

# LGBTQ MENTAL HEALTH

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AMERICAN PSYCHOLOGICAL ASSOCIATION

Washington, DC

# 9

## Whose Paradise?

### *An Intersectional Perspective on Mental Health and Gender/Sexual Diversity in Thailand*

Timo T. Ojanen, Peter A. Newman, Rattanakorn Ratanashevorn, Jan W. de Lind van Wijngaarden, and Suchon Tepjan

#### CASE STUDY 1: CHAI

Chai<sup>1</sup> was born in a city in Northern Thailand. His aunt and uncle, both university professors, have raised him since he was 10 years old. As a teenager, Chai became aware that he was attracted to other men. He behaved in a slightly more feminine manner than his classmates, and his uncle's colleagues teased his uncle about this. Believing in a link between hormones and sexual orientation, his aunt sent him to an endocrinologist to see whether Chai lacked testosterone. She then sent him to a psychologist, hoping that treatment could make Chai heterosexual. Finally, his desperate guardians enlisted three traditional healers, who explained that Chai was born gay in this life because in previous lives he had committed sexual misconduct against women. On a carefully chosen day, a traditional healer had the family burn Chai's clothes in a rice field and conducted rituals over Chai's naked body to expel a female spirit—indicative of how Thai popular culture approaches gender and sexuality as a single dimension and may invoke spiritual beliefs to explain homosexuality.

<sup>1</sup>The names and identities of the individuals in the case studies have been altered, and the narratives extensively redacted, to preserve their confidentiality.

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These humiliating experiences made Chai depressed. When he started having suicidal thoughts, his friends sought mental health care for him. He saw a psychologist for several months, was diagnosed with depression, and took medication. Chai's situation improved. His 9 months studying in the United States was a turning point. He temporarily cut ties with his aunt and uncle, gaining new self-confidence and friends. Chai is thriving now as a respected academic, doing the lesbian, gay, bisexual, transgender, intersex, and queer (LGBTIQ)<sup>2</sup> research he had dreamed of, far from his hometown and family.

### CASE STUDY 2: MALEEWAN

Maleewan is a transgender woman in her early 30s from a Buddhist, Southern Thai middle-class family. After high school, she chose to attend university far away from home. She hoped to establish an independent life, free from the devaluation by her disapproving parents, who expected her to behave like a man. While at university, Maleewan found out she had HIV. She could not tell her parents, and she thought of ending her life. With support and intervention from her professors and trusted friends, Maleewan got over the initial shock and started antiretroviral therapy. Dealing with this trauma, she decided to see a psychiatrist, who diagnosed her with depression and prescribed antidepressants. However, she felt that the psychiatrist was not very helpful. She then approached a counselor specializing in gay and transgender clients, who was able to discuss HIV and sexuality in a non-judgmental way.

Maleewan's parents still expect her to downplay her femininity. She is continuing her studies, trying to become a lecturer. She feels her master's degree program is unsupportive, and she continues to struggle with academic and relationship issues. Maleewan can sleep only a few hours per night, often wakes up screaming, and has a poor appetite and memory. She is most concerned about her worsening physical health. She continually experiences mood swings and suicidal thoughts. Maleewan uses sex and crystal methamphetamine to temporarily escape her emotional problems. Currently she is seeing another psychiatrist, who is more supportive and provides her with greater opportunities to discuss her challenges.

<sup>2</sup>We use LGBTIQ as an international, inclusive acronym. It is problematic, as it does not directly correspond to Thai identity categories. Thailand has multiple identity labels corresponding to lesbian, gay, bisexual, and transgender identities, and some intersex individuals identify as intersex. The term *queer* is mostly used as an umbrella term in academic works using queer theory as a theoretical lens (e.g., Duangwiset et al., 2014); few Thais use it as a self-assigned identity label.

### INTRODUCTION

Thailand is often represented as a "gay paradise" (Jackson, 1999). The Tourism Authority of Thailand (n.d.) exploits this representation in a website targeting mainly gay and lesbian foreign tourists. As our case examples indicate, this representation is not an accurate portrayal of the lived experiences of many Thai LGBTIQ individuals. In this chapter, we discuss this paradox between the touristic image of Thailand as carefree and LGBTIQ affirming and the sometimes oppressive realities of LGBTIQ people who live in the country.

We first discuss the cultural and historical context of Thailand and the emergence of its numerous LGBTIQ identities. We then describe the Thai context of mental health and LGBTIQ issues, including the stigma associated with each of these. We explore conceptualizations of sexual orientation and gender identity, mental health, and cultural values that differ from those of many contexts in the Global North. Next, we describe common mental health problems and their multiple antecedents among LGBTIQ individuals in the Thai context. Finally, we present our perspectives on implications for improving LGBTIQ mental health in Thailand.

### THAILAND: HISTORICAL AND CULTURAL CONTEXT

Thailand has approximately 66 million inhabitants. The official language is Central Thai, a second language for most of its speakers; the Northeast, North, and South are dominated by distinct regional languages, with 72 languages (50 are indigenous) spoken altogether in the country (Lewis, Simons, & Fennig, 2016). Politically, Thailand is a constitutional monarchy and has featured alternating civilian/democratic and military/autocratic governments since the end of absolute monarchy in 1932 (Bremmer, 2016).

Thailand takes pride in not having been formally colonized, but aspects of Indian, Chinese, and Western cultures, among others, have been adopted or adapted into Thai culture (Harrison & Jackson, 2010). One of the key Indic influences has been religion. Officially, 95% of Thais are registered as Theravada Buddhists, and the remaining 5% are mostly Muslims (4%) or Christians (National Statistical Office of Thailand, 2015). However, Thai Buddhism itself is often syncretic or hybridized with Hindu and animist beliefs (Kitiarsa, 2005).

### EMERGENCE AND EVOLUTION OF THAI LGBTIQ IDENTITIES

Many countries in South and Southeast Asia have cultures that recognize more than two genders, often including at least one transgender identity (Winter, 2012). Buddhist scriptures record that in the time of the Buddha (ca. 2,500 years ago), it was thought that there were four sexes or genders,

with many subtypes (Likhitpreechakul, 2012). In Thailand, the word *kathoey* historically referred to people of intermediate sex or gender; now it refers to transgender women (Chonwilai, 2012). It is debatable whether a distinct *kathoey* identity has been recognized for centuries or emerged only in the past century (Jackson, 2003). Thai documents prior to the past century described same-sex relations and behaviors but not identities based on being same-sex attracted or transgender (Jackson, 2003).

According to Jackson (2003), a specific *kathoey* identity emerged in the 1950s, from which more masculine *gay* identities gradually diverged from the 1960s onward; by the 1980s, masculine *tom* and feminine *dee* identities emerged among same-sex-attracted females. These identities are understood in everyday Thai culture as distinct gender categories (*phet*), leaving concepts like sexual orientation or gender identity redundant, because the attributes they describe are already contained within fixed categorical identities (Jackson, 2003). Although various Thai translations exist for the terms *gender*, *sexual orientation*, and *gender identity*, they are mostly known or used by academics and activists, not in everyday discourse (Ojanen, 2009).

The emergence of further identities and their subtypes continues; new identity terms are coined or adopted when existing terms appear inaccurate or stigmatizing (Ojanen, 2009). A study on bullying (Mahidol University, Plan International Thailand & UNESCO, 2014, p. 34) provided 14 response options for participants' *phet*, including "man" or "woman"; 11 options describing various Thai LGBTIQ identities<sup>3</sup>; and "other." Among 2,070 secondary students, 11.4% ( $n = 235$ ) chose one of the 11 LGBTIQ options in the computerized survey. Eleven (0.5%) participants chose "other," underscoring the diversity of Thai gender and sexuality terms. *Phet* definitions may be relatively fixed, but these identity labels can be appropriated temporarily or situationally and cannot be seen as static or permanent attributes of an individual, who may move between different *phet* over a lifetime (de Lind van Wijngaarden & Ojanen, 2015).

Thailand has been described as tolerant but unaccepting of transgenderism and homosexuality (Jackson, 1999). This can be understood as a willingness to acknowledge and accept the diversity of sexuality and gender identities and expressions, but only in some situations and social contexts. Characteristic of a high-context (Adair & Brett, 2005) and collectivist culture (Triandis, 1988), acceptance versus nonacceptance is not a fixed attitude but depends on what is considered appropriate for a given situation (Jackson, 2003).

The Thai context challenges some fundamental assumptions of positive LGBTIQ youth development typically associated with a Global North perspective. Perhaps foremost among these is that coming out is a universal

<sup>3</sup>These options were *kathoei* (transgender woman), *sao praphet song* (transgender woman), *phu ying kham phet* (transgender woman), *gay* (gay male), *chai rak chai* (man who loves men), *tom* (masculine lesbian), *phu chai kham phet/transman* (transgender man), *dee* (feminine lesbian with preference for toms), *les* (feminine lesbian), *ying rak ying* (woman who loves women), and *bi* (bisexual of either sex).

prerequisite of psychological well-being among same-sex-attracted youth. In a qualitative longitudinal study of young same-sex-attracted men and transgender women, largely from rural Thailand, many participants found the concept of coming out to be unintelligible or even stupid; maintaining harmony in familial relationships and not damaging the family's image were more salient goals (de Lind van Wijngaarden & Ojanen, 2015). The family was not seen as a proper context for asserting their identity. In Thai culture, controlling and deferring one's personal emotions for the sake of social harmony is a highly valued goal (Mulder, 1997). The more formal the context, the more likely the rejection of openly LGBTIQ individuals (Jackson, 2003). Visibly non-normative gender presentation appears to be the key trigger of discrimination in contexts like employment (Ojanen et al., 2018), education (Suriyasarn, 2014), and families (de Lind van Wijngaarden & Ojanen, 2015).

As in many other cultures, the social status and treatment of LGBTIQ persons are related to class, ethnicity, education, and HIV status (Ojanen, Ratanashevorn, & Boonkerd, 2016). The particular alignments of such intersectional characteristics may challenge some preconceptions. In a high-context, collectivist culture, higher socioeconomic status and educational attainment are not necessarily aligned with lesser stigmatization or marginalization; rather, these attributes may be sources of vulnerability because high-status families and individuals may feel the need to protect their public image more carefully than others (Ojanen et al., 2018). Chai's narrative suggests that his well-educated guardians were particularly concerned about the family losing face through their nephew being visibly gay. Chai's parents may also have felt more trust and confidence in accessing modern medicine and psychology as intervention modalities than less educated or less wealthy parents. Yet Chai's access to higher education and foreign travel afforded him an outlet for support and growth, which a youth from a poorer family might not have. Maleewan, likewise, benefited from her class background in being able to access higher education, but not being able to conceal her difference from mainstream gender norms might result in intense pressure to conform, from both her family and her university.

## CONCEPTUALIZATIONS OF MENTAL HEALTH IN THAILAND

An illuminating ethnographic study addressed coexisting models for understanding mental health and illness in contemporary Thailand: the modern medical model, Buddhist notions of karma (*kam*) and merit (*bun*), and animist notions of *khwan* and spirit possession (Burnard, Naiyapatana, & Lloyd, 2006). Possession by spirits or ghosts is a prevalent local explanation for mental illness; another is that a *khwan*, a life spirit, can be lost, especially through a traumatic event (Burnard et al., 2006). If a *khwan* is lost, it is believed that the individual may become mentally or physically ill, and ceremonies may be arranged for calling the lost *khwan* back (Engel & Engel, 2010). These ideologies

are adopted and adapted in various combinations by health care practitioners, religious practitioners, and laypeople.

The concept of karma may contribute to the stigmatization faced by LGBTIQ persons and those with mental health problems; both may be interpreted as the consequence of unmeritorious activities in past lifetimes, and therefore as justified and unavoidable (Burnard et al., 2006; United Nations Development Program & United States Agency for International Development, 2014). The concept of merit refers to the accumulation of good deeds, expected to result in better life circumstances in the present or future incarnations (Burnard et al., 2006). Those who experience problems related to mental health or to being LGBTIQ may attempt to resolve these by merit making—making donations to a temple or by ordaining as monks (Burnard et al., 2006). Sons in Thai Buddhist families are typically expected to ordain as monks for a period of time to pay back a debt of gratitude to their parents by dedicating the resulting merit to them. Parents may force a feminine or gay son into monkhood, hoping that ordination will make him normatively masculine; women, including visibly transgender women, are not allowed to join the monkhood and thus cannot pay their debt of gratitude to their parents in this way, so they may be expected to pay it back by taking care of their parents indefinitely (United Nations Development Program & United States Agency for International Development, 2014).

### INDIGENOUS AND MODERN MEDICAL OPTIONS FOR ADDRESSING MENTAL HEALTH ISSUES

Next we describe both indigenous and modern medical approaches to addressing mental illness. Fortune tellers (*mo du*), spirit mediums (*rang song*), and shamans (*mo phi*, literally “ghost doctors”) are often consulted when personal problems are experienced (Kitiarsa, 2012). As the case study of Chai indicates, even highly educated Thais may believe in the influence of bad karma, lack of merit, lost khwan, or spirit possession on mental health. It is less stigmatizing to consult a fortune-teller or a spirit medium than a mental health care professional, as consulting the latter implies to outsiders the presence of a mental health problem (Ojanen, 2009, 2010). Spiritual practitioners may thus be more culturally acceptable, more accessible, and available in greater numbers to provide a listening ear to those in need than mental health professionals. As Chai’s case suggests, more educated Thais might choose to solve mental health problems first through modern medicine, and if it fails, through other means. For less educated Thais, the reverse might be true. When health care practitioners’ and clients’ beliefs differ, it might impede mutual understanding and trust, unless the situation is handled sensitively.

The availability of openly gay or transgender spirit mediums in Thailand, in contrast to psychologists or psychiatrists, for whom it can be risky or difficult to be openly gay (Ojanen et al., 2016; Suriyasarn, 2014), may make spirit

mediums an attractive choice for LGBTIQ individuals experiencing various problems. Spirit mediumship also provides some LGBTIQ individuals an acceptable context for expressing gender atypical behaviors (when channeling a spirit of another gender) and gaining social acceptance and prestige. Fortune-tellers, spirit mediums, and other indigenous practitioners likely outnumber mental health practitioners; the number of practicing psychiatrists, psychologists, and social workers has been estimated at only a few hundred each for a population of 66 million (World Health Organization [WHO], 2011).

Because of understaffing, psychiatrists in state hospitals are usually able to spend only a few minutes per patient to establish a diagnosis and prescribe medication, providing few opportunities for talk therapy (Ojanen, 2010). Psychiatrists in private hospitals have more time per patient, but fees may be too high for low-income patients (Ojanen, 2010). The role of clinical psychologists has traditionally been to act as a “technician who would take orders from psychiatrists, administer tests, and write reports” (Tapanya, 2001, p. 70), implying that in many contexts, neither psychiatrists nor psychologists provide much counseling (Ojanen, 2010). Generalist physicians account for most of mental health care provision in public primary care facilities; many of them lack skills and interest in mental health (Lotrakul & Saipanish, 2006) and may not have received recent training in psychiatric issues (WHO, 2011).

### LGBTIQ MENTAL HEALTH ISSUES IN THAILAND

Scholarship has suggested that the minority stress perspective (Meyer, 2003) is useful for understanding mental health issues among Thai LGBTIQ people. For example, Yadegarfar, Meinhold-Bergmann, and Ho (2014) reported that the prevalence of depression, suicidal thinking, and sexual risk behaviors was significantly higher among those transgender women ( $n = 129$ ) who experienced more loneliness, family rejection, and social isolation. Among adult lesbian women in the Northeast ( $n = 339$ ), those who were exposed to heterosexist verbal abuse had a higher prevalence of depression (Sumonthip Boonkerd, 2014).<sup>4</sup> In a study of secondary school students ( $n = 2,070$ ), those who experienced homophobic or transphobic school bullying had significantly higher rates of depression and suicide attempts: Students bullied for gender- and sexuality-related reasons were 5 times more likely to try killing themselves than students who were not bullied (Mahidol University et al., 2014).

Evidence also indicates high rates of substance abuse among some Thai LGBTIQ groups. In a 2005 study among 474 transgender women recruited

<sup>4</sup>Thai-language publications are cited by the first name and surname of the author, and alphabetized by the first name, in keeping with Thai academic customs. Thai-language titles have been translated by the authors of this chapter unless an English-language title was indicated in the cited work. Thai titles of cited works are not provided in the interest of space but are available upon request from the corresponding author.

from Bangkok, Phuket, and Chiang Mai, 42.6% reported drug use (methamphetamine, ketamine, ecstasy, or sleeping pills) in the past 3 months (Guadamuz et al., 2011). A study in Chiang Mai comparing lesbian and bisexual women ( $n = 37$ ) with heterosexual women ( $n = 84$ ), all recruited from drinking venues, found statistically significant differences in harmful alcohol use (57% of lesbian and bisexual women vs. 31% of heterosexual women) and ever having used methamphetamine (32% of lesbian/bisexual vs. 13% of heterosexual women; Patel et al., 2013).

Tablet-form methamphetamine (*ya ba*, "crazy drug") has been designated the primary drug of concern in Thailand, accounting for 84% of all individuals receiving treatment for drug abuse (United Nations Office on Drugs and Crime, 2015). Among young men who have sex with men (MSM), crystal (locally known as *ice*) rather than tablet-form methamphetamine has a desirable public image as "cool, pure, clean and *hiso* (high society)" (Guadamuz & Boonmongkon, 2013, p. S229). It is considered useful for skin whitening and weight control; because of its high price, younger men may trade sex in exchange for it (Guadamuz & Boonmongkon, 2013). In a recent study of 499 MSM who presented for an HIV test in Bangkok, 11% reported drug use in the past 3 months, with 4% indicating regular methamphetamine use; 38% were assessed as alcoholic and 64% as depressed (Sapsirisavat et al., 2016).

Transgender individuals face additional risks to health and well-being from the unsupervised use of hormones. Among Thai transgender people, hormones are obtained mainly over the counter from pharmacies (Guadamuz et al., 2011) or through friends (Gooren, Sungkaew, Giltay, & Guadamuz, 2015). Unsupervised use may be associated with overdosing and greater side effects, such as mood swings and kidney disease. Given the intense pressure transgender women face to look beautiful and the inconvenience and expense of accessing medically supervised hormone treatment, unsupervised use of hormones and other chemicals (e.g., injectable glutathione for skin whitening) may be considered socially reasonable but is associated with health risks (Poompruek, Boonmongkon, & Guadamuz, 2014).

Finally, HIV stigma directly impacts the mental health of people living with HIV in Thailand by intensifying self-blame and shame; reducing opportunities for social and familial support; and engendering and justifying discrimination in health care, employment, and other domains (Li, Lee, Thammawijaya, Jiraphongsa, & Rotheram-Borus, 2009). Given the vast and sustained disparities in HIV incidence and prevalence among MSM and transgender women in Thailand, HIV-related stigma also exacts a negative toll on the physical and mental health of these populations more broadly (Logie, Newman, Weaver, Rongprakhon, & Tepjan, 2016). In Thailand, as elsewhere, HIV stigma and sexual stigma are associated with increased risk for HIV transmission among MSM and transgender women. Intersectional stigma operates through multiple pathways to increase HIV risk, such as minority stress and syndemic production, including depression and substance use, as well as negative judgments and discrimination in health care settings (Chakrapani, Kaur, Newman, Mittal, &

Kumar, 2018; Newman, Lee, Rongprakhon, & Tepjan, 2012). HIV and sexual stigma are associated with lower rates of HIV testing—crucial to early diagnosis and treatment, and thereby reduced HIV transmission—and create barriers in uptake and adherence to HIV prevention technologies among MSM and transgender women in Thailand (Logie et al., 2016; Newman, Rongprakhon, & Tepjan, 2013).

## LGBTIQ COMMUNITY EMPOWERMENT AND ADVOCACY

Thai LGBTIQ organizations' efforts on mental health issues have focused mostly on depathologization and direct service provision in the form of paraprofessional online and telephone counseling. In 2001, a lesbian organization, Anjaree, requested a letter from the Department of Mental Health to affirm that homosexuality is not a mental illness; the department complied, issuing a letter simply stating that the *International Statistical Classification of Diseases and Related Health Problems* (10th ed.; ICD-10) disease classification (WHO, 2007) used by Thailand does not list homosexuality as a mental illness (Ojanen et al., 2016). More recently, the Foundation of Thai Transgender Alliance for Human Rights has campaigned for delisting transsexualism as a mental illness in the ICD-10.<sup>5</sup>

Provision of counseling by Thai LGBTIQ groups, mostly online and by telephone, has been more targeted at HIV and sexual health rather than psychosocial issues, but it has played an important role by offering a listening ear to those reluctant to use formal mental health services (Ojanen, 2009, 2015). These services have gradually diversified. For example, Rainbow Sky Association of Thailand (<https://www.rsat.info>), Thailand's largest LGBTIQ organization, as of 2017 operated a sexual health and HIV testing clinic at its main office in Bangkok and had a dedicated transgender staff member for registering complaints of discrimination and helping clients to access justice, in addition to operating its *Sai Sabai Jai* (Peace of Mind Line) helpline. Other activities arranged by LGBTIQ groups may also indirectly benefit LGBTIQ mental health by improving the social climate and by providing informal peer support.

Overall, there has not been much advocacy in Thailand to demand appropriate mental health services for LGBTIQ individuals. However, in 2014, the Bangkok-based advocacy group Asia Pacific Coalition on Male Sexual Health, or APCOM, called for governments in the region to attend to LGBTIQ mental health (Hynes, 2014). To our knowledge, training programs preparing psychologists and psychiatrists usually involve little if any training on LGBTIQ issues. Including such training components from an affirmative point of view would be essential.

<sup>5</sup>Photographs and a description of their campaign activities are shown on their Facebook page ([https://www.facebook.com/pg/thaitga/photos/?tab=album&album\\_id=775719119162976](https://www.facebook.com/pg/thaitga/photos/?tab=album&album_id=775719119162976)).

## LGBTIQ-AFFIRMATIVE MENTAL HEALTH CARE

Mental health issues are somewhat neglected in Thailand, as just described. Mental health disparities experienced by LGBTIQ people due to stigma and minority stress have received even less attention. To illustrate what service providers can do in a context that lacks formal definitions for LGBTIQ competencies and has low mental health capacity, we describe three public sector clinics that have strived to provide appropriate care for LGBTIQ clients.

- The Gender Variation Clinic (<http://www.teenrama.com>) in Ramathibodi Hospital (a teaching hospital of Mahidol University) is a specialized service for LGBTIQ and questioning adolescents with psychosocial adjustment and medical issues, as well as for their parents. Focus areas include helping parents accept the identity of their child and providing transgender youth with medically supervised hormone treatment. The clinic also arranges seminars and conducts research on LGBTIQ mental health issues (Ojanen et al., 2016).
- The Thai Red Cross Tangerine Community Health Center (<http://www.facebook.com/TangerineCenter>) is the first transgender-specific health center in Asia, operated by gender-sensitive medical professionals, including transgender staff. Its focus areas include using hormones safely, preventing HIV and sexually transmitted infections, and addressing the stigma and discrimination faced by transgender people. The clinic aims to serve as a model for the region in expanding transgender people's access to competent health care and promoting their rights.
- Chulalongkorn University, a prestigious state university in Central Bangkok, operates two counseling centers: the Chula Student Wellness Center (<http://wellness.chula.ac.th>) for university students and staff, and the Center for Psychological Wellness (<https://www.facebook.com/WellnessPsyCU>) for the general public. Both centers use a client-centered and holistic approach that affirms LGBTIQ identities. The student clinic offers mental health services, as well as other programs and activities, such as a small LGBTIQ-themed film festival. Given the stigma around mental health issues in Thailand, these other activities aim to familiarize students with clinic staff, build trust, and increase comfort in accessing counseling or mental health treatment.

## CONCLUSION AND IMPLICATIONS

The mental health of LGBTIQ people in Thailand is threatened by intersectional stigma and minority stress caused by actual and anticipated discrimination, ostracism, and violence. As occurs elsewhere, Thai LGBTIQ individuals are most vulnerable when (a) their difference from the societal mainstream is most visible (e.g., they are transgender or visibly gender nonconforming and

less able to pass selectively under the radar); (b) they are in a social setting (e.g., workplace, educational institution) that expects them to fit in rather than be different (particularly in formal contexts); (c) they occupy intersectional identities or social statuses (e.g., ethnic or religious minority, living in poverty, living with HIV) that compound their vulnerability; and (d) they have limited access to social, financial, and medical support (more common if they are isolated or live on a low income).

Thailand now has a law (the 2015 Gender Equality Act; Human Rights Watch, 2015) banning discrimination on the basis of gender and gender expression. However, there is no same-sex marriage legislation or gender-recognition law for transgender individuals. As of 2019, the military government was considering a civil partnership bill that would provide limited rights to same-sex couples. Basic education students and civil servants are mostly expected by their institutions to dress, behave, and have hairstyles matching stereotypical gender roles associated with their birth sex (Mahidol University et al., 2014). Secondary school health education textbooks and the 2008 national core curriculum (on which textbooks are based) teach that being attracted to the same sex, being transgender, and masturbating too frequently are forms of sexual deviation (among others) and are to be avoided (Wijit Wongwareethip, 2016). Following a complaint under the Gender Equality Act in 2018, the Ministry of Education established working groups to identify contents that would need to be revised in new versions of the textbooks.

Unjust laws and regulations cause direct discrimination; in conjunction with outmoded school curricula and lack of training in LGBTIQ-specific competencies for mental health care providers, these produce a social climate in which being visibly LGBTIQ means being a less valuable person. Increasing evidence demonstrates associations between legal and policy statutes and the mental health of LGBTIQ persons. For example, a recent U.S. study demonstrated a significant reduction in suicide attempts among sexual minority high school students after implementation of same-sex marriage policies in their states relative to sexual minority students in states without such policies (Raifman, Moscoe, Austin, & McConnell, 2017). The specific policies and laws that may be most important and effective in Thailand for promoting LGBTIQ health may differ from those in the United States. However, convincing evidence of the positive impact of LGBTIQ-affirmative laws and policies on the mental health of LGBTIQ individuals supports such structural interventions as a powerful and far-reaching mechanism to promote the health and human rights of LGBTIQ individuals.

Access to LGBTIQ-competent care is also essential. Although Thailand still lacks locally grounded definitions of LGBTIQ competencies, care intended to be LGBTIQ affirmative can be provided in diverse contexts, as our examples indicate. Often, it is not delivered through formal mental health facilities but through community organizations, university clinics, online services, and facilities of other medical specialties (e.g., HIV care, adolescent health). Key research and advocacy areas that need further attention include defining and



training LGBTIQ competencies for health care providers in the Thai context, addressing relevant cultural notions and involving spiritual practitioners in providing care for LGBTIQ individuals, addressing mental health stigma, establishing relevant services also outside of Bangkok, and depathologizing transgender identities while increasing access to transgender health care. Attending to these issues will help to ensure that Thai LGBTIQ individuals and their family members have appropriate and acceptable forms of help available when and where they need it, as well as empower them in asserting their fundamental rights as members of Thai society.

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