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An Exploration of Young People's Experiences of Living with Mental Illness in Phuket

A thesis

submitted in partial fulfilment

of the requirements for the degree

of

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by

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(i) Yin-Yang Whirligig

A Yin-Yang Whirligig once spun me

around and around: pushing me up,

then slamming me down,

increasing the strain on my

subconscious frown. It was of my

own doing; at the ego's devise.

All the same I still think that it's

not very nice.

May everyone be

straight with me, and not hide

their truth away, as I'm

doing nowt* more than to

take life day by day.

**(Yorkshire slang): 'nothing'*

Peter (Participant)

(Poetic Self-Expression - The States of Mania)

Abstract

The primary objective of this study was to explore some of the experiences of young people living in Phuket with a mental illness. Much academic material regarding mental illness is from a Western medical perspective, leaving out consideration for Eastern cultures and context. In Phuket, life is an amalgamation of both Western and Eastern cultures, and it is not possible to research one perspective without also seeing the impact of the other. To understand how ex-pats and Thai nationals experience living with mental illness in Phuket, it is important to give people an opportunity to speak about this cultural context. Semi-structured interviews were conducted with four young adults living in Phuket with a mental illness. Thematic analysis identified common themes including where mental illness comes from, family background, interpersonal relationships, living with a mental illness, lifestyle. Participants understood their illness as arising in part from their family background, genetic components and environmental factors. Family support as well as other interpersonal relationships were important support factors for living with mental illness. Participants expressed feeling stigma from others regarding their mental illness, which led to difficulties in school, employment, housing, and interpersonal relationships. The study found that the participants had high self-awareness regarding their mental illness, their perceptions of themselves and how others view them. It is concluded that Phuket offers the participants a positive cultural context for healing based on Thai cultural values.

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I would like to take the time to acknowledge and thank all my friends in New Zealand, Australia, the United States, and Thailand for being so supportive during this, my greatest time of need. Without all your kindness, love and donations (especially in the form of money, pizza and memes!), I would not have been able to come and stay in Phuket to complete this research. I love you all so much – a constant reminder that the best family is the one you choose. Special shout outs to Sally, Holly, and Dani who have suffered through this with me almost as much as I have.

Much appreciation as well to the participants who took part in this study. Without your valuable insight, this project would not have become a reality. Thank you for your openness, vulnerability, honesty, knowledge, kindness, and laughter! Your stories will be heard, your stories will be shared, and your stories will no doubt help others who have experienced similar life journeys. My gratitude is inexpressible in words.

Thank you to my supervisors Neville and Mohi who have put up with my many annoying emails and confused jibberish drafts to finish this project. I would especially like to acknowledge my primary supervisor, Neville. Working with you has been an honour, moving from student, to fellow committee member, to supervisee. I have the upmost respect and admiration for your commitment to the field of Community Psychology.

Many thanks to my little sister Ashley, and her mother Susan. I love and miss you every single day. You gave me the strength to fight my own struggles and flourish despite them. Thank you so much for continuing to love me and have me in your life.

I would also like to acknowledge the inspiration for this project, my grandmother. I hope you are resting well and that I have made you proud. Many blessings. **ฉันรักคุณมากมากยายยาย**

And last, but not least, I would like to dedicate the completion of this Thesis to Jim Scudder, and his lovely, endlessly helpful widow, Sim Scudder. This project would not have made it without you, Jim. May you rest in peace in the great yacht in the sky, Merciless Morgan, the Scoundrel of the Seven Seas!

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Preface

It is important in Community Psychology to be transparent, and thus I think it is necessary to briefly summarise my personal background in relation to this research topic, in the interest of context.

A photo of my great-grandmother and her three sons, taken by my grandmother in their village in Thailand. This is the only photo I have of my Thai family.

I am what Thais refer to as, *khon kreung* (half person, or, mixed Thai). My grandmother, Kusol Tongbuddic, immigrated to the United States from North Eastern Thailand with my mother when she was a child. They lived in Fresno, California, where many Asian immigrants reside. Mental illness runs deep in my family on both sides. My grandmother was an alcoholic, and my mother suffered for this. My mother was sexually assaulted repeatedly by her adoptive step-father, and she was temporarily placed into foster care. Although my grandmother left her then husband, she did not leave behind her alcoholism. She had three other children. The two middle boys she left with their father, but she held onto the two girls. Abandoning children comes naturally in my family — my aunt also left her child, my grandmother on my father's side (also an alcoholic) adopted out a child, and my mother left my brother with his father, then me with my grandmother.

I was young, and my grandmother, who I called *yai-yai*, was the only family I had. We had moved to an Asian neighbourhood in Washington State, and I primarily spoke Thai. Her house was filled with smells of Thailand; incense burning, fried rice and Thai omelettes, egg rolls, humid air hanging heavy in a small dimly lit room, plants covering the entirety of one wall, golden framed pictures of the Thai Royal Family next to family photos and the High Monks, all placed above a small Buddhist shrine. I was favourited, being *see-khao thee sud* (the most white) of all the family. When I was six years old, my mother came back and took me for the

weekend, promising we were going to be together again. She left me with an elderly couple I did not know, and never returned.

My father later found me, and upon reflection, I see that out of pure bitterness he took me in as an act of rebellion, to prove he was a better parent than my mother. For an American cop, security guard, and Marine, who had worked himself out of an alcoholic and abusive childhood in a trailer park, image was everything to him. I was not without issues, having developed some problems with abandonment, but was a relatively pleasant child after some years of therapy. In my teenage years, my father remarried a third time, to a woman who I later found out was diagnosed with an extreme case of Borderline Personality Disorder. She was abusive and exceptionally manipulative in ways I still, to this day, have difficulty speaking about. During this time, I developed some severe symptoms of depression, and was in and out of in-patient hospitals, where I would do better temporarily, only to return home to abuse, and relapse again.

Eventually my step-mother got bored of abusing me and forced me onto the streets, where I spent most of my teenage years in Seattle and Portland. I tried to continue high school, but the bullying was too difficult to suffer through after rumours spread about my mental illness, drug abuse, homelessness, and many other true and untrue rumours. I was lost, rejected, hurt, broken, stigmatised, abused, and confused, over, and over again. On the streets I met others with similar stories, similar traumas, and similar illnesses. We created our own family, and with the help of outreach centres and homeless shelters, I was able to get a job. By the time I was 17, I was off the streets, in my own home, with steady employment, and a General Education Diploma. My aunt found me through the wonders of the internet, and I finally reunited with *yai-yai* again, soon before she passed away from cancer.

A photograph I took of myself and a close friend on the streets of Portland, Oregon. Printed in a dark room provided by an outreach centre. Art was a great form of coping for street kids.

To this day I still battle with symptoms of trauma, abandonment, and depression. This project alone was an excruciating battle with the symptoms of my illness. But when I left the United States to come to New Zealand, I saw a definitive shift in how mental health was dealt with and understood. I had studied already for two years in the States, but never considered that there were other ways to look at mental health besides treating the individual with therapy and psychotropics. A bi-cultural nation, New Zealand attempts to work towards progressing psychology in cultural contexts, something the United States does not focus on. Community Psychology looks at the overarching context of how mental illness develops and is maintained through social structures, rather than blaming the individual, which is all I had ever experienced in the States. As I reflected on my own life, and learned more in New Zealand, I began to wonder to what extent culture impacts mental health in other parts of the world. I also took great interest in how Māori culture focuses on the concept that a powerful sense of identity and connection to *whakapapa* (genealogy) is correlated with positive mental health. I began to wonder if part of what I was missing, and part of what I needed to understand in order to become a decent Community Psychologist one day, was my own ancestry and identity.

I decided I wanted to give back to *yai-yai*. I wanted to make her proud. When I met her again when I was 18, she was disappointed to find that I could no longer speak *pasaad Thai* (Thai language). She just kept telling me not to worry though, that it would come back. Unfortunately, she passed before I ever got to speak with her in Thai again. Coming to Thailand to work on this research was not only a journey for my education and research, it was also a journey for my own self-healing as well. I wanted other people who felt dislocated, alone, stigmatised, and abused, and were living in grief, to be heard. I wanted to see how they dealt with life, and if that was similar to how I had experienced my own transitions through life and mental illness. I wanted to know if they had found some sense of peace and community connection here in Thailand, as I did. I felt that after everything I had experienced, it was important that I give back to the community, to immigrants, to people suffering from mental illness, to people

กินข้าวกลางวันกับครอบครัวไทยใหม่ของฉันที่ภูเก็ต
(eating lunch with my new Thai family in Phuket!)

who are dislocated and abandoned. I feel lucky and so blessed to have been given the opportunity to do so for this project, and I hope to continue helping these voices be heard as I develop as an academic and professional in the future.

Thesis Outline

This thesis is divided into four main sections; the introduction, methodology, findings, and conclusions. Chapter one, the introduction, will cover relevant background literature regarding the history, aetiology and prevalence of mental illness, and review the four disorders the participants in this study live with; depression, anxiety, bipolar, and intellectual disability. This section also briefly explores how living with a mental illness affects people through label stigma, their interpersonal relationships, and their lifestyle. It will conclude by giving a succinct overview of Thai values and the details of the current study.

The second chapter will cover the methodology utilised to collect data for this study. This section will describe the theory of qualitative research methods, the use of semi-structured interviews and thematic analysis, as well as why these methods were chosen for this research. There will also be a detailed description of the recruitment process, a brief overview of the recruited participants, the procedure via which the data was collected, and ethical considerations.

Chapter three discusses the findings of the study. This part of the thesis includes quotes from the participant interviews, as well as analysis of the themes and discussions. Here there will be brief background summaries given for each participant and an outline of the discovered themes and sub-themes. The primary themes identified through thematic analysis were family background, interpersonal relationships, living with mental illness, where mental illness comes from, and lifestyle. These themes are discussed and analysed, and include quotes from the interviews from each participant to support the findings.

The closing chapter draws conclusions from the gathered data, reflects on how the study could be improved, various strengths and limitations, the implications of the results, and considerations for future research.

Chapter 1: Introduction

While a great deal of research has been done on the Western medical perspective on mental illness, dominating the academic material available on the subject, much less has been explored in terms of Eastern cultures and perspectives. As far as research done in Thailand, the gathering of information for this study only proved the lack of research done. In order to understand better how culture can affect individuals in their beliefs of what mental illness is, how it is viewed, treated, or how treatment is accessed, and to what extent, it is essential to view the dominant Western model along with other Eastern models, and how they uniquely combine to create the experiences of Thailand-based individuals living with a mental illness. In Phuket, an urban area shaped by tourism and dense English-speaking communities, life for *khon Thai* (Thai people) is distinctly different from other parts of Thailand. For ex-patriots living in Phuket, this experience is yet again unique, living away from familiar culture, friends, and family in South East Asia.

What is a 'mental illness'?

History

Over the last half a century, there have been significant changes to what is defined as a 'mental illness' in the West. Definitions of mental illness now include a greater pool of information, with a more holistic approach — focusing on the importance of mental health and overall well-being through positive psychological functioning.

As late as the 1970s, in the United States, mental illness was defined primarily by diagnosis, and disorders were still very broadly classified (Manderscheid et al., 2010). Statistical data was reported only by official diagnosis. People with mental illnesses were often institutionalised and severely stigmatised. It was during the 1970s that deinstitutionalisation began, and changes rapidly accelerated. By the 1990s, people with severe mental illnesses were being released from institutions, without the community resources to offer them support. The homeless population increased, and it was undeniable that new definitions were necessary to identify mental illness and create a new applicable framework to support them. The National Institute of Mental Health proposed that diagnosis alone was not enough to define mental

illness, and that further clarification of both duration and disability were necessary to define a debilitating mental illness (Manderscheid, et al., 2010). The definition of mental illness was changed to include disability, as in an inability to engage in functional everyday activities, and duration, as in a long-term chronic illness (Manderscheid, et al., 2010). Recovery and re-integration into the community became the goal of mental health treatment, with recovery being a process over a life-time, focusing on maintaining positive mental and physical well-being, and minimising negative symptoms (Manderscheid, et al., 2010).

Increasingly, Western approaches to mental illness are becoming more holistic and wellness-centred, viewing disease in two different dimensions: the weakness of disease, and the strength of health — bridged together by recovery (Els & De La Rey, 2006). Both positive physical and mental well-being is the goal of treating mental illness. Within the broad definition of 'positive well-being' are two orientations: happiness, and human potential. Psychologists have increased their interest in subjective well-being in overall satisfaction in life and personally inventoried ratings of happiness as it pertains to motivational process and judgement (Diener, 2000). There is also now a more dedicated concentration on psychological functioning in the broader capacity of human potential, in development of meaning, growth, and personal capacity (Neugarten, 1973). Positive psychological well-being explores a variety of experience; control, love, creativity, resilience, spirituality, compassion, and optimism (Manderscheid et al., 2010). Since the definition of mental health and illness has shifted to the concept of psychological well-being, studies have investigated areas of positive relationships, personal growth, life satisfaction, purpose, self-acceptance, environmental mastery, and autonomy (Keyes, Shmotkin, & Ryff, 2008).

In the West, the dominant view of mental illness, especially within psychiatry, is that 'mental illness' encompasses a wide variety of medical conditions, primarily marked by disorganization of the mind, personality, emotions, disability, and distress that disrupts functional feeling, mood, thinking, behaviour, and social interactions (Mental Illness, 2018). Mental illness can include the categories of depression, bipolar, schizophrenia, psychosis, dementia, intellectual and learning disabilities, developmental disorders, personality disorders, and a variety of other psychological disturbances (WHO, 2017). Mental disorders tend to have a set of loosely

correlated features which characterise them — the more attributes present in an individual case, the more severe the illness is considered (McNally, 2011).

Many Eastern countries have also taken on the development of public health psychiatry based on Western methods. In Thailand, although never formally colonised by Westerners, Siam Kings have been working on adopting active policies based on Western techniques and knowledge since as early as 1826, when Western medicine was originally introduced by foreign missionaries (Brummelhuis, 1980). By the end of the 1800s, these practices gained generous government support, and health facilities began gradually expanding with more public hospitals and health stations throughout Thailand. In 1892, the first medical school was founded in Thailand, and after 1907 indigenous Siamese medicines were phased out of the health care system (Riley, 1975). Most healthcare in Thailand is under the control of the government, and set up according to the criteria of the modern West. However, unlike Western medical care, outside of the public healthcare system doctors tend to work additionally in private practice, where more traditional methods of medicine are utilised. These streams do not work separately, or oppose each other, as in India or China (Cunningham, 1970). They exist out of a respect for ancient cultural elements, as well as an understanding of the importance of modernism and scientific medicine. Psychiatrists working in Thailand generally train abroad after receiving medical training in Thailand. Despite having established a Psychiatric Association of Thailand in 1955, few psychiatrists are trained in Thailand. (WHO, 2006)

Much of the development of psychiatric care in Thailand has been a initiated by the government, including the facilities and psychiatrists who work as civil servants (despite usually having their own private practices as well). The first psychiatric practice was established in 1889 in Thon Buri. This facility was primarily utilised to lock up 'socially uncontrollable' individuals who were without family care — many were Chinese immigrants. Much of the treatment provided for these patients consisted of traditional herb therapy, magic spells, and chair confinement (Brummelhuis, 1980). Around 1930, Thai doctors began studying modern psychiatry abroad, and further psychiatric hospitals opened and began modernising to the prevailing Western standards. Institutions were established in Surat Thani, Chiang Mai, and within and near Bangkok. Since then, psychiatric care in Thailand has rapidly developed. New

facilities have become more specialised, aided by agencies such as the World Health Organisation — setting up child guidance centres, homes for people with disabilities, neurological hospitals, drug addiction treatment centres, and forensic psychiatry practices. Unfortunately, most of these facilities are located in, or very near to, Bangkok. Outside of Central Thailand, specialised facilities were built in Songkhla, Chiang Mai, and Khon Kaen, but no specialised hospital has yet been established in Phuket. WHO (2006) notes that there has been a disproportionate amount of mental health resources concentrated in main cities, limiting access to rural users. There are no established community residential facilities or day treatment facilities in Thailand, although some temples are involved in housing patients discharged from psychiatric facilities.

Although the Thai government has supported Western methods of diagnosis and treatment of mental health issues for a long time, many average *khon Thai*s, particularly elders, those in villages, or those who have a deep association with Buddhist or Muslim belief systems, tend to appreciate and utilise more traditional methods of understanding and treating what Western perspectives describe as mental illness (*jid paed*). Thai people have a deep sense of pride, dignity, and independence, and do not like to violate this sense of the ego (Komin, 1991). Mental illness is stigmatised in Thailand, and can bring perceptions of insult or shame upon an individual with a mental illness, or those close to them. This can provoke a strong emotion as a reaction to losing 'face' and dignity (Lam et al., 2010). In order to protect the ego, Thai people create avoidance mechanisms to alleviate negative feelings or emotional outbursts, as taught in Buddhism through values of detachment, selflessness, and avoidance of emotional extremes. There is an underlying feeling or need to avoid criticism, to be considerate of the feelings of others, to not impose or hurt others' feelings (*kreung jai*). This sense of 'face' is very sensitive and requires a delicate balance of interaction between the familiar and the unfamiliar, the superior and the inferior. This means that although the government has gently pushed the public towards mental health awareness and Western methods (Fernquest, 2012), 'saving face' often remains the more important goal. Often families will care for mentally ill people at home in order to 'save face' (Burnard, Naiyapatana, & Lloyd, 2006).

In Bangkok, where there are easily accesible forms of Western treatment, mental illness is understood from a more Western perspective, but in other parts of Thailand where access to

these resources is more limited, understanding and treatment of *jid phaed* is more traditional. Definitions of mental illness and how it is treated will be dependant on where the individual is located, the severity of their 'illness', the perceived cause of the illness, access to reources, and underlying spiritual belief of the causes and treatment of *jid phaed*.

Aetiology

Most mental illnesses evolve from a unique combination of genetic and environmental influences, according to modern Western perspectives (Elder & Mosack, 2011). These influences impact heritability and severity of symptoms in an individual with mental illness. A researcher can assess the degree to which an individual may be at risk of a mental illness regarding genetic influences and environmental risk factors, by utilising genetic epidemiological techniques (Danese, 2008; Kendler, Thornton, & Gardner, 2001). Although genetic factors may put someone at risk of inheriting a mental illness, symptomology is caused by the complex interaction between genetics and environmental triggers (Sullivan, Neale, & Kendler, 2000).

In a theory presented by Paul McHugh (2005), mental disorders appear in four distinct clusters: what people 'have'; who people 'are'; what people are 'doing'; and what people have 'encountered'. In the first cluster, of what people have, or what people possess in terms of brain pathology, structure, and function, includes diseases that produce disturbance in emotion, cognition, and perception, such as bipolar disorder, schizophrenia, and Alzheimer's disease. The second cluster, of who people are, or what they are like in terms of temperament, includes extreme traits along the Big-Five factor structure of personality (McCrae & Costa, 1987), which lends to vulnerability in everyday life challenges. The third cluster, of what people are doing, refers to behavioural patterns that offer immediate positive rewards but later negative consequences, such as drug and alcohol addiction. The fourth and final cluster, of what people have encountered, extends to trauma-related psychological issues, such as post-traumatic stress disorder. People with mental illness often have co-occurring illnesses, which may fall into more than one of these clusters.

However, differing cultural expectations can define mental illness alternatively to the Western model. The symptoms someone may be diagnosed by may differ from setting to setting,

culture to culture. In Luhrmann, Padmavati, Tharoor, & Akwasi's study (2015) for example, the researchers found that the perceptions of whether hearing voices was negative or positive varied between cultures, with participants from California describing voices as intrusive and unreal, whereas participants from South India described them as providing valuable advice, and West African participants described the voices as good and powerful. If an individual hears voices from what they consider to be a spiritual guide, they are less likely to report it and treat it as a mental illness. In Thailand, research shows that although most *khon Thai* view the causes of mental illness to be either effects from drug abuse, brain pathology, genetics, environmental factors, or family break down, some people believe that *jid phaed* is caused by ghosts and spirits because the individual has done something bad (*tham mai dee*), or because they have bad karma (*kam*) (Burnard, Naiyapatana, & Lloyd, 2006). Many Buddhists also believe in the animist concept of a 'life spirit' (*Kwan*), and in the case of mental illness, it is believed that *Kwan* has left the body, and must be replenished in relation to the subconscious mind. These traditional beliefs are more common amongst people who live in rural areas, but sometimes they are also still held by people educated in Western medicine and practice, which can be an area of personal inner conflict.

Prevalence

Globally, an average of 29.3% of adults experience some form of common mental illness in their lifetime (Steel et al., 2014). Across both wealthy and impoverished countries, males are more likely to experience a substance or alcohol related disorder, and females are more likely to experience an anxiety or mood related disorder. According to the World Health Organisation (2017), although there are an estimated 450 million people in the world who suffer from mental illness living in developed countries, fewer than 10% receive medical treatment for their disorders. In countries with less access to resources, money, adequate health care, and safety, mental healthcare is even more uncommon (Miller, 2006). Almost a third of the world's nations have no budget for mental healthcare. Some countries afford only the meagre amount of a 1% allocation to mental health budgets. Unfortunately, the mentally ill are most disadvantaged in impoverished communities, with mental illness reinforcing the continuation of poverty. Mental health issues have comorbidity with heart disease, alcohol abuse, and cancer, with WHO (2017) estimating 45% of people with tuberculosis or HIV developing

depression. People suffering from mental illness are less likely to seek out and maintain therapy, not only for their mental illness, but also comorbid physical ailments as well (Miller, 2006).

The most prevalent mental disorders in the world population are depressive disorders and anxiety disorders (WHO, 2017). According to the World Health Organisation (2017), it is estimated that more than 300 million people suffer from depression (4.4% of the global population), and nearly the same number suffer from anxiety. Almost half of the population suffering from depression live in the West Pacific and South-East Asian regions. Globally, depression is ranked as the fourth leading cause of disability in the world. This increases for people aged 15 – 44, with depression ranking as the second highest cause of illness, along with alcohol abuse, schizophrenia, self-harm, and bipolar disorder also within the top 10. In Thailand, depressive disorders rank as the sixth most debilitating health problem, and anxiety disorders as the ninth (IHME, 2016).

As Brummelhuis (1980) points out, not all people with mental illness appear in statistics compiled by separated divisions. For example, in Thailand the Division of Mental Health is separate from the Division of the Ministry of Public Health, which is again different than the governing divisions for military and police hospitals. The number of people who access private practitioners is also unknown. It is difficult to be able to ascertain how many people utilise more traditional forms of treatment such as faith healing, spirit doctors, or other traditional healing practices. This poses a drastic limitation to acknowledging the potential reality of global mental illness. In Thailand, where Western medicine has become so accessible and trusted, it is also difficult to estimate the extensive service local pharmacies (*khai-yaa*) offer for people with mental illness, who can easily buy drugs such as Tramadol, Diazepam, and Xanax over the counter to treat their symptoms, without ever having to consult a specialist. It is likely many people suffering from symptoms of mental illness use these alternative forms of self-treatment, and are unaccounted for in mental health statistics.

As I have discussed with some nurses and families in Thailand during my research, many patients who do make it into a mental health facility for treatment in Thailand have a personal relationship with someone in the hospital. It is not often that people seek out and are allowed into these facilities without an 'in'; it is a very selective processes. Brummelhuis (1980)

describes observing the selection process for admission into psychiatric facilities as requiring one or more of the following factors: the individual has no one to care for them; they live in or near Bangkok; the case is 'interesting'; there are family or acquaintances working in the hospital; or the individual has money. The most frequent admissions within these hospitals tend to be cases of mental illness that have become too disruptive for the family to cope with. Again, this reiterates the potential of many people suffering with mental illness in the general population to remain statistically unaccounted for, due to 'manageable' symptoms of illness and alternative perceptions of what is acceptable social behaviour from one culture to another.

As well, although prevalence of mental disorders may seem higher in one cultural group than another, this may not be accurate. Social cultural expectations also alter perceived fears and anxieties between cultures. When utilising Western measures of social anxiety, Asians tend to consistently rank higher in levels of anxiety than Westerners (Hong & Woody, 2007; Lau, Fung, Wang, & Kang, 2009). This is perhaps because Western scales tend to base their measurements on Western concepts of distress, which in Asian contexts, can be not only advantageous, but also socially valued (Hong, 2012). What Western scales may perceive as 'anxiety' is not labelled as anxiety in Eastern cultures, but simply as beneficial social attributes. Independence and self-assertion are valued traits in Western culture, encouraging emotional expression in daily situations, and suppression of emotions primarily to withdraw from social threats (Gross & John, 2003; Wierzbicka, 1994). Asian cultures on the other hand, tend to value relationship harmony and interdependence, which can encourage emotion suppression to attain prosocial goals and maintain positive interaction, such as when there is concern about hurting someone's feelings (Butler, Lee, & Gross, 2007).

Depression

The word 'depression' comes from the Latin root *deprimere*, which translates to 'press down', or to feel heavy, sad, or down (Kanter, Busch, Weeks, & Landes, 2008). According to the Oxford English Dictionary (1989), the term 'depression' came into use in the West in 1665, to describe a lowering of spirit or mood. In major depressive disorder (MDD), depressed mood or dysphoria is the primary feature, with additional symptoms including, but not limited to, changes in sleep and appetite, lack of interest in activities, feelings of guilt, hopelessness, helplessness, fatigue, concentration issues, restlessness, and suicidal ideation (Líndal &

Stefánsson, 1991). The symptoms of depression vary greatly from person to person. Some people experience symptoms of decreased appetite and insomnia, whereas others may experience increased appetite and hypersomnia during depressive episodes. Others may experience feelings of agitation or limited psychomotor functions, feelings of overwhelming sorrow, or no feelings at all. The commonality across the spectrum of depressed individuals is the shared depressed mood symptom, with a variance in duration, severity, time course, and correlated symptoms.

Stirling (1999) describes five areas of change during a depressive episode; mood symptoms; patterns of speech and thought; suicidal ideation; perceptual abnormalities; somatic or bodily symptoms; and effects on behaviour. Mood symptoms include severe and persistent lowered mood, identified by self-described profound sadness or flatness. Some people may experience predictable shifts in mood during the day, and elevated levels of anxiety. The category of speech patterns, thought, and suicidal ideation are characterised by slow and monotonous speech, along with distorted negative feelings of guilt, sometimes marked with the development of delusions, self-blame and rumination. This blaming can be real or imagined, focusing on themselves or the people around them. Often, these thoughts and feelings can be accompanied by vague sentiments of suicidal ideation, or even suicide attempts. Perceptual abnormalities refer to severe states of depression that may lead to auditory or visual hallucinations, such as in depression with psychotic features (Rothschild, 2013). Somatic or bodily symptoms, or biological symptoms, indicate moderate to severe depression, with common issues of sleep lethargy, appetite increase or decrease, reduced libido, increased concern for illness, and heightened hypochondria (Rothschild, 2013). Effects on behaviour include a lack of interest or enjoyment in activities a person once had, or anhedonia. People suffering from anhedonia may lose interest in work, home maintenance, and taking care of themselves or their appearance (Rothschild, 2013). Some people may have symptoms of agitated depression, constantly fidgeting or pacing, or conversely, their behaviour may slow down substantially (Rothschild, 2013).

From a Western medical perspective, depression is described as a neuropsychiatric illness caused by complex interactions between environmental and genetic influences, impacted by the development of severe negative symptomology (Elder & Mosack, 2011). These symptoms

are generally experienced episodically, often treated in a primary care or mental health facility (American Psychiatric Association, 2000). A study presented by Sullivan, Neale & Kendler (2000) attributes heritability of depression to be 38% (with a 95% confidence interval). However, early onset depressive symptoms which are severe and reoccurent are correlated with a higher heritability rate than less severe cases of depression (Belmaker & Agam, 2008). Findings in identical twin, adoption and family studies confirm the significant genetic influence of depression (Kendler, Gardner, Neale, & Prescott, 2001; Lau & Eley, 2010). The original studies of the correlation between genetics and mental illness were designed through the twin studies model (Kendler, Thornton, & Gardner, 2001). These studies reported increased risk of depression in families where depression had previously occurred (Sullivan, Neale, & Kendler, 2000). Genetic studies have begun to focus on particular genes that may provide insight into depression, since biotechnology has advanced over the years, and several specific gene classes have been identified that may indicate depression (Haeffel et al., 2008; Kato, 2007). These twin studies have provided strong empiricial support that genes may even play a role as high as 50-70% of the aetiology in depression (Sadock & Sadock, 2007). With genetic aetiology playing such a large role in depression, pharmological treatment is often helpful through interventions which offer norepinephrine and serotonin reuptake, targeting depressive symptoms through their neural pathways (Belmaker & Agam, 2008). Anti-depressant treatment can be offered by a general practioner without referral. Many people suffering from depression rarely seek out a clinical or behavioural specialist for treatment for a variety of reasons, from lack of accessibility, affordability, religious beliefs, to denial, stigma, and shame (Kessler, McGonagle, Swartz, Blazer, & Nelson, 2003).

In the Thai language (*pasaad Thai*), there are words to describe depression such as: *rok-sum-sao* (tired, sad, illness), *hod-hoo* (feeling down/lack of motivation), *kid-mak* (overthinking), and *mai-sabai* (not good) (Lotrakul & Saipanish, 2009). But like other Asian ethnicities, Thai people often describe depressive symptoms alternatively through physical complaints of headaches, back pain, muscle pain, indigestion, lack of appetite, constipation, insomnia, tiredness, weakness, and vertigo (Herrick & Brown, 1999). This expression of depression in somatic symptoms is probably due to the stigmatisation of psychological illness, and is considered more culturally acceptable (Soonthornchaiya & Dancy, 2006).

Similar to Western cultures, there are also gender issues with how depression is 'unmasculine'. In one of the few studies on depression in Thailand, presented by Rungreangkulkij, Kotnara, Kittiwattanapaisan, and Arunpongpaisal (2012), the researchers found that depressive symptoms of males in Thailand often go undiagnosed and untreated because of the perceived importance of maintaining masculinity, and how depression is conceptualised. The participants in this study described depression as a feeling of being upside down, trapped in their thoughts, leaning on something, spiralling downwards, and feeling weak. Intimidated by the gender roles of masculinity, these participants originally sought help for somatic symptoms. Taking medication is considered 'weak' in Thai culture, and most participants chose instead to cope with symtoms of depression through practicing Buddhism, drinking, and engaging in pleasurable activities. How these perceptions may affect women in Thailand remains relatively unresearched.

Anxiety

Anguish and anxiety share the Latin root of *angustĭa,* which translates to 'a critical situation' or 'narrowness' — to strangle, choke, crave, worry, aspire, embarrass, press tight — in other words, to address the nature of both emotional and physical manifestations of the term (López-Ibor & López-Ibor, 2010). The core trait of all anxiety disorders from a Western perspective is a maladaptive behavioural pattern occurring in an anxious reaction, varying in frequency, intensity, persistence, triggers, consequences, and severity (Nutt & Ballenger, 2007). There is considerable comorbidity between anxiety disorders, which include generalised anxiety, phobias, social anxiety, panic disorders, post-traumatic stress disorder, obsessive-compulsive disorder, and agoraphobia, with classification primarily based on an individual's subjective verbal descriptions of symptoms. Generalised anxiety disorder (GAD) is the most commonly diagnosed anxiety disorder, typically occurring under the age of 40, with chronic fluctuating episodes, and affects women twice as much as men (Kessler, McGonagle, & Zhao, 1994). Although anxiety has a high prevalence rate (nearly the same as depression), anxiety symptoms often go unnoticed in early childhood settings.

Originally described by Freud as 'anxiety neurosis', this term covered four clinical syndromes; anxiety attacks, general irritability, anxious expectation/chronic apprehension, and secondary phobic avoidance (Freud, 1957). As time passed, 'anxiety neurosis' evolved into many different

anxiety-related mental illnesses. The defining characteristics of GAD are the overwhelming and unrelenting presence of worry and anxiety. Other psychological symptoms may occur, such as panic attacks, cognitions of interpersonal conflict, issues with social acceptance by others, and exaggerated worries regarding minor issues (Breitholtz, Johansson, & Öst, 1999). Physical symptoms may also occur, such as restlessness, tension, sleep disruption, irritability, difficulty concentrating, sweating, dry mouth, nausea/abdominal issues, heart palpitations, and tremors (Starcevic & Bogojevic, 1999). Onset of symptoms typically begin somewhere between late adolescence and early adulthood (Kendler, Neale, Kessler, Heath, & Eaves, 1992; Rogers, Warshaw, & Goisman, 1999). Like MDD, GAD is a chronic disorder that can persist for decades (Mancuso, Townsend, & Mercante, 1993; Mavissakalian & Prien, 1996).

In the past, GAD was considered a mild disorder in the West, only receiving treatment and attention if it developed alongside a comorbid disorder such as depression (APA, 1987). Now, data supports the theory that GAD is a disorder which causes serious distress and impairment on its own (Wittchen, Zhao, Kessler, & Eaton, 1994). It is associated with lower income, but not with lower education (Blazer, Burchett, Service, & George, 1991). Many people suffering from anxiety have difficulties maintaining full time employment, social relationships, and recreational activities, and have lowered overall life satisfaction (Massion, Warshaw, & Keller, 1993). GAD is usually comorbid with other mental illnesses, and correlated with poor overall emotional health and interference with everyday life functioning (Wittchen, Zhao, Kessler, & Eaton, 1994). People with GAD have a high rate of both seeking help from medical professionals and utilisation of psychotropic medication.

Studies indicate that there is a partial genetic factor which may predispose people for developing GAD (Nutt & Ballenger, 2007). However, as with most mental disorders, it is the unique environmental factors that also play a role in the development of this illness (Kendler et al., 1995; Scherrer, True, & Xian, 2000). Benzodiazepine and $GABA_A$ receptors, the parts of the brain related to fear and anxiety, are impaired in people with GAD (Ferrarese, Appollonio, & Frigo, 1990; Rocca et al., 1998). Serotonin (5-HT) also has an impact on anxiety and fear response (Taylor, Eison, Riblet, & Vandermaelen, 1985; Ramboz, Oosting & Amara, 1998).

In addition, some research indicates that aetiological relationships may differ between cultures, such as in specificity and strength of anxiety in Asians versus Westerners (Hong, 2012). According to dominant Western paradigms, emotional avoidance has been theorised to correlate with the maintenance and development of GAD, with efforts to suppress and avoid negative emotions causing and increasing the likelihood of creating negative emotions in the future, as discussed above. People suffering from GAD may experience negative emotions more frequently, and respond with emotional suppression to these negative emotions (Mennin, Heimberg, Turk, & Fresco, 2005). Emotional suppression, however, may function differently between cultures. In a study presented by (Butler, Lee, & Gross, 2007), Asian Americans were found to suppress more emotions than European Americans on a daily basis, without experiencing stronger negative emotions. This suggests that perhaps emotional suppression in East Asia may actually be a healthy coping mechanism, rather than a factor of vulnerability for developing anxiety. Asian culture is much more community orientated, focusing on a sense of priority for interdependence and coexistence through collaborative behaviours. In Thailand, village or community members tend to cooperate, share waterways for irrigation, help each other harvest and grow rice, cooperate in house-building and home improvements, and share important cultural and psychological events such as births, life crises, ordinations, serious illnesses, and funerals (Komin, 1991). Asians tend to report more difficulty separating from loved ones than Westerners which, given the cultural context, makes sense (Hong J. J., 2014). In areas such as separation anxiety, there needs to be more consideration of cultural factors such as this, in which an individual may live in a more collectivist rather than individualistic context. In a Western model, a patient may be treated for social anxiety with a treatment goal of individuation, but for *khon Thai*, this may increase feelings of overall anxiety.

In a study by Lotrakul & Saipanish (2009), general practitioners perceived anxiety disorders to be more common in Thailand than depressive disorders. This is possibly due to general practitioners being less familiar with depression than anxiety. It could also be, as outlined above, that depression is underdiagnosed because the symptoms which patients describe may not fit with the definitions of diagnosis that general practitioners are taught in medical school (as opposed to psychiatrists who receive specialised training). In Thailand it is very common to be prescribed benzodiazepines to provide rapid anxiety relief, and with being more socially acceptable in Thailand, patients are more likely to accept it over other mood stabilizers and

other possible forms of modern Western treatment (Gorman, 2002). In Sweden, another study showed that for general practitioners, private life and general practice had more influence on professional actions than professional literature or academic education (Andersson, Troein, & Lindberg, 2005). In Thailand, because of how much more likely patients are to utilise benzodiazepines and how quickly it improves symptoms, this could explain the potential to over-diagnose anxiety disorders.

Bipolar

Bipolar affective disorder is commonly referred to as *manic depression*, a term which was originally coined in ancient Greece to describe symptoms of imbalance among the 'humours', or emotional states (Martin, 2007). They believed that when melancholy became heated by the fluxes in the blood, it would turn opposingly into states of heightened mania. Later, a French psychiatrist Jean-Pierre Falret defined circular insanity as *folie circulaire*, where episodes of mania and melancholy were separated by symptom-free periods (Sedler, 1983). Falret's definition articulated the basic elements that now come together to present a diagnosis of bipolar affective disorder. In the 1980s, the term *manic depression* transitioned to the new term, *bipolar disorder.* There were a number of reasons for this shift in terminology in the West. As classification systems for mental illness became more sophisticated, the term bipolar added more clarity than manic depression. The terms *mania* and *manic* have, over time, developed negative connotations, such as terms like *manic Mondays, homicidal maniacs,* etc. Changing the label helped to remove some of that stigma for people living with symptoms, giving the label more clinical weight rather than negative emotional assumptions. The term manic depression also tends to focus specifically on the emotional range of an individual's symptoms, and thus ignores other physical and cognitive symptoms that may be present. Bipolar disorder now has four recognised types in the DSM-5 (2013): Bipolar I disorder, bipolar II disorder, cyclothymia, and bipolar disorder not otherwise specified (BP-NOS). Bipolar I disorder is diagnosed by mixed or manic episodes lasting at least a week at a time, or in such severity that the individual requires hospitalisation. People with Bipolar II disorder may have hypomania or depressive episodes, but not severe manic episodes (which exclude them from a bipolar I diagnosis). Cyclothymia is diagnosed when reoccurring mood changes have occurred for at least two years, but exhibit milder symptoms than in cases of bipolar I or II. BP-NOS

covers the areas left outside of these specifications, but while still retaining symptoms of abnormal mood instability.

Bipolar I disorder, on average, begins showing symptoms around age 18, whereas bipolar II shows symptoms around age 22 (Hirschfeld, Bowden, & Gitlin, 2006; Weissman, Leaf, & Tischer, 1988). Many people with bipolar do not seek care immediately after symptoms begin, and are often misdiagnosed for years before receiving their accurate diagnosis (Hirschfeld R. M., 2001; Lish, Dime-Meenan, & Whybrow, 1994). Bipolar is often misdiagnosed for a variety of reasons, the most common being the extensive and complex differential symptoms of the disorder. Presentation of patients can be quite similar to other psychotic or mood disorders such as depression, schizophrenia, or schizoaffective disorder. If other family members suffer from a mood disorder, it is suggestive that present symptoms may be more indicative of a mood disorder, even when the individual is also showing psychotic symptoms (Hilty, Laemon, Lim, Kelly, & Hales, 2006). Antisocial behaviour such as impulsivity, recklessness, truancy, and irritability are also common in not only bipolar disorder, but also in substance abuse, attention deficit disorders, and personality disorders such as antisocial, histrionic, and borderline personality disorder. The relationship between the individual's 'normal' behaviour and personality, versus 'abnormal' symptomology, must also be considered. Often the former is not seen by short term care providers such as general practitioners or psychiatrists. Misdiagnosis, in turn, causes exorbitant cost and undertreatment (Chang & Ketter, 2001). Although males and females tend to be equally diagnosed with bipolar I, bipolar II is more common in women, and bipolar overall is more frequently diagnosed in unmarried individuals (Kessler, Bergland, & Demler, 2005; Weissman, Leaf, & Tischer, 1988).

Although there may be arguments otherwise, there is no simple or singular hypothesis of aetiology with bipolar disorder, but prominent theories focus on the results of genetic, anatomical, pharmacological, biochemical, and sleep data (Reus & Freimer, 1997). Biochemical research looks at the causes of bipolar through imaging studies of transmitters, hormones, and steroids. As in many other mental illnesses, epidemiological evidence from identical and fraternal twin studies have been pivotal in understanding how bipolar symptoms develop in an individual. In families with history of bipolar, an individual is more likely to inherit the disorder (Goodwin & Jamison, 1990). However, the extent of how much bipolar I, bipolar II, cyclothymia,

or BP-NOS are genetically related or distinct from one another is still a mystery (Reus & Freimer, 1997). Pharmacologic and biochemical studies pinpoint catecholamine as a potential key component of bipolar, with an excess of catecholamines resulting in episodes of mania, and a depletion of catecholamines resulting in depressive episodes (Hilty, Laemon, Lim, Kelly, & Hales, 2006). Norepinephrine and dopamine have also been implicated in bipolar symptoms, with antipsychotic medications which block dopamine receptors proving effective against severe episodes of mania. Some cases of bipolar may alternatively benefit from antidepressants, possibly due to defective dampening of certain neurotransmitters (Hilty, Brady, & Hales, 1999). Currently there are many studies looking into neuroimaging to better understand where bipolar comes from, but the data has been inconsistent, and clinical significance seems unknown.

Some studies have shown a higher rate of bipolar diagnosis in Asian populations. Hwang, Childers, & Wang (2010) speculate that this could be due to a variety of reasons including misdiagnosis, patients' self-evaluation of hypomanic experiences, and the inherent difficulties with the symptomology of the clinical course of the illness. However, they do not consider the context of potential cultural differences in diagnosis and understanding of the illness, which likely also contributes to heighted statistics of bipolar disorder in Thailand, such as with GAD. Bipolar has the highest rate of suicidal behaviour compared to any other psychiatric disorder over a lifetime, and in Thailand, this a particularly heavy burden for the upper northern regions. In the Northern region of Thailand, there was a rate of 34.4 suicide attempts per 100,000 in 2010 alone (Department of Mental Health Ministry of Public Health Thailand, 2010). Bipolar ranks in the top ten of referrals in psychiatric hospitals in that region, with 23.7% of these admissions based on suicide attempts (Suanprung Psychiatric Hospital, 2012). Over the years there has been an increased awareness of the correlation between suicidal ideation and bipolar disorder, and the need to identity risk factors on different levels of healthcare, but unfortunately this has not lowered the rate of suicide attempts in people with bipolar (Ruengorn et al., 2012). Some screening tools have recently been developed to assess suicide risk in primary and secondary care levels, but psychologists are not often involved, and the methods of assessment remain relatively basic (Ruengorn et al., 2012). A more recent study (Ruengorn et al., 2012) was able to reveal certain key risk factors of suicide attempts in people with bipolar, with univariate logistic regression analysis showing that suicide attempts are

more often carried out by people who are younger, single, do not have children, and have very little social support. Respondents reported having suffered from bipolar symptoms at an early onset, as well as drinking often, feeling depressed, experiencing stressful life events, having a family history of suicide, having feelings of suicidal ideation and suicide attempts in the past, having less than five years of treatment, and being prescribed multiple medications to treat symptoms.

Intellectual Disability

In 1846, the term *simpleton* was used to describe a person with a mild intellectual disability (Howe, 1848). This was later described as *feeble-mindedness,* derived from the Latin word *flebilis*, which translates to 'be lamented' (Reynolds, Zupanick, & Dombeck, 2013). In 1912 a range was implemented to describe the severity of intellectual disability, with *idiot* (extremely disabled), *imbecile* (moderately disabled) and *feeble-minded* (mildly disabled) (Trent, 1994). Henry Goddard decided that feeble-minded was imprecise, and changed the term to *moronic*, coming from the Greek root *moros*, meaning 'dull or foolish'. These terms became derogatory slang, an insult with an attached negative stigma. To address this, and find more appropriate terminology, these words were replaced in the 1960s with the word *retarded*, which comes from the Latin word *retardare,* meaning, to be 'slow, delayed, kept back, hindered'. Although this term was, like the others, originally a neutral description of an intellectual disability, it became stigmatised and used as an insult. In an effort to further remove negative connotation, the term *intellectual disability* became the name of this disorder. As opposed to the previously deemed offensive ranking terminology, classifications of severity for intellectual disability range from mild, moderate, severe, to profound (Boat & Wu, 2015). Most people with ID fall into the mild to moderate range, allowing them to learn practical life skills and take care of themselves, travel to familiar places within their community, learn basic safety and health skills, but generally require some moderate support from family or community members (Boat & Wu, 2015).

Intelligence is defined as the capacity that an individual has to enact planning, reasoning, think abstractly, solve problems, comprehend complex ideas, learn from experience, and learn efficiently (AAIDD, 2010). These areas are generally assessed using a standardised measure of intelligence and by identifying deficits in significant adaptive and functional skills, such as the

ability to engage in age-appropriate activities in day-to-day life functions. In the DSM-5 (2013), intellectual development disorder falls under the category of neurodevelopmental disorders, along with global development delay, unspecified intellectual disability, communication disorders, language disorder, speech sound disorder, childhood-onset fluency disorder, social communication disorder, unspecified communication disorder, autism spectrum disorder, attention-deficit/hyperactivity disorder, other specified attention-deficit/hyperactivity disorder, unspecified attention-deficit/hyperactivity disorder, and specific learning disorder. The DSM-5 defines intellectual disability as a neurodevelopmental disorder with an onset of early childhood, characterised by both intellectual disabilities and difficulties in social, conceptual, and practical everyday functionality. People with intellectual disabilities have deficits in intellectual functioning in the areas of academic learning, judgement, abstract thinking, reasoning, problem solving, planning, and learning from experience, as well as an inability to conform developmentally with sociocultural standards for independence, such as meeting social responsibilities in their community (Boat & Wu, 2015). These deficits appear during early childhood.

Although there are many prominent neurodevelopmental theories of the aetiology of ID, the cause of many cases remains unknown. A variety of factors may result in an ID, such as environmental causes like exposure to toxicity from alcohol or lead, nutritional deficits, childhood brain infections, brain radiation, traumatic brain injury, and maternal infections. Prenatal and postnatal complications such as hypoxemia or periventricular haemorrhages may result in an ID (Gustafsson, 2015). Genetic factors may also play a role in the development of an ID, such as in down syndrome or fragile X syndrome (Boat & Wu, 2015).

The Economic and Social Commission for Asia and the Pacific (2015) reports that 2.2% of the Thai population has a disability, 6.9% of them being intellectually disabled. Disabilities have, particularly in the past, largely been perceived as a deserved failure, due to the bad deeds of a past life (*kam*), and can be perceived as shameful. In the past in Thailand, it was more common to keep people with intellectual disabilities at home, away from the public and out of the school systems, but as time has passed, human rights and equality in Thailand have become more prominent (Fulk, Swerlik, & Kosuwan, 2002). In schools, assistive technologies are utilised to support students with disabilities to minimise barriers such as learning and participation with

peers. Thai regulation supports that all children receive free basic education, including special education for the intellectually disabled, up until 12 years old (Office of the Educational Council, the Ministry of Education Kingdom of Thailand, 1999). Although the Thai Ministerial Regulations for Provision of Assistive Technology, Media and Services in People with Disabilities (2008) regulates the use of assistive technologies, not much information is available as to whether these technologies are readily available to areas outside of Bangkok or Chiang Mai, or to lesser income communities. Families in poor or rural areas may be less likely to be aware of special programmes or be somewhat reluctant to access them due to perceived shame (Fulk, Swerlik, & Kosuwan, 2002). Alternatively, wealthier families may choose to keep any disabilities hidden, and seek out private assistance (Vorapanya & Dunlap, 2014).

Living with a Mental Illness

Mental health is affected by not only biological determinants, but also broad-scale social and cultural factors which affect people around the world from a variety of backgrounds and lifestyles. It can cause and be influenced by both negative and positive social determinants of health. Societal conditions can affect health, and potentially can be altered by informed action (Primm et al., 2010). These conditions include occupation, education, culture, income, social exclusion, stress, housing, childhood experiences, social support, sanitation, discrimination, and lack of accessible resources. Protective factors of positive social determinants are linked to better mental health, such as strong interpersonal connections and religious or spiritual well-being, whereas negative social determinants are linked to lower mental health, such as stigma, poor physical health, victimisation, trauma, abuse, stress, and isolation. People with mental illness often suffer from extreme forms of discrimination, public and internalised stigma, poor interpersonal relationships, and a lowered sense of self-worth and quality of life (Burnard, Naiyapatana, & Lloyd, 2006; Mashiach-Eizenberg et al., 2013; Whitley & Campbell, 2014).

Label Stigma

In ancient Greece, the word 'stigma' translates to the noun of 'mark' or 'brand' (Whitley & Campbell, 2014). Slaves were often branded with the letter 'S' to signify their difference from the rest of the population (Simon, 1992). Centuries later, not much has changed. Stigma is a multifaceted and complex construct defined in a variety of ways. It is now defined as a negative

stereotype attributed to characteristics that go against socially constructed norms, a deeply discrediting attribute that divides and taints a persons' identity (Goffman, 1963; Phelan, Link, Stueve, & Pescosolido, 2000). The expression of stigma is embedded through social interaction, occurring when dominant cultural beliefs label individuals as unfavourable, leading to discrimination (Link & Phelan, 2001). Mental illness is of course a primary target of label stigma (Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000). Commonly, public perceptions of mental illness can depict an individual as violent or dangerous, ostracising them from social inclusion (Link & Phelan, 2001). This observed 'public' stigma can cause people to discredit the 'marked' individual through discrimination, criticism, ridicule, insult, and aggressive scrutiny (Goffman, 1963; Teachman, Wilson, & Komarovskaya, 2006). Stigmatising tendencies can have a negative impact on not only the individual, but also those close to them (Luty, Fekadu, Umoh, & Gallagher, 2006). Discrimination can come from loved ones, friends, the community, the larger public, and even government authorities (Foucault, 1995).

Once an individual has noticed their own potential for perceived 'self' stigma, it can become internalised, and regarding mental health, compound already existing feelings of doubt, guilt, and shame (Mashiach-Eizenberg et al., 2013; Schulze & Angermeyer, 2003; Teachman, Wilson, & Komarovskaya, 2006). Internalised stigma is associated with a lowered sense of empowerment, quality of life, social support, self-esteem, hope, and adherence to treatment (Maschiach-Eizenberg et al. 2013). Corrigan et al. (2009) described this process as a transition of three steps: awareness (of the stereotype); agreement (with the stereotype); and application (of the stereotype to oneself). Once caught in the trap of stigmatisation, people experience lowered self-esteem, efficacy, motivation, and hope, thus creating something of a self-fulfilling prophecy (Corrigan et al., 2009). This, in turn, causes the serious social dilemma of those who require treatment often not seeking it out, from feelings of shame and fear of further stigmatisation (Primm et al., 2010; Teachman, Wilson, & Komarovskaya, 2006).

Different cultures may have unique perceptions of what they consider normal functionality because culture encompasses shared meanings, values, attributes, and beliefs that shape social interaction (Boucher & Maslach, 2009). With mental illness, culture may consequently shape and influence label stigma. Chinese populations, for example, show stigmatising attitudes towards the mentally ill based on their foundations of Confucianism, which views

mental illness as a consequence of an individual's reliance on others and inability to perform valued duties and roles in society (Lai, Zhuo, Singla, Wu, & Yang, 2009). This leaves people with mental illness unable to maintain stable relationships, and they remain marginalised by the community, due to 'losing face' (Lam et al., 2010). Within the context of these cultures, people may feel they have failed their required duties in life and family obligations, and may be left feeling a sense of shame and guilt for letting down their family (Hsiao, Klimidis, Minas, & Tan, 2006; Lai, Zhuo, Singla, Wu, & Yang, 2009). Research suggests that culture has a direct impact on stigma, and that understanding culture can have important implications for stigma reduction — however, stigma across cultures has been insufficiently investigated (Griffiths et al., 2006; Hamid, Simmonds, & Bowles, 2009).

Interpersonal Relationships

With the amount of damage public and self-stigma can cause to an individual, it comes as no surprise that one of the most important conduits of reducing chronic symptoms of mental illness is secure interpersonal relationships with family, peers, friends, and the community (Moses, 2010; Tuicomepee & Romano, 2008). Unfortunately, stigma can weaken social support networks for people suffering from mental illness, causing damage to interpersonal relationships and further negative life outcomes (Geller et al., 2008; Moses, 2010). Moses (2010, p. 986) describes how in family relationships, stigmatisation is often *"imposed on rather than imposed by,"* the family members of those suffering from a mental illness. Prejudice and discrimination may be projected onto the family of someone with a mental illness, particularly in Asian cultures, causing strain, shame, embarrassment, and reluctance to speak openly outside of the family about mental illness (Tuicomepee & Romano, 2008; Yadegarfard, Ho & Bahramabadian, 2013). It is difficult to separate intra-familial stigma from other negative family interactions of rejection and hostility that may already exist in a hostile family environment, due to stress or psychopathology (Bullock & Dishion, 2007; Moses, 2010). Those diagnosed with a mental illness are more likely to have troubled family relationships with immediate and extended family members than their peers (Prange, Greenbaum, Silver, & Friedman, 1992). In the peer group and community, people may perceive individuals with mental illness to be violent and unpredictable, due to a lack of education on the topic or cultural beliefs (Burnard, Naiyapatana & Lloyd, 2006; Moses, 2010). Victims of negative stigma may face ridicule, social

ostracism and isolation, intolerance, harassment, violence, and even denial of basic human rights (Moses, 2010; Yadegarfard, Ho, & Bahramabadian, 2013). These experiences of rejection from family, peer groups, and the community, can exacerbate the pre-existing symptoms of mental illness, such as feelings of depression, loneliness, suicidal ideation, and sexual risk-taking behaviour, causing lowered feelings of security, self-worth, and overall quality of life (Yadegarfard, Ho & Bahramabadian, 2013).

Social support and close relationships are necessary for psychological well-being (Kessler & McLeod, 1985), and as discussed above, have an important value in Asian cultures. Socially anxious people tend to have fewer intimate relationships and fewer social supports, greater avoidance of confrontation and self-expression, and overall less satisfaction in their relationships than people without mental illness (Davila & Beck, 2002; Wenzel, 2002). Due to fear of stigma, people with mental illness may be afraid to disclose their illness or share personal information with others, which may make them come off as unlikable, and limit relationship development (Alden & Bieling, 1998; Voncken & Dijk, 2012). Emotional disclosure has a strong effect on feelings of closeness (Graham, Huang, Clark, & Helgeson, 2008; Reis & Shaver, 1988). People with low self-stigma tend to doubt their ability to do well in social situations, even though they have a strong need to create a positive impression on others (Clark & Wells, 1995; Rapee & Heimberg, 1997). This, in turn, leads to a fear of social situations and reinforces self-doubt, often worsening symptoms of mental illness and negative coping strategies (Salkovskis, 1991). It becomes a self-fulfilling prophecy, where the individual wants to have close interpersonal relationships, but cannot because they fear rejection, and adopt styles of low disclosure communication to prevent negative feedback. These people may avoid behaviours that draw attention to themselves to protect themselves (Alden & Bieling, 1998; Meleshko & Alden, 1993). Although people with mental illness believe that disclosure or showing of their mental illness may lead to negative perceptions, disclosure can actually increase likeability and intimacy (Gee, Antony, Koerner, & Aiken, 2012). People are more likely to disclose personal information with people they trust, like, and feel close to (Collins & Miller, 1994; Jourard, 1959). As a relationship increases in intimacy, self-disclosure increases (Cozby, 1972).

Lifestyle

Positive mental health is correlated with positive biological and physical functioning, with highly rated areas of joy, enthusiasm, happiness, and contentment linked to increased longevity, lower morbidity, and reduced negative health symptoms (Pressman & Cohen, 2005). Positive affect is linked to lower blood pressure, inflammatory response, weight, glycosylated haemoglobin, reduced amygdala activation to negative stimuli, and higher brain function (Friedman et al., 2005; Ryff et al., 2006; Steptoe, Gibson, Hamer, & Wardle, 2006; Urry et al., 2004; van Reekum et al., 2007). Positive emotional style is associated with higher antibody production, increased resistance to illness, lower levels of epinephrine, cortisol, and norepinephrine (Steptoe, Gibson, Hamer, & Wardle, 2006).

Alternatively, people with poor mental health may navigate a socio-cultural context wherein stigmatisation and poor interpersonal relationships may prevent them from receiving adequate treatment (Moses, 2010; Tuicomepee & Romano, 2008). Accessing mental health services carries great negative stigma with it, inherently causing those who need it the most to be resistant to utilising treatment, to misunderstand mental illness, and to anticipate negative responses from the people around them (Chandra & Minkovitz, 2007; Moses, 2010; Tuicomepee & Romano, 2008). Internalised stigma, poor interpersonal relationships, and a lack of adequate mental health care can lead to feelings of shame, powerlessness, meaninglessness, hopelessness, lowered self-esteem, poor treatment outcomes, and lowered sense of agency (Burnard, Naiyapatana, & Lloyd, 2006; Mashiach-Eizenberg, Hasson-Ohayon, Yanos, Lysaker, & Roe, 2013; Moses, 2010).

People with mental illness are twice as likely to smoke cigarettes than others (Lasser et al., 2000). Cigarette smokers are at higher risk of smoking-related death, and people who suffer from alcoholism, depression, and schizophrenia have high rates of mortality from both cancer and vascular disease (Bruce, Leaf, Rozal, Florio, & Hoff, 1994). Smoking may cause complications in treatment for some mental disorders, due to increasing blood levels of neuroleptics (Lohr & Flynn, 1992). Smokers may therefore require larger doses of medications to achieve therapeutic results, which can increase the risk for adverse reactions to the medications (Addington, el Guebaly, Campbell, Hodgins, & Addington, 1998; Decina et al., 1990; Yassa, Lal, Korpassy, & Ally, 1987). Many people use cigarettes as a form of self-

medication for negative symptoms of mental illness (Carmody, 1989). However, the direction of causality can also go the other way, with antecedent smoking associated with higher likelihood of depression (Wu & Anthony, 1999). Current smokers are also more likely than non-smokers and former smokers to experience their first anxiety-related episodes (Breslau & Klein, 1999). Smoking at an early age is also associated with increased risk of anxiety disorders in late adolescence and early adulthood (Johnson et al., 2000). In a study by Kelly & McCreadie (1999), people with schizophrenia who smoked were found to mostly have started smoking prior to the onset of schizophrenic symptoms. Market researchers for the tobacco industry purposefully target this at-risk demographic, focusing on individuals with a need for mood enhancement and positive stimulation to cope with depressive symptoms (Lasser et al., 2000). Smokers identify cigarettes as a way to relieve anxiety, calm down, gain self-control, cope with stress, and handle problems (Lasser et al., 2000).

Thai Values

Cultural context has a direct impact on the way people experience living with mental illness. The experiences of label stigma, interpersonal relationships, and lifestyle will be different depending on where someone is born, what culture they identify with, and where they live. In Thailand, these experiences are shaped by a Thai value system. The dominant religion in Thailand is Buddhism (Census, 2015). According to Komin (1991), there are nine identifiable clusters of values describing Thai characteristics. They are, in order of importance: ego, *bunkhun* (similar to *karma*), interpersonal relationships, flexibility in everyday life, religio-physical, education, interdependence, *buua* & *sanuk* (boredom and enjoyment), and achievement. Thai people have a deep sense of pride, dignity, and independence, and insults towards family (especially parents) are taken very personally. They believe in what is called the *bunkhun* value, or 'grateful relationship' value, which is the concept of reciprocated, sincere relationships, like the concept of *karma*. Thais use *bunkhun* value every day in social interactions to maintain interpersonal relationships. Within the cluster of 'smooth interpersonal relationships', there are eight primary areas which contribute to this value according to Komin (1991). These are, from order of importance: caring and consideration, kindness and helpfulness, responsiveness to opportunities and situations, self-control or tolerance-restraint, politeness and humility, calmness and cautiousness, contentment, and

social relations. In Thai, this tendency to focus on treating people gently and kindly in order to avoid confrontation is called *hai kiad* (giving face) (Holmes & Tangtongtavy, 1997). Thais are situation-orientated rather than principle-orientated and see problems as flexible, they focus instead on remaining calm through emotion suppression, *sam ruam* (exercise restraint) (Toews & McGregor, 1998). Thais are often involved in religious rituals and ceremonies related to work, community, and home life. Thai people value education as a means of competence rather than knowledge, to increase prestige, social status, or salary (Komin, 1991). They greatly value co-existence and interdependence through community spirit and neighbourliness (Butler, Lee, & Gross, 2007). Thais tend to avoid boring activities (*buua* 'boring'), with a preference instead for enhancing pleasure and fun (*sanuck* 'enjoy'). They put less emphasis on serious commitment to hard unpleasant work. Achievement and task orientation is considered the least important value for Thai people (Komin, 1991). Translation of words such as 'achievement' and 'ambition' tend to have negative connotations in Thai.

The Current Study

Previous research shows the overwhelming prevalence of mental illness around the world, and the severity of impact it can have on people in their everyday lives. However, there are certain cultural differences in how mental illness is understood and in attitudes towards those experiencing mental illness. In this thesis, I am interested in exploring these things in the context of Thailand. This study aims to explore the experiences of young adults living in Phuket with a mental illness, and how this affects them regarding label stigma and culture, interpersonal relationships, feelings of self-worth, and lifestyle. The participants in this study come from a variety of backgrounds, as both integrated foreigners and native Thais, with differing lifestyles, educations, upbringings, and cultural associations. The goal of this study is to see where these experiences overlap, and how everyday life is for young adults living in Phuket with a mental illness.

Chapter 2: Methodology

This project utilised qualitative semi-structured interviews to gather data through immersive discussion about the lived experiences of young people with a mental illness living in Phuket.

Qualitative Research

Quantitative and qualitative methods of research are often considered opposing thought processes (Hammarberg, Kirkman, & deLacey, 2016), but each has its strengths and weaknesses depending on how your project is aimed and what you expect to gather from that information. Dahlberg & McCaig (2010) point out that much of what is discussed on the differences between quantitative and qualitative analysis is shallow. The key difference between the methods is that quantitative research is an extensive study of many cases, whereas qualitative research is the intensive study of a few cases (Teorell, 2001).

Quantitative analysis, as the name implies, is a form of data analysis that focuses on numbers and counting (Thomas & Hodges, 2010). Data is generally collected via questionnaires and translated into numbers, which are then reordered and rearranged in such a way as to see patterns and understand relationships in the data. This analysis allows researchers to find commonalities and points of difference in say, age, gender, income, and other aspects of clustering. This method is best utilised for large population samples. Generally, a hypothesis is only used in quantitative research, not in qualitative studies. Qualitative analysis utilises a non-numeric approach to understand data. This generally involves methods such as data collection through words, images, articles, films, text, field notes and observations, and recorded interviews with participants. This method generally involves intensive engagement with the material in order to discover patterns and relationships within the data which relate back to the project's goals. The researcher spends time identifying themes within transcripts, for example, and selects key elements that illustrate these relationships, such as related quotes from an interview.

Interpretivist-orientated researchers may critique quantitative research as focusing on generalisability over the weight of personal narratives, failing to acknowledge researcher bias and the ambiguous nature of translating data into meaningful conclusions. Opposingly, more

positivist-orientated researchers may critique qualitative research as suspiciously lightweight, focusing on sample sizes that are too small to represent a general population, and providing biased research subjectively based on the researchers' experiences.

Community Psychologists work on a level of applied psychology in social and health research which often utilises both qualitative and quantitative research methods depending on a wide range of evidence and sources (Thomas & Hodges, 2010). This study focuses on gathering information from people as the primary data resource, exploring in detail the subjective experiences of how young adults living with a mental illness in Phuket conceptualise and identify their lives. To deeply and appropriately review this data, qualitative methods were utilised.

Using qualitative analysis not only gave me the opportunity to deeply understand the perspectives of unique experiences of each participant, but it also allowed them to speak in their own words on the topic, one which does not have much prior investigation the Thai context. Mental illness is a taboo topic across the world, and gathering information on this topic can be difficult. In Thailand, this is complicated again by the cultural perceptions of mental illness and stigma. Recruiting participants for a qualitative study was difficult, and recruiting participants for a quantitative study would have been even more so. The sample size would be too small to gather any statistically significant information. With this in-depth study of just a few select participants, analysis was more specific and detailed, allowing participants to talk more freely, and offer information and insight I had not considered previously.

Semi-Structured Interviews

As explained by Dahlberg & McCaig (2010), qualitative research can use a variety of methods, such as documentary analysis, diaries, participant observation, focus groups, unstructured interviews, or semi-structured interviews. Semi-structured interviews are a popular method that uses a predetermined set of questions to guide the interview. Each participant is asked the series of questions, and the researcher leads the conversation from one question to the next, using improvised prompts to follow through and explore relevant topics as they come up in conversation. This gives the researcher more flexibility to investigate areas of interest that otherwise may not be elaborated upon with quantitative methods. The idea is that by using

guided questions but allowing the interviewee to answer openly in a flexible way, the content of each interview will be both comparable to the others as well as unique to showcase the subjective experiences of the individual. In a one-on-one interview, the participant may feel more comfortable to share personal information than in a focus group (Thomas & Hodges, 2010).

Recruitment

Four young adults in their twenties living in Phuket were voluntarily recruited for this study. Participants were required to be between the age of 20 – 29, living in Phuket with a mental illness. Rather than requesting an official diagnosis, an open self-defined diagnosis was used, because what may be described as a mental illness across different cultures may differ from the Western diagnostic system, and access to resources for an official diagnosis in Phuket may be limited. Participant recruitment was primarily made through the distribution of flyers in the community by hand, through local community groups, by word of mouth, and by social media distribution. Phuket being a small place, word of mouth and social media distribution were the most effective recruitment techniques.

Participants received a copy of the participant Information Sheet (Appendix B) via email prior to the interview, which outlined the goals of this study and potential areas of investigation. The topic of the interview and study were discussed before commencing the interview, and all questions were answered during this time, though I communicated back and forth with some of the participants during the summary review period via email as well to create a comfortable dialogue. One participant brought a support person to the interview for comfort and translation purposes. Another participant shared their interview summary with their family before it was finalised.

Flyers (Appendix A) denoted that participation in the study was voluntary, and the participant Information Sheets and Consent Forms (Appendix E) also reiterated this. Throughout the process I reminded all participants that they could withdraw from the study up to seven days after they received a copy of their summary. From that point the information was added to the study. Participants were also informed that they could skip any questions they wish, but this did not occur. All interviewees were given pseudonyms, and all potentially identifying features

of the interviews were either removed or altered for confidentiality. The participants were informed that this study would be made available to the public through the University of Waikato Research Commons, and may additionally be published in relevant Psychology Journals or Conferences in the future. When the final report was completed, the participants were emailed to offer them a link to this study. Original recordings and transcripts, and later drafts and summaries, were collected and will be stored on my personal secure computer for five years before being destroyed.

The Participants

Initially eight participants were sought for this study, but due to the time restraints brought on by ethics approval, and the taboo nature of the subject, only four participants were recruited. However, the content of their interviews was in-depth and diverse. Two males and two females participated in the study, all between the ages of 21-29. Both females were Thai nationals, one growing up in a Christian missionary immigrant family, the other in a Thai family in Nakhon Si Thammarat. Both males were ex-patriots living and working in Phuket, one from Scotland and the other from the United States. All participants were single, one identified as Atheist, one as Buddhist, and two as Spiritual. Three participants had undergraduate educations, and one had elementary (primary) education. Two participants were employed as teachers in Thailand, and the other two were unemployed and worked primarily in odd jobs or family care positions. Three of the participants were smokers. Three participants spoke fluent English with varying levels of Thai speaking proficiency, and one spoke fluent Thai with minimal English-speaking ability.

When originally drafting up the ethics application, I decided against specifying Thai nationality for inclusion in the study. I knew that it may be difficult to gather participants from the community because not only was I new to the area, but the subject itself is not one that I felt the community may want to talk about or be familiar with. My presumptions were correct, and as my research continued, I found that *khon Thai,* while kind and open, still have a reluctance to speak with people regarding mental illness. I also did not consider the fact that the topic itself looks to recruit a demographic of people who may be difficult to keep involved, with many interested potential recruits missing appointments up to five times, due to anxiety or other mental health issues. Keeping the participant pool open to different nationalities changed the

focus of the study to an extent. Three of the participants in the study were classed as *third culture kids*, as in, people who reside or grow up in multiple countries. These people have to deal with further problems associated with being between cultures, causing loss and grief from experiences of feeling disenfranchised through loss of material things, friends, family, pets, as well as existential losses of identity and meaning (Gilbert, 2008). Therefore, this study shaped more into an exploration of experiences of mental illness both within and outside of Thai culture and nationality.

Information Gathering

Thematic Analysis.

This study is a qualitative research project that investigates detailed personal narratives to offer in-depth descriptions of the experiences of young adults living in Phuket with a mental illness. To analyse the data, thematic analysis was utilised in order to identify and report important and reoccurring themes that overlap within the data between the various participants. Thematic analysis is a simple method that offers flexibility to interpret and make meaning of data to answer key research questions (Braun & Clarke, 2006). Contrary to other forms of analytical methods, that look for patterns in qualitative data (i.e. thematic DA, IPA, grounded theory, thematic decomposition analysis), thematic analysis does not follow a specified pre-existing theoretical framework, and therefore can be used within or completely outside of different theoretical frameworks and do more within them than in the constraints of other methods. It can be constructionist, examining the way in which realities, meanings, events, and experiences are part of an effect from societal discourse; it can be essentialist or realist, reporting experiences, meanings, and reality according to participants; or it can sit somewhere between them as a contextualised method, acknowledging perceptions of individual participant experience while also acknowledging the limits of reality or broader social contexts (Clarke, 2005; Smith & Osborn, 2003; Willig, 1999). Braun & Clarke (2006) critique that, because thematic analysis can be so flexible, often research that utilises this method is left without a defined theoretical position. Given the clear need for self-expression and participant perceptions for this report, but also considering the importance of placing and acknowledging interpretations of Western and Eastern definitions of mental illness and well-being, I have decided to follow a contextualised method.

According to Braun & Clarke (2006), thematic analysis follows six steps to investigate data. Phase one: familiarising yourself with the data; phase two: generating initial codes; phase three: searching for themes; phase four: reviewing themes; phase five: defining and naming themes; and phase six: producing the report.

For this research, I developed a series of semi-structured interview questions which followed a malleable guide for each participant interview. As the interviews progressed, I was able to start identifying relevant themes and guide questions pertaining to these areas for each following participant, to investigate how these themes overlap. Although the report began with the hopes of gathering more participants, the small sample size was preferable given the brief time available for data analysis. During the initial interview and summary phase, I took daily journals to consider my thoughts and record any interesting observations of the participant's behaviour, my own behaviour and mindset at the time, potential themes that may be appearing, as well as unique experiences each interview may have provided. Summarising the data rather than complete transcription of the interviews was helpful, as often the participant would move into discussing topics which were irrelevant to the research, or I would offer discussion on my own experience to bring the conversation to a more comfortable space if the interview breached uncomfortable areas. Using a tape recorder phone app, I recorded all interviews to make sure that all quotes utilised in this report were transcribed verbatim. This gave more time to listen, not only to what was being said, but *how* it was said, in a truthful and accurate manner, and to offer exact quoting, including pauses, stuttering, laughter, and quirks in the participants' personality (Poland, 2002).

As I familiarised myself with the data through directing the interviews, adapting them according to new potential reoccurring themes, and listening to and summarising the interviews, I also began coding potential themes. Although I considered using specific data processing programmes as described by Kelle (2004), I decided learning how to use the software would take longer than coding the material manually. As I reviewed the recordings of each participant, I separated the summarised interviews according to their potential broad themes according to the aims of the thesis (e.g. family history, self-image, stigma). As I reviewed the data, I coded for potential sub themes or interesting topics (e.g. evictions and tardiness, fear of success, treatment in Chiang Mai). Throughout this process, I created a

separate document to record the codes and information about in what order the summaries were laid out, allowing me to give full, equal attention to each area of interest or potential patterns occurring across the data. For the coded quotes, I gave a brief explanation of what was being discussed and background on the topic according to the interview to give surrounding context to the data. Very little of the original recordings were left out of the summaries in case the information later became pertinent to the overall themes of the report.

By the time I reached phase three, searching for themes, I had already discovered and labelled most themes accordingly, because the interviews stayed rather true to their original form according to the questions on the semi-structured interview sheets. Although tedious, it proved beneficial to begin with these themes and arrange the summaries under their headings from the beginning. From here, I was able to look to see how these themes overlapped and where they separated in perceptions of each individual participant, and how that is relevant contextually according to their own experiences, background, definitions of illness, cultural context, and nationality. Some codes, as to be expected, were temporarily placed aside if they did not fit any overarching theme. Following this, I combined themes, dismantled and restructured codes within them, broke down themes, and read through how each participant's individual experiences supported or contradicted one another in each of these areas. I created a separate document which I copied, pasted, and rearranged themes until they became smooth and coherent patterns, creating a 'thematic map' (Braun & Clarke, 2006). Each theme was then defined and identified to offer an accompanying narrative to fit into the overall aim of the research.

Procedure.

Four young adults in their twenties living in Phuket were voluntarily recruited through word-of-mouth, social media, and flyer distribution. Interviews were recorded for review and translation purposes (Thai to English). The interviews used a malleable semi-structured format as the project grew, using thematic analysis to identify probes and potential reoccurring themes (Eriksson & Kovalainen, 2011). Areas of questioning during the interviews covered experiences of living with a diagnosis of mental illness in Phuket, such as: associated label stigma, changes in interpersonal relationships, self-worth and quality of lifestyle, cultural contexts such as traditional and modern Thai value systems, perceptions of mental illness in

Thailand, family history of mental illness, and educational and employment experiences. Brief demographic background of each participant was collected at the beginning of the interview using a short Demographic Survey (Appendix D). This sheet asked for simple demographic details such as: gender, age, English language fluency, occupation, education, marital status, and religion.

The interviews took place at a time and location that was preferable to the participant. Three participants chose to have the interviews take place in their homes, and one participant requested to meet at a relative's home. Interviews took approximately 20 to 60 minutes to complete following the semi-structured Interview Question sheet (Appendix C). After completing the interview, a summary was emailed to the participants for review and confirmation. Participants were informed that they had seven days to respond with questions, alterations, or clarification of the summary. If no response was received from the participants, the summary was accepted as accurately portrayed and added into the collected data for analysis. Data collection included recorded and summarised interviews, observation of subject, background, and culture, literature reviews, and field notes taking place before and during the project through regular thesis journaling (Gray, 2003).

Prior to commencing the interview, I explained my background and interest in the topic to the participant, reviewed the Information Sheets and Consent Form with them, discussed and answered any questions, reminded them that their participation was voluntary and that they could withdraw at any point before the summary was submitted, informed the participant of the summary, analysis, and dissemination process, and that they could request to see the final report at any point after the study. The participants were reassured that all identifying features would be removed from the interview before being summarised, and that they were free to speak both English and Thai as they felt comfortable to express their answers. Three participants spoke in English with some Thai phrases, and one participant spoke in Thai with some English phrases, with a support family member helping with English translation.

Ethical Considerations

This research project was approved by the Human Research Ethics Committee (Health) of the University of Waikato under HREC(Health)#2017-48. Raw files are stored on my locked personal computer.

As explained above this study looked to explore the experiences of young people living in Phuket who have been diagnosed with a mental illness. Part of what was discussed in the interviews for this study was how the areas of stigma, interpersonal relationships, feelings of self-worth, and feelings of life fulfillment are connected to cultural contexts, traditional and modern Thai value systems, and perceptions of mental illness in Thailand. Mental illness in Thailand can be a somewhat taboo topic because of the negative stigma attached to it, and the perceived shame it may bring to a family or community (Burnard, Naiyapatana, & Lloyd, Views of mental illness and mental health care in Thailand: a report of an ethnographic study, 2006). This means that anonymity and confidentiality were extremely important in this research, as well as recognising the significant role this study may have in the future for reshaping current negative and possibly inaccurate perceptions of people living with mental illness in Thailand. Interviews and data analysis was consistently self-reflective, culturally aware, and inclusive of the personal interests of the participant. As a researcher, I had to be aware of my own values, life experience, beliefs, and how those things may influence interactions with participants, and how I would interpret the data as the report progressed.

As a researcher living in the community for some time, transparency and confidence-building were of the upmost importance, and key contributors to building a solid rapport between the participants and I (Dahlberg & McCaig, 2010). Respect is a highly important value in most cultures, and certainly in Thailand (Komin, 1991). However, it is possible that due to the sensitive nature of the study and potential negative stigma that may be associated with mental illness, that many people were wary of participating in the study (Covarrubias & Meekyung, 2011; Henderson, Evans-Lacko, & Thornicroft, 2013; Teachman, Wilson, & Komarovskaya, 2006; Tuicomepee & Romano, 2008; Whitley & Campbell, 2014).

Being diagnosed with a mental illness can be a life changing experience. Recipients of a mental illness diagnosis often experience repercussions of negative stigma associated with the label

from the public, friends, and even family members (Covarrubias & Meekyung, 2011; Henderson, Evans-Lacko, & Thornicroft, 2013; Teachman, Wilson, & Komarovskaya, 2006; Tuicomepee & Romano, 2008; Whitley & Campbell, 2014). After being diagnosed with mental illness, people report being judged and treated differently by family and peers (Moses, 2014). They may also experience feeling a lowered sense of self-worth and quality of lifestyle (Mashiach-Eizenberg, Hasson-Ohayon, Yanos, Lysaker, & Roe, 2013). These areas of question may be painful to discuss, so it was an important part of the process to not only take plenty of breaks during the interview, but also to make sure to take the time to discuss and debrief after the sessions and in the weeks following the interviews. In most of the interviews, there were no issues with this, but the interviewees did express a feeling of 'catharsis' through the open discussion and interview process, with one participant explaining that they had a great deal of healing afterwards. In other situations, the interview was quite triggering, and with much consideration, in one situation I decided to pull a participant interview from the study, as I felt it would potentially cause more harm than help. Although this was a difficult decision to make, I felt it was in the best interest of the participant.

Participation in this study was open to any ethnicity, gender, religion, occupation, or other general features. However, the participant pool excluded anyone above 29 years old or below 20 years old to keep the data representative of young adults. The participant pool also excluded anyone without an official or unofficial diagnosis of mental illness, as this study looked to explore the experiences of those within this demographic. Participants did not have to grow up in Phuket, but they did have to currently reside in Phuket in order to participate. This ended up being somewhat limiting, as many interested potential participants outside of that age range and location did come forward but were unable to take part in the study.

Recruited participants all knew me vaguely in some capacity, either through local connections, community groups, or friends of friends, which may have created some considerations for ethical appropriateness and power distribution. In the case of this study, it was important to focus on building rapport between the participants and myself to decrease feelings of unease. Without the rapport, I feel the participants would have been much less engaged and honest with their insights. The fact that I was a similar age to my participants may have helped build

relationships with them, allowing for more comfortable and honest dialogues about sensitive topics (Dahlberg & McCaig, 2010).

Two of the participants were not Thai nationals, which shaped this study into a very different kind of research piece than I originally intended for it to be. This lack of Thai participation may be due to many reasons such as listed above with stigma, taboo, cultural differences, and participant pool exclusion. Although I once knew *passad Thai*, and I spent time learning more in Phuket, my proficiency level was not high enough to be able to explain the topic to people other than in English, which may have also caused a barrier. Though I made many connections in the community, and many people stated that they wanted to help, there was a high level of reluctance to actually speak about the topic or move forward with interviews, even by many non-natives. What this means is that the study is not based on *khon Thai* perceptions of mental illness but is instead a look at how non-Thais and Thai nationals feel mental illness is perceived in their personal lives as well as in Phuket. This made the study even more important to aim at both Western and Eastern perspectives of mental illness, and how these areas overlap and coincide in Phuket.

Chapter 3: Findings

Phuket, Thailand is a place filled with people from many diverse backgrounds, with varied nationalities, ethnicities, religious backgrounds, and cultural belief systems. It is an amalgamation of Western and Eastern perspectives, creating a unique environment for people to live, study, and work in. The participants in this study were from different countries, religious backgrounds, and family environments. Each of the participants in this study grew up outside of Phuket, but they now live here long-term and call Phuket their home.

Participant Profiles

The following section offers a brief profile on each of the four participants who took part in the study. Each profile describes the background of the participant, their experiences, family history, and personal demographic details. Each participant voluntarily contacted me to discuss their experiences of living in Phuket with a mental illness, how this label has affected the way others see them, how they feel about themselves, and their overall quality of life.

Jan (smoker) is a 26-year-old single Caucasian female with anxiety and depression. She has a bachelor's degree and has worked primarily in teaching. She is non-religious, though identifies as somewhat spiritual and was brought up in a 'Born-Again Christian' family. Although Jan recalls some Buddhist family friends, she grew up in a majority Christian missionary community living off donations in Chiang Mai where she was home-schooled. Her family is no longer religious. In comparison to the other children in the community, she struggled in her schooling due to low confidence and high anxiety. Jan lived in Thailand and worked as a teacher until moving to England where she studied and worked for a short time but was confronted by several deeply traumatising events plunging her into worsening anxiety. She returned to Thailand and now lives in Phuket. Jan's family has a history of mental illness.

Pat (smoker) is a 29-year-old single Caucasian male with anxiety and depression. He describes himself as an artist who grew up in the United States in a wealthy family. He now lives in Phuket because he could not function with his illness in the high paced, aggressive lifestyle of the US. He and his family are non-religious. Pat had problems in high school with attendance and dropped out at an early age. Pat has never had 'traditional' employment or any long term

intimate relationships due to his illness. His current employment takes the form of odd jobs, and in the past, drug distribution. His parents and siblings have all suffered from mental illness and issues with drug addiction.

Peter (smoker) is a 29-year-old single male Caucasian with bipolar. He describes himself as a poet who grew up in Scotland. His parents were immigrants from England, his mother raised Catholic and his father, Protestant, but non-practicing. His mother raised him as a 'spiritualist'. Peter's parents argued, and his family life was turbulent, but loving. His family has some history of trauma and mental illness. Peter works part time as a teacher. He has lived in Phuket for four years, living previously abroad in other countries. Peter has a history of involvement with the police, and losing jobs for a variety of reasons, often tardiness and 'heightened emotional states'. He smokes marijuana regularly and takes other recreational drugs on occasion. Peter describes his episodes of what Western diagnosis labels as 'mania' as 'the enlightened state'.

Dia (non-smoker) is a 22-year-old single female *Khon Thai* with an intellectual disability. She describes herself as a Buddhist who grew up in Nakhon Si Thammarat, most recently with her grandmother (*yai*). Her mother and father work in different provinces in Thailand. Dia moved to Phuket a year ago and now lives with her uncle, working as a nanny for her younger family members. During the interview, Dia had a relative as a support person to help for translation, to make sure she was comfortable, and ensure she understood the questions. Living with an intellectual disability, Dia has a low education level and an inability to hold a high-performance job, so she is taken care of by her family and helps with working to collect herbs, peel vegetables, and raise younger family members. Dia's family has some history of mental illness.

As the participant summaries above show, each of the participants in this study had unique backgrounds and stories to tell about their experiences living in Phuket with a mental illness. However, I was able to identify five key reoccurring themes throughout the interviews, discussed in the next section of this document.

Themes & Subthemes

1.) Where Mental Illness Comes From
2.) Family Background

- History of Mental Illness
- Growing Up

3.) Interpersonal Relationships

4.) Living with Mental Illness

- Symptoms
- Trauma
- Self-Stigma
- Self-Acceptance
- Employment
- School

5.) Lifestyle

- Thai Culture
- Treatment

Where Mental Illness Comes From.

Perspectives of where mental illness comes from were unique to each participant. This is a tricky question to comprehend and a difficult one to answer because there are a great many potential reasons that symptoms of mental illness develop. Dia has an intellectual disability and understood that she was born different than others, though why she was born differently was not something she was able to answer. Peter believes that his bipolar is a result of his way of thinking being different than others, something he learned from his mother's interest in spirituality. Jan believes that her anxiety and depression is partially genetic, along with some learned behaviour and chemical imbalance, and Pat believes that his is also partially genetic, partially to do with his intelligence, and substantially a product of his up-bringing.

Due to Dia's illness, it is sometimes hard for her to understand or comprehend certain complex concepts. Regarding where mental illness originates, Dia had difficulty understanding what that could mean, but she did understand that people are born different from one another and remains positive about the fact that she is different:

> *Yeah, the teacher, they told me that I am slow, and the teacher said that uhhh, people are uhh, are not the same, some peoples are slower than the, than the*

> *others. That what she say. But I slow because I make sure that my hand writing is good!* (chuckles) *I, see, I am very positive!*

Peter, like Dia, understood that he is different than others. He sees his episodes of mania not as a mental illness, but as a gift acquired from being more attuned to esoteric ways of thinking (see *Symptoms,* and *Treatment*). This confirms the results of the 2015 study by Luhrmann et al. that some people believe symptoms of mental illness may be of a spiritual nature. Peter likened his illness to magic:

> *I think a lot of it is through my mum's spiritual interests, and those of her friends, people I've met along my travels. I've always been very kind of open to esoteric, and from a young age, I loved magic, you know, I was fascinated by Narnia, Lord of the Rings, The Hobbit... I guess using magic in some way to create good in the world.*

Although both Jan and Peter believe that there is a genetic predisposition to developing symptoms of mental illness, Jan believes that learned cognitions and a chemical imbalance also contributes to symptoms of her anxiety and depression. Jan also believes that she naturally attracts negative things into her life because she thinks about the world negatively. One of the common symptoms of depression and anxiety is the persistence of negative thought patterns as Jan talked about (Clark D. , 2001). These repetitive emotion-focused thoughts are called 'rumination'. Rumination is an unconstructive type of repetitive thinking that focuses on depressive or anxious symptoms which can exacerbate the illness (Rood, Roelofs, Bogels, & Alloy, 2010). These thought patterns, as Jan explained, become habitual and are difficult to 'learn out of' through intentional thought control. Here Jan described her own learned behaviour and genetic predisposition:

> *I believe as well that partly, it was um, learned, like, learned behav—like, uhhm… like it became a habit. I was only—but it stems, it stems from a belief right? A belief that ultimately, that, 'everything is not okay,' and… yeah, that's it, 'everything is not okay,' from that feeling… uhm… and because I said that to myself so many times and believed that so, for so long, uhm—uhm, and then these things, I—I believe now that I attract somewhat, I believe I attract*

> *what I keep thinking about. Uhm, and this is kind of a more recent, very recent sort of thing that I—I'm considering 'cus that goes completely against science, but, uhm… It's like, retraining and uhm, yeah, but so, I—I think part of it is the genetic predisposition, part of it is the, is the learned behaviour and the habit of my thoughts, and part of it is the… what was the other one? Uhm… chemical imbalance.*

Pat, like Jan, believes that genetic predisposition is a part of why he has depression and anxiety, but he also believes there are other potential causes as well. Pat said that his high intelligence may be linked to his feelings of anxiety as he tends to over-think about things or ruminate, just as Jan does. A study by Coplan et al. (2012) showed that high intelligence is associated with either the least or the greatest extent of worry depending on whether participants had a diagnosis of generalised anxiety disorder. Pat considers himself to be intelligent, and that this contributes to his anxiety:

> *I think being really smart and having really high innnntelligence has contributed to my anxiety because when I'm talking to myself, basically my conscious to my unconscious, that motherf—ker is really capable of beating the s—t out of myself in a million different ways. It's going up against a very, very capable animal you know what I mean? Which is difficult.*

Pat also believes a large part of the development of his symptoms of anxiety and depression are from growing up alone, without stability, and without good parenting. Part of that may have a genetic component, in that both of Pat's parents suffered from mental illness (see *History of Mental Illness*). According to a study by England and Sim (2009), parents with depression are more likely than other parents to develop negative, hostile, and withdrawn parenting styles. These environments are more likely to produce children with higher rates of difficult temperament, insecure attachment, affective functioning, vulnerabilities to depression, poor interpersonal functioning and stress response, etc. Pat explained that maybe if he had been brought up in a more nurturing environment, he would not have such elevated levels of anxiety and depression:

> *Nurture or nature… I dunno. I mean, obviously, I had no cement pillars when I was growing up in any shape or form,* (chuckles) *or any type of example, of anything ever, I lived in like a house by myself it was like a mansion, livin' in like a big house,* (unintelligible) *like, it's crazy. But yeah, uhhm… but, I dunno, lack of, lack of good parenting… My mom would tell you we're born with it but… but I dunno. I think, I think it's definitely nature, nurture, but I'd definitely put—I'd probably go with nurture way more than nature. Probably be a lot better off if I wasn't with people that* (chuckles, trails off) *…I don't think, I think it's more nature, I mean, more nurture, because, I just think, I really believe if I kinda just had more of a normal upbringing… but I dunno if it's ggenetics or not. But you could, eeverything is genetic, you could argue but, you know what I mean.*

When Pat described 'growing up without pillars' and living alone without parental guidance, what he is talking about is growing up in a home environment without support, nurture or care. He believes that his upbringing had a significant impact on his mental health. He believes had he been brought up in a different, healthier, environment, then his symptoms of mental illness may not be so prominent. He also discussed his belief that this is an arguable statement, and that 'everything is genetic' to a degree, meaning he also believes that there is a correlation between his underlying illness and genetic predisposition to mental illness.

Family Background.

Participants described what their lives were like growing up in their families and communities. Each of the participants had family members with a history of mental illness, though Dia's was the least severe. In Peter's case, his family history of mental illness did not take shape until later in life, including his own, which caused some turbulence in his relationships with them. Pat's family had a history of quite severe mental illness, with most of his family being estranged and losing much of their accumulated wealth. Jan describes, opposingly, the change over time her family has gone through dealing with their history of illness, and how this has gotten better over time. These examples show the diversity individuals experience in growing up with mental illness, in how some families are supportive, others learn to be supportive, and some are less

supportive. Each participant, regardless of whether they were close with their family, saw their family as still being an important structure in their lives.

History of Mental Illness.

Each participant had a family history of mental illness. Participants discussed family mental illnesses, from drug addiction to depression, anxiety, dementia, bipolar, disordered eating, and personality disorders. Some participants had family members who had committed suicide, and family members with physical impairments as well such as deafness. Some of the participants grew up with their family members experiencing symptoms of mental illness, while the family members of others did not experience symptoms until later in life, and others still had little interaction with family members who had a mental illness. Perceived self-stigma in these cases may be a learned behaviour from observing family members with mental illness.

Peter's father was diagnosed with dementia not long ago, and was placed into a care facility. This struck Peter on a deep level, to see his father in manic states, coming off as irritable and aggressive to those around him. In some situations, Peter described his father as believing things had happened, or he thought people had betrayed him, and he would come across as threatening to friends, family and caretakers in his rest home. This has caused him to become isolated and lose friendships. Interestingly, although Peter had no qualms with considering his father's illness to be most certainly Western diagnosed dementia, he did not seem to notice the similarities between his own episodes of mania and the episodes of dementia his father had experienced. When I asked him if his father had any episodes when Peter was younger, he said he had not. Although it is likely that his father does not have bipolar, it is interesting that Peter does not see his father's illness as being an 'enlightened state' such as he described his own episodes of mania, which portray similar symptoms. Here Peter describes how his father was prescribed with Diazepam to calm him:

> *He's in a home with vascular dementia so that can obviously decline sometimes, and then even out again. It tends to be about winter time that he'll have a dip. And the last time around he had to go on Diazepam because he started to become a bit, not violent, but he would… become reactive in situations.*

It was clear that Peter saw his father's illness to be negative. He spoke with a tone that made his father's behaviour sound silly and irrational. I wondered if perhaps seeing his father's episodes had an impact on how he saw his own illness. If maybe, by separating Peter's own illness as a spiritual condition rather than a medical condition, it was somehow more acceptable and logical. Here, Peter describes his father's hallucinations:

> *He's had, he's had things that, happened when, when he was living in his house and he, he started to imagine he could see… ehmm…* (unintelligible) *ehh, like, not goblins exactly, but it'd be like, like he could see maybe, the white cushion on the kindof, this colour red,* (points to pillow) *kinda, maroon red, sofa that he had, and cream cushion with some kinda green and red flowers on it, and sometimes he would just, because there's overhead lighting and it had been dark and* (unintelligible) *he would think he could see it moving.*

Peter's mother also recently began suffering some mood instability, going into a 'seasonal depression' where she had difficulty moving and functioning daily. According to Peter, his mother was prescribed with medication and has since begun showing healthy progress. Both of his parents go through recognisable episodes of illness, that Peter recognises as being unhealthy, but does not define this in himself, perhaps to avoid self-stigma.

Pat's family suffers from mental illness on both sides. Although once a very wealthy family, Pat stated that the acquired wealth had long since dissipated due to his family's deteriorating mental health. Pat's parents both had troubled childhoods, repeating the cycle with their own children. It was clear that Pat did not think fondly of either of his parents and laid at least some blame on them for his own illnesses. Like Peter, Pat's father's illness sounded eerily similar to his own. And again, like Peter, he seemed not to recognise this, but may have developed feelings of negative-self stigma as a result of seeing those symptoms:

> *Well, my family's f—kin' nuts. My dad struggles with extreme mental illnesses. He is like, basically doesn't even function. Depressed, very very fat. Very broke, like, doesn't even take the trash out, it's like, hoarder level over there. It's like—and he's very poor. And he's just kind of in a daze and drinks and he's just kind of mellow there. But, you know, he still is there. But yeah, and his*

parents were completely, mental illness, abusive, estranged. My mom's side was also estranged with her father who has struggled with extreme mental illnesses of like, anger, abandonment. So pretty much down the line on both sides.

According to Pat, her mother has a variety of mental illnesses, including Borderline Personality Disorder, depression, narcissism, and a severe methamphetamine addiction. It was clear that she was a neglectful mother, and someone Pat was not proud of. He later emailed me to say that this interview helped him to deal with a lot of trauma and emotions he had not been thinking about for a long time. It brought up some repressed memories, and he remembered that his mother had been feeding him methamphetamine as a young child, which no doubt had a very direct impact on his childhood development:

My mom struggles with extreme mental illnesses. My mom is borderline personality, depression, narcissism—uhm, uhh… s—I mean, sociopath… I mean, she has eaten crystal meth every morning for like, the last 35 years, orally… She's out of her f—kin' mind though, I mean... She's like, visibly out of her mind, it's not even like, 'I'm her son and know the truth of it,' she's out of her f—kin' mind, she's like literally, if she walked into a room, everybody would be like, 'what the f—k is going on…' You don't have normal conversations with her.

Pat was not the only one to suffer his parents' neglect. Pat's siblings all also have mental illness, which he says has always been a "major theme" in their relationships with each other. Although Pat was reluctant to discuss more about their relationships, I wondered if there was similar childhood abuse and neglect towards them:

Yeah, I have two brothers and one sister. My sister's always been on anti-depressants, everyone's always been in and out of therapy. I mean, my elder brother struggles with depression. I mean, nobody's really got all their s—t together to be honest… It's family, what are you gonna do?

Jan's family also suffers from mental illness on both sides. Her mother's sister Sarah had depression and was partially deaf and had attempted suicide, which had a significant impact on the way her mother regarded mental illness from that moment on. Jan's father had symptoms of anxiety while Jan was growing up, and Jan saw this as being very different from her mother, who was opposingly very strong and hard-headed:

> *He's unfortunately, he's, he's how I've been, always in the fear. Always in the fear. And always in a place of lack rather than abundance… He always had anxiety… he's constantly worried about what other people think and how— and if something goes wrong and, and, and all this stuff, but my mom's never been like that.*

Jan's father's sister, Jesse, also attempted suicide, and his brother was murdered. She describes her father's experience with his sister Jesse's illness as contributing to his inability to confront Jan's mental illness. She said all this with a laughing, smiling face, downplaying the gravity of these particular traumatic events. She explained how her father tends to deal with fear using humour, and it seems that Jan may have learned this coping mechanism as well:

> *Uhh, my father… is afraid of it because he, I think he saw it, in his, in his sister. Again though, I think I—I—I don't know because when she tried to kill herself uhm… the doctors apparently he said—this is how he describes it, his sister… they were like, 'well shit Jesse, like you know, if you really wanna kill yourself we, we can help you do it,' or, like, not help you do it but like, there are easier ways there are less painful ways, like all this stuff. So—so my dad, I think, I think though he couldn't, I think he goes in and out of taking it seriously.*

No one else in Dia's family has an intellectual disability, but Dia explained that her uncle has had issues with depressive episodes. It is unclear, however, whether these are depressive episodes or just times of sadness due to loss, as Dia explains here one such event:

> *Yeah, uhh, there is one that I think that uhh, have something more like, uhh, uhmm… de—de—depression one, that like, cry, and sad. My uncle. My uncle,*

uhmm, my uncle become, uhmm, depressed because like, her, his wife leave him.

Aside from Dia's case of intellectual disability, each participant had significant family history of mental illness. Family history of mental illness is not only correlated genetically but can have an impact on symptoms of mental illness, attachment, cognition, social, and emotional and behavioural development (Manning & Gregoire, 2009).

Jan, Peter, and Pat saw their parents experiencing symptoms of mental illness. Their other immediate family members also had mental illness which directly impacted their parents' lives and perceptions of illness. In Jan's case this was positive for her mother, who developed more empathy for Jan, but negative for her father, who feared seeing symptoms of illness and was unsure of how to deal with them. In Peter's case it has been difficult seeing his parents' illness, and has potentially influenced how he views his own episodes. With Pat, he has not only witnessed his family's mental illnesses, but also suffered because of his difficult relationship with them since he was young. Manning & Gregoire (2009) confirm that significant and long-lasting cognitive deficits appear in children of mothers with mental illness, affecting attachment, ability to form relationships, emotional regulation, self-esteem, and sense of identity.

Growing Up.

Prange, Greenbaum, Silver & Friedman's (1992) research states that people diagnosed with a mental illness more often have troubled family relationships. Participants confirmed that mental illness was not discussed in their childhood, or that such illness was thought to be a result of religious sacrilege. Some participants experienced domestically violent upbringings and were exposed to their family members taking drugs. As Bullock & Dishion (2007) describe, it is difficult to ascertain whether intra-familial stigma in these families was due to negative family interactions, or perhaps exacerbated by mental illness (see *Interpersonal Relationships*). In a study by Moses (2010), 46% of the participants describe experiencing stigmatisation by family members.

In the case of Peter and Jan, neither of their families spoke of mental illness. Due to negatively held beliefs about the causes and effects of mental illness, it is not uncommon for families to avoid discussing mental illness (Moses, 2010)

Religion and spirituality was brought up by some of the participants. Although Peter's parents both come from religious backgrounds, they did not practice religion in their household. Peter explained that his mother eventually transitioned into a more spiritual following, which he embraced:

> *Over time she got into just uh, massage, through that shiatsu, and through that, tai chi, a bit of reiki, crystal healing, shamanism. She was a huge influence on me, she was, massively. She's been a real guru.*

Peter later explains that this spiritualism is part of where he believes mental illness comes from (see *Where Mental Illness Comes From*). He described a somewhat turbulent, domestic upbringing, where he and his sister often heard his parents fighting. In the interview. he went back and forth between saying that things were not that bad in his household, to then contradictorily detailing traumatic events, then between those going back to reiterate and add explanation to downplay how negative they sounded. Peter clearly wanted very badly that it be known that his childhood could have been much worse. Early childhood trauma can be an environmental factor that may impact the development of mental illness and emotional instability later in life (Sullivan, Neale, & Kendler, 2000). People often minimise when it comes to describing negative events in their lives through cognitive dissonance to protect themselves from dealing with trauma (Payne, Joseph, & Tudway, 2007). Here Peter describes his experience growing up:

> *When I was growing up, certainly, you know, it was kind of like a bit, not quite dysfunctional, but my mum and dad argued a lot. I remember when I was growing up, one of my earliest memories, I think me and my sister reflected on it, is me and her sittin there, talkin at the stairs huggin each other with the lights off in the home, we could hear mum and dad down in the dining room— we could hear them chittering at each other and they were throwin plates or something, and things were getting smashed... so there was a real strong*

> *energy, you know, from my mum, like a real vehement RAWWWHHRR! Kinda thing you know? And I dunno that she ever hit my dad or anything more than just a lil'* (thumps his hand on the bed) *you know a frustrated* (thumps his hand on the bed) *rather than a proper smack, you know, I don't think she ever…*

Despite the unhappiness in his parents' relationship, Peter's relationship with his mother has always been close. He discussed how his mother would often take the role of both parents, as his father worked frequently. However, most parents work often, and still find time to be an active part of their children's lives. It is possible that this was a way for Peter to excuse his father's absence in his life, perhaps physically, perhaps emotionally. With his father's absence, Peter and his mother created a strong emotional bond, one which he still considers very important to this day:

> *We can not talk for you know, months, a couple months at a time, just a wee email here and there, a quick chat, and then when we catch up it's like there's no gulf between us, there's no distance you know. Definite kindred spirit kind of thing.*

It can feel threatening to be confronted by family regarding exhibiting symptoms or episodes of mental illness, especially when the relationship is very close. In episodes of mania, people can suffer from psychotic symptoms including feelings of grandeur and delusional thinking, they often don't see their behaviour as being erratic or abnormal (Hilty, Laemon, Lim, Kelly, & Hales, 2006). Peter, being so close with his mother and feeling they usually see eye-to-eye, was surprised to find his mother to be quite judgemental and unsupportive during one of his episodes:

> *I had spoken to my mum and she said something was wrong, she said there's just this chaos within me, where again it seems like this period recently* (his latest manic episode, which occurred within the last week) *Yeah, she was just kind of like, "well you've got to get a grip, you need to sort yourself out," you know, and all this and, "it seems like you're losin it a bit," and all that. She didn't seem very understanding. And that, for me was an issue because she's*

> *always been very understanding, very open minded, and it seemed like, she was just kind of being very judgemental at that period. And so I guess, I guess I felt like my usual greatest, or most reliable support was compromised.*

People with bipolar can sometimes get paranoid and confused during an episode. It seems that as Pat explained above, he felt confronted and unsupported by his mother, the person he was most close to, even though it sounds like she was likely just trying to help him and was rationally worried. Irritability is also a symptom of bipolar. In a fit of anger, Pat hung up on his mother. Soon after this, he was detained for erratic behaviour at his residence, a local hostel:

> *You know, I just hung up on her. One missed call. And the next thing she heard was when I'd been arrested, and I was in the drunk tank. I wasn't drunk, but they kept me in the drunk tank. And they called my mum and said, "oh, your son's been arrested. We're holding him in a holding cell and we're gonna keep him a couple of days as a precaution, then let him go.*

Although he later elaborates on this manic episode (see *Interpersonal Relationships*), he never admits to wrong-doing. However, the way Peter discussed this incident about his interactions with his mother here seems like it may be an expression of remorse. Although he was initially upset with his mother for not understanding what he was going through, he talks about how the next thing she heard about him was a call from the police. Any mother in this situation, especially one concerned about the mental health of her child, would likely be horrified to receive this call. This caused a barrier in their relationship that they are still currently working through.

Jan's family immigrated from the United States to join one of the large growing missionary populations in Thailand. Jan explained that coming from a Christian Missionary background, her community saw mental illness as something to be ashamed of because it was an act of the devil:

> *Mental illness was dealt with, I mean, generally speaking, like, friends of my, friends of my fam—my mom's, and like, other Christian families, that we were living around, uhm, in Asia, the—if, if someone had a mental illness it was,*

'you were filled with the devil'… So if you did, you didn't get any help with it… It wasn't acknowledged. It was, yeah, uhm there could be many different things, there could be, uhm, the fact that, uhm, you know, the devil was working in you. It could be that you had picked up, some, some bad spirit. Uhm, it could be that you were 'out of the spirit'. A variety of those things.

In other Western and Eastern religions, there are similar perspectives of mental illness being the fault of the sufferer, such as the Buddhist *Kam*, so it is not surprising that within a small Missionary community in Thailand, mental illness was something to be ashamed of (Burnard, Naiyapatana, & Lloyd, 2006).

Jan described her mother as, "strong," with a mentality that, "everything will be okay," and if you are having mental health issues you just need to, "pull up your socks." Throughout Jan's life, her mother has had an air of dismissiveness in relation to perceived emotional weaknesses, pretending that nothing is wrong. This dismissive parenting style may have had an impact on the development of the severity of Jan's symptoms. It seems this negativity may have also created a stressed relationship between her and her mother, where Jan felt constantly compared to her, inadequate, imperfect (Kendler et al., 1995; Scherrer, True, & Xian, 2000):

My mother is a very strong, uhm, person and I believe that I—I realise now that she's always kind of had, maybe I wanna call it now… silly… She's always seemed to have this like, underlying feeling and, and sort of opinion present that 'everything's gonna be okay,' and that like, you know, she knows what to do she's gonna be able to do it, like yeah she'll go through hard times but, but she… she can do it. And uh, she's not fearful.

Although participants' families had difficulty understanding and accepting mental illness, family still stood out as an important support network for them. Some participants talked about the development of understanding over time, and how this has led them to relate to their family members better and evaluate why it may have been hard for them in the past with their own struggles of mental illness and trauma in their lives. Overtime, Jan's mom has gotten better since her Aunt Sarah's own confrontation with mental illness, as she describes here:

Mom always uhm, in the beginning would approach mental illness with like, basically just you know, 'pull up your socks, get on with it,' uhm, or, you don't, she doesn't want anything to be wrong with her children, so she, or she doesn't want you to think there's anything wrong with you so she always kind of dismissed it. But, with her sister, the longer—and with her sister too in the beginning she was very much like, you know, Sarah's making this up, she's just being sensitive, she's trying to get attention, blah blah blah...

Jan explained that her mother's perception has changed now, and she has become much more supportive and sensitive to Jan's needs. Despite anxieties, she told her mother about this study she was taking part of and expected to be shot down. But her mother was supportive and proud of her efforts. Jan said she had never had a more comfortable and pleasant visit with her mother. It seems their bond is rebuilding over time.

Both of Jan's parents, having a strong religious background, used to see mental illness as something inherently 'wrong' with someone, and felt guilt and fear when originally confronted by Jan's illness. Jan described her father as an anxious, worried man, afraid of confronting mental illness for feelings of being overwhelmed and guilt. She believes that a lot of his guilt comes from the fact that when she was young, they were forced to live in an isolated Missionary community off of donations, and struggled because of this:

He feels guilty more. And he, and he like he wants to help but he doesn't want—doesn't know how and he doesn't feel like he has the resources because for me it— that's kinda where my dad is, like, wants to help but, already feels so overwhelmed with everything that he's dealt with in his life thus far that he doesn't really have anything to give.

Dia's experiences were significantly different to those of the other participants, in that her environment was quite supportive, and her mental illness was acknowledged by her family in a caring way. The other participants describe a more turbulent and unsupportive upbringing. This could show the difference between growing up in a community filled with Buddhist Thai Nationals, a more community-focused outlook, versus Western or Christian communities which take a more individualistic approach to values and support. It could also potentially be a

difference in how people treat and care for those with intellectual disabilities versus how they treat others in the community with less ‘acceptable’ mental disorders. Dia described how her family takes time with her, whereas other people may not give her that kindness. She explained that younger relatives know about her disorder and allow her to act in a more ‘parental’ position because it makes her feel included and supported, which is an essential part of caring for someone with a mental illness:

> *My family support me. They say like, “that’s okay, like, we just take time to learn.” Some people do, like do not accept that…. I live in my uncle house. Annnd because my aunt get married to, and so, there is another son in that house too, so I always like, ask him, like, that son, “You need to do this, you need to do,” and he that, like, he let me tell him what to do, uhh, so that why I feel like, important, like a big sister.*

As Dia discussed, not everyone has been as kind to her regarding her illness. In one example, Dia explains that some neighbours back in her hometown had been saying unkind things about her around town. Her grandfather stood up for her and confronted the neighbours:

> *My like, my neighbour, like, like talk about it, but my grandpa went to talk to those people, they stop saying that such thing. My grandpa have taken care of that issue!* (chuckles)

Interpersonal Relationships.

This study confirmed that public stigma and the symptoms of mental illness also affect interpersonal relationships at school, with friends, and in partnerships. Participants experienced bullying from friends at school, as well as discouragement from teachers, disapproval from neighbours, and even monks. They experienced belittling from friends who knew of their illness, which can exacerbate symptoms. Possibly because of mental illness, many of the participants were very shy and discussed having difficulty making and retaining long-term friendships and partnerships. This confirms Davila & Beck’s (2002) study that socially anxious people tend to have fewer social supports and intimate relationships, greater confrontation and self-expression avoidance, and overall less satisfaction in their relationships.

The participants in this study were single. Some of the participants experienced rejection from friends after displaying traits of their illness, such as hyper-activity and anxiety. This confirms what Burnard, Naiyapatana, & Lloyd (20016) state about community and peer groups perceiving people with mental illness as violent and unpredictable. Participants spoke of feeling different from others, or less than the people around them because of their illness. They expressed feelings of frustration with other people for not listening, hearing, or understanding them because of their mental illness, or with their lack of understanding of mental illness in general. This can become a self-fulfilling prophecy as Salkovskis (1991) explains, because it can heighten symptoms of mental illness as well as feelings of self-stigma, as explained by the participants in this study.

In school, with friends, and in partnerships, the participants explained that people would often judge them because of their mental illnesses. At school, Dia felt unsupported by her teachers, even though she tried her best to keep up with classes. It may be that her teacher was not well-trained in assisting people with intellectual disabilities. Dia also talked about her friends teasing her, and Jan, similarly, discussed friends somewhat belittling her for her illness. Peter talked about his experience with friends judging him, and Pat explained that his experiences may be, largely, an expression of his own illness. In these experiences, it could well be legitimate stigmatisation of mental illness, or perhaps, a symptom of mental illness itself that they feel judged. It is likely a combination of the two in many ways. Pat is the only participant who talked about having a strong social support network of friends.

Although Dia has good relationships with her family, her community relationships have sometimes been less supportive. She has received judgement from friends, neighbours, monks, teachers, and others in the community. Dia spoke at length about friends teasing her and her teachers being unsupportive and demeaning. It is possible with Dia's intellectual disability that she may not be able to explain what she means to say (*Self-Stigma*), or that her teacher did not have adequate resources to help her for lack of training or understanding, or perhaps did not know that Dia even had a disability (Fulk, Swerlik, & Kosuwan, 2002):

> *Friends kind of, tease me. Kids say, "yeah, you cannot get nothing done," like that, so it makes me sad because I cannot keep up with them. Most of the*

> *time, uhhh, the people who listen to me is boys. Boys listen to me, but girl just, did not care… Since I have a learning disability, many times, that, uhm, my teacher say like, "hey, uhmm, you should do a-better," more like, negative, at me… Sometimes when my friend, like, tease me, I went to talk to my teacher. And they say like, "oh that is just right, you friend, just, uhhh, kidding you, just kid you, so do not take this into, what you call, seriously," and so when the teacher did not do anything, I felt sad, I felt sad, but, when I come home I am happy.*

Dia explained that there have been times where she felt very unsupported by monks at her local temple, because they can see her illness. Even though it does not sound like the monks were trying to be unkind or cruel, when they notice her disability, it makes her feel like she stands out from others, and viewed as different or slower than everyone else. Although Dia describes herself as usually a very happy person, it is clear that when others judge her, it can be a very painful experience:

> *One time, uhhh, the monk, the head monk, ask, "Hey, why, uhh, I feel like you are a bit slow than other," Uhmm so the head monk, he can like, he has some sense that he can like, can tell who is slow, who is smart, so he say, the head monk like, talk, I mean say, like, "you seem like, uhh, slow like," So I uhh, I feel unhappy, so when I get home, when I like, get in the car going home, I cry, I cry and because I feel like, I feel like people know that I am slow.*

Like Dia, Jan has experienced some stigma regarding her illness. She talked about feeling how even if she does not tell people that she has anxiety, that others must surely see it upon meeting her. This is likely a symptom of her anxiety, an irrational fear where Jan believes people can see how she is feeling although she does not sound or appear under duress (see *Symptoms*). When she does divulge to others that she suffers from symptoms of anxiety and depression, she explained that she feels belittled for her illness. Friends will assume if she is not overly talkative, that there is something wrong and they should be concerned for her. As with family (see *Growing Up*), it can feel threatening to be confronted by friends regarding symptoms or episodes of mental illness, and lack of understanding or education from others

can cause people with mental illness to feel judged or unlikeable (Alden & Bieling, 1998; Voncken & Dijk, 2012):

> *So when people ask me* (in a high voice) *"'Are you okay?" if I'm not talking or something, or if I'm just like, being quiet and being to myself and not engaging in the you know, frivolous whatever, 'cus sometimes I don't have the energy for it. And, and sometimes I'm really loud blah blah blah blah blah blah blah obviously, but, but when I'm not… or sometimes when I, I just feel don't—I, I don't feel… yeah, I feel like I don't have any feelings about, I feel kind of numb sometimes. Like, like, emotionally, like I'm not, I'm not, I'm bored with everything, and so I don't want to talk about anything. And then people say to me* (in a high voice) *"are you okay? You're being very quiet." And I'm just like, I'm obviously being quiet for a reason. I don't say that to them, but I'm just like, you know, and that's just, you know. But so, often people will ask me that. Or they'll say I'm very weird. Uhm, which I am, but, but yeah.*

Jan's quote here addressed a variety of areas. She talked about the symptoms of her illness (see *Symptoms*) causing her to feel numbness, bored, and not wanting to talk about things. This, in turn, causes other people to worry about her because they know she has a mental illness. They say she is weird for suddenly going from being very talkative, to very reserved and acting strangely. As Burnard, Naiyapatana, & Lloyd (2006) explain, people with mental illness often lack support and understanding from those around them, not because their friends and family don't care, but simply because they do not know how to act towards someone with a mental illness or how to offer them the care and support they might need. This can cause people to treat others with mental illness differently, in a way that seems belittling or uncaring, as Jan explained.

Peter considers himself a traveller, and says that his lack of social networks is in part due to this changing state, as well as there being cultural barriers to meeting new people and maintaining relationships. However, Peter also described multiple scenarios where he felt that after opening himself up, people began to dislike and judge him. He talked about how he goes from introversion, suddenly to extroversion, very open and musical, trying to engage with

people and discuss spiritual topics. As an introvert, this behaviour for him is abnormal, and can come across as overbearing and possibly delusional as he discussed coming into a state of mania, or 'Christ Consciousness' (see *Treatment*):

> *…It wasn't a bitter heart, I wasn't a wanker, I—it wasn't egotistical, messi—messianic, twat, you know, and it may have come across in that way 'cus it can do through Christ Consciousness and that kind of level of dimension of being and thinking, and especially if you're coming out of your shell from an introvert to an extrovert perspective as a traveller and meeting kindred spirits in the community and having that kind of abstract style connection, "like this is f**kin grrreat man! I can really be myself here, I can really express everything I am really freely and openly, wow this is amazing you know!" You want to just be open-hearted, you want to be loving kindness, you want to be compassionate and mindful, that's just a natural being for me.*

Peter described the beginning of an episode which ended in him being evicted and escorted out by police from a hostel residence. Peter's sudden change into heightened emotional states can sometimes cause others to perceive him as a danger to himself or the people around him. Peter's perception of how he acts during manic episodes versus how people perceive him may not be the same, as a symptom of mania (see *Symptoms*):

> *I thought we were all cool and that we all had a good connection on some level, and then it just seemed that people started to resent me. And then I was, I was very gregarious, you know, sharing my views with people, so let's sing guitar together or let's listen to a song that you like, do you want to read some of my poetry, or I'll read it to you, stuff like that. So I was being quite the minstrel, if you like, and I felt very in my element, but I must have seemed, perhaps, egotistical to some people, or, because I was usually quite introverted but I really kind of found myself, kind of, very free and expressive and some people resent that.*

As Kessler & McLeod (1985) stated, positive social support and close relationships are important to positive well-being. Although Pat explained that in social situations such as

gatherings or in the workplace, people may be unaware of his mental illness, his close friends and family are aware of it. His friends have been strong supports in his life and have helped him to reach his goals, overcome the symptoms of his illness, and offer him stability that he never had in his childhood. Pat is very emotionally aware, and concerned about making sure he offers his friends the same kind of love and support that they have offered him. He wants to make sure that they enjoy his company as much as he does theirs, and makes an effort to keep his symptoms of mental illness from potentially hurting other people:

> *If I go out to a party, I'm very good at acting and putting on a show if I'm depressed. Some close friends might sense it but, I wouldn't… bring down the energy in the room… I've got incredible people in my life. They're talented, supportive, consistent, reliable, respectable people. Along with some extremely rad groups of friends. I've got a lot of uh-mazing people in my life. Honestly. I am seriously, super blessed on that front. When I got fat, my friends, a whole bunch of them, made a bet with me to lose a bunch of weight by a certain date, that was sweet.*

Mental illness also affected what participants recognised as healthy friendships. As explained by Breitholtz, Johansson, & Öst (1999), anxiety can cause exaggerated worries and paranoid thinking, disrupting interpersonal relationships. Participants experienced fear that their friends may be making judgments about them, even though they admitted this was likely a symptom of their illness and flaws in perception. Pat was very aware of how depression and anxiety can cause negative thought patterns and isolate people from their social support networks (Alden & Bieling, 1998; Voncken & Dijk, 2012). Pat discussed how his anxiety sometimes causes him to think that his friends are judging him, leading to feelings of unease and distrust. However, he understands that this is an irrational thought and that his friends are likely coming from a place of care and support:

> *I can feel them talking behind my back and like, making judgements and like how I should be producing more art. And I hear from them that I'm not releasing stuff and that really—ff—makes it a million times worse though* (chuckles) *is the problem you know when they get that energy. Yeah, but they*

don't feel they're being negative. They feel like they're… doing a cause and effect thing to where they're going to cause me to have better things in their eyes I guess, you know... It's just a shitty thing in my head, it's not… I don't think, they're—they're, they're probably just being sweet and coming from the right place and it's probably me taking it the wrong way but that's one other thing about depression and anxiety. Well, the way you perceive things is f—ked up.

The four participants in this study were single and had not had any serious long-term relationships in their lives. Some participants explained that a combination of lack of interest, shyness, paranoia, and low self-esteem, has stopped them from seeking out relationships. One of the symptoms of anxiety is a distrust in other people: unfortunately, trust is a foundation for establishing positive relationships. Pat reflected on how symptoms of mental illness can affect the types of relationships people seek out:

A symptom of anxiety and depression, an anxiety, specifically linked to the anxiety of untrustingness, one of the symptoms of all that, is lack of interest in a healthy relationship. Of a traditional relationship. Of—of a more, you know, 'white picket fence' lifestyle, one-on-one monogamous, which, deep down I don't believe that's the only way we all should be but, since we're programmed, I have beat myself up by not having the traditional—but now, if you would want to know what I really believe, any lifestyle is completely fine. Everybody should be respected.

Pat explained above that anxiety has stopped him from seeking out traditional monogamous relationships, maybe in part due to this distrust of other people. Pat discussed having more of an interested in polyamory rather than traditional monogamy. Non-monogamy, or polyamory, is a relationship style where an agreement is made between partners to engage in consensual romantic and or sexual relationships with other people outside of the standard two-person monogamous relationship dynamic (Balzarini et al., 2017). Arrangements within these partnerships vary from person to person, but this relationship style has been growing in popularity recently. Due to socially constructed narratives of what is acceptable for a

heteronormative relationship, many people feel negatively towards the concept of consensual non-monogamy, but as Balzarini et al. (2017) explain, this is slowly changing. Contrary to what Pat believes, healthy polyamorous relationships, like healthy monogamous relationships, require deep trust and communication between partners.

Peter, like Pat, Jan, and Dia, has not had any long-term relationships. Peter believes that when he is romantically interested in someone and he tells a friend about it, that the relationship seems to mysteriously fall apart. He believes that there may be some sort of mysticism about this strange phenomenon:

> *It seems like when I tell people good news, especially about girls that I've met and am romantically interested in, when I tell people about it, shortly afterwards, things go awry. And quite often it comes up as perhaps, a subliminal mental block or message, "oh, I shouldn't tell a good friend about this, even though I trust them, and I don't think they're ever gonna do anything that's gonna affect it," by, Sod's Law, or Murphy's Law or whatever it is, something seems to go wrong when I tell people about these potential romances, which happened with this Clara, person, and other friendships.*

When talking about triggers of manic episodes, Peter confirmed that budding potential relationships cause stress which sometimes lead to an episode. Raymond (2008) theorises that in states of psychotic mania, paranoia can hide feelings of guilt and grandiosity. It may be that these things are correlated, and as Peter explains about his friendships, that upon entering a manic energised state, people begin to back away, or that Peter sees them as backing away. He may not be aware that his triggered manic states and his failed budding relationships may have something to do with one another.

Both Peter and Pat explained how their mental illnesses had a direct impact on their reputation. In a study by Ineland et al. (2008), 90% of the participants agreed that mental illness harms the reputation more than physical illness. Stigma and reputation are interchangeable terms in this context. Mental illness can have a significant impact on one's reputation, particularly if symptoms are shown publicly and negatively. Pat discussed how after starting a new prescription medication to help with his illness, his weight once again rapidly increased. He

drank alcohol which, when mixed with certain medications, can compound the potency of both the drugs and the alcohol, and cause such effects as dry mouth, lethargy, and clouded thinking (Malekshahi, Tioleco, Ahmed, Campbell, & Haller, 2015):

> *The last time I got to 400 pounds was 'cus I went to a psychiatrist and he told me I needed to take abiiiiilify, I was actually very thin at the time, doing very actually not bad. That was the most f—ked up thing I've ever taken in my whole f—kin' life and I've done a lot of drugs. That s—t was deeply weird. And then all of a sudden I ballooned to 400 pounds. Passed out at a party, ruined my rrreputation, but that's 'cus I mixed it with alcohol. So I was like this fat guy, passed out like puking, and it like, basically destroyed my reputation at the time, that I—I actually had a really good reputation at the time that I had done, I had organised a bunch of events.*

Peter was evicted from a hostel residence he was staying in after a manic episode ended in a broken bottle and police escort to jail (see *Growing Up,* and *Symptoms*). After his eviction, he attempted to find housing through other local hostel residences affiliated with his previous hostel, but they turned him away. He attempted to book into other hotels and hotels in town which had vacancies, but again, he was turned away. After the eviction, it seems word spread around town about the incident, and he was ultimately unable to find any lodging. Peter ended up moving out of town to have a fresh start:

> *You know, I tried to move after I got evicted and all that, I tried to move to another sister company backpacker hostel with the same company but a different building, and they were like, "oh no, we're—we're full now," like, they had rooms before and suddenly they were full I think they told them, "don't let him in", in another hostel, another hotel they were filled, so I think the police had spread the word, because they wanted me out of town. You know, but then, I came out, went back to the hostel in the end, I was, you know, I was a bit belligerent, to the—the—I was an all-out character… I was like, "oh," (chuckles) I said something, I was like, "oh, you'll see me on MTV!"*

The participants in this study often spoke about a self-awareness of their illness. Such as with Peter here, who joked about how he would be "on MTV" as he was in a manic state, in reaction to being ostracised due to his eviction. This kind of joke was as if to say, "you'll regret this later when I'm famous!": a statement of self-proclamation against those who judged him for his somewhat 'odd' and 'eccentric' behaviour. Jan, Pat, and Dia each expressed that they understood that others might see their behaviour as 'strange' due to their illness, but they also each found a way to embrace their unique differences from others and accept that sometimes others do not understand what they are experiencing.

Living with Mental Illness.

How mental illness effects people's lives varies from person to person. Symptoms of mental illness can cause problems, and these vary in severity and duration, with some people living with symptoms every day, while others experience symptoms only during severe episodes of mental illness. Participants in this study discussed how symptoms of mental illness impact reputation, interpersonal relationships, and even finding potential housing. Aside from Dia, the other participants each talked about living with trauma. Pat grew up in a drug addicted household, with his family members going through varying degrees of illness. He experienced trauma in his family through domestic violence, and later a best friend committed suicide. Jan experienced traumatic events after leaving the comfort of her stability in Thailand that further exacerbated her symptoms of mental illness. The participants also talked about what it was like living with their own skewed perceptions of themselves, as well as how they have come to accept their illness and embrace their lives more positively. Steady employment and school have also been issues for the participants due to their mental illness.

Symptoms.

Symptoms of mental illness vary between individuals in severity, duration, and frequency (National Institutes of Health (US), 2007). Many individuals do not appear to be visibly sick, whereas some will display physical or emotional symptoms regularly depending on their illness, level of treatment, and whether they are in the middle of an episode. Although each mental illness has its own characteristics, some of the most common symptoms according to the US National Institutes of Health (2007) are: inability to cope with daily activities or problems,

marked personality changes, strange or grandiose ideas, prolonged depression and apathy, excessive anxieties, marked changes in sleeping or eating, suicidal ideation, extreme mood swings, sudden excessive hostility or irritability, and drug and alcohol abuse. The participants in this study suffered from many of these symptoms.

Due to anxiety and depression (see *Anxiety,* and *Depression),* Jan suffers from a variety of emotional and physical symptoms. She described feelings of self-loathing, inadequacy, nervousness, strangeness, a lack of control, fear, forgetfulness, hyper-awareness, numbness, sadness, loneliness, inadequacy, and a need for constant structure and rules. She has physical symptoms on occasion which she can now generally pre-emptively control to an extent with mindfulness and anti-anxiety medications. These physical symptoms include cold sweats, disorientation, diarrhoea, and fainting. She has had phases of obsessive disordered eating and driving phobia. Here she describes her problems with eating caused by anxiety:

> *I was having eating, like eating problems, and that was affecting my mood and, and, and because of my anxiety, and all of that,—I needed to, or at the time, this is what I think, what I thought I needed is, I needed to have a specific meal plan which cost a lot of money.*

Dia has an intellectual disability (see *Intellectual Disability).* Her symptoms include difficulty with mathematics, arithmetic, writing, reading, memorisation, and comprehension. She has difficulty with daily function as well as learning difficulties. Due to the symptoms of her disorder, she is also shy because she often fears that people will judge her, or she will become confused and embarrassed. Dia's support person explains how Dia can be fearful of being alone:

> *She is very shy. When I take her to uhmm, to like, like shopping centre, uhmm Central? She had to be like, very close to me. She just, cannot, whenever I, if I walk one step, she walk one step. I think one thing that she feel like, she like, unsafe, like if she is like she might get lost or thing like that. I ask her, "Why don't you just go over there? Just go look?" She say she might not be able to come back, thing like that.*

The example above shows how Dia has difficulty being on her own. She is fearful that she may not be able to function without the help of other people. Her difficulties with memory may increase symptoms of anxiety. It impedes her daily functioning because she needs to be supervised in unfamiliar places and cannot talk with people she does not know without someone else with her. Even in the interview she could not look me in the eyes, and when her support person would leave she would become more silent, giggling nervously if I asked her a question in Thai. Luckily, when her support person was there, she was more than happy to talk, but it was easy to see that she had specific requirements to feel comfortable in her environment.

Pat, like Jan, has anxiety and depression. He has suffered with a bad stutter his entire life, which becomes a self-fulfilling prophecy; the anxiety causing the stutter, the stutter reaffirming the anxiety. Stuttering, or childhood-onset fluency disorder, is a common disorder seen generally with reoccurring reverberations, blocks of sounds, prolongations, syllables, words or phrases (Maguire & Yeh, 2012). During breaks of speech, someone with a stutter has difficulty making sounds. It can also come with physical tensing of the muscles, tremors, eye blinks, and grimacing. This disorder generally appears at an early age and, in most cases with early intervention, people recover from their symptoms. Pat's anxiety and depression have also caused him to lose interest in relationships because of his inability to trust people and his paranoia:

> *I've always stuttered very bad and I haven't been able to curb it. I'm not—and that's—I'm almost positive that it's linked to anxiety. I've struggled with depression, but, anxiety has always been a major presence in my life. And it actually makes me have a speech impediment. That's how* (chuckles) *That's how much anxiety I have. I can't really talk. It's a catch-22… Unhealthy eating. Lack of interest in healthy relationships… uhm… not being able to trust people.*

Pat has also struggled with extreme weight fluctuations throughout his life due to medications and unhealthy eating habits, sometimes reaching higher than 180kgs. This perpetuates feelings of inadequacy and defeat, fear of judgment from others and distrust. He dislikes photos being taken of him and he asserts that he has body dysmorphia, finding it difficult to

see changes in his weight. Body dysmorphia, or body dysmorphic disorder (BDD) is a common and severe disorder that causes people to feel they look ugly, overweight or deformed when, in reality, they have nothing physically wrong with them (Phillips, 2004). In Pat's case, this appears to be caused by his constant weight fluctuations, and likely negative self-stigma brought on by seeing his father's illness and obesity (see *History of Mental Illness*).

> *I'm not sure if—when my physical self is doing very well. If there is much change and difference from that part of the brain. Honestly, I don't think so. I think I'm just performing better. I don't think I ever pat myself on the back. Recently, I've had a lot of body dysmorphia. Problems in the mirror. Sometimes I look really fat to myself, sometimes I look okay. But I definitely know I don't have any part of reality when I look in the mirror you know.*

Peter has bipolar disorder (see *Bipolar*). During episodes of mania Peter becomes reckless, paranoid, sleepless, irritable, talkative, creative, delusional, obsessive, irrational, and sometimes aggressive. During these states Peter has difficulty with memory, and disruption in communication and attention, along with abnormal perceptual experiences and bizarre ideas. He may suddenly decide to quit his job, move, start a band, write multiple scripts or songs for days, stop sleeping and eating, and become increasingly isolated. With access to technology, there is increased potential for fear and paranoia. Delusions that involve the internet are becoming more widespread and are referred to as cyber-paranoia (Mason, Stevenson, & Freedman, 2014). Peter describes recently changing all his passwords during an episode out of fear of his accounts being hacked, although he cannot recall now why he thought that:

> *I felt that with social media lately. I thought I'd been hacked and stuff, and so now I'm unable to get back in.*

Although Peter accepted that a traditional Western model may describe his 'enlightened states' (see *Treatment*) as manic episodes, he does not believe he has a mental illness. During these states, Peter feels enlightened, creative, often feeling able to do a vast variety of projects all at once, increasing social media presence drastically, needing very little, if any, sleep, which can agitate symptoms, causing him to get paranoid, irritable, and what others may see as aggressive. Although Peter believes he is closer to a state of Christ Consciousness, he also

admitted that during these states things do often tend to go awry. Here Peter describes an episode that was triggered by a recent job loss, new job stress, a blossoming romance, and drug use:

> *I think it was just too intense. 'Cus it was what some people call 'Christ Consciousness' which on the surface sounds quite egotistical and big-headed, but it's not at all, it's just simply that you've risen beyond a level of ego, to that level of presence and being where you are just in the moment and you know, thoughts and forms arise, and feelings arise, but you're just aware of them and you don't get caught in the drama of it, you don't get caught in the story of it, you're very flowing, so, some might call it the 'enlightened state', you know, but still, obviously you're not saying, like, "oh, oh, I am the enlightened one," or, "I've reached the better head," it's just a different way of thinking, it's just like a different dimension from the day-to-day thought processes that we have, and it could happen in, through times of like mania, and certain things it can have a spike… but at the same time, as I'm talking, when under duress, and then it seems to be a bigger propensity for things to f**k up, or go wrong.*

During some of his episodes, Peter says he may have come off as 'aggressive'. In one case, after having a manic episode in a hostel residence he was living in overseas, police were called to escort him off the property after he broke a bottle during a heated argument. He believed someone had stolen money from him, though whether this is accurate or a symptom of his illness, he could not say. This was the episode during which he hung up the phone on his mother after he felt she was being judgmental and unsupportive (see *Growing Up*):

> *I smashed a bottle after someone stole $50 from my wallet I'd left on the table late at night while nipping to the toilet, more out of anger than to even think of using as a weapon and wasn't going about brandishing it. The manager was a stoic German and did call police to remove me from the premises based on nothing in particular… staying up late at night quietly in the public area,*

> *being super creative and peaceful, doing my meditation or tai chi stuff, talking about positive vibes to what I took to be likeminded companions.*

Although each participant in this study had a different mental illness, they all had symptoms that disrupted their daily living. One symptom they had in common was a heightened sense of fear. The other commonality was the ability to see their symptoms and handle them. Jan can now sense an oncoming episode, Peter can recognise what might trigger an episode and how to deal with emotions during one, Dia knows she needs to be in comfortable places with people that understand her limits, and Pat is aware of his symptoms and constantly working to lessen them. Despite their symptoms, the participants seem to live happy and fulfilling lives. Perhaps the calmness of relaxing and grounding Phuket beach life offers them some therapeutic support in recognising and processing symptoms of mental illness (see *Thai Culture*).

Trauma.

As Meacham states in his 2016 study, maladaptive anxiety can lead to self-fulfilling prophecies and self-reinforcement of avoidance patterns. Jan has experienced some trauma in her life but felt nervous about going into detail about the events. What she could explain though, was that she experienced some traumatic and violent events when she left Thailand when she was 18. These events not only validated the fears she already had before leaving, but also created deeper chronic feelings of paranoia for the future. This resulted in worsening symptoms of anxiety and forced her to return home to Thailand:

> *It's given me chronic, uhh, debilitating fear. Fear about everything. Which leads to anx—which leads to anxiety, or fear and anxiety, there—there in the same…*

Evidence also indicates that children who witness domestic violence are at an increased risk of developing psychosocial maladaptation (Tsavoussis, Stawicki, Stoicea, & Papadimos, 2014). Peter not only experienced the unhappy and sometimes violent relationship his parents had together, but also recently lost a close friend. During this time, Peter was living in Phuket and was unable to attend the funeral. He was informed of the horrible circumstances of the death

from his deceased friend's girlfriend. Peter discovered some things about his friend he never knew, engaging in voyeurism and online stalking, suffering from anxiety and manic episodes:

> *He hung himself off the back of the door of his apartment because he was going through some very strong anxiety to do with this psychological disorder where people experience an unusual interest in voyeurism, which is not of a sexual nature, but in which he would go into people's social media profiles and download many of their pictures, not of any nakedness or sexual things, but just of them and their lives and their friends and what they did. People that he didn't know. And so he had many hundreds of these pictures stored on his home database. I didn't know this at the time and I found out after the fact, at the funeral, because I was here, you know…*

This trauma had a deep impact on Peter's life. In a recent manic episode, a woman Peter was romantically interested in was not answering his calls. He went to her home, and she was not answering the door. Hearing a television inside, Peter began getting worried. He pushed against the door, and felt weight pressing back. Fearing the worst, that this woman had met the same ill fate as his friend, he tried to convince the landlord to let him inside, but they refused. Peter attempted to climb down from the roof onto the woman's back deck, and fell to the deck below, badly injuring himself. The landlord called the police and Peter left the premises. During episodes of mania, people can become overly communicative, overbearing, delusional, and paranoid (Hilty, Laemon, Lim, Kelly, & Hales, 2006). As well, Young et al. (2012) explain that suicide bereavement can cause complicated grief, depression and post-traumatic stress disorder. Peter's trauma interacted with his mental illness, possibly creating paranoid delusions that put himself at risk, and frightened those around him.

Self-Stigma.

The results of this study confirmed that when people are stigmatised, negative perceptions of themselves can become internalised (Mashiach-Ezenberg et al., 2013). This leads to lowered self-esteem and lowered sense of empowerment. Dia explained that her disability makes her stand out and she feels that she is not as good or as smart as the people around her. She believes that others can see this, and that they do not listen to her because of it:

> *Besides learning disability, I feel like everyone smarter than me. Because like, when I went to talk to the teacher, I try to explain what I want to tell her, but, uhh the teacher, like, kind of like, did not listen to me, but always listen to my friends. So, I feel unhappy, sad about that. Fr—fr—fr—uh frustrate. Like because like, I have to, something to say, but no one hear it.*

In Dia's case, this articulation may be difficult because she has a limited vocabulary to express what she is saying. She is also shy, so this may make it more difficult for her to reach out and explain what she wants or how she is feeling. Stigmatisation can cause people to feel frustrated and question themselves. Peter explained that when he is in a manic episode, he becomes very communicative and extraverted, excitable, expressive, and filled with energy. His spiritual nature seems to flow out more during these times, and it can be confusing for other people to relate to or understand. Although their illnesses and circumstances are different, the resulting feeling of frustration that people cannot hear or understand what he is saying is the same as Dia's:

> *It was quite frustrating when people didn't seem to get what I was saying. I guess I just came across as seeming too preachy or too 'out there'…*

Dia feels like people are smarter than her, Peter feels like he may come across as weird, and like them, Jan also feels aware of people's perception of her. This has shaped her own opinion of herself in the form of feeling inferior to others. Like Peter, Jan explained that sometimes her behaviour can seem odd to other people without mental illness.

> *I feel like it's* [her identity] *sullied. I—I—I felt like, like damaged and uhm… damaged and, and that something was wrong, just that all was not right in my world, and with me, and, and was very acutely aware of, of people, because of the anxiety, anything I did I would constantly be analysing subconsciously. So, uhm, and when the anxiety would hit, sometimes I would do bizarre things, which were not bizarre, but bizarre in, in, in people who don't have anxiety.*

As Voncken and Dijik discuss in their 2012 study, people with mental illness often do not disclose their illness to others due to fear of stigma. Jan described an experience where she went to the mall with friends who were unaware of her anxiety. As they left, she was asked to drive them back, but upon taking the keys, she had a panic attack. In this moment, she was fearful not only of the concept of driving and all it entailed, but the fact that she was in a public space and her friends must think she was behaving very oddly. To address these fears, she asked another friend to drive. It is possible in this scenario that her friends did notice, but it is also possible that her friends were unaware of what she was going through and did not notice her episode at all. As Clark & Wells (1995) explained, people with low self-stigma doubt their ability to do well in social situations. This internalised stigma can cause people to experience a fear of judgment and distrust of others, based on either past public stigma or symptoms of mental illness.

Self-Acceptance.

Self-acceptance was a key component each of the participants discussed in regards to living with mental illness. Part of the process of treating symptoms of mental illness is to accept them. To fight against the label or symptoms of the disorder will only amplify the pain associated with it (Hayes & Smith, 2005). The participants found that accepting or embracing their illness helped them to feel more positive about their decisions in life. Peter has found acceptance in his bipolar by focusing his energies on positive outlets and reframing it as a form of Christ Consciousness (see *Treatment*). Pat has come to accept his anxiety and depression by understanding how it shapes his perspective, and acknowledging that he has those thoughts and feelings but that they are not necessarily representative of reality (see *Symptoms*).

Dia has found that over time, people have begun to listen to her more, and accept her the way she is. This has reassured her that she can perform tasks like others, and that she is just a little different to other people. She understands that she is shy and that can make it difficult to show people who she is, but she feels more confident in herself now, and happy being who she is. She believes that others see this in her too, and have come to respect her more:

> *When I grow up, I feel like people listen to me more… When I go back to my home town, 'cus right now I live here, uhh, people in my home town say, "Wow,*

she, you, since youuuu live in Phuket, you uuhhh, you look smarter," something like that, so I uhh, I feel good. I do not know about here 'cus I shy. I do not like to go talk to people. Annd uhhm, I, I mean like, I feel like I can do it. Like, in my point of view, I am smart, I can do anything. I do not feel like, I don't think I, I am unhappy. I don't think, I don't think I am slow. I think I can do the thing, just like, different from other... I am not unhappy girl, I always smile.

Self-acceptance comes down to accepting what is right for an individual, which may not necessarily be what is considered normal to others. Although Jan had been training to be an advanced level teacher her whole life, circumstances changed, and she found she was unable to continue in that direction. Although her mother adamantly tried to pressure her into continuing, Jan felt like it was finally time to start focusing on her own mental health. Pressure from others, even if well-intended, can be detrimental. Here Jan talks about her decision to take a break from teaching, and change her direction in life:

People say, "Don't quit, don't give up, you can do it, blah blah blah," and, and because that's been so ingrained in our, in our society that, that, that not doing something that you set out to do is a, is a failure... but it, it really isn't. It's a matter of, you need to try something, and it, it might not be right for you but you might have to get that far to realise that it isn't right for you. And that is what the universe and everyone is intending, is, you really need to get to it before you realise, 'this is not what I want,' you know?... I would say yeah, I'm at the point of acceptance. Or beginning to, the beginning of acceptance.

Many studies illustrate a general increase in self-esteem beginning after adolescence and continuing until midlife (Orth, Robins, & Widaman, 2012; Trzensniewski, Donnellan, & Robins, 2003; Wagner, Lüdtke, Jonkmann, & Trautwein, 2012). It is possible that because the participants were within the age range of young adulthood, they started to accept their position with their identity, and in this case, mental illness. As well, none of the participants in the study were originally from Phuket but choose to live in Phuket long-term. As discussed later in this report analysis (see *Thai Culture*), Phuket offers a laid-back lifestyle based on Buddhist

philosophies of grounding, kindness, and community-focused well-being. This could also be a conduit for better mental health and self-acceptance.

Employment.

People diagnosed with a mental illness experience higher rates of unemployment than the general population for a variety of reasons, including symptoms, employer discrimination, lack of education, and financial disincentives (Baron & Salzer, 2002). Each of the participants in this study had difficulties holding steady jobs. Only Peter had employment, but had moved teaching positions in Phuket five times in the last year alone. He has been fired from multiple jobs since he was young. Many of these cases, he says, were due to tardiness, coming to work coming down from drugs, and what he described as minor incidents, such as eating food he was supposed to be serving. Some of his job losses coincide with times when he was in a manic episode. Peter tends to have a relaxed attitude about it, seeing it as all being a part of his more laid-back outlook that simply does not fit with Western standards of working:

> *Time keeping, punctuality… so I guess I've always been attuned to 'Thai time' in some way,* (chuckles) *like oh, if I'm 20 mins late it doesnae matter I'll make it up, you know. I've always had that very relaxed attitude to it, even from before I started to smoke* (marijuana).

Pat has never had a 'traditional' working position. Living primarily off his parents' wealth, he has worked more alternatively and considers himself somewhat of an entrepreneur and an artist. Although he did not reveal what he does for work now, he discussed some of his previous working experience:

> *I owned a recording studio, I sold weed, I went to junior college for a while, uh, I come from a wealthy family that's not wealthy anymore because their mental illnesses f—k it all up.*

Although Pat has never had traditional employment, he was confident that he would be fine in full time work and does not believe his mental illness would affect his performance. He explained that his biggest fear, is a fear of success, and perhaps this is one of the reasons he prefers not to work. It could also be a way to excuse himself from following societal norms, as

Jan also discussed (see *Self-Acceptance*), or as Pat earlier reflected, because he considers himself 'less mainstream' (see *Interpersonal Relationships*):

> *I think I'm really good at performing on stuff like that* [hiding symptoms of mental illness from people]. *For me, it would be a, I hide it very well, in a situation like that… and then kind of, take it out on myself later when I'm by myself… I'm ex—I have anxiety of like, fear of my own, I have like fear of success. That's what it's—it's like really f—king sad, honestly. It's not fear of failure* (chuckles) *you know what I mean? It's completely different. It's fear of success. And that's a deep, deep rooted kind of anxiety. You know what I mean? …Everything would be fine, I'd totally handle it fine! …but you wanna know the raw deep side of it, that's kind of what it is you know.*

As Pat explained, fear of failure is commonly associated with symptoms of anxiety (Hjeltnes, Binder, Moltu, & Dundas, 2015), but in his case, it was the opposite that plagued him. As Piedmont (1995) explains, it is not just fear of failure that can cause symptoms of anxiety, but also fear of success. Potentially, part of what holds Pat back from excelling in employment or work is not just that he has come from a wealthy family, but also because his symptoms of anxiety become worse at the thought of potential success.

Dia helps her family by baby-sitting the children, which she enjoys because it puts her in a position of respect and authority that she usually does not get due to her disability. She has had difficulties working in highly demanding jobs due to her disorder. In the past, her family has tried to get her to help in other positions such as gardening, collecting herbs, peeling vegetables, and selling vegetables at a family shop, but she struggles with memory, writing, reading, arithmetic, and understanding what is being said to her:

> *At first when I come here she* (the support person) *ask me to, like, pull weed, or thing like that, uhhmm, it hard for me because, when she, when she give me direction, I understand, I can do it, and after that, I forget, I just, like, I do not know how to like, make the same thing… I also collect herb, but then like, sell to, uuhh, has to, uhh one person, "Can you please collect dis herb?" And then she would give me money. And my aunt, another aunt, ask me to help,*

> *so, so, so I also help my aunt, like help her peel, uhmm, on—onion? Garlic? Because she make curry paste. So uhhm, I help with dat. At first they, uhh they want me to like, sell, because they have a shop, uhh but because I cannot count uhh, change, like this, like that, I cannot do this.*

Jan, like Pat, Peter, and Dia, has had issues maintaining steady employment and is currently unemployed. Studies indicate that stigma against mental illness persists in the labour market (Hipes, Lucas, Phelan, & White, 2016). This may result in rejection of job employment applications and negative treatment in the workplace as Jan has experienced. Jan discussed here how one of her previous employers used to shift between belittling and punishing her for her anxiety, which often made her feel like her job was at risk:

> *My boss, at, at my last job, kind of, again would say* (in a high voice) *"are you okay?" and would, and if, if I was, you know, underperforming in some way, she would be like, uhm… I don't know, it's almost like she used it as, like, she would be half-concerned, but then she'd also kind of use it as, like, uhg… I can't quite figure her out. Yeah, condescending and also, and also uhm… like, "I know you have these issues, but basically like, do you want to be fired?" or like, that, that kind of thing, double-edged, yes. And sometimes* (in a high voice) *"Are you okay? How are you doing?" You know, that's her thing. Belittling, but also making you feel like you aren't safe.*

Anxiety can cause feelings of an impending sense of doom (see *Symptoms*). In situations of employment, where studies confirm that people with mental illness may face stigmatisation, fear of job loss can be a constant pressure. As Jan, explained above, her boss was aware of her mental illness and would passive aggressively taunt her with this knowledge. Jan's boss would use a condescending tone and derogatory terminology to put her down and imply that if she did not improve her work performance, she would be fired. Victims of workplace bullying without mental illness can develop negative psychological symptoms such as problems sleeping, depression, burnout, anxiety, and increased substance abuse (Escartin, 2016). For people already facing the symptoms of anxiety, workplace stigmatisation and bullying would only exacerbate symptoms.

School.

Children with mental health problems tend to experience higher rates of academic failure and school drop-outs, falling behind in areas of numeracy and literacy compared to other children (Mundy, Canterford, Tucker, Bayer, & Romaniuk, 2017). Jan, Dia, and Pat each had difficulties in school. Jan believes that her anxiety both exacerbated and was a reaction to her performance at school, but she was unaware of the extent of its impact until she was older. As a child she recalled having learning difficulties in school and having anxiety about not being smart compared to the other students.

Pat had trouble with school, in that he would often not attend classes and was kicked out for dealing drugs. Studies show that youths who deal drugs are more likely than their peers to exhibit symptoms of depression and anxiety, and have experienced parental conflict, sensation seeking, and school problems (Jennings & Reingle, 2012). As an alternative, Pat got his General Education Diploma (GED) which stands as a High School Diploma equivalency in the United States. This qualified him for Junior College, but he dropped out. This could, in part, be due to the symptoms of his illness (see *Symptoms*). Similar to the way Peter felt (see *Employment*), Pat explained that he believes it is because of his artistic nature that he was not interested in school:

> *I was never much for school. I was a pot dealer. Well, I got kicked out* (unintelligible) *and in high school I ditched every day. Went and took the GED… and then went to junior college. So, I dunno, I think I'm just more of an artistic person who just didn't give a f—k, more than somebody who's—was—I don't—I was in school, not at school by choice, not because of anxiety. I just didn't give a f—k, you know what I mean?*

Dia stated that she had to drop out of school because her family could no longer afford her tuition. Her support person explained that this may not have been the case, and that Dia's mental illness may have been the reason she could no longer continue in school because she could not keep up with the academic requirements. Dia left school in Year Six, which under Thai regulations is the upper limit children with special needs receive free education (Office of the Educational Council, the Ministry of Education Kingdom of Thailand, 1999). If there are no

public special education resources for intellectually disabled children after Year Six, it is possible it may have been a combination of lacking resources where Dia was raised, her family not being able to afford specialised testing to diagnose her with a learning disability, or her inability to keep up academically:

> *Yes, I was happy to go to school. I was happy until like, the third grade, but after, that, what happened, about fourth grade… No still happy. I was happy to go to school because I want to learn, I want to learn even though I slow, but I still want to learn… Because yai* (grandma) *did not have uhh, have some problem with the financial, so I stopped going to school in the sixth grade, I did not go to school… I love going to school and probly be able to go to pass the grade the class.*

Peter said he did not have any issues with his education growing up and he attended some undergraduate study to become a teacher. Bipolar has a later average onset of symptoms than depression, anxiety, and intellectual disabilities (Hirschfeld, Bowden, & Gitlin, 2006; Weissman, Leaf, & Tischer, 1988). If mental illness was part of the cause for Peter's, Dia's, and Jan's difficulties in school, Peter's educational success in comparison could be because his episodes did not start until later in life.

Lifestyle.

Participants explained that the lifestyle living in Phuket is different than other places in the world, and that the Thai culture lends itself towards a more positive and holistic approach to life. However, Western treatment options are still limited, and options in Phuket are inaccessible. For the participants who followed their family's spiritual or Buddhist views, Phuket potentially offers a positive option for treatment, a location that encourages methods of Eastern healing.

Thai Culture.

The dominant religion in Thailand is Buddhism (Census, 2015), and many of the participants value systems and ways of living that reflect this. These values include concepts such as dignity

and independence, *bunkhun,* flexibility, interdependence, *buua, sanuk,* humility, kindness, and competence (see *Thai Values*).

Pat has had poor experiences in the past with medications and therapy, and does not seek out help in Thailand. He believes that Thai people do not need mental health services, unlike people in the Western world. Instead, *khon Thai* are more focused on methods of mindfulness and interconnected communities, rather than medications and individualistic treatment. They have relaxed lifestyles which focus on doing things one enjoys (*sanuk),* rather than things that are conducive to unhappiness *(buua).* In the United States and many other Western countries, high-paced living can be stressful. Pat explained that Phuket is much more relaxed and grounded than the US, founded on the calm nature of Buddhism. Here Pat explained that he sees Thai culture as being more carefree and conducive to happiness:

> *Well one of the reasons I live in Phuket, and actually the more I think about it, the main reason is, I can't function in America with depression and anxiety. I—the passiveness of the Buddhist religion, the road rage is way less, there's actually close to none here… I think Thai people take care of their own more than any other Western country I've been to, especially with mental illnesses. They're just more accepting. Seems to me that the Thai culture doesn't stress on a lot of stuff. It's not really in their nature to, get themselves worked up over somebody else. And it's just a happy culture, happier people, healthier people. Honestly, healthier people. As a general rule I think first world, Western countries like however, America, generally more mentally ill. The food's healthier. Last time I lived in America I was 400 pounds. And that was from depression… After going to Asia, within the first four months, I lost 130 pounds. Healthy. All really healthy.*

Pat also mentioned here that he believes that Western countries are more mentally ill than other countries. According to the Global Burden of Disease Collaborative Network (2016), Pat is correct. North America has the highest rate of mental health and substance abuse disorders in the world at over 20%, whereas South and East Asia account for the lower rates of mental health and substance abuse disorders, at just under 15%. However, it is important to note that

this data is likely under-estimated because not all people with mental illness appear in statistics compiled by separated divisions (see *Prevelance*). Pat also discussed that he has lost significant weight living in Phuket. Compared to most parts of the West, there are higher access to healthier foods and fewer fast food chains in Thailand. However, for *khon Thai,* things have changed rapidly for their diets. Over the last three decades, Thailand has undergone social and economic transitions that have changed food consumption patterns of the population considerably (Jitnarin et al., 2011). More people tend to eat out now than make food at home, and rates of obesity have increased dramatically.

Peter agreed that Thai culture seems to be more relaxed and that helps him with his symptoms of chaotic energy. He feels the culture is more aligned with his way of thinking:

> *I think for me it's easier here because it's more present. I think for me it's easier for me to sort of, tap into it here. It's more, ever present, through the Buddhist society and the temples that are here, and just the 'sabai sabai'* (a saying in Thai meaning, 'good good') *laid back way of life. The Thais live very much day by day, in the moment, thinking only perhaps of their next meal. To generalise, a lot of them perhaps are more future orientated, more Western thinking nowadays, but culturally, it's very much about being in the 'now'.*

Each participant spoke about the relaxed carefree culture of the *khon Thai*. Their Buddhist value system predisposes them to be more focused on living a relaxed and enjoyable life. Many people in Thailand may come up to you and ask, *"Sa bai dee mai? Khun sanuck mai?"* Which means, "How are you? Are you enjoying yourself?" as a common greeting. There is a great emphasis on creating a caring and dignified community support system (see *Anxiety*). In a study by Neff, Pisitsungkagarn, & Hsieh (2008), results suggested that self-compassion is highest in Thailand compared to the United States and Taiwan. In Thailand, interdependence is directly linked to self-compassion (the *bunkhun* value). For example, during my first month in Phuket my bike broke down, and about 10 villagers I did not know came to help me to make sure I could get to my language lessons on time. When people are in crashes, people will run over to make sure they are safe and taken care of, and if you are a woman walking alone at night,

people will make sure that you are okay. Food markets are everywhere, with fresh fruit and vegetables, cheap and healthy, if you so desire.

Treatment.

Peter subscribes to a 'spiritual' method of thinking, utilising Eastern inspired processes of achieving mental clarity and peace with himself, and has not attempted to utilise Western forms of treatment. Peter described his manic episodes as experiences of Christ Consciousness, 'chaotic energy' or 'enlightenment'. This is a spiritual concept of attaining ideal qualities like Jesus, and follows Egyptian, Judeo-Christian, Indian, and Tibetan traditions (Prakasha, 2010). This process involves following meditation methods to completely withdraw from the senses as the last step of the eight limbs of yoga. Peter believes his manic episodes bring him closer to achieving this step and feels closer to his spiritual nature. Peter copes with sudden increases in his mood or 'chaotic energy', through methods of meditation, temple visits, blessings, centring, tai chi, and learning to become more extroverted on a regular basis. Peter explained that his quality of life is better here, having access to Eastern methods of spirituality and healing that he has not had access to in other Western countries. He is drawn to Tibetan and Buddhist methods of healing and living and can easily visit temples here. He explains that when he seeks healing in temples and through mantras, he does this not only for himself but for the 'good of all beings':

> *Well I already went to the temple… It was the first time I went to a Buddhist temple in a long time. I used to go in,* (unintelligible) *quite often, and every time I would go I would feel new, rejuvenated, and that kind of sense things tend to go better in my life. Just through a lot of meditation or prayer or mantras… So yeah, I went to the temple and it was really good, did some mantras there, Tibetan and Sanskrit mantras… When I go to the temples quite often it tends to be, chants, or whatever, there's not usually monks or people praying too much.*

Pat described therapy as a child as being traumatising and worthless, forced on him by his mother. He explained that he has had many therapists in the United States, but does not believe they could 'keep up with him' so he chooses not to utilise their services. It is possible

that Pat has yet to find a therapist that he relates to, or an openness to believe it will work. Factors that influence client outcome in psychotherapy are divided into four areas: expectancy effects, extratherapeutic factors, specific therapy techniques, and "common factors" (Lambert, Barley, & Dean, 2001). It is the last group of factors – factors such as empathy, warmth, and personal relationship – that correlated most strongly with positive client outcomes. It is important for people to feel comfortable with their therapist, to create a good therapeutic alliance with mutual respect and understanding in order to achieve positive treatment outcomes. Like medication, this can take time to find a good fit:

> *I saw some other shrink for like, a couple months, but he was just absolutely awful. Yeah, I had to quit; it was terrible. I would love to see a, a real therapist, but the kind of therapist I need is in like, New York or San Francisco and it's 400 dollars an hour. And, I don't mean to sound, to toot my, to sound like, you know I'm bragging or anything, but I need someone to keep up with me you know what I mean. I need somebody who's, you know… and plus there's a lot of bad therapists out there. There's a lot of them. When I was a child, my high on meth f—ked up mother subjected me to a lot of ex—a lot, a lot of therapy. In really bad ways, like a lot of really bad experiences. Well, everyti—they, same with abilify, when they would prescribe me with some type of medicine, my body would always react in a really wrong way.*

Pat also explained above that he has had a lot of negative side effects from psychotropic medication. Some psychologists believe that psychiatric drugs actually cause more harm than good, claiming there are overstated benefits to drugs and understated death reports (Gøtzsche, 2015). Jan also explained that medication is difficult to access in Thailand. Jan has been on and off medication and is currently weaning herself off her medication because she believes it is no longer benefiting her. Medication nonadherence is a common occurrence in mentally ill populations, and increases the risk of relapse and hospitalisation, and reduces quality of life (Velligan, Sajatovic, Hatch, Kramata, & Docherty, 2017). The reason people decide to stop taking medication is varied but include reasons such as: negative attitude towards medication, negative side effects, positive side effects, lack of information, and unreliable therapeutic relationships (Haslam, Brown, Atkinson, & Halam, 2004).

Jan explained that many therapists who provide counselling in Thailand are Christian-identifying and bring this into their treatment plans. She does not feel comfortable with this. Jan reflected on her experiences of a treatment centre in Chiang Mai. Although she really enjoyed the calm of the centre, she was less comfortable with most of the families in the community who were Christian missionary immigrants. Being that Jan no longer identifies as Christian, this made it difficult to relate to her therapist and be honest with who she was and what she wanted out of treatment. Disclosing that she is bisexual, for example, was unacceptable:

> *Here in Thailand I've been on Fluoxetine since 2009, that was prescribed by Doctor Ron in Chiang Mai. The place is called Cornerstone. Beautiful practice, uhm, beautiful practice. Very calming, I just felt a sense of peace until I went into the room… Well, uh, actually I had two people there. So, I had the counsellor and then the psychiatrist. And the counsellor, my counsellor was… a woman, and uhm, with her, I felt a connection. But, again, I think she was too Christian. They were all Christian. Because they're there to help the Missionary families, and there are loads of missionary families who are relocating. A big sort of, sort of hub.*

Jan described therapists in Thailand as being cold and uncaring, possibly because of a language barrier or lack of commitment. Jan has seen several therapists inside and outside of Thailand and has also been a part of Alcoholics Anonymous and Overeaters Anonymous groups, which were unhelpful because they did not actually treat the underlying anxiety, but simply the symptoms of the anxiety. She currently sees a counsellor/life coach online who works out of Chiang Mai who she says has been helpful with making life changes and learning how to be in control of her finances:

> *It's difficult for us to get Fluoxetine. So, you have to go to a clinic. At least as far as… when I needed Fluoxetine or* (chuckles) *or an extension note back in the day when I was getting every extension note possible, uh, medical note, I had to go see her, right? And she's a psychiatrist from Suan Prung, supposedly the best mental hospital ever, uhm, she has a clinic, and no resonation with*

> *what she would say whatsoever. Kind of, it was all very textbook, but, clinical but not even, just, not even, not helpful at all. Uhm, and that was the same thing that I experienced here when I went to a clinic. I think it's a language barrier. I also think that they, they have their main job and this is just to make money on the side. And also, yeah, they don't know how to help you, somewhat.*

Dia cannot work in a highly demanding position because of her disorder and cannot go to school because of lack of financial aid for extra support for her illness. People with intellectual difficulties are often taken care of and supported by their families (see *Intellectual Disability*). As a Buddhist, she goes to the temple (*wat*) for prayers and to make merit but does not utilise *wats* as a resource for support or treatment outside of general temple worship. When she is feeling sad because of the way others treat her or when people tease her, she uses methods of grounding and self-soothing to help her stay positive:

> *So uhmm, when I, when I go to the temple, I just like, pray uhhmmm, and what do you call it? Like, offer food, and just like, regular stuff… When I am sad, to make it go away, I just like, I just have to, like what you call? Give my mind, like, what you call it? Like medi—like peaceful, make calm with myself. Then I do not feel like I am sad anymore.*

It could be concluded that although Dia states that she does not use the *wats* for treatment, praying and temple worship can be, within itself, a calming and meditative process for which helps create positive wellbeing (Behere, Das, Yadav, & Behere, 2013). Phuket offers an abundance of Eastern treatment resources in the form of mindfulness and meditative Buddhist processes. For the participants in this study, access to this lifestyle has been beneficial to their overall well-being. Both Pat and Jan have had some difficult experiences with prescribed medications and therapy under a Western model. Jan explained that recently she has begun exploring more spiritual methods of grounding and mindfulness and is experiencing positive results as a result. Pat has explained that although he would not mind seeing a good therapist again, that the lifestyle in Phuket is more conducive to better mental health and he feels he can

lead a relatively happy life without extra treatment here for the time being. Peter and Dia both find treatment through temple, prayers, and meditation.

Chapter 4: Conclusions

The primary objective of this study was to explore some of the experiences of young people living in Phuket with a mental illness. Much academic material regarding mental illness is taken from a Western medical perspective and often disregards Eastern cultures and context. Given the unique history and background of Thai culture and how people experience this culture as ex-pats and Thai nationals living with mental illness, it was important to give people an opportunity to speak. The areas of research I originally planned to investigate based on the literature review included label stigma, interpersonal relationships, and lifestyle. The interviews were semi-structured based around these key areas, but flexible enough to allow the participants to also discuss other related experiences that I may not have considered. The participants were able to not only discuss the pre-established topics, but also additionally provide insight into family background, where mental illness comes from, and a variety of other related topics.

All the participants spoke about their family backgrounds, what their lives were like growing up, and family history of mental illness. Each participant had a very different upbringing, one from a repressed missionary background, another from a domestically violent upbringing, another surrounded by family mental illness, and the last living in a very nurturing environment. Each participant confirmed that mental illness was not a topic of discussion growing up, but that this has changed over time. This understanding has not only changed their relationships with family, but also in their relationships with other people and with their own self perceptions and learned self-acceptance.

Throughout their lives, participants experienced the repercussions of stigma within their families, communities, schools, friends, partners, and employment. All the participants felt eager to create and maintain these relationships but found difficulties in doing so, either because of the perceived rejection they received from others as a symptom of their illness, the real rejection they received because of misunderstandings of mental illness or the impact the symptoms of their illness had on others. In addressing perception, the participants seemed to have an awareness that their illness can cause symptoms that others without a mental illness may see as weird, annoying, silly, frightening, or upsetting. Out of choice, or perhaps due to

the symptoms of their illnesses, the participants had difficulty maintaining intimate relationships and employment.

Despite the pitfalls that the symptoms of mental illness cause, the participants in this study seem well-adjusted, self-aware, and content in their lives and management of their illnesses. They discussed trying different forms of treatment, moving to various places, and learning how to find a way of living that works for them. None of the participants come from Phuket, yet all chose to stay in there because of the lifestyle that it offers them. They explained that in Phuket, the culture is relaxed and mindful, with treatment involving more Eastern spiritual practices. The slow-paced lifestyle, community acceptance, and spiritual methods of healing of Phuket resonated with the participants.

Reflections

Looking back on the completed study, there were some various limitations that must be considered. It is to be noted that the views expressed by the participants are that of their own individual life circumstances and development, and given the limited sample size, may not reflect others living in Phuket with a mental illness; therefore, this data is not necessarily generalisable to the greater population. It should also be noted that the participants were not originally from Phuket. In fact, only one participant was *khon Thai*. Although another participant grew up in Thailand, she was raised in an American immigrant Missionary community. The other two participants lived most of their lives overseas. This means that these results may not generalise to *khon Thai,* or people who have been raised in Phuket. The participants were all young adults in their twenties, which also limits the generalisability of the study and the results of this study do not necessarily apply to those of a much younger or older age demographic.

For a variety of reasons, participants were not easy to gather for this study. The topic is somewhat taboo not only in Thai culture but around the world, which probably made people hesitant to come forward. Anxiety and other mental illnesses can also have an impact on an individual's ability to follow through with plans. Although many people offered to be a part of the study, when it came time to coordinate interviews, people were no longer easy to reach. This was common with both *khon Thai* and ex-pats. However, the people who did come

forward to participate in this study I believe felt more comfortable doing so given my background and history of mental illness. Transparency was important and effective for this research. As well, the ethics approval process took a significant amount of time to complete. Eight months passed before flyers were distributed. It is a topic that requires significant work to gain rapport with people and build trust and reliability between researcher and participant. Given more time, more participants may have come forward.

Although I can speak some Thai, and most people in Phuket can speak English, I also believe a barrier to gathering more participants was language. Talking about mental illness is difficult enough, but not being able to express yourself completely would make that even more frustrating and probably uncomfortable, and perhaps this turned people away from involving themselves in the study. However, my level of English-speaking may have also been a strength for gathering ex-pats and English-speaking nationals. My limited Thai fluency may have also negatively impacted my ability to speak with academics and practitioners here. It was difficult, if not impossible, to get in touch with the mental health care system in Phuket. Options were limited, and those contacted stated that they could not be of assistance or never responded. Although it has been publicised that there are easily accessible Western mental health care resources in Thailand, I did not find this to be accurate, and the participants confirmed this. It seems most mental health care providers are local general practitioners, who are, as to be expected, very reluctant to speak on the topic.

Implications

In the future, there are a variety of directions this research could explore. Given an increase in sample size, the data would be much more generalisable to the population. This would be effective as further qualitative studies, but quantitative surveys based on the results of this and previous studies could be beneficial as well. People may also be more comfortable answering questions on a questionnaire than discussing topics of mental health one-on-one. Young adults in Phuket have access to internet and social media platforms, so gathering a larger population size for quantitative analysis could be possible. As the participants in this study were all young adults in their twenties, future research could investigate other age ranges to see if results are similar. Attitudes could vary between age, given various stages of mental health development,

financial security, life experience, and various other age-related changes throughout life. It could be beneficial to expand on the location of the study, to various urban and rural areas of Thailand. The views of people living with mental illness in various parts of the country could be drastically different, even within the same age group. Based on the results of this study and previous research, Chiang Mai and Bangkok seem to have the most Western mental health resources, and it would be interesting to see how this impacts people who live in these areas.

This study included both people who have grown up in and outside of Thailand. This was not the original intention of the study, but also not unexpected given the high ex-pat population in Phuket. Research in the future could focus more directly on ex-pats, *khon Thai,* or Thai nationals who are not of Thai ethnicity. In this same area, more focus could be given on the religious affiliations within these groups, such as the missionary populations in Chiang Mai and Bangkok, the spiritual ex-pat communities, or the Buddhist and Muslim *khon Thai* communities. It would also be beneficial for future researchers to be fluent in either Thai, Laos, or even Malay, to reach out to these other ethnic communities in Thailand. I believe this is the key to gaining access to not only more participants, but also the academic and medical networks to gather more detailed information on the topic.

Given more time, much more could have been done with this study. There are many different areas research could explore in the future based on the themes presented in this study, such as a focus on stigma, self-perception, interpersonal relationships, lifestyle, family background, culture, isolation, treatment, or dislocation. This is just a small insight into a very detailed and complex type of life experience that no doubt should be explored in greater depth and variety in the future.

I believe the greatest accomplishments of this study are the recognition of deep self-awareness within the participants regarding their mental illness and the way others perceive them, and the positive cultural environment Phuket seems to offer them for healing. The participants each spoke in depth about understanding how their illness affects their minds, their perceptions of themselves and others, and how their label stigma and display of symptoms affects the way others see them. The self-reflection of each participant shows how they have learned to accept and live with their illness. The fact that each of the participants expressed

feeling that Phuket offers a lifestyle which positively impacts their mental well-being is also a reflection of their self-awareness. The Buddhist-based value system Phuket follows seems to offer some people the peace, calmness, and strength they are searching for. This reflects my own experiences in Phuket living with mental illness. I hope future research can further investigate the benefits of Thai cultural values and Phuket lifestyle on mental well-being.

References

Addington, J., el Guebaly, N., Campbell, W., Hodgins, D. C., & Addington, D. (1998). Smoking cessation treatment for patients with schizophrenia. *American Journal of Psychiatry, 155*, 974-976.

Alden, L. E., & Bieling, P. (1998). Interpersonal consequences of the pursuit of safety. *Behaviour Research and Therapy, 36*, 53-64.

American Association on Intellectual Developmental Disabilities. (2010). *Intellectual disability: Definiton, classification, and systems of supports.* Washington DC: AAIDD.

American Psychiatric Association (APA). (1987). *Diagnostic Statisticual Manual of Mental Disorders* (3rd ed.). Washington, DC: American Psychiatric Association.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders.* Washington DC: APA.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Andersson, S. J., Troein, M., & Lindberg, G. (2005). General practitioners' conceptions about treatment of depression and factors that may influence their practice in this area. A postal survey. *BMC Family Practice, 6*(21), 21.

Balzarini, R. N., Campbell, L., Kohut, T., Holmes, B. M., Lehmiller, J. J., & Harman, J. J. (2017). Perceptions of primary and secondary relationships in polyamory. *PLoS ONE, 12*(5).

Baron, R., & Salzer, M. (2002). Accounting for unemployment among people with mental illness. *Behavioral Sciences & the Law, 20*(6), 585-599.

Behere, P. B., Das, A., Yadav, R., & Behere, A. P. (2013). Religion and mental health. *Indian Journal of Psychiatry, 55*(2), 187-194.

Belmaker, R. H., & Agam, G. (2008). Major depressive disorder. *New England Journal of Medicine, 358*(1), 55-68.

Blazer, D., Burchett, B., Service, C., & George, L. (1991). The association of age and depression among the elderly: an epidemiologic exploration. *Journal of Gerontology: Medical Sciences, 46*, 210-215.

Boat, T. F., & Wu. (2015). *Clinical Characteristics of Intellectual Disabilities.* Washington DC: National Academies Press.

Boucher, H. C., & Maslach, C. (2009). Culture and individuation: The role of norms and self-construals. *Journal of Social Psychology, 2009*, 677-693.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77-101.

Breitholtz, E., Johansson, B., & Öst, L. G. (1999). Cognitions in generalized anxiety disorder and panic disorder patients: a prospective approach. *Behavioral Research Therapy, 37*, 533-544.

Breslau, N., & Klein, D. F. (1999). Smoking and panic attacks: an epidemiologic investigation. *Archives of General Psychiatry, 56*, 1141-1147.

Bruce, M. L., Leaf, P. J., Rozal, G. P., Florio, L., & Hoff, R. A. (1994). Psychiatric status and 9-year mortality data in the New Haven Epidemiologic Catchment Area Study. *American Journal of Psychiatry, 151*, 716-721.

Brummelhuis, H. T. (1980). Psychiatry in Thailand: A Sociologist's View. *Journal of Social Science*(68), 57-69.

Bullock, B. M., & Dishion, T. J. (2007). Family processes and adolescent problem behavior: integrating relationship narratives into understanding development and change. *Journal of American Academy of Child & Adolescent Psychiatry, 46*(3), 396-407.

Burnard, P. (1991). A method of analysis interview transcripts in qualitative research. *Nurse Education Today*, 461-466.

Burnard, P., Naiyapatana, W., & Lloyd, G. (2006). Views of mental illness and mental health care in Thailand: a report of an ethnographic study. *Journal of Psychiatric and Mental Health Nursing*, 742-749.

Butler, E., Lee, T., & Gross, J. (2007). Emotion Regulation and Culture: Are the Social Consequences of Emotion Suppression Culture-Specific? *Emotion, 7*(1), 30-48.

Carmody, T. P. (1989). Affect regulation, nicotine addiction, and smoking cessation. *Journal of Psychoactive Drugs, 24*, 111-122.

Chandra, A., & Minkovitz, C. S. (2007). Factors that influence mental health stigma among 8th grade adolescents. *Journal of Youth and Adolescense, 36*(6), 763-774.

Chang, K. D., & Ketter, T. A. (2001). Special issues in the treatment of aediatric bipolar disorder. *Expert Opinion on Pharmacotherapy, 2*(4), 613-622.

Clark, D. (2001). The persistent problem of negative cognition in anxiety and depression: New perspectives and old controversies. *Behavior Therapy, 32*(1), 3-12.

Clark, D. M., & Wells, A. (1995). A cognitive model of social phobia. In R. G. Heimberg, D. A. Liebowitz, D. A. Hope, & F. R. Schneier, *Social phobia: Diagnosis, assessment, and treatment* (pp. 69-93). New York, NY: Guilford Press.

Clarke, V. (2005). We're all very liberal in our views': Students' talk about lesbian and gay parenting. *Lesbian and Gay Psychology Review*, 2-15.

Collins, N. L., & Miller, L. C. (1994). Self-disclosure and liking: A meta-analytic review. *Psychological Bulletin, 116*, 457-475.

Coplan, J., Hodulik, S., Mathew, S., Mao, X., Hof, P., Gorman, J., & Shungu, D. (2012). The relationship between intelligence and anxiety: an association with subcortical white matter metabolism. *Frontiers in Evolotionary Neuroscience*.

Corrigan, P. W., Larson, J. E., & Rüsch, N. (2009). Self-stigma and the "why try" effect: impact on life goals and evidence-based practices. *World Psychiatry, 8*, 75-81.

Covarrubias, I., & Meekyung, H. (2011). Mental Health Stigma about Serious Mental Illness among MSW Students: Social Contact and Attitude. *Social Work, 56*(4), 317-325.

Cozby, P. C. (1972). Self-disclosure, reciprocity and liking. *Sociometry, 35*, 151-160.

Crisp, A. H., Gelder, M. G., Rix, S., Meltzer, H. I., & Rowlands, O. J. (2000). Stigmatisation of people with mental illnesses. *British Journal of Psychiatry, 177*, 4-7.

Cunningham, C. E. (1970). Thai 'injection doctors': antibiotic mediators. *Social Science and Medicine, 4*, 1-23.

Dahlberg, L., & McCaig, C. (2010). *Practical Research and Evaluation.* London: SAGE Publications Ltd.

Danese, A. (2008). Genetic opportunities for psychiatric epidemiology: On life stress and depression. *Epidemiological Psichiatria Society, 17*(3), 201-210.

Davila, J., & Beck, J. G. (2002). Is social anxiety associated with impairment in close relationships? A preliminary investigation. *Behavior Therapy, 33*, 427-446.

Decina, P., Caracci, G., Sandik, R., Berman, W., Mukherjee, S., & Scapicchio, P. L. (1990). Cigarette smoking and neuroleptic-induced parkinsonism. *Biological Psychiatry, 28*, 502-508.

Department of Mental Health Ministry of Public Health Thailand. (2010). *Numbers and rates of psychiatric patients per 100,000 populations i 2008-2009.* Bangkok, Thailand: DMH.

Diener, E. (2000). Subjective well-being. The science of happiness and a proposal for a national index. *American Psychology, 55*(1), 34-43.

Economic and Social Commission for Asia and the Pacific. (2015). *Disability at a Glance.* Bangkok, Thailand: Social Development Division.

Elder, B. L., & Mosack, V. (2011). Genetics of Depression: An Overview of the Current Science. *Issues in Mental Health Nursing, 32*, 192-202.

Els, D. A., & De La Rey, R. P. (2006). Developing a holistic wellness model. *SA Journal of Human Resource Management, 2*, 46-56.

Eriksson, P., & Kovalainen, A. (2011). *Qualitative Methods in Business Research.* London: Sage Publication.

Escartin, J. (2016). Insights into workplace bullying: psychosocial drivers and effective interventions. *Psychology Research and Behavior Management, 9*, 157-169.

Fernquest, J. (2012). Mental health: Neglected in Thailand. *Learning From News*. Bangkok, Thailand: Bangkok Post.

Ferrarese, C., Appollonio, L., & Frigo, M. (1990). Decreased density of benzodiazepine receptors in lymphocytes of anxious patients: Reversal after chronic diazepam treatment. *Acta Psychiatrica Scandinavica, 82*(2), 169-173.

Foucault, M. (1995). *Discipline and Punish: the Birth of a Prison.* New York: Vintage Books.

Freud, S. (1957). *Collected Papers* (Vol. 1). London: Hogarth Press.

Friedman, E. M., Hayney, M. S., Love, G. D., Urry, H. L., Rosenkranz, M. A., & Davidson, R. J. (2005). Social relationships, sleep quality and interleukin-6 in aging women. *Proceedings of the National Academy of Sciences of the United States, 102*(51), 18757-18762.

Fulk, B. M., Swerlik, P. A., & Kosuwan, K. (2002). Special education in Thailand. *Teaching Exceptional Children, 34*(3), 73.

Gee, B. A., Antony, M. M., Koerner, N., & Aiken, A. (2012). Appearing anxious leads to negative judgements by others. *Journal of Clinical Psychology, 68*, 304-318.

Geller, B., Tillman, R., Bolhofner, K., & Zimerman, B. (2008). Child bipolar I disorder: prospective continuity with adult bipolar I disorder; characteristics of second and third episodes. *Archives of General Psychiatry, 65*(10), 1125-1133.

Gilbert, K. (2008). Loss and grief between and among cultures: The experiences of Third Culture Kids. *Illness, Crisis & Loss, 16*(2), 93-109.

Global Burden of Disease Collaborative Network. (2016). *Global Burden of Disease Study 2016.* Seattle, USA: Institute for Health Metrics and Evaluation.

Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identity.* New York: Simon and Schuster.

Goodwin, F. K., & Jamison, K. R. (1990). *Manic-Depressive Illness.* New York: Oxford University Press.

Gorman, J. M. (2002). Treatment of generalized anxiety disorder. *Journal of Clinical Psychiatry, 63*(8), 17-23.

Gøtzsche, P. C. (2015). Does long term use of psychiatric drugs cause more harm than good? *BMJ*.

Graham, S. M., Huang, J. Y., Clark, M. S., & Helgeson, V. S. (2008). The positives of negative emotions: Willingness to express negative emotions promotes relationships. *Personality and Social Psychology Bulletin, 34*, 394-406.

Gray, A. (2003). *Research Practice for Cultural Studies: Ethnographic Methods and Lived Cultures.* London: Routledge.

Griffiths, K. M., Nakane, Y., Christensen, H., Yoshioka, K., Jorm, A. F., & Nakane, H. (2006). Stigma in response to mental disorders: A comparison of Australia and Japan. *BMC Psychiatry, 6*, 1-12.

Gross, J., & John, O. (2003). Individual differences in two emotion regulation processes: Implications for affect, relationships, and well-being. *Journal of Personality and Social Psychology, 85*, 348-362.

Gustafsson, C. (2015). *Intellectual disabilility and mental health problems: Evaluation of two clinical assessment instruments, occurence of mental health problems and psychiatric care utilisation.* Uppsala: Acta Universitatis Upsaliensis.

Haeffel, G. J., Getchell, M., Koposov, R. A., Yrigollen, C. M., Deyoung, C. G., & Klinteberg, B. A. (2008). Association between polymorphisms in the dopamine transporter gene and depression: Evidence for a gene-environment interaction in a sample of juvenile detainees. *Psychological Science, 19*(1), 62-69.

Hamid, P. D., Simmonds, J. G., & Bowles, T. V. (2009). Asian Australian acculturation and attitudes toward seeking professional psychological help. *Australian Journal of Psychology, 61*, 69-76.

Hammarberg, K., Kirkman, M., & deLacey, S. (2016). Qualitative research methods: when to use them and how to judge them. *Human Reproduction, 31*(3), 498-501.

Haslam, C., Brown, S., Atkinson, S., & Halam, R. (2004). Patients' experiences of medication for anxiety and depression: effects on working life. *Family Practice, 21*(2), 204-212.

Hayes, S., & Smith, S. (2005). *Get Out of Your Mind and into Your Life.* Oakland, CA: New Harbinger Publications.

Henderson, C., Evans-Lacko, S., & Thornicroft, G. (2013). Mental Illness Stigma, Help Seeking, and Public Health Programs. *American Journal of Public Health*, 777-780.

Herrick, C. A., & Brown, H. N. (1999). Mental disorders and syndromes found among Asians residing in the United States. *Issues in Mental Health Nursing*, 275-296.

Hilty, D. M., Brady, K. T., & Hales, R. E. (1999). Bipolar disorder in adults: A review of recent literature. *Psychiatric Services, 50*, 201-213.

Hilty, D. M., Laemon, M. H., Lim, R. F., Kelly, R. H., & Hales, R. E. (2006). A Review of Bipolar Disorder in Adults. *Psychiatry (Edgmont), 3*(9), 43-55.

Hipes, C., Lucas, J., Phelan, J., & White, R. (2016). The stigma of mental illness in the labor market. *Social Science Research, 56*, 16-25.

Hirschfeld, R. M. (2001). Bipolar spectrum disorder: improving its recognition and diagnosis. *Journal of Clinical Psychiatry, 62*(14), 5-9.

Hirschfeld, R., Bowden, C. L., & Gitlin, M. J. (2006). Practice guidelie for the treatment of patients with bipolar disorder. *American Journal of Psychiatry, 159*, 1-35.

Hjeltnes, A., Binder, P., Moltu, C., & Dundas, I. (2015). Facing the fear of failure: An explorative qualitative study of client experiences in a mindfulness-based stress reduction program for university students with academic evaluation anxiety. *International Journal of Qualityative Studies in Health and Well-being, 10*.

Holmes, H., & Tangtongtavy, S. (1997). *Working With the Thais: a Guide to Managing in Thailand.* Bangkok: White Lotus.

Hong, J. J. (2014). Anxiety disorders in Asians and Asian Americans. *Asian Journal of Psychiatry, 7*, 74-76.

Hong, J. J., & Woody, S. R. (2007). Cultural mediators of self-reported social anxiety. *Behaivor Research and Therapy, 45*(8), 1779-1789.

Howe, S. G. (1848). *On the Causes of Idiocy.* Massachusetts: Commissioners Report.

Hsiao, F., Klimidis, S., Minas, H., & Tan, E. (2006). Cultural attribution of mental health suffering in Chinese societies: The views of Chinese patients with mental illness and their caregivers. *Journal of Clinical Nursing, 15*, 998-1006.

Hwang, S. J., Childers, M. E., & Wang, P. W. (2010). Higher prevalence of bipolar I disorder among Asian and Latino compared to Caucasian patients receiving treatment. *Asia Pacific Psychiatry, 2*(3), 156-165.

IHME. (2016). *Health Data: Thailand.* Seattle: University of Washington.

Ineland, L., Jacobssson, L., Renberg, E., & Sjölander, P. (2008). Attitudes towards mental disorders and psychiatric treatment - changes over time in a Swedish population. *Nordic Journal of Psychiatry, 3*, 192-197.

Jennings, W. G., & Reingle, J. M. (2012). On the number and shape of developmental/life-course violence, aggression, and delinquency trajectories: A state-of-the-art review. *Journal of Criminal Justice, 40*(6), 472-489.

Jitnarin, N., Kosulwat, V., Rojroongwasinkul, N., Boonpraderm, A., Haddock, C., & Poston, W. (2011). Prevalence of overweight and obesity in Thai population: Results of the National Thai Food Consumption Survey. *Eating and Weight Disorders, 16*(4), 242-249.

Johnson, J. G., Cohen, P., Pine, D. S., Klein, D. F., Kasen, S., & Brook, J. S. (2000). Association between cigarette smoking and anxiety disorders during adolescence and early adulthood. *Journal of the American Medical Association, 284*, 2348-2351.

Jourard, S. M. (1959). Self-disclosure and other-cathexis. *Journal of Abnormal and Social Psychology, 59*, 428-431.

Kanter, J. W., Busch, A. M., Weeks, C. E., & Landes, S. J. (2008). The Nature of Clinical Depression: Symptoms, Syndromes and Behaivor Analysis. *Behavioral Analysis, 31*(1), 1-21.

Kato, T. (2007). Molecular genetics of bipolar disorder and depression. *Psychiatry and Clinical Neuroscience, 61*(1), 3-19.

Kelle, U. (2004). Computer-assisted analysis of qualitative data. In U. Flick, E. von Kardorff, & I. Steinke, *A companion to qualitative research* (pp. 276-283). Thousand Oaks: Sage.

Kelly, C., & McCreadie, R. G. (1999). Smoking habits, current symptoms, and premorbid characteristics of schizophrenic patients in Nithsdale, Scotland. *American Journal of Psychiatry, 156*, 1751-1757.

Kendler, K. S., Gardner, C. O., Neale, M. C., & Prescott, C. A. (2001). Genetic risk factors for major depression in mena nd women: Similar or different heritabilities and same or partly distinct genes? *Psychological Medicine, 31*(4), 605-616.

Kendler, K. S., Neale, M. C., Kessler, R. C., Heath, A. C., & Eaves, L. J. (1992). Generalized anxiety disorder in women: a population based twin study. *Archives of General Psychiatry, 49*, 267-272.

Kendler, K. S., Thornton, L. M., & Gardner, C. O. (2001). Genetic risk, number of previous depressive episodes, and stressful life events in predictin onset of major depression. *American Journal of Psychiatry, 4*, 582-586.

Kendler, K. S., Walters, E. E., Neale, M. C., Kessler, R. C., Heath, A. C., & Eaves, L. J. (1995). The structure of the genetic and environmental risk factors for six major psychiatric disorders in women: phobia, generalised anxiety disorder, panic disorder, bulimia, major depression, and alcoholism. *Archives of General Psychiatry, 52*(5), 374-383.

Kessler, R. C., & McLeod, J. D. (1985). Social support and mental health in community samples. In S. Cohen, & S. L. Syme, *Social support and health* (pp. 219-240). San Diego, CA: Academic Press.

Kessler, R. C., Bergland, P., & Demler, O. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*, 593-602.

Kessler, R. C., McGonagle, K. A., & Zhao, S. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States: results from the National Comorbidity Survey. *Archives of General Psychiatry, 51*, 8-19.

Kessler, R. C., McGonagle, K. A., Swartz, M., Blazer, D. G., & Nelson, C. B. (2003). Sex and depression in the National Comorbidity Survey: I. Lifetime prevalence, chronicity and recurrence. *Journal of Affective Disorders, 29*, 85-96.

Keyes, C., Shmotkin, D., & Ryff, C. (2008). Optimizing well-being: the empirical encounter of two traditions. *Journal of Personality and Social Psychology, 82*(6), 1007-1022.

Komin, S. (1991). *Psychology of the Thai people: Values and behavioural patterns.* Bangkok: Magenta.

Lai, G. Y., Zhuo, H. R., Singla, D., Wu, O., & Yang, L. H. (2009). Revealing the cultural dynamics of stigma experienced by Chinese immigrants: A qualitative examination. *American Psychological Association Convention Presentations*, 1-3.

Lam, C. S., Tsang, H. W., Corrigan, P. W., Lee, Y., Angell, B., Shi, K., . . . Larson, J. E. (2010). Chinese lay theory and mental illness stigma: Implications for research and practices. *Journal of Rehabilitation, 76*, 35-40.

Lambert, M., Barley, M., & Dean, E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy: Theory, research, practice, training, 38*(4), 357.

Lasser, K., Boyd, W. J., Woolhandler, S., Himmelstein, D. U., McCormick, D., & Bor, D. H. (2000). Smoking and Mental Illness: A Population-Based Prevalance Study. *Journal of the American Medical Association, 284*(20), 22-29.

Lau, A. S., Fung, J., Wang, S., & Kang, M. (2009). Explaining elevated social anxiety among Asian Americans: emotional attunement and a cultural double blind. *Cultural Diversity and Ethnic Minority Psychology, 15*(1), 77-85.

Lau, J. Y., & Eley, T. C. (2010). The genetics of mood disorders. *Annual Review of Clinical Psychology, 6*, 313-337.

Líndal, E., & Stefánsson, J. G. (1991). The frequency of depressive symptoms in a general population with reference to DSM-III. *International Journal of Social Psychiatry, 37*, 233-241.

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology, 27*, 363-385.

Lish, J. D., Dime-Meenan, S., & Whybrow, P. C. (1994). The National Depressive and Manic-Depressive Association (DMDA) survey of bipolar members. *Journal of Affective Disorders, 31*, 281-284.

Lohr, J. B., & Flynn, K. (1992). Smoking and schizophrenia. *Schizophrenia Research, 8*, 93-102.

López-Ibor, J. J., & López-Ibor, M.-I. (2010). Anxiety and logos: Toward a linguistic anaylsis of the origins of human thinking. *Journal of Affective Disorders*, 1-11.

Lotrakul, M., & Saipanish, R. (2009). How do general practitioners in Thailand diagnose and treat patients presenting with anxiety and depression? *Psychiatry and Clinical Neurosciences, 63*(1), 37-42.

Luhrmann, T. M., Padmavati, R., Tharoor, H., & Akwasi, O. (2015). Hearing Voices in Different Cultures: A Social Kindling Hypothesis. *Topics in Cognitive Science, 7*(4), 646-663.

Luty, J., Fekadu, D., Umoh, O., & Gallagher, J. (2006). Validation of a short instrument to measure stigmatised attitudes towards mental illness. *Psychiatric Bulletin, 30*, 257-260.

Maguire, G., & Yeh, C. (2012). Overview of the Diagnosis and Treatment of Stuttering. *Journal of Experimental and Clinical Medicine, 4*(2), 92-97.

Malekshahi, T., Tioleco, N., Ahmed, N., Campbell, A., & Haller, D. (2015). Misues of atypical antipsychotics in conjunction with alcohol and other drugs of abuse. *Journal of Substance Abuse Treatment, 48*(1), 8-12.

Mancuso, D. M., Townsend, M. H., & Mercante, D. E. (1993). Long-term floow-up of generalized anxiety disorder. *Comprehensive Psychiatry, 34*, 441-446.

Manderscheid, R. W., Ryff, C. D., Freeman, E. J., McKnight-Eily, L. R., Dhingra, S., & Strine, T. W. (2010). Evolving Definitions of Mental Illness and Wellness. *Preventing Chronic Disease, 7*(1), 1-6.

Manning, C., & Gregoire, A. (2009). Effects of parental mental illness on children. *Medical Image Analysis*, 7-9.

Martin, E. (2007). *Bipolar expeditions: Mania and depressionin American culture.* New Jersey: Princeton University Press.

Mashiach-Eizenberg, M., Hasson-Ohayon, H., Yanos, P., Lysaker, P., & Roe, D. (2013). Internalized stigma and quality of life among persons with severe mental illness: The mediating roles of self-esteem and hope. *Psychiatry Research, 208*, 15-20.

Mason, O., Stevenson, C., & Freedman, F. (2014). Ever-present threats from information technology: the Cyber-Paranoia and Fear Scale. *Froniters in Psychology Psychopathology*.

Massion, A. O., Warshaw, M. G., & Keller, M. B. (1993). Quality of life and psychiatric morbidity in panic disorder and generalized anxiety disorder. *American Journal of Psychiatry, 150*, 600-607.

Mavissakalian, M. R., & Prien, R. F. (1996). *Long-Term Treatments of Anxiety Disorders.* Washington, DC: American Psychiatric Press.

McCrae, R. R., & Costa, P. T. (1987). Validation of the five-factor model of personality across instruments and observers. *Journal of Personality and Social Psychology, 52*, 81-90.

McHugh, P. R. (2005). Striving for Coherence: Psychiatry's Efforts over Classification. *Journal of the American Medical Association*, 2526-2528.

McNally, R. J. (2011). *What is Mental Illness?* Cambridge, MA: Harvard University Press.

Meleshko, K. G., & Alden, L. E. (1993). Anxiety and self-disclosure: Toward a motivational model. *Journal of Personality and Social Psychology, 64*, 1000-1009.

Mennin, D. S., Heimberg, R. G., Turk, C. L., & Fresco, D. M. (2005). Preliminary evidence for an emotion dysregulation model of generalized anxiety disorder. *Behavior Research and Therapy, 43*, 1281-1310.

Mental Illness. (2018). Retrieved from Merriam-Webster: https://www.merriam-webster.com/dictionary/mental%20illness

Miller, G. (2006). The Unseen: Mental Illness's Global Toll. *Science, 311*(5760), 458-461.

Moses, T. (2010). Being treated differently: Stigma experiences with family, peers, and school staff among adolescents with mental health disorders. *Social Science & Medicine, 70*, 985-993.

Moses, T. (2014). Determinants of mental illness stigma for adolescents discharged from psychiatric hospitalization. *Social Science & Medicine, 109*, 26-34.

Mundy, L., Canterford, L., Tucker, D., Bayer, J., & Romaniuk, H. (2017). Academic Performance in Primary School Children with Common Emotinoal and Behavioral Problems. *Journal of School Health, 87*(8).

National Institutes of Health (US). (2007). *Information about Mental Illness and the Brain*. Retrieved from NIH Curriculum Supplement Series: https://www.ncbi.nlm.nih.gov/books/NBK20369/

National Statistical Office. (2015). *Census.* Bangkok, Thailand: Ministry of Information and Communication Technology.

Neff, K., Pisitsungkagarn, K., & Hsieh, Y. (2008). Self-Compassion and Self-Construal in the United States, Thailand, and Taiwan. *Journal of Cross-Cultural Psychology, 39*, 267.

Neugarten, B. L. (1973). Personality change in late life: a developmental perspective. In C. Eisodorfer, & M. P. Lawton, *The psychology of adult development and aging* (pp. 311-335). Washington DC: American Psychological Association.

Nutt, D. J., & Ballenger, J. C. (2007). *Anxiety Disorders.* Malden, MA: Blackwell Science Ltd.

Office of the Educational Council, the Ministry of Education Kingdom of Thailand. (1999). *National Edcation Act B.E. 2542.* Bangkok, Thailand: Pimdeekarnpim.

Orth, U., Robins, R., & Widaman, K. (2012). Life-span development of self-esteem and its effects on important life outcomes. *Journal of Personality and Social Psychology, 102*, 1271-1288.

Payne, A., Joseph, S., & Tudway, J. (2007). Assimilation and Accommodation Processes Following Traumatic Experiences. *Journal of Loss and Trauma, 1*, 75-91.

Phelan, J. C., Link, B. G., Stueve, A., & Pescosolido, B. A. (2000). Public conceptions of mental illness in 1950 and 1996: What is mental illness and is it to be feared? *Journal of Health and Social Behaviour, 41*, 188-207.

Phillips, K. (2004). Body dysmorphic disorder: recognizing and treating imagined ugliness. *World Psychiatry, 3*(1), 12-17.

Piedmont, R. (1995). Another look at fear of success, fear of failure, and test anxiety: A motivational analysis using the five-factor model. *Sex Roles, 32*(3-4), 139-158.

Poland, B. D. (2002). Transcription quality. In J. F. Gubrium, & J. A. Holstein, *Handbook of interview research: context and method* (pp. 629-649). Michigan: Sage.

Prakasha, P. A. (2010). *The Christ Blueprint: 13 Keys To Christ Consciousness.* Berkeley, CA: North Atlantic Books.

Prange, M. E., Greenbaum, P. E., Silver, S. E., & Friedman, R. M. (1992). Family functioning and psychopathology among adolescents with severe emotional distrubances. *Journal of Abnormal Child Psychology, 20*(1), 83-102.

Pressman, S. D., & Cohen, S. (2005). Does positive affect influence health? *Psychological Bulletin, 131*(6), 925-971.

Primm, A. B., Vasquez, M., Mays, R. A., Sammons-Posey, D., McKnight-Eily, L. R., & Presley-Cantrell, L. R. (2010). The role of public health in addressing racial and ethnic disparities in mental health and mental illness. *Preventing Chronic Disease, 7*(1), 1-7.

Ramboz, S., Oosting, R., & Amara, D. A. (1998). Serotonin receptor 1A knockout: an animal model of anxiety-related disorder. *Proceedings of the National Academy of Sciences of the United States of America, 95*(24), 476-481.

Rapee, R. M., & Heimberg, R. G. (1997). A cognitive-beavioral model of anxiety in social phobia. *Behaviour Research and Therapy, 35*, 741-756.

Raymond, C. (2008). Hypothesis: Grandiosity and Guilt Cause Paranoia; Paranoid Schizophrenia is a Psychotic Mood Disorder; a Review. *Schizophrenia Bulletin, 34*(6), 1151-1162.

Reis, H. T., & Shaver, P. (1988). Intimacy as an interpersonal process. In S. Duck, *Handbook of personal relationships* (pp. 367-389). Chichester, UK: John Wiley and Sons.

Reus, V. I., & Freimer, N. B. (1997). Understanding the genetic basis of mood disorders: Where do we stand? *American Journal of Human Genetics, 60*, 1283-1288.

Reynolds, T., Zupanick, C. E., & Dombeck, M. (2013). *History of Stigmatizing Names for Intellectual Disabilities*. Retrieved from MentalHelp: https://www.mentalhelp.net/articles/history-of-stigmatizing-names-for-intellectual-disabilities-continued/

Riley, J. N. (1975). Western medicine's attempt to become more scientific: examples from the United States and Thailand. *Social Science and Medicine*, 75-78.

Rocca, P., Beoni, A. M., Eva, C., Ferrero, P., Zanalda, E., & Ravizza, L. (1998). Peripheral benzodiazepine receptor messenger RNA is decreased in lymphocytes of gneralized anxiety disorder patients. *Biological Psychiatry, 43*(10), 767-773.

Rogers, M. P., Warshaw, M. G., & Goisman, R. M. (1999). Comparing primary and secondary generalized anxiety disorder in long-term naturalistic study of anxiety disorder. *Depression & Anxiety, 10*, 1-7.

Rood, L., Roelofs, J., Bogels, S., & Alloy, L. (2010). Dimensions of Negative Thinking and the Relations with Symptoms of Depression and Anxiety in Children and Adolescents. *Cognitive Therapy and Reasearch, 34*(4), 333-342.

Rothschild, A. (2013). Challenges in the Treatment of Major Depressive Disorder with Psychotic Features. *Schizophrenia Bulletin, 39*(4), 787-796.

Ruengorn, C., Sanichwankul, K., Niwatananun, W., Mahatnirunkul, S., Pumpaisalchai, W., & Patumanond, J. (2012). A risk-scoring scheme for suicide attempts among patients with bipolar disorder in a Thai patient cohort. *Psychological Research and Behaviour Management, 5*, 37-45.

Rungreangkulkij, S., Kotnara, I., Kittiwattanapaisan, W., & Arunpongpaisal, S. (2012). Trapped in Thoughts: Depression Experiences from Thai Men. *20th European Congress of Psychiatry, 27*(1), 1.

Ryff, C. D., Love, G. D., Urry, H. L., Muller, D., Rosenkranz, M. A., & Friedman, E. M. (2006). Psychological well-being and ill-being: do they have distinct or mirrored biological correlates? *Psychotherapy and Psychosomatics, 75*(2), 85-95.

Sadock, B., & Sadock, V. (2007). *Kaplan & Sadock's synopis of psychiatry: Behavioral sciences/clinical psychiatry* (10th ed.). Philadelphia, PA: Lippincott Williams & Williams.

Salkovskis, P. M. (1991). The importance of behaviour in the maintenance of anxiety and panic: A cognitive account. *Behavioural Psychotherapy, 19*, 6-19.

Scherrer, J. F., True, W. R., & Xian, H. (2000). Evidence for genetic influences common and specific to symptoms of generalized anxiety disorder and panic. *Journal of Affect Disorders, 57*(1-3), 25-35.

Schulze, B., & Angermeyer, M. C. (2003). Subjective experiences of stigma. A focus group study of schizophrenic patients, their relatives and mental health professionals. *Social Sciences & Medicine*, 299-312.

Sedler, M. J. (1983). Falret's discovery: the origin of the concept of bipolar affective illness. *American Journal of Psychiatry, 140*(9), 1127-1133.

Simon, B. (1992). Shame, stigma, and mental illness in ancient Greece. In P. J. Fink, & A. Tasman, *Stigma and Mental Illness* (p. 29). Washington, DC: American Psychiatric Press.

Simpson, J., & Weiner, E. (1989). *Oxford English Dictionary.* Cary, NC: Oxford University Press.

Smith, J. A., & Osborn, M. (2003). *Qualitative psychology: a practical guide to methods.* Birkbeck College, UK: Sage.

Soonthornchaiya, R., & Dancy, B. (2006). Perceptions of Depression Among Elderly Thai Immigrants. *Issues in Mental Health Nursing, 27*, 681-698.

Starcevic, V., & Bogojevic, G. (1999). The concept of generalized anxiety disorder: between the too narrow and too wide diagnostic criteria. *Psychopathology, 32*, 5-11.

Steel, Z., Marnane, C., Iranpour, C., Chey, T., Jackson, J. W., Patel, V., & Silove, D. (2014). The global prevalence of common mental disorders: a systematic review and meta-analysis 1980-2013. *International Journal of Epidemiology, 43*(2), 476-493.

Steptoe, A., Gibson, E. L., Hamer, M., & Wardle, J. (2006). Neuroendocrine and cardiovascular correlates of positive affect measured by ecological momentary assessment and by questionnaire. *Psychoneuroendocrinology, 32*(1), 56-74.

Stirling, J., & Hellewell, J. (1999). *Psychopathology.* London: Taylor & Francis.

Suanprung Psychiatric Hospital. (2012). *Suanprung psychiatric hospital report number of patients between 2007-2009.* Chiang Mai, Thailand: Suangprung.

Sullivan, P. F., Neale, M. C., & Kendler, K. S. (2000). Genetic epidemiology of major depression: Review and meta-analysis. *American Journal of Psychiatry, 157*(10), 1552-1562.

Taylor, D. P., Eison, M. S., Riblet, L. A., & Vandermaelen, C. P. (1985). Pharmacological and clinical effects of buspirone. *Pharmacological Biochemistry and Behaviour, 23*(4), 687-694.

Teachman, B. A., Wilson, J. G., & Komarovskaya, I. (2006). Implicit and explicit stigma of mental illness in diagnosed and healthy samples. *Journal of Social and Clinical Psychology, 25*(1), 75-95.

Teorell, J. (2001). *Methods combined: a comprehensive introduction to qualitative and quantitative research in the social sciences.* Uppsala University: unpublished manuscript.

The Thai Ministerial Regulations for Provision of Assistive Technology, Media and Services in People with Disabilities. (2008). *The Thai Ministerial Regulations for Provision of Assistive Technology, Media, and Services in People with Disabilities.* Bangkok, Thailand.

Thomas, D. R., & Hodges, I. D. (2010). *Designing and Managing Your Research Project.* London: SAGE Publications Ltd.

Toews, B., & McGregor, R. (1998). *Succeed in Business: the Essential Guide for Business and Investment In Thailand.* Singapore: Times Editions.

Trent, J. (1994). *Inventing the Feeble Mind: A History of Mental Retardation in the United States.* Los Angeles: University of California Press.

Trzensniewski, K., Donnellan, M., & Robins, R. (2003). Stability of self-esteem across the life span. *Journal of Personality and Social Sciences, 84*, 205-220.

Tsavoussis, A., Stawicki, S., Stoicea, N., & Papadimos, T. (2014). Child-Witnessed Domestic Violence and its Adverse Effects on Brain Development: A Call for Societal Self-Examination and Awareness. *Frontiers in Public Health, 2*(178).

Tuicomepee, A., & Romano, J. L. (2008). Thai Adolescent Survivors 1 Year After the 2004 Tsunami: A Mixed Methods Study. *Journal of Counseling Psychology*, 308-320.

Urry, H. L., Nitschke, J. B., Dolski, I., Jackson, D. C., Dalton, K. M., & Mueller, C. J. (2004). Making a life worth living: neural correlates of well-being. *Psychological Science, 15*(6), 367-372.

van Reekum, C. M., Urry, H. L., Johnstone, T., Thurow, M. E., Frye, C. J., & Jackson, C. A. (2007). Individual differences in amygdala and ventromedial prefrontal cortex activity are associated with evaluation speed and psychological well-being. *Journal of Cognitive Neuroscience, 19*(2), 237-248.

Velligan, D. I., Sajatovic, M., Hatch, A., Kramata, P., & Docherty, J. P. (2017). Why do psychiatric patients stop antipsychotic medication? A systematic review of reasons for nonadherence to medication in patients with serious mental illness. *Patient Preference and Adherence, 11*, 449-468.

Voncken, M. J., & Dijk, K. F. (2012). Socially anxious individuals get a second chance after being disliked at first sight: The role of self-disclosure in the development of likeablity in sequential social construct. *Cognitive Therapy and Research*, 1-11.

Vorapanya, S., & Dunlap, D. (2014). Inclusive education in Thailand: practices and challenges. *International Journal of Inclusive Edcation, 18*(10), 1014-1028.

Wagner, J., Lüdtke, O., Jonkmann, K., & Trautwein, U. (2012). Cherish Yourrself: Longitudinal Patterns and Conditions of Self-Esteem Change in the Transtion to Young Adulthood. *Journal of Personality and Social Psychology, 104*(1), 148-163.

Weissman, M. M., Leaf, P. J., & Tischer, G. L. (1988). Affective disorders in five United States communities. *Psychological Medicine, 18*, 141-153.

Wenzel, A. (2002). Characteristics of close relationships in individuals with social phobia: A preliminary comparison with nonanxious individuals. In J. A. Harvey, & A. Wenzel, *A clinician's guide to maintaining and enhancing close relationships* (pp. 199-213). Mahwah, NJ: Lawrence Erlbaum.

Whitley, R., & Campbell, R. D. (2014). Stigma, agency and recovery amongst people with severe mental illness. *Social Science & Medicine, 107*, 1-8.

WHO. (2006). *WHO-AIMS Report on Mental Health System in Thailand.* Thailand: Ministry of Public Health.

WHO. (2017). *Depression and Other Common Mental Disorders: Global Health Estimates.* Geneva: World Health Organisation.

Wierzbicka, A. (1994). Emotion, language, and cultural scripts. In S. Kitayama, & H. Markus, *Emotion and Culture* (pp. 133-196). Washington, DC: American Psychological Association.

Willig, C. (1999). Beyond appearances: a critical realist approach to social constructionism. In D. J. Nightingale, & J. Cromby, *Social constructionist psychology: a critical analysis of theory and practice* (pp. 37-51). California: Open University Press.

Wittchen, H. U., Zhao, S., Kessler, R. C., & Eaton, W. W. (1994). DSM-III-R generalized anxiety disorder in the National Comorbidity Survey. *Archives of General Psychiatry, 51*, 355-364.

Wu, L., & Anthony, J. C. (1999). Tobacco smoking and depressed mood in late childhood and early adolescence. *American Journal of Public Health, 89*, 1837-1840.

Yadegarfard, M., Ho, R., & Bahramabadian, F. (2013). Influences on loneliness, depression, sexual-risk behaviour and suicidal ideation among Thai transgender youth. *Culture, Health & Sexuality, 15*(6), 726-737.

Yassa, R., Lal, S., Korpassy, A., & Ally, J. (1987). Nicotine exposure and tardive dyskinesia. *Biological Psychiatry, 22*, 67-72.

Young, I., Iglewicz, A., Glorioso, D., Lanouette, N., Seay, K., Ilapakurti, M., & Zisook, S. (2012). Suicide bereavement and complicated grief. *Dialogues in Clinical Neuroscience, 14*(2), 177-186.

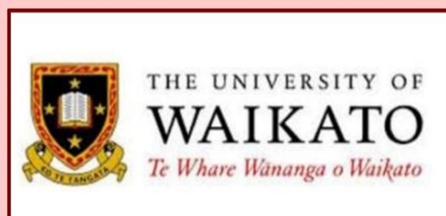
Appendices

Appendix A: Flyer

An Exploration of Young Peoples' Experiences of Living with Mental Illness in Phuket

February 2018
University of Waikato New Zealand ◦ FASS

Supervised by
Neville Robertson
& Mohi Rua



I am a Community Psychology Masters Student from New Zealand, currently looking for participants for a study exploring young peoples' experiences of living with mental illness in Phuket.

Participants will be asked to complete 1 – 2 interviews which will take approximately 40 minutes per session.

If you or anyone you know is interested in taking part in the study or have any questions, please contact me at your convenience.

Participants must:

- have a mental illness
- be between the ages of 20 – 29
- live in Phuket

All gathered information will remain anonymous.

CONTACT DETAILS:

Khun Mia Nelson

Meah.Mareah@gmail.com

08 01 391 328

This research project has been approved by the Human Research Ethics Committee (Health) of the University of Waikato under HREC(Health)#2017-48. Any questions about the ethical conduct of this research may be addressed to the Secretary of the Committee. Email: humanethics@waikato.ac.nz. Postal Address, University of Waikato, Te Whare Wananga o Waikato, Private Bag 3105, Hamilton 3240.

Appendix B: Information Sheet

'Experiences of Living with Mental Illness'

Information Sheet

What is this study about?

This study looks to explore your experience of living in Phuket with a mental illness, and how this label may affect the way others see you, how you feel about yourself, and your quality of life.

Who are the researchers?

I am an American from New Zealand. My mother and grandmother are Thai and live in America. My family has a history of mental illness, which is why I decided it was important for me to explore others' experiences of mental illness in Thailand. I am a Community Psychology Masters Student at the University of Waikato. My supervisors are Neville Robertson and Mohi Rua.

What questions will I be asked?

Along with a short background survey, the following are some questions you may be asked during the interview:

- Can you tell me a little bit about your life in Phuket?
- How would you describe your mental illness?
- Does having a mental illness affect the way people treat you?
- Did your relationship with family or friends change after learning about your mental illness?
- How do you feel about yourself in relation to your mental illness?
- Do you feel your quality of life has been altered by your mental illness?

Interviews will be conducted at a location and time that suits you, taking up to 40 minutes per session. You may be asked to be interviewed more than once. The interview will be audio recorded.

What happens with my information?

After the interview, you will receive a written summary of the session. You can ask to make any additional comments or changes at this point. If you are satisfied with the summary, I will include this information in my analysis. This study will be made available to the public through the University of Waikato Research Commons (http://researchcommons.waikato.ac.nz/) and may additionally be published in relevant Psychology Journals in the future. All information will be collected and stored on a secure computer for five years before being destroyed.

Will my identity be protected?

Identity will be protected using coding and (pseudonyms) false names. Identifying names, places, and descriptions will be altered to protect your privacy.

Will I be able to see the results of this study?

A summary of the report will be made available if you wish to view the results of the final report.

What if the interview becomes too overwhelming?

You are welcome to bring a support person with you. You may choose to decline to answer any question. You may ask to stop the recording at any point during the interview, or take a break if things become overwhelming. I will contact you the day following the interview to check in.

If you require further counselling or assistance, please contact your local clinic or one of the following resources for support:

Mental Health Centre - Bangkok Hospital Phuket	07 6254 425
Vachira Phuket Hospital	07 361 234

Who can I contact about this study?

Researcher:	Primary Supervisor:
Mia Nelson	Neville Robertson
meah.mareah@gmail.com	neville.robertson@waikato.ac.nz
09 4 934 4732	+64 7 837 9212
Ethics Convenor:	**Secondary Supervisor:**
Rebecca Sargisson	Mohi Rua
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What is my role in this study? Can I withdraw if I change my mind?

You can choose to withdraw from the study up till 7 days after receiving the summary of your interview. Please contact me as soon as possible if you wish to withdraw from the study.

This research project has been approved by the Human Research Ethics Committee (Health) of the University of Waikato under HREC(Health)#2017-48. Any questions about the ethical conduct of this research may be addressed to the Secretary of the Committee. Email humanethics@waikato.ac.nz. Postal Address, University of Waikato, Te Whare Wananga o Waikato, Private Bag 3105, Hamilton 3240.

Appendix C: Interview Questions

'Experiences of Living with Mental Illness'

Interview Questions

Thank you for taking the time to speak with me.

I would like to discuss your experiences of living in Phuket with a mental illness, and how this label may affect the way others see you, how you feel about yourself and your quality of life. Please feel free to let me know if any of the areas we discuss make you feel uncomfortable – we can stop at any point.

1.) **Can you tell me a little bit about your life in Phuket?**
    - Education? Family? Work? Religion? Growing up?

2.) **How would you describe your mental illness?**
    - Physical/mental symptoms? Spiritual/traditional causes?

3.) **Does having a mental illness affect the way people treat you?**
    - Stigma? Community members/elders? Work? School?

4.) **Did your relationship with your family or friends change after learning about your mental illness?**
    - Were they supportive? Judgemental? Blaming?

5.) How do you feel about yourself in relation to your mental illness?

- Does it make you feel helpless/strong? Has this changed over time?

6.) Do you feel your quality of life has been altered by your mental illness?

- Are you able to work? Do you have access to healthcare resources? Do people treat you differently now?

Thank you again for your time. I will be in contact with you shortly with a summary of this interview. If you have any questions, concerns, or if you just feel uncomfortable and want to talk about some of the things that have come up during the interview, please do not hesitate to contact me. If you are having serious mental health concerns and need immediate support, please contact your local clinic or one of the listed resources on the Information Sheet I have provided you. I will contact you tomorrow to touch base.

Appendix D: Demographic Survey

'Experiences of Living with Mental Illness'

Demographic Survey

Thank you for taking the time to complete this brief background survey before we begin with the interview. I can read this aloud to you or you can choose to fill in the survey yourself.

1.) Age ____________________

2.) Occupation ____________________

3.) Gender
   a. Female
   b. Male
   c. Kathoey
   d. Other ________________
   e. Prefer not to say

4.) Religion
   a. Muslim
   b. Buddhist
   c. Christian
   d. Other ________________
   e. Prefer not to say

5.) Language
   a. All English
   b. All Thai
   c. Mostly Thai, some English
   d. Mostly English, some Thai
   e. Fluent English and Thai
   f. Other ________________

6.) Marital Status
   a. Single
   b. Married
   c. Fan
   d. Other ________________
   e. Prefer not to say

Appendix E: Consent Form

'Experiences of Living with Mental Illness'

Consent Form

Research Project: An Exploration of Young People's Experiences of Living with Mental Illness in Phuket

Please complete the following checklist. Tick (✓) the appropriate box for each point.	YES	NO
1. I have read the Participant Information Sheet and I understand it.		
2. I have been given enough time to consider participating in this study.		
3. I have had all my questions answered regarding this study.		
4. I have a copy of this Consent Form and the Information Sheet.		
5. I understand that I may withdraw from this study up to 7 days after receiving the summary of my interview		
6. I know who to contact if I have any further questions about this study.		
7. I understand that I may decline to take part in any part of the study.		
8. I understand my details will remain anonymous within this study.		
9. I wish to receive the summary report of my interview.		

Declaration by participant:

I agree to participate in this research project and I understand that I may withdraw at any time. If I have any concerns about this project. This research project has been approved by the Human Research Ethics Committee (Health) of the University of Waikato under HREC(Health)#2017-48. Any questions about the ethical conduct of this research may be addressed to the Secretary of the Committee. Email humanethics@waikato.ac.nz. Postal

Address, University of Waikato, Te Whare Wananga o Waikato, Private Bag 3105, Hamilton 3240.

Participant’s name (Please print):

Signature: Date:

Declaration by member of research team:

I have given a verbal explanation of the research project to the participant and have answered the participant’s questions about it. I believe that the participant understands the study and has given informed consent to participate.

Researcher’s name (Please print):

Signature: Date: