth, a 16-year-old gay man in Greater Bangkok had terrible experiences from kindergarten to the end of primary school, where his teachers said that homosexuality was a sin. He explained about this in an email he sent in English to the interviewer: "Passing every year of primary school was very hard, I felt like I was in hell every time. Sometimes I just feel like, can I just pass away from this crisis by making me be like the other guys at school? And that made me enter a football team when I was in 3rd grade, I hope it will make me be like other guys." Perth explained that he eventually realized that he didn't like football and quit the team: "After I quit the team everything was so bad and I feel very hard to pass on everyday. I was often told by teachers that 'You're really smart and have a lot of knowledge, but you'll be a better man if you're not gay' and I got bullied every day by my classmates and teachers." He explained further that he thought of suicide and developed many kinds of psychosomatic symptoms and was in and out of hospital. He concluded: "In the past it was like I was trying to run away from my self and I just thinking like 'don't be gay' round and round in my head because of society pressure and expectation because of people don't understand enough about LGBTQ+. In my previous school … they said homosexuality is a sin … I think that's a big problem to make people miss understanding of LGBTQ+ community and these group of people when they [are] growing up. I think it'll be a big problem in the society. I believe that school is very important. There's a place that's like a second home for children that can change their life forever. If I don't have a chance to enter this school [his current secondary school] or don't have a good teacher like in this school, actually maybe I'm not living today, or stuck with a really bad crisis."

Gender and power dynamics

Perceived acceptance, discrimination or violence from family, peers, and teachers

Direct experiences of discrimination and violence are an important antecedent of mental health outcomes in the minority stress framework (Meyer, 2003), which refers to them as distal stressors, since they are external to the person experiencing them. Our survey had a series of questions to measure these negative experiences **(Appendix 1: Tables 4-6)**.

To measure discrimination, we used a scale called Experience of Discrimination (EOD), which has been validated for use with LGBT populations in Thailand (Kittiteerasack et al., 2020a). This scale measures lifetime experiences of discrimination related to SOGIESC across 12 contexts (our survey did not include the last question relating to blood donation, so it measures discrimination in 11 contexts). We chose to code the responses by counting the number of contexts (not number of incidents), because we felt that participants are more likely to remember accurately which kinds of negative experiences they have had, than the exact number of such experiences. On average, our participants reported having been discriminated against in 2.7 contexts. This figure was particularly high among intersex participants, who reported discrimination across 3.9 contexts. Across gender identity categories, cisgender women reported the fewest (2.2) experiences of discrimination and transfeminine participants reported the highest (3.6). Across sexual orientations, bi/pansexual participants reported the fewest discrimination experiences (2.4) and participants in the other/unsure category, the most (3.1). The number of discrimination contexts did not significantly differ between regions or age groups, but the 49 participants in the Deep South reported the highest number of them (3.6).

We asked survey participants about five types of violence victimization in the past 12 months. To make the findings more easily understandable, we simply report the percentage of participants who had at least some experience with each type of victimization in **Appendix 1: Tables 4-6.** The types were: ridicule (overall 75.8%), physical violence (overall 31.4%), online sexual harassment (overall 53.4%), offline sexual harassment (overall 57.9%), and online bullying (overall 36.0%). Participants identifying as intersex had higher than average rates of victimization of each type. The gender identity categories had significant differences in all but online sexual harassment. Physical violence victimization was particularly common among transmasculine (45.2%) and particularly uncommon among cisgender men (23.5%). Both online and offline sexual harassment were most commonly reported by participants in the other/unsure gender identity category (58.7%, 68.0% respectively) and least commonly by cisgender boys and men (48.5%, 48.1% respectively), of whom still almost a half had experienced sexual harassment in the past 12 months. Being a victim of online bullying was most common among participants in the other/unsure category (50.6%) and least common among cisgender girls and women (31.7%). Across sexual orientation groups, the prevalence of victimization varied significantly for all types except being ridiculed. Physical violence was least commonly (26.8%) reported by gay/lesbian participants and most commonly by heterosexual (36.9%) participants, most of whom belonged to gender minorities. Both online and offline sexual harassment as well as online bullying seemed somewhat less common among asexual participants than other groups (this might be because of their low visibility in society). Across regions, both being ridiculed and being a victim of physical violence were most common in the Deep South (89.9% / 38.8% respectively) whereas Greater Bangkok had the lowest proportion of physical violence victims (27.2%). Sexual harassment or online bullying did not significantly vary across regions. Across age groups, physical violence victimization was significantly less common among the 19-24 year-old participants (20.9%) than the 15-18 year-olds (34.9%) and online bullying had a similar pattern (32.0% vs. 37.3%).

Attempts to change an individual's sexual orientation or gender identity are known to be ineffective and harmful but nevertheless common in many countries across the globe (Bishop, 2019). We approached this issue from a broader angle than the usual focus on such attempts made by medical or psychological professionals, given that previous research has referred to other means Thai families sometimes seek for changing their child, such as shamanistic treatment (Ojanen et al. 2020). In the survey, we asked participants if they had ever been forced to do anything to change their gender or sexual identity. Overall, 42.4% reported such experiences, most commonly among transmasculine (61.5%) and gay/lesbian (49.8%) participants, with no significant differences between regions or age groups. On closer inspection, the findings indicate that such efforts were most commonly imposed on the participants directly by family members (33.6%), followed by educational personnel (15.4%), community members (6.4%), religious figures (1.7%), and people at the workplace (1.4%). Only 14 participants (0.5%) reported having been subjected to such attempts by healthcare providers, which is good news because it indicates that Thai medical or psychological professionals rarely engage in these harmful practices.

In our interviews, most participants reported some negative experiences related to their identity. These kinds of experiences included familial nonacceptance, as we have already seen above. Many participants felt pressured to change, get married with an opposite-sex partner, express themselves differently, or cut their hair, dress, speak, or walk differently. Many had faced ridicule or other forms of violence from peers and sometimes teachers at school. There were also disrespectful or awkward reactions from coworkers. For example, Job, a gay man in the South, had worked at a hotel during his term break, and had an insensitive, heterosexual male colleague: "I used to have a foreign boyfriend. This older colleague at work saw it … [and asked] 'Excuse me, was it big? Did it hurt?' And so on. And I was like 'Huh?' Sometimes it's like, okay, we can talk, but sometimes things like this, to talk right there … sometimes it's a topic that's a bit sensitive!"

Some participants experienced outright discrimination or negative reactions from strangers in the community, especially transgender participants. For example, A said that sometimes men ridiculed her and other trans women, forbade them to enter some venues, and she herself was even forbidden to join a camp activity arranged by her village, because they could not figure out where she could sleep as a trans woman. When she worked at a restaurant, customers sometimes protested about being served by a trans woman (in her subsequent job at a factory, she said everyone was respectful). Nat had experienced an intervention from a stranger: "Or like when I go to a mosque, 'You, you're a woman, why do you walk like a man? Can't you walk like a woman?' … So I was wearing my hijab and just walking there, and that's how I walk, and they just came up to me and started blaming me … and I didn't even know that person." Rick shared an example of being discriminated against in a research study: "Yeah, they literally said that like 'Oh, we don't accept that kind of people in this research, we only accept 'men' and 'women.' So, yeah, that was it. That was like one of the things that was really bad that happened to me."

Online spaces were not always as safe as our participants had anticipated. Mali, for example, having found a like-minded community in online non-binary circles, became a page admin, and in this capacity had to witness the dark side of social media: "Let's take the latest as an example. The past June, being Pride month, our page … had a project: 30 days, 30 identities. In the morning of each day, we'd post the flag and the meaning of one identity, and in the afternoon or evening we'd post experiences that we collected by interviewing people of those identities, and then shared their experiences. … We got seriously attacked by a group calling themselves *biao* or the like … they're a sexist group, they'd come to comment like, the experiences of the people we introduced are fake, making fun of us in various ways, like with a full-on phobia. … The person who gave the interview came to check out that post and was not okay, like 'why do page followers who come to gain knowledge have to read comments like this?' … Sometimes we'd not turned off commenting in time, or even if we did, others had shared it as a public post and added a caption that the person we interviewed saw it and now they're feeling down … the person we interviewed … they canceled it, told us not to post it. I respect them and understand that they don't feel safe … but it did make me feel sad … troll groups on the net, it looks innocuous, but these people cause a lot of damage to the mental health of people in our community." This experience adds another reason why online spaces are not always the answer to gaining better understanding about gender and sexual diversity issues - there is also a lot of toxicity and hate on social media.

Some participants reflected on internal hierarchies within LGBTIQNA+ groups, and sometimes on their own role in these issues related to gender and power. Savitri (23, identifying as *tut* and non-binary) and Ping (21, identifying as a pansexual man), both living in the North, reflected on the intra-community prejudice against feminine acting males. Men on dating apps tended to disappear after Savitri told them about being feminine-acting: "There is so much stigmatization, on open expression [of femininity] … both in terms of what I faced myself and saw … like I'd tell them that this is how I live my life, I'm not sure, I don't have definitions for what counts as being feminine-acting (*ok sao*) … but as soon as they found out, they were gone." Ping talked about practicing cheerleading at the university, and noted that when feminine-acting peers did not dance as well as was expected of them, they'd be berated with vulgar words by another person on the sexual and gender diversity spectrum, "but if it were a man in the team, they wouldn't face that, or if they were LGBT … but not as feminine-acting as this one, they wouldn't face that." Mali remembered that "a teacher would call a *kathoey* [student] to come dance in front of class and invite everyone to laugh. I was one of those who laughed, which is really bad. I didn't realize it yet back then. Or the thing about pink for girls, blue for boys. I used to have a male classmate who liked pink. Others bullied him and I joined in. That's also really bad, I felt guilty afterwards." Mali reflected that girls in her class were themselves being misogynistic when they for example ostracized a girl who was acting "too girly." Similarly, Jo thought about his role and responsibility in society's gender/power hierarchy: "Like cis[gender] gay men, they have the second highest privilege after cis hetero [people], like cis gay men, they have male privilege, and sometimes they don't care much, like they might ridicule those who are

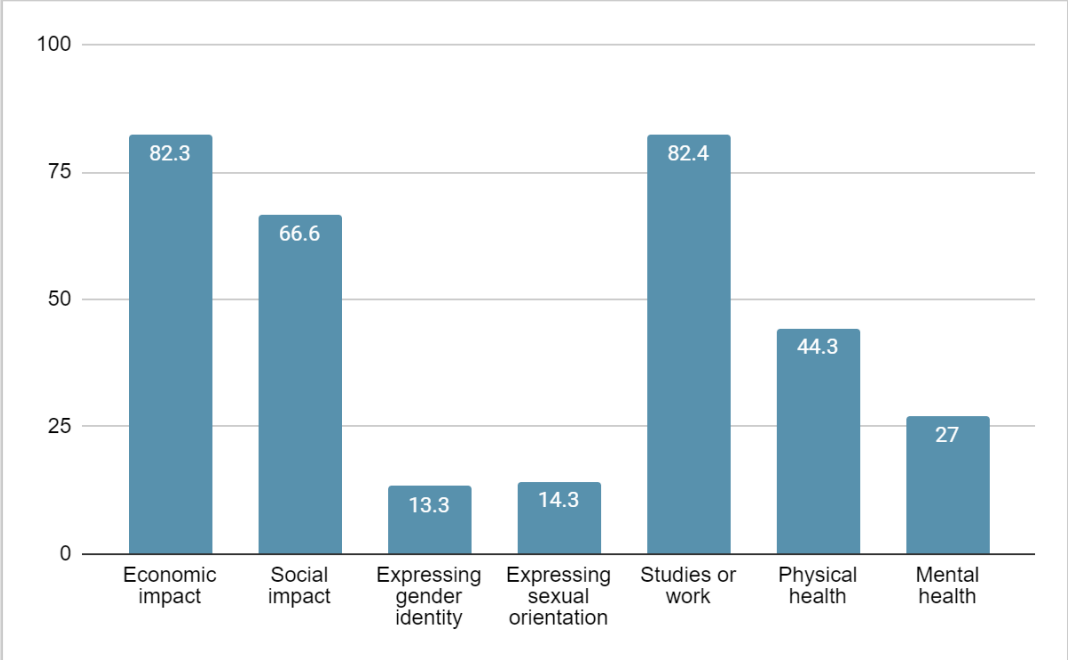
femme, or ridicule feminists … because they have that male privilege of following the standards [of masculinity] … and not make demands for trans men … because they enjoy that privilege. Actually, I also have that privilege, but I try to help make demands for others, too."

Another facet of privilege mentioned by several participants was looks. Many interviewees had memories of having been ridiculed for not looking beautiful or handsome according to Thai society's ideals, by both their LGBTIQNA+ peers and other people, both children and adults. Rick would hear from adults: "Oh, why are you not pretty like your mom?" Kla had a cleft lip and palate and was severely bullied for it as a child, until he got surgeries for it. Tao had a period when he thought he would transition into a woman, and used to hear things like "you're not pretty, you're dark, you're fat," which he tried to ignore, thinking they were an "ordinary thing in LGBT society." Eddie was ridiculed for being short. Jo, Ter, Deer, and Porsche were bullied for being "fat." Buay, a 15-year-old trans woman in the North was called a fake *kathoey* for having a large, masculine body. Tin was ridiculed for being a "*tom* with big breasts." Balloon, a 21-year-old pansexual woman in Greater Bangkok was ridiculed for breast size and having a lot of body hair. Ping was compared to other trans students and told the others were better looking. Both Po and Golf had experiences of being ridiculed by other deaf people for being "ugly" or "not pretty" (in Golf's case linked to expectations that he as a male attracted to men should transform into a woman and aspire to be beautiful in a feminine way). Print, a 21-year-old queer, non-binary, and neurodivergent person in Greater Bangkok said others would just stare in a rude manner. As these experiences show, being judged for one's looks seemed very common, and several participants felt that their LGBTIQNA+ peers were even harsher with their words than other people. Many felt angry, hurt, and insecure about themselves because of these judgmental comments from others.

Impact of COVID-19

Nearly all survey participants indicated that the COVID-19 pandemic had impacted them in some ways (**Table 7**). Most common responses included studies or work, economic impact, social impact, physical and mental health. Over ten percent indicated that the pandemic had impacted on their ability to express either their gender identity or sexual orientation (16.6% chose at least one of these options).

Table 7: Types of impact of the COVID-19 pandemic reported by participants (%)



The interviews reflected and expanded on similar themes related to the impact of Covid-19. There were some cases where the impact was somehow related to gender identity or sexual orientation. For Rick, meeting fewer people outside the home meant fewer experiences of being misgendered and not having to wear his chest binders every day, both of which felt like a relief. For some participants, having to stay home all the time was very stressful because their home was not a safe space to express their identity. B, who hid his sexual orientation from his religiously strict Muslim parents, explained: "During the Covid epidemic, I had to study at home, and so I couldn't vent about my identity; it was so tough that I thought of killing myself." Conversely, after a long period of studying online, going back to school and having to meet people could also be very stressful. Eddie was generally hiding that he was trans from most other students and worried of his secret leaking. He said he needed his psychiatrist's help to overcome the anxiety of going back to school: "The school was closed for a full year, so I wasn't used to going to school [anymore], and meeting so many people, it brought up many kinds of anxieties." Two transgender participants had their hormone use interrupted, in one case because their lowered income meant they didn't have the money to buy hormones, and in another because a news report had made her and her mother afraid of adverse interactions between hormones and the Covid-19 vaccine.

However, for most interview participants (mirroring the survey findings), the impact of the Covid-19 epidemic was similar to that experienced by other Thai youth. Many talked about financial hardship in their families, which was stressful in itself, and for some participants, it meant losing educational opportunities, because their parents could not pay their tuition fees. The epidemic also reduced the quality of their studies, for example because online classes were not effective, or because having to intern online meant not getting a genuine experience of integrating into a workplace. In general terms, the isolation, loneliness, and worrying about getting sick or transmitting Covid-19 to others impacted many participants' well-being.

Study Question #2: How do risks and protective factors operate on different levels (child as an individual, families, community and society)? What do the interactions between children, families, and societies look like, and how does it affect mental health outcomes?

Regression models to explain mental health outcomes in quantitative terms

To explore in quantitative terms how the various risk and protective factors measured in our survey could explain both positive and negative mental health outcomes, we constructed seven multiple regression models. These models assess the relative impact of the same set of predictors on depression, anxiety, and psychological well-being (**Appendix 1: Table 10**) as well as on suicidal thoughts, suicide attempts, non-suicidal self-harm, and alcohol use (**Appendix 1: Table 11**). Of the various psychoactive substances covered in the survey, we chose to focus on alcohol, since it was the only widely used psychoactive substance among our participants. These models were constructed on the basis of the minority stress model (Meyer, 2003), covering age, minority status (sex at birth), general stressors (sufficient income to cover daily expenses), distal minority stress (ever having been forced to do something for the purpose of changing one's SOGIE, lifetime number of discrimination contexts, and 12-month types of violence experienced), proximal minority stress (outness and internalized sexual stigma), as well as coping and social support (social support scores, resilience quotient scores, and having studied only positive sexual/gender diversity contents at school).

Across all seven models, resilience was a highly significant protective factor against negative mental health outcomes, and also positively associated with psychological well-being. Social support was also a relatively strong predictor of psychological well-being, but had little if any effect on the negative outcomes. Having a

sufficient income for (based on participants' own perception) was in practice used as a proxy of the general stressor of not having sufficient income, but it can equally be seen as a protective factor. Having sufficient income was negatively associated with depression, anxiety, suicidal thoughts, and suicide attempts, and positively associated with psychological well-being. Having only studied positive gender and sexual diversity contents at school surprisingly did not have a protective effect, and it was even associated with higher likelihood of self-harm. We are unsure if this finding is coincidental. Although the question intended to ask about the general tone of related teaching, participants might for example have interpreted it so that if they were taught about the social issue of SOGIESC-related discrimination, it would count as "negative teaching." If this is true, the dissonance between learning only positive contents and simultaneously experiencing SOGIESC-related victimization or discrimination might lead some students to think that something that was wrong with them personally was causing the troubles in their lives, rather than societal prejudice. This issue needs to be clarified by future research.

Of the risk factors, victimization (represented by the number of types of victimization experienced in the past year, including being ridiculed, physical violence, online sexual harassment, offline sexual harassment, and online bullying) was a significant predictor of all negative outcomes, but unrelated to psychological well-being. Lifetime number of LGBT-related discrimination contexts and ever having been forced to do something for the purpose of changing one's SOGIE were both significant predictors of anxiety and depression, but they were much weaker predictors than victimization. This might have been because the discrimination scale measured lifetime experiences, so some of the incidents might not have had much of an impact any more in our participants' lives. However, lifetime number of LGBT-related discrimination contexts was the strongest risk factor negatively associated with psychological well-being. Contrary to minority stress theory, levels of outness and internalized sexual stigma were largely unrelated to the mental health outcome variables we investigated. Higher outness and lower internalized stigma even seemed to have a minor positive association with having drunk alcohol in the past three months. This might be because children and youth with more openness about their identity and less internalized stigma might feel more confident to go out with friends and drink socially.

Background variables also played a role. Older participants were likely to be slightly less anxious and less likely to have suicidal thoughts or self-harm, but they were also understandably more likely to be drinkers. Participants who were assigned female at birth had a higher risk of each negative outcome, as well as likely to have lower psychological well-being. This corresponds to the 2013 epidemiological survey of Thai adults, in which women had almost twice the rate of anxiety and affective disorders(e.g., depression) compared to men (Kittirattanapaiboon et al., 2017). However, in our model on alcohol use, those who were assigned female at birth were also more likely to have drunk alcohol in the past three months than those assigned male at birth (contrary to the Thai epidemiological survey, in which substance use disorders were almost 10 times as common among men as women). This finding might have to do with more masculine gender norms among many of our participants who were assigned female at birth, corresponding to the finding that transmasculine participants had the highest proportion of drinkers among the gender identity categories.

Taken together, the most important findings from these models are that direct experiences of victimization are the most harmful risk factors from the point of view of mental health outcomes, and resilience is the most important protective factor among children and youth of diverse SOGIESC. In the quantitative part of Study Question 3, we use the same set of predictors (except resilience) to see if these minority stress theory informed variables could also predict resilience.

Study Question #3: How are children developing resilience? What are the key supportive factors to create/develop resilience of the children?

Regression model to explain antecedents of resilience in quantitative terms

The concept of psychological resilience refers to the ability to adapt to one's circumstances and maintain good mental health in spite of facing difficulties, or as expressed in the title of a book on resilience by the Department of Mental Health (2020b), it is an "emotional and psychological capacity that will help you to survive crises and uncertainty in life gracefully." We used a scale from this book, called the Resilience Quotient scale, which is used to measure resilience in Thai contexts. The scale measures three aspects of resilience (ability to withstand pressure, hope and encouragement, and overcoming obstacles), with higher scores indicating greater resilience.

Appendix 1: Table 4 indicates that there were significant differences in resilience scores between gender identity categories, with cisgender boys/men and transfeminine participants (i.e., two groups assigned male at birth) having notably higher scores than the other groups. Differences in resilience scores between sexual orientations and participants in different regions were statistically significant but small.

In our multivariable model on resilience (**Appendix 1: Table 12**), we again used the minority stress model (Meyer, 2003) as an explanatory framework and correspondingly selected the same predictor variables (except resilience itself) as in the models used to predict mental health outcomes under Study Question 2. Social support was by far the strongest predictor of resilience. This time, outness scores were also an important predictor, with participants who were more open about their identity with significant others having higher resilience scores. As suggested by our bivariate analyses, participants assigned female at birth had lower resilience scores than those assigned male at birth (we are not sure why this is the case, but it might be linked to experiences of male-bodied children being allowed more autonomy in childhood by their parents, which might help them develop more confidence in their own abilities). Having sufficient income to pay for basic needs also had a significant positive association with resilience. Lifetime discrimination contexts and 12-month victimization experiences were likewise significant predictors of resilience (with those discriminated against or victimized having lower resilience scores), although their contribution to resilience scores was relatively low.

Interview findings related to resilience

Our interviews also reflected what helped participants to gain resilience. Corresponding to the quantitative finding about the importance of social support to resilience, many interviewees talked about the importance of supportive relationships with parents, peers, and partners. Many also talked about supportive or more inclusive spaces, environments, and communities in general, where one could be oneself and interact with like-minded people, and where others would accept and understand what one was going through. For several participants, this meant moving to more accepting areas, whether another province or abroad. Job explained: "suppose you get into a different society, like in Bangkok or Phuket, or a city where they are more open … it'll be better … because you won't need to suffer people who question you that much, and you get to live in a society that's more open and sees your value." Print talked about finding understanding communities: "like my hobby, I grew up with dance and sports … growing up, I rejoined the dance circles, and that was my good luck, that is, dancers tend to be an environment with lots of queer people, and many of them are queer people who don't self-label, whatever…" When asked how Print found these communities, they said: "Mostly by chance, like I grew up with dance, like I said, it's so automatic that lots of queer people interact [in these circles], and

many are neurodivergent as well, so it's like I didn't try to make an effort to find them." However, this experience also shows that openness on Print's part to join these communities in the first place was necessary for gaining these sources of support.

Access to more formal sources of support, whether through NGOs, mental health services, or transgender-specific services was crucial for some, especially if they were in circumstances where a specific type of support was needed (e.g., HIV diagnosis, need for hormone treatment, emergency mental health assistance, training specifically for deaf youth with diverse SOGIESC). Rick, who used to experience intense gender dysphoria, said that "being on T [testosterone] really really helped me with everything in my life. That made me really comfortable in myself." Interactions with supportive professionals also led to transformative changes in our interviewees' perspectives. Porsche talked of a suicide attempt that brought him into the emergency department: "...and the nurse … in front of the psycho ward asked me, why were you admitted [as an inpatient]? So I told them what had happened, and this woman psychologist was there too, and she called me in to have a chat … 'by hurting yourself, it's only you who hurts, others won't get hurt with us, hurting yourself doesn't make anything better.' I heard those words and thought… 'umm, it's true what she said' , if I hurt myself, it's only me who will get hurt.'"

Insights leading to a change in one's perspective were life-saving for several participants. Pet shared hers, adding that her friends found it funny, but for her, it was profound: "At that time, I was on the footbridge around 10-11 p.m., I was there alone, sitting and crying. I had prepared myself to say goodbye to the world, everything was ready. I just sat there. My friends tried calling but didn't get through because I'd turned off my phone and everything, I had no idea. And then, suddenly, I saw a cockroach. It climbed up and it looked like it was trying to fly or trying to survive, or just live, not die. I sat there watching it, and I thought to myself, it's just an animal of that sort, but even it tries to keep on living, trying to survive. So why would I, who had more opportunities, why would I not try to live on? So that was my motivation to keep on living and adjust my perspective. That was the trigger that made me come to my senses and not do it. … It's like every time I try to kill myself, there has to be some kind of motivation that prevents me from doing it and makes me keep on going."

As suggested by the examples above, for many interview participants, the helpful internal point of view was some variant of looking on the bright side, accepting what cannot be changed, having empathy and compassion for others, refocusing on the present and mood-improving actions, as well as setting future goals. For Jay, a 22-year-old bisexual woman university student and freelance content creator in Central Thailand, exercise was the solution for short-term stress whereas goal-setting helped on deeper issues: "talking about stress, I have to mention the time when I most suffered in my life, that is when I had to choose whether to study for a Bachelor's degree. The more I compared myself to friends or my juniors, the worse it got, and in the end I had to talk with a psychologist. They gave good advice. It made me feel better but I wasn't cured yet. Then I found someone's words … 'Stress in life is mostly caused by the inability to be sufficiently responsible in some aspect of life.' … so I looked for things I'd not given enough importance yet. I started reading self-development books. From those I got the pep for a while. Put simply, I think there are two types of stress: temporary stress related to little problems and big stress about life's problems in general. For temporary stress, it might be based on our body, which then causes our mind to feel stressed. Exercise helps a lot, because it solves the bodily issue and releases endorphins, too. But for the big things, stress about life, it's mostly about not having clear goals. You have to talk with yourself [about] what you are going to do, and then set those goals and focus on them.

Focusing on goals reduces stress related to uncertainty about what you want to do in life." Jay also explained about the vision board technique (pinning pictures representing future goals on a visible board where they could be seen every day) that Jay found very helpful for staying focused on goals.

Advice from our interviewees to children and youth of diverse SOGIESC

We asked our interview participants if they had any advice for younger children and youth of diverse SOGIESC, and categorized their responses. Since the advice they shared generally reflects the issues they had personally experienced, we believe that sharing these ideas with other children and youth of diverse SOGIESC can be beneficial for their resilience.

Be yourself

Many participants advised their juniors to have the courage to be themselves. For example, Nam, a 19-year-old lesbian student in the South, said: "I'd like to say: being yourself is good, it's the best thing. Whether you like women like yourself, or you like men like yourself, I'd like everyone to accept themselves." Fa explained why this is important: "Be yourself in the way you feel comfortable! Don't care too much about other people, because they won't be in our lives forever. The one person who will be in your life forever is you. So we should be happy and confident in who we are."

Be strong, persevere, fight - it will get better

This category of advice was linked to the previous category - many interview participants reflected from personal experience of overcoming adversity that even though things can be really bad right now, it will get better with time and with continued action to improve one's life. For example, Rick said: "[if you think that], life is not well or you are never gonna be well ever again just because you are LGBT, please like think that some day, that will all pass and that you will find your spot in this world. … most of the time, it's not your fault at all, really, because it's just how the way people around you treat you. But if you find your place with the people that understand and the society that accepts you then you will be like, you will be feeling much better and that you'll feel more accepted. And you will feel more confident for yourself." Fa expanded on the importance of developing oneself: "take that time that you would otherwise spend thinking about the words others used to blame us, or didn't like us, or [said] whatever words of looking down or bullying us - take that time to develop yourself and make it better, so that those people will one day realize they did wrong: 'I shouldn't have spoken to them like that, they were after all good', let them feel guilty about it themselves, let your work slap their face rather than your hand."

Learn about gender/sexual diversity

As we saw above from the examples of many interview participants, learning more about gender/sexual diversity helped them to understand themselves and others better. So, several participants also recommended that younger children or youth of diverse SOGIESC learn about this diversity out there. For example, B said: "Know that in the world there are people of many different genders [*phet*] and they are human beings just like us." In a similar note, Po recommended that her juniors should watch foreign news, to see how gender and sexual diversity rights were recognized abroad: "I'd recommend them to watch foreign TV programs about LGBT [people] … I see news about recognition, like in the States they have rights…"

Find people or communities that accept and support you

Related to finding information, many participants recommended that their juniors seek out people who can accept and support them, in keeping with their experiences of finding supportive others, often online. Corresponding to their own experiences, Print explained: "I'd like you to feel that society is bigger than just

the world within your school or whatever circles you're in … I'd like you to see that you can come out to outside society, you can talk to other people … finding resources online to make yourself feel better, make yourself feel that you're not alone … I hope everyone could talk with strangers on a level that's still safe, so as not to be alone, because often, trying to make it alone doesn't end well."

Practice safer sex and protect yourself from violence

Given that some participants had traumatic experiences of experiencing sexual violence or contracting HIV, they wanted to advise their juniors to take precautions against these issues. For example, Tao simply said: "Be careful in your life, so you won't make the same mistake I made." Similarly, B advised: "... and protecting yourself from sexual violations, because it can happen to us … know your reserved [i.e., private] parts, even with people you trust, like your dad … Safety first!"

Seek help when needed

Finally, many participants advised their juniors to seek help when needed. Ping explained: "Find people you can consult on bullying or mental health. If you don't have anyone at home, anyone you can trust, you can call the Department of Mental Health, or go to a hospital near your home where they have a psychiatrist. Or if you study at a university or school where they have people to listen to you, you can tell them. Going to see a psychiatrist is not like you're crazy or have bad nerves."

Conclusions

Study Question #1: What are the risk factors/protective factors for mental health and wellbeing of children/youth with diverse SOGIESC?

Our survey indicated concerningly high levels of anxiety and depression (over 70% had at least mild symptoms and circa 20% had severe symptoms of either depression or anxiety) as well as suicidal thoughts (over 50%), attempts (circa 16%) and non-suicidal self-harm (25%). These rates were highest among transmasculine and bi/pansexual participants. Our interviews reflected how experiences of nonacceptance, discrimination and various forms of violence were linked with mental health problems, as were other kinds of adverse circumstances and stressful life situations. On the other hand, having access to supportive peers, families, online communities, and health professionals was helpful to our participants.

Study Question #2: How do risks and protective factors operate on different levels (child as an individual, families, community and society)? What do the interactions between children, families, and societies look like, and how does it affect mental health outcomes?

The first take-home message from our models conducted for this study question is that all kinds of violence (ridicule, physical violence, online and offline sexual harassment, as well as online bullying) had the strongest positive associations with mental health problems, including depression, anxiety, suicidality, self-harm, and alcohol use. In other words, the more experiences of violence they had, the higher the likelihood of having mental health problems was. Secondly, experiences of discrimination were associated with lower well-being scores and somewhat higher depression and anxiety levels as well as self-harm. Thirdly, participants who had been forced to do something that was intended to change their SOGIE had somewhat higher anxiety and depression scores. Perhaps most importantly, resilience was the strongest protective factor for all types of mental health problems, and it was also a very strong predictor of psychological well-being. Social support was also an important predictor of psychological well-being.

Study Question #3: How are children developing resilience? What are the key supportive factors to create/develop resilience of the children?

First, our interviewees' accounts of resilience point at the importance of finding ways to shift one's perspective. Second, our findings highlight that having sufficient social support is paramount for psychological resilience. Third, being allowed to openly express one's gender identity and sexual orientation helps to build resilience. Finally, adverse life circumstances (such as poverty, violence, or being discriminated against) reduce resilience among children and youth of diverse SOGIESC. Recalling that resilience in turn was the strongest predictor of positive and negative mental health outcomes, the overall conclusion is that when children and youth of diverse SOGIESC are supported and live in circumstances free from discrimination, violence, and poverty, their mental health will be significantly better.

Recommendations

From our interview participants

Since we asked all our interview participants what they wanted the Thai government and NGOs to do, we decided to share their recommendations here. For the research team's own recommendations, see the next section. We categorized the messages from our interview participants into the following six categories:

1. Law:

1.1 Pass a same-sex marriage law that guarantees fully equal rights to all couples.

1.2 Pass a gender recognition law (i.e., allow individuals to change their legal sex).

1.3. Strengthen legal protection against discrimination.

2. Education:

2.1 Improve teaching about mental health, gender and sexual diversity, and human rights in primary, secondary, and tertiary education.

2.2 Increase awareness-raising about anti-bullying, equality, and LGBTIQNA+ sensitivity.

2.3 Provide information to parents and guardians about mental health and gender and sexual diversity.

2.4 Tackle gender-based discrimination by encouraging gender-neutral facilities, expressions, and uniform/hairstyle options.

3. Attitudes:

3.1 Use social media, key opinion leaders, LGBTIQNA+ influencers, films, books, and songs to challenge stereotypes and normalize the image of LGBTIQNA+ people and gender/sexual diversity in Thai society.

3.2 Cultivate acceptance within families (e.g., through activities arranged by schools or local government bodies).

4. Mental health services:

4.1 Make mental health services (including the hotline 1323) more accessible for all people (e.g., more staff, increased contact channels, increased publicity, reduced waiting times).

4.2 Continue the destigmatization of mental health service use in Thai society.

4.3 Hire psychologists or psychiatrists in every school and university, and have teachers promote services.

4.4 Train medical and mental health staff on LGBTIQNA+ topics.

4.5 Increase suicide and mental illness prevention.

4.6 Expand the coverage of specific clinics for LGBTIQNA+ youth.

5. Health service costs:

5.1 Ensure that all couples (including same-sex couples) have equal rights, benefits, and welfare provisions.

5.2 Include mental health services in both private and public health insurance schemes.

5.3 Provide subsidies and financial support for hormone therapy and gender-affirming surgery.

6. NGOs:

6.1 Expand access to counseling.

6.2 Promote activities for LGBTIQNA+ youth.

6.3 Expand access to training for deaf children and youth on LGBTIQNA+ related topics (e.g., identities, sexual health, how to stay safe from violence).

From the research team

This section outlines the research team's recommendations for the Ministry of Education, educational institutions, the Ministry of Public Health, and for NGOs.

1. Ministry of Education:

1.1 Issue regulations and provide resources to educational institutions to

1.1.1 implement a whole-school anti-bullying policy that defines online and offline violence and bullying and explains why they are unacceptable, what the institution will do to prevent bullying and how incidents will be managed, specifies responsibilities of each stakeholder and builds their capacity, and creates a monitoring and reporting system;

1.1.2 use gender-neutral forms of address, allow unisex uniforms, hairstyles, and facilities (e.g. private unisex toilets and changing rooms) to provide flexibility for children and youth in expressing their gender identity;

1.1.3 explicitly forbid discrimination on the basis of SOGIESC in their regulations; and

1.1.4 increase capacity of teaching and other staff in understanding SOGIESC issues and using respectful terminology related to gender and sexual diversity groups.

1.2. Increase contents in the core curriculum of basic education that are of relevance for children and youth of diverse SOGIESC, to do with:

1.2.1 understanding and respecting all kinds of orientations, identities and expressions;

1.2.2 how to stay safe from bullying and violence, and;

1.2.3 safer sex practices, inclusive of consent and safer sex practices for non-heteronormative partners.

1.3 Collaborate with the Department of Mental health to assist educational institutions in establishing and maintaining low-barrier, youth-friendly, non-discriminatory, school-based mental health services so that children and youth will have easier access to mental health services, with referral to other services when needed.

1.4 Increase teaching that normalizes the use of mental health services and equips children and youth with knowledge on how they can take care of their mental health and where they can access services if needed, so that children and youth can access services with confidence that they won't be judged for it.

2. Educational institutions

2.1 Strive for a gender-neutral approach including how students are addressed and activities are arranged; hairstyle and uniform regulations; and providing unisex facilities (e.g., private unisex toilets).

2.2 Create a culture that respects SOGIESC diversity by

2.2.1 building capacity and improving attitudes of teachers and school staff related to SOGIESC issues and;

2.2.2 encouraging students to form clubs and informal support mechanisms open to all students to build their awareness on gender and sexual diversity issues and provide support to students who need it.

2.3 Design and implement a whole-school anti-bullying policy that defines online and offline violence and bullying and explains why they are unacceptable, what the institution will do to prevent bullying and how incidents will be managed, specifies responsibilities of each stakeholder and builds their capacity, and creates a monitoring and reporting system.

2.4 Promote understanding of mental health issues and how to access appropriate support, inclusive of

2.4.1 informing students where and how they can access mental health services;

2.4.2 increasing teachers' capacity to detect mental health issues in students and provide basic emotional support, and;

2.4.3 communicating with parents and guardians about mental health issues to improve their understanding about these issues and why children and youth may need to use mental health services.

2.5 Consult students directly (with anonymous responding options) when designing policies, activities, and facilities in cases where children and youth of diverse SOGIESC may have specific needs.

3. Ministry of Public Health, including Department of Mental Health

3.1 Increase financial resources and skilled staff in existing mental health services, such as hospital-based services and the hotline 1323, to be better able to serve the number of children and youth who need to use these services.

3.2 Expand the geographic coverage and capacity of clinics providing holistic care for children and youth of diverse SOGIESC, including transitioning-related assistance, such as hormone treatment or puberty blockers, to improve access to these services.

3.3 Provide mental health promotion activities and training that enhance resilience among children and youth, including suicide prevention campaigns for children and youth with diverse SOGIESC.

3.4 Provide additional options for mental health assistance, especially low-barrier online services, to serve children and youth who may not be able or willing to access hospital-based services.

3.5 Increase collaboration with educational institutions to provide easier referral mechanisms to services.

3.6 Educate service providers on sensitivity to gender and sexual diversity issues on a continuous basis, to ensure that children and youth of diverse SOGIESC feel understood and respected when using services.

3.7 Continue mental health destigmatization efforts to ensure that children and youth who have the need feel safe to access services without fear of being judged.

4. Non-governmental organizations, particularly those working on SOGIESC issues and/or children and youth:

4.1 Increase activities related to mental health awareness to address the specific mental health challenges among children and youth of diverse SOGIESC.

4.2 Facilitate opportunities for children and youth with intersectional characteristics, such as those who belong to ethnic minorities or are stateless, Muslims in the Deep South, or children and youth with disabilities, to advocate for their needs and access additional support and activities relevant to their specific needs.

4.3 Provide training for children and youth to be aware of their rights, how to protect themselves from all forms of violence, and how to seek help.

4.4 Provide low-barrier counseling to children and youth of diverse SOGIESC, to offer an alternative to hospital-based services.

4.5 Expand activities that increase understanding and acceptance of gender and sexual diversity among parents and other family members of children and youth of diverse SOGIESC.

4.6. Increase linkages to existing mental health services, to facilitate referrals of clients who have needs exceeding what the organization can provide.

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Appendices

Appendix I: Detailed Findings Tables

Table 1: Mental health outcomes, disaggregated by gender identity category and intersex characteristics

Variable	Gender identity category						Inter-sex	All
	Non-binary (635)	Trans-feminine (238)	Trans-masculine (104)	Cis-gender woman (1194)	Cis-gender man (405)	Other/ unsure (518)	(174)	(3094)
Depression, 9Q scale mean (2608, 2595)[a]	12.0	8.9	14.2	11.8	8.4	12.2	12.1	11.3
Depression, 9Q, % with at least mild depression (2608, 2595)[a]	77.2	52.9	85.4	74.1	52.8	75.0	73.9	71.1
Depression, 9Q, % with severe depression (2608, 2595)[a]	19.3	10.6	31.5	19.2	10.0	20.0	22.5	18.0
Anxiety, GAD-7 scale mean (2966, 2951)[a]	9.8	7.8	10.7	9.7	7.3	10.0	10.0	9.3
Anxiety, GAD-7, % with at least mild anxiety (2966, 2951)[a]	81.4	67.2	86.3	80.5	63.6	84.0	78.8	78.2
Anxiety, GAD-7, % with severe anxiety (2966, 2951)[a]	22.7	15.1	28.4	22.5	12.7	23.7	28.1	21.1
Thought of suicide in past 12 months, % (2648, 2635)[a]	63.4	46.9	67.4	58.8	46.4	61.9	66.2	58.2
Attempted suicide in past 12 months, % (2647, 2634)[a]	17.5	12.5	24.4	15.5	9.9	17.6	21.6	15.6
Nonsuicidal self-harm in past 12 months, % (2651, 2637)[a]	28.3	14.0	44.4	26.0	13.3	27.9	35.3	25.0
Psychological well-being, scale mean (2961, 2946)[a]	38.4	43.4	35.5	38.2	41.1	36.0	37.8	38.6
Self-esteem, RSES scale mean (2968, 2956)[a]	27.7	30.6	26.4	27.1	30.2	27.0	27.7	27.8

[a] Significant differences between gender identity categories (Chi-Square for categorical variables / ANOVA for continuous variables)

Table 2: Mental health outcomes, disaggregated by sexual orientation

Variable	Sexual orientation					All
	Asexual (167)	Bi- / pan-sexual (1550)	Hetero-sexual (315)	Gay/ lesbian (826)	Other/ unsure (236)	(3094)
Depression, 9Q scale mean (2608)[a]	12.8	12.2	11.0	9.8	10.6	11.3
Depression, 9Q, % with at least mild depression (2608)[a]	80.3	76.4	70.6	60.8	65.4	71.1
Depression, 9Q, % with severe depression (2608)[a]	24.1	20.8	16.5	13.6	12.2	18.0
Anxiety, GAD-7 scale mean (2966)[a]	9.6	10.0	8.9	8.3	8.8	9.3
Anxiety, GAD-7, % with at least mild anxiety (2966)[a]	78.9	82.6	80.1	69.6	76.6	78.2
Anxiety, GAD-7, % with severe anxiety (2966)[a]	23.6	24.2	18.2	16.9	17.0	21.1
Thought of suicide in past 12 months, % (2648)[a]	56.0	64.4	59.9	48.5	49.5	58.2
Attempted suicide in past 12 months, % (2647)[a]	12.1	18.5	13.6	11.6	15.8	15.6
Nonsuicidal self-harm in past 12 months, % (2651)[a]	27.5	29.1	22.0	19.1	20.0	25.0
Psychological well-being, scale mean (2961)[a]	36.4	37.8	40.0	40.1	38.2	38.6
Self-esteem, RSES scale mean (2968)[a]	27.1	27.2	28.2	29.1	27.7	27.8

[a] Significant differences between sexual orientation groups (Chi-Square for categorical variables / ANOVA for continuous variables)

Table 3: Mental health outcomes, disaggregated by region and age group

Variable	Region						Age		All
	Bangkok (840)	Central (604)	Deep South (49)	North (435)	Northeast (798)	South (358)	15-18 (2324)	19-24 (741)	(3094)
Depression, 9Q scale mean (2964, 2943)[b]	11.4	11.7	10.8	10.5	11.7	11.1	11.6	10.6	11.3
Depression, 9Q, % with at least mild depression (2964, 2943)[b]	72.7	73.0	62.5	66.2	71.9	69.9	72.8	65.9	71.1
Depression, 9Q, % with severe depression (2964, 2943)[b]	18.0	19.6	17.5	13.8	19.5	17.6	18.8	15.3	18.0
Anxiety, GAD-7 scale mean (2964, 2943)[a,b]	9.6	9.5	8.5	8.6	9.6	9.0	9.6	8.4	9.3
Anxiety, GAD-7, % with at least mild anxiety (2964, 2943)[b]	79.0	79.7	80.0	73.3	78.9	78.4	80.2	71.9	78.2
Anxiety, GAD-7, % with severe anxiety (2964, 2943)[a,b]	21.0	22.4	15.6	18.1	23.4	16.0	22.3	17.2	21.1
Thought of suicide in past 12 months, % (2646, 2628)[b]	58.4	60.7	45.0	55.1	58.7	57.7	61.7	46.8	58.2
Attempted suicide in past 12 months, % (2645, 2627)[b]	14.8	16.9	10.0	15.1	15.7	16.7	16.7	12.6	15.7
Nonsuicidal self-harm in past 12 months, % (2648, 2631)[b]	24.1	26.8	30.0	22.5	25.3	26.0	26.9	18.8	25.0
Psychological well-being, scale mean (2959, 2939)[b]	38.6	38.4	37.8	38.6	39.0	38.1	38.3	39.4	38.6
Self-esteem, RSES scale mean (2966, 2945)[b]	27.7	27.7	27.9	28.2	27.9	27.8	27.6	28.7	27.8

[a] Significant differences between regions (Chi-Square for categorical variables / ANOVA for continuous variables)

[b] Significant differences between age groups (Chi-Square for categorical variables / t-test for continuous variables)

Table 4: Substance use and possible predictors of mental health outcomes, disaggregated by gender identity category and intersex characteristics

Variable	Gender identity category						Intersex	All
	Non-binary (635)	Trans-feminine (238)	Trans-masculine (104)	Cis-gender woman (1194)	Cis-gender man (405)	Other/ unsure (518)	(174)	(3094)
Substance use								
Used tobacco products in past 3 months, % (3052, 3037)[a]	15.3	10.3	27.2	11.8	12.1	14.3	21.4	13.4
Drank alcohol in past 3 months, % (3054, 3039)[a]	48.7	44.1	56.3	42.0	44.6	45.9	56.1	45.0
Used cannabis in past 3 months, % (3054, 3039)[a]	6.0	3.4	8.7	2.8	4.5	5.0	10.4	4.3
Used krathom in past 3 months, % (3043, 3028)[a]	2.2	3.4	5.9	2.0	4.3	2.4	7.0	2.7
Used other substances in past 3 months, % (3052, 3037)[a]	0.2	1.7	1.0	0.3	2.3	1.0	5.2	0.8
Minority stress, distal								
Experience of discrimination, mean (3094, 3068)[a]	2.8	3.6	3.1	2.2	2.7	3.1	3.9	2.7
Ridiculed in past 12 months, % (3077, 3063)[a]	76.5	81.9	80.8	72.2	76.0	78.9	81.0	75.8
Physical violence victimization in past 12 months, % (3066, 3052)[a]	33.3	31.5	45.2	30.5	23.5	34.9	44.2	31.4
Online sexual harassment in past 12 months, % (3055, 3041)	56.0	50.6	55.3	53.9	48.5	53.8	58.7	53.4
Offline sexual harassment in past 12 months, % (3042, 3028)[a]	62.2	54.7	51.5	60.0	48.1	57.9	68.0	57.9
Online bullying in past 12 months, % (3050, 3036)[a]	39.2	40.0	49.5	31.7	39.8	34.5	50.6	36.0
Forced to do something for changing SOGIE, % (3094, 3068)[a]	51.3	59.7	61.5	34.5	42.2	38.0	47.7	42.4
Minority stress, proximal								
Outness scale score, mean (2761, 2750)[a]	27.5	45.2	32.9	23.5	29.9	24.4	34.2	27.4
Internalized sexual stigma, mean (3050, 3036)[a]	1.7	1.8	1.7	1.7	2.0	1.9	1.9	1.8
Resilience								
Resilience quotient (RQ) scale score, mean (2871, 2858)[a]	55.2	58.5	54.8	54.8	58.4	53.6	55.5	55.4

[a] Significant differences between gender identity categories (Chi-Square for categorical variables / ANOVA for continuous variables)

Table 5: Substance use and possible predictors of mental health outcomes, disaggregated by sexual orientation

Variable	Sexual orientation					All
	Asexual (167)	Bi- / pan-sexual (1550)	Hetero-sexual (315)	Gay/ lesbian (826)	Other/ unsure (236)	(3094)
Substance use						
Used tobacco products in past 3 months, % (3052)	9.7	14.3	11.3	14.4	8.7	13.4
Drank alcohol in past 3 months, % (3054)[a]	26.1	48.6	38.9	47.2	34.7	45.0
Used cannabis in past 3 months, % (3054)	5.4	4.6	2.6	4.4	3.7	4.3
Used krathom in past 3 months, % (3043)	3.0	2.6	1.9	2.9	2.8	2.7
Used other substances in past 3 months, % (3052)	1.8	0.5	0.3	1.0	1.8	0.8
Minority stress, distal						
Experience of discrimination, mean (3094)[a]	2.8	2.4	3.0	2.9	3.1	2.7
Ridiculed in past 12 months, % (3077)	71.5	76.2	77.7	75.8	72.9	75.8
Physical violence victimization in past 12 months, % (3066)[a]	34.9	32.5	36.9	26.8	31.2	31.4
Online sexual harassment in past 12 months, % (3055)[a]	45.1	57.5	53.2	49.1	46.8	53.4
Offline sexual harassment in past 12 months, % (3042)[a]	49.1	61.6	60.3	53.9	49.3	57.9
Online bullying in past 12 months, % (3050)[a]	26.5	38.0	34.7	35.1	35.2	36.0
Forced to do something for changing SOGIE, % (3094)[a]	38.9	40.3	43.5	49.8	31.4	42.4
Minority stress, proximal						
Outness scale score, mean (2761)[a]	19.9	24.9	28.6	34.4	22.4	27.4
Internalized sexual stigma, mean (3050)[a]	1.9	1.7	2.0	1.8	2.1	1.8
Resilience						
Resilience quotient (RQ) scale score, mean (2871)[a]	54.7	55.0	55.7	56.7	54.2	55.4

[a] Significant differences between sexual orientation groups (Chi-Square for categorical variables / ANOVA for continuous variables)

Table 6: Substance use and possible predictors of mental health outcomes, disaggregated by region and age group

Variable	Region						Age		All
	Bangkok (840)	Central (604)	Deep South (49)	North (435)	North-east (798)	South (358)	15-18 (2324)	19-24 (741)	(3094)
Substance use									
Used tobacco products in past 3 months, % (3050, 3030)[a]	13.4	9.8	10.4	17.1	13.1	15.5	12.9	14.8	13.3
Drank alcohol in past 3 months, % (3052, 3031)[a,b]	48.1	41.0	18.8	50.7	45.1	41.1	41.7	55.1	45.0
Used cannabis in past 3 months, % (3052, 3031)[b]	4.7	3.7	0.0	5.4	4.2	3.9	3.7	6.4	4.3
Used krathom in past 3 months, % (3041, 3020)	2.6	2.7	0.0	2.6	3.3	1.7	2.6	2.7	2.7
Used other substances in past 3 months, % (3050, 3029)[b]	0.6	1.0	0.0	1.6	0.4	0.6	0.6	1.4	0.8
Minority stress, distal									
Experience of discrimination, mean (3084, 3065)	2.6	2.5	3.6	2.8	2.7	2.8	2.6	2.7	2.7
Ridiculed in past 12 months, % (3075, 3054)[a]	73.4	76.4	89.8	72.8	75.9	81.7	76.5	73.3	75.8
Physical violence victimization in past 12 months, % (3064, 3043)[a,b]	27.2	32.1	38.8	30.4	33.1	37.1	34.9	20.9	31.5
Online sexual harassment in past 12 months, % (3054, 3033)	49.1	57.3	53.1	54.6	53.8	54.7	53.6	52.7	53.4
Offline sexual harassment in past 12 months, % (3040, 3019)	59.4	55.1	61.2	59.2	56.3	60.4	57.3	59.7	57.9
Online bullying in past 12 months, % (3048, 3027)[b]	33.8	39.1	40.8	33.7	36.3	37.9	37.3	32.0	36.1
Forced to do something for changing SOGIE, % (3084, 3065)	43.8	41.7	42.9	42.8	42.1	41.3	42.4	42.4	42.5
Minority stress, proximal									
Outness scale score, mean (2759, 2741)[b]	26.9	26.6	30.3	28.0	28.0	27.0	26.4	29.9	27.3
Internalized sexual stigma, mean (3048, 3027)[a,b]	1.7	1.7	2.5	1.8	1.8	1.9	1.8	1.7	1.8
Resilience									
Resilience scale score, mean (2869, 2849)[a]	54.7	54.8	55.5	56.7	56.1	55.3	55.3	56.0	55.4

[a] Significant differences between regions (Chi-Square for categorical variables / ANOVA for continuous variables)

[b] Significant differences between age groups (Chi-Square for categorical variables / t-test for continuous variables)

Table 7: Access to support and mental health services, disaggregated by gender identity category

Variable	Gender identity category						Intersex	All
	Non-binary (635)	Trans-feminine (238)	Trans-masculine (104)	Cis-gender woman (1194)	Cis-gender man (405)	Other/ unsure (518)	(174)	(3094)
Social support, MSPSS scale mean (2919, 2905)[a]	52.3	56.5	51.4	53.5	57.1	49.2	53.1	53.2
Studied only positive gender and sexual diversity content at school (3094, 3068)[a]	16.1	16.4	24.0	20.3	24.4	21.2	28.7	20.1
Knows where they could access mental health services if needed, % (3063, 3048)[a]	68.1	55.3	57.3	63.1	62.4	56.7	60.5	62.2
Perceived need to access mental health services in past 12 months, % (3067, 3051)[a]	64.5	40.9	66.3	59.7	43.8	58.8	49.1	57.3
Used mental health services when needed in past 12 months, % (1756, 1744)[a]	26.4	25.8	23.2	18.5	23.3	18.2	28.2	21.4
Using mental health services resulted in improvement, past 12 months, % (380, 378)[a]	59.3	57.7	93.3	72.6	73.2	70.9	60.0	68.4
Mental health service provider was respectful and understanding of their SOGIESC, past 12 months, % (383, 381)[a]	89.9	88.5	93.8	99.3	97.6	94.6	96.0	94.8
Perceived difficulty of accessing general health services (score from 1-7, with higher score indicating more difficulty), mean (3049, 3034)[a]	3.6	3.4	3.8	3.6	3.3	3.7	3.6	3.5
Perceived difficulty of accessing mental health services, score from 1-7, with higher score indicating more difficulty, mean (3047, 3032)[a]	4.2	3.7	4.2	4.3	3.8	4.3	4.0	4.2

[a] Significant differences between gender identity categories (Chi-Square / ANOVA)

Table 8: Accessing support and mental health services, disaggregated by sexual orientation

Variable	Sexual orientation					All
	Asexual (167)	Bi- / pan-sexual (1550)	Hetero-sexual (315)	Gay/ lesbian (826)	Other/ unsure (236)	(3094)
Social support, MSPSS scale mean (2919)[a]	47.7	53.2	54.5	54.6	50.7	53.2
Studied only positive gender and sexual diversity content at school (3094)	24.0	20.1	21.6	19.9	14.4	20.1
Knows where they could access mental health services if needed, % (3063)[a]	64.5	59.3	64.6	61.8	53.2	62.2
Perceived need to access mental health services in past 12 months, % (3067)[a]	58.7	46.8	62.9	60.2	52.0	57.3
Used mental health services when needed in past 12 months, % (1756)	17.0	25.6	20.8	23.0	17.4	21.4
Using mental health services resulted in improvement, past 12 months, % (380)	65.6	73.3	67.8	65.2	59.1	68.4
Mental health service provider was respectful and understanding of their SOGIESC, past 12 months, % (383)	93.9	96.0	94.6	91.3	95.5	94.8
Perceived difficulty of accessing general health services (score from 1-7, with higher score indicating more difficulty), mean (3049)	3.7	3.6	3.6	3.4	3.7	3.5
Perceived difficulty of accessing mental health services, score from 1-7, with higher score indicating more difficulty, mean (3047)[a]	4.4	4.2	4.2	4.0	4.2	4.2

[a] Significant differences between sexual orientation groups (Chi-Square for categorical variables / ANOVA for continuous variables)

Table 9: Accessing support and mental health services, disaggregated by region and age group

Variable	Region						Age		All
	Bangkok (840)	Central (604)	Deep South (49)	North (435)	Northeast (798)	South (358)	15-18 (2324)	19-24 (741)	(3094)
Social support, MSPSS scale mean (2917, 2897)	53.5	53.7	52.3	53.3	53.1	51.6	53.0	53.9	53.2
Studied only positive gender and sexual diversity content at school (3084)[b]	18.9	23.3	8.2	21.4	18.9	19.0	21.1	16.6	20.1
Knows where they could access mental health services if needed, % (3061, 3040)[b]	64.5	63.0	57.4	61.9	60.5	60.1	59.3	70.9	62.2
Perceived need to access mental health services in past 12 months, % (3064, 3044)[a]	65.4	55.6	58.3	54.2	52.5	54.8	56.3	60.3	57.2
Used mental health services when needed in past 12 months, % (1753, 1743)[a,b]	26.0	18.6	32.1	19.2	20.0	16.9	18.6	29.1	21.3
Using mental health services resulted in improvement, past 12 months, % (379, 376)	70.0	70.8	80.0	66.7	67.9	57.1	67.8	68.7	68.3
Mental health service provider was respectful and understanding of their SOGIESC, past 12 months, % (382, 379)[b]	92.9	96.9	100.0	88.9	96.5	100.0	97.2	90.1	94.8
Perceived difficulty of accessing general health services (score from 1-7, with higher score indicating more difficulty), mean (3047, 3026)[a]	3.6	3.7	4.0	3.5	3.4	3.5	3.5	3.5	3.5
Perceived difficulty of accessing mental health services, score from 1-7, with higher score indicating more difficulty, mean (3045, 3024)[a,b]	4.3	4.3	4.5	4.0	4.1	4.1	4.2	4.1	4.2

[a] Significant differences between regions (Chi-Square for categorical variables / ANOVA for continuous variables)

[b] Significant differences between age groups (Chi-Square for categorical variables / t-test for continuous variables)

Table 10: Linear regression models predicting depression, anxiety, and psychological well-being scores

Variable	Depression (9Q, *n* = 2042)			Anxiety (GAD-7, *n* = 2331)			Psychol. well-being (*n* = 2333)		
	B	*β*	*SE*	*B*	*β*	*SE*	*B*	*β*	*SE*
Constant	23.48	-	1.49	21.60	-	1.16	2.15	-	2.11
Age (number)	-.047	-.01	.06	-.15**	-.06	.05	.00	.00	.09
Sufficient income	-1.07***	-.07	.27	-.79***	-.07	.21	.85*	.04	.38
Female sex	2.39***	.15	.31	1.37***	.11	.24	-2.00***	-.08	.44
Lifetime discrimination contexts (EOD: number, max 11)	.13*	.05	.05	.10*	.05	.04	-.36***	-.09	.07
Types of violence victimization in past 12 months	1.02***	.23	.09	.80***	.23	.07	-.03	-.01	.12
Ever forced to do something to change SOGIE	.72**	.05	.27	.49*	.04	.21	.64	.03	.39
Studied only positive gender and sexual diversity content at school	.512	.03	.33	.09	.01	.25	-.21	-.01	.46
Outness Inventory (OI) score	.00	.01	.01	.01	.01	.01	.01	.02	.01
Internalized sexual stigma score	.27	.03	.17	-.08	-.01	.13	.15	.01	.23
Social support (MSPSS) score	-.01	-.02	0.01	.01	.02	.01	.12***	.17	.01
Resilience score	-.28***	-.37	.02	-.23***	-.38	.01	.56***	.47	.02
Adjusted R^2			**.31**			**.28**			**.38**

Note: * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$.

Table 11: Logistic regression models predicting suicidal thoughts and alcohol use

Variable	Suicidal thoughts (*n* =2071)		Suicide attempts (*n* = 2071)		Self-harm (*n* = 2074)		Alcohol use (*n* = 2395)	
	AOR	95% CI	AOR	95% CI	AOR	95% CI	AOR	95% CI
Age (number)	.89***	.85-.93	.95	.89-1.02	.88***	.83-.94	1.14***	1.10-1.19
Sufficient income	0.80*	.65-.97	.73*	.55-.97	.88	.70-1.11	1.06	.89-1.26
Female sex	1.49**	1.19-1.87	1.46*	1.04-2.05	2.08***	1.55-2.80	1.26***	1.03-1.54
Lifetime discrimination contexts (EOD: number, max 11)	1.01	.97-1.05	1.04	1.00-1.09	1.08***	1.04-1.12	1.03	1.00-1.06
Types of violence victimization in past 12 months	1.29***	1.21-1.38	1.41***	1.30-1.54	1.38***	1.28-1.48	1.17***	1.10-1.23
Ever forced to do something to change SOGIE	1.22	.99-1.50	1.20	.91-1.56	1.12	.89-1.42	1.05	.88-1.25
Studied only positive gender and sexual diversity content at school	1.00	.79-1.30	1.07	.76-1.50	1.44**	1.10-1.90	.83	.70–1.02
Outness Inventory (OI) score	1.00	.99-1.01	1.01	.99-1.02	1.00	.99-1.01	1.02***	1.01-1.02
Internalized sexual stigma score	.95	.84-1.07	1.03	.89-1.21	.82	1.42	.89*	.80-.99
Social support (MSPSS) score	.99*	.98-.1.00	.99	.99-1.00	.99*	.98-.99	1.00	1.00-1.01
Resilience score	.94***	.93-.95	.94***	.93-.96	.95***	.93-.96	.98**	.97-.99

Note: * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$. Alcohol use was measured for the past 3 months, whereas the other dependent variables were measured for the past 12 months.

Table 12: Linear regression model predicting resilience scores

Variable	Resilience (*n* = 2403)		
	B	*β*	*SE*
Constant	42.50***	-	1.72
Age (number)	.15	.03	.08
Sufficient income	1.68***	.09	.35
Female sex	-2.21***	-.11	.39
Lifetime discrimination contexts (EOD: number, max 11)	-.18**	-.06	.06
Types of violence victimization in past 12 months	-.36**	-.06	.11
Ever forced to do something to change SOGIE	-.61	-.03	.36
Studied only positive gender and sexual diversity contents at school	.47	.02	.42
Outness Inventory (OI) score	.07***	.12	.01
Internalized sexual stigma score	-.23	—.02	.21
Social support (MSPSS) score	.21***	.35	.01
Adjusted R^2			**.23**

Note: * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$.

Appendix II: Interview Guideline

1. Background

a. Please introduce yourself – what would you like us to know about you?
b. What pseudonym would you like us to use for you in the research report?
c. How old are you?
d. What do you do at present? Do you study / work? (If yes, at what kind of place?)
e. What kind of family did you grow up in? Who in your family are you close with? (probe: What do your parents do for a living?)
f. Who do you live with these days? (probe: characteristics of the place where they stay, or no place in case they're homeless)
g. What kind of area do you live in? (probe: Urban/rural, characteristics of the environment and community)
h. What religion does your family have? Do you follow that religion too?
i. Which ethnicity are you?
j. Do you have any disabilities? (If yes, which kinds? How do they affect your daily life?)
k. What word do you use to call your sexual/gender identity? And how do you understand the meaning of that word? In the English version of our research report, should we use he, she, or some other word for you?

2. Stressors and characteristics of minority identity:

a. In your life, what kinds of things make you stressed or not comfortable? What has the biggest impact on your daily life?
b. How has the COVID-19 epidemic that's lasted for a couple years now influenced your well-being? (probe: has it affected your ability to express your gender/sexual identity?)
c. How do you think these stressful things we talked about impact your level of happiness or mental health? How?
d. Have you told anyone in your family that you're [participant's sexual/gender identity word]?
    i. [if not] Could you tell me why you've not told them about your identity?
    ii. [if not] Do you think they know about your identity?
    iii. [if some family members know] How did they find out that you're [participant's sexual/gender identity word]?
    iv. [If some or all family members know] What do they think about you being [participant's sexual/gender identity word]? (Probe: past/present)
e. Besides your identity, what in your family makes you stressed or uncomfortable?

[If the participant is a student]

a. What about your school/university? Have you told other students about you being [participant's sexual/gender identity word]? What about the instructors? Have you told them?
    i. [if they did not tell] Could you tell me why you're not out to others at school/university?
    ii. [if they did not tell] Do you think the other students and instructors know about your identity?
    iii. [if they did not tell] Do you know of other students in the same situation that they've not told others about their gender/sexual identity? (probe: if yes, have you talked with them? Are you supporting each other?)
    iv. [if some/all people know] How did those students or instructors find out about you being [participant's sexual/gender identity word]?
    v. [if some/all people know] What do the other students and teachers think about you being [participant's sexual/gender identity word]? (Probe: past/present)

b. Do you have any experiences of being bullied? How did you handle it? Does your school have any bullying prevention measures?
    i. [yes] What are they like?
    ii. [no] So if there's an incident of bullying, what do you do / whom do you tell?
c. Has there ever been any instruction or talk about sexual/gender diversity at your school/university?
    i. [If yes] What did they teach/say? (probe: identities, rights, how to treat each other?) Was it from a positive or negative angle? How did you feel about what they said about gender/sexual diversity?
    ii. [Follow-up to previous question] Have you ever come across information on sexual/gender diversity online? [if yes] Was it similar or different from what you learnt at school/university?

[If the participant is working]

a. What about your workplace? Have you told your colleagues and boss that you're [participant's sexual/gender identity word]?
    i. [If not] Could you tell me why you're not out to others at work?
    ii. [If not] Do you think your colleagues and boss know about your identity?
    iii. [If not] Do you know of colleagues in the same situation, that they've not told others about their gender/sexual identity? (probe: if yes, have you talked with them? Are you supporting each other?)
    iv. [If some/all people at work know] How did your colleagues/boss find out about you being [participant's sexual/gender identity word]?
    v. [If some/all people at work know] What do your colleagues and boss think about you being [participant's sexual/gender identity word]?

[for all participants]

a. Besides from what we already talked about, are there any others to whom you've told or expressed that you're [participant's sexual/gender identity word], either in the real world or online? Why? How did they react?
b. [if the participant has told anyone] How did you feel about telling others?
c. Besides from what we already talked about, have you come across any other experiences of others not accepting or understanding you as a [participant's sexual/gender identity word] person? Please tell me what happened. (Probe: discrimination, bullying, disrespect)
d. Have you got any experiences of being judged based on your appearance? How? (Probe: Were there any experiences of other LGBT people stigmatizing you?)
e. How do you yourself feel about being [participant's sexual/gender identity word]? Why?
f. How important is being [participant's sexual/gender identity word] to you? Why?
g. Have you ever felt that being [participant's sexual/gender identity word] clashes with the other roles you have in your life? (Probe: Being a son/daughter / student at that school / employee at that workplace / a follower of this religion / at odds with ethnic group's beliefs, etc.) How?
h. Do you think that being [participant's sexual/gender identity word] makes your life more difficult? What kinds of life plans or dreams do you have? Do you think your identity is an obstacle to meeting your life goals or following your dreams? How?
i. Having reached this point in the interview, how do you feel at the moment?

2. Coping and social support:

a. When something that makes you stressed or uncomfortable happens to you, how do you cope with it?
b. How do you manage your emotions in stressful situations? (probe: Do you use any substances – alcohol, drugs?)
c. What do you have in your life that gives you encouragement or makes you feel better in stressful situations?
d. Who do you have in your life who listens to you, understands you, or helps you? How do they help you? (Probe: Do you have a partner, or are you currently dating? Do they listen to you/understand you?)
e. If you feel like you can't cope with some problems, where do you think you could access psychological support? If you use the services there, how much do you think it would help? Why? Have you ever received such services? (probe: family members, friends offline/online, teachers/colleagues, religious leaders, NGOs)
f. Do you know of and have you ever thought of using mental health services? How helpful do you think that would be? Why? Have you got any experiences related to this?
    i. [If yes] What was good for you and what was not so good, or needs improvement?
    ii. [If yes] What did you do before going to receive those services? Did you look up some information? Or consult someone?
    iii. [If not] Why have you not accessed help at the services you know of?
g. What would you like the government or NGOs to do to improve the mental health or happiness level of sexual/gender diverse youth? Why?
h. And in Thai society overall, what would you like to change?
i. Having come through some problems in your life, is there some in those experiences you'd like to share or give as advice to sexual/gender diverse youth?
j. Finally, do you have anything else you'd like to share with Save the Children or the research team?

3. Ending

a. We've reached the end of the questions now. Many thanks for the information.
b. How do you feel right now?
c. Do you have any questions for the research team?
d. Thank you for giving your valuable time for this interview.

Appendix III: Research Committee, Partner Organizations, and the Youth Advisory Board

Number of participants in the Youth Advisory Board: 24

Organizations and individuals represented in the Research Committee:

- Varoth Chotpitayasunondh, MD, Ph.D., Department of Mental Health, Ministry of Public Health
- Parinda Khongkhachan, Love Frankie
- Rena Janamnuaysook, Institute of HIV Research and Innovation (IHRI)
- Lalit Leelathipkul, MD, Adolescent Medicine Specialist, Department of Pediatrics, Sexual Health Clinic,
  Thammasat University Hospital
- Katherine Gambir, Women's Refugee Commission

Civil society partner organizations and groups:

- Bangkok and central region: APCOM, Hinghoy Noy, Non-Binary Thailand, Pink Monkey, Sisters
- Northeastern region: Isaan Gender Diversity Network
- Southern region: Luuk Rieng, Phayoon Sri Trang
- Northern region: Young Pride Club, Nam Kwan Si Rung, Phayao Youth News Agency (PYNA), MPlus, GirlXGirl

Appendix IV: Glossary of Thai terms

Bi	Bisexual
Biao	"Know-it-all" - an opinionated and arrogant person
Chai rak chai	Man who loves men
Dao / duean / queen	Literally, “star, moon, queen” (gendered categories for beauty contest winners)
Dee	Gender-normative woman attracted to *toms*
Gay	Gay male
Kathoey	Trans woman or transfeminine, sometimes used for feminine gay males
Kha	Politeness particle typically used by women
Khrap	Politeness particle typically used by men
Les	Lesbian woman
Ok sao	Feminine-acting
Phet	Literally, “sex”, but used in everyday speech for sex, gender, and sexuality
Phet thi sam	Literally, “third sex,” used by the general public to refer to LGBTIQNA+ groups
Phi	Older sibling, sometimes used to refer to slightly older persons in general
Phu chai kham phet	Trans man
Phu ying kham phet	Trans woman
Sao praphet song	Trans woman (literally, “second category girl”)
Tom	Butch lesbian or transmasculine person
Tut	Feminine gay male or transfeminine person (often used derogatorily)
Ying rak ying	Woman who loves women

Who can I contact if I have a question or comment about this document?

Dr. Timo Tapani Ojanen

Email Address: timotapaniojanen@gmail.com

Office Address: Faculty of Learning Sciences and Education, Thammasat University,
99 Mu 18, Phahonyothin Road, Khlong Nueng, Khlong Luang, Pathum Thani 12121 Thailand

Peeranee (Ami) Suparak

Email Address: ami.suparak@savethechildren.org

Office Address: Save the Children Thailand 518/5 Maneeya Centre Building, 14th Floor, Ploenchit Rd.,
Lumpini, Pathumwan, Bangkok 10330 Thailand

Contact Save the Children Thailand

Your feedback and complaints are important and will help us improve! Do not hesitate to contact us via

Phone number	:	092-418-9187 (Monday - Friday, 9:00 AM - 5:00 PM)
Email	:	feedback.thailand@savethechildren.org
ID Line	:	sci.feedback
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