PERSONAL GROWTH EXPERIENCES OF YOUNG ADULTS RECOVERING FROM MAJOR DEPRESSIVE DISORDER

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ABSTRACT

Major depression is one the most severe form of depressive disorder. In Malaysia, a remarkably increasing trend of the prevalence of depression among young adults was indeed an alarming phenomenon in the country and it necessitates responsiveness and act. The objective of this study was to investigate and describe the subjective personal growth experience of young adults recovering from major depressive disorder (MDD), taking an in-depth look at the essence of their personal growth journey during recovery based on their own perspectives. A qualitative, transcendental phenomenological research design was adopted by using in-depth, semi-structured, phenomenological three-interview series to collect data, supported with audio recordings, interview transcripts, and documents. A fitting sample of nine Malaysian young adults (one man and eight women) with MDD, ranging from 20-39 years (Mean age=28), were recruited from tertiary healthcare setting in Perak and Kuala Lumpur, Malaysia. Pseudonyms were used in a total of 27 in-depth interview sessions were carried out with each session ranging from 45 to 90 minutes. The method of data analysis was based on Colaizzi's phenomenology data analysis. The findings focused on the narrative sharing from young adults recovering from MDD, indicated by evidence in participants' statements. Research findings revealed a total of fourteen personal growth themes: (a) Revealing the struggles, (b) Self-discovery and personal strength, (c) Personal responsibility, (d) Readiness for change, (e), Hope, (f) Redefining the meaning, (g) Forgiveness, (h) Acceptance, (i) Supportive relationship, (j) Medication, (k) Attending counselling, (l) Religion and spirituality, (m) Care for others, and (n) Employment, which have facilitated the participants to recover from MDD. All emerging themes were separated into two main elements: personal growth processes (eight themes) and personal growth contributors (six

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themes). In conclusion, all themes in both elements were interconnected throughout the recovering journey of major depressive young adults. Hence, practitioners and researchers need to be more objective and conscientious of both elements to understand their prospective clients' personal growth experiences. The ability in identifying every aspect in personal growth processes and contributors will give extra credits for practitioners or researchers to embrace a holistic view of the personal growth experiences faced by young adults upon helping them to reach recovery stage. The crucial implications of this study for counselling and psychotherapy practice, education and training; psychotherapy models on personal growth and healing from MDD; future research; and policy development were discussed. It is recommended in the future to have more researchers conduct more qualitative studies as it will help contribute to deeper understanding about personal growth experiences recovering from MDD, particularly based on the young adults' perspective.

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PENGALAMAN PERTUMBUHAN PERIBADI ORANG DEWASA MUDA PULIH DARI KECELARUAN KEMURUNGAN MAJOR

ABSTRAK

Kemurungan major merupakan antara salah satu bentuk kecelaruan kemurungan yang paling teruk. Di Malaysia, trend yang meningkat secara ketara dalam prevalens kemurungan dalam kalangan orang dewasa muda memang merupakan fenomena yang membimbangkan dalam negara ini dan ia memerlukan kesegeraan dan tindakan. Objektif kajian ini adalah untuk meneroka dan memahami pengalaman pertumbuhan peribadi secara subjektif dalam kalangan dewasa muda yang melalui proses pemulihan dari kecelaruan kemurungan major (MDD), dengan mengambil pandangan yang mendalam tentang intipati proses pengalaman pertumbuhan peribadi mereka semasa penyembuhan berdasarkan perspektif diri mereka sendiri. Reka bentuk kajian kualitatif, transendental-fenomenologi telah diaplikasikan dengan menggunakan tiga tahap temu bual fenomenologi yang mendalam dan berstruktur separa untuk mengumpulkan data, serta disokong dengan rakaman audio, transkrip temu bual, dan dokumen. Peserta kajian melibatkan sembilan orang dewasa muda Malaysia (seorang lelaki dan lapan orang wanita) yang mempunyai MDD dan berumur dalam lingkungan 20-39 tahun (Purata umur = 28) telah direkrut daripada pusat rawatan kesihatan tertier di Perak dan Kuala Lumpur, Malaysia. Nama samaran telah digunakan dalam dua puluh tujuh sesi temu bual yang dijalankan dan setiap temu bual mengambil masa selama 45 hingga 90 minit. Data kajian dianalisis dengan menggunakan kaedah fenomenologi data analisis Colaizzi. Hasil kajian memberi tumpuan kepada perkongsian naratif daripada orang dewasa muda yang pulih dari MDD berdasarkan kepada keterangan dalam kenyataan peserta. Hasil kajian menunujukkan empat belas tema

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pertumbuhan peribadi: (a) Mendedahkan pergelutan dalaman, (b) Penemuan kendiri dan kekuatan dalaman, (c) Tanggungjawab kendiri, (d) Kesediaan untuk berubah, (e) Harapan, (f) Mentafsir semula makna, (g) Kemaafan, (h) Penerimaan, (i) Perhubungan yang menyokong, (j) Farmakoterapi, (k) Kaunseling, (l) Keagamaan dan kerohanian, (m) Aktiviti sosial, dan (n) Pekerjaan, yang telah membantu peserta untuk pulih daripada MDD. Semua tema yang muncul dibahagikan kepada dua elemen utama: proses pertumbuhan peribadi (lapan tema) dan penyumbang pertumbuhan peribadi (enam tema). Secara kesimpulannya, kesemua tema dalam kedua-dua elemen tersebut saling berkait sepanjang perjalanan pemulihan orang dewasa muda yang mengalami kemurungan major. Oleh itu, para pengamal dan penyelidik perlu lebih objektif dan teliti terhadap kedua-dua elemen untuk memahami pengalaman pertumbuhan peribadi bakal klien mereka. Keupayaan untuk mengenal pasti setiap aspek dalam proses dan penyumbang pertumbuhan peribadi akan memberikan kredit tambahan untuk para pengamal atau penyelidik untuk merangkul pandangan menyeluruh tentang pengalaman pertumbuhan peribadi yang dihadapi oleh orang dewasa muda semasa membantu mereka mencapai peringkat pemulihan. Implikasi penting dalam kajian ini terhadap amalan, pendidikan, dan latihan kaunseling dan psikoterapi; model psikoterapi mengenai pertumbuhan peribadi dan pemulihan daripada MDD; penyelidikan masa depan; dan pembangunan dasar telah dibincangkan. Cadangan bagi masa depan disarankan agar lebih ramai penyelidik menjalankan lebih banyak kajian kualitatif kerana ia akan membantu menyumbang kepada pemahaman yang lebih mendalam tentang pengalaman pertumbuhan peribadi yang pulih daripada MDD, terutamanya berdasarkan perspektif orang dewasa muda.

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LIST OF SYMBOLS AND ABBREVIATIONS

ACHA–NCHA	:	American College Health Association - National College Health Assessment
AIDS	:	Acquired Immune Deficiency Syndrome
AOO	:	Age-of-onset
APA	:	American Psychological Association
BDI	:	Beck Depression Inventory
BMI	:	Body Mass Index
CURES	:	Chennai Urban Rural Epidemiology Study
DASS	:	Depression, Anxiety and Stress Scale
DHHS	:	Department of Health and Human Services
DMDD	:	Disruptive Mood Dysregulation Disorder
DSM	:	Diagnostic and Statistical Manual of Mental Disorders
GAD	:	Generalized Anxiety Disorder
HADS	:	Hospital Anxiety and Depression Scale
HRPB	:	Hospital Raja Permaisuri Bainun
IPA	:	Interpretative Phenomenological Analysis
IPH	:	Institute for Public Health
LPPKN	:	*Lembaga Penduduk dan Pembangunan Keluarga Negara*
MDD	:	Major Depressive Disorder
MDE	:	Major Depressive Episode
MPA	:	Malaysian Psychiatric Association
NCS-R	:	National Comorbidity Survey Replication
NHMS	:	National Health Morbidity Survey
NIMH	:	National Institute of Mental Health

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NMRR	:	National Medical Research Register
NSDUH	:	National Survey on Drug Use and Health
OKU	:	Special Needs Person
PHQ-9	:	Patient Health Questionnaire 9
PIMH	:	Perinatal and Infant Mental Health
PTSD	:	Post-traumatic Stress Disorder
PMR	:	Lower Secondary Evaluation
SADS-L	:	Schedule for Affective Disorders and Schizophrenia-Lifetime Version
SAMHSA	:	Substance Abuse and Mental Health Services Administration
SPM	:	Malaysia Certificate of Education
U.S	:	United States of America
WHO	:	World Health Organization
WMH	:	World Mental Health
WMH-CIDI	:	World Mental Health Composite International Diagnostic Interview

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Chapter 1 Introduction

Background of the Study

Globally, depression is a prevalent but severe disorder which may affect anyone (U.S. Department of Health and Human Services, National Institutes of Health [NIH], National Institute of Mental Health [NIMH], 2015a). Hence, it is believed to be the prominent root of disability worldwide, and at any rate, about 350 million people are experiencing with depression (World Health Organization [WHO], 2012). Depression in Malaysia is reported as one of the most frequent mental illnesses reported which affects nearly 2.3 million people in the long term in their lives, but regrettably, this mental disorder remains under-detected and untreated (Mukhtar & Oei, 2011a, 2011b). Furthermore, from the literature reports the prevalence of depression in Malaysia was estimated to be between eight to twelve percent (Ng, 2014). Mukhtar and Oei (2011a) indicated that in Malaysia, the picture of depression is still fragmented and vague.

Given that, in Malaysia, a survey named National Health Morbidity Survey (NHMS) is administered and conducted once every ten years, with the first, second and third edition performed in 1986, 1996, and 2006 respectively (Director General of Health Malaysia, 2014). Starting from the year 2011 until 2014 (NHMS IV), NHMS was conducted in a four yearly cycle of annual data collection including mental health problems (Institute for Public Health [IPH], 2015). Recently, the current round of survey (NHMS V) has yielded the first and latest report for 2015. The results revealed that the percentage of young adults aged 16 years and above in Malaysia who have mental health problems (particularly depression), has presented a growing trend of the prevalence, featuring an increase from 10.7% (in 1996) to 29.2% (in 2015). In other words, depression was generally higher among younger

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adults, wherein young adults aged 16 to 19 (34.7%) was the highest, followed by aged 20 to 24 (32.1%), and aged 25 to 29 (30.5%) (Ahmad et al., 2015).

Meanwhile, according to Ng (2014), in Malaysia the prevalence of depression was estimated to have remarkably significant increasing in trend, summarizing the findings of 57 published articles in Malaysia about depression, between the years 2000 to 2013. Concerning treatment for depression in Malaysia, it is vastly suggested in local clinical practice guidelines both pharmacological treatment and psychotherapy which is more commonly used in regional healthcare settings. Additionally, Mukhtar and Oei (2011a) reviewed 13 published articles on the commonness of depression studies conducted in Malaysia and had reported that the prevalence figures varied from as low as three point nine percent to as high as 46%, which might be limited by local factors and methodological differences.

Unsurprisingly, one of the mental illnesses that have made headlines in worldwide is the increase in the number of depressed people, a consequence of a lot of factors. Having said that, Kessler and Bromet (2013) revealed that up to 20% of adults and up to 50% of children and adolescents were reported to develop depressive symptoms throughout the world. Major depressive disorders were said to have an early onset at a younger developing age, decrease one's functioning, and frequently are recurring (Marcus, Yasamy, van Ommeren, Chisholm, & Saxena, 2012). Wherein, one in four young adults at some point in their lives, will experience a depressive episode (Kuwabara, van Vorhees, Gollan, & Alexander, 2007). Consequently, depression will become the preeminent cause of deficiency worldwide concerning total years dissipated due to this disability, and at least 350 million people in all populations across the world live with depression (Marcus et al., 2012; WHO, 2012). For instance, there is also an increasing global need to curb depression

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as well as other mental health illnesses (Kuwabara et al., 2007; Marcus et al., 2012; Ng, 2014).

Statistically, in terms of gender, statistics in the United States suggested that adult females were diagnosed two to four times as often as males (Culph, Wilson, Cordier, & Stancliffe, 2015; Leach, Christensen, Mackinnon, Windsor & Butterworth, 2008; Rochlen et al., 2010). It was recorded that males succeed in deliberately killing themselves at approximately four times the frequency of females and represented 77.9% of all suicides even though women are particularly than men to have suicidal thoughts (U.S. Department of Health and Human Services, NIH, NIMH, 2015a; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014).

Correspondingly, NIMH (2013) underlined that apart from major depression and other depressive disorders that affect both genders, it has been found that women are also affected by postpartum depression and premenstrual dysphoric disorder. For instance, a woman is believed to have postpartum (or peripartum) depression if the depressive symptoms emerged either at the time if pregnancy or during the confinement month/the month after delivery, and there is an increased risk among individuals who have had occurrences of depression previously before pregnancy. On the other hand, premenstrual dysphoric disorder includes symptoms that continuously occur a week before one's menstrual cycle and intensification within a few days (e.g., severe mood swings, depressed mood, and anxiety), which are serious enough to disrupt everyday events or routines and interactions with others.

In reality, the outcome of depression will often be regarded as a problem which affects both the depressed person and their loved ones, but it remains hidden and unspeakable (Ng, 2014). Although it is treatable, most people with depression

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refuse effective treatments due to the lack of access to treatments, the limited understanding of the consequences of depression, lack of family cohesion, socioeconomic and the stigma associated with depression which lead to social insincerity (Malaysian Psychiatric Association [MPA], 2006; WHO, 2012). Furthermore, depression is also associated with direct and indirect financial burdens as a result of incapability to work, health utilization expenses, and even costly to caregivers (e.g. families and relatives) who have to take care and support their loved ones who are diagnosed or experiencing depression (MPA, 2006). In a WHO paper written for World Federation for Mental Health 2012, mental illness particularly depression was a notable contributor to the worldwide affliction of disease (Marcus et al., 2012).

Depression may lead to suicide at its worst (Marcus et al., 2012), and the most common disorders associated with suicidal behaviour were depression and alcohol use disorders (WHO, 2014). As estimated by the WHO, in the year 2020 in the Asia Pacific, a higher number of people will die because of suicide instead from tuberculosis region whereby the most frequent cause of people taking their lives is depression (MPA, 2006). WHO's (2014) first report on suicide prevention revealed that more than 800 000 people died of suicide annually, with around one person every 40 seconds. The estimated suicide rate was the highest in the WHO South-East Asia Region, which showed a peak among the young and the second peak among the elderly. In the same report, the myth that people who talk about suicide do not mean to do it is real, in a sense that these people were experiencing anxiety, depression, hopelessness, and may be reaching out for help or support.

In addition, other illnesses may also cause depression, or become a consequence of major depression. For instance, people experiencing anxiety

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disorders, (e.g., post-traumatic stress disorder (PTSD), obsessive-compulsive disorder, panic disorder, social phobia, and generalized anxiety disorder), were commonly prone to have underlying depression, especially PTSD (Culph et al., 2015). Mood disorders normally occur together with alcohol and other substance abuse or dependence. On another note, depressed individuals with co-occurring serious medical or physical illnesses (e.g. heart disease, stroke, cancer, AIDS, diabetes, and Parkinson's disease) have more struggles and frustrations adjusting as well as adapting to their medical illness. They also have to spend higher medical expenditures than individuals who don't have co-existing depression (U.S. Department of Health and Human Services, NIH, NIMH, 2015b).

Consequently, there were higher extents of people with major depression among younger individuals due to the highest rates of onset and current depression among those in their late teens (youth) and early 20s (early adulthood) (Eisenberg, Golberstein, & Gollust, 2007a; U.S. Department of Health and Human Services, NIH, NIMH, 2012). NIMH (2012) also stated that numerous people experienced the first signs of depression in their college years or another word, young adult years. However, many depressed college students were not seeking the help that they need. This may be due to the lack of knowledge of where to go for help, the belief that treatment will not alleviate the judgmental view of others if they get mental health care, or some of them view their symptoms as merely part of the typical stress of college (Eisenberg, Gollust, Golberstein, & Hefner, 2007b). In 2011, the findings of a national survey of college undergraduates at a second and fourth year of study, the American College Health Association - National College Health Assessment (ACHA–NCHA) revealed that approximately 30 percent of college undergraduates testified feeling so depressed. They reported that it was challenging to perform and

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function daily even prior or during their college years (American College Health Association [ACHA], 2012).

Undeniably, the experience of an emotional turmoil among depressed individuals as they struggled to understand what is happening to them, despite being relatively well studied in older adults, much less was identified about such responses and experience of depressed young people (McCann, Lubman, & Clark, 2012). McCann et al. (2012) in their study with an objective to explore young people's experiences who diagnosed with depression. The findings revealed the emerging overlapping themes which indicated that young people might respond to their depression in few ways such as in self-protective, destructive and sometimes life-threatening actions. They were (1) struggling to cohere of their depression, (2) rolling down, (3) withdrawing from peers, and (4) intending self-harm or suicide.

Although past researchers have shown research interest in topics regarding depression continuously, a much more considerable effort was required to look into depression issues among young adults, with a focus on their personal growth and recovery experiences (McCann et al., 2012). Thus, with this in mind, young adulthood was a life stage that attracted increasing attention from researchers, as it appeared to be a period of possibilities and a time of progressing psychological pressure (Arnett, 2000; Kuwabara et al., 2007). This notion was supported by Erikson's (1959, 1968) developed ideas on human and psychosocial development wherein he illustrated adolescence as a phase of identity crisis and inner conflict, while young adulthood is having the crisis of intimacy versus isolation.

Hence, it was vital to understand the personal growth experiences recovering from major depressive disorder among young adults to have an in-depth understanding of the crisis in young adulthood particularly those who suffered from

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major depressive illness. Fundamentally, personal growth is indicated as any process by which individuals gain in mindfulness or understanding of themselves (personal awareness), and as an outcome, experiences changes in their thoughts, emotional state, beliefs or values, attitudes, behaviours, or perspectives of themselves in a route of improved congruency and truthfulness with their personal goals and values in lives (Ryff & Singer, 1996). On the other hand, personal healing referred to a foremost focus on the recovery process following a coping stage (Onken, Craig, Ridgway, Ralph, & Cook, 2007). As a part of self-managing one's life and mental health to reduce psychiatric symptoms and achieve higher levels of wellness (Onken et al., 2007; Ridgway, 1999), personal recovery involved an on-going process of positive internal growth and healing in the mind, body, and spirit (LeCount & Koberstein, 2000; Onken et al., 2007).

Similarly, considering symptomatology, personal healing or recovery was contextualized from two important perspectives: first, beliefs in recovery in the nonappearance of depression symptoms (Davidson & Strauss, 1992; Tooth, Kalyanasundaram, & Glover, 1997) and second, beliefs in recovery as a definite sense of personal growth and self-achievement regardless of lasting symptoms or acknowledging individual's capability in overcoming the public impression of the illness such as stigmatizing, discrimination, bias, social-structural dogmas and customs (Crowley, 2000; Deegan, 1996; Onken, Dumont, Ridgway, Dornan, & Ralph, 2002; Onken et al., 2007).

Furthermore, personal recovery from major depression was not only limited to relief of symptoms or response to treatment but also the improvement in personal growth, psychological well-being and quality of life (Burcusa & Iacono, 2007). Therefore, research on young adults' personal growth recovering from major

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depression centred by their view and live experience has positive research value, and it was needed. The current study aimed to provide such unique data to practitioners concerning the personal growth experiences of young adults with major depression that stamp from the individual interpretation of their perspectives.

In this study, the terminology personal growth will be used throughout to describe the young adults' personal growth experiences recovering from major depressive disorder.

Statements of the Problem

In Malaysia, the current survey (NHMS V) yielded the latest report in 2015 revealed that the prevalence of depression was estimated to have remarkably significant increasing trend among adults aged 16 years and above in Malaysia which increased from 10.7% in 1996 to 29.2% in 2015 (Ahmad et al., 2015; Ng, 2014). This increasing statistics also meant that the number of depressed adults will continue to increase over the years and it has indicated a manifestation that is distressing to the society in general. Besides, one of the mental health illnesses that should not be ignored is depression due to its immense morbidity and strain. Depression generates deficiency in functional well-being and abate in quality of life (Lim, Jin, Ng, 2012; Rapaport, Clary, Fayyad, & Endicott, 2005), decrement in health (Moussavi et al., 2007), physical distress and health problems (Strine, Kroenke, Dhingra, Balluz, & Gonzalez, 2009). Subsequently, depression may cause deficiencies in one's role at home, work, relationships and social structure (Chong, Vaingankar, Abdin, & Subramaniam, 2012). These can result in limitation of daily life events (Strine et al., 2009), job insecurities (Lee, Park, Min, Lee, & Kim, 2013), and increased possibility of early mortality because of physical illnesses and suicide

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(Kessler & Bromet, 2013) which will negatively impact our social welfare. Hence, there is an urgent need to stretch out to this group of people.

There is an increasing awareness on the importance of achieving recovery from major depression, avoiding adverse outcomes (e.g. relapse), and preventing chronicity (Chong et al., 2012; Lee et al., 2013), yet lacking understanding of major depression, its personal growth towards healing and recovery made this mental health issue remain undetected and untreated (Mukhtar & Oei, 2011a; Ng, 2014). Furthermore, the risk of a major depressive disorder to worsening or becoming chronic depends on residual subthreshold depressive symptoms during recovery (Judd et al., 2000). Hence, understanding depression and the fact that it is treatable are important in increasing the depressed person's willingness to seek professional help, improving symptoms, refining coping, and reducing the risk of relapse (Christensen, Griffiths, & Jorm, 2004; Roh, Jeon, Kim, Cho, Han, & Hahm, 2009; Thompson, Hunt, & Issakidis, 2004). Psychological well-being, for instance, personal growth includes a strengthened sense of autonomy, mastery, and self-acceptance. Therefore, these positive attitudes and perceptions were considered important because there was evidence that the absence of well-being (e.g. personal growth) creates vulnerability to relapse (Dowrick, 2009).

Meanwhile, most of the studies were conducted in Western settings. On the other hand in Malaysia, researches related to depression done in local universities remain unpublished (Ng, 2014). People who developed depression experienced emotional turmoil as they struggled to understand what was happening to them. While the experience has been comparatively well documented in older adults, much less was known about the personal growth and healing experience of young adults with depression in Malaysia. Thus in this study, the researcher intends to explore the

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personal growth experiences of young people diagnosed with major depression recovering from it.

While reviewing the literature on the personal growth experience recovering from major depression, remarkable difficulties were encountered due to the lack of studies on this area thus making the understanding of such experience from young adults' perspective more challenging. Although adolescent depression received an enormous literature that covered the clinical and treatment findings, socio-demographic issues, and etiological perspectives (Hammen, 2009), there was a notable lack in studies of major depression in Malaysia (Mukhtar & Oei, 2011a, 2011b) that place an emphasis on young adults' personal growth perspective in terms of recovery and healing. This appeared to be restraining the unique personal growth among young adults regarding their own experiences dealing or struggling with major depression. As a result of the lack of studies regarding young people's perspective on major depression, the current concepts which were based on major depressive adults' perspective was expected to contribute to the existing literature, especially in Malaysia.

As for researchers, to get a holistic view of the full impact of depressive disorders in young adulthood, further work is needed on the interactions between depressive symptoms, health care system factors, and developmental pathways during this important developmental period (Kuwabara et al., 2007). Besides that, the findings of Kuwabara et al. (2007) also stressed the need for clinicians working with young adults experiencing depressive disorders to investigate how they comprehended their own illnesses in their own healing and personal growth that helped them recover functional status and prevent delayed developmental milestones. Thus, it is important to have more studies aimed at promoting a deeper understanding

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of the personal growth experiences in terms of personal growth processes and personal growth contributors of these recovering from major depression based on young adults' perspective. The outcome of this study provides ideas for practitioners and clinicians to plan their interventions when working with depressed young people.

It is essential to allow young people to label their major depression using their terminology, in order to gain a better understanding of depression in this population (Breland, Burriss, & Poole, 2010). Therefore, instead of focusing on a narrowly defined set of clinical symptoms, it was suggested to acknowledge and support the young people's self-description of depression, their individual strengths, personal growth and healing process, as well as promoting positive and safe outlets for anger and externalizing behaviours to them (Ofonedu, Percy, Harris-Britt, & Belcher, 2013).

The information derived from literature review led to the revealing of the research gap in understanding personal growth recovering from major depression. The personal growth of individuals recovering from depression did not indicate the condition of being free of symptoms but on the ability of individuals previously struggling with depression to function well, and to develop a sense of personal well-being. However, most researches highlighted symptoms relief rather than focused on depressed persons' positive personal growth experiences (e.g. healing) of countering the intensification of suffering from depression (Martínez-Hernáez, DiGiacomo, Carceller-Maicas, Correa-Urquiza, & Martorell-Poveda, 2014). This may result in researchers facing limitations in understanding the actual phenomenon encountered by major depressive young adults.

As Erikson's (1959, 1968) formulated ideas on psychosocial development, young adults are facing a vast challenge in their developmental movement. During

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adolescent years they are facing identity crisis and inner turmoil, while the crisis in young adulthood is one of intimacy versus isolation (Erikson, 1959, 1968). Hence, the feelings of discouragement and a diagnosis of major depression appeared to aggravate young adults' situation, inviting greater threats for both mental and physical health wherein making their lives even more miserable (Haarasilta, Marttunen, Kaprio, & Ario, 2003). While, personal growth, on the other hand, casts some light on reducing the negative consequences of major depression, by which the term itself provides positive meaning, adding to the sense of well-being and healing among depressed young adults.

In summary, the importance of understanding the lived experience in informing the development of appropriate early intervention services for young people with depression was illustrated by McCann et al. (2012). Despite much considerable research, not much was documented on the symptomatology and treatment of depression in adults and, to a lesser extent, on young people (Haarasilta et al., 2003; McCann et al., 2012), limited research has been conducted concerning major depressive adults' personal growth and recovery experiences. Hence, a qualitative approach based on young adults' perspective is considered the most suitable for this study to close this considerable research gap. The outcome of this study provides ideas for practitioners to understand and assist their clients or patients from different perspectives as well as to promote positive mental health awareness to the society pertaining major depression.

Purpose of the Study

The phenomenological research study is aimed at gaining a better understanding of the subjective personal growth experience of young adults recovering from major depressive disorder. The purpose of this study is to take a

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more in-depth look at the essence of young adults' personal growth experiences recovering from major depressive disorder based on their own perspectives.

Research Question

In this study, the question of, "How do young adults experience personal growth recovering from major depressive disorder?" was used to ensure an in-depth discovery. The question was asked to seek and to identify the essence of the personal growth experience of young adults who have recovered from major depressive disorder.

Significance of the Study

The current study aimed to understand the personal growth experience among major depressive young adults. Findings of the study have contributed to the following areas.

Firstly, this study was envisioned to provide rich and detailed description of the personal growth experience encountered by young adults with major depression for creating awareness and provide assistance for mental healthcare professionals such as general practitioners, psychiatrists, clinical psychologists and counsellors in order to enrich the provision of quality services in mental health profession (Badger & Nolan, 2006; Comninos & Grenyer, 2007; Fullager, 2009; Hill, 1999; Houghton, 2007; Peden, 1992, 1996; Ridge & Ziebland, 2006; Steen, 1996; Vidler, 2005). It is crucial to grasp what are the lived experiences of the young adults who diagnosed with a major depressive disorder. Understanding this unique piece of information is remarkably beneficial to counsellors or psychotherapists for them to set an effective direction in counselling sessions when dealing with young adults with major depression.

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Next, treating depressed individuals required great effort and helping depressed clients involved greater challenges even at the exploration stage (von Below, Werbart, & Rehnberg, 2010). This study furnished first-hand personal growth experiences from the young adults' own words which can help deeply hidden depression among them. By understanding the personal emotional turmoil and the meaning of individual's personal growth healing from major depression, fitting information could be considered to develop a more specific module and model targeting the young adults in a multicultural country. Hence, this study also marked a crucial consideration for attempts to develop a depression scale that is more applicable to young adults Malaysian as well as individuals of other age groups.

Thirdly, uniquely, insight into the personal growth experience significantly helps in the early identification of depression in young adults which provides a new or expanded basis of care that may reduce or diminish the negative ramifications of depression, and potentially decrease the incidence of relapse. Moreover, understanding the context in which young adult depression occurred can influence strategies for prevention. It was also important to improve mental health literacy in the community to increase awareness of depression, to connect with major depressive people and how mental health professionals, including counsellors, respond effectively to the major depressive young person. It has been found that young adults often have to embrace negative attitudes and beliefs about depression treatment (Kangas, 2001; Karp, 1994; Lewis, 1995; Maxwell, 2005), which delayed them from seeking early diagnosis and treatment for depression and motivated the intention not to accept the physician's diagnosis of depression (Cornford, Hill, & Reilly, 2007; van Voorhees, Fogel, Houston, Cooper, Wang, & Ford, 2005).

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Fourthly, understanding the lived personal growth experience is essential in developing appropriate early intervention services for young people with major depression. To date, limited research has been conducted in this aspect despite considerable research documenting the symptomatology and pharmacological treatment (Martínez-Hernández et al., 2014) of depression in adults and, to a lesser extent, on young people. Besides, in most studies conducted on major depression, it is often connected with a wide range of negative attributes people make about it (Cornford et al., 2007). Therefore, this study adopts a qualitative approach, despite the value of such methodology for providing a deep and rich understanding of young people's personal growth journey recovering from major depressive disorder. Essentially, the outcome of this study will provide a significant need to improve young people's understanding of depression and its treatment, reducing community stigma and providing accessible and youth-focused services will remain as an important target for intervention.

Fifthly, the entire study was expected to provide a new direction on researches about major depression, especially in the Malaysian context. This topic is especially crucial for settings in Malaysia as there was a total lack of studies on depression focusing on young adults (age 20 – 39) in relation to the country's population (Mukthar & Oei, 2011; Ng, 2014). In addition, by exploring young adult's personal growth recovering from major depression, the outcome of the research findings aimed to bridge and to fill in the gap between the past and the current research papers. Substantially, the bridged knowledge gap is assisting and refining the training, education, and skills of the helping professionals. This study also revealed useful information used to address issues related to the experience of

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depression by including perspectives and responses solely among young adults in a phenomenological study.

Lastly, the findings of this study were aimed to contribute to current psychotherapy theories in order to understand major depressive young adults' personal growth experiences recovering from major depression. In this study, four theories were identified and reviewed. They were: existential theory, multiple self-states theory, cognitive theory, and comprehensive model of healing. In this study, existential theory specifically logo theory successfully highlighted the importance of the personal growth process and contributors or resources used by the participants to experience recovery from major depression. These theories were used to provide an understanding of personal growth experience encountered by major depressive young adults. The identified models described depression and personal growth experience of individual suffering from major depressive disorder using their own strengths. Each model was able to present the inner and outer resources that assisted individuals in personal growth journey recovering from major depression. However, in order to describe the contributors and processes involved in individuals' personal growth journey recovering from major depression, each model mentioned was unable to completely stand alone. Therefore, the findings of this study are plausible to be applied as a framework by the theorists to enrich the contemporary theories as well as to create new personal growth and healing theories related to major depression.

Theoretical Framework

Theoretical framework is defined as "any empirical or quasi-empirical theory of social and/or psychological processes, at a variety of levels (e.g., grand, mid-range, and explanatory), that can be applied to the understanding of phenomena" (p. 869) and "for researchers who embrace the pervasive and influential role of theory in

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qualitative research, the entire research process is theory-laden" (p. 870) (Given, 2008). The theoretical framework for this study was not decreed the research process uncritically but was to provide a guideline for this research while taking perspectives of the participants seriously (Given, 2008).

The main theoretical framework for this research was existential theory (May, 1983). This theory was used to capture the individual strengths of young adults with major depression in their healing journey, for instance, personal growth based on the key theoretical principles of the existential theory of psychotherapy which included the I-am experience, four existential ways of being, the daimonic, the nature of anxiety, normal and neurotic guilt, existential psychodynamics, existentialism and pessimism, self-awareness, and theory of psychopathology (Sommers-Flanagan, & Sommers-Flanagan, 2015).

The key theoretical principles mentioned above were united as the world of a person, as described by Rollo May (1983). Substantially, in existential theory, the self of being and the searching of meaning both play a significant role in an individual's journey to personal growth and healing. The important search of meaning was addressed in detail by Frankl (1984).

Viktor Frankl developed and tested himself the concept of logotherapy and existential analysis (Wong, 2014). Existential-logotherapy means healing or therapy through meaning and literally with three basic tenets (Wong, 2014) or phenomenological assumptions (Lewis, 1995): freedom of will (one's freedom to choose his response to the life conditions), the will to meaning (the basic human desire or motivation to understand one's own purpose of life), and the meaning of life (one should discover his own specific meaning of life that is already present, not to invent a meaning) (Frankl, 1967, 1969, 1986, 2000; Lewis, 1995; Wong, 2014). In

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Frankl's beliefs, depression occurred at the psychological (feelings of inadequacy when trying an attempt beyond one's ability), physiological (the energy would drain away) and spiritual levels (when one is tensed about who he is and who he thinks he should be) (Souter, 2013).

From Frankl's theoretical perspective, he claimed that humans have a will to meaning and that meaning exists in the world and is up to us to find it, which in other words, individuals are by nature meaning focused and motivated by the desire to understand the world in which they live and to search for something out there that demands their devotion (Frankl, 2000). Thus, Frankl referred his psychological model as dimensional ontology, in which the spirit has included an understanding of the human person and in the clinical techniques derived from this model (Frankl, 2000; Lewis, 1995; Wong, 2014).

In sum, the existential theory's description of healing was parallel with the research outcome particularly in the aspect of the personal growth process and contributor elements. All the major depressive young adults faced struggles in their journey of personal growth and recovery from major depression. It required them to build and use their inner resources as well as outer resources in assisting them to experience personal growth and healing.

Figure 1.1 depicts the theoretical framework used as a guiding map in this study.

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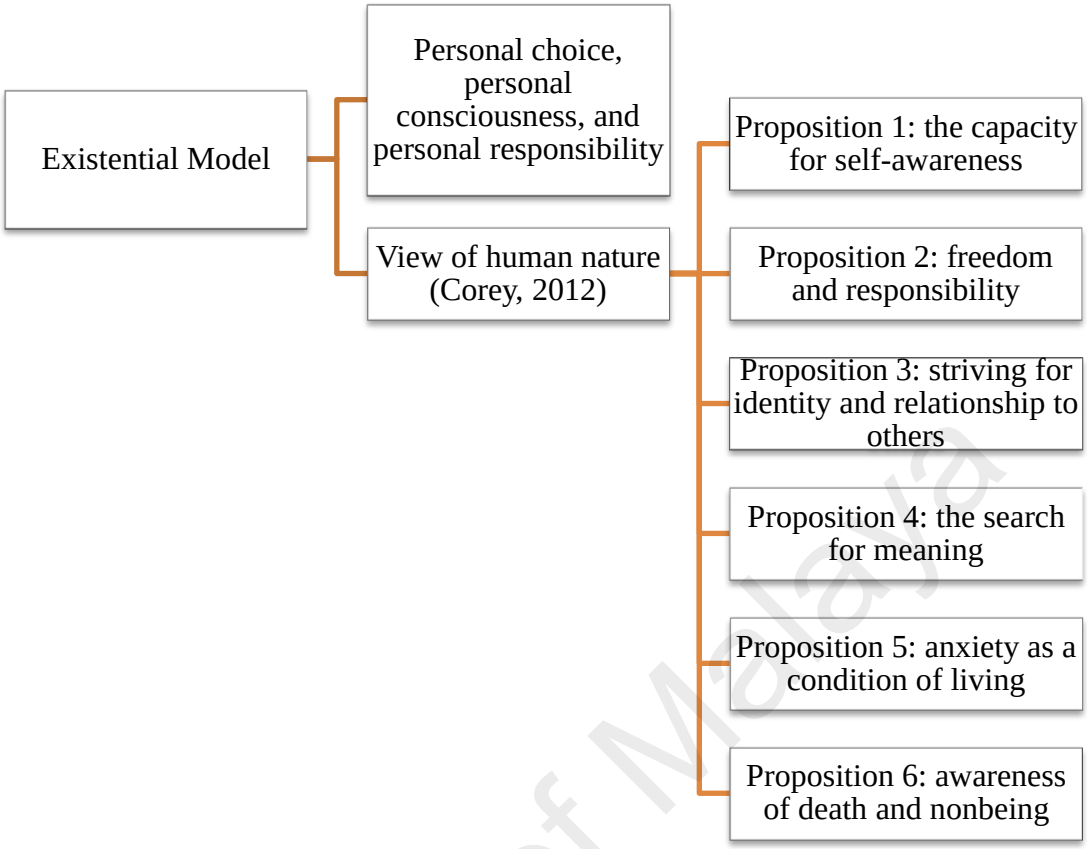

Figure 1.1. Theoretical framework (Source: Corey, 2012)

Operational Definitions

For the purpose of this study, seven important terminologies are further clarified. They are: depression, young adult, major depressive disorder / major depression, major depressive young adult, recovery / healing, personal growth, and personal growth experience. The operational definitions for each term are listed below.

Depression. *Dictionary of Psychology* defined depression as a psychoneurotic or psychotic disorder marked especially by sadness, inactivity, difficulty in thinking and concentration, a significant increase or decrease in appetite and time spent sleeping, feelings of dejection and hopelessness, and sometimes suicidal tendencies.

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Young adult. Defined as a person in the age range of 19 to 40 years old (Erikson, 1959, 1968).

Major Depressive Disorder / Major Depression. Defined by the *Diagnostic and Statistical Manual of Mental Disorders: DSM-5* (2013) as "a period of at least two weeks during which there is either a depressed mood or the loss of interest or pleasure in nearly all activities." The individual also experiences at least four additional symptoms drawn from a list that includes changes in appetite or weight; disturbances in sleep and psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating or making decisions; recurrent thoughts of death or suicidal ideation, plans, or attempts. The symptoms persist for most of the day, nearly every day for at least two consecutive weeks. The episode is accompanied by clinically significant distress or impairment in social, occupational, or other important areas of functioning. For some individuals with milder episodes, the function may appear to be normal, but requires markedly increased effort. In more extreme cases, the person may be unable to perform minimal self-care or to maintain minimal personal hygiene. These two terminologies were used interchangeably in this study.

Major depressive young adult / Young adult with major depression Defined as a person in the age range of 19 to 40 years old who is diagnosed with Major Depressive Disorder / Major Depression. These terminologies were used interchangeably in this study.

Recovery / Healing. Indicated a full remission that lasts for a defined period and conceptually, it refers to the end of an episode of the illness but not the end of the illness itself (Frank et al., 1991). These terminologies were used interchangeably in this study.

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Personal growth. Indicated as one of the important components of individual's psychological well-being which encompasses being aware of one's thoughts, emotional state, biases, and judgments and to be able to apply this particular understanding to act with conscientiousness and in better unity with his values and one's potential (Ryff & Singer, 1996).

Personal growth experience. Indicated as a continual development process of being conscious with one's psychological healing / recovery experience or transition from a place of inertia in his or her depression to an engagement in the personal growth process. Individual formed new relationships that supported his / her personal growth journey of healing and engaged in the necessary recovery and personal development to effect change, integrating new strategies into his / her life (Onken et al., 2007; Ryff & Singer, 2017).

Limitations of the Study

The findings of this study were the only representative of the participant's group. A total of nine young adults were identified through purposeful sampling. Purposive sampling, however, did allow young adults recovering from major depression to give testimony to their unique descriptions of their personal growth journey. The aim of this study was to gain an in-depth understanding of young adults' personal growth journey recovering from major depressive disorder. The outcome of the study findings cannot be generalized to all the young adults who have a major depressive disorder in Malaysia.

Chapter Summary

Major depression is one of the most severe forms of the depressive disorder. Every year it interferes with the ability to function for 121 million persons (Marcus et al., 2012). In Malaysia, statistics disclosed a remarkably significant increasing

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trend of the prevalence of depression among young adults aged 16 years and above which has increased from 10.7% in 1996 to 29.2% in 2015. This was indeed an alarming trend in the country and it necessitates responsiveness and action. The findings of this study described the experiences of the young adults during their personal growth journey of recovery from major depressive disorder. This information has apprised counsellors, psychotherapists, and other mental health professionals of the importance of developing approaches to help young adults with major depressive disorder in order to effectively support their recovery. Furthermore, in order to assist and to connect with young adults with major depression in overcoming their emotional turmoil, anguish and despair so that they are able to function in their daily lives, an effective intervention is essential to identify positive coping mechanisms to manage their personal lives. Subsequently, to develop such an effective intervention, individuals' perspective on personal growth recovering from major depressive disorder was undeniably needed in order to have a holistic view of personal growth experience recovering from major depression. One of the personal growth processes that helped them to recover was to speak out and to reveal their struggles in major depression. Hence, they were able to share their recovery journey through research studies based on their voices. Essentially, this study provides a source for young adults who have experienced recovery from major depression to share their personal growth experience. Next chapter discussed past literature related to this study.

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Chapter 2 Literature Review

Introduction

This chapter encompassed literatures that were reviewed and organized into eight sections. They are: epidemiology of depression, the emic of depression, treatment approach, the prevalence of depression, model of personal growth and healing, past research on personal growth and healing experiences, overview research of depression in Malaysia, and major themes in personal growth recovering from depression. Deficiencies in literature related to the personal growth experience of young adults recovering major depression are stated in the final part of the chapter.

Epidemiology of Depression

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), depressive disorders comprises the presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the one's capacity to function (American Psychiatric Association, 2013). For instance, the listed depressive disorders in the DSM-5 include disruptive mood dysregulation disorder (DMDD), major depressive disorder (MDD), persistent depressive disorder (Dysthymia), premenstrual dysphoric disorder, substance / medication induced depressive disorder, depressive disorder due to another medical condition, other specified and unspecified depressive disorder. Currently, the DSM-5 includes a relatively new diagnosis which is identified as disruptive mood dysregulation disorder (DMDD) to address concerns about the potential for over diagnosis of and treatment for bipolar disorder in children. Major depressive disorder in the DSM-5 is described as a classical illness in depressive disorders which characterized by presenting depressive symptoms "during the same 2-week period and represent a

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change from previous functioning" with "at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure" (American Psychiatric Association, 2013).

Furthermore, Beck (1967) stated in his book, Depression: Clinical, Experimental, and Theoretical Aspects, mentioned that depression has been categorized under the classification of melancholia as labelled by a number of primordial writers including Hippocrates who came out with the first clinical explanation of melancholia in the fourth century B. C. Looking back at these symptoms described, the descriptions of depression and fundamental signs and symptoms used today in diagnosing depression greatly matches those stated by ancient philosophers and physicians alike with signs such as disturbed mood, self-castigation, self-debasing behaviour, wish to die, physical and vegetative symptoms (agitation, loss of appetite, weight-loss and also sleeplessness) and also delusions of having committed unpardonable sins (Beck, 1967).

From above, it can be noted that the manifestations of depression has been observed since the age of antiquity with regards to various aspects of behaviour including traditional psychological divisions of affection, cognition, and conation as indicated by historical descriptions. Beck (1967) described depression in terms of few attributes. These attributes are: (1) a definite change in mood such as sadness, loneliness, lethargy; (2) a destructive self-concept related with self-criticisms and self-blame; (3) regressive and self-punitive desires such as wishes to desertion, hide, or end his life; (4) vegetative alterations such as anorexia, sleeplessness, loss of libido; and (5) change in movement such as delay or anxiety.

On the other hand, Hammen and Watkins (2008) believed that for a non-professional (e.g. lay-person) and the usage in daily language, the terminology of

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“depression” indicates a series of experiences which ranges from hardly noticeable temporary shrink in mood to a subtle diminishing or a serious disorder. It was noted by them unlike what was understood by a lay-person, depression referred as an assemblage of experiences containing not only mood, but also physical, mental, and behavioral experiences that describes more elongated, impairing and severe illnesses that may be clinically diagnosable as a syndrome of depression. Contrary from Beck's understanding which focused on specific attributes, Hammen and Watkins (2008) concentrated on four universal domains (broader domains when compared to Beck's) which comprise cognition, behaviour, affection, and functioning.

Regarding affective symptoms, Hanafiah and Van Bortel (2015) indicated that depression classically ambiguous itself as feeling low, down in the dumps, depressed mood, unhappiness, loss of interest / pleasure, emptiness, irritability (especially in depressed children), and once enjoyable experience is no longer gratifying. From the past literature, it also identified that anhedonia or in other words they are experiencing a loss of interest or pleasure is one of the most common aspects of the depression syndrome that adults and teenagers from numerous parts of the world will have (Hamman & Watkins, 2008). Henceforth, depression itself should sometimes be noted as a disorder of thinking. Additionally, negative beliefs and thoughts about oneself, the world, and the future can become the root of depression. Very frequently, depressed individuals often feel remorseful as they reside on their perceived inadequacies and have similar view reflecting hopelessness on their capabilities to control anticipated outcomes. Consequently, various bad results from all these would arise which including suicide at the worst (Hammen & Watkins, 2008).

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Besides, physical motor behavioural changes can also be influenced by depression. The behavioural change according to Hammen and Watkins (2008) includes the decrease in motivation which can either directly or indirectly disturb one's psychomotor movements such as walking and speech. For instance, depressed individuals may likewise experience a lack of energy to carry out their regular activities. Moreover, physical distortions such as changes in appetite, sleep, and energy can also arise from depression.

According to Blenkiron (2010), major depression, depressive episodes, disorder or illness are termed as a clinically significant depression. Nonetheless, it might have been stereotyped due to its manifestation in several other notable forms of sadness, grief, disenchantment, self-deprecation, over-expectation or even a desire for change. Thus, a mnemonic for depression was constructed by Blenkiron (2010) based on the ten letters of the term 'depression' to assist therapists, counsellors, psychologists, and psychoanalysts to remember the core symptoms. They are: D stands for depressed mood; E stands for energy absent (lethargy); P stands for pleasure (interest) lost; R stands for retardation or agitation; E stands for eating distortions (appetite/weight); S stands for sleep distortions; S stands for suicidal thoughts or ideations; I stands for impaired attentiveness; O stands for only me to blame (guilt/remorse/worthlessness); and N stands for not able / inadequacy to function or perform tasks.

Comparable to those described above, due to the pervasive use of the term and its existence in various other milder forms; by the general public, the word "depression" needs to be clarified as multiple myths and fictional understanding of the nature of depression has arisen to the public interest (Downing-Orr, 2013). Those myths comprise: (1) depression is known as a consequence of personality flaw or

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moral feebleness; (2) signs of depression do not have to be taken earnestly compared to physical health issues (e.g., cancer and heart disease); (3) accumulation of all emotional indications towards depression; (4) implementation of positive thought / attitude and stop floundering in self-pity will help individuals who are depressed; (5) depression is an emotional / affective disorder or an illness triggered by neurochemical discrepancy.

Thus, in contemplation to allow individuals, patients and clients to obtain the best available care and support, Downing-Orr (2013) recommended that the myths such as the above must be clarified, defined and illustrated. For instance, she implied that the feature of depression is psychobiological in which it may branch out from both psychological and also physical illnesses which includes attentiveness, emotional, and motivational conflicts. In another word, it is "illness, several illnesses, or symptomatic of another health problem that strikes both the mind and body." Hence, by highlighting on the physiological feature of depression, this definition widens currently apprehended rigid understandings and also to embolden allied healthcare professionals also to observe and explore the source of depression in every case discretely as well as to discourage present predetermined ideas concerning the feature of depression.

Epidemiological data on the prevalence, course, socio-demographic correlates, and societal costs of major depression throughout the world has been reviewed by Kessler and Bromet (2013), in conjunction with the WHO World Mental Health (WMH) Survey Initiative. Major findings yielded from this review on epidemiology of depression across cultures are: (1) major depression disorder is commonly occurring in all countries where epidemiological surveys have been carried out, (2) lifetime prevalence estimates of major depression vary widely across

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countries, with generally higher prevalence in high income versus low-middle income countries, (3) consistent evidence in age-of-onset (AOO) distributions shows that there is a wide age range of risk, with median AOO typically in early adulthood, (4) course of major depression is often chronic-recurrent, (5) women constantly have lifetime risk of major depression roughly twice that of men across nations, (6) correlations with other socio-demographic information are far less consistent, and lastly, (7) although some of these individual-level associations are stronger in high income than low-middle income countries, major depression is associated with a wide range of indicators of impairment and secondary morbidity.

In summary, we can clearly see that ancient scholars first noted depression in regard to its symptoms and effects. Nevertheless, it was categorized under the universal term of melancholia which comprises an extensive range of behaviours and it was infrequently explored upon on what was the foremost foundation of depression at that time. Fundamentals were later constructed whereby researchers distinguished that depression was an affective / emotional disorder in which the emphasis is thoroughly on the psychological (cognitive, behavioural and emotion) features of depression (Beck, 1967; Hamman & Watkins, 2008; Hanafiah & Van Bortel, 2015). We can also notice that the literature given at that time showed that depression is a psychological problem which results in physical manifestations. Nevertheless, newer studies have started to arise and focus upon the two-way interaction between both physical and psychological aspects of the disorder itself which influence a person drastically (Downing-Orr, 2013). Alongside, the definition of depression has also evolved with each study from the definition. Originally, it was identified using five specific attributes including alteration in mood, negative self-concepts, regressive thoughts and behaviours, physical states and also a change in activity level. This was

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later expanded into four specific domains which include affection, behaviour, cognition and physical functioning of a person (Beck, 1967; Hamman & Watkins, 2008).

The Emic of Depression

Over centuries, depression was a phenomenon well documented and recognized cross-culturally. There was a great interest among cross-cultural psychologists and anthropologists on the various ways people experience, perceive, and seek help for depression across cultures (Bullard, 2010). In spite of strong focus on universally human behaviours, emotions, and cognitions, many researchers seek to distinguish ethnic and sociocultural differences which are fundamentally contrasting across cultures and thus making the emic and etic approach to cross-cultural psychology an essential consideration when examining psychological research questions (Bullard, 2010; Berry, Poortinga & Pandey, 1997; Brislin 1983).

In the etic approach, a universal, externally generated framework was employed to understand local concepts and experiences (e.g., psychiatric classification in the form of DSM-IV or ICD-10 criteria) (Bullard, 2010; Dowrick, 2009). Central to an etic approach was the perceptions of professionals and as conceptualized by a bio-medically driven psychiatry, mental health problems are assumed to be automatically valid in any settings, underpinning the bulk of epidemiological research worldwide, especially in Western industrialized countries (Lloyd, Pouwer, & Hermanns, 2012). For instance, how the etic perspective would view depression by looking at it as a series of symptoms (e.g., loss of interest, feelings of sadness that last for more than two weeks) that can be evaluated based on their frequency of occurrence and the severity interfering with daily function (DePoy & Gitlin, 2015).

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On the other hand, emic (insider) approach places an emphasis on cultural phenomenon and seek to understand the experience, conceptualization, and response to psychiatric phenomena which may or may not be regarded as mental health problems within different societies and cultures (DePoy & Gitlin, 2015; Dowrick, 2009). From here, we can see that the perceptions of the local community were acknowledged in the emic approach (Lloyd et al., 2012). Utilizing this allowed the researcher to understand a phenomenon through perspectives of a person in that specific culture rather than by using an externally developed framework in the emic approach.

It should be noted that from the emic perspective, various discoveries otherwise unknown has been discovered involving culturally-bound syndromes and each cultural variant may be taken as a unique syndrome (Andrasik, 2005). For instance, the manifestations of depression in India were somatic complaints, agitation and anxiety (Teja, Narang & Aggarwal, 1971) while in Indonesia, depression was manifested as loss of energy and sleep disturbances which are most common but the feelings of sadness were often absent (Pfeiffer, 1968) (as cited in Andrasik, 2005). Hence, syndromes that might be considered cultural variants of depression were taken as unique culture-bound syndromes by using the emic approach (Kleinman, 1995; Andrasik, 2005).

Substantially, by utilizing the understanding and specific cultural pool of knowledge, researchers inferred that there were diverse meanings and varying expressions of depression as a complex web of feelings and actions that are part of a bigger story about daily life and challenges and understanding this was able to yield vital insights into the context of this experience of depression (DePoy & Gitlin, 2015). Furthermore, this approach (emic) provided ways on how people label these

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feelings of depression and recommends new ways of detecting and treating depression or assumes that depression was merely a part of a continuum of human emotion which may not be as serious as inferred by etic approach which does not need to be treated.

From the understanding above, under or over diagnosing the presence and severity of depression might be an outcome of having an easy assumption of a universal symptom presentation (classification under a general umbrella of diagnoses) and this has become the greatest concern for the clinician. If the emotional vocabulary of a specific ethnic population manifests sadness, discouragement, or hopelessness in words different from that typically associated with the DSM, it may lead to serious diagnostic errors (Dana, 2000). Furthermore, it was also crucial to recognize the lack of an equivalent term within a culture of representing depression as either a disease symptom or syndrome (Dana, 2000).

Currently, the trend of treatment for depression in Malaysia was through pharmacological means and biological theories, these were still commonly used in clinical practices in community settings and hospitals (Hanafiah, & Van Bortel, 2015; Mukhtar & Oei, 2011b; Ng, 2014; Razali & Hasanah, 1999). Therefore, unsurprisingly, psychological aspects in the disease recognition and understanding process especially for depression, has a tendency to be ignored by the development of psychotropic medication in Malaysia (Deva, 2006; Kok, 2015; Mukhtar & Oei, 2011b). In Malaysia, the establishment of empirical evidence supporting the use of clinically applied psychotherapeutic treatments for depression has thus far not been established. Hence, it continued unidentified as of present whether psychological tools for the evaluation and assessment of depression and the theories for depression

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were valid and reliable for use in Malaysia (Hanafiah, & Van Bortel, 2015; Mukhtar & Oei, 2011b).

In summary, it is vital to establish the validity of Western-derived psychological theories and psychological instruments to be utilized in the treatment of depression in different cultures, taking into consideration the psychological theories and treatment that were more susceptible to cultural influences in Malaysia (Hodges & Oei, 2007; Parker, Cheah, & Roy, 2001; Mukhtar & Oei, 2011b).

Treatment Model Approach

Biomedical model approach. The biomedical model is also identified as psychobiology or the neuroscience perspective declares that behaviour is influenced by physiology, with natural behaviour results from a state of balance within the body while atypical behaviour is a result of uncontrolled physical or mind function (Elder, Evans, & Nizette, 2008).

On the other hand, this is not a new idea whereby in the fourth century BC the Greek physician, Hippocrates, associated mental illness to brain taxonomy. Hippocrates ideas were later outweighed, nevertheless, throughout the Dark Ages and well along during the Renaissance, the notion of thinking and explanations deviated to bewitchment or satanic control (Alloy, Riskind & Manos 2005; Davison, Neale & Kring 2004). Biophysical descriptions returned in the nineteenth century accompanied the emergence of the public health movement.

The advanced technology improves the understanding of organic determinants of behaviour in recent times. For instance, it has led to research and treatment that attract focus to four main areas. They are: (1) nervous system illnesses, (2) structural changes to the brain, (3) endocrine or gland dysfunction, and (4) familial (genetic) transmission of mental illness (Elder et al., 2008).

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One of three key approaches to studying depression across cultures other than ethnographic approach and cultural approach, the biomedical approach assumes that, "the disorder exists if individuals report having the familiar symptoms of depression, and if associated factors show similar relations to the disorder across cultural contexts," regardless of the cultural context (Gotlib & Hammen, 2014). Thus, researchers employing a biomedical approach based on epidemiological data, and focus on the prevalence rates of major depression, and risk and protective factors in different nations and cultural groups, by using structured diagnostic interviews or self-report surveys (Gotlib & Hammen, 2008).

Depression anticipates "profound changes in the psychic organization of the self, and he takes exception to the view that depression should be treated in a biomedical model without taking into account the psychological superstructure of the person, according to Rey's (1994) belief (Lubbe, 2010). Rey seek to delineate how the mental struggle in depression is expressed by body part pain, alternately than psychological (e.g. mental) pain, by concentrating on the twofold theory or structure of destructive integration through oral hostility and exclusion of the lost piece through anal aggression (a mood of inconsistency), which "leaves the internal object in a state of ill health of death", as described in Lubbe (2010):

In other words, these classic vegetative signs of depression, as proposed by Rey (1994a) (p. 37) also represent "psychobiological attempts at sparing the object further ill health in addition to trying to affect a repair. For instance, the slowing of body movements, the lessening of oral activity, oversleeping, the prevention of outpourings of destructive faeces through constipation and the waning of sexual impulses to avoid sadism during intimacy."

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On the other hand, in terms of mental pain, Freud (1917) and Abraham (1911, 1924) establish a different core blueprint, which defined depression (melancholia) as a response "to object removal characterized by a regression to a narcissistic identification", and also "to a deep unconscious ambivalence towards the object" (Lubbe, 2010). Hence, essentially, this emphasis summarizes the defensive organization in depression and that a significant analytic goal is to make conscious both the mourning and the ambivalence (Lubbe, 2010).

In the biomedical model (or disease model) of psychopathology, psychological disorders are viewed as consequences of biological malfunction or disruption, in which mental disorders like depression can be understood as illness in the same way as physical conditions (Russell & Jarvis, 2003). Hence, regarding treatment, biomedical approaches are based on the idea that these biological malfunctions or disruption can be corrected or at least their effects can be reduced (Russell & Jarvis, 2003). In other words, mental disorders are treated in the same way as a physical disease, which means that they can be classified, diagnosed and treated by medical personnel (Russell & Jarvis, 2003).

Mental disorders such as schizophrenia, major depressive disorder (MDD), attention-deficit / hyperactivity disorder (ADHD), and substance use disorders are assumed as biologically-based brain diseases, according to the biomedical model (Deacon, 2013). Andreasen (1985) described the main precepts of biomedical model as: (a) mental illnesses are initiated by organic anomalies predominantly found in the brain, (b) there is no significant dissimilarity between mental illnesses and physical illnesses, and (c) organic treatment is stressed. In the biomedical model, to uncover the biological causes of mental disorders becomes the central objective of study into the description of mental illnesses. Ultimately, the objective of treatment seeks to

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discover the “magic bullets,” which are the specific healing agents that precisely target the illness progression without damaging the organism, just like the way penicillin is used for curing a bacterial infection (Moncrieff, 2008; Deacon, 2013).

Mental disorders are viewed as brain diseases caused by chemical imbalances that are corrected with disease-specific drugs in the biomedical model. Hence, biologically-focused approaches and pharmacological treatment (the use of psychiatric medications) have dominated the U.S. healthcare system for more than three decades to target presumed biological abnormalities (Deacon, 2013). Furthermore, Deacon (2013) stated that despite enormous empirical gains, in such approach, treatment process was abandoned, treatment innovation and dissemination was restrained, and the tensions between practice- and science-oriented clinical psychologists were exacerbated.

Despite the domination of the biomedical model in treating depression (Deacon, 2013), it receives critique that a particular intervention emerged from the biomedical model is proven to be an effective treatment. It is a proof of a correlational, but not a causal relationship with the illness or disorder (Elder et al., 2008). For example, antipsychotic medication is effective by working on dopamine levels to manage schizophrenic symptoms. However, an elevated dopamine level is not a cause of schizophrenia. In contrast to the biomedical model, the first psychological explanation of human behaviour in the late nineteenth century – psychoanalytic theory developed by Sigmund Freud, strongly emphasize the role of unconscious processes (intra-psychic forces, developmental factors, and family relationships) in determining human behaviour. The fixation at a specific developmental stage or conflict that is unresolved, results in mental illness (Elder et al., 2008).

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Russell and Jarvis (2003) also indicated that Freud's theory of depression provides an alternative to the biomedical model in explaining symptoms of depression. According to Freud's hydraulic model of the mind, the lack of energy (one of the depressive symptoms) can be explained in such a way that energy is expended maintaining the repression of the rage against the abandoning loved one, not merely biochemical or physiological changes.

Another appealing alternative to the biomedical approach was the neglected biopsychosocial medical model proposed by Engel (1977). This model suggested that multiple explanatory perspectives can inform our understanding of complex natural phenomena (Deacon, 2013) and the physicians are required to include the social, psychological, and biological aspects of his or her basic professional knowledge and skills (Engel, 1977). It embraces the ideas of studying mental disorders at different levels of analysis (i.e., molecular genetics, neurochemistry, cognitive neuroscience, personality, environment), with no level is superior or fundamental to any other (Deacon, 2013). Collaboration across theoretically and technically diverse healthcare professions is encouraged by the biopsychosocial approach (Deacon, 2013).

Psychological model approach. There are three independently developed approaches in the psychological treatment of mental disorders: (1) the psychodynamic method, (2) the existential-humanistic approach, and (3) the cognitive behavioural approach, which often oppose each other (Ray, 2014). The techniques from these three different approaches receive more willingness to be integrated to develop effective treatments for particular disorders.

The foundation of psychodynamic perspective laid by Sigmund Freud is that psychological problems manifest inner mental conflicts and that a key to personal growth towards recovery is the conscious awareness of those battles (Ray, 2014).

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Besides, conflicting responses to communication with others and the situation are magnitudes of our evolutionary history, social stimuli, and individual experiences. Freud's specific treatment came to be called psychoanalysis, and it was based on the search for conflicting ideas and emotions on an unconscious level, and the way in which the person has relationships or repeats negative relationships with others based on history rather than current interactions (Ray, 2014). To treat disorders like anxiety and depression, insight therapy which embraces the principle of bringing patterns of behaviour, feelings, and thoughts into consciousness, has been used to discuss past trends and relationships to determine how the present is influenced by them.

Secondly, from the existential-humanistic perspective, the individual's experience at the moment and the way how he interprets the experiences become the focal point, with an importance on processing and considering both internal and external experiences of human life. Both Carl Jung and Karen Honey who were influenced by Freud focused on the value of personal inner experience (Ray, 2014). Jung concentrated in the close relationship between instinctual processes and the environmental factors affecting them while Freud highlighted the sexual drives and self-defence instincts in experience (Ray, 2014).

It was essential to gather different characteristics of an individual's personality to create a unified self, which would provide meaning to one's life in Jung's therapy (Ray, 2014). The two terms, introversion and extroversion, introduced by Jung, were used to contemplate one's tendency to value internal or external particulars. Ray (2014) indicated that Honey established the notions of self-realization and a real self, which betokened the acknowledgement of who an individual is and what one recognize pertaining their interactions and connections with themselves and others.

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As the existential-humanistic movement developed, this approach was also referred to as humanistic-existential therapies, with the emerged humanistic movement led by Carl Rogers's client-centred therapy which was also known as person-centred therapy. This approach has three fundamental characteristics, which are the therapist's empathic understanding, unconditional positive regard, and also genuineness and congruence. Further, another renowned humanistic psychologist, Abraham Maslow was well-known for his hierarchy of needs. His idea is grounded on the theoretical notion for understanding the nature of human needs whereby one must fulfil or meet the lower-level hierarchy of needs (e.g., hunger, thirst, and safety) before attaining higher-level of his hierarchy of needs (e.g., belongingness and love, esteem, and self-actualization) (Ray, 2014).

Emotion-focused therapy or experiential process therapy, developed by Leslie Greenberg, was based on the humanistic principles that emotion, either adaptive or maladaptive, was observed as dominant in the experience of self, and as the essential element that results in change and management of emotional experiences (Ray, 2014). Another therapeutic meditation technique, mindfulness, which was initially established in Theravada Buddhism, included an increased, focused, purposeful mindfulness of the current moment to observe mind and feelings without responding to them in present, and would direct to the reduction in self-deprecation (Ray, 2014). In short, the existential-humanistic perspective focuses on the emotional level, the value of internal processes, and the way how these internal processes are explored and experienced, which can result in changes in behaviour and experience.

On the other hand, the behavioural perspective is emphasized on the level of actions and behaviours. Beginning with Ivan Pavlov's classical conditioning in which a conditioned stimulus is producing a conditioned response, behaviourists

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noticed that classical conditioning was an underlying mechanism in the development of mental illness. John Watson who is frequently referred as America's first behaviourist, underlined the environmental facets of behaviour and jilted the theoretical value of internal conceptions, with his distinguished statement stressing the role of environment, as cited in (Ray, 2014) (p. 49) "Give me a dozen healthy infants, well-formed, and my specified world to bring them up in and I'll guarantee to take anyone at random and train him to become any specialist I might select – doctor, lawyer,, artist, merchant-chief, and yes, even beggar-man and thief, regardless of his talents, penchants, tendencies, abilities, vocations, and race of his ancestors."

Furthermore, the 20th century's most vocal proponent of behaviourism, B. F. Skinner's significant contribution to experimental psychology was the concept that behaviour can be elicited or shaped if reinforcement follows its occurrence (Ray, 2014). Substantially, another behaviourist, Albert Bandura suggested that humans or organisms would imitate others' behaviours even without support through observational learning, which was also known as modeling (Ray, 2014).

The third approach in the psychological treatment of mental disorders is from the cognitive behavioural perspective. It demonstrates that dysfunctional thinking is typical to all mental disturbances, and it is likely to change the way an individual thinks as well as individual's emotional circumstances and behaviours by learning in therapy how to understand one's thinking (Ray, 2014). In a cognitive therapy for depression developed by Aaron Beck, a cognitive triad regarding depression is used to describe the model. The first component including the individual's negative view of self, followed by the second component describing the individual's tendency to

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interpret experiences negatively, and also the third component which indicating that the individual regards the future negatively (Ray, 2014).

Based on the cognitive behavioural perspective, cognitive behavioural therapy (CBT) is directed at altering the individual's faulty logic and maladaptive behaviours (Ray, 2014). The therapy aimed at changing the automatic thoughts associated with: (1) catastrophizing – nothing will work out, (2) personalization – everything relates to you, (3) overgeneralization – an event is how it always is, and (4) dichotomous thinking – everything is either good or bad.

In summary, the psychodynamic or psychoanalytic approaches emphasize insight, the existential-humanistic approaches focus on emotional processing, while the cognitive behavioural approaches pinpoint the importance of action.

Psychoanalytic and psychodynamic model approach. Psychodynamic approaches could be considered a milestone of modern psychological thought, with the systematic reflection on the treatment of depression, dates back at least to the time of Hippocrates and Galen (Ingram, 2009). With Sigmund Freud (1856-1939) being the intellectual forebear, the family of treatments which is termed as the psychodynamic, dynamic or psychoanalytic therapies, shares a common origin (Ingram, 2009).

Moreover, psychoanalysis acts as both a psychological system and treatment approach, with its remarkable scope, originality, ability to generate controversy, and also the famous ideas such as defence mechanisms and "slips" of the tongue (Ingram, 2009). To outline human misery in all of its many shades and variations, Freud devoted a large portion of his voluminous body of work. Hence, unsurprisingly, Freud and his followers showed great interest in the seemingly common human downturn of depression (Ingram, 2009).

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Sigmund Freud begins the history of psychoanalytic and psychodynamic approaches to depression with his classic work "Mourning and Melancholia" (Freud, 1917; Stein, Kupfer, & Schatzberg, 2007; Gabbard, 2014). In Freud's view, the later vulnerability to adulthood depression results from the early childhood losses (Stein et al., 2007; Gabbard, 2014). Freud's concept is that anger is directed inwardly due to the identification of the self of the patient with the lost object, leading to the commonly marked self-depreciation in depressed patients (Stein et al., 2007; Gabbard, 2014).

In most of the Western world, the biomedical model has marginalised psychoanalysis since the DSM-3 (Lawlor, 2012). As a treatment, psychoanalysis has carried less credit in the new world of evidence-based medicine, and both its methodology and practice have been heavily criticised (Lawlor, 2012). However, as cited in Halasz, Anaf, Ellingsen, Manne, & Thomson Salo (2002):

The same outcome is for both, the biomedical and the psychodynamic, to cooperate an enrich each other. Freud may be out of fashion in medicine, but as Andrew Solomon (2001) found after his journey through depression, 'in fact, the Freudian model, though flawed, is an excellent one.' Anthropologist T. M. Luhrman (2000) came to the same conclusion after her long investigation into psychiatry. The danger, she warned, 'is that the biomedical model will become the only approach to mental illness within psychiatry, and the dominant popular understanding of psychiatric illness within our culture (p.23)'.

And there is concern that with the extreme proponents of the biomedical model speculating about perfecting the mind, as some seek to rectify the body, that notion already floated, like medication to 'cure' shyness and 'psychopharmacological plastic surgery,' will be believed, or even worse, embraced.

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Our emotional responses are not viruses to be suppressed, but meanings to be unpacked. Meaning, though, is not reducible to a product of the mind, any more than it is a function of neurotransmitters. It is inter-subjective, and therefore cannot be the product of a single, but requires both a social structure and interaction. (p. 58)

In Freud's opinion, the only possible way that someone can give up an significant figure in his or her life is by identifying with a lost object inside. Freud suggested that melancholic patients have a severe superego and their guilt is related to showing aggression toward loved ones (Stein et al., 2007).

One of the components of psychoanalytic theory that is related to a psychodynamic model of depression is the study of defence mechanism. While certain defence mechanisms may help develop depression, others may help protect against depression. In psychodynamic models of depression, the unique characteristics of defence mechanism and object relations in each depressed individual are taken into consideration (Stein et al., 2007). Two underlying psychodynamic types emerged from Blatt's (1998, 2004) studies involving large populations of depressed patients, are the anaclitic type and the introjective type (Stein et al., 2007). The former type is distinguished by feelings of helplessness, loneliness, weakness associated with chronic fears of being abandoned and unprotected, and vulnerability to disruption of interpersonal relationships, and the normally used defence mechanisms are denial, disavowal, displacement, and repression.

Contrarily, the latter type in depressed patients is mainly related to self-development, views intimate relationships as secondary, and uses different defence mechanisms like intellectualization, reaction formation, and rationalization (Stein et al., 2007). The manifestations of depression among the anaclitic types are mainly

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dysphoric feelings of abandonment, loss, and loneliness, while feelings of guilt and worthlessness, are manifested by the introjective types, with a sense of failure and a sense of losing autonomy and control (Stein et al., 2007).

Psychotherapy in psychodynamic or psychoanalytic approaches is based on a set of principal tenets: (1) much of mental life is unconscious, (2) past is prologue, (3) transference as one of the technical psychoanalytic strategies, (4) countertransference provides useful information, and (5) patient is helped to understand resistance rather than remove it (Stein et al., 2007). The therapeutic frame is central to psychodynamic therapy, in which the therapist is requisite to preserve relative anonymity, to set sessions in time and place, and to deal with an extra-sessional contact in sessions (Hales, 2008).

According to psychodynamic authors, Busch, Rudden, and Shapiro's (2007) work on hypothetical stages of therapy for depression, it is important to take an extensive history of the patient's depression, overall development, and general functioning (e.g., employment history, interpersonal life) in the beginning stage, in order to uncover the dominant depression themes and to inculcate insight into the development and maintenance of these problems (Ingram, 2009). An exploratory work on history allows the therapist to reveal the hidden or suppressed wishes, fears, impulses, and desires in the patient's inner world, and also to understand the particular way in which the patient deals with them, allowing the therapist to form a dynamic conceptualization of the patient's depression (Ingram, 2009). Then, the treatment goals and the general plan to reach these goals will be determined by utilizing this conceptualization. Nonetheless, a good therapeutic alliance is a crucial achievement of this stage and is likely a precondition for treatment progress.

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In the management of depression, it is essential for the psychodynamic therapist to listen attentively to patient's experiences and themes that may have developed into depression, including internalized anger, overdeveloped superego or sense of responsibility, or feelings of helplessness and dependency (Hales, 2008). The transference emerged will repeat within the therapeutic relationship, to be understood and brought into the therapy. It is also vital for the psychotherapist to deal with the patient's unconscious sense of responsibility and anger, resulting from the unavoidable evocations of earlier feelings of loss during the termination of psychodynamic therapy (Hales, 2008).

The Prevalence of Depression

In the year 2012, the WHO conducted the World Mental Health (WMH) Survey in 17 countries revealed that on average; one in 20 people have reported having an episode of depression in the previous year (Marcus et al., 2012). There were many studies conducted worldwide to examine the prevalence of depression (Patten, 2015). Furthermore, Kessler and Bromet (2013) found that up to 20% of adults and up to 50% of children and adolescents reported having depressive symptoms throughout the world.

On the other hand, in surveys using structured diagnostic interviews, point prevalence rates of current major depressive disorder are considerably lower, with typically less than one percentage among children (Merikangas & Angst, 1995), up to six percent of adolescents (Kessler, Avenevoli, & Merikangas, 2001), and two to four percent of adults (Kessler & Bromet, 2013). In other words, many people have subsyndromal depressive symptoms, indicated by the discrepancy between the high symptom prevalence and low depressive disorder prevalence. The recent data obtained from large national general population epidemiological surveys, the WHO

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World Mental Health (WMH) surveyed in 18 countries including a combined sample of 89, 037 respondents (Bromet et al., 2011) reported five point five percent prevalence estimate in the ten WMH surveys in high-income countries and five point nine percent in the eight surveys in low- to middle-income countries (Gotlib & Hammen, 2014).

In the United States of America (U.S.), the mental health findings obtained from the 2013 National Survey on Drug Use and Health (NSDUH), illustrated that six point seven percent or 15.7 million adults aged 18 and above, had at least one major depressive episode (MDE) in 2013 (SAMHSA, 2014). The percentage of adults having a past year MDE remained stable between six point six percent in 2005 and six point seven percent in 2013, and was higher among females (8.1%) than males (5.1%). Those aged 18 to 25 reported highest the percentages (8.7%) of having past MDE in 2013, even among women (11.6%). Unemployed adults (9.5%) also reported a higher percentage of having past MDE when compared to those who worked part time (7.8%) and those who worked full time (5.3%).

Nonetheless, adults aged 18 to 25 among those with serious mental illness in 2013 reported the lowest percentage (54.0%) among those who used mental health services, as compared to adults aged 26 to 49 (68.4%) and 50 or older (74.9%). Among the 6.7% or 15.7 million adults in 2013 with a past MDE, as mentioned before, 28.3% or 4.4 million of them had serious thoughts of suicide, in contrast to a much lower percentage of adults without a past MDE (2.2%) reported to have serious thoughts of suicide. On top of that, young adults aged 18 to 25 also recorded the highest percentage of adults having serious thoughts of suicide (7.4%) with a higher percentage in females (8.1%) than in males (6.8%), followed by those who aged 26 to 49 (4.0%) and 50 or older (2.7%) (SAMHSA, 2014).

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NSDUH also found that 10.7% or two point six million youths aged 12 to 17 had past year MDE in 2013, with seven point seven five or one point nine million of them having severe impairment in one or more domains, and showing a trend which generally increased with age. Substantially, among youths aged 12 to 17 in 2013, females (16.2%) were significantly more likely than males (5.3%) to have past year MDE and past year MDE with severe impairment (12.0% vs. 3.5%). Among youths aged 12 to 17 with past year MDE, the percentage of those who took illicit drugs in the past year was higher than those without past year MDE (33.2% vs. 15.1%) (SAMHSA, 2014).

In another study, Poongothai, Pradeepa, Ganesan and Mohan (2009) carried out the largest population-based study from India to investigate the prevalence of depression and illustrated that among urban south Indians, the overall prevalence of depression was 15.1% and significantly higher in females than males (16.3% vs. 13.9%) at all age group. 25,455 samples were enlisted from the Chennai Urban Rural Epidemiology Study (CURES) which comprising 46 of the 155 organization wards of Chennai city in South India. It was found that the prevalence of depression increased with increasing age, with depressed mood as the most common symptom (30.8%), followed by tiredness (30.0%). Higher prevalence of depression was found among the divorced (26.5%) and widowed (20%), and also those in the lower socioeconomic status (19.3%).

Besides, in a study conducted by Kim et al. (2007) involving 981 adult respondents (413 were men; 568 were women) in the urban part of Jeju Island, Korea, reported that both the prevalence of depression (9.47 in males and 11.36% in females), and the prevalence of depressive symptoms (15.01% in men and 18.37% in women) were higher in females. The research also yielded several findings with

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significant differences: respondents who have high stress levels, problem drinking, poorer sleep quality were significantly more likely to have depressive symptoms than those who reported low self-assessed level of stress scores, low risk of problem drinking, and better sleep quality, respectively.

Moving along to a household survey of 6,616 Singapore adult residents conducted using face to face interviews with the World Mental Health Composite International Diagnostic Interview (WMH-CIDI), the lifetime and 12-month prevalence estimates for major depressive disorder were 5.8% and 2.2%, respectively (Chong et al., 2012). The findings indicated that major depressive disorder was significantly higher among the females, Indians, those who were divorced / separated, or widowed, with the highest risk of onset among young adults aged 18–34 years. Approximately half of the respondents with lifetime MDD (49.2%) and 12-month MDD (54.6%) were having at least one comorbid chronic physical conditions. On top of that, 59.6% of those with lifetime MDD had never sought professional help.

In Malaysia, National Health Morbidity Survey (NHMS) is conducted once every ten years, with the first, second and third edition were performed in 1986, 1996, and 2006 respectively (Director General of Health Malaysia, 2014). Starting from the year 2011 until 2014 (NHMS IV), NHMS was conducted in a four yearly cycle of annual data collection including mental health problems (IPH, 2015). The current round of survey (NHMS V) yielded the first and latest report for 2015, revealed that the prevalence of mental health problems among adults aged 16 years and above in Malaysia showed an increasing trend, which escalated from 10.7% in 1996 to 29.2% in 2015 (Ahmad et al., 2015).

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Furthermore, the prevalence of mental health problems was also determined according to socio-demographic profiles and obtained several important findings (Ahmad et al., 2015). By state, the highest prevalence was reported to be in Sabah and Labuan (42.9%), followed by Kuala Lumpur (39.8%), and Kelantan (39.1%). There were no significant differences in the prevalence of mental health problems between urban (28.8%) and rural (30.3%) areas. By gender, despite no significant differences, females reported a higher prevalence than males (30.8% vs. 27.6%). By ethnicity, mental problems had the highest prevalence rate among Other *Bumiputras* (Indigenous) (41.1%), followed by others race (33.2%).

NHMS 2015 also noted that mental health problems were generally higher among younger adults, in which adults aged 16 to 19 (34.7%) was the highest, followed by aged 20 to 24 (32.1%), and aged 25 to 29 (30.5%). In terms of marital status, those who were single had the highest prevalence (32.1%). By occupation, government / semi-government employees recorded the lowest prevalence of mental health problems (24.6%). As compared to higher income families, adults from low household income families were having higher prevalence of mental health problems.

In another noteworthy study conducted by Ng (2014), the prevalence of depression in Malaysia was estimated to be between eight and 12%, summarizing the findings of 57 published articles in Malaysia regarding depression, between the years 2000-2013. Women of low socio-economic background or those with comorbid medical condition were revealed to have higher prevalence of depression. Assessment tools such as Beck Depression Inventory (BDI), Depression, Anxiety and Stress Scale (DASS), Patient Health Questionnaire 9 (PHQ-9) and Hospital Anxiety and Depression Scale (HADS) are commonly used in Malaysia. In terms of

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treatment for depression, both pharmacological treatment and psychotherapy are commonly used in Malaysia and are highly recommended in local clinical practice guidelines.

On the other hand, Mukhtar and Oei (2011a) reviewed 13 published articles on the prevalence of depression studies in Malaysia and reported that the prevalence figures varied from as low as three point nine percent to as high as 46%, which might be limited by local factors and methodological differences. Mukhtar and Oei (2011a) also highlighted the high prevalence rate of depression amongst patients in primary care (ranged from 6.7% to 14.4%), clinical settings (3.9% to 46%), and in the general community such as elderly and women (6.3% to 13.9%).

In addition, based on a cross sectional study in a community determined the prevalence of depressive symptoms and the potential risk factors associated with depression among 972 adult women (Mean age = 37.91 ± 10.91) in all districts of Selangor in July 2004, the prevalence of depressive symptoms was 8.3% in Selangor (Sherina, Rampal, & Azhar, 2008). Depressive symptoms were significantly associated with race (Indians, 13.2%), religion (Hindus, 14.6%), absence of formal education, history of having a miscarriage and difficulty in getting pregnant ($p<0.05$). In another cross-sectional study conducted in Hulu Langat, Sepang and Klang from June, 11 to December, 30 2012, the prevalence of depression was found to be 10.3% among adults in the community of Selangor (Maideen, Sidik, Rampal, Mukhtar, 2014), which statistically showed an increasing trend.

Lastly, a cross sectional study involving 520 rural residents in East Coast Peninsular Malaysia yielded findings that indicated the prevalence of depressive symptoms was at 11.30%, with distinctively higher prevalence among females. Those who were highly educated, in contrast to Sherina et al. (2008), were more

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prone to depressive symptoms (Wong & Lua, 2011). Considering depression among the individuals with headache in Kuala Lumpur, the lifetime prevalence of major depression was 17% whereas the current prevalence of major depression among the patients was 8%. Subjects with migraine headache had higher rate of depression than the other types of headache (Zuraida & Parameswaran, 2007).

Models of Personal Growth in Healing/Recovering

In searching for a model of personal growth and healing from major depression, the researcher was guided by the previous literature. The researcher identified three healing models for discussion and review. They were: Existential model, Multiple self-states model, Cognitive model, and Model of healing. Each theory selected was described in the following section.

Existential model. "Freedom is existence, and in its existence precedes essence" and "Man's essence is his existence" (Sartre, 1953, p.5). The former statement was explained in May's words, "That is to say, there would be no essence – no truth, no structure in reality, no logical forms, no logos, no God nor morality – except as man in affirming his freedom makes these truths" (May, 1962, p.5-6). Personal choice, personal consciousness, and personal responsibility are strongly emphasized in existentialism. This ensures individuals who "construct their own reality and are continuously capable of self-reinvention" to own all behaviour, as stated by Sartre: "I am my choices" (Sartre, 1953, p.5), as cited in Sommers-Flanagan, & Sommers-Flanagan (2015).

Existential philosophy and phenomenology are fundamental to the existential model of psychotherapy, with a focus on some key theoretical principles: (1) the I-am experience, (2) four existential ways of being, (3) the daimonic, (4) the nature of anxiety, (5) normal and neurotic guilt, (6) existential psychodynamics, (7)

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existentialism and pessimism, (8) self-awareness, and (9) theory of psychopathology. Based on the existentialists' beliefs in the conscious access to the entire human experience of an individual, an existential model seeks to augment individual's self-awareness or self-discovery, rather than interpreting or uncovering individual's unconscious processes (Sommers-Flanagan, & Sommers-Flanagan, 2015).

Frankl (1984) specified that contrasting theoretical perspective claims two things: (1) humans have a will to meaning, and (2) meaning does exist in the world, and it's up to us to find it. Thus, in existential model, the self of being and the searching of meaning both play an important role in an individual's journey to recovery. Logotherapy model, in its origin, represents meaning (logos) and healing (therapeia), which confronts clients directly with the need for meaning and emphasizes clients' complete responsibility for their own lives and choices when pursuing meaning (Sommers-Flanagan, & Sommers-Flanagan, 2015). Humans can find meaning and resolve their existential neuroses through a few possible ways derived from Yalom (1980) and Frankl (1967): altruism, dedication to a cause, creativity, self-transcendence, suffering, God/religion, hedonism, and also self-actualization.

The goal of existential model was to facilitate the self-awareness of individuals for reaching their authentic selves, in which self-awareness of the ultimate concerns (death, freedom, isolation, and life's meaning) is included. According to Keshen (2006), based on existential model, psychopathology (e.g. depression) involves sequences such as: (a) there is a will to meaning (or purpose) in life, (b) the individual is unable to "find or fulfil" authentic meaning or purpose, (c) the individual therefore experiences an "existential vacuum," (d) symptoms associated with this vacuum (e.g. anhedonia, worthlessness, boredom, anxiety,

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apathy, emptiness, low self-esteem, or low mood, and (e) the individual engages in an unfulfilling "purpose substitute" instead of directly addressing the need for purpose or meaning in life. this purpose substitute might involve addictions, excessive television viewing, overzealous emphasis on acquisition, and so on. (Keshen, 2006, p. 288)

On the other hand, although the inherent pessimism is related to existentialist thought (e.g., life and death, freedom and responsibility, love and individual isolation, life's meaning and nihilistic meaninglessness), the key of the entire existential thought is to provide hope and not to depress, but to provide hope (Frankl, 1984). Life with major depression is indeed a struggle and full of suffering, but above all, life is to be lived, making all the difference as individuals encounter the ultimate concerns mentioned earlier.

Existential analysis or logotherapy focuses on positive meaning and the human spirit and literally refers to "healing or therapy through meaning" (Wong, 2005). The core tenets of logotherapy encompass (1) freedom of will, (2) the will to meaning, and (3) the meaning of life (Frankl 1967, 1969, 1986, as cited in Wong, 2005).

The first tenet is 'freedom of will', according to Frankl (1978), "human freedom is finite freedom. Man is not free from conditions. But he is free to take a stand in regard to them and the conditions do not completely condition him" (p.47). With freedom comes responsibility possessing the freedom of will, while responsibility refers to practising our freedom to make the right decisions based on the demands of life.

The second logo therapeutic tenet, 'will to meaning' is "the basic striving of man to find meaning and purpose" (Frankl, 1969, p.35), which is made possible by

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the human capacity of self-transcendence, enabling people to be free from the confines of time and space. Seeking happiness requires self-transcendence, as fulfilment is a by-product of meaning: "Only to the extent to which man fulfils a meaning out there in the world does he fulfil himself" (Frankl, 1969, p.38).

The third tenet is the 'meaning of life'. There are three ways of finding meaning in existential theory suggested by Frankl (1984): "(1) by creating a work or doing a deed; (2) by experiencing something or encountering someone; and (3) by the attitude we take towards unavoidable suffering" (p.133). In situations of inescapable suffering such as major depression, attitudinal values become exceptionally important (Wong, 2005).

Existential frustration according to Wong (2005) is a general human experience as a outcome of external factors and internal obstacles blocking the search for meaning. An individual may cultivate existential vacuum when the will to meaning is disheartened. Furthermore, existential vacuum does not perceive as a neurosis or disease, but a prevailing discernment of meaninglessness or emptiness, enacted by a state of apathy, which may illuminate our emptiness and initiate a quest for meaning (Wong, 2005).

Affliction and misery tend to trigger the search for meaning, but it is not a necessary condition for meaning (Wong, 2005). Frankl (1984) reckoned that "If there is a meaning in life at all, then there must be a meaning in suffering. Suffering is an ineradicable part of life, even as fate and death" (p.88). Based on his own experience and observation of prisoners and clients, Frankl (1963, 1984) found that if people are convinced that a suffering has its meaning, they are willing to endure it, whereas despair results from suffering without meaning.

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Contrary to the cognitive behavioural locus of positive psychology, Frankl featured on the term "being" rather than "doing" (Batthyany & Russo-Netzer, 2014). Even though Frankl proposed that one of the methods to encounter meaningfulness is actual action in concrete situations, he also indicated that our actions have to be constant with logos or the will to meaning as the actual world of action can stay meaningless deprived of any orientation to the spiritual (noetic) element of being human (Batthyany & Russo-Netzer, 2014). To live the good life, Frankl diminished the focal point of doing certain things but emphasized more on achieving the will to meaning, which in other words, Frankl encouraged individuals "to live out our spiritual nature of human beings by living a life of self-transcendence and responsibility (Batthyany & Russo-Netzer, 2014).

Multiple self-states model. Progressively, more therapists, philosophers, and researchers believe that an individual's psyche who has relatively good mental health and who is relatively abreast with himself resides of diverse forms of the self (Yerushalmi, 2003). For instance, this "multiplicity of selfhoods" is amongst the outlines and patterns which blend into a sensibility of I-ness (Mitchell, 1991; Slavin & Kriegman, 1992). According to this approach, Mitchell (1993) illustrated that various self-organizations develop in different relationships such as with particular significant others and with distinctive aspects of the equally significant other. Therefore, it is standardizing for these different self-organizations to remain rather unconnected from an unavoidable struggle with each other.

Primarily, the self is viewed as a manifold, compelling, fluctuating, and as stemming its meaning from the intersubjective situation in which ones experienced (Slavin & Kriegman, 1992; Yerushalmi, 2001a, 2001b, Yerushalmi, 2003). Yerushalmi (2003) also explained that there is a specific nature of the psychic system

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as well as a comprehensive perspective of a phenomenon in each of the self's disengaged subsystems. Likewise, it is gradually being presumed that every individual himself causes separate characteristics of self within each form of relationship (Aron, 1996; Bromberg, 1994; Davies, 1996; and Gergen, 1991).

According to Bromberg (1991, 1993), individuals only indistinctly understand and aware of different self-states and realism that lie within us when coming to the primary experience of self. This circumstance mainly assists in sustaining the healthy impression and idea that they have an organized nature (e.g. personality). Substantially, self-states is demonstrated as an efficient part that captivates in constant internal mediation with other self-states such as the realities, beliefs, and perceptions. Thus, this integrated psychic–experiential form derives from existence through processes of dissociation (which in adaptive a mental function as repression).

Every individual may have both interpersonal and intrapersonal experiences when responding to either internal stresses or external circumstances. The state of personal crisis is one of the most serious conflicts in the life of an individual as well as to his or her continual personal growth process. Fundamentally, one will seek for psychological aid when his or her aptitude to adapt and adjust is negotiated as well as when a person experience psychologically discrepancy and feelings of vulnerability (Yerushalmi, 2003).

As the model of multiple self-states are generally played a vital part of psychoanalytic therapy, it seems important especially in crisis situation (e.g. depression) (Yerushalmi, 2003). Moreover, it is when crisis arise that a person will start to initiate to reflect his or her own existence and to seek a genuine changes that can redefine the meaning of his or her life.

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Cognitive model. As a result of a turnabout from psychoanalysis, Ellis and Beck, who were two protagonists of the first significant systems of cognitive therapy, show certain similarities in their departure points, despite all the differences in their work (Hoffmann, 2012). Ellis acknowledged critically with psychoanalysis by reaching at the growing recognition of the significance of cognitive factors in psychic disorder. He started off with the doubt regarding the appropriateness of the method of passively waiting for "insights", linking current problems to some past events, and often failed to bring on the desired changes when these insights occurred (Hoffmann, 2012). Ellis then employed a method by convincing patients of the misconceptions of their internalized assumptions, and introducing to them more rational views to change their emotions and behavior (cognitive restructuring) (Hoffmann, 2012).

Similarly, the basis of Beck's therapeutic approach embraces a rationalistic view of man. Beck set out his thinking in cognitive terms after working on the problems of depression, looking for empirical validation of psychoanalytic concepts (Beck & Valin, 1953; Beck & Hurvich, 1959), and in turn, was influenced by the difficulty of supporting the hypotheses (Hoffmann, 2012). Beck (1963, 1967) developed a new cognitive theory of depression, indicated that "typically depressive cognitive "schemata," which becomes virulent subsequent to a juncture with particular elicitors, who have an increasingly strong influence on the patient's total thinking and can condition the other phenomena of the depressive syndrome."

Cognitive therapy, among the newest developments in psychotherapy, plays an important role in practice, especially when used in combination with behavioral therapy (Hoffmann, 2012). However, the current theoretical status of cognitive therapy has to be viewed as highly unsatisfactory which represents an extension of

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laws that have a completely different dominion in the area of basic research, with the only exception, Beck's cognitive model that underwent a number of empirical examinations, at least in the field of depression (Hoffmann, 2012).

Model of Healing. A detailed model that explained the body-mind-spirit connection in healing has been developed by Dietrich Klinghardt, namely the Five Levels of Healing: the Physical Level, the Electromagnetic Level, the Mental Level, the Intuitive Level, and the Spiritual Level (Marohn, 2003). This comprehensive model of healing acted as an approach for understanding various chronic illnesses like depression. Similar to any health problem, depression may originate in any of the five levels. One of the basic principles states that if an interference or imbalance at any one level is untreated, it will spread upward or downward to the other levels, and thus depression may involve multiple or even all five levels (Marohn, 2003).

Another basic principle states that implementation of healing interventions can be done at any level, but the balance restored at lower levels (e.g., the Physical Level) was not long-lasting without addressing the upper-level (e.g., the Intuitive Level) imbalances. Hence, this explained why some cases of depression remains unresolved even after rebalancing or treating the biochemistry of the brain as only the Physical Level of illness and healing has been addressed (Marohn, 2003).

The First Level or the Physical Body addresses all physical functions, including the body's structure and biochemistry, in which an altered biochemistry (e.g., poor diet) can lead to imbalance at this level. Factors such as surgery, injury, dental work, nutritional imbalances, microorganisms, heavy metals, and other toxins at the Physical Level may contribute to symptoms of mental illness, including depression.

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The Second Level or the Electromagnetic Body involved the energetic field of the body, with biophysical stress (devices with own electromagnetic fields, e.g., cell phones, televisions), and geo-pathic stress (electromagnetic emissions from the Earth, e.g., underground streams, fault lines) as the sources of disturbance. Interference at this level may stream down to the First Level.

The Third Level or the Mental Body also referred to the Thought Field which is an energetic field including phenomena outside the Physical Body such as memory, thinking, and the mind. This level was considered as "the home of psychology" where one's attitudes, beliefs, and early childhood experiences house in. Early traumatic experiences or an unresolved conflict situation results in disturbances, or faulty mental circuitry at this level. When these traumatic experiences were replayed over and over in the brain, constant stress signals keep running through the autonomic nervous system, affecting the first two levels. Mostly, this level is not the source of mental disorders but the fourth level is.

The Fourth Level of the Intuitive Body is also known as the Dream Body, and refers to the collective unconscious called by Jung. Humans are deeply connected with one another, flora and fauna, and the global environment at this level, with experience comprising dream states, as well as negative related states like nightmares, possession, and curses. At this level, individuals are deeply affected within themselves by something that isn't of their own but that is of somebody else.

Finally, the Fifth Level or the Spiritual Body addresses self-healing, and refers to the relationship between the individual and God, indicating that God reaches them and wants them to learn and experience their strengths and weaknesses. Hence, at this level, the healing of this level leaves the exploration to the patient with an appropriate attitude of great respect and humbleness, without being intruded by

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practitioners (Klinghardt, 2005). Klinghardt (2005) suggested that this healing model can be valuable to understand truly about holistic medicine, and eases the practitioner to navigate the "sometimes chaotic landscape of healing techniques".

In sum, both the existential model and cognitive model underlined the personal growth resources used by the major depressive individuals. On the other hand, the healing model highlighted the personal growth processes that major depressive individuals have gone through in their recovery journey. The findings of the study revealed personal growth experiences of young adults recovering from major depression consisted of personal growth processes and personal growth contributors to help them in their recovery journey. Therefore, integration of both aspects of contributors and processes were crucial in order to understand depressed young adults' journey of recovery from major depression as each model has its own limitations in describing personal growth and healing.

Past Research on Personal Growth Experiences in Healing/Recovering

The following section discussed the related past studies which focused on depression as well as personal growth experiences recovering from major depression.

Depressive disorders have an early onset at a young age (Marcus et al., 2012). Inevitably, the personal growth experience of recovery among young adults, emerging adults, or youths with depression involves various aspects dealing with their remarkable fluctuations, discontinuities, and uncertainties, indicating a major transition of considerable change and significance in and at this period of life (Arnett, 2000; Kuwabara et al., 2007).

As mentioned earlier, mental health problems were generally higher among younger adults, in which adults aged 16 to 19 (34.7%) was the highest, followed by aged 20 to 24 (32.1%), and aged 25 to 29 (30.5%), as reported in NHMS 2015

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(Ahmad et al., 2015). Young adults were also reported having serious thoughts of suicide, with a higher percentage in females than in males, and taking illicit drugs, but were the least willing to seek and receive mental health services (SAMHSA, 2014).

In terms of personal growth and healing experience, young adults often embrace negative attitudes and beliefs about depression treatment, which make them stop from being diagnosed and treated for depression. In a cross-sectional study involving 10,962 young adults aged 16 to 29 years conducted by van Voorhees et al. (2005), the intention not to accept the physician's diagnosis of depression was reported by twenty-six percent of the participants. Negative beliefs and attitudes (e.g., medications are ineffective in treating depression, denying the presence of a biological cause for depression,), subjective social norms (e.g., believing one with depression would be embarrassed if one's friends knew about it), and past treatment behavior (e.g., no prior treatment, medication or counseling is helpful) were associated with the intent not to accept a diagnosis of depression, indicating why young adults are reported with low rates of treatment for depression (van Voorhees et al., 2005).

On the other hand, Klineberg, Biddle, Donovan, and Gunnell (2011) explored the ability of 3,004 young adults aged 16–24 to identify depressive symptoms at two levels of severity (Part A: anxiety and ambiguous depressive symptoms; Part B: symptoms of clinical depression) in a vignette, and to explore their perceptions on how a young person might respond to these symptoms (what young people think someone with depressive symptoms should do and actually would do). The major findings of this study included: (1) 61.4% (n = 647) of respondents recognized severe depressive symptoms (Part B); (2) as compared to young women, young men were

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less likely to recognize depressive symptoms, and less likely to recommend help seeking despite recognizing a mental health problem, particularly men from more underprivileged backgrounds. Essentially, these findings may associated with the high suicidal rate in young men, especially those from more deprived backgrounds (Hawton, Houston, & Shepperd, 1999), and (3) although 64.7% of the respondents who recognized a mental health problem suggested professional help seeking, but in contrast, only 16.4% of them perceived that a severely depressed person actually would see a doctor, indicating the discrepancy between the knowledge of what someone with depressive symptoms should do, and the suggested actions on what a depressed individual actually would do (Klineberg et al., 2011).

Moreover, the mediating and moderating effects of family social support on the relationship between acculturation and depression were investigated in Rivera's (2007) study involving a sample of 850 South Florida Latinos from the Miami-Dade County area. The findings illustrated that even in the late adolescence to early adult years, there was a significant relationship between acculturation and increased risk for depression that was mediated by family social support, while no moderating effects were discovered (Rivera, 2007). It is interesting and crucial to address social context in the acculturation–mental health relationship as the findings revealed that being female, being less educated, and being in a worse family financial situation were stronger predictors of depression than acculturation alone (Rivera, 2007).

A random sample of 942 young people aged 15 to 24 was interviewed as part of the Finnish Health Care Survey 1996 to investigate how major depressive episode (MDE), chronic physical illness and their co-existence were associated with treatment seeking in adolescents (15-19 years old) and young adults (20-24 years old) (Haarasilta et al., 2003). Health care use for physical causes was common, but

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MDE was undertreated among adolescents, and young adults and antidepressant medication were seldom used in Finland in 1996 (Haarasilta et al., 2003). Although young people suffering from both MDE and chronic illness were reported to be more likely to use services for physical disease (73.9%), only 1.5% (n = 14) of all respondents reported recent use of psychiatric services (Haarasilta et al., 2003). From the results, only 14 out of 35 subjects among 68 subjects with MDE, who were predicted to be in need of psychological health treatment, had sought care for depression (Haarasilta et al., 2003).

Another study was made in Finland where a school-based survey was carried out by using a prospective follow-up design, involving 2,070 Finnish ninth grade students (mean age = 15.5) in a two-year follow-up (Fröjd, Marttunen, Pelkonen, von der Pahlen, & Kaltiala-Heino, 2007). 41% of adolescents meeting criteria for depression at baseline remained or again depressed after two years whereby one third of the depressed adolescents at baseline still reported a perceived need for help for depression two years later but only a minority of them had sought professional help. In this study, depression at baseline was significantly associated with the concerns about changes in adolescent's mental health or behaviour among parents and significant others such as siblings, peers, boy/girl-friends, and teacher. The concerns of mother, peers and teacher were related to higher probability of depressed adolescent's recent help-seeking for depression. Essentially, access to mental health services was vital but leaving young people alone to cope with mental health problems was insufficient without involving adolescents' social network members to guarantee adequate intervention for depressed adolescents (Fröjd et al., 2007).

Rawana and Morgan (2014) conducted a study which involved 4,359 adolescents and young adults aged 12-21 to examine the relationships between

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important developmental factors, such as body mass index (BMI), self-esteem, and eating- and weight-related disturbances (e.g., body dissatisfaction and weight management effort) and their interactive effects with gender differences on the developmental trajectory of depressive symptoms. Although females started off with higher initial levels of depressive symptoms than males, on average, depressive symptoms in both genders decreased slightly at age 12-14, began to increase from age 14-17, and then began to decrease at age 21, indicating that the highest vulnerability to depression was among mid-adolescents as compared to other adolescent age groups. When compared to boys, adolescent girls were at increased risk for elevated depressive symptoms across adolescence and young adulthood, which could be explained by the significant association between low levels of self-esteem and higher levels of depressive symptoms among females, and hence, addressing the importance of fostering positive self-esteem among adolescent and young females. The findings also illustrated that engaging in weight management effort was associated with lower initial levels of depressive symptoms in early adolescence, showing the protective effect of specific weight management strategies.

Moving along, Dumont and Provost (1999) classified 297 adolescents (141 eighth graders, mean age = 14 years; 156 eleventh graders, mean age = 16 years and eight months) into three groups: well adjusted, resilient, and vulnerable, in a study to examine group differences and the positive role of specific internal factors (e.g. self-esteem, coping strategies) and external factors (e.g. social support, social life) in preserving adolescents who were suffering depression. The results showed that self-esteem, problem-solving coping skills and methods, and participation in antisocial or illegitimate activities with friends or associates were prominent predictors for distinguishing the three groups. First, well-adjusted adolescents had higher self-

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esteem than those resilient adolescents, while resilient adolescents had higher self-esteem than those vulnerable adolescents. Second, the groups were notable by the involvement in antisocial or illegal activities with friends or associates (vulnerable adolescents), which followed by resilient adolescents had higher scores than well-adjusted adolescents. Finally, concerning the positive coping strategy of problem-solving as a distinguishing protective factor to buffer the destructive effect of stress, the findings showed that resilient adolescents are significantly more likely to use these problem-solving coping strategies than vulnerable and well-adjusted adolescents (Dumont & Provost, 1999).

Qualitative research evidence regarding the children (anyone up to the age of 18) and young people's (those in their teens) views about their experiences of own problems, worries, help-seeking, and about their expectations of adults and professionals' help, were reviewed by Hill (1999). Children and young people's feedback illustrated that it was essential for professionals to address children and young people's concerns and perspectives on how they could most appropriately be helped. Although the views of children and young people were not suggested to outweigh other considerations, provided that those who required help were dissatisfied, alienated, or confused by the way how help was offered, and that the assessment of their overall needs was only based on preconceived ideas, they owned a right to be closely attended to. Wanting to be treated as whole human beings, children were reluctant to be simply related to a 'problem' or 'disorder', contributing to their greater response to relationship- and behavior-oriented conversations undertaken by professionals to establish trust. The findings also stressed the importance of involving informal helpers like family, peers, and sometimes teachers, who were the main confidants and supporters of most children and young people,

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knowing that many young people were suspicious of specialist professionals who were strangers to them. In children's views, intimate relationships were equally important for both positive well-being and negative outcomes, and personal qualities and counseling were much valued on the basis of a genuine respect given to a child's view of own social world. In many circumstances, it was suggested to include the people in a child or young people's social network whom they already had confidence in, for help to be more productive (Hill, 1999).

On the other hand, a qualitative study of non-professional-help-seeking was conducted using in-depth interviews among 105 young adults (17-21 years old) struggling with depression, who were divided into three groups. They were: 37 having a previous diagnosis of depression, 33 having self-perceived emotional distress, and 35 controls (Mart ínez-Hern áez et al., 2014). The results revealed that the reasons for not needing treatment were: (1) male study participants and female controls mostly normalized depressive symptoms; (2) females with self-perceived anguish inclined to mention difficulties of treatment access and fear and worry of telling a outsider about their personal problems; and (3) formerly diagnosed females described distrust in the treatment welfares and fearful of the societal consequences if they sought help. Therefore, for best practices, participants recommending educational initiatives and structural changes to mental health care services.

The role of gender and prior experience with health services strongly contributed to participants' reasons for avoidance in seeking professional help for depression, by which young women tended to refer to prior experience of distress and help-seeking, while the young men tended to view perceived distress as a normal part of life, and used strategies that delayed awareness and recognition of depressive symptoms (Mart ínez-Hern áez et al., 2014). Besides, female participants preferred to

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bring the distress sources to conscious awareness and problematize their symptoms by talking about it with peers (Martínez-Hernández et al., 2014).

The most frequently cited causes for non-help-seeking in Martínez-Hernández et al. (2014) were normalization of the problem, stigma, fear of receiving a diagnosis, professional help not needed, and self-reliance, which in line with the findings of Gulliver, Griffiths, and Christensen (2010) stated that stigma, lack of confidentiality and trust, difficulty identifying the symptoms of mental illness, concern about the characteristics of the provider, and reliance on self were the primary causes for avoiding professional services. In order to facilitate help-seeking in young people, and to make adolescent users and their social context adapt to mental health care services, it is vital to understand their views better, and to involve them as active participants (Gulliver et al., 2010).

The experiences of overcoming depression in 17 young adults with diagnoses within the depression spectrum in individual or group psychoanalytic psychotherapy were explored by using interviews (at termination of psychotherapy and at 1.5 years' follow-up) and grounded theory analysis of transcripts (von Below et al., 2010). The analyzed transcripts were summarized into 15 distinct themes or categories, which were then organized into five general domains: (1) experiences of positive change and new abilities; (2) in-therapy contributions to positive change, and (3) extra-therapeutic contributions to positive change; (4) obstacles to therapy; and (5) negative experienced outcomes.

According to von Below et al. (2010), the patients' experiences of positive changes and new abilities (feeling better, finding oneself, finding one's way of life, viewing life differently) extended beyond symptom relief. In-therapy contributions (sharing what's inside oneself, gaining perspectives and understanding, therapy as a

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place and time for oneself) could diminish obstacles in therapy and represent a change in and of itself, while extra-therapeutic factors (the march of time, other treatments) led to positive change. Patients felt strengthened by the experience with the alleviating impact of in-therapy factors, but when not, obstacles in therapy (feeling uncomfortable in therapy, problems in therapy, wanting treatment to be different) created a feeling that problems remained or exacerbated. Negative experienced outcomes (finding it difficult to do things differently, feeling worse, and getting stuck in problems) could obstruct the experienced changes and also contribute to the experience of obstacles in therapy, however, positive changes could reduce these negative outcomes.

The depressed young adult patients valued symptom relief, but they perceived it to be interrelated with the acquisition of personal identity, meaning, and a sense of coherence (von Below et al., 2010). The patient's view regarding a therapist who actively led them to "sharing their thoughts and feelings, gaining perspective and understanding, viewing life differently and acting differently", and suggested that a focus on self-identity questions was a successful way of overcoming depression among young adults (von Below et al., 2010). For clinicians, these findings put extra demands on both psychotherapeutic techniques and an awareness of the experiences of overcoming depression in emerging adulthood (von Below et al., 2010). For researchers, the results stressed the importance of defining the age-specific challenges and drawbacks in the clinical and non-clinical population of young adults and future research was recommended to investigate the ways to overcome obstacles to psychotherapy in young adults, as well as agreement between the patient's views of personal recovery and their treatment choice (von Below et al., 2010).

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Emerging adulthood has been defined as the period of life between adolescence and adulthood, from the end of high school through most of the twenties and represented an era of possibility, identity exploration, and self-focused, but also a time of instability and flux, which was full of great possibilities and remarkable risks (Carbonell, Reinherz, & Beardslee, 2005). A qualitative study was carried out by Carbonell et al. (2005) recruited 25 emerging adults from a longitudinal community study cohort of 26-year-olds, who had experienced hardships in early life, and thus were at elevated risk for depression, to explore their personal adaptation and coping strategies through the course of their childhood, adolescence, and into emerging adulthood. To some respondents, the in-depth interview experience was treated as a thought-provoking journey into their past and a reassessment of their current lives and hopes, which was also an opportunity for reflection.

Furthermore, a variety of coping strategies for personal growth and healing used across participants at various points in their earlier lives to overcome difficulties, were coded and categorized into three general types: (1) active evasion of adversity, (2) seeking and activating support, and (3) "letting go" (Carbonell et al., 2005). For instance, the importance of seeking social support from adults and peers was repeatedly mentioned by respondents when asked about their advice to others who were dealing with difficult times. The strategy of "letting go" of, or moving on from, the experiences and after-effects of adversity included forgiveness, leaving the house, and spending time alone or with other people, kept participants away from experience of vulnerability to firm deprivations in the past, while maintaining an ongoing but limited relationship with abusive family members.

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Overview Research of Depression in Malaysia

Depression is the most common mental illness reported in Malaysia, which affects approximately 2.3 million people in Malaysia at some point in their lives, but still remained under-detected and untreated (Mukhtar & Oei, 2011a; 2011b). Furthermore, according to Mukhtar and Oei (2011a), the overall depiction of depression in Malaysia was patchy and vague. Ng (2014) stated that there was lack of studies on depression among subgroups in Malaysia, particularly in the male population in Malaysia. Furthermore, it was also revealed that there were many thesis and research projects about depression in the local universities which were yet to be published (Ng, 2014). To date, although cognitive behavioral therapy (CBT) was the recently practiced psychotherapy but pharmacotherapy still dominated the treatment for depression in Malaysia (Mukhtar & Oei, 2011b).

The depression literacy in a sample of 314 urban and rural Indians in Malaysia was investigated by Loo and Furnham (2013). The findings showed that urban participants were more likely than rural participants to identify depression, using the actual term depression. Religious observance and lifestyle factors were highly rated as treatment for depression by both groups. Information campaigns were recommended to increase the awareness about depression targeting the rural population.

In different studies, 18% of the elderly patients aged 60 years and above in Klinik Kesihatan Butterworth, Seberang Perai Utara, Pulau Pinang, Malaysia were found to have depression in a cross-sectional study conducted from April to September 1999 (Sherina, Nor, & Shamsul, 2003). The factors associated with depression were females, those who were unmarried, without formal education, low total family income, and living in urban areas.

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Specifically, Chinese females, smokers, and alcohol users reported a higher risk of suicidal ideation in a retrospective evaluation of medical records from January 2002 to December 2007 conducted at the psychiatric clinic at the Penang (Malaysia) Public Hospital (Khan, Sulaiman, & Hassali, 2012). By age, the elderly aged 50 and above, followed by adolescents and youths aged 15-24, were also found at a higher risk. Other factors that may lead to suicidal ideation among the patients with depressive disorders included comorbid medical complications and social problems.

In a current study conducted by Hanafiah and Van Bortel (2015), 15 mental health professionals (such as psychiatrists, psychologists and counsellors) from both government and private sectors were recruited to be part in-depth, face-to-face, semi-structured interview. The results of the study revealed seven emerging principal themes from thematic analysis of stigma of mental illnesses from the perspectives of the mental health professionals. These include: "(1) main perpetrators, (2) types of mental illness carrying stigma, (3) demography and geography of stigma, (4) manifestations of stigma, (5) impacts of stigma, (6) causes of stigma, and (7) proposed initiatives to tackle stigma." In Malaysia, stigma of mental illness is common particularly among people who diagnosed with schizophrenia, bipolar disorder and depression. Manifestation of stigma often involved labelling, rejection, social exclusion, and employment. Hence, stigma of mental illness in Malaysia and its consequences needs to be addressed.

Moving along, in a questionnaire-based survey in Penang with 1855 respondents undertook face-to-face interviews, the majority (n = 910, 79.2%) significantly agreed that family and friends can enhance the depression recovery process by providing more care and attention to the patient (Khan, Sulaiman, Hassali, & Tahir, 2009). 38.0% of respondents (n = 437) perceived depression as a normal

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medical condition and could diminish automatically. Most of the respondents believed that depression could be prevented by maintaining a good social life. 50.7% did not believe they were at risk, and some noticed a lack of awareness regarding the signs and symptoms. Nevertheless, a positive attitude towards the complications and prevention of depression was explored (Khan, Sulaiman, Hassali, & Tahir, 2009).

For those undertaking tertiary education in Malaysia, Nordin, Talib, Yaacob, and Sabran (2010) recruited a total of 1467 undergraduates in Malaysian public universities to assess the association between gender, ethnicity, academic field of study, year of study and the mental health status of the respondents. University students represented early adulthood, which is the transitional period between adolescence and adult life, and they encountered life's issues such as personal and social adjustment, academic and career concerns, stress and other related psychosomatic issues, that might lead to an unhealthy mental condition. The findings of this study revealed that a majority (65.6%) of undergraduates were mentally healthy while 34.4% exhibited potential mental health problems, indicated that one third of the Malaysian undergraduate population in public universities was suffering from anxiety and worries, and were confronted with social dysfunction and confidence levels in their daily life. The study also found that Malaysian undergraduates' mental health state differed in terms of ethnicity, field of study, and year of study except for gender. Indian undergraduates, social science undergraduates, and Second Year students showed better mental health.

Balami, Salmiah, and Nor Afiah (2014) also focused on public Malaysian university utilizing a cross-sectional study among 495 first year students (18-26 years) of a public Malaysian university to determine the association between three psychological factors such as depression, anxiety and stress with prehypertension.

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The study reported the prevalence of pre-hypertension among first year university students was 30.1%, and the percentage of severe and extremely severe depression was 3.8% and 1.2%. Exceptionally, it was found that severe or extremely severe depression had more than 3 times higher risk in getting pre-hypertension as compared to no depression. Only severe or extremely severe level of depression emerged as the psychological determinant of prehypertension in this study.

Shamsuddin et al. (2013) conducted a similar study featuring cross-sectional method involving 506 students (aged 18-24 years) from four public universities in the Klang Valley, Malaysia to assess the prevalence of depression, anxiety and stress, and to explore their correlations among Malaysian university students. Based on the Depression Anxiety Stress Scale-21 (DASS-21) (Lovibond & Lovibond, 1995), 27.5% of the participants had moderate, and 9.7% had severe or extremely severe depression; 34% had moderate, and 29% had severe or extremely severe anxiety; and 18.6% had moderate and 5.1% had severe or extremely severe stress scores. Students in the older age group (20-24 years) and those who were from rural areas scored significantly higher for both depression and anxiety. Older students, females, Malays and those with either low or high family incomes compared to those with middle incomes showed significant higher stress scores. Both Shamsuddin et al. (2013) and Nordin et al. (2010)'s study addressed the literature gap specifically on depression, anxiety and stress among Malaysian university students, and stressed the necessity of urgent attention and further exploration by health care professionals and the university administrative staff to develop better intervention programs and appropriate support services targeting this group and that greater attention should be given to student with unhealthy scores for their mental health despite a majority of the undergraduates were found to be mentally healthy.

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Winding down towards secondary education, a study participated by 1407 secondary school adolescents aged between 13 and 17 from selected states in Malaysia showed that there were moderate significant relationships between loneliness, stress and self-esteem with depression, with stress being highlighted as the strongest predictor of adolescent depression (Yaacob, Juhari, Talib, & Uba, 2009). Another study conducted by Ibrahim, Amit, and Suen's (2014) indicated that, of the 190 students (103 males and 87 females), aged 15 to 19 from two different schools in Kuala Lumpur, 11.1%, 10.0%, and 9.5% reported that they were experiencing severe depression, anxiety and stress, respectively. Depression, anxiety, and stress were revealed to be significantly correlated with suicidal ideation, with only depression emerging as a predictor for suicidal ideation. Hence, the presence of depression was underlined in predicting suicidal thoughts among adolescents. The findings also highlighted that to reduce depression and suicidal thinking or ideation, support and care should be provided for youths to strengthen personal growth, for instance positive coping skills and strategies to manage distress.

Another researcher had also carried out a qualitative study to investigate emerging adults or young adolescents (18-24 years) who have gone through depression to understand their struggles during this developmental stage and to explore their recovery journey (Kok, 2015). Eight participants aged 18-24 years who were diagnosed with depression at the age of 14-18 but were on the route of recovery were recruited by using snowball sampling, in-depth interviews, and interpretative phenomenological analysis. The emerging themes included (1) Triggering Events: Transitional Stage, (2) Triggering Events: Being Rejected, (3) Triggering Events: Coping with Loved One's Cancer, (4) Recovery and Reflection, and (5) Religious Guidance. Some triggering events of depression like difficulties during transition

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from high schools to universities or transition from being single to engaging with intimate relationships, experience of rejection, and also when loved one was diagnosed as having cancer. Reflection during the recovery stage involved psychosocial support and religious guidance. The vulnerability of transitional stage among emerging adults in highly industrialized or post-industrialized countries was highlighted in this study.

In another qualitative, narrative research conducted by Kok and Lai (2014), the experiences and emotions of teenage depression were understood by attending to the metaphors described by the participants in their story of depression. It was understood that the depression narratives indicated a state of despondency characterized by feeling of inadequacy, reduced social activity, pessimism about the future, or feeling of hopelessness, and metaphors played a facilitating role in conceptualization of such experience. Three participants (22-24 years) were recruited using snowball sampling, with each participant being interviewed for approximately 45 minutes to one hour, thrice within a month. The findings revealed three metaphors, namely *Volcano*, *Black Hole*, and *Being Bitten by Big Fish*, which helped the participants to get closer to the depth of the mind, and to express the unbearable pains from the poetic perspectives. The thematic analysis suggested that the depressed adolescents described their experience of depression as passive, involuntary and painful, whereas an "ah-ha" moment represented the significant turning point to the route of recovery, which was associated with the positive and supportive social environment context of the depressed adolescent, providing unconditional positive regards by the significant others and thus, enhancing the healing or recovery from teenage depression.

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A study conducted by Nurasikin et al. (2012) focused on examining a total of 228 psychiatric patients (Mean age = 40.2) with a majority of male, single Malay Muslims patients' level of religious commitment and coping methods and its relationship with distress level. Higher religious commitment was significantly associated with lower distress, while practices of negative religious coping, severe psychiatric symptoms and diagnosis of anxiety disorder or major depression were associated with higher distress level.

There was a need to address discrepancies in the reported prevalence rates of depression in Malaysia (Ng, 2014). There were also lack of studies looking into the depression among subgroups in Malaysia, such as adolescent depression and male depression. There were several instruments available for assessment of depression in Malaysia but their suitability for the local setting needs further research. Mukhtar and Oei (2011a) also urged to take the depressive symptoms seriously due to their severity in reducing productivity, and in boosting morbidity and mortality of the individual, as well as society and the nation. Thus, by considering this phenomenon, the lack of local research findings on major depression had led to the research of the current study.

Major Themes in Personal Growth Recovering from Depression

In order to gain a better understanding of personal growth in terms of healing and recovery in major depression, it is vital to make clear the course of depression. Based on past literature, Gotlib and Hammen (2008) addressed the importance of understanding the course of depression that affects associated psychosocial outcomes, comorbidities, and treatment. Frank et al. (1991) recommended five terms to describe the change points in depression: episode, remission, response, relapse, and recurrence.

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An episode is referred to having a certain number of symptoms for certain duration. Next, a remission is conceptually defined as the point at which an episode ends, which is a period of time in which an individual no longer meets criteria for the disorder, and it can be partial or full. An individual still exhibit more than minimal symptoms in partial remission, while he or she who no longer meets criteria for the disorder and has no more than minimal symptoms (does not necessarily imply the absence of any symptoms) is said to be in full remission. Nonetheless, a response is a remission due to a treatment intervention, which assumed that a remission occurs at or near the time of a treatment intervention although the causality between treatment and response was difficult to prove. Episode, remission, and response are acute phenomena (Frank et al., 1991; Gotlib & Hammen, 2008).

It is crucial to differentiate relapse from recurrence in terms of recovery among major depressive people. Recovery indicates a full remission that lasts for a defined period and conceptually, it refers to the end of an episode of the illness but not the end of the illness itself (Frank et al., 1991). Then, a relapse implied the early return of symptoms following an apparent response. Relapses are episodes that occurred during continuation treatment which is defined as treatment lasting from four to six months after the initial response. A relapse is expected to occur soon after discontinuation of treatment because the treatment has presumably suppressed rather than eradicated the disease. Recurrence, on the other hand, is defined as a new episode occurring after recovery from a previous episode. It is not necessary for the re-emergence of symptoms to occur right after ending treatment because the patient presumably has been brought into a state of well-being (e.g. personal growth) (Frank et al., 1991; Gotlib & Hammen, 2008). Subsequently, Gotlib and Hammen (2008) also mentioned that these definitions relied on assumptions and statistical likelihoods

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instead of valid biological markers for major depression. However, they indicated that those were reasonable working definitions and were utilized in many studies (Gotlib & Hammen, 2008).

Young adulthood was characterized by remarkable transitions, and contributed to potential development in social damage in adult life (Kuwabara et al., 2007). In a qualitative study titled "I just have to stick with it and It'll work": Experiences of Adolescents and Young Adults with Mental Health Concerns by using semi-structured interviews by Bluhm, Covin, Chow, Wrath and Osuch (2014), the experience of 37 adolescents and young adults (aged 16-25) with depressive or anxiety symptoms about factors affecting their treatment-seeking decision and their feelings regarding their mental health issues were explored focusing upon: (1) participants' understanding of the nature of their mental health diagnosis, (2) participants' views on how their problems affected their relationships with family and friends, and (3) participants' perceptions on the nature and appropriate treatment of mental health problems, including factors that influenced their decision in seeking or continuing treatment.

Woll (2007) indicated that wherever depression goes, stigma and discrimination follow, bringing the feelings of worthlessness, helplessness, and hopelessness. The presence of social stigma and the internalized stigma have hindered most depressed individuals from seeking and receive the help they need. The fundamental mechanism of personal growth in healing and recovery may be hope since hopelessness was the overwhelming message of stigma, self-stigma, and depression (Woll, 2007). Helping professionals share a common responsibility to teach individuals how to hope via medicine, psychotherapy, case management,

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outreach, organizing, and training, but this may become the most challenging skill to acquire for those who have fought hopelessness for a long time.

On the other hand, Bloch (2009) in his book*, "Healing from Depression: 12 Weeks to a Better Mood"*, developed a series of coping strategies to assist personal growth healing from depression based on five different types of self-care activities: (1) physical self-care (e.g., exercise, nutrition, medication), (2) mental-emotional self-care (e.g., cognitive restructuring, daily affirmations, self-forgiveness), (3) social support (e.g., family, friends, psychiatrist/therapist), (4) spiritual connection (e.g., prayer, meditation, finding purpose and meaning), and (5) lifestyle habits (e.g., setting goals, relaxation, humour, stress reduction), which aimed to experience a better mood, free from depression and anxiety.

Findings from the reviewed studies suggest that personal growth elements during recovery journey from major depressive disorder were more than remission of symptoms (Ridge & Ziebland, 2006). Hence, themes that emerged from the qualitative literature are essential to the elements of personal growth recovering from major depression including psychosocial, spiritual, and professional support, self-care, personal transformation, accurate information, and personal responsibility (Badger & Nolan, 2006; Fullager, 2009; Houghton, 2007; LaFrance & Stoppard, 2006; Peden, 1992, 1996; Ridge & Ziebland, 2006; Schreiber, 1996; Steen, 1996; Vidler, 2005). Further, quantitative studies found correlations between recovery from depression and variables including, pharmacotherapy, emotional support, perceived social support, psychosocial impairment, interpersonal relationships, and the experience of hope (Buckley & Herth, 2004; Comninos & Grenyer, 2007; Nasser & Overholser, 2005; Ng, 2014; Solomon et al., 2008).

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On the other hand, studies have shown that perceived emotional and social support appeared to be a significant factor contributing to personal transformation and personal responsibility (Badger & Nolan, 2006; Vidler, 2005). Another study revealed that the experience of hope had led individuals to experience forgiveness and receive spiritual support in their journey of recovery from major depression (Comninos & Grenyer, 2007; Nasser & Overholser, 2005; Solomon et al., 2008).

According to Bluhm et al.'s (2014) best knowledge, this was the first qualitative study focusing on evaluating the adolescent or young adult population's experiences of mental health problems. The emerged themes were found and divided under two comprehensive, but associated, themes: "Managing the Experience of Affective Illness" and "Understanding Affective Illness" (Bluhm et al., 2014). The subthemes under "Managing the Experience of Affective Illness" include (1) active participation, (2) medication, (3) supportive relationships, (4) stigma as a problem, and (5) the experience of affective illness alters participants' own attitudes; whereas "Understanding Affective Illness" encompassed the understanding of (1) first symptoms, (2) causes of affective illness, and (3) feelings of living with affective illness.

However, much was still unknown on depressed young people's experience and responses of an emotional turbulence as they struggled to understand what was happening to them (McCann et al., 2012). Therefore, McCann et al. (2012) sought to explore the experience of young people diagnosed with depression, and recruited 26 young people from a youth mental health service, in a qualitative interpretative study, by using semi-structured, audio-recorded interviews (McCann et al., 2012). The emerging overlapping themes showed that young people may respond to their depression in self-protective, harmful and sometimes life-threatening ways: (1)

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struggling to make sense of their depression, (2) spiralling down, (3) withdrawing from friends, and (4) contemplating self-harm or suicide. Young people encountered considerable struggles responding to depression, isolated themselves to preserve friendships, afraid of stigma, and attempted self-harm or suicide to bring a dramatic end to their suffering. In spite of this, interventions counteracting community stigma and providing accessible, youth-focused services, could improve young people's understanding of depression and its treatment.

Previous studies had also indicated that one out of four young adults reported the highest risk for depressive disorders among all age groups (Kuwabara et al., 2007). Among young people, mild-to-moderate depression was related to impaired social functioning and also high rates of affective disorder in later adult life (Iliffe, Gallant, Kramer, Gledhill, Bye, Fernandez, Vila, Miller, & Garralda, 2012; Pine, Cohen, Cohen, & Brook, 2014). The burden of depression in adulthood could be reduced by the earlier recognition of depression in young people and yet, teen depression was underdiagnosed and undertreated (Iliffe et al., 2012).

In a qualitative study, Kuwabara et al. (2007) sought to explore a relatively natural description about the interpretation and lived experience of depression among 15 emerging adults aged 18-25 years with major or minor depression, the experience of emerging adults focusing on treatment seeking, developmental tasks, and the social vulnerabilities of their depression, were investigated, using in-depth interviews. Using grounded theory, the thematic analysis resulted in four major themes, which were (1) identification as an individual with depression, (2) healthcare experiences related to diagnosis and treatment, (3) relationships and social support, and (4) role transitions from adolescence into adulthood and general functioning. The

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relationship between these themes impaired developmental milestones, worsening the sense of identity and depressed mood.

The interactions between the lack of clarity about medical definition of own disorder, sadness versus depression, lack of financial assistance, stigma by self and from others, social withdrawal and isolation, and the clash between current depressed mood, past failures, and future expectations were found to be possibly exacerbating depressive symptoms (Kuwabara et al., 2007). A failure in engaging treatment seeking, relationships and role transitions might lead to the onset and maintenance of depressive disorders among emerging adults (Kuwabara et al., 2007). Nonetheless, encouraging findings suggested that improved community mental health literacy helped increase awareness of depression and of how primary care practitioners and mental health professionals respond effectively to the young people (McCann et al., 2012).

Moving on from young adults, depressed women's quality of life could be improved and the suffering of severe depression could be eased by the use of treatment programs (Cumby, 2006). Due to the lack of published research on understanding women's experience of treatment in depression programs, a phenomenological study was conducted by Cumby (2006) involving six women (36-50 years old) who were previously diagnosed with depression ranging from three to twenty years to describe their personal experience taking part in inpatient treatment, mental health day treatment, and mental health outpatient treatment. One-on-one unstructured interviews using phenomenological approach outlined by Colaizzi (1978) allowed participants to present their experiences in their own words as much as possible. The clustered data resulted in six interrelated themes: (1) feeling a sense of safety and relief, (2) frustration of learning to navigate the system, (3) making

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connections with others in a similar situation, (4) finding therapeutic staff members, (5) learning new insights and skills, and (6) gaining some control over own illness, reflecting how depressed women experience treatment for their depression.

Cumby (2006) found that women felt safe and relieved once treatment was accessible. Before engaging in treatment, fear was rampant among these women, whose fear was associated with the experience of uncertainty, unfamiliarity and complexity of the mental health care system, leading to the frustrations, frightening, and confusions among women. After engaging in treatment, women described important connections (mutual support) with other members in their treatment program has significantly aided them in the reduction of emotional isolation. In spite of believing that the openness and honesty were significant to their treatment and recovery, it was only when women with depression perceived therapeutic staff members to be non-judgmental, understanding, and supportive that they began to accept their own thoughts, feelings, and experiences, openly and honestly. From participants' point of view, treatment encompassed gaining or learning new insights into their depression (e.g., exploring the connection between their thoughts and feelings, learning how childhood experiences led to depression, developing an improved sense of self-esteem, and gaining insights into their anger), and skills to manage their depression (e.g., establishing structure in one's life, developing writing skills as a means of exploring feelings, gaining assertiveness skills, practicing relaxation techniques, and learning goal setting skills). Such insights and skills acquired, helped women in overcoming disempowerment and helplessness, and in gaining a sense of personal mastery or control over their treatment, their illness, and their lives, which were fundamental to their personal growth and recovery (Cumby, 2006).

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Moreover, women with insufficient social supports, poor health and a history of stressful life events were at risk of poor perinatal mental health (Myors, Schmied, Johnson, & Cleary, 2014). Myors et al.'s (2014) qualitative study sought to describe the experience of women in accessing specialist perinatal and infant mental health (PIMH) services, considering no studies reporting the effectiveness and experience of women in PIMH services. 11 women being clients of a PIMH service who took part in either face-to-face or telephone interviews yielded data for thematic analysis. This resulted in an overarching theme, 'My special time,' which comprises of three subthemes: (1) 'there is someone out there for me', (2) 'it wasn't just a job,' and (3) 'swimming or stranded: feelings about leaving the service.' Overall, a positive experience of PIMH service was reported, with the therapeutic relationship between participant and the clinician acting as a key component, enabling women's personal growth as individuals and as mothers (Myors et al., 2014). The findings illustrated that women who had complex support needs, despite feeling hesitant about help-seeking, were also willing to engage with PIMH services. Essentially, health professionals were required to provide a 'secure base' other than relational and professional skills, allowing women to feel safe disclosing their personal stories.

Unlike women, there was a slight difference with regards to the manifestation of depression among men. A research conducted by Heifner (1997) utilized an exploratory, descriptive qualitative research by using semi-structured, in-depth interviews, involving 14 men talking about their experiences with depression to explore the meaning of those experiences. There were a few emerging themes in the study which came to a conclusion that "men who are likely to develop a clinical depression (1) have accepted rigid, traditional gender identity roles, (2) believe acceptance by others is dependent on performance, (3) lack connectedness with

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others, especially with other men (traditional masculine socialization), (4) have developed a hidden self, and (5) feel out of control with no or few internal or external options. Depression challenged their beliefs about being male, and the beliefs challenge the process of treatment and recovery.

Another major theme in healing or recovery can be found in relationships and their very own self-personal concepts. As explored by Kyriakopoulos (2011) who carried out a qualitative evaluation on how individuals with self-reported anxiety and depression experienced participating in a combination of individual counselling and an adventurous outdoor experience (adventure therapy), including six participants (aged 20-25 except a female in her mid-forties), using semi-structured interviews. The findings of Interpretative Phenomenological Analysis (IPA) revealed four major domains categorized from 12 emerging themes: (1) enhancing intrapersonal relationships, (2) improving interpersonal relationships, (3) offering an experiential outdoor venue for achieving therapeutic change, and (4) offering a secure, personal place for achieving inner healing (Kyriakopoulos, 2011).

The introduction of an outdoor venturous activity into counselling was perceived to be beneficial to the way how interviewees related towards themselves and other people (Kyriakopoulos, 2011). The counselling sessions were also perceived as offering a safe therapeutic space for interviewees to unveil their anxieties and to achieve inner healing; whereas outdoor experiences offered them an experiential venue that contrasted with the interviewees' present phenomenological reality, for achieving personal change and enhancing the therapeutic process. Such findings highlighted the significant role of the social context in determining positive mental health from a psychotherapeutic perspective (Kyriakopoulos, 2011).

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Utilizing a person's cognitive capabilities, the person's own understanding of major depression and the ability to use this understanding in managing the illness were said to be the important aspects of a person's capacity for personal growth and recovery (Nunstedt, Nilsson, Skärsäter, & Kylén, 2012). Nunstedt et al. (2012) aimed to explain how individuals suffering from major depression describe their understanding of their own depression and how this understanding was utilized to handle their illness, by employing a qualitative interpretative design among 20 DSM-IV's (American Psychiatric Association, 1994) major depressive patients (aged 23-68 years) who were interviewed in 2008. Three key themes emerged from content analysis in this study were: (1) awakening insight, (2) strategies for understanding and managing, and (3) making use of understanding, each with respective subthemes (Nunstedt et al., 2012).

It was recommended that a person's own experiences and insights of the effects of his or her own major depression in the context of their own lives and growth should be treated as the foundation to understand depression, rather than merely based on general symptoms and treatments gained from others (Nunstedt et al., 2012). Individual understandings of the illness varied across participants' ability to handle their depression, and therefore, there was a crucial need for further research on an individual's understanding of depression and on how he or she used of this understanding to manage, recover from, and lower the risk of relapsing into depression (Nunstedt et al., 2012).

To briefly summarize the subtopic on the understanding of the personal growth process and recovery from depression, the researcher first focused on individuals' handling of depression and the major themes that were found by researchers from the studies conducted. Next it shifted to the gender differences in

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the personal growth and healing experience in which women's safety, social support, health and stressful life events were things which correlate towards depression while males tend to focus upon traditional gender roles of men, development of hidden selves, and also the acceptance and the lack of connectedness with their peers. Finally, a person's unique relationships with people and their very own self-personal concepts which aid the personal growth and healing process as well as their very own capability in understanding and dealing with their very own depression were discussed.

Deficiencies in Literature on Understanding Personal Growth Experience of Young Adults Recovering from Major Depression

To date, concerns regarding serious impacts of major depression have fostered a considerable amount of studies focusing on the experience, the treatments, the treatment-seeking behaviour, and also on other issues regarding depression (Mukhtar & Oei, 2011b; Ng, 2014). However, the personal growth experience of depressed individuals has yet to be brought into sharp focus, which was clearly indicated by the deficiencies in literature investigating directly on such personal recovery experience. Searching related articles in several databases using the key terms including “major depression,” “personal growth experience,” “healing experience,” and “recovery from major depression” often results in minimal amounts of relevant articles, with a great deal of articles focusing on either the symptomatology and the impacts of major depression and also on the somatic healing of illnesses other than major depression.

Proceeding from here, in order to understand the personal growth journey of recovery from young adults’ depression better, an existential, phenomenological, naturalistic description should be excerpted from adolescents, youths, young adults

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and also emerging adults' own experience, own words and also their own perspectives. Although past researchers have shown tremendous amount of interest in topics regarding depression, much effort was needed to look into depression issues among young adults with a focus on their recovery experience which may be deemed as vital for contributing to the considerable gap in understanding personal growth recovering from major depression especially in Malaysia.

Chapter Summary

Overall, this chapter covered literatures that were reviewed and organized into eight sections. They were: epidemiology of depression, the emic of depression, the prevalence of depression, model of personal growth and healing, past research on personal growth and healing experiences, overview research of depression in Malaysia, and major themes in personal growth and recovery from depression. Deficiencies in literature related to the personal growth experience of young adults recovering major depression stated in the final part of the chapter, revealed considerable gap in the understanding of the personal growth process from major depression. The next chapter discussed about methodology applied in this study.

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Chapter 3 Methodology

Introduction

The purpose of this study was to understand the personal growth experiences of major depressive young adult recovering from major depression. This chapter comprised of descriptions of qualitative research paradigm, the rationale for choosing the qualitative approach, and transcendental phenomenological method as research design to explore the research question of this study. Next, the researcher's background, data collection methods, data analysis, trustworthiness, the potential risks and benefits, the protection of human subjects in this study, and chapter summary were included in this chapter.

Qualitative Research Design

In this study, a qualitative research methodology was adopted to achieve the objective of this study. A qualitative research methodology enables the researcher to explore and understand things in their natural contexts, with an attempt to illustrate or to describe phenomena regarding the meanings individuals brought to them (Denzin & Lincoln, 1994; Klenke, 2008). Subsequently, to distinguish a qualitative research from other approaches, many attempts have been made to synthesize a list of its characteristics (Hatch, 2002). First, natural settings without being manipulated allowed the researcher to study the lived experience of real people in real settings and to explore human behaviours within the contexts of their natural occurrence. Second, the qualitative study tried to understand the world from the perspectives of the people living in it. Third, the principal data for qualitative researches were collected directly by the researchers themselves. Fourth, an extended first-hand engagement was required whereby the researchers must spend enough time to intensely engage in the natural settings they were studying, together with the

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participants, to understand participants' perspectives in natural contexts. Fifth, the wholeness and complexity of social contexts could be systematically examined while preserving complex, detailed narratives without breaking them down into isolated, incomplete, and disconnected variables. Lastly, qualitative researchers depended on subjective judgments as the inner states of human activities were not directly observable and more subjective judgments were required when moving from description, analysis, towards interpretation of data.

Due to the characteristics stated above, qualitative research design exhibited its strength by providing an extensive, thick, detailed description of personal growth experience among young adults living with major depression. Furthermore, the insider's view of a phenomenon and the flexibility to detect unexpected insights during the research process were able to be addressed (Klenke, 2008; Lundberg, 1976). Qualitative research also brought the researcher closer to her informants, and allowed her to focus on the participants' lived experiences and their critical voices (Klenke, 2008). For these reasons, qualitative research methodology has fitted the research purpose of this study to gain a better understanding of the subjective personal growth experience of major depressive young adult and to take an in-depth look at the essence of young adults' personal growth recovering from major depression from their own perspectives.

In addition, according to Patton (2015), qualitative inquiry may contributes to the understanding of the world in seven ways: (1) illuminating meaning, (2) studying how things work, (3) capturing stories to understand people's perspectives and experiences, (4) elucidating how systems function and their consequences for people's lives, (5) understanding context: how and why it matters, (6) identifying unanticipated consequences, and (7) making case comparisons to discover important

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patterns and themes across cases. These contributions positively added value to this study as the personal growth experiences recovering from major depressive disorder among young adults which was still at the exploration stage, especially in Malaysia. Comparison and contrast were conducted via different individuals participating in this study, making space for studying their similar but unique meaning-makings and experiences, which helped to unveil the valuable themes for this study.

Moreover, qualitative research design eased the process of capturing the experiences shared by the participants because it described and interpreted data in words, stories, observations, and documents (Patton, 2015). There are three types of data yielded by qualitative findings, which were (1) in-depth, open-ended interviews, (2) direct observations, and (3) written communications (Patton, 2015). Their respective detailed descriptions are shown in Table 3.1. In this study, in-depth interviews were the primary type of data collected. Thus, audio-recordings and transcriptions were needed to record the young adult's perceptions on their personal growth journey of recovery from major depression.

Table 3.1

Three Types of Qualitative Data

Types of Qualitative Data	**Description**
Interviews	Open-ended questions and probes yield in-depth responses about people's experiences, perceptions, opinions, feelings, and knowledge. Data consist of verbatim quotations with sufficient context to be interpretable.
Observation and fieldwork	Fieldwork descriptions of activities, behaviours, actions, conversations, interpersonal interactions, organizational or community processes, or any other aspect of observable human experience are documented. Data consist of field notes: rich, detailed descriptions, including the context within which the observations were made.

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Documents	Written materials and documents from organizational, clinical, or program records; social media postings of all kinds; memoranda and correspondence; official publications and reports; personal diaries, letters, artistic works, photographs, and memorabilia; and written responses to open-ended surveys are collected. Data consist of excerpts from documents captured in a way that records and preserves the context.

Source: (Patton, 2015)

Merriam and Tisdell (2016) described six types of qualitative research which were chosen from various types of qualitative research, suiting to their commonness in social sciences and applied fields of practice: (1) basic qualitative study, (2) phenomenological study, (3) ethnography, (4) grounded theory, (5) narrative analysis, and (6) qualitative case study. A basic qualitative study is the most common form and seeks to understand how people make sense of their experiences and thus, Merriam and Tisdell (2016) placed it as a centre because the other types of qualitative research share exactly the same characteristics with it, although each has an added dimension.

Therefore, the essence or underlying structure of a phenomenon becomes the interest in a phenomenological study (Merriam & Tisdell, 2016), which specifically best fit to the purpose of this study to seize the essence of personal growth experience among young adults recovering from major depression. Therefore, after putting together the distinctive characteristics, potential contributions, types of data yielded, and its subtypes, the researcher selected a qualitative research methodology to understand in-depth about young adults' personal growth experiences recovering from major depression.

Phenomenological Research Design

Phenomenology research design suggested that human behaviour was a product of how individuals interpret the world, and phenomenology aimed to grasp and understand how individuals came to interpret theirs and others' actions

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meaningfully (Crotty, 1998/2014). Uniquely, this matched perfectly with the heart of this research as the researcher aimed to figure out how young adults interpret their own world of fighting against major depression and eventually experiencing personal growth from it, without focusing on interpretations from the researcher. The young adult participants have experienced themselves not only the suffocating period of major depression but also the feelings of breaking free from it. These experiences were subjective and understanding can only be induced through their own descriptions on their personal meaning-making activities.

In addition, "phenomenology, step by step, attempts to eliminate everything that represents a prejudgment, setting aside presuppositions, and reaching a transcendental state of freshness and openness, a readiness to see in an unfettered way, not threatened by customs, beliefs, and prejudices of normal science, by the habits of the natural world or by knowledge based on unreflected everyday experience" (Moustakas, 1994, p. 41). For this reason, the researcher has 'bracketed' her predominant comprehension to the best of her abilities and to allow the experience of phenomena speak at first hand (Crotty, 1998/2014).

Further, phenomenology inquiry addressed the question: "What is the structure and essence of experience of this phenomenon for these people?" (Kirk, MacDonald, & O'Sullivan, 2006, p. 28) and the phenomenon could be an emotion, a relationship, a job, a program, or a culture (Kirk et al., 2006; Patton, 1990). Hence, the research question answered in this study was: "How do young adults experience personal growth from major depression?" The phenomenon was the personal growth process. This experience for young adults suffering from MDD has best revealed via the use of phenomenology.

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On top of that, phenomenology research gained its qualitative status for obtaining phenomenological data from language and discourse (Kirk et al., 2006; Polkinghorne, 1989). From the perspective of a qualitative research, a phenomenological study illustrated "the common meaning for several individuals of their lived experiences of a concept or a phenomenon" (Creswell, 2012, p. 76). For instance, each participant in this study has their individual lived personal growth experience (e.g., spiritual practice, counselling, social support) but in essence, all participants were making the common meaning which was to make the breakthrough from major depression. The participants' descriptions of such meaning-making process, which comprised of "not only what was experienced but also how it was experienced" (Sullivan, 2009, p. 379), was examined by the researcher to investigate the essence of such experience or phenomenon by conducting a phenomenological research (Sullivan, 2009).

Referring to Moustakas (1994) and van Manen (1990), Creswell (2012) listed several defining features of phenomenological studies. The typical features were (1) an emphasis on a phenomenon to be explored, of a single concept or idea (e.g., personal growth experience from major depression); (2) the exploration of this phenomenon with a group of individuals who have all experienced the phenomenon (e.g., young adults who were diagnosed with major depressive disorder); (3) a philosophical discussion about the basic ideas involved in conducting a phenomenology (e.g., the feelings, thoughts, struggles and efforts during recovery); (4) in some forms of phenomenology, the researcher brackets herself out of the study by discussing personal experiences with the phenomenon (e.g., the researcher sets her prejudgments aside and emphasized on the participants' perspectives); (5) a data collection procedure that involves typical interviewing individuals who have

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experienced the phenomenon (e.g., in-depth, semi-structured phenomenological interviews were used in this study to collect data); (6) data analysis that can follow systematic procedures that move from the narrow units of analysis (e.g., significant statements like sharing about major depression with friends and family), and to broader units (e.g., meaning units like supportive relationship), and to detailed descriptions that summarize two elements, "what" the individuals have experienced and "how" they have experienced it, and (7) a phenomenology ends with a descriptive passage that discusses the essence of the individuals' experience and the "essence" is the culminating aspect of a phenomenological study (e.g., the essence of personal growth experience recovering from major depressive disorder) (Creswell, 2012, p. 78-79).

According to Sullivan (2009), phenomenological research was built on a strong philosophical foundation. It mainly divided into two popular types which shared some common but also several distinctive features: (1) transcendental or descriptive or Husserlian phenomenology and (2) hermeneutical or interpretive or Heideggerian phenomenology (Creswell, 2012; Holloway & Brown, 2012; Sullivan, 2009; Watson, McKenna, Cowman, & Keady, 2008). In this case, Holloway & Brown (2012) suggested that either approach can be used on condition that the integrity of the particular chosen approach is preserved.

Thus, transcendental phenomenology, which was also known as empirical, existential, or psychological phenomenology, focused on uncovering, illustrating, and describing the essence stem from the phenomena of interest (Watson et al., 2008), less on the analysis and perception (e.g. interpretations) of the researcher, and focus more on a narrative description of the participants' experiences (Creswell, 2012), which exactly coordinated with the researcher's intention to understand the

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inner states of participants without inserting the researcher's own mind-sets. Despite the fact that the researcher's interpretation was needed for data analysis, the effect was limited because the participant's confirmation must be acquired to ensure the accuracy of findings.

In contrast, hermeneutical phenomenology placed the focus on interpreting the texts of life (hermeneutics) as they related to lived experience (phenomenology), and required the researcher not only to describe but also to interpret the participants' descriptions (Sullivan, 2009), which differ from the researcher's attempts in this study. As mentioned earlier, there was a remarkable literature gap in the understanding of personal growth experience recovering from major depression especially among young adults. Therefore, when the essence of a person's experience must be explored, described, and potentially interpreted, phenomenology was chosen as the research method because it involved a small number of participants but a great detailed exploration in the data generated by participants (generally via interviews) to "arrive at the very heart of an experience" (Sullivan, 2009, p. 379).

In one of the Husserl's essential concepts which known as 'epoche' or bracketing, the researcher is required to put away her experiences and biases as much as possible to take a "fresh perspective toward the phenomenon under examination" (Creswell, 2012, p. 80). Moustakas (1994, p. 34) also stated that transcendental means "in which everything is perceived freshly, as if for the first time" (Creswell, 2012, p. 80). Epoche was controversial and unnecessary in hermeneutical phenomenology but was desirable in transcendental phenomenology (Sullivan, 2009). This allowed transcendental phenomenological researchers to be fully concentrated on the essence of participants' experiences without being influenced by the researchers' own experiences and biases, which was strictly implemented by the

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researcher throughout this study "in order to perceive anew the experiences of their participants" (Sullivan, 2009, p. 379).

Nevertheless, Moustakas (1994) admitted that epoche was seldom perfectly achieved (Creswell, 2012), and thus it can be considered a weakness of transcendental phenomenology (Sullivan, 2009). Therefore, Wall, Glenn, Mitchinson and Poole (2004) suggested novice researcher to place bracketing within a continuous activity of reflection and to be aware that there is no standard method for undertaking bracketing (Sullivan, 2009). It was more of "a psychological orientation towards oneself rather than an observable set of procedures to be adopted by a researcher" (Wall et al., 2004, p. 22).

Transcendental phenomenology has its unique procedures. As illustrated by Moustakas (1994), the steps initiated by recognizing a phenomenon to explore or study, bracketing out ('epoche') the researcher's experiences, collecting data from a number of identified individuals who have experienced the phenomenon of the study, and then continue to analyse data by reducing the collected data information to meaningful statements or quotes and merging these meaningful statements into themes (Creswell, 2012). Next, a textural description of the individuals' experiences (for instance, what the participants experienced) was developed by the researcher, followed by a structural description of individuals' experiences (for instance, how the participants experienced it regarding the conditions, situations, or context). Lastly, the researcher combined all of the descriptions to deliver a full essence of the experiences (Creswell, 2012). Therefore, these systematic steps became the fundamental attributes of the data collection and data analysis process in this study due to the strong basis of transcendental phenomenology.

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Rationale for Research Design

By referring to the purpose of this study, the researcher aimed to explore the personal growth experiences of young adults recovering from major depressive disorder. The "essence" of participants' first-hand experiences of personal growth recovering from major depression was investigated to obtain a detailed, unconstrained description of this phenomenon. An emphasis on personal growth experiences from young adults' perspectives was exceptionally beneficial to move towards a deeper understanding of the meaning behind the recovery journey trodden by young adults who suffered from major depression. Hence, a qualitative, transcendental phenomenological research approach was adopted in this study.

There were several compelling reasons for choosing this approach. First, phenomenology was one of the principal components under a constructivist paradigm (Crotty, 1998/2014; James & Busher, 2009; Schwandt, 1994) and offered the researcher to grasp and understand how individuals come to interpret theirs and others' actions meaningfully (Crotty, 1998/2014). Second, a qualitative research attempted to make sense of phenomena in terms of the meanings people brought to them by studying things in their natural settings (Denzin & Lincoln, 1994; Klenke, 2008). Qualitative research method also exhibited distinctive characteristics stated above (Hatch, 2002) which was also its strength for providing extensive, thick, detailed description of personal growth experience among major depressive young adults. Third, phenomenological analyst sought to capture the meaning and common features, or essences, of an experience or event, through close examination of individual experiences (Starks & Trinidad, 2007).

Phenomenological approach has been chosen in this study because the experiences of major depressive young adults must be explored and described, and it

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only required a small number of participants but provided a great detailed exploration in the data to reach the essence of the participants' experiences (Sullivan, 2009). Fourth, a transcendental phenomenological approach allowed the researcher to be fully concentrated on the essence of participants' experiences (Sullivan, 2009). With the inclusion of bracketing concept, this study preserved and prioritized the lived experiences of the participants without being bounded by the researcher's own experiences. Therefore, a qualitative, transcendental phenomenological research method was believed to be the best fit for this study to enable detailed exploration of the inner world of personal growth experiences of young adults recovering from major depression.

Researcher

In this section, the researcher's background, role, and biases were addressed to ensure the researcher was transparent with her own prejudgment and preconceived ideas of issues of major depression (Moustakas, 1994). This was intended to highlight a controversial issue that often happens in qualitative research, wherein the researcher was the primary instrument for the data collection and analysis (Creswell, 2007; Merriam, 2001). Subsequently the researcher played a significant role in describing the meaning of the data collected from the participant (Merriam, 2001). Therefore, the explanation about the researcher's background, role, and personal biases of the study were necessary to be described. As proposed by Denzin and Lincoln (2000), it was part of qualitative research methods to ensure that information that pertains to training, fieldwork, data collection procedures, and data analysis be reported.

Researcher's background. The researcher has been working as a licensed counsellor for seven years. Throughout these years, she has encountered

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adolescences and adults suffering from major depressive disorder. Providing counselling services to these groups in mental health setting has triggered her interest in this issue. She used to practice as a training counsellor and trainer in local governmental tertiary health care agencies, namely *Hospital Serdang* and *Lembaga Penduduk dan Pembangunan Keluarga Negara* (LPPKN). Currently she is working at *Hospital Raja Permaisuri Bainun* (HRPB) Ipoh, Perak as a licensed counsellor as well as a trainer. In HRPB, *Hospital Serdang* and LPPKN she has served a number of clients who experienced major depressive disorder.

During her work as a counsellor, there were many clients diagnosed with major depressive disorder referred for counselling sessions. Throughout her years of service at hospital setting, she witnessed some of the clients recovered and some still suffers from depressive episode. This phenomenon increased the researcher's eagerness to understand how individuals who have recovered were able to manage their daily life and cope with their depressive episodes. The experiences above have guided the researcher to have a strong passion for issues related to the personal growth experiences recovering from major depression. As a result of this passion, the researcher initiated this study and sought to use this study as a stepping stone for her to get to know and understand the phenomenon of major depression.

Researcher's role. The researcher is "critical for the quality of the scientific knowledge and for the soundness of ethical decisions in qualitative inquiry" (Willig & Stainton-Rogers, 2007, p. 268). The moral integrity (knowledge, experience, honesty, and fairness) of the researcher, her sensitivity and commitment to moral issues and action, outweighed the abstract ethical knowledge and cognitive choices (Willig & Stainton-Rogers, 2007). The researcher was responsible to only publish the findings which are "as accurate and representative of the field of inquiry as possible,

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which are checked and validated as fully as possible, and striving towards a transparency of the procedures by which the findings have been obtained" (Willig & Stainton-Rogers, 2007, p. 268).

In this study, young adults who have major depressive disorder were the primary source of information on their personal growth experiences, gathered through interviews. Through interviews, the researcher was able to access the context of people's behaviour and thus it also provides a platform for the researcher to understand the meaning of the participants' behaviours (Seidman, 2006). Seidman (2006) described that "the root of in-depth interviewing is an interest in understanding the experiences of other people and the meaning they make of the experience" (p. 9). Therefore in this study, the researcher's primary role was as an interviewer. Throughout the entire study, the researcher paid close attention to ethical considerations during each and every phase of this study, starting from the beginning until the completion of this study.

Researcher's biases. As part one of the actions to ensure the trustworthiness of the data, the researcher decided to identify her own personal biases on issues of major depressive disorder, in order to increase her awareness and minimize the influence of personal biases that influence the study's outcomes. A total of nine biases were identified: (a) the person experiencing depression is the expert regarding his or her own life, (b) symptoms described in diagnostic schedules such as the DSM-5 are credible but do not encompass a comprehensive descriptions of experiences of depressive disorder, (c) depression is an all-encompassing experience that cannot be reduced to a list of signs and symptoms, (d) depression creates a need to withdraw from people, (e) depression can be an immobilizing force, (f) oppression within the life world of young adult can result in depression; depression is an

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oppressive force in and of itself, (g) depression can lead to feelings of overwhelming worthlessness, (h) young adults who are depressed sometimes express their depression as anger, and (i) people who are depressed may display negativism. The researcher continuously reminded herself throughout the process of data collection not to be predisposed by her own personal biases especially in the process of interview sessions and throughout the progression of analysing data collected from the interview sessions.

Data Collection

In order to support the purpose of study to explore the personal growth experiences of young adults recovering from major depression, this study inculcated useful data collection methods. Research tools used, sampling method, procedures, interview protocol, and plans for exits, were presented in the following sections.

Research tools.

Interview. Prior to the interview, the participants were enquired to complete a demographic questionnaire (Appendix C). The researcher conducted a phenomenological interviewing session that characterized by the three-interview series designed by Dolbeare and Schuman (Schuman, 1982). The length of the interviews varied from 45 to 90 minutes, with most of the interview sessions lasting for approximately one hour. The data was collected from the participants who have experienced the phenomenon and data collection method comprised in-depth and multiple interviews with participants (Creswell, 2012).

Every participant answered the questions that comprised the researcher's interview protocol (Appendix D). Questions such as, "How was your life before and after depression?" "How is your personal growth experience recovering from major depression?" and "What do these personal growth and healing experiences from

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major depression mean to you?" were focused and prompts were used in order to uncover the essence in participants' lived experience recovering from major depression and prompting them to describe more about their personal growth journey. For instance, the participants in this study disclosed that he or she was worried, frustrated, angry, sad, or puzzled initially but gained confidence gradually during recovery from major depression. Participants also disclosed their personal growth experiences in terms of what they have done to recover and heal from major depression, such as treatment-seeking, spiritual practice, medication, or social support. Furthermore, the participants also described about the contexts that have influenced their recovery process, like encouragement from family or emotional support from boyfriend.

In this study, the interviews were recorded by audiotape, which were later transcribed to provide a word-by-word record of what was said during the interview (Kervin, Vialle, Herrington, & Okely, 2006). Johnson (2002) mentioned that it was important to record semi-structured interviews because the participant's words must be presented verbatim in the analysis to preserve meaning (Saks & Allsop, 2007). At the same time, it was necessary for participants to understand why the interview was employed audiotape to effectively record the enlightening contents of interviews. Although refusal was rare, the process of getting permission from the participants must always be respected (Becker, Bryman, & Ferguson, 2012).

Documentation. To gain a better understanding of the personal growth experience among the young adults with major depression, written documents or other artifacts were used by the researcher in this study. Documents referred to a wide range of written, physical, and visual materials, or other tools termed artifacts, which can be classified into four categories: (1) public records (e.g., federal reports

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and agency reports); (2) personal documents that are typically first-person narratives (e.g., diaries, letters, and scrapbooks); (3) physical materials (e.g., equipment, paintings, and photographs); and (4) researcher-generated documents that are prepared by the researcher for the participants to complete/fill and to be returned to the researcher (e.g., keep a journal or to draw a picture) (Ary, Jacobs, Sorensen, & Walker, 2013). In this study, the researcher employed document analysis of reflective journals, diaries, and also drawings as part of the documentation of data collection.

The researcher made a compilation of all her reflective journals about her feelings, impersonations, views, and experiences during the interview sessions, while reading transcripts, as well as during data analysis and data synthesis. This allowed the researcher to continue to address her own biases and assumptions to purely obtain the description of the participants' healing experience recovering from major depression. As all the participants were fully committed with their own responsibilities at work and also at home, most of them found it challenging to prepare a diary before and after the interview sessions. However, most of them managed to share several drawings that symbolized their healing experiences.

In summary, after considering all the related elements of each types of documentation, the researcher decided to use in-depth, semi-structured, phenomenological interviews to serve as the primary data collection method in this study, which were supported with audio recordings and interview transcripts. Additionally, documents comprised of the researcher's reflective journals and drawings which were utilized to enhance the data collection phase in this study.

Sampling. Cilesiz (2009, p. 240) stated that transcendental phenomenology "is concerned with lived experience and seeks reality in individuals' narratives of

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their experiences of and feelings about specific phenomena, producing their in-depth descriptions" (Lichtman, 2011, p. 244). In this study, young adults' personal growth experiences and feelings about their recovery journey from major depression which yielded in-depth descriptions were explored in this study. The researcher was interested to capture essence of the lived experiences of this phenomenon. Hence, purposive sampling was utilized in this study to recruit targeted participants because data from only a few individuals who have experienced the phenomenon can provide a detailed account of their unique experience, which was sufficient to uncover its core elements (Starks & Trinidad, 2007).

According to Engel and Schutt (2014), in purposive sampling, "each sample element is selected for a purpose, usually because of the unique position of the sample elements" (p. 105), which may include "studying the entire population of some limited group or a subset of a population" (p. 105) or "to examine the effectiveness of some intervention with clients who have particular characteristics, such as a specific diagnosis" (Engel & Schutt, 2014, p. 105). However, it was noteworthy that a purposive sample was adequate to represent the issues studied but not the broader population (Engel & Schutt, 2014).

According to Patton (2015), there were no rules for sample size in qualitative inquiry and it depends on what the researcher wants to know, the purpose of study, "what's at stake, what will be useful, what will have credibility, and what can be done with the available time and resources" (p. 311). Morse (2000, 2001) stated that sample size in qualitative research studies depended on five things which were: the scope of the study, the nature of the topic, the quality of the data, the study design, and the use of shadowed data (Starks & Trinidad, 2007).

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Furthermore, typical sample sizes for a phenomenological research like this study ranged from one to ten persons (Starks & Trinidad, 2007), or six to twelve persons as recommended by Thomas and Pollio (2002) (Morse, 1994*;* Ray, 1994). However, the researcher considered whether to interview the additional four or six participants because it would be unnecessary when redundancy was evident after hearing the narratives of six participants (Thomas & Pollio, 2002). These suggestions helped the researcher in this study to decide on a number of nine participants with unique position of the sample elements recruited.

Selection of participant. WHO (2011) defined youths as those aged between 15 and 39 years. On the other hand, the age range for young adulthood was from 20 to 40 years old (intimacy versus isolation) based on Erik Erikson's psychosocial stages of adulthood crisis (as cited in Franzoi, 2010). Therefore, the age frame for the participants in this study was set between 20 to 39 years to best fit both WHO and Erik Erikson's age range for young adults. Particularly, only Malaysian young adults were recruited because this research was featured in the Malaysian context. Specifically, the participants must have been diagnosed for major depressive disorder at any mental health setting in Malaysia and the diagnosis must be certified by specialist to prove the status as major depression patients. In this case, the researcher who was currently serving at tertiary setting could confirm the participants' status when they were referred by doctors or psychiatric department with consent.

Furthermore, participants were chosen among the young adults who currently or had recovered from major depression for at least one episode, not less than one year, and were able to share their personal growth experiences recovering from major depression. This was correspondent with Guideline Eight for prevention in

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Psychology which suggested that psychologists should engage in systemic preventive interventions that strengthen the health of individuals, prevent psychological and physical distress and disability, because individuals with systemic barriers (e.g., major depressive disorder) may not be able to achieve maximum health or full social participation (American Psychological Association [APA], 2014). Instead of highlighting the dark side of major depression among young adults, the researcher wanted to call attention to the bright side of their effort made to release themselves from the constraints of major depression, promoting effective healthy lifestyle behaviours in reducing societal problems (APA, 2014).

Besides, it was also essential for this purposive sample to receive counselling or psychotherapy beforehand because it was through counselling or psychotherapy sessions, the researcher detected the participants. Without seeking for treatment, or if the patients have recovered without attending any counselling session, the potential participants remain undetected and it will be challenging to achieve the purpose of study. Their personal growth experience recovering from major depression will not be revealed too.

Moreover, purposive sampling was strictly being employed in this study and thus, the researcher was able to approach the participants who received counselling session beforehand by referring to the counselling unit records and psychiatric department records after getting consented approval from Malaysia Research Ethical Committee (MREC), National Medical Research Registry (NMRR), hospital director, and head of department. It was essential because without meeting with any counsellor or psychiatric specialist, the researcher was unable to assess whether the participant met the criterions of having personal growth experience recovering from major depression. Even there were patients who were under treatments from

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psychiatric department their states of recovery cannot be fully confirmed without accessing their past history to check back whether they certainly showed the signs or symptoms of recovery even if the patients claimed that they have already recovered from major depression.

Another unavoidable act for the researcher was obtaining every participant's consent to participate in this study, to attend three audio-taped interviews, to share about their personal growth fighting against major depression, and also the participant's agreement to sign an informed consent form, making certain of his or her readiness to disclose an opening ascending into his personal experiences. In this study, the researcher recruited a fitting sample of nine individuals who were: (1) Malaysian young adult aged between 20 to 39 years, (2) being diagnosed for major depressive disorder at a local mental health setting, (3) currently or had experienced healing from major depression for at least one episode, (4) currently or had received counselling or psychotherapy, (5) willing to participate in audio-taped interviews, each for 60 to 90 minutes, (6) willing and able to share the cognitive, emotional, spiritual, social and physical experience of personal growth experiences recovering from major depression, and (7) signed an informed consent form. Exclusion criteria were individuals who cannot understand English or Bahasa Malaysia, diagnosed with severe major depressive disorder by psychiatrist, and at time of interview must not be hospitalised or exhibited evidence of other severe psychosis, or impairment due to alcohol or substance abuse. Selection of participants continued until thematic saturation was achieved whereby no new themes emerge from the data, leading to the final sample size of this study, nine participants.

Procedures. Under ethical consideration, formal institutional approval was obtained from the director of the tertiary setting in Perak and Kuala Lumpur prior to

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conduct the study. The researcher selected participants among clients from counselling unit and psychiatric department in selective tertiary setting upon approval from director of hospital. After verifying potential participants who met the selection criteria for this study, both the researcher and participant set a time to meet at an individual counselling room where privacy was protected.

Firstly, each participant was informed that this study has been approved by the National Medical Research Register (NMRR) with NMRR number NMRR-16-732-30570, and that he or she was needed to attain the purpose and procedures of this study, read and signed an informed consent form, agreed with audio-taped interviews, and also learnt about the potential risks and benefits, the right to withdraw at any time throughout the study, as well as the private and confidential issues associated for taking part in this study. Substantially, this study also followed guidelines for prevention in Psychology approved by the APA Council of Representatives in February 2013 (APA, 2014).

Upon agreement to be interviewed, an informed consent form was given to each participant to be read and signed prior to the interview and anonymity (pseudonym) was used throughout the study. Any questions from the participants regarding this study or contents of the informed consent form were allowed to ensure the voluntary participation in this study. The signed copy of the informed consent form was kept by the researcher while another photocopy was given to each participant.

After completing the entire process of signing and returning the informed consent form, the first in-depth, semi-structured and open-ended phenomenological interviews began. Pseudonyms were used to protect the privacy and confidentiality of the participants while audio-recordings in conjunction with the interviews and

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follow-ups are transcribed. Data collected from participants during multiple interviews which consists of audio-tapes and transcripts, was stored in a password protected folder accessible only to the researcher and ongoing data analysis took place throughout the study.

Interview protocol. In this study, an in-depth, semi-structured, phenomenological interview protocol which adhered to Seidman's (2006) three-interview series was utilized to elicit the essence of personal growth experiences among young adults suffering from major depression. This phenomenological interview protocol was also guided by the research question of the current study. As mentioned before in this chapter, an interview guide was crucial during preparation for the interview (Weiss, 1994; Hesse-Biber & Leavy, 2010).

During the first interview, the aim was to obtain information linked to the participant's life history wherein the context of the participants' experience was established and the researcher's task was to put the participant's experience in context by asking him or her to tell as much as possible about him or herself regarding the topic up to the present time (Seidman, 2006). In this study, Interview One (Focused Life History) aimed to ask the participants about their past lives, going as far back as possible, up until the time they were said to have recovered after being diagnosed with major depressive disorder. They were asked to describe their early experiences in any situation involving his or her family, friends, and colleagues, during the period of gradual recovery from major depression.

Next, in the second interview which focused on the details of experience, participants reconstructed the details of their experience within the context in which it occurred and its purpose was to concentrate on the concrete details of the participants' present lived experience in the topic area of study (Seidman, 2006).

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Therefore, the concrete details of the present lived experience were reconstructed by the participants during Interview Two (The Details of Experience) in this study. As suggested by Seidman (2006), the researcher did not ask for opinions but rather on the details of the participants' personal growth experiences, "upon which their opinions may be built" (p. 18). For example, the researcher probed the participants to share their personal growth experience recovering from major depression. The aspects of "how" and "what" from the participants were used extensively in the second interview to probe and to clarify the stories focusing on their personal growth experience.

In the third interview regarding "reflection on the meaning" (p. 18), participants were encouraged to reflect on the meanings their experiences hold for them (Seidman, 2006). Hence, Interview Three (Reflection on the Meaning) focused on the participants' reflection on the meaning of their personal growth experience, which emphasized "the intellectual and emotional connections between the participants' work and life" (Seidman, 2006, p. 18). Such questions were to reflect upon the meaning it had made and a contribution to the participants' thinking although it did not serve as a satisfaction or reward. For instance, as modified from the sample question in Seidman (2006, p. 18), questions like "Given what you have shared about your life before you recovered from major depression and given what you have shared about your current life, how do you understand personal growth recovering from major depression? What sense does it make to you?" and also future-oriented question like "Now that you are in the recovery stage, where do you see yourself going in the future?" were asked in the third interview in this study.

Most of the participants started to share about their past experience as well as their personal growth and how they slowly recovered from their major depression

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during the first interview session as they were mostly able to express well. In the second interview session, every theme which emerged in the first interview was further explored to acquire an in-depth understanding about personal growth experience recovering from major depression. Most of the participants repeated the similar themes shared in the first and second interview sessions even at the third interview session. Therefore, the researcher believed that the stage of saturation was reached and decided to end the data collection process.

Plans for exits. Marshall and Rossman (2014) indicated that the researcher's exit strategy is the logical extension of entry, access, role, reciprocity, and ethics, but is often forgotten. Hence, a plan for exit strategy was needed and it may be the thank you and goodbye after every interview session. Hammersley and Atkinson (2007) pointed out that it is important for the researcher to be aware that the interview may be an important part of the participant's social life and this involved ethical implications considering the participants' feelings and expectations, and is more relevant to research with potentially vulnerable interviewees (Jones, Brown, & Holloway, 2012), like this study.

Therefore, self-care strategies to deal with fatigue, compassion stress and other powerful emotions were included in the researcher's plans for role management (Marshall & Rossman, 2014). Following each interview that reopens old wounds, each participant was debriefed and asked if further mental health assistance needed. In this case, the researcher followed the Guideline Five of prevention in Psychology (APA, 2014) in which psychologists are encouraged to consider ethical issues in prevention research and practice. For instance, contactable counsellors and psychiatrists were ready to be arranged for mental health assistance upon request and

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follow up is provided after the interview sessions to make sure the participants' welfare were supported.

The participants were gradually exposed to a picture of how the completion of this study might look like, starting from the first briefing, getting their consent, constantly mentioning about their contributions to this study and the society, asking their opinions about the analysed themes, until verbally thanking the participants and giving each of them a token (motivational quotes bookmark) for contributing time and sharing valuable experiences upon completion of the interviews to express the researcher's gratitude. Each interview was then transcribed by the researcher and any identifying information was filtered to protect the privacy and confidentiality. In addition, audio recordings were destroyed after being transcribed in pseudonyms to prevent disclosure of any recognizable information from the participants.

Data Analysis

In this study, Colaizzi's method which was based on Moustakas's modification of three methods of data analysis suggested by Stevick (1971), Colaizzi (1973), and Keen (1975) was used in data analysis (Moustakas, 1994). A total of eight steps of data analyses were applied to analyse the data collected in this study. Each step was described in the following paragraphs.

In the first step, to gather a complete description of the participants' personal growth experiences, a phenomenological approach was used. Participants were directed by questions such as "what" and "how" during the interview sessions and followed by probing questions on substantial healing experiences. It was to make sure a comprehensive understanding of the participants' personal growth experience was achieved. The second step entailed the researcher to verbatim transcribe the entire interview sessions conducted. 27 verbatim transcriptions were produced in this

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study. In the third step, the researcher identified the related statements with significant importance to be analyzed.

Moving along to the fourth step, each similar significant statement was grouped together into a broader category. In this study, the researcher identified a total of fourteen meaning units which were: (a) Revealing the struggles, (b) Self-discovery and personal strength, (c) Personal responsibility, (d) Readiness for change, (e), Hope, (f) Redefining the meaning, (g) Forgiveness, (h) Acceptance, (i) Supportive relationship, (j) Medication, (k) Attending counselling, (l) Religion and spirituality, (m) Care for others, and (n) Employment.

In the fifth step, the researcher described the individual textural descriptions (generated by "what" questions) and imagined "what" the experience of healing by each participant was. In the sixth step, the researcher aimed to create the individual structural descriptions or "how participants experience the phenomenon in terms of the conditions, situations, or context" (Creswell, 2012).

Next, in the seventh step, in order to help the researcher to understand the personal growth experiences of the nine participants as a whole, a composite textural description and a composite structural description (Moustakas, 1994) were constructed. Finally, in the eighth step, the composite structural description was combined with the composite textural description to create a universal description of the personal growth experiences, in order to reach the essence of the experience of the phenomenon.

The researcher used some computer software in analysing collected data. Computer software which mainly used was Microsoft Office Word and NVIVO. NVIVO software was used to assist the researcher to manage, organize, and keep track of the collected data (Bazeley, 2007). The researcher used Microsoft Office

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Word to do a manual data analysis in step five to the final step of data analysis. Chapter 4 reported in detailed each step of data analysis with examples.

Potential Risks and Benefits

There was an existence of both potential risks and benefits in this study. The potential risks included the complex or depressed mood that might be concealed or resurface again due to the sharing of experiences related to major depression. Although the personal growth experience recovering from major depression was the core interest of this study, the emotional experience associated with unpleasant feelings arising within the participant was unavoidable. To deal with this, before ending each interview, the researcher was aware of this possibility and carefully brought back the focus to the personal growth experience of recovery journey which might give better feelings to the participant. After every interview, the participant was asked whether he or she needed counselling, psychotherapy, or psychiatric services. The researcher always focused on maintaining a therapeutic relationship with the participants.

While the presence of potential risks was unavoidable, the potential benefits for taking part in this study were superior to the potential risks. The three-interview series were centralized on the participants' experience of personal growth recovering from major depression and thus, could ignite the positive feelings by which the participants felt successful for breaking free from the mental illness. The findings of this study were exceptionally beneficial not only to themselves, but also to the bigger group of people suffering from major depression, and also to fill the research gap in the current literature. Apart from these contributions, all the participants received verbal thanks and a token for their valuable participation in this study. All these

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consequences were briefed prior to the interviews and stated in the informed consent form.

Trustworthiness of the Study

In this section, the strategies used by the researcher to ensure the trustworthiness of the study are presented. Lincoln and Guba (1985, p. 300) used four criterions: "credibility, transferability, dependability, and confirmability" as "the naturalist's equivalents" for "internal validity, external validity, reliability, and objectivity", in order to establish the "trustworthiness" of a qualitative study (Creswell, 2012, p. 246; Kumar, 2011, p.184-185).

Table 3.2 depicts the comparisons of these four criterions for trustworthiness which represent parallels to the positivists' criteria respectively.

Table 3.2

Comparisons of Quality Criteria in Quantitative and Qualitative Research

Quantitative	Qualitative	Issue Addressed
Internal Validity	Credibility	Truth value
External validity	Transferability	Generalizability
Reliability	Dependability	Consistency
Objectivity	Confirmability	Neutrality

Source: (Ary et al., 2013; Kumar, 2011)

Credibility. Credibility refers to "confidence in the truth value of the data and interpretations of them" and qualitative researchers "must strive to establish confidence in the truth of the findings for the particular participants and contexts in the research" (Polit & Beck, 2008, p. 539). Credibility is a crucial criterion in qualitative research that has been proposed in several quality frameworks, which involves two aspects: first, carrying out the study in a way that enhances the believability of the findings, and second, taking steps to demonstrate credibility to external readers (Polit & Beck, 2008, 2014).

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There are several techniques to increase trustworthiness such as prolonged engagement, persistent observation, triangulation, peer debriefing, member checking, negative case analysis, journaling, thick description, audit trail, and others (Roberts & Greene, 2002). However, Roberts and Greene (2002) also stated that "while not all techniques would be possible or even appropriate for every study, almost any study can be improved by the inclusion of some of these techniques" (p. 782). In this study, prolonged engagement, triangulation, peer debriefing, member checking, and audit trail were incorporated throughout the study to ensure and maximize the trustworthiness of the entire study.

Prolonged engagement is defined as the "investment of sufficient time in the data collection process so that the researcher gains an in-depth understanding of the culture, language, or views of the group under study" (Houser, 2008, pp. 484-485) and hence, suggested that the researcher must be involved in the study long and intensive enough to avoid the inherent biases (Roberts & Greene, 2002). In this study, the researcher spent seven months in the research field to obtain data from the participants. The credibility of conclusions was supported by prolonged engagement with the participants, which included extended contact with the participants and the setting to control the biases leading to premature conclusions (Houser, 2008). Prolonged engagement also ensured that the researcher could utilise the time availability to develop ideas, and to do the necessary thinking, discussing, reading, and others, allowing spontaneous and creative ideas to emerge (Roberts & Greene, 2002).

On the other hand, triangulation involved the use of more than one data collection method (e.g., doing observations as well as interviews) and/or analysis method, multiple interviewers or observers with different experience and

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background, and also adding a different type of measurement (e.g., quantitative methods) in a study (Roberts & Greene, 2002). In this study, there was only one investigator involved and thus no method of observation involved and triangulation via different investigator was unlikely. Therefore, in this study, triangulation was achieved by triangulated multiplicities of perceptions from interview sources as well as triangulated the interview sources with the participants' personal drawing on their personal growth process.

Peer debriefing is the concept in qualitative research that is similar to supervision or peer supervision in social work (Roberts & Greene, 2002). This concept assumes that the researcher is unlikely to be able to detect and control her own bias, but the researcher bias can be minimized by involving regular discussion with other people not involved in the study throughout the research process (Roberts & Greene, 2002). Peer debriefing strategy aimed "to review ideas as they emerge, to examine coding schemes, to reflect on problems as they arise, to help the researcher with the more emotional aspects of the work, and, of course, to help the researcher explore his or her own bias" (Roberts & Greene, 2002, p. 783).

This study involved participants with major depression and the researcher faced intense emotional sharing from the participants. Thus, the researcher used peer debriefing strategy to help her to balance her stimulated negative emotion so that the researcher may continue to stay objective and have sharing outlet to neutralize the effected emotion. In this study, the researcher worked with two licensed counsellors who were working in tertiary setting and went through seven peer debriefing meetings. Both of them were responsible for helping researcher to reflect on any biases throughout the study.

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Moving along, member checking strategy can be done at several stages in the study, by sharing the results with other members (e.g., participants and clinicians), and also presenting the findings at professional meetings (Roberts & Greene, 2002). This strategy was aimed to validate the obtained data in interpretation of the participants (Merriam, 2001). In this study, the interview summaries and the major findings were reviewed by both researchers and participants to ensure and to validate the accuracy of the contents. Besides, the researcher also consulted other members who worked with major depressive young adults such as counsellors, psychiatrists and general practitioners by sharing the results of this study.

Finally, an audit trail strategy referred to the researcher can trace any concept developed in the study, or any decision made in the course of the study, to its basis in the data, by using various techniques to improve trustworthiness. Roberts and Greene (2002) stated that "while an audit trail may not be visible in a journal article, or even a book based on a qualitative study, study evaluators can request an audit trail on any concept of interest, and one can examine the methodology of a proposed (or completed) study to see if audit trails were developed for these concepts" (p. 784). In this study, the researcher created audit trail by coding and clustering the contents of transcriptions periodically and then compared this to the identified emerging themes, in order to reconstruct how the study was conducted, to review what has been done, and to consider alternative plans.

Transferability. Transferability, analogous to generalizability, means that qualitative findings can be transferred to or applied in other settings or groups. The responsibility of the researcher was to provide enough descriptive data that the applicability of the data to other contexts can be evaluated by practitioners and the readers, as Guba and Lincoln (1994) stated that: "thus the naturalist cannot specify

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the external validity of an inquiry; he or she can provide only the thick description necessary to enable someone interested in making a transfer to reach a conclusion about whether transfer can be contemplated as a possibility" (Polit & Beck, 2014, p. 323). Thus, the data collection and analytic proses utilized in this study provided detailed rationale and the clear descriptions of the sampling and procedures increased the transferability of this study. The findings of this study were compared and contrasted with the reviewed literatures and provided promising guidelines for further replications.

Dependability. One of the criterions in trustworthiness is dependability which aimed to validate the stability of data over time and over conditions, parallels to reliability (Polit & Beck, 2008, 2014). The dependability question is, according to Polit and Beck (2014): "Would the study findings be repeated if the inquiry were replicated with the same (or similar) participants in the same (or similar) context?" (p. 323). Credibility also cannot be attained without the presence of dependability, just as validity in quantitative research cannot be achieved in the absence of reliability (Polit & Beck, 2008, 2014). Audit trail was necessary from time to time to assess the dependability and trustworthiness of this study. Thus, this study had clearly presented the frameworks, methodology, and the findings of study.

Confirmability. Confirmability which is parallel to objectivity is the potential for congruence between two or more independent people about the data's accuracy, relevance, or meaning (Polit & Beck, 2008, 2014). Thus, in this study, the criterion focused on establishing that the data represents the information provided by participants, and that the interpretations of those data were not imagined by the researcher (Polit & Beck, 2008, 2014). The findings reflected the participants' voice and the researcher had identified her own biases, motivations, or perspectives on the

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issue of major depression, which were addressed in the previous section (Polit & Beck, 2008, 2014). For instance, audit trail was conducted and maintained in this study. Member checking also served in the conformability to improve the trustworthiness and to ensure the result of the finding is virtuously based on the participants' perspective of their healing journey from major depression.

Authenticity. Lastly, authenticity, on the other hand, refers to the extent to which the researcher fairly and faithfully shows a range of different realities, and "emerges in a report when it conveys the feeling tone of participants' lives as they are lived" (Polit & Beck, 2014, p. 323). Readers were invited into a vicarious experience of the lives being described, and were able to develop a heightened sensitivity to the issues being depicted if a text has authenticity (Polit & Beck, 2008, 2014). For instance, epoche or bracketing was constantly used in this study to avoid or 'bracket out' the researcher's own prejudgment, biases, and also to help maintain a fresh perspective from one participants' experience to another. The researcher also returned to each participant and asked for confirmation if the descriptions reflected the participant's experiences (Speziale, Streubert, & Carpenter, 2011).

Protection of Human Subjects

Ethics. The researcher considered what ethical issues might surface during the study and to plan how these issues needed to be addressed during the process of planning and designing a qualitative study (Creswell, 2012). As cited in Creswell (2012), Weis and Fine (2000) recommended researchers to consider ethical considerations including researchers' roles as insiders or outsiders to the participants, assessing issues that the researchers may be fearful of disclosing, establishing supportive, respectful relationships without stereotyping and using labels that participants do not embrace, acknowledging whose voices will be represented in the

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final study, and writing researchers themselves into the study by reflecting on who they were and the people they study.

Table 3.3 depicts the summary of ethical issues in qualitative research specifying the ethical considerations occurred in different phases, types of ethical issues, and ways to address the issues.

Table 3.3

Ethical Issues in Qualitative Research

Research Process	Type of Ethical Issue	How to Address the Issue
Prior to conducting the study	• Seek hospitals approval in selected states • Examine professional association standards • Gain local permission from site and participants • Select a site without a vested interest in outcome of study • Negotiate authorship for publication	• Submit for institutional review board approval • Consult types of ethical standards that are needed in professional areas • Identify and go through local approvals; find gatekeeper to help • Select site that will not raise power issues with researchers • Give credit for work done on project; decide on author order
Beginning to conduct the study	• Disclose purpose of the study • Do not pressure participants into signing consent forms • Respect norms and charters of indigenous societies • Be sensitive to needs of vulnerable populations (e.g., children)	• Contact participants and inform them of general purpose of study • Tell participants that they do not have to sign form • Find out about cultural, religious, gender, and other differences that need to be respected • Obtain appropriate consent (e.g., parents, as well as children)
Collecting data	• Respect the site and disrupt as little as possible • Avoid deceiving participants • Respect potential power imbalances and exploitation of participants (e.g., interviewing, observing) • Do not "use" participants by gathering data and leaving site without giving back	• Build trust, convey extent of anticipated disruption in gaining access • Discuss purpose of the study and how data will be used • Avoid leading questions; withhold sharing personal impressions; avoid disclosing sensitive information • Provide rewards for participating

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Analyzing data	• Avoid siding with participants (going native) • Avoid disclosing only positive results • Respect the privacy of participants	• Report multiple perspectives; report contrary findings • Assign fictitious names or aliases; develop composite profiles
Reporting data	• Falsifying authorship, evidence, data, findings, conclusions • Do not plagiarize • Avoid disclosing information that would harm participants • Communicate in clear, straightforward, appropriate language	• Report honestly • See APA (2010) guidelines for permissions needed to reprint or adapt work of others • Use composite stories so that individuals cannot be identified • Use language appropriate for audiences of the research
Publishing study	• Share data with others • Do not duplicate or piecemeal publications • Complete proof of compliance with ethical issues and lack of conflict of interest, if requested	• Provide copies of report to participants and stakeholders; share practical results; consider website distribution; consider publishing in different languages • Refrain from using the same material for more than one publication • Disclose funders for research; disclose who will profit from the research

Source: (Creswell, 2012; Lincoln, 2009; Mertens & Ginsberg, 2009)

The ethical considerations addressed in this study included informed consent, confidentiality, and consequences (Willig & Stainton-Rogers, 2007) which were further explained in the following sections.

Informed consent. In this study, the research participants were informed about the overall purpose of the study and the main features of the design through briefing and debriefing, as well as of any possible risks and benefits associated with the participation in this research (Willig & Stainton-Rogers, 2007). The voluntary participation of each interviewee was obtained and informed about their right to withdraw from the study at any time before they signed the informed consent form. Furthermore, the information about confidentiality, who will have access to the

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interview or other material, the researcher's right to publish the whole interview or parts of it, and the participant's possible access to the transcription were also addressed in the informed consent form.

Before signing an informed consent form, each participant was informed and required to read about the approval of this study by the National Medical Research Register (NMRR) – NMRR-16-732-30570 (IIR), the purpose and procedures of this study, the interviews are audio-recorded, the potential risks and benefits associated with this study, the right to withdraw at any time throughout the study, his or her anonymity, as well as the private and confidential issues for joining this study. The participants were allowed to ask any questions related to this study or contents of the informed consent form, to ensure their voluntary participation. The researcher kept the signed copy of the informed consent form while another photocopy was returned to each participant.

Confidentiality. Confidentiality designated that private data ascertaining the participants will not be reported. In this study, it was important to make confidentiality protection clear before the interview about who will later have access to the interviews, as it can raise serious legal problems in extreme cases. Confidentiality "relates to the issue that on the one hand, anonymity can protect the participants and is thus an ethical demand, but, on the other hand, it can serve as an alibi for the researchers, potentially enabling them to interpret the participants' statements without being gainsaid" (Willig & Stainton-Rogers, 2007, p. 267).

In this study, pseudonyms were chosen and used during the interview and the writings to protect the privacy and confidentiality of the participants. Any distinctive information was destroyed by editing the audio-tapes and labelling all data with respective pseudonyms. Data collected from multiple interviews, in the forms of

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audio-tapes and transcripts, were stored in a password protected folder only accessible to the researcher. Upon completion of the entire research, the audio-tapes were destroyed to protect the confidentiality of the participants.

Consequences. The consequences of a qualitative study entailed the possible harm to the participants as well as the expected benefits of taking part in the study. It was explained in detail under the previous section of the potential risks and benefits of this study. From an ethical perspective, the total "potential benefits to a participant and the importance of the knowledge gained should outweigh the risk of harm to the participant" (Willig & Stainton-Rogers, 2007, p. 267), in order to permit a decision to get involved in the study.

In addition, the researcher was aware of an enticing openness and intimacy of much qualitative research can lead participants to disclose information they may later regret (Willig & Stainton-Rogers, 2007). Considerably, it was also the researcher's responsibility to include and to reflect on the possible consequences not only for the participants, but also for the larger group they represent and in this study it comprised of young adults suffering from major depression. The findings of this study also instilled awareness within the society about major depression and revealed the inner states of our young generations, to be specific, young adults, when they are striving for recovery. In this study, the participant's self-confidence was elevated when they were sharing about their successful healing experience. In spite of negative consequences, this study was beneficial to both the individuals and their societal world, significantly exceeding the risks associated throughout this study.

Chapter Summary

In order to examine the purpose of this study and to understand the personal growth experiences of major depressive young adults' recovery journey, the

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researcher undertook the methodology best suited for the entire study. Taken together, this chapter began with presenting the qualitative research, phenomenological research design, followed by the rationale for choosing the qualitative, transcendental phenomenological method as research design. Next, a detailed description of the researcher, data collection, data analysis, potential risks and benefits, trustworthiness, and also the ethical considerations of this study were described in this chapter, leading to the findings presented in Chapter 4. The detailed description was essential to deliver readers with a better picture of the researcher's aim and direction of the study. The next chapter reported in detail each step of data analysis with examples.

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Chapter 4 Findings

Introduction

The findings of the study are presented in this chapter. This chapter will first provide a detailed description of the participants and essences of participants' personal growth experiences recovering from major depressive disorder, followed by process of bracketing and steps of data analysis used in the study. Next, the details of the findings analysis which comprised of individual's textural and structural descriptions as well as composite textural and structural descriptions are discussed. Lastly, summary of the results and chapter summary are presented.

Description of the Participants

A total of nine young adults (one man and eight women) with major depressive disorder participated in the study. Participants ranged in age from 20 to 39 years old, with a mean age of 28. All were Malaysians (three Chinese, two Malays, two Indians, and two Indigenous) recruited from tertiary hospitals in Perak and Kuala Lumpur, Malaysia. In terms of marital status, seven participants were single and two were married. Their education level varied from high school certificate to post-graduate degree. All the participants were diagnosed with major depression by psychiatrists with outpatient follow up. Every participant reported being in recovery from major depression for at least one year. The following section described the participants' background and a brief description of the experience of major depressive young adults. All names used were pseudonyms.

Participant 1 – Jacky.

Background. Jacky was a 37-year-old Chinese man. He is married and he works as a primary school teacher. Jacky has a degree in language study and took diploma in education for him to work as a teacher. He was 35-year-old when he was

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first diagnosed with major depressive disorder and he struggled with his own recovery from major depression for more than one and half years before he first experienced personal growth in his journey of recovery which he learned to let go of what he couldn't control and move on.

Description of the experience. Jacky first experienced major depression when he was 34 years old. After graduating from a local university, a language major Jacky went for a diploma study in education for him to work as a teacher. He taught mostly English subject in a Chinese primary school. Most of the subjects in school were taught in Chinese Mandarin except for language subjects. At that time, Jacky has a very high goal to do his best to teach his pupils and to get work satisfaction.

However, he's slowly experienced heavy workloads at school and received higher expectations from his superior. At one point, his pupils' performances dropped and he received a lot of negative comments from his superior. Jacky was unable to find any work satisfaction at work and without knowing it, he already started to live a negative life. All the above incidences caused Jacky to have a lot of negative thoughts about himself. Jacky described:

> *My life was very negative. My thoughts and opinions were negative. My life became more and more negative because every day I was so busy with my work, with my teaching, with my marking…marking books and a lot of lessons. I was also occupied with the coordination and also meetings with my colleagues, my superiors, and my principal.*
>
> *(Jacky/Int1/lines181-184)*

Due to his work stress, Jacky became very hot tempered and always scolded his pupils. He even brought home his emotions and had a lot of arguments with his wife. He was unable to sleep at night and felt tired easily. He was getting thinner and suffered very bad headaches, back pain and neck pain. He stopped going out with

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friends and has no appetite most of the time. Jacky became passive, stopped having any entertainment, and has less communication with his friends

In Jacky's journey of personal growth and recovery, he encountered many challenges. According to Jacky, the biggest support and encouragement was from his wife who keeps reminding him to stay in a positive thought and motivates him to a happier life. Furthermore, he also highlighted several aspects which helped him in healing from major depression namely support received from colleagues and family members, taking medication on time, attending counselling, revealing his struggles in major depression, redefining the meaning of life and work, being aware of his personal responsibility, learned to forgive himself, readiness to change the way he thinks, self-discovery and personal strength, and hope for a better tomorrow. Jacky holds strongly the aspect of support from his wife. In his appreciative look he said:

> *My wife helped me a lot. My wife played the biggest role. Since I only have a small family - my wife and I. So actually my wife many times she was the one who consoled me, to comfort me, and also my wife helped me to reduce my stress regarding work because my wife is also a teacher. We understand the difficulty and the pressure of teaching. So we also help each other. But most of the time, my wife was the one who helped me.*
>
> *(Jacky/Int2/lines239-244)*

Jacky took one and half years to move on and into the stage of recovery and personal growth, and he considered his early stage of personal growth was not without ups and downs. The journey to recovery from major depressive disorder was not a tranquil journey for Jacky. Figure 4.1 is a visual map that reflects Jacky's journey of personal growth recovering from major depression.

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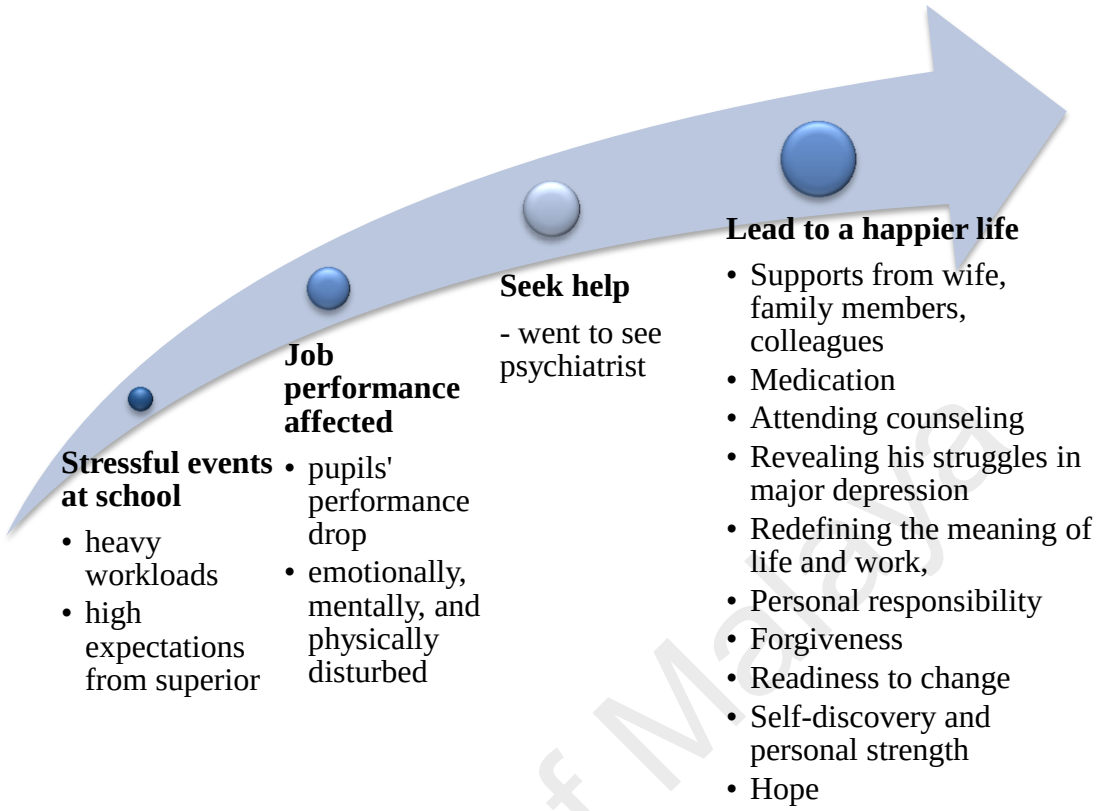

Figure 4.1. Visual map of Jacky's experience of personal growth

Participant 2 – Flower.

Background. Flower was a 26-year-old Chinese lady, working as an optometrist in a private medical centre. She is the only child from a single parent family. Her father passed away when she was one year old. She had struggles with bullies during her primary school and depression for many years since her high school time before it got worse during her final year in university in which she pre-attempted suicide once. She was stopped by her cousin sister at that critical time.

According to Flower, she only has the courage to disclose the depressive mood to her mother after she had completed her degree and went back to her hometown when she was 23 years old. With her mother's encouragement and support, Flower went to seek help and she was diagnosed with major depressive disorder at the age of 24. She believed that several aspects have helped her in

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recovering from major depressive disorder. During the time Flower was being interviewed, she was actively involved in church activity.

Description of the experience. Flower's father passed away when she was one year old. She had very low self-confidence because of the name-calling and teasing she received since she was at kindergarten. Flower was sick most of the time during her childhood because of her asthma and thyroid problem. She perceived herself as ugly, fat, sick baby, poor, fatherless, and useless most of the time since she was five years old. The bullying stopped when she was 13 years old after she entered secondary school.

Flower perceived her secondary school as a good one because she has good friends and they didn't look down on her. However, during her university years, her depressive mood came back as she was discriminated by her course mates. She was forced to put up with their prejudice and discrimination against her. Flower frequently used crying to help herself in reducing the emotional and mental struggles she faced. She used to cut herself, binged eating, and has attempted once to jump off the building.

It took Flower more than one year for her to experience personal growth and she perceived herself at the early stage of recovery process. For Flower, her personal growth started to take place after she disclosed to her mother about her depressive mood and her sufferings for the past years. She described her reasons to seek treatment:

> *What make me seek for treatment? Definitely was my parent…my mom. I meant particularly my mom because my dad already passed away long time ago. So, my mom is my…like my only family member. So when I think about her, like how she was taking care of me last time and all, so definitely it give me encouragement despite all the depression... everything. My mom did give me the encouragement that you know, I will still live on, somehow.*
>
> *(Flower/Int1/lines139-144)*

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Flower learned to accept her depression and felt relief when she revealed her struggles by communicating with her mother. She redefined the meaning of her life and underlined her personal responsibility to live the life she always hopes. She believed that support and encouragement from her mother, cousin sister, and her good friends was the real support system to her self-discovery and personal strength. Forgiveness and hope were also one of the healing processes Flower believed that it has helped her to move on.

Another aspect which helped Flower's personal growth throughout her journey of recovery was from religion and spirituality in which she felt connected and experienced the sense of belongings. She stated:

> *Then of course, another factor was from God, spiritual support. You know, when I went to church, when I prayed and when I worshipped… that was the time that I felt connected to God and I felt that there's a sense of you know… belonging, and it's like there's a sense of meaning that I need to keep on moving.*
>
> *(Flower/Int2/lines176-179)*

Flower also emphasized that medication, readiness to change, employment and attending counselling had helped her and had made her into who she is today. She has a positive attitude toward her counselling sessions where she learned to embrace both her weaknesses and strengths, positive and negative, and also happiness and sadness. Flower perceived herself living a fulfilling life with a new meaning in life. Figure 4.2 is a visual map that reflects Flower's journey of personal growth recovering from major depression.

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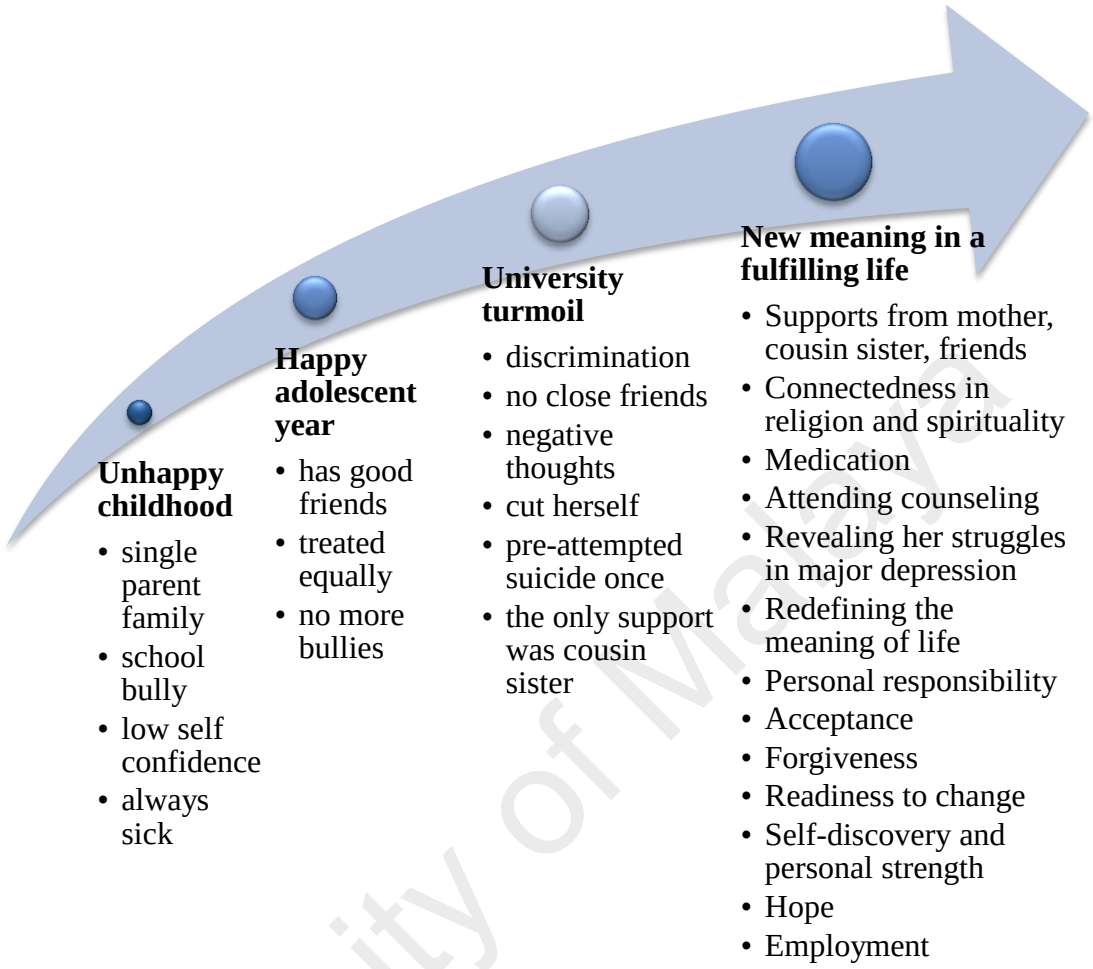

Figure 4.2. Visual map of Flower's experience of personal growth

Participant 3 – Winnie.

Background. Winnie was a 25- year-old single Chinese lady, working as an account clerk at a logistic company since 19 years old. Her father ran away when she was ten years old because of heavy debts. She is the only child and stays with her mother and her old grandfather since then. She only studied until Form Five and got SPM (Malaysia Certificate of Education). She didn't pursue her tertiary education because of financial constraint.

Winnie was diagnosed with major depressive disorder when she was 21 years old by psychiatrist. She is now in a romantic relationship. Winnie believed that she is

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in her early stage of recovery journey. She first experienced personal growth healing when she was 24 years old, two years after she was diagnosed. Winnie has been actively involved in church activities to care for others in need.

Description of the experience. Winnie used to be a happy go lucky girl, didn't have to worry much about life, received all the love from her parents, spoiled by her parents, has good grades and has a lot of friends. All these ended when she was ten years old. Her father ran away from home due to heavy debts and was chased by loan shark (A'Long). Her mother desperately went in search for her husband but she couldn't find him. Winnie was blamed as an unlucky child and was scolded all the time.

During her secondary school years, she suffered emotionally and mentally due to sabotage and discrimination by her classmates as well as her schoolmates who travelled in the same school bus. She has no friends and spent most of her time alone. She was able to manage it for the first three years but it got worse when she was in Form Four and Form Five. She became reclusive and refused to go to school and church at that time. But because of her mother, she still dragged herself to school and endured her miserable five years of secondary school. Winnie didn't share anything with her mother or her grandfather because she didn't want to be anyone's nuisance.

After she had completed her SPM, she didn't further her study because her family couldn't afford to support her. She went out to work and got her first job as an account clerk which she worked until now. Her colleagues noticed her depressive behaviours and encouraged her to seek for help. With her colleagues' and manager's support and encouragement she went to see a psychiatrist. She was diagnosed with major depressive disorder after six years of suffering without diagnosis and only experienced personal growth journey of recovery nine years after the first episode of

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depression. Winnie was reviewed by three counsellors and the third counsellor changed her life in which she experienced personal growth after attending a few counselling sessions with her third counsellor.

Winnie believed that there were several aspects which assisted her in her healing journey from major depression. As her mother and grandfather didn't know what happened to her, Winnie received most of the support from her colleagues, manager, and boss. With tearful eye she said:

> *My boss and colleagues knew about the diagnosis. They saw the symptoms even before I get diagnosed but they thought I can go through it. That time they hired people – new staff, new admin. I was being kept back to a room. I meant they were not really keeping me back into a room, just that they didn't want me to handle so many stuffs anymore. They want me to focus on international sales because I was mainly in charged on website and stuffs. So they needed me to let go of the front desk sales and everything. Then after diagnosed, I started to take medication and it was pretty tough for me because I was super sleepy. I couldn't concentrate so mostly at work I was sleeping. My boss and colleagues, they really treated me very well so that's why I was really very appreciating them.*
>
> *(Winnie/Int1/lines239-247)*

After revealing her struggles of depression with her colleague, Winnie felt relief and believed that her recovery process started from there. She stated that:

> *After talked to her, I felt relief because there's someone beside me. So at least there's someone that I can hold on to. That's how I felt at that time, something on there like that.*
>
> *(Winnie/Int2/lines63-64)*

Winnie also believed that by attending counselling, it built a foundation for her. She also pinpointed that religion and spirituality assisted her to have hope, forgiveness, and acceptance as personal growth process. She said that:

> *It just something that clicks on my heart then I felt like I think it's time for me to let go. So that's where happened. But it didn't really happen that suddenly because before I went to the conference I have attended counselling sessions so it's like having some foundation. So when a speaker brought out that message there's something clicked on my heart and that's when I started to have the thought that I want to start a new life.*
>
> *(Winnie/Int2/lines131-135)*

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Winnie perceived that she was switching her life from a negative mode to a positive one. Figure 4.3 is a visual map that reflects Winnie's journey of personal growth from recovering major depression.

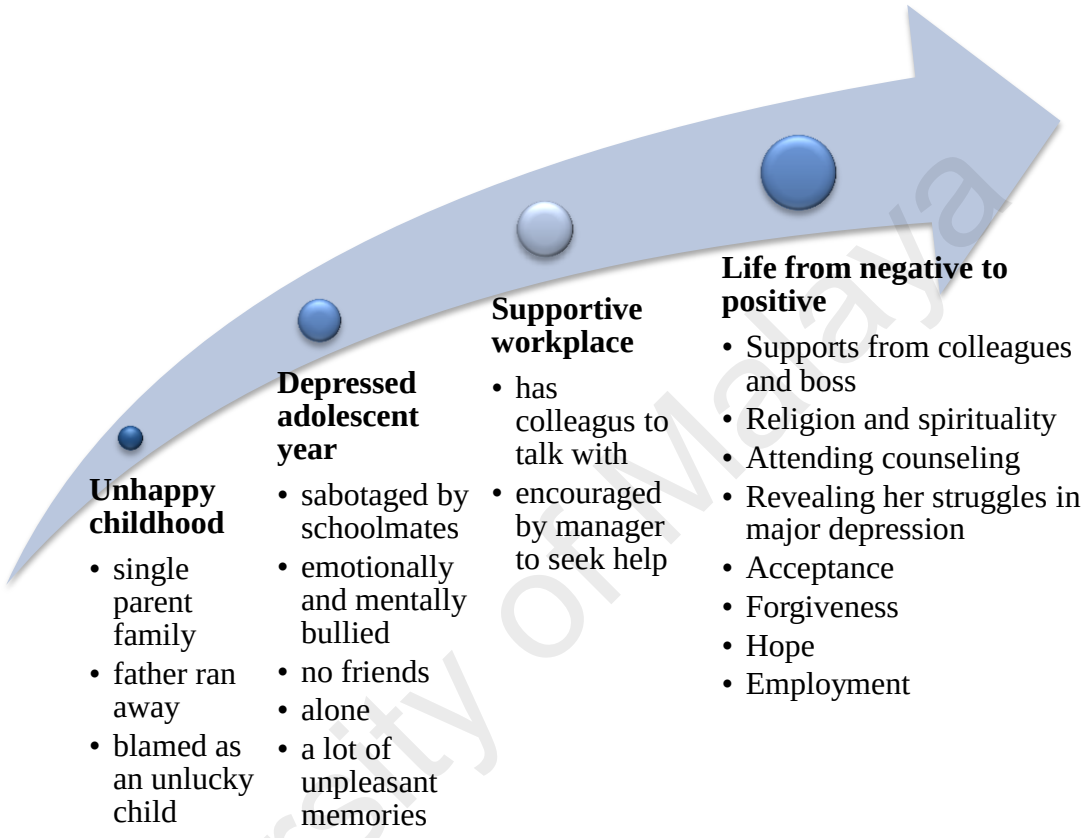

Figure 4.3. Visual map of Winnie's experience of personal growth

Participant 4 – Shiela.

Background. Shiela was a 24-year-old Malay lady, only completed her study until Form Three or PMR (Lower Secondary Evaluation). She was the third child out of five siblings but her eldest sister and her younger brother had passed away at a very young age. Her father passed away three years ago.

Although still facing ups and downs in life, Shiela admitted she was in early stage of recovery from major depression. She admitted she was still facing a lot of struggles in her daily life to come to terms with personal growth but she believed that

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it was manageable. Shiela was first diagnosed with major depressive disorder when she was 22 years old. She was 24 years old when she experienced her first recovery, two years after she was diagnosed.

Description of experience. Shiela started to have behavioural changes when she was 15 years old. She was raped by her friend when they were having study group at her friend's house. She remembered her friend invited her to play Play Station II and then suddenly he locked the room and forced himself on her. She was devastated. She could only cry. She didn't tell anyone including her parents about the incident. She was scared.

Her abdomen was getting bigger after a few months and her schoolmates teased her. She was not aware that she was pregnant at that time. She thought she had gained weight as she ate a lot. Much later her parents noticed that she was always lost in her thought and locked herself in the room, her late father brought her to see a doctor and did a medical check-up. Only then they found out that she was pregnant. She was discriminated and isolated by her friends after her delivery and confinement. She has no friends at school and finally Shiela decided to quit studying during Form Three.

Shiela suffered emotionally and mentally because of the incident. However, her late father supported her and she was able to face it until he passed away when Shiela was 21 years old. Following that year, Shiela broke down and pre-attempted suicide. She was diagnosed with major depression disorder when she was hospitalized. She believed that there were several aspects which assisted her in healing. Shiela attended counselling sessions by two different counsellors at two hospitals. At the same time she stressed the importance of medication. She stated:

> *When I went to see counsellor, I felt okay. At least okay because for example, I was able to express and after that I felt relieved... erm... so consider okay.*

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For my case, I couldn't find anyone to help me and I might become more serious. So counsellor helped me and listened to me. I felt I was listened when I was with my counsellor.

(Shiela/Int2/lines824-827)

Okay. To be frank, after taking medication, I became okay. That's meant after ate the medicine I felt like I am not that pressure because the medicine actually calmed me down.

(Shiela/Int2/lines1218-1220)

As Shiela didn't get any emotional support from her family, she gets most of the support foundation from her friends. By revealing her struggles to someone who can be trusted and close to her, she felt supported and able to move on. She mentioned:

I expressed everything to my close friend about anything that happened on me. I will express it all.

(Shiela/Int2/lines278-279)

Shiela believed that when she was ready for change and the change must start from within only then she would be able to recover. From there, she discovered her own strength and direction and be able to hope again. She said:

But the thing is… the thing is if we want to recover, we need to know ourselves too. It's starting with our own selves. If own self if we feel like wanting to recover, it was starting with our inner selves. I will recover. If not starting from myself then it won't happen and it couldn't be done.

(Shiela/Int3/lines127-131)

I always said to myself that I hope that I myself can recover, can control, and can face all the problems that I am facing with the right way and not the wrong way. I talked to myself. If I have my own problems, I must seek for help and ask opinions from others. Don't ever do anything that is unexpected, I told myself. Whatever problems also I need to be strong and I need to be calm.

(Shiela/Int3/lines964-969)

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Shiela perceived herself at the early stage of recovery where she was standing on her own feet in life. Figure 4.4 is a visual map that reflects Shiela's journey of personal growth recovering from major depression.

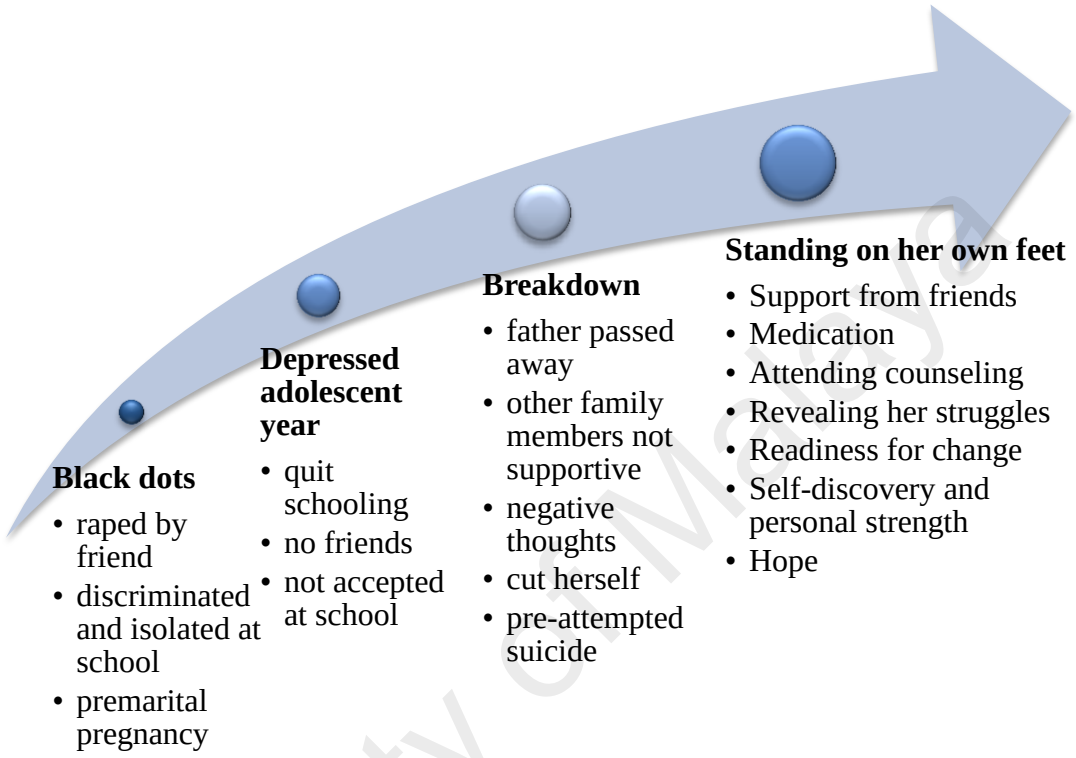

Figure 4.4. Visual map of Shiela's experience of personal growth

Participant 5 – Fajar.

Background. Fajar was a 29-year-old Malay lady, married with four children (three sons and one daughter whereby her eldest son is an OKU (special needs person). She completed her study until SPM (Malaysian Certificate of Education) level. Fajar was diagnosed with major depressive disorder just before turning 28 years old. She first experienced healing when she was 29 years old.

Fajar was working as a sales supervisor before she resigned to become a full time housewife at the age 26. Fajar believed that her personal growth recovering from major depression started when her daughter begged her to live on. Fajar

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considered herself as an introverted artistic person and she enjoyed spending quality time with her children.

Description of the experience. Fajar's depression started after she discovered her husband's affair. She tried to make her husband admit it but he kept denying and eventually Fajar found proof in his hand phone. Her husband made a lot of promises and said he only loved her and would not find that woman anymore. Fajar trusted him.

However, she was unable to live at peace because her husband behaved suspiciously. She started to have a lot of negative thoughts and was unable to sleep well. She tried to hurt herself a few times when her husband treated her coldly following their first argument. She caught her husband for the second time when she smelt someone's perfume which neither belong to her or her husband. She even found intimate photos of other women.

Fajar was devastated and felt cheated. She felt she had lost everything because her husband was the love of her life and her only emotional pillar as she was not close with her own parents and siblings. Her husband didn't give her any explanation and just walked out after their argument. Fajar was trying to end her life when her seven years old daughter rushed in and begged her to live on for their sake. She stated:

> *It was her who woke me up at that time. I did not realize what I was doing). She said "Mummy, mummy…look at brother. If mummy is not around, what will happen to brother?" During that time, I held my bleeding wrist until I was sent to hospital. From that moment, I tried to get up.*
>
> *(Fajar/Int1/lines563-566)*

In the personal growth journey recovering from major depression, Fajar faced many challenges. She expressed that in her recovery journey, there were several aspects which played important roles. She redefined the meaning of her life with four

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children. She looked at her life differently and didn't put all of her hopes on her husband anymore. In tearful eye she said:

> *I want to become stronger and try to get up although I felt exhausted and tired. Even when I felt like I did not want to. But, I still tried because I have four blessings that are the most special ones. Those are my children. They had strengthened my will to live. It seems like even without my husband also I can survive, because I have my children.*
>
> *(Fajar/Int2/lines146-150)*

Other than that, support from friends and her mother-in-law was able to make her feel accepted and being heard. She also found direction and from prayers to enable her to remain calm.

> *During that period it was really hard for me to get up but I tried…until I started to pray, to study Al-Quran*). *Although I had forgotten almost half of it, about the readings, I tried slowly to read them again and tried to pray although I could not sit and pray. I prayed on chair and learnt again how to pray and so on* and *Insya-Allah the God Allah, I have changed.*
>
> *(Fajar/Int2/lines154-159)*

She expressed that she was getting bolder in revealing her own struggles with major depression as well as to accept another part of her. She discovered herself and her personal strength as well as her responsibility from her journey of recovery. After attending counselling sessions, Fajar believed these counselling sessions have helped her to understand herself better and to move on.

> *Counselling really helps a lot from the aspect of self-care, self-management, how to control emotions etc.*
>
> *(Fajar/Int2/lines510-511)*

Fajar perceived her mental strength was enhanced throughout her personal growth process to live a meaningful life. Figure 4.5 is a visual map that reflects Fajar's journey of personal growth recovering from major depression.

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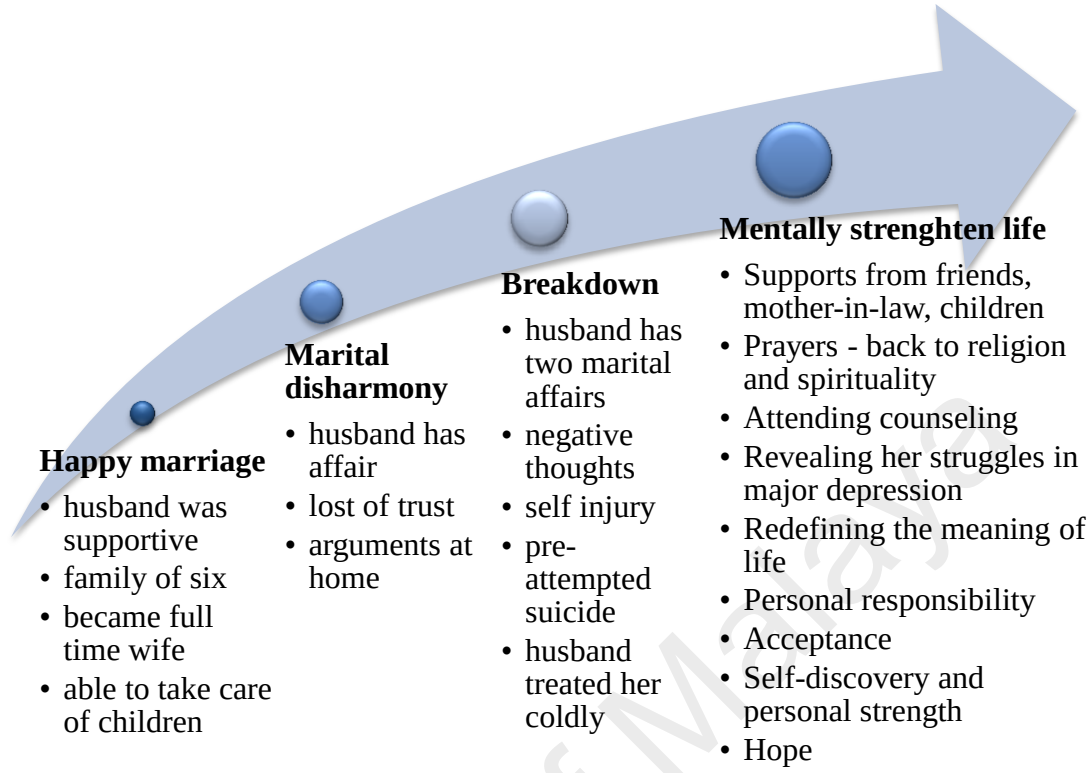

Figure 4.5. Visual map of Fajar's experience of personal growth

Participant 6 – Priya.

Background. Priya was a 32-year-old Indian lady, completed her education until SPM (Malaysian Certificate of Education) level. She is still single and has four siblings. Priya was first diagnosed with major depressive disorder when she was 30 years old.

She believed that she was in early stages of healing from major depression when she experienced her first healing when she was 31 years old. She has gone through five years of ups and downs in life before she was diagnosed with major depression. Priya expressed that her recovery started after she met the right counsellor who has helped her a lot throughout the personal growth journey recovering from major depression.

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Description of the experience. Priya was a happy, cheerful and helpful woman for the past 25 years before she experienced a sudden panic attack when she was on the way to work. She has a boyfriend at that time and she called him for help. It was happened in a train. She went to see a private doctor and she was diagnosed with panic attack after few tests. The more Priya tried to fight it the more it hit back to her. Priya was prescribed with medication to cope with her anxiety by her doctor.

However, it didn't stop there. Her attitude changed soon after that. She became sensitive and has a lot of negative thoughts. She became easily irritated, fight with her boyfriend without reason, and there were a few times she wanted to jump off from the highest floor of the building where she was working at.

Shortly after that, her boyfriend left her and cancelled their engagement because he couldn't take it anymore. Priya locked herself for three days and didn't take any food. She cried almost every day. Priya was not supported by her family members and they never want to know about her current condition. The only person who supported her was her father. Unfortunately, her father left the house after a bad argument with her mother and since then Priya lost her only support system.

Priya didn't tell anyone about her condition. She has a lot of suicidal thoughts throughout those five years. The worst argument with her mother and eldest sister forced Priya to leave the house and stayed with her aunt for two months and then one month plus with her friend. She attempted suicide during her stays at friend's house after they had an argument. Priya was diagnosed with major depressive disorder when she was hospitalized. She went back to her mother's house after almost two months.

During that time, Priya continued her medication and attended counselling session. She was actively searching for personal growth and healing as well as the

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meaning of life. She felt she was slowly able to accept and to forgive herself. She was reviewed by two different counsellors at different hospitals. Her sessions with the second counsellor changed her life and she had made a big positive impact on Priya. She expressed:

> *Actually after I came back here, they (psychiatrists at P Hospital) actually referred me to general hospital (I Hospital) here, and also to the counsellor at hospital. Then so far everything changed better. I see a positive side and all the things are helping me because I'm here being back to my hometown, for more than one year.*
>
> *(Priya/Int1/lines756-759)*

Throughout her personal growth journey of recovery, Priya believed that there were several aspects which helped her to recover and to accept herself. She perceived God has given her a second chance to live after she had failed many attempts to end her own life. Thus, religion and spirituality gave her strength to hope and to move on. She discovered herself and her personal strength and was ready for change – for a better life. Priya slowly experienced a more supportive relationship with her family members and her friends after that. These entire breakthroughs led Priya to come to the point of recovery. She stated:

> *Okay. One of the most important things was because I tried to suicide and I did not die. In fact it was not one attempt but it were few attempts. So when I know that I am not dying and I will not die, I already have the thought: "Oh, God is giving me more, longer years to live. I can't every year think of dying, dying, dying and not successful. What if I don't have anyone when I am old and no one takes care? I will become beggar." Those thoughts started to pop out in my brain. Then it also created a fear after I left medication for few years, seeing this doctor and that doctor. So the real thing came after the last attempted suicide, but failed. I told myself: "No more doing this. Start taking the medicine and get better! See whether what doctor had said, will it come true. In the sense of doctor said you can't stop the medication unless we ask you to stop and we think that you already get better." So I really make a point that: "Okay Priya, we must do this this time and see how it goes." Furthermore, they actually propose a counsellor also, which I thought it was also a good thing because I have someone to talk. Because when I visit the doctor, it was all about medication. Doctor will be asking: "How do you feel? How this one, how that one, do you need to increase the dose?" something like that. But if you have a counsellor, it's like you are having a*

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professional friend and the counsellor is not someone you had met before. She is like a friend…a friend who understands people's problem. That is what I think about counsellors.

(Priya/Int2/lines184-200)

Priya further explained how religion and spirituality as well as personal responsibility had made a huge impact on her personal growth journey:

I always believe during my major depression, the faith was like always not there – It comes, it goes. But I know that when I tried to take my life and did not die, then I know God really loves me and there must be a reason why I am still here. So one factor is definitely God, although I don't see Him and I don't know how He looks like, but I know He's there. So yes God. And also I think that another factor was, I also doing it for my family actually. Yes, I love my family even though how much we argued but the fact is they are my family and during my schooling time they gave me education. So I also want to become someone and to help them. I don't mind if they love me or what, but I know I have love for them.

(Priya/Int2/lines262-269)

Presently, Priya perceived herself living a more acceptable life. Figure 4.6 is a visual map that reflects Priya's personal growth journey of recovery from major depression.

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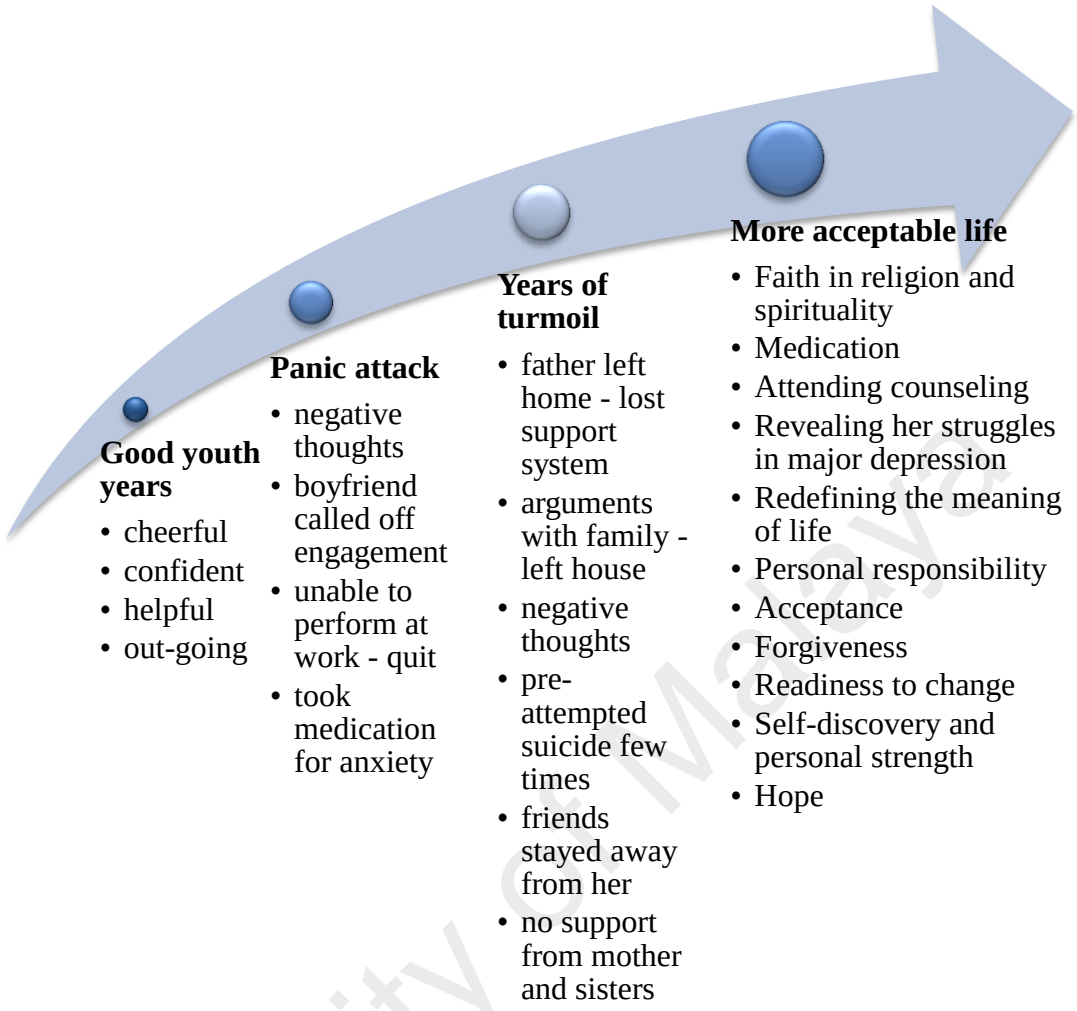

Figure 4.6. Visual map of Priya's experience of personal growth

Participant 7 – Catherine.

Background. Catherine was a 30-year-old single Iban lady, pursuing her second-degree study in a local University. She is self-supporting herself working as a part-time promoter. Catherine was first diagnosed with major depressive disorder when she was 27 years old and she experienced her personal growth journey of recovery when she was 29 years old. Catherine perceived herself in the early stage of recovery from major depression. The personal growth recovery from major depression took place after she revealed her struggles with depression to her close friend.

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Description of the experience. Catherine used to be a person full of confidence and whatever she did she believed that she could do it well. She was a high achiever before the depression came knocking into her life. She was a very cheerful person, full of life, and academically she was always in the top three positions in her class. Catherine had never experienced failure in her life before she started her second-degree study. She has taken a road that was less taken by other people. She took up medical course for her second degree and encountered a lot of hardship during this course and it came to a point that she felt the burden was too unbearable.

Catherine failed the first major exam a few times and she spent a lot of money to retake the same papers. It was a major setback and it was also her first taste of failure in academic which she had never experienced before. It became worst when her course mates passed all the exams except for her. She lost her hope and direction in her life. Even in her sleep, she slept with tears. Her confidence dropped drastically. Every day what she could only were the ways of how to end her misery in life. She perceived that taking her own life would end all miseries. Catherine expressed that during her recovery journey which was not an easy process. She stated:

> *Yeah, you know the journey was not easy. It's full of challenges. I would say it's really, really not easy. I would say I really need a lot of supports and I felt counselling really helped me a lot. At least it motivated me. It's not just the medication alone, because you know when I took medication, it will help to lessen my depressive mood but then the thought is still there and yeah, counselling really helped me a lot.*
>
> *(Catherine/Int1/lines244-248)*

Catherine believed that there were several aspects which assisted her in her personal growth journey of recovery from major depression. She experienced a sense

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of acceptance and forgiveness from her major depression. According to Catherine, when she was ready for change she realized that she still has somewhere to go and moving forward means having to fight for a chance to live, to stand up as well as to hope again. By revealing her struggles, she discovered herself and learned about her own strengths. She said:

> *Actually I feel like it is easier for me to cope now. It's easier for me to bounce back from all these and from the counselling therapy itself actually I get to know myself well. You know, I realized that last time I might not have resilience and from the counselling I learned all these and how to cope with my problem, how to bounce back. So having more resiliency and yeah, that is what I remember from my counselling therapy and that's how I am trying to cope with myself now. And I am trying to be more forgiven, you know, more grateful towards my life, trying to accept myself well. You know, I was trying to accept myself. The reason of my existence in this world, you know. I am actually a very important person in this world as a daughter, as a friend, and as some individual in this world. I realized that I did accept myself more and I appreciated myself more. I set my goal, and you know, during the therapy, my counsellor told me to not drown too much into the past and don't drown too much into the future as well. So now I am trying to live in the moment, trying to achieve my goal as much as possible. That's how I tried to get out from my depression and you know it is okay if I couldn't do something. It is not that everything that you want to do, you must do it. You can do it but you are just underestimating yourself, you know, it is okay if you can't do it, it is acceptable to give yourself more time to do something. It is okay.*
>
> *(Catherine/Int2/lines43-58)*

Based on Catherine's sharing, supportive relationship was important during her personal growth journey of recovery. She stated:

> *So the first time when I tried to open up to my family and let them know that I was actually diagnosed with depression, they were surprise but thankfully they were also being supportive by trying to understand my hardship, what I have been going through and provided to me their full supports and you know, maybe I would say like becoming less stressful I would say like you know. Maybe like just trying to help me in any way that they could give: their mental support, any support. In the end, you know, family is the one that helps you a lot in the process actually.*
>
> *(Catherine/Int2/lines43-58)*

Catherine redefined the meaning of her life to one that is hopeful. During the sharing, she said:

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The moment I realized how to appreciate myself, my existence then at least my view of, the grim of light, you know whether you can see half glass of full water or half glass of empty water, it really changed a lot.

(Catherine/Int2/lines209-212)

In the personal growth journey of recovery from major depression, Catherine experienced something that she had never thought she would face. Now, she is living a hopeful life with a new meaning in life for her to continue to learn. Figure 4.7 is a visual map that reflects Catherine's personal growth journey recovering from major depression.

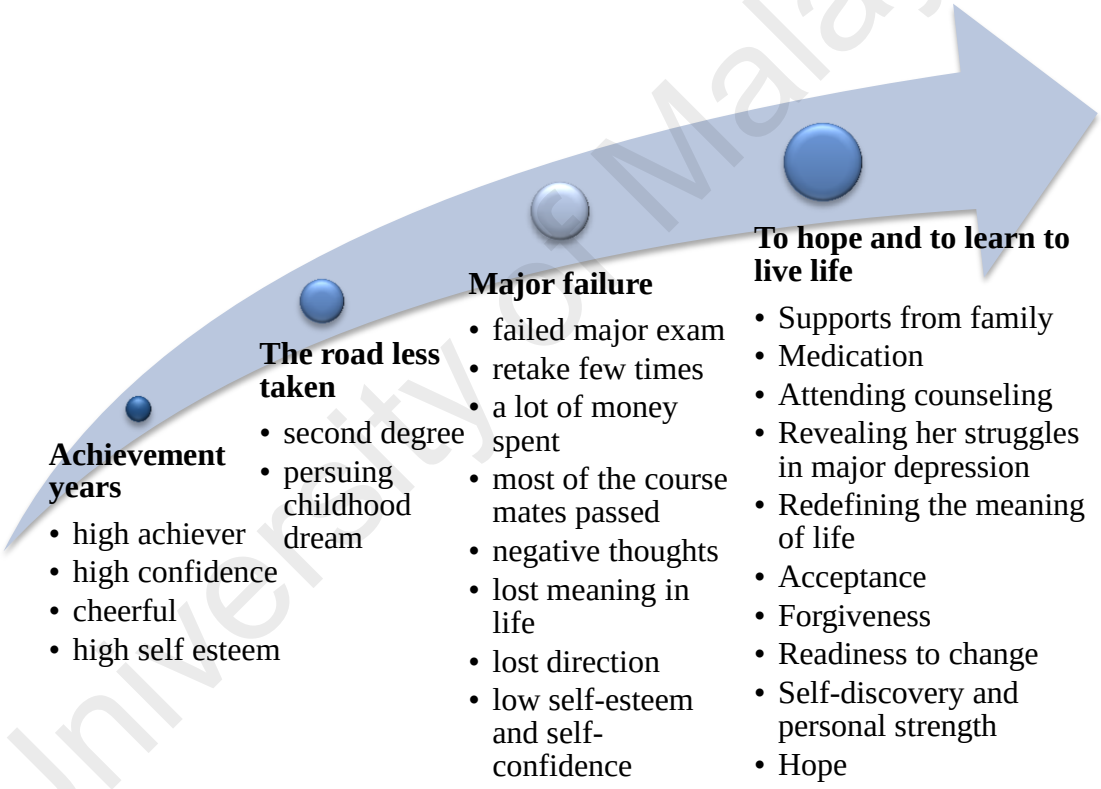

Figure 4.7. Visual map of Catherine's experience of personal growth

Participant 8 – Bella.

Background. Bella was a 29-year-old Iban lady and had completed her bachelor degree and working as a radiographer in a private centre. She is single and is the only child in her family. Bella was 26 years old when she was first diagnosed with major depressive disorder. She experienced her recovery episode one and half

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years after her diagnosis. Bella described her personal growth recovering from major depression as the early stage.

Description of the experience. Bella used to be a happy girl before her adolescent years. When she was around 15 and 16 years old, she was teased by her friends for being fat and ugly. Bella was hurt emotionally and decided to become thin and to look good for others. She wanted to be thin so that everyone would like her and she cared a lot about what other people said about her and she took it seriously. Bella kept on thinking about it and believed that looking good and slim was necessary. She was a bulimic. Bella couldn't control herself and she felt very guilty every time she did it and she would cut herself just to release her guilt. One day however she overdid it and was hospitalized. She was diagnosed with major depressive disorder with underlying eating disorder during her hospitalization.

Bella described her personal growth journey of recovery as a journey to survive. She believed not only medication helped her but also other factors had contributed to her personal growth. One of them was employment. She noted:

> *Working was the only way to keep me occupied but sometimes other than that I would just stayed in the room and doing nothing and most of the time I would cry.*
>
> *(Bella/Int1/lines212-213)*

She recalled what she hoped her life to become after she discovered herself and her strength. She stated:

> *After some recovery and support from other people, I realized that I can be and I am a person. And discovering that changed the way I see myself. Now I am healthier and happier. I am not dependent on others to survive.*
>
> *(Bella/Int1/lines376-378)*

Revealing the struggles in major depression and having supportive relationships encouraged Bella's healing and redefined the meaning of her life as

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well. She felt hopeful again and learned to care for herself and others. Bella believed that by attending counselling and taking medication have helped her to express herself and to relieve her symptoms during the early stage of recovery from major depression. Bella described:

> *I think my psychiatrist and counsellor also help me a lot also especially during the counselling sessions. I learned how to deal with my emotions, how to express myself and how to cope with my life better. So I think all these really help me a lot.*
>
> *(Bella/Int2/lines44-26)*

Bella accepted herself for who she is and being aware of her own thoughts via meditation as well as found calmness and peace through religion and spirituality. She learned that it was acceptable for not being perfect and to live the present. Bella expressed:

> *Yes, of course. It helps actually because it really helps to calm me down because it has method like "how to calm my mind," "aware of our own thoughts" as sometimes we are not so aware of what we are thinking. We just feel very depressed, very down but we do not know why. Maybe there was no reason. But meditation can help to focus and to be aware of own thoughts. So we just look at them, look at the thoughts. Through that I feel like I can calm myself down.*
>
> *(Bella/Int2/lines209-214)*

Bella believed she was the survivor from major depression and now she is living a gratifying life. Figure 4.8 is a visual map that reflects Bella's personal growth journey recovering from major depression.

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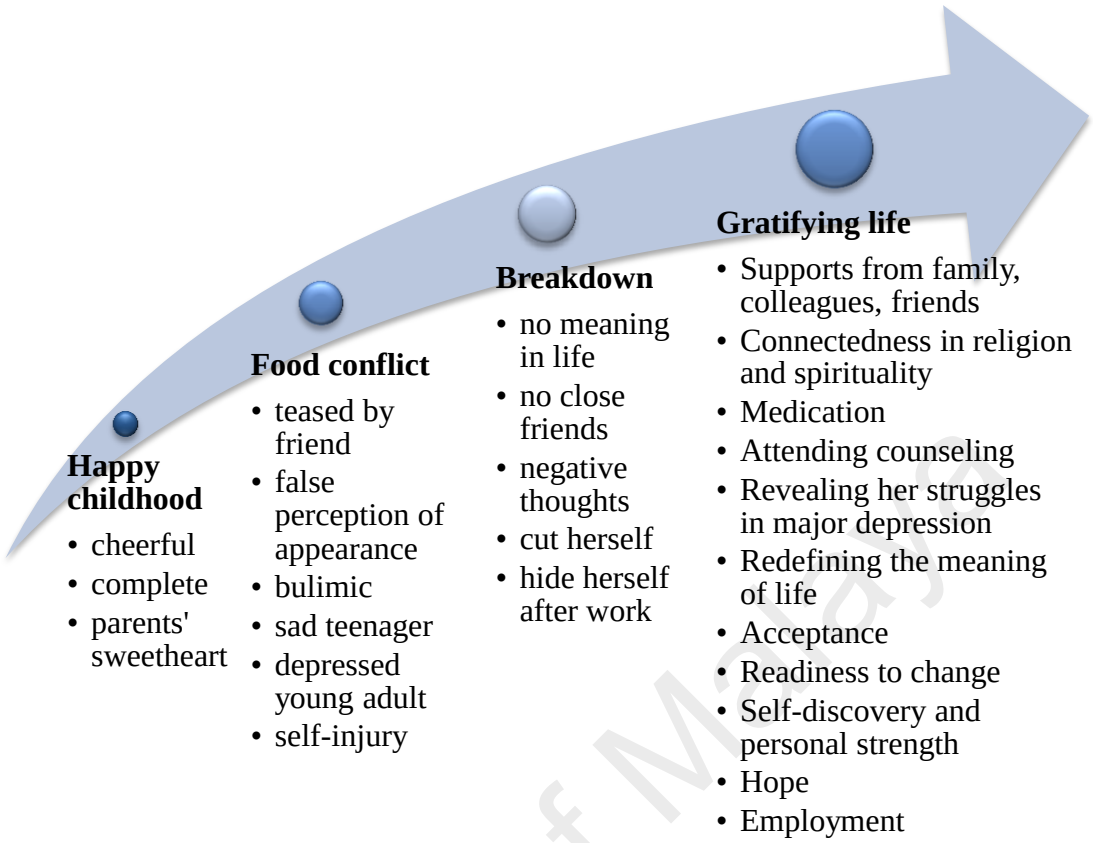

Figure 4.8. Visual map of Bella's experience of personal growth

Participant 9 – Pooja.

Background. Pooja was a 30-year-old single Indian lady who was working as a financier in a financial organization after completing her bachelor degree. She was diagnosed with major depressive disorder when she was 27 years old and experienced her first recovery episode when she was 29 years old. Pooja is the second child of four siblings. She is from an upper-class family.

Description of the experience. Pooja felt neglected since young. She was brought up by her grandparents until she was 13 years old before she went back to her own family. Her other siblings were taken care by their parents. Pooja felt that her parents didn't love her and abandoned her. She has no one to share her feelings with and she felt lonely during her primary and secondary school. Pooja was never a bright student compared to her siblings. Her parents ostracized her and they

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expressed their disappointments toward her. In order to prove to her family members that she could succeed, she studied very hard and completed her degree.

Unfortunately, business and account study was her parents' idea. She wanted to do art initially. As being a financier was not her passion, Pooja did not enjoy her work and felt frustrated. Pooja also faced a lot of relationship problems because she perceived herself having insecurity issue and worried that her partners would leave her. Pooja tried to end her life after her last boyfriend broke up with her. She was diagnosed with major depressive disorder when she was hospitalized.

Pooja perceived herself in the early stage of recovery. Despite the difficulty, she believed there were several aspects that helped her in her personal growth journey of recovery. She decided to get better and received treatment from psychiatrist (taking medication) and attended counselling sessions. As she didn't get support from her family initially, most of the support was from her housemate, friends, colleagues, and bosses. Pooja underlined the importance of religion and spirituality during her personal growth journey of recovery. She stated:

> *I think that another important thing is my religion. I am happy with my religion because when I had this like disease last time I could not cope. I tried to ask their help and they really helped me. They guided me in my life. I really want to thank them for their help. Until now I will go and see them to ask for more guidance from them because they know my situation.*
>
> *(Pooja/Int2/line574-61)*

Pooja believed that she must be ready for change and to accept and to forgive herself for her to ascertain her strength as well as to redefining the meaning of her life. She tried to change the way she portrayed herself to the world.

> *I try to get new clothes because I want to feel a new self-image. I try to do make up I try to take care of myself and try to do my hair nicely because I want to maintain a good self-image in front of people. I want to show to people that I had changed. I want to be… hmm… I want to live and I want to totally change myself. I want to live a colorful life.*

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(Pooja/Int2/line199-203)

What kept Pooja going was the hope and responsibility. She envisioned:

I can see that I have a bright future… bright future because I have the confident. I am no more in the depressive state. I am trying myself to recover from this because I know how the feeling to have depression or any mental illness is. So I don't want and I will not let myself to go to depression again. I want to move forward in my life. I want to have a bright future, and also... you know, since I experienced this… most sufferings in my life… I want to help people with similar problem like me. Definitely I will help because I feel that people who undergo all this can have more experience on handling and helping people with mental illness. Yes, definitely I will help them. That is one of my aims in the future.

(Pooja/Int3/line258-266)

Pooja reflected herself living an accomplishing life with a new hope in her life. Figure 4.9 is a visual map that reflects Pooja's personal growth journey recovering from major depression.

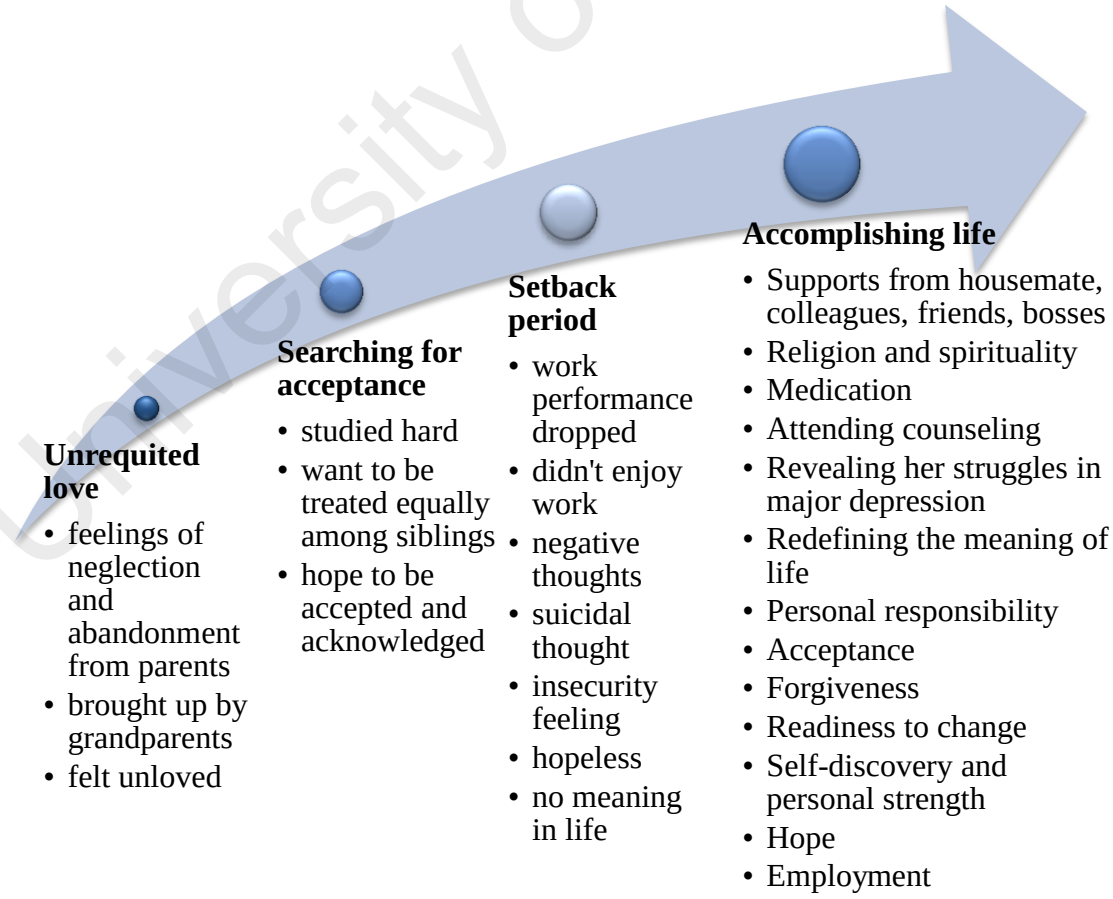

Figure 4.9. Visual map of Pooja's experience of personal growth

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Bracketing Process

In this study, 'epoche' or bracketing was applied in different stages to set aside researcher's experiences and biases as much as possible. Bracketing process took place before data was collected until all the collected data was wholly analysed. During bracketing stage, a total of nine personal biases of the researcher were identified in order to recognize her own personal biases on issues of major depressive disorder. Those were: (i) The person experiencing depression is the expert regarding his or her own life world, (ii) Symptoms described in diagnostic schedules such as the DSM-5 are credible but do not express the whole experience of depression, (iii) Depression is an all-encompassing experience that cannot be reduced to a list of signs and symptoms, (iv) Depression creates a need to withdraw from people, (v) Depression can be an immobilizing force, (vi) Oppression within the life world of young adults can result in depression; Depression is an oppressive force in and of itself, (vii) Depression can lead to feelings of overwhelming worthlessness, (viii) Young adults who are depressed sometimes express their depression as anger, and (ix) People who are depressed may display negativism.

The researcher continued to notify herself not to be affected by her personal biases throughout the data collecting process, mainly before and during the interview sessions as well as during the stage of analysing data collected from the interview sessions to ensure the objectivity during the data analysis. Lastly, to identify the emergent themes based on major depressive young adults' perspective, bracketing was used by the researcher.

Steps of Data Analysis

In this study, Colaizzi's method was used in data analysis (Moustakas, 1994). This method is based on Moustakas's modification of three methods of data analysis

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suggested by Stevick (1971), Cocolailaizzi (1973), and Keen (1975). In this study, eight steps of data analyses were applied to analyse the data collected by the researcher. The following section concisely reports step one to step three and thorough references can be referred at the appendices. Subsequently, the findings in chapter four reports step four to step eight of data analysis.

In the first step, to gather a complete description of the participants' personal growth experiences, a phenomenological approach was used. Participants were prompted by questions such as "what" and "how" during the interview sessions and followed by probing questions on substantial personal growth experiences recovering from major depression. It was to make sure a comprehensive understanding of the participants' personal growth experience was achieved. The second step entailed the researcher to verbatim transcribe the entire interview sessions conducted. 27 verbatim transcriptions were produced. In the third step, the researcher identified the related statements with significant importance to be analysed.

Moving along to the fourth step, each similar significant statement was grouped together into a broader category. In this study, the researcher identified a total of fourteen meaning units which were: (a) Revealing the struggles, (b) Self-discovery and personal strength, (c) Personal responsibility, (d) Readiness for change, (e), Hope, (f) Redefining the meaning, (g) Forgiveness, (h) Acceptance, (i) Supportive relationship, (j) Medication, (k) Attending counselling, (l) Religion and spirituality, (m) Care for others, and (n) Employment.

In the fifth step, the researcher described out the individual textural descriptions (generated by "what" questions) and imagined "what" the experience of personal growth by each participant was. In the sixth step, the researcher aimed to

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create the individual structural descriptions or "how participants experience the phenomenon in terms of the conditions, situations, or context" (Creswell, 2012).

Next, in the seventh step, to help the researcher to understand the personal growth experiences of the nine participants as a whole, a composite textural description and a composite structural description (Moustakas, 1994) were constructed. Finally, in the eighth step, the composite structural description was combined into the composite textural description to create a universal description of the personal growth experiences, to reach the essence of the experience of the phenomenon. Step four to step eight of the data analyses are described in detail in the next sections.

An Overview of the Central Research Question

The core research question in this study was: "How do young adults experience personal growth recovering from major depressive disorder?" The research question stayed focused in order to provide an in-depth understanding of the phenomenon of young adults' personal growth recovering from major depression. The detailed descriptions of the research outcomes are presented in the following section.

Findings

In this section, Moustakas' suggested flow of data analysis was applied to report the research findings. First, the clusters of meaning that emerged from this study are reported. Next, detailed descriptions on individual textural and structural descriptions of personal growth experience are reported alongside the descriptions on composite textural and structural personal growth experience. Lastly, the essence of the personal growth experience of the participants recovering from major depressive disorder is presented.

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Clusters of Meaning

Fourteen themes were revealed in this study. They were: (a) Revealing the struggles, (b) Self-discovery and personal strength, (c) Personal responsibility, (d) Readiness for change, (e), Hope, (f) Redefining the meaning, (g) Forgiveness, (h) Acceptance, (i) Supportive relationship, (j) Medication, (k) Attending counselling, (l) Religion and spirituality, (m) Care for others, and (n) Employment. Table 4.1 presented the themes emerged from the study as well as evidence in participants' statements.

Table 4.1

Themes and Evidence in Participants' Statements

Theme 1: Revealing the struggles	
Participants	**Evidence in participants' statements**
Jacky	I was very worried. I was scared that other people will know my case…my MDD.
Flower	I was in a denial stage which I denied that myself have depression, and I really scared to admit that I have actually have depression.
Winnie	I didn't dare to tell anyone. Mainly because I didn't want other people to look down on me and also the second thing was I was scare they will speak directly to my parents that's why I didn't dare to tell.
Shiela	Frankly speaking, I am not sure whether they can accept or not? About my past. That's what I was afraid about. I am very afraid of that part.
Fajar	There were many challenges also which I didn't feel like talking to others. I prefer to stay alone because it was challenging to talk to others and it was really difficult because I felt ashamed.
Priya	The negative is like, at the beginning it was very difficult to seek help because the feeling of shyness and being afraid of what others will be thinking and sometimes I do have the perception what the doctor will be thinking.
Catherine	Actually admitting depression is an illness and not something that is my fault in some way or another, it is a hard thing to admit to myself and I meant, you know depression means you are weak and crazy and this doesn't happen to normal people.
Bella	I can see they're worried but at the same time I think they also didn't want other relatives to know about it because I know, if I myself also feel so scared as sometimes I don't want to be labelled as a crazy person.

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Pooja	I felt like when I had MDD…During the time, I just felt like… you know, I just felt like I don't want to face anyone especially some of my friends who don't know about my condition. And then I felt that I just avoided them because I felt embarrassed to face them… which I felt I could not mix with them like how I mix with them previously.

Theme 2: Self-discovery and personal strength	
Participants	**Evidence in participants' statements**
Jacky	I feel that I have the greatest responsibility. If I don't help myself, who else can help me? If I don't help myself, who can actually help me? Because the people around me: my good colleague, my counsellor, it is impossible for them to be around me for 24 hours.
Flower	I know my purpose in life and that I can empowered myself so that I can… How do I say? It was like an assignment in life. It's like they give me assignments and I need to complete it. It's like I got things to do. I still got things to do and I need to, you know continue living so that I can finish and reach my goal and yeah, all those.
Shiela	But the thing is if we want to recover, we need to know ourselves too. It's starting with our own selves. That's why sometimes I will tell myself that I need to be strong. I need to be strong because if I am weak people around us will trample on me.
Priya	I myself have to be strong in order to succeed in my mission of getting better and out of this Major Depression.
Catherine	I focused a lot on my individual strength, you know, my resiliency; I tried to figure out my talents, my capacity and how to cope with all the problems. So that I am actually trying to understand myself more instead of realizing my weaknesses only and why don't make the weaknesses into my strength.
Bella	I think it was mostly strength base. So now I am focusing more on my own strengths for example my coping abilities, my resilience and my talents.
Pooja	It's inside. I just have to try to improve myself from that. I want to be a better person as much as I can.

Theme 3: Personal Responsibility	
Participants	**Evidence in participants' statements**
Jacky	Because for the sake of family, I also must cheer up. That means I have to consider and to concentrate, to focus more on my family. School is school, so I have to let it go.
Flower	I need to repay their kindness, I need to repay for whatever all the things that they have, you know. They helped me and you know that kind of things so that they keep me going on.

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Shiela	If I have my own problems, I must seek for help and ask opinions from others. Don't ever do anything that is unexpected, I told myself. Whatever problems also I need to be strong and I need to be calm.
Fajar	But, I still tried because I have four blessings that are the most special ones. Those are my children. They had strengthened my will to live.
Priya	And also I think that another factor was I also doing it for my family actually. Yes, I love my family even though how much we argued but the fact is they are my family and during my schooling time they gave me education. So I also want to become someone and to help them. I don't mind if they don't love me or what, but I know I have love for them.
Pooja	Even though I don't have a good relationship with my parents, I feel that as their child I still need to do a lot for them. I still respect them and I want to give them a good life. I want them to stay with me in the future because I want to take care of them. I want to show them their love because I feel all this is my responsibility which I need to do.

Theme 4: Readiness for change	
Participants	**Evidence in participants' statements**
Jacky	Although my wife is staying with me for 24 hours; I still need to take this step myself.
Flower	To me, I just need to know that I am in this condition and I need to move forward. And I need to move on, carry on, despite a lot of things that happened in my life
Shiela	If own self if we feel like wanting to recover, it was starting with our inner selves. I will recover. If not starting from myself then it won't happen and it couldn't be done.
Fajar	And I want to change. To go further. I do not want to stay here (depression) only. I need to go to the next stage.
Priya	The change for me it was within me. The eagerness and the feeling to really want to get better as well as the feeling of wanting to show to my parents that I will be back like previously, the feeling of wanting to go to work again and wanting to study back.
Catherine	I know that I still have somewhere to go and accepting my illness, moving forward and there is something that I need to do. Otherwise the cycle will continue and things will get worse and that was how I started to go for counselling and that was a small step I am giving myself to fight for a chance to live and stand up again.
Bella	I felt like I needed to do something with my life. I meant, I cannot continue to be like that. I know that something is wrong but then it seems hmm… I just felt maybe I can do something to change it.

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Pooja	Because I felt that, it's no point blaming others for disappointing me because the problem is within me. I try to look back at what are my weaknesses and I will try to improve it. I try to become more self-confident. That's why I try to trust people because I feel that not everyone is the same people.

Theme 5: Hope	
Participants	**Evidence in participants' statements**
Jacky	All I learnt was I wanted to live. I hope to be worthy to myself. I just hope to get the job done well and to be worthy to myself as well as to be worthy for the people around me.
Flower	Keep on going and keep on going. You know, just be determined. Perseverance, yes, this is the word that I want to say, perseverance. I need to just to persevere and, you know, just keep on going and hope that one day my goal I want to reach, will reach eventually.
Winnie	I hope that I am being able to enjoy my life. I want to spend time for myself that means going out for movie alone or what-so-whatever – It's more like how to enjoy life again.
Shiela	I always said to myself that I hope that I myself can recover, can control, and can face all the problems that I am facing with the right way and not the wrong way. I talked to myself.
Fajar	I want to become stronger and try to get up although I felt exhausted and tired. Even when I felt like I did not want to.
Bella	I want to become a better person for my family and also for my future family.
Pooja	I hope that I am recovering and I have the confidence that I can be fully recovered. I can live a good life like others.

Theme 6: Redefining the meaning	
Participants	**Evidence in participants' statements**
Jacky	I realized that I have to slowly change my way of thinking about my job. Although my job is challenging, I still have to cope with it and to catch up with it. Although I cannot perform my best, but I put in my effort.
Flower	I would say that last time I won't really express my love to them. That means I didn't know how to express and to me it's something like a bit shameful and I was a bit shy to express my love to them. But when after I went through this thing with them and through their encouragement and their support all the time, I realized that I am now I appreciate every moment that I have with them. I tried my best to, you know; express my love for them, and to show them through action and words.
Winnie	I think it was something like changing the old self into a new person.

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Priya	So far the experience changed me from negative to positive. I think that was a good experience for me because it actually helped me to stand on my own. Stand on my own and also to decide what I want in my life.
Catherine	And at the same time actually I learned about self-care which means you know, I learned to appreciate myself more and I learned how to say no and it is not that every human being have to be perfect, I just have to be me to know what I need, to know what I need to do to make myself better.
Bella	After some recovery and support from other people, I realized that I can be and I am a person. And discovering that changed the way I see myself. Now I am healthier and happier. I am not dependent on others to survive.

Theme 7: Forgiveness	
Participants	**Evidence in participants' statements**
Jacky	I can only say is it fine to work smart. Don't be influenced by so many instructions given and the deadline been given to me. Work is work. When teacher leave the school, teacher should have his private time.
Flower	I think it was a learning process. It's like you need to learn to forgive rather than you know, than hate others you know and don't let go all those kind of feelings, and also need to learn to be thankful.
Winnie	It just something that clicked my heart then I felt like "I think it's time for me to forgive and to let go."
Catherine	I tried to cope with myself and I tried to be more forgiving, you know more grateful towards my life.
Pooja	I want to forgive myself because that was one the thing that I want to do. So, forgive myself for doing all the stupid things in my life. I am not a 100%, but I just accept the way God created me.

Theme 8: Acceptance	
Participants	**Evidence in participants' statements**
Flower	I get to accept my condition already because before that was more like denial.
Winnie	Now, I won't be so sensitive and I know how to differentiate which things are just joking and they didn't really mean it and which is just talking for fun and also the real stuff. And I tend to be more acceptances to myself and started to think wider perspective rather than a blockage perspective.
Fajar	I have gotten peace. I accept all these trials, challenges and sufferings with an open and sincere heart.
Catherine	I was trying to accept myself. I was trying to accept myself and the reason of my existence in this world.

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Bella	I think it is still there. It just that sometimes I feel low and sometimes I am happy but now I accept both of them because I think they are part of my life. So I try to accept them as a part of my life.
Pooja	I really need to accept myself. All my weakness or strength, I accepted myself. It's inside. I just have to try to improve myself from that.

Theme 9: Supportive relationship	
Participants	**Evidence in participants' statements**
Jacky	My wife helped me a lot. My wife played the biggest role. Since I only have a small family - my wife and I. So actually my wife many times she was the one who consoled me, to comfort me, and also my wife helped me to reduce my stress regarding work because my wife is also a teacher.
Flower	The first thing I think of is my family. So it was like the major support for me. So that's why family for me is very important
Winnie	It was just all my colleagues were there and then to their greatest extent they accompanied me and then also took care for me in terms of workload. So for this I am also very grateful.
Shiela	There was a school friend. She also gave words of encouragement. I am very close with her. She is really a good friend. She always supports me and mostly she will ask me to be more patient.
Fajar	I received family support, from the aspects of mental, physical everything. Family helped a lot for example my mother-in-law taught me a lot about prayers). I am not ashamed though that is my mother-in-law. I had treated her like my mother because I have already been together with her for eleven years.
Priya	My mother she actually helped during this healing process throughout this year because she actually accompanied me to see the doctors and also to attend my counselling session.
Catherine	I actually feel grateful to myself and of course my family and my friends who supported me all along by standing at my side, encouraging me, trying to understand me, giving me support.
Bella	I think my family really played a very important role in helping me in recovery. My parents were very supportive when and after I was diagnosed with depression. So they really helped me a lot. Now every time if I have problems or I am feeling down, I will call them. They always encourage me so and make me feel like I can… I can do better.
Pooja	My support system definitely is my boyfriend, my friends, my colleagues, my bosses, and also my housemate. I still contact with her because I feel like she is the person that was there with me when I really need her. Until now I still go and find her, try to talk with her and she will always encourage me to think about my future.

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Theme 10: Medication	
Participants	**Evidence in participants' statements**
Jacky	Okay. Well, my healing process started when I started...when I started my medication prescribed by doctor.
Flower	I am still taking medication but currently I am already stabilized and according to the psychiatrist they are going to cut down on my dosage soon.
Shiela	To me actually the medicine is important because it was able to calm me down.
Priya	I am still continuing the medication.
Catherine	When I took medication, it will help to lessen my anxiety.
Bella	And taking my medication regularly also helps me to be calm and to calm me down.
Pooja	I always take my medication on time because I know that I still sometime if I never take medication maybe I will back to my depressed state because I still need more time to recover fully from my depression and yeah, I take my medication regularly.

Theme 11: Attending counselling	
Participants	**Evidence in participants' statements**
Jacky	I attended counselling sessions for several times. I found my counselling session useful in my recovery.
Flower	I actively attended counselling and I definitely you know, I followed all the follow up that the doctor gave me. All the appointments that the doctor gave me; it was the most important part.
Winnie	But it didn't really happen that suddenly because before I went to the conference I have attended counselling sessions so it's like having some foundation.
Shiela	When I went to see counsellor, I felt okay. At least okay because for example, I was able to express and after that I felt relief so consider okay.
Fajar	I went for counselling. Counselling helps a lot from the aspect of self-care, self-management, how to control emotions etc.
Priya	Actually during my counselling session, I have someone to talk and to share things because rather than medication, I need someone to talk to. So during those monthly visits with counsellor, it actually helped me.
Catherine	I had gone through a lot of counselling sessions and so from the counselling sessions actually it has helped me a lot.
Bella	I think my psychiatrist and counsellor also help me a lot also especially during the counselling sessions. I learned how to deal with my emotions, how to express myself and how to cope with my life better.

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Pooja	You know through this period of recovery, I have been absolutely blessed with wonderfully patient counsellor who helped me to see to know what I deserved in my life and what I can have in my life.

Theme 12: Religion and spirituality	
Participants	**Evidence in participants' statements**
Flower	Then of course, another factor was from God, spiritual support. You know, when I went to church, when I prayed and when I worshipped, that was the time that I felt connected to God and I felt that there's a sense of you know, belonging, and it's like there's a sense of meaning that I need to keep on moving.
Winnie	I felt like just one touch that everybody will fall to God's shoulder so I didn't need to care with the burden. God will help me to carry it.
Fajar	During that period it was really hard for me to get up but I tried. I started to pray how to study holy book although I had forgotten almost half of it. I tried slowly seeking peace in prayer again.
Priya	I always believe in God.
Bella	I also learned to lean on teaching of Buddha as my route rather than running away from love and finding my security in the numbness that illness give me. So I learned that actually it is okay not to be okay and actually it is also okay to have good days and bad days.
Pooja	I think that another important thing is my religion. I am happy with my religion because when I had this disease last time, I could not cope. Then I tried to ask their (temple and prayers) help and they really helped me. They guided me in my life.

Theme 13: Care for others	
Participants	**Evidence in participants' statements**
Bella	Sometimes I will visit the orphanage home or some other place which I think I found the meaning of life. I feel it is very meaningful to help other people.
Pooja	I am also doing some charity because I feel that by doing charity it can help me and also help others. I am really happy to do some good work because it makes me happy. Because I feel that I benefit others.

Theme 14: Employment	
Participants	**Evidence in participants' statements**
Flower	Once I started to work, I just move on and tend to enjoy life more. And I went through the same thing like others did.

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Winnie	They (bosses) would not fire me due to this behaviour of mine, but allowed me to keep staying in the company and learning about more things. Then taught me many things and promoted me step-by-step.
Bella	I need to have a regular job, regular income.
Pooja	I need to do my responsibility and also in my career. That is one of the important thing that I want to achieve. I want to do well in my career.

Individual Textural and Structural Description of Personal Growth Experience

Participant 1 – Jacky.

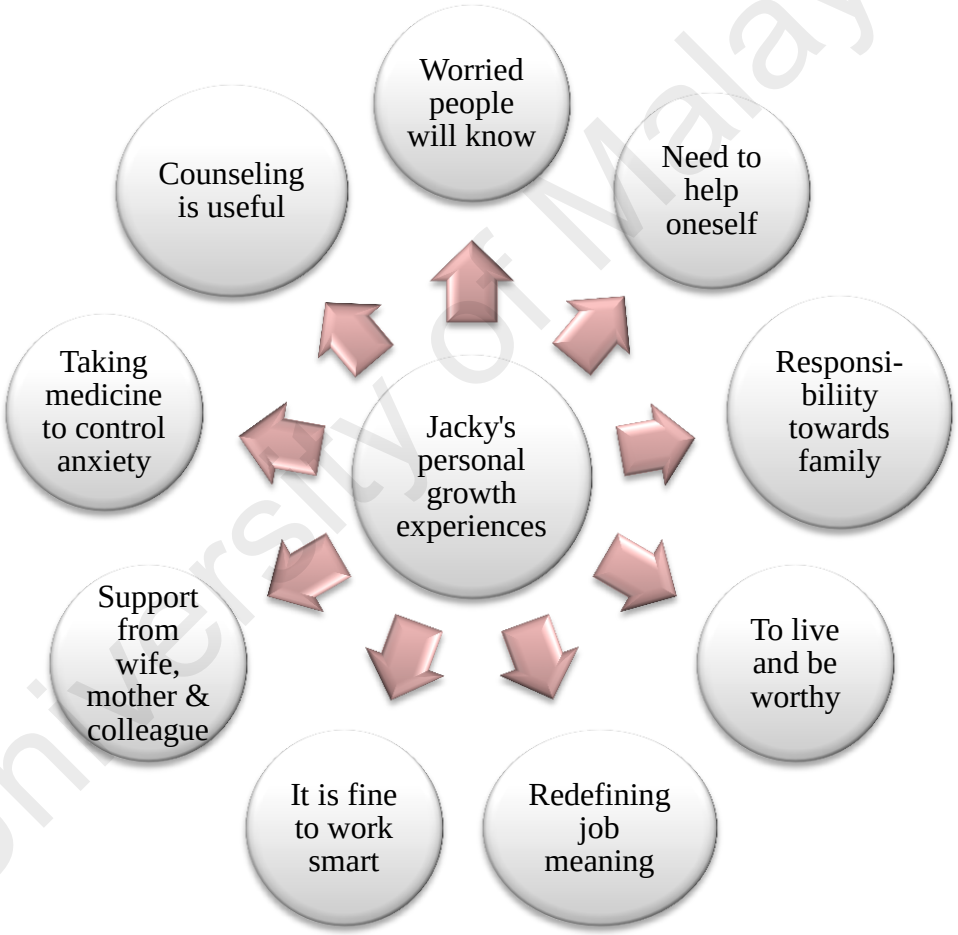

Figure 4.10. Jacky's personal growth experiences

Several aspects were shared by Jacky regarding his personal growth recovering from major depressive disorder (see Figure 4.10). They were: worried people will know, need to help oneself, responsibility towards family, to live and be worthy, redefining job meaning, it is fine to work smart, support from wife, mother

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and colleague, taking medicine to control anxiety and counselling is useful. Each aspect is discussed and supported by Jacky's statements.

Worried people will know.

Textural description. Jacky revealed about his worries that people will know about his MDD (Major Depressive Disorder). He reported a number of negative feelings and thoughts he has stumbled upon on his personal growth journey of recovery. Jacky used words such as "weak," "worry," "useless," "frustrated," "can't do it," "passive," "inconsistent," "inferiority," and "angry" to describe the negative feelings and thoughts he has faced. Furthermore, Jacky also linked his worry to the way people perceived him if they get to know his condition.

Words such as "bias," "discriminate," and "judge" was used to describe possible responses from his colleagues or his friends. Jacky used statements such as, "I was very worried. I was scared that other people will know my case…my MDD," "I was worried they will discriminate me," "I easily get angry and frustrated with my work," "I think people will have bias on me," and "I can't do it, that's what is in my mind."

Structural description. Jacky conveyed that he was in a negative state emotionally and mentally during his major depression. He also expressed his worry about revealing his struggles in major depression to his colleagues or friends because of their possible negative perceptions. He only revealed his major depression to one of his colleagues because she was a school counsellor. It was a challenging time for Jacky before he was able to reveal his struggles from major depression.

Figure 4.11 was drawn by Jacky to symbolize his struggles from major depressive disorder. He perceived his life was like a stormy ocean with no signs of

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promising good weather. He was struggling to survive in that stormy ocean. He described himself as a sailing yacht.

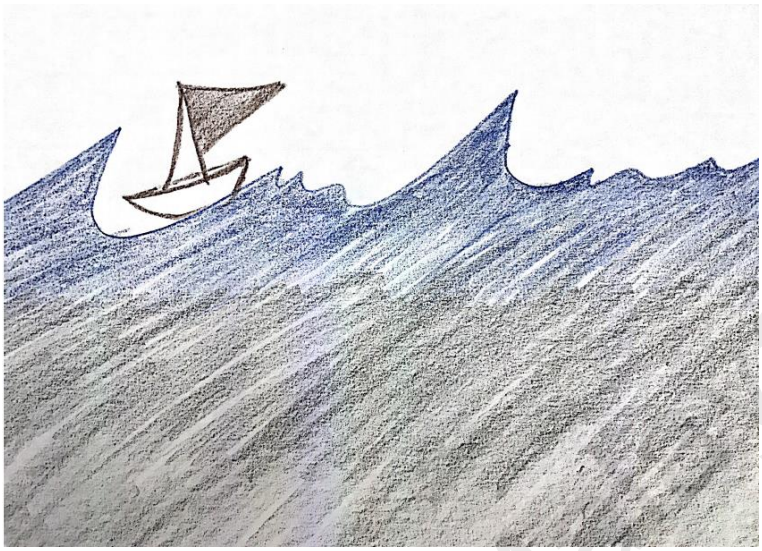

Figure 4.11. Jacky's symbolic drawing of his struggles

Need to help oneself.

Textural description. The need to help himself is perceived as one of the important aspects by Jacky in helping him to overcome his major depression. Jacky talked about, "At least I need to do something," "If I don't help myself, who else can help me?" "I still need to take this step myself," and "I must do some improvement on myself." Jacky stressed the need to help himself has allowed him to move on in his life.

Structural description. Jacky described the need of him to help himself in his recovery processes. The need to help oneself perceived as a readiness for change from negative life to positive life. Jacky realized that no one can help him to take the first step to move on except himself. Thus, he has to make the decision to help himself from within. This aspect of readiness for change has helped Jacky to start to allow changes to happen on him and helped him to draft his life transformation plan in life and at work.

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Responsibility towards family.

Textural description. Jacky stated that he was from a small family and now he has a small family of his own – he and his wife. Therefore, he felt that he has to take care of his family and because of that responsibility he has to stand up and move on. Jacky used phrases such as, "I need to take care of my wife. It's my responsibility to take care of her," "I must take care of myself before I am able to take good care of my wife," "Since I only have a small family - my wife and I," "By now, my first priority is for my family, and I am looking forward to having my child," and "Because for the sake of family, I also must cheer up. That means I have to consider and to concentrate, to focus more on my family. School is school, so I have to let it go."

Structural description. Jacky emphasized a lot on his responsibility towards his family in his interview session. He believed that this aspect has motivated him to move to personal growth and committed in the process of recovery. Jacky realized that his priority should be his family and not his work. According to Jacky, he has to take care of himself before he is able to take care of his family. He has learned which to concentrate and to focus for the sake of his family.

To live and be worthy.

Textural description. Jacky perceived that to live and be worthy is essential in his personal growth process. He used statements such as, "I just want to live and be worthy," "I just want to survive and to live every day because it is not easy," "The healing process also allowed me to open up to a bigger world," "For me to grow and to learn more," "Maybe I used to think that this world is full of unfairness. Yeah, there's no fairness and worthiness," "All I learnt is I want to live and I hope to be worthy to myself," and "I just hope to get the job done well, to be worthy of my own

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and to be worthy of the people around me." Jacky associated his perception of 'to live and be worthy' as a hope in his personal growth journey of recovery.

Structural description. Jacky described his hope as to live in his life and to be worthy to himself as well as to the people around him. He believes his struggles have made him to be more open to the world and he continued to learn and grow as a better person today. Jacky believed the importance of hope in his personal growth process and without it he will have no strength to carry on with his life. He used to think that this world is full of unfairness and unworthiness. Eventually when he started to practise hopes, he is able to live and feel worthy once again.

Redefining job meaning.

Textural description. Jacky redefined the meaning of his job by changing his thinking and perception towards his job. He shared statements such as, "I realized that I have to slowly change my way of thinking about my job. Although my job is challenging, I still have to cope with it and to catch up with it, "I start to change my perspective, the way of thinking and meaning of my job," "So it's all depends on how to value it," and "I start to find out that my case was not the worst."

Structural description. In Jacky's perspective, he has to change his way of thinking and how he looks at things if he wants to reach his job satisfaction. He realized that by redefining the meaning of his job, he is able to cope with his work stress as well as to face every challenge at his workplace. Furthermore, Jacky believed that the way he valued his work and how he is going to put a value on it is essential in redefining the meaning of his career. He came to a realization that his case is not the worst after all.

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It is fine to work smart.

Textural description. Jacky shared the necessity to feel fine to work smart. He used statements like "Because the work style, the workload, and the working habit nowadays are very busy. So I can say most of the people have the chance to develop this MDD. So you and I have to manage the EQ. I meant it is fine to work smart," "I can only say is to work smart. Yes, it is fine to work smart," "Work is work. When I leave the school, I should have my own private time with my family," and "When working, I work smart and when I go back to my family I forget about my work."

Structural description. In Jacky's sharing of working smart, he perceived it as forgiveness. He allowed himself to work smart as a way to forgive himself for not being a perfect teacher. Jacky relates his EQ management with his working style, workloads and working habit in his personal growth journey of recovery. He believed that EQ management included forgiveness which played an important aspect in his recovery process because he developed major depression due to his job.

Support from wife, mother and colleague.

Textural description. Regarding the aspect of support, Jacky revealed a few people who supported him throughout his personal growth recovering from major depression. He used statements such as, "So actually my wife, many times she was the one who consoled me, to comfort me, and also my wife helped me to reduce my stress regarding work because my wife is also a teacher," "When doing sport, I have my partner, my wife," "But most of the time, my wife was the one who helped me," "My mother also supported me. She listened to me. My mother hopes that I will recover slowly and able to manage my daily life and my health," and "My colleague, she always gives me motivation and encouragement. She is a school counsellor. She

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will lend me some motivation books for me to read and gave me some bookmarks with encouraging quotes."

Structural description. Jacky was supported mainly by his wife, mother and his colleague from the beginning until he experienced his first few episodes of recovery. He claimed that his wife played the major role in supporting him as he spent most of the time with his wife. Jacky expressed that he was facing a lot of challenges at work and was stressed. His wife was the one who assisted and encouraged him the most because she was able to understand his condition as both of them are in the same field. Jacky also received supports from his mother who will listen to him and from his colleague, he has received a lot of motivation from time to time.

Taking medication to control anxiety.

Textural description. Jacky revealed the need of taking medication to control his anxiety. He used phrases such as, "Medication helped me to control the hormone, my inner hormone so that I am able to control my anxiety and also so that I am more balanced," "I was more balanced in my physical and also mentally," and "I can sleep better."

Structural description. Jacky addressed the necessity to take medicine to control his hormone so that his anxiety is manageable. He claimed that it was a requisite at the beginning of his treatment with psychiatrist so that he is more balanced physically and mentally. Other than that, medication also helped Jacky to sleep when he was first diagnosed with major depression.

Counselling is useful.

Textural description. During interview sessions, Jacky highlighted the aspect of counselling as useful in his personal growth experience recovering from major

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depression. Jacky used statements such as, “Without the counselling session, I think I will continue to feel very bad. I will continue to feel I lost hope about my life and I lost hope about my job,” “I found it helpful. After telling my problem I felt more relaxes,” “I found myself calmer down and easier towards myself,” and “I attended counselling sessions for several times. I found my counselling session useful in my recovery.”

Structural description. Jacky emphasized the aspect of attending counselling session as something very useful and without it he might continue to feel bad, lost his hope in life as well as his job. He perceived counselling as a platform to share his problems and he felt relaxed, calmer and easier after that. Jacky interconnected each element of his healing as a whole and believed it as the most prevailing aspect in his personal growth journey of recovery.

Figure 4.12 was drawn by Jacky to symbolize his life when he started to experience personal growth process. He described himself as a boat safely tied to the moor on high ground and no longer has to face the stormy ocean. He was in despair, experienced healing, and now has a hopeful and meaningful life. He perceived his life after counselling sessions as more relaxed and calmer.

Figure 4.12. Jacky’s symbolic drawing of his personal growth process

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Participant 2 – Flower.

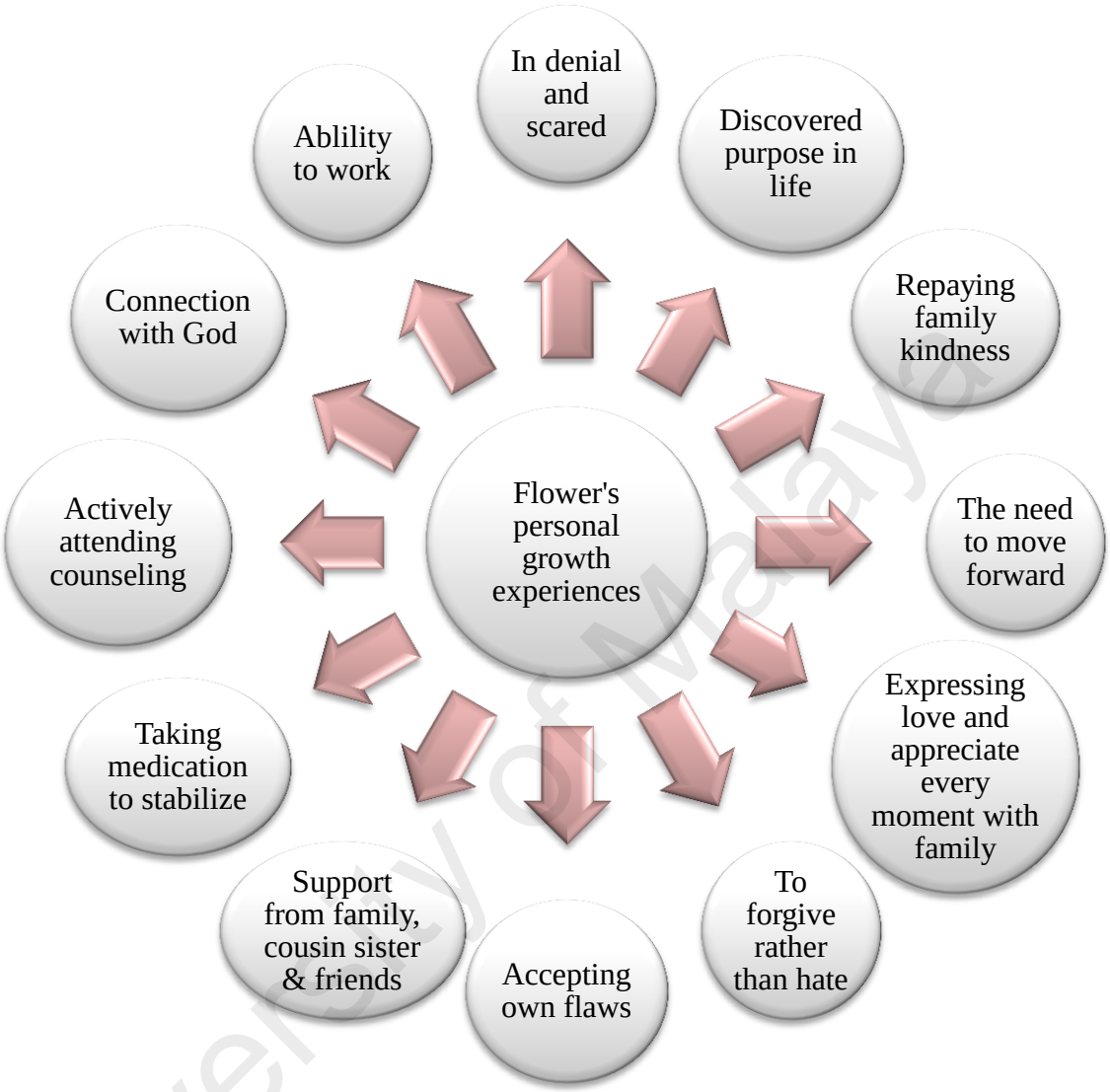

Figure 4.13. Flower's personal growth experiences

Flower disclosed several aspects of her personal growth journey of recovery from major depressive disorder (see Figure 4.13). They were: in denial and scared, discovered purpose in life, repay family kindness, the need to move forward, expressing love and appreciate every moment with family, to forgive rather than hate, accepting own flaws, support from family, cousin sister and friends, taking medication to stabilize, actively attending counselling, connection with God, and ability to work. Each aspect is discussed and supported by Flower's statements.

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In denial and scared.

Textural description. According to Flower, she was in denial and scared to reveal her struggles in major depression to anyone. She also feared of rejection and hatred from others. Flower used statements such as, “I was in dilemma because it’s more like, I know there’s something wrong with me but still I didn’t want to seek for help,” “Before that was more like denial. I was in a denial stage which I denied that I have depression and I was really scared to admit that I have actually have depression,” “I was very scare of rejection, I would say,” “I also worried that once I told my friends they will start to go away from me,” and “All these rejection and hatred, these were the things that I really scare. That’s why initially I suppressed a lot.”

Structural description. When Flower noticed that she has symptoms of depression, she was in dilemma because she knew something was wrong but she didn’t want to seek help. She was in denial as well and scared to admit that she has depression. Flower was worried that once she shares with her friends they will leave her and rejects her. Feeling of fear of rejection and hatred has caused her to reveal her depression to any other persons except for her cousin sister and mother.

Figure 4.14 was drawn by Flower to symbolize her struggles with major depression. She described herself living in the lowest point of her life and perceived herself as lazy, useless, hopeless, pathetic, fat, and stupid. She was in anguish, experienced a lot of dejection, and tried to come out from that stage of her life.

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Figure 4.14. Flower's symbolic drawing of her struggles

Discovered the purpose in life.

Textural description. Flower expressed that discovery of the purpose in life played an important part in her personal growth journey recovering from major depression. She described her discovery as looking into her strengths and weaknesses. Flower used phrases such as, "I want to live. I want to continue living. I want to take care of my mom. I want to take care of my family – mother and grandparent. I want to just enjoy my life until the day I really need to go," "I started to look into my strengths and weaknesses so that I can carry on," and "Seeking the meaning of life means that I have the purpose, you know I know my purpose in life and so that I can empower myself."

Structural description. In Flower's perspective, when she has discovered herself and her personal purposes in her life, she was able to move on and carry on her life differently. Throughout her personal growth journey, she was seeking for the purpose in life and linked it with her self-discovery and personal strengths. She believed her strength was to live a meaningful life – for her to live, to enjoy life, to take care of her loved ones, and to continue to empower herself in life.

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Repaying family kindness.

Textural description. The desire to repay family kindness plays a part in helping Flower to recover from major depression. She shared statements such as, "But after that I can see that my mom was there for me and my family was there for me. That's mean it's like someone still need me and I actually can, you know I can repay their kindness," "I need to repay their kindness, I need to repay for whatever, all the things that they had helped me and you know that kind of things so that it keeps me going on," and "Yeah, more like that la, because I'm a person who have a quite strong sense of responsibility."

Structural description. Flower perceived repaying family kindness as a responsibility in which she holds dearly. She claimed that she is a person with a strong sense of responsibility and it is her responsibility to take care of her only family member who is her mother. Flower wish to repay her mother's kindness for being there for her when she was struggling with her major depression. She believed that this aspect was a force for her to keep going in her personal growth journey of recovery.

The need to move forward.

Textural description. Flower stressed the need to move forward in helping her to recover from major depression. She used statements such as, "It was very difficult steps for me to you know, to make my first step to move forward. But once you stepped the first step and then continuously, you will feel much better each time," and "To me, I just need to know that in this condition, I need to move forward and I need to move on and carry on despite of a lot of things that happened in my life."

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Structural description. Flower described the need to move forward as her readiness for change. She has encountered difficulties for her to make her first step to move forward. However, she felt better each time after she took her first step to change. Flower realized that she can't stay in the same condition and that she has to move forward, move on, and carry on with her life. Thus, she decided that she is ready for change for the need to move forward.

Expressing love and appreciate every moment with family.

Textural description. Flower spoke of the importance of expressing love and appreciates every moment with family in helping her to stay on track in personal growth journey of recovery. She expressed, "I would say that last time I wouldn't express my love to them and I didn't know how to express it," "For me it's something very shameful and I was a bit shy to express my love for them," "But when I went through this thing with them and through their encouragement and their support all the time, I realized that it's important to appreciate every moment that I have with them," "Although actions speak louder than words but sometimes words also are needed to help me and my family in the healing process.," and "Although actions speak louder than words but sometimes words also are needed to help me and my family in healing process. Those words which can encourage people, to support people, and to push people forward, gave them and I the energy to go forward with positive energy."

Structural description. Flower described the aspect of expressing love and appreciating every moment with family is how she redefines the meaning of her relationship with her mother. Previously, she wouldn't and didn't know how to express her love to her family especially to her mother. Flower described it as something shameful. She indicated the importance of appreciating time together and

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the need to express love to help her and her family in the personal growth process. Flower perceived those expressive words as encouraging, supporting and able to provide positive energy to move on.

To forgive rather than hate.

Textural description. Flower has linked her personal growth recovering from major depression with the aspect to forgive rather than hate. She used statements such as, "I think it was a learning process. It's like you need to learn to forgive rather than hate others and don't want let go all those kind of feelings," "And to forgive more and not hate more," and "Yeah, although I am still in the process of healing, I starting to you know accept who am I now and to forgive the previous me."

Structural description. Even though Flower has a lot of bad memories of being bullied during her primary school and being discriminated during her university days, yet she perceived it as a learning process and learnt to forgive rather than hate others. She expressed that she wants to forgive more and not to hate others as well as herself. Letting go of negative feelings has helped Flower to recover from her major depression.

Accepting own flaws.

Textural description. Flower associated personal growth with accepting her own flaws. She used statements such as, "In every way, I accepted the facts that I actually have problems and I am going to solve it, something like that," "I started to make myself, to force myself actually to think another way rather than negative way and I focused on things that I can do rather than things I can't do," "I started to accept myself, my flaws and I started to move forward rather than staying in the past," and "But sometimes certain thing you know, you can't just let it be. You just need to face it and you know, face it and solve it, and just get rid of it."

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Structural description. Flower accepted the facts that she has problems and she decided to resolve by choosing to look at it in another way rather than the negative way. She focused on things that she can do rather than things she can't do. Flower started to accept her flaws to move forward rather than staying in the past. She also indicated that there are some things that she has to face and resolve.

Support from family, cousin sister and friends.

Textural description. Flower connected her personal growth recovering from major depression with receiving support from her family, cousin sister and her close friends. She used statements such as, "So, my mom is my only family member. So when I think about her, like how she took care of me last time and all, it definitely gave me encouragement despite all the depression and everything. My mom gave me the encouragement that you know, I will still live on somehow," "My cousin sister was the one who always stayed beside me during the down time," "But after that, thanks to my family, I meant like my mom, my grandparent and also some of my friends who actually encouraged me, so that I got back and carried on with my life," "My mom and cousin sister, they're accepted me as who I am. It's like even though I have depression and everything, they were still treat me like a normal person. They didn't make me feel like I am different or I was weird or I was abnormal that kind of feeling. And they still brought me out and they were still support me in any way they can," and "The most important things to me were the love from family and love from close friends. They're the one that support me emotionally."

Structural description. Flower received support from her family, cousin sister and her friends throughout her personal growth journey of recovery from major depression. She perceived support as the most important aspect in her personal

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growth and without it she will never move on. Furthermore, the encouragement, unconditional treatment, and love from them have supported her emotionally.

Taking medication to stabilize.

Textural description. Flower pointed out the necessity of taking medication to stabilize her emotion. She used phrases such as, "I am still taking medication but currently I am already stabilized and according to the psychiatrist they are going to cut down on my dosage soon," and "And of course with my medication it helped because at first I couldn't sleep at all and you know, at night I just opened my eyes wide until the next morning."

Structural description. From Flower's perspective, medication is necessary to stabilize her emotion. She described her current condition as stable and the dosage will be cut down soon by the psychiatrist. Flower shared that medication helped her to sleep at the beginning of her treatment in major depression.

Actively attending counselling.

Textural description. Flower linked her personal growth recovering from major depression with actively attending counselling. She used statements such as, "During the counselling session my counsellor helped me you know, to list down my good points and weaknesses," "I meant I actively attended the counselling sessions and I definitely followed all the follow up which the doctor gave me," and "The first step to see counsellor was very tough. Yes, I gone through that too but when once you go through that first step, then you will slowly see the changes."

Structural description. According to Flower, she actively attended counselling sessions and her counsellor assisted her to identify her strengths and weaknesses. She admitted that the first step for her to see the counsellor was difficult

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but she slowly experienced the changes. Flower never missed any of her follow ups with her counsellor.

Connection with God.

Textural description. Flower expressed her personal growth recovering from major depression with connection with God. She used phrases such as, "Then of course, another factor was from God, spiritual support. You know, when I went to church, I prayed and when I worshipped that was the time in which I felt connected to God and I felt that there's a sense of belonging. It's like there's a sense of meaning that I need to keep on moving," and "I felt that God was looking upon me and He's constantly you know, took care and protected me all the time. It's like He gave me the life I have now so I should actually appreciate it and do something good."

Structural description. In Flower's perspective, when she was praying and worshiping God, she felt connected to God. She linked her connection with God as a spiritual support and also sense of belonging. Flower described that she received protection from God and was taken care of by Him. She identified "God" as a protector and provider in her personal growth journey of recovery. Therefore, she has learned how to appreciate her life and to do good things out of it.

Figure 4.15 was drawn by Flower to symbolize her connection with God. She described God as a dove which gives hope, protection, and care that had given her strength to overcome her struggles in major depression. She was in darkness, experienced personal growth and healing, and now on the stage of recovery from major depression.

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Figure 4.15. Flower's symbolic drawing of her personal growth process

Ability to work.

Textural description. Flower associated her personal growth recovering from major depression with the ability to work. She used statements such as, "Actually now I can perform and work better at my workplace compared to last time definitely. I can interact more with my colleagues and willing to talk more with my colleagues, I mean other than the working things," and "Even though I was stressed at work, still somehow, I found ways to handle it a bit with correct ways. To be able to work helped me to feel less depressed."

Structural description. Flower described the ability to work has helped her to feel less depressed. During her personal growth journey of recovery, she perceived her performance and interaction at work were getting better. According to Flower, although sometimes she felt stressed at work, somehow, she was still able to manage it well.

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Participant 3 – Winnie.

Figure 4.16. Winnie's personal growth experiences

Winnie shared several aspects of her personal growth journey of recovery from major depressive disorder (see Figure 4.16). They were: scared of people's perception, to enjoy life, changing old self to new, to forgive and to let go, to accept self, support from colleagues, bosses and friends, having some foundation from counselling, put all the burden onto God's shoulder, and to stay, work and progress in the same company. Each aspect is discussed and supported by Winnie's statements.

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Scared of people's perception.

Textural description. Winnie shared about her fear of people's perception as a part of her personal growth journey recovering from major depression. She described a lot of fears in revealing her struggles from major depression to others. She used statements such as, "Mainly because I didn't want other people to look down on me and also second thing was they may tell directly to my parent so that's why I didn't dare to tell," "However, it was unhelpful when some people thought that I was seeking for attention. It also made me felt complicated," and "So sometimes I was much fed up and scared of people's perception towards me."

Structural description. Winnie experienced a lot of fears in revealing her struggles in major depressive disorder. She was scared of people's perception after they got to know her illness. She didn't want people to look down on her and to inform her mother who is a single a parent. So most of the time Winnie didn't dare to tell any person about her struggles. Winnie expressed her confused feelings of dejection and worried that people would assume her as an attention seeker.

To enjoy life.

Textural description. Winnie described that one of the important aspect in personal growth recovering from major depression was to enjoy life. She connected hope with enjoying life. Winnie used phrases such as, "I hope that I am being able to enjoy my life," "I hope that I am being able to enjoy my life. I want to spend time for myself that means going out for movie alone or what-so-whatever – It's more like how to enjoy life again," "I started to be happier and I enjoy my life," "Just follow the flow," and "After this I will live my life well and appreciate it every day."

Structural description. In Winnie's perspective, hope played an important part in her personal growth journey of recovery. According to her, she hopes she is

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able to enjoy her life, spend more time on herself and learn how to enjoy life again. She believed that she is able to live her life better and to appreciate it every day. Losing hope might cause Winnie to stop enjoying her life and she could relapse back into depression.

Changing old self to new.

Textural description. The aspect of "changing from old self to new" associate to Winnie and has greatly motivated her in her personal growth experience recovering from major depression. She described it as one way to redefine the meaning of her personal growth and healing. Winnie used statements such as, "I think it was something like changing from the old self into a new person," "And starts to think even wider perspective rather than blockage perspective," and "If there's something which will make me very sad, I will also let go."

Structural description. Winnie perceived her personal growth process as the experience of changing her old self into a new person with a broader perception about her life as well as herself rather than the impasse perception she has before this. She linked her changes with how she redefines the meaning of personal growth form major depression. This aspect helped Winnie to let go things which may make her sad.

To forgive and to let go.

Textural description. Moving along, Winnie perceived this idea of "to forgive and to let go" as an essential aspect in helping her pull through from major depression. Winnie used phrases such as, "I am grateful that I let go my past and move on, move on with my life. If not I am going to spend another don't know how many years dragging along with no purpose and meaning in life," "It just something

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that clicked my heart then I felt like “I think it’s time for me to forgive and to let go,” and “Go with the flow. Just live with this “go with the flow” attitude,” “

Structural description. Winnie expressed her gratefulness of letting go her past and chose to move on with her life. She described that after she went for religious conference and attended counseling sessions, she gained insight into the importance of forgiveness and letting go of her painful past. Letting go has helped Winnie to break free from feelings of anger and hatred towards her friends who had hurt her previously. Otherwise she may spend more purposeless and meaningless years wallowing in her negative feelings.

To accept self.

Textural description. Winnie connected her personal growth recovering from major depression with acceptance. She revealed that acceptance was one of the most important aspects in personal growth journey. Winnie used statements such as, “Most importantly was still myself. It was depended whether I want to accept or I don’t want to accept myself,” and “Now, I won’t be so sensitive and I know how to differentiate which things are just joking and they didn’t really mean it and which is just talking for fun and also the real stuff. And I tend to be more acceptances to myself and started to think wider perspective rather than a blockage perspective.”

Structural description. According to Winnie, the most important person in acceptance was herself. She described that it was her decision to accept or not to accept herself. Winnie made her choice to accept herself and ever since then, she became less sensitive and wiser in differentiating between jokes and serious matters as well as thinking in a broader perspective rather than an impasse perspective she had before.

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Support from colleagues, bosses and friends.

Textural description. Winnie received support from colleagues, bosses and friends in her personal growth journey recovering from major depression. These people played an important role in helping her to stand up and move on from her depressive state. She used statements such as, "So throughout the past few years they – my boss and my colleagues taught me a lot of things and that was where I grew as a stronger person," "Then after diagnosed, I started to take medication and it was pretty tough for me because I was super sleepy. I couldn't concentrate so mostly at work I was sleeping. My boss and colleagues, they really treated me very well so that's why I was really very appreciating them," "I was being kept back to a room. I meant they were not really keeping me back into a room, just that they didn't want me to handle so many stuffs anymore," "After I talked to her, I felt much relief because there's someone beside me. So at least there's someone that I can hold on to. That's how I felt at that time, someone was there for me," "I feel supported by him," "It was just all my colleagues were there and then to their greatest extent they accompanied me and then also took care for me in terms of workload. So for this I am also very grateful," and "What helped were my colleagues and then my counsellor, as well as my friends around me. They were always helping me."

Structural description. In Winnie's perspective, when she was at her lowest point, she received a lot of support from her colleagues, bosses and friends. She described her bosses and colleagues as people who listened to her, taught her a lot of things so that she can become stronger, tolerated her when she was down with side-effects from medication, reduced her workload so that she was able to rest, and people whom she can talk to. She frequently mentioned how grateful she felt for her colleagues and her bosses who have helped her to fight through her major

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depression. Winnie also felt grateful to have a few friends and her counsellor who have supported and helped her in her personal growth journey of recovery.

Having some foundation from counselling.

Textural description. Winnie related that having some foundation from counseling has assisted her in her personal growth in healing from major depression. She used statements such as, "But it didn't really happen that suddenly because before I went to the conference I have attended counselling sessions so it's like having some foundation," "I came for the counselling session so that was how the foundation built," "I think because I got the foundation which my counsellor helped me," and "I found out counselling was helpful."

Structural description. In Winnie's perspective, she received spiritual enlightenment after she has built a certain foundation from her counselling sessions. She described that her counsellor has greatly helped her in building a foundation that assists her throughout her personal growth journey and she found that counselling sessions were helpful. Winnie indicated that her spiritual enlightenment did not happen suddenly.

Putting the burden onto God's shoulder.

Textural description. In Winnie's personal growth journey of recovery, she believed in divine helps. She expressed her belief in putting all her burden onto God's shoulder. She used statements such as, "So when a speaker brought out that message there's something clicked on my heart and that's when I started to have the thought that I want to start a new life," "I felt like just one touch that everybody will fall to God's shoulder so I don't need to care with the burden, God will help me carry. So that's where I was being touched plenty of times," "I didn't expect

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anything so it just happened," and "I think the spiritual was helped to move a bigger step while others were like baby steps."

Structural description. Winnie believed that God will help her to carry her emotional burden so that she didn't have to worry about it. She received spiritual enlightenment at one religious conference and decided to start her life anew after that. Winnie described it as a sudden but firm decision. She perceived spirituality has helped her to move on to a higher realm in her personal growth journey recovering from major depression.

Figure 4.17 was drawn by Winnie to symbolize her spiritual enlightenment during her personal growth process. She spoke of the life changing decision she had made to help her to come out from major depression.

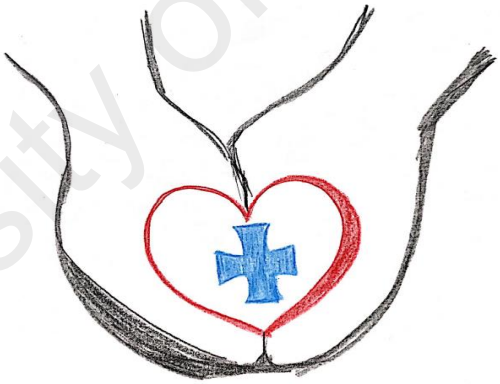

Figure 4.17. Winnie's symbolic drawing of her personal growth process

To stay, work and progress in the same company.

Textural description. Finally, the aspect of employment has helped Winnie to feel needed in many ways in her personal growth journey of recovery. She described it using statements such as, "They (bosses) would not fire me due to this behavior of mine, but allowed me to keep staying in the company and learning about more things. Then taught me many things and promoted me step-by-step," and "I was given a chance by my boss and that's make me felt less depressed."

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Structural description. Winnie perceived that to stay, work and progress in the same company has helped her to feel less depressed as she felt she was needed in the company. Despite all the negativity arising during her onset of major depression, her bosses continued to trust her and allowed her to stay in the company to learn and progress by promoting her accordingly.

Participant 4 – Shiela.

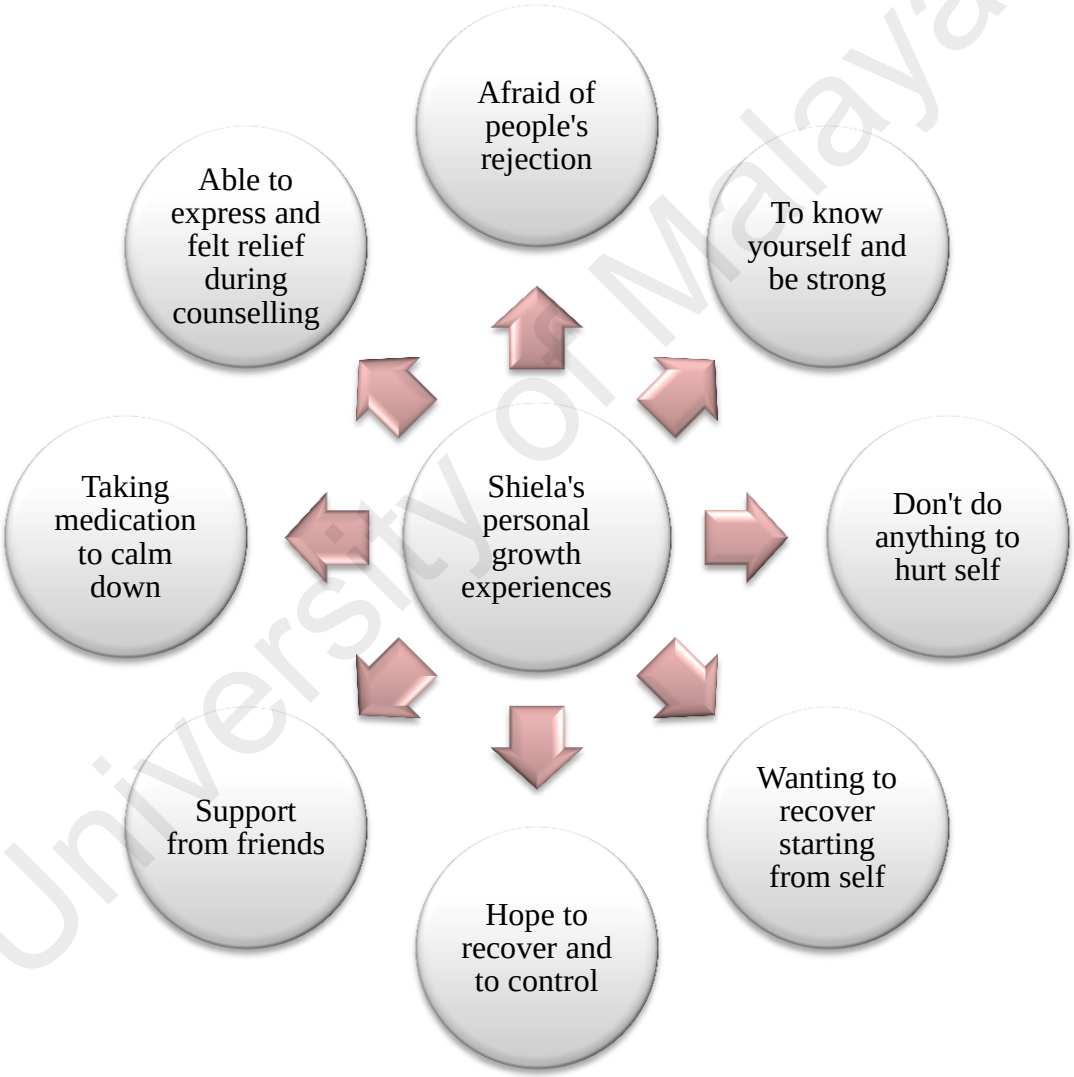

Figure 4.18. Shiela's personal growth experiences

Shiela expressed several aspects of her personal growth journey of recovery from major depressive disorder (see Figure 4.18). They were: afraid of people's rejection, to know yourself and be strong, don't do anything to hurt self, wanting to

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recover starting from self, hope to recover and to control, support from friends, taking medication to calm down, and able to express and felt relief during counselling. Each aspect is discussed and supported by Shiela's statements.

Afraid of people's rejection.

Textural description. Shiela shared that she was afraid of people's rejection regarding her past history and her major depression. She linked it as a part of her personal growth journey recovering from major depression. Shiela used statements such as, "Frankly speaking, I am not sure whether they can accept or not about my past. That's what I was afraid about. I am very afraid of that part," "I don't know if anyone can accept me and marry me or not," and "Maybe my future-in-law family will look at me differently and unable to accept the fact that I am no longer a virgin."

Structural description. In Shiela's journey of personal growth, she experienced two aspects of negative feelings. The first was related with the fear of people's refusal to accept her past history as she was raped when she was fourteen years old. She was afraid her future-in-laws may not be able to accept this fact. The second was related the fear of people's negative perception of her mental illness. She described her uncertainty whether any person would accept and marry a non-virgin with major depressive disorder.

Figure 4.19 was drawn by Shiela to symbolize her struggles with major depression. She described herself in despair after she was raped and was worried of people's rejection. To her, life was bleak and she tried hard to reach out for help, and hoped to move out from the dark valley of life.

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Figure 4.19. Shiela's symbolic drawing of her struggles

To know yourself and be strong.

Textural description. Shiela connected her personal growth recovering from major depression with the aspect of knowing herself and to be strong. She explained it using statements such as, "But the thing is if we want to recover, we need to know ourselves too. It's starting with our own selves," "It's really difficult to tell the duration of healing because it was all depending on us and how we look at ourselves also," "I told myself that I need to be strong. Because if I am weak, people around me will trample on me," "I always encouraged myself in front of the mirror," and "All is possible with ourselves and not with others. Others cannot help us but only ourselves can help our own selves."

Structural description. Shiela reflected the aspect of self-discovery and personal strength as one of the personal growth aspects in her journey to stand up again from major depression. She agreed that she has to be strong if she wants to recover it has to start from her. She discovered the duration of healing was mainly dependent on her and how she viewed herself. Shiela always encouraged herself and

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believed that only she alone can help herself to get better so that people will not despise her.

Don't do anything to hurt self.

Textural description. Shiela related her personal growth recovering from major depression with self-responsibility by making sure she will not do anything to hurt herself. She used phrases such as, "If I have my own problems, I must seek for help and ask opinions from others. Don't ever do anything that is unexpected, I told myself. Whatever problems also I need to be strong and I need to be calm," "I will go for sing if I feel like I want to hurt myself," "Listening to music or go out for a window shopping also helped to distract myself," and "I will talk to my friends and they will ask me to think of God and people who care about me."

Structural description. According to Shiela, one of the important aspects in helping her to recover from major depression was to make sure that she does not do anything to harm herself. She perceived it as her personal responsibility. Shiela mentioned about her ways to distract herself whenever she has the thought of hurting herself such as singing, listening to music, window shopping, and talking to her friends.

Wanting to recover starting from self.

Textural description. Shiela linked her personal growth recovering from major depression with her desire to recover from the mental illness. She shared this aspect using statements such as, "If own self if we feel like wanting to recover, it was starting with our inner selves. I will recover. If not starting from myself then it won't happen and it couldn't be done," "If we want to recover, we need to know ourselves too. It's starting with our own selves," and "I want to live a happy life."

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Structural description. Shiela perceived that the readiness to come out from major depression started from her will to recover. She described it as one of the aspects in her personal growth journey in order to live a happy life. According to Shiela, her healing will not happen if she was not ready and didn't want to recover.

Hope to recover and to control.

Textural description. Shiela connected her personal growth recovering from major depression with her hope to recover and to control. She used phrases such as, "I always said to myself that "I hope that I myself can recover, can control, and can face all the problems that I am facing with the right way and not the wrong way" I talked to myself," "I believed slowly but surely I am able to let go and forget about my dark history," "I hope someday I will find someone who can accept me for who I am and have a family together," "I want to be strong for my future family," and "I hope to be given a chance to come out from all these."

Structural description. According to Shiela, looking forward to getting healed, able to control and face all the problems using the right way was her hope. She reflected hope as an important aspect in her personal growth recovering from major depression. During her process of recovery from major depression progressed, Shiela hoped for someone who can accept her and then, to build a family together so that she can continue to be strong for her future family. She believed that she will slowly be able to let go of her past if given the chance to come out from major depression.

Support from friends.

Textural description. Pertaining to support, Shiela shared that she received it from her friends throughout her personal growth journey recovering from major depression. She used statements such as, "There was a school friend. She also gave

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words of encouragement. I am very close with her. She is really a good friend. She always supports me and mostly she will ask me to be more patient," "When I was under stress or pressure I will express it to my close friends," "I expressed everything to my close friend about anything that happened on me. I will express it all," "When I had expressed it all, I felt that my heart felt relief, not suppressed anymore," and "Friends were the one who gave encouragement most of the time."

Structural description. Shiela reiterated that she received support mainly from her friends. She acknowledged support as a vital aspect to sustain her personal growth recovering from major depression. According to Shiela, she felt relief and didn't bottle up her feelings after she expressed everything to her friends. She also felt supported and encouraged whenever she expressed it out.

Taking medication to calm down.

Textural description. Shiela perceived the necessity of taking medication to calm her down during the beginning of her recovery. She shared it using statements such as, "To me actually the medicine is important because it was able to calm me down," "After took my medicine I felt okay," and "Sometimes doctor will ask me to take medicine so medicine did help."

Structural description. In Shiela's perspective, one of the essential aspects of recovery was the use of medication. She claimed that she was able to calm down after she took the medication. Shiela found out that medication did help her and she felt fine.

Able to express and felt relief during counselling.

Textural description. Shiela shared that she was able to express and felt relief during counselling sessions, and that attending counselling has played a significant part in helping her to recover from her major depression. She used statements such

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as, “When I went to see counsellor, I felt okay. At least okay because for example, I was able to express and after that I felt relief so consider okay,” “I went to counselling sessions with two counsellors at different hospitals,” and “For my case, I couldn’t find anyone to help me and I might become more serious. So counsellor helped me and listened to me. I felt I was listened when I was with my counsellor.”

Structural description. According to Shiela, counsellor has helped and listened to her when she attended counselling sessions. She expressed that counselling was one of her outlet to express herself and felt relief after doing so as she didn’t have anyone else to hear her out. Shiela also get to know herself better and this has helped her in the healing journey from major depression.

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Participant 5 – Fajar.

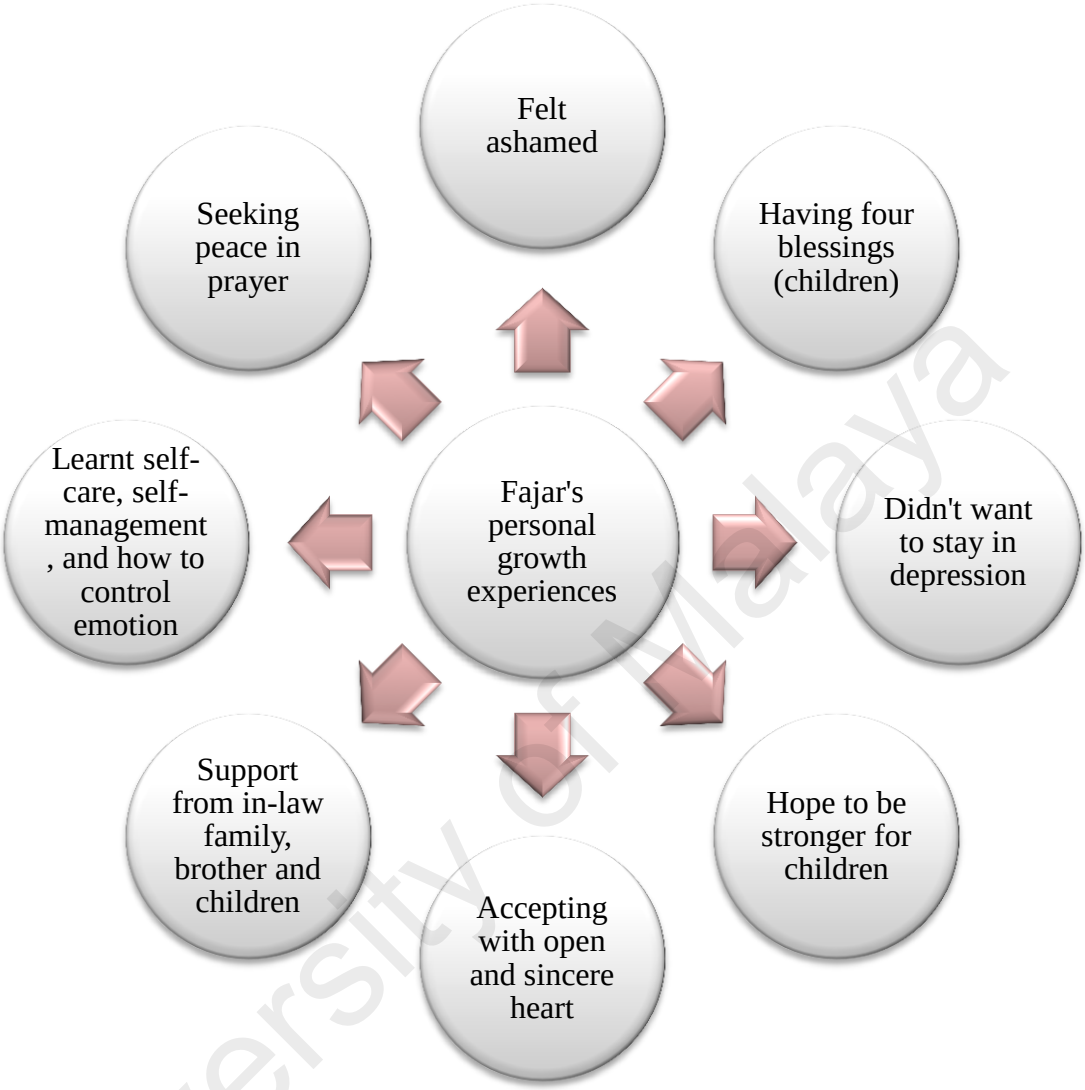

Figure 4.20. Fajar's personal growth experiences

Fajar shared several aspects of her personal growth journey recovering from major depressive disorder (see Figure 4.20). Those were: felt ashamed, having four blessings (children), didn't want to stay in depression, hope to be stronger for children, accepting with open and sincere heart, support from in-law family, brother and children, learnt self-care, self-management, and how to control emotion, and seeking peace in prayer. Each aspect is discussed and supported by Fajar's statements.

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Felt ashamed.

Textural description. Fajar expressed her embarrassment during the interview session having to reveal her struggles to her listeners. She used statements such as, "There were many challenges also which I didn't feel like talking to others. I prefer to stay alone because it was challenging to talk to others and it was really difficult because I felt ashamed," and "I also didn't go to class reunion because I felt ashamed as that time I was having depression."

Structural description. In Fajar's perspective, revealing her struggles in major depression to others played a part during her healing from major depression and it was challenging. She expressed her discomfort which make her stopped sharing and talking to others, especially to her friends about her major depression. According to Fajar, she avoided class reunion because of her embarrassment of having major depressive disorder.

Having four blessings (children).

Textural description. Fajar described that the aspect of responsibility took place when she acknowledged the importance of her children's existence in her life. She shared it using statements such as, "But, I still tried because I have four blessings that are the most special ones. Those are my children. They had strengthened my will to live," "I tried to stand up for my children," "But I have my life connector," and "I think maybe I was given a chance to change, to become better, to be a real mother who is more understanding to my children,"

Structural description. Fajar connected her personal growth recovering from major depression with her responsibility towards her children. She perceived her children as her life connecter and they were the ones who strengthened her will to continue to live. Fajar shared in her interview sessions that how her daughter begged

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her to stay alive when she wanted to end her life by cutting her wrist, she realized that she has been given a second chance to be a better mother for her children.

Didn't want to stay in depression.

Textural description. Fajar revealed her desire to not stay in depression. Her decision and readiness to move on from her major depression was one of the aspects in helping her to move on to her recovery journey. She used phrases such as, "And I want to change and to go further. I do not want to stay here (depression) only. I need to go to the next stage," "For me, this depression is just temporary in my life," "I don't want to live like this forever," and "I want to change my life to a happier one with my children."

Structural description. Fajar's decision not to stay in depression has helped her to move on in her life. She linked her personal growth recovering from major depression with her readiness for change and to go further in her life. She believed that her major depression was just momentary and that she wanted to change her life to be more joyful with her children.

Hope to be stronger for children.

Textural description. In the interview sessions, Fajar hoped to be stronger for her children. She connected her personal growth recovering from major depression with hope. Fajar used phrases such as, "I want to become stronger and try to get up although I felt exhausted and tired. Even when I felt like I did not want to," "I still tried because I have four blessings that are the most special ones. Those are my children," and "They had strengthened my will to live. It seems like even without my husband also I can live, because I have my children."

Structural description. According to Fajar, she earnestly looked forward to getting stronger and to be able to stand up again regardless of how exhausted she felt

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for the sake of her children. She reflected hope as an important aspect in her personal growth recovering from major depression. As recovery from major depression progressed, Fajar believed that she was able to live even without her husband as long as she has her children who acted as her life line.

Figure 4.21 was drawn by Fajar to symbolize hope to be healed. She described hope as one of the aspect throughout her personal growth process that has helped her to face her major depression and to overcome her past experiences. She had once dwelt in despair but now her hope is for a better life for the sake of her children.

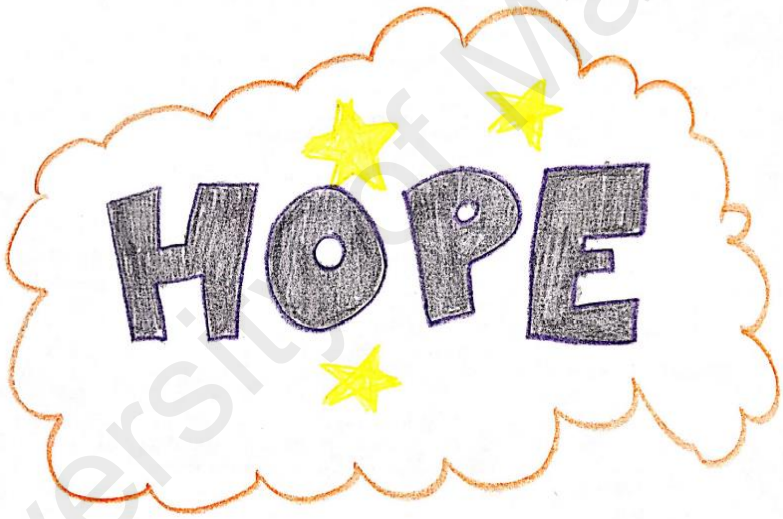

Figure 4.21. Fajar's symbolic drawing of her personal growth process

Accepting with open and sincere heart.

Textural description. Fajar shared the importance of acceptance in her personal growth journey recovering from major depression. She used phrases such as, "I have gotten peace. I accept all these trials, challenges and sufferings with an open and sincere heart," "I was grateful with what God has decided for me," and "For me, I decided not to care too much if that thing happens again."

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Structural description. Fajar connected her personal growth recovering from major depression with acceptance. She believed that this aspect was one of the reasons she was able to move on. Fajar shared that she has accepted her tribulations with an open and sincere heart. She was grateful to God for His guidance and assured that she would not be troubled by her problems again.

Support from in-law family, brother and children.

Textural description. Fajar reported that she received support from her in law family, brother and children. All the support has helped her in her personal growth recovering from major depression. Fajar used statements such as, "I received family support, from the aspects of mental, physical everything. Family helped a lot for example my mother-in-law taught me a lot about prayers. I am not ashamed though that is my mother-in-law. I had treated her like my mother because I have already been together with her for eleven years," and "Only those who are closed with me that know and they were still treating me as usual like how they did previously and keep giving me support and encouragements."

Structural description. Fajar received a lot of support mentally, emotionally, and physically from her family. She expressed that she felt supported and encouraged when people who were close with her still giving her the same treatment like usual. She also received spiritual support from her mother-in-law who gave her spiritual teaching. This action from her mother in law has helped her to get closer to her God which also was one of the aspects that had contributed to her recovery from major depression.

Learnt self-care, self-management and how to control emotion.

Textural description. Fajar shared that she learned self-care, self-management and how to control emotion after she attended counselling sessions. She

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associated her personal growth recovering from major depression with attending counselling sessions. Fajar used statements such as, “I went for counselling. Counselling helps a lot from the aspect of self-care, self-management, how to control emotions etc.,” “I need to control emotions,” “And counselling really helped a lot,” and “The coping ways were very helpful.”

Structural description. In Fajar’s perspective, during her struggles with her major depression, counselling has helped her to manage herself. She stressed that from counselling sessions, she practiced self-care, self-management, and also how to deal with her own emotions. Fajar believed that counselling was helpful in her personal growth process recovering from major depression.

Seeking peace in prayer.

Textural description. Fajar connected her personal growth recovering from major depression with spiritual belief. She mentioned the aspects of God in every interview sessions. Fajar used statements such as, “During that period it was really hard for me to get up but I tried. I started to pray how to study holy book although I had forgotten almost half of it. I tried slowly seeking peace in prayer again,” “Until I started to pray and to study Al-Quran. Although I had forgotten almost half of it, about the readings, I tried slowly to read them again and tried to pray although I could not sit and pray. I prayed on chair and learnt again how to pray and so on and Insya Allah the God Allah, I had changed,” “And I tried to get myself closer to the God,” “It’s the God who gave me the strength,” and “I prayed and appreciated it.”

Structural description. Fajar emphasized the aspect of prayers and religious teachings in helping her to sustain her recovery from major depression. She believed that prayers brought her peace and it helped her most of the times in her healing journey. The aspect of religion and spiritual support has guided Fajar and granted her

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the strength throughout her process of personal growth recovering from major depression.

Participant 6 – Priya.

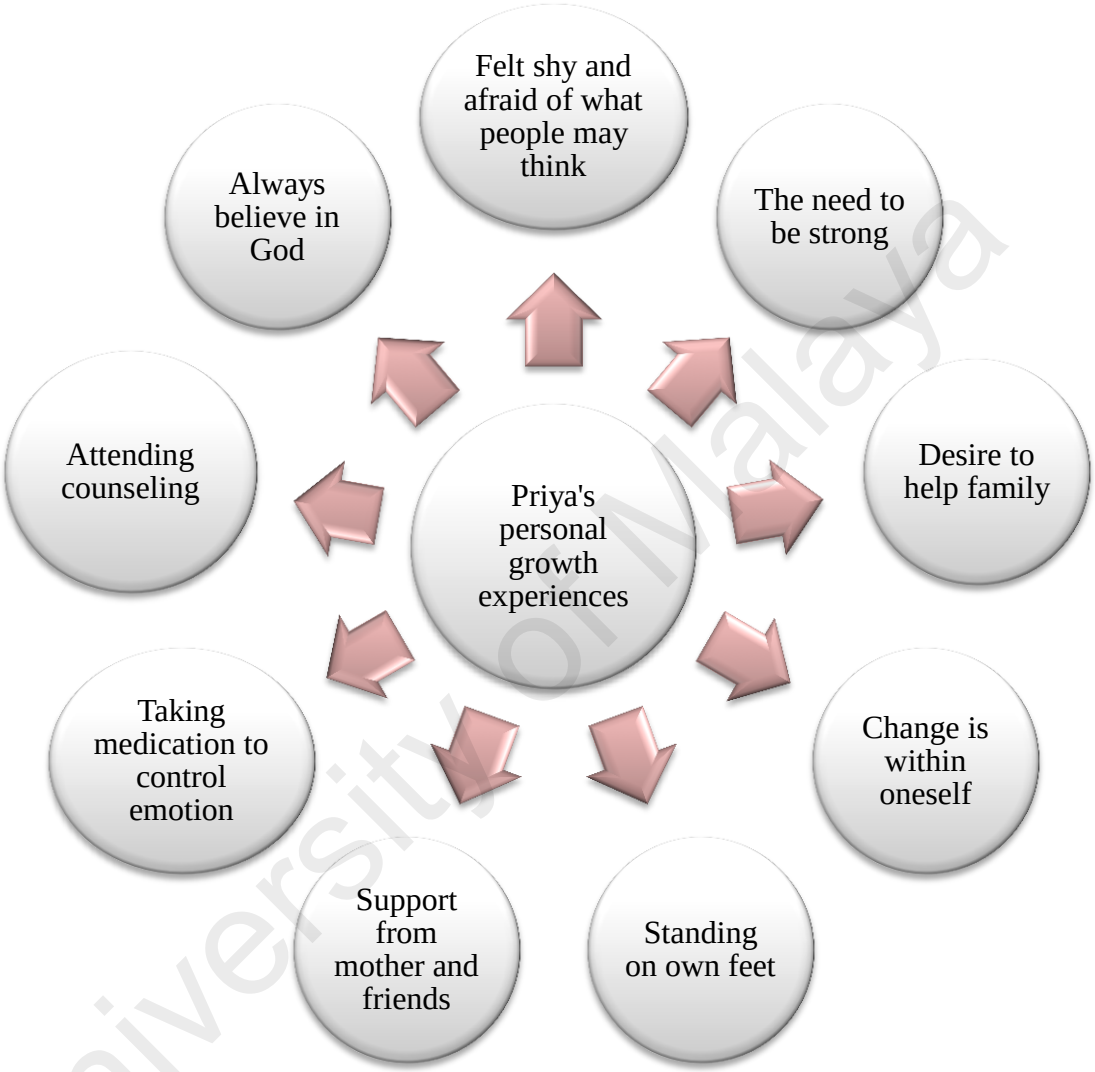

Figure 4.22. Priya's personal growth experiences

Priya disclosed several aspects of her personal growth journey recovering from major depressive disorder (see Figure 4.22). They were: felt shy and afraid of what people may think, the need to be strong, desire to help family, change is within oneself, standing on own feet, support from mother and friends, taking medication to control emotion, attending counseling, and always believe in God. Each aspect is discussed and supported by Priya's statements.

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Felt shy and afraid of what people may think.

Textural description. Priya shared her embarrassment and fear as part of her healing journey. She felt shy and afraid of people's thinking regarding her mental illness. Priya used statements such as, "The negative is like, at the beginning it was very difficult to seek help because the feeling of shyness and being afraid of what others will be thinking and sometimes I do have the perception what the doctor will be thinking," "Previously, when I sought for help and treatment, I was a person who always felt afraid. Afraid to talk to people, low self-confidence and also always have this negative thought of what people will think about me and what people thought about me," "I was afraid on how my friends will think about me if they know I have major depression because I used to be a happy person," and "My eldest sister, every time after we had argument she always said, "Don't ever forget that you actually went to this mental hospital before and we can just simply put you back." So actually I felt sad because my sister also an educated person but she can say something like that. For me it's more like threatening me.

Structural description. During Priya's sharing, she revealed her struggles and challenges in seeking initial help to resolve her depressive disorder was not easy. She was afraid of the views and comments that she may hear from health care practitioners and her friends about her mental illness. Priya claimed that she was overcome by low self-esteem and low self-confidence and bogged down in negative thoughts. She felt sad and threatened when her elder sister said to her that she would be sent back to mental hospital if Priya continued to interfere with her personal life. According to Priya, the aspect of revealing her major depression to others has played a part in her personal growth journey recovering from major depressive disorder.

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Figure 4.23 was drawn by Priya to symbolize her struggles with major depression. She spoke of negative experiences which had made her live in frustration and without support and love from anyone. She was in the lowest period of her life and tried to move out from that vacuum.

Figure 4.23. Priya's symbolic drawing of her struggles

The need to be strong.

Textural description. Priya shared about her need to be strong for her to recover from major depression. She expressed it using statements such as, "I myself have to be strong in order to succeed in my mission of getting better and out of this major depression," "Because due to the eagerness in me that I wanted to get better, so I like to be strong, don't really cares about what other think and seek for help," "So the positive thing I learnt was not to think all those negative things…," and "What I did was I always like tell myself that "This is not what supposed to be like, this is not really the real Priya, the real me, I can do more, I can, I can contribute more to the society", just because I'm having this fear, I can't let the fear to stop me to make myself better.

Structural description. Priya perceived her need to be strong as her personal strength which has helped her overcome her major depression. She believed that her

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own personal strength has helped her to move on from her major depression. Priya kept motivating herself to think positively at all time and kept reminding herself that she can do better and able to contribute to the society as well. She is not allowing fear to stop her from getting better.

Desire to help family.

Textural description. Priya shared about her desire to help her family. She linked her personal growth recovering from major depression with her responsibility towards her family. Priya used statements such as, "And also I think that another factor was I also doing it for my family actually. Yes, I love my family even though how much we argued but the fact is they are my family and during my schooling time they gave me education. So I also want to become someone and to help them. I don't mind if they don't love me or what, but I know I have love for them," "I want to help my family financially by going back to work again," and "Although my sister threatens me few times, but I still want to help her because she is my sister."

Structural description. Priya revealed that one of the aspects of her personal growth process recovering from major depression was her desire to assist her family. She sees it as her responsibility to help her family regardless of whether they reciprocate her love. Priya expressed that she still loves her family and she doesn't mind whether they love her or not because she perceived them as a family.

Change is within oneself.

Textural description. Priya linked her personal growth recovering from major depression with her readiness to change. She shared that the change was within her whether she wanted to come out from her major depression or not. Priya used phrases such as, "The change for me it was within me. The eagerness and the feeling to really want to get better as well as the feeling of wanting to show to my

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parents that I will be back like previously, the feeling of wanting to go to work again and wanting to study back," "I can't say I enjoyed, but I really glad that I actually took few of the decisions that actually made me to have a better life," "So as for me the thing was like, it is in me – the depression was in me and it's not like something physically I am hurt and I need to heal myself," and "First I need to do for myself because there is a reason for me to be here, perhaps in future I can help a lot of people I won't know."

Structural description. Priya believed that one of the essential aspects to help her in her personal growth recovering from major depression was her readiness for change. According to her, the change was within her and she envisioned herself going back to work, continuing her study, and proving to her family that she is getting better. Priya expressed her relief with her decisions which has helped her to have a better life.

Standing on own feet.

Textural description. Priya perceived the way she redefined the meaning of healing as one of the important aspects in personal growth recovering from major depression. Priya shared using statements such as, "So far the experience changed me from negative to positive. I think that was a good experience for me because it actually helped me to stand on my own. Stand on my own and also to decide what I want in my life" "I hope I am able to be independent again and to take care of myself," and "I really wish that, really soon, that I will be secured with a job, that is one thing that haven't been done yet."

Structural description. Priya described standing on own her feet as how she redefined the meaning as part of her personal growth process as she recovering from major depressive disorder. She experienced changes from negative to positive and

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believed that it has helped her to stand on her own feet or in other words, became independent. Priya envisioned herself to have a secure job and be able to take care of herself.

Figure 4.24 was drawn by Priya to symbolize redefining the meaning to be healed. She spoke of changes she had made to help her to redefine the meaning of her healing and her struggles. She was in despair, experienced redefinition, and now believed herself standing on her own feet.

Figure 4.24. Priya's symbolic drawing of her personal growth process

Support from mother and friends.

Textural description. Priya shared that she received support from her mother and friends throughout her personal growth journey recovering from major depressive disorder. The support from her mother and friends played a part in her personal growth recovering from major depression. She used statements such as, "My mother she actually helped during this healing process throughout this year because she actually accompanied me to see the doctors and also to attend my counselling session," "Everyone was happy and also they started to call me for this and call me for activity like jogging and hiking, because they are my partner in

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hiking and they started to call me out again: “Hey, come lets join, this one, this one”. Nowadays till this point our meeting sessions are getting more and more and became more positive and happy.”

Structural description. According to Priya, she received constant support from her mother after she was diagnosed with major depressive disorder. Priya felt supported when her mother accompanied her for her appointments at hospital. This made Priya felt that she was not alone and cared for. On the other hand, she felt not forgotten when her friends called and invited her to join their outing activities. This made her feel happier and it increased her positivity. Priya believed that support from her mother and friends has played an important role in her personal growth recovering from major depression.

Taking medication to control emotion

Textural description. Priya shared that she took medication in order to control her emotion during her personal growth journey recovering from major depression. She used statements such as, “I am still continuing the medication,” “So the real thing came after the last suicide attempt, but failed. I told myself: “No more doing this. Start taking the medicine and get better! See whether what doctor had said, will it come true. In the sense of doctor said you can’t stop the medication unless we ask you to stop and we think that you already get better,” and “Okay, and actually daily you really need to take your medication. That is also another part that you must do.”

Structural description. Priya reaffirmed that medication has helped her to control her emotion in her personal growth process recovering from major depression. She highlighted the importance of taking medication daily and mustn’t stop it until the psychiatrist asks her to. According to Priya, she stopped her

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medication once during her initial diagnosis and she was unable to manage her condition. Thus, she reminded herself to be compliant to medication.

Attending counselling.

Textural description. Priya acknowledged the benefits she received from attending counselling in her personal growth recovering from major depression. She used phrases such as, "Actually during my counselling session, I have someone to talk and to share things because rather than medication, I need someone to talk to. So during those monthly visits with counsellor, it actually helped me," "And I say that it's really helping me, and I'm becoming happier," and ". So after all the counselling sessions, the more I go visit the doctors, I feel like confident, I feel happy, I feel I know that, I will be getting better very soon."

Structural description. Priya believed that attending counselling was vital to her personal growth recovering from major depression. She expressed that it was an outlet to share her problems and to have someone to talk too. Priya described it as helpful and she was getting better after she attended counselling sessions. According to her, she has learned a lot of things through counselling sessions and she felt supported by her counsellor.

Always believe in God.

Textural description. Priya commented that her spiritual belief has helped her in the personal growth recovering from major depression. She expressed using statements such as, "I always believe in God," "always believe during my major depression, the faith was like always not there – It comes, it goes. But I know that when I tried to take my life and did not die, then I know God really loves me and there must be a reason why I am still here," "So one factor is definitely God, although I don't see Him and I don't know how He looks like, but I know He's there.

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So yes God," and "So when I know that I am not dying and I will not die, I already have the thought: "Oh, God is giving me more, longer years to live. I can't every year think of dying, dying, dying and not successful. What if I don't have anyone when I am old and no one takes care? I will become beggar."

Structural description. Priya believed that apart from the support she received form her mother and friends; spiritual support also has played an important role in her personal growth recovering from major depression. She felt that the reason why she's still alive after her many attempts to end her life and that how God intervened. Priya continued to believe and have faith to move on in her life to become a happier and better person in future.

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Participant 7 – Catherine.

Figure 4.25. Catherine's personal growth experiences

Catherine disclosed several aspects of her personal growth journey recovering from major depressive disorder (see Figure 4.25). They were: admitting depression meant being weak and crazy, understanding own strengths and weaknesses, moving forward with small steps, just to be me, be more forgiving, to accept myself, support from family and friends, taking medicine to lessen anxiety, and gone through counselling. Each aspect is discussed and supported by Catherine's statements.

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Admitting depression meant being weak and crazy.

Textural description. Catherine shared that she was struggling to come to term with her problem of major depression at the beginning of her personal growth journey recovering from major depressive disorder. She linked it as one part of her personal growth journey recovering from major depression. Catherine used statements such as, "Actually admitting depression is an illness and not something that is my fault in some way or another, it is a hard thing to admit to myself and I meant, you know depression means you are weak and crazy and this doesn't happen to normal people," "…that time I was in denial as you know, how people would see you when you actually go and seek for help for what people considered as mental illness," "I was waiting for the day to pass, not too sure what to do, feeling insecure, focusing on how people would react and how society will feel me," and "I was so scared on how people would eventually see me and you know was it the same way I see myself at that moment, I just don't know."

Structural description. To Catherine, admitting her own major depressive disorder meant that she was being weak and crazy. She viewed it as something which would not be experienced by normal person. She felt it was difficult for her to disclose it initially and she was in denial as well. Catherine described all these as her challenges in revealing her struggles of major depression in the personal growth recovering from major depressive disorder. She was concerned about others' perception towards her once they got to know her illness.

Understanding own strengths and weaknesses.

Textural description. Catherine shared several aspects of understanding her own personal strengths and weaknesses that helped her to experience personal growth during recovery from major depression. She used phrases such as, "I focused

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a lot on my individual strength, you know, my resiliency; I tried to figure out my talents, my capacity and how to cope with all the problems. So that I am actually trying to understand myself more instead of realizing my weaknesses only and why don't make the weaknesses into my strength," "…after went through all these: the counselling, the medication, the social support, the transformation (changes) you know, the moment I realized how to appreciate myself, my existence then at least my view of the grim of light you know, whether you can see half glass of full water or half glass of empty water, it really changed a lot," and "I been getting stronger, willing to accept my flaws, really well and also my weakness. I feel like I have been more like open minded after all these and for physically actually I have less thought of hurting myself."

Structural description. Catherine described her self-discovery of strengths and weakness as one of her personal growth aspects throughout her healing journey from major depression. According to Catherine, she has focused on her resiliency and continued to figure out her aptitudes, capability and coping skills. She believed in understanding herself more rather than recognizing her weaknesses only. As Catherine progressed in recovery, she changed her weaknesses into her strength and appreciated herself. She viewed her world differently and became open to life challenges.

Moving forward with small steps.

Textural description. Catherine connected her personal growth recovering from major depression with the readiness to move forward with small steps. She mentioned several times pertaining to her needs and readiness for change during her interview sessions. Catherine used statements such as, "I know that I still have somewhere to go and accepting my illness, moving forward and there is something

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that I need to do. Otherwise the cycle will continue and things will get worse and that was how I started to go for counselling and that was a small step I am giving myself to fight for a chance to live and stand up again," "I tried to be positive and be more confident about my life," "Little by little, I walked out from my depression," and "I slowly learn to move on."

Structural description. Catherine believed that one of the aspects which have helped her to move on from major depression was her desire to change. She described her 'small steps' as an opportunity she gave to herself to fight for a chance to live and stand up again. According to Catherine, she did her best to be positive and confident in her life. She believed that one day she will recover and slowly learn to move on.

Figure 4.26 is the picture drawn by Catherine to symbolize the steps she took after she had gone through a series of transformation which allowed her to move forward from her major depression. She described herself as moving on step by step.

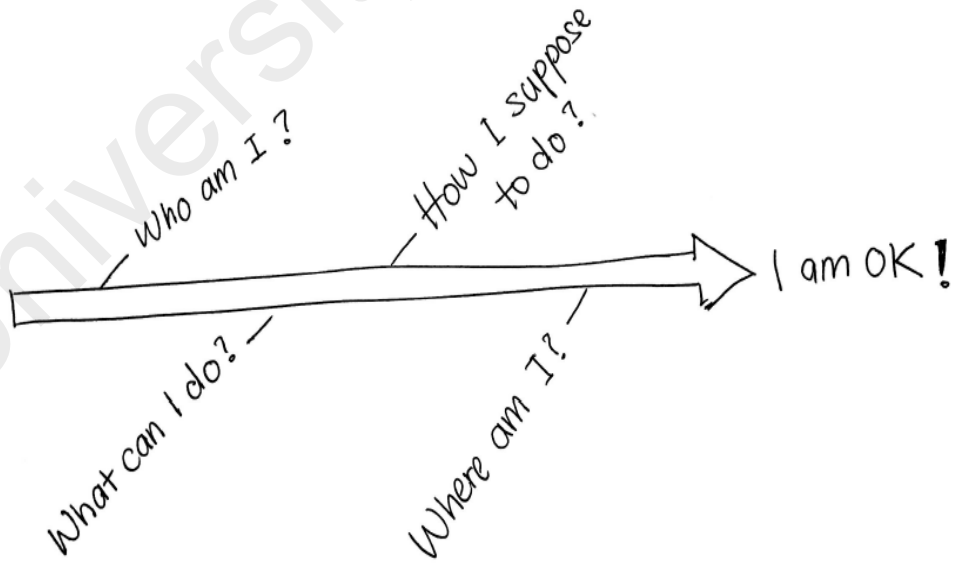

Figure 4.26. Catherine's symbolic drawing of her steps to move forward

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Just to be me.

Textural description. Catherine linked her personal growth recovering from major depression with being true to herself. She described it as her way to redefining the meaning of her healing journey. Catherine shared using statements such as, "And at the same time actually I learned about self-care which means you know, I learned to appreciate myself more and I learned how to say no and it is not that every human being have to be perfect, I just have to be me to know what I need, to know what I need to do to make myself better," "Both sad and happy were inside me. I have to learn how to be both," and "I just have to voice it out and be myself."

Structural description. Catherine believed that her personal growth recovering from major depression was connected to how she redefines the meaning of her healing journey. She perceived that by being real to herself, she learned to appreciate herself by practicing self-care and came to the understanding that it was fine for her to be imperfect sometimes. Catherine shared that she just has to be herself to identify her needs, emotions, and learn to express herself.

Be more forgiving.

Textural description. Catherine linked the aspect of forgiveness in her personal growth recovering from major depression. She revealed the importance of self-forgiveness which has played an important role in her recovery journey. Catherine used phrases such as, "I tried to cope with myself and I tried to be more forgiving, you know more grateful towards my life," "…it is okay if I couldn't do something. It is not that everything that you want to do, you must do it. It is okay," and "But sometimes when you don't really do well, sometimes when you make mistakes, you just have to forgive yourself so that you can move on and do better next time."

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Structural description. Catherine believed that forgiveness has played an important aspect in her personal growth recovering from major depression. She did her best to forgive and to cope with herself. According to Catherine, she found herself more forgiving to herself if she couldn't do something well. She perceived self-forgiveness as a way to move on and to improve herself in the future. She also felt that she was able to forgive those who had hurt her before easily after she started to forgive herself for her own weaknesses.

To accept myself.

Textural description. Catherine associated her personal growth recovering from major depression with the aspect of acceptance. She used statements such as, "I was trying to accept myself. I was trying to accept myself and the reason of my existence in this world," "…trying to accept myself well," "I realized that I did accept myself more and I appreciated myself more," "You can do it but you are just underestimating yourself, you know, it is okay if you can't do it, it is acceptable to give yourself more time to do something," and "I learned to appreciate myself more and I learned how to say 'no' and it is not that every human being have to be perfect."

Structural description. In Catherine's perspective, the aspect of self-acceptance was one of the essential aspects contributed to in her personal growth journey recovering from major depression. According to Catherine, she believed that by accepting herself, she was able to appreciate herself and to give a chance to herself as well as to the reason of her existence in life. She acknowledged her choice to say no and the fact that not everyone has to be perfect.

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Support from family and friends.

Textural description. Catherine described the support she received from her family and friends which had helped her throughout her personal growth journey recovering from major depression. She shared using statements such as, "I actually feel grateful to myself and of course my family and my friends who supported me all along by standing at my side, encouraging me, trying to understand me, giving me support," "So the first time when I tried to open up to my family and let them know that I was actually diagnosed with depression, they were surprise but thankfully they were also being supportive by trying to understand my hardship, what I have been going through and provided to me their full supports and you know, maybe I would say like becoming less stressful I would say like you know. Maybe like just trying to help me in any way that they could give: their mental support, any support. In the end, you know, family is the one that helps you a lot in the process actually," and "I actually have been amazed by how much kindness and support that people, especially some of my friends have shown me since I've been more open about my struggle and I really do appreciate them."

Structural description. Catherine viewed the support that she received from family and friends had played an important role in her personal growth recovering from major depression. She expressed her gratefulness to her family and friends who supported, encouraged, and understood her throughout her recovery process. Other than that, Catherine also felt accepted by her family and friends after they got to know her major depression. She continued to feel supported emotionally and mentally even after she had revealed her struggles to her family and close friends.

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Taking medicine to lessen anxiety.

Textural description. Catherine perceived the need of taking medication to lessen her anxiety in recovering from major depression. She used statement such as, "When I took medication, it will help to lessen my anxiety," "Medication helped initially," and "My dose of medication already decreased along the treatment."

Structural description. According to Catherine's own experience, medication was necessary to reduce her anxiety at the beginning of her treatment. She shared that her medication dosage is slowly reduced as she gets better.

Gone through counselling.

Textural description. Catherine reported that she has gone through counselling during her personal growth journey recovering from major depressive disorder. She perceived counselling as one of the aspects which had helped her to overcome her major depression. Catherine used statements such as, "I had gone through a lot of counselling sessions and so from the counselling sessions actually it has helped me a lot," "It's full of challenges. I would say it's really, really not easy. I would say I really need a lot of supports and I felt counselling really helped me a lot. At least it motivated me," and "It's not just the medication alone, because you know when I took medication, it will help to lessen my depressive mood but then the thought is still there and yeah, counselling really helped me a lot."

Structural description. Catherine believed that counselling sessions has assisted her to face her major depression. She felt that counselling was helpful and gave a lot of motivation to carry on with her life. She believed that medication alone will not help her. According to Catherine, the medication has helped her to lessen her anxiety but counselling dealt with her depressive thoughts.

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Participant 8 – Bella.

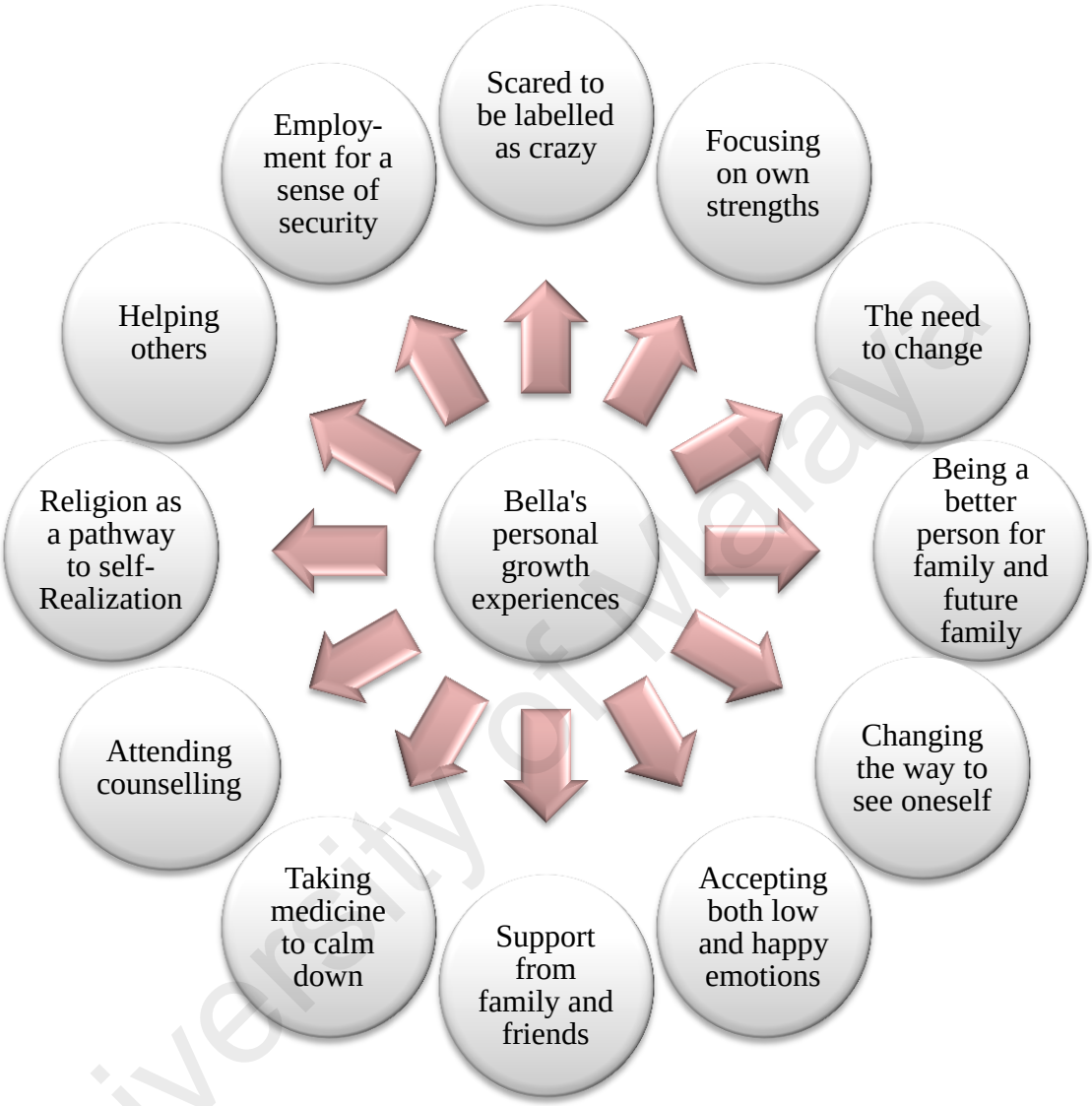

Figure 4.27. Bella's personal growth experiences

Bella disclosed several aspects of her personal growth journey recovering from major depressive disorder (see Figure 4.27). They were: scared to be labelled as crazy, focusing on own strengths, the need to change, being a better person for family and future family, changing the way to see oneself, accepting both low and happy emotions, support from family and friends, taking medicine to calm down,

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religion as a route, helping others, and employment for a sense of security. Each aspect is discussed and supported by Bella's statements.

Scared will to be labelled as crazy.

Textural description. Bella shared about her fear to be labelled as crazy as a part of her personal growth journey recovering from major depression. She described a lot of fears in revealing her struggles from major depression to others as she was scared and felt embarrassed with her illness. She used statements such as, "I can see they're worried but at the same time I think they also didn't want other relatives to know about it because I know, if I myself also feel so scared as sometimes I don't want to be labelled as a crazy person," "I felt very shameful about my illness as well," "I think for me it was a very shameful thing to let other people know about it so actually I never tell anyone about this," and "Sometimes I was also scared. I always felt that way and worried that people will eventually see me the same way I see myself."

Structural description. Bella experienced a lot of fears in revealing her struggles in handling major depressive disorder. She was scared of people labelling her as crazy especially her relatives if they got to know about her illness. According to Bella, she felt ashamed regarding her illness and worried that eventually people will see her the same way she sees herself. So most of the time Bella didn't dare to tell any person about her struggles in major depression.

Focusing on own strengths.

Textural description. Bella connected her personal growth recovering from major depression with personal strength. She shared about focusing on her own strengths to overcome her major depression. Bells used statements such as, "I think it was mostly strength base. So now I am focusing more on my own strengths for

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example my coping abilities, my resilience and my talents," "I am giving myself a fighting chance. I don't want to feel depressed and down forever. And yeah, I think I can do better," "It was very hard I know. It is very hard I know but it is worth it," "These things were not easy but they are possible. They are becoming less and less scary if I face them and I go through them," and "I can talk about the things I am struggling with without feeling guilty because I have learned that I have a choice and I am allowed to use it."

Structural description. Bella perceived that by focusing on her own strength such as her coping abilities, resilience and her talents, she was giving herself a chance. She believed that she was able to do better and her fights will be all worth it. Bella described that her struggles will become less scary and easier to handle as she goes through it. After all the struggles, she has learned that she has a choice and she was allowed to use her choices.

The need to change.

Textural description. Bella linked the need to change with her personal growth process recovering from major depression. She believed that she was ready to change once she has the need to do so. Bella used phrases such as, "I felt like I needed to do something with my life. I meant, I cannot continue to be like that. I know that something is wrong but then it seems hmm… I just felt maybe I can do something to change it," "I was not alone and I realized it didn't have to be like this forever to struggle with the mental illness. We all deserve support, happiness and we all deserve a life…" and "I try to make my life more meaningful."

Structural description. The need for Bella to change was emphasized during the interview sessions. She believed that she has to do something with her life and she was not alone to fight with her major depression. She described her needs to

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change her life and she can't live a depressive life forever. Bella envisioned that by changing her life, her life will become more significant.

Being a better person for family and future family.

Textural description. Bella described her desire to become a better person for her family and future family. She connected her personal growth experiences recovering from major depression with her personal responsibility. Bella envisioned herself to be a better person and said, "I want to become a better person for my family and also for my future family."

Structural description. Bella believed that the desire to become a better person for her family and future family has helped her in personal growth prosess recovering from major depression. She perceived it as her personal responsibility which played an important part during her healing journey.

Changing the way to see oneself.

Textural description. Bella linked her personal growth recovering from major depression with the way she sees herself. She believed that by changing the way she sees herself, she will be able to see her life in a different meaning. Bella used statements such as, "After some recovery and support from other people, I realized that I can be and I am a person. And discovering that changed the way I see myself. Now I am healthier and happier. I am not dependent on others to survive," and "Yeah. Now I just think that I just live with what I am. I shouldn't care about what other people say."

Structural description. According to Bella, she believed that during the time she experienced personal growth and received support from others, she was able to appreciate her life differently. Bella described that she was able to live a better life without being troubled by what people said about her.

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Accepting both low and happy emotions.

Textural description. Bella linked the aspect of acceptance with her personal growth recovering from major depression. She used statements such as, "I think it is still there. It just that sometimes I feel low and sometimes I am happy but now I accept both of them because I think they are part of my life. So I try to accept them as a part of my life," "…I think we were encouraged to put out the best view of ourselves and to hide our perceived bad parts uh from other people," "sometimes I can accept that I can sometimes be down. I meant feel very down and sometimes I can be happy but there were times that I felt that I feel I am drained out. I don't even have energy anymore to face anybody. But I accepted it. I meant it is okay to be not okay, I know," and "At times I will give myself some space, some time to rest maybe. I should say to rest and that time I also need some time to stand up."

Structural description. Bella believed that acceptance has played as one of the important aspects in her healing from major depression. According to Bella, by accepting both of her low and happy emotions, she was able to move on and learned to give herself some space and time to rest as well as to stand up again. She reflected that it was fine for her to feel not okay sometimes, and accepted it as part of her.

Support from family and friends.

Textural description. Support from family and friends were perceived as important aspect by Bella in helping her to experience personal growth recovering from major depression. She used statements such as, "I think my family really played a very important role in helping me in recovery. My parents were very supportive when and after I was diagnosed with depression. So they really helped me a lot. Now every time if I have problems or I am feeling down, I will call them. They always encourage me so and make me feel like I can… I can do better," and "Other than that

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I also feel my friends and my colleagues also helped me a lot. Now we always go out together after work or during my free time. So I feel very happy with them as I can share my problems with them too and they're always sharing with me their solutions."

Structural description. Bella acknowledged that when she was struggling with major depression, she has received a lot of support from her family and friends. The support she received has helped her in her personal growth recovering from major depression. Bella believed that her family has played an important role in helping her in recovery. She was supported by her parents and they encouraged her throughout the healing journey. According to Bella, her friends and colleagues also gave her a lot of support and she felt happy because she was able to share her problems with her friends.

Taking medicine to calm down.

Textural description. Bella perceived that her medication was able to help her to calm her down in her recovery from major depression. She described the importance of medication by using statements such as, "And taking my medication regularly also helps me to be calm and to calm me down," and "Just that maybe the medication can keep me calm…"

Structural description. In Bella's perspective, medication has helped her to calm down during her personal growth journey recovering from major depression. She highlighted the importance of taking medication regularly in order to control her emotions.

Attending counselling.

Textural description. Bella linked the benefits she received from attending counselling in her personal growth recovering from major depression. She used

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phrases such as, “I think my psychiatrist and counsellor also help me a lot also especially during the counselling sessions. I learned how to deal with my emotions, how to express myself and how to cope with my life better,” “So I think all these really help me a lot,” “Actually my psychiatrist she recommended me to go for counselling session,” “…I have someone to talk to because I attended counselling sessions for a few times,” “my psychiatrist and also my counsellor actually helped me to express myself more and to share with them about my problems so that I think I can cope better after talking to them,” and “About the coping skills my counsellor and my psychiatrist also taught me about it.”

Structural description. Bella believed that the aspect of attending counselling has played an important part in her personal growth recovering from major depression. She expressed that she has an outlet to share her struggles in major depression when she was in counselling sessions. Bella shared that she has learned how to express herself in a healthier way and also learned about better coping skills to deal with her problems in life.

Religion as pathway to Self-Realization.

Textural description. Bella shared several aspects of her spiritual support that has guided her in her personal growth recovering from major depression. She connected her personal growth journey with the aspect of religion as pathway to self-realization. Bella used statements such as, “I also learned to lean on teaching of Buddha as my pathway rather than running away from love and finding my security in the numbness that illness give me. So I learned that actually it is okay not to be okay and actually it is also okay to have good days and bad days,” “Yes, of course. It helps actually because it really helps to calm me down because it has method like “how to calm my mind,” “aware of our own thoughts” as sometimes we are not so

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aware of what we are thinking. We just feel very depressed, very down but we do not know why. Maybe there was no reason," and "But meditation can help to focus and to be aware of own thoughts. So we just look at them, look at the thoughts. Through that I feel like I can calm myself down."

Structural description. Bella believed that her religion has assisted her to live a better pathway in her personal growth journey recovering from major depression. She also believed that she found peace in her religion which provided as her the spiritual support. According to Bella, she learned several aspects of acceptance through her religion. She felt that religion has calmed her down after she practiced meditation and be more mindful about her own thoughts.

Helping others.

Textural description. Bella shared that while helping others it also assists in her own personal growth process recovering from major depression. She described it using phrases such as, "Sometimes I will visit the orphanage or some other places which I think I found the meaning of life. I feel it is very meaningful to help other people," "If I have free time I also participating in some charity activities organize by some religion association," "By helping them, and also they were helping me at the same time," and "…helping other people also I feel that it is really helping me a lot in this recovering because I will not always think of negative thoughts and I am not alone anymore. And I didn't feel I am useless. I am also needed by others."

Structural description. In Bella's sharing, she believed that helping others has helped her to find the meaning of her life and she found it meaningful to help others. She perceived that by helping others, at the same time she has received helps as well in her personal growth recovering from major depression. According to Bella, she had stopped thinking negatively. She feels that by helping others, she felt

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she was not alone. Furthermore, she also felt that she was needed by others and didn't feel useless.

Employment for a sense of security.

Textural description. Bella connected her personal growth recovering from major depression with employment as a sense of security. She spoke of the importance of employment in helping her to sustain her recovery process. Bella used statements such as, "I need to have a regular job, regular income," "Working was the only way to keep me occupied but sometimes other than that I would just stayed in the room and doing nothing and most of the time I would cry," and "I felt secure when I have job because it made me think I am still useful and have direction in life."

Structural description. Bella perceived that having a job was one of the aspects which have helped her in personal growth recovering from major depression. She believed that through work she was able to occupy herself with something else rather than steeping herself in negative thoughts and feelings. She expressed her feeling of security when she has a job. Bella believed that having a job has helped her to feel worthwhile and have goals in her life.

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Participant 9 – Pooja.

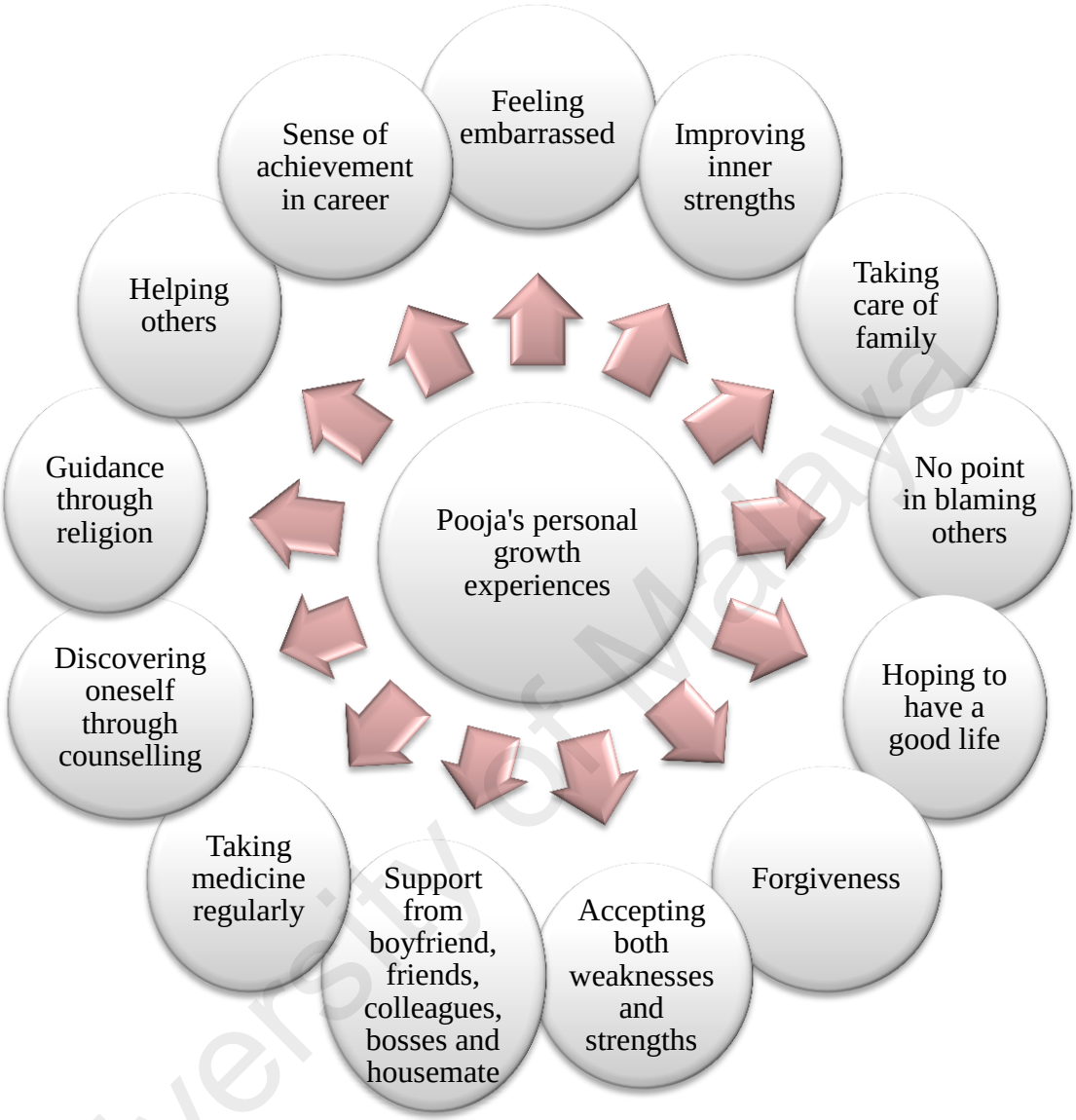

Figure 4.28. Pooja's personal growth experiences

Pooja disclosed several aspects of her personal growth journey recovering from major depressive disorder (see Figure 4.28). They were: feeling embarrassed, improving inner strengths, taking care of family, no point in blaming others, hoping to have a good life, accepting both weaknesses and strengths, support from boyfriend, friends, colleagues, bosses and housemate, taking medicine regularly, discovering oneself through counselling, helping others, and sense of achievement in career. Each aspect is discussed and supported by Pooja's statements.

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Feeling embarrassed.

Textural description. Pooja described her feeling of embarrassment as a hindrance to her personal growth journey recovering from major depression. She also encountered feeling lost and fear of discrimination at the beginning of her journey. She used phrases such as, "I felt like when I had MDD, during the time, I just felt like you know, I just felt like I don't want to face anyone especially some of my friends who don't know about my condition. And then I felt that I just avoided them because I felt embarrassed to face them which I felt I could not mix with them like how I mix with them previously," "I was totally lost. I didn't know what to do and I felt I had nobody to share my feelings," and "I felt embarrassed when some people who were not close to me know that I have some depression. You know I was scared to face them because I don't want them to discriminate me. I don't want them to start pitying me. I don't want that kind of feelings."

Structural description. Pooja perceived that one of the aspects which played a significant part in her personal growth journey was to reveal her struggles with major depression. She has experienced feelings of embarrassment, lost, fear of discrimination, and loneliness. Pooja was unable to face any person and had chosen to shun everyone at the beginning of the treatment of her major depression. She also revealed that she was lost and didn't have anyone to share her feelings too. Pooja believed that the feeling of fear and embarrassment stopped her from sharing because she was worried of being prejudiced and discriminated by her friends as well as her family.

Figure 4.29 was drawn by Pooja to symbolize her struggles in major depression. She spoke of negative thoughts, feelings, and actions which had made

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her feel discriminated, unloved, and unsupported. She was in anguish and lived in denial and tried to move out from the rut.

Figure 4.29. Pooja's symbolic drawing of her struggles

Improving inner strengths.

Textural description. In Pooja's perspective, improving her inner strength was one of the aspects which have helped her in her personal growth recovering from major depression. She connected improving inner strength with self-discovery in her healing journey. Pooja used statements such as, "It's inside. I just have to try to improve myself from that. I want to be a better person as much as I can," "So I don't want and I will not let myself to go to depression again. I want to move forward in my life. I want to have a bright future," "I feel that I am a survivor and not the victim of all this," "The strong feeling needs to come from within yourself. You need to have the feeling to become strong rather that depending on people," and "I also try to look at the positive and inspirational messages and try to get something from them. I always want to think positively nowadays. I don't want the negative thoughts to control me because I think that everything comes from my mind and if I cannot control my mind I feel that I cannot control my life."

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Structural description. Pooja believed that her own internal strength was one of the aspects which have helped her in personal growth recovering from major depression. Furthermore, she also believed that by improving herself, she was able to become a better person and envisioned herself not to fall into depression again. Pooja viewed herself as a survivor in her personal growth journey and able to move on in her life. She perceived this strength was from within and not from others. Thus, the aspect of self-discovery and personal strength has helped Pooja to overcome her fear of not being able to be healed from major depression. She practiced positive thinking and control her thoughts so that she was able to control herself.

Taking care of family.

Textural description. Pooja believed that her 'desire to take care of her family' was one of the aspects which have played a part in her personal growth recovering from major depression. Pooja described it using statements such as, "Even though I don't have a good relationship with my parents, I feel that as their child I still need to do a lot for them. I still respect them and I want to give them a good life," "I want them to stay with me in the future because I want to take care of them. I want to show them their love because I feel all this is my responsibility which I need to do," and "But I still respect my parents and my siblings. I still go and try to meet with them and try to talk with them you know trying to gain back our relationship."

Structural description. Pooja perceived her desire to take care of her family as her personal responsibility which has played a part in her personal growth process recovering from major depression. She believed that it was her responsibility as a daughter to fulfill her responsibility, to respect and to provide them with a good life despite what had happened in the past. Pooja felt that she wanted to take care of her

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family and to show to her family her love for them. She shared that she was trying to talk and mend back her relationship with her family.

No point in blaming others.

Textural description. In Pooja's perspective, the aspect of readiness for change was linked to her decision to stop blaming others for her problems. She used statements such as, "Because I felt that, it's no point blaming others for disappointing me because the problem is within me. I try to look back at what are my weaknesses and I will try to improve it. I try to become more self-confident. That's why I try to trust people because I feel that not everyone is the same people," "Then only they can overcome their problems. If not they will be their own prisoners. They will end their lives maybe. They maybe will commit suicide," and "You know, nothing is permanent in this life and also the only person that can help him is the person himself because the person must have insight."

Structural description. Pooja has reached a point whereby she decided to stop blaming others for everything which caused her major depression. She believed that it was finally time for her to change and started to look into her own weaknesses for improvement. Pooja described the aspect of readiness for change as one of the essential aspects in personal growth recovering from major depression. She has learned to trust again, be more self-confident, and to break free from self-imprisonment.

Hoping to have a good life.

Textural description. Pooja connected her personal growth recovering from major depression with hope. She described how the aspect of hope has helped her to remain hopeful in her personal growth journey. Pooja used phrases such as, "I hope that I am recovering and I have the confidence that I can be fully recovered. I can

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live a good life like others," "I try to get new clothes because I want to feel a new self-image. I try to do make up I try to take care of myself and try to do my hair nicely because I want to maintain a good self-image in front of people. I want to show to people that I had changed. I want to be… hmm… I want to live and I want to totally change myself. I want to live a colorful life," and "I still survive! I can be a successful person now. And then now I have the confident that I can live a normal life like others. I just feel that I can see a bright future for me."

Structural description. Pooja believed that one of the important aspects in her personal growth recovering from major depression was hope. She felt that hope was fostered throughout her recovery process. Hope enables Pooja to change her self-image and to enhance her self-confidence. Pooja described her hope has become stronger as her recovery from major depression progressed. She envisioned herself living a bright future like normal people.

Forgiveness.

Textural description. Pooja shared that she chose to forgive during her personal growth process recovering from major depression. She believed that forgiveness has played an important part in her personal growth recovering from major depression. Pooja described it using statements such as, "I want to forgive myself because that was one the thing that I want to do," "So, forgive myself for doing all the stupid things in my life. I am not a 100%, but I just accept the way God created me," "I realized that through forgiveness, I can finally move on," "I told myself to stop blaming my parents for everything that happened on me," and "I forgave my family too."

Structural description. Pooja believed that the aspect of forgiveness was vital in her personal growth process recovering from major depression. She chose to

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forgive herself because she realized that only through forgiveness she was finally able to move on in her life. Pooja also decided to forgive her family and to stop blaming her parents for all the hurts she experienced during her childhood time. According to Pooja, the aspect of forgiveness helped her to experience self-acceptance.

Accepting both weaknesses and strengths.

Textural description. Pooja linked her personal growth recovering from major depression with acceptance. She stated that one of the aspects which helped her in her personal growth process recovering from major depression was acceptance. Pooja used phrases such as, "I really need to accept myself. All my weakness or strength, I accepted myself. It's inside. I just have to try to improve myself from that," "I just tried to move forward," "I just feel that I am a really strong person," "But when I look at myself I feel that I survive and I am not and never going to end up like them. I still survive! I can be a successful person now," and "Sometimes I cannot think like a normal people. I cannot live a happy life. I just felt that I want to isolate myself from people and sometimes I just felt this is not my world. But I learnt to accept it as part of me."

Structural description. Pooja spoke of accepting both of her strengths and weaknesses as part of her personal growth recovering from major depression. She believed that the aspect of acceptance has helped her to move forward and to accept herself as a strong person. Pooja perceived that acceptance of what has happened has assisted her to look at herself differently. She described herself as a survivor and looked forward to becoming a successful person in her life.

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Support from boyfriend, friends, colleagues, bosses, and housemate.

Textural description. Pooja stated that the support she received in helping her to recover from major depression was the support she received from her boyfriend, friends, colleagues, bosses and housemate. She shared about the support and encouragement she received during her personal growth journey. Pooja described it using statements such as, "My support system definitely is my boyfriend, my friends, my colleagues, my bosses, and also my housemate. I still contact with her because I feel like she is the person that was there with me when I really need her. Until now I still go and find her, try to talk with her and she will always encourage me to think about my future," "My housemate, she was a very good person. She really tried to understand my situation and she gave me support," "They gave me encouragement that I can be like a normal person," "My colleagues, they were also very supportive throughout my healing process," "My bosses never do any discrimination but they gave me support and encouragement for me to continue to change to a normal person," "I found that the most important is the support system," and "He really supported me understood my feelings. He really tolerate with me. I feel very happy whenever I am with him and also he gave me the courage to change myself."

Structural description. Pooja received a lot of encouragement, support, understanding, toleration, and also non-discrimination treatment from boyfriend, friends, colleagues, bosses and housemate even though they knew about her major depression. Pooja reflected how she was supported and encouraged at work and also when she was with her friends. She expressed her gratefulness for the support she received and believed that the aspect of support has played a major role in personal growth recovering from major depression. Pooja felt that she was not alone and through support she was able to trust and lived her life happier than before.

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Taking medicine regularly.

Textural description. Pooja shared that she took her medication regularly to help her to recover from major depression. She used statements such as, "I always take my medication on time because I know that I still sometime if I never take medication maybe I will back to my depressed state because I still need more time to recover fully from my depression and yeah, I take my medication regularly," "I don't want to miss any doses," and "Because I know the importance of medication is to help and to control my emotion and my thinking."

Structural description. Pooja stressed that medication helped her to control her emotion and thoughts in her recovery from major depression. She highlighted the importance of taking medication daily and mustn't stop it because she still needs time to be fully recovered from major depression. Pooja stated the possibility of relapse of her depressive state if she missed her medication.

Discovering oneself through counselling.

Textural description. Pooja believed that she learned about herself through counselling in her personal growth journey recovering from major depression. She used phrases such as, "You know through this period of recovery, I have been absolutely blessed with wonderfully patient counsellor who helped me to see to know what I deserved in my life and what I can have in my life," "From counselling I got to know that depression is something that can be controlled and that we can survive that depression because you cannot let depression to conquer us," and "I learnt about myself through counselling."

Structural description. Pooja believed that after she attended counselling sessions, she was able to learn more about herself. She expressed her gratefulness to her counsellor who has helped her to see what she deserved and can have in life.

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Pooja's hope to heal was fostered after her counsellor told her that depression was treatable and controllable. She believed that the aspect of attending counselling has played an important part in personal growth recovering from major depression. According to Pooja, she got to know about herself through counselling sessions.

Guidance through religion.

Textural description. Pooja shared aspects of her spiritual experience and support that has guided her in her personal growth recovering from major depression. She connected her personal growth journey with the aspect of religion as guidance. Pooja used statements such as, shared "I think that another important thing is my religion. I am happy with my religion because when I had this disease last time, I could not cope. Then I tried to ask their (temple and prayers) help and they really helped me. They guided me in my life," "I really want to thank them for their help. Until now I will go and see them to ask for more guidance from them because they know my situation," "I mean like my temple and prayers," and "I tried meditation as well."

Structural description. Pooja believed that her religion has guided her through her personal growth journey recovering from major depression. She shared that when she faced difficulty coping with her illness she received a lot of guidance through prayers and members from the temple. Pooja also believed that she found peace in her religion which acts as her spiritual support. According to Pooja, until now she is still seeking guidance from her temple. She felt that she found peace after she practised meditation and be more mindful about her own thoughts.

Helping others.

Textural description. Pooja shared her views that helping others is helping herself to manage her personal growth journey recovering from major depression.

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She described it using phrases such as, “I am also doing some charity because I feel that by doing charity it can help me and also help others. I am really happy to do some good work because it makes me happy. Because I feel that I benefit others,” and “I will try to involve with them and try to meet new people. Share the life experiences.”

Structural description. Pooja believed that one of the aspects which helped her in her personal growth recovering from major depression was helping others in need. She felt that by helping others it has helped her to find the meaning of her life and she found it meaningful to help others. She perceived that by helping others, at the same time she received help as well in her healing process from major depression when she shared about her recovery journey with others.

Sense of achievement in career.

Textural description. Finally, Pooja connected her personal growth journey recovering from major depression with her sense of achievement in career. She spoke of the importance of employment in helping her to sustain her recovery process. Pooja used statements such as, “I need to do my responsibility and also in my career. That is one of the important thing that I want to achieve. I want to do well in my career,” “This is my life and it is very important in my life. I want people to respect me, I want to do well in my career and I am trying my best to involve in the big projects you know,” “I want to be a successful person in my career. So I gave my 100% concentration on my job. I just tried my best to do my work you know, I just gave my 100% to my work nowadays,” and “I try to develop my career.”

Structural description. Pooja described her responsibilities and commitments in her career and her goal was to achieve it. She believed that her career has played an important role in her personal growth recovering from major depression. Pooja

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highlighted the importance of her career and hoped she was able to do well in her career. She focused fully on her job and envisioned the development of her career. Pooja believed that to have a sense of achievement in her career has helped her to feel worth and have goals in her life.

Summary

Each major depressive young adult participant shared many aspects of personal growth elements which helped them in their recovery from major depressive disorder. Each personal growth elements reported by the participants presented many similarities and connections. All these themes were organized into themes that developed in the group.

Later, the composite analysis of the personal growth experiences recovering from major depressive disorder experienced by nine young adults will be discussed in the next section.

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Composite Textural and Structural Description of Personal Growth Experiences

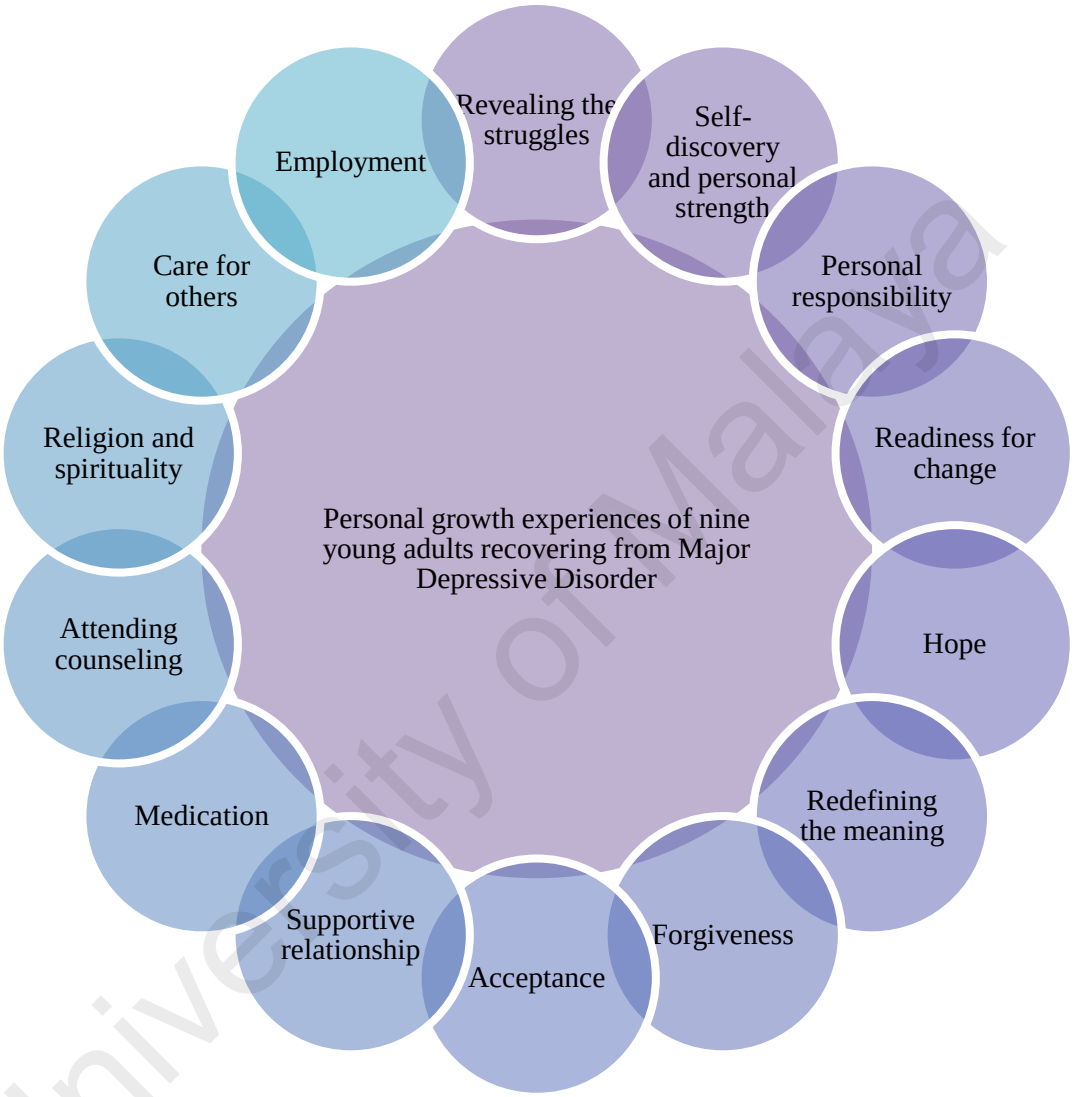

Figure 4.30. Composite personal growth experiences recovering from major depressive disorder

A total of fourteen personal growth elements were identified by the nine major depressive young adults who participated in the research (see Figure 4.30). The identified elements were: (a) Revealing the struggles, (b) Self-discovery and personal strength, (c) Personal responsibility, (d) Readiness for change, (e) Hope, (f)

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Redefining the meaning, (g) Forgiveness, (h) Acceptance, (i) Supportive relationship, (j) Medication, (k) Attending counselling, (l) Religion and spirituality, (m) Care for others, and (n) Employment. In the next section each of the elements is further discussed and supported with the participants' personal statements.

Theme 1: Revealing the struggles.

Textural description. All of the nine participants shared about revealing their struggles with major depression in their personal growth journeys of recovery from major depressive disorder. They reported a number of negative feelings and thoughts they have stumbled upon on their personal growth journey. They often used terms such as "hopeless," "meaningless," "lost," "gave up," "fear," "weak," "worry," "useless," "frustrated," "can't do it," "passive," "inconsistent," "denial," "embarrass," "scare," "inferiority," "shy," "shameful," and "angry" to describe the negative feelings and thoughts they had encountered. Furthermore, when talking about before revealing their illness to others, the participants expressed their concern regarding acceptance from others as well as treatment and judgment after they had revealed it. They used terms such as "bias," "discriminate," "weak," "crazy," and "judge" to describe possible treatments from others.

Structural description. Revealing the struggles has been perceived by participants as part of the process in their personal growth journey recovering from major depression. The participants experienced a lot of negative feelings and thoughts before and after they were diagnosed with major depressive disorder. They reached to a point where they could not cover their major depression symptoms any longer. Before they have the courage to reveal their illness, participants were troubled by the acceptance, perceptions and treatments from others especially from the loved ones, friends, health care professionals, and colleagues. However, they

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chose to reveal their live experience in a firm way after accepting the fact that they needed help. Although there was some fear of exposing their hidden thoughts and feelings which have been part of them for some time, participants perceived that it has helped them to become truthful by aligning their inner thoughts and feeling with people around them. Thus, revealing has fostered other personal growth aspects which assisted them to recover and sustain ongoing personal growth process recovering from major depression.

Theme 2: Self-discovery and personal strength.

Textural description. Seven participants have identified self-discovery and personal strength as helping them in their personal growth to recover from major depression. They described self-discovery and personal strength with several aspects which were discovery of weaknesses and strengths, self-motivation, resiliency, coping abilities, and self-understanding. Participants used statements such as, "I feel that I have the strength," "I know my purpose in life and that I can empowered myself so that I can heal slowly but surely," "But the thing is if we want to recover, we need to know ourselves too," "That's why sometimes I will tell myself that I need to be strong. I need to be strong because if I am weak people around us will trample on me," "I focused a lot on my individual strength, you know, my resiliency; I tried to figure out my talents, my capacity and how to cope with all the problems," "I am actually trying to understand myself more instead of realizing my weaknesses only and why don't make the weaknesses into my strength," "I am focusing more on my own strengths for example my coping abilities, my resilience and my talents," and "It's inside. I just have to try to improve myself from that."

Structural description. In terms of self-discovery and personal strength, participants highlighted that the discovery of weaknesses and strengths, self-

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motivation, resiliency, coping abilities, and self-understanding had helped them in overcoming their struggles with major depression. They have learned to acknowledge on their strength base positively. Participants believed that by developing personal strength such as resiliency, self-understanding, self-motivation, coping abilities, and ascertaining of own weaknesses and strengths, they felt a sense of empowerment in their personal growth journey recovering from major depression. These actions have helped participants to build their self-confidence and fostered hope, forgiveness, and acceptance throughout their recovery proses. Participants perceived it as a meaningful aspect in their personal growth as they became able to face every setback in their lives which were described as complex and ongoing.

Theme 3: Personal responsibility.

Textural description. The aspect of personal responsibility was perceived by six participants as one of the important elements in their personal growth recovering from major depression. There were two aspects in personal responsibility addressed by these participants namely responsibility toward self and family. For both aspects of responsibility, they used statements such as, “Because for the sake of family, I also must cheer up. That means I have to consider and to concentrate, to focus more on my family,” “I need to repay their kindness, I need to repay for whatever all the things that they have, you know,” “But, I still tried because I have four blessings that are the most special ones. Those are my children,” “And also I think that another factor was I also doing it for my family actually,” “I want to give them a good life. I want them to stay with me in the future because I want to take care of them. I want to show them their love because I feel all this is my responsibility which I need to do,” “If I have my own problems, I must seek for help and ask opinions from others.

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Don't ever do anything that is unexpected, I told myself," and "Whatever problems also I need to be strong and I need to be calm."

Structural description. The participants believed that one of the aspects which have helped them in personal growth journey of recovery from major depression was personal responsibility. They believed it was a crucial aspect which affected their decision making and readiness for change. Four participants disclosed that their responsibility towards their family was generally connected to their personal growth. They experienced the urge to take care of the family and to perform their role as a filial petite child and a good parent. One of the participants highlighted his responsibility to take care of his spouse and to fulfill his wedding vow. Thus, they chose to move on from major depression. Other participants perceived that their responsibility toward themselves was the reason for them to move on from major depression. They realized that they have to take care and to love themselves if they want to make changes in their lives. Responsibility was also believed to be a vital energy that was present throughout the recovery and played as an important personal growth process to sustain on-going personal growth recovering from major depression.

Theme 4: Readiness for change.

Textural description. Among nine participants, eight of the participants addressed the importance of readiness for change in their personal growth journey recovering from major depression. They perceived it as something from within and acted as a force for them to make a decision to move on from their struggles in major depression. Participants described their readiness for change by using statements such as, "I still need to take this step myself," "To me, I just need to know that I am in this condition and I need to move forward," "If own self if we feel like wanting to

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recover, it was starting with our inner selves," "And I want to change and to go further. I do not want to stay here (depression) only," "The change for me it was within me," "I know that I still have somewhere to go and accepting my illness, moving forward and there is something that I need to do," "I felt like I needed to do something with my life," and "Because I felt that, it's no point blaming others for disappointing me because the problem is within me. I try to look back at what are my weaknesses and I will try to improve it."

Structural description. The readiness for change has been perceived by the participants as a life-line where they can rely on when confronted by the inner emotional turmoil in their state of major depression. They believed that even though others can influence change, change itself ultimately comes from within. Each participant reflected their struggles and determined what it would take to face their sense of meaninglessness and powerlessness to begin to move out from major depression. They also stated the choices between two ways – to move on or to stay in major depression. It was perceived as necessary to identify the need to make changes and to seek help. According to every participant, readiness for changes started in a variety of ways. Four participants were cognitively aware of their depressive symptoms but realized that they were unable to upshot change without external support. With this realization, they allowed themselves to receive help and readily accept whatever comes from the diagnosis pertaining to major depressive disorder. On the other hand, four participants recognized their symptoms as an illness and not as a weakness. This Realization has helped them to move and accept help, treatment, and a readiness to talk.

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Theme 5: Hope.

Textural description. Seven out of the nine participants spoke of hope in their personal growth journey of recovery from major depression. Participants recovering from major depression portrayed hope as their belief of a better future. They described it using statements such as, "I hope to be worthy to myself," "I need to just to persevere and, you know, just keep on going and hope that one day my goal I want to reach, will reach eventually," "I hope that I am being able to enjoy my life," "I hope that I myself can recover, can control, and can face all the problems that I am facing with the right way and not the wrong way," "I want to become stronger and try to get up although I felt exhausted and tired," "I want to become a better person," and "I hope that I am recovering and I have the confidence that I can be fully recovered."

Structural description. Hope has been perceived as a belief in a better future by participants in their personal growth journey recovering from major depression. When participants hoped, they anticipated making positive changes and reaching achievable goals. They felt a vital energy of self-assured anticipation that assisted them to visualize possibilities for themselves that they have previously discounted. Participants believed that hope was a vital life energy they have experienced from the onset of recovery and throughout the personal growth journey in order to sustain on-going recovery from major depression. They hoped for relief from symptoms in the early recovery process and hoped for change as well as progress as they lived their lives. Later, they generally hoped for a better future as the personal growth recovering from major depression progressed. Most of the participants envisioned a specific improvement in life and within themselves. Hope was also perceived as a source of energy and strength for the participants as they pursued their goals and

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dreams for the future. Furthermore, participants also believed that hope was fostered in connections with themselves, family and friends, counsellors, God, and colleagues.

Theme 6: Redefining the meaning.

Textural description. Among nine participants, six participants connected their personal growth recovering from major depression with the aspect of redefining the meaning. This aspect consists of redefining the meaning of job, relationship, one's self, and the healing. To describe this aspect, participants stated had used using statements such as, "I realized that I have to slowly change my way of thinking about my job," "I looked at my relationship with my family in a different way now," "So far the experience changed me from negative to positive," "I just have to be me to know what I need, to know what I need to do to make myself better," "I realized that I can be and I am a person," "I learnt that I am deserve a support and a happy life," and "I look myself as a survival."

Structural description. Redefining the meaning was addressed by participants in this study as part of their recovery from major depression. Regarding the aspect of redefining the meaning, participants identified four facets which have experienced changes. One of the participants realized that by redefining the meaning of his job, he was able to cope with his work stress as well as to face every challenge at his workplace. He believed that by changing his way of thinking and the way he looks at things, he learned a better way to reach his job satisfaction. Another participant emphasized on how her decision to redefine the meaning of her relationship with her mother has empowered her during her personal growth journey. Most of the participants believed that when they redefined the meaning of one-self and healing, they experienced positive changes in terms of their perceptions toward

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their struggles with major depression, trials and challenges in lives, the value and meaning of their healing, and most importantly, the way they acknowledge themselves as a whole. Participants believed that the aspect of redefining the meaning was connected with other aspects such as forgiveness, acceptance, readiness for change, as well as hope. This aspect of personal growth recovering from major depression was also believed to be continually improved in making positive changes and to reach attainable goals set by the participants.

Theme 7: Forgiveness.

Textural description. Five out of nine participants highlighted the aspect of forgiveness as part of their personal growth process recovering from major depression. This aspect comprises of self-forgiving and to forgive others. The aspect of self-forgiving was frequently stressed by the participants in the interview sessions. The participants used statements such as, "I try to forgive myself if I can't get it done. I can only say is it fine to work smart," "It's like you need to learn to forgive rather than you know, than hate others you know and don't let go all those kind of feelings, and also need to learn to be thankful," "I think it's time for me to forgive and to let go," "I tried to cope with myself and I tried to be more forgiving, you know more grateful towards my life," and "I want to forgive myself because that was one the thing that I want to do." Other than self-forgiving, the participants also believed the importance of forgiving others. They used statements such as, "I chose to forgive them and move on in my life," and "I can't continue my life if I am still having anger in me. So I forgive those people and try to live my life better."

Structural description. The participants believed that forgiveness was important in their personal growth recovering from major depression. Forgiveness for them consists of forgiving one's self and forgiving others who had hurt them

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before. Participants perceived that by forgiving themselves and others, they allowed themselves to be free from negative emotions such as pain, hurt, hatred, anger, sadness, and incompetency. This action of forgiving others has given them inner peace to experience setbacks without feeling a sense of failure, despair, hopelessness, doubts, and interjection. Most of the participants connected self-forgiveness as a decision they have to make for them to experience healing, gratitude toward life, letting go, as well as inner peace and freedom. Their decision to forgive one-self and others has helped them to move on from the past hurts, perceived their challenges positively, and to become a better and happier person.

Theme 8: Acceptance.

Textural description. Six of the participants described acceptance was linked to their personal growth recovering from major depression. The acceptance shared by them includes acceptance of self, acceptance by others, and acceptance of their past hurts. Participants used statements such as, "I get to accept my condition already because before that was more like denial," "And I tend to be more acceptances to myself and started to think wider perspective rather than a blockage perspective," "I accept all these trials, challenges and sufferings with an open and sincere heart," "I was trying to accept myself. I was trying to accept myself and the reason of my existence in this world," "Now I accepted both of them because I think they are part of my life. So I try to accept them as a part of my life," "I really need to accept myself. All my weakness or strength, I accepted myself," "My family accepted me for who I am," "My friends accept me even after I told them my illness," and "My colleagues and bosses knew about my illness and they still treat me the same and didn't discriminate me."

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Structural description. The participants believed that acceptance was one of the significant aspects which played an important part in their personal growth journey recovering from major depression. There were three categories of acceptance highlighted by the participants. It includes self-acceptance, acceptance by others, and also acceptance of past hurts. When they opened their heart to accept whatever things that happened to them with a different perception, it helped them to learn to accept not only their past but also to accept themselves as well. Acceptance fostered throughout the participants personal growth journey recovering from major depression when they learned to acknowledge both of their strengths and weaknesses as part of them as well as to believe that their past hurts have made them stronger and better person in their lives. Self-acceptance involved acceptance of own flaws, both positive and negative feelings and thoughts, strengths and weaknesses, and their imperfections. The acceptance from others provided a sense of normalcy for the participants by encouraging, motivating, and supporting socialization. The participants felt that they received the same treatment, weren't discriminated by others, and have a sense of being understood when they experienced acceptance from others. It encouraged them to seek for help and to move on with their major depression. For them, finding acceptance from others was empowering. Acceptance of the past hurts took place when the participants allowed and learned to accept their past as part of their lives as well as to believe that everything happened for some reason to help them to build their emotional and mental strengths.

Theme 9: Supportive relationship.

Textural description. All the participants spoke of the significance of the support they received throughout the personal growth journey which has helped them to recover from major depression. The supportive relationship which they have

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varies from family, friends, colleagues, bosses, and spouses. In regard to support from family, the participants described using statement such as, “I received family support, from the aspects of mental, physical everything,” “I think my family really played a very important role in helping me in recovery. My parents were very supportive when and after I was diagnosed with depression,” and “My mother she actually helped during this healing process.” Participants also described the support they received from friend. They used statements such as, “There was a school friend. She also gave words of encouragement,” and “I actually feel grateful to myself and of course my family and my friends who supported me all along by standing at my side, encouraging me, trying to understand me, giving me support.” Another support was from colleagues and bosses. Participants used words such as, “It was just all my colleagues were there and then to their greatest extent they accompanied me and then also took care for me,” “My bosses always encourage me so and make me feel like I can do better.” In terms of support from spouse, the participant described “My support system definitely is my boyfriend,” and “My wife helped me a lot. My wife played the biggest role.”

Structural description. The supportive relationship has been perceived by the participants as one of the important aspects in their personal growth process recovering from major depression. Three participants emphasized that support from their spouse has played an important role in their recovery journey and all the nine participants connected their personal growth with the support they received from family and friends. Most of the participants perceived supportive relationship they received from family, friends, and spouses had played a vital role in their personal growth journey. They believed that the gist in the supportive relationship they received were the encouragement, motivation, emotional and mental support, fair

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treatment, acceptance, care, love, presence (not alone), unconditional treatment, listening, tolerance, and trust. Four participants believed that they received support from their colleagues and bosses. They perceived that the gist from the support they received were encouragement, support, respect, understanding, toleration, and also nondiscrimination.

Theme 10: Medication.

Textural description. The participants shared about the role of medication in their personal growth journey of recovery from major depression. They used statements such as, "Well, my healing process started when I started my medication prescribed by doctor," "I am still taking medication but currently I am already stabilized," "To me actually the medicine is important because it was able to calm me down," "I am still continuing the medication.," "When I took medication, it will help to lessen my anxiety," "And taking my medication regularly also helps me to calm down," "I always take my medication on time because I know that I still sometime if I never take medication maybe I will back to my depressed state," and "I take my medication regularly."

Structural description. Medication was perceived as a requisite in the participants' personal growth recovering from major depression. Participants experienced varying responses to different medications and often have initial conflict to its use in improving their depressive symptoms due to a stigmatized view on depression. All the participants who took antidepressants to support their personal growth journey emphasized the importance of it. Medication was believed to be able to calm their negative emotions, lessen the anxiety, and reducing negative thoughts. These actions have provided a space for the participants to begin the process of getting well. The participants also believed that early termination of medication

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without approval from psychiatrists will initiate the reoccurrence of depressive symptoms as experienced prior to medication.

Theme 11: Attending counselling.

Textural description. Every participant shared having gone through counselling sessions during their personal growth journey of recovery from major depression. They used terms such as, "actively attending counselling," "having some foundation from counselling," "able to express and felt relief during counselling," "learnt self-care, self-management, and how to control emotion from counsellor," "attending counselling," "gone through counselling," and "knowing self through counselling."

Structural description. In participants' perspective, attending counselling has played an important role in facilitating their personal growth recovering from major depression. Several aspects in this element were identified by the participants. All the participants believed that counselling sessions were helpful in their personal growth recovering from major depression. They perceived counselling sessions as an outlet for them to express their problems, emotion, and struggles with major depression. Counselling sessions were also an outlet for the participants to build their foundation and to get to know more about depression. Participants experienced counselling as a channel to learn about self-care, self-management, and emotional management. Some of the participants expressed that they were able to understand about themselves more as they progressed in recovery with the help of their counsellors. Substantially, the participants addressed two supportive behaviors in counselling sessions which were presence and listening. The participants claimed they could feel the presence of their counsellors when they conveyed their understanding and acceptance of what the participants had experienced. Most

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importantly, they felt they were being listened to and were permitted to repeat their stories, describing how major depression and their past had affected them.

Theme 12: Religion and spirituality.

Textural description. Six out of nine participants shared that religion and spiritual beliefs have helped them in personal growth journey recovering from major depression. The participants used the terms such as, "God", "Lord," "temple," "faith," and "believe" to describe their religion and spiritual belief which had assisted them throughout their personal growth journey. They also connected several aspects of their spiritual belief which has facilitated their personal growth processes such as prayers, religious teaching and reading, and meditation. The participants used terms such as, "prayers," "reading Al-Quran," "meditation," "praying," "asking God for direction," and "teach Al-Quran."

Structural description. There were a few religion and spiritual aspects described by the participants. The participants felt connected with God, able to put all their burdens onto God's shoulder, felt peace through prayers, continued to believe in God, perceived religion as pathway in recovery, and received guidance through religion. Participants felt connected to God when they visited churches or temples. They believed that they were protected, loved, and was given strength and a chance by God to stand up and to live a better life. The participants also felt relief after they chose to put all their troubles and problems onto God's shoulder. They believed that they didn't have to worry about them that much anymore. Furthermore, they also reported that prayers and meditations have helped them to feel more peaceful and calm when they faced difficulties in their lives. They also became more hopeful towards their future. The participants continued to believe in God to build back their trust foundation and to be more accepting towards their own weaknesses.

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They also believed religion as a route and guidance to sustain their personal growth processes recovering from major depression.

Theme 13: Care for others.

Textural description. Two of the women participants shared on the aspect of caring for others in their personal growth journeys of recovery. They used words such as, "help others," "doing charity," "care for others," "listen to people," and "supporting others" when they described caring and helping others who were in need. Participants shared their experiences of caring for others to old folks at old folk's homes, people in need at hospital, during charity activities organized by church and temple, and also friends who may have similar symptoms of depression. Further, they also spoke of their experiences in helping children at orphanage home.

Structural description. The act of caring for others was perceived by participants as one of the prevailing aspects in their personal growth journey of recovery from major depression. They believed that it helped them to recover from major depression by sharing about their struggles to those people in need and to motivate them to stand up again. This action has made the participants feel proud and useful to others as well as to gain own progression as an individual. Furthermore, when they reached out to those who were in need, they believed it fostered their inner strength to move on and to empower them to live a better life. The participants also experienced the changes of the meaning in their lives when they reached out and cared for others. They described as having more meaningful life when they got to help someone else who was in need.

Theme 14: Employment.

Textural description. Four out of nine participants spoke of the aspect of employment in their personal growth journey of recovery from major depression.

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This element of personal growth was connected to their perspective they have experienced regarding their career. They believed that to be able to work, to continue to progress in career, and to achieve the sense of security and achievement in career has made them feel less depressed. Participants also described it as something that made them feel useful and occupied. They also emphasized the importance of being treated in a respectful manner and also equally at workplace. Participants shared that having an achievable goal was helpful in moving out from major depression.

Structural description. Employment was perceived as one of the personal growth element in the journey of recovery from major depression. Participants felt conflicted when they were struggling with major depression and at the same time they need to work to sustain their daily lives. Thus, for them to have a job was important in their personal growth recovering from major depression to feel proud and useful. In career, the participants believed that they were able to develop goals that were realistic and attainable. Hence, being employed was crucial to enhance sense of security and achievement which was believed to be helpful for the participants to move out from major depression.

Summary

Overall, through this composite analysis fourteen personal growth elements were developed for discussion. Those were themes of, "revealing the struggles," "self-discovery and personal strength," "personal responsibility," "readiness for change," "hope," "redefining the meaning," "forgiveness," and "acceptance," "supportive relationships," "medication," "attending counselling," "religion and spirituality," "care for others," and "employment."

Each theme was developed based on the textural description analysis used by the nine participants. From the analysis of the composite structural description, a lot

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of similarities emerged in description for instance on themes of readiness for change, forgiveness, and acceptance. Substantially, each theme that emerged has portrayed a remarkable connection between the themes in participants' personal growth journey of recovery from major depression. Thus, it was believed that each personal growth theme played an important role in enriching other personal growth themes.

Essence of the Personal Growth Experiences of Young Adults Recovering from Major Depressive Disorder

In this qualitative study of young adults' personal growth experiences recovering from major depressive disorder, a total of fourteen major elements of personal growth interconnected to recovery from major depression have been identified. All the fourteen themes were separated into two components namely personal growth processes and personal growth contributors. Eight elements were the processes that the participants have experienced throughout their healing journey whereby another six elements were linked to the elements which have contributed to personal growth. All the elements in the components of personal growth processes and personal growth contributors were interconnected during the personal growth journey of recovery from major depressive young adults.

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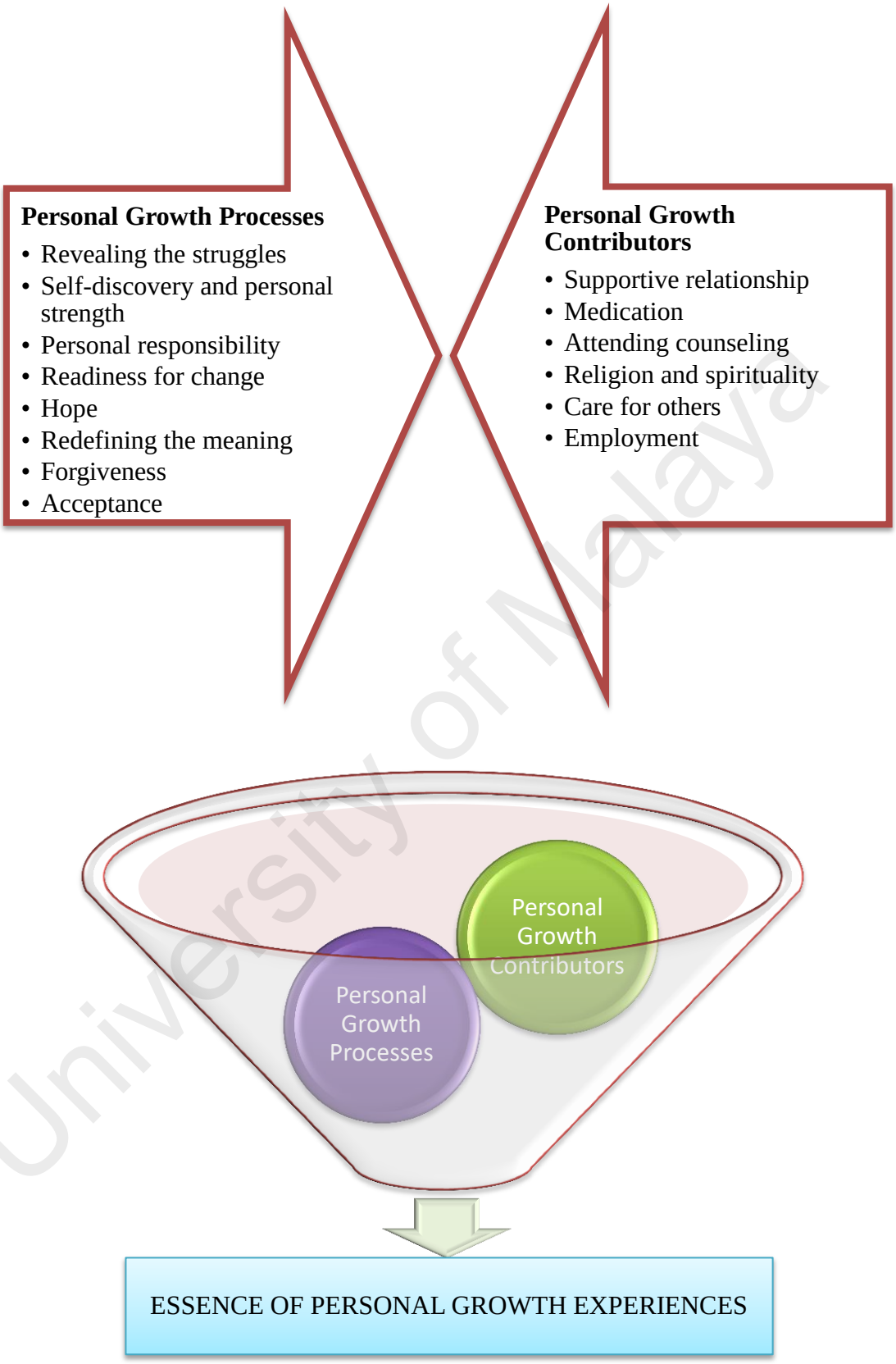

Figure 4.31. Overview of the essence of personal growth experiences of young adults recovering from major depressive disorder

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Personal growth processes.

Personal growth route recovering from major depression was not a tranquil journey for young adults with major depressive disorder. Undeniably, participants have to go through a number of personal growth processes. They have faced a lot of challenges as a part of their personal growth journey in which they have to reveal their struggles with depression, then slowly discovered their own personal strength, aware of their own personal responsibility, ready for change, learned to hope again, redefined the meaning of their personal growth, they learned to forgive themselves and others who had hurt them before, and finally they reached a point of acceptance. Each participant experienced almost similar personal growth processes in their personal growth journey recovering from major depression although the flow of the processes may be different.

One of the most expressed struggles shared by the participants was the fear of people's perception and also embarrassment. They often experienced negative thoughts and emotions such as fear, embarrassment, useless, hopeless, helpless, anger, and worry. Those negative feelings are often connected with the fear of revealing their struggles in major depression to others. Participants were worried about people's judgments, treatments, and their acceptance after they disclosed their mental illness. They were haunted by how others will treat them after the disclosure. Each participant has encountered fear of discrimination, bias, and being looked down by people after revealing their struggles.

Participants slowly discovered their inner strength. Some of them started to acknowledge both of their personal strengths and weaknesses. Some discovered their external strength which have helped them to be strong and to come out from their major depression. Whatever participants once perceived as weaknesses they allowed

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themselves to improve it. They focused on their own strong points to bounce back from their major depression. This element of self-discovery and personal strength was helpful to construct their personal resiliency and to get to know themselves better. The element of self-discovery and personal strength was a vital dynamism that is present at the beginning of recovery, was essential to sustain continuing recovery from major depression, and facilitates participants to achieve their goals.

Every participant was aware of the importance of the element of personal responsibility in their personal growth journey. Responsibility was varied from self to family. As participants were aware of their responsibility, they learned that they have to stand up for themselves and people whom they loved. Most of the participants viewed their responsibility towards their family as something they have to fulfil. They believed it as one of the reason which has pushed them to continue to overcome their major depression. Furthermore, they also believed that responsibility has made them become a useful and better person as well as being portrayed as filial children in repaying family kindness.

The process of personal growth recovering from major depression took place when participants were ready to change. The element of readiness for change was perceived differently by each participant. Readiness for change in their journey of recovery was experienced as a need to help oneself, the need to move forward, the desire to enjoy life, didn't want to stay in depression, the change is within oneself, moving forward with small steps, the need to change, and no point in blaming others. Thus, readiness for change was perceived as an energy to move on from major depression and experience personal growth. This personal growth process of readiness for change has helped them to evolve in their personal growth journey of recovery from major depression.

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Hope was a vital energy as conceived by participants at the onset of their personal growth and it developed as they live their lives. As recovery from major depression progressed, most of the participants generally hope for relief from symptoms and a better future as well as improvements in life based on their dreams and resources. The element of hope experienced by participants includes the hope to live and be worthy, expressing love and appreciating every moment with family, to recover and take control of own life, hope to be stronger for family, and the hope to have a good life.

Each participant experienced a process of redefining the meaning of personal growth, as they learned to redefine the meaning of their personal growth through job satisfaction, love for family, changing old self to new, standing on own feet, concept of survival, values in life, being true to self, and changing the way to see oneself. Recovering from major depression was perceived to be a lengthy process which required great determination. Hence, each participant believed that by redefining the meaning of their personal growth journey they were able to energize themselves forward in recovering from major depression.

The process of forgiveness happened when the participants chose to forgive themselves and those who hurt them before. Forgiveness was believed as one of the most important elements in their personal growth journey as they started to treat themselves better. Most of the participants perceived their forgiveness as their self-care in which they experienced modesty, to forgive rather than to hate, and letting go their hurts and past grievances. Most of the participants experienced positive inner changes following with forgiveness. Forgiveness allowed them to move on and to free themselves from negative emotions.

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Finally, most of the participants experienced benefits of acceptance. They learned to accept themselves such as their weaknesses, flaws and every emotion they have experienced. Acceptance was perceived as a personal growth process which helped them to accept what had happened in their past. This process was a series in which progressed from the process of forgiveness. Most of the participants believed that through acceptance they are able to open their heart sincerely to seek and accept help in their personal growth journey.

All the participants perceived their personal growth as a continuous process and they have no definite answer on when the process will end or when they will fully recover from major depression. Personal growth journey for them was like a roller-coaster with ups and downs. Each participant disclosed that ultimate healing may or may not be accomplished in their personal growth journey, but most importantly they will continue to head towards the recovery goals. Thus, each personal growth process element was what the participants needed to empower them to move on and to hope for a better tomorrow.

Personal growth contributors.

The personal growth processes and personal growth contributors were both interconnected and contributed to all of the participants' personal growth experiences recovering from major depression. Six elements which contributed to participants' experience of personal growth recovering from major depression were the supportive relationship they received, taking medication, attending counselling, religion and spiritual beliefs, caring for others, and employment have helped them greatly in the personal growth journey of recovery from major depression. Personal growth contributors have assisted the process of healing from major depression experienced by the participants.

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Supportive relationship was connected with encouragement, motivation, emotional support, love, care, respect, acceptance, and to have someone to talk to as well as being heard. All the participants highlighted that the most important aspect was acceptance from others. They also repeatedly emphasized on the two supportive behaviors which were presence and listening. Supportive relationship perceived as a vital external energy which has helped the participants to overcome their fear to disclose their struggles with major depression. Most of the support was from family and friends. Some of the participants also received support from their colleagues, bosses, and spouse. Acceptance from others encouraged the participants to talk and share their problems without feeling fearful.

Medication was believed to remove negative feelings and reducing negative cognition by participants. Most of the participants found that once they started taking antidepressant that was effective, they started to see things brighter and gave them relief from negative thoughts and negative feelings such as anxiety. Antidepressants played a role to lift and stabilize mood sufficient enough so that participants were able to address distressing experiences.

Another aspect which has contributed to the participants' personal growth experiences was attending counselling. All the participants found that counselling sessions were helpful. They became hopeful after they were told that depression was treatable by their counsellors. Some participants learned new coping strategies after they recognized that their previously used coping mechanisms have the potential to weaken health and didn't resolve their depression. Counselling sessions were also perceived as an outlet for them to express their problems and feelings which troubled them. All the participants found comfort and support after they attended counselling sessions.

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All of the participants have encountered many forms of challenges and sufferings throughout their personal growth journey of recovery from major depression. Their lives were described as meaningless, directionless, lost, no lights, surrounded by darkness, and have "two black dogs" following them. Religion and spirituality has contributed as spiritual support that fostered hope and guided each participant in their recovery from major depression. Some participants believed God was protecting and supporting them as well as giving them a chance to live again. They learned that meditation and prayers have established a lot of inner peace and a meaningful life. The hope of participants is nurtured in connection with God and themselves. This spiritual belief and support allowed participants to lay their troubles and put their trust onto something more powerful than human.

Caring for others was one of the healing contributors for a few participants. When they helped someone, it becomes a source of empowerment for them. Participants perceived that they were able to help themselves when they helped others. They could open up about their struggles with major depression with others who are struggling with depression but yet have the courage to seek help. Reaching out others also gave participants a new meaning in life and to feel useful in life. Participating in charity or social activity neutralized both the aloneness and loneliness of major depression.

Finally, employment contributed in a few participants' personal growth recovering from major depression. Being able to work and progress in career has played a part in personal growth journey for those participants as it gave them a sense of security and achievement in their career. Having an achievable goal was helpful in moving out from major depression. In career, the participants were able to

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develop goals that were realistic and attainable. To be able to do something makes those participants feel proud and useful.

Chapter Summary

In summary, fourteen themes were identified from this study. They were: revealing the struggles, self-discovery and personal strength, personal responsibility, readiness for change, hope, redefining the meaning, forgiveness, acceptance, supportive relationship, medication, attending counselling, religion and spirituality, care for others, and employment. All these themes were later extracted into two components known as the personal growth processes and the personal growth contributors. These two components were to reveal the essence of personal growth experiences recovering from major depressive disorder. Noticeably, both the personal growth processes and the personal growth contributors were interconnected in generating personal growth for major depressive young adults. From this study, the essence of the young adults' personal growth experience recovering from major depressive disorder involved a dynamic process in which they may need to go through numerous phases of the personal growth processes in order to attain ultimate sense of recovery from major depression. Auxiliary, personal growth contributors were essential to facilitate the personal growth processes in helping the participants to recover from major depression. The personal growth processes and the personal growth contributors are interconnected and facilitated the journey of young adults' personal growth recovering from major depressive disorder. Next chapter encompassed discussion, implications, recommendations, and conclusion of this study.

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Chapter 5 Discussion, Implications, Recommendations, and Conclusion

Introduction

This qualitative study investigated young adults' personal growth recovering from major depressive disorder by using a phenomenological approach. The nine participants interviewed were young adults diagnosed with a major depressive disorder and were in the phase of personal growth recovering from the illness. This study focused on the narrative description from major depressive young adults to develop a comprehensive understanding of their live experiences recovering from major depression.

This chapter comprised of discussion and implications of the research findings as well as recommendations for future research. Implications consist of: implications for the psychotherapy and counselling practice, implications for psychotherapy and counselling education and training, implications for psychotherapy models on personal growth in healing from major depression, implications for research, and implications for policy development. The final part of the chapter discussed recommendation for future research and conclusion.

Overview of Research

To date, major depression is known to be one of the serious and prevalent mental health problems among young adults in Malaysia. Thus, this phenomenological research study was intended to investigate and describe the subjective lived experience of young adults recovering from major depressive disorder. This study has provided an increased insight into the experience of young adults coping with this illness in their lives. The voices of these young adults should be made known to the existing help-care bodies by inseminating knowledge about this phenomenon.

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This transcendental phenomenological qualitative research study took place in Perak and Kuala Lumpur, Malaysia and the study was guided by Colaizzi's phenomenological method. A purposive sample of nine medically diagnosed with major depressive disorder young adults, ranging in age from 20 to 39 years old, were recruited and they had participated in a total of twenty-seven semi-structured interview sessions in which they had shared the story of their major depression experiences.

Throughout the research study, the researcher set aside her own presuppositions and assumptions by using phenomenological reduction or bracketing. Semi-structured interview sessions were conducted over a period of seven months after obtaining approval from National Medical Research Registry (NMRR) and Medical Research and Ethics Committee (MREC), Ministry of Health Malaysia, as well as after obtaining informed consent from each of the participants. Thematic saturation in this study was apparent following the seventh participant.

The researcher used Colaizzi's eight procedural steps as a guided analysis of the data in this study. The findings of the study revealed an in-depth description of the subjective, lived personal growth experience of young adults recovering from major depressive disorder. The results showed fourteen personal growth elements encountered by participants throughout their growth journey of recovery from major depression were identified in the research study.

From the fourteen elements identified, eight were described as personal growth processes (e.g., revealing the struggles, self-discovery and personal strength, personal responsibility, readiness for change, hope, redefining the meaning, forgiveness, and acceptance). On the other hand, another six elements were described as personal growth contributors (e.g., supportive relationships, medication, attending

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counselling, religion and spirituality, care for others, and employment) which significantly facilitated the recovery processes of participants throughout their personal growth from major depression. Every element in both personal growth processes and personal growth contributors are interconnected in the participants' personal growth journey of recovery from major depression.

Summary of Research Findings

Research findings revealed a total of fourteen personal growth themes experienced by the nine major depressive young adults who participated in the research. Those themes were: (a) Revealing the struggles, (b) Self-discovery and personal strength, (c) Personal responsibility, (d) Readiness for change, (e) Hope, (f) Redefining the meaning, (g) Forgiveness, (h) Acceptance, (i) Supportive relationship, (j) Medication, (k) Attending counselling, (l) Religion and spirituality, (m) Care for others, and (n) Employment.

Essentially, the outcomes of this study revealed that the constructs or elements emerged in the finding reports of young adults' personal growth experiences recovering from major depressive disorder have assisted them in their personal growth journey. Furthermore, the findings also revealed that the additional personal growth constructs inevitably contribute towards helping young adults in recovering from major depression. In this study, the findings revealed positively the previous studies of personal growth healing from major depression. Negative experiences and positive coping strategies were reported by the participants as part of their personal growth journey.

However, it was noticed by the researcher that past and current literature regarding depressive disorders were feeble in addressing the issue of revealing the struggles, care for others, and also employment in personal growth journey

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recovering from major depression. Thus, these personal growth elements were perceived as a valued finding, and specifically for those who are in helping profession and continuously working with major depressive people.

In this study, it was found that all the young adult participants have undergone a process of personal growth recovering from major depression which comprises of two main constructs namely personal growth processes and personal growth contributors. Both elements were interconnected throughout the personal growth journey of the participants. In sum, it was important to be aware and understands the role of each theme and between both the elements. These contributed to more objectives and being full of care manner in understanding personal growth of young adults recovering from major depressive disorder.

Figure 5.1 to 5.14 illustrates all the abovementioned themes.

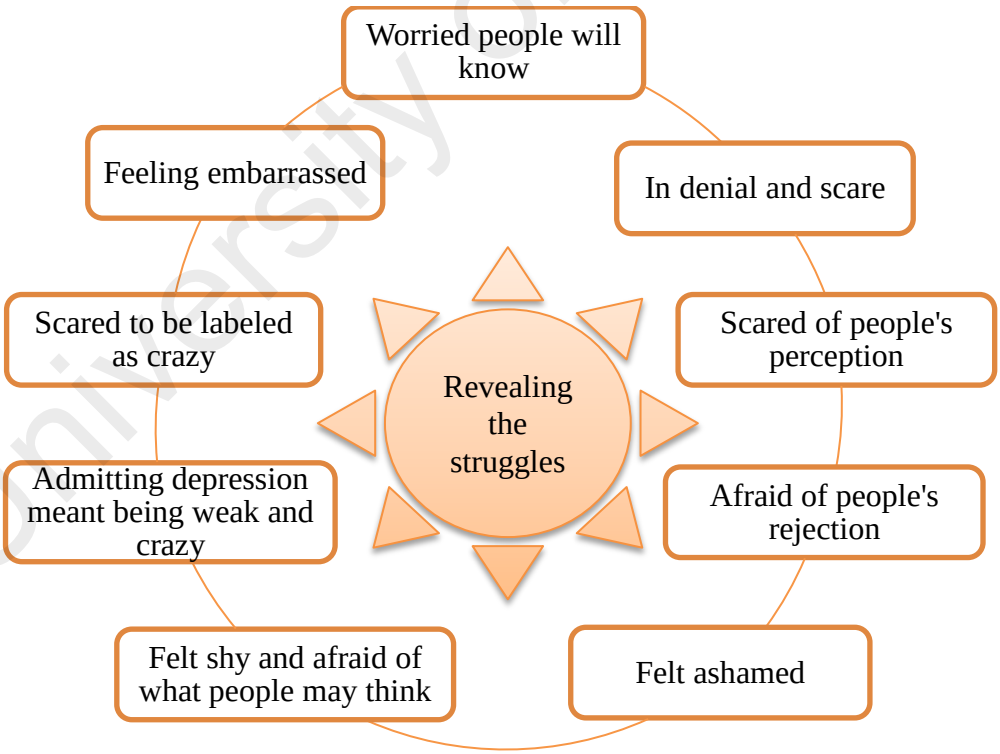

Figure 5.1. Theme 1 – Revealing the struggles

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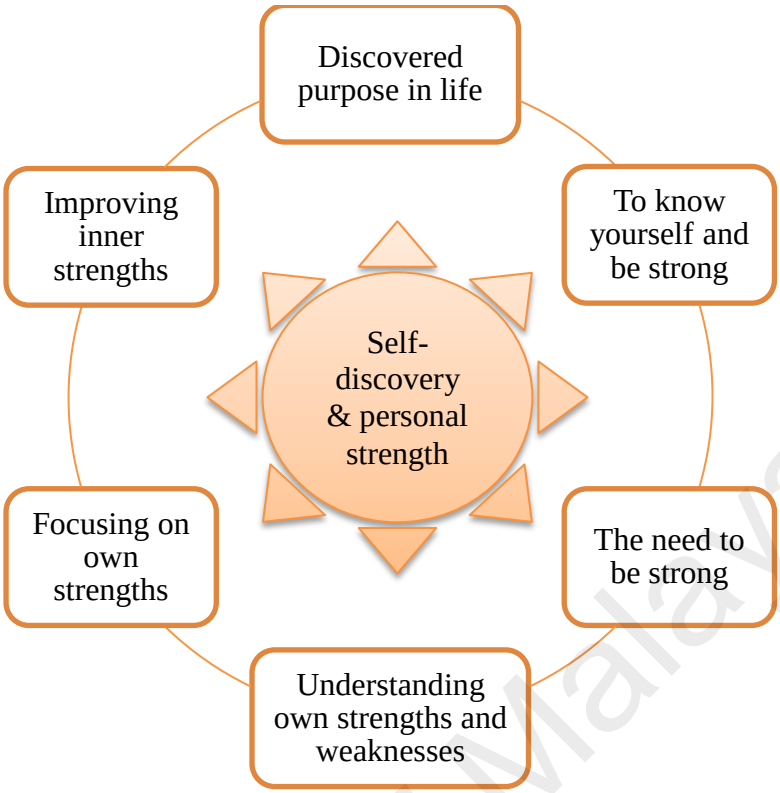

Figure 5.2. Theme 2 – Self-discovery and Personal strength

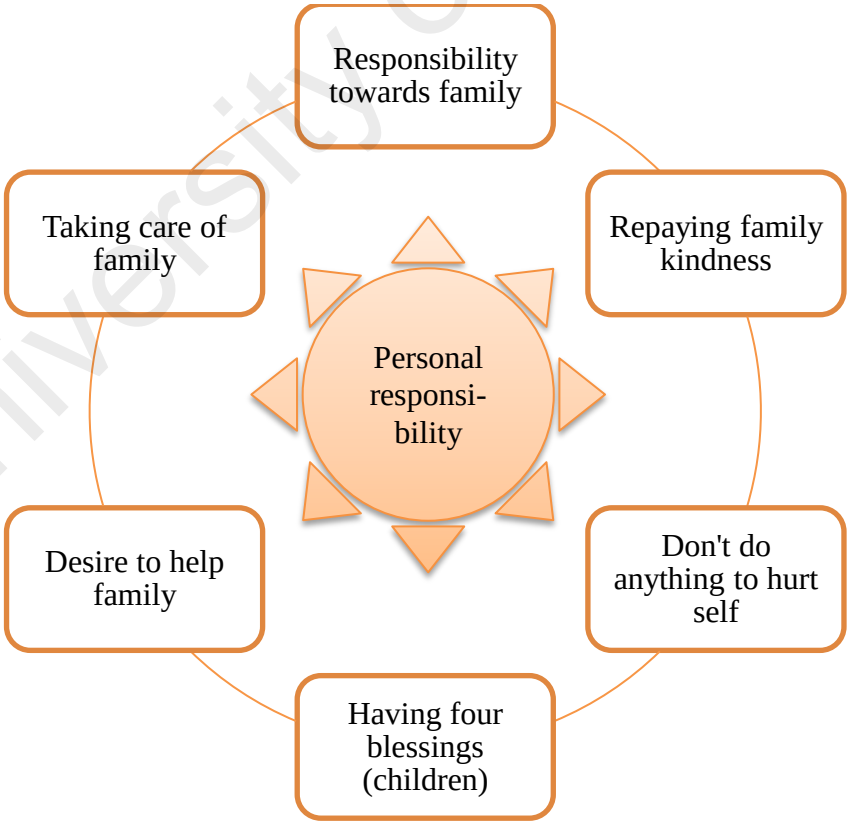

Figure 5.3. Theme 3 – Personal responsibility

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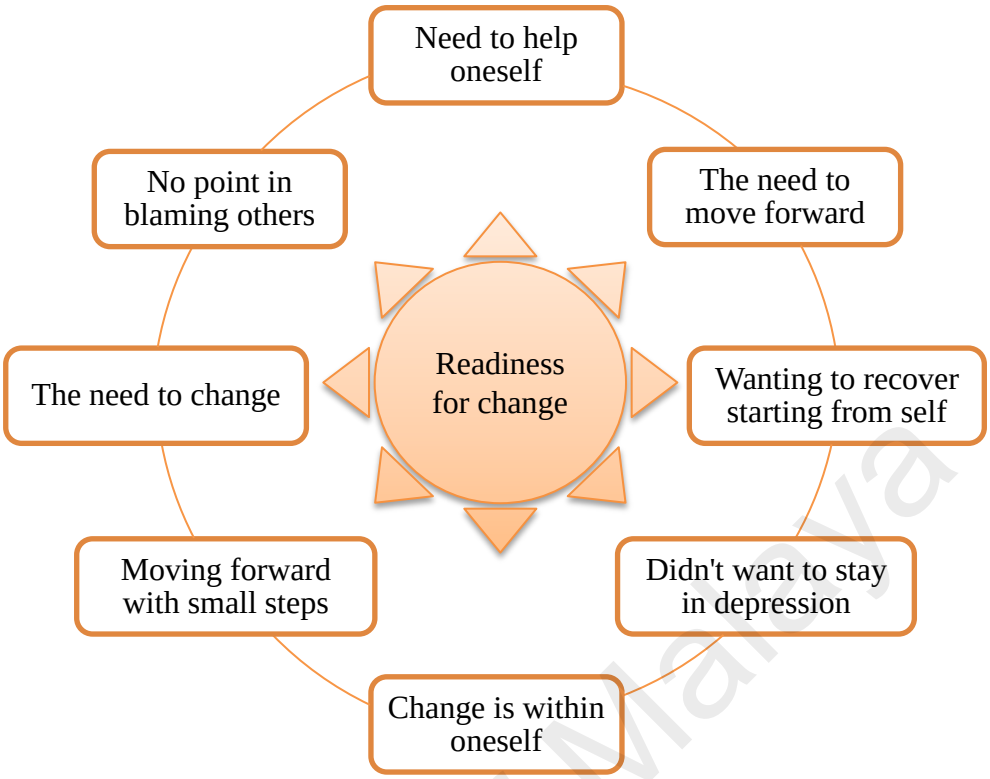

Figure 5.4. Theme 4 – Readiness for change

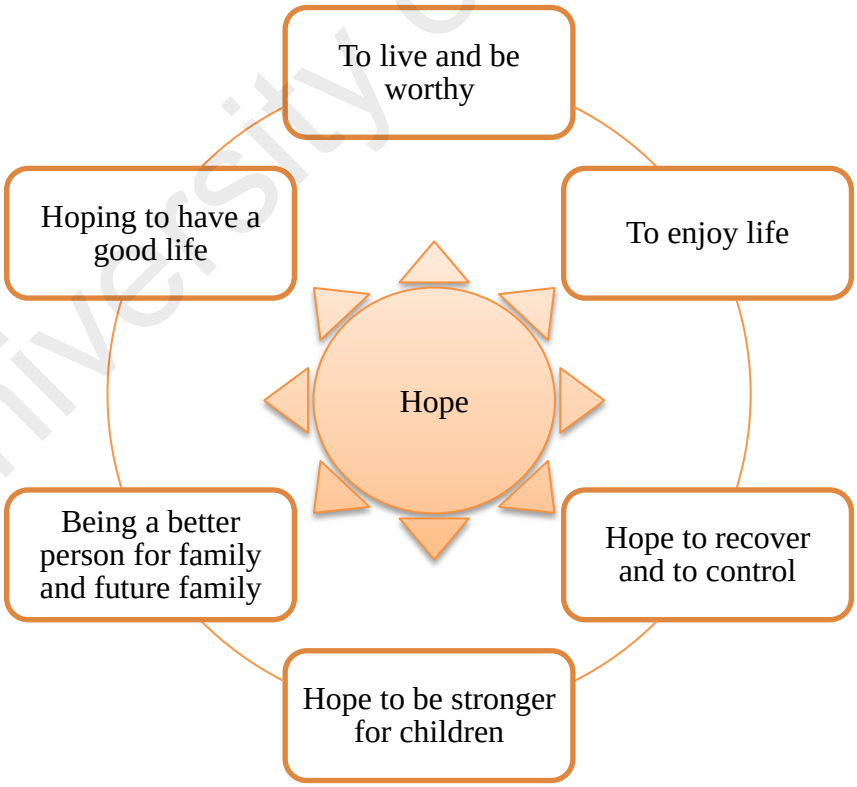

Figure 5.5. Theme 5 – Hope

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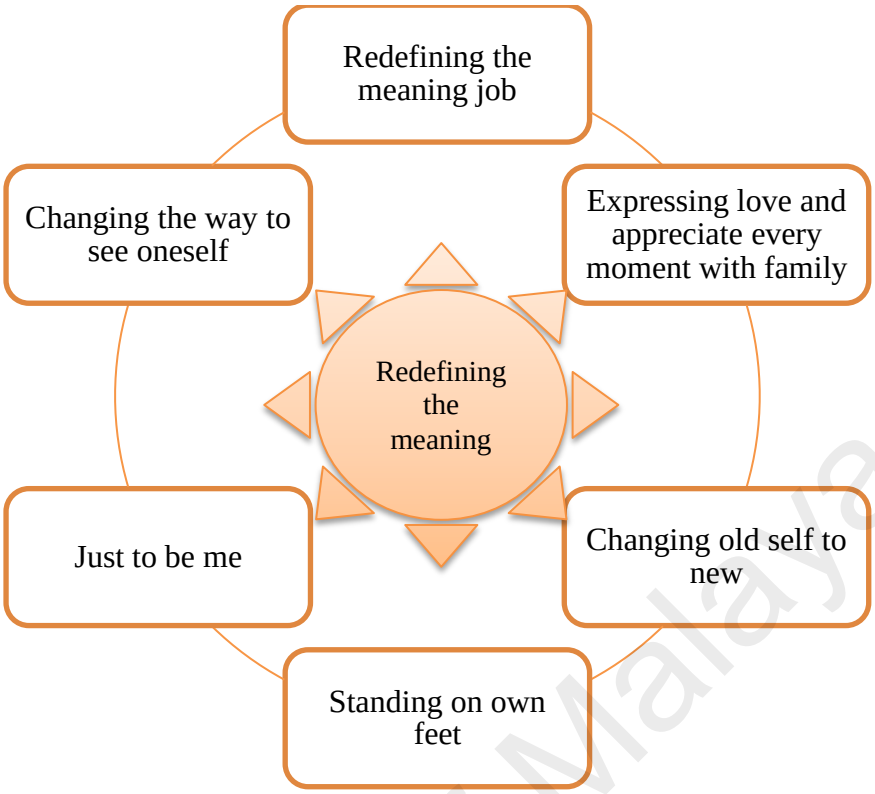

Figure 5.6. Theme 6 – Redefining the meaning

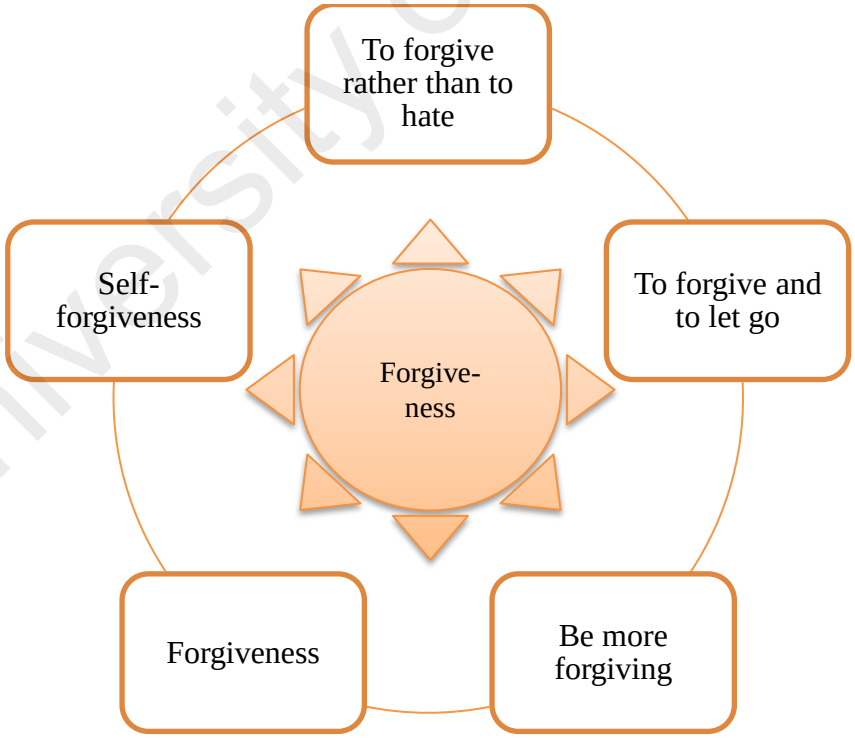

Figure 5.7. Theme 7 – Forgiveness

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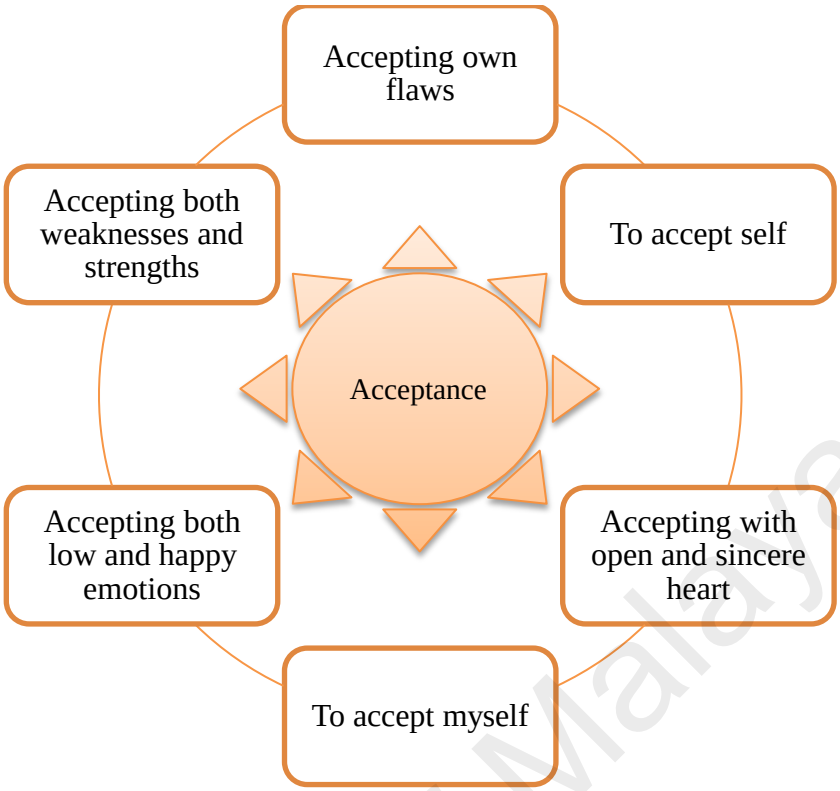

Figure 5.8. Theme 8 – Acceptance

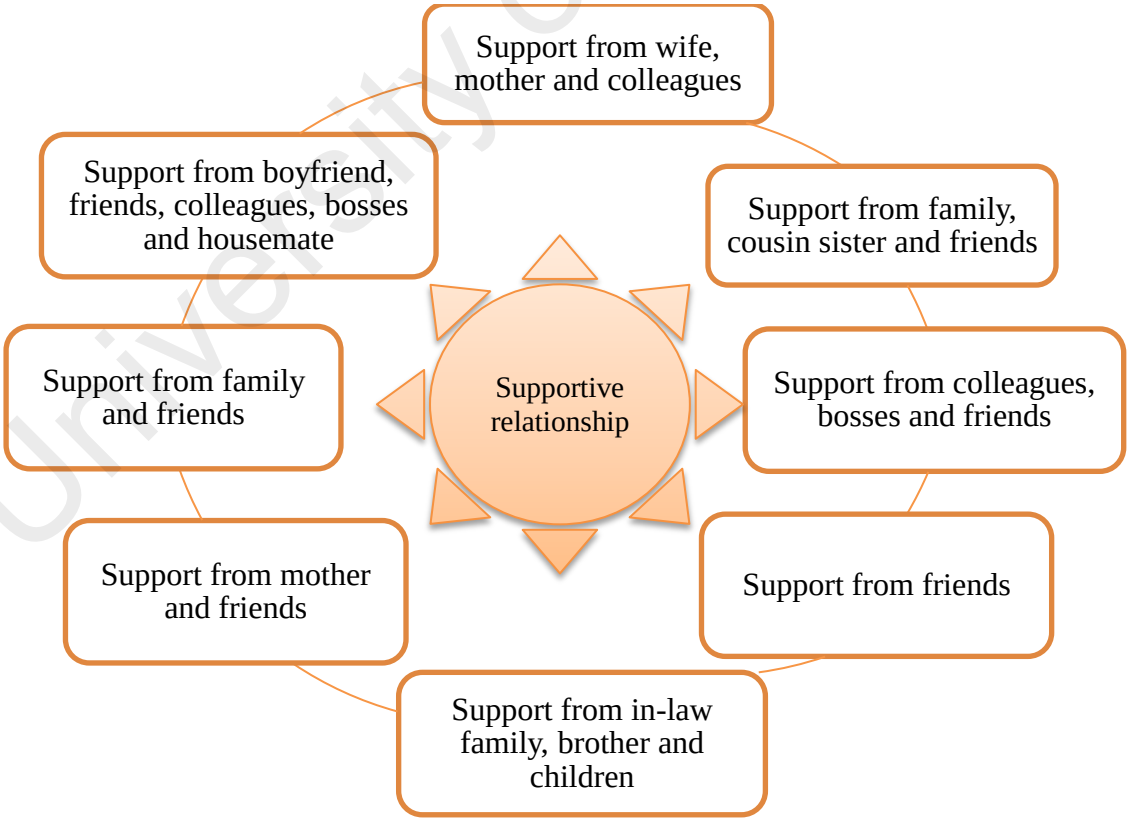

Figure 5.9. Theme 9 – Supportive relationship

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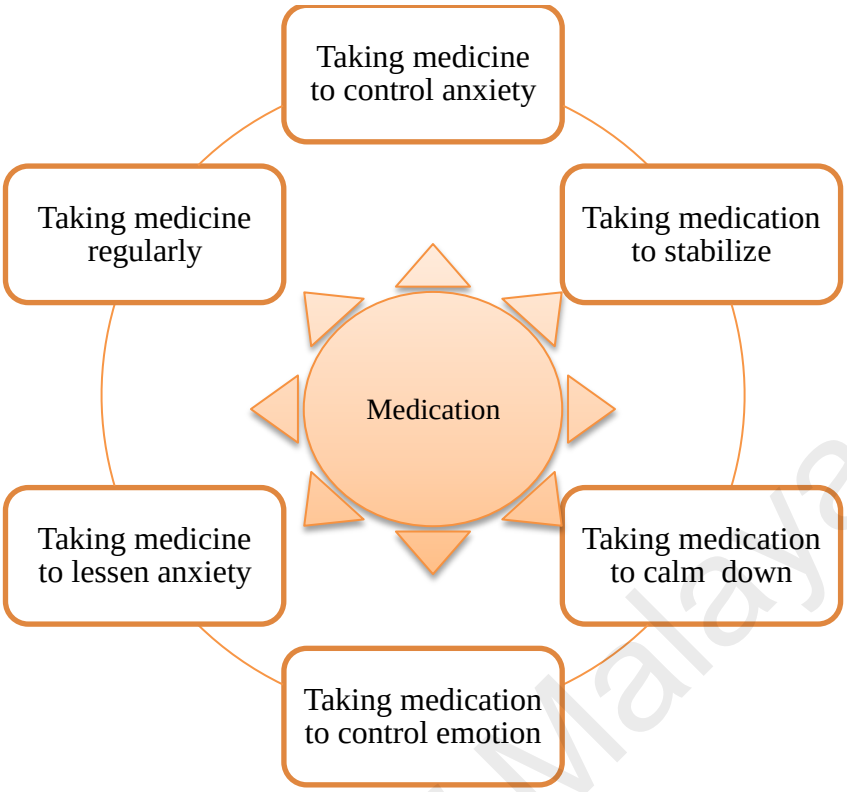

Figure 5.10. Theme 10 – Medication

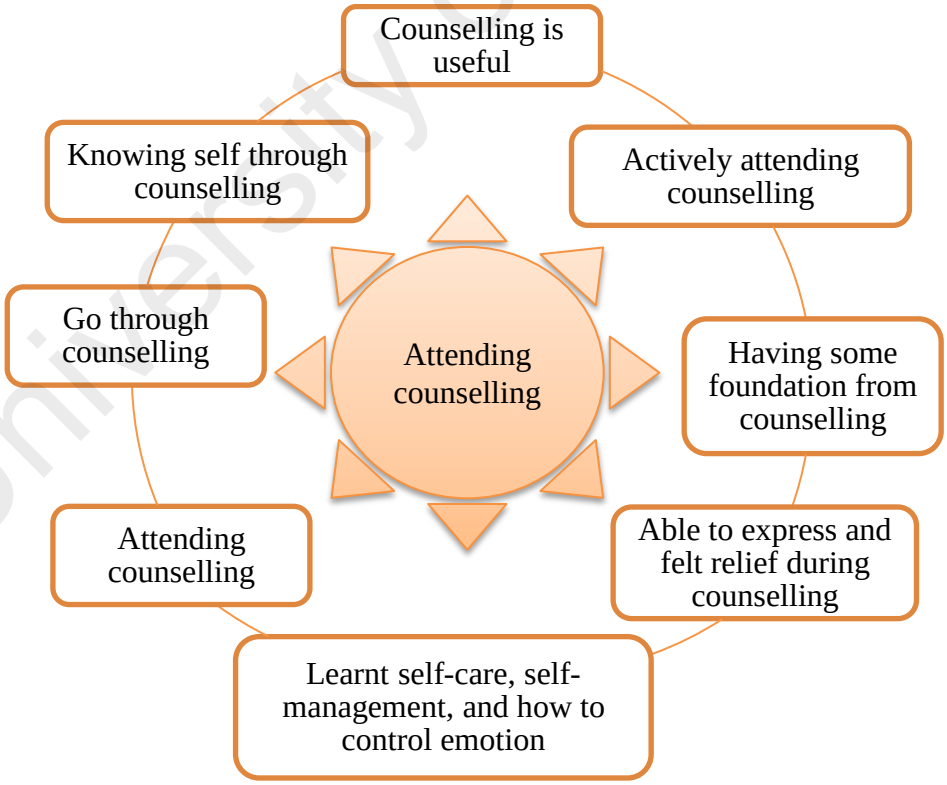

Figure 5.11. Theme 11 – Attending counselling

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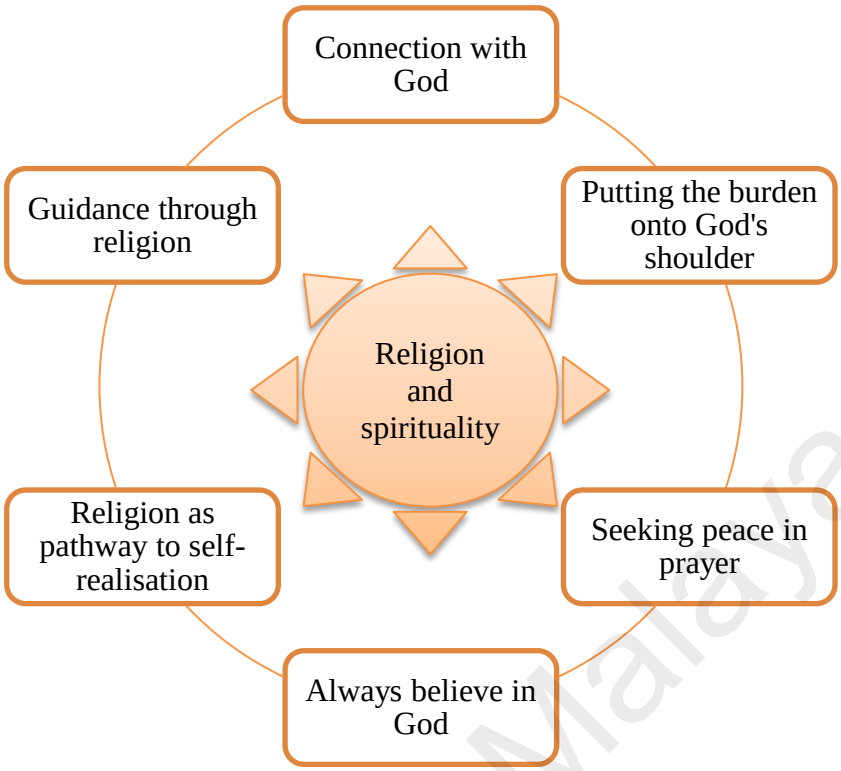

Figure 5.12. Theme 12 – Religion and spirituality

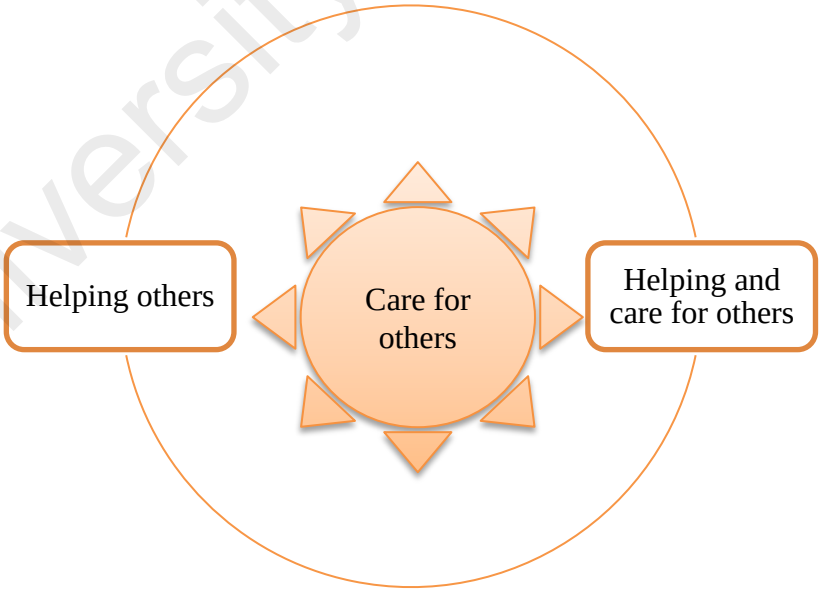

Figure 5.13. Theme 13 – Care for others

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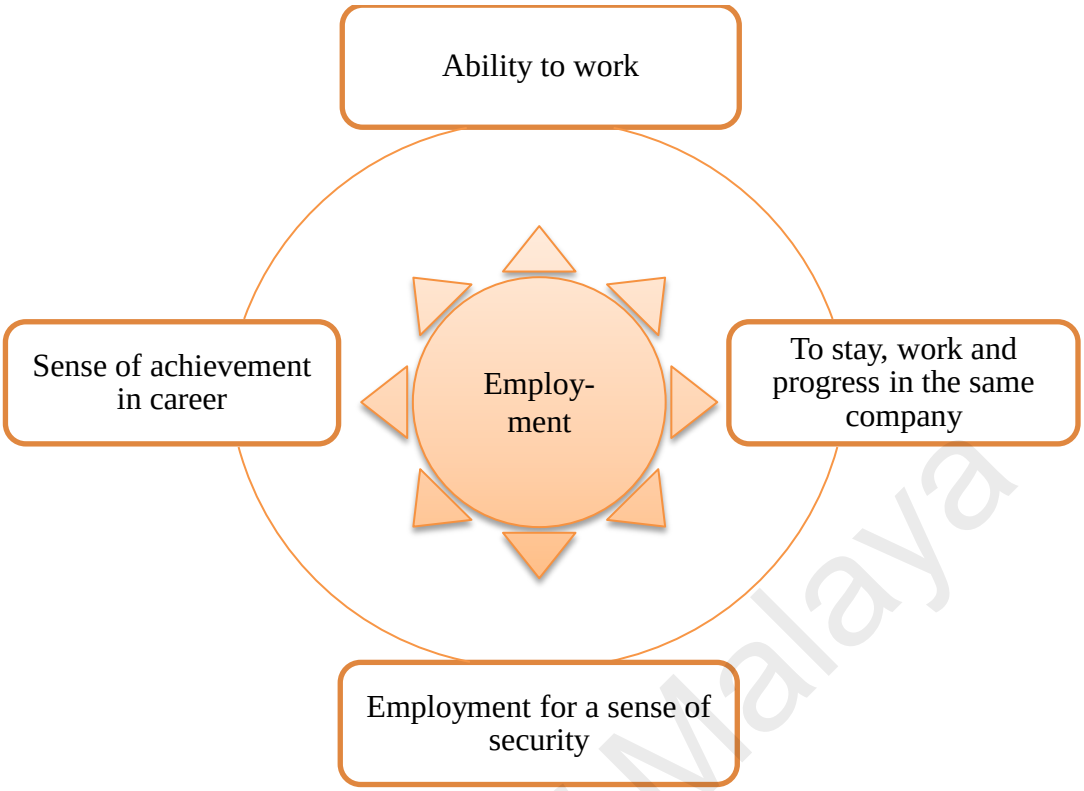

Figure 5.14. Theme 14 – Employment

Discussion of the Research Findings

This research discovered fourteen themes of young adults' personal growth experiences recovering from major depressive disorder. All the fourteen themes were separated into two components namely personal growth processes and personal growth contributors. Eight themes were perceived as personal growth processes in journey of recovery which comprised of "revealing the struggles," "self-discovery and personal strength," "personal responsibility," "readiness for change," "hope," "redefining the meaning," "forgiveness," and "acceptance." On the other hand, six themes were perceived as personal growth contributors which consisted of "supportive relationships," "medication," "attending counselling," "religion and spirituality," "care for others," and "employment," which have helped significantly in the personal growth recovering from major depression. All the themes in the

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components of personal growth processes and personal growth contributors were interconnected during the recovering journey of major depressive young adults.

This study revealed the transition and turning point of the participants coming out from major depression and reflected their lived experiences engaged in the personal growth process. The result is a contribution to improve the understanding of the major depressive disorder and its available treatment, reducing social stigma, and providing supportive and meaning-focused service which is known as an essential target for intervention. The findings of this study also contributed to current psychotherapy theories (e.g., existential theory and cognitive theory) in understanding young adults' personal growth recovering from major depression.

Furthermore, this study benefits counsellors or psychotherapists as they have a holistic view of the personal growth experiences (both personal growth processes and personal growth contributors) encountered by major depressive young adults. Consequently, by understanding major depressive young adults' personal growth experiences, counsellors and psychotherapists may be able to incorporate new strategies into their practices. Details on each theme will be discussed in the next section.

Revealing the struggles. In most studies conducted on major depression, it was often connected with wide range of negative attributes people make about it (Cornford, Hill, & Reilly, 2007). In this study, revealing the struggles has been perceived by participants as part of the process in their personal growth journey of recovery from major depression which is consistent with the past studies.

It has been found that regarding personal growth experience, young adults often embrace negative perspectives and beliefs on depression treatment (Kangas, 2001; Karp, 1994; Lewis, 1995; Maxwell, 2005). This attitude makes them delay and

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hesitant from being diagnosed and treated for depression and motivating the decision not to accept the physician's diagnosis of major depression (Cornford et al., 2007; Van Voorhees et al., 2005).

In this study, the participant revealed that they experienced a lot of negative feelings and thoughts before and after they were diagnosed with major depressive disorder. They reached a point where they could not cover their major depression symptoms any longer. Before they have the courage to reveal their illness, participants were troubled by the thoughts of rejection, perceptions and treatments from others especially from the loved ones, friends, health care professionals, and colleagues.

Negative beliefs and attitudes (e.g., medications are ineffective in treating depression, denying the presence of a biological cause for depression), subjective social norms (e.g., believing one with depression would be humiliated if one's friends knew about it), and past treatment behaviour (e.g., no prior treatment, medication or counselling is helpful) were related with the intention not to accept a diagnosis of major depression, indicating why young adults reported low rates of treatment for depression (Van Voorhees et al., 2005). Tseng, Bhugra, and Bhui (2007) ascertained differences in the experiences of individuals from divergent cultural backgrounds and beliefs, the reactions and feedbacks to mental health illnesses are also subjected to cultural and social influences. Karasz and Watkins (2006) suggested that different cultural structures view of normalcy, dogmas, and responses to the experience of mental illness with different perspectives.

Subsequently, it was found that participants chose to reveal their lived experience in a firm way after accepting the fact that they needed help. However, the previous studies did not highlight the association of exposing negative attributes of

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struggles with a positive decision of an individual to come out from major depression.

In sum, although there was some fear of exposing their hidden thoughts and feelings which has been part of themselves for some time, participants perceived that it helped them to become truthful by aligning their inner thoughts and feeling with people around them. Thus, it is important to understand that revealing the struggle has fostered other personal growth aspects which assisted them to recover and sustain ongoing personal growth process recovering from major depression.

Self-discovery and personal strength. In terms of self-discovery and personal strength, in this study participants highlighted it as the discovery of weaknesses and strengths, self-motivation, resiliency, coping abilities, and self-understanding that helped them in overcoming their struggles with major depression. This outcome was supported by one study whereby one of the themes related to recovery from depression was personal strength (Badger & Nolan, 2006).

From the researcher's perspective, it has been found that the theme focused on personal empowerment and self-help whereby they learned to acknowledge and to develop newer and more positive conceptions of themselves, their strength base, and abilities to solve problems positively (Rogers, Chamberlin, Ellison, & Crean, 1997). Participants believed that by developing personal strength such as resiliency, self-understanding, self-motivation, coping abilities, and ascertaining of own weaknesses and strengths, they felt a sense of empowerment in their personal growth journey of recovery from major depression (Badger & Nolan, 2006; Dumont & Provost, 1999; Kyriakopoulos, 2011).

Furthermore, Dumont and Provost (1999) in their studies to examine the positive role of specific internal factors revealed that positive problem-solving

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coping strategy, resiliency, and self-esteem contributed in protecting youth who were experiencing depression.

While conducting this study, the researcher had identified that the actions of self-discovery and personal strength have helped participants to build their self-confidence and fostered hope, forgiveness, and acceptance throughout their recovery process (Kyriakopoulos, 2011). Self-discovery is found to be associated with self-realization (Petersen, 2011) in which defining oneself means reflecting out what is important and worthy in one's disparity from others' (Taylor, 1994).

In this perspective, what is essential is to be genuine to oneself and his or her unique innermost voice (Taylor, 1994). Hence, authentic self-realization has become a predominant moral model which is conditioned by the reflective cultivation of one's core. Participants perceived it as a meaningful aspect in their personal growth as they became able to face every setback in their lives which were described as complex, on-going, and authentic self-realization (Petersen, 2011).

Personal responsibility. The following theme discloses how participants believed that one of the aspects which has helped them to recover from major depression is personal responsibility. This outcome was in line with Ridge and Ziebland's (2006) study of men and women in recovery from depression whereby taking responsibility was also one of the key themes that emerged in their study.

It was found that participants believed the aspect of responsibility was a crucial aspect which affected their decision making and readiness for change. It is associated with Frank's existential-logotherapy approach for treating depression which highlighted the aspect of assuming individual responsibility for one's own existence and for pursuing the innate values in life (Frankl, 2000; Yip, 2008). Participants disclosed their responsibility towards their family (Badger & Nolan,

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2006; Fullagar, 2009; Ridge & Ziebland, 2006) was generally connected to their personal growth in recovery journey and they experienced the urge to take care of the family and to perform their role as a filial petite child and a good parent.

Furthermore, other participants perceived that their responsibility toward themselves was the reason for them to move on from major depression. They realized that they have to take care and to love themselves if they want to make changes in their lives. These insights also emerged in the participants' narratives in the few studies conducted previously (Badger & Nolan, 2006; Fullager, 2009; LaFrance & Stoppard, 2006; Peden, 1992, 1996; Ridge & Ziebland, 2006; Schreiber, 1996; Steen, 1996; Vidler, 2005).

In sum, it has been found that responsibility is another healing factor and it was also believed to be a vital energy that was present throughout the recovery and played as an important personal growth process to sustain ongoing personal growth recovering from major depression.

Readiness for change. The readiness for change has been perceived by the participants as a point where they were confronted by the inner mayhem by their state of major depression. This finding is corroborated by a research done by Harris, Brown, and Robinson (1999) whereby the participants' narrative of a necessity for a change in lives is supported by in the indication that anew start experiences do in fact enhance the probabilities of remission. Readiness for change has similarity with the term "coming out" stated by Corrigan and Matthews (2003).

In this study, it is found that participants believed that even though others can influence change, change itself must ultimately come from within. Each participant reflected their struggles and determined what it would take to face their sense of meaninglessness and powerlessness to begin to move out from major depression

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(Corrigan et al., 2010; Harris, Brown, & Robinson, 1999; Nunstedt et al., 2012). This study outcome was in line with a study carried out by Nunstedt et al. (2012) which aimed to explore individuals' understanding of their own depression and how this understanding was used to prepare and to be ready for transformation or change.

They also stated the choices between two ways either to move on or to stay in major depression. It was perceived as necessary to identify the need to make changes and to seek help (Frankl, 1984; Nunstedt et al., 2012). According to every participant, readiness for changes started in a variety of ways. Four participants were cognitively aware of their depressive symptoms but realized that they were unable to upshot change without external support. With this realization, they allowed themselves to receive help and come to acceptance with the outcomes of the diagnosis of major depressive disorder (Nunstedt et al., 2012).

Furthermore, it was also found that the aspect of readiness for change is substantiated in Frank's description associated with existential psychology which emphasized that although it is true that individuals cannot always change negative things that have happened (or are happening) to them, each person always has a choice as to how to respond to adversity. This means that even though good cannot directly stem from pain, good can come from an individual's response to pain (Frankl, 1984).

In sum, it is found that readiness for change is related to the notions of existential, psychodynamic, and archetypal theoreticians similarly (e.g., Buber, 1958; Friedman, 1992; Hillman, 1996; Horney, 1950; Maslow, 1968; May, 1983; Yalom, 1980), which have postulated the concept that each being is born with a sole purpose, aptitude, or fate in life, and living a worthy and decent life means serving that purpose. In another word, in service to the soul of the world. The finding

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corroborated with the perspective whereby living a worthy life does not indicate a personal choice or individual expression. Destiny of fate cannot be mixed up with despair as human still have to continue making choices as to what they want to do with the life they are living. Nevertheless, some choices take them nearer to gratifying their life's purpose (Adame & Knudson, 2008).

Hope. In this study, hope was perceived as belief in a better future by participants in their personal growth recovering from major depression. When participants hoped, they anticipated making positive changes and reaching achievable goals (Perez, 2013). They felt a vital energy of self-assured anticipation that assisted them to visualize possibilities for themselves that they had previously discounted (Perez, 2013). This outcome was in line with a study conducted by Houghton (2007) to explore the relationship between hope and recovery from depression as well as another study conducted by Perez (2013) to explore the live experience of hope in women recovering from major depression.

It was found that the participants believed that hope was a vital life energy which they have experienced from the onset of recovery and throughout the personal growth process in order to sustain ongoing recovery from major depression. They hoped for relief from symptoms in the early recovery process and hoped for change as well as progress as they lived their lives (Houghton, 2007; Perez, 2013).

Later, they generally hoped for a better future as the recovery process from major depression progressed. Most of the participants envisioned a specific improvement in life and within themselves. Hope was conceptually associated with several themes such as, support relationship, therapeutic professional relationships, and spiritual support (Dufault & Martocchio, 1985; Farran, Herth, & Popovich, 1995; Herth, 2005; Miller & Powers, 1988; Perez, 2013).

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In sum, it has been found that hope is also perceived as a source of energy and strength for participants as they healed and pursued their goals and dreams for the future. Furthermore, participants also believed that hope was fostered in connections with the participants themselves, family and friends, counselors, God, and colleagues.

Redefining the meaning. The following theme, namely redefining the meaning was addressed by participants in this study as part of their personal growth journey of recovery from major depression. Regarding the aspect of redefining the meaning, participants identified a few aspects which had made them experience personal growth. One of the participants believed that by redefining the meaning (Frankl, 1963, Wong, 2005) of his job, he is able to cope with his work stress as well as to face every challenge at his workplace. He believed that by changing his way of thinking and the way he looked at things (von Below et al., 2010), he learnt a better way to reach his job satisfaction. This was consistent with the Frank's existential-logotherapy (short-term existential approach) (Schulenberg, Hutzell, Nassif, & Rogina, 2008; Sharf, 2015) which emphasized on the importance of values and meaning of individual's life (Frankl, 2000; Yip, 2008).

It was found that by placing one's suffering within a large context to make sense of it (Frankl, 2000; Yip, 2008), participants emphasized on how their decision to redefine the meaning of their struggles with major depression had empowered them during their personal growth journey. This outcome was in line with the study conducted by von Below et al. (2010). According to von Below et al. (2010), individuals' experiences of positive and constructive changes and new aptitudes (feeling well, discovery oneself, identifying one's way of life, looking life differently) extended beyond symptom relief.

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In addition, most of the participants believed that when they redefined the meaning of one-self and personal growth, they experienced positive changes, more happier, more hopeful (Bailey, Eng, Frisch, & Snyder, 2007) in terms of their perceptions toward their struggles with major depression, trials and challenges in lives, the value and meaning of their personal growth and healing, and most importantly the way they acknowledge themselves as a whole (Frankl, 2000; von Below et al., 2010; Yip, 2008). It has been found that the aspect of redefining the meaning was connected with other aspects such as forgiveness, acceptance, readiness for change, as well as hope.

In sum, this aspect of personal growth in recovering journey from major depression was also believed to be continually improved in making positive changes and to reach attainable goals set by the participants.

Forgiveness. In this study, it was found that the aspect of forgiveness was important for participants during their personal growth journey of recovery from major depression. Forgiveness to them was perceived as forgiving one's self and forgiving others who had hurt them before. In addition, participants believed that by forgiving themselves and others they allowed themselves to be free (Bloch, 2009) from negative emotions such as pain, hurt, hatred, anger, sadness, and incompetency. The aspect of forgiveness found in this study was corroborated with the guide underlined by Bloch (2009) whereby one of the self-care activities healing from depression was mental-emotional self-care (e.g., cognitive restructuring, daily affirmations, self-forgiveness).

Furthermore, it was found that this outcome corroborated by a study conducted by Carbonell et al. (2005) whereby forgiveness was perceived as a way of "to let go" of, or to move on from, the experiences and after-effects of adversity

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included forgiveness, leaving the house, and spending time alone or with other people, kept participants away from experience of helplessness to firm deprivations in the past, while maintaining an on-going but limited relationship with others.

In sum, the researcher found that this action of forgiving others has given participants inner peace to experience setbacks without feeling a sense of failure, despair, hopelessness, doubts, and outburst (Bloch, 2009; Carbonell et al., 2005). This can be seen when most of the participants connected self-forgiveness as a decision they have to make for them to experience personal growth and healing, gratitude toward life, letting go, as well as inner peace and freedom (Frankl, 2010). Their decision to forgive one-self and others had helped them to move on from the past hurts, perceived their challenges positively, and to become a better and happier person.

Acceptance. The researcher found that acceptance is one of the significant aspects which played an important part in the personal growth journey of recovery from major depression. There were three categories of acceptance which were highlighted by the participants namely self-acceptance, acceptance by others, and also acceptance of past hurts. Substantially, when they opened their heart to accept whatever things that happened to them with a different perception, it helped them to learn to accept not only their past but also to accept themselves as well (Cavanagh, Strauss, Forder, & Jones, 2014). It was supported by Frank's statement which stressed on accepting the individual's subjective experience of suffering in an empathic way, the meaning of depression and life will be restored (Frankl, 2000; Yip, 2008).

Subsequently, it was found that the aspect of acceptance fostered throughout the participants' personal growth journey of recovery from major depression when

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they learned to acknowledge both of their strengths and weaknesses as part of them as well as to believe that their past hurts had made them stronger and better person in their lives (Perez, 2013; Woll, 2007; Yip, 2008). It is vital for the researcher to recognize and understand the element of acceptance in major depressive young adults' personal growth journey.

There were two facets of acceptance found in this study namely self-acceptance and acceptance of others (Cavanagh et al., 2014). Self-acceptance involved acceptance of own flaws, both positive and negative feelings and thoughts, strengths and weaknesses, and their imperfections (Frankl, 1984). On the other hand, the acceptance from others provided a sense of normalcy for the participants by encouraging, motivating, and supporting socialization (Perez, 2013). The participants felt that they received the same treatment, were not discriminated by others, and had a sense of being understood when they experienced acceptance from others. It encouraged them to seek for help and to move on with their major depression. For them, finding acceptance in others was empowering.

In sum, acceptance of the past hurts took place when the participants allowed and learnt to accept their past as part of their lives as well as to believe that everything happened for some reason to help them to build their emotional and mental strengths (Bauman & Waldo, 1998).

Supportive relationship. In this study, it was found that the aspect of supportive relationship has been perceived by the participants as one of the important aspects in their personal growth process. Three participants highlighted that support from their spouse had played an important role in their personal growth journey and all the nine participants connected their personal growth process with the support they received from family and friends. It is supported by previous studies (Barrera &

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Garrison-Jones, 1992; Beeber, 1998; Jacobson, Dobson, Fruzzetti, Schmaling, & Salusky, 1991; Nasser & Overholser, 2005; O'Blenis, 2006) which highlighted the quality of supportive relationships in helping individuals who have depression.

Most of the participants perceived the supportive relationship they received from family, friends, and spouses had played a vital role in their personal growth journey (Carbonell, Reinherz, & Beardslee, 2005; Vidler, 2005). They believed that the gist in the supportive relationship they had received were the encouragement, motivation, emotional and mental support, fair treatment, acceptance, care, love, presence (not alone), unconditional treatment, listening, toleration, and trust (Bloch, 2009; Carbonell et al., 2005). This outcome was supported by one of the study conducted by Mart ínez-Hern áez et al. (2014) and Vidler (2005) which had also found that the continuous support from family and friends were one of the key to recovery from depression.

In was found that some participants had received valuable support from their colleagues and bosses. Thus, they perceived that the gist from the support they received were encouragement, support, respect, understanding, toleration, and also non-discrimination (Gulliver, Griffiths, & Christensen, 2010), which in line with the findings of Gulliver et al. (2010) and Mart ínez-Hern áez et al. (2014). However, it was common to note that most of the organization still perceived depression as a problem and as something that was not discussed in workplaces (Davies, 2008).

Medication. The researcher found out that in Malaysia, pharmacotherapy dominates the treatment for depression and is known as a primary treatment in major depression (Mukhtar & Oei, 2011b). In this study, medication was perceived as a requisite in the participants' recovery journey from major depression. This outcome of the study corresponded with Fullager (2009) study which revealed the connection

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of medication in women's recovery journey from depression. However, participants experienced varying responses towards different medications available and were often had conflict of opinions to its use in improving their depressive symptoms due to a stigmatized view on major depression (Bluhm et al., 2014; O'Blenis, 2006).

All the participants whom took antidepressants to support their personal growth journey emphasized the importance of it. It has been found that medication was believed to be able to calm their negative emotions, lessen the anxiety, and reducing negative thoughts (Mukhtar & Oei, 2011b). These actions had provided a space for the participants to begin the process of getting well.

Thus, it is corresponding with the study that described medication (antidepressant) as one of the elements to enable depressive people to restore the ability to function normally (Hollon, Thase, & Markowitz, 2002) and to juggle multiple roles which they felt obligated to fulfill (Bluhm et al., 2014; Fullager, 2009; Hollon et al., 2002; Mukhtar & Oei, 2011b; Ng, 2014). Furthermore, the participants also believed that early termination of medication without approval from psychiatrists may cause a reoccurrence of depressive symptoms as experienced prior to medication.

Attending counselling. In this study, researcher noted that participants perceived the aspect of attending counselling played an important role in facilitating their healing from major depression. This element was identified by the participants whereby they believed that counselling sessions were helpful in their healing from major depression. This outcome was in line with the past literature of getting help and care for depression from mental health professionals such as psychiatrist, psychotherapist and counsellor (Haarasilta et al., 2003, Mukhtar & Oei, 2011b; O'Blenis, 2006; Perez, 2013).

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Furthermore, participants perceived counselling sessions as an outlet for them to express their problems, emotion, and struggles with major depression. Hence, it has been found that counselling sessions also functioned as an outlet for the participants to build their foundation and to get to know more about depression. This outcome is supported by few studies which emphasized on the importance of therapeutic professional relationship to address young people's concerns and perspectives on how they could most appropriately be helped (Badger & Nolan, 2006; Comninos & Grenyer, 2007; Fullager, 2009; Hill, 1999; Houghton, 2007; Peden, 1992, 1996; Ridge & Ziebland, 2006; Steen, 1996; Vidler, 2005).

Furthermore, the researcher also discovered that participants undergoing counselling claimed that counselling session is an invaluable channel for them to learn about self-care, self-management, and emotional management. Some of the participants agreed that they were able to understand about themselves more as they progressed in personal growth in healing with the help of their counsellors. The patient's view regarding a therapist who enthusiastically led them to share their thoughts and feelings, attainment perspective and empathetic, viewing life in a different way and acting inversely, and suggested that a focus on self-identity questionnaire was an efficient way to assist and to curb depression among young adults (von Below et al., 2010).

Substantially, the participants addressed two supportive behaviours in counselling sessions which were 'presence' and 'listening'. They felt the presence when their counsellors conveyed understanding and acceptance of their major depression as well as their trust in them. On the other hand, they felt they were being listened to and were permitted to repeat their story, describing how major depression and their past had affected them (O'Blenis, 2006).

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Religion and spirituality. In this study, it was found that there were few religion and spiritual aspects described by the participants. The participants felt connected with God, able to put all the burdens onto God's shoulder, felt peace through prayers, continued to believe in God, perceived religion as a route to recovery, and received guidance through religion (Badger & Nolan, 2006; Fullager, 2009; Houghton, 2007; Nasser & Overholser, 2005). It was in line with most studies which underlined on the affirmative assistance of religious beliefs to sufferers of major depression (Bloch, 2009; Smith, McCullough, & Poll, 2003), coping with major depression (Desrosiers & Miller, 2007), and relapse rate of the disease (Miller et al., 2012). Religion has indeed been presented as a foundation of relief, faith, power (Koenig, 2007), and hope in confronting the adversity of life (Ai, Peterson, Tice, Bolling, & Koenig, 2004).

Subsequently, it has been found that participants felt connected to God when they visited churches or temples. They believed that they were protected, loved, and was given strength and a chance by God to stand up and to live a better life (Bloch, 2009; Smith et al., 2003). The finding is consistent with a study conducted by Kok (2015) to investigate emerging adults who have experienced depression to explore and understand their struggles during this developmental stage and to explore their recovery journey. One of the themes emerged was religious guidance.

Furthermore, the researcher also found that prayers and meditations were able to help participants to feel more at peace and calm when they faced difficulties in their lives (Bloch, 2009). This outcome is supported by a study conducted by Nurasikin et al. (2012) where higher level of religious commitment was associated with psychosis symptoms relief. They also became more hopeful towards their future. The participants continued to believe in God to retain their trust in life and to

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be more accepting towards their own weaknesses. They also believed religion as a route and guidance to sustain their recovery processes (Kok, 2015).

Care for others. It was found that the aspect of caring for others was perceived by participants as one of the prevailing aspects in their personal growth journey of recovery from major depression. They believed that it helped them to recover from major depression by sharing about their struggles to those people in need and to motivate them to stand up again (Cornford, et al., 2007; O'Blenis, 2006; Ridge & Ziebland, 2006).

Furthermore, it was found that the act of caring for others had made the participants feel proud and useful to others as well as to gain own progression as an individual. This outcome was in line with a study conducted by Cornford, et al. (2007) which they stated that "eliciting ideas such as engagement with tasks and with other people, working at relationships and forcing oneself outwards may be appropriately encouraged in the initial consultations. Encouraging patients to talk about what is positive about their situation (such as support from partners, family or work mates), reinforcing any positive assessment and encouragement to work at positive aspects may also be an appropriate strategy."

Additionally, the researcher discovered that when participants reached out to those who were in need, they believed it motivated their inner strength to move on and to empower them to live a better life (Lewis, 1995). In sum, the participants experienced the changes of the meaning in their lives when they reached out and cared for others. Participants experienced a more meaningful life when they got to help someone else who was in need (Lewis, 1995; Solomon et al., 2008).

Employment. It was found that the aspect of employment played as one of the personal growth element in participants' journey of recovery from major

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depression. This is supported by a study conducted by Badger and Nolan (2006) to explore recovery from depression with 60 adults treated for depression in primary care setting whereby one of the themes emerged from the study which attributed to their recovery was employment.

Subsequently, it was found that participants felt conflicted when they were struggling with major depression and at the same time they need to work to sustain their daily lives. In other words, psychosocial functioning (in this study was employment) was significantly related to the probability of recovery from episodes of major depression (Badger & Nolan, 2006; Ridge & Ziebland, 2006; Solomon et al., 2008). Thus, for them to have a job was important in their personal growth journey of recovery from major depression to feel proud and useful. In career, the participants believed that they were able to develop values and goals that were realistic and attainable (Onken, Craig, Ridgway, Ralph, & Cook, 2007).

In sum, it was found that being employed was crucial to enhance sense of security and achievement which believed to be helpful for the participants to move out from major depression (Badger & Nolan, 2006; Onken et al., 2007).

In conclusion, the abovementioned elements that emerged in the finding reports of young adults' personal growth experiences have facilitated them to recover from major depression. In this study, it was found that all the young adult participants have undergone a process of personal growth recovering from major depression which comprised of two main elements namely personal growth processes and personal growth contributors. Both of the elements were interconnected throughout the personal growth journey of the participants. Therefore, it is essential to be aware and understand the role of each theme and its elements.

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This contributes objectively to a comprehensive understanding of the young adults' personal growth experiences recovering from major depression.

Figure 5.15 depicts an overview of the essence of personal growth experiences of young adults recovering from major depressive disorder.

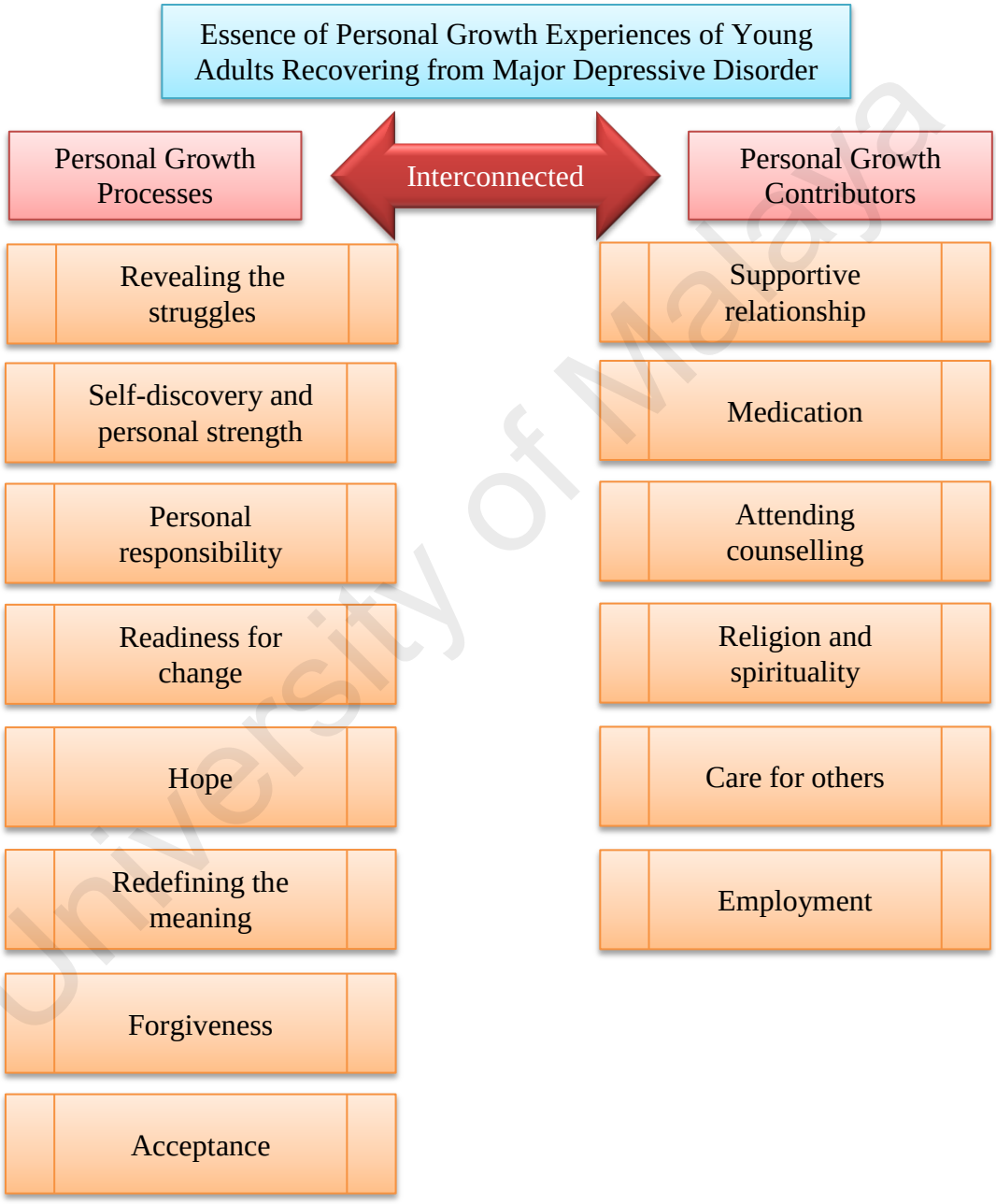

Figure 5.15. Overview of the essence of personal growth experiences of young adults recovering from major depressive disorder

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Implications

Implications for psychotherapy and counselling practice. Young adult participants emphasized several aspects which were vital to their personal growth journey of recovery from major depression. Therefore, the outcomes of this research study conveyed significant implications for psychotherapy and counselling practice with major depressive young adults. This study revealed a detailed description of young adults' personal growth experience recovering from major depression, which has crucial direct implications for counselling and psychology practice. Consequently, to apply the findings of the research study to the corresponding practices, the following are suggestions which have been made.

Firstly, the young adult participants in this study revealed the important for knowledge of and understanding about major depression for themselves and for their peers, parents, colleagues, and the public in general. Hence, it is essential for the mental health care practitioners in helping profession to have an in-depth understanding of the personal growth recovering from major depression among young adults. In this study each participant had revealed that they have to go through several personal growth processes which included a lot of challenges as a part of their personal growth journey of recovery whereby they have to reveal their struggles with depression, then slowly discovered their individual particular strength, aware of their own personal responsibility, ready for change, learnt to hope again, redefined the meaning of their healing, they learned to forgive themselves and others who had hurt them before, until finally, they reached the point of acceptance of themselves.

Besides, in this study each participant also shared the personal growth contributors which have contributed to their personal growth journey of recovery from major depression. Those were supportive relationship they received, taking

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medication, attending counselling, religion and spiritual beliefs, caring for others, and employment which have helped them significantly in the personal growth journey. The result underlined the personal growth contributors that contributed to participants' recovery from major depression and the personal growth processes that were involved in the personal growth journey of recovery were interconnected throughout the recovery process. Hence, in providing therapeutic intervention to major depressive young adults, it is vital for the practitioners in helping profession to not only to an emphasis on aspects or factors that aid them but also the processes that the major depressive young adults will come across in their personal growth journey.

Secondly, an in-depth understanding of major depressive young adults' personal growth experiences would equip a novice practitioner to become an effective counsellor and therapist in providing therapeutic intervention services. All the participants of the study indicated the need for the use of medication (antidepressants) in their recovery journey. Without an in-depth understanding of the function of antidepressant in young adults' healing from major depression, mental health care practitioners may end up doing more maltreatment than being supportive to them. Therefore, practitioners who are working with major depressive young adults need to understand that it is part of the personal growth contributor for them as suggested by Woll (2007). Anticipatory guidance and counselling about the benefits versus risks of medication use, the actions and possible side effects of antidepressants, the time lag prior to symptom relief, and the need for extended treatment could help avoid improper and perhaps dangerous misuse or premature discontinuation of medication. Hence, it required practitioners to be patient, prepare themselves with knowledge about pharmacotherapy, and allow sufficient time to see the major depressive young adults directed improvement from the intervention.

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Thirdly, another remarkable aspect of research findings was the impact of counselling sessions in each participant. All the participants agreed on the importance for them to attend counselling sessions as one of the outlet to receive help. They revealed that in counselling sessions they felt accepted, trusted, supported, and also experienced the benefits of presence and listening provided in the sessions. Unfortunately in Malaysia, there are not many relevant studies focused on this area which therefore caused a lack of attentiveness and awareness among mental health care practitioners about this personal growth contributor. It is important for physicians, therapists, psychologists, and counsellors to equip themselves with knowledge and understanding about supporting clients in emotional relief, emphasized the value of working with rather than working on helping to bridge relationships to develop a sense of empowerment and trust among major depressive young adults.

Finally, counselling and psychotherapy practitioners can utilize and apply the study outcomes to manoeuvre treatment and intervention plans for their patients or clients who have a history of major depressive disorder. Treatment and intervention plans can be manoeuvred according to the individual personal growth processes experienced by the major depressive young adults. As revealed in the findings, recovery happens when participants can discover their strength and are aware of the personal responsibility. If the major depressive young adult is in the stage of soul-searching and trying to identify their strengths, thus the treatment and intervention plan should include approaches that allow them to slowly search for themselves – their inner strengths for personal growth. Therefore, practitioners are abed to integrate intervention strategies using expressive art therapy, creative writing, and meaning-centered therapy to assist major depressive young adults to express their

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struggles with major depression, to identify their strength and responsibility, and to redefine the weaknesses which they have experienced in the personal growth journey. In the process to implement and apply this strategy, practitioners are encouraged to identify and connect the resources that are considered to be personal growth aspects for the major depressive young adults such as, supportive relationship, forgiveness and acceptance, hope, and spiritual beliefs. Practitioners can encourage their patients and clients to talk about what is positive and encouraging about their situation (for instance support from spouses, family or colleagues), strengthening any positive assessment and encouragement to endeavor life at positive aspects may also be a suitable strategy. Practitioners can work thoroughly with the family members, friends, and professional pastoral or religious counsellors to enhance personal growth of young adults recovering from major depression.

Implications for psychotherapy and counselling education and training. Understanding of major depression begins with psychotherapy and counselling education and training. Hence, the findings of this study have significant implications for psychotherapy and counselling education and training for helping professions field, specifically those who are working in mental health setting as well as those who are working with major depressive people. The study findings revealed that participants' personal growth recovering from major depression involved unique personal growth processes and personal growth contributors that worked closely hand-in-hand in helping them to recover from major depression. A comprehensive and in-depth understanding of the experience of major depression for young adults and their personal growth can provide a basic supportive counselling and psychotherapy care that goes beyond the treatment of symptoms only as suggested

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by Ridge and Ziebland (2006). The experience of major depression must be taught in a way that signifies the meaning of major depression for young adults.

Substantially, practitioners in helping profession without a prior and sufficient training will have higher possibilities to face challenges in assisting depressive young adults recovering from major depressive disorder. In a study conducted by Mart ínez-Hern áez et al. (2014), participants expressed the difficulties to access treatment, fearful to tell a stranger about their problems and reported suspicion in the treatment benefits and of the social consequences if they sought for help. Thus, the subsequent recommendations are improvised to integrate the discoveries into psychology and counselling training for novices as well as any practitioners who are keen or who are presently working with major depressive young adults.

Firstly, the findings of the research study perchance operated as a framework in evolving training modules for veteran practitioners as well as novice practitioners. The current results revealed the facets of personal growth processes and personal growth contributors. Hence, the training modules related to helping young adults with a background of major depression should be incorporated into two aspects to assure practitioners benefit a more comprehensive perspective on young adult client's personal growth recovering from major depression. This method of training allows practitioners to understand the personal growth processes and able to signify the personal growth contributors that may occur in assisting major depressive young adult clients.

Furthermore, in the process to develop a training module and guideline for therapeutic intervention with major depressive young adults, considering the integration of an approach grounded in the personal growth processes and come up

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with an effective and comprehensive therapeutic intervention guides or strategies. Findings can be used to implement a useful guideline and module to identify therapeutic intervention plans that can bring about personal growth of recovery for the major depressive young adults. Through a variety of therapeutic strategies, practitioners can recognize opportunities to strengthen caring connections that foster personal growth processes such as, hope, forgiveness and acceptance, self-discovery and personal strengths, readiness for change, personal responsibility, and redefining the meaning of personal growth in which will increase the possibility of ensuring an efficient therapy session for the depressed young adults who are seeking support from them. Consequently, clinical experiences, for example, guided by the findings of this study, can include opportunities to encourage supportive interactions with loved ones, spiritual expression, and self-care.

Finally, the findings revealed that the personal growth journey for each participant was a challenging process. Participants experienced ups and downs in dealing and managing their major depression, taking time for healing and recovery. Therefore, to work with this unique group necessitates counsellors and therapists to be patient, non-judgmental, understanding, and thoughtful as well. Hence, these findings put additional needs on both psychotherapeutic techniques training and education whereby an attentiveness of the experiences of overcoming depression in emerging adulthood is highlighted (von Below et al., 2010). Furthermore, psychotherapy and counselling education and training programmes must incorporate the study of stigma as it relates to mental illness, as well as to other health challenges, into their curricula.

Implications for psychotherapy models. The findings of the study have notable implication on the contemporary theoretical view on young adults' personal

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growth recovering from major depression. Consequently, three implications on theoretical were pinpointed: the awareness of the existing theories limitation in understanding personal growth from major depression, the need to expand the present theories on personal growth, and a necessity to have integration of theories to attain comprehensive view on personal growth recovering from major depression.

Firstly, the findings of this study identified that there is a limitation of the related theories of personal growth in understanding the individuals' perception on personal growth throughout their journey of recovery from major depression. Based on the results of the study, the personal growth experiences faced by young adult participants involved in the personal growth processes as well the personal growth contributors. Four theories were distinguished and reviewed in the literature review section; they were the existential theory, multiple self-states theory, cognitive theory and comprehensive model of healing. In this study, existential theory specifically logo theory has positively underlined the importance of the personal growth contributors or sources used by the participants to experience personal growth recovering from major depression. On the other hand, the theory of comprehensive model of healing and the theory multiple self-state highlighted on the personal growth processes that participants have to go through in their personal growth recovering from major depression. However, each theory only successful emphasized one personal growth aspect, it's either the personal growth contributors or the personal growth processes, and thus it is unable to present a comprehensive perspective of personal growth in major depression. This phenomenon is comprehensible because it is still lacking a research conducted based on young adults' perspective on personal growth recovering from major depression. Thus, this

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may eventuate to more theories on personal growth recovering from major depression which has not successfully capture the essence of personal growth.

Secondly, there is a necessity to expand the related personal growth theories to enrich the understanding of personal growth from major depression. Based on the literature review of the three theories, most of the theories are unable to reflect thoroughly the importance of both personal growth processes and personal growth contributors to recover from major depression. Therefore, there is a necessity to broaden the current theory to have more comprehensive perspectives which comprise of the aspect of personal growth processes and personal growth contributors.

Lastly, there is also a necessity for integration of theories to attain comprehensive views on personal growth recovering from major depression. The identified limitation of the existing theories, it brings about the need to have a theoretical notion that can equip an in-depth understanding perspective on personal growth recovering from major depression from the individuals' perspective. Consequently, study findings recommended that there is a need for future researchers and practitioners to incorporate several theories to obtain the comprehensive notion of one's personal growth recovering from major depression. The integration of the theories is believed to be able to assist the researcher with a platform to understand the actual personal growth experiences experienced by young adults. This belief will have helped the researcher to develop a more robust framework that can be applied to their study. Besides, the integration of the theories is also believed to be able to provide practitioners with a more holistic view on personal growth which will lift to holistic strategies of intervention for the depressed young adults who come to seek for help.

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In summary, findings implied that there are several deficiencies in current related theories of healing to provide a comprehensive view on personal growth recovering from major depression, especially in the young adults' perspective. Furthermore, findings also suggested further expanding and integrating theories regarding personal growth, because it is believed that it will be able to provide a comprehensive notion on personal growth recovering from major depression from the young adults' perspective.

Implications for future research. The findings of the study have significant implication on the research of young adults' personal growth journey of recovery from major depression. The findings of this study also support the need for further qualitative studies exploring the personal growth experience of major depression in young adults.

The young adults in this study described making the transition from lingering in a place of comfort in their major depression to engaging in the personal growth journey. Further investigation into the conditions necessary for making this transition could support young adults in moving more readily to engage in the journey. Hence, the question is what provides the participants the motivation to move on from major depression?

The findings of a phenomenological study are considered to be theoretical. With a better understanding of the live experience, subsequent research may identify a theoretical process of personal growth for young adults with major depression. To re-emphasize, approximately 2.3 million people in Malaysia to date still remain under-detected and untreated (Mukhtar & Oei, 2011a; 2011b). Hence, the reasons and consequences of their hiding behavior taken on by some people with depression are real cause for concern. In this study, participants shared one of the aspects in

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personal growth journey namely “revealing the struggles” which has helped to illuminate the essence of concealing behaviours in major depression.

A majority of the participants believed personal responsibility would be a valuable personal growth process in their recovery journey from major depression. Investigation into the benefits and risks of personal responsibility could provide evidence to validate this form of healing aspect especially in the context of Asian country in which the values of collectiveness and filial piety or obligation are still strongly embraced.

The findings of this study signified that while the personal growth experiences for young adults recovering from major depression endures some interconnection between personal growth processes and personal growth contributors, there are notable transformations suggesting that there is a need to generate and validate reliable tools and assessment to measure both of the components in young adults who are depressed and recovering from major depression.

Implications for policy development. The findings of the study have significant implication for the policy development in Malaysia. In this study, all the participants revealed that they have encountered considerable struggles responding to major depression, isolated themselves to preserve any relationships, afraid of stigma and bias, and attempted self-harm or suicide to bring a dramatic end to their suffering. Furthermore, young adults are reported with the highest risk for depressive disorder among all age group (Ahmad et al., 2015). Young adults are known as an important group in a developing and developed country and they are everywhere from universities to workforce settings. Thus, this stage of human development is an important period to promote mental and emotional health.

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The public education system and public industry system are ideal places to implement policy that supports the promotion of mental and emotional health. Inclusion of topics related to mental health and illness in colleges and universities curricula could promote a greater understanding of major depression among young adults, providing them with the tools to identify and address major depression within themselves and with their peers. A greater presence of policy makers with an understanding of major depression in young adults within the organization or industry system can not only provide support but also provide an important advocate and liaison for young adults returning to university or work when they are in the recovery stage. Undeniably, employment is a valuable personal growth contributor in the recovery process healing from major depression.

The participants in this study also emphasized the need for greater public awareness related to mental health and more specifically to major depression. The stigma associated with mental illness was recognized as a factor encouraging young adults to obscure their major depression. Mental health care practitioners, individually and through their professional associations, can promote healthy public policy related to the stigma surrounding mental illness.

Recommendations for Future Research

The research findings have a substantial impact on the practitioners' counselling and psychotherapy practice, impacts on their education and training, impacts on psychotherapy models, impacts on counselling and psychotherapy research, and impact on policy developments. Several recommendations for prospective research were identified and discussed in this section for the deliberation of practitioners and researchers.

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Firstly, it is suggested to use the study's outcomes as a framework for exploring personal growth experience experienced by young adults with major depression, because it incorporated two essential areas comprising of the personal growth processes and personal growth contributors. Based on this framework it enables the researcher to cover a wide spectrum of personal growth elements that provide to young adults' personal growth recovering from major depressive disorder. A researcher may reconsider adopting these findings as a core to design an assessment or to design an intervention program or to develop a practice and education module for practitioners.

Secondly, it is suggested to have future researchers distinguish ways to stretch out to the different gender. Thus, one of the limitations was that it did not actively involve a balanced ratio of gender. In this study, only one male participant was willing to be part of the study. Struggles and personal growth experienced by young male adults may be different from female, young adults. Other than that, female, young adults were more willing to share when compared to male young adults. It was because young male adults with major depression perceived that sharing with strangers about their depressive disorder is like exposing themselves as "weak and unmanly". Thus, future researchers have to be ready for situations where young male adults may feel hesitant to participate in a study. Researchers have to reflect their likelihoods to gain conviction and acceptance from this group beforehand to be able to involve them as part of the research.

Thirdly, it is recommended that further prospective investigation is to be done on each of the personal growth element in Malaysian context which has diversity concerning multicultural and ethnic background. Future research is because there was deficient in in-depth studies of these elements to connect with the young adults'

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personal growth recovering from major depression, especially in Malaysia. In most of the earlier studies on personal growth in healing recovering from major depression, these elements were often seldom reviewed or discussed except for the aspect of pharmacotherapy (medication) and supportive relationship. The impacts and perspectives of each personal growth element is strongly recommended for further investigation because it is considered a very significant personal growth element for the all the participants.

Fourthly, it is recommended to conduct further qualitative research with young adults healing from major depression. This suggestion is based on the reviewed literature that previous and present studies on young adults from major depression are extremely limited in a Malaysian context. Most of the studies remained unpublished, and most of the articles found and researches conducted by Malaysian researchers focused mainly on causes and symptoms generally at all ranges of age. Therefore, it is urged to have more regional and international researchers to study the issue of major depressive disorder, particularly for the young adults in Malaysia.

Fifthly, it is recommended for future researchers to stretch out to young adults who are facing more struggles in recovering from major depressive disorder. In this study, participants who had agreed for this study have been found to be able to cope with the depressive episodes reasonably well. It is believed that there are still young adults who have to struggle daily fighting against the depressive remorse without much success. They are the group of young adults whose views, thoughts, and feelings should be heard as well. However, to stretch out to this group of people, researchers will require a lot of patience and creativeness. It required a lot of patience on the part of the researcher to gain the assurance from the depressed young adults.

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Researchers would require creativity and detailed plans to discover ways to reach out to these young adults with major depression.

Lastly, the lack of studies based on young adults with major depressive disorder is less common in Malaysia, but it has already made its presence in other developed countries. Hence, it is recommended and urged in the future to have more practitioners and researchers to conduct more qualitative studies because it will contribute to an extensive understanding on personal growth recovering from major depression, mainly based on the young adults' perspective.

Conclusion

The main objective of this transcendental phenomenological study was to investigate and describe the subjective lived personal growth experience of young adults recovering from major depressive disorder. The current study reveals the struggles, self-discovery and personal strength, personal responsibility, readiness for change, hope, redefining the meaning, forgiveness, acceptance, supportive relationship, medication, attending counselling, religion and spirituality, care for others, and employment has contributed to the body of knowledge on related issues pertaining to major depressive disorder. It is found that both personal growth processes and personal growth contributors are interconnected in contributing towards personal growth recovery for major depressive young adults. Hence, practitioners and researchers need to be more objective and be more conscientious in integrating both personal growth processes and personal growth contributors in order to understand their prospective clients' as well as participants' personal growth experiences. In conclusion, the ability to identify every aspect of personal growth processes and personal growth contributors is an extra credit for practitioners and

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researchers to have a holistic view of the personal growth experiences faced by young adults in order to help them to reach recovery stage.

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References

Aalto-Setälä, T., Marttunen, M., Tuulio-Henriksson, A., Poikolainen, K., & Lönnqvist, J. (2002). Depressive symptoms in adolescence as predictors of early adulthood depressive disorders and maladjustment. *American Journal of Psychiatry, 159*(7), 1235-1237. doi: 10.1176/appi.ajp.159.7.1235

Abraham, K. (1911). Notes on the psycho-analytical investigation and treatment of manic-depressive insanity and allied conditions. In K. Abraham (Ed.), *Selected papers on psychoanalysis* (pp. 137-156*).* London: Hogarth Press.

Abraham, K. (1924). A short study of the development of the libido, viewed in the light of mental disorders. I. Melancholia and obsessional neurosis. In K. Abraham (Ed.), *Selected papers on psychoanalysis* (pp. 418-501). London: Hogarth Press.

Abraham, K. (1924). A short study of the development of the libido in the light of mental disorders: I. Melancholia and obsessional neurosis. In K. Abraham (Ed.), *Selected papers on psychoanalysis* (pp. 422–433). New York, NY: Basic Books.

Adame, A. L., & Knudson, R. M. (2008). Recovery and the good life: How psychiatric survivors are revisioning the healing process. *Journal of Humanistic Psychology, 48*(2), 142-164. doi: 10.1177/0022167807305544

Adler, E., & Clark, R. (2007). *How it's done: An invitation to social research*. Belmont, CA: Cengage Learning.

Ahmad, N. A., Razak, M. A. A., Naidu, B. M., Awaluddin, S. M., Chan, Y. Y., Kasim, N. M., … Ibrahim, N. (2015). Mental health problems of adults. In Institute for Public Health (Ed.), *National Health and Morbidity Survey 2015 Volume II: Non-communicable diseases, risk factors & other health problems* (pp. 185-189). Retrieved from http://www.iku.gov.my/images/IKU/Document/nhmsreport2015vol2.pdf

Ai, A. L., Peterson, C., Tice, T. N., Bolling, S. F., & Koenig, H. G. (2004). Faith-based and secular pathways to hope and optimism subconstructs in middle-aged and older cardiac patients. *Journal of Health Psychology, 9*(3), 435-450. doi: 10.1177/1359105304042352

Allen, N. B., Hetrick, S. E., Simmons, J. G., & Hickie, I. B. (2007). Early intervention for depressive disorders in young people: The opportunity and the (lack of) evidence. *The Medical Journal of Australia, 187*(7), S15–S17. (PMID 17908018)

University of Malaya

Alloy, L. B., Riskind, J. H., & Manos, M. J. (2005). *Abnormal psychology: Current perspectives* (9th ed.). New York, NY: McGraw-Hill.

Allport, G. W. (1961). *Pattern and growth in personality*. New York: Holt, Rinehart & Winston.

American College Health Association. (2012). *American College Health Association-National College Health Assessment II: Reference group executive summary* (Fall 2011 ed.). Hanover, MD: American College Health Association.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders (DSM-IV)* (4th ed.). Washington, DC: American Psychiatric Pub.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (DSM-5)* (5th ed.). Washington, DC: American Psychiatric Pub.

American Psychological Association. (2014). Guidelines for prevention in psychology. *The American Psychologist*, *69*(3), 285-296. doi: 10.1037/a0034569

Andrasik, F. (Ed.). (2005). *Comprehensive handbook of personality and psychopathology, adult psychopathology* (Vol. 2). Hoboken, NJ: John Wiley & Sons.

Andreasen, N. C. (1985). *The broken brain: The biological revolution in psychiatry*. New York, NY: Harper & Row.

Arieti, S. (1977). Psychotherapy of severe depression. *The American Journal of Psychiatry, 134*(8), 864-868. doi: 10.1176/ajp.134.8.864

Arnett J. J. (2004). *Emerging adulthood: The winding road from the late teens through the twenties*. New York: Oxford University Press.

Arnett, J. J. (2000). Emerging adulthood: A theory of development from the late teens through the twenties. *American Psychologist*, *55*(5), 469-480. doi: 10.1037//0003-066X.55.5.469

University of Malaya

Arnett, J. J. (2007). Suffering, selfish, slackers? Myths and reality about emerging adults. *Journal of Youth and Adolescence, 36*(1), 23–29. doi: 10.1007/s10964-006-9157-z

Aron, L. (1996). The relational orientation. In *A meeting of minds*. Hillsdale, NJ: Analytic Press.

Ary, D., Jacobs, L., Sorensen, C., & Walker, D. (2013). *Introduction to research in education* (9th ed.). Belmont, CA: Cengage Learning.

Badger, F., & Nolan, P. (2006). Concordance with antidepressant medication in primary care. *Nursing Standard, 20*(52), 35-40. doi: 10.7748/ns2006.09.20.52.35.c4492

Bailey, T. C., Eng, W., Frisch, M. B., & Snyder, C. R. (2007). Hope and optimism as related to life satisfaction. *The Journal of Positive Psychology, 2*(3), 168-175. doi: 10.1080/17439760701409546

Balami, A. D., Salmiah, M. S., & Nor Afiah, M. Z. (2014). Psychological determinants of pre-hypertension among first year undergraduate students in a public university in Malaysia. *Malaysian Journal of Public Health Medicine, 14*(2), 67-76. Retrieved from http://www.mjphm.org.my/mjphm/journals/2014%20-%20Volume%2014%20(2)/PSYCHOLOGICAL%20DETERMINANTS%20OF%20PRE-HYPERTENSION%20AMONG%20FIRST%20YEAR%20UNDERGRADUATE%20STUDENTS%20IN%20A%20PUBLIC%20UNIVERSITY%20IN%20MALAYSIA.pdf

Barrera, M., & Garrison-Jones, C. (1992). Family and peer social support as specific correlates of adolescent depressive symptoms. *Journal of Abnormal Child Psychology, 20*(1), 1-16. doi: 10.1007/BF00927113

Batthyany, A., & Russo-Netzer, P. (Eds.). (2014). *Meaning in positive and existential psychology*. New York, NY: Springer.

Battista, J., & Almond, R. (1973). The development of meaning in life. *Psychiatry, 36*(4), 409–427. doi: 10.1521/00332747.1973.11023774

Bauman, S., & Waldo, M. (1998). Existential theory and mental health counselling: If it were a snake, it would have bitten!. *Journal of Mental Health Counselling, 20*(1), 13-27. (ERIC No. EJ571456)

University of Malaya

Baumeister, R. F. (1991). *Meanings of life*. New York, NY: Guilford Press.

Bazeley, P. (2007). *Qualitative Data Analysis with NVivo*. Thousand Oaks, CA: SAGE Publications.

Beck, A. T. (1963). Thinking and depression: I. Idiosyncratic content and cognitive distortions. *Archives of General Psychiatry, 9*(4), 324-333. doi: 10.1001/archpsyc.1963.01720160014002

Beck, A. T. (1967). *Depression: Clinical, experimental, and theoretical aspects* (Vol. 32). Philadelphia, PA: University of Pennsylvania Press.

Beck, A. T., & Hurvich, M. S. (1959). Psychological Correlates of Depression: 1. Frequency of "Masochistic" Dream Content in a Private Practice Sample. *Psychosomatic Medicine, 21*(1), 50-55. doi: 10.1097/00006842-195901000-00007

Beck, A. T., & Valin, S. (1953). Psychotic depressive reactions in soldiers who accidentally killed their buddies. *American Journal of Psychiatry, 110*(5), 347-353. doi: 10.1176/ajp.110.5.347

Becker, S., Bryman, A., & Ferguson, H. (Eds.). (2012). *Understanding research for social policy and social work: Themes, methods and approaches* (2nd ed.). Bristol, UK: Policy Press.

Beeber, L. S. (1998). Treating depression through the therapeutic nurse-client relationship. *The Nursing Clinics of North America, 33*(1), 153-172. (PMID 9478912)

Berry, D. (2004). The relationship between depression and emerging adulthood: Theory generation. *Advances in Nursing Science, 27*(1), 53–69. (PMID 15027662)

Berry, J. W., Poortinga, Y. H., & Pandey, J. (Eds.). (1997). *Handbook of cross-cultural psychology: Vol. 1. Theory and method* (2nd ed.). Needham Heights, MA: Allyn & Bacon.

Bibring, E. (1953). *The mechanism of depression*. In P. Greenacre (Ed.), *Affective disorders* (pp. 13-48). New York, NY: International Universities Press.

Blaikie, N. (2007). *Approaches to social enquiry: Advancing knowledge* (2nd ed.). Cambridge: Polity Press.

University of Malaya

Blatt, S. J. (1998). Contributions of psychoanalysis to the understanding and treatment of depression. *Journal of the American Psychoanalytic Association*, *46*(3), 723-752. doi: 10.1177/00030651980460030301

Blatt, S. J. (2004). *Experiences of depression: Theoretical, clinical, and research perspectives*. Washington, DC: American Psychological Association.

Blenkiron, P. (2010). *Stories and analogies in cognitive behaviour therapy*. West Sussex, UK: John Wiley & Sons.

Bloch, D. (2009). *Healing from depression: 12 weeks to a better mood*. Lake Worth, FL: Nicolas-Hays.

Bluhm, R. L., Covin, R., Chow, M., Wrath, A., & Osuch, E. A. (2014). "I just have to stick with it and it'll work": Experiences of adolescents and young adults with mental health concerns. *Community Mental Health Journal*, *50*(7), 778-786. doi: 10.1007/s10597-014-9695-x

Borrini-Feyerabend, G., & Buchan, D. (1997). *Beyond fences: seeking social sustainability in conservation. Volume 2: A resource book*. Switzerland: IUCN.

Bowlby, J. (1969). *Attachment and loss, Vol 1: Attachment*. New York, NY: Basic Books.

Breland-Noble, A. M., Burriss, A., & Poole, H. (2010). Engaging depressed African American adolescents in treatment: Lessons from the AAKOMA PROJECT. *Journal of Clinical Psychology*, *66*(8), 868–879. doi: 10.1002/jclp.20708

Brislin, R. W. (1983). Cross-cultural research in psychology. *Annual Review of Psychology*, *34*(1), 363-400. doi: 10.1146/annurev.ps.34.020183.002051

Bromberg, P. M. (1991). On knowing one's patient inside out: The aesthetics of unconscious communication. *Psychoanalytic Dialogues, 1*, 399–422.

Bromberg, P. M. (1993). Shadow and substance: A relational perspective on clinical process. *Psychoanalytic Psychology, 10*, 147–168.

University of Malaya

Bromberg, P. M. (1994). “Speak that I may see you”: Some reflections on dissociation, reality and psychoanalytic listening. *Psychoanalytic Dialogues, 4*, 517–547.

Bromet, E., Andrade, L. H., Hwang, I., Sampson, N. A., Alonso, J., de Girolamo, G., ... Kessler, R.C. (2011). Cross-national epidemiology of DSM-IV major depressive episode. *BMC Medicine*, *9*(1), 90-105. doi: 10.1186/1741-7015-9-90

Buber, M. (1958). *I and thou*. New York: Scribner.

Bullard, E. W. (2010). *A Cross-cultural analysis of help-seeking for symptoms of depression in Japanese primary school teachers: Ethnicity, self-construal, and subjective perception*. Boca Raton, FL: Universal-Publishers.

Buckley, J., & Herth, K. (2004). Fostering hope in terminally ill patients. *Nursing standard*, *19*(10), 33-41. doi: 10.7748/ns2004.11.19.10.33.c3759

Burcusa, S. L., & Iacono, W. G. (2007). Risk for recurrence in depression. *Clinical Psychology Review, 27*(8), 959-985. doi: 10.1016/j.cpr.2007.02.005

Busch, F. N., Rudden, M., & Shapiro, T. (2004). *Psychodynamic treatment of depression*. Washington, DC: American Psychiatric Publishing.

Busch, F. N., Rudden, M., & Shapiro, T. (2007). *Psychodynamic treatment of depression.* Washington, DC: American Psychiatric Publishing.

Butler-Kisber, L. (2010). *Qualitative inquiry: Thematic, narrative and arts-informed perspectives*. Thousand Oaks, CA: SAGE Publications.

Carbonell, D. M., Reinherz, H. Z., & Beardslee, W. R. (2005). Adaptation and coping in childhood and adolescence for those at risk for depression in emerging adulthood. *Child and Adolescent Social Work Journal*, *22*(5-6), 395-416. doi: 10.1007/s10560-005-0019-4

Cassell, C., & Symon, G. (Eds.). (2004). *Essential guide to qualitative methods in organizational research*. Thousand Oaks, CA: SAGE Publications.

Cavanagh, K., Strauss, C., Forder, L., & Jones, F. (2014). Can mindfulness and acceptance be learnt by self-help?: A systematic review and meta-analysis of mindfulness and acceptance-based self-help interventions. *Clinical Psychology Review*, *34*(2), 118-129. doi: 10.1016/j.cpr.2014.01.001

University of Malaya

Chiu, E. (2004). Epidemiology of depression in the Asia Pacific region. *Australasian Psychiatry*, *12*(1), S4-S10. doi: 10.1111/j.1039-8562.2004.02097.x-i1

Chong, S. A., Vaingankar, J., Abdin, E., & Subramaniam, M. (2012). The prevalence and impact of major depressive disorder among Chinese, Malays and Indians in an Asian multi-racial population. *Journal of Affective Disorders*, *138*(1), 128-136. doi: 10.1016/j.jad.2011.11.038

Christensen, H., Griffiths, M. K., & Jorm, F. A. (2004). Delivering interventions for depression by using the internet: Randomised controlled trial. *British Medical Journal, 328*(7434), 265–268. doi: 10.1136/bmj.37945.566632.EE

Chung, W. Y., Chen, C., Greenberger, E., & Heckhausen, J. (2009). A cross-ethnic study of adolescents' depressed mood and the erosion of parental and peer warmth during the transition to young adulthood. *Journal of Research on Adolescence*, *19*(3), 359-379. doi: 10.1111/j.1532-7795.2009.00592.x

Cilesiz, S. (2009). Educational computer use in leisure contexts: A phenomenological study of adolescents' experiences at Internet cafes. *American Educational Research Journal*, *46*(1), 232-274. doi: 10.3102/0002831208323938

Cilesiz, S. (2010). A phenomenological approach to experiences with technology: current state, promise, and future directions for research. Educational Technology Research and Development, *59*(4), 487-510. doi: 10.1007/s11423-010-9173-2

Colaizzi, P. F. (1973). *Reflection and research in psychology: A phenomenological study of learning*. Dubuque, IA: Kendall/Hunt Publishing Company.

Comninos, A., & Grenyer, B. F. S. (2007). The influence of interpersonal factors on the speed of recovery from major depression. *Psychotherapy Research*, *17*(2), 230-239. doi: 10.1080/10503300600849140

Conway, C. M. (Ed.). (2014). *The oxford handbook of qualitative research in American music education*. New York, NY: Oxford University Press.

Corey, G. (2008). *Theory and practice of counseling and psychotherapy* (8th ed.). Pacific Grove, CA: Brooks/Cole.

Corey, G. (2012). *Theory and practice of counseling and psychotherapy* (9th ed.). Pacific Grove, CA: Brooks/Cole.

University of Malaya

Cornford, C. S., Hill, A., & Reilly, J. (2007). How patients with depressive symptoms view their condition: A qualitative study. *Family Practice, 24*(4), 358-364. doi: 10.1093/fampra/cmm032

Corrigan, P. and Matthews, A. (2003) Stigma and disclosure: implications for coming out of the closet, Journal of Mental Health, 12, 235–48.

Corrigan, P. W., Morris, S., Larson, J., Rafacz, J., Wassel, A., Michaels, P., … Rüsch, N. (2010). Self-stigma and coming out about one's mental illness. *Journal of Community Psychology, 38*(3), 259-275. doi: 10.1002/jcop.20363

Cranford, J. A., Eisenberg, D., & Serras, A. M. (2009). Substance use behaviors, mental health problems, and use of mental health services in a probability sample of college students. *Addictive Behaviors, 34*(2), 134-145. doi: 10.1016/j.addbeh.2008.09.004

Creswell, J. W. (2012). *Qualitative inquiry and research design: Choosing among five approaches* (3rd ed.). Thousand Oaks, CA: SAGE Publications.

Crotty, M. (2014). *The foundations of social research: Meanings and perspectives in the research process*. London: SAGE Publications. Retrieved from https://books.google.com.my/books (Original work published 1998)

Crowley, K. (2000). *The power of procovery in healing mental illness*. San Francisco: Kennedy Carlisle.

Crumbaugh, J. C., & Maholick, L. T. (1964). An experimental study in existentialism: The psychometric approach to Frankl's concept of noogenic neurosis. *Journal of Clinical Psychology*, *20*(2), 200–207. doi: 10.1002/1097-4679(196404)20:2<200::AID-JCLP2270200203>3.0.CO;2-U

Culph, J. S., Wilson, N. J., Cordier, R., & Stancliffe, R. J. (2015). Men's sheds and the experience of depression in older Australian men. *Australian Occupational Therapy Journal, 62*(5), 306-315. doi: 10.1111/1440-1630.12190

Cumby, J. (2006). *Women's experience of treatment for depression: A phenomenological study* (Doctoral dissertation, Memorial University of Newfoundland). Retrieved from http://research.library.mun.ca/10364/1/Cumby_Jill.pdf

Daly, J., Speedy, S., & Jackson, D. (Eds.). (2009). *Contexts of nursing: An introduction* (3rd ed.). Sydney, Australia: Elsevier.

University of Malaya

Dana, R. H. (Ed.). (2000). *Handbook of cross-cultural and multicultural personality assessment*. Mahwah, NJ: Erlbaum.

Davidson, L., & Strauss, J. S. (1992). Sense of self in recovery from severe mental illness. *British Journal of Medical Psychology*, *65*(2), 131–145. doi: 10.1111/j.2044-8341.1992.tb01693.x

Davies, J. M. (1996). Linking the "pre-analytic" with the postclassical. *Contemporary Psychoanalysis, 32*, 553–576.

Davies, L. (2008). Workplace Learning: Depression as an" Undiscussable" Topic in Eight Information and Communications Technology Organisations in South Australia. *Australian Journal of Adult Learning*, *48*(2), 291-315. (ERIC No. EJ809725)

Davison, G. C., Neale, J. M., & Kring, A. (2004). *Abnormal psychology* (9th ed.). New York, NY: Wiley.

Deacon, B. J. (2013). The biomedical model of mental disorder: A critical analysis of its validity, utility, and effects on psychotherapy research. *Clinical Psychology Review*, *33*(7), 846-861. doi: 10.1016/j.cpr.2012.09.007

Debats, D. L., van der Lubbe, P. M., & Wezeman, F. R. A. (1993). On the psychometric properties of the Life Regard Index (LRI): A measure of meaningful life. *Personality and Individual Differences*, *14*(2), 337–345. doi: 10.1016/0191-8869(93)90132-M

Deegan, P. (1996). Recovery as a journey of the heart. *Psychiatric Rehabilitation Journal*, *19*(3), 91–97. Retrieved from http://toronto.cmha.ca/files/2012/11/Deegan1996-Recovery-Journey-of-the-Heart1.pdf

Denzin, N. K., *&* Lincoln, Y. S. (1994). *Introduction*: *Entering the field of qualitative research*. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 500-515). Thousand Oaks, CA: SAGE Publications.

Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General*. Washington, DC: Department of Health and Human Services.

DePoy, E., & Gitlin, L. N. (2015). *Introduction to research: Understanding and applying multiple strategies* (5th ed.). St Louis, MO: Elsevier Health Sciences.

University of Malaya

Desrosiers, A., & Miller, L. (2007). Relational spirituality and depression in adolescent girls. *Journal of Clinical Psychology, 63*(10), 1021-1037. doi: 10.1002/jclp.20409

Detmer, D. (2013). *Phenomenology explained: From experience to insight*. Chicago: Carus Publishing.

Deva, M. P. (2006). Depressive illness--the need for a paradigm shift in its understanding and management. *Medical Journal of Malaysia, 61*(1), 4-6. Retrieved from https://www.researchgate.net/publication/7072449_Depressive_illness_-_The_need_for_a_paradigm_shift_in_its_understanding_and_management

Director General of Health Malaysia. (2014). *National Health and Morbidity Survey (NHMS) is vital to the country's health planning*. Retrieved from http://kpkesihatan.com/2014/09/18/national-health-and-morbidity-survey-nhms-is-vital-to-the-countrys-health-planning/

Downing-Orr, K. (2013). *Rethinking depression: Why current treatments fail*. New York, NY: Springer Science+Business Media.

Dowrick, C. (2009). *Beyond depression: a new approach to understanding and management*. Oxford: Oxford University Press.

Dufault, K., & Martocchio, B. (1985). Hope: Its spheres and dimensions. Nursing Clinics of North America, 20, 379-391.

Dumont, M., & Provost, M. A. (1999). Resilience in adolescents: Protective role of social support, coping strategies, self-esteem, and social activities on experience of stress and depression. *Journal of Youth and Adolescence,28*(3), 343-363. doi: 10.1023/A:1021637011732

Eisenberg, D., Golberstein, E., & Gollust, S. E. (2007a). Help-seeking and access to mental health care in a university student population. *Medical Care, 45*(7), 594-601. doi: 10.1097/MLR.0b013e31803bb4c1

Eisenberg, D., Gollust, S. E., Golberstein, E., & Hefner, J. L. (2007b). Prevalence and correlates of depression, anxiety, and suicidality among university students. *American Journal of Orthopsychiatry, 77*(4), 534-542. doi: 10.1037/0002-9432.77.4.534

Elder, R., Evans, K., & Nizette, D. (2008). *Psychiatric and mental health nursing*. Sydney, NSW: Elsevier Australia.

University of Malaya

Engel, G. L. (1977). The need for a new medical model: a challenge for biomedicine. *Science, 196*(4286), 129-136.

Engel, R. J., & Schutt, R. K. (2014). *Fundamentals of social work research*. Thousand Oaks, CA: SAGE Publications.

Erikson, E. H. (1959). *Identity and the life cycle*. New York, NY: International Universities Press.

Erikson, E. H. (1968). *Identity: Youth and crisis*. New York, NY: Norton.

Farran, C., Herth, K., & Popovich, J. (1995). Hope and Hopelessness Critical Clinical Constructs. Thousand Oaks, CA: SAGE Publications, Inc.

Frank, E., Prien, R. F., Jarrett, R. B., Keller, M. B., Kupfer, D. J., Lavori, P. W., ... Weissman, M. M. (1991). Conceptualization and rationale for consensus definitions of terms in major depressive disorder: Remission, recovery, relapse, and recurrence. *Archives of General Psychiatry, 48*(9), 851-855. doi: 10.1001/archpsyc.1991.01810330075011

Frank, J. D. (1993). *Persuasion and healing*. Baltimore: The John Hopkins University Press.

Frankl, V. E. (2000). *The Will to Meaning. Foundations and Applications of Logotherapy. A Psychotherapy which Teaches that Man is Free to Shape his Own Character*. London: Souvenir Press Ltd.

Frankl, V. E. (1963). *Man's search for meaning: An introduction to logotherapy*. New York, NY: Pocket Books.

Frankl, V. E. (1965). *The doctor and the soul: From psychotherapy to logotherapy*. New York, NY: Vintage Books.

Frankl, V. E. (1967). *Psychotherapy and existentialism: Selected papers on logotherapy*. New York, NY: Washington Square Press/Pocket Books.

Frankl, V. E. (1969). *The will to meaning: Foundations and applications of logotherapy*. New York, NY: The World Publishing Co.

Frankl, V. E. (1978). *The unheard cry for meaning: Psychotherapy and humanism*. New York, NY: Simon & Schuster

University of Malaya

Frankl, V. E. (1984). *Man's search for meaning*. New York, NY: Simon and Schuster.

Frankl, V. E. (1986). *The doctor and the soul: From psychotherapy to logotherapy* (Revised and expanded). New York, NY: Vintage Books.

Frankl, V. E. (2014). *The will to meaning: Foundations and applications of logotherapy* (Expanded Edition). New York, NY: Penguin Group. (Original Work published in 1969)

Franzoi, S. (2010). *Psychology: A discovery experience*. Mason, OH: Cengage Learning.

Friedman, M. (1992) Do old fallacies ever die?. *Journal of Economic Literature, 30*(4), 2129-2132. Retrieved from http://mcadams.posc.mu.edu/econ/Friedman,%2520The%2520Regression%2520Fallacy.pdf

Freud, S. (1917). Mourning and melancholia. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 14, pp. 237-260). London: Hogarth Press.

Freud, S. (1923). The ego and the id. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 19, pp. 1-66). London: Hogarth Press.

Fröjd, S., Marttunen, M., Pelkonen, M., von der Pahlen, B., & Kaltiala-Heino, R. (2007). Adult and peer involvement in help-seeking for depression in adolescent population. *Social Psychiatry and Psychiatric Epidemiology, 42*(12), 945-952. doi: 10.1007/s00127-007-0254-4

Fullager, S. (2009). Negotiating the neurochemical self: Anti-depressant consumption in women's recovery from depression. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine, 13*(4), 389-406. doi: 10.1177/1363459308101809

Gabbard, G. O. (2014). *Psychodynamic psychiatry in clinical practice*. Washington, DC: American Psychiatric Publishing.

Galamabos, N., Barker, E., & Krahn, H. (2006). Depression, self-esteem, and anger in emerging adulthood: Seven-year trajectories. *Developmental Psychology, 42*(2), 350–365. doi: 10.1037/0012-1649.42.2.350

University of Malaya

Geller, B., Zimerman, B., Williams, M., Bolhofner, K., & Craney, J. L. (2001). Bipolar disorder at prospective follow-up of adults who had pre-pubertal major depressive disorder. *American Journal of Psychiatry, 158*(1), 125-127. doi: 10.1176/appi.ajp.158.1.125

Gergen, K. J. (1991). *The saturated self: Dilemmas of identity in contemporary life*. New York: Basic Books.

Gillham, B. (2005). *Research Interviewing: The range of techniques: A practical guide*. Maidenhead, UK: Open University Press.

Gillies, V., Harden, A., Johnson, K., Reavey, P., Strange, V., & Willig, C. (2005). Painting pictures of embodied experience: The use of nonverbal data production for the study of embodiment. *Qualitative Research in Psychology, 2*(3), 199-212.

Giorgi, A. P., & Giorgi, B. M. (2003). *The descriptive phenomenological psychological method.* In P. M. *Camic, J. E.* Rhodes, & L. Yardley (Eds.), *Qualitative research in psychology: Expanding perspectives in methodology and design* (pp. 243-274). Washington, DC: American Psychological Association.

Given, L. M. (2008). *The Sage encyclopedia of qualitative research methods*: Sage Publications.

Glantz, M. D., Anthony, J. C., Berglund, P. A., Degenhardt, L., Dierker, L., Kalaydjian, A., ... Kessler, R. C. (2009). Mental disorders as risk factors for later substance dependence: estimates of optimal prevention and treatment benefits. *Psychological Medicine, 39*(8), 1365-1377. doi: 10.1017/S0033291708004510

Gotlib, I. H., & Hammen, C. L. (Eds.). (2008). *Handbook of depression* (2nd ed.). New York, NY: Guilford Press.

Gotlib, I. H., & Hammen, C. L. (Eds.). (2014). *Handbook of depression* (3rd ed.). New York, NY: Guilford Press.

Gould, W. B. (1993). *Viktor E. Frankl: Life with meaning*. Pacific Grove, CA: Brooks/Cole.

Grimstad, S. (2013). *Business driven environmental action in agricultural based tourism micro-clusters in Norway and Australia* (Doctoral dissertation). University of Newcastle, Australia.

University of Malaya

Griswold, K. S., Aronoff, H., Kernan, J. B., & Kahn, L. S. (2008). Adolescent substance use and abuse: recognition and management. *American Family Physician*, *77*(3), 331-336. Retrieved from http://www.aafp.org/afp/2008/0201/p331.pdf

Guba, E. G., & Lincoln, Y. S. (1994). *Competing paradigms in qualitative research*. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 220-235). Thousand Oaks, CA: SAGE Publications.

Gulliver, A., Griffiths, K. M., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: a systematic review. *BMC Psychiatry*, *10*(1), 113-121. doi: 10.1186/1471-244X-10-113

Haarasilta, L., Marttunen, M., Kaprio, J., & Aro, H. (2003). Major depressive episode and health care use among adolescents and young adults. *Social Psychiatry and Psychiatric Epidemiology*, *38*(7), 366-372. doi: 10.1007/s00127-003-0644-1

Halasz, G., Anaf, G., Ellingsen, P., Manne, A., & Thomson Salo, F. (2002). *Cries unheard: a new look at attention deficit hyperactivity disorder*. Melbourne, Australia: Common Ground.

Hales, R. E. (2008). *The American psychiatric publishing textbook of psychiatry*. Washington, DC: American Psychiatric Publishing.

Hammen, C. (2009). Adolescent depression stressful interpersonal contexts and risk for recurrence. *Current Directions in Psychological Science*, *18*(4), 200-204. doi: 10.1111/j.1467-8721.2009.01636.x

Hammen, C., & Watkins, E. (2008). *Depression* (2nd ed.). Hove, UK: Psychology Press.

Hammersley, M., & Atkinson, P. (2007). *Ethnography: Principles in practice* (3rd Rev. ed.). Andover: Routledge.

Hanafiah, A. N., & Van Bortel, T. (2015). A qualitative exploration of the perspectives of mental health professionals on stigma and discrimination of mental illness in Malaysia. *International Journal of Mental Health Systems*, *9*(1), 10-22. doi: 10.1186/s13033-015-0002-1

Harlow, L. L., Newcomb, M. D., & Bentler, P. M. (1986). Depression, self-derogation, substance use, and suicide ideation: Lack of purpose in life as a

University of Malaya

mediational factor. *Journal of Clinical Psychology, 42*(1), 5–21. doi: 10.1002/1097-4679(198601)42:13.0.CO;2-9

Harris, T., Brown, G. W., & Robinson, R. (1999). Befriending as an intervention for chronic depression among women in an inner city. 2: Role of fresh-start experiences and baseline psychosocial factors in remission from depression. *The British Journal of Psychiatry, 174*(3), 225-232. doi: 10.1192/bjp.174.3.225

Hatch, J. A. (2002). *Doing qualitative research in education settings*. Albany, NY: State University of New York Press.

Hawton, K., Houston, K., & Shepperd, R. (1999). Suicide in young people. Study of 174 cases, aged under 25 years, based on coroners' and medical records. *The British Journal of Psychiatry, 175*(3), 271-276. doi: 10.1192/bjp.175.3.271

Heifner, C. (1997). The male experience of depression. *Perspectives in Psychiatric Care, 33*(2), 10-18. doi: 10.1111/j.1744-6163.1997.tb00536.x

Herth, K. (2005). State of the science of hope in nursing practice. In J. A. Elliot (Ed.), Interdisciplinary perspectives on hope (pp. 169-211). Hauppauge, NY: Nova Science Publishers.

Hesse-Biber, S. N., & Leavy, P. (2010). *The practice of qualitative research*. Thousand Oaks, CA: SAGE Publications.

Hill, M. (1999). What's the problem? Who can help? The perspectives of children and young people on their well-being and on helping professionals. *Journal of Social Work Practice, 13*(2), 135-145. doi: 10.1080/026505399103368

Hillman, J. (1996). *The soul's code: In search of character and calling*. New York, NY: Random House.

Hodges, J., & Oei, T. P. (2007). Would Confucius benefit from psychotherapy? The compatibility of cognitive behaviour therapy and Chinese values. *Behaviour Research and Therapy, 45*(5), 901-914. doi: 10.1016/j.brat.2006.08.015

Hoffmann, N. (Ed.). (2012). *Foundations of cognitive therapy: Theoretical methods and practical applications*. New York, NY: Springer Science & Business Media.

University of Malaya

Hollon, S. D., Thase, M. E., & Markowitz, J. C. (2002). Treatment and prevention of depression. *Psychological Science in the Public Interest, 3*(2), 39-77. doi: 10.1111/1529-1006.00008

Holloway, I., & Brown, L. (2012). *Essentials of a qualitative doctorate*. Walnut Creek, CA: Left Coast Press.

Horney, K. (1950). Neurosis and human growth: The struggle toward self-realization. New York, NY: Norton.

Houghton, S. (2007). Exploring hope: Its meaning for adults living with depression and for social work practice. *Australian e-journal for the Advancement of Mental Health, 6*(3), 186-193. doi: 10.5172/jamh.6.3.186

Houser, J. (2008). *Nursing research: Reading, using, and creating evidence*. Sudbury, MA: Jones & Bartlett Learning.

Husserl, E. (1970). *The crisis of European sciences and transcendental phenomenology: An introduction to phenomenological philosophy*. Evanston: Northwestern University Press.

Hysenbegasi, A., Hass, S. L., & Rowland, C. R. (2005). The impact of depression on the academic productivity of university students. *Journal of Mental Health Policy and Economics, 8*(3), 145-151. (PMID 16278502)

Ibrahim, N., Amit, N., & Suen, M. W. Y. (2014). Psychological factors as predictors of suicidal ideation among adolescents in Malaysia. *PLoS One, 9*(10), e110670. doi: 10.1371/journal.pone.0110670

Yüksel, P., & Yıldırım, S. (2015). Theoretical frameworks, methods, and procedures for conducting phenomenological studies in educational settings. *Turkish Online Journal of Qualitative Inquiry, 6*(1), 1-20. doi: 10.1007/s12275-013-2393-5

Iliffe, S., Gallant, C., Kramer, T., Gledhill, J., Bye, A., Fernandez, V., ... Garralda, M. E. (2012). Therapeutic identification of depression in young people: lessons from the introduction of a new technique in general practice. *British Journal of General Practice, 62*(596), e174-e182. doi: 10.3399/bjgp12X630061

Ingram, R. E. (Ed.). (2009). *The international encyclopedia of depression*. New York, NY: Springer Publishing Company.

University of Malaya

Institute for Public Health. (1999). *The Second National Health and Morbidity Survey (NHMS II) 1996.* Malaysia: Ministry of Health.

Institute for Public Health. (2008). *The Third National Health and Morbidity Survey (NHMS III) 2006.* Malaysia: Ministry of Health.

Institute for Public Health. (2011). *National Health and Morbidity Survey 2011. Vol. II: Non- Communicable Diseases.* Malaysia: Ministry of Health.

Institute for Public Health. (2015). *NHMS 2011*. Retrieved from http://www.iku.gov.my/index.php/research-eng/list-of-research-eng/iku-eng/nhms-eng/nhms-2011-eng

Ivey, A. E., Ivey, M. B., & Zalaquett, C. P. (2014). *Intentional interviewing and counseling: Facilitating client development in a multicultural society* (8th ed.). Belmont, CA: Brooks/Cole.

Jacobson, E. (1971). Transference problems in depression. In E. Jacobson (Ed.), *Depression: Comparative Studies of Normal, Neurotic, and Psychotic Conditions* (pp. 242-263). New York, NY: International Universities Press.

Jacobson, N. S., Dobson, K., Fruzzetti, A. E., Schmaling, K. B., & Salusky, S. (1991). Marital therapy as a treatment for depression. *Journal of Consulting and Clinical Psychology*, *59*(4), 547-557. doi: 10.1037/0022-006X.59.4.547

Jacobsson, G. (2005). *On the threshold of adulthood: Recurrent phenomena and developmental tasks during the period of young adulthood* (Doctoral dissertation). Department of Education, Stockholm University, Stockholm.

James, N., & Busher, H. (2009). Epistemological dimensions in qualitative research: The construction of knowledge online. In J. Hughes (Ed.), *SAGE Internet Research Methods* (pp. 5-18). London, UK: SAGE Publications.

Johansson, R., Carlbring, P., Heedman, Å., Paxling, B., & Andersson, G. (2013). Depression, anxiety and their comorbidity in the Swedish general population: point prevalence and the effect on health-related quality of life. *PeerJ, 1*, e98. doi:10.7717/peerj.98.

Johnson, J. M. (2002). In-depth interviewing. In J. F. Gubrium & J. A. Holstein (Eds.), *Handbook of Interview Research: Context and Methods* (pp. 103-119). Thousand Oaks, CA: SAGE Publications.

University of Malaya

Jones, I., Brown, L., & Holloway, I. (2012). *Qualitative research in sport and physical activity*. Thousand Oaks, CA: SAGE Publications.

Jones, S. C., & Roberts, K. (2007). *Key topics in psychiatry*. Philadelphia, PA: Elsevier Health Sciences.

Jones-Smith, E. (2014). *Theories of counseling and psychotherapy: An integrative approach* (2nd ed.). Thousand Oaks, CA: SAGE Publications.

Judd, L. L., Paulus, M. J., Schettler, P. J., Akiskal, H. S., Endicott, J., Leon, A. C., ... & Keller, M. B. (2000). Does incomplete recovery from first lifetime major depressive episode herald a chronic course of illness?. *American Journal of Psychiatry, 157*(9), 1501-1504. doi: 10.1176/appi.ajp.157.9.1501

Jung, C. G. (1953). *Two essays on analytical psychology*. New York, NY: Pantheon Books.

Kangas, I. (2001). Making sense of depression: perceptions of melancholia in lay narratives. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine, 5*(1), 76-92. doi: 10.1177/136345930100500104

Kapitan, L. (2010). *Introduction to art therapy research*. New York, NY: Routledge.

Karasz, A., & Watkins, L. (2006). Conceptual models of treatment in depressed Hispanic patients. *The Annals of Family Medicine, 4*(6), 527-533. doi: 10.1370/afm.579

Karp, D. A. (1994). Living with depression: Illness and identity turning points. *Qualitative Health Research, 4*(1), 6-30. doi: 10.1177/104973239400400102

Keen, E. (1975). *Doing research phenomenologically: Methodological considerations*. Unpublished manuscript, Bucknell University, Lewisburg, PA.

Kervin, L. K., Vialle, W. J., Herrington, J. A., & Okely, A. D. (2006). *Research for Educators*. Melbourne, Australia: Thomson Learning.

Keshen, A. (2006). A new look at existential psychotherapy. *American Journal of Psychotherapy*, *60*(3), 285-298. (PMID 17066759)

University of Malaya

Kessler, R. C., & Bromet, E. J. (2013). The epidemiology of depression across cultures. *Annual Review of Public Health, 34*, 119-138. doi: 10.1146/annurev-publhealth-031912-114409

Kessler, R. C., Avenevoli, S., & Merikangas, K. R. (2001). Mood disorders in children and adolescents: An epidemiologic perspective. *Biological Psychiatry*, *49*(12), 1002-1014. doi: 10.1016/S0006-3223(01)01129-5

Khan, T. M., Sulaiman, S. A., & Hassali, M. A. (2012). Factors associated with suicidal behaviour among depressed patients in Penang, Malaysia. *Archives of Medical Science*, *8*(4), 697-703. doi: 10.5114/aoms.2012.28601

Khan, T. M., Sulaiman, S. A., Hassali, M. A., & Tahir, H. (2009). Attitude toward depression, its complications, prevention and barriers to seeking help among ethnic groups in Penang, Malaysia. *Mental Health in Family Medicine*, *6*(4), 219-227. (PMID 22477913)

Kim, M. D., Hong, S. C., Lee, C. I., Kwak, Y. S., Shin, T. K., Jang, Y. H., ... Hwang, S. E. (2007). Prevalence of depression and correlates of depressive symptoms for residents in the urban part of Jeju Island, Korea. *International Journal of Social Psychiatry*, *53*(2), 123-134. doi: 10.1177/0020764006075022

Kirk, D., MacDonald, D., & O'Sullivan, M. (Eds.). (2006). *Handbook of physical education*. London, UK: SAGE Publications.

Klein, M. (1979). Mourning and its relation to manic depressive states. In *Melanie Klein: Love, guilt and reparation and other works 1921-1945: The writings of Melanie Klein* (Vol. 1, pp. 344–369). London: Hogarth Press. (Original work published 1940)

Kleinman, A. (1995). Do psychiatric disorders differ in different cultures? The methodological questions. In N. R. Goldberger & J. B. Veroff (Eds.), *The Culture and Psychology Reader* (pp. 631-651). New York, NY: New York University Press.

Klenke, K. (2008). *Qualitative research in the study of leadership*. Bingley, UK: Emerald Group Publishing.

Klineberg, E., Biddle, L., Donovan, J., & Gunnell, D. (2011). Symptom recognition and help seeking for depression in young adults: A vignette study. *Social Psychiatry and Psychiatric Epidemiology*, *46*(6), 495-505. doi: 10.1007/s00127-010-0214-2

University of Malaya

Klinghardt, D. (2005). The 5 Levels of Healing. *Explore!*, *14*(4), 1-7. Retrieved from http://www.klinghardtacademy.com/images/stories/5_levels_of_healing/Klinghardt_Article_5_Levels_of_Healing.pdf

Koenig, H. (2007). Religion and depression in older medical inpatients. *American Journal of Geriatric Psychiatry, 15(4),* 282–291. doi: 10.1097/01.JGP.0000246875.93674.0c

Kok, J. K. (2015). Life transition for the emerging adults and their mental health. *International Journal of Social Science and Humanity, 5*(12), 1035-1039. doi: 10.7763/IJSSH.2015.V5.600

Kok, J. K., & Lai, W. Y. (2014). Attending to metaphor in adolescence depression. *Jurnal Psikologi Malaysia, 28*(1), 51-64. Retrieved from http://spaj.ukm.my/ppppm/jpm/article/view/126/96

Kolkelmans, J. J. (Ed.), (1967). *Phenomenology*. Garden City, NY: Doubleday.

Kumar, R. (2011). *Research methodology: A step-by-step guide for beginners* (3rd ed.). Thousand Oaks, CA: SAGE Publications.

Kuwabara, S. A., van Voorhees, B. W., Gollan, J. K., & Alexander, G. C. (2007). A qualitative exploration of depression in emerging adulthood: Disorder, development, and social context. *General Hospital Psychiatry, 29*(4), 317-324. doi: 10.1016/j.genhosppsych.2007.04.001

Kyriakopoulos, A. (2011). How individuals with self-reported anxiety and depression experienced a combination of individual counselling with an adventurous outdoor experience: A qualitative evaluation. *Counselling and Psychotherapy Research*, *11*(2), 120-128. doi: 10.1080/14733145.2010.485696

Lafrance, M. N., & Stoppard, J. M. (2006). Constructing a non-depressed self: Women's accounts of recovery from depression. *Feminism & Psychology*, *16*(3), 307-325. doi: 10.1177/0959353506067849

Lawlor, C. (2012). *From melancholia to Prozac: A history of depression*. Oxford: Oxford University Press.

Leach, L. S., Christensen, H., Mackinnon, A. J., Windsor, T. D., & Butterworth, P. (2008). Gender differences in depression and anxiety across the adult lifespan: The role of psychosocial mediators. *Social Psychiatry and Psychiatric Epidemiology*, *43*(12), 983-998. doi: 10.1007/s00127-008-0388-z

University of Malaya

LeCount, D., & Koberstein, J. (2000, August). *SOAR Case management services: Making recovery a reality—Toward a system-integrated approach.* Keynote address at the Mental Health Services Conference, Wellington, New Zealand.

Lee, W. W., Park, J. B., Min, K. B., Lee, K. J., & Kim, M. S. (2013). Association between work-related health problems and job insecurity in permanent and temporary employees. *Annals of Occupational and Environmental Medicine, 25*(15), 1-9. doi:10.1186/2052-4374-25-15

Lent, R. W. (2004). Toward a unifying theoretical and practical perspective on well-being and psychosocial adjustment. *Journal of Counseling Psychology, 51*(4), 482–509. doi: 10.1037/0022-0167.51.4.482

Lewis, S. E. (1995). A search for meaning: Making sense of depression. *Journal of Mental Health, 4*(4), 369-382. doi: 10.1080/09638239550037424

Lichtman, M. (Ed.). (2011). *Understanding and evaluating qualitative educational research*. Thousand Oaks, CA: SAGE Publications.

Lim, L., Jin, A. Z., & Ng, T. P. (2012). Anxiety and depression, chronic physical conditions, and quality of life in an urban population sample study. *Social Psychiatry and Psychiatric Epidemiology, 47*(7), 1047–1053. doi:10.1007/s00127-011-0420- 6.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: SAGE Publications.

Lincoln, Y. S. (2009). Ethical practices in qualitative research. In D. M. Mertens & P. E. Ginsberg (Eds.), *The handbook of social research ethics* (pp. 150–169). Thousand Oaks, CA: SAGE Publications.

Lloyd, C. E., Pouwer, F., & Hermanns, N. (Eds.). (2012). *Screening for depression and other psychological problems in diabetes: A practical guide*. New York, NY: Springer Science+Business Media.

Loo, P. W., & Furnham, A. (2013). Knowledge and beliefs about depression among urban and rural Indian Malaysians. *Mental Health, Religion & Culture, 16*(10), 1009-1029. doi: 10.1080/13674676.2012.728579

Lovibond, S. H., & Lovibond, P. F. (1995). *Manual for the depression anxiety stress scales* (2nd ed.). Sydney, Australia: Psychology Foundation of Australia.

University of Malaya

Lubbe, T. (2011). *Object relations in depression: A return to theory*. New York, NY: Routledge. Retrieved from https://books.google.com.my/books?id=GnmrAgAAQBAJ&pg=PA36&dq=biomedical+model+depression+freud&hl=en&sa=X&redir_esc=y#v=onepage&q=biomedical%20model%20depression%20freud&f=false

Luhrmann, T. M. (2000). *Of two minds: The growing disorder in American psychiatry*. New York, NY: Alfred A. Knopf.

Lundberg, C. C. (1976). Hypothesis creation in organizational behavior research. *Academy of Management Review*, *1*(2), 5-12. doi: 10.5465/AMR.1976.4408646

Maddi, S. R. (1970). The search for meaning. In M. Page (Ed.), *Nebraska symposium on motivation* (pp. 137–186). Lincoln, NE: University of Nebraska Press.

Maideen, S. F. K., Sidik, S. M., Rampal, L., & Mukhtar, F. (2014). Prevalence, associated factors and predictors of depression among adults in the community of Selangor, Malaysia. *PloS one*, *9*(4), e95395. doi: 10.1371/journal.pone.0095395

Malaysian Psychiatric Association. (2004). *Consensus statement on management of depression* (Community programme on depression). Retrieved from http://www.psychiatry-malaysia.org

Malaysian Psychiatric Association. (2006). *Depression*. Retrieved from http://www.psychiatry-malaysia.org/article.php?aid=56

Manson, S. M., Shore, J. H., & Bloom, J. D. (1985). The depressive experience in American Indian communities: A challenge for psychiatric theory and diagnosis. In A. Kleinman & B. Good (Eds.), *Culture and depression: Studies in the anthropology and cross-cultural psychiatry of affect and disorder* (pp. *331-368*). Berkeley: University of California Press.

Marcus, M., Yasamy, M. T., van Ommeren, M., Chisholm, D., & Saxena, S. (2012). Depression: A global public health concern. In World Federation for Mental Health (Ed.), *Depression: A global crisis* (pp. 6-8). Retrieved from http://www.who.int/mental_health/management/depression/who_paper_depression_wfmh_2012.pdf?ua=1

Marohn, S. (2003). *The natural medicine guide to depression*. Charlottesville, VA: Hampton Roads Publishing.

University of Malaya

Marshall, C., & Rossman, G. B. (2014). *Designing qualitative research* (6th ed.). Thousand Oaks, CA: SAGE Publications.

Mart ńez-Hern áez, A., DiGiacomo, S. M., Carceller-Maicas, N., Correa-Urquiza, M., & Martorell-Poveda, M. A. (2014). Non-professional-help-seeking among young people with depression: a qualitative study. *BMC Psychiatry*, *14*(1), 124-134. doi: 10.1186/1471-244X-14-124

Maslow, A. H. (1968). *Toward a psychology of being* (2nd ed.). Princeton, NJ: Van Nostrand.

Maxwell, J. A. (2013). *Qualitative research design: An interactive approach* (3rd ed.). Thousand Oaks, CA: Sage publications.

Maxwell, M. (2005). Women's and doctors' accounts of their experiences of depression in primary care: the influence of social and moral reasoning on patients' and doctors' decisions. *Chronic Illness, 1*(1), 61-71. doi: 10.1177/17423953050010010401

May, R. (1983). *The discovery of being: Writings in existential psychotherapy*. New York, NY: Norton.

May, R. (1996). *The meaning of anxiety* (Rev. ed.). New York, NY: WW Norton & Company.

Mayo Clinic. (2015). *Depression (major depressive disorder)*. Retrieved from http://www.mayoclinic.org/diseases-conditions/depression/basics/definition/con-20032977

McCann, T. V., Lubman, D. I., & Clark, E. (2012). The experience of young people with depression: A qualitative study. *Journal of Psychiatric and Mental Health Nursing, 19*(4), 334-340. doi: 10.1111/j.1365-2850.2011.01783.x

Merikangas, K. R., & Angst, J. (1995). The challenge of depressive disorders in adolescence. In M. Rutter (Ed.), *Psychosocial disturbances in young people: Challenges for prevention* (pp. 131-165). Cambridge, UK: Cambridge University Press.

Merriam, S. B. (2001). *Qualitative research and case study applications in education*. San Francisco, CA: Jossey-Bass Publishers.

University of Malaya

Merriam, S. B., & Tisdell, E. J. (2016). *Qualitative research: A guide to design and implementation* (4th ed.). San Francisco, CA: Jossey-Bass.

Mertens, D. M., & Ginsberg, P. E. (Eds.). (2009). *The handbook of social research ethics*. Thousand Oaks, CA: SAGE Publications.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd ed.). Thousand Oaks, CA: SAGE Publications.

Miller, J. F., & Powers, M. J. (1988). Development of an instrument to measure hope. *Nursing Research, 37*(1), 6-10. doi: 10.1097/00006199-198801000-00002

Miller, L., Wickramaratne, P., Gameroff, M. J., Sage, M., Tenke, C. E., & Weissman, M. M. (2012). Religiosity and major depression in adults at high risk: A ten-year prospective study. *American Journal of Psychiatry*, *169*(1), 89-94. doi: 10.1176/appi.ajp.2011.10121823

Mitchell, S. A. (1993). Aggression and the endangered self. *Psychoanalytic Quarterly, 62*, 351–381.

Moncrieff, J. (2008). *The myth of the chemical cure: A critique of psychiatric drug treatment*. Basingstoke, Hampshire, UK: Palgrave Macmillan.

Montesinos, A. H., Rapp, M. A., Temur-Erman, S., Heinz, A., Hegerl, U., & Schouler-Ocak, M. (2012). The influence of stigma on depression, overall psychological distress, and somatization among female Turkish migrants. *European Psychiatry*, *27*(2), S22-S26. doi: 10.1016/S0924-9338(12)75704-8

Morse, J. M. (2000). Determining sample size. *Qualitative Health Research*, *10*(1), 3-5. doi: 10.1177/104973200129118183

Morse, J. M. (2001). Using shadowed data. *Qualitative Health Research, 11*(3), 291-292. doi: 10.1177/104973201129119091

Morse, J. M. (1994*). Designing funded qualitative research*. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 220-235). Thousand Oaks, CA: SAGE Publications.

Moussavi, S., Chatterji, S., Verdes, E., Tandon, A., Patel, V., & Ustun, B. (2007). Depression, chronic diseases, and decrements in health: results from the

University of Malaya

World Health Surveys. *The Lancet, 370*(9590), 851-858. doi: 10.1016/S0140-6736(07)61415-9

Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: SAGE Publications.

Mukhtar, F., & Oei, T. P. S. (2011a). A review on the prevalence of depression in Malaysia. *Current Psychiatry Reviews, 7*(3), 234-238. doi: 10.2174/157340011797183201

Mukhtar, F., & Oei, T. P. S. (2011b). A review on assessment and treatment for depression in Malaysia. *Depression Research and Treatment, 2011*, 1-8. doi: 10.1155/2011/123642

Myors, K. A., Schmied, V., Johnson, M., & Cleary, M. (2014). 'My special time': Australian women's experiences of accessing a specialist perinatal and infant mental health service. *Health & Social Care in The Community, 22*(3), 268-277. doi: 10.1111/hsc.12079

Nasser, E. H., & Overholser, J. C. (2005). Recovery from major depression: the role of support from family, friends, and spiritual beliefs. *Acta Psychiatrica Scandinavica, 111*(2), 125-132. doi: 10.1111/j.1600-0447.2004.00423.x

Ng, C. G. (2014). A review of depression research in Malaysia. *The Medical Journal of Malaysia, 69*, 42-45. (PMID 25417950)

Nordin, N. M., Talib, M. A., Yaacob, S. N., & Sabran, M. S. (2010). A study on selected demographic characteristics and mental health of young adults in public higher learning institutions in Malaysia. *Global Journal of Health Science, 2*(2), 104-110. doi: 10.5539/gjhs.v2n2p104

Nunstedt, H., Nilsson, K., Skärsäter, I., & Kylén, S. (2012). Experiences of major depression: Individuals' perspectives on the ability to understand and handle the illness. *Issues in Mental Health Nursing, 33*(5), 272-279. doi: 10.3109/01612840.2011.653038

Nurasikin, M. S., Khatijah, L. A., Aini, A., Ramli, M., Aida, S. A., Zainal, N. Z., & Ng, C. G. (2012). Religiousness, religious coping methods and distress level among psychiatric patients in Malaysia. *International Journal of Social Psychiatry, 59*(4), 332-338. doi: 10.1177/0020764012437127

O'Blenis, B. D. (2006). *The Experience of Depression in High School Adolescent Women: A Phenomenological Study* (Master's thesis, the University of New

University of Malaya

Brunswick). Retrieved from ProQuest Dissertations and Theses database. (ProQuest ID 304935451)

Ofonedu, M. E., Percy, W. H., Harris-Britt, A., & Belcher, H. M. (2013). Depression in inner city African American youth: A phenomenological study. *Journal of Child and Family Studies, 22*(1), 96-106. doi: 10.1007/s10826-012-9583-3

Onken, S. J., Craig, C. M., Ridgway, P., Ralph, R. O., & Cook, J. A. (2007). An Analysis of the Definitions and Elements of Recovery: A Review of the Literature. *Psychiatric Rehabilitation Journal*, *31*(1), 9-22. doi: 10.2975/31.1.2007.9.22

Onken, S. J., Dumont, J. M., Ridgway, P., Dornan, D. H., & Ralph, R. O. (2002). Mental health recovery: What helps and what hinders? A national research project for the development of recovery facilitating system performance indicators. *Phase one research report: A national study of consumer perspectives on what helps and hinders recovery*. Alexandria, VA: National Technical Assistance Center for State Mental Health Planning. Retrieved from http://akmhcweb.org/docs/RecoveryPIWebDescription.pdf

Owens, J., Francis, D., Usher, K., & Tollefson, J. (1997). *Risks and rewards of reflective thinking*. Townsville, Australia: James Cook University.

Park, C. L., & Folkman, S. (1997). Meaning in the context of stress and coping. *Review of General Psychology, 1*(2), 115–144. doi: 10.1037//1089-2680.1.2.115

Parker, G., Cheah, Y. C., & Roy, K. (2001). Do the Chinese somatize depression? A cross-cultural study. *Social Psychiatry and Psychiatric Epidemiology*, *36*(6), 287-293. doi: 10.1007/s001270170046

Patten, S. B. (2015). *Epidemiology for Canadian students: Principles, Methods and critical appraisal* (2nd ed.). Newbury Park, CA: SAGE.

Patton, M. Q. (1990). *Qualitative evaluation and research methods*. Newbury Park, CA: SAGE Publications.

Patton, M. Q. (2015). *Qualitative research & evaluation methods: Integrating theory and practice* (4th ed.). Thousand Oaks, CA: SAGE Publications.

Peden, A. R. (1992). *The process of recovering in women who have been depressed*. (Doctoral dissertation, The University of Alabama). Retrieved from ProQuest Dissertations and Theses database. (ProQuest ID 303947633)

University of Malaya

Peden, A. R. (1996). Recovering from depression: A one-year follow up. *Journal of Psychiatric and Mental Health Nursing, 3*(5), 289-295. doi: 10.1111/j.1365-2850.1996.tb00128.x

Perez, L. (2013). *The lived experience of hope in women recovering from major depression*. (Doctoral dissertation, New York University). Retrieved from Proquest Dissertations and Theses database. (UMI No. 3574442)

Petersen, A. (2011). Authentic self-realization and depression. *International Sociology, 26*(1), 5-24. doi: 10.1177/0268580910380980

Pfeiffer, W. (1968). The symptomatology of depression viewed transculturally. *Transcultural Psychiatric Research Review, 5*, 121-123. doi: 10.1177/136346156800500203

Pine, D. S., Cohen, E., Cohen, P., & Brook, J. (2014). Adolescent depressive symptoms as predictors of adult depression: moodiness or mood disorder?. *American Journal of Psychiatry*. *156*(1), 133–135. doi: 10.1176/ajp.156.1.133

Ping, N. C. L., & Sumari, M. (2012). Malaysia women survivors' perspective on healing from childhood sexual abuse through spirituality. *Procedia-Social and Behavioral Sciences, 65*, 455-461. doi: 10.1016/j.sbspro.2012.11.148

Polit, D. F., & Beck, C. T. (2008). *Nursing research: Generating and assessing evidence for nursing practice* (8th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.

Polit, D. F., & Beck, C. T. (2014). *Essentials of nursing research: Appraising evidence for nursing practice* (8th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.

Polkinghorne, D. E. (1989). Phenomenological research methods. In R. S. Vale & S. Halling (Eds.), *Existential-phenomenological perspectives in psychology: Exploring the breadth of human experience* (pp. 41-60). New York, NY: Plenum Press. doi: 10.1007/978-1-4615-6989-3 3

Pollio, H. R., Henley, T. B., & Thompson, C. J. (1997). *The phenomenology of everyday life: Empirical investigations of human experience*. Cambridge, UK: Cambridge University Press.

Poongothai, S., Pradeepa, R., Ganesan, A., & Mohan, V. (2009). Prevalence of depression in a large urban South Indian population – the Chennai Urban

University of Malaya

Rural Epidemiology Study (CURES-70). *PLoS One*, *4*(9), e7185. doi: 10.1371/journal.pone.0007185.

Prasher, V. (1999). Presentation and management of depression in people with learning disability. *Advances in Psychiatric Treatment*, *5*(6), 447-454. doi: 10.1192/apt.5.6.447

Ramirez, J. L. (2007). *Navigating inward and outward through depression* (Doctoral dissertation, The University of Alabama). Retrieved from ProQuest Dissertations and Theses database. (ProQuest ID 303947633).

Rapaport, M. H., Clary, C., Fayyad, R., & Endicott, J. (2005). Quality-of-life impairment in depressive and anxiety disorders. *American Journal of Psychiatry, 162*(6), 1171-1178. doi: 10.1176/appi.ajp.162.6.1171

Rawana, J. S., & Morgan, A. S. (2014). Trajectories of depressive symptoms from adolescence to young adulthood: The role of self-esteem and body-related predictors. *Journal of Youth and Adolescence*, *43*(4), 597-611. doi: 10.1007/s10964-013-9995-4

Ray, M. A. (1994). The richness of phenomenology: Philosophic, theoretic and methodologic concerns. In J. M. Morse (Ed.), *Critical issues in qualitative research methods* (pp. 117–133). Thousand Oaks, CA: SAGE Publications.

Ray, W. J. (2014). *Abnormal psychology: Neuroscience perspectives on human behavior and experience*. Thousand Oaks, CA: SAGE Publications.

Razali, S. M., & Hasanah, C. I. (1999). Cost-effectiveness of cyclic antidepressants in a developing country. *Australian and New Zealand Journal of Psychiatry*, *33*(2), 283-284. doi: 10.1080/0004867990061

Reker, G. T., & Wong. P. T. P. (1988). Aging as an individual process: Toward a theory of personal meaning. In J. E. Birren & V. L. Bengston (Eds.), *Emergent theories of aging* (pp. 214–246). New York, NY: Springer.

Rey, H. (1994). *Universals of psychoanalysis in the treatment of psychotic and borderline states: Factors of space-time and language* (J. Magagna, Ed.). London: Free Association Books.

Ridge, D., & Ziebland, S. (2006). "The old me could never have done that": How people give meaning to recovery following depression. *Qualitative Health Research*, *16*(8), 1038-1053. doi: 10.1177/1049732306292132

University of Malaya

Ridgway, P. (1999). *Deepening the recovery paradigm: Defining implications for practice. A report of the recovery paradigm project.* Unpublished manuscript, School of Social Welfar, University of Kansas, Lawrence, Kansas.

Riley, S. (2001). Art therapy with adolescents. *The Western Journal of Medicine, 175*(1), 54-57. Retrieved from ProQuest database. (PMID 11431405)

Rivera, F. I. (2007). Contextualizing the experience of young Latino adults: Acculturation, social support and depression. *Journal of Immigrant and Minority Health*, *9*(3), 237-244. doi: 10.1007/s10903-006-9034-6

Roberts, A. R., & Greene, G. J. (Eds.). (2002). *Social workers' desk reference*. New York, NY: Oxford University Press.

Rochlen, A. B., Paterniti, D. A., Epstein, R. M., Duberstein, P., Willeford, L., & Kravitz, R. L. (2010). Barriers in diagnosing and treating men with depression: A focus group report. *American Journal of Men's Health*, *4*(2), 167-175. doi: 10.1177/1557988309335823

Rogers, E., Chamberlin, J., Ellison, M., & Crean, T. (1997). A consumer-constructed scale to measure empowerment among users of mental health services. *Psychiatric Services*, *48*(8), 1042-1047. doi: 10.1176/ps.48.8.1042

Roh, M. S., Jeon, H. J., Kim, H., Cho, H. J., Han, S. K., & Hahm, B. J. (2009). Factors influencing treatment for depression among medical students: a nationwide sample in South Korea. *Medical Education*, *43*(2), 133-139. doi: 10.1111/j.1365-2923.2008.03255.x.

Rothman, K. J. (2012). *Epidemiology: An introduction* (2nd ed.). Oxford, UK: Oxford University Press.

Rubin, H. J., & Rubin, I. S. (1995). *Qualitative interviewing: The art of hearing data*. Thousand Oaks, CA: SAGE Publications.

Russell, J., & Jarvis, M. (Eds.). (2003). *Angles on applied psychology*. Cheltenham, UK: Nelson Thornes.

Ryff, C. D. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological well-being. *Journal of Personality and Social Psychology, 57*(6), 1069–1081. doi: 10.1037/0022-3514.57.6.1069

University of Malaya

Ryff, C. D. & Keyes, C. L. M. (1995). The structure of psychological well-being revisited. *Journal of personality and social psychology, 69*(4), 719.

Ryff, C. D. & Singer, B. (1996). Psychological well-being: Meaning, measurement, and implications for psychotherapy research. *Psychotherapy and psychosomatics, 65*(1), 14-23.

Ryff, C. D., & Singer, B. (1998). The contours of positive human health. *Psychological Inquiry, 9*(1), 1-28. doi: 10.1207/s15327965pli0901_1

Saks, M., & Allsop, J. (Eds.). (2007). *Researching health: Qualitative, quantitative and mixed methods*. Thousand Oaks, CA: SAGE Publications.

Sandler, J., & Joffe, W. G. (1965). Notes on childhood depression. *The International Journal of Psycho-Analysis, 46*, 88-96. (PMID 14289320)

Sartre, J. P. (1953). *Existential psychoanalysis* (H. E. Barnes, Trans.). Chicago: Henry Regnery Company.

Schreiber, R. (1996). (Re)defining my self: Women's process of recovery from depression. *Qualitative Health Research, 6*(4), 469-491. doi: 10.1177/104973239600600402

Schulenberg, S. E., Hutzell, R. R., Nassif, C., & Rogina, J. M. (2008). Logotherapy for clinical practice. *Psychotherapy Theory, Research, Practice, Training, 45*(4), 447-463. doi: 10.1037/a0014331.

Schuman, D. (1982). *Policy analysis, education, and everyday life*. Lexington, MA: Heath.

Schwandt, T. A. (1994). Constructivist, interpretivist approaches to human inquiry. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 118-137). Thousand Oaks, CA: SAGE Publications.

Seidman, I. (1998). *Interviewing as qualitative research: A guide for researchers in education and the social sciences* (2nd ed.). New York, NY: Teachers College, Columbia University.

Seidman, I. (2006). *Interviewing as qualitative research: A guide for researchers in education and the social sciences* (3rd ed.). New York, NY: Teachers College, Columbia University.

University of Malaya

Seligman, M. E. P. (2002). *Authentic happiness: Using the new positive psychology to realize your potential for lasting fulfillment.* New York, NY: Free Press.

Shamsuddin, K., Fadzil, F., Ismail, W. S. W., Shah, S. A., Omar, K., Muhammad, N. A., ... Mahadevan, R. (2013). Correlates of depression, anxiety and stress among Malaysian university students. *Asian Journal of Psychiatry*, *6*(4), 318-323. doi: 10.1016/j.ajp.2013.01.014

Sharf, R. S. (2015). *Theories of psychotherapy & counselling: Concepts and cases* (6th ed.). Boston, MA: Cengage Learning.

Sherina, M. S., Nor, A. M. Z., & Shamsul, A. S. (2003). Factors associated with depression among elderly patients in a primary health care clinic in Malaysia. *Asia Pacific Family Medicine*, *2*(3), 148-152. doi: 10.1046/j.1444-1683.2003.00080.x

Sherina, M. S., Rampal, L., & Azhar, M. Z. (2008). The prevalence of depressive symptoms and potential risk factors that may cause depression among adult women in Selangor. *Malaysian Journal of Psychiatry*, *17*(2), 64-72. Retrieved from http://www.mjpsychiatry.org/index.php/mjp/article/viewFile/42/41

Slavin, M. O., & Kriegman, D. (1992). *The adaptive design of the human psyche.* New York: Guilford Press.

Smith, D. J., & Blackwood, D. H. (2004). Depression in young adults. *Advances in Psychiatric Treatment*, *10*(1), 4-12. doi: 10.1192/apt.10.1.4

Smith, T. B., McCullough, M. E., & Poll, J. (2003). Religiousness and depression: evidence for a main effect and the moderating influence of stressful life events. *Psychological Bulletin*, *129*(4), 614-636. doi: /10.1037/0033-2909.129.4.614

Snyder, S. M., & Rubenstein, C. (2014). Do incest, depression, parental drinking, serious romantic relationships, and living with parents influence patterns of substance use during emerging adulthood?. *Journal of Psychoactive Drugs*, *46*(3), 188-197. doi: 10.1080/02791072.2014.914610

Stevick, E. L. (1971). An empirical investigation of the experience of anger. In A. Giorgi, W. F. Fisher, & R. Von Eckartsberg (Eds.), *Duquesne studies in phenomenological psychology* (Vol. 1, pp. 132–148). Pittsburgh: Duquesne University Press.

University of Malaya

Solomon, A. (2015). *The noonday demon: An atlas of depression*. New York, NY: Scribner. (Original work published 2001)

Solomon, D. A., Leon, A. C., Coryell, W., Mueller, T. I., Posternak, M., Endicott, J., & Keller, M. B. (2008). Predicting recovery from episodes of major depression. *Journal of Affective Disorders, 107*(1), 285-291. doi: 10.1016/j.jad.2007.09.001

Sommers-Flanagan, J., & Sommers-Flanagan, R. (2004). *Counseling and psychotherapy theories in context and practice: Skills, strategies, and techniques*. Hoboken, NJ: John Wiley & Sons.

Sommers-Flanagan, J., & Sommers-Flanagan, R. (2015). *Counseling and psychotherapy theories in context and practice: Skills, strategies, and techniques* (2nd ed.). Hoboken, NJ: John Wiley & Sons.

Souter, K. (2013). *Understanding and dealing with depression*. Chichester, West Sussex: Summersdale Publishers Ltd.

Speziale, H. S., Streubert, H. J., & Carpenter, D. R. (2011). *Qualitative research in nursing: Advancing the humanistic imperative*. Philadelphia, PA: Lippincott Williams & Wilkins.

Starks, H., & Trinidad, S. B. (2007). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research, 17*(10), 1372-1380. doi: 10.1177/1049732307307031

Steen, M. (1996). Essential structure and meaning of recovery from clinical depression for middle-adult women: A phenomenological study. *Issues in Mental Health Nursing, 17*(2), 73-92. doi: 10.3100/016 12849609034998

Stein, D. J., Kupfer, D. J., & Schatzberg, A. F. (Eds.). (2007). *The American Psychiatric Publishing textbook of mood disorders*. Washington, DC: American Psychiatric Publishing.

Strine, T. W., Kroenke, K., Dhingra, S., Balluz, L. S., Gonzalez, O., Berry, J. T., & Mokdad, A. H. (2009). The associations between depression, health-related quality of life, social support, life satisfaction, and disability in community-dwelling US adults. *The Journal of Nervous and Mental Disease, 197*(1), 61-64. doi: 10.1097/NMD.0b013e3181924ad8

Substance Abuse and Mental Health Services Administration. (2014). *Results from the 2013 National Survey on Drug Use and Health: Mental health findings*

University of Malaya

(NSDUH Series H-47). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Sullivan, L. E. (Ed.). (2009). *The SAGE glossary of the social and behavioral sciences*. Thousand Oaks, CA: SAGE Publications.

Sussman, M. B., Steinmetz, S. K., & Peterson, G. W. (Eds.). (1999). *Handbook of marriage and the family* (2nd ed.). New York, NY: Plenum Press.

Szajnberg, N. M., & Massie, H. (2003). Transition to young adulthood: A prospective study. *International Journal of Psychoanalysis, 84*(6), 1569–1586. doi: 10.1516/R70A-KVKF-9R16-0UA0

Taylor, B. J. (2010). *Reflective practice: A guide for healthcare professionals* (3rd ed.). Maidenhead, UK: Open University Press.

Taylor, C. (1994). The politics of recognition. In A. Guttman (Ed.), *Multiculturalism: Examining the politics of recognition* (pp. 25-73). Princeton, NJ: Princeton University Press.

Teja, J. S., Narang, R. L., & Aggarwal, A. K. (1971). Depression across cultures. *The British Journal of Psychiatry*, *119*(550), 253-260. doi: 10.1192/bjp.119.550.253

Thomas, S. P., & Pollio, H. R. (2002). *Listening to patients: A phenomenological approach to nursing research and practice*. New York, NY: Springer Publishing Company.

Thomée, S., Härenstam, A., & Hagberg, M. (2011). Mobile phone use and stress, sleep disturbances, and symptoms of depression among young adults-a prospective cohort study. *BMC Public Health*, *11*(1), 66-76. doi: 10.1186/1471-2458-11-66

Thompson, A., Hunt, C., & Issakidis, C. (2004). Why wait? Reasons for delay and prompts to seek help for mental health problems in an Australian clinical sample. *Social Psychiatry and Psychiatric Epidemiology, 39*(10), 810–817. doi: 10.1007/s00127-004-0816-7

Tillich, P. (1961). Existentialism and psychotherapy. *Review of Existential Psychology and Psychiatry, 1*, 8-16.

University of Malaya

Timmreck, T. C. (2002). *An introduction to epidemiology* (3rd ed.). Sudbury, MA: Jones & Bartlett Learning.

Tooth, B. A., Kalyanasundaram, V., & Glover, H. (1997). *Recovery from schizophrenia: A consumer perspective*. Queensland, Australia: Centre for Mental Health Nursing Research.

Tseng, W. S., Bhugra, D., & Bhui, K. (2007). *Textbook of cultural psychiatry*. Cambridge, UK: Cambridge University Press.

U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Mental Health. (2003). *Men and depression* (NIH Publication No. Qf 11-5300). Retrieved from https://www.nimh.nih.gov/health/publications/men-and-depression/men-and-depression_142046.pdf

U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Mental Health. (2012). *Depression and college students* (NIH Publication No. 15-4266). Retrieved from https://www.nimh.nih.gov/health/publications/depression-and-college-students/depression-college-students-pdf-new_151591.pdf

U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Mental Health. (2013). *Depression in women* (NIH Publication No. TR 16-4779). Retrieved from https://www.nimh.nih.gov/health/publications/depression-in-women/tr-16-4779_153310.pdf

U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Mental Health. (2015a). *Depression: What You Need to Know* (NIH Publication No. 15-3561). Bethesda, MD: U.S. Government Printing Office. Retrieved from https://www.nimh.nih.gov/health/publications/depression/depression-booklet_34625.pdf

U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Mental Health. (2015b). *Teen depression* (NIH Publication No. 15-4302). Retrieved from https://www.nimh.nih.gov/health/publications/teen-depression/teen_depression_508_150205.pdf

U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Mental Health. (2015c). *Depression*. Retrieved from http://www.nimh.nih.gov/health/topics/depression/index.shtml#part_145398

University of Malaya

Üstün, T. B., Ayuso-Mateos, J. L., Chatterji, S., Mathers, C., & Murray, C. J. (2004). Global burden of depressive disorders in the year 2000. *The British Journal of Psychiatry, 184*(5), 386-392. doi: 10.1192/bjp.184.5.386

van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy*. Albany, NY: State University of New York Press.

van Voorhees, B. W., Fogel, J., Houston, T. K., Cooper, L. A., Wang, N. Y., & Ford, D. E. (2005). Beliefs and attitudes associated with the intention to not accept the diagnosis of depression among young adults. *The Annals of Family Medicine, 3*(1), 38-46. doi: 10.1370/afm.273

Vidler, H. C. (2005). Women making decisions about self-care and recovering from depression. *Women's Studies International Forum, 28*(4), 289-303. doi: 10.1016/j.wsif.2005.04.014

von Below, C., Werbart, A., & Rehnberg, S. (2010). Experiences of overcoming depression in young adults in psychoanalytic psychotherapy. *European Journal of Psychotherapy and Counselling,12*(2), 129-147. doi: 10.1080/13642537.2010.482745

Vygotsky, L. (1987). *Thought and language* (A. Kozulin, Ed.). Cambridge, MA: MIT Press.

Wall, C., Glenn, S., Mitchinson, S., & Poole, H. (2004). Using a reflective diary to develop bracketing skills during a phenomenological investigation. *Nurse Researcher, 11*(4), 20-29. doi: 10.7748/nr2004.07.11.4.20.c6212

Watson, R., McKenna, H., Cowman, S., & Keady, J. (Eds.). (2008). *Nursing research: Designs and methods*. Edinburgh, Scotland: Churhill Livingstone Elsevier.

Weiss, R. S. (1994). *Learning from strangers: The art and method of qualitative interview studies*. New York, NY: Free Press.

Weitzman, E. R. (2004). Poor mental health, depression, and associations with alcohol consumption, harm, and abuse in a national sample of young adults in college. *The Journal of Nervous and Mental Disease, 192*(4), 269-277. doi: 10.1097/01.nmd.0000120885.17362.94

Wengraf, T. (2001). *Qualitative research interviewing: Biographic narrative and semi-structured methods*. Thousand Oaks, CA: SAGE Publications.

University of Malaya

Willig, C. (2013). *Introducing qualitative research in psychology* (3rd ed.). Maidenhead, Berkshire: McGraw-Hill Education.

Willig, C., & Stainton-Rogers, W. (Eds.). (2007). *The SAGE handbook of qualitative research in psychology*. Thousand Oaks, CA: SAGE Publications.

Woll, P. (2007). *Healing the Stigma of Depression: A Guide for Helping Professionals*. Chicago, IL: Midwest AIDS Training and Education Center. Available from https://aidsetc.org/sites/default/files/resources_files/HealingtheStigmaofDepression.pdf

Wong, P. T. P. (2014). Viktor Frankl's meaning seeking model and positive psychology. In A. Batthyany & P. Russo-Netzer (Eds.), Meaning in existential and positive psychology (pp. 149-184). New York, NY: Springer.

Wong, P. T. P. (2002). Logotherapy. In G. Zimmer (Ed.), Encyclopedia of Psychotherapy (pp.107-113). New York, NY: Academic Press.

Wong, P. T. P. (2005). Existential and humanistic theories. In J. C. Thomas, & D. L. Segal (Eds.), *Comprehensive handbook of personality and psychopathology* (pp. 192-211). Hoboken, NJ: John Wiley & Sons, Inc.

Wong, S. Y., & Lua, P. L. (2011). Anxiety and depressive symptoms among communities in the east coast of Peninsular Malaysia: A rural exploration. *Malaysian Journal of Psychiatry*, *20*(1), 1-13. Retrieved from http://www.mjpsychiatry.org/index.php/mjp/article/viewFile/143/119

World Health Organization. (2001). *The World Health Report 2001 – Mental Health: New understanding, new hope*. Retrieved from World Health Organization website: http://www.who.int/entity/whr/2001/en/whr01_en.pdf?ua=1

World Health Organization. (2008). *The global burden of disease: 2004 update*. Retrieved from World Health Organization website: http://www.who.int/healthinfo/global_burden_disease/GBD_report_2004update_full.pdf?ua=1

World Health Organization. (2017). *Depression: What you should know*. Retrieved from http://www.who.int/campaigns/world-health-day/2017/handouts-depression/what-you-should-know/en/

World Health Organization. (2011). *Health of adolescents in Malaysia*. Retrieved from http://www.wpro.who.int/topics/adolescent_health/malaysia_fs.pdf

University of Malaya

World Health Organization. (2012). *Depression, a hidden burden*. Retrieved from http://www.who.int/mental_health/management/depression/flyer_depression_2012.pdf?ua=1

World Health Organization. (2014). *Preventing suicide: A global imperative*. Retrieved from http://apps.who.int/iris/bitstream/10665/131056/1/9789241564779_eng.pdf?ua=1&ua=1

Yaacob, S. N., Juhari, R., Talib, M. A., & Uba, I. (2009). Loneliness, stress, self esteem and depression among Malaysian adolescents. *Jurnal Kemanusiaan, 7*(2), 85-95. Retrieved from http://www.jurnal-kemanusiaan.utm.my/index.php/kemanusiaan/article/view/208/200

Yalom, I. D. (1980). *Existential psychotherapy*. New York, NY: Basic Books.

Yalom, I. D. (1995). *The theory and practice of group psychotherapy* (4th ed.). New York, NY: Basic Books.

Yerushalmi, H. (2001a). Psychoanalysts' multiple relational perspective. *The Psychoanalytic Quarterly, 70,* 359–385.

Yerushalmi, H. (2001b). Self-states and personal growth in analysis. *Contemporary Psychoanalysis, 37*, 471–488.

Yerushalmi, H. (2003). Facilitating personal growth. *Psychoanalytic psychology*, 20 (2), 363.

Yip, P. S. F. (Ed.) (2008). *Suicide in Asia: Causes and prevention*. Hong Kong: Hong Kong University Press.

Zuraida, N. Z., & Parameswaran, R. (2007). Prevalence of depression among patients with headache in Kuala Lumpur, Malaysia. *Malaysian Journal of Psychiatry*, *16*(2), 59-64. Retrieved from http://www.psychiatry-malaysia.org/file_dir/14259369924781b0d2cd35a.pdf

University of Malaya