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The role of spirituality in depression recovery

A thesis presented in partial fulfilment of the requirements for the degree of

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Abstract

Depression is one of the fastest growing causes of disability worldwide, with an estimated 17.5% of New Zealanders living with the condition. Current biomedically based approaches dominant in New Zealand have shown limited success in achieving long-term recovery, with relapse rates at over 50%. In contrast to the disease model of depression, humanistic, Eastern, and Indigenous frameworks take a holistic approach to mental distress and consider spirituality essential for wellbeing. Prior research has consistently shown that spirituality serves a therapeutic and protective function in depression. However, the causal mechanisms by which spirituality confers such benefits remain unclear. In this study, nine individuals were interviewed about their experiences of recovering from depression using spirituality. The therapeutic effects of spirituality were clustered into three major themes: Inner Transformation, Connection and Belonging, and Resilience. Inner Transformation subsumed themes of existential authenticity and self- compassion. Connection and Belonging included feeling supported and wanting to support others. Resilience subsumed themes of acceptance, meaning, expanded perspective, and emotional intelligence. For participants, spirituality was found to be an important part of depression recovery and a field of study that the discipline of psychology would greatly benefit from engaging with. Further studies could focus on developing a more comprehensive understanding of spiritual beliefs and practices in New Zealand, exploring mental health professionals' attitudes towards spirituality, and investigating any negative effects spirituality may have on recovery from mental distress.

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Table of contents

1. Introduction 1

2. Depression 4

2.1 Definition of depression 4

2.2 Prevalence of depression 5

2.2.1 Ethnic differences 5

2.2.2 Gender differences 7

2.3 Current conceptualisations and treatments 8

2.3.1 Antidepressants 8

2.3.2 Cognitive Behavioural Therapy 12

2.4 Cultural issues 13

2.4.1 Implications for New Zealand 16

2.5 Alternative conceptualisations and treatments 17

2.5.1 An existential perspective 17

2.5.2 Indigenous perspectives 19

2.5.3 Eastern perspectives 22

2.6 Summary 24

3. Spirituality 26

3.1 Western spirituality 26

3.2 Indigenous spirituality 28

3.3 Eastern spirituality 31

3.4 Summary 33

4. Therapeutic nature of spirituality 35

4.1 Quantitative studies 35

4.1.1 Risk of developing depression 35

4.1.2 Severity and chronicity of symptoms 36

4.1.3 Hopelessness, existential meaning, and suicidality 38

4.1.4 Limitations of quantitative studies 39

4.2 Qualitative studies 40

4.2.1 Limitations of existing qualitative studies 42

4.3 Research objectives of the current study 43

4.4 Summary 44

5. Method 46

5.1 Research design and philosophy 46

5.2 Ethics 46

5.3 Participants 46

5.3.1 Selection criteria 46

5.3.2 Participant characteristics 48

5.4 Procedure 50

5.4.1 Interview structure 51

5.5 Data analysis 52

5.6 Trustworthiness 57

5.7 Summary 59

6. Results 60

6.1 Aetiological explanations of depression 60

6.1.1 Childhood stress 60

6.1.2 Trauma 61

6.2 Spirituality in New Zealand 63

6.2.1 Ineffability 63

6.2.2 Belief in something greater 64

6.2.3 Compassionate behaviour 65

6.2.4 Disclosure concerns 65

6.3 Therapeutic effects of spirituality 66

6.3.1 Inner transformation 68

6.3.1.1 Existential authenticity 68

6.3.1.2 Self-compassion 71

6.3.2 Connection and belonging 73

6.3.2.1 Receiving support 73

6.3.2.2 Giving support 75

6.3.3 Resilience 76

6.3.3.1 Acceptance 76

6.3.3.2 Meaning 77

6.3.3.3 Expanded perspective 78

6.3.3.4 Emotional intelligence 79

6.4 Summary 82

7. Discussion 83

7.1 Understanding of depression 83

7.2 Meaning of spirituality 84

7.3 Therapeutic effects of spirituality 87

7.4 Limitations 92

7.5 Future research 94

8. Conclusion 96

9. References 97

Appendix A Facebook Advertisement 117

Appendix B Study Information Sheet 118

Appendix C Participant Consent Form 120

Appendix D Interview Schedule 121

List of tables and figures

Table 1 Participant Demographics 50
Table 2 Initial Coding of Data 54
Table 3 Tentative Themes 54
Table 4 Final Themes 56

Figure 1 Therapeutic Effects of Spirituality: Map of Themes and Subthemes 67

1. Introduction

Depression is a psychological condition characterised by low mood, loss of interest in previously enjoyable activities, psychomotor, sleep, and appetite disturbances, and, sometimes, suicidal ideation (American Psychiatric Association, 2013). It is one of the fastest growing causes of disability worldwide (Wojnarowski et al., 2019; World Health Organization, 2017), with 15.7% of New Zealand adults estimated to suffer from the condition as of 2018 (Ministry of Health, 2019). The dominant conceptualisations of depression in New Zealand are based on a biomedical disease concept of an internal dysfunction caused by biochemical and cognitive abnormalities (Beidel & Turner, 1986; Malhi et al., 2021). While such abnormalities are theorised to arise from a combination of genetics and negative life experiences (Malhi et al., 2021), they are ultimately appraised as a failure on the sufferer's part to adaptively cope with life's challenges (Jadhav, 1996).

The most common treatments prescribed to sufferers involve antidepressant medication and Cognitive Behavioural Therapy (CBT) (Malhi et al., 2021) – treatments whose main goal is to readjust the sufferer's biology and cognition. These treatments are limited in their success at helping depressed individuals recover. There is much debate as to the efficacy of antidepressants, with a significant body of research pointing to the placebo effect as the main driver of positive patient responses to the medication (Kirsch, 2009; Lacasse & Leo, 2015; Rutherford & Roose, 2013; Zilcha-Mano et al., 2019). Additionally, non-adherence to antidepressant treatment has been estimated at 30% - 60% (Buus et al., 2012; Lee et al., 2010). While helpful to some people, many individuals who undergo CBT relapse following treatment. Even among individuals who receive specially designed relapse-prevention CBT, relapse rates stand at around 50% (Zhang et al., 2018).

Many other conceptualisations and treatments of depression exist that have not received the funding and attention in New Zealand that has been afforded to the biomedically based approaches. Some approaches were developed in the West[1], while others are traditional in Eastern[2] and Indigenous cultures. One characteristic shared by most

[1] 'West' or 'Western' in this context refers to what are often termed as 'WEIRD' societies– Western, Educated, Industrialised, Rich and Democratic (Apicella et al., 2020). Such societies are largely found in the United States, the United Kingdom, Western Europe, and some Central European countries.

[2] 'Eastern' in this context refers to societies of the Sinosphere and the Indian subcontinent.

alternative understandings of depression is their holistic approach to individuals as entities whose wellbeing is dependent on a balanced interaction among the physical, emotional, social, and spiritual elements of their lives (Cohen, 2003; Kam et al., 2019; Karasz, 2005; NiaNia et al., 2019; Scheid, 2013; Storck et al., 2000; Wang & Iwamasa, 2018). That is, depression is not a purely internal phenomenon but a symptom of an imbalance within the individual's wider life sphere. Consequently, treatment of depression requires an exploration and resolution of difficulties in several aspects of the sufferer's life (Cohen, 2003; Karchmer, 2013; NiaNia, Bush, et al., 2017; Scheid, 2013).

Spiritual health is considered as important as physical wellbeing in such approaches and, in many cultures, is treated as foundational to physical, emotional, and social wellbeing (Cohen, 2003; NiaNia, Mana, et al., 2017; Valentine et al., 2017). While many Western scholars conflate the concepts of religion and spirituality (Abu-Raiya et al., 2016; Snider & McPhedran, 2014), there is now an emerging consensus that the two are distinct (Del Rio & White, 2012; Hill et al., 2000; Knoblauch, 2013). Religion concerns itself with a search for the transcendent in the context of a community of shared beliefs and in accordance to the norms of that community. In contrast, spirituality is an individual pursuit of the transcendent that enables the seeker to find meaningful and value-driven ways of being without deference to religious norms and doctrines (Del Rio & White, 2012; Hill et al., 2000).

A growing body of research attests to the therapeutic effects of spirituality on depression. Researchers have found that individuals who identify as spiritual are at reduced risk of developing depression (Portnoff et al., 2017). Among those who become depressed, highly spiritual individuals experience less severe symptoms (Luna & MacMillan, 2015; Peselow et al., 2014), may be less likely to relapse (Ramadas & Simões, 2018), find greater meaning in life (Bamonti et al., 2016; Sullivan, 1993), are more hopeful, and less likely than non-spiritual individuals to contemplate or commit suicide (Abollahi & Abu Talib, 2015; Abu Talib & Abollahi, 2017). Additionally, as spirituality is an individual and, often private, pursuit, it does not require medical intervention or significant financial investment. Spirituality, therefore, may provide an avenue for recovery that is more palatable and accessible to some depression sufferers than more traditional treatments (Brook, 2019).

While it is now understood that spirituality serves a protective function in depression, little is understood about how it confers such benefits (Bamonti et al., 2016;

Ramadas & Simões, 2018). Most studies conducted on spirituality and depression are quantitative and examine correlation rather than causation. Additionally, and to the researcher's best knowledge, all such studies have been conducted overseas. As New Zealand is a largely secular country with a significant indigenous and immigrant population, local research is needed to understand how spirituality is conceptualised and used in recovery in this unique environment.

The present study sought to understand how spirituality serves a therapeutic function in depression in New Zealand by utilising a qualitative phenomenological approach. Participants shared their lived experience of depression and recovery using spirituality through in-depth interviews. The resulting data set was then thematically analysed to gain insight into the shared elements of participants' experiences. The main research questions were:

- How do New Zealand participants conceptualise spirituality?
- What aspects of spirituality did they find helpful in their depression recovery?
- How did those aspect of spirituality assume a therapeutic function for them?

This thesis is organised as follows: Chapter 2 will explore the concept of depression – it will present current definitions and prevalence estimates and explore current and alternative approaches to the condition. Examples of Western, indigenous, and Eastern approaches will be provided. Chapter 3 will explore the Western academic understandings of spirituality and provide examples of indigenous and Eastern spirituality. Chapter 4 will present current scientific evidence for the therapeutic effects of spirituality on depression and explain the rationale behind, and aims of, the present study. Chapter 5 will present a detailed outline of how the study was conducted and the data analysed. Chapter 6 will present the results. Chapter 7 will offer a discussion on the findings as they relate to existing literature, state the limitations of the present study, and suggest avenues for future research in the area of depression and spirituality. Finally, Chapter 8 will conclude the thesis.

2. Depression

This chapter presents Western definitions of depression, prevalence rates, and outlines the conceptualisations and treatments of depression currently dominant in New Zealand. Issues with current approaches are discussed. Alternative conceptualisations of depression are also explored. As the three most populous groups in New Zealand consist of European, Māori, and Asian ethnicities, their approaches to depression are explored. Existential analysis is presented as an alternative to the biomedical approach that originated in the West. Te Whare Tapa Whā - A Māori approach to wellbeing – is also outlined. Finally, Traditional Chinese Medicine conceptualisations of a depressive pattern presentation are included as an example representative of Asian approaches to emotional distress.

2.1 Definition of depression

According to the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5), the main diagnostic tool used in New Zealand, Major Depressive Disorder is characterised by low mood, loss of pleasure, insomnia or hypersomnia, cognitive impairment, feelings of guilt and worthlessness, sudden weight loss or gain, and recurrent thoughts of death (American Psychiatric Association, 2013). A more chronic presentation of depression, Persistent Depressive Disorder (PDD) or Dysthymia, is described as either an attenuated presentation of MDD that lasts for more than two years, or a presentation that meets the diagnosis for MDD and persists unresolved for more than two years. In addition to the basic symptoms of depression that appear in the diagnoses of both MDD and PDD, nuanced presentations of the condition are recognised in the DSM-5 with specifiers, and include features of anxious distress (e.g. feeling unusually restless and unable to concentrate because of worry) and psychosis (delusions or hallucinations), among others. (American Psychiatric Association, 2013).

The International Statistical Classification of Diseases and Related Health Problems (ICD-11), the most recent version of the disease classification manual used by the World Health Organization (WHO), includes four diagnoses under the category of 'depressive disorders': single episode depressive disorder, recurrent depressive disorder, dysthymic disorder, and mixed depressive and anxiety disorder; single episode and recurrent depressive disorder can also be diagnosed to include psychotic features

(World Health Organization, 2018). While the ICD-11 comes into effect on 1 January 2022, the main change from the ICD-10 is the addition of dysthymic and mixed depressive and anxiety disorder to the ICD-11 under the ‘depressive disorders’ category.

For the purposes of analysing the global and regional prevalence of depression, the WHO uses the overarching category of ‘depressive disorders’ (World Health Organization, 2017). The WHO states that “depressive disorders are characterized by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, feelings of tiredness, and poor concentration” (World Health Organization, 2017, p. 7). This thesis subsumes both the DSM-5 and WHO definitions under the term ‘depression’ as it takes a phenomenological, rather than a clinical, approach to the condition and the phenomenology of the core symptoms of MDD and PDD is shared by all those who report being depressed.

2.2 Prevalence of depression

Depression is currently the most common manifestation of psychological distress and is one of the leading causes of disability worldwide (Wojnarowski et al., 2019). The WHO estimates that around 4.4% of the world’s population suffers from depression (World Health Organization, 2017) – a condition with a lifetime prevalence of approximately 16% and high relapse rates (Zhang et al., 2018). Individuals with one prior episode of depression have a 50% likelihood of relapse following treatment; relapse rates rise to 80% after two episodes, and as high as 90% after three episodes (Zhang et al., 2018). The Royal Australian and New Zealand College of Psychiatrists reports that “at least 80% of those affected by depression will experience at least two episodes of illness (recurrence) in their lifetime” (Malhi et al., 2015, p. 1095). Additionally, the WHO estimates that the number of individuals living with depression has increased by 18.4% between 2005 and 2015 (World Health Organization, 2017), making it one of the fastest growing causes of disability worldwide. In comparison to global prevalence statistics, New Zealand has one of the highest rates of depression with a total of 15.7% of New Zealand adults estimated to suffer from the condition in 2018 (Ministry of Health, 2019).

2.2.1 Ethnic differences

In New Zealand, analysis by ethnicity shows that depression is experienced by 18.3% of Māori, 7.2% Pasifika, 4.9% Asian, and 18.5% New Zealand European/Other (note that the

'Other' category includes all ethnicities that do not fall under Māori, Pasifika, Asian, or New Zealand European). It has been proposed that individuals belonging to the Māori, Pasifika, and Asian groups are underdiagnosed compared to the New Zealand European group. Lee et al. (2017), through a probability analysis, have shown that the low rates of official diagnosis among those groups are disproportionate to the high levels of distress experienced by them. Conversely, the rates of diagnosis among New Zealand Europeans are disproportionately high in relation to the levels of distress experienced by them (Lee et al., 2017). Māori are less likely to receive outpatient treatment for depression than New Zealand Europeans (Tapsell et al., 2018). Inequitable access to healthcare, stigma surrounding depression, issues with cultural sensitivity, and the increased need for trust between Māori patients and their doctors before disclosing psychological distress have been proposed as some of the reasons for underdiagnosis (Thomas et al., 2010).

Researchers investigating mental health among Pasifika in New Zealand estimate the rates of depression as equivalent to, or higher, than that of New Zealand Europeans, despite reported low prevalence rates (Tutty & Goodyear-Smith, 2014). A combination of socioeconomic constraints, poor availability of linguistically and culturally appropriate mental health services, conceptualisation of depression as more of a spiritual than health problem, and high levels of stigma towards mental illness in the Pasifika community, are believed to contribute to an underreporting and underdiagnosis of depression in this demographic (Paterson et al., 2018; Tutty & Goodyear-Smith, 2014).

Similarly, Asian populations in Western countries are known to be underrepresented in mental health statistics despite levels of psychological distress that are equivalent to those of the majority populations – a finding that emerged from the use of culturally sensitive assessment techniques (Ahmad et al., 2018). In New Zealand, it is uncommon for members of the Asian community to approach mental health services (Williams & Cleland, 2016). Being reserved and in control of emotions are characteristics valued by many Asian cultures and admitting to and discussing psychological problems with outsiders may bring shame on the sufferer's family unit (Ahmad et al., 2018; Williams & Cleland, 2016). Many Asian individuals are also more likely to approach spiritual or alternative practitioners for help due to their view of depression as a spiritual malady or a sign of yin and yang imbalance. Finally, the general view of emotional distress as weakness results in high rates

of somatisation among Asian populations, meaning that health practitioners may mistake such culturally influenced symptoms of depression for a physical ailment (Ahmad et al., 2018; Williams & Cleland, 2016).

2.2.2 Gender differences

In New Zealand, the rates of depression are typically higher for women (20.3%) than men (11%) (Ministry of Health, 2019). Several theories have been proposed to explain the gender differences in depression. As these differences first become pronounced during puberty, some investigators attribute depression vulnerability to sex hormones (Bulhões et al., 2019; Eid et al., 2019; Wilhelm et al., 2002). Others suggest that intrapersonal differences in personality, and cognitive and coping styles between men and women make women more prone to depression (Boughton & Street, 2007; Wilhelm et al., 2002). When taking the context of an individual's life into account, however, it may be that the difference between gender roles and the comparative powerlessness, discrimination, and higher incidence of stressful life events (such as sexual abuse and assault) experienced by women predispose them to depression (Boughton & Street, 2007).

Another theory that takes account of both gender differences and the construct of depression itself proposes that the symptoms used to diagnose depression follow a feminine-pattern presentation, with feelings of sadness and crying featuring prominently (Boughton & Street, 2007; Bulhões et al., 2019). It has been reported that men are more likely to show signs of depression by engaging in impulsive and aggressive behaviour, and substance abuse (Boughton & Street, 2007; Eid et al., 2019; Wilhelm et al., 2002). Therefore, current statistical gender differences may be artifacts of the diagnostic instruments used, where women are over-diagnosed, and men are under-diagnosed (Bulhões et al., 2019). Despite suggestions that the low numbers of reported depression in men indicate men's reluctance to seek help, research to date has not supported this proposition (Boughton & Street, 2007; Bulhões et al., 2019). It is likely that the gender differences in depression are multifactorial (Boughton & Street, 2007), and further research is needed into both how depression is conceptualised in New Zealand, and the experiences and life context of men and women who suffer from depression.

2.3 Current conceptualisations and treatments

Due to the dominance of the biomedical disease concept of depression in New Zealand, the treatments currently considered best practice involve the use of antidepressant medication and evidence-based psychotherapy (Malhi et al., 2015; Malhi et al., 2021). As cognitive behavioural therapy (CBT) has the widest evidence base in the form of randomised controlled trials (RCTs) (Hans & Hiller, 2013; Malhi et al., 2015), it is the therapy of choice for many practitioners and organisations (Malhi et al., 2015). The Royal Australian and New Zealand College of Psychiatrists advises that psychotherapy may be sufficient for mild to moderate depression, but that severe and chronic (and relapsing) presentations require the inclusion of antidepressant medication (Malhi et al., 2015). As 80% of individuals initially diagnosed with depression are likely to experience at least two episodes in their lifetime (Malhi et al., 2015), it appears likely that most of those individuals will be prescribed antidepressants at some point. While other treatments for depression are available in New Zealand, this section will focus on and critically analyse CBT and antidepressants; these are the most commonly used treatments – especially in the public health system, which is where most New Zealanders are likely to receive treatment.

2.3.1 Antidepressants

Antidepressants are thought to treat depression by acting on certain neurotransmitters in the brain (Taylor et al., 2005). The first psychotropic medications that became known as antidepressants were discovered in the 1950s; at the time, the focus of psychopharmacology was on treating severely psychotic and agitated patients (Braslow & Marder, 2019). Imipramine, which was later classed as a tricyclic antidepressant, was developed in 1955 and, although ineffective at calming psychotic and maniacal agitation, was found to alleviate some symptoms of depression. Monoamine oxidase inhibitors (MAOIs) were introduced around the same time as tricyclics but remained in limited use due to their serious side effects. The first of selective serotonin reuptake inhibitors (SSRIs), fluoxetine, was developed in 1974 (Braslow & Marder, 2019). SSRIs are theorised to increase the amount of serotonin in the brain by inhibiting its reuptake (Braslow & Marder, 2019; Jain et al., 2014). SSRIs are the frontline antidepressants prescribed today as they produce comparatively fewer side effects, although tricyclics and MAOIs are available as alternatives for patients who cannot tolerate or do not respond to SSRIs (Malhi et al., 2021) . In 2015,

12.5% of all New Zealanders over the age of 15 were prescribed antidepressants (an increase of 21% since 2008) (Wilkinson & Mulder, 2018).

Although the use of antidepressant medication is widely accepted as necessary and beneficial by both the medical community and the lay public, it is viewed as a controversial practice in parts of the psychological and psychiatric communities. The use of antidepressants in the treatment of depression was initially driven by the chemical imbalance 'theory' which posited that depression was the result of serotonin deficiency in the brain (France & Lysaker, 2007; Lacasse & Leo, 2015). While there has never been any well-developed theory of neurotransmitter deficiency (France & Lysaker, 2007; Pies, 2019), and the discipline of psychiatry as a whole has never subscribed to it (Pies, 2019), the 'chemical imbalance' explanation has been communicated to the public and general practitioners since the discovery of SSRIs – the most commonly prescribed class of antidepressant (Lacasse & Leo, 2015). There is still intense debate as to how and why this occurred as no consistent biological evidence in support of a neurotransmitter deficiency or imbalance has been found (France & Lysaker, 2007; Lacasse & Leo, 2015; Pies, 2019). Much of the blame is attributed to the pharmaceutical industry who, through their direct-to-consumer advertising (with the United States and New Zealand being the only developed countries where such advertising is legal (Greene & Watkins, 2015; Lexchin & Menkes, 2019)), has reified the chemical imbalance cause of depression in public discourse (France & Lysaker, 2007; Park & Ahn, 2013). However, as Lacasse and Leo (2015) point out, psychiatry has either been silent in debunking the chemical imbalance myth or has actively promoted it – mostly when explaining to their patients why they should take antidepressants.

Despite rejecting the chemical imbalance 'theory', psychiatry points to clinical trials of antidepressants to show that they are effective at alleviating severe depression. Many studies have been conducted on the efficacy of antidepressants, with largely positive results when examining their effect on severe and chronic depression (Kennedy et al., 2009; Pizzi et al., 2011; Ravindran et al., 2012). For example, a study by Jain et al. (2014) found the SSRI vilazodone produced an early and sustained response beginning in the first week of treatment and resulted in a 50% reduction in depression scores in the treatment group. In the context of persistent depression, or dysthymia, Ravindran et al. (2012) showed that the SSRI paroxetine resulted in a significant improvement of depression scores. Additionally,

quality of life ratings, and daily, social, and occupational functioning levels were significantly higher in the treatment group at the end of the study (Ravindran et al., 2012). As part of a growing body of research comparing the efficacy of different antidepressants, Kennedy et al. (2009) found escitalopram – a newer generation SSRI – to produce significantly improved outcomes when compared with older SSRIs and other antidepressants. The results showed that escitalopram produced significantly higher recovery and remission rates, with overall response rates of 53.1% (versus 49.4.%) increasing to 64.4% (versus 55.8%) in the severely depressed group. Remission rates were also higher for the escitalopram group with 47.7% as opposed to 41.6% for all other groups (Kennedy et al., 2009)

While the above results are encouraging, the existing body of antidepressant publications needs to be regarded with caution. A study by Turner et al. (2008) uncovered significant publication bias in the area of antidepressant efficacy research. To have a new drug approved in the United States, a pharmaceutical company must send the results of all trials conducted on the drug to the Food and Drug Administration (FDA). Based on data obtained from the FDA through the Freedom of Information Act, Turner et al. (2008) conducted an analysis of the trials. After reviewing the results, the authors concluded that a) 37 positive results were published (one positive result was not), b) 11 negative results that were published were presented in such a way as to portray the results as favourable to the medication under study, and c) 22 negative results were not published. Based on the published data, 94% of the trials had positive results. When all the data was analysed, however, only 51% of the trials had positive results (Turner et al., 2008).

More recently, De Vries et al. (2019) investigated whether pooled-trials publications contribute to antidepressant efficacy publication bias. Pooled-trials publications combine several trials into one publication, whereas stand-alone trial publications report on a single study. The authors found that 41.1% of negative studies were published in a pooled-trials format, compared to just 3.7% of positive studies. Additionally, all positive trials were published in some format, as opposed to only 82.4% of negative trials. As well as inflating the apparent number of positive results by publishing positive studies individually and combining several negative studies into a single publication, the pooled-trials approach can produce misleading results by replacing the principal research question (which had a negative outcome) with secondary research questions (that had more favourable

outcomes). De Vries et al. (2019) found this to be the case in their research, with only 12.1% of pooled-trials publications reporting on the original research question. Only 4.7% of studies reported a definitively negative conclusion, with 13.1% being neutral, and 82.2.% being positively framed (De Vries et al., 2019). Based on the findings of De Vries et al. (2019) and Turner et al. (2008), the evidence base underlying psychiatry's confidence in antidepressants may be much less robust than generally accepted.

Despite the questionable methods employed in antidepressant research publication, many psychiatrists point to their own clinical experience with severely depressed patients to support the efficacy of antidepressants (Lacasse & Leo, 2015). However, several studies have indicated that much of antidepressant efficacy is attributable to the placebo effect (an improvement in symptoms despite the administration of an inert, rather than active, pharmacological agent (Benedetti, 2014)), with patient expectancy being the most researched contributor to this effect (Kirsch, 2009; Lacasse & Leo, 2015; Rutherford & Roose, 2013; Zilcha-Mano et al., 2019). The placebo effect in antidepressant trials is responsible for 30% of improvement, compared to medication effects of 50% (Rutherford & Roose, 2013; Zilcha-Mano et al., 2019). Additionally, meta-analyses of trials submitted to the FDA "have reported that the placebo groups in these trials average 1.5 standard deviation units of improvement, which is 75% of the improvement shown in the antidepressant groups" (Zilcha-Mano et al., 2019, p. 2414).

While the contribution of the placebo effect to treatment success is already high, the magnitude of the effect in clinical trials has also been rising 7% per decade, leading to fewer than half of all clinical trials presented to the FDA being able to show medication efficacy independent of the placebo effect (Rutherford & Roose, 2013). As demonstrating medication efficacy over and above the placebo effect has resulted in increased time and cost of developing psychotropic medications, Rutherford and Roose (2013) report that several large pharmaceutical companies have reduced or discontinued such research. Additionally, it is estimated that 30% - 60% of individuals prescribed antidepressants stop taking them within the first 12 weeks in contravention of medical advice. (Buus et al., 2012; Lee et al., 2010). Antidepressant non-adherence has been found to be related to patients' psychosocial (rather than biological) understandings of depression and concern over medication side-effects and efficacy (Buus et al., 2012). Notably, medication non-adherence

does not appear associated with a lack of illness insight in depressed individuals (Lee et al., 2010). Nevertheless, and despite the questionable evidence base, poor treatment adherence statistics, and ethical concerns surrounding the championing and use of antidepressants, they remain a core component of depression treatment in New Zealand.

2.3.2 Cognitive Behavioural Therapy

Cognitive Behavioural Therapy (CBT) is a type of psychotherapy that is based on cognitive and behaviourist models of human psychological functioning (Petersen et al., 2016). CBT is an amalgamation of two initially distinct types of psychotherapy – behaviour modification developed mainly by B. F. Skinner in the 1950s (Labrador, 2004; Petersen et al., 2016; Rosal, 2018), and cognitive therapy developed by Aaron Beck in the 1970s (Petersen et al., 2016). CBT has been manualised to treat a variety of psychological disorders, ranging from mood disorders to somatoform disorders, and as an adjunct therapy for improving functioning and quality of life of individuals with various physical disorders. The manualisable nature of CBT has made it the therapy of choice for many mental health organisations and practitioners as the success of CBT theoretically does not depend on the personality of the therapist, but on clearly delineated steps that the therapist must take the client through during therapy (Binnie & Spada, 2018; O'Donohue & Fisher, 2012). Additionally, CBT has been shown to be effective over a relatively small number of sessions, meaning that it may be cheaper than other forms of therapy that require a larger number of sessions (Churchill et al., 2001; Gajic-Veljanoski et al., 2018; O'Donohue & Fisher, 2012). CBT has also been shown to be deliverable online through various modules – an application that many become more popular in the Covid-19 era with depressed individuals unable or unwilling to attend medical or counselling clinics (Malhi et al., 2021)

CBT has a strong evidence base as measured using the number of randomised controlled trials (RCTs) conducted (Malhi et al., 2015; Taylor et al., 2020). CBT has been shown to be more effective than placebo and equally as effective as antidepressants in the treatment of mild to moderate depression (Malhi et al., 2015; Malhi et al., 2021) . However, between 10% and 49% of individuals who undergo CBT relapse (Wojnarowski et al., 2019). While CBT designed specifically for relapse prevention has been shown to be effective in preventing relapse and recurrence of MDD, there is no agreement in the literature as to the timeframe over which relapse rates should be measured. While current guidelines take 12

months post treatment to be a sufficient time period when assessing the effectiveness of relapse-prevention CBT (Wojnarowski et al., 2019), individuals initially diagnosed with depression tend to relapse throughout their lifetime, meaning that the 12-month period may not provide an accurate picture of the long-term effectiveness of CBT in addressing the causes of depression (Zhang et al., 2018). Additionally, even during the 12-month period, the risk of relapse is reduced by only 50% (Zhang et al., 2018), meaning that a significant proportion of depressed individuals are likely to relapse despite receiving relapse-prevention CBT.

Moreover, the RCTs that most CBT effectiveness data comes from are conducted under strictly controlled and largely artificial conditions. For example, therapists in RCTs are rigorously trained in CBT and must adhere to a treatment manual, and the participants selected for the trials must fit rigid inclusionary and exclusionary criteria, meaning that the samples used may not be representative of populations seeking depression treatment in clinical settings (Binnie & Spada, 2018; Hans & Hiller, 2013). Hans and Hiller (2013) investigated the effectiveness of and dropout rates for CBT in naturalistic clinical settings. While CBT was still found to be effective overall, it was not as effective as in RCTs. Additionally, the mean drop-out rate was found to be 24.53%, with a range of 0% to 68%, suggesting that CBT, whether in an individual or group format, does not suit everyone who seeks treatment for depression.

2.4 Cultural issues

To further appreciate the potential shortcomings of the predominant conceptualisations and treatments of depression, it is important to understand the history and foundations of the current psychiatric nosological and diagnostic systems. The DSM, although regularly revised and updated, is still based on the major illness categories proposed by Western European psychiatrists in the 18th and 19th centuries (Kendler, 2009). Of note is these categories do not describe biologically identifiable disease entities that are found in physical medicine, but are a mixture of observed symptoms and trajectories, and personal clinical opinion (Kendler, 2009). While it could be said from a positivist viewpoint that repeated observation of certain symptoms and their co-occurrence with specific outcomes provides an empirical basis for psychiatric disorders, it is the interpretation of

those observations as an illness located within an individual (Moreno Leguizamon, 2005) that reveals the ethnocentric basis of the current approach to mental distress.

The main assumptions underpinning Western psychiatric thinking are that the self is “a bounded, unique, homogeneous and autonomous entity” (Jadhav, 1996, p. 271) and that the mind and body are separable (Jadhav, 1996; Moreno Leguizamon, 2005). While Descartes, arguably the father of body-mind dualism, regarded the mind as something intangible that was not privy to empirical observation, medicalisation of the human experience of health and illness during the 20th century has made mind synonymous with brain (Moreno Leguizamon, 2005). The human being is now regarded as an entity that is the composite of its physical parts – parts that interact successfully, resulting in health, or unsuccessfully, resulting in illness. It is, therefore, akin to a machine that can be taken apart, fixed, and put back together (Moreno Leguizamon, 2005). The dominant cognitive and behaviourist theories driving modern psychological treatment view the mind in a similar way - as an aspect of a human being that can be reconfigured by following a manual for a specific dysfunction of information processing and/or conditioning (Binnie & Spada, 2018; Gaudiano, 2008).

In addition to the dichotomous view of a human being as either functional or dysfunctional, the very notion of what is considered functional in the current approaches to mental distress are culturally embedded. In questioning the appropriateness of Western conceptualisations of depression applied to the experiences of distressed individuals in India, Jadhav (1996) explores the vocabulary that is used in Western diagnoses. He traces the earliest written records of a syndrome characterised by listlessness, restlessness, and despair to medieval Christian monks for whom such a condition was a routine part of adjustment to a cloistered existence in the monastery. Additionally, guilt was a direct product of sin and so was a correct and commendable emotion that provided an avenue for self-improvement. As European thinking shifted from theism to naturalism, and the hegemony over medicine moved from the clergy to scientists, behaviours and emotions once closely connected to Christianity and being Christian (rather than being unwell) became associated with biological dysfunction (Jadhav, 1996). Jadhav also links the notion of fatigue to the advent of the industrial revolution, where the right amount of goal-directed activity by individuals became essential for national economic wellbeing. Therefore, the

inclusion of psychomotor agitation or retardation as a symptom of depression in the DSM may also be culturally determined. While conditions approximating Western understandings of depression are found all over the world (Brown et al., 2012; Chentsova-Dutton et al., 2014), the combination of specific symptoms as found in the DSM diagnoses into a discrete and universal medical syndrome is essentially a Western construct (Dorwick, 2013; Jadhav, 1996).

It is clear from Jadhav (1996)'s analysis of some of the concepts that appear as symptoms of MDD in the DSM that the pathologising of such experiences has a long and culturally-bound history. While the DSM diagnoses clearly continue the thread of Western European thought in terms of normality and dysfunction, the DSM itself is even more narrowly culturally constrained than its foundations. The DSM is a text that was created in the United States, according to the norms of that culture within a unique geopolitical and ideological environment (Horwitz, 2011; Strand, 2011). The symptoms that the DSM considers crucial to the diagnosis of MDD – namely depressed mood and loss of pleasure - focus on the absence of positive feeling. This, some argue, is a direct result of the value the American culture places on positive emotion, pleasure, and absence of suffering (Chentsova-Dutton et al., 2015; Chentsova-Dutton et al., 2014).

While there are similarities between the DSM diagnoses of MDD and PDD and the presentations of 'depression' across various cultures, such as deep sadness, anhedonia, sleep and appetite disturbances, and reduced concentration (Kendler et al., 2015; Kessler & Bromet, 2013), there are also significant differences. For example, in their study of depression among Aboriginal men in central Australia, Brown et al. (2012) found that, while participants reported profound sadness, it was a sadness driven by persistent worry. Moreover, the worry was not for themselves, but for their families and communities. Participants lacked the hopelessness, guilt, and self-reproach that is characteristic of Western depression, but felt a deep sense of grief, loss, and concern for those close to them (Brown et al., 2012). Reports of persistent worry are more likely to be diagnosed as an anxiety disorder, rather than depression, according to the DSM (American Psychiatric Association, 2013), which would be misleading in the context of these men's lives. Additionally, and especially in younger men, the tell-tale signs of depression

were substance abuse and violence – behaviours that would not be recognised as indicative of depression in the DSM.

Similarly, Brintell et al. (2013) found that for Javanese depression sufferers, the most distressing feature of the experience was in the interpersonal domain. Participants felt unable to connect with others or fulfill their responsibilities to those around them. Again, and contrary to the individualistic nature of DSM diagnoses, their concern was not for themselves, but for those close to them. Additionally, while hopelessness was a strong feature of depression for these participants, it was experienced in terms of not being able to contribute to society, rather than as a lack of vision and future direction for a person as a self-centred and autonomous being (Brintell et al., 2013). Issues of relational dynamics are recurring themes in depression presentation across collectivist[3] societies (Karasz, 2005; Mayston et al., 2020). As the DSM depression diagnoses are based on a highly individualistic concept of self, the interpersonal dimension is not addressed as a symptom category. Therefore, these diagnoses not only potentially miss and misinterpret such individuals' experiences, but also lead to treatments that are inappropriate and harmful.

2.4.1 Implications for New Zealand

In New Zealand, a country that has a large indigenous population, and has quickly become a melting pot of global cultures through immigration, the narrowly ethnocentric approach to mental distress mandated by the DSM is unlikely to be wholly appropriate. The 2018 census shows that, while 70.2% of the population identifies as New Zealand European, 16.5% identifies as Māori, 15.1% as Asian, and 8.1% as Pasifika; the Asian ethnic group consists largely of Chinese, followed by Indian, and Filipino (Stats NZ, 2019). Additionally, most New Zealand Europeans are not North American, and to assume that a system of classification and treatment designed in the United States is appropriate for all Westerners because they shared a similar heritage in the distant past, is equally questionable. Further, most individuals suffering from mild to moderate depression do not gain access to specialist mental health services in New Zealand

[3] Collectivist societies can be described as societies that are communal and where "social units with common fate, common goals, and common values are centralized; the personal is simply a component of the social" (Oyserman et al., 2002, p. 5)

(Government Inquiry into Mental Health and Addiction, 2018), meaning that a large proportion of the population is unlikely to benefit from the dominant clinical treatments.

2.5 Alternative conceptualisations and treatments

Despite the dominance of the DSM and the associated pharmacological and disorder-specific psychological treatments, many other explanations and treatments for depression exist – both within Western psychological and philosophical disciplines, and in every non-Western culture around world. This section will explore Existential Analysis, Te Whare Tapa Whā, and Traditional Chinese Medicine as examples of alternative Western, Indigenous, and Eastern approaches.

2.5.1 An existential perspective

One approach developed in Western Europe is Existential Analysis. Existential Analysis was chosen as an example as it is an approach that was developed by a practising psychiatrist, Victor E. Frankl. It is, however, an approach that is humanistic and deals with issues of meaning and the human spirit that traditional scientific psychological treatments largely avoid (Frankl, 1986). While still individualistic in the sense that it places the onus for getting better on the individual, Existential Analysis positions the individual in the context of their life situation and, in contrast to the dominant approaches, views suffering as an opportunity for growth rather than a hindrance to wellbeing that must be eliminated. Frankl (1986), in his analysis of melancholia (a diagnosis that subsumed what is now called depression at the time of Frankl's writing), attributes the onset of the problem to a 'vital low' experienced by the individual. This vital low may well have organic causes but the only symptoms attributable to it are "psychomotor and secretory inhibitions" (Frankl, 1986, p. 201). The rest of the symptoms, including self-reproach, irrational guilt, hopelessness, loss of meaning, and suicidal ideation, are the result of the individual's appraisal of their vital low in terms of their life task and their ability to accomplish it.

As the individual, who may have been active and successful before the onset of the vital low, views themselves as inadequate and insufficient in light of the sudden loss of their ability to function at their previous level, existential anxiety sets in. Such anxiety results from the perceived difference by the depressed person of who they are and who they ought to be. The greater the gap between who the person thinks they are and who they believe

they should be, and the greater their perceived impotence to become their ideal self, the more the depressed individual becomes depersonalised and removed from the world. They are unable to envision the future, and their existence loses meaning. As the condition worsens, these feelings of worthlessness and meaninglessness extend to the world around them, leading to derealisation. In the current neoliberal capitalist climate that privileges individualism, competition, and continuous improvement , it is unsurprising that so many individuals struggle with anxiety and feelings of inadequacy (Sugarman, 2015).

More recently, Ratcliffe (2013) has explored the spiral into depression in terms of an individual losing hope. While hope is assumed to be an intentional state, in which an individual consciously hopes for something, Ratcliffe (2013) argues for the existence of pre-intentional hope. Pre-intentional hope is not action oriented but is the existential state in which the individual is able to experience the possibility of hope even in situations where all other hope seems gone. It is the presence of pre-intentional hope that gives people the ability to survive and persevere in the direst and, for all intents and purposes, hopeless circumstances. Ratcliffe argues that depression signifies the loss of pre-intentional hope. He states, “it is the possibility of hoping that is experienced as absent” (Ratcliffe, 2013, p. 605) Without pre-intentional hope, which is necessary for the existence of all other hopes, all practical aspects of life become meaningless. The inability to experience the possibility of hope places the depressed individual in a distinct temporal dimension – one in which the future, if it can be framed at all, is framed not in terms of possibilities but of dread. Due to the pre-conscious nature of such a state, the predicament faced by a depressed individual is not an issue of practical cognition that encompasses goals and thinking styles, but one of profound disorientation and separation from everyday existence (Ratcliffe, 2013).

Through logotherapy, Frankl (1986) advocated a solution to address the predicament faced by the depressed person. In Frankl’s view, the individual, either afflicted by an organic illness or devastated by a life event, is free to choose his or her attitude and by so doing, to live a fulfilling and meaningful life fully present in the world. Moreover, Frankl views the vital low that is the precursor to the downward emotional spiral of existential anxiety and hopelessness as a temporary condition that eventually resolves. Chronicity and degeneration are caused by the individual’s inability to appraise this transient condition as part of their personal destiny and an opportunity for the realisation of attitudinal values.

The realisation of attitudinal values involves the acceptance and ownership of one's suffering as a test of one's humanity – accepting what cannot be changed and, at the same time, using one's fate as a springboard to higher fulfilment.

While Frankl (1986)'s approach may appear to place the pathogenesis within the individual, he argues that the realisation of values that is key to a meaningful life can only occur in the context of community and an individual's particular life situation. Just as healthy, fulfilled persons find their individuality and personal value by holding themselves responsible to the community, so an unwell individual loses that sense of individuality and self-appreciation by forgetting or neglecting that responsibility. More recently, Wong (2015) has extended on logotherapy with his Meaning Therapy (MT). MT utilises evidence-based cognitive and behavioural assessment tools and interventions, addresses depressogenic lifestyle factors, and gives importance to meaning-making, relationships, and spirituality. MT posits that sustained recovery from depression requires the development of a meaningful, wholesome, and fulfilling life that enables the individual to feel valued, connected and useful.

2.5.2 Indigenous perspectives

Indigenous cultures, likewise, view symptoms of depression as occurring in the context of an individual's life, without dismissing biological or cognitive contributors to their distress (Cohen, 2003; Kam et al., 2019; Lang & Jansen, 2013). While there are as many models of health and wellness as there are cultures, Indigenous models appear to share several characteristics. Firstly, they are holistic in nature – that is, they consider health to be contingent on the balance between the physical, emotional/mental, social/familial, and spiritual aspects of a person's life, as well as the person's interdependence with other sentient beings and the environment (Cohen, 2003; Kam et al., 2019; Karasz, 2005; NiaNia et al., 2019; Storck et al., 2000; Wang & Iwamasa, 2018). Secondly, unlike the DSM, which is primarily concerned with classification, non-Western models are more interested in aetiology and pathogenesis than nosology (Kam et al., 2019; Lang & Jansen, 2013). Thirdly, due to their holistic basis, Indigenous models are more flexible in terms of offering a personalised solution that fits with an individual's reality in terms of personality, history, social reality, phenomenology, and beliefs, thereby improving the effectiveness of the intervention (Cohen, 2003; Lang & Jansen, 2013; Storck et al., 2000; Wang & Iwamasa,

2018). Fourthly, much like existential analysis, traditional cultures view suffering as an unavoidable part of life that provides an avenue for growth and transformation, and consider questions of meaning as central to wellbeing (Cohen, 2003). Finally, those cultures that have succeeded in preserving traditional methods of healing despite the pressures to conform to the Western biomedical conceptualisation of health and illness, consider spirituality foundational to wellbeing (Cohen, 2003; Lang & Jansen, 2013; NiaNia et al., 2019; Sachdev, 1989; Storck et al., 2000; Tuhiwai Smith, 1999).

As Māori are the indigenous peoples of New Zealand, their approach to mental distress will be presented in this section. As Māori take a holistic and deeply spiritual approach to health and wellbeing, depression is not treated as a distinct biological or psychological ailment in traditional Māori healing (Mark & Lyons, 2010; NiaNia, Bush, et al., 2017).

Te Whare Tapa Whā

Te Whare Tapa Wha (meaning 'the four walls of the house') is a holistic health and wellbeing model developed by the psychiatrist and Māori health advocate Sir Mason Durie (O'Hagan et al., 2012). The 'house' represents an individual's total well-being, with the 'four walls' each representing an integral aspect of that wellbeing (McNeill, 2009). Just as a house becomes unstable when one of its walls is weakened, so an individual's wellbeing suffers when one of its components is neglected. The 'four walls' of wellbeing are: taha tinana (physical), taha hinengaro (emotional/psychological/behavioural), taha whānau (familial), and taha wairua (spiritual) (McNeill, 2009; Rochford, 2004). These four dimensions of wellbeing are discussed in more detail below.

Taha tinana

This dimension deals with ailments of the physical body. However, as all Māori healing, it is also based on a spiritual foundation (NiaNia, Bush, et al., 2017). Rongoā (a form of healing that uses medicinal plants, as well as other physical objects believed to confer healing) is often used to treat issues in the physical dimension. Romiromi (deep tissue massage) and mirimiri (soft tissue massage) are used to unblock energy centres and balance energy flows around the body, and to soothe the person's wairua (spirit) (NiaNia, Bush, et

al., 2017). The physical dimension also includes lifestyle factors that influence bodily health (Rochford, 2004).

Taha hinengaro

This dimension deals with the emotional, psychological, and behavioural aspects. One of the major issues faced by most Māori whanau is intergenerational trauma (O'Hagan et al., 2012). Colonisation traumatised many Māori through land confiscations, cultural, linguistic, and commercial dispossession, and separation of families for the purposes of assimilation (McNeill, 2009). Much cultural knowledge and wisdom that had been orally transmitted down the generations was lost in this process, and the physical movement of whanau members away from their ancestral home to attend boarding schools or to work in the cities meant a fracturing of the whānau unit and a loss of identity for many of its members (McNeill, 2009).

This loss of cultural identity and its attendant benefits, such as healthy self-esteem and sense of security, are recognised as significant contributors to mental distress among Māori (McNeill, 2009; Rochford, 2004). The lack of guidance, sense of loss, feelings of powerlessness and anger have contributed to some Māori adopting self-destructive coping strategies (Rochford, 2004). The rates of illicit drug use and suicide are disproportionately high among Māori (Coronial Services of New Zealand, 2020; Ministry of Health, 2016), as is the incidence of family violence and other crime (King & Robertson, 2017; New Zealand Police, 2018). To heal such wounds it is considered important for an individual to embark on a journey of learning their whakapapa (genealogy), Te Ao Māori (the Māori worldview), and their history and traditions, thereby reclaiming their cultural identity, establishing a more secure sense of self, and creating a more positive and harmonious way of being in the world (McNeill, 2009; NiaNia, Bush, et al., 2017; O'Hagan et al., 2012; Rochford, 2004).

Taha whānau

This dimension deals with the familial and relational aspects of a person's life. While family in Western cultures usually refers to an individual's nuclear family, in Māori culture the whānau includes the extended family and ancestors (McNeill, 2009; NiaNia, Bush, et al., 2017; O'Hagan et al., 2012). Harmony and balance within the whānau, both in terms of its

present dynamics and unresolved ancestral issues, are essential for wellbeing (Mark & Lyons, 2010; NiaNia, Bush, et al., 2017). A harmonious whānau consists of several generations, where the elders are taken care of by the younger members, and the younger members are in turn guided and supported by the elders (O'Hagan et al., 2012).

Taha wairua

This dimension deals with matters of spirit and spirituality. While wairua is a distinct dimension in Te Whare Tapa Whā, it is important to note that it is foundational to all other dimensions (Mark & Lyons, 2010; Moon, 2003; Valentine et al., 2017). As Māori consider wairua to be the basis of human existence, it affects and is affected by all aspects of a person's life. As such, wairua is considered when addressing imbalances in any of the other three dimensions. Balancing the body, mind, and whānau involves spiritual practices and the invocation of spiritual forces in the form of ancestors and gods (McNeill, 2009; Moon, 2003; NiaNia, Mana, et al., 2017). A more detailed exploration of wairua and other important components of Māori spirituality is presented in section 3.2 of this thesis.

2.5.3 Eastern perspectives

Like Indigenous perspectives, Eastern approaches to health and wellbeing are holistic and based on an interdependent concept of self (Lee, 2015; Yeh, 2000). While Western medicine understands human beings as discrete and independent biological organisms, Eastern traditions consider the individual an extension of the universe that is directly affected by cosmic forces. Further, in contrast to the materialistic and strongly atheistic tenets of Western medicine, Eastern medical disciplines are founded on established spiritual frameworks (Lee, 2015; Yeh, 2000). For example, in Taoism - an ancient Chinese philosophy underlying much Asian medical knowledge - the functioning of the human body is influenced by the rhythms of the cosmos and physical health depends on a harmonious relationship between the body and its environment (Yeh, 2000). In Ayurveda – the main traditional system of health in India - an individual is seen simultaneously as a body, a soul in its present reincarnation, and a social being possessed of a unique combination of wisdom and ignorance (Yeh, 2000). Most Eastern systems share the concept of the five elements as foundational to human physiological and emotional functioning (Lee, 2015; Lu et al., 2004). While the specific conceptualisations of the elements vary (for example, ether,

air, earth, fire, and water in Ayurveda (Lee, 2015); and wood, fire, earth, metal, and water in Traditional Chinese Medicine (Lu et al., 2004)), all systems agree that health is dependent on a balance of those elements. They also consider harmony among the dimensions of the mind, body, spirit, and relationships prerequisite to wellbeing (Lee, 2015; Yeh, 2000).

While many discreet Eastern medical systems exist, this section will present Traditional Chinese Medicine (TCM) as an example of Eastern approaches to depression. TCM was chosen to represent Eastern perspectives as a) the Chinese currently represent the largest proportion of the Asian ethnic group in New Zealand (Stats NZ, 2019), b) TCM, as compared to other Asian health systems such as Ayurveda in India, has the most amount of research literature available in English, and c) due to high rates of Chinese immigration all over the world, TCM has gained global prominence as a valid alternative to traditional Western medicine (Scheid, 2013).

Traditional Chinese Medicine (TCM)

TCM is an ancient Chinese system of diagnosis and treatment. Unlike Western biomedicine, which concerns itself with identifying discrete disease entities and devising treatments specific to a biological disorder, TCM priorities patterns of symptom presentation in conjunction with the patient’s life context (Kam et al., 2019; Karchmer, 2013; Scheid, 2013). As all Eastern health systems, TCM is holistic in that it considers the mind-body-spirit triad in diagnosis and treatment (Kam et al., 2019; Scheid, 2013).

Traditionally, depression does not appear as a condition in TCM, providing further evidence for the argument that depression as a discrete illness is a Western construct. However, due to the global dissemination and increased dominance of Western biomedicine, TCM practitioners have had to draw parallels between the Western concept of depression and patterns of presentation recognised in TCM that share the most similarities with depression (Kam et al., 2019; Karchmer, 2013; Ng & Leng, 2018; Scheid, 2013). The TCM concept that most resembles depression is that of stagnation or constraint of qi (Karchmer, 2013). Qi can be defined as the life force – something that allows living things to be (Karchmer, 2013; Scheid, 2013). When qi is allowed to flow freely through the body, the individual is healthy; when qi is constrained, it begins to stagnate and the individual falls ill. Qi stagnation can lead to numerous health problems, with the pattern of presentation

indicating the location of stagnation and thereby leading to a specific intervention. In the case of emotional disorders, centuries of TCM development have led to the liver as the site of qi stagnation. As the liver becomes constrained, qi becomes trapped and begins to stagnate (Karchmer, 2013; Scheid, 2013). The liver here does not refer to the physical organ, but to an energy centre through which qi passes (Scheid, 2013). In the case of depression, or liver qi stagnation, the liver has become blocked, preventing qi from flowing and thereby damaging other energy centres, such as the spleen and the heart.

While there is consensus on the aetiology of the pattern of presentation that is indicative of depression, TCM practitioners are likely to provide varying diagnoses and treatments (Kam et al., 2019). For example, if the patient is a middle-aged female, some practitioners may diagnose a depressive pattern while others may diagnose a menopausal pattern. However, the diagnosis itself is largely irrelevant as it is the cause, i.e. liver qi stagnation, that is of concern (Karchmer, 2013; Scheid, 2013). A TCM treatment usually consists of several components, such as herbal medicines, massage, and acupuncture (Karchmer, 2013; Scheid, 2013). Practitioners vary in the specific types of medicines they prescribe, as their preference depends on their training and philosophical orientation (Kam et al., 2019). TCM recognises that there are many ways of treating the same problem, and practitioners refine and adjust their formulations to the patient's characteristics and life situation (Kam et al., 2019; Scheid, 2013). Therefore, a TCM practitioner is not using medicines to heal a physical malady but is rebalancing the person as a whole in the indivisible mind-body-spirit dimension. Similar to Indigenous approaches to mental distress, and unlike Western medicine, TCM strives to treat the person rather than the disorder.

2.6 Summary

The biomedical approach to mental distress currently dominates and guides the conceptualisation and treatment of depression in New Zealand. While antidepressants and CBT are the recommended and most used interventions, a high number of depression sufferers relapse repeatedly despite receiving treatment.

Existential analysis is a treatment devised in the West that views depression as an absence of meaning and hope, rather than a biological dysfunction. Indigenous and Eastern cultures take a holistic approach and view depression as an imbalance in the sufferer's

mental, physical, emotional, spiritual, and relational landscape. While current dominant approaches focus on treating the disorder - as conceptualised according to a narrow ethnocentric framework - other approaches prioritise the individual as a being with a unique story and in a wider life context.

As a prelude to discussing the therapeutic role of spirituality in depression, the following chapter presents definitions and conceptualisations of spirituality using a similar format. First, Western understandings are presented, followed by examples of Indigenous and Eastern conceptualisations.

3. Spirituality

This chapter first presents Western academic understandings of spirituality and how it is differentiated from religion. Māori spirituality is discussed as an example of the role spirituality plays in Indigenous life and worldviews. Finally, Eastern spirituality is explored to highlight the contrast between the foundations of Eastern and Western worldviews. Asian immigrant communities comprise a significant and growing proportion of the New Zealand population, and spiritual practices with roots in Eastern spirituality are popular and increasingly influential in the West. Therefore, a foundational knowledge of some tenets of Eastern spirituality are important for understanding how spirituality may be conceptualised in New Zealand.

3.1 Western spirituality

Western understandings of spirituality typically focus on differentiating it from religion. While some authors view spirituality and religiosity as overlapping and, at times, inseparable concepts (Abu-Raiya et al., 2016; Snider & McPhedran, 2014), there is now strong argument in the literature that the two concepts are phenomenologically separate (Del Rio & White, 2012; Hill et al., 2000).

Many definitions of spirituality and religion exist, with religion generally more narrowly and easily defined than spirituality (Knoblauch, 2013; Koenig, 2009). One example can be found in Luna and MacMillan (2015). They state that “religion involves an organised system of values and rituals which an individual practices within a community organisation” (Luna & MacMillan, 2015, p. 514). Spirituality has a more complicated definition, with the authors stating it is a:

> “complex and multidimensional construct that appears to have two distinct components: (1) an existential dimension, and (2) a relational dimension. The existential dimension encompasses the search for meaning in life that involves a sense of connection to oneself, and to the broader environment. On the other hand, the relational dimension of spirituality concerns an individual’s relationship with God or a higher power”. (Luna & MacMillan, 2015, p. 514).

While many authors have attempted to clearly distinguish between the concepts of religion and spirituality using varying criteria, Hill et al. (2000) argue that many definitions are too narrow, exclusionary, or dichotomous at one extreme, and too broadly inclusive at the other. To avoid the pitfalls of under- and over-inclusiveness, Hill et al. (2000) offer some criteria for the dimensions of spirituality and religion as a good starting place for the operationalisation of the two constructs. Spirituality only requires individuals to engage in a search for the sacred. Religion requires them to conduct this search while also looking to fulfil more materialistic goals, such as belonging to a community, and to conduct such a search using methods that receive validation from said community. Thus, religiosity does not preclude spirituality, but spirituality does not need to satisfy as many criteria as religiosity.

More recently, Knoblauch (2013) argued for the emergence of what he terms ‘popular spirituality’. Unlike ‘alternative spirituality’ – the kind of spirituality that was born in the West in the 1960’s and held distancing from organised religious institutions as one of its core values – popular spirituality bridges the divide between organised religion and individualistic spirituality. As is evident from Hill et al. (2000)’s operationalisation of religion and spirituality, the internal aspects of spirituality, i.e. those experiences that do not require the involvement of a religious institution, are shared by both the religious and the non-religious. Knoblauch (2013) calls this shared aspect “the great transcendence” (Knoblauch, 2013, p. 86). He warns not to confuse ‘great transcendence’ with the more ‘general transcendence’ of transpersonal psychology. He states,” While the latter referred to the (human) ability to relate to something not ‘present’ in the material environment, great transcendence indicates an intentional relation of human actors to something which surpasses the everyday life world” (Knoblauch, 2013, p. 86).

Del Rio and White (2012) likewise posit that religiosity and spirituality are separate constructs, despite the two often being conflated in the clinical and academic literature. They argue that, while religiosity is culturally determined and requires an individual to behave in accordance with established norms as a way of accessing the transcendent, spirituality is an individual pursuit that involves the individual making sense of their life and connecting with the transcendent in a way that seems best to them. They also suggest that spirituality does not require a belonging to a defined faith community. It is intrinsic to

human beings – that is, while people are not obliged to desire a connection with the transcendent, that desire and ability to satisfy it is available to all human beings as their birthright. Moreover, as spirituality is intrinsic to being human, the authors suggest that it is a universal phenomenon that finds many different expressions. Although not adhering to a pre-determined set of formal behavioural rules, Del Rio and White suggest that spiritual individuals, through the process of making sense of their lives, create a personalised 'code of conduct' that enables them to express their spirituality in everyday life and through everyday actions. Conversely, while religion can provide a community and set of directives which enable an individual to achieve connection with the transcendent and establish a value-driven way of living, it is also a somewhat artificial social construction that varies from culture to culture. The proposition of spirituality as intrinsic and universal, and religion as socially constructed and culturally bound, is supported by the fact that numerous religions and faith communities around the world share connection with the transcendent and meaning-making as their goals.

It can be concluded from the above discussion that spirituality is a highly individual, personal, and multifaceted phenomenon that involves an individual looking to connect with the transcendent, make sense of their lives, and devise a way of living that accords with their personal values and beliefs. While many types of formal and informal spiritual practice exist, Del Rio and White (2012)'s argument shows that they are largely irrelevant in terms of defining an individual as spiritual or as having experience of spirituality. Further, although some religions can be detrimental to the development of an individual spirituality through their insistence on dogma and conformity, some individuals' spiritual journey may benefit from affiliation with a religious institution or faith community, provided that those institution or communities' norms and teachings align with that individual's values and worldview. Therefore, while spirituality and religion are certainly distinct phenomenological concepts, they do overlap and cannot be treated as antagonistic to each other.

3.2 Indigenous spirituality

Indigenous cultures do not concern themselves with definitions as spirituality is an integral part of their worldview and everyday life (Valentine et al., 2017)– it is an experiential phenomenon rather than a concept that needs to be intellectualised and

communicated in a neat, logical manner. Such cultures consider people to be first and foremost spiritual beings who owe their existence to (a) supreme being(s). This supreme being is identified by different names in each culture, including the Creator or Great Spirit among Native American nations (Cohen, 2003) and Io among Māori (NiaNia, Bush, et al., 2017). As all other manifestations of existence, such as flora, fauna, and inanimate objects of nature, such as rocks, are also products of the supreme being, they too are first and foremost spiritual beings (Mark & Lyons, 2010; NiaNia, Bush, et al., 2017). Moreover, as human beings are dependent on nature and the environment for their sustenance, non-human manifestations of existence are deeply respected and often elevated to stand above humanity in terms of wisdom and ability and, consequently, are called upon for help in human intra- and interpersonal affairs (Cohen, 2003; Mark & Lyons, 2010; NiaNia, Bush, et al., 2017).

Due to greater availability of English-language material on the beliefs and practices of Māori culture, and its relevance in the New Zealand context, it will be presented here as an example of Indigenous spirituality. It is important to note that, as the researcher is a Westerner, the interpretation of Māori spirituality presented here was conducted through a non-Indigenous lens.

Māori spirituality

Māori conceptualise the world in holistic and relational terms (Mark & Lyons, 2010). Most importantly, spirituality is not just something that is practised or believed in but is the foundation of everything that exists in this world, including human beings (Valentine et al., 2017). While Māori culture is tremendously rich and complex in terms of life philosophy and tradition, the concepts that are central to everyday living include those of wairua, mauri, mana, tapu, noa, and whenua (Moon, 2003; Sachdev, 1989). Some of these concepts are discussed further in this section.

Wairua, although near impossible to translate, has been described as the spirit, or that which is essential for human existence (Moon, 2003) . Health and wellbeing depend on wairua (NiaNia, Mana, et al., 2017; Valentine et al., 2017), as do harmonious social relations, and an individual's balanced relationship with the natural environment (Moon, 2003; Valentine et al., 2017). Wairua is central to traditional Māori healing as it is the essence of a

person and nothing can be done about sickness without taking care of wairua first. When a person dies, it is the wairua that leaves the body and travels to the spirit world; according to Hohepa Koreopa, a Tuhoe tohunga (healer and authority on matters of spirit and custom), some of the dying person's wairua can transfer to others before departing, thereby strengthening their own wairua (Moon, 2003). Proper funeral and burial rituals must be observed to enable the deceased person's wairua to travel to the spirit world; if the person is not laid to rest properly their distressed spirit may linger in this world. Much of the work of the tohunga or traditional healers involves practices that rectify such situations, whereby they enable the distressed spirit to continue onto the spirit world (Moon, 2003).

The concept of mauri can be understood as an energy or life force and, unlike wairua, which is the foundation of animate existence, is possessed by all things in this world (Moon, 2003). For example, plants have mauri, as do places, objects, and language. In a sense, it is a force that allows everything to come into being, be it an emotion, an interaction, a situation, or a tree. Importantly, mauri is unique to each person, place, or thing. Whenever an event occurs, be it a person chopping down a tree for firewood or a discussion between two people, each party contributes its mauri to the process – that is, everything in life is an interaction of mauri. Mauri can be weakened, strengthened, and moved or transferred but only when allowed by its holder. For example, a person's mauri can only be weakened if that person allows it to be weakened (albeit unconsciously) and the head of a household is the holder of that household's mauri (Moon, 2003).

The concepts of tapu and noa are intertwined. Tapu refers to something that is sacred or prohibited, and noa to something that is safe to access (Sachdev, 1989). Much Māori ritual involves turning things, places, and situations from tapu to noa (Moon, 2003; Sachdev, 1989). This process is essential as breaches of tapu can have severe and long-lasting consequences. Misfortune, sickness, and death are some of the consequences of a breach of tapu that has not been rectified (Sachdev, 1989). There are many different places and situations where a tapu may exist or be placed, such as births and deaths. As the deceased are considered tapu, anyone who has been in contact with a corpse becomes tapu and needs to be made noa by cleansing themselves with water (Sachdev, 1989).

Whenua, which is commonly translated as 'land', is another concept that is central to Māori genealogy and wellbeing (Mark & Lyons, 2010). While the term 'land' seems simple

enough to understand for the Western mind, in te ao Māori whenua is more than just fields, forests, and mountains. Whenua is part of Māori whakapapa (genealogy) and mountains and lakes are considered a person's ancestors rather than mere landmarks or resources to be exploited (Mark & Lyons, 2010; Moon, 2003). In terms of wellbeing, the health of a person is inextricably linked to the health of the whenua – if the whenua is abused or neglected, the person tied to that whenua will be unwell (Mark & Lyons, 2010). Sometimes, healing the whenua is what is required before the person can be helped. As people depend on the land for survival, Māori culture places utmost importance on respecting and caring for the land and everything that grows or roams on it (Moon, 2003). As mentioned earlier, everything has mauri, and the land – including forests, waterways, and flora and fauna – is no exception. Therefore, any interaction a person has with the land involves an interaction of mauri and is, therefore, a spiritually significant event (Moon, 2003).

3.3 Eastern spirituality

Eastern spirituality is a broad term used to describe spiritual beliefs and practices that originate and are performed in predominantly Asian countries, such as India, China, Tibet, Bhutan, and Thailand, among others. Historically, the term 'spirituality' was not used by Asian societies as the various beliefs and practices of this region were part of religion (Palmer, 2018). However, as the East and West began to interact in modernity, some Asian nation-states sought to distance themselves from religion – a concept that stood in contrast to evolution, perceived progress, and epistemological maturity in the West. 'Spirituality' was a safer term that could be used to communicate with the West on matters of local ethics, custom, and epistemology (Palmer, 2018). Therefore, when Westerners refer to Eastern spirituality, they are really referring to the tenets and practices of Eastern religions.

While many and varied, all Eastern spiritual traditions share transcendence as a common goal (Palmer, 2018). Transcendence refers to attaining freedom from the limitations and confusion imposed by the body, mind, and society. While in some ascetic traditions transcendence can lead to rejection, most other traditions pursue transcendence for the betterment of humanity (Palmer, 2018). Transcendence is achieved primarily through introspection – looking for the truth within (Palmer, 2018; Robinson, 2020). Eastern thought is holistic, prioritises experiential knowledge (Cazalis, 2017), and accepts

contradiction as natural and necessary. While contradiction in Western thought indicates irreconcilable conflict between two polarities, in Eastern thought it simply represents a natural relationship between interconnected and complementary parts of the whole (Robinson, 2020).

While many different Eastern spiritual traditions exist, this section will present Buddhism as an example of Eastern spirituality. Buddhism has had an influence on most major Eastern spiritual traditions and has been keenly embraced in the West. While only around 1.1% of the New Zealand population affiliates itself with Buddhism as a formal religion as of 2018 (Stats NZ, 2020a), many people informally borrow from Buddhist thought and practice on their spiritual journeys (Frisk, 2012). As well as acquiring adherents in the form of spiritual seekers, Buddhism has drawn interest from the Western scientific community due to its potential for overcoming epistemological and methodological impasses impervious to the solutions available to Western science (Cazalis, 2017). Additionally, Buddhist techniques, such as mindfulness and acceptance, have recently been incorporated into some Western psychological interventions (Frisk, 2012). Examples of such therapies included Mindfulness-based CBT (MCBT) and Acceptance and Commitment Therapy (ACT) (Frisk, 2012).

Buddhism

Buddhism is a non-theistic religion and philosophy that is now well established in the West, both as a formal religion and a system of spiritual practices that can be followed by secular spiritual practitioners and members of non-Buddhist religions. The main aim of all Buddhist practice is liberation from suffering through the attainment of nirvana (Gyatso & Chodron, 2014; Hanh, 1999). Gyatso and Chodron (2014), quoting from the *Paṭisambhidāmagga*, define nirvana as “the stilling of all formations, the relinquishing of all attachments, the destruction of craving, dispassion, cessation” (Gyatso & Chodron, 2014, p. 159).

The Four Noble Truths provide the foundational teaching on the nature of suffering and the means to its cessation. The First Noble Truth asserts that life is suffering (Hanh, 1999). This is not to say that life is inherently terrible, but that suffering is an unavoidable part of everyday existence in the realm which humans inhabit – the realm of desire (Gyatso

& Chodron, 2014). The Second Noble Truth asserts that suffering arises from identifiable causes, the Third Noble Truth states that it is possible to eliminate the causes of suffering, and the Fourth Noble truth posits that suffering can be eliminated by practising the Noble Eightfold Path (Hanh, 1999).The Noble Eightfold path prescribes eight practices that should be followed in everyday life. They are: right view, right thinking, right mindfulness, right speech, right action, right diligence, right concentration, and right livelihood (Gyatso & Chodron, 2014; Hanh, 1999).

Meditation is the main practice utilised in Buddhism. Through realising the true nature of their mind, consciousness, and reality, Buddhist practitioners let go of attachment (Goldstein, 2016; Gyatso & Chodron, 2014; Hanh, 1999). Nonattachment here does not mean detachment or indifference, but the ability to fully appreciate all that exists due to its fragility and eventual demise without clinging. Without clinging to things that are impermanent and realising that life is a complicated web of causes and conditions – many of which are out of an individual's direct control – the practitioner frees themselves from suffering (Goldstein, 2016; Gyatso & Chodron, 2014; Hanh, 1999). The practice of Buddhism can greatly enrich and improves a person's life in terms of better mental and physical health, relationships, and vocational choices (Hanh, 1999).

3.4 Summary

Western understandings of spirituality focus on differentiating it from religion using a reductionist approach. Spirituality is conceptualised as an individual's highly personal search for connection with the transcendent, a framework that enables meaning-making, and a guide for constructing a value-driven way of living. Religion is concerned with all of the above but achieves it in the context of a community united by a set of beliefs and in accordance with the norms of that community.

Indigenous spirituality lacks such concrete definitions as it is inherent in everyday ways of being and doing. An individual in such cultures cannot be complete and healthy without taking care of their spirituality.

Eastern spirituality focuses on transcendence of the material as its goal. Practitioners discover the truth of their being through introspection and appreciation of the

interconnectedness of all things. Citing Buddhism as an example, spiritual practitioners develop non-attachment – a practice that enables them to stop grasping the impermanent and thereby freeing them from suffering.

The following chapter presents research that has been conducted into the relationship between spirituality and depression, and shows the various benefits conferred by spirituality on depressed individuals.

4. Therapeutic nature of spirituality

This chapter presents research conducted on the relationship between spirituality and depression. Several quantitative studies that have explored spirituality's relationship to depression risk, symptom severity, hopelessness, existential meaning, and suicide are analysed. Four qualitative studies on the importance and role of spirituality in mental health are presented. Finally, the chapter concludes by outlining the research objectives and approach of the present study based on the reviewed literature, identified limitations of existing research, and the potential benefits of the findings for New Zealand.

4.1 Quantitative studies

While most studies conducted on spirituality and depression conflate the constructs of religion and spirituality (Abu-Raiya et al., 2016; Peselow et al., 2014; Snider & McPhedran, 2014; Yi et al., 2006), studies that use measures independent of theism and religiosity demonstrate consistent positive effects of spirituality on mental health and existential wellbeing. Many studies also focus on chronically or terminally ill populations, as questions of existential meaning and death (traditionally seen as issues for spirituality and religion to deal with) are theorised to assume prime importance for people in such circumstances. As the focus of this thesis is on depression as a primary condition, and spirituality and religion have been shown to be distinct constructs, this section presents a selection of studies that a) make an attempt to differentiate spirituality from religion and b) treat depression and suicidality as the primary conditions of concern.

4.1.1 Risk of developing depression

In looking at the potential protective effects of spirituality on depression development, Portnoff et al. (2017) found that high spirituality halved the risk for depression among a random sample of individuals for the United States of America (USA), India, and China. Interestingly, the authors also found that when the areligious Delaney spirituality questionnaire (Delaney, 2005) was used, the risk for depression was halved in participants in the USA, India, and China. However, when the more theistically specific Fetzer DSES (Abeles et al., 1999) was used, depression risk was decreased in the USA and India but not in China. Demographically, a large proportion of the Chinese population

identified as non-religious (43.3%) when compared to the USA (35.9%) and India (1.8%). This suggests that theistic conceptualisations of spirituality may only be helpful to those who are religious. Conceptualisations that prioritise secular and experiential aspects of spirituality, on the other hand, appear beneficial for both the religious and non-religious.

4.1.2 Severity and chronicity of symptoms

To examine the effects of spirituality on individuals who already suffer from depression, Luna and MacMillan (2015) examined the relationship between spirituality, depression symptom severity, and psychosocial functioning in an ethnically diverse sample of university students in the USA. The authors used the Spiritual Transcendence Index (STI; Seidlitz et al., 2002) to measure levels of spirituality. The STI consists of two subscales: one that captures an individual's relationship with God (the God subscale), and one that measures the importance of spirituality in an individual's life (the Spirituality subscale). Participants who scored highly on the Spirituality subscale had significantly lower degrees of depression symptom severity and psychosocial impairment. The authors suggest that spirituality may reduce self-judgement in depression sufferers, and lead to a value-driven and, consequently, purposeful and fulfilling life (Luna & MacMillan, 2015).

Conversely, participants who scored highly on the God subscale had higher degrees of symptom severity and psychosocial impairment (Luna & MacMillan, 2015). The authors suggest that the latter result could be due to participants' perceptions of God as punitive and judgmental, resulting in excessive feelings of guilt and shame. Previous studies have indeed found that, compared to belief in a benevolent God, belief in an authoritarian God is associated with low self-esteem and external locus of control (Benson & Spika, 1973), as well as increased aggressive behaviour and decreased willingness to forgive (Johnson et al., 2013).

To understand the influence of spirituality in clinical populations, Peselow et al. (2014) examined the influence of spirituality on depression scores before and after treatment in a sample of outpatients at a United States depression and anxiety clinic. The authors used the Spiritual Orientation to Life scale (SOL; Galanter et al., 2007; Goldfarb et al., 1996) to gauge spirituality and asked participants if they believed in God. It was found that high spirituality according to the SOL was significantly positively correlated with

improvement in depression scores, dysfunctional attitudes, and hopelessness post-treatment. While belief in God was correlated with improved depression scores, it did not change dysfunctional attitudes or hopelessness. Combined with Luna and MacMillan (2015)'s findings, it appears that spirituality conceptualised without strict theistic requirements consistently confers therapeutic benefits on depressed individuals, whereas theistic and/or religious conceptualisations of spirituality do not. It also appears that theistic/religious individuals' God concepts play an important and nuanced role in the various aspects of mental wellbeing. Conflating religion and spirituality in depression research, therefore, is likely to lead to inconsistent findings. Further, the above findings may be particularly relevant to the New Zealand population due to a large proportion of individuals who identify as non-religious (48.2%) (Stats NZ, 2020b).

Looking specifically at long-standing and persistent depression, Ramadas and Simões (2018) analysed the relationship between depression, mindfulness, and spiritual well-being in a sample of Portuguese outpatients suffering from chronic depression. Spirituality was treated as distinct from religion and this study; consequently, participants' religiosity or belief in God was not assessed. Mindfulness was measured using the five-facet mindfulness questionnaire (FFMQ; Baer et al., 2006) and spiritual wellbeing was assessed using the spiritual well-being questionnaire (SWBQ; Gomez & Fisher, 2003). The authors found that, overall, higher scores on both the FFMQ and SWBQ were associated with lower depression scores. Interestingly, the association was higher between the FFMQ and depression during treatment, and between the SWBQ and depression following treatment. It appears that, while the practice of mindfulness is helpful in alleviating the symptoms of depression, spiritual wellbeing may be important for the sustained resolution of symptoms and relapse prevention (Ramadas & Simões, 2018).

Both findings are perhaps unsurprising. Mindfulness trains practitioners to remain in the present moment without judgement (Goldstein, 2016; Hanh, 1999) – a state that is opposite to a depressed individual's tendency to judge themselves harshly, ruminate on the past, and be fearful of the future (Frankl, 1986; Ratcliffe, 2013). Spiritual wellbeing encompasses an individual's positive relationship with themselves, others, the environment, and the transcendent (Diebels & Leary, 2019; Ramadas & Simões, 2018) – a state of connection and communion that is contrary to the sense of isolation and inferiority that

Frankl (1986) and Ratcliffe (2013) theorise triggers the spiral into depression and maintains the condition's chronicity.

4.1.3 Hopelessness, existential meaning, and suicidality

Hopelessness is considered a key feature in the development of suicidal ideation as individuals who lose hope for a cessation of their pain are more likely to seek an end to suffering by ending their lives (Klonsky & May, 2015). A study by Abollahi and Abu Talib (2015) on the influence of spirituality on hopelessness and suicidality among Iranian adolescents showed that, while hopelessness alone was responsible for 13% of the variation in suicidality, spirituality was responsible for 42% of total variance. While individuals who were high in hopelessness and low on spirituality were high in suicidal ideation, those high in hopelessness and spirituality were low on suicidal ideation. The authors concluded that high spirituality was an important buffer against suicidality in depressed individuals who were feeling hopeless.

Another study by Abu Talib and Abollahi (2017) on depression, hopelessness, spirituality, and suicidality among Malaysian adolescent produced largely the same findings. Using the Daily Spiritual Experiences Scale (Underwood & Teresi, 2002), the authors found that depression, hopelessness, and spirituality explained 26% of the variance in suicidal ideation. Likewise, they found individuals who were low in spirituality and high in hopelessness to be higher in suicidal ideation than those who were high in hopelessness but high in spirituality. It may be that spiritual individuals in these studies retained what Ratcliffe (2013) terms 'pre-intentional hope', enabling them to retain the understanding that hope is still possible despite their current situation and protecting them from suicidality. However, as the Beck Hopelessness Scale (Beck et al., 1974) and the Children's Hope Scale (Snyder et al., 1997) that were used in these studies treat hope as a homogeneous and goal-directed construct, and pre-intentional hope is not goal-directed, the above studies do not allow for a differentiation between individuals who have retained or lost pre-intentional hope.

Abollahi and Abu Talib (2015) also found that the variable most associated with decreased suicidal ideation on the Index of Core Spiritual Experience (ICSE) (Kass et al., 1991) related to an individual's relationship with a Higher Power, rather than variables

related to religiosity. They concluded that it is spirituality, defined as an individual's relationship with the sacred, rather than formal religious practice, that confers protection against suicidal ideation. Abu Talib and Abollahi (2017) also concluded that an individual's relationship with a higher power conferred protection against hopelessness and suicidal ideation due to the comfort, reassurance, and a more positive perception of events that come from such a relationship. However, the authors advise caution when interpreting these two studies as they were both carried out in strongly Muslim communities. Islam expressly prohibits suicide so the influence of religion and culture on suicidal ideation, and the presence of social desirability bias in participant responding, cannot be ruled out (Abollahi & Abu Talib, 2015; Abu Talib & Abollahi, 2017).

A lack of meaning in life has been empirically linked to both hopelessness and suicidality both within and outside the context of clinical depression (Marco et al., 2016; Schnell et al., 2018). A study by Bamonti et al. (2016) examined the relationship between depression symptom severity, spirituality, and meaning in life in older US outpatients. Spirituality and meaning in life were measured using the Spiritual Transcendence Index (Seidlitz et al., 2002) and the Geriatric Suicide Ideation Scale (Heisel & Flett, 2006) respectively. The authors found that high spirituality was associated with increased meaning in life among older depressed individuals, thereby reducing suicide risk. The authors found that, while there was no significant correlation between spirituality and depression symptom severity, those with higher levels of spirituality reported higher meaning in life. As higher meaning in life is associated with better resilience and ability to view depression as a life challenge to overcome rather than a hopeless uncontrollable state (Bamonti et al., 2016; Frankl, 1986; Wong, 2015), it may enable depressed individuals to engage in adaptive coping behaviours and view their suffering as meaningful (Bamonti et al., 2016). These findings are consistent with the premises of Wong (2015)'s Meaning Therapy where meaning in life is considered central to wellbeing, with spirituality essential for developing a healthy perspective and constructing a meaningful life meta-narrative.

4.1.4 Limitations of quantitative studies

While positive links between spirituality and depression have been identified, methodological shortcomings exist. There is little consistency among quantitative studies in terms of construct operationalisation, measurement instruments used, and the correlations

examined. Such inconsistencies are likely due to the lack of an established theoretical consensus as to what spirituality is (Victor & Treschuk, 2020). The heterogeneity of the questionnaires used may reflect each researcher's unique understanding of spirituality, with some considering theism constitutive of spirituality (Bosco-Riuggiero, 2020) and others deeming it separate (Ramadas & Simões, 2018). Similarly, the correlations examined are likely influenced by the researchers' inferences as to the most likely emotional, cognitive, and behavioural consequences of certain beliefs and meaning frameworks (Bosco-Riuggiero, 2020).

In addition to potentially mirroring researcher-specific conceptualisations of spirituality, the use of structured questionnaires risks limiting findings from the outset. The need for clear construct operationalisation in the creation of a structured questionnaire requires imposing a definition and, consequently, meaning of spirituality on participants (Morgado et al., 2017). Filtering participant experiences through a specific conceptual lens is likely to miss much of the idiosyncratic and unconventional experiences of spirituality (Laird et al., 2017). Likewise, the meaning of the experience and recovery from depression has been pre-determined by a researcher using diagnostic criteria and related outcome measures. Therefore, all that is currently known is essentially how a researcher's conceptualisation of spirituality correlates with clinically determined recovery outcomes.

Finally, quantitative analysis can only be relied on to observe the external manifestations of internal processes – it is not well-suited to establishing cause and effect relationships between internal processes (Toomela, 2010). Spirituality is a highly experiential, subjective, and internalised phenomenon. Likewise, depression encompasses myriad internal events, with only some of them observable through overt behaviours. Therefore, qualitative studies that reveal the internal processes that endow spirituality with a therapeutic function in depression are needed (Toomela, 2010).

4.2 Qualitative studies

A comparatively small number of authors have conducted exploratory qualitative studies into experiences of recovery involving spirituality. A study conducted by Moritz et al. (2011) with 15 clinically depressed individuals in Canada utilised a spiritual intervention and assessed its effects on participants through in-depth interviews. The authors found that six

months following the intervention, participants enjoyed an expanded spiritual awareness, a sense of connection to self, others, and a universal energy, more positive thinking patterns, reduced emotional reactivity, and improvements in mood and relationships. The authors concluded that spirituality provided participants with an expanded frame of references that enabled many of the positive changes sought by traditional psychotherapeutic interventions, such as CBT. They also suggested that, while faith-based CBT is suitable for adherents of Christianity or Islam, a spiritual intervention that does not draw from a specific religion achieves equivalent results for individuals of any or no religious affiliation (Moritz et al., 2011). This study suggests that spirituality adds a dimension to people's lives that may be missing from the materialistic narratives that dominate Western culture, thereby enabling holistic and far-reaching inner transformations that are unattainable by traditional reductionist interventions.

Using a case-study approach, Cheng (2015) explored the experience of a Hong Kongese woman's recovery from severe depression using Buddhist teachings. They found that the practices of mindfulness and meditation, immersion in Buddhist scripture, and adherence to Buddhist behavioural precepts enabled their participant to change her negative thought patterns, increase self-awareness and self-compassion, achieve emotional acceptance, improve resilience to stressful events by developing calmness, and improve interpersonal relationships by eliminating negative habits. The Buddhist tenets of compassion and selflessness also shifted her focus from herself to helping others, thereby lessening her preoccupation with her problems and reducing psychological suffering (Cheng, 2015). This study demonstrates that Buddhism, while teaching a concept of self and reality at odds with Western understandings, can successfully treat the causes of a condition highly prevalent in Western societies.

Two qualitative studies have been conducted on the importance of spirituality to individuals suffering from various forms of mental distress. While not focused on depression specifically, both these studies found that spirituality was considered very important and helpful to the participants. Wilding et al. (2006) interviewed six individuals in Western Australia whose experiences of mental distress encompassed depression, anxiety, psychosis, and bipolar disorder. They found that spirituality was a highly personal and unique experience and a lifelong journey that aided in participants' personal growth. Participants

also felt a desire to share their spirituality with health professionals but feared being labelled mentally unwell, or that professionals would not be willing to discuss spiritual matters. The authors recommended that health professionals needed to be open to their own and their clients' spiritual beliefs as they were an integral part of the recovery journey.

Sullivan (1993) interviewed 40 individuals in the US who had previously met the criteria for a serious and chronic mental disorder and were now in recovery. While most of the participants in the study had been diagnosed with schizophrenia rather than depression, this study still adds to the understanding of the role and value of spirituality in recovery from mental distress. Sullivan (1993) found that 49% of his sample considered spirituality to be one of the most important elements of their recovery. Those individuals found that spirituality helped them cope and solve problems, provided them with social support through belonging to a community of like-minded individuals, and enabled them to find meaning in their experiences and remain optimistic that there were good things in store for them. Sullivan (1993), while acknowledging that obsessive preoccupation with spiritual and/or religious matters may be indicative of a serious problem, also recommended that mental health professionals not ignore their clients' spiritual needs. He suggested that professionals find ways to either engage with their clients' spirituality directly or refer them to organisations or groups that can assist the client on their spiritual journey.

4.2.1 Limitations of existing qualitative studies

The main limitation of the studies described above is that they were all conducted overseas. While they reveal a depth and variety of experience unachievable by quantitative studies, their relevance to the New Zealand population needs to be assessed with caution. Sullivan (1993)'s study was conducted in the USA, a country that has much higher rates of religious affiliation than New Zealand (79.9% versus 44.9% (Stats NZ, 2020a; United States Census Beareuau, 2012)). Participant experiences of spirituality in this study did appear to be heavily influenced by religion through their discussions of God and worship attendance. Due to the secular nature of New Zealand society, conceptualisations and experiences of spirituality in this country are unlikely to be as closely related to religion as in the USA. Similarly, Cheng (2015)'s participant engaged with Buddhism through immersion in scripture and participation in the Buddhist religious community in Hong Kong. While Buddhist philosophy and mindfulness practice enjoys some popularity in New Zealand, the

absence of a strong and established Buddhist tradition in this country means that the depth of religious immersion undertaken by Cheng (2015)'s participant is likely to be available to only a small number of New Zealanders.

Moritz et al. (2011) and Wilding et al. (2006)'s studies were conducted in Canada and Australia - countries that could be deemed culturally similar to New Zealand. However, the Canadian study employed a spirituality intervention and so guided participants' involvement with spirituality in recovery. While highly informative and promising in terms of potential interventions, this study does not explain how or why individuals who are depressed engage with spirituality of their own accord. The Australian study, while examining participants' self-initiated spiritual journeys, did not restrict its sample and included individuals suffering from psychosis and bipolar disorder as primary conditions. As those conditions are likely to vary in their phenomenology, treating them as one may have resulted in a very general understanding of the therapeutic role of spirituality while dismissing the more idiosyncratic but crucial aspects of participant experiences.

4.3 Research objectives of the current study

The principal aim of this research project is to gain an understanding of how a selection of adults living in New Zealand recovered from depression with the help of spirituality. While a growing body of research is showing that spirituality protects against depression, most of that research is quantitative. Therefore, while the existence of the protective influence of spirituality is now supported, there is little clear understanding of the mechanisms by which those protective influences are conferred. Quantitative research into spirituality and depression also suffers from the limitations of construct simplification for the purpose of generalisation, and inconsistencies in construct operationalisation and the correlations studied. Existing qualitative research, while more comprehensive and nuanced in its investigations, is comparatively rare. Additionally, all research on spirituality's role in depression prevention and recovery has been conducted overseas, meaning that the extent of its relevance to the experiences of New Zealanders is unclear.

By asking New Zealanders about their experiences of depression and spirituality without imposing a framework of meaning on their experiences, researchers can better understand spirituality's role in helping individuals recover from chronic psychological

suffering. Given the growing prevalence and chronicity of depression worldwide and in New Zealand, the current medical approaches' limited success in addressing those issues, and the evidence for the significance of spirituality in helping individuals recover, the research project proposed here will be an important addition to the growing movement to find alternative treatments for psychological distress. Considering the dominance of the medical model of mental distress and the generally secular nature of New Zealand society, this thesis will help shed light on how spirituality is conceptualised, practised, and used as a recovery tool in New Zealand's unique environment.

In considering the above, the main research questions driving this study are:

- How do New Zealand participants conceptualise spirituality?
- What aspects of spirituality did they find helpful in their depression recovery?
- How did those aspect of spirituality assume a therapeutic function for them?

It is hoped that this knowledge will add to New Zealanders' ability to regain and preserve mental and existential wellbeing.

4.4 Summary

While most studies into depression and spirituality conflate the concepts of spirituality and religion, those studies that attempt to differentiate between the constructs show that spirituality consistently confers protection against depression. Highly spiritual individuals are less likely to become depressed. Those who do become depressed, however, tend to suffer from less severe symptoms or are able to glean meaning from their suffering and engage in adaptive coping behaviours. Spirituality has been implicated in both improved treatment outcomes and sustained recovery. Spirituality's association with increased meaning in life and reduced feelings of hopelessness also makes it a powerful protector against suicidal ideation.

While existing quantitative studies lack conceptual and methodological consistency, and miss many idiosyncratic but important aspects of spiritually informed recovery, existing qualitative studies are not entirely applicable to the New Zealand population due to the high levels of religiosity among overseas participants and the inclusion of other serious psychological issues alongside depression.

The present study uses a qualitative phenomenological approach to understand how spirituality is conceptualised and experienced as therapeutic for depression in the unique New Zealand environment. The next chapter outlines how this project attempted to achieve its research objectives.

5. Method

This chapter outlines the research philosophy and ethical considerations behind this study. The participant recruitment process and the sample's demographic characteristics are then presented. The procedure employed in conducting the study is described and the approach taken in analysing the data is presented in detail. Finally, the trustworthiness of this study is addressed.

5.1 Research design and philosophy

This is a qualitative research project that has been designed in line with a phenomenological epistemology. Phenomenology posits that reality is known through lived experience and has as its focus the meanings individuals attach to their experiences (Spencer et al., 2014; Starks & Brown Trinidad, 2007). As depression and spirituality are deeply experiential phenomena, and the focus of the study was on participant understandings of how spirituality aids recovery from depression, the phenomenological approach was deemed well suited to the aims of this project.

5.2 Ethics

This project was reviewed and approved by the Massey University Human Ethics Committee: Southern B, Application SOB 20/13. To minimise harm to the participants who may have become distressed during the study, participants were informed of their right to withdraw from the interview at any time and advised of the ability of the researcher and her supervisor to obtain professional psychological assistance for them, if needed.

5.3 Participants

5.3.1 Selection criteria

Participants for this project were recruited using purposive sampling. Unlike quantitative studies which aim to generalise findings in terms of the distribution of a phenomenon in a population, this study was focused on understanding how the phenomenon was experienced and understood by participants in as much detail as possible (Liamputtong & Ezzy, 2005). Purposive sampling seeks out participants who have lived

experience of the phenomenon under study and who are, therefore, most likely to communicate a rich and nuanced understanding of the phenomenon. Through an in-depth exploration of the experience of recovering from depression using spirituality, purposive sampling should enable the generation of thematic patterns within the experience, rather than provide an estimate of the prevalence of the experience across the population of individuals with depression (Liamputtong & Ezzy, 2005). In other words, the use of purposive sampling enables an understanding of the ‘how and why’, rather than ‘how often’ or ‘to what extent’.

To be eligible for the study, participants had to be at least 18 years old and able to give full informed written consent. The sample included individuals who had experienced depression and used spirituality to recover. An official diagnosis of depression was not required. As a large number of New Zealanders, especially those in the mild to moderate severity range, do not access mental health services to receive a diagnosis (Government Inquiry into Mental Health and Addiction, 2018), requiring the presence of a clinical diagnosis may have significantly limited the pool of suitable participants and resulted in a sample that was not representative of the general population. Additionally, there is some evidence that some individuals who are spiritually inclined, such as those who have had intense spiritual experiences, are less likely to access and subjectively benefit from conventional (e.g. psychiatric and medication) treatment approaches (Brook, 2019), so requiring participation in the mainstream process of diagnosis and treatment may have excluded many such participants.

While individuals who were actively experiencing mental distress at the time of data collection were discouraged from participating, no screening instruments were used to exclude participants as the understanding of recovery varies from person to person. While recovery can mean the resolution of symptoms and a return to ‘premorbid’ levels of wellbeing and functioning, whether unassisted or with clinical intervention (Hummelvoll et al., 2015), it can also mean an ongoing process in which an individual regains the ability to live an engaged, meaningful, and hopeful life without achieving a complete absence of symptoms (Hummelvoll et al., 2015; Scott et al., 2018). As recovered individuals who fit into the latter category may still display symptoms of depression from time to time, the use of a clinical screening instrument would likely exclude them from participation based on the

biomedically orthodox view of recovery as symptom elimination. Therefore, in line with the recovery movement's ethos of empowerment and self-determination (Hummelvoll et al., 2015), and combined with this study's emphasis on lived experience, potential participants were trusted to decide for themselves whether they fit the profile of a recovered depression sufferer.

As depression is highly comorbid with other forms of mental distress, such as anxiety and substance abuse (Lai et al., 2015; Zbozinek et al., 2012), individuals who suffered from other types of distress along with depression were not excluded. Such an exclusion criterion may have resulted in an overly homogeneous sample that was not reflective of a real-world depression sufferer in New Zealand. Participants were not questioned on the existence of other forms of distress or substance use. If any comorbidities existed and, more importantly, were considered by the participants to be an important part of their experience, it was expected that they would be explored by the participants during interviews.

As one of this study's aims was to understand what spirituality meant to a New Zealand sample, no set definition of spirituality was used to include or exclude participants - individuals could choose to participate if their recovery experience included spirituality as understood by them. As New Zealand is a predominantly secular society (Stats NZ, 2020b) that is steeped in materialistic scientific discourse, it was important to allow participants to attach their own meanings to the term "spirituality" in order to gain understanding of the phenomenon in the local context. Attempting to provide a definition, be it with an unintentionally religious, anti-religious, or materialist slant, would have likely discouraged many participants from choosing to share their story for fear of being unsuitable, misunderstood, and misrepresented.

5.3.2 Participant characteristics

A total of nine participants comprised the sample for this project. Seven of the nine participants were recruited using existing acquaintanceship networks and snowball sampling. Two participants were recruited through Facebook, where the researcher placed an advertisement seeking voluntary participation from individuals who had suffered from depression and used spirituality to recover (see Appendix A). It is established in the

methodological literature that a small sample size is best for an in-depth qualitative study such as this, with between six and 12 participants sufficient (Guest et al., 2006; Starks & Brown Trinidad, 2007). It is generally accepted that saturation is quickly achieved with small sample sizes and that no new information is likely to be gleaned by increasing the sample. Such was the case in this study, where saturation had been achieved prior to the completion of the data collection phase. Saturation was determined as the point at which no new insights into participants' understanding of spirituality or its therapeutic effects could be gleaned. Data collected past this point is likely to be redundant (Saunders et al., 2018). Additionally, this project had a limited timeframe which was disrupted by Covid-19 restrictions and delays. Therefore, it was decided that sampling beyond saturation would result in inefficient use of resources, where the quality of analysis may suffer with little to no benefit added by a larger sample.

The sample consisted of seven female and two male participants. In terms of age, four of the participants were in their thirties, two in their forties, two in their fifties, and one in their sixties. Seven of the participants identified their ethnicity as New Zealand European, one identified as British and one as Indian. Participants were located in both the North and South Islands of New Zealand, with one based in Canterbury, two in Nelson/Marlborough, two in Wellington/Kāpiti, three in Manawatū and one in the Auckland region (see Table 1). Participants reported varying degrees of past depression, with some remaining functional in their daily lives and others requiring hospitalisation. Some participants reported complete and long-standing resolution of all symptoms. Others took a preventative approach in which they actively managed their potential for becoming depressed again – more detail on this aspect of recovery will be presented in the results section of this thesis.

Table 1

Participant Demographics

Participant	Gender	Age	Ethnicity	Location
Participant 1	Female	48	NZ European	Wellington/Kāpiti
Participant 2	Female	48	NZ European	Wellington/Kāpiti
Participant 3	Female	37	British	Canterbury
Participant 4	Male	63	NZ European	Manawatū/Wanganui
Participant 5	Female	52	NZ European	Nelson/Marlborough
Participant 6	Female	34	NZ European	Manawatū/Wanganui
Participant 7	Female	36	NZ European	Auckland
Participant 8	Male	57	NZ European	Nelson/Marlborough
Participant 9	Female	30	Indian	Manawatū/Wanganui

5.4 Procedure

Upon receipt of ethics approval, participants who were known to the researcher and/or her supervisor were contacted via e-mail and provided with the study information sheet (see Appendix B) and invited to participate in the study. Participants recruited through Facebook contacted the researcher either via e-mail or through Facebook Messenger and were e-mailed the study information sheet. Participants who expressed willingness to participate after reading the information sheet were e-mailed a consent form (see Appendix C) which they signed and returned prior to the interview. Interviews were arranged to fit with each participant's schedule and conducted in their own (i.e., not work) time, free of interruptions.

Six interviews were held and recorded online using Zoom as these participants resided in different parts of the country, from Canterbury to the Auckland region. The uncertainty regarding travel restrictions created by Covid-19 made online interviewing the method of choice. Two face-to-face interviews with participants who resided in Manawatū were held at Massey University and one was held at the participant's residence. All three face-to-face interviews were recorded using a sound recorder function on the researcher's laptop. The Zoom interviews were passcode protected to ensure privacy. To further

maintain privacy and confidentiality, recordings made using both Zoom and the sound recorder function were stored on the researcher's computer instead of a server that is accessible through the Internet.

5.4.1 Interview structure

In-depth interviewing is one of the methods of data collection deemed most appropriate for use in a phenomenological study as it allows the researcher to glean the meaning of an experience for a participant through the participant's telling of their story (Liamputtong & Ezzy, 2005; Starks & Brown Trinidad, 2007). The interviews followed a semi-structured format in which participants were free to discuss whichever aspects of their experience of depression and recovery using spirituality they deemed most salient.

A semi-structured interview approach was chosen as it provided a balance between the participants' ability to express themselves freely and the researcher's need to keep to the study's focus during the interview (Brinkmann, 2014; Madill & Gough, 2016). Considering the breadth of the topic and the absence of strict definitions of the phenomena under study, an unstructured approach may have resulted in data that were too heterogeneous and disconnected to allow for the formation of thematic patterns in accordance with the research questions (Brinkmann, 2014). Conversely, a structured approach would have limited participants' expression by precluding the exploration of unforeseen and idiosyncratic aspects of their experience in relation to the phenomena under study (Brinkmann, 2014; Madill & Gough, 2016).

A brief interview schedule (see Appendix D) was used by the researcher to prompt conversation where necessary and to gain a deeper understanding of the phenomenon under study. Examples of open-ended questions asked included: "Do you want to start by telling me about your experience(s) with depression?" If a participant needed to be prompted, questions such as "When did you first realise you were depressed?" and "How did you know you were depressed? What was different?" were asked. Some of the questions regarding spirituality included "What made you seek out a spiritual approach to recovery? What does 'spirituality' mean to you? What spiritual practices did you employ or engage in during your recovery journey?"

5.5 Data analysis

The interview recordings were transcribed by the researcher using the Otranscribe online tool (Bentley, n.d.). The transcripts were then analysed using inductive thematic analysis. Thematic analysis is a method that is not tied to any specific epistemology and so can be used across several different epistemological approaches (Braun & Clarke, 2006). Phenomenology, the epistemology driving this project, is an epistemology that posits that reality is constructed through lived experience (Spencer et al., 2014), prioritises the meaning individuals attribute to their experiences (Liamputtong & Ezzy, 2005; Spencer et al., 2014) and considers the meaning of an experience to be communicable through language (Starks & Brown Trinidad, 2007). Thematic analysis concerns itself with looking for patterns of meaning across or within data (Braun & Clarke, 2006). Therefore, it was deemed appropriate to use a method that concerns itself with the meaning of a phenomenon in combination with an epistemology that (a) also concerns itself with the meaning of an experience and (b) assumes that the researcher can glean the meaning of an experience from the qualitative data provided by participants.

The inductive version of thematic analysis was chosen because very little is currently known in psychology about people's lived experience of using spirituality to recover from depression. Therefore, an approach that seeks to build an understanding of a phenomenon from patterns in the data, rather than one that seeks to mine data in accordance with a preconceived theory, was deemed most appropriate. During the analysis, a search for semantic, rather than latent, themes was conducted. In a semantic analysis "the themes are identified within the explicit or surface meanings of the data, and the analyst is not looking for anything beyond what a participant has said" (Braun & Clarke, 2006, p. 84). Due to the paucity of knowledge regarding the phenomenon under study, it was deemed necessary to first establish whether a consistent pattern of meanings exists and what it looks like. A latent analysis of underlying or 'hidden' meanings in the data would be premature at this stage.

The qualitative software NVivo was used to analyse the data following Braun and Clarke (2006)'s 6-phase approach. The steps undertaken in each of the six phases, along with examples from the data, are presented below.

Phase 1: Familiarisation with the data

As the interviews were manually transcribed by the researcher, the process of transcription served as the first phase of familiarisation with the data. During transcription, salient points of each participant's experience were noted. As transcription progressed, recurring and/or salient points were tentatively grouped into potential emergent themes in the researcher's notebook. Once all the interviews had been transcribed, the transcripts were each read once to provide an overall direction for Phase 2 of the data analysis process based on the semantic structure of the data.

Phase 2: Generation of initial codes

Initial codes were generated using NVivo. The main research question concerned itself with spirituality's role in helping participants recover from depression, and so was kept at the forefront of the coding decision process. However, the lack of a clear definition of spirituality in the New Zealand context meant that all sentiments related to spirituality, be they directly connected to the recovery process or not, were assigned initial codes. It was decided that an understanding of what spirituality meant to the participants would enable a better understanding of its therapeutic role in their recovery, both as a unique phenomenon and in complement or contrast with other recovery tools accessed by the sample. Additionally, as participants chose to describe their experiences and understandings depression in detail, it was decided that participant discussions of the aetiology of depression would be included as a separate theme.

While reading through each transcript individually, the researcher selected excerpts of the data and created a tentative node (an NVivo representation of a code) that appeared to describe the essence of what the participant was communicating. An example of such nodes is provided in Table 2. As coding progressed through the transcripts, excerpts were either coded to previously created nodes or new nodes were created. Following the initial coding of all transcripts, the transcripts were re-read to ensure that no salient information was missed during the first round of coding.

Table 2

Initial Coding of Data

Excerpt from data	Initial node
Ah I definitely have tried to make it, I definitely have felt, because I've felt that ultimate love,	Feel loved
I think it just means, I don't know, it's a knowing there's something bigger than just this, and that there's a bigger, a bigger purpose	Perspective

Phase 3: Search for themes

On completion of the second round of coding, the nodes were organised into themes. Nodes were grouped into themes based on their essential similarity – that is, how closely the sentiments they described resembled each other in terms of the meaning of an experience to the participants. Unlike nodes, whose purpose was to describe an expressed sentiment at face value, themes were higher order meaning categories that could subsume several nodes. An example of tentative themes and their constituent nodes is presented in Table 3.

Table 3

Tentative Themes

Theme	Node
Depression	Self-abuse
	Suicidal
	Unsuitable intimate relationships
Authenticity	Rejection of self-abuse
	Different person
	Rejection of suicide
	Self-love, acceptance, and compassion
	Suitable intimate relationships

Phase 4: Review of themes

At this stage, the themes were reviewed to establish whether they could stand alone as major themes, or if they were better combined into one larger theme. Sometimes, the original themes were disbanded, and the nodes reallocated to newly formed themes that better represented the essence of the phenomenon. Coded excerpts that, upon review, were not judged to be relevant to the thematic patterns established from the data were discarded. As themes took shape, parts of transcripts that had previously been missed or judged irrelevant were also coded to the newly formed and/or refined themes.

Phase 5: Definition and naming of themes

Once an overall theme had been established, the nodes within that theme were combined into sub-themes where appropriate. Once combined into subthemes, the nodes were merged so that each sub-theme (or overall theme where no subthemes had been created) consisted of a set of excerpts from the data. For example, the nodes under the themes 'Depression' and 'Authenticity' shown in Table 3 were combined into the theme 'Inner transformation. This theme was then split into sub-themes of 'Self-compassion' and 'Existential authenticity', as shown in Table 4. The nodes comprising the original 'Authenticity' theme included how participants felt about themselves following recovery, as well as how their self-presentation and conduct in the world changed following recovery. Consequently, while the nodes that described participants' relationship with the outside world remained under the 'Existential authenticity' theme, those that dealt with the participants' relationship with themselves were moved to the 'Self-compassion' sub-theme. This step eliminated the theme of 'Depression' as the nodes comprising that theme in fact described how participants felt about themselves and their conduct in the world before recovery. Although the behaviours and emotions reported by participants before and after recovery were contradictory, they all related to the same aspect of a participant's experience – namely the change, or transformation, in how they related to themselves and the outside world.

Table 4

Final Themes

Theme	Sub-theme	Node
Inner transformation	Self-compassion	Self-abuse
		Suicidal
		Rejection of self-abuse
		Rejection of suicide
		Self-acceptance, love and compassion
	Existential authenticity	Unsuitable intimate relationships
		Suitable intimate relationships

It was also at this stage that final names for the themes were determined. The names were chosen to reflect the essence of what a theme meant to the participants – the 'gist' of what the participants tried to communicate about their experience. A preliminary thematic map was created to ensure that the themes made sense on their own and, when viewed in relation to each other, accurately represented the data.

Phase 6: Producing the report

While descriptions and explanations of themes were given, an effort was made to present the themes in detail using participants' own words. As well as providing a rich and contextualised presentation of a theme, the use of detailed excerpts should allow the reader to judge for themselves whether the themes chosen by the researcher were supported by the data. Although the themes are presented sequentially, they should not be viewed as constituting a hierarchy. Each of the themes was as salient as the others and represented an equally important part of the experience for participants. A thematic map showing the interaction between the therapeutic effects of spirituality is presented in Figure 1. Some of the excerpts were edited slightly to enable the essence of what the participant was saying to come through. The edits were minor and involved removing

distractors, such as fillers and unnecessary repetition, and any personally identifying information in the form of names or places.

5.6 Trustworthiness

Trustworthiness is the criterion by which the quality of qualitative research can be judged (Morrow, 2005). Trustworthiness can be established by attending to a variety of factors, with priorities differing among authors. However, one aspect of trustworthiness that is considered important by all qualitative researchers is reflexivity. Reflexivity deals with the context in which research is produced; context here refers not only to the setting in which research is conducted, but also to the researcher as an active participant in knowledge creation (Lazard & McAvoy, 2020). Unlike quantitative research, which holds objectivity as desirable and achievable, qualitative research not only accepts that subjectivity is impossible to eliminate but embraces it as an important part of conducting research. As a co-creator of knowledge, the researcher's identity, background, prejudices, and ideology cannot be removed from the process of knowledge production. Therefore, to establish quality, it is important for the researcher to continuously self-reflect throughout the research process (Dodgson, 2019; Lazard & McAvoy, 2020).

In addition to reflexivity, dependability – a clear record of how the researcher arrived at the findings – needs to be maintained and reported so the reader can judge whether the process employed was rigorous enough to produce valid results (Merrick, 1999; Morrow, 2005). Transferability deals with the extent to which the findings can be generalised – not in the sense of quantitative research, where findings can be generalised to entire populations through statistical analyses of large data sets – but how the findings hold in a certain context (Morrow, 2005). Finally, confirmability pertains to the acceptability of the results – that is, whether the results and their implications are supported by the data (Merrick, 1999). Each of these four criteria are discussed below.

Reflexivity

The topic for this study was chosen due to the researcher's own experiences, and her understanding of both depression and spirituality were acknowledged at the beginning of the study. Throughout the research, the researcher was in regular consultation with her

supervisor to identify and minimise bias. The researcher's background as a white, immigrant, educated female – while impossible to eliminate as an influence – were considered during interviewing and while analysing data. Care was taken not to make assumptions when interviewing participants who resembled the researcher's profile, and to open-mindedly appreciate another perspective when a participant was unlike the researcher in one or more areas.

Dependability

Each step in the research process has been outlined in detail. The reasons for and assumptions behind the study design, participant selection, and data analysis have been made explicit. Each step in the data analysis phase has been described in detail with examples. The reader should have a clear understanding of how the results were derived.

Transferability

While the study stipulated participants had to have suffered from depression, it did not provide a definition of spirituality. The lack of operationalisation of spirituality allowed for a wide variety of experiences, meaning that the sample was not restricted to a narrow profile. A spiritually heterogeneous sample is more likely to be representative of the population of individuals who recover from depression with the aid of spirituality in New Zealand. Therefore, any commonalities in the therapeutic effects that participants received from spirituality are likely to be transferable to other individuals in this group, regardless of their specific spiritual practice and/or understanding.

Confirmability

Background descriptions are provided for each theme and sub-theme, as well as some participants where required, enabling the reader to locate the supporting participant quotes in context. Extended and detailed excerpts from participant accounts are provided. The reader can judge whether the identified themes and the ensuing discussion are supported by the data.

5.7 Summary

This study was designed in line with a phenomenological approach that sought to understand participants' lived experience of depression and spiritually guided recovery. Nine participants were recruited using purposive sampling and the snowball method utilising existing acquaintanceship networks. Inductive, semantic thematic analysis was used to interrogate the data. Braun and Clarke (2006)'s 6-phase approach was employed to generate themes and subthemes. Trustworthiness of the research was maximised by attending to reflexivity, dependability, confirmability, and transferability.

6. Results

This chapter consists of three sections describing the main themes, with associated subthemes presented within the relevant sections. The first section is an overview of participants' understandings of what had caused them to become depressed. The second section presents what spirituality and being spiritual entailed for the participants. The final, and largest, section presents the therapeutic effects of spirituality on depression as reported by participants.

6.1 Aetiological explanations of depression

While this study was not originally concerned with a detailed investigation of participant understandings of depression, participants did often provide etiological explanations while recounting their experiences. None of the participants described their depression in terms of an organic illness or chemical imbalance despite the dominant medical discourse on depression in New Zealand. Participants traced the origins of their depression to a combination of life events, with most identifying childhood stress and trauma as predisposing factors. Participant's explanations of how those factors contributed to their depression are presented below.

6.1.1 Childhood stress

Several participants traced the origins of their difficulties to stressful events in childhood which, combined with a lack of appropriate emotional support from the parental figures in their lives, eventually resulted in depression. Participant 6 (female) recounted her first bout of depression as a child:

> …for me my depression started when I was really young. I think it probably started with anxiety around the age of five, so… starting school, my parents split up around the same time as well… and then mum decided she wanted to train as a teacher… so she moved us kids here and so we were separate from dad and I just.. yeah, anxiety got worse… (Participant 6, female)

She did not feel that her parents were concerned about how she was feeling or that they provided her with the interaction and support she needed as a child. She described

how this sense of abandonment manifested in a second bout of depression when she was an adult:

> …my sister had also started having her kids and she was doing parenting in a really different way which was really responsive to her kids and respecting them as a person and guiding them through their emotions. So, then it dredged up all this crap from my childhood about not being treated that way and how I felt… it created this sense for me of not feeling like I had any value… (Participant 6, female)

Participant 7 (female) also recounted the role of stressful childhood event and a difficult relationship with her parents as the causes of her struggles with depression:

> …[my mum] would... exaggerate things to get sympathy from other people for having to care for a sick child, rather than actually focusing on what I needed as an individual and the support that I needed. My dad was extremely, extremely religious and his religion and I did *not* mix. His position was "you'll be fine if you just went to church and you prayed". (Participant 7, female)

Participant 8 (male) described his realisation that depression was something that he had lived with from a very young age:

> When I became depressed, I was aware that the feeling I had was very familiar from a very, very young age but a diluted version, so when I finally... had the full-on depression, it wasn't unfamiliar, it was just more of what I'd been experiencing for most of my life, if that makes sense… (Participant 8, male)

6.1.2 Trauma

Trauma was also a prominent theme in some participants' accounts of their depression. Participant 9 (female) described how, despite her tenacity and hard work in all areas of her life, her father's abuse of her and her family had gradually depleted her emotional resources:

> …my dad used hit us all the time, and used to hit my mum all the time… because he was also working with narcotics and stuff, we used to get searched like criminals - he would go through our wardrobes and stuff and it was really an invasion of personal private space. (Participant 9, female)

She described the day that her resolve had finally failed, and severe depression had set in. She had received first place in one of the most competitive academic examinations in her region and an article about her had been published in the newspaper:

> …that day he really beat the shit out of me. For topping. For doing well. I don't go out, I don't see friends - this is when I'm seventeen, that's when you pass out from high school. I have done everything what he wants and he's never happy, and now on the biggest achievement that I have had in my life, he's actually beating my mum, my sister, me… taking my achievement away. And that was really the trigger… that whole beating session was felt a lot stronger than anything else that had ever happened. After that, there was a... phase of nihilism, like, I would not feel stuff… I had gone just completely numb. I would not speak because to me nothing really mattered anymore. Like I said, I did everything by the book, I was being perfect, and nobody gives a shit… (Participant 9, female)

Participant 2 (female) related how, after years of trying to understand why she had become so depressed, she finally realised the role of childhood trauma in her experiences:

> …I think it was bringing up memories or thoughts of things that have happened in my past that linked to why I was feeling the way I did… but it wasn't really till I actually went back to study… that's when I started to click everything into place … that was understanding trauma because I didn't know about the effects of trauma and childhood trauma and what that does to people and then I went A-ha! if I only I had known that a bit earlier, that would have probably snapped me out of it. (Participant 2, female)

Participant 5 (female) located her predisposition to depression in the trauma suffered at birth:

> …I see depression as... the result of life circumstances and... the result of overwhelm from life experiences. So I think the body reacts to life experiences and when it's had enough, it comes out… as depression or anxiety. I was born as a Caesarean and there was quite a lot of trauma around that birth. [Babies] were fed every four hours and left in the hospital nursery for five days while the mother recovered. There's great knowledge there now that that traumatised more than one generation of children,

right from the word go. So, when you're born into that kind of trauma - depending on how it's managed after you leave hospital and depending on what kind of family you go home to - that trauma is either resolved or it's not. (Participant 5, female)

6.2 Spirituality in New Zealand

While all participants considered themselves spiritual, there was great variety in the spiritual experiences and practices they engaged in. Some participants followed what may be considered formal spiritual practice and regularly engaged in meditation and energy work. The types of meditation employed were also varied and included transcendental, grounding, awareness, and mindfulness practices. Energy practices ranged from Daoist and Kundalini yoga, to cranial-sacral therapy, and various form of energy healing, such as Reiki. For other participants, spirituality was more about beliefs and how they guided their everyday thoughts and actions, without necessarily engaging in formal practice. Still for others, spirituality was a sudden revelation that seemed to come out of nowhere and profoundly change their understanding of themselves and the world.

None of the participants identified as religious. Only some participants were openly critical of organised religion. For example, Participant 7 (female) explained that her spirituality had been condemned as devil-worship by her fundamentalist Christian father, and Participant 5 (female) expressed that Abrahamic religions' emphasis on God as external and superior to human beings prevented people from realising the divinity within. However, all participants agreed that religion was not the same as spirituality and it was not necessary to engage with religion to be spiritual. As little is currently known about the spiritual landscape of New Zealand (apart from the fact that traditional religious affiliation is on the decline), all participants were asked to describe what spirituality meant for them or how they would define it. Three main themes emerged in participants discussions of their experience of spirituality: the ineffability of the experience, adherence to spiritually informed beliefs and behaviours, and concerns regarding disclosing their spiritual experiences and beliefs to others.

6.2.1 Ineffability

The sentiment that came through most strongly was that the experience of spirituality was something participants knew to be real but found difficult to explain to

someone who has not experienced it. Participant 7 (female) stated that "it's an internal feeling so you know what it means inside, but to actually verbalise it to someone else… it's really, really difficult". Participant 1 (female) gave the following description of her spiritual experience:

> …the light that you can't explain, the feeling that you can't explain. You can't use words; we don't have the words in English to describe what happened or what it felt like or what it looked like. We don't have those words so I'm just doing the best I can, babbling away to you, trying to explain it… (Participant 1, female)

Participants also emphasised the importance of experiential, rather than intellectual, knowledge in understanding spirituality. Participant 8 (male) explained: "I think it's a gnosis rather than a mental thing. It's not something I can conceptualise". Participant 9 (female) similarly remarked "you have to genuinely experience something that is beyond explanation to believe in those things".

6.2.2 Belief in something greater

Despite the difficulty in communicating the experiential aspect of spirituality, participants were able to formulate a definition based on the belief in something greater than their immediate physical reality. Participants gave the following explanations of their beliefs:

> …so for me, spirituality is sort of believing that we are more than just a body, that we're a soul or a spirit or an entity or something bigger, and that it's connected to something bigger than us – and you can call it God, or love, or the universe, or whatever you wanna call it… (Participant 6, female)

> …in some way, I guess, it's probably a belief that… a belief in something greater than my existence on this planet at this time. (Participant 5, female)

> …spirituality for me is the belief in something greater that can positively or negatively influence a person's life, depending on how they harness it and what they believe in… it's like a guiding light to just kind of… keep you going. (Participant 7, female)

6.2.3 Compassionate behaviour

Spirituality for participants was also expressible through their behaviour towards others. Their belief in being part of something greater encouraged them to see and treat other people with understanding and compassion. How they treated others essentially became a part of their identity. Participant 8 (male) defined his spirituality as "really connecting to yourself… knowing yourself and connecting to more than yourself; it's almost like knowing yourself by being selfless". Participant 3 (female) explained: "I try and look for signs everywhere and be nice to people and do good things, so it's kind of in everything you do." Participant 9 (female) stated that

> …you have to be respectful to everything around you, from office property to how you deal with animals to how you deal with kids, to elderly, to people who are dead… making sure that you live in the living memory of them and that's how you can have a happy life. (Participant 9, Female)

6.2.4 Disclosure concerns

One point that most participants agreed on was that spirituality was a taboo topic in New Zealand. While one of the challenges to communicating spiritual experiences or knowledge to others was the conceptual and linguistic poverty of the English language, another major obstacle was the fear of miscomprehension and negative judgement. In the context of depression recovery, participants were wary of sharing their beliefs and experiences as they feared being misdiagnosed or viewed as seriously mentally ill. Participant 2 (female) whose spirituality involved communicating with the spirit world remarked:

> …so this is where you border on when you have a mental illness… or you've been told you've got depression, and then you start hearing voices, and hearing things and being told things, you can be labelled crazy. So, I was very cautious of that a lot… (Participant 2, female)

Participant 3 (female), who regularly communicated with her deceased brother, explained: "If you go around telling people that you're talking to your dead brother, it just sounds nuts and people could think you're schizophrenic or… there's strong views on it that you just… you're really careful."

Participants who did not engage in any form of psychic or post-death communication felt equally uncomfortable about openly sharing their beliefs. Participant 8 (male) remarked "I pick and choose who I talk about stuff to" and Participant 9 (female) similarly stated "you can't do that with everybody because they'll think you're fucking coocoo." Participant 7 (female) explained her reluctance to openly discuss her spiritual beliefs:

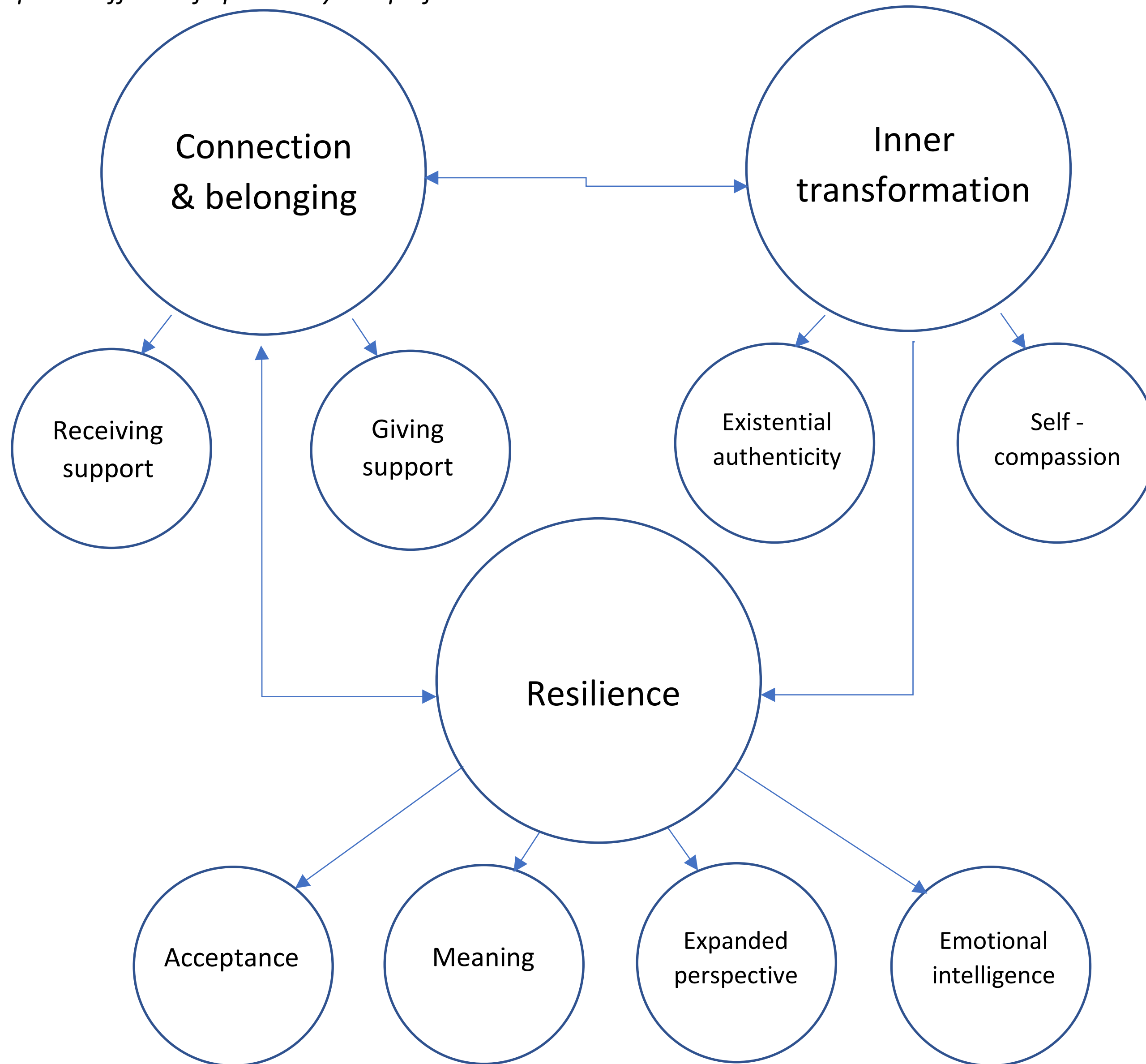
> …everyone wants to feel like they belong, everyone wants to feel normal because it's been programmed into us from such a young age that you want to fit in and you don't want to be the outlier, that even when it comes to beliefs, it makes you… closet them, essentially… and especially for me, with my history of feeling isolated, I don't wanna feel even more isolated and people thinking I'm weird when I'm already so self-conscious. (Participant 7, female)

6.3 Therapeutic effects of spirituality

While all participants found spirituality helpful in their recovery, it is important to note that all of them had engaged other services on their journey. Every participant had received some form of counselling, and for some, the counselling sessions were a catalyst for discovering their spirituality. One participant had also engaged the services of a psychologist. While all participants found counselling helpful, spirituality was identified as a distinct avenue of recovery that was highly personal and often private. Several individuals did not feel comfortable discussing their spiritual beliefs with health professionals - sometimes for the fear of negative judgement mentioned above, and at other times because they did not feel it was relevant in terms of formal therapy or that their counsellor would be open to discussing spiritual matters. In terms of the therapeutic effects of spirituality, three superlative themes were found: inner transformation, connection and belonging, and resilience. A thematic map showing the relationships among the themes is presented in Figure 1. Each of the three themes and their attendant subthemes are then discussed.

Figure 1

Therapeutic Effects of Spirituality: Map of Themes and Subthemes



6.3.1 Inner transformation

Whether through a sudden spiritual experience, or through sustained spiritual practice, participants reported a fundamental change in how they viewed and treated themselves. While depressed, participants engaged in negative self-talk, felt helpless, lived to please other people, and sometimes felt that the world would be better off without them. By developing existential authenticity and self-compassion, they were able to empower and learn to love and accept themselves, thereby pulling themselves out of depression and preventing themselves from deteriorating as far in the future. These subthemes are presented in more detail below.

6.3.1.1 Existential authenticity

Participants identified spirituality as important in helping them understand who they were as individuals. This understanding encouraged them to find a way of living in which their behaviours were more congruent with their view of themselves as a person. Their authenticity manifested in their relationship with themselves, as well as their relationships with other people.

Relationship with self

The first step in developing congruence was the creation by participants of a personalised value system driven by their spiritual beliefs and experiences. When describing how spirituality helped her overcome the beginnings of possible depression, Participant 6 (female) stated:

> I started to realise that I have a very kinda strong value system for myself which is linked to the spirituality and, in hindsight I can say this, you know, looking back I think this is what happened but at the time I was just trying to connect into actually what were my values and… what did I feel like was the point of being here and it was less about what everyone else was doing, more about me trying to grow and that sort of helped me come over this… depression hill I guess… (Participant 6, female)

The same participant explained how she now defined what being successful in life meant to her:

> …am I aligning to my values, do I have values, you know, do I have kind of like a personal moral code that I live by, is it a good one, have I grown as a person, you know, am I kind to people, that's what matters to me. (Participant 6, female)

It was clear in the interview that the spiritually-informed outlook on herself and life had become such a normal part of everyday existence for this participant, that naming it as 'spirituality' – something separate from the mundane – required conscious analysis of how her personal code of conduct had come into being. This situation was shared by most participants – needing to look back at how things had been, how they were now, and the process by which the change occurred – to separate out something that was now such an integral part of them and how they lived. When asked whether there was a certain point at which he felt he had recovered, Participant 8 (male) stated:

> …in a way it did seem like a sudden end, but I suppose… there was a lot of energy building and emotional release and other things around that time. I suppose it seemed sudden because… I'd had that feeling my whole life and suddenly it wasn't there anymore, it was like ahh thank God. So there was a hell of a lot more peace and it was almost like I started to… kinda reinvent myself from then on. (Participant 8, male)

Relationship with others

As participants began living in accordance with their values, rather than the values and demands of others, they found their intimate relationships transform for the better. Several participants described how their spiritual journeys enabled them to stop the cycle of unhealthy and unfulfilling romantic relationships and attract partners that were right for them.

> …it coincided with me ending a relationship… and I was just so gutted by this relationship ending and I was sobbing for like days, and not long after that I had this dream and then… the depression was gone. And the woman who I ended the relationship with, we met for breakfast, and I thought to myself "I'm so glad I'm not with you anymore". So there was somehow some kind of parallel in what was going on for me externally. And then, oddly, I attracted - or met - my wife now so... it's like I created space for that to happen. (Participant 8, male)

Participant 1 (female), who had an intense spiritual experience precipitated by an agonising period of suicidal depression, also reported a positive transformation in her intimate relationships. Prior to the experience, her husband had left her and their child and she got involved in relationships that she knew were not right for her. She briefly described those relationships:

> …got this… some loser boyfriend - that didn't help… and a couple of other guys that, I mean, it was ridiculous really, they told me they were in love with me after about six weeks... all very flattering, but… seriously concerned about, you know… so there was all this sorta stuff going on and then got dumped by these two guys… (Participant 1, female)

Following the spiritual experience, her inner transformation manifested in a drastic change in her choice of romantic partners. She stated:

> …I knew that I wouldn't get a dodgy guy ever again 'cause I was a different person so you attract a different kind of person… and then I met the love of my life three months later who's completely different to anybody I've ever been with, he's just fabulous. (Participant 1, female)

Participant 4 (male), who was helped down the spiritual route by his psychologist, realised that he had been exploited while all the while thinking that he was the reason his relationship was not working. He briefly described this period:

> …I was being used to someone else's advantage and I didn't realise that, and I didn't see what was happening and the psychologist actually helped me define things and see them for what they actually were and for what I actually was. (Participant 4, male)

The psychologist helped him understand that he was a heyoka empath – a term that derives from Native American spiritual beliefs and is used in the West to describe someone who is intensely aware of and absorbs other people's emotions and problems and is driven to alleviate others' suffering. The psychologist also explained that people like him were easily manipulated emotionally and needed to learn to protect themselves. In light of this knowledge, his relationship problems started to make sense:

> …I sort of found out that I was empathic and that I was actually what they call a heyoka empath and I'd been living with narcissism for 25 years and didn't even know what it was or how it operated. So from day one I was fighting a losing battle that I didn't even know I was fighting, you know. And I'd been manipulated, and I didn't even know I was being manipulated. (Participant 4, male)

As his understanding of himself and his situation deepened, he began to find ways to remain true to who he was without jeopardising his own wellbeing in the process. He stated:

> …in the past I've never had the boundary and my help became pretty close to fatal for me... Now I can help and put up a boundary which enables me to help again if I have to, because the boundary is there so I only go that far. I also now understand that you can't do everything, you can't help, you know, sometimes it's outta your control. I had trouble understanding that and that did not help my depression, you know, my being sad, and being down… in fact it made me 10 times worse. (Participant 4, male)

6.3.1.2 Self-compassion

As well as becoming their authentic selves, participants realised that the way they had been treating themselves was destructive and unnecessary. Whether by a sudden breakthrough or through gradual realisation, all participants made the decision to be kinder and gentler to themselves. Several participants described how they felt and behaved towards themselves while depressed:

> …I feel like what I did to myself, the messages you tell yourself, it's… just awful. I just told myself that everybody would be better off without me. I was absolutely so close to doing it… so close. I made a noose and practised using it, and decided I was gonna kill myself that night… (Participant 1, female)

> … it feeds back into those negative thoughts… all your parents' voices… and their messaging was "you're shit"; not "I'm not down with that behaviour, let's try something different" or whatever. It was just like "you're shit, you've failed as a person". So then when stuff would happen… that self-talk starts going "I'm shit, it'll

> never get better than this, what's the point", you now, and you quickly spiral down… (Participant 6, female)

For Participant 7 (female), her emotional overwhelm manifested physically in self-harm. She had engaged in self-harm regularly and explained why she felt she had to do it:

> …it was just that release valve if there's nothing else, everything is just too much, no one understands, I can't talk to anyone about it because my parents... insane in their own ways… my only friends were online and overseas, and... there were times where it was all-consuming, isolating and... you just don't know what else to do and you can just feel it building in you… (Participant 7, female)

Spirituality, which for her was based on Wiccan beliefs, helped her stop self-harming:

> …one of the things about Wicca is "harm none, do what you will". And I was talking to someone one day and they kind of said that that phrase means yourself as well. And then… there was that light bulb moment and... there's been times when I've been really stressed where I've been tempted, but I never have and I never would again because… that's going in my head, you know, "harm none, do what you will". And then just to have the realisation that you're doing it for the wrong reasons and... you're putting that bad energy out there. If I'm putting this bad energy out there by harming myself, is that partly why I feel so isolated? So I stopped. (Participant 7, female)

Other participants also described a change in how they viewed and, consequently, treated themselves as a result of their spiritual journeys:

> …I had some very unhealthy fixed ideas about myself and the world and through this energy work and various other things I'm starting to see the world as a very different place. That's about that… not being so binary and looking at things more as a continuum and less fixed. So things aren't fixed in people, in us or others. So I think that was another milestone in my road to starting to look at how I judge things... A part of this non-judging is becoming accepting of who I am and what I'm about, and other people and where they're at… (Participant 8, male)

> The parts of spirituality for me that were important were the self-love and the compassion for myself, the full radical acceptance of myself. (Participant 2, female)

> …what spirituality and meditation did was that it gave me the sense that I don't have to be somebody or do something. You don't have to constantly be living in this pressure. You're allowed to be normal; you don't have to constantly prove to anybody that you're good academically or stuff like that… If it's not serving you, it is not helping you, it is not doing anything in your life, just quit that. (Participant 9, female)

6.3.2 Connection and belonging

Prior to the onset of depression, and during its course, participants reported feeling isolated and abandoned. They desperately wanted to experience human connection but were either unable to or had looked for it in the wrong places. Their spiritual journeys and experiences broke down the invisible wall that seemed to keep them separate from the rest of humanity and enabled them to connect with people who added to, rather than took away from, their lives. Additionally, spirituality enabled them to feel that they had a place in this world and were not alone even when no human connection was present. This inviolable sense of connection and belonging was achieved through participants feeling like they were receiving something from the universe and their compassionate need to give to others.

6.3.2.1 Receiving support

Participants felt that their spiritual knowledge, practices, and experiences made them feel supported and guided. Even individuals who were still more physically isolated than they wanted to be felt that they had a support system in place and that they belonged in this world. This confidence of having a place and a purpose was antithetical to feelings that no one cared and the world would be better off without them. Participant 2 (female), who felt she was communicating with superterrestrial beings, described what they told her and how that helped in her recovery:

> They were telling me “you've got a lot of fear, you need to help yourself release this fear out of your body, we are gonna help you if you trust us, you need to lie down

> now cause we're gonna do a healing on you". I was getting fully supported and guided and it felt good to me. (Participant 2, female)

Participant 3 (female), who felt she received communication from her deceased brother in the form of dreams, colours, and songs, explained:

> …so I suppose when you start having the dreams or when you start seeing the purple or the songs come on, it just makes you feel like there's somebody there that's got your back. I think spirituality does definitely help 'cause it keeps you company if you're lonely or if you're getting lost. It fills you so you don't feel empty. (Participant 3, female)

Participant 7 (female) spoke of how spirituality helped counter the feelings of isolation she had struggled with since she was a teenager:

> …just knowing that there are other people putting that energy out there so they may not be around me physically at that moment in time but they're still there in spirit so to speak… and that helped me to feel less isolated. (Participant 7, female)

She went on to explain why she sometimes got tarot readings – even though some people around her thought it was a waste of money:

> …so for me it's a case of the universe sees me. Even if I feel like the world is crappy and no one's gonna give me a call, I feel like at least, on some level, I'm still being seen. And for me that's really important - I want to feel seen, I want to feel acknowledged, I want people to understand the pain and hurt that I'm going through… (Participant 7, female)

Other participants explained how spirituality helped them feel connected and supported.

> …spirit world is all about love and… it's all about hearing the messages you need. In those messages there will never be a telling off, there will only be something to uplift your mana, it will only be something to make you a better person, make you better able to cope with the challenges that you've got. (Participant 1, female)

> …to know that you're not alone, and that's what spirituality really does for you because... you can't feel alone when you know what you know. (Participant 5, female)

6.3.2.2 Giving support

Feeling that they were accepted and supported inspired participants to treat others with compassion and kindness. While some entered the helping professions or began volunteering following the development of their spirituality, those who could not focused on small acts of kindness that may brighten someone's day. Having compassion and respect for others in turn made participants feel better about themselves in that they were good people who lived according to their values. As well as increasing their sense of self-worth and congruence, the need to give to and care for others helped participants see beyond themselves and their struggles, thereby helping them resist depression's pull into isolation and self-judgement. Participants described this aspect of their experience:

> …when the depression comes you can become quite guarded and… you pull away, you don't wanna let people in, and you don't trust people… but then, when you step into that other side, it's more open and it's more like helping people and following your purpose which is bigger than just the anxiety or the depression… just doing small acts of kindness, just being kind to people… 'cause you do that and then you feel better… the spiral starts going up rather than down. (Participant 3, female)

> …[it] helps me to empathise with people more and to empathise with my parents and understand that, while they did things that affected me in huge ways, I can understand more that the way they behaved was taught to them by their parents and it goes back and back and back and back… kindness for me is... part of one of the cores of my value system… (Participant 6, female)

Finally, Participant 5 (female) summarised how the expanded sense of self she had attained by connecting to her spirituality can manifest in the world:

> I think when people's sense of self extends to everyone else - so I am me but I am everything else on the planet - you become so much more careful about how you treat yourself and treat other things - people, other beings, you know, everything…

> what you do unto others you do to yourself and I think that extends way beyond just people, that's your environment and other animals… (Participant 5, female)

6.3.3 Resilience

All participants felt that they could now face adversity without becoming depressed. While they accepted that things could be difficult from time to time, and that they would feel sad and struggle emotionally, their previous psychological state now seemed foreign to them. The idea of committing suicide, which several participants had come close to, or tried, executing when depressed, now seemed equally unfathomable. Their spiritual journey had taught them to accept the things they could not control, find meaning in their experiences, gave them perspective, and helped them develop the emotional intelligence necessary to remain strong in the face of adversity.

6.3.3.1 Acceptance

One of the issues participants had struggled with prior to recovery was the need to have everything under control. They felt that if things were not working out as they thought they should, that they had failed in some way. Negative self-talk and self-destructive behaviour were often triggered by those situations. By engaging with their spirituality, participants learnt to recognise what was outside their control and to let it go. Participant 3 (female) explained her new approach to setbacks: “it's almost like what will be will be”. Participant 4 (male), who found himself in a situation that would have previously seen him frantically trying to control events to help someone struggling, stated:

> It's out of my control so don't try control it, don't try to do more than you can. I'm stronger and happier, in a happier place now than I would have been in doing that. And I've even had close friends say to me “you're a lot more comfortable doing what you had to do than you normally would” and I think I am too because I understand that that's as far as I can go with it… it's up to someone else's call to do what they have to do… (Participant 4, male)

Participant 6 (female), who had struggled with some resentment related to her upbringing, spoke of how her spiritual beliefs helped her let go and make peace with her parents:

> …I can't control that past, but I control where I can go forward, and how I think about going forward, and if I kinda focus on that idea that we are all one or connected, then it's easier to empathise with them and what they've been through and kinda myself… (Participant 6, female)

6.3.3.2 Meaning

Most participants had times while depressed when they wondered why they had to feel this way when they had tried so hard to do everything right. Some felt that life was passing them by while everyone else they knew seemed happy and led meaningful lives. Looking back at their journey through a spiritually informed outlook, they were able to understand why they had to go through such a difficult time. Participant 1 (female), who had a spiritual experience while acutely suicidal, explained:

> …I actually felt that probably in a past life I committed suicide and so in this life, this was my challenge, not to do it, and that I had to get through it on my own, with no help from the spiritual world. And then afterwards, when I did get through that, I felt that I was getting that reassurance or message. I believe that we're all in this life… to get through some challenges and that we've chosen this life 'cause there are some things we need to work through. (Participant 1, female)

Participant 4 (male), who had developed a substance addiction to mask his suffering, looked back at how he was able to come through the experience when so many others did not:

> I would go "how did I survive that?!" I survived that because there was someone else that's gonna be dependent on me and it has worked out *exactly* that way. There's someone out there that needs my help so I was spared… I don't think I'd be who I am now if it wasn't for the bad moments. They are there for a reason, they are life's lessons. (Participant 4, male)

Participant 7 (female), who had missed out on a significant portion of her teenage years due to being heavily medicated for depression, looked back at how her experiences had prepared her for realising her future aspirations:

> I had my experiences that I've had - good and bad - for a particular reason. And, looking at fostering kids, like, that's something I've been wanting to do since I was a teenager. I think part of it is because of wanting to give children the support that I feel that I didn't have, and I believe that my depression, my anxiety, panic attacks before school, having it so young, it's given me such a great understanding of what children that may come through my house have. (Participant 7, female)

Participant 6 (female) first explained her experiences in terms of her wider belief system:

> …we come back to earth over and over and over to experience everything, including all the bad shit… and that has also helped me with my depression. It's like, this is just an experience and I've come here to experience this, and maybe how to overcome it in a meaningful way, and then once you've done that, you go back to the ether, or back to the source, the collective energy… (Participant 6, female)

She was then able to locate the experiences of depression as an important motivating factor in her own life – something initially unpleasant that now allows her to live authentically:

> It doesn't feel good and I don't like being depressed and I will hopefully always work to not be depressed but, at the same time, it *has* taught me a lot. It has taught me to be more forgiving of myself, that there are some things that I value and there's things I don't value. Those injustices and those things that I don't value cause me to be depressed, and then when I get depressed, I get to a point where I'm kinda angry enough [that] it powers me up in a way to fight back against those injustices... (Participant 6, female)

6.3.3.3 Expanded perspective

As well as being able to make sense of their experiences, spirituality helped expand the participants' perspective by teaching them that they were a part of something much bigger. Seeing the bigger picture and their place in it enabled participants to get through difficult times without becoming despondent and fatalistic. Participant 3 (female) who had a close relationship with her deceased brother explained:

> So I suppose it gives you a future ‘cause you think “things are tough, he's gonna help me, I've just gotta have faith” and I've just gotta… just relax, breathe, and just try and sit in that feeling rather than the worry and the anxiety… you just put it to your brother and it's almost like… it's bigger than you, so you give it to him and he can take care of it. (Participant 3, female)

Participant 5 (female) related a sudden change in perspective that occurred after consulting a channelled medium (an individual who serves as a conduit for a spirit wishing to communicate with the living):

> It was like somebody switched a light on for me and… I realised there was a whole bigger picture out there and… it put what I was going through into a different perspective, like it just… I realised there was more to life than the misery that I was sitting in. (Participant 5, female)

Participant 9 (female), who had spent many years living with an abusive father, was able to move on with her life once she could see the bigger picture:

> …that's where I decided that I am twenty-eight, I cannot let what happened to me ruin the next fifty, sixty years that I have. I just... want to live a happy life. I cannot be “oh I'm gonna show him, I want the worst to happen to him”. Can't really forgive him but I just shifted my focus to myself. It was completely unfair what happened to my mum and my siblings but there's no point in feeling all worried; it happened, and I can't drag the whole baggage the rest of my life. (Participant 9, female)

6.3.3.4 Emotional intelligence

Finally, participants came to realise the importance of emotion – both as manifested while they were depressed and as a crucial part of recovery. Learning to recognise, accept, and take responsibility for their emotions enabled participants to become more integrated. Whereas previously they avoided negative emotions or tried to change them if they perceived them as limiting or ego-dystonic, they now understood that feeling was part of being human and that negative emotions served a purpose – often as an indicator that there was something in their lives that needed attending to. Participant 2 (female), who had

suffered from post-natal depression, described her inability to cope emotionally during that period:

> …I was on high alert and… just crying and panicky and just not knowing what to do. I just felt really incapable and I just wasn't me, I just didn't feel like myself, I wasn't myself. And I just didn't really know who I was either… kind of like, "who am I now?" (Participant 2, female)

During her recovery journey, she understood the importance of emotion for spiritual and personal growth. She stated:

> My version of spirituality is very interlinked with the emotions and the acceptance of the emotions and that very emotional journey that we go on as we do release our old selves or our old identities, and become more aligned with spiritual… our soul values… (Participant 2, female)

Participant 4 (male) described his depression as an emotional depression, where he was still able to function in daily life but was constantly emotionally overwhelmed:

> I was in a permanently sad place, there's no doubt about that. I'm a very emotional person so tears come easy for me, you know, and… I was crying all the time. I was crying all the time at the most stupid things, you know. I mean, people would go "hey, hey, don't worry about it, it's nothing" and it *was* nothing but I was just in that place where everything was ohhh… everything was… teary. It was terrible. (Participant 4, male)

As part of his recovery, as well as seeing a psychologist and a counsellor, he attended several Native American healing sessions that took him back to the origin of his emotional struggles. He described the effect of those sessions:

> …I guess [I had] a huge change… a huge shift in my energy and my general feeling about myself, you know… and I actually could feel myself getting stronger after seeing [the spiritual healer] on a daily basis. I started maybe to cry every third day instead of every day. I started to interact with people again.

He also found that nature, which was one of the main pillars of his spirituality, enabled him to deal with his emotions in a healthy way. He explained the effect of being in

nature had on him:

> It most certainly calms me and puts me in a place where "ok, I need to think about that but I need to think about that at a reasonable level, you know, and not let [it] stress me out". So, I'm able to actually think about things in these places or deal with stuff in these places that I can't in other environments so it makes me emotionally stronger to deal with stuff. (Participant 4, male)

Participant 8 (male) recognised how his avoidant coping style had contributed to his depression:

> I probably compartmentalised as much as I could from a very young age - emotions - and stored them up and bottled them up. Hence it's, you know, at a point later on when I was doing the energy work and spiritual work there was a lot of releasing but... that compartmentalising contributed to depression. (Participant 8, male)

He described the contrast between how he used to deal with emotions and how he works through them now:

> …if I fucked up then I keep it to myself, bottle it all up… you know, that was my way of coping. And now if I think I've fucked up, and it's playing on my mind a bit, I'll talk to someone about, you know, "I did this". The other thing I do - which is new - I will take their love and care and wisdom on board. I used to kind of shut it away. I used to push it away, you know, but now I know, because I feel differently about me, I feel differently about how others are treating me as well… (Participant 8, male)

Participant 9 (female), who had spent her life ignoring her emotions by immersing herself in work and study, attended an insight meditation retreat as part of her recovery journey. During such retreats, attendants are not allowed to speak and must turn inward to understand themselves. She reported what happened at the retreat and the realisation she came to:

> …second day I'm just sitting there and crying, and I'm like… howling there and crying because all these emotions that I'd *never* dealt with are there in front of me. People though that somebody died. I howled and howled and howled and howled and howled and howled and took everything out of me there was, that emotion

> because... can't really keep it pent up, it shows in other things. (Participant 9, female)

Participant 5 (female) who had engaged various spiritual and other self-improvement techniques during her recovery, looked back at how she had become empowered by taking an honest look at her emotional landscape:

> It made me more mindful and aware of my own actions. So, in that sense, it gave me self-responsibility which, prior to that, I would say I probably behaved quite a lot like a victim. So, I would project or transfer my emotions onto other people as opposed to taking them on as my own and being responsible for how I was feeling about things and acting appropriately. (Participant 5, female)

6.4 Summary

Participants viewed the causes of their depression in humanistic, rather than biomedical, terms. Childhood stress and trauma were identified as the major causes of childhood, adolescent, and adult-onset depression. Spirituality was conceptualised as ineffable and expressible through a belief in something bigger that transcended the material. It was also communicable through compassionate and benevolent behaviour towards other sentient beings and the environment. However, participants were selective in who they discussed their spirituality with for fear of negative judgement. Therapeutic effects of spirituality included inner transformation by developing self-compassion and existential authenticity. Spirituality also helped participants find a sense of connection and belonging by providing them with support and, in turn, encouraging them to support others. Participants also achieved greater resilience by developing acceptance, finding meaning in their experience, expanding their perspective, and improving their emotional intelligence.

The next chapter discusses the findings in the context of existing theories and research on both depression and spirituality, outlines the study’s limitations, and suggests avenues for future research.

7. Discussion

Due to the limited long-term success of biomedical and disorder-focused conceptualisations and treatments of depression currently dominant in New Zealand, combined with growing evidence for the therapeutic benefits of spirituality in depressed individuals around the world, this study sought to explore how individuals in New Zealand recovered from depression using spirituality. As 'spirituality' is a broad and contentious concept, this study also attempted to gain an understanding of what 'spirituality' and being a 'spiritual' person meant. Through in-depth interviews with nine individuals who were as varied in their backgrounds as in their spiritual beliefs and practices, several themes were derived that were strikingly consistent across the sample – both in terms of the conceptualisation of spirituality, and its therapeutic effects on depression. Although not considered one of the research questions at the beginning of the study, participants' detailed accounts of their experiences of depression allowed for insight into their etiological understandings of the condition. A discussion of the key themes derived from this research, and how they relate to the research questions, is presented below.

7.1 Understanding of depression

In terms of aetiology, all participants approached their depression in humanistic terms. All participants could locate the causes of their depression in their life experiences. Seeing their depression as driven by meaningful experiences helped them weave their suffering into the wholesome and seamless life narrative that they could tell in their recovery. This is an important insight as it suggests that, at least for individuals who are spiritually inclined, the biomedical explanation - which provides little opportunity for locating the experience of depression in a wider life context - may be of little utility or benefit.

Alternative models of wellbeing that fit with participants' understandings of depression already exist in New Zealand. One example presented earlier is Te Whare Tapa Whā - a model that gives equal priority to the physical, relational, psychological, and spiritual dimensions of an individual's life (McNeill, 2009; O'Hagan et al., 2012; Rochford, 2004). Participants in this study engaged in physical healing through various forms of energy

therapy, worked on their negative cognitive, emotional, and behavioural habits, investigated and improved their interpersonal relationships, and made spirituality an important part of their lives. While developed as a Māori model of health and wellbeing, the findings of this study suggest that Te Whare Tapa Whā's holistic and humanistic foundations are likely to appeal to a large proportion of the New Zealand population regardless of ethnicity.

Participants largely described their experiences of depression in line with DSM symptomatology. This is unsurprising, as eight of the nine participants were of European or British heritage, and one Indian participant was well-versed in Western psychological science. However, additional issues of anger, isolation, and substance abuse were also discussed. All participants reported feelings of isolation and loneliness as fundamental to their feelings of despair. As a relational issue, this aspect of depression is not addressed in the DSM as a symptom but was a central feature of being depressed for this sample. Additionally, and similar to findings by Brown et al. (2012) with Aboriginal men, one of the men in this study reported a state of constant anger, tension, and frustration while depressed, and the other discussed engaging in substance abuse to mask his feelings of depression. Again, these issues do not fit into the stereotypically female-pattern symptom presentation mandated by the DSM (Boughton & Street, 2007; Bulhões et al., 2019) and could be misconstrued as purely addiction or personality issues during diagnosis. It is, therefore, important that clinicians take a broader view of depression symptomatology and not discount presentations that do not fit into the ethnocentric and gender-biased DSM diagnostic criteria. Further, the identification and treatment of depression can be improved by developing theoretical models that acknowledge the importance of relationships and issues of emotional avoidance.

7.2 Meaning of spirituality

Spirituality was experienced by participants as an aspect of their lives that was highly personal and individual. Even participants whose spiritual beliefs and practices were influenced by an established tradition (e.g. Wicca or Buddhism) did not wholeheartedly embrace all the tenets and rituals of that tradition – they took only the aspects they felt were compatible with their lives and beneficial to their development and wellbeing. Some participants combined elements of several spiritual traditions to form a coherent system of

beliefs and behaviours. For other participants, there was no need to refer to any existing spiritual framework for guidance. They did not feel that they required a comprehensive belief system to draw from or a formal practice to engage in – they simply felt that being true to themselves and striving to be good to others helped them transcend the afflictions of everyday life. This finding, along with the highly heterogeneous experiences of spirituality reported by participants, is compatible with Del Rio and White (2012)'s proposition that spirituality is a need and potentiality that may be intrinsic to human beings. Moreover, when its more superficial aspects, such as specific belief systems and practices, are disregarded, spirituality may indeed be universal, with its more obvious and organised aspects culturally determined.

While some participants mentioned their attraction to Māori spirituality, all those participants identified as New Zealand European and appeared to have an understanding of te ao Māori that lacked full immersion and adherence and was, therefore, just one part of their spiritual universe. As New Zealand does not have any other well-established and highly influential spiritual traditions (such as may be found in India, for example) it is not surprising that individuals disinterested in traditional religious institutions will look to a variety of spiritual frameworks when embarking on a spiritual journey. Moreover, the generally secular nature of New Zealand society may mean that individuals feel comfortable exploring alternative spiritual pathways without feeling fearful of, or constrained by, restrictive religious authorities and norms.

Conversely, while freedom of religious expression is constitutionally protected in New Zealand ("New Zealand Bill of Rights Act," 1990), the ever-increasing dominance of materialistic scientific discourse in New Zealand society means that some participants felt uncomfortable discussing their spirituality for fear of negative judgement. Some felt they would be shunned or ridiculed by those around them and feared becoming isolated. Participants felt they had to hide an important aspect of themselves, thereby positioning spirituality as something that was simultaneously personally beneficial and socially detrimental. In the context of individuals diagnosed with depression, the dangers associated with revealing their beliefs and practices were magnified due to the potential for misdiagnosis and administration of inappropriate medication, such as antipsychotics. It appears that these fears are not unique to the participants in this study, as Sullivan (1993)

and Wilding et al. (2006) found similar concerns among their American and Australian participants when investigating the role of spirituality in recovery from mental distress. In keeping with the current research, their participants were also concerned with misdiagnosis and their beliefs being discounted as symptoms of their condition. This is an area of concern, as individuals could be missing out on the therapeutic benefits of something that is effective, free of cost, and easily accessible due to the narrow definitions of normality and abnormality prevalent in New Zealand's biomedically biased mental health system.

Finally, spirituality was conceptualised by participants in non-theistic terms. While most participants did not suggest that religion was entirely antagonistic to spirituality, they did not see it as necessary and, at times, viewed it as a hindrance to spiritual development. One participant mentioned how her father's fundamentalist Christian religion prohibited her spirituality by associating it with devil-worship. Another felt that Abrahamic religions' focus on God as external and superior to human beings prevented people from realising the divinity within by triggering feelings of guilt and shame for elevating themselves undeservedly. This finding supports Hill et al. (2000)'s argument that religion and spirituality should be treated as separate constructs in research. The fact that participants clearly identified as non-religious suggests that, at least in New Zealand, there is a strong perceived difference between religion and spirituality. Spirituality was viewed as something personal, empowering, and flexible in terms of an individual's ability to shape it according to their needs. Religion was associated with doctrine, externally imposed norms of thought and behaviour, and a surrender of personal power to a predefined supernatural entity and/or a religious institution.

From a theoretical perspective, while some authors assert that spirituality is synonymous with intrinsic religiosity (e.g., inner beliefs as opposed to overt religious practices) (Peselow et al., 2014), this study suggests the use of the terms 'religion' or 'religiosity' in research is likely to alienate many New Zealanders who consider themselves spiritual but do not identify with an established religious tradition, such as Christianity. Therefore, it is important that researchers are clear on their own understanding of the relationship between religion and spirituality, as the decision to conflate or separate the two constructs may result in two very different participant samples. Religious participant's understandings of spirituality are likely to be influenced by their religious traditions and its

attendant God concepts. As discussed earlier, an authoritarian God concept can lower self-esteem and increase aggression, worsening mental health outcomes. (Benson & Spika, 1973; Johnson et al., 2013; Luna & MacMillan, 2015). This study found secular spirituality in New Zealand to be based on non-judgement, compassion, and altruism, leading to improved mental wellbeing. Unknowingly combining such disparate groups of people into an undifferentiated sample could lead to inconclusive or inconsistent results.

7.3 Therapeutic effects of spirituality

Perhaps the most important aspect of spirituality as a therapeutic agent was its ability to provide support and connection to participants when they felt disconnected and isolated from the world around them. As Frankl (1986) and Ratcliffe (2013) propose, the most debilitating and difficult-to-escape parts of depression is the sufferer's inability to find meaning, connection, and support in the material world. Ratcliffe (2013) argues that depressed individuals find themselves existing in a temporal dimension that is distinct and separate from the everyday. The future is either inconceivable or is viewed with dread instead of hope. Individuals are unable to engage in goal-directed thinking or activity and their connections with other people falter as they gradually lose the ability to find meaning in everyday existence (Ratcliffe, 2013). Depersonalisation and derealisation ensue, making the depressed individual impervious to the motivators and reinforcements available to healthy people (Frankl, 1986; Ratcliffe, 2013). Spirituality, which involves transcendence of the material, was something the participants could connect to when they felt separated from the material dimension. Spirituality was, in effect, both an anchor and a bridge – something that kept participants holding on to life and provided a path towards reintegration into the material world.

The transcendent nature of spirituality may also be one explanation behind the findings of Abu Talib and Abollahi (2017) and Abollahi and Abu Talib (2015) that depressed individuals who feel hopeless but are highly spiritual are less likely to contemplate suicide than their non-spiritual counterparts. The ability to ground themselves in spirituality when their material existence lacks any positive direction may serve a protective function for such individuals. Additionally, the risk for suicide is heightened by increased severity and chronicity of depression, meaning that early and sustained intervention is important in

suicide prevention (Beautrais et al., 2005). In the context of the present study, the flexibility of spirituality – that is, the individual's freedom to shape their own version of spirituality – meant that participants could fulfill their needs and find solutions in a timely fashion and in a way that was most helpful to them. This way, they did not have to rely on external sources of help that they may have been unable or unwilling to access or benefit from at the time. Therefore, spirituality, conceptualised as a flexible individual pursuit, may be an important factor in suicide prevention.

Participants' beliefs and practices also enabled them to find a sense of belonging and acceptance missing in their daily activities and relationships. Feeling that they were a part the universe enabled them to see themselves in a more positive light – not as someone that the world would "be better off without" (Participant 1), but as imperfect but worthy beings travelling a challenging path. This compassionate acceptance of themselves enabled participants to gradually change their thinking patterns and behaviours so that they could challenge negative self-talk and self-destructive behaviour. By simultaneously accepting themselves as they were and allowing themselves room to grow, participants started living more congruent lives. They began to act in accordance with their beliefs and values and, consequently, replaced unfulfilling and destructive relationships and vocations with those that promoted their wellbeing.

The ability to feel connected is consistent with findings from research by Brown et al. (2012) and Brintell et al. (2013) with depressed individuals from traditionally collectivist cultures. These authors found that participants' inability to feel connected in interpersonal relationships were central to feelings of profound sadness and anxiety. Although most participants in the present study were European New Zealanders and would be considered to fit the individualistic Western concept of self as mandated by the DSM, their suffering was rooted in a sense of isolation and lack of deep and meaningful connection with others. Accordingly, their healing began with the recognition of themselves as just one part of something bigger, and their need for support and acceptance.

Having developed self-compassion and existential authenticity, participants were able to approach their emotions with curiosity rather than hostility. An individual's adaptive relationship with their emotions is often termed 'emotional intelligence'. While many definitions of emotional intelligence exist, it can be conceptualised as an aspect of human

intelligence that combines cognition and emotion to enable constructive and situationally appropriate thought processes and behaviours (Abdollahi et al., 2020). The ability to recognise and understand complex emotions, and to consciously choose when to engage or disengage with a certain emotion according to its contextual appropriateness are key components of emotional intelligence (Abdollahi et al., 2020). While depressed, participants in this study tended to suppress or become overwhelmed by their emotions. They often blamed others for how they felt and internalised their frustrations through excessive guilt, self-harm, and suicidal ideation, or externalised them by becoming angry with other people. In their recovery, participants learnt to approach their emotions from a healthy distance, discovering why they arose and understanding that they would pass. Learning to recognise, accept, and take responsibility for regulating their emotions enabled participants to become more integrated within themselves.

Increased emotional intelligence made participants much more resilient in the face of adversity. They could face life as a whole human being – someone who could engage both the head and the heart, and make wiser and more constructive decisions. Resilience can be understood as an individual's ability to withstand adversity and recover from a distressing event (Ozawa et al., 2017). Individuals high in resilience are understood to be at lower risk from developing psychological distress following adverse or traumatic life events. Among those who do develop psychological difficulties, resilience is implicated in faster recovery and sustained remission (Min et al., 2013; Ozawa et al., 2017). Several authors have suggested that spirituality may foster resilience by improving emotional intelligence. Spirituality is thought to reduce negative affect by increasing opportunities for experiencing positive emotions, provide comfort and reassurance in times of emotional distress, encourage engagement in adaptive coping strategies, and improve emotion regulation by enabling individuals to maintain a sense of peace (Bamonti et al., 2016; Min et al., 2013; Ozawa et al., 2017; Rentala et al., 2017). The participants in this study endorsed all of these mechanisms, lending support to the above theories.

The combination of connection and belonging, inner transformation, acceptance, and emotional intelligence enabled participants to shift their focus from themselves to the world around them. Their spiritual experiences taught them that their wellbeing was inseparable from the wellbeing of others. Participants had a strong need to be of service –

be it to other people, animals, or the environment – and they strove to live and act in ways that minimised suffering and improved wellbeing. This need to move outwards was a crucial step in participants reconnecting with the material world. It is here that they began to build meaningful connections with other people, thereby eliminating the sense of isolation that was an integral part of their depression. These changes in perception and behaviour can be defined as self-transcendence.

It is established in the literature that self-transcendence is negatively correlated with depression (Ellerman & Reed, 2001; Haugan & Innstrand, 2012; Liu et al., 2021; Wegemer, 2020). Self-transcendence has been linked to a self-construct that views the self as interdependent and impermanent – that is, not as discrete and separate from the external world, and as a continuum of experience rather than a fixed and unchanging entity (Wegemer, 2020). Such self-construct is in line with the teachings of Buddhism, where suffering is said to be caused by an erroneous belief in the self as independent and permanent (Gyatso & Chodron, 2014; Hanh, 1999; Wegemer, 2020). It also consistent with the holistic and relational views of the self dominant in Indigenous and other non-Western cultures (Brintell et al., 2013; Brown et al., 2012; Cohen, 2003; Mark & Lyons, 2010). Viewing the self as solid, independent, and enduring has been linked with traits of neuroticism (a tendency towards negative affect) and materialism (a focus on acquisition of pleasure and avoidance of pain) that are implicated in the development and maintenance of depression (Wegemer, 2020). Conversely, viewing the self as illusory and impermanent leads to emotional stability and nonattachment to materialistic concerns through reduced self-centredness and increased openness to change. Individuals in this category also experience empathy without becoming overwhelmed by others' distress and engage in more altruistic behaviour (Wegemer, 2020). Several studies looking at correlations between self-transcendence and depression across age groups have found self-transcendence to improve mental wellbeing. Such improvements appear to be achieved through the development of altruistic values that increase connectedness and positive emotion (Liu et al., 2021), acceptance (Ellerman & Reed, 2001), and self-acceptance and adaptability to change (Haugan & Innstrand, 2012). All these improvements were endorsed by the participants in this study, lending further support to the beneficial role of self-transcendence in depression recovery.

Finally, towards the end of their recovery journey, participants could find meaning in their experiences. They could locate depression as a necessary, albeit unpleasant, part of their lives. They could see how depression aided their spiritual growth and enriched their lives. This ability to find meaning in suffering is consistent with Frankl (1986)'s proposition that depression only becomes chronic due to the sufferers' negative interpretations of their experiences. It also supports Wong (2015)'s proposition that meaning construction is an essential component of a comprehensive therapeutic program. When reframed in more positive terms as part of a coherent life narrative and an individual's life task, depression becomes just one part of an individual's journey – an opportunity to grow and thrive driven by adversity (Frankl, 1986; Wong, 2015).

The process of constructing a meaningful life narrative is similar to narrative therapy – a psychological therapy based on a constructionist orientation that views individuals as the creators and products of the stories they tell themselves and others about their roles and identities (Madigan, 2019). Individuals engaged in narrative therapy are encouraged to reframe the deficit-based personas they have acquired during their struggles – both through negative self-talk and other people's negative reactions to them – and work to see and present themselves in a more positive light. Through this process, individuals are empowered to tell all parts of their story – good and bad - without it diminishing their sense of self-worth (Madigan, 2019).

While narrative therapy requires the guidance of a trained therapist, participants in this study were able to conduct self-directed therapy using their spiritual beliefs, experiences, and practices. Spirituality may have aided participants in this regard by facilitating cosmic transcendence. While the self-transcendence discussed earlier can be described as ego-transcendence in that it is concerned with a movement outwards and away from self-centred concerns, cosmic transcendence describes an expansion outside the immediate physical reality through unification with the universe, the spirit, or the divine (Wong, 2016). Cosmic transcendence is characterised by feelings of awe and a knowledge of everything being one (Wong, 2016). Several participants in this study related peak experiences of cosmic transcendence, and all endorsed a belief in oneness. There is evidence that cosmic transcendence, through its emphasis on the unity and necessity of everything in life and the universe, is associated with the ability to construct a robust

framework of meaning - especially among individuals who identify as non-religious (Braam et al., 2006). This finding may be helpful to narrative therapists as it identifies another avenue for narrative construction that can overcome difficulties in multiple areas of a client's self-concept. Additionally, individuals who cannot access professional therapy and are open to spirituality could be encouraged to re-story their lives with the help of their beliefs, thereby receiving the benefits of narrative therapy without the cost.

Overall, the results of this study were strikingly similar to those of Moritz et al. (2011) in Canada, where depressed participants engaged in a spirituality intervention. That study found that participants gained an expanded perspective on life and their situation, reduced their negative thinking and emotional reactivity, felt more connected to themselves, others, and the universe, and enjoyed improved interpersonal relationships. Of note is that the Moritz et al. (2011) study was identified by this author after the data from this project had been analysed. The fact that the two studies arrived at their conclusions independently provides further support for clearly identifiable, holistic, and comprehensive therapeutic effects of spirituality for depressed individuals. Both studies suggest that Westerners, despite their immersion in materialistic and individualistic cultural discourse, are open to and can greatly benefit from engaging with the immaterial and transcendent dimension of human existence.

7.4 Limitations

One limitation of this study was the small number of men interviewed. As has been shown both by previous research and the present study, men's expressions of depression can differ from those of women. For example, men are more likely to suppress their emotions and express their distress through substance abuse, aggression, and reckless behaviour (Boughton & Street, 2007; Eid et al., 2019; Wilhelm et al., 2002). To devise better identification and therapy tools for men, it is important to understand how they view, experience, and approach both depression and spirituality. The difficulty this project had in finding male participants may be a reflection of their reluctance to admit their emotional distress and inability to cope with it (Ogrodniczuk & Oliffe, 2011). Bulhões et al. (2019) suggest the core symptoms of depression, such as sadness, may be contrary to societal masculine ideals. The need to avoid being negatively judged for engaging in unmasculine

displays of emotion, such as crying, leads men to hide their distress (Boughton & Street, 2007; Bulhões et al., 2019). The influence of societal gender roles is likely to be relevant here, as the stereotypical male role in New Zealand society is that of a tough, self-possessed, and rational individual for whom emotional vulnerability is a sign of weakness (Terry & Braun, 2009; Thaggard, 2017). It is this socialised suppression and masking of distress that mental health campaigns aimed at preventing men's suicide are currently attempting to address (Health Navigator New Zealand, 2020; Movember, n.d.-a, n.d.-b).

The issue of the stereotype may have also deterred men from discussing spirituality, as the belief in something transcendent and immaterial is at odds with what is considered rational in a materialistic society steeped in positivistic scientific discourse (Glyde, 2015). It is also possible that some men may have felt uncomfortable with the researcher being female. When asked if he knew of other men who might participate in this study, one participant said he knew some who fit the participant profile, but that they would not speak of their experiences to the researcher. Perhaps a male researcher would be better suited to exploring men's experiences of depression and spirituality, as males inhabit a shared landscape in terms of gender roles, expectations, experiences, and understanding.

Another limitation was that most of the participants identified as New Zealand European. While this demographic represents the majority population in New Zealand, Māori and immigrant populations are an integral part of New Zealand society. The growing numbers of immigrants and the revitalisation of Māori culture mean that it is vital for the discipline of psychology to understand the views and experiences of these populations. As has been shown by research, most non-Western individuals are likely to be collectivist (Brintell et al., 2013; Brown et al., 2012) and consider spirituality an integral part of their lives (Cohen, 2003; Mark & Lyons, 2010). Therefore, the dominant ideas surrounding the aetiology, symptomatology, and therapy for depression are unlikely to be helpful to such populations. Future research could explore the conceptualisations of depression and the role of spirituality in recovery with a specific focus Māori and immigrant populations. Such research would contribute towards an expanded theoretical and practical understanding of the lived experience of, and recovery from, depression in New Zealand.

Additionally, even though the advertisement for this project stated that both religious and non-religious individuals were welcome to take part, no religious individuals

expressed interest in participating. It may be that the term ‘spiritual’ holds connotations of what Knoblauch (2013) terms ‘alternative spirituality’ for more religiously conservative individuals in New Zealand. More research is needed, however, as this study did not explore the reasons behind the absence of religious participants from the sample – nor did it actively seek to recruit those who identified as religious. The importance of language, however, is something that may be of interest to scholars who seek to further refine the meanings of, and relationships between, the constructs of religion and spirituality in this country.

7.5 Future research

As seen in the literature review section of this thesis, there is significantly more research on depression than spirituality in Western scholarship. Finding literature on spirituality and its relationship with depression was a challenge, especially in relation to studies that attempted to differentiate between spirituality and religion. However, it is clear from literature that does exist, and the findings of this study, that many individuals in the West consider spirituality important. Despite social pressures to conform to materialistic scientific explanations of the self and the world, many continue to seek transcendence of the material. It is, therefore, important to the area of mental health to expand understanding of the spiritual dimension of people’s lives.

The avenues for such inquiry are numerous, ranging from further research on how individuals conceptualise spirituality to the range of practices and beliefs they engage in. Given participants’ assertion that spirituality is distinct from religion, it is important that researchers design the studies to clearly differentiate between the two concepts. As this study used a small sample, more qualitative studies are needed to develop a wider understanding of spirituality in New Zealand. For quantitative studies, it is recommended that nontheistic measurement tools, such as the Spiritual Orientation Scale (Lazar, 2021), are used to assess spirituality in participants.

Considering findings that people who suffer from mental distress are apprehensive of discussing their spiritual beliefs for fear of judgement and misdiagnosis, it would also be beneficial to explore New Zealand mental health professionals’ attitudes towards, and conceptualisations of, spirituality. Recent research conducted by Lindsay et al. (2020) on the

spiritual experiences of Māori in New Zealand found that participants did not feel comfortable discussing their spirituality with health professionals "for fear of being labelled 'psychotic' or 'crazy'" (Lindsay et al., 2020, p. 17). Conducting research with New Zealand health professionals would help understand whether participants' fears are founded, how open those professionals are to exploring spiritual matters, and what (if any) educational assistance they may need or are prepared to receive.

Finally, this study explicitly focused on the positive effects of spirituality on depression. However, research by Cashwell et al. (2007), Fox and Picciotto (2019), and Picciotto et al. (2018) shows that some individuals engage in spiritual bypass, where they use spirituality as an avoidance tactic. For example, individuals whose spiritual beliefs regard anger as a wholly undesirable emotion, repress it by avoiding confrontation and allowing others to behave in destructive and inappropriate ways (Cashwell et al., 2007; Picciotto et al., 2018). Such individuals can also develop an overly optimistic worldview, believing that everything will be well without any effort on their part. Some of the consequences of this attitude is failure to financially provide for themselves and their dependents, and apathy towards making positive changes in life (Picciotto et al., 2018). Bypassing individuals who fall prey to spiritual narcissism can become isolated as they view themselves as superior to the apparently less-spiritually accomplished around them (Picciotto et al., 2018).

Given the scarce but concerning research on the potential negative effects of spiritual bypass, it would be prudent to investigate if and how engaging with spirituality may have impeded some individuals' recovery. Cashwell et al. (2007) have suggested that some individuals intentionally choose a spiritual path than enables them to avoid dealing with difficult and unpleasant emotions. However, as has been shown by previous research and the findings of this study, holistic and sustained recovery requires comprehensive emotional work. Consequently, it would be interesting to investigate the differences between individuals who follow a path of positive spiritual development and those who use spirituality as an avoidance tactic, thereby worsening their situation. Such research could help establish whether these diverging paths are due to individual differences, external influences, or something else entirely. The findings from such research could help practitioners and depression sufferers recognise whether a particular spiritual path is therapeutic or harmful.

8. Conclusion

Despite the dominance of materialistic medical discourse in the field of mental health, spirituality remains an important part of healing for many New Zealanders. Spirituality provides an avenue for individuals to feel connected and hopeful despite the feelings of isolation and despair that are characteristic of depression. It also enables them to change any negative cognitive, emotional, and behavioural patterns without developing a deficit-based persona grounded in the notion that there is something wrong with them as human beings. The flexibility of spiritualty in New Zealand means that people can engage in interventions that are tailored to their needs in a timely fashion, at minimal to no cost, and without the need for access to the mental health system. Spirituality is also inexhaustible, enabling individuals to draw on their beliefs and practices throughout their lives, both in facing new challenges and simply continuing to grow and develop as human beings. The high rates of mental distress in New Zealand, combined with the clear benefits and minimal costs of engaging with spirituality in depression prevention and recovery, make the field of spirituality an important area of study for the discipline of psychology in New Zealand. Furthermore, with the mental health system difficult to access for many, any intervention that individuals can conduct on their own or by using resources already available in the community is worth exploring. It is hoped that spirituality's role in mental health will continue to be investigated. Its establishment as a valid and respected part of psychological and existential wellbeing can only benefit New Zealand through decreasing the prevalence and chronicity of mental distress. Psychology's engagement with spirituality would also help restore to prominence an important dimension of human existence that has long been neglected and stigmatised in the West.

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Appendix A Facebook Advertisement

Kia ora everyone!

I'm doing a master's thesis in psychology and am looking for participants for my research project.

I would like to interview people who experienced depression in the past and used spirituality to recover. I'm really interested in people's experiences in terms of depression, what spiritual practices they used and/or any spiritual experiences they had, and how they think those practices and/or experiences helped them.

You don't need to have had an official diagnosis of depression, or to belong to any particular spiritual or religious tradition (although you can). The interviews will be no longer than two hours and you won't have to fill out any questionnaires. It's entirely up to you what you choose to tell me, and you'll receive a $40 gift voucher as a thank you for taking part in the project.

If you think you might be interested in participating, please pm or e-mail me on russiaanna@yahoo.co.nz and I can send you some more information about the study.

Appendix B Study Information Sheet

Te Kura Hinengaro Tāngata/School of Psychology | Te Kunenga ki Pūrehuroa/Massey University | Manawatū Campus | Private Bag 11222 | Palmerston North 4442 | Aotearoa New Zealand

The role of spirituality in depression recovery

INFORMATION SHEET

Researchers' Introduction
My name is Anna Khayrullina and I am working towards my Master of Science (Psychology) degree at Massey University. I immigrated to Aotearoa New Zealand from Russia in 2002 at the age of 12. I decided to do this project as I experienced chronic depression for a number of years as a teenager and adult, was not helped by the conventional medical treatments, and eventually used spirituality to recover on my own.

Project Description and Invitation
The growing prevalence and chronicity of depression worldwide suggests the current medical approach to depression is not always effective. This study aims to learn from individuals who have experienced depression and used spirituality to recover. It focuses on what spirituality means to people in Aotearoa New Zealand, what (if any) tools and practices people used in their recovery, and what it was about their spiritual practice and/or experiences that they believe helped on their journey to recovery.

I would like to invite you to participate in this project and share your experiences as I believe your knowledge could make a valuable contribution to our effort of improving the mental and spiritual wellbeing of New Zealanders.

Participant Identification and Recruitment
Participants in this project are recruited mainly through existing acquaintanceship networks. First, individuals known to me and my supervisors are approached with the invitation to participate. The individuals who agree to participate may then be asked if they know of anyone else who fits the participant profile of this project and may be interested in participating. If enough participants cannot be recruited in this way, some people may be recruited through an advertisement on Facebook.

If you are aged 18 or over, are able to give written informed consent, have suffered from depression in the past, and used spirituality to recover, you are eligible to take part in this study. If you are under 18 years of age, are unable to give written informed consent, or are currently struggling with mental health difficulties, you may not take part in this study. The reason that current mental health struggles preclude you from participating is that we do not want to risk distressing you further by asking you to bring up potentially painful memories.

This study will involve around 5-7 participants. The reason for this number is that, in a project such as this, each participant is likely to provide a wealth of information. A larger number of participants may not provide much more information, as researchers tend to start seeing repetitions of themes after around 7 people have been interviewed. Interviewing fewer than 5 people, however, may not provide the variety and richness of information that this project requires.

Should you choose to participate, you will be given a $40 voucher as a token of gratitude. Should you need to travel to the Massey University Palmerston North campus from further afield, such as Wellington, you will receive a $100 petrol voucher as compensation.

While I will only ask you to talk about things and relate experiences that you are comfortable discussing, you may become distressed when relating the time you spent dealing with depression. If you find yourself becoming uncomfortable, you have the right to refuse discussing the matter at hand, to stop the interview, or withdraw from the study altogether. I do not anticipate any other harm that could come to you in this study.

Project Procedures

Should you decide to take part, you will be asked to talk about your lived experience of depression and how you used spirituality to recover from it. It will be entirely up to you as to which experiences you want to discuss as this project is about understanding your experiences and what spirituality means to you as an individual. It is anticipated that the interview will take no more than two hours.

My aim is for you to tell me only the things that you feel comfortable talking about so that participating in this project does not distress you in any way. However, I appreciate that talking about potentially painful memories can be upsetting for some people and I and my supervisor take your wellbeing seriously. Should you choose to participate, you will be provided with a list of qualified individuals and organizations in your region that you can contact for help and/or advice.

Neither I nor my supervisor have any conflicts of interest and/or role in this project.

Data Management

The audio recording of your interview will be transcribed by me without any third-party involvement. The transcribed data will be anonymized to protect your identity. You will be given a code number that identifies the transcript of your interview so that your name or any other identifying information will never appear in the data or final report. Once the audio recordings have been transcribed, they will be destroyed by me so that they cannot be accessed in the future. The transcripts and your Participant Consent Form will be stored either on my password-protected computer or in a locked cabinet in my supervisor's office (if campus is open for business post Covid-19) or at my home (if campus is still closed). Only I and my supervisor will be able to access this cabinet. A summary of the research findings will be sent to you by me via e-mail or post (whichever you prefer).

Your identification will remain completely anonymous. Your name will never appear in any of the data or reports due to the anonymization process, and only I and my supervisor will have access to your Participant Consent Form. Once the project is completed, this form will also be destroyed.

Participant's Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- *decline to answer any particular question;*
- *withdraw from the study (any time before November 2020);*
- *ask any questions about the study at any time during participation;*
- *provide information on the understanding that your name will not be used unless you give permission to the researcher;*
- *be given access to a summary of the project findings when it is concluded;*
- *ask for the recorder to be turned off at any time during the interview.*

Project Contacts

If you would like to take part or have any further queries about the study, either before or during the course of this project, please contact either me, Anna, or my supervisor, Nicole.

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Committee Approval Statement

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern B, Application SOB 20/13. If you have concerns about the conduct of this research, please contact Dr Gerald Harrison, Chair, Massey University Human Ethics Committee: Southern B, telephone 06 356 9099 x 83570, email humanethicsouthb@massey.ac.nz.

Appendix C Participant Consent Form

Te Kura Hinengaro Tāngata/School of Psychology | Te Kunenga ki Pūrehuroa/Massey University | Manawatū Campus | Private Bag 11222 | Palmerston North 4442 | Aotearoa New Zealand

The role of spirituality in depression recovery

PARTICIPANT CONSENT FORM - INDIVIDUAL

I have read and understand the Information Sheet. I have had the details of the study explained to me, any questions I had have been answered to my satisfaction, and I understand that I may ask further questions at any time. I have been given sufficient time to consider whether to participate in this study and I understand participation is voluntary and that I may withdraw from the study at any time.

1. I agree/do not agree to the interview being sound recorded.
2. I agree to participate in this study under the conditions set out in the Information Sheet.

Declaration by Participant:

I ___________ [print full name]__________ hereby consent to take part in this study.

Signature: ________________________ Date: ________________

Appendix D Interview Schedule

The role of spirituality in depression recovery

SCHEDULE FOR SEMI-STRUCTURED INTERVIEW

Q1. Do you want to start by telling me about your experience(s) with depression?

Other possible related questions

- When did you first realise you were depressed?
- How did you know you were depressed? What was different?

Q2. What made you seek out a spiritual approach to recovery?

- What does 'spirituality' mean to you?
- How do you define the term spiritual?
- Did you try other treatment approaches?

Q3. What spiritual practices did you employ or engage in during your recovery journey?

Q4. In what way did those practices help you towards recovery?

Q5. Are you still engaged in spiritual practice? If so, in what way? If not, why?

Q6. How do you maintain that practice?