

A REVIEW OF DEPRESSION AND ITS RESEARCH STUDIES IN MALAYSIA

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Abstract: *Depression is a common but serious illness that should not be overlooked due to its morbidity and burden. This paper provides a review of the literature on depression and emphasises some important issues of the condition. The studies were identified using electronic databases, yielding a review on key issues like definition, symptoms, outcomes and treatments of depression, and its research studies in Malaysia. Findings revealed that recent studies have started to focus on both physical and psychological symptoms of depression, its impairment in functional well-being, as well as common treatments ranging from biomedical to psychological and psychoanalytic approaches. Thus far, a very limited research has been conducted concerning major depressive adults' healing experiences and, to a lesser extent, young people. Further exploration is urgently needed to close the considerable research gap.*

Keywords: *depression definition; depression symptoms; depression outcomes; depression treatments; depression research in Malaysia*

Introduction

Depression is a prevailing but serious illness (National Institute of Mental Health [NIMH], 2011). It is the principal cause of dysfunctions globally and estimated 350 million people live with depression (World Health Organisation [WHO], 2012). In Malaysia, depression is the most common mental illness affecting approximately 2.3 million people at some point in their lives, but this health issue remains undetected and untreated (Mukhtar & Oei, 2011a; 2011b). The prevalence of depression in Malaysia was estimated to be between eight and twelve percent (Ng, 2014). Mukhtar & Oei (2011a) indicated that depression in Malaysia is still pictured as fragmented and vague.

On the one hand, Kessler and Bromet (2013) found that up to 20 percent of adults and up to 50 percent of children and adolescents were reported to experience depressive symptoms throughout the world. Major depressive disorder is understood to have started at a young age, decrease individual functioning, and often recurring (Marcus, Yasamy, van Ommeren, Chisholm, & Saxena, 2012). According to Kuwabara, van Vorhees, Gollan, and Alexander (2007), one in four young adults suffer a depressive episode, making depression as the prevailing cause of dysfunctional worldwide in regards of total years lost due to disability, and estimated 350 million people in this world experiencing depression (Marcus et al., 2012; WHO, 2012).

In Malaysia, the current report released by National Health Morbidity Survey (NHMS) in 2015 revealed that the prevalence of mental health problems among adults of 16 years and above in Malaysia shows an increasing trend, escalating from 10.7% in 1996 to 29.2% in 2015. In other words, mental health problems are commonly higher among younger adults, with adolescents aged 16 to 19 (34.7%), followed by those aged 20 to 24 (32.1%), and those aged 25 to 29 (30.5%) (Ahmad, Razak, Naidu, Awaluddin, Chan, Kasim, & Ibrahim, 2015).

In reality, depression affects both the depressed individuals and their loved ones, but it remains hidden and unspeakable although it is treatable (Ng, 2014). Most people with depression refuse effective treatments due to the lack of access to treatments and the stigma associated with depression (WHO, 2012). Depression is typically related with direct and indirect financial problems due to: (i) inability to work; (ii) health care cost; and (iii) horrendously high living cost to individuals who are accountable to look after and care for their family members suffering from depression (Malaysian Psychiatric Association [MPA], 2006). Also, depression may lead to suicide at its worst (Marcus et al., 2012). Two top disorders associated with suicidal behaviour are depression and alcohol misuse (World Health Organisation [WHO], 2014).

Culph, Wilson, Cordier, & Stancliffe (2015) posited that other diseases like anxiety is a cause of depression, or become a result of it, especially post-traumatic stress disorder (PTSD). Depressed individuals with co-occurring serious medical illnesses such as heart disease, stroke, cancer, AIDS, diabetes, and Parkinson are facing more difficulties in adapting with their medical conditions, and spend more medical costs than those who do not have co-existing depression (National Institute of Mental Health [NIMH], 2015).

Unsurprisingly, there is a high proportion of the population with major depression among young adults, and they belong to the group having the highest number of individuals experiencing depression, as early as their late teens (youth) and early 20s (early adulthood) (Eisenberg, Golberstein, & Gollust, 2007; National Institute of Mental Health [NIMH], 2012). Many people experience the first symptom of depression during their college years or in other word, young adult years, but many depressed college students are not seeking the help they need (NIMH, 2012). In 2011, about 30 percent of college students were reported feeling so depressed that it was difficult for them to sometimes function (American College Health Association [ACHA], 2012).

The depressed individuals experience emotional instabilities as they struggle to apprehend what are happening to them. The study of depression, despite being comparatively well documented in older adults, much less is known about such experiences and responses in depressed young adults (McCann, Lubman, & Clark, 2012). The study of McCann et al.

(2012) indicated that young adults respond to their depression in self-protective, harmful, and sometimes life-threatening ways. Among the major symptoms are: (i) struggling to make sense of their depression; (ii) spiralling down; (iii) withdrawing from friends; and (ii) contemplating self-harm or suicide. Major depression recovery is not limited to “relief of symptom” or “response to treatment”, but also “improvement in psychological well-being and quality of life” (Bircusa & Iacono 2007). Having said that, not all young adults are able to cope with their major depression.

Depression and Its Symptoms

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), depression encompasses the presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect individual capacity to function (American Psychiatric Association, 2013). The DSM-5 also describes major depressive disorder as a classic condition and it is characterised through symptoms during a similar, consecutive two-week period and it represents a change from previous functioning with at least one of the symptoms is either (i) depressed mood or (ii) loss of interest or pleasure.

Moreover, Beck (1967) stated that depression has been labelled under the classification of “melancholia” as described by a number of ancient writers including Hippocrates who made the first clinical description of melancholia in the fourth century BC. In his book, Beck (1967) defined depression as having these attributes: (i) specific alteration in mood e.g. sadness, loneliness, and apathy; (ii) negative self-concept associated with self-reproaches and self-blame; (iii) regressive and self-punitive wishes e.g. desires to escape, hide, or die; (iv) vegetative changes e.g. anorexia, insomnia, and loss of libido; and (v) change in activity level e.g. retardation or agitation.

According to Hammen and Watkins (2008), for the laymen and its use in everyday language, the term “depression” connotes a range of experiences, from a slightly noticeable momentary diminished in mood to a profound impairment or a life-threatening disorder. Unlike what is understood by the laymen, a clinically diagnosable depression refers to a constellation of experiences which include not only mood, but also physical, mental, and behavioural experiences that defines more prolonged, impairing, and severe conditions. Unlike Beck’s (1967) attempt on taking precise attributes, Hammen & Watkins (2008) focused on four common domains, namely affective, cognition, behavioural, and functioning.

Next, in regard to affective symptoms, depression typically manifests itself as depressed mood, sadness, feeling low, down in the dumps, emptiness, irritability (especially in depressed children), loss of interest or pleasure, and once pleasurable experience is no longer enjoyable (Hanafiah & Van Bortel, 2015). Studies also point out that one of the most common features of depression among adults and teenagers from various parts of the world is anhedonia, where individuals experience a loss of interest or pleasure (Hamman & Watkins, 2008). It should be noted that depression itself is sometimes noted as a “disorder of thinking”.

Negative thoughts about oneself, the world, and the future may cause depression and depressed people often feel guilty as they dwell on their perceived shortcomings and have similar cognition reflecting hopelessness on the ability to control desired outcomes. All of the attributes combined together may lead to bad outcomes including suicide (Hammen & Watkins, 2008). Other than that, physical motor behavioural changes influenced by

depression include diminishing of confidence and motivation that directly or indirectly affect individuals' psychomotor movements such as walking and speech. Depressed patients also experience a lack of impetus to carry out daily activities. In this case, physical changes include changes in appetite, sleep, and energy level.

Blenkiron (2010) stated that clinically significant depression is termed as “major” depression, depressive episodes, disorder, or illness. However, due to its presence in other notable forms such as sadness, grief, disappointment, self-criticism, over-expectation, or even a yearning for change, the term is perceived as overused. Therefore, he created a mnemonic for depression based on the ten letters of the word “depression” to help therapists to remember the main symptoms. “D” is for depressed mood, “E” is for energy loss (fatigue), “P” is for pleasure (interest) loss, “R” is for retardation or agitation, “E” is for eating changes (appetite/weight), “S” is for sleep changes, “S” is for suicidal thoughts, “I” is for impaired concentration, “O” is for only me to blame (guilt/worthlessness), and “N” is for not able to function.

Similar to the above, due to its presence in many other milder forms and the widespread use of the term “depression” by the general public, various myths and fictional understanding of the nature of depression has ascended to the limelight which needs to be clarified. These myths include: (i) depression as a result of character flaw or moral weakness; (ii) symptoms of depression not to be taken seriously compared to physical health problems e.g. cancer and heart disease; (iii) grouping of all emotional symptoms towards depression; (iv) adoption of positive attitude and stop wallowing in self-pity help people who are depressed; (v) depression as an emotional disorder or illness caused by neurochemical imbalance (Downing-Orr, 2013).

Downing-Orr (2013) suggested that in order to allow patients and clients to receive the best possible support and care, the aforementioned myths must be illustrated, challenged, and clarified. She suggested that the nature of depression is psychobiological which stems from psychological and physical ailments which involve emotional, motivational, and concentration disturbances, where it is regarded as an illness, several illnesses, or symptomatic of another health problems that strike the mind and the body. This newly broadened definition has a rigid view on emphasising the physiological nature of depression and has encouraged allied healthcare professionals to examine and investigate the cause of depression in every individual case. It also discourages existing preconceived notions regarding the nature of depression.

In short, although ancient scholars first discovered the symptoms and effects of depression, the illness was initially labelled as “melancholia” that encompasses a wide range of behaviours and rarely touched upon what was the main cause of depression at that time. Foundations were later built where researchers noted that depression was an affective disorder which solely focuses upon the psychological aspects of depression namely affective, behavioural, and cognitive (Beck, 1967; Hamman & Watkins, 2008; Hanafiah & Van Bortel, 2015). Also, literature in the past showed that depression is a psychological problem which results in physical manifestations, but newer studies have started to focus on the two-way interaction between physical and psychological aspects of the disorder itself that drastically influences an individual (Downing-Orr, 2013).

Outcomes and Treatments of Depression

Depression is a mental health problem that should not be overlooked due to its morbidity and burden. Depression causes impairment in the functional well-being and leads to low quality of life (Lim, Jin, Ng, 2012; Rapaport, Clary, Fayyad, & Endicott, 2005), decrement in health (Moussavi, Chatterji, Verdes, Tandon, Patel, & Ustun, 2007), as well as physical distress and health problems (Strine, Kroenke, Dhingra, Balluz, & Gonzalez, 2009). Subsequently, depression causes impairment in a person's role at home, work, relationship, and social network (Chong, Vaingankar, Abdin, & Subramaniam, 2012), resulting to limitation of daily activities (Strine et al., 2009), job insecurities (Lee, Park, Min, Lee, & Kim, 2013), and increased risk of early mortality due to physical disorder and suicide (Kessler & Bromet, 2013).

The risk of major depression is deepened and becoming chronic based on residual sub threshold depressive symptoms during recovery (Judd et al., 2000). Understanding depression is important to raise the depressed person's willingness in seeking professional support, improving symptoms, reducing the possibility of relapse, and refining the approach they cope with the illness (Christensen, Griffiths, & Jorm, 2004; Roh, Jeon, Kim, Cho, Han, & Hahm, 2009; Thompson, Hunt, & Issakidis, 2004). Indeed, psychological well-being includes a strong sense of autonomy, mastery, and self-acceptance. These positive attitudes and perceptions are important because the absence of well-being creates vulnerability to relapse (Dowrick, 2009).

Woll (2007) indicated that wherever depression goes, stigma and discrimination follow, bringing them feelings of worthlessness, helplessness, and hopelessness. The social and internalised stigmas of the depressed individuals reduce many people's willingness and ability to seek and receive the help they need. The fundamental instrument of healing is hope, as hopelessness is the overwhelming message of stigma, self-stigma, and depression. The professionals hold responsibility to teach individuals cope with the illness via medicine, psychotherapy, case management, outreach, organising, and training, because this is the most challenging skill to acquire for those who have fought for a long time.

On the one hand, Bloch (2009) in his book, "Healing from Depression: 12 Weeks to a Better Mood" developed a series of coping strategies based on five different types of self-care activities: (i) physical self-care such as exercise, nutrition, and medication; (ii) mental-emotional self-care such as cognitive restructuring, daily affirmation, and self-forgiveness; (iii) social support such as family, friends, psychiatrist, and therapist; (iv) spiritual connection such as prayer, meditation, and finding purpose and meaning; and (v) lifestyle habit such as setting goals, relaxation, humour, and stress reduction. These initiatives help individuals to experience a better mood, free from depression and anxiety.

Biomedical approaches

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

Mental disorders such as schizophrenia, major depressive disorder (MDD), attention deficit or hyperactivity disorder (ADHD), and substance-use disorders are assumed as biologically-based brain diseases (Deacon, 2013). Andreasen (1985) described the main principles of biomedical model as: (i) mental disorders are caused by biological abnormalities principally located in the brain; (ii) there is no meaningful distinction between mental diseases and physical diseases; and (iii) biological treatment is emphasised.

In the biomedical model, uncovering the biological sources of mental disorders is the principal aim of researching the nature of mental disorders. Ultimately, the goal of treatment seeks to discover the “magic bullets”, which are the precise therapeutic agents that specifically target the disease process without harming the organism, just like the way penicillin is used for curing bacterial infection (Deacon, 2013; Moncrieff, 2008).

Mental disorders are viewed as brain diseases caused by chemical imbalances that are corrected with disease-specific drugs and hence, biologically-focused approaches and pharmacological treatments, which include the use of psychiatric medications, have dominated the U.S. healthcare system for more than three decades to target the presumed biological abnormalities (Deacon, 2013). Thus far, biomedical model is dominant in treating depression (Deacon, 2013), but even though a particular intervention emerged from the biomedical model is proven to be an effective treatment, it is only a proof of correlational and not as causal relationship with the illness or disorder (Elder, Evan, & Nizette, 2008). For example, antipsychotic medication is effective to regulate dopamine level in managing schizophrenic symptoms; however, an elevated dopamine level is not the cause of schizophrenia (Elder et al., 2008).

Another appealing alternative to the biomedical approach was the neglected biopsychosocial medical model proposed by Engel (1977). Engel (1977) suggested that multiple explanatory perceptions inform our understanding of multifaceted natural phenomena and the physicians are required to comprise the social, psychological, and biological facets in his or her basic professional knowledge and skill. It embraces the ideas of studying mental disorders at different levels of analysis, namely molecular genetics, neurochemistry, cognitive neuroscience, personality, and environment. In this sense, no level is superior or fundamental to another. Teamwork across theoretically and technically varied healthcare professions is encouraged by the biopsychosocial approach (Deacon, 2013).

Psychological approaches

There are three independently developed approaches in the psychological treatment of mental disorders: (i) the psychodynamic approach; (ii) the existential-humanistic approach; and (iii) the cognitive behavioural approach, which often oppose each other. The techniques from these three different approaches have more willingness to be integrated in order to develop effective treatments for specific disorders (Ray, 2014).

First of all, the foundation of psychodynamic perspective laid by Sigmund Freud is that inner mental conflicts are manifested through psychological problems and the key to recovery is conscious awareness of those conflicts. Freud’s specific treatment is called psychoanalysis based on the search for conflicting ideas and emotions on an unconscious level, and the way individuals have relationships or repeat negative relationships with others are based on past history rather than current interaction (Ray, 2014). In order to treat disorders like anxiety and

depression, insight therapy that embraces the principle of bringing patterns of behaviour, feelings, and thoughts into consciousness is used to discuss past patterns and relationships in determining how does the present is influenced by them.

Second, from the existential-humanistic perspective, individual experience in the moment and the way how an individual interprets the experiences become the focus, with an emphasis on processing and understanding the internal and external experiences of human life, which result in the changes of behaviour and experience (Ray, 2014). For example, Jung's therapy focused on gathering different aspects of individual personality to create a unified self, which provides meaning to life, while Honey established the concepts of self-realisation and a real self. The humanistic movement led by Carl Rogers's client-centered or person-centred therapy includes three key characteristics: therapists' empathic understanding, unconditional positive regard, as well as genuineness and congruence. Emotion-focus therapy by Greenberg was centred on humanistic principles that emotion is viewed as dominant in the experience of self, and as the crucial element that results in changes and management of emotional experiences.

The third approach in psychological treatment of mental disorders is from the cognitive behavioural perspective which illustrates that dysfunctional thinking is common to all psychological disturbances and it is possible to change the way individuals think, as well as their emotional state and behaviour by learning in therapy how to understand the thinking. In Beck's cognitive therapy for depression, a cognitive triad regarding depression is used to describe the model: the first component is about individuals' negative view of themselves, the second component describes their tendency to interpret experiences negatively, and the third component indicates the way they regard the future negatively (Ray, 2014).

Based on the cognitive behavioural perspective, cognitive behavioural therapy (CBT) is directed at altering individual faulty logic and maladaptive behaviour. The therapy aims to modify the automatic thoughts related with: (i) catastrophizing – nothing is going to work out; (ii) personalisation – everything relates to you; (iii) overgeneralisation – an event is how it always is; and (iv) dichotomous thinking – everything is either good or bad (Ray, 2014). In essence, the psychodynamic or psychoanalytic approaches emphasise insight, the existential-humanistic approaches focus on emotional processing, and the cognitive behavioural approaches pinpoint the importance of action.

Psychoanalytic and Psychodynamic approaches

Psychodynamic approach has reached a milestone in the modern psychological thought, with a systematic reflection on the treatment of depression dated back to at least the time of Hippocrates and Galen (Gabbard, 2014; Ingram, 2009). With Sigmund Freud (1856-1939) being the intellectual forebear, the family of treatments which is termed as psychodynamic or psychoanalytic therapy shares a common origin.

Psychoanalysis acts as a psychological system and a treatment approach. It has a remarkable scope, originality, and tends to generate controversy and involves some popular ideas like defence mechanism (Ingram, 2009). Freud dedicated a large portion of his huge body of work to framework human miseries in many perspectives and discrepancies and he believed that the later vulnerability to adulthood depression results from early childhood losses (Gabbard, 2014; Ingram, 2009; Stein, Kupfer, & Schatzberg, 2007), where the concept of anger is

directed inwardly due to patients' self-identification with loss of objects. This leads to a common "self-depreciation" in depressed patients (Stein et al., 2007; Gabbard, 2014).

A psychotherapy in psychodynamic or psychoanalytic approaches is based on a set of core tenets: (i) much of mental life is unconscious; (ii) past is prologue; (iii) transference as one of the technical psychoanalytic strategies; (iv) countertransference provides useful information; and (v) patient is helped to understand resistance rather than remove it (Stein et al., 2007). The therapeutic setting is the fundamental to psychodynamic therapy, where the therapist is prerequisite to retain relative privacy to set sessions in time and place, as well as to deal with extra-session communication in sessions (Hales, 2008).

Next, Hales (2008) stated that in the treatment of depression, psychodynamic therapist must listen attentively to patient's experiences and themes that may have developed into depression including internalised anger, overdeveloped superego or sense of responsibility, or feelings of helplessness and dependency. The emerged transference typically repeats within the therapeutic relationship to be understood and brought into the therapy. It is also essential for the therapist to deal with patient's insensible sense of responsibility and anger subsequently from unavoidable evocations of previous feelings of loss during the end of psychodynamic therapy (Hales, 2008).

Currently, the trend of treatment for depression in Malaysia is through pharmacological means and biological theories which are still commonly used in clinical practices in the community setting and hospitals (Hanafiah, & Van Bortel, 2015; Mukhtar & Oei, 2011b; Ng, 2014; Razali & Hasanah, 1999). Therefore, unsurprisingly, the psychological aspect of disease recognition and understanding process especially for depression has a tendency to be ignored by the development of psychotropic medication in Malaysia (Deva, 2006; Kok, 2015; Mukhtar & Oei, 2011b). In Malaysia, empirical evidences supporting the use of clinically applied psychotherapeutic treatments for depression is yet to be established, hence it remains unknown if the current whether psychological instruments for the assessment of depression and the theories for depression are valid and reliable to be used in Malaysia (Hanafiah, & Van Bortel, 2015; Mukhtar & Oei, 2011b). It is vital to establish the validity of Western-derived psychological theories and psychological instruments to be utilised in the treatment of depression in different cultures, taking into consideration the psychological theories and treatment that are more susceptible to cultural influences in Malaysia (Hodges & Oei, 2007; Mukhtar & Oei, 2011b; Parker, Cheah, & Roy, 2001).

Overview Research on Depression in Malaysia

In Malaysia, depression is the most common mental illness affecting approximately 2.3 million people at some point in their lives, but this health issue remains undetected and untreated (Mukhtar & Oei, 2011a; 2011b). Mukhtar and Oei (2011a) argued that the picture of depression in Malaysia is fragmented and unclear. Ng (2014) stated there was lack of studies on depression among subgroups in Malaysia, particularly in the male population in Malaysia (Ng, 2014). However, Ng (2014) also mentioned that there are many unpublished theses and research projects on depression in the local universities. In terms of psychotherapy, Cognitive Behavioural Therapy (CBT) has recently practised but pharmacotherapy still dominates the treatment for depression (Mukhtar & Oei, 2011b).

The “depression literacy” in a sample of 314 urban and rural Indians in Malaysia was investigated (Loo & Furnham, 2013). Urban participants were more likely than rural participants in identifying depression using the actual term “depression”. Religious observance and lifestyle factors were highly rated as treatment for depression by both groups. Information campaigns were suggested to raise the awareness about depression by using the rural people as a target. In a different study, 18 percent of the elderly patients aged 60 years and above in Klinik Kesihatan Butterworth, Seberang Perai Utara, and Penang were found to have depression in a cross sectional study conducted from April 1999 to September 1999 (Sherina, Nor, & Shamsul, 2003). The factors associated with depression were females having low formal education, unmarried, low total family income, and living in urban areas.

Specifically, Chinese females, smokers, and alcoholics were reported as having a greater risk of suicidal thought in a retrospective evaluation of medical records from January 2002 to December 2007 at a psychiatric clinic in Penang (Khan, Sulaiman, & Hassali, 2012). The elderly aged 50 and over led the number of increased risk, followed by adolescents and youths aged from 15 to 24. Other factors towards suicidal ideation among the patients with depressive disorders include comorbid medical complications and social problems.

In a recent study, 15 mental health professionals from government and private sectors including psychiatrists, psychologists, and counsellors took part in detailed, face-to-face, semi-structured interviews (Hanafiah & Van Bortel, 2015). From the perspectives of mental health professionals, seven emerging principal themes from thematic analysis of “stigma of mental illness” include: (i) main perpetrators; (ii) types of mental illness carrying stigma; (iii) demography and geography of stigma; (iv) manifestations of stigma; (v) impacts of stigma; (vi) causes of stigma; and (vii) propose initiatives to tackle stigma. The stigma of mental disorder is well-known in Malaysia particularly among people suffering from schizophrenia, bipolar disorder, and depression. Manifestation of stigma often involves labelling, rejection, social exclusion, and employment. Hence, the stigma of mental illness in Malaysia and its consequences needs to be addressed.

In a questionnaire-based survey in Penang with 1855 respondents undertook face-to-face interviews, the majority (n = 910, 79.2 percent) significantly agreed that family and friends can enhance the depression recovery process by providing more care and attention to the patient (Khan, Sulaiman, Hassali, & Tahir, 2009). From the total of 38 percent of respondents (n = 437) perceived depression is perceived as a normal medical condition and gets diminished automatically. Most of the respondents believed that depression is co-prevented towards maintaining a good social life. Meanwhile, the other 50.7 percent didn't accept they were at risk, and some noted the lack of awareness concerning the signs and symptoms. Nonetheless, positive attitude towards the difficulty and prevention of depression was explored (Khan et al., 2009).

For those undertaking tertiary education in Malaysia, Nordin, Talib, Yaacob, and Sabran (2010) recruited a total of 1,467 undergraduates in Malaysian public universities to assess the association between gender, ethnicity, academic field of study, year of study, and mental health status of the respondents. University students represent early adulthood, which is the transitional period between adolescences, and they encountered life's issues such as personal and social adjustment, academic and career concerns, stress, and other related psychosomatic issues that lead to an unhealthy mental condition. The findings of the present study revealed that a majority (65.6 percent) of undergraduates were mentally healthy. Meanwhile, 34.4

percent exhibits potential mental health problems, indicating that one third of the Malaysian undergraduate population in public universities were suffering from anxiety and worries, and were confronted with social dysfunction and confidence level in their daily lives. The study also discovered that Malaysian undergraduates' mental health state differs in terms of ethnicity, field of study, and year of study – except for gender (Nordin et al., 2010)

Balami, Salmiah, and Nor Afiah (2014) also focused on public Malaysian university utilising a cross-sectional study among 495 first year students aged 18 to 26 in a public Malaysian university to determine the association between three psychological factors such as depression, anxiety, and stress with prehypertension. The study reported that the prevalence of pre-hypertension among first year university students was 30.1 percent, and the percentage of severe and extremely severe depression was 3.8 percent and 1.2 percent respectively. It was exceptionally found that severe or extremely severe depression is three times higher risk in getting pre-hypertension compared to no depression. Only severe or extremely severe level of depression has emerged as the psychological determinant of prehypertension in this study.

Shamsuddin et al. (2013) conducted a similar study featuring cross-sectional method involving 506 students (aged 18 to 24) from four public universities in the Klang Valley to assess the prevalence of depression, anxiety and stress, and to explore their correlations among Malaysian university students. Based on the Depression Anxiety Stress Scale-21 (DASS-21) (Lovibond & Lovibond, 1996), 27.5 percent of the participants experience moderate depression, while 9.7 percent had severe or extremely severe depression. Next, 34 percent had moderate, and 29 percent had severe or extremely severe anxiety. Furthermore, 18.6 person had moderate and 5.1% had severe or extremely severe stress scores. Students in the older age group (20-24 years) and those who were from rural areas scored significantly higher for both depression and anxiety. Older students, females, Malays, and those with either low or high family income showed a significantly higher stress scores. Shamsuddin et al. (2013) and Nordin et al. (2010) addressed the literature gap specifically on depression, anxiety, and stress among Malaysian university students. There is a necessity of urgent attention and further exploration by healthcare professionals and the university's administrative staff to develop better intervention programs and appropriate support services targeting this group. Greater attention should be given to student with unhealthy scores for their mental health despite a majority of the undergraduates was found to be mentally healthy.

Winding down towards secondary education, a study participated by 1,407 secondary school adolescents aged 13 to 17 from selected states in Malaysia showed that there were a moderately significant relationship between loneliness, stress, and self-esteem with depression; with stress appeared as the strongest predictor of adolescent depression (Yaacob, Juhari, Talib, & Uba, 2009). Another study conducted by Ibrahim, Amit, and Suen (2014) indicated that out of 190 students (103 males and 87 females) aged 15 to 19 from two different schools in Kuala Lumpur, 11.1 percent, 10.0 percent, and 9.5 percent were reported experiencing severe depression, anxiety, and stress, respectively. Depression, anxiety, and stress were revealed to be significantly correlated with suicidal ideation, with only depression emerged as a predictor for suicidal ideation. Thus, the role of depression in predicting suicidal ideation among adolescents in the Malaysian context was emphasised. The findings suggested that in order to reduce depression and suicidal ideation, assistance should be provided for teenagers to help strengthen their positive coping strategies in managing distress.

Another research was also carried out using qualitative study to investigate the emerging adults or young adolescents (aged 18 to 24) who have gone through depression to understand

their struggles during this developmental stage and to explore their recovery journey (Kok, 2015). Eight participants aged 18 to 24 who were diagnosed with depression at the age of 14 to 18 but were on the route of recovery were recruited using snowball sampling, in-depth interviews, and interpretative phenomenological analysis. The emerging themes were: (i) triggering events: transitional stage; (ii) triggering events: being rejected; (iii) triggering events: coping with loved ones' cancer; (iv) recovery and reflection; and (v) religious guidance. Some triggering events of depression include difficulties during transition from high schools to universities or transition from being single to engaging with intimate relationships, experience of rejection, and also when loved ones were diagnosed as having cancer. Reflection during the recovery stage involved psychosocial support and religious guidance and the vulnerability of transitional stage among the emerging adults in highly industrialised or post-industrialised countries was highlighted in this study (Kok, 2015).

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

Nurasikin et al. (2012) focused on examining a total of 228 psychiatric patients (mean age = 40.2) with a majority of them being males, single, and Malay Muslims patients to evaluate their coping methods against the level of religious commitment and its relationship with distress level. Higher religious commitment was significantly associated with lower stress, while practices of negative religious coping, severe psychiatric symptoms, and diagnosis of anxiety disorder or major depression were associated with higher stress.

There is a need to address discrepancies in the reported prevalence rate of depression in Malaysia as the studies on depression among subgroups in Malaysia are still lacking (Ng, 2014), such as "adolescent depression" and "male depression". There are several instruments available to assess depression in Malaysia but their suitability for the local setting needs further research. Mukhtar and Oei (2011a) also pressed to take the depressive symptoms earnestly due to their severity in decreasing productivity, as well as in increasing morbidity and mortality of individual, society, and nation.

Conclusion

In summary, to date, the apprehension regarding serious effects of major depression has fostered a significant amount of studies concentrating on the symptomatology, outcomes,

managements, experiences, and also on other problems regarding depression. Searching related articles in several databases using key terms like “major depression” and “healing experience” often results in minimal amount of relevant articles, with a great deal of articles focusing on the symptomatology, the impacts of major depression, and the somatic healing of illnesses other than major depression.

Although there is a growing awareness of the importance of recovering from major depression, the lacking of understanding about depression and its healing makes this mental health issue remain unnoticed and untreated (Mukhtar & Oei, 2011a; Ng, 2014), which is clearly indicated by the deficiencies in literature investigating directly on such personal growth and recovery experience. Although considerable research documenting the symptomatology and treatment of depression in adults exist, limited research conducted concerning major depressive adults’ recovery experiences and, to a lesser extent, young people (Haarasilta, Marttunen, Kaprio, & Aro, 2003; McCann et al., 2012). Thus, in order to better understand the recovery from youth depression, a naturalistic description should be excerpted from individual experiences of adolescents, youths, young adults, and emerging adults. This greatly contributes to a considerable gap in understanding the healing experience from major depression.

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