PERSONAL RECOVERY IN DEPRESSION: THE ROLE OF PEER SUPPORT IN MALAYSIA

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ABSTRACT

Rising depression burden of disease on individuals themselves and society at large has spurred efforts to uncover appropriate recovery-oriented practices. In Malaysia, the role of peer support has not been adequately understood nor implemented into frameworks of recovery for depression despite its efficacy shown in overseas studies. This study investigates service users' experiences of personal recovery and its conceptualisations, processes and outcomes through peer support, and peer support mechanisms that support personal recovery in depression. A qualitative study design was undertaken, and guided by the constructivist grounded theory methods with a pragmatic approach. Semi-structured interviews were conducted with 9 participants; verbatim transcripts were coded and analysed with a constant comparison method, until theoretical saturation was achieved. The analysis showed that personal recovery is conceptualised as a journey through the four prominent stages of (1) *awareness*, (2) *acceptance*, (3) *adaptation* and (4) *advancement*, generated by intrapersonal and interpersonal processes when service users are engaged in peer support mechanism consisting of *identity*, *relation* and *impact* dimensions. The emergent concepts were integrated to construct the *Peer Support Depression Recovery Framework,* which consists of the processes and outcomes of personal recovery in depression and its relevant peer support mechanisms. As such, peer support in Malaysia is experienced as helpful for service users to catalyse personal recovery in depression, similar to preceding studies. The implications and limitations of this study are discussed along with recommendations for future studies.

Keywords: depression, personal recovery, peer support, recovery model, personal recovery processes, personal recovery outcomes, peer support mechanisms, recovery framework, constructivist grounded theory, recovery-oriented practices

ABSTRAK

Peningkatan beban penyakit kemurungan terhadap individu sendiri mereka sendiri serta masyarakat telah mendorong usaha untuk mengungkapkan rawatan berorientasikan pemulihan yang sesuai. Di Malaysia, peranan sokongan sesama penghidap (*peer support*) belum cukup difahami atau dilaksanakan dalam kerangka pemulihan kemurungan walaupun keberkesanannya ditunjukkan dalam kajian luar negara. Kajian ini menyelidiki pengalaman pengguna perkhidmatan dalam pemulihan peribadi dan konseptualisasi, proses dan hasilnya melalui sokongan sesama penghidap, dan mekanisme sokongan sesama penghidap yang membawa kepada pemulihan peribadi dalam kemurungan. Reka bentuk kajian secara kualitatif dijalankan berdasarkan kaedah "*constructivist grounded theory*" dan pendekatan pragmatisme. Temu ramah separa berstruktur dijalankan dengan 9 peserta kajian; transkrip kata demi kata dikod dan dianalisis mengikut proses perbandingan berterusan, sehingga mencapai ketepuan teori. Analisis menunjukkan bahawa pemulihan peribadi dikonseptualisasikan sebagai perjalanan melalui empat tahap, iaitu (1) kesedaran, (2) penerimaan, (3) penyesuaian dan (4) kemajuan, yang dihasilkan oleh proses-proses intrapersonal dan interpersonal ketika pengguna perkhidmatan terlibat dalam mekanisme sokongan sesama penghidap yang terdiri daripada dimensi identiti, hubungan dan pengaruh. Konsep-konsep yang timbul disepadukan untuk membina *Kerangka Pemulihan Depresi Sokongan Sesama Penghidap*, yang terdiri daripada proses dan hasil pemulihan peribadi dalam kemurungan dan mekanisme sokongan rakan sebaya yang relevan. Oleh itu, sokongan sesama penghidap di Malaysia ditunjukkan berguna bagi pengguna perkhidmatan untuk memangkinkan pemulihan peribadi dalam kemurungan, sama seperti kajian sebelumnya. Implikasi dan limitasi kajian ini dibincangkan bersama dengan cadangan untuk kajian akan datang.

Kata kunci: kemurungan, pemulihan peribadi, sokongan sesama penghidap, model pemulihan, proses pemulihan peribadi, hasil pemulihan peribadi, mekanisme sokongan sesama penghidap, kerangka pemulihan, *constructivist grounded theory*, rawatan berorientasikan pemulihan

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LIST OF ABBREVIATIONS

4As	Awareness, Acceptance, Adaptation, Advancement
APA	American Psychology Association
BRIDGES	Building Recovery of Individual Dreams and Goals through Education and Support
IPR	Interview Protocol Refinement
JEPeM-USM	Jawatankuasa Etika Penyelidikan Manusia Universiti Sains Malaysia
MHCC	Mental Health Commission of Canada
MIASA	Mental Illness Awareness and Support Association
NPMH	National Policy on Mental Health
P1	Participant 1
P2	Participant 2
P3	Participant 3
P4	Participant 4
P5	Participant 5
P6	Participant 6
P7	Participant 7
P8	Participant 8
P9	Participant 9
RCTs	Randomised Control Trials
UPSIDES	Using Peer Support In Developing Empowering Mental Health Services
WHO	World Health Organisation
WRAP	Wellness Action Plans

CHAPTER 1

INTRODUCTION

1.1 INTRODUCTION

This chapter provides the background of the study, relevant to depression and the current status of recovery-oriented practices in Malaysia. The problem statement and the rationale for the study highlights the research gap of personal recovery and peer support in the country. Next, the research questions and objectives are presented along with the significance of the study within the recovery paradigm and peer support model for depression. The conceptual definitions and framework follow to clarify the context of the study.

1.2 BACKGROUND OF STUDY

Depression is a mental health condition that stands as one of the most prevalent globally (Kessler et al., 2005), with up to a count of 264 million worldwide sufferers of some form of depressive disorders (James et al., 2018). Published prevalence studies on depression in Malaysia provided an estimation of eight to twelve percent (Ng, 2014), with higher rates recorded among those with medical comorbidities (Mukhtar & Oei, 2011). In 2011, a conservative estimation of 2.3 million Malaysians suffering from depression in their lifetime was calculated (Mukhtar & Oei, 2011); this number is believed to be still on the rise ("29% of Malaysians," 2018). This is a worrying trend as the burden of disease of depression manifests in high rates of suicidality and disability besides implicating cost on the society and economy (Whiteford et al., 2015).

Based on the *Diagnostic and Statistical Manual for Disorder of Mental Disorders* (*DSM-5*; American Psychiatric Association [APA], 2013), disruptive mood dysregulation disorder, major depressive disorder, persistent depressive disorder and premenstrual dysphoric disorder are some of the categories of depressive disorders. Depression is often characterized by the presence of sad, empty, or irritable mood, along with somatic and cognitive disturbances that significantly hamper individuals daily functioning (APA, 2013). Besides that, individuals suffering from depression would experience a loss of interest in pleasurable activities, accompanied by a range of symptoms such as weight loss, insomnia, fatigue, inappropriate guilt, poor concentration and suicidal ideation (APA, 2013). Hopelessness, negative self-view, social isolation and loneliness are also common markers of depression (Haeffel et al., 2017; Matthews

et al., 2016; Montesano et al., 2017). Together, these cause debilitating and distressing effects on life for those suffering with depression.

In overcoming these difficulties, treatments are available in the form of pharmacology targeted at biological factors (Ceskova, 2016) and psychotherapy targeted at psychosocial factors (Lemmens et al., 2016). While depression is commonly experienced and highly treatable (Hollon & Ponniah, 2010), it is found that only less than half of these individuals with depression actually receive proper care and only 10 to 25% are provided with evidence-based treatments (Voytenko et al., 2018). In Malaysia, similarly, many sufferers of depression go unnoticed and untreated (Mukhtar & Oei, 2011).

Recognising the growing prevalence of depression in Malaysia and its severity, local researchers have recently endeavored in uncovering the lived experiences of individuals who have recovered from depression and the factors that promoted recovery (Chan, 2018; Kok & Lai, 2017). Locally, qualitative studies are considered rare in the field as previous studies on depression, albeit many, were quantitative in nature or assessed pre- and post-tests of interventions (Chan et al., 2017). With the richer data derived from respondents of the qualitative studies about their recovery experiences, themes of psychosocial recovery were highlighted against the standard clinical outcomes (Chan, 2018; Kok & Lai, 2017). These findings align with the recovery model, also known as “personal recovery”, that is distinguished by dimensions of establishing connectedness, regaining hope, reforming positive identity, uncovering meaning in life, and developing empowerment, responsibility and control (Andresen, 2007; Glover, 2012;

Leamy et al., 2011). The growing interest in research and awareness in recovery themes of depression can further catalyse our adoption of recovery-oriented practices that have already been established as a viable and imperative component in mental health services in developed countries (Ramon et al., 2007; Thornicroft & Slade, 2014).

The National Policy on Mental Health (NPMH) in Malaysia presently defines mental health as ‘‘the capacity of the individual, the group, and the environment to interact with one another to promote subjective well-being and optimal functioning, and the use of cognitive, affective and relational abilities, towards the achievement of individual and collective goals consistent with justice’’ (Haque, 2005; p. 183); the statement denotes essential components of recovery according to the user-defined recovery model that goes beyond the measures of clinical outcomes (Davidson, 2005; Jacob, 2015). More recently, the rhetoric by the government is further reinforced by introducing a “wellness paradigm” under the Eighth Malaysian Plan’s Vision for Health (Malaysia, 2001, p. 477) as a progressive approach, characterised by the empowerment of individuals, their families and their communities to achieve the aspiration of health and quality of life (Merican et al., 2004).

Though recovery-oriented practices for mental illness are present in Malaysia, it is in its nascent stage as awareness and training of clinicians on the multidimensional needs of recovery beyond the biomedical model are still wanting (Midin, 2015). Initiatives to provide more holistic care for individuals receiving mental health treatments include the establishment of day-care

centers for psychosocial rehabilitation, run by both the government and non-governmental organizations, using psychological, social and occupational methods to enable those with chronic and severe mental illness to function in the community (ParameshvaraDeva, 2004; Haque, 2005; Zam, 2010). Such practices should encompass the nurturance of values at the personal level, such as hope, self-determination, empowerment of service users and collaboration between organisations and service users, which are all contributive towards holistic recovery (Midin, 2015). The progress in mental health appears to be in line with recovery-oriented practices that endorse the broader concept of recovery, but upon closer examination, the ideals remain unfulfilled amidst the pervasive disease-oriented perspective of both clinicians and the public, lack of understanding of the wellness concept, and subsequently, the absence of specific and actionable plans and strategies to be implemented (Merican et al., 2004). We have yet to critically inquire and reflect on the status quo, lagging behind in improvements already made in developed countries (Haque, 2005; Thornicroft & Slade, 2014).

The lacklustre progress of recovery-oriented practices could be due to it being poor in conceptual clarity. Slade et al. (2008) reviewed the international body of literature and found that while recovery-oriented practices are rhetorically and globally emphasised, it may not be met with the same conceptual clarity on what it really entails. The authors delineated between clinical recovery and personal recovery: clinical recovery is taken from the illness framework and entails the sustained state of remission where symptoms become absent and function is restored, which are objectively measured and operationalised in research invariantly across persons; while personal recovery emerged from service users narratives that emphasises on living a satisfying,

hopeful and productive life, despite possible illness limitations, which is subjectively defined by individuals (Slade et al., 2008). As clinical recovery is more quantifiable, it has been more commonly used to establish rates of recovery in most medical professional publications (Slade et al., 2008). However, personal recovery research that capitalises on lived experience of patients instead of empirical evidence is encouraged as a research paradigm shift to move into a more value-based practice of mental healthcare (Slade et al., 2008).

With this context, we may come to appreciate the absence of the recovery paradigm influencing best practices here in Malaysia that should include peer support, since it has long been recognised and encouraged by the World Health Organization (WHO) as a "core service requirement" (2013, p.16). The recovery movement emerged from lived experiences of mental health service users and is actively embodied through peer support (Mead et al., 2001). In fact, peer support is among other components of practice identified as necessary to facilitate recovery, such as assertive community treatment, supported employment, education and housing, illness self-management, and stigma reduction (Bejerholm & Roe, 2018). Peer support may exist in a variety of forms, such as self-help groups, Internet-based support groups, peer-delivered services, peer-run services, peer partnerships, and formalised peer employment (Solomon, 2004). The diversity of peer support services also optimises choice for service users to engage and navigate in their own recovery journey (Onken et al., 2002).

1.3 PROBLEM STATEMENT AND STUDY RATIONALE

The processes and outcomes of recovery related to peer support in depression has been demonstrated in prior research (e.g. Bryan & Arkowitz, 2015; Joo et al., 2018; Theurer et al., 2017) but little is known about its viability and impact in Malaysia. Rather, the management of depression in Malaysia's public health system has been largely dominated by the biomedical model that emphasises on pharmacotherapy combined with psychotherapy interventions aimed at clinical outcomes (as cited by Chan, 2018; Kok & Lai, 2017). Thus, subjective or personal recovery of Malaysians is hardly known or even heard of because individual experiences lack amplitude without the avenue provided by peer community nor by research. The lack of research for recovery and the role of peer support is not uncommon among low to middle income countries (LMICs) that tend to be slightly behind in most progressive approaches in mental health due to prevalent paternalistic and biomedical orientation, and culturally hierarchical nature (Moran et al., 2020; Pathare et al., 2018; Puschner et al., 2019; Ryan et al., 2019).

Leaving this potential recovery resource of peer support unexamined and lacking in a local evidence base may further hamper its progress to meet the multidimensional recovery needs of local mental healthcare users and the international standards of mental healthcare systems (Pathare et al., 2018; WHO, 2013). It has been argued that by keeping the status quo, a stigmatising cultural context is perpetuated in the psychiatric system that can continue to isolate "mental patients" because of how psychiatric labels of diagnosis and prognosis denote "problems" as pathological, abnormal and chronic (Mead et al., 2001). In contrast, an attention

shift to research on peer support could be the essential pathway that brings progress to the mental health system in Malaysia to include and validate the diversity of personal recovery as complementary to clinical recovery (Puschner, 2018). In order for progress to ensue, the critical evaluation of whether the current model of diagnosis and treatment in Malaysia is truly sufficient in providing the route to holistic recovery for patients with depression needs to be contrasted with the model of recovery and the role of peer support. The study rationale is derived from a few pivotal paradigm shifts that are necessary for local research to tap into these uncharted areas of knowledge in Malaysia, particularly in valuing person-centered, strength-based and community-based approaches for personal recovery in mental healthcare and its research.

Because personal recovery is essentially person-centred, it is necessary that recovery be evaluated from the service users' perspective. Placing lived experiences front and center in the research as an informer for the growth of knowledge in recovery and peer support provides a significant shift to assign value and authority to service users (Adame & Leitner, 2008; Davidson et al., 2008). Recovery accounts derived from qualitative studies in Malaysia and overseas provide meaningful data for constructing frameworks of recovery and of the relevant peer support; therefore, it has been asserted that the worthwhile focus of research should be on building theoretical foundations of peer support services and its necessary change mechanism that facilitate recovery outcomes (Barrenger et al., 2019). As such, it is essential to shift the research agenda from focusing on clinical outcomes to outcomes that correspond with what is most valued by service users themselves to further develop services that meet the actual needs of individuals (Barrenger et al., 2019).

There is also a need to overcome the dominant biomedical approach in diagnosing and treating depression with a strength-based approach that is promoted through recovery and peer support. Qualitatively deriving recovery accounts places the emphasis on resources and personal change/growth rather than on problems and weaknesses that traditional psychiatry seeks to remediate (Bellamy et al., 2017; Monteiro et al., 2014). Local research needs to begin to understand and highlight the interpersonal and intrapersonal resources that are afforded by peer support in promoting recovery here in Malaysia, bringing a significant paradigm shift to strength-based approach that may leverage on inherent personal strengths for personal recovery.

Taking principles of peer support into account, such as mutuality, dialogue, and shared responsibility and power (Mead et al., 2001; Stratford et al., 2019), unique individual strengths can be amplified when shared and exchanged among one another for mutual benefit by using peer support as the primary platform in community building. Community-based studies ought to be best conceptualised based on communities built among service users themselves, rather than what is dictated by the dominant narrative and control of traditional psychiatry of what it means to be mentally ill (Mead & Filson, 2017). As such, local research needs to derive the collective voice of lived experiences in empowering communities that provide insights to actual experiences of recovery and what it means to flourish in communities (Mead & MacNeil, 2005).

Together, these premises provide the urgency and priority for this study to take on a

qualitative approach to uncovering the lived experiences of service users in light of personal recovery and peer support because it adds person-centered, strength-based and community-based components to the body of literature in Malaysia. This is in hopes to shift the current approach to mental healthcare towards a more progressive manner.

1.4 RESEARCH QUESTIONS

In exploring personal recovery in depression among those involved in peer support, the following research questions drove the research agenda:

- How do these service users conceptualise their personal recovery and change in depression?
- What are personal recovery themes (outcomes/processes) that emerge from lived experience of service users in peer support?
- What are the peer support mechanisms that are essential for personal recovery?
- How are these themes and mechanisms synthesized into a peer recovery support framework in Malaysia?

1.5 RESEARCH OBJECTIVES

To answer these research questions, a qualitative approach is most pertinent for studies in the area of recovery because of valuable lived experiences of persons in recovery and their own conceptualisation of their journey in a subjective manner needed to inform the body of knowledge new to Malaysia, and in order to precipitate future hypotheses and research agenda while remaining most relevant to the needs of mental health service users themselves (Davidson et al., 2008). Most adequately, the study based the inquiry into the peer recovery model on a

constructivist grounded theory approach (Charmaz, 2006; Glaser & Strauss, 1967) as it is shown to be strategic in developing the framework of concepts and processes relevant to this topic.

As such, this study took on a qualitative approach to derive the accounts of personal recovery in depression for persons involved in peer support in Malaysia through semi-structured, in-depth interviews and meet the following objectives:

- To understand personal recovery defined from the service users' perspective
- To identify personal recovery themes (processes/oucomes) facilitated by peer support
- To identify key mechanisms provided through peer support that facilitates personal recovery
- To construct a peer recovery support framework for depression relevant to the Malaysian context

1.6 SIGNIFICANCE OF STUDY

This study is among the few designed qualitatively to extract richer and in-depth data pertaining to the recovery paradigm that goes beyond clinical outcomes for depression, and the first, to the author's knowledge, of study on how peer support contributes to personal recovery in Malaysians living with depression. This study contributes to local and international recovery and peer support knowledge base. From research productivity pertaining to the peer support model, greater awareness and understanding of service users in peer support will be imperative towards providing the rationale for a paradigm shift and policy revision of the current mental healthcare

system through a cohesive peer support model relevant to depression recovery, its extended impact towards society, and its potential as an essential dimension in recovery-oriented practices for depression in Malaysia as a progressive step forward. Peer support can also be further promoted as a community-based and task-sharing implementation to ease the mental health burden in Malaysia when presented with evidence to relevant stakeholders as accessible, affordable, and equitable (Johnson et al., 2018; Pathare et al., 2018; Puschner et al., 2019; Ryan et al., 2019; Solomon, 2004). An eventual conceptual framework of peer support facilitating depression recovery relevant locally from this study will also help boost future research for further validation and ensure the adequate and successful adaptation of the peer support model in a culturally sensitive manner without losing its essential components (Stratford et al., 2019).

1.7 OPERATIONAL DEFINITIONS

This study focuses on depression recovery among adults that are involved in peer support in a particular community-based and peer-run organisation in Malaysia; the operational definitions to further outline and limits the scope of the study is presented in Table 1.1

Table 1.1 Operational Definitions

Term	Operational definition
Depression	Depression in this study is not confined to any particular disorder, but may include any depressive disorders under the *DSM-5* (APA, 2013).
Personal recovery	Personal recovery is differentiated from clinical recovery in mental health, in which symptom reduction is not a prerequisite, but emphasis is on subjective sense of recovery defined by service users themselves (Davidson, 2005; Slade, 2009).
Personal recovery processes	Processes that underlie personal recovery outcomes.
Personal recovery outcomes	Features of personal recovery where change is experienced by service users.
Service users	Individuals who are currently engaged in the mental healthcare system and receiving some form of treatment.
Peer support	Peer support is "the provision of emotional, appraisal and informational assistance by a created social network member who possesses experiential knowledge of a specific behaviour or stressor and similar characteristics as the target population (Dennis, 2000; p. 329).
Peers	Individuals involved in some form of peer support specifically in the context of mental health.
Peer supporters	Individuals providing support to other peers specifically in the context of mental health, and may also receive support from peers.
Peer support mechanisms	Components described as “unique contribution” (Watson, 2017) of peer support effectiveness on recovery outcomes.

1.8 THEORETICAL APPROACH AND CONCEPTUAL FRAMEWORK

Charmaz's (2006) constructivist approach to grounded theory, which aligns more closely to Strauss' pragmatic and symbolic interactionist theoretical perspective (McCall, C., & Edwards, 2021), is taken as the main theoretical approach. The pragmatic perspective "emphasizes the importance of prior beliefs as starting points" (Morgan, 2020, p.68), which is taken to form the necessary conceptual framework in this study (i.e. mechanism-process-outcome chain). The symbolic interactionist perspective sees human interaction with things that have derived meaning from prior social interactions in turn are re-interpreted in specific contexts (Blumer 1969); this frames the exploration of the role of peer support for personal recovery, from the basis that individually construed meaning is derived from interaction with other peers, that in turn forms micro-level experiences and changes pertaining to personal recovery. From the constructivist approach, the researchers' rendered grounded theories, besides research participants' perspectives, are also accounted as valid contributions towards the constructions of reality (Charmaz's, 2006).

As this study uses the grounded theory method, the emergent framework is formative from research data, rather than from an *a priori* theoretical approach. Nonetheless, in order to arrive at a research-oriented framework, a pragmatic approach (Charmaz, 2006; Morgan, 2020) is taken to presume the sensitising concepts and relationship of "peer support mechanisms," "personal recovery processes," and "personal recovery outcomes" to guide the inquiry beginning with the research objectives. As such, the study investigates within the scope of peer support as

defined in Section 1.7 to answer the research questions structured into the conceptual framework illustrated in Figure 1.1 as a presumed causal chain model; peer support mechanisms are unique characteristics of peer support that activate personal recovery processes, which underlie the effective outcomes of personal recovery.

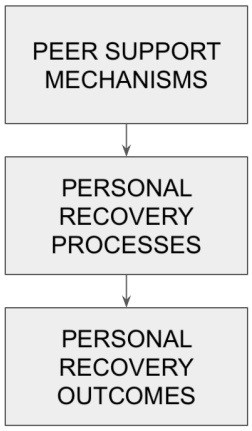

Figure 1.1 Conceptual Framework

1.9 CHAPTER SUMMARY

In summary, this chapter orientated towards the importance and lack of studying personal recovery in depression and peer support for its empirical, clinical and community value, placing weight on person-centered and recovery-oriented practices in Malaysia from a service-users' perspective. It also clarified the direction of the study to achieve its objectives through constructivist grounded theory with a pragmatic approach. The next chapter will present the body of literature relevant to this study.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

The review of literature begins with an overview of personal recovery from international and domestic research, presents efficacy studies of peer support, draws a connection to peer support recovery, examines key mechanisms of peer support relevant to depression recovery, highlights relevant theories that underpin peer support and reviews international context of peer support.

2.2 PERSONAL RECOVERY IN DEPRESSION

A recent review by Kok and colleagues (2018) examined the psychosocial factors to depression recovery and found themes of (a) hope, optimism, resilience and self-efficacy; (b) working on oneself; and (c) other social factors that are essential in bringing transformation to self and functional living. This piqued local research to attend to psychosocial factors at both personal and community levels and further assertions to not neglect psychosocial factors necessary in considering mental health policy (Kok et al., 2018). Studies of qualitative nature followed in recent years to uncover the relevance of these psychosocial factors among the depression recovery of Malaysians.

Accounts of personal growth are central to understanding recovery as revealed through both psychosocial processes and contributors (Chan, 2018). It was found that recovered participants attributed supportive relationship, medication, counseling, religion and spirituality, concern for others and vocation to their personal growth, which facilitated processes of disclosing personal struggles, discovering self and strengths, assuming self-responsibility, being ready for change, experiencing hope, reframing meaning, choosing forgiveness and acceptance (Chan, 2018). Chan (2018) assert that the findings should inform clinical practice to empower patients with depression to focus on personal growth aspects, such as incorporating factors that contribute to personal growth and prioritize markers of personal growth, without neglecting the importance of pharmacotherapy. However, these implications were only discussed within the psychotherapy practice.

Likewise among youths, Kok and Lai's (2017) analysis of interviews found themes of rediscovering self and reconnecting with significant others as marks of recovery after initial loss of identity and disconnectedness related to depression. It was also highlighted that inability to conform to norms within the problematic stigmatizing standards of society aggravated depression (Kok & Lai, 2017). The research uncovered the importance of social-ecological dimensions of depression that cannot be met through biomedical treatments alone (Kok & Lai, 2017). The author suggested that psychosocial and information needs ought to be met to promote recovery among youths to provide more holistic prevention and intervention for depression other than clinical interventions (Kok & Lai, 2017).

These findings confirm previous research that established the concepts of the recovery model. The recovery model, also known as "personal recovery", is defined as "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles . . . a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness" (Anthony, 1993, p.17). Personal recovery is distinguished by dimensions of establishing connectedness, regaining hope, reforming positive identity, uncovering meaning in life, and developing empowerment, responsibility and control (Andresen, 2007; Glover, 2012; Leamy et al., 2011).

Research on conceptual frameworks illuminates the processes and outcomes that need to be prioritised in clinical practice in order to promote personal recovery, similar to what was

found in the local studies. Andresen (2007) delineated between the processes and stages of recovery through his longitudinal study of patients with schizophrenia in Australia. He synthesized the personal recovery processes of (a) finding and maintaining hope, (b) re-establishment of positive identity, (c) building a meaningful life and (d) taking responsibility and control. Additionally, he showed that patients journey past a sense of loss to awareness, preparation, rebuilding and growth, each with its personal recovery processes redefined successively (Andresen, 2007).

Leamy and colleagues (2011) undertook a comprehensive review to generate a conceptual framework of personal recovery from mental illness, collating 97 studies from 13 countries, where important themes of recovery journey, processes and stages emerged. Summarising these findings, the recovery process shown to constitute connectedness; hope and optimism about the future; identity; meaning in life; and empowerment (making up the acronym *CHIME*) is suggested for clinical relevance and reflective practice that is geared towards promoting recovery outcomes (Leamy et al., 2011). The *CHIME* model for clinical use found further validation when compared to Meyer's (2018) literature review to extract user-defined depression recovery accounts from six qualitative studies using a meta-analytic approach. Of the criterias examined, identity, empowerment, meaning and purpose, and connectedness had the largest frequency effect sizes from the data available, suggesting that personal recovery dimensions weighted more on the recovery of depression that service users value most (Meyer, 2018).