

Youth and Stakeholder Perspectives on Depression Literacy and Game Design in Thailand's Southern Border Provinces

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Abstract

This formative qualitative study examined how youth and stakeholders in Thailand's Southern Border Provinces understand depression and what they would require of a board game intended to promote mental health literacy. It formed the needs-assessment phase of a larger research and development project. Eighteen key informants were recruited using purposive and snowball sampling: two psychiatrists, two board game experts, 10 youth volunteers aged 15–24 years, and four mental health personnel. In-depth interviews were analyzed through qualitative content analysis. Four themes were constructed. Informants perceived youth knowledge of depression as limited and closely tied to fear of stigma. Stigma and religious misattribution were described as delaying help-seeking. Religious practice was reported both as a valued source of comfort and, when depression was equated with weak faith, as an interpretation discouraging professional help; concealment and withdrawal were described alongside it. All groups considered a board game acceptable and specified design requirements: expert-verified information; locally familiar situations and language; a clear position that religious practice supports rather than replaces professional care; and mechanics that allow responses through characters rather than personal disclosure. Because no game was developed or tested, these findings describe perceived acceptability and proposed design requirements and point to the need for co-design and evaluation.

Keywords

Board game; depression; mental health literacy; religious coping; youth

Introduction

Depression is a major public health concern. It affects emotional, social, educational, and family life, and its impact is especially serious when symptoms begin during adolescence or early adulthood. The World Health Organization (2025) reported that approximately 332 million people worldwide have depression, representing 4% of the global population; the estimated prevalence among adults is 5.7%. In young people, the signs are not always obviously clinical. They may look like a student pulling away from school, losing interest in friends, doing worse in class, arguing more at home, or, in the most serious cases, harming themselves. Because these early signs are easy to miss, timely recognition and culturally appropriate prevention matter greatly.

In Thailand, adolescent depression remains a persistent concern. A national school-based survey found that 17.5% of adolescents screened positive for possible depression (Panyawong et al., 2020). However, help-seeking stays low even when young people are clearly distressed. Seera et al. (2020), for instance, found that Thai medical students were less likely than their Indian counterparts to seek professional help, and that higher psychological distress went hand in hand with avoiding it. In the Southern Border Provinces, several further factors are likely at work, including language, religion, family expectations, the security situation, and how the wider community views mental illness.

Recent Thai research also suggests that student depression is best understood through both cognitive and social pathways. Songsin et al. (2026) found that negative automatic thoughts predicted depressive symptoms among senior high school students, whereas social support pulled in the opposite direction. This matters here because young people in the Southern Border Provinces do not suffer in isolation. How they see themselves is shaped at home, at school, within their religious community, among peers, and increasingly online.

Pattani, Yala, and Narathiwat are predominantly Malay-Muslim provinces that have lived with long-standing civil unrest. Research with youth in the region has linked conflict-related worries and family disruption to psychiatric symptoms (Ford et al., 2026). A setting like this can sharpen the ordinary stresses of growing up. For many young people, then, emotional pain is read not simply as a personal health problem but through the shared experience of living in a conflict-affected, tight-knit community.

For many Muslim youth in the region, religion sits at the center of daily life. In a cross-sectional study in Thailand's southernmost provinces, stricter religious practice was associated with fewer psychiatric symptoms among male youth aged 18–24 years (Ford et al., 2026). At the same time, distress is sometimes explained in spiritual or supernatural terms. Work in transcultural psychiatric settings has shown that attributing symptoms to jinn or other spiritual causes can shape whether people seek professional care and how they engage with treatment (Lim et al., 2018). The problem, then, is not religion itself but how religious meaning is interpreted and applied when a young person begins to show depressive symptoms.

Mental health literacy refers to the knowledge and beliefs that help people recognize, manage, or prevent mental disorders (Jorm, 2012) and is the primary conceptual lens used in this study. When youth and families are unsure what depression actually is, they may read the symptoms as laziness, weak faith, or personal failure. Those interpretations then shape how informants

describe people's actions: staying silent, avoiding the issue, putting off help, or relying solely on informal coping. Consistent with this, Buasan et al. (2024) found that higher mental health literacy was associated with less severe depression, which strengthens the case for literacy-focused prevention.

In this article, a board game refers to a structured, face-to-face tabletop activity in which a small group of players interacts through a shared board, cards, and rules, and in which the learning content comes from the situations and decisions the rules generate rather than from direct instruction. Board games and other game-based activities have long been used in education because they allow learners to approach difficult topics through rules, roles, and shared play. A systematic review of serious games promoting aspects of mental health literacy among children and adolescents found that such games are generally feasible and can improve knowledge and help-seeking intentions, while noting that effects on stigma are less consistent and that design quality varies widely (Zeiler et al., 2025).

Lau et al. (2017) similarly reported that serious games for mental health were generally accessible and feasible and showed potential benefits for mental health outcomes. Kaewsomnues et al. (2023) found that game-based learning can help people take in new knowledge. In a more recent study, Respati et al. (2024) evaluated a mental health board game with adolescents in remote areas of Indonesia, a Muslim-majority country. They reported gains in mental health knowledge, stigma awareness, and peer engagement. A tabletop format was considered for this context in preference to digital or lecture-based alternatives for three practical reasons: it needs neither a reliable internet connection nor a personal device; it is played in a co-present group, which makes peer conversation part of the activity rather than a by-product; and it allows a facilitator to notice distress and respond in the room. It can also ease the pressure of speaking about oneself directly, because young people can respond through a character, a situation, or a decision in the game rather than talking about their own symptoms. Whether these advantages hold in this particular setting, however, is an empirical question about local acceptability, and it is the question the present study set out to examine.

Adolescent depression, mental health literacy, religious coping, and game-based learning have each been studied. However, few studies have examined how these strands converge in the specific setting of Thailand's Southern Border Provinces. Existing evidence largely sits in separate literatures. National surveys have documented substantial adolescent depression in Thailand alongside low rates of professional help-seeking (Panyawong et al., 2020; Seera et al., 2020). Research in the Southern Border Provinces has linked conflict-related exposure and family disruption to psychiatric symptoms among youth (Ford et al., 2026). Studies in Muslim populations have shown that stigma conditions the relationship between religiosity and help-seeking (Fekih-Romdhane et al., 2023), and that attributing symptoms to spiritual causes shapes engagement with professional care (alHarbi et al., 2023; Lim et al., 2018).

Reviews of serious games report feasibility and knowledge gains but inconsistent effects on stigma, with little evidence from Muslim-majority or conflict-affected settings (Lau et al., 2017; Zeiler et al., 2025), and a board game trialed with adolescents in remote Indonesia offers one of the few relevant precedents (Respati et al., 2024). What remains unclear is how youth and stakeholders in this specific setting describe depression and its social and religious interpretation, and what they would consider acceptable in a culturally responsive mental health literacy game. This study therefore had two aims: first, to explore how youth and relevant stakeholders understand depression, interpret depression-related behavior, and perceive the barriers shaping coping and help-seeking among youth in Thailand's Southern Border Provinces; and second, to identify what stakeholders consider necessary and

acceptable in a board game program intended to support depression prevention in this context. The study is reported as formative qualitative research: it precedes and is intended to inform the design of such a program rather than to evaluate one.

Conceptual framework

This study is framed primarily by mental health literacy (Jorm, 2012), which focuses on how young people recognize depression, what they believe causes it, and what they consider an appropriate response. Because recognition and response in this setting are inseparable from social and religious meaning, the framework treats three interrelated sociocultural processes as part of that framework rather than as separate variables: stigma, religious interpretation and coping, and help-seeking. These processes are linked empirically in Muslim populations, where religiosity is associated with more favorable help-seeking attitudes when stigma is low and less so when stigma is high (Fekih-Romdhane et al., 2023), and where beliefs about the causes of mental health problems shape the acceptability of psychological treatment (alHarbi et al., 2023; Lim et al., 2018).

The KAP framework is retained only as an organizing structure for the knowledge, attitude, and practice content incorporated into the proposed board game (Launiala, 2009). The relationship between framework and data is stated plainly here because it bears on how the findings should be read: the interview guide was organized around the three KAP domains, so those domains shaped what informants were asked about, whereas mental health literacy and the sociocultural processes above were used to interpret the material that resulted.

Materials and methods

Research design

The study followed a qualitative design grounded in an interpretive paradigm (Creswell & Poth, 2018; Lincoln & Guba, 1985). This approach was chosen because the interest was in meanings, explanations, and everyday responses to depression, not in measuring how common it is. Individual in-depth interviews suited the topic well: depression, stigma, and religious interpretation are sensitive matters, particularly for youth and for service providers who work within a close-knit community. More precisely, the study is a formative qualitative needs assessment. It reports the qualitative needs-assessment component of a larger research and development project on a depression-prevention board game for youth in the Southern Border Provinces, carried out as part of the first author's doctoral research; the survey component of that project and the subsequent development and testing phases are reported separately and are not drawn on here except where explicitly stated.

Two consequences of this design should be stated at the outset. First, because the interview guide included questions about a board game and board game designers were purposively recruited, the design cannot establish that a board game is the most appropriate intervention for this population; the study itself, to some degree, invited support for the format. The design can establish how stakeholders in this setting interpret depression and what they would require of such a game if one were developed. Second, the study collected accounts and perceptions; it did not observe depression-related behavior. This study followed the

Consolidated Criteria for Reporting Qualitative Research (COREQ; Tong et al., 2007), and a completed checklist is provided in Appendix A.

Participants

Eighteen key informants were selected for their direct experience with youth mental health, community life, or educational game design in the Southern Border Provinces. The sample comprised psychiatrists (P1–P2; $n = 2$), board game and educational game experts (BG1–BG2; $n = 2$), youth volunteers aged 15–24 years living in Pattani, Yala, or Narathiwat (Y1–Y10; $n = 10$), and mental health personnel working in mental health services (M1–M4; $n = 4$). Informant characteristics are presented in Table 1. Purposive sampling was used first, followed by snowball sampling as informants pointed toward others with relevant experience. Youth informants were purposively selected from respondents to a survey conducted earlier in the same project whose answers indicated risk-related depressive behavior, so that the group would include young people with some proximity to the experience under discussion rather than a general student sample. Four stakeholder groups were included to compare the perspectives of service providers, intervention designers, and intended users using the same set of questions.

Three groups with a potential stake in the topic were not interviewed: religious leaders, parents, and teachers. The sampling frame for this phase focused on two questions: how young people understand and respond to depression, and what intended users and designers would require of a game; the three groups fell outside that frame. In the case of religious leaders, there was also a judgment that interviewing them about depression and faith risked positioning the study as an assessment of religious authority, which is sensitive in this setting. This is a limitation rather than a neutral design choice. Because religious interpretation proved central to the findings, the study reports how youth and health professionals describe religious meaning, not how those who hold religious authority would frame it; parents and teachers likewise appear in the data only through others' accounts.

Interviews were reviewed as data collection went on. No new theme appeared after the 14th informant, and the four subsequent interviews confirmed that no further themes emerged, in line with existing guidance (Creswell & Poth, 2018; Guest et al., 2006).

Table 1: Characteristics of Key Informants

Code	Stakeholder group	Sex	Age (years)	Highest education	Role relevant to the study
P1	Psychiatrist	Not reported	Not reported	Not reported	Diagnoses and treats depression in youth
P2	Psychiatrist	Not reported	Not reported	Not reported	Diagnoses and treats depression in youth
BG1	Board game expert	Male	33	Bachelor's degree	Designer of board games and educational games
BG2	Board game expert	Male	32	Bachelor's degree	Designer of board games and educational games
Y1–Y5	Youth volunteer	Male ($n = 5$)	15–24	Secondary education	Youth resident in Pattani, Yala, or Narathiwat; intended users of the program

Code	Stakeholder group	Sex	Age (years)	Highest education	Role relevant to the study
Y6-Y10	Youth volunteer	Female ($n = 5$)	15–24	Secondary education	Youth resident in Pattani, Yala, or Narathiwat; intended users of the program
M1	Mental health personnel	Not reported	Not reported	Not reported	Mental health service provider in the area
M2	Mental health personnel	Not reported	Not reported	Not reported	Mental health service provider in the area
M3	Mental health personnel	Not reported	Not reported	Not reported	Mental health service provider in the area
M4	Mental health personnel	Not reported	Not reported	Not reported	Mental health service provider in the area

Youth informants are grouped by sex, and their ages are reported as ranges rather than individually because individual ages, combined with province of residence, could make them identifiable in small communities. For the same reason, sex, age, and highest education are not reported for the psychiatrists or for the mental health personnel: psychiatric specialists and mental health service providers in the three provinces are small professional groups, and those details, together with the professional role given in the table, would identify an individual informant to any reader familiar with local services. None of the information withheld is used anywhere in the analysis.

Ethical considerations

Ethical approval was granted by the Institutional Review Board for Human Subjects Research, Sirindhorn College of Public Health, Yala (Certificate of Approval No. SCPHYLIRB-2567/091), valid from 5 March 2024 to 5 March 2025. Data collection took place between December 2024 and February 2025, within the approval period. All informants gave written informed consent, and for those under 18, consent was also obtained from a parent or guardian. Participants were told that participation was voluntary and that they could withdraw at any time. To protect confidentiality, real names were replaced with codes, and the interview data were kept in password-protected files.

Data collection

The semi-structured interview guide covered three areas: the informant's general background; their knowledge, attitudes, and practices around depression; and their expectations for a board game program. Three experts reviewed the questions, and every item reached an item-objective congruence index of at least 0.80. The guide was piloted with individuals who were not included in the study sample before data collection began. Interviews took place from December 2024 to February 2025 at locations the informants chose. Each interview ran about 45 to 60 minutes and was audio-recorded with permission.

After each interview, field notes captured context, non-verbal cues, and the interviewer's immediate reflections. Where further clarification was needed, follow-up (repeat) interviews

were carried out with some informants. The first author conducted interviews in Thai or Patani Malay, depending on each informant's preferred language. The first author transcribed the recordings verbatim within 48 hours. Quotations selected for this English-language article were translated into English by the first author. Both authors then checked the translations against the source-language transcripts. The authors made the final wording decisions and verified that the translations preserved the original meaning and culturally specific terms.

Data analysis

The interviews were analyzed using qualitative content analysis following Elo and Kyngäs (2008). Coding proceeded from the transcripts rather than from a pre-existing coding frame, but it did so within the three broad areas covered by the interview guide: the informant's background; knowledge, attitudes, and practices concerning depression; and expectations of a board game program. The analysis is therefore not inductive in the strict sense of being free of prior structure, and it is described here as inductive coding within predetermined domains: the guide shaped what informants were asked about, while the codes, subcategories, and themes reported below were developed from what informants said.

Analysis involved repeatedly reading the transcripts, coding openly, grouping related codes, building subcategories, abstracting them into main themes, and then checking the emerging interpretation against the transcripts. Data analysis and coding were conducted solely by the first author. Trustworthiness was supported through an audit trail documenting coding decisions and the development of codes, subcategories, and themes; researcher reflexivity was maintained through reflexive notes recorded during data collection and analysis; and supervisory review of the analytic process and interpretations. Feedback from the supervisory review was used to refine the analytic framework and interpretations, with relevant transcripts, field notes, and audit-trail records re-examined whenever clarification was required.

Additional credibility strategies included triangulation across the four informant groups, and member checking involved returning summary findings to selected informants, who were asked whether the interpretation matched their intended meaning. Coding and data management were supported by ATLAS.ti (ATLAS.ti Scientific Software Development GmbH, 2026). Reliance on a single primary coder is acknowledged as a limitation.

Researcher reflexivity

The first author is a male psychologist who has worked in the Southern Border Provinces and is a doctoral candidate in human and social development. This background gave him a useful feel for the context, but it also carried the risk of insider assumptions. To guard against that, the first author kept reflexive notes after each interview, discussed emerging interpretations with his dissertation supervisor, and used member checking so that his own reading would not be imposed on what informants actually said (Lincoln & Guba, 1985).

Results

The analysis produced four themes, summarized with their subcategories and contributing informant groups in Table 2. The findings present informants' accounts and perceptions rather than observed behavior; when informants describe what young people do, they describe what they have seen or been told, not what this study measured. Read together, the themes show how knowledge about depression, community attitudes, religious interpretation, and described responses are bound up with one another in the daily lives of youth in the region. They also outline what informants considered necessary for a culturally responsive board game. Where the four stakeholder groups differed in emphasis, this is noted.

Table 2: Themes, Subcategories, and Contributing Informant Groups

Theme	Subcategories	Informants contributing
1. Limited knowledge and misconceptions about depression	Uncertain understanding of depression; misattribution of symptoms; sources of information	P1–P2, M1–M4, Y1–Y10
2. Social stigma and religious misattribution as barriers	Community stigmatization; religious misattribution; reframing by professionals	Y1–Y10, M1–M4, P1–P2
3. Religious coping and social avoidance as dominant patterns	Religious coping; social avoidance and concealment	Y1–Y10, M1–M4, P1
4. Requirements for a board game integrating cultural responsiveness with accurate knowledge	Acceptability of the format; conditions for acceptability; functions valued by informants	BG1–BG2, Y1–Y10, P1–P2, M1–M4

Note: Appendix B provides the full coding tree, including individual codes.

Theme 1: Limited knowledge and misconceptions about depression

Informants described depression as something many youth had heard of but did not really understand. Young people often mistook it for ordinary sadness, stress, tiredness, or simply a lack of motivation. Some families and community members, they said, read depressive symptoms as laziness, weak faith, or the effect of supernatural forces. Psychiatrists and mental health personnel noted that this confusion frequently delayed help-seeking until symptoms had already grown severe.

Most young people who come to see me already have severe symptoms. They don't know what is wrong with them – they just think they are stressed or tired. They are afraid of social stigma if they seek help, and their families think they are lazy or weak in faith.

(P1, Psychiatrist)

Youth informants said social media was usually where they first learned anything about mental health. They named TikTok, Facebook, and Instagram because these were easy to reach and already part of daily life. Even so, they were unsure how accurate the information really was. Depression was rarely discussed formally at school, and health education from hospitals came only occasionally rather than as anything continuous.

The four groups approached this theme from different positions. Psychiatrists and mental health personnel described the consequences of delayed recognition, which they met at the

point of presentation, when symptoms were already severe. Youth informants described the situation upstream of that: uncertainty about what they were feeling and no trusted source to check it against. Board game experts, who did not work clinically with depression, addressed the same theme as a design problem, arguing that content like this must be carried by ordinary language and simple mechanics if young players are to engage with it at all.

I know a little about depression from TikTok, Facebook, and Instagram, but I'm not sure if it's accurate. We never talked about this at school. Occasionally, a hospital would come to give information, but only rarely.
(Y5, Youth Volunteer)

Theme 2: Social stigma and religious misattribution as barriers

Stigma stood out as a central reason youth and families steered clear of professional help. Informants tied it to two connected processes. On the one hand, community members might brand a person with depression as weak, lazy, or unable to control their emotions. On the other hand, people might read the symptoms as a sign of weak faith or of not practicing religion properly. Either way, disclosure became risky because reaching out for help could invite judgment from family, neighbors, or peers.

If family members or people in the community know you have depression, they will say you have weak faith, that you don't pray, or that you don't trust Allah. This is a key reason why some families and community members cannot accept it.

(Y3, Youth Volunteer)

The biggest problem is social stigma. People with depression hide their symptoms and dare not tell anyone. By the time they come to see the doctor, the condition is usually already very severe.

(M2, Mental health personnel)

Psychiatrist informants were careful to point out that this barrier is not a problem with Islam itself. As they saw it, Islamic teaching supports caring for both body and mind. The trouble lies in local misunderstandings, where religious language is sometimes turned into blame directed at the person who is suffering. This distinction matters because it leaves room to design mental health promotion that works alongside Islamic values rather than against them.

Islam does not say that mental illness is a punishment. Our religion teaches us to care for our health – both body and mind. The problem is the misunderstanding that distorts the true teachings, leading to mental suffering that is kept hidden.

(P2, Psychiatrist)

Theme 3: Religious coping and social avoidance as dominant patterns

For many informants, religious coping was the first response that came to mind. Youth spoke of prayer, Quranic recitation, du'a, and turning to religious figures as familiar, acceptable ways to handle emotional distress. Medical informants did not dismiss any of this; they saw these practices as genuine sources of support. Their worry was narrower: that some youth and families leaned on religious coping as the only response and put off professional care even when symptoms were serious.

When I feel very sad or empty inside, I pray more and read the Quran. I believe that if my faith is strong enough, the feelings will go away.

(Y7, Youth Volunteer)

Most young people who reach us already have severe symptoms. They tried to cope through prayer and du'a according to their beliefs, and most importantly, they concealed this from those around them – afraid of family judgment and social stigma.

(P1, Psychiatrist)

Alongside religious coping, avoidance was common. Informants described young people who pulled away from friends, hid symptoms from family, went quiet at school, or lost themselves in online activity. In this social setting, concealment was not simply denial. For some youth, it was a way to shield themselves from judgment or labeling.

Taken together, informants described religious meaning as working in two directions at once. As a practice, prayer, Quranic recitation, and du'a were described as providing comfort, structure, and hope, and no informant suggested displacing them. As an explanation, however, equating depression with weak faith was described as making disclosure risky and delaying professional care. These are distinct processes with different implications for intervention design, and they are treated separately in the discussion below.

Religious coping has real value – it is not wrong at all and should be strongly promoted. But we need to help young people understand that mental health care is part of caring for oneself, because that is what Islam supports – not contradicts or prohibits.

(M4, Mental health personnel)

Theme 4: Requirements for a board game that integrates cultural responsiveness with accurate mental health knowledge

Informants in all four groups regarded a board game for depression prevention as an acceptable and worthwhile format, though they were clear about what would make it acceptable. The game should draw on local situations, familiar language, and examples that Muslim youth would recognize. It also needed to carry accurate mental health information without leaving players feeling exposed. Several informants valued the idea that a character or scenario could hold the difficult subject, letting youth talk about depression without having to describe their own symptoms directly.

A board game is an effective tool that facilitates learning and understanding because it makes learning fun and does not create stigma among players. Players feel safe talking about their feelings through game characters rather than speaking about themselves directly.

(BG1, Board Game Expert)

If a board game can integrate Islamic teachings about caring for the mind, especially regarding depression, it will become another tool to greatly reduce social stigma – because youth will see the importance of mental health care without it conflicting with religion – creating new dimensions in society in the future.

(P2, Psychiatrist)

If there's a fun board game that helps us better understand depression, we'd be interested in playing it. Nowadays, just hearing the word 'depression' sounds scary – nobody dares to talk about it openly.

(Y9, Youth Volunteer)

What young people in this area need is not just medication or treatment. They need a safe space to talk about their feelings without stigma. A board game could be a good platform to open quality conversations for everyone.

(M4, Mental health personnel)

The requirements described by the informants are set out in Table 3, alongside the design implications drawn from them. Two points deserve emphasis. First, medical informants attached conditions to the content: specialists had to verify material on warning signs and referral pathways before use, because inaccurate information could put players at risk. Second, youth informants attached conditions to the process: they did not want to be required to talk about themselves, wanted the option to skip sensitive topics without losing their place in the game, and wanted confidentiality agreed within the group before play began. One qualification applies to this theme as a whole. Informants were asked directly about a board game, and two were recruited as board game designers, so read the support reported here as an assessment of the format presented to them, not as evidence that a board game outperforms other ways of addressing the same barriers.

Table 3: Requirements Described by Informants and the Design Implications Drawn From Them

Requirement described by informants	Source (theme; informants)	Proposed design implication
Content must fit the cultural and religious context of the area	Themes 2 and 4 (BG1, Y3, P2)	Use local situations and familiar language; state explicitly that religious practice supports emotional well-being but does not replace professional help
Accurate information is needed to correct misconceptions	Theme 1 (P1, M1–M4)	Knowledge content covering symptoms, causes, treatment, and emergency warning signs, verified by specialists before use
Pressure to disclose personal experience must be reduced	Themes 3 and 4 (Y1–Y10)	Let players respond through characters and hypothetical scenarios; provide a mechanism for skipping sensitive topics without penalty
Stigma must be reduced and help-seeking encouraged	Theme 2 (Y3, M2)	Link in-game help-seeking to real referral routes available in schools and the community; include scenarios on the effects of labeling and ridicule
Emotion-management skills should be usable immediately	Theme 3 (P1, M1–M4)	Include brief, practicable techniques such as paced breathing and routines for sleep and eating
The activity must be enjoyable and encourage group participation	Theme 4 (BG1, BG2)	Team-based mechanics with a facilitated reflection at the end of play to consolidate learning

Note: The design implications in the third column are propositions derived from informants' accounts. They have not been developed into a game or tested in this study.

Discussion

In these interviews, the way depression was described and responded to among youth in the Southern Border Provinces rested on more than individual knowledge. Uncertainty about depression, fear of stigma, religious interpretation, and avoidance were described as running together as one connected pattern. A young person might notice sadness, emptiness, or fatigue, yet hesitate to call it depression, because the label itself can carry social and religious consequences. These are informants' accounts of what happens rather than observations of behavior; the study did not measure what young people do, and the discussion follows accordingly.

The limited knowledge reported by the youth informants fits earlier Thai evidence of substantial adolescent depression alongside low rates of professional help-seeking (Panyawong et al., 2020; Seera et al., 2020). What this study adds is a sense of how that barrier is lived locally. The youth were not just short on information; they were also bracing for what others might say if they asked for help. This backs the argument that mental health literacy has to work on two fronts at once: the factual knowledge and the social meanings that attach to depression. The link Buasan et al. (2024) reported between higher literacy and less severe depression points the same way.

Religion's place in help-seeking also came into sharper focus. Earlier work has shown that beliefs about what causes mental health problems, along with stigma and views on treatment, can shape whether people in Muslim communities engage with psychological care (alHarbi et al., 2023). In this study, religious practice itself was never described as harmful. The difficulty surfaced only when depression was reduced to weak faith, or when professional help was seen as unnecessary. This is consistent with the mental health literacy framework used here, in which what people know and believe about depression conditions what they treat as an appropriate response (Jorm, 2012), and with evidence from Muslim populations that stigma moderates the relationship between religiosity and help-seeking attitudes, so that religiosity is associated with more favorable attitudes only where stigma is low (Fekih-Romdhane et al., 2023).

Religious coping, then, deserves careful handling in any intervention. Prayer, Quranic recitation, and *du'a* can provide comfort, structure, and hope, and nothing in these findings argues for replacing them with clinical language. What the data suggest instead is that prevention programs should frame professional mental health care as part of the Islamic responsibility to look after one's health. Presenting it this way may dissolve the false choice between faith and treatment, a tension that broader work on Muslim mental health care has also described (alHarbi et al., 2023).

The strong interest in a board game reflects a practical need: a safer way to talk. Serious games have been reported as feasible and potentially useful for mental health education (Lau et al., 2017; Zeiler et al., 2025); game-based learning can help people acquire knowledge (Kaewsomnues et al., 2023); and a board game with adolescents in remote Indonesia produced gains in knowledge and stigma awareness (Respati et al., 2024). In this study, though, informants valued the format as more than a teaching device. They saw it as a social bridge, a format that could correct the misinformation circulating on social media, introduce options for seeking help, and open discussion through scenarios that feel culturally familiar. This

resonates with research emphasizing context-responsive health literacy tools and stakeholder involvement (Paktanyasit & Sukonthasub, 2026; Tanthaisong & Boonsawasdgulchai, 2026).

It is worth setting out how the requirements in Table 3 translate into mechanics, since they otherwise read as a list of preferences. Scenario cards that present a character's situation let a player comment on someone else's predicament rather than their own, which is what youth informants asked for; in cognitive terms, this offers a way to examine harsh interpretations of the self at one remove, of the kind Beck (1979) described, without requiring a young person to disclose their own. Chance or event cards distribute who has to speak, so that no single player becomes the focus of attention. Role-based decisions—what would this character do next, and what would follow—engage the practice component of the KAP structure as rehearsal rather than instruction, which matters because direct advice about help-seeking is precisely what informants expected youth to resist.

A facilitated debriefing at the end converts what happened in play into explicit knowledge, and provides the point at which accurate information can be stated plainly. These design propositions come from the present findings and existing game-based learning research; none has been tested in this population, and each would need to be examined for psychological safety as well as effect, particularly given that scenario-based content on depression can be distressing for players who recognize themselves in it.

Together, the four themes point to what a board game would need to do. It should explain depression in plain language and take some of the blame away. It should show that religious coping and professional care can support one another rather than compete. Moreover, it should give youth a low-pressure way to practice reaching out for help through in-game scenarios. Without these pieces, a game might be fun to play yet still miss the deeper barriers the interviews revealed.

Beyond its implications for game design, the study speaks to a broader question in population and social studies: how social and religious structures shape the recognition and management of a health condition. The material here suggests that stigma in this setting is not only interpersonal but discursive. It operates through a shared religious vocabulary that is otherwise a source of support, which is part of what makes it difficult to confront directly: challenging the misattribution risks being heard as a challenge to the faith. That has implications well beyond board games. It suggests that interventions that position professional care as an alternative to religious coping are likely to encounter resistance. In contrast, those that locate care within an existing framework of religious responsibility for health may not. This is consistent with accounts of help-seeking in other Muslim communities (alHarbi et al., 2023; Fekih-Romdhane et al., 2023) and extends them to a conflict-affected minority setting within a Buddhist-majority state, where language, religion, and the security situation are layered on top of the barriers documented elsewhere in Thailand (Ford et al., 2026; Panyawong et al., 2020; Seera et al., 2020).

Limitations

Several limitations should be kept in mind. First, the study reports perceptions and accounts. It did not observe depression-related behavior, recruit young people with a clinical diagnosis, or systematically collect first-person illness experiences, so conclusions about what young people actually do lie beyond its reach. Second, the youth informants were volunteers

recruited through community networks. Although they were selected from survey respondents whose answers indicated risk-related depressive behavior, young people who take part in community organizations may have higher baseline health literacy and greater willingness to discuss mental health than out-of-school youth, school leavers, or those isolated from such networks, who may face more stigma and be harder to reach. The findings should not be read as representing youth in the region as a whole.

Third, religious leaders, parents, and teachers were not interviewed, although all three appear in the data through others' accounts; religious interpretation, in particular, is therefore described here without the voices of those who hold religious authority. Fourth, primary coding was conducted by a single researcher. Triangulation across four informant groups, supervisory review of the analytic process and interpretations, and member checking strengthened trustworthiness, but independent double coding was not undertaken. Fifth, the design pre-committed to a board game: participants were asked about one, and game designers were recruited, so the enthusiasm reported here is an assessment of a proposed format rather than a comparison among alternatives. Sixth, sampling was purposive and snowball-based, so the findings are not intended to be statistically generalizable. Finally, despite the reflexive measures described earlier, the first author's insider position may still have shaped the interpretation.

Conclusion

This formative qualitative study examined how youth and stakeholders in Thailand's Southern Border Provinces understand depression and what they would require of a board game program intended to support depression prevention. Four themes were constructed: uncertain knowledge and misconceptions about depression; social stigma and religious misattribution that discourage help-seeking; religious coping bound up with avoidance and concealment; and a shared view that a board game would be acceptable if it joined accurate mental health information with culturally and religiously familiar content. Taken together, these accounts indicate that mental health promotion for Muslim youth in conflict-affected communities has to be both scientifically sound and locally meaningful.

For practice, the findings support proceeding with co-design and feasibility testing of a board game that teaches depression literacy while respecting Islamic values and local ways people talk about emotional distress. The requirements in Table 3 offer a starting specification. However, they are stakeholder requirements rather than a validated design: any game built from them should be co-designed with youth, mental health staff, religious scholars, and community members, rather than handed to them, in line with established co-design practice for youth mental health interventions (Chinsen et al., 2025). For policy, the findings suggest strengthening mental health education in schools across the Southern Border Provinces and engaging religious teachers as allies in reducing stigma.

Future research should co-design a prototype and then test it in sequence: its feasibility, its psychological safety for participants, and only then its effectiveness in changing depression literacy, stigma, and help-seeking intentions. Nothing in the present study establishes that a board game reduces depression or stigma; these findings generate a hypothesis rather than proving it. It would also be worth studying how mental health literacy can be woven into school activities, and how religious leaders might take part in community-based depression

prevention without deepening stigma, a question this study could not address because religious leaders were not among its informants.

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Use of AI tools

During manuscript preparation and revision, ChatGPT (OpenAI) supported English-language editing and revision, including language-level checking of translated quotations, restructuring selected passages, drafting text in response to reviewer comments, and improving clarity; Grammarly was used for grammar and readability checks. These tools were not used to collect data, transcribe or code interviews, develop themes, interpret findings, or generate any part of the results. The authors made all analytic decisions, reviewed the full manuscript, and take full responsibility for its accuracy and integrity. The authors checked AI-assisted suggestions against the original transcripts, the thesis, cited sources, and study records, and critically reviewed and revised them before inclusion. As a final pre-submission step, a native English-speaking language expert reviewed the English text for linguistic accuracy, clarity, and naturalness. The authors made all final wording decisions and verified the accuracy and existence of every cited reference.

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Appendices

Appendix A

COREQ 32-Item Checklist for Reporting Qualitative Research

No.	Item	Reported in the manuscript
Domain 1: Research team and reflexivity		
1	Interviewer/facilitator	All interviews were conducted by the first author (F.A.). (Materials and Methods - Researcher Reflexivity)
2	Credentials	Psychologist and doctoral candidate in human and social development. (Researcher Reflexivity)
3	Occupation	Psychologist with professional experience in the Southern Border Provinces. (Researcher Reflexivity)
4	Gender	Male. (Researcher Reflexivity)
5	Experience and training	Professional experience in the region and doctoral-level research training; the interview guide was expert-reviewed (IOC $\geq$ 0.80) and piloted. (Researcher Reflexivity; Data Collection)
6	Relationship established	Informants were recruited for their professional expertise or direct relevance; no prior personal relationship was required. (Participants)
7	Participant knowledge of the interviewer	Participants were informed of the study's purpose and the researcher's role during the informed consent process. (Ethical Considerations)
8	Interviewer characteristics	The first author's insider position was acknowledged and managed through a reflexive journal, supervisory review of the analytic process and interpretations, and member checking. (Researcher Reflexivity)
Domain 2: Study design		
9	Methodological orientation and theory	Qualitative design within an interpretive paradigm; qualitative content analysis following Elo and Kyngäs (2008), with inductive coding within the predetermined domains of the interview guide. Mental health literacy is the primary conceptual framework. (Research Design; Conceptual Framework; Data Analysis)
10	Sampling	Purposive sampling, with snowball sampling as a secondary strategy. (Participants)
11	Method of approach	Informants were approached directly and through referrals from other informants. (Participants)
12	Sample size	18 key informants. (Participants)
13	Non-participation	No informant who was invited declined to participate. (Participants)
14	Setting of data collection	Interviews took place at locations chosen by informants in Pattani, Yala, and Narathiwat. (Data Collection)
15	Presence of non-participants	Only the informants and the interviewer were present during the interviews.
16	Description of sample	2 psychiatrists, 2 board game experts, 10 youth volunteers aged 15–24 years, and 4 mental health personnel. (Participants)

No.	Item	Reported in the manuscript
17	Interview guide	Semi-structured guide covering three areas; reviewed by three experts (IOC $\geq$ 0.80) and piloted before use. (Data Collection)
18	Repeat interviews	Yes; follow-up (repeat) interviews were conducted with some informants for clarification. (Data Collection)
19	Audio/visual recording	Interviews were audio-recorded with participants' permission. (Data Collection)
20	Field notes	Field notes were made after each interview to record context, non-verbal cues, and reflections. (Data Collection)
21	Duration	Each interview lasted about 45–60 minutes. (Data Collection)
22	Data saturation	No new theme emerged after the 14th informant, and the four subsequent interviews were used to confirm that no further themes emerged. (Participants)
23	Transcripts returned	Transcripts were not returned to participants; however, summary findings were returned for member checking. (Data Analysis)
Domain 3: Analysis and findings		
24	Number of data coders	One primary coder. Coding was performed by the first author, with the analytic process and interpretations reviewed by the dissertation supervisor, alongside triangulation across the four informant groups and member checking. No independent double coding was undertaken; this is acknowledged as a limitation. (Data Analysis)
25	Description of the coding tree	Provided in Appendix B (codes, subcategories, and the four main themes).
26	Derivation of themes	Themes were developed from the interview data through open coding within the three domains covered by the interview guide, rather than assigned from a pre-existing coding frame; the analysis is therefore described as inductive coding within predetermined domains. (Data Analysis)
27	Software	ATLAS.ti was used to support coding and data management. (Data Analysis)
28	Participant checking	Member checking was carried out by returning summary findings to selected informants. (Data Analysis)
29	Quotations presented	Participant quotations are presented with identifiers (e.g., P1, Y5, M4). (Results)
30	Data and findings consistent	Findings are supported by participant quotations throughout the Results. (Results)
31	Clarity of major themes	Four major themes are clearly presented. (Results)
32	Clarity of minor themes	Sub-patterns are described within themes (e.g., social avoidance alongside religious coping). (Results)

Note: Checklist based on Tong et al. (2007). Each item refers to the section of the revised manuscript in which it is reported.

Appendix B

Coding Tree: Codes, Subcategories, and Main Themes

Theme 1: Limited Knowledge and Misconceptions about Depression

Uncertain understanding of depression

- Confusing depression with ordinary sadness, stress, or tiredness
- Interpreting symptoms as a lack of motivation

Misattribution of symptoms

- Attributing symptoms to laziness or weak faith
- Attributing symptoms to supernatural causes

Sources of information

- Social media (TikTok, Facebook, Instagram) as the first source
- Doubt about the accuracy of online information
- Little formal mental health education at school

Theme 2: Social Stigma and Religious Misattribution as Barriers

Community stigmatization

- Labeling as weak, lazy, or unable to control emotions
- Fear of judgment from family, neighbors, or peers

Religious misattribution

- Depression seen as weak faith or insufficient religious practice

Reframing by professionals

- Barrier arises from local misunderstanding, not Islam itself
- Islamic teaching supports care for both body and mind

Theme 3: Religious Coping and Social Avoidance

Religious coping

- Prayer, Quranic recitation, and du'a
- Consulting religious figures
- Religious coping as the first or only response

Social avoidance and concealment

- Withdrawal from friends and silence at school
- Concealment from family
- Distraction through online activity
- Concealment as self-protection from judgment

Theme 4: Requirements for a Board Game Integrating Cultural Responsiveness and Accurate Knowledge

Support for a board game

- Cross-stakeholder agreement on its usefulness

Conditions for acceptability

- Local situations, familiar language, and recognizable examples
- Accurate mental health information
- Avoiding content that makes players feel exposed

Functions valued by informants

- A character or scenario carries the difficult topic
- The game as a social bridge to correct misinformation and open discussion