Exploring the meaning of low self-esteem that is inherent in depression, an interpretive phenomenological study

By

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Declaration

This thesis titled "Exploring the meaning of low self-esteem that is inherent in depression, an interpretive phenomenological study", contains no material which has been accepted for the award of any other degree of diploma in any university and that, to the best of my knowledge and belief, contains no material previously published or written by another person except where due reference is made in the text of the thesis.

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Abstract

The purpose of this research was to explore the lived experience of low self esteem inherent in depression for participants who directly accessed mental health care in a rural mental health service in the South East Region of South Australia. Five participants were interviewed. Data was collected from interviews in which participants reflected on the connection of low self esteem often inherent in depression in nine domains of life and how this had impacted on the participant's day to day life. Data was collected using a phenomenological methodology, and the data was analysed using Colaizzi's7 step method. Meaning was aggregated into themes using the structure of cognitive behavioural therapy to explore the interaction of cognition, behaviour, physiology and affect. Results illustrated a significant negative experience of low self esteem in depression with associated thoughts and behaviours. These thoughts and behaviours maintained suffering and distress in all domains of life except spirituality and to a lesser degree citizenship. Participant's experience of the mental health service was generally viewed as worthwhile.

This research confirms the value of psychological interventions by skilled health professionals. The subjective experience of low self esteem appeared to have become a part of life, not dissimilar to an addiction whereby people do not know how to live without it. The experience of low self esteem in depression for the participants was a long battle and gaining new insights through contact with mental health services may be viewed as too little too late. The research demonstrated the long term benefits of a co-ordinated approach to early interventions within the primary and secondary education system. With the estimated rates of depression on the rise there is a challenge for mental health professionals at the grass roots level to disseminate vital information to young people about the complexity of the mind. Understanding the experience of low self esteem in depression during our formative years may abort these negative experiences before they become entrenched and gain a psychological hold, which may develop into the formation of unhelpful habitual thoughts and unhelpful habitual behaviours, and loss of life through suicide.

Keywords: low self-esteem, depression, lived experience, domains of life, qualitative nursing research.

Chapter 1 – Introduction

Introductory paragraph

This research aims to develop a deeper understanding about the role of low self-esteem for people with a depressive illness. As low self-esteem and depression go hand in hand with people perceiving themselves as hopeless and worthless (Bloch & Singh 2001) exploring this connection may enable a greater understanding of the phenomenon of low self-esteem, for those who live the burden of depression, for mental health practitioners. This will facilitate a more sensitive approach to patient care. Mental health nursing focuses on a person's subjective experience to understand a person's inner world and focuses on understanding how people then relate to themselves and the world around them (Australian College of Mental Helath Nurses 2012).

Research Problem

Self-esteem is a personal and subjective experience with unique features that contribute to a person's journey to wellness and impacts on their quality of life and their relationships with others (Westbrook, Kennerley & Kirk 2010). People who develop depression often believe that life is not worthwhile as they grieve for the life that they had and their aspirations for the future (Elder, Evans & Nizette 2012). Depression is an insidious illness and has been identified as the most prevalent mood disorder affecting 9.7% of Australians in 2011 – 2012 (Statistics 2013). This represents a significant burden of disease in both direct cost through the treatment and management of illness, and indirect costs through loss of employment, disability and premature deaths(Butcher, Mineka & Hooley 2007).

Purpose of the Study

Insights gained through research may have the potential to influence a clinicians reasoning in their direction of care, decision-making and education in professional practice. The role of this research study is to explore the lived experience of low self-esteem in people who suffer from chronic depression and have received treatment in a rural mental health service in the South East Region of South Australia. Service provision spans 21,327 square kilometres. Five participants reflected on the fundamental meaning of low self-esteem inherent in their depression on their every day lived experience.

Aim of the Study

The research aims to develop a deeper understanding about the role of self-esteem for people with a depressive illness. Exploring this connection may enable a greater understanding of the phenomenon of self-esteem for mental health practitioners to facilitate a more sensitive approach to patient care.

The research has been situated in qualitative phenomenological methodology paradigm bringing together a greater understanding of the participant's personal life experiences of low self esteem inherent in depression. Using phenomenology this research is relevant to nursing for its particularly valuable contribution to uncover the subjective meaning of human existence not amenable to empiricist approaches (Rapport & Wainwright 2006).

The research intends to explore and develop an understanding of what the essence of self esteem is for a person with depression, it seeks to interpret and disclose the participant's experiences of low self-esteem associated with depression and identify the impact and influence of low self esteem on an individual's quality of life.

Concept of Analysis

Interviews of the lived experience were carried out to derive meaning from the narratives of the participants interviewed to define what was meaningful and what mattered to the participants in the complexity of everyday situations (Dierckx de Casterlé et al. 2011). Using the fundamental cognitive behavioural therapy biopsychosocial framework of analysis this research endeavoured to uncover the experience of low self esteem in depression through the integration of meaning into themes and categories (Westbrook, Kennerley & Kirk 2010).

Outline of the thesis content

The findings demonstrated significant negative subjective experiences of low self esteem inherent in depression associated with the participant's thoughts and behaviours which maintained suffering and distress in all domains of life except spirituality and to a lesser degree in the domain of citizenship. The inevitable physical and emotional pain encountered in light of the perplexing issues of life demonstrated a tendency to possess a person's focus and diminish a person's insight to move forward. Relief of suffering was evident by the participant's willingness to embrace others and with connection to community, their willingness to engage their efforts into participation in mental health services, their willingness to accept and engage in change, their ability to forgive and a willingness to participate in activities of value to the participant.

The participant's experience of mental health services was generally viewed as invaluable and liberating. Participants gained insights and tools into their experience of low self esteem inherent in depression and they aspired to become masters at challenging their unhelpful thinking styles and behaviours and in the development of strategies to enhance emotional regulation. This research confirms the value of psychological interventions by skilled professionals using a holistic approach, linking the mind, body and soul with value centred action to lift people up and add new dimensions of understanding for a better life.

Significance of the Study

The research has been valuable in demonstrating how the subjective experience of low self-esteem in depression appears to become a part of life, not dissimilar to an addiction whereby people do not know how to live without it. As with addiction, overcoming low self esteem inherent in depression is life changing, personally challenging and rewarding. The human experience of low self esteem in depression tended to lead onto the formation of unhelpful habitual rituals that shaped the participants life by way of maintaining their suffering. Suffering was maintained through resistance to change, persistent rumination, and resentment, inability to forgive, internalisation of external experiences, habitual poor health practices, habitual and destructive behaviours perpetuating conflict, procrastination and fear of uncertainty.

Unfortunately participants have experienced a long battle with their addiction and their new understandings gained through contact with mental health services may be viewed as too little too late leading to regret and a sense of a life unfulfilled. The call of this research is to demonstrate the long term benefits of early interventions before the experience of low self esteem inherent in depression becomes entrenched and gains addictive qualities with habits and behaviours which grow in strength and power shaping a person's experiences of life from the past.

Chapter2 – Literature Review

The literature was reviewed to explore the phenomena of low self-esteem inherent in depression to understand the lived experiences of person's with a depressive illness. The search terms: "depression", "low self-esteem", "lived experience", "mental illness" and "phenomenology" were paired together with the truncate term of AND using Pub Med, Scopus and Academic Search Premier databases. Out of the 91 articles searched, 32articleswere of relevance to this literature review which were then located, printed and referenced to endnote from Academic Search Premier. Dissertations were not included in the search methods.

The literature search engines identified copious articles based in the empirical, analytical and systematic paradigm as to how low self-esteem occurs and how it is maintained. The literature review cited an evolving acceptance and support for the usefulness of qualitative research, and in particular phenomenology in bringing to light the lived experience of participants, to gain a better understanding and insight for the readers, from the expert's point of view with regard to a particular phenomena of interest.

The articles located in the literature search fundamentally sought to draw a logical inference to determine the cause and effect of self-esteem measured alongside of certain social determinants of health. Such determinants of health included low social economic status, those living within minority groups, those participating in particular health behaviours or with reference to people's experience of serious physical illnesses. Using self- reported instruments in data collection these articles were quantitative in design.

The most commonly used assessment tool was found to be the Rosenberg's Self-Esteem Scale. The methods and tool used in these articles elicited the participant's collective opinions pertaining to their private self-reported life experience of low self-esteem, and perceived impact of low self-esteem relative to particular personality traits, or social identity, or their quality of life living within a marginalised community

This research thesis seeks to understand the lived experience of low self-esteem on a person's quality of life and their relationships with others inherent in depression from a uniquely personal and subjective viewpoint. Phenomenological research of this kind may gain a greater understanding of the debilitating effects of low self-esteem through accessing unquantifiable experiences.

Health

Health is no longer defined as a mere absence of disease and is more appropriately defined as a dynamic ever-changing condition which is required to support's a person's ability to function and achieve their full potential at any given time(Farrell 2005).Wellness and recovery are a reflection of health, which is deeply personal, and a unique process that involves planning and commitment as individuals work towards a life transformed by hope, self-identity, meaning and personal responsibility within the limitations of illness (Slade 2009).

In both medical and psychiatric western medicine, judgements are made about a person's health. These judgements seek elicit a likely diagnosis. Provide guidance regarding the misappropriate treatment and their foreseeable outcomes through a medical assessment. These judgements are based on history taking and examination around the presenting complaint and the accounts of the person's experiences elicited during an interview process (Schultz & Videbeck 2013).

The diagnosis is likely to be a disease, disorder or a syndrome and in their usage there is a degree of overlap (Meadows 2007). As with physical health, mental health is depicted as a sliding scale of complexity stretching from ideal to total mental or physical collapse (Gibb 2012).

In a mental health assessment the journey along the sliding scale incorporates brain disorders which leave clear physical signs of damage, to mental disorders which is less straightforward (Gibb 2012). The later lies in how the brain is functioning - be it a chemical imbalance, a restricted ability to co-ordinate and process information, or the murky ground of personality disorders (Gibb 2012).

Mental Health

Mental health can be defined as a positive psychological state of well-being whereas other definitions express it as an absence of mental health problems (Kitchener 2012).

According to the World Health Organisation (WHO)

> *"Mental health is defined as a state of emotional and social wellbeing in which an individual realises his or her own abilities, and can cope with the normal stressors of life, can*

work productively, and is able to contribute to his/her own community"(www.who.int/topics/mental_health/en/ 2013)

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5):

> *"A mental disorder is a syndrome characterised by clinically significant disturbance in an individual's cognition, emotional regulation, or behaviour that reflects a dysfunction in the psychological, biological or developmental processes underlying mental function. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities" (DSM-5 2013)*

Mental Disorders

A mental disorder is a diagnosable illness, which is a persistent pattern of disturbance of a person's cognition, emotional and behaviour state, disrupting that person's ability to carry out daily activities and engage in a satisfying quality of life (Kitchener 2012). People experiencing mental disorders often report symptoms and behaviours that may impair their ability to work and to form relationships and they may also report impaired access to physical health care, a secure income, education, housing, transport, legal advice and leisurely activities (Murphy & Murphy 2006). For these reasons the experience of mental illness or poor mental health may have a significant impact on people's experiences socially, emotionally and physically. This is a psychological 'syndrome' associated with distress or dysfunction, and carries an increased risk of death, pain or disability (Peterson 2010).

The role of the health profession and in particular mental health clinicians is to holistically provide coordinated clinical care for people with mental health disorders and this role requires a clinical framework to guide professional care and formulate evidence based plan of care (Inc 2012). Philosophers, healers, health professionals and scientists alike have curiously pondered the complexity of the human mind, leading to various psychological, sociological and nursing theories in search of a universal theory to encapsulate this complex human experience (Elder, Evans & Nizette 2012). A contemporary perspective held by mental health clinicians today assumes that biological, sociocultural, and psychological factors combine to produce psychological disorders (Myers 1998; Olver & Hopwood 2012).

Determinants of Mental Health

The biopsychosocial approach is a valuable framework used today in modern psychiatry, which postulates that clinical problems result from the continuous interplay of biological, psychological and social factors at variable degrees (Bloch & Singh 2001; Olver & Hopwood 2012).

From the biopsychosocial perspective biological, psychological and social factors interact to produce specific psychological disorders (Crisp & Taylor 2009; Myers 1998). Biological factors, which influence psychiatric disorders, include evolution, individual genes, brain structure and chemistry (Crisp & Taylor 2009). Psychological factors may be derived from stress, or trauma, learned helplessness, mood related perceptions and personal memories (Myers 1998; Peterson 2010). Sociocultural factors, which also contribute to an individual's psychological distress, involve their roles, and expectations, and the perceived definitions of normality and disorder (Myers 1998; Peterson 2010).

Genes may initiate the framework for a person's earliest cognitive, emotional and behavioural response's, however it is influenced by the continuous interaction over a life span with personal and social environments which lead to the specific psychological and behavioural syndromes diagnosed in clinical psychiatry (Bloch & Singh 2001). Health professionals who diagnose patients with a mental disorder using diagnostic criteria require, specialist training and expertise to competently identify symptoms, behaviours, cognitive functions, personality traits, physical signs and syndromes to differentiate from normal variations or transient responses to stressful situations, events or circumstances (DSM-5 2013).

Classifying Psychological Disorders

The DSM-V is universally used by psychiatrists, clinicians and drug companies to create a more unified approach to describing and prescribing treatment for an enormous range of complex psychological disorders (Gibb 2012).

The DSM-V was developed in co-ordination with the World Health Organisation's International Classification of Diseases (ICD-10) with the aim of describing each disorder, to predict its future, to implement appropriate treatment and to also stimulate research into its causes (DSM-5 2013; Myers 1998). The DSM-V has been developed to harmonise with the World Health Organisation (WHO) International Classification of Diseases (ICD-10) with the inclusion of dual codes for every mental disorder the human brain may experience (Gibb 2012).

Classification of mental illness is of great benefit in describing, treating and researching the causes of psychological disorders, however it can also lead to 'labelling' those who are diagnosed and defining them by this clinical tag (Gibb 2012). This is problematic as it creates stigma by ignoring everything else that contributes to a person's identity due to negative stereotypes still associated with mental illness born out of ignorance and fear (Gibb 2012). Critics say that labelling psychological disorders is at best arbitrary and at worst seen as value judgements that masquerade as science (Byrne et al. 2013; Myers 1998).

Depression

Depression is an insidious illness that can affect a person at any time. People experiencing a significantly depressed mood may also experience associated disability, role impairment, and substance use co-morbidity (Castle, Piterman & Berk 2012; Davies 2003). Some groups of people are more vulnerable and they have an increased risk of experiencing depression. This includes people with a chronic, life-threatening physical illness, people with illnesses affecting the central nervous system, and people adjusting to developmental changes or role changes in the vicissitudes of life (Olver & Hopwood 2012; Tiller 2012). Depression is a mood state characterised by a syndrome of events with signs and symptoms grouped under the categories of emotional, behavioural and physical (Olver & Hopwood 2012). People experiencing depression may find that they experience all or some of the emotional, behavioural, psychological and physical symptoms. Signs and symptoms are commonly distinguished from 'normal' by their severity, persistence and duration (Peterson 2010).

Episodes of depression are diverse in nature and are clinically diagnosed depending on the severity, persistence, duration and the presence of these characteristic signs and symptoms (Organisation 2004). This out dated text has been cited from a project underwritten by the New South Wales Institute of Psychiatry, and copyrighted by the World Health Organisation Collaborating Centre for Evidence in Mental Health Policy, and it has been included in multiple citations in this thesis for its relevance in 2014.

Major Depression or clinical depression diagnostic criteria as per the DSM-V states

> *"Of the 9 specified symptoms persons who present with five (or more) of these 9 symptoms which have been present during the same 2-week period and represent a change from previous functioning: at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure"(DSM-5 2013).*

People with depression often experience a loss of pleasure, and interest in most activities known as anedonia. This is a predominant feature of serious depression (Davies ***2003; Tiller*** 2012). The neuro-vegative symptoms of depression include loss of appetite, insomnia, decreased energy and libido, difficulty with concentration and memory and psychomotor retardation (Organisation 2004; Videbeck 2011). Depressed persons can be excessively self-critical and suffer a critical loss of self-esteem or failure to live up to the expectations of oneself (Davies 2003; Kuehner & Buerger 2005).

In 2003 around ten percent of people who present to a medical practitioner report the symptoms of depression suggesting that the prevalence of this illness carries a significant burden on our community (Davies 2003). Since this time the proportion of person's reported to have a mental or behavioural condition has increased from 9.6% in 2001 to 11.2% in 2007(Australian Bureau of Statistics 2013). Depression has been identified as the most prevalent of mood disorders by the Australian Bureau of Statistics (ABS), followed by anxiety with 2.1 million people or 9.7% of Australians in 2011 – 2012 reporting to have depression (Australian Bureau of Statistics 2013). The burden of disease due to depression has both direct cost through treatment and management of the illness, and indirect costs though loss of employment, disability and premature deaths (Butcher, Mineka & Hooley 2007). Depressed people face the challenges of access to appropriate health care, accommodation and adequate financial support (Elder, Evans & Nizette 2012). Given the stigma associated with depression, people may be reluctant to seek help and treatment and its prevalence may be under-reported (Goldney et al. 2010).

During depressive episodes people are prone to low self-esteem due to an overgeneralised autobiographical memory, and the recalling of events leading to rumination with associated depressive behaviours such as avoidance, and overcompensation, and depressive thoughts such as I'm worthless, and un-loveable (Leahy, Holland & McGinn 2012). Self-critical thoughts are powerful and potentially toxic as depressed persons often may have a decreased likelihood to discount their negative illusions, and their inability to offer situational explanations for failure that does not imply personal responsibility (Leahy, Holland & McGinn 2012)

Self-esteem

Self-esteem is a person's perception of their value in society as a good human being, worthy of the affections of others (Crisp & Taylor 2009; Davies 2003). This also includes the opinion of competence one attributes to oneself (Peterson 2010). Our perceptions have the ability to form a personal identity and attach a value judgment to that belief, which is a vulnerability factor for

depression (Orth & Robins 2013). Low self-esteem is a product of our negative core beliefs and negative early life experiences and it has a major impact on many aspects of a person's life (Cann, Lubman & Clark 2012; Edelman 2002).

Individual self esteem evolves from birth and becomes more or less established at the onset of adult hood and shapes adult life (Cann, Lubman & Clark 2012; Weber & Kelly 2003). A celebrated psychoanalyst Erik Erikson (1902 – 1994) developed eight psychosocial stages central to the development of one's sense of self from birth to older adulthood (Elder, Evans & Nizette 2012).

The human capacity to judge and place a negative value on ourselves as a person can lead to a range of cognitive symptoms such as worthlessness, inferiority, unattractiveness and failure, which can lead to thoughts of self-harm or successful suicide (Butcher, Mineka & Hooley 2007). People have an intrinsic level of self-esteem and self-worth, which is lowered in depression to varying extents (Bloch & Singh 2001; Schultz & Videbeck 2013). This sense of self-worth may be dependent on the support and love a person receives from others or it may be attached to achievements and the approval of one's self and others (Johnson 2010).

Self-esteem is of major importance as it is the way we appraise our total worth affecting the way we feel, think and act most of the time (Schultz & Videbeck 2013). Levels of self esteem can be important mediating factors and predictors in a person's level of satisfaction Self-esteem is of major importance as it is the way we appraise our total worth affecting the way we and aspirations, and their ability to keep perspective in key domains of their life (Lafrenière et al. 2011).

Low self-esteem and depression

Low self-esteem and depression go hand in hand with people perceiving themselves as hopeless and worthless (Bloch & Singh 2001). People suffering from depression experience the symptoms of low self-esteem and have a perception of being unloved (Byrne et al. 2013). People that hold endorsed maladaptive assumptions or underlying distorted automatic negative thoughts about themselves as being un-loveable, or helpless or ugly or incompetent are vulnerable to future depressive episodes and this may become a self-perpetuating situation (Leahy, Holland & McGinn 2012). Depression and low self-esteem are complex mood disorders and can be a frightening and overwhelming human experience for people causing significant psychological distress impacting on their quality of life and their relationships with others (Gibb

2012). People who develop depression often believe that life is not worthwhile as they grieve for the life that they had and their aspirations for the future (Elder, Evans & Nizette 2012).

Interpreting and understanding ones sense of self-worth and value in society develops early in life during our formative years of adolescence and young adulthood and moderates the level and shape of the trajectory of self-esteem into late adulthood (Erol & Orth 2011).

Feelings of inferiority or failure to live up to the expectations of significant others govern people's reactions and their behaviours (Johnson 2010). Once these negative core beliefs become manifested and rigid during the developmental stage of young adolescents and adults' negative thoughts trap a person's mind, increasing access to negative attribution styles, reduces self-efficacy, limits alternatives and restricts structured problem solving (Leahy, Holland & McGinn 2012).

These negative perceptions exacerbate low self-esteem and restrict a person's ability to connect with their goals and purpose in life. Drawing on negative conclusions leads to feelings of global pessimism (Strandmark 2004). This global pessimistic attribution style of thinking and negative self judgements continues to play out by repeating old habits and patterns of thinking, feeling and behaviour which is likely to maintain or exacerbate depression (Butcher, Mineka & Hooley 2007).

Given that depression and psychological distress predispose people to the risk of suicide, effective early intervention and prevention strategies, in the development of a positive personal identity is of major importance (Kilkkinen et al. 2007)

Sense of self-concept and self-esteem

In order to provide further background and a link to earlier research it is fundamental to tease out a greater understanding of self-esteem. A person's sense of self-concept and self-esteem can be confused by the use of other interchangeable terms such as self-worth, self-respect, and self-love (Krozier 2011; Videbeck 2011). It may be helpful to differentiate between the terms of self-concept and self- esteem.

Self-concept is the cognitive component of self, and self-esteem is the affective aspect, however the two ideas are inseparable with self-esteem being relative to self-concept (Krozier 2011; Peterson 2010).The affective aspect of self-esteem of includes self-love, and self-acceptance which develops earlier in a person's life dependent on the nurture and love received in the developmental phase of life, whereas the development of self-esteem based on competence including self-pride and self-confidence which is constructed through appreciation of one's own

capabilities (Johnson 2010). The cognitive component of self-concept includes evaluations of one's self reflected by external situations specific to opinions of self-worth including ones self concept of role performance, body image and self-identity which tend to fluctuate with everyday experiences (Johnson 2010). The cognitive component of self-concept is likely to develop from a comparative approach which creates despair regarding one's own imperfections relative to their perceptions of others superior qualities (Fralich 20012).

Self-concept is a collective and coherent perception of what we think about ourselves. Self-concept is a collection of opinions and beliefs about oneself and through this awareness of our identity we evaluate who we are, the meaning we give to our life, the purpose and direction we choose, what commitments we make to ourselves and others, and our level of involvement in the different dimensions of life (Bloch & Singh 1998; Videbeck 2011).

Self-esteem is defined by both descriptive and evaluative self-statements that affect how we feel, the choices we make and our ability to feel safe and happy in our world by the way we appraise our total worth (Videbeck 2011). As a result we develop a self-concept, which may generate positive or negative personal feelings of worth, and value in our own eyes, and perceptions of our worth in the eyes of others (Weber, Puskar & Ren 2010). A person's ongoing evaluations of themselves is generally self judgement of in accordance to a person's power or ability to influence and control personally important situations, their sense of significance and acceptance by others as a worthwhile human being, their competence and ability to achieve important goals and their adherence to their personal virtues and values (Videbeck 2011).

Global Self Esteem

Global self is the summation of specific components of self-esteem. In cognitive-social terms this is a person's self identity or working self-concept (Eschkol, David & Jeffery 2011).For example a sports person may value their particular ability to play tennis consequently how well they perform will significantly influence their global self esteem. People who fall short of their hopes to perform well in an activity or competency which is valuable and matters to them is a vulnerable situation which may lead to depression and co-exist with low self-esteem (Myers 1998; Orth & Robins 2013; Peterson 2010).

Acceptance Commitment therapist describe this construct as the conceptualised self or cognitive fusion to negative self-judgments, and comparing ourselves to others which is

problematic and maintains depression and feelings of worthlessness leading to psychological inflexibility (Cristea et al. 2013).For example, should a doctor be completely fused with "I am a qualified surgeon" and he bases his self-worth on his identity, and then injures himself and is unable to work. He may struggle to adjust, and his conceptualised self may contain a strong element of "Without my job as a surgeon, I am worthless" leading to low self esteem (Harris 2009).

Perceived Self and Ideal Self

By the time of adulthood most people have a relatively well-established basic self-concept, and a basic level of self esteem (Krozier 2011; Peterson 2010). People at this time have a reasonable idea about their perceived self, which is how they see themselves and also how they are seen by other people, and likewise they have some idea about their ideal self (Peterson 2010). They therefore have thought about how they should be, or how they would prefer to be (Johnson 2010). This conflicting dual view between a person's ideal self and their perceived self may serve as the impetus to self-development activities or in some cases lead to low self-esteem if the discrepancy is wide enough (Franck, Raedt & Houwer 2007; Krozier 2011).

Development of ideal self and identity in cognitive, perceptual, emotional and social functioning begins in infancy in the context of individuality, and group identity which is particularly challenging considering the course of life events in life such as loss, injury and multiple perceptions of self, which disrupt a person's development and impact on a person's overall sense of self (Elder, Evans & Nizette 2012).

Explicit and Implicit Self-Esteem

Defining and measuring self-esteem has left researchers struggling to agree on its definition and how to measure it. The development of an understanding of self-esteem has been marked by an evolution to the current emphasis on implicit and explicit self esteem (Tafarodi 2006). Implicit self-esteem is presumed to be unconscious, automatic, non-verbal associative and effortless, therefore measurement is a problematic dilemma (Buhrmester, Blanton & Swann 2011). As implicit self-esteem is unconscious, methods used to measure implicit self-esteem must be indirect in a manner free from the self-presentational process of automatic negative self evaluation and in doing so give shape to something which can only be inferred (Bosson, Swann Jr & Pennebaker 2000). Explicit self-esteem is reported as a conscious and reflexive global evaluation of how people feel about themselves, a conscious self-judgement (Tafarodi 2006).

The jury is still out on the possibility that two complete self-esteem's existing within the one mind and that measurements are available to tap into the conscious and the unconscious form of self-esteem, which is not only distinct but also inconsistent with conscious self-esteem (Tafarodi 2006).

Explicit self-esteem is considered to develop from a lifetime of experiences, most significantly through the appraisals of others, self evaluations of one's own behaviour and social comparisons (Buhrmester, Blanton & Swann 2011). It is generally believed that there are benefits to having a positive view of oneself. When people feel good about themselves they cope effectively with challenges and negative feedback, and believe they are valued and respected in their social world substantially impacting on the quality and productivity of life (Centre for Clinical Interventions 2005).Conversely fusion with a positive concept of self also has the potential to be problematic and may easily lead to arrogance, narcissism and an intolerance of others, which represents a significant problem along with a negative self-awareness (Harris 2009).

Self-report measures of subjective well-being capture explicit self-esteem as these measures rely on participant's conscious representation of themselves (Schimmack & Diener 2003). This research study seeks to understand explicit low self-esteem as a conscious phenomenon existing as a psychological phenomenon through the lived experience of depression (Tafarodi 2006).

Measures of Self-Esteem

To capture the role of explicit self-esteem the Rosenberg' Self-Esteem Scale is a very direct approach of asking participants about their opinions or evaluations of themselves (Johnson 1998). The standard measure of global self-esteem and global feelings of self-worth for adults is the Rosenberg's Self-Esteem Scale (RSE)(1965), based on a 10 point format ranking-order using a likert-type format response ranging from strongly disagree to strongly agree (Kernis 2005). Other reported measurements used in quantitative indices of self-esteem include Coppersmith's Self-Esteem Inventory (1967), and Janis and Field's 1959Feelings of Inadequacy Scale (Tafarodi 2006).

Assessing and distinguishing between the measurements of explicit and implicit self-esteem is outside the scope of this thesis, and in particular implicit self-esteem measures as these do not rely on the participant's conscious representations of themselves (Schimmack & Diener 2003). The RSE is generally uni-dimensional and not specific to particular domains of life (Johnson

1998). The answers or responses to each of the scale or measures of self-esteem are possibly sensitive to response bias relative to psychological defences by the participants as they may adjust their response to guard their self-image and maintain social acceptability (Johnson 1998). For this reason the validity of these measures are in doubt as they may be inflated by self-reports capturing self-positivity biases (Franck, Raedt & Houwer 2007).

Much of the current research investigating self esteem in depression attempts to investigate or conceptualise self esteem as a vulnerability factor with particular depressive personality styles namely dependency and self-criticism or different neurotic types such as passive, anxious, competitive and self-focused (Johnson 2010). These research studies seek to conceptualise and explore a depressive person's overreliance on external sources in moderating feelings of self-worth and suggest that low self esteem is more of a generalised stress response (Butler, Hokanson & Flynn 1994)(Zolnierek 2011)

Whilst existing empirical research compares and conceptualises implicit and explicit self-esteem, and its association with externalising and internalising psychological problems, and they appear sophisticated in their findings, their research was not designed to explore the participants narratives regarding the lived experience (Creemers et al. 2012).Multiple research studies have investigated self-esteem using self-reporting tools intended to reflect participants experiences and associated psychological dimensions (Lundberg et al. 2009). Another research study by Orth and Robins was concerned with the nature of the relationship between low self esteem in depression, describing the link using theoretical models including the vulnerability model, scar model and the diathesis-stress model (Orth & Robins 2013). From this research they suggested that future research to analyse the relationships between self esteem and depression on a day to day level. This research seeks to explore this relationship, and it may be valuable and add to the growing body of research on low self esteem in depression (Orth & Robins 2013).

Murphy and Murphy (2006) explored the role of self-esteem on individual's quality of life in various settings of social functioning using the World Health Organisation Quality of Life measure (WHOQOL-100) along with the Rosenberg Self-Esteem Scale (RSE) and the Generalised Self Efficacy Scale (GSES). In their summary they too suggested a need to examine the quality of life domains further through participant interviews. Hence the impetus for the researcher's to conduct this research study. This research study seeks to compare individual experiences and it may allow us to understand the experience of individuals with low self esteem and depression to further appreciate the impact of stigma with a goal to provide effective interventions (Murphy & Murphy 2006).

Phenomenology

Using an interpretive phenomenological approach the proposed study seeks to illicit a deep understanding of the impact and the experience of low self-esteem for people with a diagnosis of depression. In the phenomenological tradition of nursing research this research method may add value to our understanding and support effective nursing practice (Rapport & Wainwright 2006).

Based on the participant's narratives this proposed research has the potential to influence their response to treatment and clinical outcomes, measured by the participants' perspectives, their beliefs and their expectations (Bockting et al. 2004). This humanistic approach of assisting people to find meaning in their experience has developed, and gained enduring interest stemming from the theories developed by several prominent psychiatric nurses including Hildegard Peplau, and Phil Barker (Elder, Evans & Nizette 2012).

Interviews to explore the lived experience

It is of great value to understand the meanings of experience derived from the narratives of participant's interviews particularly in psychiatric nursing research as with the philosophy of phenomenology rather than those defined by assessment tools (Zolnierek 2011). Interview questions identify what the researcher wants to know, and the questions are focused on the person's experience rather than cultural aspects or social processes to define the participant's perspective as to what is meaningful, and what matters (Zolnierek 2011).

Interviews of the lived experience study the reality of how people experience their life in the presence of a specific condition open to inclusion of the complexity of the everyday world allowing the researcher to connect with the situation as lived by the participants (Dierckx de Casterlé et al. 2011). Researchers uncover the meaning of events and occurrences as they read interview transcripts as texts and try to uncover collective meanings contained within the text to their situation by discerning common factors expressed by the participants (Dierckx de Casterlé et al. 2011).

Knowledge, which is embedded in life stories, is memorable and interesting because researchers analyse and find complex patterns, find descriptions of identity construction and reconstruction, and understand the evidence of the participant's truths and meanings (Etherington 2009). These stories can move us emotionally, change public and political

attitudes and opinions, and possibly influence future mental health care interventions particularly relevant for mental health clinicians (Etherington 2009).

By using narrative phenomenological methods the symptoms are viewed within the context of a person's everyday life experience. Narrative research techniques explore and understand a person's everyday life which accompanies mental illness and not simply as an illness entity as reflected by a one size fits all disorders that is categorised in texts on altered psychopathology (Borg & Davidson 2008). If we do not fully understand the ways in which the symptoms and problems manifest within a person's day to day experiences, relationships and pursuits where recovery from mental illness takes place we overlook the importance of the "little things" in life as with many studies which focus solely on illness and impairment (Borg & Davidson 2008).

By way of interviews participants provide an expert, and subjective perspective of everyday life regarding the salient and important activities in their lives emphasising their human experience as it evolves in a social and historical context (Borg & Davidson 2008). Through interviews it may be possible to understand, in kind the true experience of recovery needed to sustain and maintain the participants in their daily lives, and the participants own efforts to recover (Borg & Davidson 2008).

In phenomenological research the qualitative data is collected by unstructured, semi-structured or structured interviewing styles to gain insight into the phenomenon of interest (Miller & Babcock 1996). The interview method most researchers use is found to be unstructured representing a conversational interview style where the interview may follow any direction, and the outcome is unknown (Schneider et al. 2013). The interview style used in this research study used a semi-structured style with particular topics for discussion making it possible to follow tangents and seek clarification using open ended questions as characteristic of qualitative research (Schneider et al. 2013). Levels of self esteem can be important mediating factors and predictors in a person's level of satisfaction and aspirations, and their ability to keep perspective in key domains of their life (Lafrenière et al. 2011).

Domains of Life

This research study seeks to understand the meaning of low self esteem that is inherent in depression for people in 9 particular domains of life.

1. Marriage/intimate relations.
2. Family relations.

3. Friendship/social relations.
4. Career/employment.
5. Education/personal growth and development.
6. Recreation/leisure.
7. Spirituality.
8. Citizenship
9. Health/physical well-being (Edelman 2002).

Therapy

The recommended psychological treatment for depression is Cognitive Behavioural Therapy (CBT) as supported by the UK National Institute for Clinical Excellence (NICE) demonstrating a solid and wide evidence base for its efficacy and effectiveness (Westbrook, Kennerley & Kirk 2010). There are two phases to CBT in the management of depression. The first phase aims to help people with depression achieve symptom relieve by using simple strategies to reduce the impact of negative automatic thoughts (NAT), and the second phase involves challenging and confronting NAT's directly with the aim to find alternative thoughts, and look for evidence and devising behavioural experiments to test out NAT's and the new alternative thoughts (Westbrook, Kennerley & Kirk 2010). The approach guides people to examine the accuracy and helpfulness of NAT's, and identify realistic alternative thoughts (Westbrook, Kennerley & Kirk 2010).

The CBT model has been elaborated and enhanced giving rise to additional approaches such as schema-focused therapy, mindfulness based cognitive therapy (MBCT) and relational framework theory, which provided a theoretical basis for acceptance commitment therapy (ACT) (Westbrook, Kennerley & Kirk 2010).

From a fundamental gestalt theoretical perspective people can change this cycle of negativity when they fully accept the present moment and aim for self-knowledge, acceptance, self-responsibility and focused attention on personal growth emphasising the wholeness of peoples experiences (Kelly & Howie 2011).

Schema-therapy is an integrative approach, which combines the proven CBT principles with interpersonal therapy, attachment theory and experiential therapy and has an explicit interest in the aetiology of current symptoms (Eschkol, David & Jeffery 2011).

ACT has been developed out of the theory of human language and cognition called relational frame theory and its core message is to accept what is out of personal control in one's life and

commit to taking action based on a person's values (Harris 2009). RFT seeks to explain how people make sense of and organise interpersonal messages with others, and provides a behavioural account from the inferences people make about their relationships with others(Harris 2009; Shanley & Jubb-Shanley 2007). Above all however the relationship between the client and the therapist is of central importance as this is the vehicle, which supports the benefits of therapies (Eschkol, David & Jeffery 2011).

The relationship with the therapist provides a corrective emotional experience along with empathetic confrontation to assist people understand their core emotional needs and learn adaptive patterns of having those needs met (Eschkol, David & Jeffery 2011).

This humanist philosophy or approach of developing an understanding of another person's perspective and view of the world is a partnership between the client and the therapist to develop a working alliance to build strength and resilience, hope and empowerment (Shanley & Jubb-Shanley 2007).

A search of existing literature indicated that there were no published studies using interpretative phenomenological methodology to explore the role of low self-esteem that is inherent in depression in Regional South East of South Australia.

Chapter 3 – Methodology

As part of this research the aim is to gain a clear understanding of the theory or methodology that underpins the methods which have been helpful in seeking to address the research question. Under the qualitative and quantitative paradigmatic umbrella of methodologies nurses have a range of research design approaches available to them (Schneider et al. 2013). With the development of evidence based nursing and evidence-based medicine it is well accepted that effective research activity translates to quality healthcare provision (Schneider et al. 2013).

By using an interpretive phenomenological approach to qualitative research this research study investigated the lived experience of low self-esteem inherent in depression. This may enrich the readers understanding the role and experience of low self-esteem on a day-to-day basis. The experience of low self-esteem has been explored in nine domains of life (Murphy & Murphy 2006).

Phenomenology is a well-founded qualitative methodology relevant to nursing research for its particularly valuable contribution to uncover the subjective meaning of human existence not amenable to empiricist approaches (Rapport & Wainwright 2006). From this vantage point using qualitative methodology this research explicitly asks people to characterise their fundamental experience of low self esteem inherent in depression to uncover and view their subjective meaning. This research is based on the assumption that the experience of low self esteem inherent in depression is viewed as a uniquely personal process involving the development of independent effects on thought, behaviour and feelings. In light of this the researcher seeks to uncover this assumption, and to explore the lived experience further and tap into the conviction of the participant's account of their underlying construct. Distinct from traditional measures phenomenology supports this research for its ability to characterise the association between low self esteem inherent in depression, in the nine domains of life, rather than reduce the experience to a valanced association. Empirical quantitative methodology is certainly useful although it differs in its nature and its properties and would fail to generate and capture the participants self view, and is limited by construct measures of low self esteem by focusing on single identification measures of assessment. Empirical quantitative research reduces the experience to a limited number of variables rather than uncovering the situation in all its richness and complexity (Dierckx de Casterlé et al. 2011). In contrast, qualitative research

enables the users of research to connect with the situation as lived by the participant (Dierckx de Casterlé et al. 2011).

Phenomenology has been increasing applied to nursing research and it has a diverse philosophical heritage which has evolved into a range of approaches to explore the lived experience of health and wellbeing embodied in experiential meaning and descriptions of a human experience as it is lived(Finlay 2009).Using phenomenology this research is thought to be conducted to correspond consistently with its methodology as it allows the participants to consciously reflect on their association with low self esteem inherent in depression and contemplate prior to responding in a non-confrontational, non punitive environment. Nursing research literature on phenomenology often makes distinctions between these diverse philosophical paradigms to describe their research as either descriptive or interpretive and report disparities between the two camps (Rapport & Wainwright 2006). As there are a number of schools of phenomenology and there are also many perspectives and various forms of phenomenology that have developed in phenomenological research, phenomenological methodology is subsequently a perplexing issue to unravel (Dowling 2007). Both the descriptive and interpretive positions have been criticised for their authenticity by other researchers and it can be argued that nurse lead research need not focus on perpetuating the disputes with the phenomenological traditions but rather concentrate on developing an understanding of the phenomena to add value to nursing practice (Rapport & Wainwright 2006). The key assumption underlying the methodology of phenomenology remains consistent, acknowledging and supporting its popular approach and intention to seek and understand personal experiences and interpretations of the participants involved although criticism of its pure essence is debateable amongst the academic community and appears to be arbitrary in nature.

Phenomenology originated from European philosophy developing back in the early 1900's and it has a dual position now that it has been adapted and used as an approach to research providing health professionals with rich understandings of the human existence along with considerable challenges as well due to the many different philosophical schools of thought and interpretations (Schneider et al. 2013). Phenomenology has since emerged and flourished in France, and America contributing to the advancement of phenomenological diversity and specificity with modifications, refinement and expansion in the way in which phenomenological research is undertaken (Edward & Welch 2011). Essentially there are two popular parallel strands of phenomenology, descriptive and interpretive, which have developed originally from the works of Edmund Husserl (1859-1938) and Martin Heidegger (1889-1976) respectively, which have been understood and applied to research in different ways (Tuohy et al. 2013).

Husserl is considered to be the father of phenomenology and as a philosophy it is seen as the study of the "life world" as a way to explore the lived experience of a phenomena with the aim of describing the characteristics of the phenomena to 'describe things as they appear to the consciousness' (Tuohy et al. 2013). Heidegger, a student and colleague of Husserl doubted Husserl's interpretation of how people understood and gave meaning to their existence through their relationship between consciousness in a world of objects, and for Heidegger he focussed his efforts on studying the practical 'situatedness' or context of the experience to understand the person's experience of existence (Schneider et al. 2013).This research methodology has been selected as for its ability to bolster and focus on people's thoughts, feelings and behaviours in light of situational influences in the nine domains of life to reflect the potentially relevant and perplexing issue of low self-esteem inherent in depression. Researchers need to be mindful that the different qualitative methodologies broadly share many similar properties and need to choose the methodology that it suits the purpose of their question because each different qualitative approach produces different research outcomes (Schneider et al. 2013). With Heidiggarian phenomenological as the methodological basis, the researcher used this as the most appropriate means to explore the issue of low self has assessed methodology esteem inherent in depression.

Michael Crotty a theologian and academic published the text 'Phenomenology and nursing research' in which he criticised much of the current phenomenological research stating that the research conducted by nurses was not pure phenomenology espoused by Husserl or Heidegger and Crotty called this type of nursing research 'new' phenomenology (Barkway 2001).This discrepancy has drawn considerable attention with a strong degree of support for its merit by experienced theologians of research, and conversely distinct objection by others to Michael Crotty's proposal. The researcher simply acknowledges the potential existence of strong preferential approaches to phenomenology and merely intends to draw on the ambiguous nature of phenomenological methodology to generate a free balanced understanding of the socially important phenomena of low self esteem by reflecting on the sentiments of the participants responses. Stemming from the school of psychology, psychologist Amedo Giorgi argued that Crotty's scientific phenomenology to understand 'subjective experiences' was misplaced because nurses are asking for participants to describe their experience dependant on the manner in which it is experienced (Giorgi 2000). Crotty attracted national and international attention for his adverse opinions and he fearlessly advised researchers not to claim Husserlain or Heideggerian methods especially if the subjective understanding of the experience of the phenomena is objectively scrutinised (Barkway 2001). Phenomenological methodology has evolved over the past three decades and its approach in nursing research has raised concerns amongst academics in the field of research that during this evolutionary period believing that

researchers have lost sight of its philosophical origins which sought to facilitate an understanding of the essence of the phenomena pre-reflectively without interpretation (Dowling 2007).

Arising from Heidegger's phenomenological theory was the approach to enquiry involving the use of hermeneutic understanding, and this theoretical attitude to understanding and interpretation of text uses the notion of the hermeneutic circle (Annells 1996). The 'hermeneutic circle' recognises a person's pre-understandings and its influence a person's sense of their situation, and the meaning to their experience developed through the historical, cultural and personal preconceptions that define their view of being in the world (Schneider et al. 2013). Heidegger explained the 'hermeneutic circle' and phenomenology as a kaleidoscopic view whereby understanding pieced together as one, influenced by the past and the present, which is articulated in a shared language (Schneider et al. 2013). Another philosopher Hans Georg Gadamer who was student of Heidegger was also deeply influenced by the works of Husserl and Heidegger and he sought to expand their ideas resulting in the concept of Gadamerian hermeneutics (Liamputtong 2009). The hermeneutic circle is described as a process of interpretation by the circular process involving continuous re-examination of the statements of experience with the participants of phenomenological research with the aim of asking further questions to establish the meaning of being between the researcher and the participant (Rapport & Wainwright 2006).

The research methodology used in this research uses Heidegger's understanding of phenomenology to enable regard to be given to the context of the experience and not just the experience alone to include conscious and unconscious thoughts, beliefs, assumptions and influences by reflecting on the past and present to describe the person's lived experience (Tuohy et al. 2013). Using a Heideggian phenomenological attitude in this research the researcher has followed Colaizzi's reliable method for conducting phenomenological research in its procedure in the process of data collection and data analysis (Dowling 2007). Colaizzi developed his method of procedural steps of approach to enquiry as a process of validating the findings and contributing to the rigour of phenomenological enquiry by returning to the analysis of the transcripts for additional information, clarification and elaboration of the findings (Edward & Welch 2011).

Colaizzi's7 step method:

1. Reading and transcribing the participant's descriptions.
2. Extraction of significant phrases and statements.
3. Formulation of meaning using creative insight.

4. Aggregation of meanings into themes and categories.
5. Integration of data into an exhaustive description of the phenomena.
6. Identify the essential structure of the phenomena.
7. Returning to participants for validation. (Edward & Welch 2011).

Heideggerian interpretive phenomenology aims to understand shared meanings respecting the concept of self-knowing and that the truth is as a person sees it and experiences it, which is understood through the use of language (McConnell-Henry, Chapman & Francis 2011). The insights gained through this research could assist mental health professionals to gain a greater understanding of the debilitating effects of low self-esteem. Insights gained may have the potential to influence a clinician's reasoning in their direction of care, decision-making and education in professional practice. Phenomenological research of this kind is meaningful to participants as it highlights and accesses unquantifiable experiences. Heideggarian phenomenology does not seek to provide answers but rather it endeavours to invite readers to take their own journey as they are exposed to the thinking of the participants and listen for the voice of their own thinking, connecting with their own past experiences in their own situation (Smythe et al. 2008).

Cognisant of the fact that the experience of living with low self-esteem is different for each individual this proposed research has the potential to help us understand the experiences of others (Rose, Fleischmann & Wykes 2004). Research focused on improving patient outcomes promises to enhance our understanding of the subjective meaning of low self-esteem, by capturing the complexity of their world and their personal experiences (Anker, Duncan & Sparks 2009).

Understanding the participants' perspective of low self-esteem on their ability to function in social and occupational settings, and integrate into the community may inform the nature of nursing interventions and improve outcomes for this population (Zolnierek 2011). Exploring this connection may also enable a greater understanding of the phenomenon of low self-esteem for mental health practitioners to facilitate a more sensitive approach to patient care. This paper endeavours to offer relevant and appropriate knowledge for readers and mental health practitioners to explore people's life stories bringing together many layers of understanding about their personal and social lives and their experiences in the contexts in which they are embedded (Etherington 2009).

This research study employed phenomenological methodology used in qualitative research for its philosophical base in the interpretive paradigm to capture the fundamental meaning of low self-esteem in the participants every day experiences (Liamputtong 2009). The principles of

interpretive research such as phenomenology are focused to explore, describe and generate meaning about phenomenon as it occurs, and where it exists (Schneider et al. 2013). Within the interpretive paradigm this research study sought to understand the human experience of low self-esteem in the context in which it occurs (Beanland et al. 1999).

Heideggerian phenomenology is 'ontological' for its interest in the practical situation of human experience beyond the factual accounts to discover the nature of 'being' (Smith 1997). Using Heideggerian's existentialism approach, this research study focused on the individuals lived experience to understand their existence, and the meaning of the phenomena in their world (Schneider et al. 2013). Heideggerian's phenomenology aims to describe and interpret the participants' experience to identify commonalities, and develop practical knowledge (Smith 1997).

Through qualitative research such as phenomenology we begin to interpret and understand human experience, and the meanings people bring to them (Beanland et al. 1999). This approach aims to discover the subjective experience of low self-esteem for participants with depression, to ultimately to explore the essence of the phenomena (Beanland et al. 1999). This research is thought to reflect on the participants convergent accounts of the experience of low self esteem inherent in depression that is captured from the participant's interpretation and is arguably and un-questionably true, and not merely speculation. Nursing can be regarded as both an art and a science requiring the choice of methodology used in nursing research to be determined according to the perspective of the enquiry (Smith 1997). The art of nursing through a qualitative approach acknowledges the complexity of human beings, and it is interested in the unique meanings peoples attribute to their life situation (Beanland et al. 1999).

The traditional quantitative scientific method attempts to predict and control care by changing one variable to affect change in another variable, and then to understand how and why the differences are related (Schneider et al. 2013). This research is therefore based in the phenomenological qualitative approach, looking closely at what low self-esteem means to the participants in order to bridge the gap between theory and practice (Smith 1997).As each person is an individual with a felt need to be understood in their uniqueness and commonality with others using a holistic and eclectic approaching a background of biopsychosocial knowledge to understand the diverse experience of people with low self-esteem in depression (Crisp & Taylor 2009). Heidiggerian phenomenology used in this research is the favoured interpretative methodology selected for its ability to focus and to generate a plausible and unique window of understanding regarding the experience of low self esteem inherent in depression by unveiling the accounts of the participants.

Confidence in the measures used in quantitative research to measure self-esteem may restricted as the validity of these measures are in doubt as they may be inflated by self-reports capturing self-positivity biases (Franck, Raedt & Houwer 2007). A dubious assumption suggests that self-esteem can be reduced to a simple self-reported association or conditioned response to standardised tools to measure self-esteem (Buhrmester, Blanton & Swann 2011). The findings of quantitative research using self-reports to measure of self-esteem do not describe, explore or explain the participants full account of their person experience, their perceptions of the phenomena of self-esteem, how the experience of low self-esteem in depression has shaped their lives from their perspective (Crisp & Taylor 2009). To circumvent this problem this research study will interview participants to illuminate the participants' retrospective assertions of themselves to reflect the casual role of explicit low self-esteem in everyday life experiences (Buhrmester, Blanton & Swann 2011).

Self esteem reflects a person's judgement about themselves and it grows out of a reflective process on one's own self appraisal over time and stems from a lifetime of experiences (Buhrmester, Blanton & Swann 2011). Self esteem is also considered a relatively stable viewpoint, which one holds about themselves' but it is capable of state fluctuations depending on the perceived positive and negative associations made by oneself to external events, external situations and other people's behaviours (Buhrmester, Blanton & Swann 2011). People's ability to accurately and faithfully report their true self-evaluations using assessment tools to measure and assess self esteem is in doubt because the outcome measurements are relative to whatever is happening at that actual moment when completing the assessment the assessment tool (Buhrmester, Blanton & Swann 2011). These outcome assessment tools are commented for their simplicity and brevity however they do not gain a person's retrospective assertions about themselves (Murphy & Murphy 2006). Given that self-esteem is a reflective process comprising the affective, cognitive and emotional domains of subjective wellbeing there is a need to investigate the lived experience of low-self esteem in depression relative to their domains of life (Çivitci 2010).

This research study has been developed to encompass the Code of Ethics for Nurses to respect and value quality informed nursing health care to promote the health and wellbeing for all people in the research domain (Council 2008). In nursing qualitative research has acquired great value in the field of ethics of care though a connectedness with the lived experience in order to generate and explain information relevant to ethical nursing care (Dierckx de Casterlé et al. 2011).

The value in understanding the meaning of participants experience who receive mental health care may be used to explore the experience of the participants and to identify how the understandings gained from this research study can inform mental health clinicians in the provision of clinical care (Zolnierek 2011)

No matter which approach is used in nursing research the selection is based on the nature of the study and the type of information the research seeks to understand (Schneider et al. 2013). Data collection and data analysis is a systematic examination of phenomena in a manner in which the findings are believed to be valid and reliable, which is the intention of this research (Crisp & Taylor 2009).

Chapter 4 – Methods

Before embarking on research the aim is to gain an understanding of the whole experience by focusing on key parts (Liamputtong 2009). This requires the research to be conducted within research design parameters. Research design requires planning and direction, which is logical, systematic and conducted within defined parameters (Liamputtong 2009). The nine domains of life are the parameters of this research to assist in presenting systematic and logical research findings. Given the diverse ways in which the notion of life experiences can be defined, merit has been given nine domains of life for its ability conceptualise the participants lived experience (Crisp & Taylor 2009). Adhering to the principles of ethical research the steps taken to conduct this research were respectful of the vulnerable nature of people with a mental illness (Kashdan et al. 2014). The ethical aspects and the consideration given to protect the privacy, confidentiality and anonymity of the participants will be addressed in this methods chapter.

The discussion in this thesis pertains to how people experience these nine domains of life in the presence of low self-esteem and depression.

1. Marriage/intimate relations.
2. Family relations.
3. Friendship/social relations.
4. Career/employment.
5. Education/personal growth and development.
6. Recreation/leisure.
7. Spirituality.
8. Citizenship
9. Health/physical well-being
   (Edelman 2002).

The participant inclusion criteria invited people over the age of 18 who had a diagnosed depressive illness that directly accessed a regional primary mental health care service in the South East Region of South Australia to be part of the research. This diagnosis was indicated on the participants General Practice Referral Form and the General Practice Mental Health Care Plan prior to their attendance to the service where the research was conducted. This organisation provided mental health services to people living in a rural community setting. People who were experiencing a current or recent acute depressive episode resulting from recent stress, loss, grief or postpartum blues were excluded from recruitment to protect their

emotional well-being. Through the code of ethical conduct this exclusion criteria of the participants was designed to reduce the incidence and impact of preventable adverse events, and to do no harm as a risk management process (Australia & Council 2005). Other exclusion criteria included participants exhibiting inappropriate verbal or physical behaviour's prior to or during the research study, and participants with significant delusions, hallucinations, cognitive impairment or intellectual disability. Participants who were not proficient with the English language were also excluded from this research study. This was assessed through ease of communication with the participant. Participants were recruited on the understanding that they were not clients of the researcher to comply with the requirements of the University of Adelaide Human Research Ethics Committee.

Source

Persons who directly accessed mental health care in a region mental health service in the South East Region of South Australia for the services of mental health care and who meet the inclusion criteria were invited to participate. Consequently the data was intended to be pertinent to the research methodology which requires participants to have experienced the phenomenon under investigation (Liamputtong 2009).This purposive sampling of specific individuals provided targeted information as part of data saturation in developing a comprehensive insight (Morse 1995). Participation was voluntarily initiated by the clients themselves in response to the participant information sheet (Appendix 2).

Number

Interpretive phenomenological research elicits detailed accounts from the participants of their experiences, and it requires large volumes of narrative data to be analysed. For this reason the sample sizes tended to be small (Beanland et al 1999). Similarly a smaller sample size lends itself to elicit a deep understanding of the phenomenon by providing rich accounts of 'meaning' (Liamputtong 2009). Using a small sample size the proposed research sought to fully explore the research question effectively and efficiently to reach data saturation during the data collection process until no new data emerged (Liamputtong 2009).

Reaching data saturation is the hallmark of quality in qualitative research, with the richness of data derived from the participant's detailed descriptions building a comprehensive and convincing contribution to knowledge (Morse 1995). It was envisaged that a flexible purposive sample to a maximum of 8 people would meet the aims of this proposed research. In accordance with the expectation and approval from The University of Adelaide, Human Research Ethics

Committee (HREC) the participants were to be not permitted to be active clients of the researcher.

A lesser number of 5 people participated in this research study. This can be attributed to a change in funding arrangements for the mental health programs provided by the organisation. The organisation was no longer viable to support some of the mental health programs which had previously been provided. During this time of transition there was a subsequent attrition of clinical staff in this process. This transition process occurred in December 2012 during the recruitment stage of the research study. With a limited number of other clinicians available the ability to recruit the anticipated number of 8 participants was consequently restricted and difficult.

Participant recruitment

Participants were invited to be involved through an information flyer placed on the Regional Office's notice boards. The flyer provided information on the purpose, methods and demands of the research project. Flyers also informed readers of the expectations of their involvement, the voluntary nature of participation, their right to withdraw at any time during the research study, and the methods used to protect their privacy and confidentiality. Additional flyers were available for interested participants to take home. After considering this information participants were invited to contact the researcher at the Regional Office to register their willingness to be involved in the research study. The first 8 respondents who fit the inclusion criteria were to be accepted. The interviews then took place once the participants had read both the flyer and the complaints form, and signed the consent form. No payment or reimbursement was offered.

This particular data collection strategy offered a valuable opportunity to explore each participant's unique experience to yield extensive personal accounts of the experience of low self-esteem (Schneider et al 2008). During the interview session the researcher, with the participants' consent, took notes and digitally recorded the conversations. In addition the researcher took mental notes of the interview to collect and reflect on the unspoken observations of the participant's non-verbal cues to gain a more sensitive understanding of the participant's experiences (Beanland et al 1999).

Mental note taking throughout the interview allowed the researcher to recall particular aspects of information, and also to clarify points of interest throughout the interview (Liamputtong 2009). Digital records were used with the consent of each participant as written in the consent form, and the on-going approval of the participant. In the event of participants declining to be

recorded extensive notes could have been used to record the data. This was not required as the participants approved of the digital method of recording. Using a sensitive approach if needed recording could have been ceased if the participant was concerned or uncomfortable with the recording of the interview, and extensive notes would have be taken to insure the authenticity of the data (Liamputtong 2009). The recordings provided a permanent medium to capture both the dynamics of the interview and to allow for the conversation to be replayed as note taking may be distracting, interrupted or inappropriate at a particular point in the interview (Liamputtong 2009). Through these processes the researcher ultimately sought to unravel and explore the meaning of self-esteem and its impact on the participant's quality of life (Smith 1997)

Ethical approval

Ethical approval and clearance was sought and gained from The University of Adelaide Human Research Ethics Committee prior to the commencement of the research study (Appendix 5). Research involving vulnerable people had the potential to be complicated, confronting and difficult for the participants when discussing such personal issues such as depression and low self-esteem (Appendix 4). It was therefore imperative to the researcher to be respectful and maintain a sensitive and compassionate approach (Liamputtong 2009).

Confidentiality and privacy

Participants were informed of the steps taken to ensure that their personal information and confidential details were protected by de-identification of all information collected and reported on (Appendix 3). The researcher took responsibility to protect the participant from any covert activities or methods used in conducting this research. Transcripts were stored individually in separate folders for each participant, and placed in a code-locked bag along with the IPOD touch digital recorder when not in use. This code-locked bag remained the property of the researcher. Each folder and each page of documentation acquired for each individual participant involved in the research project was de-indentified by a number-letter system.

The venue for conducting the interviews was located with respect of the needs of the participants regarding privacy, confidentiality and anonymity. The interview time and date was flexible to suit the needs of the participant and the environment was appropriate to reduce distractions and interruptions demonstrating respect for the participant's privacy and confidentiality (Appendix 2).

Participants who meet the study criteria were involved in a face to face (one on one) unstructured but purposeful interview with the researcher for about one hour. The time frame of one hour allowed sufficient time to gain a meaningful insight to the phenomena of low self-esteem (Schnieder et al 2007). Participants were invited to reflect on the following questions. What influence has depression had on your self-esteem? If low self-esteem was identified as a consequence of depression, then how has low self-esteem impacted on each of these domains of their life? By using open ended questions participants were guided to tell their stories in depth, and map the direction of their life experience of low self-esteem (Liamputtong 2009). This method of interviewing freed participants to speak openly and freely to explore the experiences that were of importance to them (Geldard&Geldard 2005). This approach encouraged the interview to evolve as a conversational encounter allowing the researcher to be guided in any possible direction, to follow tangents and to seek clarification (Schneider et al 2008). Through this method of interviewing, and in tandem with the observation of non-verbal behavioural cues the data were collected.

To facilitate and enhance the quality of the participant's experience whilst attending the interview the researcher was sympathetic to the emotional needs of the participants to feel relaxed and comfortable. The location of the interviews was advantageous for its familiarity to the participants. All participants had attended the interview locations on previous occasions and had built a relationship with the staff and welcoming atmosphere of the organisation. To put the participants at ease to feel comfortable and settle into the interview the interview was carried out in a room where they were familiar with the surroundings, the layout of the building and the reception area prior to the interview. These rooms are designed to ensure privacy and confidentiality, free from the distractions of telephones, and intrusive outside noises. During the interview this allowed the participant to remain focused and unaware of goings on outside of the interview room.

In a counselling situation these rooms are used and designed to provide optimal therapeutic interventions. Attention is given to comfort and calmness providing space and order to allow people to express their concerns fully and in confidence free of irritation. These locations were considered to be ideal for the participant interviews to be conducted. They were selected to reassure the participants and enable the interview to be respectful and ethically appropriate. In these consulting rooms the participant could be offered additional support if they needed to talk with their own clinician should they need to discuss any issues they may have concerns with as a result of the interview process. This was not required however it was available in the interest of the welfare and well being of the participant.

Chapter 5 – Analysis

Data analysis followed the general pattern of Colaizzi's step method of phenomenological enquiry for its rigorous approach of comparing the interview data with the researchers notes of observation and reflection (Edward & Welch 2011). Using this type of methodological framework required the data to be analysed thematically to enable themes to emerge (Liamputtong 2009). This involved searching across the data in each transcript individually, and then collectively, constantly comparing it to the observations and the reflections noted by the researcher about the non-verbal behavioural cues for patterns of meaning (Liamputtong 2009).

Colaizzi's7 step method:

1. Reading and transcribing the participant's descriptions.
2. Extraction of significant phrases and statements.
3. Formulation of meaning using creative insight.
4. Aggregation of meanings into themes and categories
5. Integration of data into an exhaustive description of the phenomena.
6. Identify the essential structure of the phenomena.
7. Verification of the data with the participant
   (Edward & Welch 2011).

During the process of analysis data were analysed using the cognitive behavioural therapy framework for each domain of life, and a summary of the themes have been provided after each domain of life in two tables. Table one includes themes regarding positive subjective experiences and the negative subjective experiences. Table two includes themes regarding the relief of suffering and the maintenance of suffering.

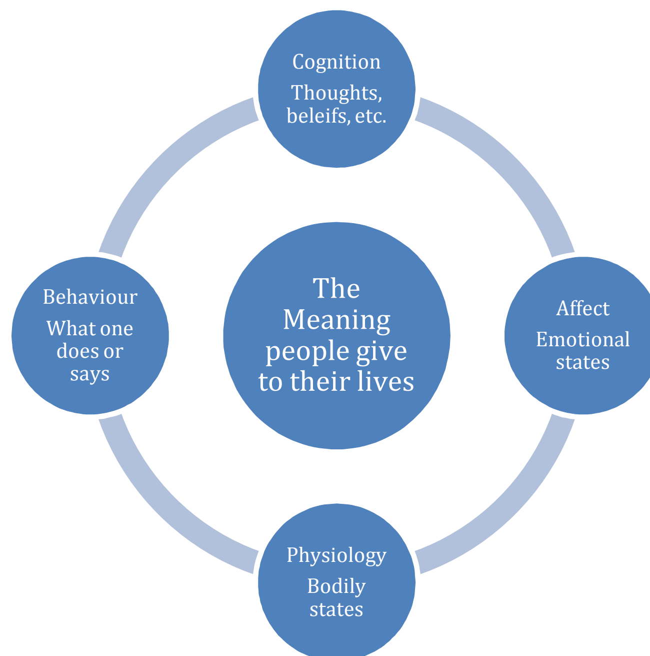
Using the skill of reflection to better understand the themes, the researcher returned to the original transcripts constantly to enable new understandings to emerge (Pringle, Hendry & McLafferty 2011). Digital recordings and interviews were transcribed into typed form and analysed line - by – line examining words, phrases and sentences relevant to the question searching for words to interpret the insights arising (Schneider et al. 2013).

Following each interview the researcher commenced data analysis by transcribing the interview verbatim (word by word, and line by line), and also reported on the observed conversation style and emotional expressions of the participant from the researchers journal notes (Liamputtong 2009). This information was stored in a word document for each participant. Data analysis was

commenced as soon as possible after each interview to allow for a better understanding of the data through the immediacy of time (Liamputtong 2009). The researcher followed the general steps of Colaizzi's framework for phenomenological data analysis with each individual transcript (Edward & Welch 2011). By following Colaizzi's general steps data collection, data analyses and verification of back to the participants this allowed the researcher to work within the timeframe of the proposed research project (Beanland et al 1999). The transcripts were then examined collectively searching across the data to find repeated descriptions of the phenomenon of low self-esteem as it is lived in the everyday experience (Liamputtong 2009). This process endeavoured to provide an exhaustive description of the experience through the integration of meanings as explained by the researcher (Edward & Welch 2011)

Using the fundamental structure of cognitive behavioural therapy to explain how people give meaning to the events in their life the researcher has analysed the data using the model which contains the interacting systems of cognition, behaviour, physiology and affect (Westbrook, Kennerley & Kirk 2010).

Figure 1 Interacting systems



Interacting systems: Interactions between thoughts, emotions, behaviour and physiology in the different environments or domains of life (Westbrook, Kennerley & Kirk 2010).

Themes have been interpreted in terms of positive and negative subjective experiences, and how suffering was relieved and maintained.

Marriage/Intimate Relationships:

Thoughts

All participants were in agreement on the negative impact of low self-esteem on their marriage and intimate relationships. Participants expressed a chronic negative impact over a long period of time. They were not fully aware of the impact or magnitude until much later in life.

Two participants recognised a significant association with their troubled childhood and adolescent emerging for as long as they could remember and that this has had a significant influence on their experience of life today.   In retrospect the participants reported that:

> *"Through my childhood I experienced a diminished ability to view myself as worthy to be loved any more, believing that I were not good enough, and I was unable to do anything right"(participant 2B).*
>
> *"I blame myself for failing to live up to my partners needs and I thought that my partner could do better in a relationship with someone else"(participant 4D).*

Three of the participant's reflected on their partner's strength and commitment in providing support and encouragement over time which provided participants with strength and held them up through the hard times.

The participants often blamed themselves for having a chronic disposition of continual depression and questioned themselves to find answers to understand what was going on, why am I like this and why do I need so much reassurance? The solutions to these questions could not be identified and these thoughts had hold of them, and were controlling their life experiences. This lead to feeling despaired. They had failed to unearth the root cause of potent thoughts. These thoughts had gained a strong hold, and this lead to suicidal attempts and thoughts of suicide, as this seemed the only option to fulfil the solution.

One participant thought that "the illness of depression impacted on their relationship rather than low self-esteem". They stated that:

> *"Being unwell and being told I had depression was very different. I was diagnosed for 2 years before I was able to accept the diagnosis. I thought it was better to be unwell for eighteen years rather than live with the fact that I have a label or diagnosis"(participant 4D).*

The participant thought that this was precipitated by his or her own preconceptions of mental illness, and how society had characterised people with the diagnosis of a mental illness. That stigma of mental illness was unbelievably attached to them. Analogies used to express these thoughts included that:

> *"Everything shut down, my mind went to ricotta cheese, I must be banana's or looney" (participant 3C)*
>
> *"The experience was like a limb in a plaster cast wasting away" (participant 4D).*

Generally participant's had a preference for self help and thought that seeing someone for help was ridiculous, and being told to pull yourself together because that does not help.

Behaviours

Participants reported inconsistent behavioural fluctuations that were thought to be irrational and without any logical explanation. The participants stated that they:

> *"Sabotaged their relationships by both ignoring their partners or conversely giving them curry and treating their partners as inferiors" (participant 3C).*
>
> *"Created friction and making mountains out of molehills leading to arguments and disagreements leading to shouting and cranky responses"(participant 4D).*

Participants told their partners not to talk to them and withdrew from conversations, keeping quiet and refusing to talk. One participant reported that:

> *"This was done to make them see that I was a bad person and not good enough for their partner" (participant 4D).*

The participants ostracised themselves from different circles in their relationships and spent more time with their mates or their children. The participants reported that they sometimes provoked confrontation or they avoided contact and involvement with the lives of their partners and children. One participant reported:

> *"I made six attempts of suicide to deal with the spiral of depression" (participant 1A).*

The participant thought they had failed as a partner.

One participant

> *"I wanted to ignore my partner for days after an argument". I withdrew by going for a walk for hours at which time I cried in despair during the walk. On return from my walk my partner "would carry on as if nothing had happened which made me frustrated which made things worse, but on the other hand it was good" (participant 5E).*

Emotions

Participants explained feelings of being on edge, angry, uptight and trapped. They felt uncared for and cornered in the experience of mood swings they felt irritable, insecure, undervalued, worthless, hopeless and suicidal.

> *"The stigma of feeling different and less of a person compared to other people left me feeling volatile and vulnerable with no interest or enthusiasm for life, and ostracised from the world I live in"(participant 4D).*

Bodily Sensations

Participants reported the symptoms of anxiety including sleep disturbance, restlessness, headaches and gastro-intestinal upsets. Three of the participants agreed on:

> *"Experiencing sudden outburst of crying in situations which was inappropriate and unjustifiable" (participant 3C).*

Two participants noted:

> *"A significant problem with sexual dysfunction and lack of libido which exacerbated my experience of low self-esteem and feelings of unattractiveness and lack of appeal along with unwanted weight gain adding to my negative view of my physical appearance"(participants 1A & 2B).*

Both experienced a perceived loss of physical attractiveness, and diminished sexual relations within the marriage and intimate relationships with their partners, conceivably a silent and consistent concern of the participants infused in their experience of low self-esteem inherent in depression.

Themes

Table 1- Marriage/intimate relations: Positive and negative subjective experiences

POSITIVE SUBJECTIVE EXPERIENCES	NEGATIVE SUBJECTIVE EXPERIENCES
Supportive partners	Chronic of negative impact Recognise magnitude of impact through reflection (rumination) Denial and difficulty in accepting mental illness Physical, emotional and verbal abuse in childhood Self blame and self loathing Looking for solutions and explanations without resolution Suicidal thoughts and suicidal attempts Self imposed stigma and perceived societal preconceptions Irrational and illogical communication styles Sabotaging the relationship Creating fiction and provoking arguments Shouting at partner or ignoring partner Ostracising and avoidant behaviours Feeling uptight, angry, insecure and trapped No interest or enthusiasm for life Sleep disturbance, headaches, restlessness Sexual dysfunction, weight gain Perceptions of physical unattractiveness

Table 2- Marriage/intimate relations: Relief and maintenance of suffering

RELEIF OF SUFFERING	MAINTENANCE OF SUFFERING
Willingness to embrace others	Resistance to change Habitual conflict behaviours Habitual poor health practices Rumination Inability to forgive Resentment Internalisation of external experiences

Family relations:

Thoughts

The participant's experience of low self-esteem inherent in depression demonstrated various responses. This was related to their individual and different family structures and the influence and capacity of their parents to express a sense of unconditional love. Those participants who experienced a positive regard from their family when growing up they reported happy family life experiences. Depending on the degree of severity the participants thought that they kept their illness private from their family and had a tendency to try to hide their situation. Two participants indicated that:

> *"My experience and understanding of family was complex and strained early in life. I experienced disapproval from one parent particular, and I had a better relationship with the other" (participant 2B).*

> *"The loss of a parent to suicide left an indelible scar for life and I was disconnected from family as a consequence of being cared for by other people" (participant 1A).*

Over half of the participants thought that their illness came overnight and that it came with big crash leading to hospitalisation at which time they were unaware that they were so unwell. The participants were unable to keep their illness a secret in these circumstances.

When the participants were hospitalised they thought that:

“I went down-hill even further being struck down by the diagnosis and the reality of being admitted to hospital for a mental illness” (participant 1A).

“My low self-esteem was exacerbated by my hospitalisations. It affected my ability to work, and provide for myself and my family, which provided me with a purpose and meaning to life”(participants 4D & 1A).

One participant stated:

“I made every effort not to be hurt emotionally or physically ever again because of a troubled family” (participant 1A).

Whilst another participant spent a life time thinking that:

“I need to try harder to gain the approval of my parent by constantly carrying out gestures to prove them that they were a worthy child and sibling. To prove that I can do things and that I am good enough. I was denied the love and approval shown to my siblings and I craved for the same acceptance” (participant 2B).

One participant stated that they experienced a strong family connection and this was consolidated later in life when the siblings united and they were caring for their elderly parent. After this time the participant provided care for their sibling and nursed them back to recovery. It was after this time that they were diagnosed with depression. They applauded their sibling for the support that was shown to them during this time and attributes their compassionate understanding to having experienced depression as well. In contrast another participant thought that:

“The death of my mother lead to the further decline and fall of my already fractured family” (participant 4D).

At the time of their diagnosis the ability to maintain self-esteem was challenged as they reported:

“My family described me to be the unstable sibling with a loose screw” (participant 4D).

Having a distant and conflictive relationship with my biological father compounded the situation” (participant 4D).

Behaviours

Three participants agreed in a similar tone that they:

> *"Acting out to be the life of the party, and try to make everyone laugh" (participant 1A & 3C & 4D).*

One participant stated that their behaviours appeared to offend some people and yet others accepted them and they got on. One participant stated that:

> *"I morphed into an impermeable being, completely bullet proof. I was immune to pain by building a barrier creating and putting on a facade with every situation, and every event and even other people's behaviour's as if they were of nil consequence. I was quick to tell everyone else to harden up as well"(participant 1A).*

The participant walked away from important times in their life and become dependent on alcohol. The participant began drinking more and more to contain their overactive mind to avoid the emotional turmoil of life. Another participant was determined to ensure their relationship with their children was a vast improvement of their own experience. The participant stated that:

> *"I treated my children in a completely contradictory manner to my own upbringing to ensure that my children were not exposed to favouritism, unfair disapproval and feelings of worthlessness" (participant 2B).*

Participants became involved in mental health services on seeking help from their general practitioner or as a result of hospitalisation. Participant's reported gradual improvements in their mental state once they found a personable and skilful clinician. Not all clinician's capabilities were viewed as the same, and the participant's who were less able to connect with the clinician criticised mental health services for their absence of clinical expertise and professionalism.

> *"I've been lucky with physical problems, but I can't say the same with psychiatric things. Is it really help or are people just pigeon holed? The DSM-V is made up by a whole heap of academics, and do they really know what it is? Do you have to be in the DSM-V to get help from a mental health professional or are you just another case study? Do they look you up in a book and say to themselves that someone else was a bit like this*

as well so it must be what you have? Some psychologist like to sit and then you feel embarrassed about the long silences so you talk at them" (participant 3C). "They did absolutely nothing for me"

"The support and education provided to me by the clinician around depression and low self-esteem was brilliant". The clinician's ability to connect with my particular situation and the clinician's explanations of a depressive illness helped. It was amazing and it has really changed my life" (participant 2B).

"I was able to recognise when I was beginning to tense up and feel that something was going to happen, and I implemented the skills suggested by the clinician as to how to cope with these situations" (participant 2B).

Using the visualisation of a stop sign as a cue to invest in problem-solving techniques, and taking up a creative activity the participant did not hesitate in reporting these techniques as extremely helpful.

"The skills I have acquired and developed have enabled me to support my partner and family through the symptoms of low self esteem and depression" (participant 2B).

Emotions

Participants reported similar feelings of worthlessness, feeling bad, and devalued by their siblings during a very difficult time in their life. One participant stated:

"I was disappointed when my mental illness was brushed off by one sibling after I had been my sibling's primary carer during their physical illness" (participant 5E).

Bodily Sensations

Participant's responses did not to express any experiences related to bodily sensations with regard to low self esteem inherent in depression in relation to family relations.

Themes

Table 3- Family relations: Positive and negative subjective experiences

POSITIVE SUBJECTIVE EXPERIENCES	NEGATIVE SUBJECTIVE EXPERIENCES
Strong family connections were consolidated in the hardships of life	Complex and strained childhood and upbringing
Conscious efforts to build better relationships with own children	Parental disapproval and criticism
Conscious effort to praise own children	Parental suicide
Contact with mental health services	No strong family connections
Explanations about mental illness	Acute onset of symptoms
Learning early recognition of deteriorating mental illness	Diagnosis exacerbated symptoms (down – hill slide)
Learning strategies and techniques to deal with symptoms	Unable to work and provide for family
Engagement in problem-solving techniques	Persistently wanting to please
Taking up a creative activity	Death of family members
	Negative family attitude around mental illness
	Building barriers to emotional experiences
	Overcompensating behaviours
	Feelings of worthlessness and misunderstanding by family

Table 4- Family relations: Relief and maintenance of suffering

RELEIF OF SUFFERING	MAINTENANCE OF SUFFERING
Willingness to embrace others	Habitual conflict behaviours
Willingness to engage effort and	Resistance to change

participate in mental health services Willingness to accept and embrace change Willingness to participate in activities of value Willingness to become more informed about mental illness Resistance in adversity	Rumination Inability to forgive Internalisation of external experiences Fear of reality Fear of uncertainty

Friendships/Social Relations:

Thoughts

One participant stated that:

> *"I had lost my self esteem but not my friends because we shared a common interest in art. I had lost confidence in my ability to create a piece of art" (participant 5E).*

They questioned their painting and asked the opinions of another club member. Their art friends reassured them that nothing was wrong with it. The participant thought that they would be viewed as a painful person because of the depression, as they explained their experience to their art group friends when they asked. The participant reported that:

> *"I pushed myself to go out and thought that if I did not enjoy myself that would be too bad. I did not want to go out to the group meetings with friends but this did not stop me from going" (participant 5E).*

Another participant explained themselves as a follower and not a leader. They were quite self-conscious and needed to make an effort to fit in. They thought that they were different and unable to push themselves out like they did so they just tagged along. On reflection the participant stated that their life in the military has bolstered his confidence and that they have grown from the experience of military life.

One participant stated that they thought that:

> *"I was at the bottom of the hole and there was no way out and I wanted to be dead. A wonderful mental health worker would come around every week and I wanted her to go away and leave me alone in one way, and in another way I wanted her to come in with a magic bottle to help them" (participant 1A).*

The participant could not read or write and when their son came home from school to watch them and keep them safe. The experience of needing to be cared for by their son tore them apart emotionally.

Another participant stated that:

> *"I was too unwell both physically and mentally to establish lasting friendships and social networks when initially unwell" (participant 4D).*

This participant lived in several different locations, and had two significant relationship breakdowns. The participant reported losing some friends permanently, because the participant thought that when friends know you when you are very unwell they always see you as that. The participant stated that they are still quite unwell today but they manage their illness better now.

One participant thought that:

> *"I could not mix with others because I was not one of them and I could not do what they were able to do. I would not be liked by others. Looking back on this experience it was a horrible thing" (participant 2B).*

They did not want to go out but had to because the children wanted to go to functions so they had to make themselves go for the children's sake. They stated that:

> *"After receiving counselling for my illness I realise now that I have missed out on so much due to my low self esteem and depression. Since attending counselling and putting the tools to cope with situations into practice I have found that everything fell into place. I am now more confident, more relaxed and I can sit and talk with people. I am growing older, more confident and I seem closer to others and a part of a group" (participant 2B).*

Behaviours

One participant reported:

> *"I locked myself in my home and taping the curtains to the walls" (participant 1A).*

The participant reported behaving badly towards the mental health worker. The participant was verbally abused the mental health clinician when they came to visit because they feared other people. They stated that:

> *"The worker was magnificent and I would still be here if it wasn't for the worker. The worker put in the hard yards and it was sheer hard work that enabled me to overcome my agoraphobia" (participant 1A).*

The participant stated that even today they have a phobia about answering the phone.

Participants generally stated that they pushed themselves to go out and mix with their friends and attend social activities. They wanted to stay home but did not want to get caught up in the rut of staying home because they were depressed.

Emotions

Participants were generally united in the feeling of fear. Fear that they were not good enough and that they felt guilty because of their inadequacy to mix like other people appeared capable of doing.

Bodily Sensations

Two participants identified the physical reaction of crying often. Crying came easily and uncontrollably at times.

Themes

Table 5- Friendship/social relations: Positive and negative subjective experiences

POSITIVE SUBJECTIVE EXPERIENCES	NEGATIVE SUBJECTIVE EXPERIENCES
Supportive friends Taking action to participant Resisted temptation to avoid socialisation Exposure to new experiences bolstered	Loss of confidence Seeking reassurance Self perception as a follower Self conscious Sense of hopelessness

confidence Contact with mental health service Mental health services who demonstrate persistence and perseverance Recovery through managing illness Being encouraged to participant Attending counselling Putting the tools from counselling Active behaviours to break rut forming behaviours	Suicidal thoughts No hope in sight No magic bottle to help Unable to read or write Poor mental and physical well being Moving locations Unstable friendships and social networks Negative self commentary Fear of being disliked Fear of disapproval Avoided socialisation Locking away in the home Resistance to mental health interventions Agoraphobia Inadequate self perceptions Uncontrollable crying

Table 6- Friendship/social relations: Relief and maintenance of suffering

Relief of Suffering	Maintenance of suffering
Willingness to embrace others Willingness to engage and participate in mental health services Willingness to accept and embrace change Willingness to participate in activities of value Willing to actively gain new knowledge	Resistance to change Habitual conflict behaviours Habitual poor health practices Rumination Inability to forgive Resentment Internalisation of external

and skills Acceptance and resistance to allow for adversity	experiences Procrastination Fear of uncertainty

Career/Employment

Thoughts

One participant stated that they had been retired for a very long time and they did not report any experience of low self esteem in depression throughout their career and years of employment. One participant stated that:

> *"I set the bar at school very high and I then continued to set the bar high whilst employed in the banking industry. It was not important to be better than anyone else, but it was important to be as good as them. Finding that I had made a mistake was unacceptable to me" (participant 4D).*

Finding mistakes was extremely frustrating and this precipitated low self esteem perpetuated by a barrage of negative self talk because they had made a mistake. The participant stated that:

> *"I was unaware that my mental illness was becoming more unstable at the time, and that looking back at the time I was all over the shop" (participant 4D).*

This participant become more informed about mental illness through their involvement in mental health groups. They experienced trouble with the boss and got a bad reputation for their bad attitude at which time they imploded at work and walked out the door never to return to work again.

> *"I left this job immediately and did not return" (participant 4D)*

After this time they went through six jobs in quick succession at which time they explained that their self esteem was not there at all, and their memory of this time was limited to snapshots of time only.

Another participant worked in the military and reported that the basic training was intense with no time to think. At work they were driven to keep to schedules, and that it was after work when they stopped that they found a need to drink alcohol to cope with their underlying inclination to focus on negativity. Generally they thought they were floating along pretty well at

this time, and that their low self esteem and depression was manageable. One participant reported that their low self esteem was problematic and that it originated from her school years.

> *"I wanted to get into agriculture as a career but their headmistress at the time and mother were not encouraging advising me that I was not good enough to work in agriculture and I was persuaded to settle for a career in catering" (participant 2B).*

Having successfully attained the certificates in catering they become pregnant and their mother disapproved of her pregnancy seeing this as a thoughtless act after all that their mother had done for them to get them into catering.

The participant then moved to Australia and married an Australian, which her mother strongly disapproved of. The participant stated that they secured employment in administration and loved it.

> *"My colleagues encouraged me and pushed me a bit to run programs and take responsibility. This was a real boost to my self esteem" (participant 2B).*

The participant stated that during this time they desperately wanted, and wished to be praised by their mother for these achievements, and that their mother still had a hold on them. They stated that their sister was always praised my mother, which exacerbated their experience of low self esteem. The participant stated that:

> *"Mother repeatedly reminded me about my sisters many virtues and that there were harsh comparisons made between the two sisters by their mother. After many years of emotional turmoil and efforts to gain their mothers approval I decided it was time to take control and make my own decisions and this has been possible through the support of my mental health clinician and the stop sign technique" (participant 2B).*

One other participant took early retirement from the railways and moved to a new location to start a new life. Prior to retiring they loved the work in the railways and the lifestyle that went with the work. They stated that:

> *"I struggled with the change of retirement and moving to a new location more than I had anticipated. I was lost. I had changed*

from going to work daily to doing nothing and my mind would not shut down" (participant 1A).

They worked in a timber mill for some time and found it difficult to adjust because the boss was constantly picky. On occasion they were overcome with frustration and flew at the boss, grabbed him by the throat and almost rendered the boss unconscious.

"I left that job immediately and did not return" (participant 1A).

Behaviours

Participants reported significant behavioural changes as a result of situations occurring in their employment and career ventures. One participant stated that:

"My behaviour was erratic during this time and I lost contact with a lot of friends, and my behavioural changes had become offensive. I crashed and burnt. I then started taking medications to manage my fluctuating moods and behaviours. The medications proved to be helpful and I gained a few friends again"(participant 4D).

Another participant reported that the culture of the workplace included smoking and drinking and they enjoyed joining in as part of the group. This was not reported as something in which they regret, and stated that even today they really enjoy these activities.

"I had to learn to read and write at a late age to improve my ability to gain employment and that this was a long hard road at the time however I have the certificates that I are proud of" (participant 1A).

They stated that their self esteem prior to learning to read and write was at rock bottom and they could not go outside of their home. They would either sit in a chair in the middle of the room frozen by fear or pacing around inside their home unable to see a way out of their depression and low self esteem.

"I did not want anyone to know what I was going through at the time and I avoided contacted with everyone" (participant 1A).

Emotions

Participants reported feeling frustrated and worthless with and that they experienced constant mood swings. The participants stated that:

"I felt bad about having bad attitudes towards themselves and others and this was affecting my work" (participant 4D).

"I had frequent suicidal tendencies because I was not working" (participant 1A).

Bodily Sensations

The participants experienced difficulty sleeping, poor appetite, nausea, crying, trembling and hyperventilation. One participant was sure that they were experiencing a heart attack at the time.

Themes

Table 7- Career/employment: Positive and negative subjective experiences

POSITIVE SUBJECTIVE EXPERIENCES	NEGATIVE SUBJECTIVE EXPERIENCES
Becoming more informed about mental illness	High expectations
Strongly disciplined employment culture	Unable to accept mistakes
Collegial support and encouragement	Perpetual negative self talk
Responsibility, achievements and participation	Bad attitude at work
Support of mental health services	Conflict with employer
Medication to manage moods	Chaotic personal relationships
Learning to read and write	Discouraging and critical parents and educators
Steadfast commitment to resist giving up	Change of location
	Retirement
	Unproductive activities
	Imploding in workplace
	Erratic and offensive behaviours
	Use of drugs and alcohol
	Self imposed isolation from others
	Suicidal thoughts and attempts
	Insomnia
	Trembling, hyperventilation
	Poor appetite

Table 8- Career/employment: Relief and maintenance of suffering

RELEIF OF SUFFERING	MAINTENANCE OF SUFFERING
Willingness to engage effort and participation in mental health services Willingness to accept and embrace change Willingness to participate in activities of value Acceptance and resistance to adversity Willingness to actively gain new knowledge and skills	Resistance to discipline Resistance to change Habitual conflict behaviours Habitual poor health practices Rumination Inability to forgive Resentment Internalisation of external experiences Procrastination Fear of reality Fear of uncertainty

Education/Personal Growth and Development:

Thoughts

One participant reflected on the personal growth they experienced from being in charge of nine men during their work life, and the participant stated that this was pretty good. They also thought that there was mateship and camaraderie amongst the group in an outback township. The participant moved location to another state for a new life and early retirement. They reported that they may as well have moved to another country. The participant stated that:

> *"The move nearly destroyed me. Personal development had gone and I needed to find work to make ends meet. I had never needed to read or write or do mathematics before in my life and every job I applied for required this knowledge. I was devastated and my self esteem was shattered" (participant 1A).*

The participant went to TAFE and learnt how to read and write. It took sheer hard work and determination and the support of mental health clinician. The participant has many certificates of achievement and they love to read. The participant has successfully fought hard for their education and personal development and now reaps the rewards of improved self esteem.

Another participant reported a history of structured military type education and professional development in their early adult life and they did not want to go back to school because they fill their mind with books. They reported that:

> *"My personal development has been fulfilled with reading literature and taking up an interest in motor cycles and fishing. I have a treasured Triumph motor cycle have been building and this has provided me with a "pick up" (participant 3C).*

The participant also found pleasure in collecting vintage fishing gear. The participant's partner had pestered them to go back to school but the participant did not wish to take up someone else's spot.

One participant reported:

> *"I dropped out of school prior to year eleven because I had such high expectations on myself and I'm not sure now if I could actually comprehend the work. I have completed studies in multi-media and computers just for personal growth" (participant 4D).*

The participant stated that they become involved in mental health advocacy because they wanted to get some book knowledge along with the lived experience. The participant stated that:

> *"The more I became involved in the consumer care cafe or consumer forums the more my self esteem went up. I was empowered through the consumer forums to do some public speaking, and a series of other things and I was in instrumental pushing for a few things to happen and when they actually happened my sense of self worth returned" (participant 4D).*

The participant pointed out that they experienced personal development and a sense of self worth and that had not happened for a very long time. The participant reflected that:

> *"The demise of my self esteem was because of self-stigma because I had high expectations of myself and other people also put forward their expectations of me. I envisaged climbing through the ranks in my job, settling down and getting married, buying a home, having kids and the great Australian dream. When other people in your family do well, and they are well educated (including the generation who have gone before you)*

> *then you try live up to that expectation. When it doesn't happen you think about what went wrong and blame yourself even if it is out of your control. Maybe I disliked the job or maybe it was harder than I thought" (participant 4D).*

The participant thought that they devalued themselves with negative self talk reflecting on not having done anything constructive, and not achieving anything.

Another participant stated that:

> *"My personal development was cemented in myartwork. It was my main outlet and that it was the pleasure of life. When I lost my self-esteem I did not trust my ability as an artist. I thought that the bottom had fallen out of my world. I had lost my confidence and my sense of self worth in the artwork had plummeted" (participant 5E).*

The participant reflected that giving their attention to their artwork during retirement had kept them going.

Behaviours

Participants all reported a committed approach in their behaviours to regain their self of self esteem through education and personal development. One participant:

> *"I applied for employment and enrolled in courses to support my need for skills in reading, writing and arithmetic" (participant 1A).*

Another participant gained education and training in aged care and managed well completing the coursework with success. One participant passionately became involved with mental health advocacy activities, allowing them the opportunity to speak in public and influence the direction of mental health care services. Another participant reflected that they experienced structured education and training in years passed and have no desire for structured education. They are now avid readers, and love building motorbike engines, restoring vehicles and appreciating and collecting vintage fishing gear. One participant reported attending the medical clinic concerned their low self esteem and loss of confidence. They reported that:

> *"The doctor put me on drugs and I was so high that I painted a wonderful painting. It was the best that I had ever done. I merely picked up the brush and painted and my confidence was back" (participant 5E).*

Emotions

There were definite polarities in the participants reported emotions. Participants stated that:

> *"Low self esteem in depression was shocking. I viewed myself as a failure, unable to generate a sense of purpose and meaning in my life" (participant 5E).*

One participant stated that they felt useless and terrified.

However having the opportunity for educational advancement and access to encouragement and support to pursue ones passion participants used words to express their experience of their lives as wonderful, great fun and worthwhile.

Bodily Sensations

Participants reported the symptoms of anxiety when attending to educational and personal development activities mediated by new experiences consistent with the feelings of fear and terror. They reported:

> *"I pushed through the discomfort of feeling nauseous, fidgety, restless, uptight, headaches and trembling to achieve my goals" (participant 5E).*

Themes

Table 9- Education/personal growth and development: Positive and negative subjective experiences

POSITIVE SUBJECTIVE EXPERIENCES	NEGATIVE SUBJECTIVE EXPERIENCES
Taking responsibility Being in charge Mateship and camaraderie Sheer hard work Contact with mental health services Education and training at TAFE New skills and knowledge Strengthened social networks Pride in achievement Personal satisfaction in creative talents	Moving to a new location Financial strain Unable to gain employment Unable to read and write Failing to meet own expectations Failing to meet perceived family expectations Fear of failure Self imposed stigma Loss of confidence in creative ability

Stimulation through gaining knowledge Involvement in consumer forums Public speaking and advocacy Return of self worth Medication management	Loss of standing in community Loss of identity Unable to establish purpose and meaning in life

Table 10- Education/personal growth and development: Relief and maintenance of suffering

RELEIF OF SUFFERING	MAINTENANCE OF SUFFERING
Willingness to embrace others Willingness to engage effort and participation in mental health services Willingness and acceptance to embrace change Willingness to participate in activities of value Acceptance and resistance to adversity Willingness to actively gain new knowledge and skills	Resistance to change Habitual conflict behaviours Rumination Inability to forgive Resentment Internalisation of external experiences Fear of reality Fear of uncertainty

Recreation/Leisure:

Thoughts

One participant was part of a walk group four times a week for one hour and they walked with their partner and their dog on the other three days morning and nights. They reported that:

> *"It was hard going when I was experiencing depression and low self-esteem" (participant 5E).*

They were walking for the good of their health to control diabetes and joint aches and pains. They stated that they wanted to stay home and their partner would push them to attend. The participant went on to explain that they could have stayed home and wallow in self pity because that's what they felt like doing. My partner would cuddle and kiss me and tell me I was all right,

and they would tell me that I would get better. My partner was very supportive of me and I made myself attend his favourite group every fortnight and it was very hard to do.

One participant was not a sports person and they never played sport but they had a keen interest in cars and motorbikes, and of course they loved quilting as well. They stated that:

> *"Low self esteem did not hold me back because my family were involved in the same interest, and it was pleasurable" (participant 2B).*

Another participant stated that they never played team sports like football and cricket because they loved deer hunting. They stated that when they become unwell their shooting licence was taken off of them, which they reported as a good thing under the circumstances. The participant has now taken up Tai Chai and thinks that:

> *"Tai Chai is really good because of the level of concentration this activity demands and the attention to breathing leaves no room for their mind to think about anything else" (participant 4D).*

One participant expressed their concerns with low self esteem inherent in depression relative to recreation and sport after moving state. The participant played Rugby League in the outback prior to moving. When they moved state the participant stated:

> *"I did not know anyone and I was motivated initially and went on a walk daily for leisure, but gradually I missed a day here and there and before I knew it I was doing nothing" (participant 1A).*

One participant experienced a nagging thought in the back of their mind that they should be doing something, and they hoped that if they did not think about the problem it might just go away. The participant thought that everything was too much effort, too much trouble and they feared something they try might go wrong" They feared the unknown and stated that:

> *"I was in an internalised state" (participant 3C).*

Emotions

One participant stated that:

> *"After I returned home from walking I felt good" (participant 5E).*

Participants with a keen interest in their leisure and recreational activities experienced pleasure. Conversely one participant felt lethargic, unmotivated and disinterested in all leisure and recreational activities.

One participant stated that:

> *"You sit there in a pretty dark place. You don't see any windows and you can't look out at anything. You don't want to see much either. It's a complete feeling on ennui, and yet not wanting to be indolent. Knowing that you are feeling unhappiness, and not interested where you are anymore, but you do not intend to leave either" (participant 3C).*

Bodily Sensations

Weight gain was the only reported bodily sensation expressed by one participant.

Themes

Table 11- Recreation/leisure: Positive and negative subjective experiences

POSITIVE SUBJECTIVE EXPERIENCES	NEGATIVE SUBJECTIVE EXPERIENCES
Participation in walk groups	Loss of shooting licence
Breaking through the discomfort to achieve	Moving state
Pet therapy	Nagging desire to do something
Improved physical health	Denying the problem
Resisting temptation of self-pity	Unable to make the effort
Sharing interest of family	Fear of the unknown
Supportive partner	Being in an internalised state
Taking up Tai Chai	Sitting in a dark space
Activities that demand concentration and free the mind	Unable and disinterested to look outside
	Unhappy and not interested to change
	Weight gain

Table 12- Recreation/leisure: Relief and maintenance of suffering

RELEIF OF SUFFERING	MAINTENANCE OF SUFFERING
Willingness to embrace others Willingness to accept and embrace change Willingness to participate in activities of value Acceptance and resistance to adversity and take on new challenges Willingness to fully engage in the moment Willingness to actively gain new knowledge and skills	Resistance to change Habitual poor health practices Rumination Inability to forgive Denial and fear of reality Resentment Internalisation of external experiences Fear of uncertainty Procrastination

Spirituality

Thoughts

One participant responded by stating that they did not feel any connection with spirituality and their experience of low self esteem did not draw any attention in the domain of spirituality. The participant thought that it was relevant that:

"My taste in music changed dramatically" (participant 1A).

The participant was strongly connected to country and western music up until they become mentally unwell at which time they experienced a bizarre connection with what he called rabbit/dog music like Poison and Alice Cooper. This participant also responded by explaining:

"I have a strong connection and special bond with my dog" (participant 1A).

The two were inseparable and the participant stated that the dog responded to my low moods by remaining by his side with his head leaning on the participant. This connection was significant and powerfully therapeutic for the participant.

For three participants they had not really gone for religion describing their beliefs as agnostic or atheist. One of these participants went to Sunday school as a child and believed it to be a good

place to learn good basic moral values. They stated that they held their father's belief that you will find out when you cark it. Then another participant reported that their daughter was into Buddhism and this was an interesting topic, which they enjoyed discussing and exploring the beliefs and practices of Buddhism.

One participant stated that they were Anglican and attended church three times. Once when you were christened, then again when you were married and thirdly you attended when you were buried in a church. This participant did not think much about spirituality until they went to see a mental health counsellor who put her onto meditation. The participant then attended other meditation classes and found these classes to be very different to the meditation they experienced with their counsellor. The participant described them as more of a spiritual class, and although the participant did not report a specific spiritual awareness or awakening they found the classes helpful.

Emotions

One participant reported emotions of darkness and heaviness and one participant stated that:

> *"I feared my depression" (participant 5E).*

These were the only emotions expressed by the participants regarding the experience of low self esteem inherent in depression in the domain of spirituality.

Bodily Sensations

Participants did not report any bodily sensations with regard to low self esteem inherent in depression and spirituality.

Themes

Table 13- Spirituality: Positive and negative subjective experiences

POSITIVE SUBJECTIVE EXPERIENCES	NEGATIVE SUBJECTIVE EXPERIENCES
Pet therapy Meditation Contact with a mental health worker Mindfulness practices	Change of preference in music Darkness and fear of depression

Table 14- Spirituality: Relief and maintenance of suffering

RELEIF OF SUFFERING	MAINTENANCE OF SUFFERING
Practicing mindfulness and mediation	Fear of uncertainty

Willingness to engage effort and participation in mental health services Willingness to participate in activities of value	Internalisation of external experiences Resistance to change

Citizenship:

Thoughts

One participant stated that:

> *"I made myself continue with delivering meals on wheels when I was depressed because I knew that beating this illness needed a fighting spirit if I was to get well again" (participant 5E).*

Another participant stated that they kept to themselves, spending time with their partner and this decision was not a result of low self esteem but rather a conscious decision. One of the participants reported that:

> *"I have never been interested to be on committees. I would prefer to contribute anonymously to worthwhile causes including the Orangatang project or the Tasmanian Devil project" (participant 3C).*

One participant explained:

> *"I had a wonderful experience as a volunteer ambulance driver in the outback in a little old ambulance railway carrier. I enjoyed being a part of this community and the experience bolstered my self esteem which was present in my depression" (participant 1A).*

The participant moved to another state and they were unable to be involved in citizenship activities because they thought that they were way out of their depth. Firstly the new location was described as isolative due to a much larger population of people and they found that everywhere they went they were expected to read and write, and through this experience their self-esteem plummeted. They stated that:

> *"I knew that I could do the work, but I could not put things down on paper" (participant 1A).*

The participant wished that they could keep drinking to cope with the experience of low self esteem inherent in depression. Their negative life experiences and the move to another town precipitated a spiral downwards in a snowball effect. Participants reported that:

> *"My marriage of 25 years ended and this affected my relationship with their son, affecting my relationship with my daughter in law and then my grandchildren" (participant 1A). My life was fractured on so many levels and I was in a bad place" (participant 4D).*

One participant stated that they become involved in the state emergency services and they were heavily involved in committees until they were diagnosed with a mental illness and they were told by their doctor to quit. The participant stated that:

> *"By the time I was ready to get back into the state emergency service I had lost the trust of the people so that was the end of that" (participant 4D).*

The participant got deeper and deeper into mental health advisory groups and consumer advisory groups. After twelve months they got out:

> *"I needed to do this because my circle of friends all had a mental illness. As one person become unwell everyone rallied around them to the detriment of their own health, so as soon you get that person back on their feet someone else would go down" (participant 4D).*

It was a vicious cycle and become the impetus for the participant decided to take different tack of involvement including advocacy and systemic issues.

Behaviours

Participants actively participated in the cause, which they supported. They resisted the temptation to avoid attending and sustained their involvement to the domain of citizenship in their daily life activities.

Emotions

Participant's emotions were extreme in nature relative to their individual experience of citizenship in their community. Participants reported:

> *"I have good memories of a great experience during my involvement and participation in activities of citizenship and a*

deep sense of personal satisfaction. I felt good about myself" (participant 1A).

Conversely the participants felt frustrated, ashamed, weighed down and overwhelmed and to some degree betrayal. The participants stated that:

> *"I was more than willing and capable to be a useful and valuable member of the community and my efforts were detrimental to my self esteem in a background of a depressive illness because I felt discriminated in light of my short comings" (participant 4D).*

Bodily Sensations

One participant stated that they blacked out at times, and another participant reported persistent bouts of tearfulness.

Themes

Table 15- Citizenship: Positive and negative subjective experiences

POSITIVE SUBJECTIVE EXPERIENCES	NEGATIVE SUBJECTIVE EXPERIENCES
Participation in volunteering	Body pain in aging
Empowered through fighting spirit	Moving to a new location
Anonymous support in projects of care	Loss of connection with community
Accessing psychological support for pain	Isolation
Holistic mind/body approach to health care	Self soothing with drugs and alcohol
Involvement in mental health advisory groups	Marriage breakdown
Remaining true to personal values and beliefs	Family conflict
Good memories	Fractured global life experience
Willing and capable self views	Perceived loss of trust from others
	Snowball effect
	Personal burnout helping others with a deteriorating of mental state
	Preconceived belief of discrimination from others
	Feeling inadequate
	Black outs
	Persistent tearfulness

Table 16- Citizenship: Relief and maintenance of suffering

RELEIF OF SUFFERING	MAINTENANCE OF SUFFERING
Willingness to embrace others and connect with community Willingness to engage effort and participation in mental health services and psychological services Willingness to participate in activities of value Willingness to resist adversity and accept new challenges	Resistance to change Rumination Inability to forgive Resentment Internalisation of external experiences Procrastination Fear of uncertainty Self soothing through alcohol and drugs Fear of reality

Health/Physical Well-Being

Thoughts

One participant explained that:

> *"My experience of low self esteem inherent in depression was debilitating due to my physical health. I was unable to sleep and it had impacted in a horrendous way. I experienced terrifying night mares and traumatic ruminations due to post traumatic stress disorder. I experienced a negative self commentary about being so crook that I was headed for the looney bin forever where I would be locked up in a cage and the key would be thrown away, and I would be fed like a monkey" (participant 1A).*

The participant was unable to experience psychological pain or physical pain and they thought they were done for. The participant took to self-harming behaviours just to feel pain.

Another participant reported that they were never one to go gyms or anything.

The participant stated that:

> *"When I was bought up I had to eat everything on my plate, and I was not allowed to have anything else unless until my plate was cleared. This rule did not apply to my siblings and they were not punished for not doing as they were told. I experienced a wallop from my parent using a broom handle if I did not do as I was told to do, and on one occasion the broom handle actually broke when she was hit me" (participant 2B).*

The participant always thought they were a silly person growing up because they were exposed to so much negativity about themselves being not capable and not good enough. This was the starting point of their depression but they were always too busy to be depressed they thought. They thought that:

> *"I was not only too busy, but I was not the depressive sort of person, but in retrospect I must have been depressed for most of my life" (participant 2B).*

The participant attended an acute pain clinic in Bendigo and they found it really helpful because they spoke to the participant and explained many things to them, which the participant described as fantastic. The participant explained how their low self esteem really came through in their marriage with regard to sexual relations. They stated that:

> *"I did not want to be seen or touched by my partner and I closed down with my sexual contact with their partner" (participant 2B).*

Another participant stated that:

> *"I smoked so much which had an impact on my health and well being due to a combination of stress, boredom, too much time on my hands and needing something to do with their hands to keep themselves occupied" (participant 4D).*

When the participant was hunting and involved in the training for the state emergency services they stated that their physical health and well being was better but since then they have aged they have got lazier. The participant also contributes in regards to their lack of motivation:

> *"To the type of medications I was taking to manage my mental illness because the medication tended to leave me feeling flat and there is nothing that could be given to give me a boost" (participant 4D).*

On a nice day the participant takes out their camera and they stated that they well walk anywhere to get the photo they want and this improves their sense of self esteem and their health and physical well being.

One participant was unable to eat when they were depressed and lost about twenty kilograms. They reported that:

> *"I question why are people are so regimented to eat at certain times and because I do not see the point of having three meals a day, and point of view causes for conflict in my married life" (participant 3C).*

The participant reported that they really like to smoke but most of the time they can't be bothered to smoke and that they enjoyed a few good alcoholic drinks. The participant stated that:

> *"I have been very lucky with access to services for my physical health but I can't say the same for my mental health issues" (participant 3C).*

The participant stated that psychologist like to sit and you spoke at them because you felt embarrassed about the long silences. This was their impression of psychologists until they met another clinician and they were absolutely brilliant. The participant went on to report that beyond blue was disappointing, because at the time of their first contact the participant feeling cranky as a result of their symptoms of a mental illness and they found that beyond blue did not want to know them and the participant thought that most people would be feeling cranky at first contact. The participant was not in favour of government system clinicians.

One participant reported seeing a psychiatrist and they were told that they were depressed because they were not coping well with so much physical pain, and that they needed new hip and two new knees. The participant was put on pain patches and as the dosage increased to manage the pain they went off, and they went crazy. The participant stated that:

> *"I was unable to differentiate if was the physical pain that was causing the depression or if the depression was making the physical pain worse but I did know that my mind was not right" (participant 5E).*

To make things worse to be assessed in the city was inhibited by long waiting times, and the visit to the orthopaedic surgeon was also a long wait as well. The participant was advised to come back later when they could hardly walk. The participant noticed that:

> *"My physical mobility was progressively declining and time was marching forward. I was fearful that the time would come when I would be unable to walk. I also have diabetes and this exacerbates and restricts my lifestyle choices. Since having diabetes and pain I am constantly told that I can't do this and I can't do that. I've had given up sex because of the hip pain, I've had to give up smoking because that's was bad for me, and I've had given up alcohol. We are struggling financially so I'm unable to attend many of the social functions, which I'm interested in and secondly I'm in so much pain that I couldn't really walk any distance. I've also stopped going shopping for clothes because I can't get out of the car" (participant 5E).*

Their experience of poor health and restricted physical well being was explained as debilitating and it prevented them from doing so many routine day activities, which contributed to their low self esteem and the experience of depression.

Behaviours

Two participants reported that:

> *"I increased my intake of alcohol to overcome the pain and distress of low self esteem and depression contributing to the decline of my health and physical well being" (participant 4D).*

Three participants smoked tobacco and one of them also smoked cannabis. Sometimes they smoked heavily and then less on other occasions depending on the degree of stressful triggers in their day to day life activities. One participant stated that:

> *"I often de-compensated during times of change leading to increased risk taking behaviours of alcohol and tobacco misuse, self harm including superficial and serious cutting, and burning causing significant distress to my partner and exacerbating conflict in our relationship" (participant 1A).*

Four participants made reference to the value of walking in maintaining their health and physical well being and three participants were accompanied by their dog when walking for their companionship.

One participant tried to get out every day with their partner and walk to the shops, and on some occasions they would have a coffee while they were out to show people that they do things and

that they were not depressed. One participant reflected on their interview at the end of the interview and they stated that:

> *"It was impossible to put self esteem all in one basket. Their self esteem might be high in one domain of life and a whole lot different in another domain. With all those domains of life if you put a score on them you'd get one in one and ten in the other and I think that a person's self esteem is built up on all of the components" (participant 4D).*

Emotions

Participants reported recurrent low moods and associated lack of motivation in maintaining their health and physical well being with low self esteem inherent in depression.

Bodily Sensations

One participant experienced a release of pressure in their head after self harming behaviours precipitated by the sight of blood flowing from their injuries. Two participants reported sexual dysfunction. All participants reported fluctuations in their appetite and interest in food leading to both weight gain and weight loss. Insomnia was also reported by two participants which left them feeling lethargic and without energy to participate in healthy living and physical activity.

Themes

Table 17- Health/physical well-being: Positive and negative subjective experiences

POSITIVE SUBJECTIVE EXPERIENCES	NEGATIVE SUBJECTIVE EXPERIENCES
Involvement with psychological services Participation in person interest activity Physical activity	Deterioration of physical health Insomnia and nightmares Rumination Negative self talk Uncertainty of the future Self harm Physical, verbal and emotional abuse Self loathing Inferiority Denial of mental illness Physical unattractiveness Boredom and stress Time wasted

	Life unfulfilled Negative side effects of medication Weight changes Dissatisfaction with use of DSM-V Frustration with mental health services Self imposed stigma and perceived societal stigma Pain of aging Self soothing with alcohol and drugs Lack of motivation Mood instability Sexual dysfunction Lethargy

Table 18- Health/physical well-being: Relief and maintenance of suffering

RELEIF OF SUFFERING	MAINTENANCE OF SUFFFERING
Willingness to participate in activities of personal value Willingness to engage effort and to participate in mental health services and psychological services Willingness to embrace and accept change Willingness to resist adversity and challenges Willingness to move forward in the face of hardships	Resistance to change Habitual poor health practices Rumination Inability to forgive Resentment Internalisation of external experiences Fear of reality Fear of uncertainty Resistance to new experiences Self soothing through alcohol and drugs

Chapter 6 – Discussion

This qualitative research study aimed to explore the experience of low self esteem inherent in depression by gathering themes from the narratives of the participant's individualised stories. In the following discussion, themes have been gathered together, and then these themes have been applied to each of the nine domains of life.

Gathering of Themes

The participant's reported experience of low self esteem inherent in depression within the nine domains of life was complex, unique and profoundly personal. The analysis of the participant's subjective experience into themes has personalised the experience of low self esteem in depression. The art of living is difficult to quantify because of the transient nature of the lived experience. For example the framework used to develop theoretical models may not fully 'be with' the lived experience of a young person living with a parent who has a mental illness when attempting to conceptualise low self esteem in depression (Foster, O'Brien & Korhonen 2012). Without knowledge of the lived experience academic and scientific understandings alone appear superficial and simplistic. This research has been valuable in demonstrating how the subjective experience of low self esteem inherent in depression appears to become a part of life, not dissimilar to an addiction whereby people do not know how to live without it. The participants in this study appeared to have little faith in their ability to live without it because of a perceived belief that the experience of low self esteem in depression has in some way become their life's destiny. The human experience of low self esteem in depression tended to precipitate the formation of unhelpful habitual rituals that shaped the participant's life and maintained their low self-esteem and suffering.

The inevitable physical and emotional pain of the human experience, which has been encountered in light of the perplexing issues of life have a tendency to possess a person's focus and diminishes a person's insight to move forward. Suffering is maintained through a resistance to change, persistent rumination, resentment, inability to forgive oneself, internalisation of external experiences, habitual poor health practices, habitual and destructive behaviours perpetuating conflict with others, procrastination and fear of uncertainty. Through willingness to engage and participate with a mental health service and psychological services participants have embraced change, developed their strengths to accept and resist adversity, actively participate in value centred actions and discovered the value of the practice of mindfulness. Unfortunately some participants have experienced a long battle with their experience of low self-esteem inherent in depression through their passage of life, and their new found

understandings may be viewed as too little too late leading to regret and a sense of a life unfulfilled as time is always marching on and they may be psychologically left behind due to persistent rumination and autobiographical memory.

Historically the art of living has captured the imagination of people throughout the ages and is explained in the "Desiderata" a widely known poem which was copyrighted in 1927 by Max Ehrman (Appendix 1).

Marriage/Intimate Relations

The participant's narrated their experience of low self-esteem inherent in depression as it played out in their day to day life and their descriptions demonstrated some commonalities as postulated by Olver and Hopwood (2012) as a continuous interplay of biological, psychological and social factors. The experience affected the participants on a very personal level, which was explained as painfully complex. This complexity has been illustrated by Tiller (2012) who identified the complexities of life as chronic illness, life-threatening illnesses, developmental changes and role changes in the vicissitudes of life. Consistent with the literature(World Health Organisation 2004) these research findings highlighted how the ebb and flow of life situations provoked reactions, which cause disconnection from partners, and carried a devastating potential for the destruction of marriages and intimate relationships. The participant's experiences were deeply entrenched leading to suffering and discomfort as they were overburdened by negative thoughts and feelings about themselves consistent with reports in the literature (Leahy, Holland & McGinn 2012). Also supported by the literature was a sense of shame and failure stemming from deeply embedded conclusions and assumptions that they were conditioned to accept as valid and true views of themselves (Bloch & Singh 2001). Participants searched for happiness and they were deeply disappointed by the obstacle of self criticism and their unfortunate unhelpful patterns of behaviours that dominated in their circumstances, and which lead them to a profound and contracted view of their life experience as described by Leahy, Holland and McGinn(2012).

Family Relations

As evident in the literature (Erol & Orth 2011) those participants with early vivid memories of receiving genuine love, care and attention from their parent or caregivers reported a cohesive and heart warming understanding of family and unity which promoted a positive internal self concept and enabled visions of hope for themselves. Clearly described by Davies (Davies 2003), participants were bombarded with negative messages from their family and in particular their

parents attitude that undermined their experience of happiness, and tainted their self respect. Their belief in their capabilities and full potential to achieve their goals was temporary, and distracted by indoctrinated harsh negative appraisals and negative messages about themselves. This was supported by Leahy, Holland and McGinn(2012) who described this as autobiographical memory and rumination.

Friendships/Social Relations

Participants experienced friendships and essentially viewed them as a critical part of life with the potential to elicit new visions about themselves and to increase the magnitude of their abilities. These findings were reinforced in the research as important mediating factors and predictor of personal satisfaction in life (Lafrenière et al. 2011). The experience of families and social relationships was distorted for the participants who held negative appraisals of self, precipitating a fear of rejection, associated with the sense that they should reinvent themselves in order to be acceptable and of equal importance supporting the claims of Edelman (2002). Participants invested endless energy in weighing up their different internal opinions of themselves, and at times remained in a state of inertia due to lack of clarity about who they really are, which compromised their ability to commit to the things of life that they wanted to. These negative thinking styles were well illustrated and similar to the findings of Peterson (2010). Illustrated by (Westbrook, Kennerley & Kirk 2010) and confirmed by the lived experience of the participants, cognitive behavioural therapy was found to be an effective and efficient strategy to challenge and confront negative automatic patterns of thinking. Friendships and social activities were complicated and compromised by preconceived negative notions held by participants about themselves, causing understandable stress, tension and anxiety especially in new and unfamiliar situations as held up to be true by to the literature (Johnson 2010). Participants attributed blame on themselves for their problems and insecurities and they were unable to discern their discomfort from outside pressures or negative internal dialogue as expressed by Strandmark (2004). Also confirmed in the literature (Johnson 2010)were the participants feelings of failure that governed their reactions; so that those who gave up and returned to their old ways of isolating themselves from their friends and social activities often criticised themselves for not trying hard enough. As reinforced by Leahy, Holland and McGinn(2012), participants resented themselves and they resented outside pressure to participate and engage with others, however this pressure to participate was exactly the encouragement they needed to combat the self-perpetuating nature of unhelpful habit forming behaviours (Leahy, Holland & McGinn 2012).

Career/Employment

Participants found meaning and purpose through their workplace responsibilities, which served them well and this was eloquently described as developing one's self-worth and value in society (Erol & Orth 2011). Participants experienced moments of inspiration and enthusiasm generated through their employment and gained a sense of command over their lives, which was framed in the literature as a positive sense of self-concept (Videbeck 2011). Whether they were working with sophisticated communication systems, in service provision or managing organisational activities there was a conceptual blueprint that employment provided an accessible positive expression of oneself in the world. As supported by the literature (Lafrenière et al. 2011) the participant's ability to keep perspective in the key domain of employment sustained the participant's level of satisfaction in life and their level of self esteem.

Conversely career changes and times of un-employment held participants in a state of all consuming, destructive emotional insecurity which was precisely described in the literature as falling short of one's hopes to perform in activities of value to a person (Orth & Robins 2013). Contributing to what the literature describes as psychological inflexibility (Cristea et al. 2013). The findings of this research pointed to the same conclusion as the literature review that participants with low self esteem inherent in depression viewed themselves in the world through a negative filter. This view leads to high expectations of their performance, which invaded rationality in times of vulnerability and illness (Kilkkinen et al. 2007). Participants were upset by difficulties with employer management which was compounded by their upbringing and the limitations they placed on themselves as a result of the alienating and intimidating parenting they were exposed to when they were young which was also found by Johnson (2010). Participants recognised employment as a crucial life-phase and when illness did not prevail they were committed to accessing gainful and meaningful employment.

Education/Personal Growth and Development

Participants mastered their goals in educational and personal growth and development using an anchored approach of attending courses, participating in classes, reading books and attending groups of like-minded people to develop new skills, noted in the literature as a contributing factor to cognitive-social global self identity (Eschkol, David & Jeffery 2011). Embedded in the participant's desire for success and sense of determination was an underlying and threatening fear of rejection. Once again building on the findings of the literature, preconceived limitations, and negative internal dialogue were powerful forces that convinced participants not to bother expending any energy on education and personal development because they were wasting their time achieving the impossible and destined to fail (Leahy, Holland & McGinn 2012). This human

experience of psychological inflexibility is described by acceptance commitment therapists Cristea, Montgomery et al (2013) as cognitive fusion. With courage and commitment participants used all their will and determination to force through this underlying construct and associated chronic disposition of needless self criticism, which was often entrenched through painful childhood experiences. Challenging this mindset and subsequent achievement of personal satisfaction transformed the participant's experience of low self-esteem in depression and contributed to a moment of objective evidence of their positive self worth, this was also supported by the work of Springer(2012). This commitment to take action is the core message of acceptance commitment therapy as a way of regaining personal control in one's life (Harris 2009).

Recreation/Leisure

Initiating action in the direction towards participation in recreation and leisure activities was the greatest obstacle for the participants, expressed in the literature as a classic symptom of a depressive illness (Videbeck 2011). This conflict between ideal self and perceived self appeared to be either the impetus to change it exacerbated low self esteem and inaction as written in the literature (Krozier 2011). The complexity of life with a background of depression understandably closed off the participants' energies to engage in pleasurable activities. As reported in the literature (Organisation 2004) fluctuations of mood, combined with sleep deprivation and the effects of certain medications emerged as more than reasonable accounts for reduced motivation and lethargy. Buhrmester, Blanton et al(2011)went on to explain that levels of motivation and energy develop from a life time of experiences and give shape to productivity and quality of life(Buhrmester, Blanton & Swann 2011). Participants expressed a sense of disparity between their desire to cultivate a balanced life where attention was given to recreation and leisure in their lives, and their inaction to cultivate a life committed to their ideal wishes which Leahy, Holland et al (2012)describe as a powerful and toxic disparity. The literature (Bloch & Singh 2001) confirmed that this impaired ability to carry out and respond to life was associated with significant distress. Research participants expressed elements of pre-intentional energy to participate in activities in which they enjoyed. Sometimes the desire progressed into action, however this process required hard work and effort amidst the difficult happenings of life, and as the literature (Butcher, Mineka & Hooley 2007) confirmed, old habits and behaviours play out repeatedly to maintain and exacerbate depression. Participants who were relentless in their efforts to participate in leisure and recreational activities reported a positive shift in their mood and this also increased motivation through a lurking anticipation of better days ahead and a desire to enhance their existence. Appreciating this experience, the literature (Edelman 2002) encourages the promotion of a lifestyle focused on setting goals and

commitment to hard work that moves people towards life-enhancing and meaningful daily life experiences.

Spirituality

Participants reported an impoverished influence of spirituality on their self esteem in a background of depression. The distinctly different spiritual orientations in this world were curiously explored. Participant's childhood experiences of Christian teachings were tentatively embraced as a good basic moral path. Interestingly participants infused and augmented their responses on spirituality with soulful connections to music and to their pets. The absence or presence of spirituality in the participant's domain of life was not reported as a remarkable influence oneself esteem inherent in depression.

Citizenship

In the domain of citizenship participation in community activities bolstered the participant's self-esteem and sense of belonging. Involvement regardless of whether it was direct or indirect generally generated a subjective culture of living with an open heart to the needs of others. The literature (Westbrook, Kennerley & Kirk 2010) suggested personal benefits in the development of social functioning nurturing a confident sense of self. Some participants indicated a preference for anonymous and subtler support for a recognised cause, whilst others were attracted to the delivery of services and the distribution of care to those in need. These potentially relevant associations were shown in the literature (Byrne et al. 2013)to reflect the participant's experience of improved self esteem through an essential awareness of their humanity and compassion for others. In some situations participants needed to relinquish their committed involvement to their community and they elicited a sense of disappointment in the process of letting go and a degree of instability as a result of mounting pressure and demanding circumstances beyond the participants control. As illustrated in the literature (Orth & Robins 2013) these situations carry a significant burden of distress adding to the experience of low self esteem in depressed people. The absence of citizenship was not reported to undermine self esteem inherent in depression however there were reciprocal benefits in their courage to touch the lives of others.

Health/Physical Well Being

As evident in the literature (Cristea et al. 2013) the quest for optimal health and physical well being was viewed as on ongoing process hampered by both physical and emotional pain with distinct implications on the participant's self-esteem and the maintenance of their suffering.

Participants become mentally paralysed and struggled to change unhelpful habits despite years of effort to deliberately break automatic routines and this state of mind was at times dependent on the love and support they received from others, which was also described by Johnson(2010). Yet at other times no amount of support could override the participants underlying distorted and maladaptive thoughts and behaviours (Johnson 2010).People's psychological development evolved over time, and this was documented in the literature (Elder, Evans & Nizette 2012) as a multi-factorial situation resulting from changes in life experiences and life events. Core themes suggested that participants felt powerless to control their addictive tendencies to frequently smoke tobacco or cannabis, misuse alcohol, and consume excessive amounts of foods and this was supported by Erol and Orth (2011) as a common coping mechanism. Participants had the best intentions and they wanted to intervene but without any formal plan or investment in self regulation as postulated in the literature (Leahy, Holland & McGinn 2012)this led to an endless cycle of behaviours which undermined their health and well being with a repetition of entrenched character traits. Unhelpful addictive health habits failed to illuminate their painful emotion and physical suffering as intended, and only served to exacerbate and create a further source of anguish and self condemnation. The literature(Leahy, Holland & McGinn 2012) framed this failure to employ personal responsibility as a rebound affect which exacerbated self-critical thoughts and strengthening the depressed persons powerfully toxic negative view of themselves. Aging health concerns were significant to the health and well being of some participants with the deterioration of bodily functions through the wear and tear of aging. Participant's struggled with the cause and effect circumstances of aging, and the difficulties of finding effective pain management options. Dissatisfied and proactive participants who found medical interventions insufficient in controlling their pain took advantage of whole mind and body concepts, using evidence based techniques including the principles of mindfulness which was supported in the literature (Fralich 20012) and validated by the participants as having commendable results. In the literature review psychological therapies and treatments have been found to strengthen resilience and self awareness in the management of low self-esteem inherent in depression (Westbrook, Kennerley & Kirk 2010).

Conclusion

The participants reported experiences of low self-esteem inherent in depression and this was a powerful reminder of human vulnerability and resilience in the face of fear and uncertainty. Participants continually battled to dismantle negative core belief systems indoctrinated from a very early age but mental health professionals helped them overcome these systems of belief. The participant's old coping mechanisms tended to lurk just under the surface and when faced with aggravation or obstacles they are entrapped by negative thoughts that further diminish

their sense of self and invariably their self esteem particularly in the presence of a depressive illness.

The participant's experience of mental health care from skilled and inspirational mental health professionals was generally viewed as invaluable and liberating. Some ill-equipped mental health professionals left participants feeling apprehensive and uncomfortable. Those participants who reported a positive experience gained insights into their experience of low self-esteem inherent in depression, and with new tools they aspired to become masters at challenging their unhelpful thinking styles and behaviours through the development of strategies and techniques to enhance emotional regulation. Therefore it is recommended that interventions need to be delivered by skilled professionals with clinical experience and knowledge of human development combined with effective care planning techniques on an individualised basis.

Mental health professionals are compelled to approach the perplexing issue of low self esteem in depression with a conscious focus on the everyday lived experience of people in their care. Building on peoples' strengths and challenging peoples' negative key assumptions by using a holistic approach of linking the mind, the body and the soul with value centred actions. It is fundamental for health professionals to develop their inner wisdom and knowledge by viewing the whole landscape of a person's lived experience to gain a true perspective of any situation without judgement or prejudice.

The status quo is inevitable therefore developing coping strategies is required to manage change building on both the art and science of mental health awareness. The main focus of mental health nurses is to understand a person's subjective experience in order to empower people and add new dimensions for a better life rather than purely the amelioration of negative subjective experiences and symptoms. This understanding cannot be claimed as new knowledge emerging out of this research as these principles have been skilfully woven into focused psychological interventions by nursing and psychological clinicians in educational and clinical situations from a theoretical framework grounded through evidence based practice.

Recommendations for practice and future research

In line with current trends and rapidly growing research within psychiatry exciting, new information and developments in neuroscience should not be ignored but embraced (Arden 2010). Recent developments and evidence based research suggests that by gaining a solid grounding in the fundamental aspects of emotional regulation people have the potential to rewire the brain by developing new connections between neurons as an antidote to the suffering of depression (Arden 2010). Cultivating a culture of both exposure and accessibility to

emotional regulation has the potential to reduce long term suffering, and lift the silence and stigma of mental illness with the implementation of mental health nurse educators in school curriculums. Promoting and educating the next generation about the relevance of emotional regulation for mental and physical well being as well as intellectual intelligence. From the reported findings in this research it might be argued that further research into what programs are currently available within the school curriculum, and if they are adequate would be informative and worthwhile information.

This research demonstrates the long term benefits of a proactive early intervention approach by skilled expert mental health professionals with possible employment as educators in schools. To address the experience of low self esteem inherent in depression in its infancy before it becomes entrenched and gains addictive qualities with habits and behaviours which grow in strength and power shaping a person's experience of life. Given the longevity of the participant's negative subjective experiences of low self esteem in depression it is clear from this research that the drive in mental health services and psychological services needs to be strongly focused on early intervention. It appears to be worthwhile if not imperative to incorporate formal and structured programs into the curriculum at all levels of schooling. From the analysis of this research it is clear that adolescence was a critical time for the participants and the influence of disruptive processes in this developmental stage has had reportedly long-term negative effects leading to depression and low self-esteem (Cann, Lubman & Clark 2012).

Using a co-ordinated approach future research should continue to examine thorough focus groups of students, teachers and parents their opinions on depression and low self esteem. The purpose of these focus groups would be to elicit and map strongly held beliefs and understandings. With this information the potential value of mental health nurses in the school system as part of the professional multidisciplinary team may be enlightening (McCloughen, Gillies & O'Brien 2011). The identified needs from the focus groups may be further developed into action research by implementing early intervention programmes, seminars and conferences convened by mental health nurse educators, and measured against people's experience of the programs in school performance, coping skills, emotional regulation and self-esteem (Cann, Lubman & Clark 2012). Systematic and rigorous research will potentially unlock key understandings of the human experience of living with a mental illness to move forward, and change the face of the future.

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Appendices

Appendix 1Desiderata

"Go placidly amid the noise and haste, and remember what peace there may be in silence.

As far as possible without surrender be on good terms with all persons.

Speak your truth quietly and clearly; and listen to others, even the dull and ignorant; they too have their story.

Avoid loud and aggressive persons, they are vexations to the spirit.

If you compare yourself with others, you may become vain and bitter;

For always there will be greater and lesser persons than yourself.

Enjoy your achievements as well as your plans.

Keep interested in your career, however humble; it is a real possession in the changing fortunes of time.

Exercise caution in your business affairs; for the world is full of trickery.

Be let this not blind you to what virtue there is; many persons strive for high ideals; and everywhere is full of heroism

Be yourself.

Especially, do not feign affection.

Neither be critical about love; for in the face of all aridity and disenchantment it is as perennial as the grass.

Take kindly the counsel of the years, gracefully surrendering the things of youth.

Nurture strength of spirit to shield you in sudden misfortune. But do not distress yourself with imaginings.

Many fears are born of fatigue and loneliness. Beyond a wholesome discipline, be gentle with yourself.

Your are a child of the universe, no less than the trees and the stars;

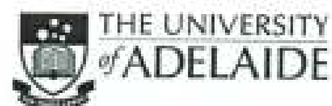
You have a right to be here.

And whether or not it is clear to you, no doubt the universe is unfolding as it should.

Therefore be at peace with God, whatever you conceive Him to be, and whatever your labours and aspirations, in the noisy confusion of life keep peace with your soul.

With all its sham, drudgery and broken dreams, it is still a beautiful world. Be careful. Strive to be happy".

Appendix 2 Participant Information Sheet



APPENDIX 2

Participant Information Sheet:

WOULD YOU LIKE TO BE INVOLVED IN A RESEARCH STUDY?

Volunteers Aged 18 years and over
Are Invited to Participate in Research

Hello, my name is Katie Fisher and I am a student in the Master of Nursing Science degree within the School of Nursing at The University of Adelaide. I am currently investigating the experience of low self-esteem for people with depression. I am inviting you to volunteer your time to participate in this study.

Your participation is voluntary, and you are free to withdraw from the research study at any time without any penalties or effect on your future mental health care in any way. Although the purpose of this research project is to improve health care professionals' understanding of low self-esteem during depression, your involvement may not be of any benefit to you.

To take part, you will be asked to attend one interview for approximately one hour at the Limestone Coast Division of General Practice Office at a suitable time which is mutually agreeable. With your consent the interview will be recorded on audio, and some notes will be taken during the interview. You will have the opportunity to have a member of your family or friend present with you during the interview.

It is hoped that this study will assist mental health professionals to broaden their knowledge, and to enhance their support for people with low self-esteem in depression. The results of this study may be published, but all participants will remain anonymous and no personal results will not be divulged. Your participation is confidential through de-identification and safe storage of all information collected. No persons other than the research team will have access to your data.

If you have any questions or concerns please do not hesitate to contact myself, Katie Fisher (Mental Health Nurse) at the Limestone Coast Division of General Practice on 0439364176.

Alternatively if you have questions or problems associated with the practical aspects of your participation in the project, or wish to raise any concerns or lodge a complaint about the project, then you should consult the project co-ordinator: Professor Anne Wilson from The University of Adelaide (08) 83033593.

Thank you for interest to participate in this research study.

HREC_Low_Risk_Review_Application_Form_V1-6.doc

Appendix 3 HREC Consent Form

APPENDIX 3

Human Research Ethics Committee (HREC)

CONSENT FORM

1. I have read the attached Information Sheet and agree to take part in the following research project:

Title:	**Understanding the experience of low self-esteem for participants with depression.**
Ethics Approval Number:	**H-2012-089**

2. I have had the project, so far as it affects me, fully explained to my satisfaction by the research worker. My consent is given freely.

3. I have been given the opportunity to have a member of my family or a friend present while the project was explained to me.

4. Although I understand that the purpose of this research project is to improve the quality of medical care, it has also been explained that my involvement may not be of any benefit to me.

5. I have been informed that, while information gained during the study may be published, I will not be identified and my personal results will not be divulged.

6. I understand that I am free to withdraw from the project at any time and that this will not affect medical advice in the management of my health, now or in the future.

I agree to the interview being audio recorded. Yes ☐ No ☐

7. I am aware that I should keep a copy of this Consent Form, when completed, and the attached Information Sheet.

Participant to complete:

Name: ____________ Signature: ____________ Date: ________

Researcher/Witness to complete:

I have described the nature of the research to ______________________

(print name of participant)

and in my opinion she/he understood the explanation.

Signature: ____________ Position: ____________ Date: ________

HREC_Low_Risk_Review_Application_Form_V1-6.doc

Appendix 4 Complaints Procedure

APPENDIX 4

The University of Adelaide
Human Research Ethics Committee (HREC)

This document is for people who are participants in a research project.

CONTACTS FOR INFORMATION ON PROJECT AND INDEPENDENT COMPLAINTS PROCEDURE

The following study has been reviewed and approved by the University of Adelaide Human Research Ethics Committee:

Project Title:	**Exploring the meaning of low self-esteem that is inherent in depression, an interpretive phenomenological study.**
Approval Number:	**H-2012-089**

The Human Research Ethics Committee monitors all the research projects which it has approved. The committee considers it important that people participating in approved projects have an independent and confidential reporting mechanism which they can use if they have any worries or complaints about that research.

This research project will be conducted according to the NHMRC National Statement on Ethical Conduct in Human Research (see http://www.nhmrc.gov.au/publications/synopses/e72syn.htm)

1. If you have questions or problems associated with the practical aspects of your participation in the project, or wish to raise a concern or complaint about the project, then you should consult the project co-ordinator:

Name:	**Dr Anne Wilson, Associate Professor, Course Coordinator, Discipline of Nursing, University of Adelaide.**
Phone:	**(08) 83033593**

2. If you wish to discuss with an independent person matters related to:
   - making a complaint, or
   - raising concerns on the conduct of the project, or
   - the University policy on research involving human participants, or
   - your rights as a participant,

   contact the Human Research Ethics Committee's Secretariat on phone (08) 8303 6028.

HREC_Low_Risk_Review_Application_Form_V1-6.doc

Appendix 5 HREC Ethics Approval

RESEARCH BRANCH
OFFICE OF RESEARCH ETHICS, COMPLIANCE AND INTEGRITY

SABINE SCHREIBER
SECRETARY
HUMAN RESEARCH ETHICS COMMITTEE
THE UNIVERSITY OF ADELAIDE
SA 5005
AUSTRALIA

TELEPHONE [illegible]
FACSIMILE [illegible]
email [illegible]
CRICOS Provider Number [illegible]

9 August 2012

Associate Professor A Wilson
School of Population Health and Clinical Practice

Dear Associate Professor Wilson

PROJECT NO: H-2012-089
Exploring the meaning of low self esteem that is inherent in depression, an interpretive phenomenological study

I write to advise you that the Human Research Ethics Committee has approved the above project. Please refer to the enclosed endorsement sheet for further details and conditions that may be applicable to this approval. Ethics approval is granted for a period of three years subject to satisfactory annual progress reporting. Ethics approval may be extended subject to submission of a satisfactory ethics renewal report prior to expiry.

The ethics expiry date for this project is: 31 August 2015

Where possible, participants taking part in the study should be given a copy of the Information Sheet and the signed Consent Form to retain.

Please note that any changes to the project which might affect its continued ethical acceptability will invalidate the project's approval. In such cases an amended protocol must be submitted to the Committee for further approval. It is a condition of approval that you immediately report anything which might warrant review of ethical approval including (a) serious or unexpected adverse effects on participants (b) proposed changes in the protocol; and (c) unforeseen events that might affect continued ethical acceptability of the project. It is also a condition of approval that you inform the Committee, giving reasons, if the project is discontinued before the expected date of completion.

A reporting form for the annual progress report, project completion and ethics renewal report is available from the website at http://www.adelaide.edu.au/ethics/human/guidelines/reporting/

Yours sincerely

Dr John Semmler
Acting Convenor
Human Research Ethics Committee

RESEARCH BRANCH
OFFICE OF RESEARCH ETHICS, COMPLIANCE AND INTEGRITY

[illegible]
SECRETARY
HUMAN RESEARCH ETHICS COMMITTEE
THE UNIVERSITY OF ADELAIDE
SA [illegible]
AUSTRALIA

TELEPHONE [illegible]
FACSIMILE [illegible]
email [illegible]
CRICOS Provider Number [illegible]

Applicant: Associate Professor A Wilson

School: School of Population Health and Clinical Practice

Project Title: ***Exploring the meaning of low self esteem that is inherent in depression, an interpretive phenomenological study***

THE UNIVERSITY OF ADELAIDE HUMAN RESEARCH ETHICS COMMITTEE

Project No: **H-2012-089** RM No: 0000013633

APPROVED for the period until: **31 August 2015**

Thank you for the responses dated 9.7.12 and 5.8.12 to the matters raised by the Committee. It is noted that this study will be conducted by Katie Fisher, Masters student.

Refer also to the accompanying letter setting out requirements applying to approval.

Dr John Semmler
Acting Convenor
Human Research Ethics Committee

Date: 6 AUG 2012

Appendix 6 Participant Invitation

20/03/2014

Mrs Katie Fisher,

c/- PO Box 90,

Mundulla, S.A. 5270

Mr XXXXXXXX,

XXXXXXXXXXX,

XXXXXXX, S.A. 5268

Dear XXXXX,

I hope this letter finds you well. As you would recall I am a student in the Master of Nursing Science degree investigating the experience of low self-esteem for people with depression. My research study is slowly progressing and I would like to thank you for generously volunteering your time to participate in this study.

Through this process I wish to invite and include you, to ensure the authenticity of the data which I have collected. Therefore please find enclosed a copy of my transcribing of this interview for you to reaffirm. You may wish to include any additional response you may like to mention, or to make any comment you wish regarding the accuracy of my transcribing.

I would like to remind you of the voluntary nature of your involvement in the research project, and that you that you have the right to not respond to this invitation. If you would like to respond I welcome your response and I would like to aim for a four week turnaround period. If you could please respond prior to the 25/04/2014 I would be extremely grateful.

Thank you for your interest to participate in this research study.

Yours faithfully,

Katie Fisher