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From "Suem Sao" to "Rok Suem Sao" and After: An Ethnography of the Diagnosis and Treatment of University Students Diagnosed with Major Depressive Disorder

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Abstract

This ethnographic study explored the subjectification and psychiatrization journeys of Bangkok youths who went from realizing they were suffering from *Suem Sao* (Depression) to being diagnosed with *Rok Suem Sao* (Major Depressive Disorder). Through ethnographic interviews, the research examined how cultural perceptions and societal stigma influenced the acceptance and internalization of their depression diagnosis and its social and personal consequences. Focusing on seven young adults, a complex interplay between culture and medical diagnosis was revealed. Firstly, pre-psychiatrization, participants generally accepted their psychiatric labels, often due to the perceived authority and credibility of professionals. Secondly, during psychiatrization, some participants felt dissatisfied with the treatment as doctors strongly relied on prescriptions and lacked communication skills, particularly incorporating inappropriate scenarios of Dhamma into the treatment or unintentionally gaslighting conversation. Thirdly, post-psychiatrization, this study documented the pervasive stigma associated with depression, which significantly impacts an individual's willingness to seek help, tell others, and their subsequent treatment experiences, such as discrimination, feelings of hiding, and burden from having depression, particularly in academic environments. Participants reported a range of responses to their diagnoses, from relief at having their feelings validated by doctors to continued struggles with accepting their condition amidst ongoing stigmatizations.

Keywords: *Thai mental health, depression, psychiatrization, subjectification, psychiatry*

Introduction

Suem Sao is a common term for sadness or depression in Thailand. This condition is becoming more recognizable as it becomes more visible on social media and talked about in public. Interestingly, many who experience depression in Thailand are young people. Despite its growing recognition, a significant gap remains in understanding how many young people seek therapy for depression or accept that they have depression. When symptoms persist and worsen, individuals may consult psychologists or psychiatrists for further investigation. If such symptoms continue for more than two weeks, medical standards classify this condition as a Major Depression Disorder (MDD).

Rok Suem Sao, is one of the most common psychiatric illnesses, with at least 1.5 million people aged 15 and above having been diagnosed with it in Thailand. This condition a significant cause of death among youths, and according to Mental Health Department data (Hfocus, 2023), the number of patients is increasing. For this reason, depression has become more talked about in Thai society than ever before. However, despite the increased discussion, depression is still not as accepted in society to a large extent. The media and society still frequently present or perceive a misrepresentation of depression as a disease experienced by people who are weak, seeking attention, or of bad character, leading to widespread stigmatization in the community. The problem with stigmatization is that many people who feel depressed do not want to see a doctor because they do not want society to judge them.

For these reasons, the researcher investigated the experience of how young MDD patients in Bangkok experienced a process of subjectification, and the ways in which they come to recognize and internalize their identity as someone who was clinically depressed. The underlying social implications in terms of accepting the given diagnosis, as well as the process of psychiatrization and its aftermath, were explored by employing a psychological/anthropological way of thinking along with ethnography, to capture the nuanced experiences of young individuals with depression in Bangkok.

The researcher believes that this qualitative approach was ideal for this topic since it allowed for an in-depth exploration of participants' personal and cultural narratives for both the subjectification and psychiatrization processes. Ethnographic interviews facilitated direct engagement in the participants' environments, providing insights into how cultural beliefs, stigma, and healthcare practices intersected with their lives. This method is particularly effective in understanding the subjective and complex nature of depression within a specific cultural context, making it an essential tool for this type of research.

The researcher aimed to identify a common pattern with the psychiatrization process in Thailand, and to answer some questions such as: Was it easy for respondents to accept that they were officially clinically depressed? What were their reactions? For the psychiatrization and its aftermath, what was their journey after receiving the MDD label? Did anything change in their lives? Their overall experiences after receiving such a diagnosis were voiced through ethnographic interviews.

Literature Review

This section begins with definitions of subjectification and psychiatrization.

For *Subjectification*, Foucault viewed it as the procedures by which subjects are led to become who they are. For him, subjects emerge in two interconnected ways: they are subject to, and subject themselves to rules; and determine who they are through their own free acts. He discusses these two senses of subject as "subject to someone else by control and dependence; and tied to his own identity by a conscience of self-knowledge" (Foucault, 1982, p. 331). His thinking about this evolved through a process of self-observation, self-analysis, self-interpretation, self-knowledge, and even self-empowerment. Subjectification "refers to the procedures by which the subject is led to observe himself, analyze himself, and recognize himself as a domain of possible knowledge…the way the subject experiences himself in a game of truth where he relates to himself" (Foucault, 1982). Thus, subjectification refers to how participants recognize, internalize, and adopt certain identities. In this paper, they took on and identified with the feelings and diagnosis of someone with Major Depression.

For *Psychiatrization*, Beeker and her colleagues (2021, p. 3) sought to understand the growing use of mental health services in societies around the world, calling this "a psychiatrization of society". They viewed psychiatrization as "a complex process of interaction between individuals, society and psychiatry through which psychiatric institutions, knowledge, and practices affect an increasing number of people, shape more and more areas of life, and further psychiatry's importance in society as a whole" (2021, p. 3). Psychiatrization can include the medicalization of behaviors and emotions in everyday life, as well as seeing a psychiatrist, (over)use of psychiatric treatments, and so on.

Previous research on depression in Thailand and Southeast Asia should also be noted. Kaewpila et al. (2020) studied the factors contributing to depression among Thai medical students, examining how institutional, cultural, and individual factors interacted to influence their mental health. In-depth interviews with medical students who had been identified through screening as experiencing moderate to severe depression gathered detailed insights into their personal and environmental challenges. These researchers found that a combination of high institutional demands, personal vulnerabilities, and inadequate support systems led to significant levels of stress and depression among these medical students. Their findings are useful for this study since they reveal that depression in Thailand, especially for young medical students, is still visible and complex.

Another larger scale study by Dessauvagie et al. (2021) involved a systematic review of six ASEAN countries—Cambodia, Laos, Malaysia, Myanmar, Thailand, and Vietnam–concerning depression. The results suggested a prevalence of mental health problems among university students as well as a lack of willingness to seek professional help. These findings are beneficial to this study since they provide a cultural background indicating low mental health literacy in ASEAN countries and potential stigmatization, which are significant barriers. This inspired the researcher to look at the problem of seeking professional help in Thailand, the pathway to psychiatrization among young individuals.

In the context of psychiatrization, Rose (2006) studied global trends of psychiatric diagnoses and treatments, as well as the social and ethical implications of such trends. He argued that psychiatric practice has widened, leading to the medicalization of many behaviors that might previously have been considered within the range of normal human experience. He argued that there has been an expansion in viewing personal and social problems through a medical lens, and increasing acceptance of psychiatric drugs as solutions for a wide array of issues. Thus, the researcher incorporated this notion into patient interviews to establish whether or not this is true for Thai society.

Whooley (2017) also discussed that the Diagnostic and Statistical Manual of Mental Disorders (DSM) has gone through many revisions yet failed to advance its scientific understanding of mental health conditions, often reflecting changes in social attitudes and politics rather than scientific discoveries. Whooley suggests that use of the DSM as a diagnostic tool perpetuates the professional power of psychiatrists by enabling them to define and control the mental health discourse. This power is not necessarily derived from a deep understanding of the disorders but rather from the ability to set the terms and standards by which mental health is understood and treated. Thus, diagnosis can also be used as a political tool to limit people. However, since Whooley's work was based in an American context, this study explored whether such labels can also be oppressive in the Thai context.

According to Horwitz and Wakefield (2023), the medical model treats depression as a disease with specific symptoms and biological causes that often require pharmaceutical interventions. Social model thinkers, on the other hand, posit that depression originates from external stressors, events, and experiences; hence depression should be treated by considering social and environmental factors as well. These authors also suggest that treatments should be tailored and might often include social interventions rather than only medical ones. Since depression can be viewed not only from the medical side, but also from the social side, the main focus of this current research project was to investigate the experience and consequences of depression from a social perspective.

The book entitled *Culture and Depression: Studies in the Anthropology and Cross-Cultural Psychiatry of Affect and Disorder* (1985), combines depression with anthropological fieldwork. It argued that depression is not universal but differs according to culture. This variation extends to symptoms, diagnosis, and treatment practices. The book also advocated the integration of anthropology, psychology, and psychiatry to develop a more nuanced understanding of depression that respects cultural differences and incorporates them into practice and research. Many contributors to this book had investigated depression in various cultures, thus inspiring the researcher to investigate the processes of subjectification and psychiatrization in Thailand.

Methodology

The researcher conducted semi-structured interviews with seven individuals currently diagnosed with MDD. The recruitment process initially identified 11 potential participants; however, the inclusion criteria necessitated a diagnosis of MDD, leading to the disqualification of two participants. Furthermore, one participant voluntarily withdrew from the study, citing concerns that the interview process might evoke traumatic memories. Another participant was excluded due to a personal situation that led to emotional instability; this decision was taken as a precautionary measure to allow the participant time for self-healing and to prevent potential mental health damage. Consequently, the final participant cohort comprised seven individuals, six of whom were female, and one was male.

Prior to the interviews, all participants were required to submit documentation or verification of their current symptoms to ascertain their mental health status. This preliminary step ensured that participants were in a suitable condition to engage in the interview process, safeguarding their well-being throughout the study.

The study participants mostly consisted of individuals with whom the author had been acquainted during a period of admission to a psychiatric ward. Some were selected using a snowball technique, with one participant guiding the researcher to meet friends who suffered from the same condition. Interview duration varied, ranging from approximately 45 to 80 minutes. Most participants were higher education students, mostly undergraduates, with some recent graduates. Interviews were conducted both in-person and online via Zoom, according to participant availability.

Questions were asked in two major stages: 1: Examining the Process of Subjectification, consisting of four sub-thematic questions, and 2: Examining the Consequences of Receiving a Diagnosis/Label, also consisting of four sub-thematic questions. In the first stage of the interview, the researcher asked the participants about the starting point at which they recognized their depressed emotions *(Suem Sao)*. They were also asked how they handled their feelings at that time, leading them to see a psychiatrist for official support, as well as their reaction when diagnosed with MDD. The participants' responses allowed the researcher to learn about their subjectification process. For the second stage of the interview, the researcher asked the participants about their psychiatrization experience and the consequences of receiving a diagnosis that might impact both personal and social aspects.

At the outset of the interview, the researcher commenced the session by engaging in a discussion centered around the participant's daily life, serving as a preliminary exercise to create a conducive atmosphere for dialogue. This approach subsequently facilitated a seamless transition to the first thematic question. Depending on the appropriateness of the context, additional sub-questions were posed to elucidate further insights. Considering the privacy of the participants, no audio or visual recordings were made during the interview sessions. However, the researcher carefully documented significant details in Thai. These notes were subsequently translated and summarized into English to enable a comprehensive analysis of the data. The analytical process focused on distilling key ideas expressed by participants in relation to the thematic questions and theoretical framework.

For the framework of this project, the researcher primarily used the Top-Down and Bottom-Up concepts proposed by Beeker et al. (2021) in their work entitled *Psychiatrization of Society: A Conceptual Framework and Call for Transdisciplinary Research*. These authors suggested that psychiatrization is a complex process that involves the interaction between individuals, society, and psychiatry itself. In order to understand this phenomenon, the traditional top-down approach might be outdated. Instead, a combination of both top-down—an institute that seeks to diagnose patients—and bottom-up—patients who want their condition to be confirmed by doctors—should be considered for a more comprehensive interactive process. This framework can be used to better understand why patients have such reactions when realizing their depression, allowing for a clearer understanding of how young people in Bangkok experience subjectification and psychiatrization in a more interdisciplinary way.

Results

Information about the seven participants is shown below in Table 1.

Table 1 *Participant Demographic Profiles*

Case	Sex	Age	Birthplace	Occupation	Current Diagnosis	Current Condition
Case #1	Female	26	Nakhon Pathom	Employee	MDD, PTSD	Worse
Case #2	Female	23	Nakhon Nayok	Student	MDD, PTSD, Panic Attack, ADHD	Getting Better
Case #3	Female	26	Lopburi	Legal Officer	MDD	Getting Better
Case #4	Female	25	Samut Sakorn	Student	MDD	Getting Better
Case #5	Male	32	Nonthaburi	Lecturer	MDD, ADHD	Getting Better
Case #6	Female	23	Buriram	Student	MDD	Worse
Case #7	Female	21	Bangkok	Student	MDD, Anxiety	Getting Better

Pre-Psychiatrization: Process of Receiving a Diagnosis and Subjectification

In all seven cases, the research participants developed depressive symptoms during childhood or in adolescence. In some cases, there might also be an underlying genetic relationship. The depressive symptoms *(Suem Sao)* among research participants varied, but overall, the issues can be broadly summarized into the following major themes: academics, being bullied, family and relationships, and possibly genetics. Despite the variety of causes, the factors that led research participants to decide to see a psychiatrist may be divided into two categories: 1) deciding to go by themselves; and 2) being observed by others, leading them to seek medical help.

Firstly, only one participant decided to go to a psychiatrist on her own. Participant #6 told her mother that she felt like she was experiencing stress, but her mother dismissed it as normal teenage behavior. She then researched depression on the Internet, including hospital websites and patient experience videos. Feeling that the symptoms fitted hers, she asked her mother to take her to the doctor and eventually learned that her condition was not just stress but clinical depression.

Secondly, the other participants reported that they did not initially decide to see a psychiatrist, but others who had observed them suggested they seek professional help. For example, Participant #1 was approached by a teacher about self-inflicted injuries, which made her consider seeing a psychiatrist. Participant #2 was approached by a primary school teacher to whom she was close, who noticed her deteriorating condition and suggested she see a doctor. Participants #3 and #7 had similar situations, being approached by friends who already suffered from depression and saw their similar symptoms. Participant #4 was influenced by her mother, who had previously suffered from depression, and noticing her symptoms, urged her to go to the hospital. Participant #5 decided to seek help after consulting with a psychologist and realizing his condition was more than just normal stress.

It is particularly interesting that the nature of depression is often initially misunderstood as being merely stress, leading many people to delay seeking medical help unless someone observes and recognizes their abnormal symptoms. This is troubling, since it may delay a diagnosis of depression until it may be too late for effective treatment.

In terms of subjectification, after participants realized their abnormal emotions, many still doubted their condition. It should be noted that despite consulting those around them, some participants did not embrace their diagnosis. As a result, they considered their abnormality to be stress or sometimes craziness instead, as reported by one of the participants (Participant #6), who said, “Am I going to be insane?” This reflects that becoming “depressed” is identified as being undesirable.

When asked about their feelings upon being diagnosed with depression, Participants #1 and #2 did not initially believe the diagnosis until seeing the official medical certificate, only then accepting that they were truly suffering from depression. Participant #3 mentioned that she was not particularly concerned or shocked by the diagnosis; she simply wanted to recover and sought help from her doctor. Participant #4 expressed a desire to understand exactly what was wrong with her and emphasized the importance of a correct diagnosis by the doctor. She finally accepted her condition of depression, comparing it to a mountain being lifted off her chest because she finally knew what was wrong with her. This case reflects the significant power of medical confirmation for patients who feel hopeless and lost regarding their condition. Participant #5 reported feeling unsurprised by his diagnosis because he had been through considerable difficulties, so he accepted the doctor’s diagnosis readily. Participant #6 was shocked to learn of her condition and did not want to acknowledge it. She clearly expressed her concerns about being diagnosed with depression due to its social stigma, being perceived as a condition of those with “bad character/personality.” Nevertheless, she did not deny it, even stating, “I unfortunately got Major Depression,” and emphasized that knowing helped in getting timely and accurate treatment. Finally, Participant #7 accepted that she had depression even before the doctor confirmed it because she had already started self-harming. She had checked her symptoms online and knew they matched those of depression, so the diagnosis did not surprise her.

It can be concluded that each of the participants had a different subjectification process when diagnosed, but overall, they did not find it difficult to accept that they were clinically depressed. Some immediately accepted their illness when told by a doctor, while others did when they saw concrete evidence, like a medical certificate. However, due to the participants' backgrounds, many initially doubted their own abnormal emotions. Visiting a doctor served as both social confirmation and solidification of their identity as someone genuinely ill. Interestingly, it was difficult for patients to resist this diagnosis because it came from a medical authority that appeared rational and trustworthy, while the severity of many participants' conditions meant that immediate medical attention was required. Thus, it can also be concluded that most participants did not develop subjectification themselves, but rather by confirmation from a doctor. While not embracing it entirely, they unwillingly accepted it due to their deteriorating health conditions, reflecting their belief that MDD has never been perceived as an ordinary illness, but a peculiar condition.

On the one hand, this aligns with the idea of subjectification from Foucault (1982, p. 778), who proposed that a human becomes a "subject" from institutional practices, particularly the "dividing practice," which separates the healthy from the sick. Thus in this case, many participants–along with society–have internalized the concept of dividing practice, resulting in them partially embracing it while also wanting confirmation from a psychiatric institution with the power to guide their "lost" feelings at the time. On the other hand, there is a normalization of stress rather than recognizing it as a problem. This may be why many participants become so used to being sad that they became numb to their feelings and tend to avoid seeing a doctor; since they had already normalized these feelings, they no longer recognized them as being abnormal unless told by others.

Psychiatrization: Process of Treatment

After research participants were officially diagnosed with depression *(Rok Suem Sao),* treatment that involved taking medication prescribed by a psychiatrist started. Participants' experience in seeking medical help varied, as highlighted in the following.

After being diagnosed with depression, Participant #1 began to understand her behavior better, realizing it stemmed from an imbalance of chemicals in her brain. After receiving a medical certificate diagnosing her with depression and taking medication for a while, she truly accepted she was suffering from the condition. She described her experience at a particular hospital as somewhat unsatisfactory. After graduating from university, she had to switch hospitals. She recounted an interaction with a doctor at the new hospital, who inappropriately joked, "Don't commit suicide, because if you do, it would be the doctor's fault," which she felt was an entirely unacceptable comment. The doctor suggested she make merit, which made her unsure whether she was dealing with a medical doctor or a fortune teller. The researcher viewed this as a maladaptive attempt to relate to the patient in a way that could negatively affect her due to gaslighting, reflecting the doctor's lack of communication skills. Furthermore, the doctor suggested cultural activities like making merit, which could dangerously stigmatize the patient by suggesting that she was sinful or that her condition was due to sin, worsening her depression and self-image. In the worst-case scenario, if a patient decided to commit suicide to escape these imposed feelings of guilt, it would clearly be seen as inappropriate advice for someone with depression. From the patient's perspective, seeking a doctor's help means that one can't find a solution, yet is judged and advised to make merit instead of receiving proper treatment.

Similarly, Participant #2 shared that after being diagnosed her with depression, she initially refused to accept the diagnosis, feeling 50/50 about it. However, she eventually accepted it when seeing it officially written on her medical certificate. She described her treatment process as strange. Like most patients, initially she was prescribed medication, but struggled with side effects at first. Interestingly, similar to the case of Participant #1, Participant #2 mentioned that her doctor suggested she listen to life coaches, chant prayers, become a monk, and listen to Dharma teachings, with which she disagreed. Participant #2 felt that despite the doctor offering many options, it seemed like a covert way of pressuring her to follow them. This could be seen as a healthcare worker taking a position of authority by dictating the treatment (Beeker et al., 2021; Rose, 2007). She disagreed with the doctor's approach, viewing life coaching as nonsensical and deceitful. At that time, many scandals and news stories on life coaches supported her view. This example reflected how doctors may try to adapt their practice to current situations, although sometimes this be inappropriate. The researcher noted that doctors need better critical thinking skills, enabling them to discern how best to communicate with patients to avoid misunderstandings. Moreover, Participant #2 shared that once she began going to see the doctor, she felt that the number of diagnoses kept increasing. Initially diagnosed with depression, she was later diagnosed with additional conditions such as PTSD, ADHD, and anxiety disorder, which she found intriguing. The researcher viewed these additional diagnoses as a deeper dimension of psychiatrization, with the participant being viewed as the doctor's customer.

After being diagnosed with depression in England and having taken basic medication for a while, Participant #5 was ready to return to Thailand, and thus permanently discontinued his treatment in England. He began treatment at a university hospital in Thailand, where he started his second degree. He shared that the difference between the treatment experiences in Thailand and England was the amount of time the psychiatrists had to offer. In England, even though he did not see a specialist psychiatrist but a general practitioner, he felt like someone was listening to him. He emphasized that part of his positive response might be due to his good experiences in England, where the university's psychology team would inquire and ask questions that encouraged self-reflection. He felt he gained something from each session, and importantly emphasized that the treatment team's communication style in England seemed more empathetic. Although he did not say it was bad in Thailand, he felt that the doctors did not have sufficient time for patients due to high patient volume, leading to less communication. It seemed that treatment from the Thai doctors focused more on prescribing medications than healing minds. When asked how the psychiatrist could help, sometimes he could not answer because he felt at a loss, too, leading to conversations that ended abruptly. This is another case reflecting communication problems with doctors in Thailand. Focusing solely on medication while ignoring basic human factors like communication, which is also a tool for helping patients, may lead to unresolved issues.

The remaining participants mostly mentioned suffering from side effects of medication when entering the prescribed treatment procedure. One participant (Participant #6) mentioned that she behaved more politely because she did not want others to view her as being troublesome for having clinical depression. This reflected that stigmatization had a considerable impact on her identity, and psychiatrization has somehow shaped how she should behave (as discussed in the next section).

Overall, the main theme arising from the process of treatment and psychiatrization experienced by the seven participants was the heavy dependency on psychotropic prescriptions from psychiatrists and a lack of proper communication from the doctors. Two sub-concerns, therefore, emerged: localization of practice, such as recommending that patients listen to Dhamma, and inappropriate communication, such as (unintentional) gaslighting from the doctor, both of which can cause serious harm to patients. These issues reflect the necessity for additional communication skills training for doctors, both culturally and strategically.

Post-Psychiatrization or Post-Diagnosis: Stigmatization at the Social and Personal Level

The study participants shared both the positive and negative social and personal impacts that they experienced after being diagnosed with depression (stigmatization). Interestingly, before asking this question, the interviewer enquired whether the participant had told anybody about their sickness or emotions. Many participants reported that they did not tell anybody, choosing to hide their depression from those around them. The interviews revealed that all seven participants opted to conceal their condition in some way. Some chose to inform only their families, while others, due to family issues, confided in a few friends or a partner.

Participant #3 shared that she was afraid to tell her family due to fear of being judged as an adult; she worried they would not understand the gravity of her situation. Instead, she chose to confide in her friends, who became concerned and ultimately helped her to seek medical attention. Alternatively, Participant #6 decided to tell her mother because of their close and trusting relationship, which made her feel comfortable enough to share. These cases reflect how family relationships played a crucial role in the participants' decisions with whom they chose to share their feelings and emotional state with at the time. In addition, due to the potential stigma of telling others about their depression, many participants foresaw a negative outcome, which prevented them from disclosing such concerns.

Many participants shared their experiences after receiving a diagnosis and the many ways, both socially and personally, that it affected their lives. While a mixture of positive and negative impacts were seen, the negative effects seemed to be more pronounced. The following four cases are of particular interest.

Participant #7 shared that after being diagnosed with depression, she felt it allowed her to see her own worth more clearly and connect with others who also suffered from depression, providing a chance to re-evaluate herself. However, some aspects were not so positive, especially regarding her friends. Her friends noticed a decline in her work performance, began to find her annoying, and saw her as a burden to the team; they did not understand her at all. Initially, her mother did not understand either, even accusing her of wanting to be depressed. However, after realizing the severity of her condition, her mother tried to adjust and learn more about it, while her siblings started to communicate better with her. Her university professors and the department staff also began to provide more support and care. She believes that people became more empathetic toward her after they understood the difficulties she faced due to depression. However, this is merely the positive feedback shared by the participant; she also recounted quite a few negative experiences, particularly with her friends, reflecting a similar pattern also observed in other research participants.

Participant #4 shared that after receiving her diagnosis, she had more direction and knew what to do. She did not feel like a burden, but was concerned because her mother was very worried about her becoming a burden. However, she realized that after being diagnosed with depression, she was treated differently in a way she did not like, and just wanted people to understand what she had been through. Nevertheless, not everyone empathizes with those who are depressed or understands what they are going through. As her condition worsened, she decided to tell a small group of friends. She had to undergo Electroconvulsive Therapy treatment, which caused her to lose some skills when returning to her studies, making it difficult for her to perform as well as before. She had to ask professors for recorded lectures and watch video clips repeatedly because she could not grasp the lessons. However, her peers in the class were displeased, thinking she was receiving preferential treatment. She shared that her friends accused her of exploiting her depression for personal gain, which hurt her deeply, making her regret sharing her condition with them since it led to gossip. Additionally, some professors were completely unaware of the realities of depression; she mentioned that one professor showed no empathy toward her at all. Ultimately, she felt good about having a clear diagnosis of depression, but also despised the other aspects, knowing that the term "depression" could also imply that she was a social outcast, a drag, or a burden to society who needed looking after.

Similarly, Participant #2 shared that at first she had not told anyone outside her family about her depression. However, she needed to inform the head of her department about her illness, which led to her peers becoming aware of her depression even though she did not want anyone to know for fear of being judged. After being diagnosed with depression, she felt worse about herself, as if she was a burden to her family and friends who had to deal with her mood changes. She also mentioned significant side effects from her medication, which caused her to gain weight. However, she jokingly said that at least depression taught her not to trust people easily, which she saw as a double-edged sword. She also shared similar experiences to those of Participant #4 about her education, saying that she was gossiped about because her peers thought that being depressed meant getting special treatment from professors. In reality, she did not want any special privileges; she just wanted to complete her studies like everyone else.

Participant #5 felt bad about himself because he felt like a burden. He also mentioned that when he became depressed, his friends gradually started to disappear. He was the oldest participant in the group being studied, so his experience with depression did not coincide with those of other participants. He had been suffering from depression since 2018, a time when there may have been less awareness about mental health in Thailand. He emphasized that this period was particularly difficult compared to the present, when more empathy exists toward such conditions. The direct social impact that he experienced after diagnosis was non-acceptance from his family. At that time, having depression was equated to being suicidal—it was not considered normal. Those labeled as depressed were seen as people who could never be happy, leading to suppression because parents would prohibit them from posting about sadness, expressing it, or showing any signs of wanting to end their lives, making it confusing for them to determine whether this was beneficial or detrimental. On the one hand, it could be seen as concern, while on the other, the significant stigma attached to depression by society meant that his parents did not want him to be associated with the disease.

After being diagnosed with depression, patterns observed among the research participants can be divided into personal and social impacts, with the general experience in Thai society being quite negative. On a personal level, some participants felt they had become a burden, while others did not see themselves as such. However, a significant number clearly felt like a burden and internalized the concept of stigma in some way. Historically in Thai society, depression was seen as a disease experienced by people who are unhappy with life and likely to eventually commit suicide, while in contemporary times, it has become viewed as a disease experienced by people who are likely to create a burden for others. However, many participants do not want to burden anyone, demonstrating that individuals with depression tend to be concerned about how others perceive them because they do not want to be seen as burdensome. Furthermore, having depression also changes self-perception, both positively and negatively, such as becoming more cautious in friendships due to experiences of betrayal or becoming more self-reflective.

On a social level, research participants reported that those around them had negative perceptions of depression. A clear stigmatization of depression exists in Thai society, especially in academic institutions like universities or schools, which are not safe spaces for students with depression. There is a perception that those who are depressed receive more privileges, leading to biases that may not reflect reality, but arise from the competitive nature of academic environments. This diminishes empathy toward those with depression and reinforces the stigma that depression in Thai society is not just about weakness, but also about being a burden. This leads people who do not understand depression to believe that those who are weak receive special privileges when–in fact–patients do not desire special treatment, but only fair support to avoid being a burden to anyone. Patients already bear the weight of self-stigmatization. Depression is almost seen as a despicable disease among teenagers in competitive university environments, where peers view those experiencing it as a drag on the group. As such, they need special help. However, people with depression do not want special treatment; they just need understanding. Moreover, interviews revealed that people surrounding the research participants generally lacked understanding or awareness about mental health, which could be why misconceptions and stigmatization still occur. Of particular concern is that university society is highly competitive, and individuals forget to practice empathy toward each other, viewing illness into a matter of attention seeking. Thus, it is important to focus on raising awareness about depression before society misinterprets it further, causing more people to suffer from its social impacts.

Psychiatrization Process in Thailand

In the end, the complex subjectification and psychiatrization processes of depression among young people in Bangkok can be divided into three phases.

In terms of subjectification and pre-psychiatrization, the study examined how participants initially recognized their depressive symptoms and the pathways to seeking psychiatric help. The findings suggested that many participants would only visit a psychiatrist if encouraged to seek help by someone close to them who noticed their distress. Furthermore, after being labeled clinically depressed, they had mixed feelings about accepting it, implying that the stigma associated with mental illness in Thai culture played a significant role in their hesitation to embrace the diagnosis.

The psychiatrization stage covers the experiences of participants receiving and reacting to medical treatment for depression. During the interviews, participants reported varied experiences with psychiatric treatment and doctor interaction, with some expressing dissatisfaction with a purely medical approach, which often failed to consider a patient's cultural context.

During the post-psychiatrization (post-diagnosis) stage, various social and personal consequences after receiving treatment were discussed. These included the social impact experienced by participants, such as the significant social stigma associated with being labeled as someone suffering from depression, affecting their relationships and social interactions. Many opted to hide their diagnosis from others outside of their immediate families or close friends. As for personal impact, the diagnosis of depression had mixed impacts on participants' self-perception. Some felt more understood and supported, while others felt more isolated and stigmatized.

Discussion

Studying the experiences of depressed young adults in Bangkok has helped to clarify how young people internalize cultural stigma and acceptance of psychiatric labels. In this section, similarities and differences in this study's results are compared to those of other scholars, and the limitations and potential development of this research are discussed.

Firstly, the phenomenon experienced by the interviewed group was that they did not want to seek help or tell others about their condition in the beginning unless it was necessary. This study suggested that most participants somehow concealed their symptoms from their social circles and did not initially visit the doctor on their own. In other words, most only decided to see a psychiatrist due to the worsening of their condition and the influence of others. Many also ignored the condition, saying that it was just normal stress and they could cope. This situation is similar to a study in Catalonia by Martínez-Hernáez et al. (2014), who suggested that many young individuals perceived their mental health issues as manageable without professional intervention, choosing instead to rely on personal coping mechanisms. However, it is important to note that a major difference between the two papers might be due to the cultural context. While Martínez-Hernáez et al. (2014) suggested that stigma and accessibility issues were significant barriers, this study implies that collectivist cultural and social pressures from family and society in general perpetuate social stigma.

Secondly, it is worth noting how the participants accepted psychiatric labels and went along with them, without doubting the diagnosis. This contrasted with the research conducted in Sweden by Lindholm and Wickström (2020), who suggested that young people in Sweden did not simply accept psychiatric labels as fixed or unchangeable. Instead, they actively engaged with these labels, often redefining or transforming their meanings. They borrowed the term "Looping Effects" from Hacking (2004, p. 279) that suggests that classifications not only categorize individuals, but also affect them—people change in response to being classified. These changes can then lead to modifications in the classifications themselves, a process referred to as looping effects. However, possibly due to cultural differences, looping effects did not occur in the Thai context, but in fact, participants seemed to internalize and passively accept labels from psychiatrists. This reveals that medical rhetoric is still effective in Thai society, and is aligned with Rose (2007), who argued that biomedical powers, including psychiatry, have extended their reach into almost every aspect of human life. This could explain why patients did not contest psychiatric labels, seeing them through the lens of Foucauldian biopower and the formation of subjectivities.

Thirdly, despite being a small element of the research, it is interesting that psychotropic medicines are still utilized as a primary way to treat depression, rather than considering the social perspective. This was aligned with Rose (2006), who argued against the overuse of psychiatric medicine in mental health. Notably, some participants reported during the interviews that psychiatrists did not have time for them, merely asking about the medication, which made them feel like talking to a robot pharmacist rather than a psychiatrist willing to listen. This potentially suggests that Thai doctors do not really have time for patients due to their workloads and systems.

Lastly, comparing the findings of this study to similar research on the experiences of depressed patients, Martin and Atkinson (2020) revealed that UK students felt disengagement and isolation as depression took hold, describing it as "The weariness of the world was upon me," and "It all fell down to chance." This present study also implied the same, in that many participants also experienced loneliness. Interestingly, they experienced isolation due to ostracism from university friends who internalized negative concepts of depression and judged them, reinforcing their depressive symptoms. However, unlike participants in Martin and Atkinson's (2020) study, who reported significant barriers to accessing mental health services, the findings of this present study suggested a different dynamic. In Bangkok, the authority of medical professionals often led to a quicker acceptance of psychiatric labels, potentially influencing the speed and manner in which students seek help. This difference might be attributed to cultural variations in the perception of mental health and figures in authority, as well as the availability and societal acceptance of mental health services.

This research study had several limitations. Firstly, the sample was small and not representative of the population of Bangkok. Furthermore, the participants were university students, whose way of life or immediate priorities in life may be different from other groups of people. Another limitation may be that the participants of this study were already acquainted with the researcher, which may deemed unprofessional; nonetheless, the participants were able to provide a very insightful and deep understanding of their lived experiences since they trusted the researcher. For further studies on this topic, participants may be recruited directly from hospitals to enable a larger sample. Furthermore, research needs to be conducted systematically over a longer period. It is hoped that greater attention will be given to psychiatrization and psychological anthropology to shed more light on the lived experiences of patients suffering from stigmatization.

Conclusion

From its findings, this study revealed that acceptance and internalization of a depression diagnosis are deeply influenced by cultural perceptions, such as that of society toward mental health, which often results in societal stigma. Participants displayed varying degrees of readiness to accept their psychiatric labels. Most participants ultimately accepted them, often influenced by the authoritative status of medical professionals within the Thai culture. The findings also suggest that while psychiatrization helps frame and treat depression, it tends to overlook the patient's voice, experiences, and social situations. This leads them to be placed into fixed cultural and clinical categories that may not align with their cultural and personal narratives. In addition, many participants also reported inappropriate actions from doctors, which the researcher saw as an attempt at medical localization, a practice that is harmful rather than helpful. This misalignment highlights the need for a more culturally sensitive approach to the psychiatric treatment of depression in Thailand.

This research study offers valuable insights for psychiatrists by demonstrating the importance of understanding the cultural dimensions of diagnosing and treating depression among young people. It highlights discrepancies between patients' cultural identities and predominantly Western psychiatric models, along with the need to pay greater attention to the patient's voice and stressing the need for culturally sensitive mental health practices. Psychiatric professionals can utilize these insights to develop more culturally attuned communication strategies and treatment plans. Additionally, these professionals should be urged to consider the broader social and cultural narratives that shape patients' lives and their acceptance of and response to psychiatric diagnoses. Furthermore, this research offers a beneficial insight into the difficulties faced by university students suffering from MDD. This study can be used to adapt a policy for universities or other educational institutions to help students better understand their struggles.

Since this research was conducted in an academic environment, promotion of a more human-centered mental health curriculum in education institutions is suggested. This could prevent unnecessary stress and competition, significantly reducing stigma and promoting more empathy. Furthermore, this study advocates that current psychiatric practices in Thailand be adapted to better integrate with Thai cultural contexts, such as by enhancing doctors' communication and empathetic skills. The society also needs increased mental health awareness to foster more empathetic understanding and decrease discrimination toward illness and disability. Initiatives could include community outreach programs to educate the public about mental health, cultural competence training for healthcare providers, and development of advocacy programs involving patients and community leaders. Such efforts could help to create a supportive environment that encourages individuals to seek help without fear of judgment or discrimination.

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