Tohpaeroh, M. et al. (2024)
Jurnal Keperawatan Soedirman – Vol 20, No 1 page 16-25
http://jos.unsoed.ac.id/index.php/jks/index

ORIGINAL ARTICLE

PREVALENCE AND PROTECTIVE FACTORS AGAINST DEPRESSION AMONG ADOLESCENTS IN THREE SOUTHERN BORDER PROVINCES OF THAILAND

Muslin Tohpaeroh[1]*, Benjawan Saetung[2], Latifah Jehloh[1], Sarinee Sawan[3]

1. Faculty of Nursing, Princess of Naradhiwas University,Thailand
2. Naradhiwas Rajanagarindra Hospital,Thailand
3. Faculty of Nursing, Prince of Songkla University,Pattani Campus,Thailand

Article Information
Received: 26 March 2024
Revised: 16 October 2024
Accepted: 18 Februari 2025

*Corresponding Author
Muslin Tohpaeroh
muslin.t@pnu.ac.th

DOI
10.20884/1.jks.2025.20.1.11684

ABSTRACT

Depression in adolescents is a significant public health issue because adolescents are the age group that most often engage in self-harm. Thus, it is crucial to study the protective factors against depression that integrate internal and external factors. This study aimed to determine the prevalence and examine the protective factors against depression among adolescents in southern Thailand. This study used a descriptive-predictive research design. A total of 440 high school students served as the study's samples. They were selected using purposive sampling techniques with a multistage sampling procedure. Data were analyzed using ordered logistic regression analysis. The results showed that 66.4% of the sample had depression, with most of the students having mild depression at 46.8%. Seven protective factors were found to prevent depression in adolescents. Adolescents who have healthy family relationships and moderate spiritual well-being, in terms of existential well-being, were 16.28 and 0.73 times less likely to have depression, respectively. Meanwhile, adolescents with low levels of psychological immunity in optimism, low and moderate levels of apperception, lack of belief in the power of wisdom and low support from the community, and low and moderate levels of spiritual and religious well-being were more likely to have depression.

Keywords: *Adolescents; depression; protective factors*

ISSN : 1907-6637 **e-ISSN : 2579-9320**

BACKGROUND

Adolescent depression is a serious and multifaceted mental health problem affecting Thai adolescents. It impacts adolescents, families, societies, and the nation, resulting in a reduced quality of life and a burdened society (Kongsuk et al., 2014). In Thailand, depression is a major public health problem because of its high severity and suicide risk compared to other mental illnesses (Lotrakul & Sukanich, 2015). According to the report on the burden of disease and injury in the Thai population in 2019, the second leading cause of disability-adjusted life years (DALY) in males aged 15-29 years was self-harm, which accounted for 7.0%. This age group also had the highest number of DALY from self-harm among all age groups. In women, depression was found to be the third leading cause of DALY at 5.5 % (International Health Policy Program, 2023), which is consistent with the Mental Health Situation Report in Thailand stating that 53,000 people attempt self-harm annually to commit suicide, with an average of six people per hour, of which 4,000 people succeed. Such statistics resulted in 400-million-baht annual losses (Department of Mental Health, 2019). Thus, depression is a psychiatric disorder that impairs quality of life, raises mortality rates, and increases a country's economic burden. The disorder decreases a person's capacity to work or learn and impedes social and familial interactions (Løvgren et al., 2019; Salk et al., 2016; Verboom et al., 2014). Therefore, it is critical to study the associated factors affecting depression in adolescents to reduce its prevalence and impact.

Adolescent depression and its related factors have been studied in various fields and groups in almost every region of Thailand. The results of such studies have been published in numerous literature reviews in the past ten years. According to studies conducted in adolescent groups of university students, the prevalence of depression ranges from 3.8% to 69.3%. However, research on the factors influencing depression in adolescents has varied results. Such factors

can be classified into internal and external factors. Internal factors include gender, life strength (Laksaneeyanawin & Wattanaburanon, 2022), self-esteem (Moonsorn, 2022), stress (Surawan, 2021), spiritual intelligence (Seangsanaoh et al., 2017), rumination (Suttineam & Suttineam, 2020), history of suicide attempt (Jiamjaroenkul & Limsuwan, 2015), coping with stress by focusing on managing problems using one's abilities, avoidant coping and anti-drug willpower, poor health status (Uthis et al., 2018), body image dissa tisfaction (Surawan, 2021), history of substance abuse (Uthis et al., 2018) and history of being a victim of sexual harassment (Surawan, 2021). Meanwhile, external factors include the death of a parent (Sangkool & Mosikanon, 2016), negative life events (Suttineam & Suttineam, 2020), low academic results (Anantaseriwidhya Punyapas, & Hosiriet, 2021), financial problems (Sangkool & Mosikanon, 2016), lack of life assets (Suntornvijitr et al., 2018), parenting styles (Worasan, 2015), family strength (Uthis et al., 2018), family relationships, family attachments and close peer attachments (Kongprapun, 2020), socio-demographic support (Suntornvijitr et al., 2018), bullying (Moonsorn, 2022), pranking (Anantaseriwidhya et al., 2021), participation in physical activities (Samarksavee & Sangon, 2015), sexual relationships (Pandii, 2015), internet addiction (Laksaneeyanawin & Wattanaburanon, 2022), social support from teachers, family, and friends (Anantaseriwidhya et al., 2021), and positive psychological capital (Suttineam & Suttineam, 2020). Nevertheless, these research results are influenced by the characteristics of each region, including social, cultural, and environmental contexts.

This research acknowledges the significance of both internal and external factors as "protective factors." There has been no comprehensive study on protective factors against depression among Thai adolescents that considers internal, psychosocial, spiritual, and cultural influences. A study conducted in 2016 in three southern border provinces of Thailand investigated adolescents who were dealing with violent incidents. The study found that 23.3% of adolescents experienced depression, which was negatively correlated with life strength (Suksri et al., 2016). The results may have been influenced by the political unrest in the three border provinces in Thailand, which occurred for over two decades. In addition, the outbreak of COVID-19 in the last 4 years has adversely affected people's economic, social, and mental conditions. Therefore, the researcher aimed to investigate the prevalence and effects of protective factors, including family relationships, life assets, psychological immunity, and spiritual well-being, on adolescent depression in the three southern border provinces of Thailand. The research findings on protective factors may help reduce the occurrence of depression. This information can also be used to plan preventive activities for depression among adolescents in the three southern border provinces of Thailand.

METHOD

Study Design

This study used a descriptive-predictive research design. The descriptive research aspect was employed to determine the prevalence of depression in adolescents. Meanwhile, predictive research was used to forecast the protective factors against depression among adolescents, employing a cross-sectional approach. This study was part of the research project entitled "Intra-individual and Sociocultural Factors Influencing the Happiness and Mental Health Problem in New Normal of Adolescents in the Three Southern Border Provinces of Thailand" (Tohpaeroh et al., 2022). The data were collected from October 2021 to December 2021.

Sample

The sample comprised female and male secondary or high school students (grade 7-12) studying in a school under the jurisdiction of the Secondary Education Area Office of District 15 (Yala, Pattani, and Narathiwat Provinces) and were selected by purposive sampling based on the following inclusion criteria: 1) age between 13-19 years old; 2) free from major illnesses like cancer, AIDS, or heart disease; 3) for adolescents under the age of 18, parental or guardian approval is required to participate in the research. The exclusion criteria were as follows: 1) a history of psychiatric illness diagnosed by a doctor, 2) a history of suicide attempts, and 3) a family history of depression. The G*Power tool was used to calculate the sample size for this study. Z tests were used to select the experimental group. Logistic regression statistics were identified, and the statistical significance level (α) was established at 0.05. Additionally, a power analysis was performed at 0.95. A sample size of 413 participants was used. Then, to prevent error and data loss, the researcher increased the sample by 5%. As a result, 440 adolescents were selected for the sample. The multi-stage sampling technique was employed in the first stage, starting with cluster sampling and dividing the sample into three groups by province (Narathiwat, Pattani, and Yala). In the second stage, simple random sampling without replacement was used to select large schools in each province. In the third stage, simple random sampling by drawing lots without replacement was used to select classes in grades 7-12 and collect data according to the number of students in the classrooms. The step-by-step sampling procedure is explained in Figure 1.

Instruments

The research instruments employed included demographic characteristics, the Thai version of the Patient Health Questionnaire for Adolescents (PHQ-A), and an instrument for assessing protective factors on adolescent depression. Demographic characteristics included gender, age, religion, family characteristics, parents' occupation, parents' marital status, parents' educational level, academic results, family income, and relationship with family members. The Thai version of PHQ-A assessed depression in adolescents aged 11-20 years was developed by Panyawong et al. (2018). The instrument is a self-report questionnaire containing nine items divided into five levels with 0-3 Likert scales. The scores are interpreted as no depression (scores of 0-4 points), mild depression (5-9 points), moderate depression (10-14 points), moderately severe depression (15-19 points), and severe depression (20-24 points). Meanwhile, the instruments for assessing protective factors on adolescent depression are as follows:

1. A life asset assessment form for Thai children and adolescents aged 12-25 years was developed by Tripathi (2009). The instrument consists of 48 positive questions, divided into five areas of power: power of self (15 items), power of family (8 items), power of peers and creative activity (6 items), power of wisdom (school) (11 items), and power of community (8 items). The questionnaires are ranked on a 4-point rating scale with scores of 0-3 points. The scores were interpreted after collecting the points on each indicator. Total scores of 60% are considered not to pass the criteria, 60-70% are classified as moderate, and scores exceeding 80% are considered very good.
2. A measure of adolescents' psychological immunity. This instrument is a multidimensional measure of immunity in students developed by Bhanthumnavin and Vanindananda (2008) based on McGuire's immunization theory. In this study, the researcher modified the instrument to make it suitable for adolescents in

Thailand's three southernmost border provinces by using straightforward and clear language appropriate for adolescents and considering the local context and culture. Nevertheless, the original message was maintained. An example was also included for better understanding. This instrument addresses adolescent students' current situation and activities in their daily lives and within their community.

3. Spiritual Well-being scale. This instrument was created by Paloutzian and Ellison (1982) and translated into Thai by Noipiang (2002). The researcher modified and adapted the questions about religious well-being to suit adolescents living in the three southern border provinces. Two dimensions of spiritual well-being are covered by 20 questions, comprising 10 questions on spiritual well-being regarding existential well-being and 10 on spiritual well-being regarding religious well-being; 9 questions in this assessment have negative meanings. The questionnaires are ranked on a 6-point rating scale with scores of 1-6 points. Interpretation of spiritual well-being scores in each dimension and overall is divided into low, moderate, and high levels.

Three experts tested the content validity of all the instruments. The Index of Item Objective Congruence (IOC) was between 0.92 and 1. The Cronbach's alpha coefficient was calculated to check the confidence of the PHQ-A, a life asset assessment form for Thai children and adolescents, measure of adolescents' psychological immunity, and Spiritual Well-being scale, which yielded scores of 0.85, 0.95, 0.87 and 0.80, respectively.

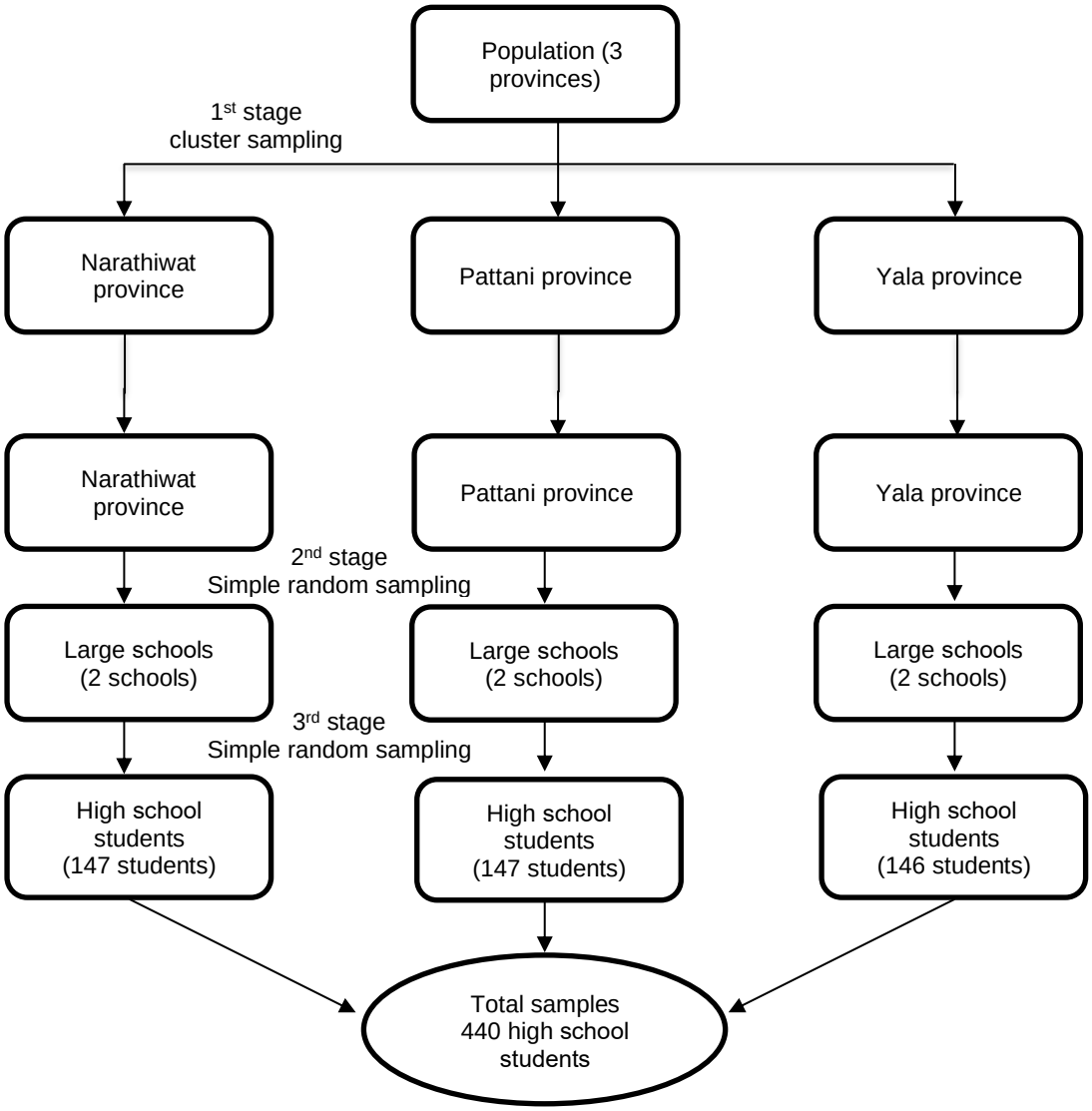

Figure 1. Step-by-step multi-stage sampling technique

Data Collection

After the research project was approved by the Human Research Ethics Committee of the Narathiwat Provincial Public Health Office, the researcher wrote to the directors of all three schools to clarify the research's purpose and ask for permission to collect data. Then, the researcher selected the respondents according to the specified qualifications and coordinated with the class teachers to arrange the date, time, and place to meet with the respondents to introduce the researchers, describe the purpose of the study, research procedures, and obtain the respondent's and their parent's consent to participate in the research for respondents under 18 years of age. Next, data was collected by asking respondents to sign the consent forms, distributing the research questionnaires, and arranging for the respondents to sit far enough apart. The researchers allowed the

respondents to ask questions about things they still did not understand and asked them to complete the questionnaire truthfully. After the respondents completed the research questionnaires, the researcher checked them for completeness before analyzing the data.

Data Analysis

The prevalence of depression in adolescents was analyzed using frequency, percentage, mean, and standard deviation. The prevalence of depression was determined using the cut-offs for PHQ-A as defined by Panyawong et al. (2018). The predictive power of protective factors on adolescent depression was analyzed using ordered logistic regression statistics. The dependent variables were converted into three values: 0 for no depression, 1 for mild depression, and 2 for moderate to severe depression. The assumption of ordered logistic regression was tested before analysis. The protective factors were then evaluated to determine if there was a significant relationship between the predictor variables and the odds of being in a particular category.

Ethical Considerations

This research project was approved by the Human Research Ethics Committee of the Narathiwat Provincial Public Health Office, Ministry of Public Health Certificate No. 15/2021. The researcher was mindful of respecting the privacy of the respondents who voluntarily participated in the study and their ability to withdraw from the research at any time without any impact. For participants under 18 years, the researcher asked their parents for written consent to participate. Data obtained from the participants were treated confidentially. The findings were presented as a whole, and all data will be destroyed within one year.

RESULTS

Most respondents were female (67%) with a mean age of 15.55 years, muslim (50%), lived in a nuclear family (58.6%), had fathers or mothers engaged in government service (36.7% and 31.4%, respectively), and had parents who were married and living together (73.6%). Most of the respondents' fathers' and mothers' had a bachelor's degree (33.4% and 45.7%, respectively), moderate academic results (50.5%), sufficient family income (84.5%), and healthy family relationships (84.1%) (**Table 1**).

1. Prevalence of adolescent depression: 66.4% of the sampled adolescents had depression, with most having mild depression at 46.8% (Mean = 6.60, S.D. = 4.31), followed by no depression at 33.6%, and moderate to severe depression at 19.6%. The moderate-severe level is a combination of 3 levels (moderate, moderate-severe, and severe).

Table 1. Demographic characteristics of adolescents based on depression level (n = 440)

Demographic characteristic	Depression level		
	None n (%)	Mild n (%)	Moderate - severe n (%)
Sex			
Male	54 (37.2)	71 (49.0)	20 (13.8)
Female	94 (31.9)	135 (45.8)	66 (22.4)
Family types			
Nuclear family	98 (37.12)	121 (45.83)	45 (17.05)
Extended family	39 (31.96)	61 (50.00)	22 (18.04)
Single parent family	11 (20.36)	24 (44.45)	19 (35.19)
Marital status			
Married and lived together	117 (36.1)	151 (46.6)	56 (17.3)
Separated	5 (27.8)	12 (66.7)	1 (5.6)
Divorced	15 (23.4)	30 (46.9)	19 (29.7)
Father died	9 (33.3)	10 (37.0)	8 (29.6)
Mother died	2 (28.6)	3 (42.9)	2 (28.6)
Family income			
Sufficient	133 (35.7)	175 (46.9)	65 (17.4)
Insufficient	9 (25.7)	16 (45.7)	10 (28.6)
Not interest	6 (18.8)	15 (46.9)	11 (34.4)
Academic results			
Good	85 (41.7)	88 (43.1)	31 (15.2)
Moderate	62 (27.9)	111 (50.0)	49 (22.1)
Poor	1 (7.1)	7 (50.0)	6 (42.9)

Based on Table 1, the adolescents in the three southern border provinces without depression were mostly males (37.2%) who lived in nuclear families (37.6%), had married parents who lived together (36.1%), had sufficient family income (35.7%), and had good academic performance (41.7%). Most of the adolescents in the respondents who had moderate to severe depression were females (22.4%) who lived in single-parent families (35.19%), had parents who were divorced (29.7%), had no interest in family income (34.4%), and poor academic results (42.9%).

2. Protective factors affecting adolescent depression in the three southern border provinces

Most adolescents without depression were found to have good family relationships (37.0%) and high psychological immunity, risk preference, consciousness, and coping strategies (62.3%, 40.3%, 67.1%, and 53.8%, respectively). The findings on life assets for all five powers were very good: the power of self (50.3%), power of the family (45.0%), power of peers and creative activity (50.4%), power of wisdom (school) (60.2%), and community power (57.9%). The adolescents' spiritual well-being in terms of existential well-being and religious well-being were also high (44.6% and 53.9%, respectively), as shown in **Table 2**. Conversely, the results showed that most adolescents with moderate-severe depression had poor family relationships with a low level of psychological immunity in all four dimensions. Their life assets also failed to meet the criteria in all five powers, and their spiritual well-being was low in both dimensions (**Table 2**).

Table 2. Protective factors adolescent depression based on depression level (n = 440)

Variable	Depression level			p-value
	none n (%)	mild n (%)	moderate – severe n (%)	
Family relationship level				
Good	137 (37.0)	172 (46.5)	61 (16.5)	0.000
Moderate	11 (15.9)	34 (49.3)	24 (34.8)	
Poor	0	0	1 (100)	
Psychological immunity				
Optimism level	6 (10.0)	28 (46.7)	26 (43.3)	0.000
Low	99 (31.8)	155 (49.8)	57 (18.3)	
Moderate	43 (62.3)	23 (33.3)	3 (4.3)	
High				
Risk preference level				
Low	16 (22.5)	38 (53.5)	17 (23.9)	0.238
Moderate	105 (34.8)	140 (46.4)	57 (18.9)	
High	27 (40.3)	28 (41.8)	12 (17.9)	
Consciousness level				
Low	9 (14.8)	21 (34.4)	31 (50.8)	0.000
Moderate	86 (28.7)	165 (55.0)	49 (16.3)	
High	53 (67.1)	20 (25.3)	6 (7.6)	
Coping strategies level				
Low	9 (20.5)	19 (43.2)	16 (36.4)	0.000
Moderate	104 (31.4)	163 (49.2)	64 (19.3)	
High	35 (53.8)	24 (36.9)	6 (9.2)	
Life assets				
Power of self				
Not pass criteria	11 (20.4)	26 (48.1)	17 (31.5)	0.000
Moderate	22 (21.2)	59 (56.7)	23 (22.1)	
Good	38 (29.5)	59 (45.7)	32 (24.8)	
Very good	77 (50.3)	62 (40.5)	14 (9.2)	
Power of the family				
Not pass criteria	14 (15.7)	39 (43.8)	36 (40.4)	0.000
Moderate	13 (21.3)	37 (60.7)	11 (18.0)	
Good	22 (31.4)	36 (51.4)	12 (17.1)	
Very good	99 (45.0)	94 (42.7)	27 (12.3)	
Power of peers and creative activity				
Not pass criteria	36 (24.2)	72 (48.3)	41 (27.5)	0.000
Moderate	27 (25.0)	61 (56.5)	20 (18.5)	
Good	25 (39.1)	26 (40.6)	13 (20.3)	
Very good	60 (50.4)	47 (39.5)	12 (10.1)	
Power of wisdom (school)				
Not pass criteria	31 (17.9)	84 (48.6)	58 (33.5)	0.000
Moderate	36 (31.0)	64 (55.2)	16 (13.8)	
Good	25 (43.1)	27 (46.6)	6 (10.3)	
Very good	56 (60.2)	31 (33.3)	6 (6.5)	
Power of community				
Not pass criteria	71 (25.6)	136 (49.1)	70 (25.3)	0.000
Moderate	20 (37.7)	27 (50.9)	6 (11.3)	
Good	13 (38.2)	16 (47.1)	5 (14.7)	
Very good	44 (57.9)	27 (35.5)	5 (6.6)	
Spiritual well-being				
Existential well-being level				
Low	9 (18.4)	24 (49.0)	16 (32.7)	0.010
Moderate	106 (33.4)	149 (47.0)	62 (19.6)	
High	33 (44.6)	33 (44.6)	8 (10.8)	
Religious well-being level				
Low	4 (10.3)	16 (41.0)	19 (48.7)	0.000
Moderate	103 (31.7)	158 (48.6)	64 (19.7)	
High	41 (53.9)	32 (42.1)	3 (3.9)	

Table 3. Results of the ordered logistic regression analysis

Variable	Estimate	Std. Error	Wald	df	Sig.	95% Confidence Interval	
						Lower	Upper
Family relationship (poor level[a])							
Good	-16.281	.296	3026.982	1	.000**	-16.861	-15.701
Moderate	-15.647	.000	.	1	.	-15.647	-15.647
Psychological immunity:							
Optimism (high level[a])							
Low	1.071	.498	4.621	1	.032*	.095	2.048
Moderate	.274	.360	.577	1	.448	-.432	.980
Risk preference (high level[a])							
Low	-.603	.407	2.196	1	.138	-1.400	.195
Moderate	-.437	.303	2.086	1	.149	-1.030	.156
Consciousness (high level[a])							
Low	2.355	.435	29.236	1	.000**	1.501	3.208
Moderate	1.190	.309	14.854	1	.000**	.585	1.796
Coping strategies (high level[a])							
Low	.720	.482	2.230	1	.135	-.225	1.664
Moderate	-.038	.343	.012	1	.912	-.710	.634
Life assets:							
Power of self (very good level[a])							
Not pass criteria	.233	.409	.326	1	.568	-.568	1.034
Moderate	.282	.321	.773	1	.379	-.347	.911
Good	.330	.288	1.310	1	.252	-.235	.894
Power of the family (very good level[a])							
Not pass criteria	.226	.325	.485	1	.486	-.410	.862
Moderate	-.258	.330	.612	1	.434	-.904	.388
Good	-.301	.310	.948	1	.330	-.908	.305
Power of wisdom (school) (very good level[a])							
Not pass criteria	1.182	.410	8.314	1	.004*	.378	1.985
Moderate	.722	.377	3.677	1	.055	-.016	1.460
Good	.315	.381	.682	1	.409	-.432	1.061
Power of peers (very good level[a])							
Not pass criteria	-.536	.367	2.131	1	.144	-1.255	.184
Moderate	-.434	.348	1.550	1	.213	-1.116	.249
Good	.020	.355	.003	1	.955	-.676	.716
Power of community (very good level[a])							
Not pass criteria	.779	.398	3.836	1	.050*	-.001	1.559
Moderate	.306	.427	.515	1	.473	-.530	1.142
Good	.521	.470	1.232	1	.267	-.399	1.442
Existential well-being (high level[a])							
Low	-.473	.445	1.129	1	.288	-1.346	.400
Moderate	-.733	.332	4.868	1	.027*	-1.383	-.082
Religious well-being (high level[a])							
Low	1.994	.495	16.244	1	.000**	1.024	2.964
Moderate	1.083	.343	9.994	1	.002*	.412	1.755
Nagelkerke R-Square = .372							

[a] *reference group, * p < 0.05 ** p < 0.01*

Table 3 shows that all protective factors in the model were able to explain the variation in depression in adolescents at 37.2% and that adolescents with good family relationships were 16.28 times less likely to have depression than adolescents with poor family relationships and adolescents with low psychological immunity in terms of optimism, who were 1.07 times more likely to have depression than adolescents with high levels of psychological immunity in terms of optimism. Moreover, adolescents with low and moderate psychological immunity in terms of consciousness were 2.35 times and 1.19 times more likely to have depression, respectively. Adolescents who did not pass the criteria for life assets in terms of the power of wisdom (school) were also 1.18 times more likely to have depression than adolescents with a very good level of it. Next, adolescents with life assets in terms of power of community that did not pass the criteria were 0.77 times more likely to have depression than those with a very good level. Adolescents with moderate spiritual well-being in terms of existential well-being were 0.73 times less likely to have depression than those with a high level. Adolescents with low and moderate spiritual well-being in terms of religious well-being were 1.99 times and 1.08 times more likely to have depression, respectively, than those with high spiritual well-being.

DISCUSSION

The Prevalence of Thai Adolescent Depression in Three Southern Border Provinces in Thailand

The findings showed that most respondents had mild depression. At this level of depression, the symptoms are mild and caused by a response to high-pressure or stressful situations and disappointment. People with mild depression do not lose their ability to perform various functions, can carry on with their daily lives, and can recover independently once the situation or crisis has passed or managed (Lam, 2018; The Royal College of Pediatricians of Thailand, 2018). The respondents had mild depression because they remained in stressful situations that required them to adapt to the new

normal due to the COVID-19 pandemic. Although the situation has become more relaxed, it continues to directly impact how adolescents perform routine daily activities and activities appropriate for their age, school, and their family's economic conditions (Vatanasin, 2023). The unrest in the area also remains unpredictable. Additionally, due to gender factors, most teenagers who are at risk of stress are females because women naturally tend to think about finer details, have more anxiety and sadness than men, and experience periods of hormonal changes that affect mood, such as during the menstrual cycle (Wipulakorn, 2015). Moreover, adolescent girls have twice the incidence of depression than males (Arunpongpaisal & Vasiknanonte, 2015; Avenevoli et al., 2015).

Protective Factors on Adolescent Depression in Three Southern Border Provinces in Thailand

Internal and external factors protecting Thai adolescents form depression.

Internal factors

Psychological immunity

Optimism is the attitude or mindset that things will unfold favorably. Optimism plays an important role in helping find what makes life worth living. It causes positive emotions, alleviates current negative feelings, reduces depression, and promotes good health (Suwanvathin & Watakakosol, 2022; Thongkhum et al., 2021). Conversely, adolescents with a negative self-view who see only personal mistakes or view the world negatively will have low self-esteem and are likely to be predisposed to depression when confronted with stressful situations, such as failed examinations, parents' divorce, and abandonment. Without appropriate support, their symptoms may worsen and result in a depressive disorder (Lotrakul & Sukanich, 2015). This finding is consistent with a study of the factors correlated with depression among adolescents, which revealed that low self-esteem is significantly correlated with depression, emphasizing that self-esteem is the best predictor for adolescent depression (Chaisuwannarak & Thommachot, 2020).

Furthermore, psychological immunity and consciousness help adolescents to perceive their thoughts and feelings and enable them to let things pass without becoming obsessed with situations and negative feelings about themselves and the people around them. As a result, consciousness helps reduce stress and depression, creates sympathy, prevents judgment, and promotes forgiveness. It also improves happiness in daily life, greater satisfaction in life, good work ability, and the ability to co-exist with people happily (Phaokuntatakorn & Jiratjitan, 2021). This statement was consistent with a systematic literature review concerning guidelines on care for depression among Muslim adolescents, which found that positive psychology therapy and a focus on adjusting thoughts and behaviors reduced depression effectively (Watcharathaksin et al., 2021).

Spiritual well-being

Thai society, and Thai adolescents specifically, rarely perform religious practices, meditation, and observance of morals (Institute for Population and Social Research, 2016), which may have caused depression to occur more easily. The above findings align with studies that found spiritual intelligence negatively influences depression and can be used to predict depression among older adolescents with statistical significance (Seangsanaoh et al., 2017). Following religious principles and teachings promote spiritual well-being (Pobon & Sivabaedya, 2015), which creates balance and happiness in life due to a feeling of love and protection from sacred or supernatural entities. Moreover, a study among Muslim adolescent students found that conducting religious activities could reduce depression with statistical significance (Nadeem et al., 2017). Spirituality has also been gaining recognition as a potential treatment for depression (Pečečnik & Gostečnik, 2022).

External factors

Family relationships

This study's findings are consistent with Kongprapun (2020), who found that family relationships were the best predicting factor for depression, whereby adolescents with good family relationships had low rates of depression. Moreover, qualitative research by Auapisithwong (2020) found that family relationships were the main contributor to depression. The study found that the scores for the Thai family relationship survey among depressed adolescents were lower than the control group. It also found that depressed adolescents had statistically and significantly lower scores than other adolescents in the performing activities dimension.

Furthermore, previous studies discovered that adolescent depression is associated with inadequate parental care. The study found that most adolescents with moderate-severe depression were living in single-parent families (62.0%), which is a highly stressful family environment. Single-parent families, regardless of the reasoning, whether it is death, divorce, or abandonment for negligence, may result in feelings of loss, fear of abandonment, need for love, lack of self-confidence, loss of social relationships, and emotional and behavioral problems in children. In cases where parents are divorced or separated, adolescent children experience anxiety, shock, depression, and sadness (Praneetham & Sitthijirapat, 2015).

Life assets

Adolescents with life assets who receive effective support from schools and communities can effectively manage situations that threaten their daily lives or high-pressure environments such that they do not have depression (Vatanasin, 2023). Life assets are a key factor in building relationships and living with others. They are important forces in life that reduce an individual's risky behaviors or problems. The above findings were consistent with factors significantly associated with depression in adolescents, including poor school environments and low self-esteem (Chaisuwannarak & Thommachot, 2020). This study's findings were also consistent with a study conducted on depression predictors among lower secondary school students in expanded education opportunity schools, which found life assets and social support to be capable of co-predicting depression among lower secondary school students at 21.00%. Moreover, life assets were negatively correlated with depression and capable of predicting depression among students with statistical significance (Suntornvijitr et al., 2018). Promoting the power of the community can also prevent the incident rate of depression among adolescents. A study found that promoting community power programs can prevent suicidal behavior in a person with depression. The respondents of this study also had statistically significantly reduced suicidal risk behavior after participating in this program (Anusak et al., 2021).

STRENGTHS AND LIMITATIONS

The strength of this study was the use of a multistage sampling process, which can reduce selection bias and prevent inaccurate results. However, the samples in this study were limited to adolescents enrolled in Thai educational systems in the southern border regions. It did not address other adolescents from diverse cultural backgrounds, those who do not attend public schools, homeless adolescents, or adolescents who reside in children's shelters. Additionally, the perception of family, school, and community as additional protective factors should be further explored by qualitative methods.

CONCLUSION AND RECOMMENDATIONS

The mildly depressed group should be given importance because they are the most likely group to develop deeper depression. The protective factors derived from this study are healthy family relationships, psychological immunity with an emphasis on optimism and consciousness, spiritual well-being, and life assets, especially the power of wisdom (school) and the power of community. These factors can be used to plan activities to prevent depression in adolescents. Depression should be monitored and screened among adolescents, especially adolescent girls in single-parent families with insufficient family income and low academic performance. The monitoring and screening results should be assessed periodically and continually.

This study demonstrates that nurses should integrate protective factors from the individual, their family, school, and community levels to prevent depression in adolescents. Nurses should also encourage healthy family relationships and optimism to improve psychological immunity, as well as high life assets and high levels of existential and religious well-being. Future quasi-experimental research should develop programs for preventing depression in adolescents by promoting family relationships, psychological immunity, life assets, and spiritual well-being.

REFERENCES

Anantaseriwidhya, T., Punyapas, S., & Hosiri, T. (2021). Prevalence and factors associated with depression among boarding school students in Suratthani. *Chiang Mai Medical Journal*, *60*(4), 574–585. https://doi.org/10.12982/CMUMEDJ.2021.50

Anusak, B., Tatiyananthaporn, S., & Khamthita, P. (2021). การพัฒนารูปแบบการเสริมสร้างพลังชุมชนในการป้องกันการฆ่าตัวตาย จังหวัดลำพูน. (The development of a community empowerment model for preventing suicide of Lamphun Province). *Journal of the Phrae Hospital*, *29*(2), 65–77. https://thaidj.org/index.php/jpph/article/view/11612

.Arunpongpaisal, S., & Vasiknanonte, S. (2015). *Textbook of depressive disorders*. Klungnana vitthaya.

Auapisithwong, S. (2020). A study of association between family relationship and adolescent depression. *Journal of Mental Health of Thailand*, *28*(3), 231–239. https://he01.tci-thaijo.org/index.php/jmht/article/view/225452/165920

Avenevoli, S., Swendsen, J., He, J.-P., Burstein, M., & Merikangas, K. R. (2015). Major depression in the national comorbidity survey–adolescent supplement: Prevalence, Correlates, and Treatment. *Journal of the American Academy of Child & Adolescent Psychiatry*, *54*(1), 37-44.e2. https://doi.org/10.1016/j.jaac.2014.10.010

Bhanthumnavin, D., & Vanindananda, N. (2008). *Research to develop a multidimensional psychological measurement tool for psychological immunity*. National Research Council of Thailand. https://dric.nrct.go.th/Search/SearchDetail/231423

Chaisuwannarak, K., & Thommachot, P. (2020). Factors associated with depression in adolescents with cyberbullying. *Journal of the Psychiatric Association of Thailand*, *65*(2), 191–204. https://he01.tci-thaijo.org/index.php/JPAT/article/view/243558/165375

Department of Mental Health. (2019). *Thai people commit suicide, 53,000 people per year, average 6 people/hour: guidelines for prevention*. https://dmh.go.th/news-dmh/view .asp ? id=29720

Institute for Population and Social Research. (2016). *Thai people's health project*. Mahidol University.

International Health Policy Program. (2023). *Burden of disease attributable to risk factors in Thailand 2019*. Handypress. รายงานภาระโรคจากปัจจัยเสี่ยงของประชากรไทย-พ.ศ.2562.pdf

Jiamjaroenkul, J., & Limsuwan, N. (2015). Depression among junior high school students in Muang District, Chiang Mai Province. *Journal of the Psychiatric Association of Thailand*, *60*(4), 253–264. https://he01.tci-thaijo.org/index.php/JPAT/article/view/45613

Kongprapun, N. (2020). Factors influencing adolescent depression case study: Rajamangala University of Technology Suvarnabhum. *Journal of Social Science and Buddhistic Anthropology*, *5*(11), 302–315. https://so04.tci-thaijo.org/index.php/JSBA/article/view/246966

Kongsuk, T., Phimtra, S., & Leejongpermpoon, J. (2014). *Quality of life and predictions in Thai depression patients*. Http://Www.Prasri.Go.Th/Res/ Depression/2557.Php.

Laksaneeyanawin, T., & Wattanaburanon, A. (2022). Factors affecting depression of upper secondary school students in Mueang Chonburi District Chonburi Province. *Research and Development Health System Journal*, *15*(3), 59–73. https://he02.tci-thaijo.org/index.php/RDHSJ/article/view/258574

Lam, R. W. (2018). *Depression.* (3rd ed.). Oxford University Press.

Lotrakul, M., & Sukanich, P. (2015). *Ramathibodi essential psychiatry* (4th ed.). Department of Psychiatry Faculty of Medicine Ramathibodi Hospital Mahidol University.

Løvgren, A., Røssberg, J. I., Nilsen, L., Engebretsen, E., & Ulberg, R. (2019). How do adolescents with depression experience improvement in psycho dynamic psychotherapy? A qualitative study. *BMC Psychiatry*, *19*(1), 95. https://doi.org/10.1186/s12888-019-2080-0

Moonsorn, S. (2022). *Predictive factors of depression among high school students* [Master's thesis]. Burapha University.

Nadeem, M., Ali, A., & Buzdar, M. A. (2017). The association between Muslim religiosity and young adult college students' depression, anxiety, and stress. *Journal of Religion and Health*, *56*(4), 1170–1179. https://doi.org/10.1007/s10943-016-0338-0

Noipiang, T. (2002). *Perceived severity of illness social support and spiritual well-being among breast cancer patients* [Master's thesis]. Chiang Mai University.

Paloutzian, R., & Ellison, C. (1982). Loneliness, spiritual well-being and the quality of life. In L. A. Peplau & D. Perlman (Eds.), *Loneliness: A Sourcebook of Current Theory, Research, and Therapy*. Wiley.

Pandii, W. (2015). Prevalence of depression and its association in late adolescence: a case study in Sisaket Technical College. *Thai Journal of Public Health*, *45*(3), 298–309 https://he02.tci-thaijo.org/index.php/jph/article/view/49144.

Panyawong, W., Pavasuthipaisit, C., & Santitadakul, R. (2018). *Development of the Thai version of the patient health questionnaire for adolescents (PHQ-A)*. https://dmh-elibrary.org/items/show/395

Pečečnik, T. M., & Gostečnik, C. (2022). Use of spirituality in the treatment of depression: Systematic literature review. *Psychiatric Quarterly*, *93*(1), 255–269. https://doi.org/10.1007/s11126-020-09881-9

Phaokuntatakorn, W., & Jiratjitan, N. (2021). Effects of Mindfulness-Based Therapy Program on depression and quality of life among patients with Major Depressive Disorder. *Journal of Mental Health of Thailand*, *29*(4), 286–296. https://he01.tci-thaijo.org/index.php/jmht/article/view/247270

Pobon, B., & Sivabaedya, S. (2015). Factors related to spiritual well-being of adolescents In studying secondary at pakmaiwittayanukul school, Sisaket province. *Journal of Education Graduate Studies Research*, *9*(2), 62–71. file:///C:/Users/DEW/Downloads/document%20(6).pdf

Praneetham, W., & Sitthijirapat, P. (2015). *The Contemporary of single dad in Thai society*. Http://Www.Dspace.Spu.Ac.Th/Bitstream/123456789/5911/1/%E0% 824.Pdf.

Salk, R. H., Petersen, J. L., Abramson, L. Y., & Hyde, J. S. (2016). The contemporary face of gender differences and similarities in depression throughout adolescence: Development and chronicity. *Journal of Affective Disorders*, *205*, 28–35. https://doi.org/10.1016/J.JAD.2016.03.071

Samarksavee, N., & Sangon, S. (2015). Factors associated with depression in nursing students. *The Journal of Psychiatric Nursing and Mental Health, 29*(3), 11–27. https://he02.tci-thaijo.org/index.php/JPNMH/article/view/90483

Sangkool, J., & Mosikanon, K. (2016). Depression in hearing impaired high school students in Sodsuk sasongkhla School, Thailand. *Songklanagarind Medical Journal*, *34*(5), 281–288. http://smj.medicine.psu.ac.th/index.php/smj/article/view/9

Seangsanaoh, S., Vatanasin, D., Hengudomsub, P., & Pratoomsri, W. (2017). The Influence of interpersonal factors on depression among late adolescents. *Journal of Boromarajonani College of Nursing, Bangkok*, *33*(3), 59–69. https://he01.tci-thaijo.org/index.php/bcnbangkok/article/view/120099

Suksri, A., Nintachan, P., & Taweekoon, T. (2016). Relationships between resilience and depression and aggressive behaviors in adolescents exposed to violence. *The Journal of Psychiatric Nursing and Mental Health*, *30*(2), 97–112. https://he02.tci-thaijo.org/index.php/JPNMH/article/view/95939/74915

Suntornvijitr, S., Hengudomsub, P., Vatanasin, D., & Dethchaiyo, P. (2018). Predicting factors of depression among secondary school students in Extended Educational Opportunity Schools. *Nursing Journal of the Ministry of Public Health*, *28*(2), 53–66. https://he02.tci-thaijo.org/index.php/tnaph/article/view/144722

Surawan, W. (2021). https://he01.tci-thaijo.org/index.php/JPAT/article/view/247409Suttineam, K., & Suttineam, U. (2020). Factors influencing depression of students at Rajabhat Baun Somdetchaopraya University. *The Journal of Psychiatric Nursing and Mental Health*, *34*(3), 43–61. https://he02.tci-thaijo.org/index.php/JPNMH/article/view/245349

Suwanvathin, P., & Watakakosol, R. (2022, January 24). *"Optimism" psychological capital (part 3)*. https://www.psy.chula.ac.th/th/feature-articles/psy-cap-optimism.

The Royal College of Pediatricians of Thailand. (2018). *Clinical practice guideline for adolescents with depression*. Beyond Publishing.

Thongkhum, K., Peungposop, N., & Sakunpong, N. (2021). Positive psychology interventions and application for promoting resilience in the elderly. *Journal of Psychology Kasem Bundit University*, *11*(1), 38–50. http://journal.psy.kbu.ac.th/index.php?action_page=20&username=&idUser=&status_log=

Tohpaeroh, M., Hayee, F., Akachi, N., Choorat, N., Saetung, B., & Sawan, S. (2022). *Intra – individual and sociocultural factors influencing the happiness and mental health problem in new normal of adolescents in Three Southern Border Provinces of Thailand* (Research Report). Princess of Naradhiwas University.

Tripathi, S. (2009). *Developmental asset for Thai children and youth*. Thai Health Promotion Foundation.

Uthis, P., Suktrakul, S., Sonlar, K., & Sawangpon, M. (2018). Factors related to depressive symptoms among adolescent amphetamine users. *Journal of Health Science of Thailand*, *27*(6), 965–977. https://thaidj.org/index.php/JHS/article/view/5410

Vatanasin, D. (2023). *Adolescent depression: Basic concept and nursing care* (2nd ed.). Wanida Karpim Limited Partnership.

Verboom, C. E., Sijtsema, J. J., Verhulst, F. C., Penninx, B. W. J. H., & Ormel, J. (2014). Longitudinal associations between depressive problems, academic performance, and social functioning in adolescent boys and girls. *Developmental Psychology*, *50*(1), 247–257. https://doi.org/10.1037/a0032547

Watcharathaksin, K., Yumyuang, N., Aekwarangkoon, S., Vanaleesin, S., Nuampet, U., Namsa, J., Luksavimon, L., Sutthisompohn, S., & Vanprom, W. (2021). Guidelines for Muslim adolescents with depression: A systematic review. *Princess of Naradhiwas University Journal*, *13*(3), 173–194. https://li01.tci-thaijo.org/index.php/pnujr/article/view/244990/172585

Wipulakorn, P. (2015). *Modern woman Risk of stress - mental health problems*. 2015. https:// www.thaihealth.or. th/?p=258549.

Worasan, J. (2015). Parenting styles and depression among tenth – twelfth-grade students: The demonstration school of Ramkhamhaeng University. *Journal of Politics, Administration and Law*, *7*(3), 67–91. https://ojs.lib.buu.ac.th/index.php/law/article/view/4507