Spiritual Recovery of People Living with Bipolar Disorder in Malaysia

By

Nurasikin Mohamad Shariff

MnSc, BhSc. (Nursing)

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Abstract

Introduction: Studies looking into spirituality, mental well-being and recovery have reported positive findings from people with mental health problems, yet only scant attention has been paid to the context of bipolar disorder (BD). Furthermore, the taxonomy of spirituality is fraught with complexities in relation to mental health studies due to contextual variables. Such variables are influenced by religious and non-religious constructs. The contribution of the present study is in exploring spiritual care in the quintessentially religious world views of a Malaysian population.

The aim of the study: To provide a conceptual understanding of spirituality in religiously affiliated service users with BD in the context of Malaysia.

Methodology and Methods: The methodology for data collection was informed by the Constructivist Grounded Theory by Charmaz. The recruitment of participants for this study took place at two outpatient mental health premises in Kuala Lumpur, Malaysia. Specifically, this study employed a semi-structured interview method involving 25 participants. All interviews were audio-taped and transcribed verbatim, then analysed using the thematic analysis approach.

Findings: Eight themes emerged from the analysis: experiencing spiritual despair, engaging in spiritual meaning-making, orienting the spiritual life, keeping faith in God, devoting oneself to God, having a sense of spiritual harmony, improving the sense of self-control, and establishing a positive life adaptation. Having identified the individual themes, they were then grouped under three overarching themes, each of which has been written about as a chapter in this dissertation; 1) restoring hope, meaning and

purpose, 2) maintaining a positive sense of self, and 3) adapting to live with BD.

Discussion: Upon completing the data analysis, Bourdieusian Theory (BT) is applied in order to conceptualise spirituality as spiritual capital. In relation to the theorisation work, it applied the conceptual tools of BT – the capital (i.e. resource) and the habitus (i.e. the subjectivity) – and the BT explanatory model on symbolic transformation and the aggregation of capitals. In line with this theory, three different salient resources identified in the findings (i.e. religion, interpersonal relationship, medicine) were interpreted for their symbolic exchange of spiritual capital. Interestingly, the salient capitals are also capable of offering a route for mental health recovery as they help in understanding the psychological resilience in this sample of service users with BD.

Conclusion: The present study highlights the phenomenon of the salient capitals with the application of BT for spiritual capital, particularly the interesting incorporation of medicine as part of spiritual approaches. As the current study discusses spiritual capital only from the context of the religiously affiliated sample diagnosed with BD, future scholars may wish to explore the phenomenon in the context of their own fields of interest.

Keywords: bipolar disorder, Bourdieusian, recovery, spiritual, mental health, grounded theory

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"In the name of God, the Most Gracious, the Most Merciful."

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I've changed. Irrevocably. Permanently. My soul is richer and my heart is fuller in brokenness than it ever was without. I've learned true despair, and it's made me learn to appreciate true joy.

(scribbleandcrumbs)

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List of abbreviations

APA	American Psychiatric Association
BD	Bipolar disorder
BT	Bourdieusian Theory
CPG	Clinical practice guideline
ECT	Electroconvulsive therapy
EQ	Emotional quotient
GT	Grounded theory
GGT	Glaserian grounded theory
SGT	Straussian grounded theory
ConGT	Constructivist grounded theory
MH	Mental health
MHC	Mental healthcare
MHS	Mental health service
MPA	Malaysian Psychiatric Association
SQ	Spiritual quotient
TA	Thematic analysis
WHO	World Health Organization

Chapter 1: Introduction

1.1 Chapter introduction

In this chapter, the constructs involved in the present study are discussed, namely those of spirituality, bipolar disorder (BD), mental health service (MHS) and the Malaysian religious context. After having comprehensively discussed these constructs, the focus then shifts to justifying the undertaking of the present study.

The chapter begins with the researcher's own reflections on spiritual issues among service users with bipolar disorder (BD) in the context of Malaysia. It then moves on to discuss the background of users' accounts on the spiritual sense of recovery. This is reviewed against the biomedical approach widely employed in the treatment of BD, in contrast to the mental healthcare (MHC) policy which has a focus on accommodating the place of spirituality and religion as part of the users' needs. Central to the present study is that Malaysia is well known for its multi-religious population. Hence, it can offer a better understanding of spirituality within the religious frame of Malaysia, while at the same time serving as an exemplar for the Asian religious context. The latter review on the position of spirituality in relation to MHS in Malaysia then justifies the undertaking of the present study in carrying out a study in the Malaysian context.

1.2 Researcher's interest

Having served as a mental health nurse with experience of working with service users with BD, I have always made it a priority to be aware of the importance of spirituality for them. My personal experience of observing the spiritual issues encountered by two service users with BD in the course of their stay on a psychiatric ward at the University of Malaya Hospital

(UMMC), Kuala Lumpur, Malaysia, led to the development of my interest in studying this issue academically.

The first service user, i.e. Madam Ani, was a Muslim housewife in her 50s. She was hospitalised due to a depressive episode of BD. Madam Ani was described by her psychiatrist as demonstrating diligent medication adherence and a relatively higher degree of religiousness, manifesting in positive thoughts and adherence to religious activities. Her psychiatric report described her history as showing potential signs of recovering from symptoms over two to three consecutive years. Overall, although Madam Ani was recovering well, she was undergoing a depressive episode in her life due to a psychosocial issue between her and her spouse, i.e. a marital conflict involving a third party. The episode was so stressful that it led to her developing suicidal thoughts, for which she was prescribed electroconvulsive therapy (ECT).

The second service user, Mr Ganesh, was a (Malaysian) Indian Christian who was diagnosed with manic symptoms, together with alcohol dependence. He was placed on the psychiatric ward due to being aggressive while on the public area. Mr Ganesh had served as a veterinary surgeon, but he was no longer able to perform his job appropriately as a result of his psychiatric condition. In addition, he was unable to resolve issues in his personal life, such as financial crises and family disputes. Mr Ganesh felt that his life had become meaningless; he felt abandoned by his parents and had lost faith in his religion.

I approached these two service users for my clinical case study as part of the requirements for my master’s degree programme, and their profiles were presented to the psychiatric specialist. It was learnt from the discussion with the specialist that I had to help address their spiritual

needs thoroughly, particularly in relation to their life crises at that time. As a health professional, however, I was unable to lend support to such needs due to the rather narrow biological and psychological approaches embedded within MHC policy. Having had a discussion with the psychiatrist in charge of these service users, I was informed that it was sensitive to enquire about the service users' faith in God and religious practices while they were in hospital, having been through traumatic events in their lives. Worse still, it was then unclear as to whether I would be able to refer the service users to pastoral care since there was no formal chaplain system available within our local hospital services.

Upon closely scrutinising the spiritual issues, it can be seen that Malaysian users, by and large, are born within and live with various religious perspectives and practices in their everyday lives – they are also surrounded by their families and communities, almost all of whom have their own religions. Yet Malaysian MHS does not actively help to address the religious-spiritual concerns of its users. It is rather left to those users, or to their immediate family members, to use their initiative with regard to their religious-spiritual concerns.

Having learnt about such developments in the country, I felt the need to carry out the present study as part of my doctoral dissertation. In doing so, as a mental health nurse, I feel the urge to provide holistic mental healthcare addressing the complete well-being needs of service users, including those related to spirituality. As a nurse lecturer, it is incumbent upon me to ensure that my students understand where and how spirituality fits in the promotion of both mental health (MH) and well-being. However, in order to be able to achieve this, it is my personal view as a Malaysian that we may need an understanding of the importance of spirituality from

the perspective of service users experiencing mental health problems such as BD within the Malaysian context.

1.3 Study background

In the previous section, the researcher reported her reflections on spiritual issues by citing two examples of cases in Malaysia. This section, in contrast, brings in the voice of a service user diagnosed with BD, particularly by mentioning her true sense of recovery in a spiritual sense.

A further insight into the spiritual issues is provided through the story of Cathy Conroy, a former mental health advocate from Goulburn, New South Wales, who has been living with BD. Conroy (2004) illustrates her experience of dealing with BD symptoms by seeking the blessing of Almighty God to give her the necessary strength:

> *I felt not only the full array of manic depressive symptoms, but a head cluttered with racing thoughts, intense anger and a wild and shocking inability to see the worth in myself; a desire, too, to denigrate the people I loved. I was a terrible mess, and I wondered how I would ever escape the chaos. I wrote to Our Lord at this time, apologising for my constant longing for reassurance. I asked if I had betrayed the light of Him in me, beseeching a sign of strength.*
>
> (Conroy, 2004, p. 138)

It can be seen that Conroy's story represents her voice as a service user in terms of how she lives with the symptoms of BD and its impact on her loved ones, or, as she perceives it, 'the chaos'. Here, Conroy describes herself as having to live with rapid mood swings, as a 'terrible mess' and she outlines the impact this has had on her thoughts, emotions and the way she has treated her loved ones. For Conroy, BD is a serious mental

disorder that leads to her feeling torment due to the rapidly cycling mood swings she experiences, and she described feeling *'close to being broken, ashamed, stripped and burnt out'* (p. 136).

Conroy then pondered how she might be able to free herself from the terrible nature of her lived experiences (i.e. to recover). She also began to doubt her loyalty to Almighty God, while also constantly seeking reassurance and strength from Him. In addition, Conroy highlighted her 'true sense of recovery' as a deeply spiritual sense of self:

> *awakening to the world on a sacred journey more intense and unified is indeed a path of grace, new discovery, meaning, responsibility and direction.*
>
> (Conroy, 2004, p. 140)

In relation to the contents of Conroy's story, spiritual matters have been reported to loom larger in individual consciousness, particularly at times when mental health problems, such as transitions or crises, strike (D'souza, 2007). However, only small studies examining spirituality from the perspective of service users have been reported and discussed in the literature (Pike, 2011). Hence, Conroy's (2004) story has shed light on the way in which religious/spiritual resources may help individuals diagnosed with BD to cope and recover. Specifically, Conroy's account serves as an eye-opener to the way in which spiritual matters are relevant to a user's sense of recovery, which appears to differ from the perspective of the traditional psychiatric route (i.e. the biomedical approach). Such a scenario leads to the core of the present study, i.e. that the perspectives of the users on their spiritual sense of recovery, particularly those diagnosed with BD, should be comprehended.

The following section discusses the context of BD in comparison to the traditional psychiatric route. This discussion leads to the next argument of the present study, i.e. that the users' experience of living with the trauma of BD can be left uncomprehended if approached solely through biomedical care, as is outlined in the following section.

1.4 An overview of bipolar disorder in the worldwide context

The background to the study discussed in the previous section has highlighted the need to understand service users diagnosed with BD in relation to matters of spirituality, to include coping with the negative impact of living with BD. This section highlights the use of the medical model for the purpose of establishing symptoms and not for determining the spiritual needs of service users with BD.

This section thus reveals the prevalence and recurrence of BD, the main features of BD symptoms and the biomedical treatments that are available. The prevalence and recurrence of BD is presented next.

1.4.1 The prevalence and recurrence of BD

This section discusses the prevalence rates of BD in a few well-known countries such as the U.S. and India. It also highlights a range of concerns among users related to the impact of having to live with BD from the time they developed the symptoms, particularly for those affected since a young age.

The worldwide prevalence of BD is estimated at 60 million individuals, as reported by the World Health Organization (WHO, 2016). Of the many countries in the world, the U.S. had the highest prevalence of bipolar disorder (BD) (4.4 per cent of the population), while India had the lowest (0.1 per cent of the population) (Merikangas et al., 2011).

It has to be noted that the relatively higher rate of recurrence of BD indicates that it is a chronic disease (Cruz et al., 2010). Moreover, it is one of the leading disorders associated with suicidal behaviour among individuals (Costa et al., 2015; Gonda et al., 2012; Rihmer, 2009). Some of the main concerns in relation to living with BD are that service users, for the most part, develop the disorder during their adolescence, which is a critical period in terms of their educational, occupational and social development (Merikangas et al., 2011). The following section presents the main features of BD symptoms with the aim of providing an overview of how users with BD have to cope with it.

1.4.2 Main features of the symptoms

Since BD is a uniquely complex psychiatric condition (Pesut et al., 2011), service users may experience changes in their mood state that range from patterns of mild depression and brief hypomania to a severe rapid cycling or predominant mania with psychotic features (De Fazio et al., 2015; Müller-Oerlinghausen, Berghöfer & Bauer, 2002). Additionally, these mood states can be interspersed with periods of 'normal' moods (Pesut et al., 2011). It is worth noting that these main features can be severe enough to lead to a range of dysfunctions and problems in many aspects of the users' lives, including their work, family responsibilities and social activities (American Psychiatric Association [APA], 2017).

Nonetheless, service users need to cope with the traumatic impact of BD symptoms (Darling et al., 2008), similar to the story of Conroy (as shared in the study background). The course of the manic state of BD, akin to continuous agitation, often results in humiliation and social devastation. The depressive state may cause demoralisation and often manifests as a reverse effect of the manic state (Braam, 2009). The medical model is

often resorted to in a bid to minimise the symptoms of BD, thereby resulting in a biomedical intervention. This is presented in greater detail in the following section.

1.4.3 The biomedical intervention in the approach to care

In relation to the previous section, in which the main symptoms of BD were discussed, this section presents the biomedical approach to care in order to highlight the approach taken with regard to symptom amelioration. The present study argues for the need for service users to be placed at the centre of care in order to help minimise the adverse impact of their BD.

For over a century, the Western world has been dominated by medicalisation as one of the dominant paradigms in the approach to the treatment of mental health problems (Tew, 2013). In the context of BD, medicine is capable of treating the associated mood states, and it is believed that service users are capable of going on to lead full and productive lives (APA, 2017). It is also worth highlighting that the main aim of the treatment of BD is a prevention of the recurrence of symptoms (Müller-Oerlinghausen et al., 2002). Thus, the biomedical approach to care has emphasised adherence to medicine, specifically as a means of reducing the symptoms (Darling et al., 2008).

Despite the above discussion, it can be argued that the biomedical approach is not in line with the intended outcome that is desired for service users (Braam, 2009). Such a view can be associated with the issue of non-adhering individuals who are diagnosed with BD (Sajatovic et al., 2009; Zeber et al., 2008). Besides, the development of the 'anti-psychiatric' movement in the West is a reflection of service users' protest against the biomedical intervention approach (Cooper, 1967; Ralley, 2012; Szasz, 1960). It is possible to view the anti-psychiatric movement in the light of

service users being able to demand their rights in relation to both treatment and care. Such a discussion is presented in the following section on MHC policy.

1.4.4 Mental healthcare policy in the global context

In contrast to the biomedical approach to care, which was discussed in the previous section, the WHO has rightly highlighted the importance of protecting the rights of users globally. This includes putting emphasis on policies in relation to enforcing the protection of users' rights. As such, service users are able to have their voices heard or demands met in support and care in ways that go beyond the biomedical approach, which is delineated in this section.

The WHO's Mental Health Action Plan 2013–2020 envisions users with mental health problems being able to access culturally appropriate health and social care (Saxena, Funk & Chisholm, 2014). The plan calls for governments across many nations around the world to help develop national policies that protect the rights of users (Saxena et al., 2014).

In relation to the above-discussed plans, in nations such as the UK, the recent MH policy document (2011) incorporates the strategy 'No Health Without Mental Health' (Department of Health, 2011). There is a clear commitment to service users on the part of the UK government, as evidenced by the following extract:

> *Putting people who use services at the heart of everything we do – 'No decision about me without me' is the governing principle. Care should be personalised to reflect people's needs, not those of the professional or the system. People should have access to the*

information and support they need to exercise a choice of provider and treatment.

(Department of Health, 2011, http://www.dh.gov.uk).

Such a policy is in line with the post-psychiatric movement and establishes further initiatives to work collaboratively with MH service users, wherein there is likely to be a distribution of power (Bracken & Thomas, 2001; Kecmanovic, 2009).

However, such policies are typically found to be rather slow at focusing on the needs of those with particular mental health problems such as BD. With regard to BD, Goodwin et al. (2016) asserted that the lack of focus seen in care policy appears to exacerbate the serious problems that are faced by individual service users. However, in recent years, MH practitioners have increasingly considered the needs of users, as seen in methods that include managing the MH needs of users with the integration of religious and spiritual dimensions (D'Souza, 2007). It is worth highlighting that the present study operationalises spirituality within the religious frame in the following section, which relates to the context of service users in expressing their spiritual issues with religious ideas in line with the researcher's reflection and the study background.

1.5 An overarching definition of spirituality with religion

The previous section highlighted the need for MHC policy to support the needs of service users, which in turn allows for the discussion of religion and spirituality as elements integral to care approaches. The present section focuses on an overarching definition of religion and spirituality prior to emphasising that both are always viewed together, particularly with regard to the paradigm of religion.

The origin of the word ‘religion’ can be traced back to its Latin root *religio*, which signifies a bond between humanity and a superhuman power (Hill et al., 2000). Religion has been well defined by many, with a popular definition established by Koenig, King and Carson (2012, p. 45):

> *Religion involves beliefs, practices and rituals related to the transcendent, where the transcendent is God, Allah, Hashem, or a Higher Power in Western religious traditions, or to Brahman, manifestations of Brahman, Buddha, Dao, or Ultimate truth/reality in Eastern traditions.*

The notion of spirituality represents the idea of being a religious person. Despite the definition of religion positioning it as standing separate from spirituality, Hollins (2005) highlights that religion is indeed frequently referred to in relation to spirituality.

The following understanding of spirituality is taken from the example of Koenig (2008a, p.349):

> *A subset of deeply religious people who have dedicated their lives to the service of their religion and to their fellow humans, and whose lives exemplify the teachings of their faith traditions.*

From this notion of spirituality as a subset of religion, we can state that religion (i.e. practices in private or within religious organisations) can provide an avenue or context for spiritual experiences (Fallot, 2007; Swinton, 2005; Wright, 2005).

In sum, the definitions of both religion and spirituality are closely associated with each other. In this respect, to consider these two concepts as interrelated is to understand the context in which religion is relevant to

the population concerned. In a similar vein, Sheldrake (2012) emphasised that context is seen as an important element in relation to the consideration of spirituality. Following on from these definitions of religion and spirituality, the next section discusses the major world religions with the aim of offering a cursory understanding of spirituality within the religious paradigm.

1.6 Major religions in the world

As mentioned in the previous section, the following section seeks to offer a cursory understanding of spirituality from the perspectives of the world's major religions. In this regard, this section touches upon four major world religions, namely Islam, Christianity, Hinduism and Buddhism, with the followers of such religions being known as Muslims, Christians, Hindus and Buddhists respectively. These and other religious groups, such as Jews, are found across the globe in either a majority or minority depending on the regions in which they reside (Sheldrake, 2012). The characteristics of the four major religions are given in Table 1.1

Table 1.1: Major Religions of the World

Religion	Description of Beliefs	Dominant Region in the World
Christianity	Christianity departs from Judaism and Islam in its assertion of the divinity of Jesus, venerated as a Prophet and the Son of Mary in Islam. Aside from the Trinity and the belief that Jesus was crucified to redeem mankind (Koenig et al., 2012), it focuses on the teachings of Jesus Christ in the New Testament. Believers speak to and maintain a relationship with God. The religious text is the Bible (Sheldrake, 2012).	Western countries
Islam	The specific origins of the religion come from Prophet Muhammad (pbuh) – his principal sayings (known as sunnah) were collected in the Qur'an (Rassool, 2000). Islam emphasises a personal commitment to God – this includes attentiveness and an obedient submission to God's will, as well as acting in ways that achieve God's will (Haque, 2005).	The Middle East and South East Asian region, such as Malaysia and Indonesia.
Hinduism	A complex philosophical tradition, scriptures, devotional or folk religion. A mystical form of polytheism; Hinduism affirms a belief in a primordial Godhead (Brahman), as well as innumerable fragments of the divine that inhabit all things (Joshanloo, 2013; Sheldrake, 2012). Brahman is the Supreme, Universal Spirit that is the ultimate origin of everything (Joshanloo, 2013).	India
Buddhism	Similar in some respects to Hinduism, but is considered fundamentally to be a variety of traditions based on the teaching of Siddhartha Gautama. The teachings were intended as a recipe to be freed from suffering, to escape the cycle of rebirth and to achieve enlightenment (*nirvana*) (Sheldrake, 2012; Ting & Ng, 2012).	Eastern countries such as China and Korea.

To sum up, this section has highlighted several of the major world religions, focusing particularly on the differences concerning the prevailing beliefs across the globe; from the Western, Middle East and Eastern regions. The different religions across the global context, namely Christianity, Islam, Buddhism and Hinduism, as presented in Table 1.1, can also be found in Malaysia, as presented in the next section.

1.7 The Malaysian context

In contrast to the previous section in which the presence of the major world religions – Christianity, Islam, Hinduism and Buddhism – was discussed, this section looks at the major religions on both the global and Malaysian levels. Later in this section, the present study argues that Malaysian MHS should consider religion and spirituality as part of the recovery approach. This is accompanied by a justification of the need for spiritual care in MHS that is modelled by the service users by comprehending their needs in relation to the Malaysian cultural context.

The structure of this section is as follows: a brief introduction to Malaysia in terms of its multi-ethnic population, from the historical to the current context; the religious composition in hierarchical order; spiritual healing as part of the religious context, and spiritual care as yet to be integrated into MHS in the context of Malaysia.

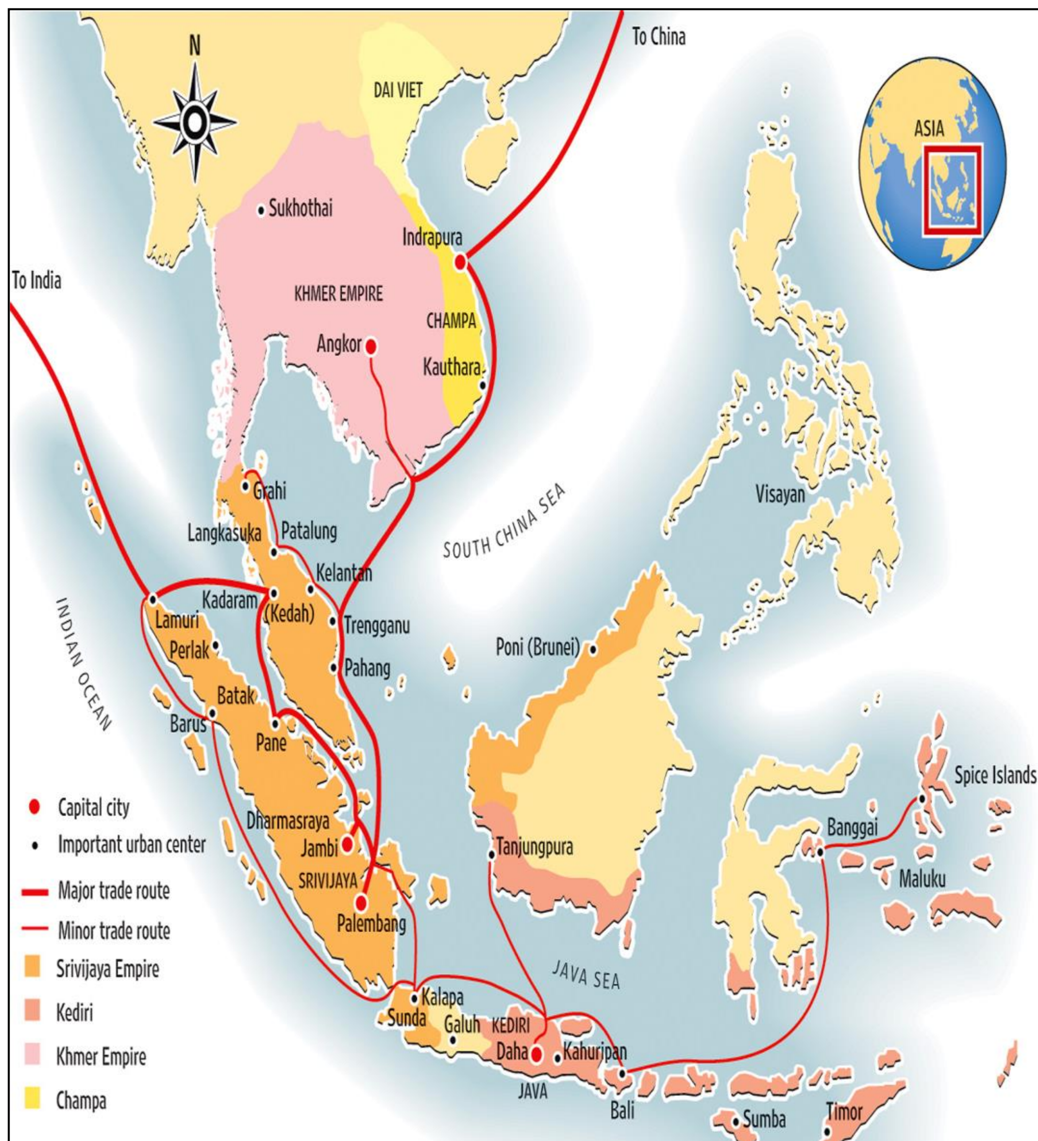
1.7.1 A brief introduction

Malaysia is well known for its multi-ethnic population, comprising mainly ethnic Malays, Chinese and Indians (Grundman, Truemper & Ludwig, 2004). A serviceable definition of 'ethnic' is:

> *Pertaining to a race or nation having common racial, cultural, religious or linguistic characteristics specially designating a racial or other group within a larger system.*
>
> (Fenton, 2003, p. 14)

In the context of Malaysia, ethnicity is highly correlated with religion (Department of Statistics, 2011). The concept of religion in Malaysia defines many individuals' values, belief systems and sense of being, and it is also seen as an integral part of community life (Ting & Ng, 2012). Each religion in Malaysia has a different set of beliefs and practices, and, although they are diverse in nature, are also embedded, tolerated and celebrated within the highly sensitive Malaysian society (Ting & Ng, 2012).

In the context of the discussion above, it can be explained that the contemporary ethnic composition in Malaysia has evolved as a result of historical events in relation to the trade that took place on the Malay Peninsula when the British were still in power. The Malay Peninsula has long been a strategic meeting point between East and West (Figure 1.1: Trade Routes of South East Asia, c. 1200 CE), connecting the maritime routes between India and China since ancient times (Kartapranata, 2008). It was largely populated by Malays prior to the era of British colonialism (Parameshvara Deva, 2004).



(Kartapranata, 2008)

Figure 1.1: Trade Routes of South East Asia, c. 1200 CE

The multi-ethnic composition was accelerated with the importation of labour from those countries during the era of British colonialism. This led to a massive influx of Indian and Chinese minorities representing Hinduism and Buddhism and thus joining the indigenous Muslim Malays and smaller Arab and aboriginal minorities (Muhamat et al., 2012; Montesino, 2007; The Commonwealth, 2017). The next section discusses the religious composition prevalent in Malaysia in statistical rank order.

1.7.2 The religious composition of Malaysia

This section serves to illustrate that service users in the context of Malaysia face various adversities related to the religious beliefs of Islam, Christianity, Hinduism and Buddhism (i.e. as derived from other regions such as in the Middle East, Western and Eastern world views).

The multi-religious groups living in Malaysia comprise the following: Muslim Malays (63.1%), Chinese as followers of Buddhism (19.8%) or Christianity (9.2%), followed by Indians, who are mainly Hindu (6.3%). Only 0.7% of Malaysians identify themselves as atheist (Department of Statistics, 2011).

According to Sheng (2007), a small number of Chinese and Indians have converted to Christianity and Islam. Other minority religions in the country include Taoism (among the Chinese) and Sikhism (among Indians) (Ting & Ng, 2012). In relation to the freedom to practise religions in Malaysia, it is important to note that Islam is the country's official religion, and any issue concerning religious expression that may adversely harm the society is handled by the government of the day (Mohd Sani & Abdul Hamed Shah, 2010).

In view of this, religion in Malaysia flourishes in the lives of service users individually – they mostly have a religious identity and are therefore free to practise their religions in Malaysia. In addition, there is no nuanced understanding of religion and spirituality as separate concepts in Malaysia. This is because both are often referred to interchangeably as a means of helping to guide individuals' decisions concerning how they conduct their lives (Md. Yusoff, 2011). Besides, Malaysian society contains various approaches to spiritual healing that reflect the religious-cultural views on the treatment of mental health problems. The following section highlights

the awareness of this current study that spiritual healing practices are part of a religious paradigm in the Malaysian context.

1.8 The context of spiritual healing

In addition to the presence of multi-religious groups in the context of Malaysia, as was highlighted in the previous section, each religious tradition also has its own ethnic spiritual healers and approaches (Abdullah et al., 2016), which is referred to in this section as faith healing. This section thus highlights the awareness of faith healing in the context of Malaysia, incorporated within the religious paradigm of Malaysian society.

Religion within the Malaysian cultural context implies the traditions of spiritual or faith healing practices (Chong, Mohamad & Er, 2013); this is based on the lay perceptions of religio-cultural beliefs as to what potentially causes mental health problems (Swami et al., 2009). In accordance with this, Malaysian citizens have typically sought traditional or religious healers for a cure (Razali, Khan & Hasanah, 1996; Sheng, 2007). This section delineates spiritual healing in relation to the religious faith beliefs in each religion practised in the context of Malaysia.

It has to be noted that Muslims and Christians share similar concepts of faith healing. In Islamic healing, Muslims believe that illnesses are often caused by the *loss of semangat* (soul substance) or possession by the devil (Haque, 2008), to which diagnoses of mood disorders, schizophrenia and major depression are commonly ascribed (Razali et al., 1996). Consequently, Muslims and Christians often seek religious healers who use Qur’anic recitation or Christian exorcism to expel the evil spirits suspected of residing in the bodies or homes (Abdullah et al., 2016; Haque, 2005; International Christian Assembly, 2017). Christians believe that it is God’s

will for the sick to be healed and that the power of Jesus Christ is available to all who ask (International Christian Assembly, 2017).

Hindus and Buddhists also believe in faith healing, and this includes involvement in a broad range of activities such as rituals (*puja*), amulets (*tabeez*), specific rings, cauterisation, chaining in temples, exorcism of jinn and ghosts, animal sacrifices and other practices (Sarkar, 2014). It has to be noted that ethnic Chinese living in Malaysia follow a variant of traditional Chinese medicine that is imbued with Eastern (i.e. Buddhist and Taoist) principles but which is not religious per se. Chinese people seek help from Chinese physicians (*sinseh*) and in the form of acupuncture and *chi'i-gong* (a type of martial art) (Haque, 2005). Similarly, Indians are known for their Ayurvedic folk practices such as including dietary and herbal medicine as part of their efforts to cure mental illness (Haque, 2005; Galanter, 2005).

Referring to the above, the existence of spiritual healing as a religious-cultural paradigm is thus evident in the context of Malaysia. The concern is that service users may refrain from using MHS to treat mental health problems in favour of turning to faith healing. Such a preference may contradict the medical model in terms of its scientific course and treatment modalities.

Moreover, service users who attend MHS in Malaysia are commonly labelled as mentally ill, or *orang gila* ('crazy individual'), by society: this phenomenon remains a barrier to their recovery and limits service users' attempts to seek help both within and outside MHS (Bernama, 2012; Crabtree & Chong, 2000; Koh, 2013). It is therefore high time for Malaysian MHS to consider the development of an appealing approach in order to secure the attendance of service users. In particular, this would

involve the provision of services that include the integration of spiritual care so as to match the needs of users. The next section discusses the place of spirituality in MHS in the context of Malaysia in the purview of positive mental health outcomes among service users, particularly those diagnosed with BD.

1.8.1 The background of bipolar disorder and its treatment within the Malaysian socio-cultural context

It is estimated that three per cent of the Malaysian population of 31.7 million people have BD, although the actual number remains unknown (Department of Statistics Malaysia, 2016; Kadir, 2013). In an article published in Sinar Online, Dr. N Umadevi (2012) states that the second-largest number of psychiatric attendees at Hospital Bahagia Ulu Kinta (i.e. the largest mental health institution in Malaysia) are diagnosed with BD following schizophrenia.

In the acute phase, the majority of people with BD require clinical management from a psychiatrist in hospital until they are sufficiently stable to be discharged to the community (Malaysia Health Technology Assessment Section, MaHTAS, 2014). The references for the clinical management of BD are derived from the standard Malaysian clinical practice guideline (CPG), as prepared by the Ministry of Health, Malaysia (MOH), in collaboration with the Malaysian Psychiatric Association and the Academy of Medicine Malaysia. The CPG contains the criteria for admission and referral to mental health services, the prescription of medications, i.e. mood stabilisers, antipsychotics, anti-depressants and ECT, with the latter reserved for those with severe symptoms of mania or who are deemed to be at high risk of suicide (cf. MaHTAS, 2014).

With medication being used as the main form of clinical management in BD, service users are monitored for side effects, including weight gain, tremor or signs of toxicity, especially in the case of lithium therapy (MaHTAS, 2014).

In an article published by Malaysian Digest, Dr. Amer Siddiq (2015), a consultant psychiatrist (Addiction Medicine) at University Malaya Medical Centre (UMMC), explains that it is necessary for service users with BD to attend follow-up care as an MHS outpatient. This is for the purpose of monitoring both their symptoms and the efficacy of the prescribed medication. Follow-ups usually take place on a monthly or alternate-month basis. Outside the scope of their regular follow-ups, service users are also able to access immediate care at MHS in the event of a worsening of their symptoms, such as being aggressive or attempting suicide.

Apart from clinical management, MHS professionals provide psychoeducation to service users on the self-management of BD to help ensure that their daily functioning, such as being a student or worker, is not affected (Kadir, 2013). Such education is also extended to the family, friends and relatives in order to maximise support for the individual (Malaysian Psychiatric Association, 2006).

In addition to medication, psychosocial interventions, for example cognitive behavioural therapy, psychoeducation and family-based interventions, have significantly improved the treatment adherence of service users with BD in Malaysia (Awaluddin et al., 2015). Psychosocial concerns, such as the need for vocational rehabilitation or other structured purposeful activities, are also considered in MHS (MaHTAS, 2014).

Despite there being a standardised CPG, MHS also has to contend with issues concerning the continuity of care in BD (Malaysia Health Technology Assessment Section, MaHTAS, 2014). The main issues are on a clinical basis, including the regular monitoring of users' mental state, relapse management and monitoring of the pharmacological side effects (Dr. Amer Siddiq, 2015). Yet despite all of the elements that are included, MHS in Malaysia is yet to acknowledge spiritual care as part of managing individuals with BD, and this is discussed next.

1.8.2 The place of spirituality in mental health services

This section discusses the integration of spirituality into care. It is worth noting that such an integration is recognised in Western MHS as part of the effort to provide holistic care in MHS. The focus of this section is thus on discussing the relevance of considering the spiritual care model for adoption/adaptation into Malaysian MHC policy as well as in MHS.

MHS, i.e. the conventional practice, is widely shaped by Western sciences, in which most MH practitioners offer biomedical models of care depending on the depth of their scientific knowledge (Koenig, 2007). Notwithstanding its prevalence, however, such a practice is criticised on the basis that it fails to offer holistic care since it does not recognise spirituality as part of a person's wholeness (Koenig, 2000; Ross, 2010). In addition, MHS has been criticised for a lack of wisdom in the approach to care that makes life meaningful (Blanch, 2007).

In response to its critics, MHS has become one of the most significant areas of healthcare and as one seen to be capable of highlighting the discourse on integrating spirituality into the wider care (Sheldrake, 2012). Lending support to this, Swinton (2014) strongly emphasised that spirituality has the potential to enable a care approach that is genuinely

person-centred. In this respect, MHS, as seen in the Western world, has provided access to spiritual services, including chaplaincy services (Rogers & Pilgrim, 2001) and multi-faith centres for religious practices (Tabei, Zarei & Joulaei, 2016).

Nonetheless, it was discovered that access to spiritual support for service users has not been addressed in either the policy or MHS in the context of Malaysia. However, the *Psychiatric and Mental Health Service Operational Policy* (Ministry of Health Malaysia, 2011) highlights the need for a multidimensional approach to recovery, providing the following guidance on how it should be measured:

> *A successful recovery service should be multimodal in nature and refers to the concurrent utilisation of patient and family education, illness management, job placement (supported employment) and cognitive remediation.*
>
> (Malaysian Ministry of Health, 2011, p. 82)

Despite the fact that this represents a much more comprehensive approach than the traditional biomedical model, there is, however, a clear-cut total absence of specific consideration of 'spiritual care' (or faith-based intervention), utilising community support only in terms of family and employment. Considering these points, it is evident that the Malaysian MH policy has yet to recognise the role of spirituality and religion as promoting factors in the recovery process.

On the contrary, the lack of recognition of the need for a spiritual approach for care could be attributed to the empowerment issue prevalent among service users in the context of Malaysia. In such a sense, Malaysian service users may continue to harbour an inclination to prefer physician-centred

care services under the traditional paternalist model (Crossley, 2006; Ng et al., 2013; Shah & Mountain, 2007). In this sense, Malaysian service users venerate health personnel and are at a power disadvantage when it comes to requesting non-biomedical care. In conjunction with this, it is therefore considered timely for Malaysian MHS to raise awareness of the need to provide access to spiritual support for Malaysian users in relation to BD, as reflected in the interest of the present study.

The justifications for the current study's need to comprehend spiritual matters from the subjective accounts of service users (with BD) in the Malaysian context are discussed in the following section.

1.9 Chapter summary

This chapter summary justifies the need for the present study to focus on spirituality from the perspective of service users diagnosed with BD in the Malaysian context. It aims especially to bring empirical evidence for the purpose of understanding the matter of spirituality in light of spiritual issues, support and strength to live with BD.

The rationale of this present study is to develop an explanatory model of spirituality for BD users in Malaysia. This includes empowering MH practitioners as well as policymakers in Malaysia to recommend an appropriate spiritual model for care capable of augmenting recovery.

The next chapter, Chapter 2, will provide further justifications for the present study. In doing so, it discusses the tensions identified in relation to the conception of spirituality and scholars' discourse to help resolve such tensions. In line with this scenario, the present study highlights that the concept of spirituality is in flux in the literature; as such, the concept of

spirituality (if the spiritual model of care is to be recognised by Malaysian service users) should be explored in the Malaysian context.

1.10 Thesis outline

This section outlines the structure of this dissertation.

Chapter 2 comprehensively reviews the literature with three fundamental purposes. The first of these is to provide a rationale supporting the need to carry out the present study. It also critically discusses and informs the methodological choice of a qualitative approach, as delineated in Chapter 3. Lastly, this chapter focuses on the research aims to be addressed further in Chapter 3.

Chapter 3 is informed by Constructivist Grounded Theory (ConGT). In this regard, the chapter presents the theoretical assumptions in line with ConGT as a methodological approach prior to the data collection, followed by the data collection methods employed to gain rich information from the participant accounts of the Malaysian sample with BD.

Chapters 4, 5 and **6** report the eight themes that emerged in the findings under the three main headings of 'Restoring hope, meaning and purpose', 'Maintaining a positive sense of self' and 'Adapting to live with bipolar disorder'.

Chapter 7 presents the theoretical foundations for discussion in line with BT. In applying BT, the present study operationalises the spiritual resources in the findings as 'the salient capitals for spiritual capital'. The spiritual capital is then highlighted in terms of its fundamental role for meaning-making from the psychological aspect of human beings.

Chapter 8, mobilising the salient capitals, discusses them for each theme independently. The spiritual capital is then discussed from the perspective of its crossover between the psychological aspect and the influence of the social context upon the Malaysian study participants living with BD.

Overall, the discussion indicates that the salient capitals are conducive to spiritual recovery among the sampled participants in the present study.

Chapter 9 discusses and summarises the overall contributions of the present study and its findings, at the same time as acknowledging its limitations and outlining potential suggestions for future researchers. It also contains the researcher's reflective account on the research conduct.

Chapter 2: Literature Review

2.1 Introduction

This chapter contains a review of the literature on spirituality, religion and mental health for the purpose of generating a statement of the problems to be addressed in the current study. These comprise, firstly, the recognition of the spiritual approach in mental health recovery in the West, which is later looked at with the tension in individual versus community spirituality in comparison to the Eastern context. This is followed by a debate on the problematic concept of spirituality following the emergence of a contemporary understanding. The implications of the literature review for the current study consist of an emphasis on subjectivity, problematic study measurements and a lack of evidence for spirituality in the context of bipolar disorder (BD). Finally, this chapter contains a statement of the problem, which includes the aim of the current study.

2.2 The recognition of the spiritual approach for mental health recovery

The recognition of the spiritual approach for mental health recovery is supported by the current conception of mental health recovery. Therefore, this section deliberates on the conception of recovery – with and without a medical model – and highlights how the concept of mental health recovery can be related to spirituality.

In the medical model, recovery tends to be defined based on the need to eliminate symptoms (Lukoff, 2007). Pitt et al. (2007) described recovery as a dynamic process (in contrast to treating only the symptoms) with no endpoint or cure. Aside from being purely biomedical, recovery has now

become a concept in MH that has a broader focus (Bonney & Stickley, 2008). As such, psychosocial and spiritual needs are being recognised as equally important in terms of promoting the mental health and well-being of service users in the community (Bassett, Lloyd & Tse, 2008).

Davidson and Roe (2007) provided an example of this when they outlined the difference between recovery from and recovery in mental health:

> *'Recovery from' serious mental illnesses involves the amelioration of symptoms and the person returning to a healthy state following the onset of illness. This definition is based on explicit criteria of the levels of signs, symptoms, and a deficit associated with the illness and identifies a point at which remission may be said to have occurred.*
>
> *'Recovery in' mental illness refers to a process of minimising the destructive impact of the illness, while simultaneously identifying and building on a person's strengths and interests in order for the person to have an identity and a life beyond that of a ''mental patient''.*
>
> (Davidson & Roe, 2007, pp. 463-464)

Referring to the excerpt above, the conceptions put forth indicate that a normal healthy life is built through managing the symptoms and prevention of recurrence of the disorder, as well as building strengths. The first definition is firmly embedded in clinical and biomedical practice, as opposed to viewing people with mental health problems holistically (Davidson & Roe, 2007).

From the viewpoint of Davidson and Roe (2007), the second definition, for 'in recovery', focuses on minimising the impact of the disorder for an individual, which includes re-establishing a meaningful life for them in the community, despite the illness. In this respect, the important emphasis in recovery is on the destructive impacts of living with mental health problems (Wood et al., 2010). This also indicates that it is possible for people with mental health problems to fully recover (Lukoff, 2007).

It has to be noted that the concept of recovery is interrelated with spirituality in the lives of people with mental health problems (Basset et al., 2008; Davidson & Roe, 2007). In MH, recovery is described as a self-directed transformative process, in which a new sense of self develops (Deegan, 2002). Spirituality, on the other hand, involves oneself valuing his/her worth as a human being (Lukoff, 2007). In this regard, Deegan (2002) asserted that spirituality (i.e. including religious beliefs and spiritual activities as part of living) functions as a resource for the transformative process. It acts as a source of coping ability (Bassett et al., 2008; Fallot, 2007; Murphy, Fitchett & Canada, 2008), strength, determination and resilience to face adversity (Bassett et al., 2008; Gilbert, 2011).

Moving on, important consideration should be given to the controversy surrounding religion in people with mental health problems. This arises since religious belief may adversely affect a person's health if believers are encouraged to avoid or discontinue medical care (Mueller, Plevak, & Rummans, 2001). Thus, the controversy in MHS revolves around whether there might be adverse effects of discussing religious or spiritual issues for people with mental health problems. This issue is often referred to as an incident of religious delusion, i.e. one of the positive psychotic symptoms of mental disorder (Weisman de Mamani et al., 2010).

Despite the above, religious beliefs are currently becoming more respected within psychiatry and may be seen as helpful and adaptive since they are not perceived as leading to adverse effects, such as religious delusion (Cook et al., 2011). Additionally, religion and spirituality have been reported as among the most salient sources of help for many people with mental health problems (Fallot, 2007). Sullivan (2009) suggested that there is still much to learn about the role of religion and spirituality in people with mental health problems, including both negative and positive aspects.

In this respect, Deegan (2002) urged MH practitioners to help people with mental health problems to build the requisite skills for achieving recovery. In doing so, MH practitioners have to be aware of the individual versus community tensions with regard to the idea of promoting spirituality. The following section will discuss the literature on understanding the approaches for individual versus community spirituality.

2.2.1 The tensions in individual versus community spirituality

This section aims to analyse the trend in the conceptualisation of spirituality as it has implications for spiritual care in MHS, with particular regard to paying attention to the cultural context. There are two contradictions in the idea of how the individual can experience spirituality: the individualistic and community spirituality.

With regard to the Western frame of spirituality, Huss (2014) and Koenig (2008a) assert that individualism is its essential characteristic. Taylor (2007) expounds that spirituality focuses on the individual's subjective expression of feeling and intrinsic motivation. Despite its link to being religious, spirituality appears to be an individual phenomenon as it is a deeply personal experience. In the same vein, Tacey (2005) proposes that

spirituality does not have to involve any religious constitution. As such, this focus on individualised spirituality naturally aligns well with the healthcare notion of focusing on person-centred care (Russinova & Blanch 2007). In other words, MH practitioners can employ the individualistic approach to spirituality as a means of encouraging personal subjective expression and, thus, implement spiritual care on a person-centred basis.

The critique concerning individual spirituality is that MHS tends to offer spiritual care while overlooking the role of the community in supporting the spiritual needs of service users (Pesut et al., 2008). Moreover, the idea of individual spirituality appears to ignore the fact that the religious community can play a role in shaping the spirituality. Rovers and Kocum (2010) posited that community spirituality is best described as affiliation, which is often rooted in, or belongs to, a faith tradition. Furthermore, Pesut et al. (2008) asserted that spirituality comprises individual and social elements that are embodied within beliefs and experiences. Swinton (2001) presented a contradicting notion as he explained that spirituality is both an intra- and interpersonal experience that is shaped by individuals' experience and the communities in which they live.

Another critique is that individualistic spirituality relies heavily on Western assumptions and thus, the notion of communal societal influences is removed (Paley, 2009). Supporting this, Pesut et al. (2008) posited that individualistic spirituality (such as in Western society) may have little relevance for those who come from a society where there is an emphasis on communal spirituality. Moreover, scholars such as Fallot (2007) and Tew et al. (2011) stated that an individual approach (including a focus on spirituality) for recovery will serve to isolate service users from society and render them less empowered to seek spiritual help. In this sense, the idea of individualistic spirituality does not fit with protecting the empowerment

of service users in seeking help over spiritual matters in that particular community.

To resolve this tension between the focus on individual and communal spirituality, some imperative considerations need to be given with regard to the cultural context, especially within the non-Western society. Indeed, Hill and Pargament (2008) highlighted the need for culturally sensitive constructs for non-Western religious and spiritual traditions. Moreover, Lepherd (2015) posited that ethnic origin or culture, along with other environmental influences, affect the depth and intensity of spirituality. To further support the relevance of the cultural consideration of spirituality, Mok, Wong and Wong (2010) conducted a study exploring the meaning of spirituality among Hong Kong Chinese. They concluded that the context of a relationship has the potential to strengthen and renew the sense of spirituality (Mok et al., 2010).

Members of the community are not always supportive of the users of MHS, despite being aware that community spirituality needs to be considered. This can be viewed as social discrimination against people with mental health problems. Fallot (1998) and Gilbert (2007) are among scholars who have advocated the view that religious communities can be stigmatising and discriminating towards people with mental health problems. Thus, religious members can provoke anxiety, shame and disappointment among people with a mental health problem (Sullivan, 2009). Consequently, a person with a mental health problem may be deterred from participating in their faith community due to the associated social stigma (Sullivan, 2009). Hence, service users may experience a profound loss arising from being isolated by the society, which may culminate in an erosion of their sense of well-being (Mauk & Schmidt, 2004; Sullivan, 2009).

Regardless of the challenges faced in promoting spirituality, research has proven that spirituality has the ability to generate a positive outcome for people with many types of mental health problems. The following section further elaborates on the accumulation of empirical evidence in religion, spirituality and mental health problems.

2.2.2 The empirical evidence on religion and spirituality in mental health problems

The conflicting views on the impact of cultural and social factors on religion and spirituality were highlighted in the previous section. This section delineates why spirituality, as informed by the empirical evidence, is relevant to MHS.

Over the last two decades, a vast quantity of research has been carried out in relation to religion and spirituality in the area of mental health. The role of spirituality and religion in contributing to positive mental health outcomes in people with various mental health problems has been highlighted by many studies (Baetz & Toews, 2009; Granqvist & Kirkpatrick, 2013; Koenig, Al Zaben & Khalifa, 2012). Some of the instances of the positive effects of religion and spirituality in people with mental health problems relate to mental health recovery, including having a sense of meaning and purpose, and a sense of control over circumstances (Koenig, Al Zaben & Khalifa, 2012; 2008; Russinova & Blanch, 2007).

Prior to the year 2000, in excess of 100 quantitative studies had been carried out aimed at examining the relationship between religion and unipolar depression, and this body of work continues to rapidly evolve (Koenig et al., 2009). This is evident in recent systematic review papers and handbooks on religion and health, and in mental health (Koenig, King,

& Carson, 2012; Koenig, 2015; Koenig, 1998; Moreira-Almeida, Koenig, & Lucchetti, 2014; Pargament, Mahoney, & Shafranske, 2013; Tabei et al., 2016). Aside from depression, numerous studies have reported the positive effects of religion and spirituality across other types of mental health problems, including psychosis (Pesut et al., 2011), anxiety (Galek et al., 2014) and substance misuse disorders (Galek et al., 2014; Koenig et al., 2009; Panczak et al., 2013).

A vast amount of research on spirituality has concluded that it has a positive effect on the sample groups with depression (i.e. one of the symptoms of BD) (Koenig et al., 2009). However, Pesut et al. (2011) asserted that this has not adequately represented the complex experiences of people who are diagnosed with BD, and this is presented in the next section.

2.2.3 The lack of evidence in the context of BD

The evidence provided in the previous section appears to be sufficiently convincing to inform about the benefits of spirituality across many types of mental health problems. This section discusses the research evidence in the context of BD with the use of religion as an indicator for measuring mental health outcomes.

To date, most of the research undertaken in the context of BD has focused on its clinical symptoms, while the literature addressing spirituality and religion in BD remains in its infancy (De Fazio et al., 2015; Bonelli & Koenig, 2013; Galvez, Thommi & Ghaemi, 2011; Pesut et al., 2011). One of the reasons for this is that the medical paradigm for BD remains dominant in this research area. For example, Fletcher, Parker and Manicavasagar (2013) emphasised that medication is compulsory in the first-line treatment of BD and is prescribed based on the presence of mood

state. For instance, an oral dopamine antagonist (e.g. Valproate) is used to treat mania, with an anti-depressant used to treat the depressive state.

As for the clinical symptomatology of BD, Pesut et al. (2011) posited that users' connections to spirituality and religion are complex. This is because the degree of religiousness of people with BD may increase or decrease in line with the changing BD episodes of mania and depression; as such, mania increases religious motivation, whereas depression decreases it (Braam, 2009). Spirituality is thus dynamic and can manifest and evolve according to the situation (Pike, 2011; Swinton, 2010).

Nonetheless, research with regard to BD has been guided by a biomedical model conception, in which relatively little attention has been paid to how service users maintain their spiritual aspects (Pesut et al., 2011). Moreover, some studies in the context of BD employ only religion as an indicator of mental health outcomes and managing BD symptoms (Cruz et al., 2010; Mitchell & Romans, 2003). Other studies carried out in the context of BD have reported that religion can serve as a protective factor against suicide (Azorin et al., 2013; Dervic et al., 2011). These studies have yielded mostly quantitative findings, while their generalisability has been limited due to the heterogeneity (i.e. diverse characteristics) of the study samples (De Fazio et al., 2015; Pesut et al., 2011).

In addition to this, very few studies were found to have explored the experiences of service users with BD concerning traumatising experiences, in comparison to those conducted on a clinical basis (Jones et al., 2013). For instance, one source of trauma is the experience of dealing with social stigma due to being recognised as diagnosed with BD and seeking mental health treatment (Mansell et al., 2010). It has been suggested in the literature that BD users need to recover in their lives to a point that goes

beyond the symptoms of BD. Scholars such as Pesut et al. (2011) and Russell and Browne (2005) asserted that, in general, service users with BD need to recover from the trauma and maladaptive coping. Therefore, the spiritual aspect can also serve as a threat, particularly in stressful circumstances (Huguelet et al., 2016), which often manifests as 'giving up' and self-blame (Nitzburg et al., 2016; Pesut et al., 2011; Russell & Browne, 2005).

In contrast, however, Pesut et al. (2008) advocated that service users can experience stressful circumstances in a positive way. Similarly, Galvez et al. (2011) outlined how users with BD may potentially develop resilience and realism as a result of their experience of living with BD. A qualitative study carried out by Michalak et al. (2006) revealed that people with BD discussed their well-being in relation to spirituality. Perkin and Repper (2003) revealed various personal narratives of individuals with BD on the phenomenon of spiritual enlightenment or awakening, which relates to them having the insight to make their life more valuable when they are well.

As in the above, Drysdale (2004) explained that spiritual awakening can change people's perceptions and views of life for the better and that it is often religious in nature. Stroppa and Moreira-Almeida (2009), in their review of the literature, reported that people with BD have greater religious/spiritual involvement and frequently use religious and spiritual coping mechanisms. In a separate study, Stroppa and Moreira-Almeida (2013) also suggested that positive spiritual experiences in people with BD can be associated with manic episodes.

Nevertheless, there are also circumstances when religious involvement does not only hinder mental health but becomes intricately entangled with neurotic and psychotic symptoms (Blazer, 2009). The literature on clinical observation in BD has been biased in reporting the negative role of religion often associated with BD symptoms, as seen in users experiencing mania with religious delusion (Menezes & Moreira-Almeida, 2010; Mohr et al., 2010; Ouwehand et al., 2014; Stroppa & Moreira-Almeida, 2013). One such example is found in a review of the literature by Stroppa and Moreira-Almeida (2009) that presents religious delusions of mystical content, beliefs and religious conversions in service users with BD, which were in fact old cases from studies carried out in the 1980s. It therefore has to be noted that empirical research has struggled to demonstrate the adverse effect of religious involvement on any mental health problems, including BD (Koenig et al., 2009; Pike, 2011; Weisman de Mamani et al., 2010).

As such, Swinton (2005) strongly recommends the need to differentiate between the positive and adverse effects of religious involvement (particularly in relation to BD as in this section) since a bias towards the adverse effect of religion may serve to close it down as a potential source of recovery. Raab (2007) shared his insightful personal experience of treating people with BD, wherein the religious delusions (i.e. as an outward expression) concealed that they were helpless inside and served as a call for assistance. Culliford (2007) suggested that religious delusion may be a symptom that serves to protect users from the sense of meaningless that is hidden within.

Overall, research evidence of spirituality in the context of BD is more focused on clinical concern and lacking in religious and cultural understanding. With this in mind, the conception of spirituality is reviewed

to further probe the need for this study. As such, the researcher deems that the concept of spirituality is a debatable concept.

2.3 The tension in the concept of spirituality

This section emphasises how the concept of spirituality is problematic in light of the literature.

Scholars have agreed that it is very challenging to develop a universal concept of spirituality that is applicable across the global context (Foster, 2006; Paley, 2009; Pesut et al., 2009a; Sheldrake, 2012; Swinton, 2010). Draper and McSherry (2002) asserted that universalising the concept of spirituality may only contribute to a paradoxical effect in spiritual care. This is due to the adversities of perspectives, in which spirituality is understood in globalised societies (Cour & Hvidt, 2010). As a result, this section presents the tensions in denoting the concept of spirituality to suit the cultural context of the service users.

The emergence of the concept of spirituality with religion has its origins in the essence of the Christian world view in the nineteenth century (Huss, 2014). The original conceptualisation that positioned spirituality within a religious frame is referred to by a number of scholars, including Fallot (2001), Huss (2014), McSherry and Cash (2004), Narayanasamy (1999), Sheldrake (2012) and Swinton (2001). This is based on the premise that religious characteristics are common constructs in spirituality (Blazer, 2009; Koslander & Arvidsson, 2007; McSherry & Cash, 2004; Pike, 2011; Reinert & Koenig, 2013).

For instance, rituals, prayers and worship in religion, such as in Islam and Christianity, are forms of spirituality (Swinton, 2010). Consequently, this is how spirituality comes to derive the meaning that it is connected to

religious activities such as prayers, meditation or contemplation (Carson & Stoll, 2008; Culliford, 2007). In this respect, scholars such as Ahmad and Khan (2015), Dyson, Cobb and Forman (1997), Fallot (1998), Gilbert (2011) and Hill et al. (2000) identified that the two concepts, although different, cannot be separated completely. Thus, spirituality in its traditional construct is synonymously viewed with religion in the literature (Miller & Thoresen, 2003; Tanyi, 2002; Sullivan, 2009; Weisman de Mamani, et al., 2010).

During the last quarter of the twentieth century, the concept of spirituality as discussed in the literature moved away from its religious origins, as has been seen in the decline of traditional religious belonging in Western countries (Sheldrake, 2012). This evolution in the conception is believed to suit all users in MHS regardless of any particular religious or secular ideologies. The latter version of spirituality appears to be a catch-all term aimed at accommodating all views, including secular, sacred and religious views (Rovers & Kocum, 2010).

The concept of spirituality has thus evolved from being one viewed specifically through the traditional religious lens to now include a more contemporary view of society. Consequently, spirituality is conceptualised in many ways (Johnstone et al., 2012), with the fundamental understanding of being a multifaceted and multidimensional phenomenon (McSherry, 2007; Swinton, 2010). It also involves finding meaning, purpose and hope (Büssing et al., 2014; Tanyi, 2002), ultimate value (Swinton, 2005), religious beliefs, practices and social connections (Chen & Koenig, 2006), personal experiences and perspectives (Pesut, 2013) and culture (Carson & Stoll, 2008). This reflects the expansion of spirituality in its multifaceted inclusion (Cook et al., 2011).

One broad definition of spirituality is given by Koenig (2008a) as follows:

> *Spirituality is defined and measured in terms of meaning and purpose in life, social connectedness, peacefulness, harmony, wellbeing, contentment, and comfort. Gratefulness, capacity to forgive, self-discipline, and other positive human values may also be included as indicators of spirituality.*
>
> (Koenig, 2008a, p.351)

Within this more secular movement, the term 'new spirituality' is defined by Marianski and Wargacki (2012) as:

> *It envelops all aspects of life and is described as a new style for the post-modern spiritual culture; it is democratic, easily accessible, individualistic, and it exceeds the boundaries of institutionalised religions; therefore, it is often out-of-church.*
>
> (Marianski & Wargacki, 2012, p.26)

In this vein, the new concept of spirituality offers an advantage in terms of its function of enabling spiritual care in the context of the secular society. This is because it provides a neutral ground for MH practitioners to understand the complex nature of spirituality, either with or without a religious context (Cook et al., 2011; Paley, 2009).

To provide spiritual care for people with pluralistic spiritual views, various Western scholars have highlighted the importance of diffusing the concept of spirituality beyond religion (Baetz et al., 2009; Huguelet & Koenig, 2009; Koenig et al., 2009; Koenig, 2008a; Nelson, 2009; Paley, 2008b; Swinton & Pattison, 2010). It is hoped that this may serve to prevent

reductionist tendencies that limit spiritual care to only particular groups (Hill & Pargament, 2008; Swinton & Pattison, 2010).

The diffusion of this concept fits within particular groups that deny any connection with religion within the secularisation movement in Western society (Koenig et al., 2009). This includes the decline of organised religion such as Christianity (Culliford, 2007; Paley, 2009) and demonstrates that levels of religious activity and affiliation (i.e. among Christian believers) are extremely low (Paley, 2008b; Sheldrake, 2012).

In addition to the context of healthcare, Pesut (2008) asserted that the concept of spirituality should be sufficiently broad to embrace both an individual's psychological and religious experiences, which consequently enables the convergence of psychosocial needs and religion in healthcare.

2.4 Debates in the conception of spirituality

As discussed in the previous section, scholars are wary of the preference for a broad conception of spirituality and its application in the areas of research and healthcare. Thus, this section presents the debates among scholars in arguing the concept of spirituality against contemporary constructs.

The first issue relates to the broad conception of spirituality, which has led to the criticism of its lack of precision and, therefore, it is considered to be a problematic concept (Dein, Cook & Koenig, 2012; Rovers & Kocum, 2010). The concern regarding precision elicited a critique from Henery (2003), as he pointed out that the broad construct of spirituality does not fit with the scientific paradigm due to its imprecise construct.

The second issue concerns the assertion among some scholars that the broad conception of spirituality (i.e. apart from religion) will be meaningless to certain religious faith groups (Clarke, 2006; Cour & Hvidt, 2010; McSherry & Cash, 2004; Pesut et al., 2008). Consequently, the concept of spirituality (in most of the studies) has reflected its multifaceted characteristics, which are not always appropriate to other contexts, such as culture and religion (Jordan et al., 2014). Clarke (2006) argued that the separation of religion from the spiritual construct itself impacts on the current ambiguity surrounding the concept since religion itself is spiritual.

According to the secular mainstream, the broad conception can be manipulated for the purpose of re-inventing spiritual care (Paley, 2009). In this vein, Paley (2008a) questioned whether spirituality is solely a psychological issue and whether spiritual care, such as that seen in the UK, can be reduced to only psychological intervention. However, since there is evidence that emotional states and experiences are part of spirituality, Paley's discourse is seriously challenged; indeed, Narayanasamy (2010) contended that Paley attempted to discard the notion of spirituality through his dismissive claim. Based on the amplification of evidence of spirituality in the context of illness, the notion should not be relegated to only the psychological (Narayanasamy, 2010).

Yet the decline of religion in the West, or the claim on secularity, may not always indicate a reduction of spirituality to only a matter of psychology. Various scholars in the West, such as Marianski and Wargacki (2012), Swinton (2010) and Taylor (2007), shed some light on the possible resurgence of religion in their society. This is because religious topics manifest in various areas of life, including television, advertising, music or politics, and not only in the form of church-based religion (Marianski & Wargacki, 2012).

In that sense, people in the West are not necessarily becoming less religious; rather, they are becoming disillusioned with formal religious structures (Swinton, 2010) whilst nevertheless continuing to declare themselves as believing in God (Taylor, 2007). Thus, people in the West have a tendency to draw upon various forms of spiritual practices, such as meditation, charitable work or certain special forms of prayer (Taylor, 2007). In other words, this is the idea of 'ordinary religion', namely a religion that is much more personal and less dependent on formal structures (Swinton, 2010).

While some scholars have contended the broad conception, Pesut et al. (2008) proposed a narrowing down of the conception in order for it to apply in healthcare practices. One particular suggestion for achieving conceptual clarity is to contextualise it to a particular world view (Clarke, 2006; McSherry & Cash, 2004; Swinton & Pattison, 2010). In a similar vein, scholars such as Pike (2011) and Swinton (2006) have suggested pinning the concept down to cultural dimensions. This latter view therefore affirms that spirituality is a culturally bound phenomenon, in which the conception should be congruent to it (McSherry & Cash, 2004; Pesut et al., 2008; Swinton, 2001; 2010). One approach to providing a conceptual understanding that is congruent to the cultural context of service users is by comprehending spirituality in its subjective nature, which is derived from the perspective of the service users. This is presented in the next section.

2.4.1 The subjective nature of spirituality

This section focuses on the emphasis by scholars on the subjective nature of spirituality, which is something that deserves qualitative exploration, and this is reviewed against the problematic quantitative measurement of spirituality. The justification for pursuing this current study by means of a qualitative approach to understanding the concept of spirituality from the perspective of service users is presented at the end of this section.

A number of scholars have underscored the subjective nature of spirituality (Koslander & Arvidsson, 2007; Pesut, 2008) or referred to the personal and subjective side of a religious experience (Hill & Pargament, 2008). Hence, spirituality may have multiple defining characteristics which are associated with personalised meaning (Lepherd, 2015; McSherry & Cash, 2004). Besides, spirituality may have different meanings to particular religious faith groups (Nelson, 2009). This may be due to the influence of the community since it plays a role in shaping the meaning of spirituality, including the role of religions and ethnic groups (Pesut et al., 2008).

With regard to the view of the above, some scholars, such as Ammerman (2013), Fallot (2007) and Swinton (2010), have also proposed that researchers should consider the conceptualisation of spirituality from the participants themselves in such a way that also includes culture, religion, race, ethnicity and other social factors. To do so would highlight various important factors in the diagnostic and care planning process, including religious and spiritual beliefs and other aspects of cultural context (Sullivan, 2009). Nonetheless, there is no need to focus on the differences in each religion of the studied population in order to study spirituality in the context of mental health concerns (Swinton, 2010). This is because the understanding of spirituality tends to be more complicated due to the fact

that particular religious world views can often influence the way people understand and respond to mental health problems (Swinton, 2010). Hence, Swinton (2010) suggested that it is unnecessary to revise the concept of spirituality with a differentiation of religion in Malaysia.

Having said that, a focus on understanding spirituality from the perspective of service users through empirical work remains scarce. One such example, however, is a grounded theory (GT) study conducted by McSherry (2006) which revealed the following six principal components related to the experience of 53 service users: individuality, inclusivity, integrated, inter-/intra-disciplinary, innate and institution. It is noteworthy that this study revealed only the components to be considered in the formulation of spiritual care services within the healthcare system. Thus, the understanding of spirituality in McSherry's (2006) study is limited to the context of recovery within the healthcare system.

Another study by Klingemann, Schï and Steiner (2013) explored the meaning of spirituality from the service users' perspective by means of asking the participants to visualise it through drawing. The participants included samples with addiction problems in Switzerland and the United States. The existence of the study affirms the need for a rich conceptual understanding of spirituality from the subjective account of service users. Although this qualitative approach offers an exploration of rich data pertaining to spirituality from the context of users, such a conception is believed to be limited to other contexts with different world views.

Therefore, it is deemed that the study of spirituality fits with qualitative investigation. In addition, qualitative enquiry may provide rich content, together with a detailed contextual explanation (Nelson, 2009). This may then contribute to more sensitive and socio-culturally contextualised

approaches to theory development (MacDonald et al., 2015). The next section discusses the significance of a qualitative over quantitative approach, i.e. with regard to the problematic measurements of spirituality.

2.4.2 The problematic measurements of spirituality in quantitative study

This section deals with the research undertaking and deliberates the critics on the problematic study measurements of spirituality in quantitative studies. There are two reasons for this problem. Firstly, the overlapping construct in the measurement of spirituality and mental well-being, and secondly, doubt as to whether a study on the measurement of spirituality is applicable to a non-Western context.

It has been highlighted by some scholars that the measures of religion/spirituality and mental well-being consist of overlapping constructs (Cour & Hvidt, 2010; Dein et al., 2012; Koenig et al., 2009; Reinert & Koenig, 2013; Weber & Pargament, 2014). Also, it is deemed that the lack of precision in the concept of spirituality has acted to hinder researchers in coming up with a measurement of spirituality (Koenig et al., 2009). Hence, it is argued that while many previous studies have used the measurement of 'religion', they have also gone on to make nebulous claims regarding the concept of 'spirituality' and its impact on health (Yousuf et al., 2010).

Continuing with the overlapping study measurement between spirituality and mental well-being, there is almost no distinction when the indicators of both include psychological traits (Koenig, 2008a; Koenig, King & Carson, 2012). Jordan et al. (2014), in a critique of this problematic conception, argued that little attention is paid to the similarities and differences among them. These measurements were found to produce a complicated interpretation of the findings (Park, 2007) and were found to not be

sufficiently convincing to predict mental well-being (Dein et al., 2012). In this respect, Dein et al. (2012) argued that this area of study remains in its infancy. With this concern in mind, Moreira-Almeida et al. (2014) suggested refining the understanding of the interplay between religion, spirituality and mental health.

In addition, quantitative measures for spirituality are not always relevant to non-Western society (Tabei et al., 2016). This is due to the fact that they reflect a Western secular context in assuming the spiritual in material terms and the psychological in expansive terms (Swinton, 2001). In this vein, scholars with a non-Western world view, such as Ahmad and Khan (2015) and Ho and Ho (2007), suggest that the dominant Western literature in spirituality may not directly apply to other contexts. For instance, Ho and Ho (2007) raised serious doubts as to whether such measures are capable of reflecting the richness and complexity of spirituality. Moreover, scarce literature was found on other religious world views, such as Middle Eastern and Eastern (Ho & Ho, 2007). Given such a background, the following section of this current study highlights the implications of the literature review for the purpose of informing empirical work in spirituality with religion in the context of Malaysia.

2.5 The implications of the literature review for the current study

Based on the literature, it can be concluded that Western scholars have highlighted the benefits of spirituality, along with religious and social considerations, in supporting the mental health recovery process. Therefore, a study setting of spirituality, which is rich with the understanding of religion, can be derived since Malaysia comprises a multi-religious population.

Additionally, the role of religious involvement in spirituality, particularly in the context of BD, is still scarce. Hence, it is deserving of an empirical study in order to provide an understanding of its role in augmenting the recovery of service users with BD. On top of that, extending the concept to the cultural context of a particular society may reduce the problems with the concept of spirituality in the literature. This further confirms the need for this study to explore spirituality from the perspective of service users diagnosed with BD in Malaysia and thus explains the need to provide a conception of spirituality as derived from empirical data.

Furthermore, an understanding of the concept of spirituality from a sample with BD provides the ability to update the body of knowledge on, and the potential protective effects of, religion among religious service users. Indeed, this may reduce the latent biomedical bias and conditioning imbued in mental health professional training and education. The next section highlights the problem statement and the aim of this study.

2.6 Problem statement

The concept of spirituality in contemporary understanding has been problematic in healthcare for two reasons. Firstly, due to its late reintroduction to the Western health paradigm, and secondly, latent resistance due to the historical experiences of Judeo-Christian civilisation (i.e. the unreceptive predisposition of the Western biomedical paradigm to acknowledge and include religion as a component of care).

The concept of ‘spirituality’ was specifically constructed by the contemporary understanding to avoid the use of ‘religion’. This has led to the introduction of a broader array of spiritual experiences than is implied by traditional forms of organised religion. Nevertheless, the nebulous nature of the conceptualisation of spirituality, as well as the underlying

secular affirmations of Western scholars, has resulted in a complex and multidimensional construct. Consequently, the concept is of restricted utility for healthcare in non-Western cultural milieus. This is particularly the case where 'religion' remains a vibrant and living force, such as in Malaysia.

Notwithstanding the philosophical angst among Western researchers concerning what spirituality is and how it should be dealt with, a vast body of knowledge on religio-spirituality has emerged with great potential benefits for mental health recovery. The paucity of research in the specific context of BD and the general context of Eastern cultures mandate this study to specify a conceptual understanding of spirituality among those who are diagnosed with BD in Malaysia, i.e. an empirical study of a multi-religious and multi-ethnic population.

Hence, the aim of this current study is as follows:

To provide a conceptual understanding of spirituality in religiously affiliated service users with bipolar disorder in Malaysia.

2.7 Chapter summary

Having conducted a review of the literature, it has been found that spirituality is integral to the MH recovery approach. However, it is accompanied by tensions between the promotion of individualistic and community spirituality. Although this reflects the need to consider the cultural context of the service users in terms of how spirituality is understood, the literature has indicated that there is a lack of evidence in the context of BD in comparison to the positive evidence that has been accumulated across other types of mental health problems.

The gap that has been identified in the literature is that the conception of spirituality is debatable following the emergence of the contemporary version in its broad constructs (which suits the pluralistic world paradigm of service users), and this is argued to be a meaningless concept in the traditional view of spirituality, i.e. with religion. This chapter has also highlighted the subjective nature in relation to comprehending what spirituality is from the perspective of service users with BD. Hence, it is evidenced that there is a need for a qualitative enquiry in this study, and this is presented in Chapter 3.

Chapter 3: Methodology and methods

3.1 Introduction

With reference to the previous chapter, it can be seen that the present study addresses the following research problems that were identified and discussed in the literature review: 1 – the current conceptual vagueness of spirituality, as seen in the review of literature and dominated by the Western secular world view; and 2 – only scant empirical studies having been carried out looking into participants with bipolar disorder (BD). This chapter discusses the methodological approach as an attempt to respond to the research aim: to explore the conceptual understanding of spirituality from the perspective of a group of people with religion in Malaysia who have been diagnosed with BD.

The present study was methodologically informed by constructivist grounded theory (ConGT). Prior to justifying the rationale for using ConGT, the study discusses the philosophical underpinnings, namely symbolic interactionism and interpretivism, which led to the choice of grounded theory (GT). The structure of the methodological section reflects the background and characteristics of ConGT. At the end of this section, the study justifies its use of a combination of ConGT and social theory from Pierre Bourdieu by outlining their compatibility (the use of Bourdieu's theory will be explained in detail in Chapter 7, p.197)

Next in this chapter, the methods section covers the practical applications of data collection, including the recruitment of the participants. In line with the ConGT approach, this study discusses the rationale for using semi-structured interviews and highlights a contradiction with Glaserian grounded theory (GGT). The use of thematic analysis (TA) as a departure

from the coding procedure in ConGT will also be argued and justified in the methods section.

Later in the methods section, the strategies employed to ensure the trustworthiness of the data involved in the thesis are presented. Finally, this chapter attempts to address any ethical concerns and the limitations of the methodology of the study.

3.2 Methodology section

Before delving into the details of the choices that were made in relation to the methodological approach involved in the data inquiry, this section aims to illustrate the nature of the methodology. Next, it covers the philosophical assumptions of the researcher, which provide the ontological and epistemological underpinnings that guided the choice of GGT.

Crotty (1998, p. 2) defined methodology as:

> *The strategy, plan of action, process or design lying behind the choice and use of particular methods and linking the choice and use of methods to the desired outcomes.*

In this respect, a good methodology is always informed by the theoretical orientations, i.e. the ontological and epistemological underpinnings of the present study. This is considered to be appropriate, as good qualitative research should be *'theoretical'* in nature (Carter & Little, 2007, p. 1324).

Crotty (1998, p. 2) defined the theoretical perspective (i.e. of research) as:

> *the philosophical stance informing the methodology and thus providing a context for the process and grounding its logic and criteria.*

The following section discusses symbolic interactionism and interpretivism as the philosophical stance of the present study.

3.2.1 Philosophical underpinning

As discussed earlier in Chapter 2, the general ideas about the spiritual construct are derived from subjective knowledge (i.e. meanings) (Pesut, 2005). Specifically, this general idea is capable of informing the researcher of the '*research paradigm*'; that is, the world view concerning the nature of knowledge (i.e. reality or truth) (Hallberg, 2006).

A research paradigm or paradigm of inquiry is defined as the types of beliefs widely held by individual researchers (Creswell, 2014). In other words, the researcher needs to subscribe to the philosophical beliefs about his/her inquiry; that is, the ontological and epistemological perspectives that underpin the research (Goulding, 1998).

It is worth noting that ontology revolves around the nature of what exists (Ritchie et al., 2013, p. 24). Annells (1996) pointed out that the researcher chooses the ontology with which they are personally comfortable and which fits with the nature of the investigation.

In line with this, the epistemology responds to the ontological assumptions by which it is concerned with how meaning can be acquired (Ritchie et al., 2013; Annells, 1996). The epistemology directs the choice of methodology and data-related methods employed (Carter & Little, 2007). This will be discussed in detail with regard to the symbolic interactionism (i.e. the ontological stance) in the following section.

3.2.1.1 Symbolic interactionist view

The symbolic interactionist view rose to prominence via the influence of George Herbert Mead (1934), through his theory about the relationship between self and society (in Carter & Fuller, 2015). However, it was Herbert Blumer who first attempted to explain Mead's theory in terms of its methodological implications for research (Carter & Fuller, 2015). Specifically, Blumer (1969) further elaborated on the theory of symbolic interactionism and explained how subjective meanings are derived by individuals, noting the following in particular:

- The individual interacts with objects (i.e. physical, social and situations). Interaction takes place within a particular socio-cultural context.
- Meanings are acquired from social interactions. Individuals define and categorise physical, social objects and situations in line with their meaning.
- Meanings are continuously recreated and involve interpretative processes in the course of social interactions.

The core task of symbolic interactionist researchers, therefore, is to identify the meaning associated with various symbols from the individuals' subjective accounts (Blumer, 1969).

By adopting the symbolic interactionist view as the theoretical orientation at the beginning of the study, the researcher adheres to the belief that the meanings related to spirituality (as derived from this qualitative inquiry) arise from social interactions. Thus, the findings may reflect the socio-cultural context of the study participants, for example, religious symbols and practices. In support of this choice, O'Byrne (2011) and Crotty (1998)

stated that the generation of meaning is always socially constructed and thus, meaning may not be isolated from the world. In line with this, the role of the researcher in the present study is underpinned by the epistemological stance of interpretivism; that is, to interpret the meaning, as stated in the following section.

3.2.1.2 Interpretivist approach

Referring to the symbolic interactionist view on the generation of meaning, the present study adopts an interpretivist stance. In other words, it is actively involved in the interpretation of the participants' subjective accounts (Green & Thorogood, 2004). Aldiabat (2011), lending support to this, argued that symbolic interactionists hold the interpretivist tradition. In relation to the adoption of an interpretivist stance, any qualitative researcher may consider two methodologies that hold the interpretivist tradition, namely phenomenology and narrative inquiry. Both of these methodological approaches are explained in this section to help indicate the awareness of the researcher in the present study prior to the choice of GT being made.

Phenomenology describes phenomena as *'it manifests itself to consciousness, to the experiencer'* (Moran, 2000, p. 4). It is considered fundamental to phenomenology to recognise subjectivity by means of the perception of the experiencer through a close examination of individual experiences (Moran, 2000; Stark & Trinidad, 2007). One potential counterargument against phenomenology is that it is normally presented in the form of thematic descriptions of meaning or in relation to the essence of an experience (Stark & Trinidad, 2007).

In a similar vein, narrative inquiry can be seen as a representation of an experience so as to provide an understanding of people's experiences and to bring to light the subjectivity and identity of the individuals involved (Reissman, 1993). Analysis of the narrative begins with the act of a subject telling a story, resulting in a synthesis and the creation of a 'plot' of interview text (Clandinin & Connelly, 2000; Reissman, 1993). As mentioned above, critiques of both methodologies largely cite the limitations posed by the descriptive presentation of the findings (Thomas & James, 2006). The choice of constructivist grounded theory (ConGT) as the methodology for the data inquiry is explained in the following section.

3.2.2 Constructivist grounded theory approach

This section begins with the link between the ontology and epistemology, since the methodology flows from the researcher's ontological and epistemological stance (Annells, 1996; Ponterotto, 2005). In this respect, this section begins with the background of GT, followed by a justification of the choice of ConGT.

3.2.2.1 The historical context in the development and evolvement of grounded theory

GT is inspired by the symbolic interactionist view of the assumption as to how meaning is socially constructed (Lomborg & Kirkevold, 2003). The major strength of GT is its ability to move data from the descriptive to the conceptual level (Artinian, Giske, & Cone, 2009).

The traditional GT research conducted by Glaser and Strauss in 1964 is one of the examples which is informed by symbolic interactionism (in Carter & Fuller, 2015). Glaserian GT (GGT), as advocated by Glaser and Strauss (1967), is suitable for exploring complex social phenomena in relatively unexplored areas. Specifically, in relation to this inductive approach, Glaser

(1978) put the main emphasis on analysing action and process rather than only subjectivity. Thus, the generation of the theory is viewed as being a social process, which reflects the form of social interaction in its study context (Glaser & Strauss, 1967).

Another form of GT to have evolved is Straussian grounded theory, or SGT, as pioneered by Strauss and Corbin (1990). Strauss, despite having worked with Glaser on the traditional GGT, proceeded to take on a more deductive approach. SGT thus allows for early verification with the literature review in conceptualising the data (Heath & Cowley, 2004; Mills, Bonner & Francis 2008). Glaser (1992) criticised the Straussian approach by contending that it is not an inductive but rather a deductive approach.

Constructivist GT (ConGT) is a re-modelled version of the traditional GT approach. It was developed by Cathy Charmaz along with the current popularity of constructivism within social research (Breckenridge et al., 2012). The principal aim of ConGT is to assist the researcher in synthesising the data, by acknowledging the researcher as a co-constructor of the meaning (Breckenridge et al., 2012; Mills et al., 2008; Nagel et al., 2015). Charmaz (1990) provided an example of being the co-constructor of meaning in her early work, where her prior experience as an occupational therapist brought with it the assumption that people with chronic illnesses are suffering. In this respect, ConGT contradicts GGT in the inductive approach, in which the researcher uses preconceived concepts to commence the data collection (Simmons, 2011). The rationales for ConGT are provided next.

3.2.2.2 Rationale of the methodology

Following the overview of the evolvement of GT in the previous section, it is deemed that the choice for obtaining the conceptual understanding in the context of spirituality situated within the context of living with BD is in favour of ConGT, or conceivably the Glaserian GT theoretical approach. This section will make the distinction between these two versions of GT in order to justify that ConGT is congruent with the researcher's preconception and interest in response to the problem statement of the current study.

GGT is deemed to offer an excellent methodological approach that accommodates the lack of literature on spirituality in a group with BD (as discussed in Chapter 2). The choice of SGT is naturally rejected for this study. Nonetheless, the subjective nature of spirituality as presented in Chapter 2 (refer to p. 46) also indicates the need to employ ConGT as opposed to GGT. This is evident in Glaser's (2002) stance, whereby he made a strong case that the use of only interview data is contradicted by GGT: traditional GT prefers observation for actions and practice and should take only a small amount of interview data. This is because the stance of GGT is that the researcher should act as an independent objective analyst of experience, rather than as a co-constructor of meaning (Mills et al., 2008).

In relation to the above, it should be stressed that ConGT has its own stance. It places great emphasis on the conceptual understanding of social behaviour through the interpretive understanding of the participants' meaning (Breckenridge et al., 2012). Simmons (2011), in holding a staunch constructivist position, affirmed that it is impossible to avoid preconceptions or the incorporating of something of the researcher

themselves in the interpretation of meaning. Despite such preconceptions, the hallmark of GT is to inductively derive categories directly from the data (Charmaz, 1996).

This study thus makes a case that ConGT is congruent with the researcher's preconception and interest in determining the concept to be studied; in this case, spirituality in BD. In this regard, the researcher acknowledges her role as the co-constructor of meaning in line with the ConGT approach. The researcher of the present study put herself in the same position as Charmaz in terms of acknowledging that her interest in understanding the concept of spirituality among the sample of participants with BD is shaped by her professional experience (refer to 1.2 Researcher's interest, p.1).

The theoretical perspective of symbolic interactionism being congruent to ConGT leads the researcher to look at the participants' meaning as a set of psychosocial processes bound within the social setting (Charmaz, 1990). In this respect, the researcher is in favour of ConGT as her means of understanding the concept of spirituality (as derived from this qualitative inquiry) that is contextualised within the Malaysian sample.

3.2.3 The characteristics of constructivist grounded theory guided by Charmaz (1996, 2006)

Common to all approaches to GT are coding and constant comparison, memo writing, strategies of theoretical sampling and saturation, and theoretical sensitivity (Charmaz, 2006; Glaser and Strauss, 1967). The difference seen in ConGT is that it is built on the use of the semi-structured interview, and its coding approach uses four levels of coding. This section will guide the reader to imagine the process of theorising with the full

utilisation of the ConGT package. This section begins by describing the characteristics of ConGT in collecting data, as guided by Charmaz (2006).

3.2.3.1 Collecting data

ConGT is in favour of subjective data with the use of the semi-structured interview as its guide. Charmaz (2006) explained that the researcher only brings her preconception for sensitising concepts prior to starting the data collection but not in relation to the outcome. Charmaz (2006) responded to Glaser's (1998) view on the tendency to force the data with the use of the interview guide, stating that it is open-ended and meant for exploring the topic of interest. The researcher then develops specific concepts as they study their data throughout the research process (Charmaz, 1996). Moreover, the researcher, as the interviewer, is there to listen, and the participant will do most of the talking while further clarification is sought by the researcher as the interview session proceeds. Despite the identical use of a semi-structured interview guide in ConGT, the basic tenet in GT for simultaneous data collection and analysis using the coding approach is also followed.

3.2.3.2 Coding the data with constant comparative analysis

Charmaz (1996, 2006) uses four phases of coding according to the progress of theoretical development in ConGT. The codings are as follows:

1) Initial coding: The researcher needs to examine each line of data (i.e. the interview transcript) and define the actions or events that they see as occurring in it or as represented by it.
2) Focus coding: This is a selective phase whereby the researcher creates categories (or themes) from the initial codes that occur most frequently. The researcher then needs to sort and integrate these codes into relevant categories. By creating the categories,

Charmaz (1996) strongly believes that codes are raised to the conceptual level of interpretation.

In carrying out the focus coding, Charmaz (1996, p. 42) guides the researcher to use constant comparative analysis. The steps are as follows: 1) comparing different people (such as their beliefs, situations, actions, accounts or experiences); 2) comparing data from the same individuals with themselves at different points in time; and (3) comparing categories in the data with other categories.

3) Axial coding: This is another phase of coding that follows the categorical development. Charmaz (2006) explains that the researcher can create subcategories and make links between them within the same category. In this way, the researcher is able to obtain a theoretical sense of the data.
4) Theoretical coding: Theoretical codes are integrated codes and are built through the substantive analysis, i.e. the initial, focus and axial coding. Theoretical coding is the phase in which the researcher engages in producing an analytic story in a coherent way. According to Charmaz (2006), the analytic story reflects the theoretical direction of the data. To help the research focus on theoretical development, ConGT urges the researcher to engage in memo writing.

3.2.3.3 Memo writing

Memo writing is a crucial method in GT (in general) in which the researcher brings the analytical idea from the raw data into a form of writing (Charmaz, 2006). The process of writing memos should ideally begin during the phase of category development. The researcher can bring raw data in the form of verbatim accounts from different sources or participants

to ensure the conceptual analysis is grounded and ready for precise comparisons. Thus, memo writing helps the researcher to define patterns among the individual participants (Charmaz, 1996). As the researcher has some ideas on categories, he or she may then proceed to further theoretical sampling, aiming for saturation of the categories.

3.2.3.4 Theoretical sampling and theoretical saturation

As coding and constant comparative analysis continue in joining the data collected, the ConGT researcher goes for further sampling, referred to as theoretical sampling. Theoretical sampling is sampling for richer data as informed by the tentative categories obtained through the previous analysis (Charmaz, 2008). Theoretical sampling seeks to verify and saturate the emerging categories (Charmaz, 2006; Engward, 2013). Through theoretical sampling, the researcher may not focus on individuals per se, but rather on certain experiences, events or issues (Charmaz, 1996). Last but not least, the researcher has to rely on her own theoretical ability or sensitivity for theorising, as outlined in the next section.

3.2.3.5 Theoretical development and reviewing the literature

In generating an 'interpretive theory', the researcher needs to acknowledge subjectivity and to offer an imaginative interpretation (Charmaz, 2006, p.127). Charmaz (2006) specifically touched upon the need to gain theoretical perspectives from classical sociological theory and cultural studies. In this respect, Charmaz (2006) invites the researcher to view ConGT partly as a method for opening theoretical ideas. In other words, ConGT is not a fixed package that has to be strictly followed until completion of the theorisation work.

ConGT also ensures that the interpretive theory is inductively generated; after the development of themes, the researcher embarks upon a thorough literature review to compare the findings with relevant literature in the field (Charmaz, 1996). The treatment of literature in ConGT is similar to that in GGT, in that both approaches place an emphasis on inductivity. Glaser (1998) took the following stance on the use of a literature review:

> *When the grounded theory is nearly completed during the sorting and writing up, then the literature search in the substantive area can be accomplished and woven into the theory as more data for constant comparison.*
>
> (Glaser, 1998, p. 67)

In light of this, it is helpful to return to Glaser's original idea concerning what comprises theoretical sensitivity. Theoretical sensitivity is assisted by the researcher's background, which can influence the way in which he or she theorises, and is developed through intensive reading in sociology and other fields to gain theoretical perspectives (Glaser, 1978). According to Glaser (1978), this is how GT researchers think sociologically, since sociological theory provides the necessary theoretical perspectives.

Responding to this, in the next section the researcher reviews the compatibility of ConGT with sociological theory, namely Bourdieu's theory, in her theorisation approach.

3.2.4 The combination of ConGT and sociological theory

Having presented all of the characteristics of ConGT, this section outlines the researcher's points of departure from utilising ConGT in its wholeness in the current study. This is because after considering sociological theory, specifically the Bourdieusian Theory (BT), the researcher identifies the

points of divergence from ConGT for the theorisation of data. This section discusses why BT is compatible with ConGT.

Early on, subscribing to symbolic interactionism from the outset brings a sociological perspective (Carter and Fuller, 2015), particularly with regard to the researcher's belief about the nature of meanings derived from social interactions. Nonetheless, it is helpful to return to the original idea in GT about theorising with the researcher's theoretical sensitivity; it is developed through intensive reading in sociology and other fields to gain perspectives on the categories generated from the data (Glaser, 1978). In brief, rather than delimiting, GT acknowledges the usefulness of social theory such as BT and encourages the researcher to use it for their theorising.

BT is compatible with ConGT in the aspect of theorising; ConGT provides the theoretical opening for understanding the data (Charmaz, 2006), while Bourdieu's conceptual tools are useful to assist in theoretical development (Calhoun, 2006). ConGT fits the researcher's aim for reaching the subjective data, whereas BT offers theoretical insight with its sophisticated tools for the conceptualisation of spirituality through its socio-cultural lens. The latter strongly considers the shared belief of people to perceive and appreciate certain things (Bourdieu, Wacquant & Farage, 1994).

The application of BT for theorisation begins following the completion of data analysis for the generation of themes and is presented in detail in Chapter 7: The theoretical foundation for discussion (refer to p. 197).

3.2.5 Summary

This section has provided a summary of ConGT as the methodological approach of this study. In addition, the philosophical underpinnings, such as the symbolic interactionism and interpretivism, were justified as being compatible with ConGT.

The following methods section outlines the semi-structured interview as a data gathering method, which adheres to ConGT. The other method is free from the theoretical orientation of ConGT. It outlines the details of the recruitment process and data gathering approach, data analysis, the strategies used to ensure the credibility of the findings and, lastly, the ethical considerations undertaken in this current study.

3.3 Methods section

This section presents the practical implementations of the research inquiry process. Crotty (1998, p. 2) defined methods as *'the techniques or procedures used to gather and analyse the data related to a research question'*. The methods are the most flexible, pragmatic and intrinsically 'a-theoretical' component of the research process (Carter & Little, 2007).

This section presents the research process in recruiting the study participants, including the recruitment sites and recruitment strategies used. The setting of the recruitment sites of the study sample in Malaysia is explained in the following section.

3.3.1 Recruitment sites

This study was conducted in the mental health outpatient departments of two different hospitals, namely University Malaya Medical Centre (UMMC) and Hospital Kuala Lumpur (HKL). These two sites provided the best possible diversity of people in Malaysia as both provide MHS, centralised in

Kuala Lumpur for the residents of Kuala Lumpur and Selangor. Notably, these states are the two most highly populated, multi-ethnic and multi-religious states in Malaysia (Department of Statistics Malaysia, 2011).

The first hospital, UMMC, has a greater number of psychiatric consultants and provides training for postgraduate psychiatry clinicians. It is preferred by a majority of civil servants, with their treatment being paid for by the government. However, some service users who can afford private payment schemes also choose UMMC rather than a government-run hospital. The second hospital, HKL, is a government-run hospital, with services provided free of charge. Most MHS users who come to this hospital are referred by their GP, either from Selangor or Kuala Lumpur.

3.3.2 Recruitment strategies

The recruitment strategies comprise the processes involved in recruiting the study participants. They include the sampling process, the level of access to the participants and the recruitment of the participants themselves.

3.3.2.1 Sampling approach

This section provides the justification for using purposive sampling as the sampling approach, as opposed to theoretical sampling, as per GT.

In qualitative research, the sampling processes are usually determined by the methodology employed (Higginbottom, 2003). Adhering to ConGT, the sampling is referred to as theoretical sampling until such time as theoretical saturation of the data is achieved (Chiovitti & Piran, 2003).

Despite this, some qualitative research does not distinguish between theoretical and purposive sampling when the researchers seek information-rich participants for their study (Coyne, 1997; Cutcliffe, 2000). Patton (1990) simply points out that all qualitative research designs use purposive sampling. He describes that the early data gathering process allows for the patterns to emerge, and these are confirmed with new data from the next participants. In other words, the element of theoretical sampling is presented in many qualitative studies for subsequent data gathering, while in reality the participants are selected purposefully to fit the study for information-rich data.

While this study does not fully adhere to ConGT for theoretical development, it does use purposive sampling (rather than theoretical sampling) to ensure the practical logic in data collection and theorising with BT. The justification for purposive sampling is that it involves the selection of participants with specific characteristics (Higginbottom, 2004). The choice is in line with the claim by Cutcliffe (2000) that theoretical sampling has no predetermined set of inclusion criteria for the sample. The inclusion criteria for the study sample are provided next.

3.3.2.2 Inclusion criteria

The inclusion criteria used in the selection of the participants in this study are as follows:

1. Adults over the age of 18 years;
2. Diagnosed with BD based on the DSM-V or ICD-10 criteria;
3. Able to understand and speak Malay or English;
4. Able to give their informed consent to participate in the research;
5. Do not present with severe symptoms of either mania, depression or delusions of religiosity or other acute psychosis; and

6. Have a religious affiliation.

This study does not have any exclusion criteria.

3.3.2.3 <u>Sample size</u>

The current study does not have a predetermined sample size. Maltreud, Siersma and Guassora (2015) posited that the adequacy of the final sample size must be continuously evaluated during the research process itself (i.e. the process of analysis and categorisation). A total of 25 participants were found to be eligible and agreed to take part in this study.

3.3.2.4 <u>Access to participants</u>

Recruitment of the participants began with an established collaboration with psychiatrists who helped to identify the potential participants. The inclusion criteria for participant selection were given to the psychiatrists early in the morning, prior to them commencing their consultation with the service users.

The inclusion criteria were briefly explained to the psychiatrists who were on duty in the outpatient setting on the recruitment day. Flyers were displayed to promote voluntary participation among the potential participants. A rapport was established with some of the psychiatrists who had the same consultation days throughout the recruitment period of December 2014–August 2015. A total of 20 psychiatrists from both of the study sites were involved in the recruitment of participants for this study. Notably, the psychiatrists were the key persons who put forward the potential users with BD to participate in this study.

3.3.2.5 Recruiting the participants

For the first meeting, the service users met the researcher at the nurse's counter (the researcher was wearing a tag to enable her to be identified as the researcher) after being asked to do so by their respective psychiatrists immediately after the follow-up appointment.

The researcher then established a rapport with the service users by engaging in a short briefing session. This took about 10 to 15 minutes and comprised a brief introduction and the presentation of the research aim and procedures, including written voluntary consent and a recorded interview of approximately one hour.

Afterwards, the service users were informed that their participation in the study would be on a voluntary basis and that it would not affect the treatment they were receiving from the MHS. Before ending the briefing session, a study information sheet, which also contained the researcher's contact details, was handed to the potential participants. Provided that the participants were willing to be contacted to arrange their interview, details such as their name, address, mobile number, plus the best means of contacting them, were obtained. A cooling-off period of approximately one was given prior to collecting the interview data. A phone call to request voluntary participation was then made, and a second meeting was arranged for the interviews based on a date and time preferred by the service users.

Although the participants were provided with the option to consider their participation during the cooling-off period, most of the participants in this study preferred to be interviewed on the same day as they indicated their willingness to participate. This was because they had no time in the following week due to other commitments, such as their jobs.

Details of how the total of 25 participants were attained from both study sites are reported in Table 3.1. based on the data collection timeline.

Table 3.1: Data collection timeline

December 2014 to March 2015	**A total of 10 participants were recruited: 5 from UMMC and 5 from HKL.** **Recruitment was conducted at both study sites in alternate months.**
April 2015	A month was spent on coding and categorising, as well as formulating the provisional themes and sub-themes. The interview topic guide was revised.
May 2015 to August 2015	A further 4 participants were recruited from UMMC, and 11 participants were recruited from HKL. The method of conducting recruitment at both study sites in alternating months was followed. However, UMMC was quite passive with the lack of psychiatric trainees on duty during this period, which resulted in a relatively low potential of recruiting more service users with BD at UMMC.

3.3.3 Interview as data gathering

As discussed in the rationale for choosing ConGT earlier in this chapter (refer to p. 60), this study uses in-depth interviews to elicit the views of the individuals' subjective world when it is indicated as a rich source of data gathering (Charmaz, 2006).

Such one-to-one in-depth interviews, as chosen for this study, are known to '*take seriously the notion that people are experts of their own experiences and able to report how they experienced a particular event or phenomenon*' (Darlington & Scoot, 2002, p. 48).

Two spoken languages were used in the interview, namely Malay and English. All of the interviews were audio-recorded and transcribed verbatim by the researcher. In order to preserve the implicit and contextual semantics, the interviews conducted in Malay were analysed in Malay. Subsequently, the Malay transcripts were sent to translators for translation into English, and these will be used in academic presentations and discussions. The cross-checking process between the Malay and English translated transcripts is explained in section 3.3.7: Strategies for managing translation, p. 81).

3.3.4 Making the case for framing semi-structured interviews

As the in-depth interview technique is indicated as being in line with ConGT, a flexible semi-structured interview topic guide is employed. By setting up the interview guide for data inquiry, the researcher sets the agenda in reference to the literature review (Allan, 2003; Green & Thorogood, 2004). This is contradicted by Glaser (1998) in GGT as he cautions against the preconceiving of interview guides. Nonetheless, according to Charmaz (2006), a GT study should devise a few broad and open-ended questions to encourage stories to emerge.

Accordingly, it is crucial to point out that an assumption must also be made with regard to the possibility that the participants in the Malaysian sample may cite any source of strength apart from their religious faith. This includes the notion that spirituality has psychosocial elements other than religion (Pesut, 2008). Hence, this study set up the interview guide containing topics that were framed broadly in light of the literature on spirituality. The semi-structured interview thus comprised a set of predetermined open-ended questions, as illustrated in Table 3.2.

Table 3.2: Initial semi-structured interview topic guide

Topics	Reference from literature
Views about illness.	Emblen & Pesut (2001), Swinton (2005)
Ways of coping with illness and problems.	Hill & Pargament (2003), Josephson & Peteet (2007)
Views about hope/meaning/purpose of life.	Bonelli & Koenig (2013), Koenig (2008b)
Support from families, friends and community/doctors and nurses.	Emblen & Pesut (2001), Faver (2004), Fletcher (2004)

The preliminary findings from the ten interviews conducted during the mid-data collection phase encouraged the researcher to inquire more about the participants' accounts in relation to their own well-being and treatment. In taking the ConGT approach to data collection, this study adopts the stance taken by Charmaz in revisiting the interview guide. Charmaz (2006) makes the explicit point that ConGT interviewing differs from other open-ended interviews, in that the interview topics need to be focused on topics which contribute to theoretical ideas in the following interview (Charmaz, 2006). Charmaz (1990) herself revised the interview guide accordingly, with the aim of tapping into the experiences of the participants with chronic illness in her study.

In taking the ConGT approach as per Charmaz, this study therefore makes a case that the interview topics can be amended for subsequent interviews after taking into account the preliminary findings. The topics added to the subsequent interviews are presented in Table 3.3.

Table 3.3: Topics added to the subsequent interviews

• **Views on well-being.**
• **Views on treatment and services from HCP.**

In addition to the pre-determined interview topics, other questions may emerge from the dialogue between the interviewer and interviewee (Dicicco-Bloom & Crabtree, 2006). A number of focused questions were asked with regard to the participants' religious accounts following their disclosures about God and religion in their life. These questions touched upon prayers, worship and rituals (Swinton, 2010). Some examples of the questions that were asked during the interviews can be found in Appendix D.

One semi-structured interview was conducted per participant in this study, lasting for between 50 and 90 minutes.

It is worth noting that no one set of questions can be totally comprehensive in relation to eliciting the many existing concepts and practices that cohere with religious expression or the development of the meaning of life. Therefore, the researcher considered a range of concepts to encourage discussion that were appropriate to the context and were congruent with the mainstream enquiries on religious and spiritual expression.

3.3.5 Data analysis

ConGT has its own version of identifying codes and categories and the process for theoretical development (refer to p. 62), yet this study uses Braun and Clarke's account of thematic analysis (TA) to describe the elicitation of themes. The justification for using TA over the ConGT approach is presented in the next section.

3.3.5.1 Justifications for the choice of thematic analysis

In a theoretical vein, ConGT has its own representation of coding, i.e. initial, focused and theoretical coding, in addition to constant comparative methods, in order to inductively generate a theory from the data (Charmaz, 2006). Practically, however, the researcher moves to BT to conceptualise the key findings presented according to their themes. Hence, the researcher in this study uses TA to elicit themes to preserve the practical soundness in her theorising approach. To justify the choice of TA as opposed to employing analysis as per ConGT, their similarities are presented in this section.

At the outset, the researcher acknowledges the similarity between ConGT and TA in generating thematic presentations of the findings. Braun and Clarke (2006, p. 4) claim in relation to TA that 'one recipe guides analysis'. In particular reference to ConGT, Charmaz (2006) considers her guidance for line-by-line coding (i.e. initial coding) to be similar to TA. This similarity was also stated by Braun and Clarke, (2006) and Tucket (2005), thus affirming that GT coding for data is very much akin to TA.

The difference between these two approaches to analysis becomes obvious once the ConGT researcher moves to theorising. GT goes beyond TA in terms of the procedures used for theory generation (Braun and Clarke, 2006); that is, ConGT incorporates the use of theoretical coding and constant comparison (Tuckett, 2005).

In agreement with the above, Braun and Clarke (2006) strongly suggest that if a researcher does not commit to GT analysis for their theorisation work, they should select TA instead. This is because TA results in the development of meaningful themes rather than the development of a theory (Smith and Firth, 2011). Therefore, in order to provide clarity in the

practical logic of data analysis, the researcher has made a case for using TA.

3.3.5.2 Steps in thematic analysis

Braun and Clarke (2006) defined TA as 'a method for identifying, analysing and reporting patterns within data' (p. 79). The researcher follows the six steps of TA as established by Braun and Clarke (2006). The steps in inductive TA are as follows:

1. Become familiar with the data; read and re-read.
2. Generate the initial codes; code freely and diversely without paying attention to the emerging themes. The researcher can write codes in the right-hand margin of the transcript paper (see Table 3.4: Examples of coding and colour coding, p.78).
3. Search for themes or a categorisation and find repeated patterns of meaning. This step involves a constant moving forwards and backwards within and across the interview transcripts. The researcher used colours, in which similar patterns (for themes) were highlighted with the same colour. The researcher used different colours for different themes. The colour-coded codings were sorted and grouped in an Excel file according to the title of the themes and were then arranged in different Word documents (see Table 3.4: Examples of coding and colour coding, p.78).
4. Review the themes. This was done at the level of the coded data, in which reviewing was carried out at the level of the themes.
5. Define and name the themes.
6. Produce the report (as per the finding chapters: Chapter 4, 5, 6, see pp. 87 - 193). The researcher continually revised the themes as per step no. 4 while producing the findings report.

In reference to step three, the process of categorisation (i.e. the themes) continued until saturation was reached. Saturation occurs either when no further categories are discovered or constructed based on the examination of newly generated data, or the existing categories are exhausted once the existing category system has accounted for all of the meaningful or significant aspects of the phenomena in the questions (Given, 2008).

In this study, saturation was reached when no new categories emerged after the analysis of 16 interviews had been carried out. However, all 25 interviews continued to be analysed as the data continued to contribute to the depth and richness of understanding of the themes.

Table 3.4: Examples of coding and colour coding

Example of data items	**Initial codes (in right-hand margin)**
We felt like we wanted to end our lives. But nowadays I do not feel like that. I have overcome that kind of feelings. I just ask God always to open my heart to remember Him. Do not forget Him even for a moment. That is what I ask from Him. (P20, 19:7-10).	*Suicidal thought* *Always remembering God*
When we submit ourselves to Allah, Allah makes it easy for us. If a person who falls ill but yet distances himself from Allah, then the solutions for him can be difficult. Many parents may not understand this, while some in the family would even condemn him for his condition. Because of this, the person may be driven over the edge of course. Gosh, that would be a pity of course, right? Nauzubillah (may Allah forbids this) (p22, 32: 13-18).	*Submission to God* *Religious neglect/difficult to solve problems* *Lack of family understanding* *In despair*

Table 3.4 briefly illustrates the way in which the researcher conducted the first stage of analysis, i.e. the coding. The generated codings were then grouped into categories depending on the meanings. The researcher found it easier to sort the codings into categories with the use of colour coding. Eight themes were identified at the end of the analysis. These eight themes were grouped into three overarching themes, and these are presented in Chapters 4, 5 and 6 (see pp. 87 - 193).

The researcher double-checked the patterns of the themes using NVivo software, to ensure that both the derivation of the patterns and the inclusion of the participants were convincing. This process is presented in the following section.

3.3.5.3 Double-checking of patterns in themes

As discussed in the previous section, the preliminary process of data analysis was conducted manually. The researcher used NVivo software to double-check the patterns. This involved counting the inclusion of the participants in and across all of the themes in the findings (see the report on double-checking in Appendix E). Additionally, the process of double-checking allows for the identification of negative cases.

3.3.6 Report on negative cases

Together with the double-checking, two negative cases were found whereby two participants were largely excluded from the themes (Appendix E).

Negative case analysis refers to the researcher paying close attention to exclusions within the data set (Green & Thorogood, 2004). According to Cresswell and Miller (2000), the disconfirming evidence should not outweigh the confirming findings. Hence, attending to the negative cases

allows the researcher to see all of the possible understandings contained within the data, which may serve to improve the theoretical sensitivity (Schreiber, 2001) or analytical exploration of the alternative understanding (Mays & Pope, 2000).

Negative cases were included as part of the data analysis to ensure the credibility of the study (Morrow, 2005; Shenton, 2004). Hence, some subjective accounts that disconfirm the themes were reported as contradicting data in the findings chapters.

3.3.7 Ensuring the credibility of the study

Qualitative studies have been criticised for a lack of transparency in their procedures and processes (Higginbottom, 2004) and may therefore be perceived to be '*unscientific*' (Ritchie et al., 2013). Two approaches were employed for ensuring the credibility of the findings of this study, namely the reflexivity of the researcher and managing the translation process of the interview transcripts.

3.3.7.1 Reflexivity

To reiterate, the researcher positioned this study through the interpretivist position, which is a co-constructor of meaning (Morrow, 2005). Hence, the researcher needs to represent the participants' perspectives rather than their own (Evans, 2013). However, it is debatable as to whether the researcher can remain value-free (Ritchie et al., 2013). Hence, the reflexivity approach is employed in this study in order to recognise and expose the researcher's value and influence as part of the data interpretation (see Creswell & Miller, 2000; Ortlipp, 2008). A reflexive account is provided at the end of Chapter 9 (see Researcher's reflexive account, pp. 303 - 313).

The next section discusses another process for ensuring the credibility of the findings. This is done by managing the translations of the transcripts, in addition to that which is suggested in the literature.

3.3.8 Strategies for managing translation

It is noteworthy that this study addresses the issue of language difference in the original and translated English transcripts. This is because challenges in translation may occur even with the support of a professional translator (Van Nes et al., 2010).

The analysis of this study was conducted in the participants' original language, with the researcher then referring to the translated version in order to compare the meanings to be used when writing up the findings.

A total of 16 out of the 25 interviews were conducted in the Malay language, which was the language preferred by most of the Malay participants and one Indian participant.

All 16 Malay transcripts were sent to a translator to be translated into English. The procedure for checking and validating the translation in this study was carried out as outlined by Squires (2008). The purpose of this process is to: 1) ensure the trustworthiness of the translated data (Squires, 2008), and 2) address the challenges of translating the original meaning as narrated by the participants since the meaning is built from culture and religion (Chen & Boore, 2010).

The 16 Malay transcripts were divided and sent to three Malay translators, who were identified as having a good command of English and held a qualification to teach English. Nevertheless, some cultural and religious terms were retained in their original form.

The researcher checked the English translations by means of an ongoing analysis. The themes that were articulated in English were verified against both the Malay and English translations. This was done to ensure that the themes encapsulated what the participants had narrated in both the original and translated versions. Some discrepancies in grammar were corrected by the researcher. In order to ensure the credibility and trustworthiness of the translations, the researcher carried out back translations to the Malay transcript.

Two independent bilingual reviewers with a good command of Malay and English were appointed to validate the translation process. The reviewers then randomly selected two back-to-back translations of the transcripts. It was found that the back-to-back translation process was capable of addressing some discrepancies in grammar and that the translations retained the cultural or symbolic meaning appropriately. Next, some grammatical errors in the English translation were adjusted to the best possible level of clarity with a clear English grammar, closely following what was suggested in the reviews. The corrected version was then checked against the original Malay version to ensure the accuracy of the stated meaning. These reports can be found in Appendix F.

3.4 Ethical considerations

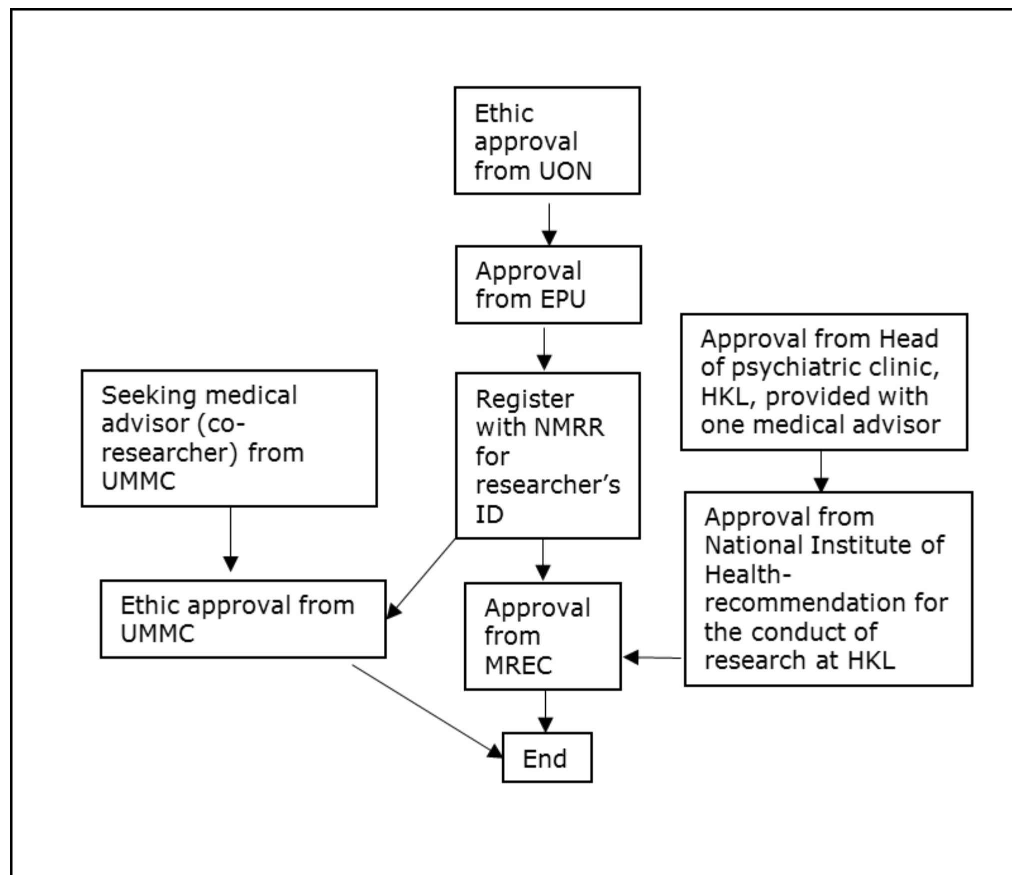
Ethical approval for this study was sought from the following organisations (see Figure 3.1:The flow of ethical approval):

1- Faculty of Medicine and Health Sciences Research Ethics Committee.
2- Economic Planning Unit Malaysia (EPU), Prime Minister's Department, Malaysian government.
3- Ethical Committee of UMMC.

4- Medical Research Ethics Committee (MREC) from the National Medical Research Register (NMRR), Ministry of Health, Malaysia.

The letters of ethical approval can be found in Appendix B.

Figure 3.1:The flow of ethical approval



3.4.1 Informed consent

The potential participants were selected by their psychiatrists and were informed about the aspects of this research that might influence their willingness to participate, in a one-to-one briefing session conducted before the cooling-off period. The information presented included the purpose of the study, its duration, the need to record the interview and the measures undertaken to protect the participants' confidentiality and anonymity in this study. Moreover, their right to withdraw from the study at any time without

penalty was also mentioned in the briefing. The participants' voluntary written consent was sought by obtaining their signature, which indicated that they had received the information and were aware of all of the implications in this study. Consent was further pursued in the second meeting for the interview as only a few of the participants had given their consent immediately following the cooling-off period.

With regard to the attaining of voluntary consent, which is part of the ethics requirement in this study, a total of 13 service users who were briefed about this study did not consent to take part voluntarily. They comprised seven Chinese, four Malays and two Indians.

3.4.2 Ensuring confidentiality

The interview recordings and transcripts were anonymised as soon as the data collection had taken place, to ensure the confidentiality of the participants. Each interview was given an identification number sequence (P01, P02, P03,…) in the record-keeping. Each participant was accorded a pseudonym (refer to Table 4.1: Participant Profiles in Chapter 4, p. 89) for the purpose of reporting the findings. As regards the record-keeping, all of the audio-recorded conversations were kept safely in a password-protected computer until the end of the study. All of the data, including the transcripts, field notes and reflective diary, were secured in a locked filing cabinet in a designated location.

3.4.3 Safeguarding considerations

Since the researcher spent time with only the participant during the interview, to protect their privacy, the researcher was responsible for considering issues in relation to safeguarding, i.e. the safety and well-being of the participants (Manning, 2013).

To reflect this, the interviews were held either in the consultation room or in a cafeteria within the hospital. Due to privacy issues, only the participant was allowed to sit with the researcher for the interview. The interviews that were held in the hospital cafeteria were conducted during non-peak hours.

In the event of a participant becoming distressed during the interview, they were allowed to take a break and go back to the clinicians available, if required. The interview was then continued only after the participant had regained their composure.

3.5 Chapter summary

Following the methodological underpinnings, this chapter presents the methodology employed, including the recruitment setting and its process of gaining subjective data from the total of 25 participants. Although ConGT has its own approach for categorising and theorising data, this study utilises TA to develop the themes from the findings. The process for ensuring the credibility of the findings is also presented in this chapter, which includes the double-checking of patterns, exploring and reporting the negative cases, the reflexivity of the researcher and strategies for managing the translation of the interview transcripts.

The next chapter, Chapter 4, is the first of the study's three findings chapters. It provides an overview of the three overarching themes under which the eight themes from the TA are grouped. This is followed by a report on the first overarching theme of the findings; 'Restoring hope, meaning and purpose'.

Chapter 4: Overview of findings and

Finding 1: Restoring hope, meaning and purpose

4.1 Introduction

In this chapter, the findings are reported based on the salient thematic analysis of the subjective account of people diagnosed with BD in Malaysia. The chapter begins with the participants' profiles, which are summarised in Table 4.1. Next, the religious-cultural terms of the participants are presented as one of the sub-headings, noting the particular religious concepts cited by participants in Malaysia.

The chapter then contains an overview of the findings of the three overarching themes that explain the eight identified themes respectively. Direct quotations are used throughout all of the themes to illustrate the findings being presented. After a direct quotation, the participant can be identified by their alias, and religious orientation; "I" for Islam, "H" for Hindu, "C" for Christian, followed by page and line numbers.

4.2 Participants' profiles

The 25 participants with BD varied in age from their 20s to their 60s, with a balanced gender distribution (48% males, 52% females). The ethnic representation in this study was dominated by Malays (n=16, 64%); this would be expected in Malaysian society. The other participants were Chinese (n=4) and Indian (n=5) Malaysians. The Malay and Chinese participants were all Muslim and Christian, respectively (of the four Christians, three were converts from Buddhism). The Indians comprised

four Hindus and one Christian. Slightly more than half of this sample is married (56%), and the others are single, divorced or widowed. The majority of this sample (21 out of 25) view themselves as middle class based on their household income. The duration of illness also varied in the sample; all of the participants had been diagnosed with BD for at least two years, and 14 out of the 25 people had lived with BD for more than 10 years.

A summary of the participants' profiles is provided in Table 4.1. Each participant is given a fictional name (i.e. reflecting the ethnic background of the individual) to protect their anonymity. The report on the total excerpts in the findings ensures that all of the participants are included in the findings report. The total number of excerpts per participant varies as the selection of excerpts had to reflect the theme in the findings chapters.

Table 4.1: Participant Profiles

No.	Name	Age (yrs)	Gender	Ethnicity	Religion	Marital status	Socio-economic class	Duration of illness (year)	Total excerpts in findings
1	Cindy	25	Female	Chinese	Christian	Single	Middle	3-4	5
2	Kasturi	58	Female	Indian	Hindu	Widow	Middle	20+	5
3	Ah Tan	59	Male	Chinese	Christian	Married	High	20+	7
4	Ahmad	22	Male	Malay	Islam	Single	Middle	3	5
5	Siti	35	Female	Malay	Islam	Single	low	3-4	4
6	Asiah	43	Female	Malay	Islam	Married	Middle	20+	5
7	Zakaria	51	Male	Malay	Islam	Married	Middle	10+	5
8	Melati	22	Female	Malay	Islam	Single	Middle	4	6
9	Suraya	23	Female	Malay	Islam	Married	Middle	5	11
10	Kumar	53	Male	Indian	Hindu	Married	Middle	30+	4
11	Normah	46	Female	Malay	Islam	Married	Middle	5	7
12	Muthu	63	Male	Indian	Hindu	Married	Middle	2	4
13	Lucy	56	Female	Chinese	Christian	Divorced	Low	20+	4
14	Ah Chong	48	Male	Chinese	Christian	Single	Middle	16	5
15	Umar	37	Male	Malay	Islam	Married	Middle	11	10
16	Rohani	50	Female	Malay	Islam	Divorced	Low	17	4
17	Osman	47	Male	Malay	Islam	Married	Middle	12	4
18	Shimala	58	Female	Indian	Hindu	Married	Middle	3	4
19	Dollah	33	Male	Malay	Islam	Divorced	Middle	7	9
20	Aminah	57	Female	Malay	Islam	Divorced	Middle	20+	8
21	Mahmud	30	Male	Malay	Islam	Married	Middle	5	10
22	Jamal	46	Male	Malay	Islam	Married	Middle	5-6	9
23	Nora	40	Female	Malay	Islam	Married	Middle	15+	11
24	Robert	46	Male	Indian	Christian	Single	Middle	20+	4
25	Sofia	36	Female	Malay	Islam	Married	Middle	18	10

4.2.1 Reflection on the representativeness of the sample

This section provides the researcher's reflection and critical comment on the representativeness of the sample in this study to the Malaysian population with BD, and its impact on the finding.

Schreiber and Stern (2001) explained that the sampling technique used by the researcher can influence the variation of the sample. In reference to this, bias in the selection of the participants is minimised if the researcher is able to ensure that variation is achieved in the sample. Nonetheless, this study has a limitation in the form of potential bias in the selection of the sample, owing to the fact that the inclusion criteria for participation in this study were initially screened by the participants' psychiatrists. This is reflected in the fact that the majority of the participants are from the middle-income group. In noting this, it is important that the researcher exercises caution when making any claims that the findings from this sample represent the whole of the Malaysian population with BD.

Notwithstanding the statistic that the majority of people in Malaysia are from the middle-income group, the current study is aware of the potential for the psychiatrists' judgement as a gatekeeper in selecting the participants for this study to support the research. It is possible that the psychiatrists had a bias towards certain patients, particularly viewing middle-class people as being more appropriate, more educated and more articulate in terms of being able to respond well to the interview, compared to low-income patients. It may be that low-income people were less considered by the psychiatrists as they viewed this group as being either unwell or unfit for the interview due to financial stressors or life dissatisfaction, and thus less advantageous to the research.

Following the above, the researcher recognised that the least variation in the findings from this sample was found in the subjective accounts of those in the low-income group. This lowest variation in the data from the low-income group can be justified by the socio-economic status of the Malaysian population as a whole. Looking at recent statistics for Malaysian household income, the incidence of poverty was 1% in rural areas and only 0.2% in urban areas (Economic Planning Unit, 2018). Narrowing this down to Kuala Lumpur as the study setting, it is populated by only 16.7% of people from the low-income group, based on household income (Murad et al., 2014).

To conclude, although the researcher cannot make any strong claim as to the demographic representativeness of the participants to the actual group of people with BD in Malaysia as a whole, the interview data elicited are nevertheless of interest. However, this study exposes spirituality and its key resources that are contextualised in BD and mental healthcare in Malaysia. The original idea was to look for participants with BD in the community of multi-ethnic and multi-religious groups, such as in Kuala Lumpur, and access to this group was greatly achieved through their attendance at the outpatient clinic.

4.3 Religio-cultural language of the participants

This section provides the context of the religio-cultural language used by the participants, wherein it presents the similarities and differences of terms related to Islam, Hinduism and Christianity. The terms are included here as they will be found in the direct quotations (i.e. the English translated versions) across the findings chapters.

The concept of God was referred to by Muslims as "Allah", by Christians as "Lord" or "Jesus Christ", and by Hindus as "Supreme Power" or "Brahman". Religious activities such as prayer were referred to as "solah" by Muslims for the five canonical daily prayers, with supererogatory prayers at various times also being cited (e.g. *tahajjud*, *dhuha* and *istikharah*). Christians practised a conversation with God, or prayer in supplication. Hindus referred to worship or prayer including mantras, meditation and yoga. In Islam, general supplications outside of prayer were referred to as *du'a*.

Religious institutions for prayer in congregation for Muslims are referred to as masjids or "*surau"*, as churches for Christians and as temples (*kuil*) for Hindus. Kaa'ba refers to Muslims' sacred site worldwide. The subjective accounts relate the goals of the participants' religious life with a belief in a transcendent reality – the afterlife in the Abrahamic religions of Islam and Christianity, whereby Divine judgement determines a place in Heaven or in Hell, and reincarnation in Hinduism. Pertaining to the latter, the Hindu participants in this study frequently mentioned karma and believe their actions have consequences, in both this life as well as in a reincarnated state.

The subjective accounts included the representation of religious figures in support of religious knowing. Muslim clerics are referred to as "imams" for those leading prayer in congregation and *"Ustaz*" for teachers (fem. "*ustazah"*). Christians referred to "priests", and Hindu clerics are referred to as "*gurus"*. While the Quran and Bible were mentioned by Muslims and Christians respectively, the Hindu participants did not cite any religious scripture.

Certain Muslim religio-cultural terms were prevalent in this Malay Muslim majority sample. The terms are "*takdir*", implying Divine Decree (i.e. fated by God), and "*Alhamdulillah*" meaning "praise is to God", to indicate their gratefulness to God in every situation (including during trials and tribulations). The Arab-Islamic term "*iman*", which essentially means "faith", was universally adopted by the participants, including the non-Muslims. The *Malay* term "*jiwa"* ("soul") was used in certain subjective accounts to represent their sense of self according to their religious perspectives.

4.4 Overview of the findings

Three overarching themes are used to group the eight themes as the key findings from the analysis of the subjective accounts of the 25 participants with BD in Malaysia in this study. This section provides an overview of the three overarching themes as outlined in Table 4.2. This study, however, will mobilise all eight themes for theorising and discuss the findings in relation to the relevant literature.

Table 4.2: The three overarching themes

Overarching themes	key themes
Restoring hope, meaning and purpose	Experiencing spiritual despair Engaging in spiritual meaning-making Orienting the spiritual life
Maintaining a positive sense of self	Keeping faith in God Devoting oneself to God Having a sense of spiritual harmony: connectedness and peacefulness
Adapting to live with BD	Improving a sense of self-control Establishing a positive life adaptation

The first theme of "restoring hope, meaning and purpose" explores the experience of spiritual despair, which the participants cited as a consequence of distance from their "faith in God" and which was restored by engaging in spiritual meaning-making. Next in this theme, the participants began to orient their spiritual life with religious or general aims and purposes.

The second theme of "maintaining a positive sense of self" captures the subjective accounts of religious faith in God and practices, with the perceived spiritual effects with regard to the positive sense of self. For the sense of spiritual harmony, "peacefulness" and "connectedness" corresponding to religious devotion were felt to be close to religious devotion to God in these subjective accounts of people with BD.

The last theme of the findings captures the positive adaptation to life with BD in the subjective accounts of those participants who improve their sense of self-control over the emotions associated with BD symptoms. This improvement is closely felt from the outcome of religious devotion in this sample with BD. The adaptation to living with BD involved a shift to a positive mindset and attitude towards life matters in those participants, and also features having faith in God and religious devotion from the earlier theme. These subjective accounts portray self-belief and self-confidence in handling life problems and being able to socialise in the community. The first theme of the findings is presented in the next section.

4.5 Theme 1: 'Restoring hope, meaning and purpose'

This section presents the findings from the first of the three overarching themes of the study, "restoring hope, meaning and purpose", which comprises three themes: "experiencing spiritual despair", "engaging in spiritual meaning-making" and "orienting the spiritual life". These themes capture the concept of dealing with the challenging life circumstances of living with BD, from despair to finding hope through the quest of spiritual meaning-making. The subjective accounts capture the element of the participants' faith in God alongside the meaning of having family and significant others in their lives in the restoration of hope, meaning and purpose. Having life direction can be found in the subjective accounts as setting life goals, either with or without spiritual aims. Nonetheless, orienting the spiritual life represents the restoration of their life purposes following a time of despair for the participants in this sample with BD. The findings of each of these themes are outlined below, commencing with "experiencing spiritual despair".

4.6 Experiencing spiritual despair

The theme of "experiencing spiritual despair" captures the sample's experience of having despair in God and of a "fated experience" (i.e. *takdir*) by God in the sense of suffering, loss or losses in changing and challenging life circumstances. The term "loss" in the subjective accounts was used to refer to the various setbacks, deficits and negative impacts that the participants encountered in their lives, particularly during the early stage of having BD. Such losses were diverse and keenly felt by the participants. In the following excerpt, Sofia describes the sense of loss she felt when hospitalised for the first time due to having a manic episode:

> When I became high [mania], I just could not accept the reality around me. That was the reason I was then hospitalised. I was studying well in the beginning. Then all of a sudden, it started when I was going to sit for my exams. I didn't know what occurred to me. I was lost.
>
> (Sofia; I; 1; 17-20).

As illustrated by the above quote, Sofia was hospitalised for the first time due to the symptoms of mania. The impairment of academic performance implied in her account suggests a loss of self-empowerment and a disorientated view of reality concerning the events that had occurred. In some instances, the side effects of medications loomed large in attributing a feeling of loss and suffering in the participants' lives, as in the case of Ah Tan, who gave an account of how his suffering and the sense of loss of his identity were negatively affected by the side effects of the medication:

> When you take Risperidone, the mind will be empty, you know. I don't think it's a good drug for me, but I don't know about the others. I just take it because a doctor asked me to try. When you cannot think of anything, you are suffering. You are not yourself any more.
>
> (Ah Tan; C; 2: 19; 3:1-3).

The above subjective account illustrates that a sense of "empty mind" can lead to a sense of lost identity, together with a sense of "suffering" over the effects of the psychotropic drug. In other words, Ah Tan suggests that a loss of cognitive ability or mental activities contributed to his sense of suffering and loss of identity. An excerpt from Ahmad contains the

metaphorical language of an "empty soul" in reference to the loss of identity:

> I had lost a lot of things – my friends, focus on studies, and I was disrespectful to my parents. I even lost myself. My soul felt empty. I didn't know who I was.
>
> (Ahmad; I; 7: 7-9).

The subjective account illustrates the sense of having multiple losses and its effect on Ahmad; losing identity and the sense of soul or "empty soul". On the other hand, such negative thoughts and feelings in the context of losses and suffering in this study may demonstrate a state of losing control over life circumstances. The majority of the participants (19 out of 25) expressed how their negative thoughts and emotions dominated their states of mind, bringing a loss of hope, meaning and direction in life. The following example of an excerpt from Melati expresses this loss of control and sense of hopelessness:

> I do not see any other reason or a way to get out of here. I just do the same thing over and over again. I don't see anything changing, and I could not expect anything. I got loss of control. The only thing that I could control is to think about whether I want to live or not.
>
> (Melati; I; 2: 4-7)

This subjective account suggests that negative thoughts and feelings of hopelessness in being able to alter life may have affected Melati's sense of control, potentially to the point of suicidal ideation. In this study, slightly more than half of the sample (14 out of 25) expressed thoughts of suicide

in the sense of life despair. Nora accounted for her suicidal behaviour after experiencing a life tragedy:

> In the beginning, I could not cope with my sadness. The first time when I wanted to commit suicide was when my ex-husband took my small child away from me. I felt like killing myself. I took the rubber hose and tied it tightly around me.
>
> (Nora; I; 9: 5-8)

This excerpt indicates how suicidal ideation and behaviour occurred during a state of despair, at which time negative thoughts and emotions dominate the mental state. Nora also accounted for her inability to cope with the unbearable sadness. Interestingly, in this study, nearly half of the sample (11 out of 25) expressed their disputes with life as challenges to God, questioning God's perceived unfairness, expressing feelings of anger and frustration with God, and an inability to accept what they viewed as an unjust fate. These subjective accounts suggest that the participants' negative thoughts and emotional expression towards God for their life circumstances were predicated on a belief in their preordainment by God, as seen in the following excerpt:

> I thought Allah was mad at me. And because of this, my frustration was doubled. When I wanted to perform my prayers, it's as if something was holding me back from doing so. I was starting to learn to pray regularly. Why must I be burdened with this condition? So the feeling of frustration that I had began to pull me down.
>
> (Jamal; I; 8: 13-17)

Here, Jamal appeared to be in a frustrating dilemma of both wishing to lead a spiritual life by performing religious rituals such as prayer, at the same time as feeling blocked and subject to disapproval due to his conception of God. He was locked in a preordained state, or in what may be termed "fated experience", which brought him down or diminished his life and possibly his satisfaction with faith and religiosity. In the following excerpt, Dollah suggests the dynamic of "faith" in the occurrence of the "fated event" in accounting for spiritual status:

> I have been like this since my divorce. I could not accept fate. An *imam* said that I could not accept what was fated for me, meaning that my faith was low.

(Dollah; I; 1: 12-14)

This subjective account illustrates how Dollah's opposition to the non-acceptance of his fate following his divorce was diagnosed by an *imam* as a reduction in his faith. In the following excerpt, Mahmud associates his reduction in faith to the thought of God's unfairness:

> My faith becomes weak most of the time when I have a lot of anger in me. I feel angry at myself. Like what I said, I am a bit embarrassed to talk about this. My heart says, 'it is not fair that God has put me in this kind of situation'. That is a possible reason for me to not perform my *solah.*

(Mahmud; I; 3: 7-11)

This excerpt indicates how an expression of faith or determination to practise a faith is negatively impacted by the experiencing of personal distress, frustration or strong emotions such as anger. It appears from this,

and other participant accounts, that at least some of this sample is experiencing a difficult mix of emotions and cognitions that could be conceived as spiritual despair or distress. This typically comprises spiritual pain or alienation. The notion of faith is deployed in a way not directly indicating spiritual despair as such, thus marking a potential deterioration of well-being and "sanity" generally among young people with BD:

> They are not able to accept their fate. And they reject the fact that they are ill. This is because they have lost their faith, sense of direction in life and finally their sanity. People who go to that extent have lost their faith in life, and that is why they refuse to hear the advice of those close to them. For example, they would refuse their medication when asked. I know that if I didn't take heed of the advice of my wife and the doctor, I would end up like that, or even worse. From my observation, I find that patients like this are mostly the young ones.
>
> (Zakaria; I; 19: 7-15)

The above excerpt indicates that such individuals may lock themselves out of the advice of others and become isolated in their decisions and, as in the above example, the participants may refuse typical or expected interventions such as medication. In other words, Zakaria views medication as a route out of spiritual despair or alienation. Nonetheless, the participants may be able to move on from this condition with the guidance of others to the same extent as they would be able to with the help of any contemporary medical intervention, as suggested by Zakaria. Robert accounts more strongly in general terms as to how the experience of living with BD without taking medication brings out the isolated self or, as he puts it, "self-centredness". This spiritual alienation is very striking,

particularly when articulated in a religious-cultural context in the belief of God and an afterlife:

> With having bipolar and you're not taking your medication, you just don't care for God; you don't care about anything. You become very self-centred, very selfish. And all you think is to kill yourself. And it doesn't matter if you go to heaven or hell.
>
> (Robert; C; 17: 1-4).

Here, in the context of not taking medication for treating BD, this subjective account suggests that being self-centred may potentially limit both the spiritual self-efficacy of the individual and their access to sources of help and guidance from others. From this example, it is perhaps more interesting to explore how maintaining emotional and indeed spiritual well-being is conjoined here with taking modern medications: a preferred intervention in many contemporary services for mental health, especially in Malaysia.

To sum up, the participants of faith or religious affiliation in this study may have experienced spiritual despair in the beginning, as indicated by the various examples of their subjective accounts. The sense of loss and suffering may lead to negative feelings towards faith and God; however, the participant narratives also indicate the possibility that "the fated experience" of losses can be mitigated, endured or transformed through the support of religious belief, faith or practice. As such, spiritual capital may combine with secular interventions such as medication to help them transition from despair into the experience of hope and meaning in life, as described under the next theme of "engaging in spiritual meaning-making".

4.7 Engaging in spiritual meaning-making

There is a potential transition from the state of spiritual despair into meaning-making, as suggested by the participants. In this theme, the narratives account for having faith in God, the acceptance of fate and the perception of being tested by God. A notion of fate (i.e. *takdir*) as preordained by God, as mentioned by Dollah, suggests its concordance with faith (i.e. *iman*):

> Faith is our stance. Faith shapes our personality. We need to have a stance and believe that Allah is always with us. Fate has been written even before we were born. If we don't have faith in Allah, we then reject the fate.
>
> (Dollah; I; 18: 14-17)

Having faith in God, as illustrated in this narrative excerpt, may shed light on one's acceptance of fate as a believer and attribute positive views towards God. The majority of the participants (18 out of 25, with religious affiliations of I=14, C=2, H=2) adopted a positive view towards God in making a spiritual meaning of BD itself, or the preordained or fated experience. The participants indicate a common understanding of having BD and the life challenges unrelated to mental health conditions that accompany the different losses as being a test from God. An example of this is Suraya, who shared her thoughts about living with BD:

> I began thinking that there were others who were sick. Maybe this was God's test on me. Who knows, maybe if I didn't get this illness I would lose myself and forget God.
>
> (Suraya; I; 8:19-22)

This narrative excerpt illustrates that Suraya has reflected on her own experiences and those of others when thinking about illness. Suraya suggests that BD serves as a reminder for her to be mindful of or to remember God and to not lose herself or perhaps her identity. In the following example, Asiah brought her positive view of God in her view of being tested:

> The more Allah loves me, the more tests for me. The more tests I face, the more mature I become.

(Asiah; I; 5: 15-17)

This narrative excerpt illuminates a belief in God's love through the test of life. It appears that a sense of growth (i.e. being "more mature") can be attained through the tested experience, as perceived by Asiah. Similarly, Nora provided her opinion on the positive view of being tested in the mind of God:

> We know that Allah is giving us a test. Hence, there must be something special that He stores for us afterwards. Besides that, He would also elevate our status in the Hereafter.

(Nora; I; 16: 17-19)

The above narrative reiterates the positive view of God and the positive gains of a believer due to the perception of being tested, which could bring a sense of acceptance to the fated experience. An acceptance of the fate of losses or gains may replace the negative feelings, as in the moment of spiritual despair, with positive thoughts and emotions. Five participants provided narrative accounts on the acceptance of fate, including the following:

> Way back then, my feelings were in a jumbled state. I was suffering. But when I began to move on, I instilled positive values in my thoughts and emotions. And then, automatically the negative feelings subsided. That meant that we had accepted our fate.
>
> (Suraya; I; 18: 11-14)

As illustrated from the above excerpt, there could be a sense of acceptance of the fated experience, which may potentially lead to positive thoughts and emotions for this and other participants. It seems to indicate that spiritual meaning-making may involve valuing or giving meaning, in addition to a sense of acceptance with regard to the suffering and losses in a hopeful way. Interestingly, the participants who narrated this may also alter their thoughts about having BD in a positive way. Nora, who provided the case of a suicide attempt when facing life tragedy, later demonstrated her acceptance of having BD:

> Now I feel that there is nothing to be depressed about. I would accept whatever conditions that You give me, Oh Allah. That's all I ask in my *du'a*. 'If You give me this disease, You will also give me its remedy'. So, I accept my fate.
>
> (Nora; I; 16: 8-12)

This narrative excerpt illuminates the acceptance of fate with the belief that God will also provide a remedy for the illness. Together with this acceptance, the narrative also indicates a good level of emotional coping. For Suraya, in the following excerpt, it is the "crucial role" of supportive people "around" her as an individual that pulls her away from spiritual despair:

> We need to bring ourselves close to religion. But when we have lost our direction, it is those around us who play a crucial role. They need to pull us, guide us. And those who guide us must make sure they do not misguide us. Meaning that, if we are to instil religious-spiritual guidance, then we need to motivate them constantly.
>
> (Suraya; I; 16; 13-16)

The above narrative excerpt suggests that religion has a role in providing a sense of direction in the participants' lives, despite the challenges they face of living with BD. In this sense, the narrative suggests that such religious guidance combined with motivational advice could facilitate spiritual meaning-making. Sofia expressed her need for support from others as well as a general context of positive religious ideation:

> The patient needs a backup regarding religion. She needs a strong religious thought, followed by the support from the family to keep her moving on. The person may look healthy on the outside. She is not physically handicapped. But then she lacks spiritually.
>
> (Sofia; I; 4: 15-19)

From the above narrative excerpt, it is interesting to note that religion plays a role in coping with suffering and losses for this population with BD. Both this and previously cited narratives have expressed the importance of "close" family in moving forwards, including but not limited to the spiritual dimension, which may well be important for advancing pathways to spiritual capital for people with BD. The role of religion is reiterated by Ah Tan, particularly in obviating participants' suicidal inclinations, as encapsulated in the following excerpt:

> When you are young, and you get problems, you might commit suicide. But when you have a religion that time, your concept of suicide is changing.
>
> (Ah Tan; C; 9: 13-14)

This example identifies the positive contribution made by religion to recovery, as narrated by the people with BD in this study, not least concerning the most extreme consequence of being in a suicidal dilemma. This kind of "spiritual recovery" may, of course, be complemented or adumbrated by non-religious human support, such that relational connections may guide the individual towards the religious capital. In this sense, the participants are not merely supported by religious faith or a return to religious practice or religious thinking and practice, but also by supportive relationships with their family members.

In this study, the majority of the sample (19 out of 25) expressed the role of support in the form of motivating and supporting others. The involvement of close and trusting forms of relationships among families and friends seemed to be a reason for and purpose of life:

> If you ask whether the family is important to me, it is indeed, sister. Without my family, there is no reason to live anymore. No purpose.
>
> (Jamal; I; 26: 21-22)

Here, the importance of the family that contributes to having reason and purpose of life is firmly emphasised by Jamal. In the following excerpt, life is valued by Umar in association with having a family:

> My life has become even more precious – more meaningful. In contrast, previously, I felt I was a useless and troublesome person. But now I have commitments; a family. And so, I value my life more now. I don't simply do negative things.
>
> (Umar; I; 8: 15-17)

Here, Umar points out that the commitment he has to his family is meaningful to him. Strikingly, in the narrative, "negative things" were likely to be hindered by a sense of self-worth and life appreciation. In living with BD, a heightened sense of self-worth and appreciation of life accompanies the valuing of family members, as indicated by the above narratives. For most of the participants, positive emotional resources such as love, care and happiness were channelled by supportive family members, particularly spouses. Nora, with a loving and supportive husband, pointed out that "support" could be a form of treatment for participants with BD:

> The treatment is actually like this. One is getting support from your closer ones, of course. Your husband, your mother, your mother-in-law. Your sister, your brother, your friends, and colleagues. So when you have all the support from all of them, you will feel that you are being loved, appreciated, needed, and you have the strength to continue living.
>
> (Nora; I; 18: 9-13)

Here, Nora referred to the social support form of treatment from all close family members, friends and colleagues as a means of elevating her sense of self-worth and belonging. Here, the term “strength” could refer to support from others, essentially with a sense of love and a feeling of belonging and appreciation. In this sense, the support has essentially become a strength factor for living with BD. The notion of “love” was also expressed as a reason or motivation for living:

> The most effective factor is love. Love is everything. When we feel like we are being loved, that makes us want to live. Having a life mission, a reason to live. If I had no reason to live, I would have committed suicide.
>
> (Dollah; I; 16: 5-7)

The above excerpt suggests the need for “love” as a positive affection that provides an inner or intrinsic motivation for wanting to live. For Dollah, feeling detached from sources of love, such as family, may potentially diminish his sense of self-worth and increase his likelihood of committing suicide. Jamal pointed out his ideology or belief about recovery that neatly informs us about the involvement of family in facilitating recovery:

> So here the first unit that is important would consist of parents, siblings, his lover or wife. They need to be given the appropriate knowledge about this [BD]. So you would need to set up a team or division that includes the family's involvement in this effort. Maybe you can send a reminder by SMS to them every two days, or offer eBook services for them to spend time reading, or probably we could pay a visit at his house. If the family unit is strong, *Insha Allah* [God willing], the result will be a speedy process of recovery. My family, Allah! I'm blessed. My mom, I am lucky.
>
> (Jamal; I; 25: 21, 26: 1-8).

The above narrative excerpt suggests the involvement of families in facilitating the recovery of BD, assuming they are provided with adequate knowledge. In other words, Jamal strongly suggests family empowerment and an initiative from the psychiatric services in order to facilitate the involvement of the family (e.g. appropriate education about BD). The support seems to be established with a secure and harmonious relationship, coupled with a good understanding of BD symptoms and treatment. It is striking here that Jamal represents the voices of service users in determining the aspects of psychiatric community care.

From this and other narratives, the inclusion of relational capital perceived from the family or interpersonal relationships with others, alongside the spiritual capital for recovery, suggests that these kinds of capital may be conceived as mutually important. In this sense, interpersonal relationships are combined with spiritual matters in the context of the Malaysian population in mediating a restoration of hope after the moment of despair of these people with BD. This may inform psychiatric services about the need for partnerships with service users and their family members

regarding power issues in Malaysia. The family empowerment and support in psychiatric treatment and care may be one of the qualities needed to facilitate the recovery of participants with BD in community care in Malaysia.

Although the majority of the participants narrated their experiences of being close to spiritual recovery, this had proven to be more elusive for two of the participants, Cindy and Melati, who lacked an identifiable source of support in a relational sense. Cindy highlighted her issue in not being able to identify a reason for living:

> Sometimes I ask myself, why should I still want to live in this world? Because I've already lost the people I could lean on [grandmother and godmother]. I need somebody who can pull me up when I fall. She can give me guidance when I need it. That is what my godmother always did. But unfortunately she is no longer here [deceased]. So I don't know who can give me that. Unfortunately, they cannot be the psychologists. So I am totally lost. So I don't know where I should go now.
>
> (Cindy; C; 12; 7-13)

The above narrative illustrates the participant's act of questioning living, as if she is losing the meaning of life without the presence of significant people in her life. Cindy appears to be in a state of being "lost" in terms of her life direction in the absence of any guidance from family and kin. It is interesting however that Cindy sees family and kin exclusively as being able to provide such guidance, something which she considers professionals are incapable of providing, although both Cindy and Melati clearly crave "guidance" or help in their lives:

> I’ve been broken in many places, and I might need a MacGyver.
>
> (Melati; I; 12: 8-9)

This narrative illustrates a metaphor of the individual perceived as being fragmented (“broken in places”). Here, Melati is using the term “MacGyver” to refer to a heroic figure in a movie to indicate her need for help from others. In terms of life events being preordained by God or “fate”, Melati expressed her preference for making decisions somewhat independently of “fate”:

> Fate is a blind acceptance. Not so much blindly as if letting yourself go, not having any choices. Like the choices are made for you. So I don’t like that. Personally, whatever few choices I need to make I like to make that. That’s the thing. Fate does not give you option for making choices, and I don’t like that.
>
> (Melati; I; 7: 1-4)

The above narrative illustrates that fate, along with its associated metaphor of “blind acceptance”, involves being unquestioning or believing in truth in the religio-cultural understanding. However, it is not necessarily approved by Melati or some of this sample, as reported in “spiritual despair” concerning life problems and a lack of support from family, resulting in the act of questioning God:

> Tell me why should I go through all these problems and why I got this type of family? Sometimes I did ask God, 'Are they my family? Are they my parents?' I can see that the journey I've been travelling for these few years, and beside me only my psychologists and doctors. I don't have other people.
>
> (Cindy; C; 7: 18-19; 8: 1-2)

From the above narrative, it can be seen that having life problems combined with a perceived lack of family support aroused indignation and "spiritual alienation" in Cindy, who, along with Melati, keenly felt the absence of meaningful others in their lives to face BD-related and life challenges ("social pain"), which Cindy referred to as metaphorically "killing" her:

> My family doesn't appreciate what I do. So actually I have survived, but they are the ones who are killing me.
>
> (Cindy; C; 7: 1-2)

Here Cindy also cites her condition of being devalued by the family. Cindy strongly pointed out that the family suppressed her sense of "survival" in the narrative. For this reason, she prefers self-isolation:

> But now I've already moved out from my house. I am not staying with my family. I already moved from my house, so you can see that at the moment I am calmer.
>
> (Cindy; C; 1: 15-17)

The narrative suggests that self-isolation is preferred as a self-defence strategy against "social pain". In the following excerpt, Cindy appears to be having difficulty making sense of her recovery from BD:

> I don't want to see any doctor. And I don't want to see anybody. Because I feel like no use, you know? Because I've been seeing doctors for so long. I've been seeing the psychotherapist for so long. Until now, what the psychologist told me, she has seen the improvement, but I didn't see any improvement at all. But I am getting worse and worse.
>
> (Cindy; C; 5: 6-10)

Here Cindy seems to be locked in a state of despair, emotional or social pain, self-isolation or the least support from the surroundings of others. The earlier narratives allude to the positive meaning of having a family of significant others, but Cindy and Melati clearly had different experiences of this dimension and for them, issues of meaning-making in the absence of guidance from others could lock them in despair. In other words, the potential for individual growth, whether spiritual or non-spiritual, is least supported in the case of these two participants.

4.8 Orienting the spiritual life

This theme captures how the participants have recognised life opportunities or life goals beyond their initial adverse events, such as losses in multiple aspects of their lived experience. This theme presents the meanings contained in the participants' articulated life goals, purpose, vision, mission and ambition, as elicited from the interview sessions. The narratives come from the majority of the participants (19 out of 25) who were counted for the next two themes: "keeping faith in God" and "devoting oneself to God".

The life direction of the participants is most likely a personal choice. In the following narrative, a reflection on experience that resulted in losses, as in the case of Jamal, provided a potential vision of what to do next:

> The next step has the right determination. We have to make ourselves follow different *dakwah* [i.e. preaching of Islam], and *tazkirah* groups [i.e. groups for Islamic ethical reminders]. When I am discharged from the hospital, it's like, what am I going to do with my life? Am I just going always to spend my time lying in bed? Some people would give in to their condition, and hence would just close the doors behind them as they reach home.
>
> (Jamal; I; 12: 8-12)

Here, Jamal suggests that "determination" may be one of the ways for moving on, despite enduring losses due to BD symptoms and hospitalisation. Jamal describes his strong view from a religious standpoint on how to become a useful person after hospitalisation, that is by participating in religious activities. He also reflects on the situation after hospitalisation when he ponders how to continue his living in comparison to others who are merely giving up.

Determination seems to be a personal awareness, or choice, of how the participants decided to move on and pursue their goals. Thus, it suggests their possible actions in assuming self-responsibility for taking their life forward. In this study, a sizeable minority of participants (9 out of 25) expressed their life goals concerning a religious aim to live. For example, three participants reflected on themselves through their identity as believers, as in the following example:

> I can conclude that during my illness, the spiritual practice that one has to do is to perform our *solah*. Each time after the *solah*, someone advised me to take some time to sit on the prayer mat and reflect on my situation, and talk to my heart. For example, what I want to be in this life. Maybe I could put all of my hopes to God. Ponder on things with my head bowed down. It doesn't have to be long, especially if it's at home. But if it is at the mosque, then it shouldn't take too long. This thing is easy to do. Except that, there is also need to have self-realisation and self-will to do so.

(Mahmud; I; 14: 10-17)

The narrative excerpt illustrates Mahmud's reflection on what he wants to be in this life. It indicates that he needs to set up life goals or purposes for life and put his hope in God to achieve these. Also, Mahmud emphasises self-determination in setting his purpose of life. An example from Suraya shows her directing her life in becoming a useful person for her religion:

> I was wandering aimlessly before. So, we have to make ourselves useful, especially for religion. We have to have faith in God's decree. Everything happens for a reason.

(Suraya; I; 15: 15-17)

This narrative excerpt suggests that every religious person should cling to faith in God and find hope in a loss of direction or aim. For Normah, this sense of direction in life appears to be aimed at the destination of the afterlife, which is a common feature among the major world religions:

> My aim to survive is my source of strength. We all sooner or later will die. So, we need to prepare for it. We need to strengthen ourselves and preserve our *solah.*
>
> (Normah; I; 15: 5-7)

The above quote indicates that having a religious aim in the form of the afterlife, as narrated by Normah, can bring strength. In pursuing this, Normah highlights the need to fulfil religious obligations ("devoting to God"). The determination for self-strengthening is striking here, suggesting self-coping and recovery from problems and challenges, along with the development of "resiliencies". The above narratives quite strongly express a will in terms of "want to", "need to" and "have to", thus indicating determination and motivation in moving forward in life. A few narratives (n=4) highlighted advancing age as a motivator in moving towards a spiritual pathway. Aminah reflected on her spiritual identity:

> As my age increased, I came to the awareness to be a better Muslim. I honestly did not read or watch any material related to my religion those days. I did not remember about death. But when I reached the age of 50s, I saw the picture of the Kaa'bah and I cried. Every time I glanced at the picture I would cry.
>
> (Aminah; I; 7; 19-20; 8; 1-2)

This narrative excerpt demonstrates an increasing awareness of death in consideration of the hereafter as age increases. The picture of the Ka'abah, the focal point of the major Islamic rituals of prayer and pilgrimage, referred to (symbolically) as the House of Allah, is connected to the spiritual identity of Muslims, making it a potent symbol for Aminah. Given this example, advanced age is a possible attribute for some of the participants with BD in moving towards spiritual identity and practices. A positive change in self was mentioned in pursuing good deeds in this world and consideration of the hereafter:

> Gradually I started to perform my obligatory prayers, to repent and ask forgiveness from God, to weep to Him. I increased in my voluntary prayers (such as *tahajjud* and *dhuha* prayers) and did any prayers that I could towards God. The best was by reading the Holy Quranic verses. I did the best that I could for my own good, as we do not know when we will die.

(Aminah; I; 8; 11-15)

The above narrative illustrates an increase of religiousness or devoutness in terms of either obligatory or voluntary religious activities by Aminah, who was preparing for an afterlife in seeking good deeds, driven by her religious aim. However, age was not the only factor linked to increased religiosity or religious aims. Nora highlighted that the intention to perform spiritual practices or live a more spiritual life is quite personal, and it may change according to priorities associated with life circumstances, including age, rather than due solely to age itself:

> At my age, I want to earn money. If we reached 50 years old or 60 years old, then we could take a rest. So it is more for my soul. More spiritual. Like when I feel depressed or lonely, I read the Quran. If I feel that I am not loved, I perform my *tahajjud* prayer.
>
> (Nora; I; 10: 3-6)

The above narrative illustrates a personal approach to the spiritual practices of a spiritual life, more keenly pursued in adverse circumstances or due to increased leisure with the advancement of age, as highlighted by Nora. In this sense, the pursuit of a life direction is more focused on material advancement at a younger age, so that people can have more in the way of leisure time to devote to spiritual activities in later life; however, this does not preclude the role of spiritual practices at a younger age as a means of improving emotional well-being, as Nora narrated. Many younger participants such as Ahmad also reflected on aiming for the hereafter, as shown in the following quote:

> I thought my life was completely over, and I had nothing in this world. But then, I still had the world Hereafter to consider. So, I should go for the Hereafter. At that time, I did not go on with my suicide attempt. My body became so weak. I opened the knot, and I lay down in bed and then decided to go to a *Pondok.*
>
> (Ahmad; I; 8: 2-5)

Here, Ahmad found a spiritual focus on the hereafter to be decisive in his rejection of suicide and a decision to invest in religious training. Umar, in the following excerpt, was quite direct in accounting for the best route to a positive recovery in identifying the key challenge of "spiritual illness",

effectively an alienation from God that requires a "return" to "righteousness":

> My illness is not physical in nature, but rather spiritual. So, if we want to provide treatment, it will influence them physically. You see, when we are mentally insane, it will influence us physically. For instance, previously, when I was into negative things - I was spiritually sick. So, how do we treat our sick spirit? We need to return to God's path of righteousness. This is as the Spirit acts as our bridge to God.
>
> (Umar; I; 8: 24-29)

The two preceding narrative excerpts from Ahmad and Umar pinpoint the recovery of a positive self-identity in BD due to the return to a spiritual pathway, whether described as aiming for the hereafter or returning to the "path of righteousness". For Osman below, spiritual fulfilment comes with his aiming for Heaven:

> It [i.e. the spiritual approach] is fulfilling. In terms of our soul. We perform our prayers, there must be something to it. We must know our direction. Where do we want to stop at? We don't want to enjoy all the time. Like people without a mission and vision.
>
> (Osman; I; 16: 15-17)

This narrative illustrates, from his point of view, that spiritual fulfilment is attached to religious devotion such as prayers. Osman highlights that the focus of having life direction with a religious aim, mission or vision could prevent people from pursuing a hedonistic life devoid of spiritual purpose.

Ah Tan has clearly indicated his life direction as being close to his Christian belief:

> Because we believe Jesus will come back in the Second Coming of Christ, so we believe that one day we will be with him. So now we are just on a pilgrimage in this world. As the purpose of life, we get to carry what He wants us to do in daily life. That means to have fellowship with one another, to love one another, to help others. So all these are our purposes.
>
> (Ah Tan; C; 6: 1-5)

This and the preceding narrative excerpts suggest a spiritual way of thinking that focuses on a spiritual or religious aim in life and directs these participants to focus on devotional activities to God. Here, personal determination or choice of life direction oriented towards serving God, religion and the afterlife was particularly associated with the Abrahamic religions (i.e. Christianity and Islam). Having faith in God may also provide an ongoing inner motivation in the life pursuit, as narrated by Jamal, who exhibited strong religious goals:

> The determination, motivation, we need them, in fact, every day. That is the reason we perform our *solah* five times daily. It's all year round until we die. "*Haiya alassolah*, *haiya alalfalah*" [verse from the call to prayer, lit. "Come to prayer, Come to success"] – it emphasises the same thing over and over again: success, success, success.
>
> (Jamal; I; 9: 3-7)

The above quote illustrates that "self-determination" and "motivation" may serve as drivers for the participants in pursuing their life goals and direction. It is likely to require willpower in an ongoing effort to move forward. Jamal accredits *solah*, particularly the five daily prayers, with inspiring an ongoing inner spiritual motivation for success in life.

Similar sentiments were expressed by nine of the participants concerning a religious aim underpinning their secular endeavours. However, the majority (n=16) did not mention this aspect, and indeed their life goals varied, including a commitment to families, individual careers and development. Ahmad pointed out the need to have life goals in general:

> You have got to decide in the future what you want to do and who you aspire to be. You've got to have a vision and ambition. For me, that was the first step. No matter how far you are from reaching there, from achieving your ambition, you still need to pursue it. Even if it is gradual, at least you move towards achieving the goal.
>
> (Ahmad; I; 14: 17-20; 15: 1)

The narrative excerpt illuminates Ahmad's perception of the need to have self-determination in general, which he highly recommends as the first step in moving forward with BD. Asiah shared her goals as elicited by the psychiatrist:

> My objective when I get out of this ward is to reduce my husband for having self-determination in general, which is highly recommended by him as the first step in moving forward with BD. Asiah shared her go, people can accept me, I can work. Unless I become unhealthy.
>
> (Asiah; I; 10: 8-12)

Here, Asiah aspires to share family responsibilities and burdens for material (i.e. economic) “success” after regaining her self-control and judgement resulting from biomedical intervention in hospital. Considering the personal function of living with BD, working under social norms, as indicated by the need to be accepted by others, the participants may seek to concurrently take care of their personal well-being. Thinking about one’s well-being in the present and future, and moving forward, may perhaps conjoin in conscious thought about their lives, as indicated by Osman:

> For me, I think I need to think about how to make myself better. I can’t be static, not doing anything. I have to think about the future. If I quit my job, I would need to think about what I would have left behind.
>
> (Osman; I; 9: 8-10)

This narrative excerpt suggests that Osman is thinking about the future for his life benefits rather than the present. Osman may provide an example of a participant who can adapt and fight for life opportunities, such as employment. In brief, life is perhaps viewed from the perspective of hope, chances or opportunities, rather than the self-limitations of BD and losses. On the other hand, the value placed by the participants on having a family

may drive them to develop self-will or determination. Sofia suggested that BD patients need to overcome their life circumstances:

> We have to start first. Strong willed, determined. What is the purpose of our life? We have a family. We must also have our ambition. That is the best for a patient with this kind of condition.
>
> (Sofia; I; 9: 1-3)

Here, the value of having a family, as it appears in the excerpt, may drive Sofia's choice of moving forward with life goals. Dollah, who regained his control over suicidal thoughts following losses, determined his life goals within the family:

> I didn't want to live. I felt like I had nothing. But I was thinking about my children. They were small. My first child was two years old, and the other one was one. I let them be looked after by my mother, let them be taken care of by my parents. Then I could die. I could die. But it happened that I didn't die. I'm still alive. Because of that, a doctor used electroconvulsive therapy, trying to save me. That led me to have goals in life, for my kids and me. If I have no goals, I would rather die.
>
> (Dollah; I; 7: 8-14)

Here, Dollah strongly indicates that having life goals, based on caring for his children, enabled him to recover from his suicidal tendencies. Defined goals within the family may perhaps help to direct the participants in moving forward, rather than giving up their hope of living. In the cases of Dollah and Sofia, biomedical intervention may be one of the options for staying healthy while living with BD. Sofia articulated her hope and

determination to lead as close to a normal life as possible with the medications:

> When I was discharged, it was my hope that I could lead a normal life like I used to. It's something like me having to remind myself constantly about this. But what is important is for me to take my medication on time as instructed, to follow the doctor's orders. When I do take my medication, my actions are normal, of course.
>
> (Sofia; I; 15; 3-6)

The narrative illuminates that hope for a "normal life" comes with a self-responsibility or initiatives to follow biomedical intervention, such as medication.

Apart from following the biomedical intervention for treating BD symptoms, as in the majority, five of the Malay participants continued in their use of alternative treatments such as Islamic healing using Quranic verse; in addition, one Malay participant uses homoeopathy (n=1). This constitutes the basis of their preference that both alternative and medical interventions are necessary. Asiah perceives the need for both alternative treatment and medication as follows:

> No difference between traditional (i.e. Islamic healing) and modern medications. Both are good for me. They make me feel better. If we rely on the hospital, we won't be able to get treatment for our inner side, it needs to be with the clerics. Cannot. Doctors are good at mental, psychiatric and science. Traditional methods can strengthen our inner side, restore our spirit. So that we can be stronger. Assisting me to be mentally stronger.

(Asiah; I; 13;18-23)

The narrative by Asiah illustrates that both traditional and modern medications are necessary for her as they are both “good” and provide her with a sense of betterment. She has the view that medication is able to treat the bipolar symptoms while traditional methods are capable of restoring the inner side, or what she refers to as “our spirit”.

Likewise, a total of eight participants spoke of seeking religious treatment in the past. In this respect, the Malay participants (n=6) sought alternative explanations and treatments for the disorder, i.e. possession of “spirit”, from Muslim scholars (i.e. *ustadh*). Two Chinese participants had acupuncture. Nonetheless, these participants later preferred medications to treat their BD symptoms, as seen in the narrative example from Osman:

> They said I was possessed. I don’t remember how to be exact. They did it the Islamic way. Using holy water which was prayed on (i.e. with Quranic verse). Despite, I felt better after seeing the famous Harun Din (i.e. religious healer)… I’ve never been there since then. The problem (i.e. symptoms) is not solved. They say this is inherited.

(Osman; I; 8; 4-12)

The above narrative by Osman represents the influence of others in believing about being “possessed”. Hence, Osman received an Islamic healing service such as using holy water and a famous Islamic healer to make him feel better. Nonetheless, Osman claimed that his condition could not be resolved solely through Islamic healing, which led him to stop seeking the services.

In this and the following excerpt, the aim of staying well in the context of BD suggests an initiative or action towards "resiliencies" to recover from BD symptoms:

> What is important is that those around me do not need to worry any more. That is my actual aim in life. I don't want people to pinpoint me as being sick. I mean, I am not a priority now. Imagine, in the past, my siblings could enjoy bathing together in the swimming pool. So, when people began to brand me as being sick, I didn't want them to do so. So, I woke up.
>
> (Suraya; I; 10: 4-8)

In this and the preceding excerpt, the determination to stay well with BD is striking; in a way it veers towards the positive approach to recovery that essentially comes from personal goals and awareness. For Sofia, taking medications and devotional activities must be accompanied by identifying meaning and purpose and each benefit that this may bring to the participants:

> If one doesn't have any ambition, well, it is going to be a little bit difficult for us to help her to recover from her mental illness. The reason is that she doesn't have any specific goals, you know. She would take her medication when instructed. However, sooner or later, she might just throw the medicines away. If we asked her to perform her prayers, she might not know the purpose of having to perform them.
>
> (Sofia; I; 11: 19-20; 12:1-4)

Here, Sofia conveys the perspective that recovery appears to be challenging if there is a lack of ambition, which indirectly highlights the necessity of having life goals or ambition. For Sofia, approaches for both spiritual and biomedical intervention could be devalued with no cognisance of the life goals associated with it.

In brief, this theme captures that participants may shape their life direction via spiritual thought, as it appears for those who strongly and positively relate their life goals or religious aim. However, these individuals are in a considerable minority (n=9). Although each person's life goals or determination may vary across their lifespan, the majority of the participants (19 out of 25) feature in the next overarching theme of "Maintaining a positive sense of self". These participants are keen to move onto a spiritual pathway that drives them towards religious faith and devotion to God.

4.9 Chapter summary

In this chapter, the theme of "restoring hope, meaning and purpose" has been presented through various themes, namely "experiencing spiritual despair", "engaging in spiritual meaning-making" and "orienting the spiritual life". In "experiencing spiritual despair", the participants described having lost hope and becoming distant or alienated from their religious faith. In this dilemma, the participants appeared to seek "spiritual meaning" in a way that may be considered "spiritual recovery". The narratives suggest that close family members are particularly important in meaning-making, as are parallel interventions from psychiatric services, such as in medication and ECT. The latter may well suggest that participants feel obliged to value or mention formal, hospital-based interventions in a positive way, either because they are subject to a dominant biomedical construction of recovery and an expectation of patient

compliance, or because they genuinely appreciate this type of support. It is particularly striking in some of these narratives how closely spiritual recovery is aligned with medicinal efficacy, not least because of the manifest relationship between spiritual well-being and compliance with treatment regimens.

The role of medication, empowerment/disempowerment and psychiatry/anti-psychiatry in the Malaysian context is considered further in the Discussion chapter. In addition to this, other movements for mental healthcare beyond that culture, as in the recovery movement developed in the UK, will also be discussed. In the narratives, there is frequently a quest for meaning, hope and purpose of life set against the many different losses that people with BD face while in the population, given their religious affiliation. Indeed, it is telling that "spiritual meaning-making" and "orienting the spiritual life" feature strongly in their recovery.

However, the strength of religiosity among these participants was not anticipated beforehand. These narratives suggest that spiritual meaning-making features strongly in their attempts to recover. Furthermore, the narratives reveal how such spiritual meaning-making and orienting the spiritual life in response to spiritual despair for some participants is co-supported by "close" family members. This suggests that promoting the spiritual aspects may be more the role of the family as opposed to that of health professionals.

The conceptualisation of spirituality from the finding in this chapter will bring the combination of religious, interpersonal relationships and medicinal aspects as highly suggested by the narratives in this sample with BD. The next chapter presents the findings related to the theme of "maintaining a positive sense of self", with the three themes of "keeping

faith in God”, “devoting oneself to God” and “having a sense of spiritual harmony: connectedness and peacefulness”.

Chapter 5: Findings 2: Maintaining a positive sense of self

5.1 Introduction

The previous chapter reported on the restoration of hope, meaning and purpose, whereby the narratives indicated the eclipsing of despair over life adversities by a quest for meaning and purpose. The participants subsequently adopted a positive view towards God, with spiritual understanding together with the support and guidance of their close family (in most cases). This chapter presents the findings from the theme "maintaining a positive sense of self", which itself consists of the following three themes: "keeping faith in God", "devoting oneself to God" and "having a sense of spiritual harmony: connectedness and peacefulness".

"Positive sense of self" refers to the participants' refinement of self-worth, feeling a sense of self-betterment or feeling good, self-assurance and security. "Maintaining a positive sense of self" may capture an understanding of how continuity in the maintenance of religious faith and practices contributes to spiritual recovery in the lives of the participants. This is facilitated by having a religion and relational agency, as well as the medicinal component. The first theme of "keeping faith in God" presents the way in which this theme relates to "maintaining a positive sense of self".

5.2 Keeping faith in God

Faith in God can be identified as trust, reliance and submission towards God taken from subjective, personal and individualistic perspectives. "Keeping faith in God" is a stable or dynamic form of internal relationship with God that is based on belief and trust placed in God. In this study, the majority of the participants (19 out of 25) accounted for having faith in God in the ongoing pursuit of a spiritual journey. The narratives indicated their expression of reliance, trust and submission to God. In this theme, "faith in God" may be clear as a foundational core in the participants' spiritual journey. Normah accounted strongly for her opinion of how spirituality could be understood in the lives of people with faith in God:

> When we talk about spirituality, it is about our true and total faith in Allah.
>
> (Normah; I; 20; 17-18)

The definition of spirituality from Normah's religious stance was connected to "total faith" or a firm belief (i.e. *iman*) in God. Though faith in God is unseen or unobserved, the personal stance of keeping faith was emphasised by Dollah:

> Faith is of utmost important. We couldn't see. Faith is our stance. Some people say that they have faith in Allah. But faith is not measured by five daily prayers. Faith is not measured by our relationship with people. Faith is our stance [affirmation of creed]. Faith shapes our personality. We need to have a stance and hold that Allah is always with us.
>
> (Dollah; I; 18: 12-16)

For Dollah, faith is independent of observable phenomena like religious rites or human relationships, instead being a deeply personal experience. These two narratives frame faith in God during the participants' spiritual journey of living with BD and other life challenges. Keeping faith in God is linked with the participants' expressions of their submission to and reliance on God, particularly when they are related to a sense of security in the present and future undertaking of their lives. There is a common pattern of a sense of selflessness by surrendering one's wishes and placing trust in God's will and mercy, from which they feel a sense of security or comfort. When experiencing difficulty in finding employment, Siti placed trust in God for her future undertaking:

> But we can only plan for our future. The fact is, our future is determined by Allah because Allah's plan is the best.
>
> (Siti; I; 5: 1-2)

In this excerpt, Siti commended her affairs to God and resigned to following His lead. The need for remembrance and dependence on God is expressed in the following narrative:

> We are born as a human being. Without God, we cannot live. That is why every person (i.e. with a religion) must remember God from time to time.
>
> (Shimala, H, 15: 9-10)

This narrative indicates the presence of faith in or dependence on God in Shimala's life. This briefly suggests the view that God's superiority sits higher than all human beings. For Zakaria, his reliance on God is

accompanied by wishing for guidance and inspiration that is conveyed in voluntary prayers:

> When I wanted to start driving a taxi, I prayed *solah hajat* and *istikharah*, then Allah gave me inspiration. I went to *Baitulmal* (i.e. a Muslim charity organisation) and received assistance from them. *Alhamdulillah* [praise to God]. Then, when I wanted to open up my food stall, I asked for guidance from Allah. What is important is, do *solah istikharah* first, and Allah provides you with the best of choices. *Alhamdulillah*. I make it a practice, and I have succeeded.
>
> (Zakaria; I; 6; 11-16)

Here, Zakaria attributes his ability to make the most of the opportunities available to him to improve his life to his total and firm faith in God. These accounts indicate that the participants may develop a positive or good sense of self about having total faith in God – viewed as the source of reliance, hope, inspiration, guidance – and for self-assurance. Thus, keeping faith in God seems to exert a positive influence on the sense of self, particularly in helping the participants move on from traumatic events. Ah Tan provided a perspective on the role of religion in shifting thoughts about suicide:

> But when you have religion, your concept of suicide is changing. You don't have the thinking of ending your life. Because you believe in God, that is why you cannot take away your life.
>
> (Ah Tan; C; 9: 13-16)

This account definitively demonstrates the role of religious faith in steering patients away from suicidal ideation. Suicidal thoughts and any other negative or perhaps destructive forms of thought and behaviour may be diminished by faith in God, as in the following example:

> The believer, he knew that he was serving God. God is the Utmost. He did not necessarily go to church, but he is praying. There is a God in the heart. If you know that God is there [in the heart], you are afraid to do something wrong.
>
> (Ah Chong; C; 24: 15-18)

Here, Ah Chong alludes to the notion of being 'God's servant', which suggests his affirmation of belief by actions such as prayer and the avoidance of wrongdoing. There is a value or appreciation about self and life in a positive way in the thought of God.

To conclude, faith in God is activated as a force in the participants' lives by a belief in God's providence and power, which can confer a sense of hope, strength, direction, inspiration and guidance. Perhaps more important for these participants with BD was how faith in God and religion could avert them from negative or destructive actions and behaviour, including suicidal tendencies. All of these effects positively contribute to a sense of self-assurance in moving on with their lives.

In concordance with keeping faith in God, the participants are likely to value and count God's blessings in their everyday life situations. Slightly more than half of the participants (15 out of 25) expressed their gratefulness for God's blessing. The Muslim participants (the majority) frequently expressed "*alhamdulillah*", signifying their gratitude to God for various positive experiences perceived as His blessing, including happiness,

good health, a supportive family and a good life. Many of the participants expressed simple pleasure for what they have, from God's mercy. Normah, who recounted performing limited religious practices while she was affected by symptoms of BD, expressed gratitude for the opportunity to rectify her spirituality:

> At times, I do think of how Allah gave me the precious chance to perform good deeds in my life, and I end up in tears. 'Oh, Allah, you bestow onto me this chance and still let me live to perform good deeds.'
>
> (Normah; I; 18: 12-15)

Normah modelled her perception of God's mercy or will towards her life with a deep sense of emotion and cognition. This included acknowledging the chances given by God as she is alive and has opportunities to perform good deeds for the afterlife. Muthu expressed his perception of God's grace in his achievements:

> Without God's blessing, we are unable to achieve anything. And thus, we must be grateful for all that God has bestowed on us. It is only then that we can gain God's blessing in life.
>
> (Muthu; H; 13: 14-16)

Here, Muthu uses the term "God's blessing", referring to his valuing and acknowledgement of God's gift. From this perception, the expression of gratefulness and thankfulness to God seems to place more weight on God's power and will over self-desire; a state of selflessness associated without one's acknowledgement of and belief in God. In this sense, some of the participants developed a positive self-attribution based on gratefulness to

God. In the following excerpt, Nora suggested a sense of life satisfaction within her thankfulness to God:

> As long as I can think logically, be reasonable, I think that is enough for me in my life. I am thankful for what I have now. Enough, I guess. Even though I may not have heaps of jewellery. Well, probably a bit. Of course, who would want to donate theirs to me anyway? That is what I hope for. And to be blessed with happiness in this life and hereafter, with my husband, my children, my mother-in-law, my mum, my siblings.
>
> (Nora; I; 26: 4-9)

For Nora, the expression of gratitude to God for "happiness" in the excerpt relates to a sense of fulfilment, comprising a good mental state, sufficient wealth and harmonious relationships with her family. "Happiness", as reiterated by Dollah, comes with a sense of satisfaction:

> The most important thing is happiness. Money doesn't guarantee happiness. But some people are happy because of money. That's not that important. Be grateful; He has given us enough.
>
> (Dollah; I; 4: 9-12)

Here, Dollah expresses his view that happiness is more important than money, despite the latter often being perceived as a proxy for the former in the contemporary world. Under this term of "gratefulness in God", the participants value living in joy under God's will, thus keeping their faith in God. Accordingly, faith in God as an expression of gratitude and devotion has meanings and values in the participants' lives in terms of shaping and

maintaining their positive sense of self. Normah referred to "spiritual strength" in a less happy moment:

> I am less happy, but I still hold onto my spiritual strength. I am aware and am grateful for that. Although I may not be perfect, God is. And, even if I don't have a job and house like others, I still have my family. So, even if I am imperfect, God still provides. Thus, that's why we ask that He provides us for our needs in this world and the Hereafter and save us from Hellfire. We want a balance of both. When I think back to my life, I realise that we always forget God's gifts to us. When we are sick, Allah heals us.
>
> (Normah; I; 18: 1-8)

The narrative illustrates a "spiritual strength" in the purview of God's blessing. In the excerpt, Normah not only considers the hereafter but also spiritual reliance on God for general needs in the world, including healing. Mahmud suggests the dynamic of faith, essentially within a personal quest for spirituality:

> Having a spiritual soul [i.e. *rohani*] is very important. As a normal human being, our faith [i.e. *iman*] may fluctuate. In fact, sometimes I observe that the non-Muslims may be better than us, I guess. That is my personal view of course. Sometimes we are only good at talking [theory], but never practising what we preach. But instead, that thing is very important for us. Most of us do things because of our norms or as an obligatory thing to do, without proper understanding. We may not seek for it [i.e. *rohani*].
>
> (Mahmud; I; 15: 3-9)

The preceding narrative illustrates the possibility of maintaining a theoretical faith in God based on learning and knowing, without having a deeper religious understanding of its implications regarding actions and observance. Mahmud points out that religious norms such as performing prayers may be mechanistic and not necessarily reflect a true faith in God. The more common spiritual aim of amassing wealth was articulated by Robert in the following excerpt:

> But I believe that upon gaining financial enrichment, I would be able to strengthen my faith in God, by doing a lot of help to the poor. People need money you know.
>
> (Robert; C; 11: 13-14)

In this sense, faith in God may be subjected to the personal wishes, joy or gratification of what believers hope or anticipate from God. Another example suggests the negotiation of the participant's, Lucy's, personal faith in God in the event of a life challenge as follows:

> I tell Lord, if He gives me suffering, I will change my view on Him.
>
> (Lucy, C, 6: 19-20)

The above narrative by Lucy suggests the dynamic nature of faith in God, whereby a changing personal valuation with regard to God is likely to be affected by life challenges, or what is referred to as "suffering" in the above. The next example by Melati expresses her despair in relation to God's love on top of personal demands:

> It is hard to believe that a God is all-loving when you've been through so much. I know it is such a classic answer, but that is how you feel. I mean you spend hours and hours praying to God, 'please send me a friend'. I am not asking for anything that is ridiculous, just one friend. But I don't have one until now.
>
> (Melati; I; 15: 6-9)

The narrative highlights the issue of faith for Melati, particularly marking her loss of faith or disappointment in God over the life she is facing and when her prayers are not answered. This "spiritual alienation" could limit the religious resources for positive attribution in self in people with BD, as highlighted in the following excerpt:

> Well, some people are comforted by it. They need to go to their priest to talk. They need to go to their *imam*. They feel better. I support it. But for me, that would not make me feel better.
>
> (Melati; I; 19:2-4)

From the above quote, Melati firmly expresses her non-belief in the seeking of religious comfort or guidance, although she does not disparage others who do so in the religio-cultural context of Malaysian society. While the majority of the participants considered faith in God as foundational to their spiritual recovery, this is not the case where seeking personal joy or gratification brings "spiritual alienation" from God. The role of religion as an avenue for cultivating a positive sense of self is explored in the next theme of "devoting oneself to God".

5.3 Devoting oneself to God

This theme represents the participants' narrative expressions of religious practices, which the majority of the participants in this study (23 out of 25) professed to undertake. The narratives indicate that religious practices are performed by the majority of the participants, except for two young females, who seemed to be locked in a state of spiritual despair (refer to Experiencing spiritual despair, p. 95). Devotion to God is understood as their narrative accounts in terms of performing various rites such as prayer, *zikr*, reciting mantras and meditation. These religious practices, integrated as part of life in this sample with BD, on a daily or at least a regular basis, can be deemed to parallel the religio-cultural lives of Malaysians of all religions. The following example mentions that religious practices are crucial and inseparable from Muslim identity:

> Indeed, the most crucial need is to perform *solah*. This is because, in Islam, it is inseparable from our daily lives.
>
> (Zakaria; I; 13: 11-12)

From the above narrative exemplar, *solah* is highlighted as a "crucial need", suggesting one's acceptance of religious obligations that seem to be integrated as part of daily life routines for Zakaria. Another participant, Asiah, suggested that recognition or mindfulness of God must be combined with religious practices for the best results:

> I pray five times a day. These are my weapons. People with BD have to remember Allah and the Prophet Muhammad a lot. Then, only then, can they be better. I can feel that.
>
> (Asiah; I; 6: 8-11)

For Asiah, the integration of religious practices such as “prayer” and “remembrance of Allah and the Prophet Muhammad” into her daily life provided a source of resilience to BD symptoms – a sense of betterment. It is even possible to perform religious practices during episodes of illness, as suggested in the following narrative:

> I had never skipped prayers. So, even when I was sick, I still wanted to perform my prayers.
>
> (Zakaria, I; 7: 17-18)

The above narrative suggests that having episodes of BD does not seem to disturb religious practices, as was the case for Zakaria. Meanwhile, for Osman, religion becomes a source of symbolic change for his age and from which he gains spiritual benefit, as follows:

> I am getting old, and I repent. I go to the mosque now. I feel recharged after praying.
>
> (Osman; I; 15: 13-14)

Osman demonstrates a consequence of “repentance” which has marked a change in his religious practice, such as him now going to the mosque. For Osman, the term “recharged” suggests a sense of self-refreshment after prayer. Another shifting point towards becoming more religious was indicated by Nora when she articulated her feelings of being recovered:

> Ever since my recovery, I felt like I was reborn, I started to double my devout practices, like performing different [i.e. voluntary] prayers – *solah istikharah*, *tahajjud*, especially *solah taubat.*
>
> (Nora; I; 18: 13-17)

The impassioned concept of being "reborn" indicates a strong feeling of a sense of betterment. It could be the starting of a new life journey for Nora, suggesting the building of a spiritual identity oriented towards becoming more righteous. From this and the preceding narrative, these participants may suggest spiritual growth with a sense of self-betterment. For Kumar, who practises Hinduism, his religious worship is focused on healing for BD:

> I go to the temple, Tuesday and Friday, morning or evening. I sit and pray. One temple only, for one God. I choose to go to the Elephant one. I think this God can heal. I also celebrate Deepavali [i.e. Dewali].

(Kumar; H; 16: 14-16)

In this and the following excerpt, religious practices or worship are based on the perceived benefit in this world and in the afterlife/hereafter, such as karma (i.e. seeking good deeds):

> You will have your karma when you die, isn't it? That's why I follow, since I was young I started doing charity. I help old and sick people.

(Shimala; H; 6:14-15)

Here, Shimala models the intention to maintain good karma based on acts of altruism (i.e. charity), embedding her Hindu beliefs within her daily life activities. Kasturi suggested that religious practices were a prerequisite to a successful day:

> According to my religion [Hinduism], I must take a bath and pray first after I get up in the early morning. Then I can start my day, and everything will run smoothly.
>
> (Kasturi; H; 6; 17-19)

In this narrative about a religious life from a Hindu, religion can be understood as a good way of life. Religion was valued by the participants as providing a good way of life in general, in addition to a positive sense of self-betterment, as suggested by the preceding participants, not least in promoting self-value. According to Mahmud, his intention of becoming "a good person" was centred on his religion:

> It's more about us wanting to be a good person. We can do it if we want to be good even though we have done bad things in the past. One day, we must feel that we need to become good. The important thing is that we follow what we are ordered to do, the straight path. Follow the five pillars of Islam, the six pillars of *iman*, as ordered. These two [sets of] pillars are vast, right? Then there are *aqidah* [creed] and *akhlaq* [ethics].
>
> (Mahmud; I; 25: 15-19)

From the above quote, personal intention or willingness seems to be the root of making positive changes spiritually, driving religious faith practices and attitudes or morals. In the following excerpt, Aminah highlights the term "determination" within the intention or aim of carrying out religious practices:

> We have frequently donated money [*sadaqah*] to others. Just a small amount like 100 or 200 will do. Just give out to those who are in need, even if they are friends or siblings. If it is not money, sometimes I would give out the clothes that I do not wear any more. If we are determined to do it, anything is possible. Do it often as the *sadaqah* we make will become deeds for our Hereafter, *in sha Allah.*
>
> (Aminah; I; 21:18-22)

The narrative demonstrates a personal determination as it relates to religious aims. In the narrative, Aminah can be seen as modelling a thoughtful or determined charitable act which has a religious value. Given that most of the participants highlighted their religious devotion in close relation to their religious identity and aims, relatively few narratives have contained suggestions of moral responsibilities. The narrative by Shimala, for example, suggests the moral obligations required so as to avoid suffering within her acknowledgement of God's gift:

> God gives a brain. So why you want to do naughty things? Who will suffer? You will suffer.
>
> (Shimala; H; 9:18-19).

The above narrative illustrates the reasonable judgement of determining that the right action is granted by God. In other words, Shimala suggests that being "naughty" or immoral may only lead to suffering, as shown in the above narrative. The next narrative by Kasturi suggests that keeping God in mind can serve to inhibit immoral conduct, outlined as follows:

> Fearing of God is very important. If we have that in mind, we won't do bad things to people like cheat people or hurt people. We know we shouldn't do that. We try to do good karma.
>
> (Kasturi; H; 9: 5-7)

Here, Kasturi illustrates an example of abiding by religion from the Hindu perspective. For Kasturi, keeping a thought on God will likely inhibit immoral conduct and thus promote good moral conduct that contributes to "good karma". The next narrative by Robert provides a general perspective on good moral conduct regardless of any religious affiliation:

> The most important the God wants, He doesn't want you to be Christian. He doesn't want you to be Muslim, Hindu or Buddhist. He just wants you to be a nice person. Don't cheat, don't do wrong things.
>
> (Robert, C, 20: 18, 21: 1-2)

The above narrative by Robert concludes that God wants everybody to be a nice person regardless of any religious affiliation. This example illustrates a common ground within all religions with regard to good moral conduct, as can be found in the Malaysian sample. However, some believers expressed a sense of improving in religiosity in terms of their relationships with co-religionists, including meeting clerics, joining communal gatherings and worshipping as part of a congregation. In the following example, Jamal, who had performed less in the way of religious practices prior to his BD diagnosis, states:

> Allah gave me a chance to meet a group of Islamic preachers [*Jamaat Tabligh*] who emphasised the importance of taking great care of our deeds in this world as well as the *muamalat* [worldly affairs]. My commitment to perform my five daily prayers also improved.
>
> (Jamal; I; 5: 5-7)

This narrative quote illustrates that religious practices may be improved through interaction with co-religionists, as reported by Jamal and five other participants. It seems that having BD does not limit the participants in interacting with others, or perhaps one's will to seek improvement in the spiritual aspects of self:

> It's improving because previously I was *jahil* [spiritually ignorant]. So when a person is ignorant about his prayers, the level of concentration is not the same with those who understand the purpose of prayers. Allah knows everything. It would not be fair to say that if a person is ignorant about his prayers, he will not perform it regularly. Of course, he would still perform his prayers. So when I was going through this experience, my *solah* and *ibadah* to God improved, it improved even when I was not well.
>
> (Jamal; I; 7: 10-16)

Jamal highlighted that devoutness comes with understanding the purpose of devotion, rather than the mechanistic performance of rites. Strikingly, Jamal's devoutness was unaffected by his BD symptoms, as neatly encapsulated in the quote. Umar claimed to pursue spiritual wisdom, and thus sought guidance:

> I also fill myself with spiritual knowledge from books. So, when I don't understand the explanation given, I would consult those who are more learned in it. In short, I would always ask in my pursuit of spiritual knowledge and wisdom. For instance, when I meet my parents, I would ask their guidance in becoming a patient person.
>
> (Umar; I; 3: 9-12)

Here Umar displays a positive attitude to seeking guidance from others, despite having spiritual materials such as books. For Umar, the form of interaction in seeking guidance may enhance the spiritual understanding. Similar to Osman, he preferred to seek guidance from a cleric:

> If I read religious books, it could result in my diversion from the true teachings of Islam. I was not good at understanding all that. Because we interpret everything on our own. It would be better if we listened to a cleric because he has the necessary knowledge.
>
> (Osman; I; 13: 6-10)

The narrative illustrates that a cleric is trusted in seeking spiritual understanding, thus indicating the relative prevalence of the spiritual guidance function in Malaysian society. Spiritual worship is practised within a group of fellowship, including among Christians, as narrated by Lucy:

> Now my master [i.e. employer] and I join a small group every Friday. We sing a worship song. After that, we pray, and we share the prayer for other people. For example, I pray for you to Lord, Lord will listen and approve.
>
> (Lucy; C; 11:9-13)

Here, spiritual fellowship could support the spiritual devotion of people with BD as narrated by Lucy, and also by Aminah in the following excerpt:

> So I prayed that God sent me friends that could guide me to the straight path. Then God allowed me to meet friends that were religious. They encouraged me to understand the religion by visiting the mosque and learning the religion via talks and lectures.
>
> (Aminah; I; 8: 16-19)

From the two preceding excerpts, spiritual fellowship or support could generate ways to promote or support religious practices, free of any social exclusion or discrimination due to having BD. In the following excerpt, Aminah points out the need to interact with others, essentially removing the sense of self-isolation in living with BD:

> One has to take the initiative in mingling with society. Be brave in asking the question, to understand others. Sometimes, when society does not notice us, we have to be brave to mingle with them. Do not stay away from the community even when you are sick. Then, when others advise us, we must be willing to listen. Be brave and mingle. It is for our good.
>
> (Aminah; I; 24: 9-13)

From the narrative, the expressions "take the initiative" and "be brave" may suggest a fighting determination to take steps or make effort for one's own benefit or positive gain. From this perspective, approaching peers for support could help to build "resiliencies" in the participants regarding the facilitation of their recovery or spiritual growth. Another narrative from

Dollah highlights the need for people living with BD to have stronger self-esteem:

> Try to ask them why they feel ashamed. I don't know why I should feel ashamed of it. Why should they feel ashamed? I don't feel ashamed. I just tell people I have bipolar disorder; they don't know what it is. I told you earlier: mission is a must, dreams, religion, spiritual fulfilment. They must have targets, reasons to live. Not knowing why they live makes them feel like that.
>
> (Dollah; I; 25: 16-21; 26: 1-3)

The narrative excerpt illustrates how purpose or goals ("mission", "dreams", "spiritual fulfilment"), and determination ("must") could overrule the feeling of "embarrassment" in people with BD. Dollah also suggested that Malaysian society is not literate when it comes to BD. Overall, the "relational capital" within Malaysian society could play a role in "spiritual recovery" in promoting and guiding these participants with BD. The participants' devotional activities could be concerned with their own spiritual aims while also being assisted and promoted by interaction, fellowship and religious communion from the religious society in Malaysia.

On the other hand, what contributes to "a positive sense of self" is not necessarily spiritual in nature for people with BD. A total of 24 out of the 25 participants pointed out the role of biomedical intervention in controlling BD; there is nothing to preclude the use of spiritual strategies in association with pharmacological approaches, and no case was found of avoiding medication based on religious beliefs. While discussing healing and church attendance, Ah Chong explained:

> That is why I take medication. The doctor said that 'God never asks you not to take medicine. Isn't that right?' So, fine, I take the medication.
>
> (Ah Chong; C; 18: 10-12)

Here, the biomedical intervention of medication use was justified by a psychiatrist to overcome latent non-compliance on the part of the patient, by explaining that it did not contradict spiritual devotion. In the following excerpt, Nora suggested that taking control of BD may assist in spiritual devotion:

> When I fell ill, I could not even bother to perform my five daily prayers. When I recovered, I would take care of my *solah*. I would perform *solah* that is *sunnah* [voluntary].
>
> (Nora; I; 12: 20-22)

From the narrative, Nora highlights a decline in spiritual practice due to being affected by BD symptoms. In this and the preceding excerpt, the participants may hold on to a biomedical intervention as a route to control BD symptoms, while also not ignoring the fact that BD symptoms may recur. On a different occasion, medications for BD may need to be adjusted or changed in parallel with the participants' effort to maintain spiritual devoutness, as in the following excerpt:

> Although Risperidone (i.e. psychotropic medicine) caused me to increase in weight, it enabled me to perform *solah*. I don't [have to] do *solah qada* [making up missed prayers] like before. Previously, I would always do it [*qada*] because I would just end up sleeping when I took Seroquel.
>
> (Normah; I; 9: 12-15)

This narrative excerpt illuminates a condition whereby religious practices such as daily prayers could be curtailed during BD episodes and when experiencing the side effects of medication. In this sense, a partnership with health professionals is deemed necessary for changing or adjusting medications to open up the route to spiritual practices (pharmacologically). The results of spiritual practices in forming a positive sense of self in relation to God are presented in the next theme of "having a sense of spiritual harmony".

5.4 Having a sense of spiritual harmony: 'connectedness' and 'peacefulness'

This theme captures the sense of connectedness and peacefulness as narrated by a majority of the participants (19 out of 25). The subjective nature of these narrative accounts is commonly associated with having faith in God and devoutness in performing religious practices. These narratives express the participants' sense of spiritual harmony regarding having a sense of "connectedness" and "peacefulness".

5.4.1 Connectedness

About half of the participants (13 out of 25) expressed their feeling of a sense of "connectedness" with God; these were the same participants who had faith in and devotion to God, as exhibited in the following quotation by Ahmad:

> When the heart is purified, of course, God will be with you along the way. When the heart has been purified, we can be close to Him.
>
> (Ahmad; I; 9: 12-14)

Here, Ahmad uses the term "purified", which appears to suggest a "spiritually cleansing" state of mind, in the sense of drawing close to or having a sense of connectedness with God. Normah refers to faith in God when revealing her perspective on connectedness with God:

> The soul is our inner soul. It connects us to our faith in Allah. For Muslims, our God is Allah.
>
> (Normah; I; 14: 6-7)

The terms "soul" and "inner soul" are used by Normah to refer to a metaphysical aspect of an individual that potentially bridges one's connection with God. The notions of "connectedness" and "faith" were neatly encapsulated by Normah, suggesting the elements of spiritual capital, not least in providing a pleasant feeling in a deep sense of prayer to God, as suggested by Kasturi:

> The patient [i.e. people diagnosed with BD] must pray a lot. That is what I believe. Deep inside I pray a lot. I feel connected to Him [i.e. God].

(Kasturi; H; 14: 2-3)

The above narrative illuminates that the sense of "connectedness" is an experience potentially resulting from prayers, as neatly encapsulated by Kasturi. These narratives capture a pleasant or comfortable relationship between oneself and God regarding a "feeling of connectedness". This feeling is channelled from having faith in God and performing spiritual practices, which was valued by Lucy, as in the following excerpt:

> I talked to an idol [Buddhist], but she cannot talk to me. The Christian's practice is different. People come and pray for me. They say 'if you don't know how to talk then never mind. The tongue is speaking. The Lord can hear'. Lord with me, connect with me.

(Lucy; C; 11: 11-14)

The above excerpt illuminates Lucy's concern with regard to the need for a sense of connectedness with God. Lucy also suggests that religious communion helps to resolve her concern by providing reassurance on how to connect to God. Aminah, who performed fewer devotional activities in the past, believed that the sense of connectedness comes with "God's mercy":

> God loved me. He opened my heart to get near to Him. I once did not know how to pray, but suddenly my heart felt that I wanted to buy religious books to learn about the religion. When I look at the mosque, I felt that it was calling me for a visit. Not to say I wanted to go to the mosque, but my heart kept on contemplating whether to go or not to go. But this heart would always give excuses. After some time, I felt that I should respond to God's calling. I went to the mosque, and I loved it. At first, when I visited the mosque I felt

> my heart was far from God. But when I visited the mosque every day I felt closer to God.
>
> (Aminah; I; 10: 9-16)

Aminah reiterated the spiritual form of connection with God as seen in other narratives in terms of her daily religious practices. Here, Aminah expressed her feeling of God's love in the sense of "spiritual closeness or connectedness". Responding to God's call, as neatly encapsulated by Aminah, suggests an experience of "spiritual awakening", which necessitated actions towards the route of spirituality. In this case, spiritual architecture (e.g. a mosque) visible in the community functions as a reminder and channel of spirituality. Here, culture associated with assembly for religious worship within the Malaysian society may potentially be inclusive as spiritual resources. A "spiritual connection" could be one of the aspects of maintaining spiritual recovery in people with BD, as indicated by Umar:

> Previously, when I was into negative things I was spiritually sick. So, how do we treat our sick soul? We need to return to God's path of righteousness. This is as the soul acts as our connection with God.
>
> (Umar; I; 8: 28-30; 9: 1)

As illustrated by the quote, the term "spiritually sick" was used by Umar to indicate the tendency of negative and unhealthy thinking and behaviour, as can be referred to in "experiencing spiritual despair". However, from this excerpt, the participant pinpointed the possibility of "spiritual recovery", particularly when one obtains a sense of being connected with God. This form of "spiritual recovery" is particularly interesting, in the sense of how

one relates him or herself to God spiritually, and what this means to them spiritually along with their faith in and devoutness to God.

5.4.2 Peacefulness

A sense of peacefulness, calmness and serenity was articulated by slightly over half of the participants (14 out of 25), as resulting from the practising of religious activities in daily life or on a regular basis. Aminah expressed her thoughts that reading and understanding the Quran would make one feel peaceful, as indicated in the following excerpt:

> Read the Quran with the translation so that we could know its meaning. Even if it is one page per day or at least two sentences. Read. That is what makes me feel at peace.
>
> (Aminah; I; 26: 7-9)

Here, Aminah indicates that recitation of the Quran combined with an understanding of its meaning might promote a sense of "peace" and a feeling of tranquillity associated with God's words recited in the Quran. Religion may act as a source of "healing" as found in Christian practices and beliefs. Ah Chong used metaphorical language about "falling", referring to the dissipation of tension and resulting in the sense of having a free mind and feeling at ease:

> The healing part, when I pray to Him, it [healing] comes to you. Sometimes at heart. Sometimes they have a healing session in the Church. After that, you go out of the church, you stand and put your hands on the forehead. You fall. After, you wake up. The burden is gone. You feel at ease.
>
> (Ah Chong; C; 8: 8-14; 9: 1)

The above excerpt illuminates the healing effects of religious worship, at least in a psychological sense, by diffusing the tension built up from worldly life stresses. In this sense, practising a religion can mediate a sense of spiritual harmony by enabling participants to relax. In other words, religious practices mediate psychological well-being, providing a safety valve whereby believers can disconnect from stressors. Having a sense of spiritual harmony could reduce BD patients' unhealthy or perhaps overwhelming thoughts and feelings of guilt that they experience in their private life. Ah Tan suggested that a sense of guilt could be diminished through mindfulness of God:

> The sense of guilt, maybe when you were young you feel like you want to commit suicide. You think about problems and what kind of life you have. But after receiving Christ, then these things go away. You don't have this feeling guilty, sin or bad things any more.
>
> (Ah Tan; C; 9: 5-7)

This narrative excerpt illuminates that an individual with BD may change his or her sense of guilt and move towards positive emotional states once the mindfulness of God has settled in the intellectual domain. Dollah encapsulated the role of religion in the psychological effects in one's life, stating:

> Religion also plays a role. It doesn't matter what religion the person is attached to, be it Hinduism, Buddhism or Islam. No religion asks us to commit suicide. All religions promote peace. For peace. So that we are relaxed. And don't go for whatever we can't get. If we insist on getting it, we would be stressed.
>
> (Dollah; I; 26: 6-9)

This narrative excerpt suggests the psychological effect of religion as being permeated with "peace" and "relaxing". These positive or pleasant feelings as reiterated from the above narratives could indicate an overall psychological improvement of people with BD. On the other hand, Dollah reflected on the psychological distress resulting from difficult or frustrating desires that may induce BD symptoms:

> If I got paid as a clerk, I wouldn't be able to buy a Ferrari. So I told myself not to go for it. If I went for it, I would be stressed out. If I were stressed out, I would be sick. This is what we call illness. Then I learnt.
>
> (Dollah; I; 3: 19-22)

From the two preceding excerpts by Dollah, there is a sense of self-refinement of what individuals ought to pursue being closely aligned with religious perspectives. In this sense, an eager desire for a material or secular life is likely to be hindered (a major theme of all world religions), with negative impacts on overall well-being and the controlling of BD. Jamal expressed that this kind of tranquillity arises from religious ideation and cannot be found in recreational activities associated with taking one away from spirituality:

> Only if we remember Allah, our heart will be at peace. There is no other way. For someone to only go to any karaoke centre to find his peace, that would not help also. Allah has stated that 'only Him', and when He says 'only Him', then there are no other sources that could make you seek and find solace. There is no other solution.
>
> (Jamal; I; 18: 19-22; 19: 1)

The above narrative excerpt suggests that the adoption of a religious ideology of peacefulness is likely to be achieved with the mindfulness of God. Jamal developed clarity about his conscious choices about spirituality as compared to modern and secular attributes of peace, calm or relaxation. It is quite revealing that peacefulness is appreciated and valued within the traditionalism of religion in Malaysian society, rather than modern leisure pursuits. However, in the context of people with BD, modern psychiatric treatment was also linked to the spiritual conditions of peace, calmness and tranquillity:

> That is a bit different. Taking our medication will make us sound asleep, totally unconscious. It ends there only. Meaning that, when we got up the next day, we will feel fresh again. Unlike seeking peace from Allah, that is a big bonus. You will feel that you are given with all that you need. You are thankful to Allah because you get something even though it may not seem much, but it is still valuable.
>
> (Nora; I; 21: 20-22, 22: 1-2)

Nora perceives a sense of calmness from medication as symptoms-based treatment. On the other hand, the perceived effect of devoutness to God is a "big bonus", as referred to in the excerpt, and is a form of God's blessing as valued by Nora that results from her religiosity. Sofia suggested the emotional ease of disturbances could be achieved with voluntary religious prayers:

> If we can't sleep, we feel disturbed or are pressured by so many other things. We may assume that we would be ok by taking the sedatives prescribed. It doesn't mean that taking the drugs is the

> perfect answer. Rather, if we stay awake in the wee hours of the morning to perform the *sunnah* prayers, that can suffice too.
>
> (Sofia; I; 10; 14-19)

The above narrative excerpt illuminates, from Sofia's point of view, that medication such as sedatives does not constitute the "perfect" or only answer to emotional disturbances or distress. Overall in this theme, the psychological domain appears to be one of the possible outcomes for positive gain in spiritual recovery as one may be able to experience pleasant emotions: calmness, peace, relaxation and ease. Perhaps these pleasant emotions add to the meaning and value of life and inspire a continuous faith in God and devotion. A narrative by Siti expressed her wish to remain well in combination with the effort to strengthen her faith in God, expressed in the following:

> I want myself to be healthy. I want myself to be relaxed. I want to strengthen my faith. I do pray now, but sometimes I miss my morning prayer. Because sometimes I sleep late.
>
> (Siti; I; 12: 10-12)

From the above narrative, Siti expresses her aim to be healthy both physically and emotionally and to make an effort to strengthen her faith by performing prayer. She also attempts to address the current limitation to her performance of morning prayer. However, Siti also goes on to suggest other possible life approaches that can bring a sense of relaxation, as shown in the following excerpt:

> Photos, pictures. I love art. I love art because it is relaxing. I like drawing, especially abstract design. There are a lot on Facebook. It gives a bright future.
>
> (Siti; I; 5: 13-15)

From the narrative, Siti relates her approaches from psychological states of relaxing with an appreciation and interpretation of art. In the narrative by Melati, a state of "calmness" is related to music in her personal preference:

> What calms me down is mostly music. I was so happy. I listen to a lot of things that are different. I don't know why. I guess it is just my preference.
>
> (Melati; I; 14: 19-20)

These two narratives highlight the other approaches that may be taken for calm and relaxation in non-spiritual ways among those who are less religious or who have lost faith in God's decree. Thus, from those narratives of the majority, continuity in religious devoutness and spiritual gain are likely to be in the form of a cyclical process in people with BD in terms of maintaining their "spiritual recovery". This is in contrast to the non-spiritual approaches to tranquillity as taken by a minority of the participants. This minority seem to suggest only psychological perspectives in the symbolic form of arts and social activities.

5.5 Chapter summary

This chapter has explored the theme of "maintaining a positive sense of self" through three themes: "keeping faith in God", "devoting oneself to God" and "having a sense of spiritual harmony". In "keeping faith in God", the participants describe that faith in God (i.e. *iman*) is foundational to

"spiritual recovery". Keeping faith in God seems to exert a positive influence on the overall sense of self and on the participants' ability to appreciate God's grace and blessing in their life. These narratives strongly suggest that spirituality and religious faith, based on "devotion to God", were central to the resilience and self-reliance of this sample with BD in Malaysia.

The narratives suggest the participants' devotion to God through their religious practices and that this is conducive to their spiritual recovery. The experience of a sense of spiritual harmony and general tranquillity among most of the participants is closely felt within their religious activities. The sense of connectedness to God, peacefulness and being grateful to God seems to add to the meaning and value in their everyday life, as well as through religious activities. Nonetheless, the narratives also suggest relational and medicinal support in a combination of religious aspects.

This theme recapitulates the role of medicine in the narratives, particularly in relation to maintaining the trajectory of spiritual recovery. In other words, having BD symptoms resulted in an interference of religious devotion among this sample with BD, although it can be controlled by medicine. The supportive role of co-religionists and peer support also contributed to a state of "spiritual recovery". From these narratives, "spiritual recovery" appeared to be based on the participants' relationship with God, devotional activities and their supportive surroundings that bolster a positive sense of self. This theme suggests a process of strengthening the positive emotions in alignment with self-efficacy and outlook. Overall, the process of maintaining a positive sense of self appears to be a psychological matter closely associated with "spiritual recovery". The next chapter presents the findings related to the theme of "adapting to

live with bipolar disorder”, with the two themes of “improving a sense of self-control” and “establishing a positive life adaptation”.

Chapter 6: Findings 3: Adapting to live with bipolar disorder

6.1 Introduction

This chapter presents the findings from the theme "adapting to live with bipolar disorder", which comprises two themes: "improving a sense of self-control", and "establishing a positive life adaptation". This theme captures a positive adaptation to living with BD, in particular among the participants who spoke regarding "keeping faith in God" and "devoting oneself to God" in the previous theme. In this theme, the narratives report on a mix of spiritual and psychological approaches in the participants' adaptation to living with BD, particularly with regard to maintaining positivity and emotional stability. More interesting perhaps is the way in which the participants report an improvement in their overall self-control in managing their lives with BD due to spiritual practices.

6.2 Improving a sense of self-control

In this theme, the majority of the narratives (22 out of 25) captured the sense of an improvement in self-control over their BD symptoms with spiritual practices. In the context of living with BD, some examples of narratives highlighted the concern about emotional instability with its link to BD symptoms. Sofia, for example, observed that others had experienced stress caused by their "studies" in the context of having a diagnosis of BD:

> Most of these patients, they fell ill because they are stressed or pressured by their studies. Their moods may constantly change all the time.
>
> (Sofia; I; 7: 11-12)

Here, Sofia points out a serious shift in emotions to the extent of having a relapse of BD due to educational stresses. The difficulty in handling emotional instability is neatly encapsulated in the following narrative from Kasturi:

> Sometimes I go into depression when I face problems, as it is difficult for me to handle. Maybe I am too sensitive; I don't know. So, last year I went through an episode again because of my son.
>
> (Kasturi; H; 1: 5-7)

The narrative illustrates a circumstance wherein a disharmonious relationship between Kasturi and the son could trigger depression, which is a sign of BD relapse. A lack of capacity to handle emotional distress was one of the trajectories leading to BD episodes in the case of Kasturi. Nora pointed out that people with BD lack the ability to cope with emotional distress:

> If we are healthy like others out there, I guess that would not be a problem. Because we have this illness, so we may not be able to cope with it [i.e. frustration].
>
> (Nora; I; 9: 18-19)

From this and the two preceding narratives, emotional disturbances are highlighted as having a profound effect on the lives of people with BD. Certain emotional disturbances such as "anger" were associated with impulsive behaviour such as "*amock*" (an Indo-Malay term from which the English phrase "run amok" is derived), as narrated in the following:

> In the past, whenever I felt angry I just let it out. It was as if I lost my senses; as if something controlled my thoughts. So, since our actions follow our thoughts, then we think of running amok, we just do it.
>
> (Umar; I; 2: 26-29)

From the above narrative, it can be taken that there is a tendency for emotional instability or outbursts such as "anger", "frustration" or the ineffective management of emotions among some of this sample with BD, as taken from their narratives. In brief, this sample of BD indicates emotional struggles in the presenting life situations – relational, educational and vocational – that potentially cause emotional distress and are associated with BD symptoms. Thus, these people with BD are concerned with maintaining a sense of self-control over their BD or emotions. Umar also underscored the sense of spiritual harmony ("connectedness with God") for gaining a sense of self-control and mastery of the emotions associated with BD symptoms, such as "agitation and running amok":

> It is more of our behaviour and our connection to God. If we keep Him in our hearts, we will feel more patient.
>
> (Umar; I; 3: 1-2)

From the above narrative, Umar highlights that keeping a "connectedness" with God in a spiritual sense could contribute to becoming more patient. Mahmud placed emphasis on controlling emotions in a general sense:

> The emotions must be under control. Any ordinary person too must be able to control his emotions. Of course, this also includes

> controlling your spiritual being. I am not trying to offer any advice here as I don't consider myself as being a pious man. However, it is still important to have balanced emotions. Regardless of who you are, if the person is a Muslim, he needs to learn to control his emotions, he will inevitably need to seek for spiritual good to achieve balance in his emotions.
>
> (Mahmud; I; 7: 19-20; 8: 1-4)

In highlighting the need for emotional control, the above narrative illustrates a spiritual mode among the general population that could be helpful for people learning to live with BD. As noted by Mahmud, a spiritual sense of harmony resulting from emotional balance and restraining destructive emotions is considered an integral part of Islamic practice. Furthermore, people with BD aspire to conform to the religio-cultural norms of behaviour within society as part of seeking a quality spiritual-emotional balance. Similarly, Muthu strongly felt that individuals with BD have to learn how to gain self-control using all available means:

> I was unable to control myself. I knew that we need to be physical, mentally, spiritually strong to control ourselves.
>
> (Muthu; H; 9: 3-5)

While this emphasises taking care of the element of "wholeness" in people with BD, Jamal pointed out the impact of a disruption in the elements of the "wholeness" of self in terms of the interplay between "soul" and "body":

> If there is damage to the brain, we can treat it. When the *jiwa* [soul] is broken, the whole body is also destroyed. Any damages to

> the brain in any science field, there is still a chance to recover, right? It's not separated from other body parts. Probably the neurones got haywire. That's all. With the diet, healthy lifestyle, then the body will be good. But inside [i.e. soul]? It's useless if the inside is already broken.
>
> (Jamal; I; 14: 3-8)

The elements of "soul" and "body" from this narrative are subjectively viewed as being integral parts of self, not least in letting the "sick soul" destroy the person as a whole. These narratives are striking in their implication that the patients believe biomedical interventions to be ultimately ineffective in offering spiritual recovery as a core component of overall wellness for people with BD. For this population with BD in Malaysia, religion could play an integral part of good self-control as opposed to a tendency towards impulsive behaviours, as narrated by Umar. Ah Chong states that without religion, people with BD could have delusions of grandeur and egoistic self-absorption:

> If you do not have religion, you think that you are the greatest. You think you are the only one in this world. You can do whatever you want.
>
> (Ah Chong; C; 23: 15-17)

As illustrated from the above narrative, religion may prevent the installation of the "super-ego" in oneself – a reflection of the religious-cultural norm of what is within and off limits. The interplay of religion and "wholeness" was reiterated by Umar, with particular reference to a close relationship with God inhibiting believers from losing control:

> As for lust, it can be in big or small, bad or good, white or black, hot or cold. But, if we surrender in total to its temptations, it will control our thoughts; making us lose our sense of self until we aren't able to distinguish between what is permitted and not permitted in Islam, and we end up just doing what we like. Like that. Between the mind and heart, there lies the soul. So, what does the soul want? It wants to be with God. How is it sustained? Through prayer, recitation of the Quran, *zikir*, *selawat* and *istighfar.*
>
> (Umar; I; 4: 38; 5: 1-6)

This is striking in terms of how the participant views religion, and the nature of seeing the self, consisting of heart, mind and also the soul, as something needed for spiritual fulfilment by sustaining one's relationship with God. Umar also narrated the outcomes from religious practices in terms of regaining "self-control" over an emotional outburst such as anger:

> I can still control my level of patience. Anytime I felt angry, I would quickly think of Allah, and I have been practising it until now. I would recite *istigfar*, asking for God's forgiveness, and taking ablution to purify myself.
>
> (Umar; I; 2: 24-26)

The above narrative illustrates that Umar had personally exhibited self-efficacy in developing his personality to control anger and be more patient by utilising spiritual practices. Suraya was also concerned with attempting to remain patient in an unsupportive environment:

> It makes me feel just irritated, but I have to stay patient. If I get angry, people will just say that I'm having a relapse.
>
> (Suraya; I; 11: 6-7)

Here, Suraya highlighted the need to remain "patient" and be calm, regardless of the unsupportive surroundings, due to her wish to avoid being misunderstood as having a BD relapse. Thus, the gaining of self-control with spiritual intervention could enhance the overall well-being of people with BD. The role of spiritual practices among people with BD in recuperating from the emotional disturbance is demonstrated by the participants in the narratives, as taken from the example of Rohani in the context of a lack of supportive others. Rohani narrates her account of a preference for confiding in God rather than friends. She says:

> I can just cry constantly. I think I have to the point where I'm beyond tears. Then, I would bleed with tears inside. Due to that, I get gastric and asthmatic. And so, I end up just confiding in Allah. I don't want to face any more pain.
>
> (Rohani; I; 16: 7-10).

The narrative by Rohani illustrates a mechanism of emotional relief from the sadness that is associated with the spiritual approach of "submission to God". In the next narrative, Asiah strongly accounts for the benefit of spiritual approaches for gaining emotional control in dealing with conflict with her husband:

> *Alhamdulillah*. I feel very happy this month. I can handle all that [i.e. control emotional outbursts]. This is the result of performing *dhuha* prayer, *tahajjud* prayer. I pray five times a day. These are my weapons. People with bipolar disorder have to remember Allah and the Prophet Muhammad a lot.
>
> (Asiah; I; 6: 8-11)

The above narrative by Asiah models spiritual approaches for maintaining joy and "happiness" that are particularly suited to people with BD. Mahmud claimed to have a "fluctuation of faith" in God, which he addressed concerning the need to gain control of his emotions:

> If I want to be on the right track [i.e. recovery], I have to ensure that my emotions are in check, then I would be able to take care of or nurture my soul. Only then would I be able to reach a certain level of intellectuality. If I can't control my emotions, and my soul is weak, then most probably I will face emotional disturbance as well.
>
> (Mahmud; I; 3: 15-18)

From the above narrative, emotional disturbance is regarded as the lack of emotional control and a "weak soul" (*jiwa lemah*). Thus, Mahmud emphasised the need to keep emotions in control for the purpose of nurturing the soul, from his spiritual perspective. Interestingly, this sample of participants with BD, which represents the narratives of a spiritual route for recovery from BD and general emotional well-being, may have developed what is termed "self-efficacy" and are thus trying to minimise any relapse of their BD. Here, the interplay between the spiritual attributes and emotional or psychological improvement of people with BD is striking and is considered in the Discussion chapter.

Other approaches to facilitating the way of "improving a sense of emotional control" are also helpful and carry weight in the lives of people with BD. Another participant, Sofia, highlighted the need for a balance between reliance on spirituo-religious practices and medical assistance for controlling mood:

> I think I am ok with my spiritual aspect. *Alhamdulillah*. It's balanced of course. Being balanced means that I can control my mood, I take my medication. I have to discipline myself with my daily life schedule, from morning starting from my *suboh* [i.e. morning] prayer until night time.
>
> (Sofia; I; 22: 14-18)

As illustrated by the above quote, the perception of the "spiritual aspect" comes into balance with the participant's ability to control her mood or emotion. It could be that emotion refers to concern about the symptoms of BD, suggesting the commitment expressed by taking medication. Thus, in living with BD, one may seek ways of devotion to God while also controlling the symptoms with medication. It seems that contemporary medicine is still viewed as being an integral part of the spiritual aspects of oneself; spirituality and medication together provide a dynamic balance for helping the participants maintain their positive sense of self. For Robert, the lowest mood or depression leads to him not taking care of his well-being, and to a morbid obsession with suicide:

> When you hit the lowest cycle or the sad part of bipolar, you don't even know how to get out of it. You don't even have the mood to eat. You don't even know how to take a shower. The only thought is about dying, and dying, and dying. So, now that I am on these

> medications, it keeps me on the lateral mood. And I don’t have any problems.
>
> (Robert; C; 9: 2-6)

From the above narrative, Robert highlights the effectiveness of medication in keeping his emotions in a controlled or “lateral mood”. Similarly, Zakaria addressed his understanding that the emotional instability relating to BD was in alignment with taking medication:

> If I don’t take it, my mood swings will revert in a week. There will always be something that I’m not satisfied with, even my wife commented on how easy it was for me to get angry.
>
> (Zakaria; I; 5: 9-11)

The above narrative illuminates how taking medications to control emotions associated with BD symptoms is predicated on trust in the medical knowledge of the manifestation of BD. However, for Sofia, medication and religious devotion both play an integral part in “improving the sense of emotional control”:

> I also took my initiative to find particular *surahs* [chapters of the Quran] used in the healing process [i.e. *ruqyah*, healing using the Quran] for me to practise daily. Sometimes I would ask others about such matters. We need to take some initiatives also. We cannot rely 100 per cent on the prescribed medication or help from others only. Assistance from other religious or devout figures can also be effective.
>
> (Sofia; I; 8: 13-17)

The above narrative illuminates that medications are one way by which to maintain BD, particularly the emotions, in a stable pattern. In parallel to spiritual approaches, the supportive role of others could serve to relieve the emotional burdens of the participants. The following excerpt by Asiah identifies one of the ways of channelling distress:

> We express what we feel inside. We won't get sick. Not necessarily expressing the feelings to the husband. I can express those feelings to my child. My child is very responsible like his dad.

(Asiah; I; 3: 14-16)

Here, Asiah suggests that the expression of emotional burden could help her to feel a sense of betterment. Indirectly, Asiah also suggests that emotional crises are likely to be managed within a supportive environment by having someone as a listener, to vent the emotional burden. Suraya expressed more firmly the need for emotional help from others by listening to her feelings:

> Because I needed to heal. I realised then that I had pent-up emotions as I was someone who liked to keep feelings inside. For me, it seemed like a trivial problem, but in reality, it wasn't. No matter how small it was, I needed to express it, but I just kept it in.

(Suraya; I; 6: 15-19)

The above narrative excerpt suggests a way of self "healing" in overcoming emotional burdens. The opportunity to express emotional burdens, frustration, distress, conflicts, dilemmas or problems seemed to be therapeutic for this participant. The next narrative by Rohani suggests her reliance on siblings and friends as a source of support:

> I have no one. And so, I can only confide with my siblings or my friends who live nearby. It's fine. I am okay. I'm just empty. Empty – no property, no children. Thinking about it brings to no end. And so, I would confide in my sister. I would visit my siblings until the day when my siblings all hate me. God forbid. God willingly, they would welcome me.
>
> (Rohani; I; 7:21-26).

The above narrative illuminates Rohani's perception of "emptiness" in reference to having neither children nor wealth. However, Rohani provides an example of being positive with regard to her circumstances by identifying means of support from her siblings within her trust in God. Kasturi, below, suggests her need for "love" and thus looks to her daughter to fulfil her needs:

> I am already a psychiatric patient. This kind of thought (i.e. being emotional) may make my condition worse. Then I leave it, I called my daughter, and we talked through the phone. I said: 'Can you come back for my sake? Because I am getting old and I am sick, I need love.'
>
> (Kasturi; H; 2: 12-18).

In this narrative, Kasturi provides an example of having understood her circumstances of being a "psychiatric patient". Thus, Kasturi suggests that psychiatric patients need to avoid negative or emotional thoughts with the support and love of their close family. Lucy identified the need to share problems with someone she is comfortable with, as in the following narrative:

> If I have a problem, I can share with my boyfriend or my lady boss. If I just keep my problem inside, I will feel very very sad and lonely.
>
> (Lucy; C; 6: 16-17)

From the above narrative, Lucy provides an example of how she overcame emotional disturbance such as "sadness" and "loneliness" by sharing problems with her boyfriend or boss. Ah Chong points out the sense of betterment of feeling as a result of sharing problems:

> It's all about the feeling; the feeling that you've been hurt. It is not about the symptoms. Sometimes you feel that she [i.e. the counsellor] hears your problems, your burden will go away. You feel okay.
>
> (Ah Chong; C; 11: 4-6)

The narrative excerpt suggests that the relief of emotional burden resulted in feeling good or "okay", as expressed by Ah Chong. In this population, the balancing of emotional ups and downs by relying on others was a common source of emotional channelling. Ah Chong and three others (Umar, Osman and Mahmud) felt more comfortable receiving professional help from a counsellor. The narrative by Kumar suggests the need for close family members in sharing problems:

> They (i.e. family) are the only people that I can share the problem with, and all the difficulties.
>
> (Kumar; H; 7: 1-2)

This, and the next narrative by Kumar, suggests that men in general are likely to consider the element of trust when sharing problems. Kumar says:

> We can talk to them (i.e. friends) but we can't trust them. We can share ideas but can't share certain things. Not every person will tell what kind of problem they are going through. If they want to tell their problem, they should speak to the right person.
>
> (Kumar; H; 15: 4-6)

The narrative by Kumar suggests his opinion on the limits of sharing problems, particularly among men. For Kumar and others, this could perhaps enable them to maintain their sense of pride and security in a way they could not do if they confided in their wives, families and friends, thereby reflecting the predominance of the traditional self-reliant male in Malaysian society:

> Do you think it is an effective way if we spill all our problems to others? You could instead become the centre of people's gossip. There were times of course that I would do that, but that is very seldom. Honestly, there are a lot of things that I don't tell others. It is very stressful.
>
> (Mahmud; I; 22: 19-21; 23:1-2)

For Mahmud, the "effectiveness" of sharing problems with others was doubtful due to the values of pride and privacy. It could be due to a lack of self-assurance and/or a fear of becoming the subject of gossip. While there are potential limitations to the relieving of emotional stress with the assistance of relational support among men, women, particularly Muslims, may also face limitations, in this case linked to Islamic culture and practice.

An example by Suraya expressed the restricted social practices in her concern related to having negative emotions:

> I tried to identify the reasons behind it [i.e. bad mood]. It was mostly due to being stuck at home; just waiting there. If I wanted to go out, I would have to wait for my husband. That's what made me feel impatient. But then, it lasts only for a while. Well, stress is like that, right. When I do my prayers, everything turns back to normal. As for me, I like going out, meeting up with others – meaning meeting up with a crowd.
>
> (Suraya; I; 14: 11-16)

The above narrative excerpt illuminates how, for Suraya, negative emotions and irascibility could be assuaged by religious and social activities. Apart from devotional practices and faith in God, which promote a spiritual sense of regaining self-control, Suraya also cited "going out" and "meeting up with others" as additional sources of maintaining a positive sense of self. Similarly, Ahmad stated that maintaining relational connections with friends helped him manage his BD:

> By being around my friends, it helps with my bipolar condition. For me, I think those with bipolar should not be left alone. If I am alone, you become emotional, and it drags me down. It's better for you to go out and meet people.
>
> (Ahmad; I; 11: 10-15)

Here, Ahmad highlighted that "socialising" is one of many ways for gaining self-control, and trying to live as normal a life as possible. "Socialising" could help people experience joy and maintain a positive sense of self, and

at least it exists within the Malaysian society. In brief, engaging with interpersonal relationships has seemed to have variable potential impacts for the participants; either positive and supportive, or negative and discriminative. Mahmud described one way of taking emotional control:

> Sometimes I feel good about the things surrounding me, sometimes not. The important thing is that when I am occupied with some activities, my mood swings (depressive episodes) can be kept under control.
>
> (Mahmud; I; 2: 8-10)

The above narrative illustrates the other aspect of keeping emotions in control, through being self-occupied with activities. For Mahmud, this could be a form of diversion from mood swings, particularly the lowest mood or depression in the case of BD.

To conclude, this theme represents the concern expressed in the narratives regarding the need to have a good sense of self-control. In this theme, the narratives strongly suggest the participants' mechanisms for establishing a sense of control, both emotionally and behaviourally, with the aid of three resources – religion, interpersonal relationships (i.e. most of the participants strongly account for the importance of family) and medicinal components. Some of the narratives highlight their opinions on certain social limitations in seeking resources for emotional distress. Nevertheless, the participants point to resources such as religion and medication that also support the effort to improve their sense of self-control. The next theme, "establishing a positive life adaptation", represents the positive outlooks or resiliencies that feature in the narratives of these participants with BD.

6.3 Establishing a positive life adaptation

In this theme, 19 out of the 25 participants gave an account of having an optimistic outlook during the remission stage of BD. The remaining participants (i.e. six) expressed their struggles and highlighted the barriers to them living positively.

In this theme, the participants expressed their optimism in viewing life, and in having an expectation for, and hope in, life. In adopting an optimistic attitude towards life, these participants expressed positive thoughts about having BD itself, as well as the prospect of a life full of opportunities, and they expressed that they felt it unlikely they would ever give up hope in life (including those who had previously experienced suicidal ideation). These participants are counted under the theme of "restoring hope, meaning and purpose" and the spiritual approaches of having faith in God, religious devoutness and a sense of connectedness or peacefulness, which are all constituted under the theme of "maintaining a positive sense of self". A positive view of having BD was neatly encapsulated by Kumar:

> This bipolar is not a serious thing. It is only a minor condition in my life because I can cope with it.

(Kumar; H; 18: 9-10)

Kumar suggested that he could deal with BD due to the fact that it was not a major impediment to his enjoyment of a normal life. Shimala, while narrating her frustration about familial conflicts and a lack of appreciation from her husband, nevertheless appeared to take an optimistic view about her self-capabilities in moving forward:

> I can sew a nice bag. I can make floral patterns. Patchwork. I can make use of my hands. I live with my husband, who has a bad attitude that always causes me headaches. I was admitted to the psychiatric ward, and I don't want to do that anymore. I want to be an active person. I want to move further on. I am asking God to help me.
>
> (Shimala; H; 20: 21-23; 21: 1)

Here, Shimala appeared to view life opportunities in moving on with her vocational talents (handcrafts). The intention or will in moving on towards a better life, coupled with "reliance in God" in the context of negative surroundings, are considered to indicate a strong determination to strive on her own. Aminah also exhibited optimism and courage due to the lessons she had learnt from her experience of BD:

> But I felt extremely confident and brave. So through these experiences, now I have become confident with myself. I think positively about everything. Those days used to be negative. I remember God a lot. I believe that if I want anything I should ask it from God and not from others.
>
> (Aminah; I; 14; 3-6)

From the narrative, Aminah attributed her more positive view and hopefulness, confidence and bravery to taking a proactive approach in numerous aspects of life. This relates in particular to reflecting on the past where she ran into negativity, and now she remembers and relies on God instead of human beings. In this sense, those earlier life adversities associated with despair and a sense of hopelessness were navigated via a more positive adaptation to living with BD. Those participants who nurtured

an optimism in life moved towards self-growth from experience, and were able to move forward with a positive mind. Suraya related her good impression and well-being to the psychiatric care she received:

> I am a positive person. In last year's appointment, that doctor [psychiatrist] declared that I was already well. He added that it was a good thing. He asked me how I managed to become like this. I said I only needed to be positive. Then, gradually, I became okay.
>
> (Suraya; I; 10: 1-4)

The narrative quote illustrates an optimistic view in confronting challenges in life; that life is full of hope and opportunities. From this example, people with BD who take an optimistic stance are likely to have self-confidence, which is one of the enabling factors in dealing with life challenges. The above narrative excerpt suggests that individuals with a positive outlook are likely to cope better with BD. Ah Tan articulated a similar but more stoic (and less positive) perspective about coping, based on living with BD for over 20 years:

> You cannot say you cannot do these things and feels like it's the end of the world for you. We have so many to handle things. The most important are to be able to cope with your daily life, your problems. If you cannot cope, then it becomes a problem.
>
> (Ah Tan; C; 15: 18-19; 16: 1-3)

For Ah Tan, people do not need to give up easily when it comes to dealing with problems. Moreover, Ah Tan particularly highlighted the important element of being able to cope with daily problems; this is because the fundamental problem that could persist in the individual is an "inability to

cope". Similarly, Nora adapted to living with BD by normalising the illness, thus overcoming the socially constructed stigma about mental illness. Nora generally conceptualised BD as a common illness requiring treatment:

> Ten years later, I have gotten used to this illness. You should regard it as a common condition, like having hypertension, as my doctor would always say. I would always apply the things that the doctor suggested in my life. Because when we follow the advice given, we would also lessen the pressure that we might have inside us.
>
> (Nora; I; 7: 24-25; 8: 1-3)

All of these examples illustrate that viewing BD with an open mind and compliance with treatment can minimise the negative pressures the condition may exert on life activities, which may otherwise worsen the condition of the BD itself. Professional knowledge and expertise were highly valued by Nora and other participants, particularly the psychiatric services and their role in supporting patients to make informed choices. As part of the adaptation to living positively with BD, participants may well make adjustments in order to socialise, as in the following example:

> I often perceive that others think negatively of me. So I would fight back; 'This is just my imagination'. We need to fight back as we need to strengthen our mental well-being. It's something like that I guess.
>
> (Sofia; I; 21: 1-4)

Here, Sofia felt that her perception that she was viewed negatively by others was unjustified paranoia; thus, she attempted to switch off such negative thoughts and to be more positive, which she found to be effective in strengthening mental well-being. In brief, this approach could be deemed as a "compensatory strategy" in maintaining mental well-being. For this and the following excerpt, an optimistic mind serves to provide the basis for courage in these participants while moving forwards, and for self-assurance of who they are to themselves and others:

> So, I wasn't afraid anymore of what people thought from the outside. Apart from that, there was this thing about the green appointment book which I had. I was always disgruntled over it as I pondered why I had it on me. The book clearly identifies me as a psychiatric patient. So, I began to ask myself whether I am mentally ill. But then, that is only stated in print. I am just fine. So, I have to be positive about it.
>
> (Suraya; I; 12: 20-21, 13: 1-6)

As illustrated from the above excerpt, Suraya faced the frightening prospect of mental health discrimination directed at people with BD, but she reflected on her stable condition in order to draw comfort and adopt a positive outlook. Ah Tan recalled how he developed self-belief as part of a meaningful view of his life as a whole:

> I live a happy life; I enjoy my work. I got a good family, my wife, my son and his wife. I think I have to go on. I mean there is nothing that humans cannot handle. It is the part of life.
>
> (Ah Tan; C; 18: 5-7)

The narrative illuminates a determination or inner motivation to move on with having a self-belief, and appreciating the joy in life from things such as employment and family members. Normah shared her motivation in handling emotions:

> Let me share with you how I motivated myself. I reminded myself that I needed to be patient. And so, *Alhamdulillah* I can handle normal pressure.
>
> (Normah; I; 5: 3-5)

Here, Normah used her self-control to handle normal pressure in a calm and patient manner. The context of living with BD and dealing with potential emotional distress could be a positive psychological approach, such as motivation, and practising being patient. For Muthu, practising being calm and patient can lead to a state of inner joy, as in the following excerpt:

> Our minds need to be calm, and then our heart will be happy. And from there, we can win the battle in our life.
>
> (Muthu; H; 5: 11-12)

The term "happy" is reiterated in the above quote, suggesting that positive psychological adaptation to the life circumstances of living with BD resulted in joy. Muthu clearly indicates the positive psychological adaptation to life in a strong sense of "recovery":

> I have recuperated now. So now, I believe that you have to think positive first. Only then the mind can be receptive. It's a mind function.
>
> (Muthu; H; 5: 13-16)

The above quote appears to be a strong indication of the positive state of mind of a person with BD, albeit not directly associated with spiritual matters of living with the condition. This positive mental approach is revealing in those narratives that are included in the earlier themes of "having faith in God" and "devoting oneself to God". The following narratives relate a positive shift of mind resulting from religious approaches, such as the example of Umar, who mentioned the effect of *tazkirah* (i.e. reminders of Islamic practices):

> We become more positive, and the situation also becomes more positive. When I had just been analysed with this disorder, I kept thinking of negative things.
>
> (Umar; I; 6: 16-17)

The narrative illuminates a shift in positive thinking in contrast to the earlier state of living with BD, and its effect of perceiving the life circumstance positively. Suraya highlighted the positive gain of a relational and religious agency that exists within Malaysian society:

> If we perform *solah* in the congregation, it is encouraged as we gain strength, a positive mindset, a sense of fulfilment in motivation, the soul and spiritually. They would not be thinking of things we didn't know. But then, we have created a wall by saying "no" before trying. And so, we need to be urged.

(Suraya; I; 23: 16-19)

From the above narrative, *solah* or prayer in congregation is perceived as being supportive for people with BD, providing both spiritual and psychological strength. Suraya suggests that individuals with BD who limit or reject a form of religious approach need to be urged by others.

The six participants who were not included in this theme highlighted the barriers to living positively. The commonalities identified from their narratives are factors around the lack of emotional control and support, having family and sociability issues, and being locked in a spiritual struggle (i.e. as for two negative cases). One example is narrated by Mahmud:

> I feel like I am sick and have wasted my years because of this. Maybe I didn't achieve the goals that I aimed for in life because I have wasted a lot of time. At the same time, I might think ah! Let it be'. Then the feeling of embarrassment develops in me. It's because of our doings. Like me, there is an obstacle in front of me that is holding me back, like it poses a challenge for me. I feel like wanting to go to sleep for a long time.

(Mahmud; I; 11: 15-20; 12: 1-2)

The narrative illustrates a condition wherein self-belief or self-esteem is likely to be affected by the lack of goal achievement, as in the case of Mahmud. The term "obstacle" suggests the potential issues relating to having no willpower in moving forward: a condition where the participants could have no sense of motivation. The next narrative by Siti highlights the lack of support and reliance from the participants' families:

> I tried to get a job then my uncle reacted like..“what kind of job?”…I felt I was useless, very useless. If he (i.e. uncle) came to give his support, I could accept that. Is that helpful? I can’t depend on my siblings.
>
> (Siti; I; 4: 10-15)

For Siti, receiving a negative reaction from the family can potentially lead to a weakening of self-esteem, as Siti indicates the sense of feeling “useless”. Furthermore, Siti found it difficult to rely on her siblings. On the other hand, Rohani, in her narrative, reveals her recurring thought of despair and of having less social support:

> I may feel that way (i.e. feeling empty) at any time. Just don’t pressure me. It is because of that I look for friends. I don’t have any close friends. Most of them cause me stress. What is the purpose of my life? People look down on me. On top of that, it is hard for me to survive, what with no cash in hand nor any savings available. I don’t even have any income. I don’t have the will to work. I can’t even lift heavy things.
>
> (Rohani; I; 20: 13-17)

The narrative illuminates negative thoughts and feelings arising from external stressors (i.e. professional and financial limitations). For Rohani, having limited resources, including material and social support, could prompt a regressing of the emotions towards despair. Rohani further narrates her manner of self-coping by keeping problems to herself in order to protect herself from facing discrimination:

> If I ever face any problems, I just keep it to myself. It is only today that I have opened up to you. I don't want to share it with others as I might disgust them. You know how the people in KL can be. When you have money, friends surround you. If you're healthy too, friends go to you.
>
> (Rohani; I; 14: 29-32)

Here, Rohani provides an example of a case where self-perception regarding the potential for facing discrimination may limit "socialisation". The narrative by Rohani also highlights that she needs to appear healthy in order to be able to socialise. Mahmud provides a different perspective on sociability as affected by his sense of esteem:

> But when I felt okay, I felt that I needed to socialise with others. But I was uncertain about whether I could do it or not. Hah, it was something like that, more or less I guess. I am just okay with it now, open to criticism. Except probably I feel a bit embarrassed sometimes.
>
> (Mahmud; I; 23: 17-20)

From the narrative, the sense of "embarrassment" or challenged self-esteem suggests a lack of efficacy in terms of living with BD and socialising. Overall, these participants provide a different lens concerning how positive life adaptation is not readily achievable due to personal and social struggle.

To sum up, the majority of the narratives reported positive thoughts of living with BD. Some, meanwhile, cited barriers to having inner motivation associated with distress, life problems and a lack of life contentment that

may suppress positive adaptation to BD. Nonetheless, a positive psychological approach contributes to how the participants move forward with BD; this could be regarded as inner resilience and as such mark a positive adaptation despite the fact that the participants are living with BD in Malaysia.

6.4 Chapter summary

This chapter has explored the theme of "adapting to live with BD" through two themes: "improving a sense of self-control" and "establishing a positive life adaptation". The narratives identified the participants' primary concern to be the need for self-control in dealing with both the life challenges they face and BD in order to avoid disharmony in relationships, finances and other life problems. Such problems have a great impact on their emotional stability and affect the potential for them to experience a relapse of their BD.

This theme offers a further understanding of spiritual recovery, in which the participants can gain self-control in dealing with emotional instability by taking spiritual approaches (i.e. religious devotion) in daily life. In other words, many of the participants developed self-efficacy within their spiritual approaches, thereby facilitating their recovery. Nonetheless, the medicinal component, that of pharmaceutical efficacy in managing BD symptoms, goes hand in hand with their attempts at recovery from BD (and indeed medical counsel helped to increase their compliance with treatment regimens).

Likewise, the supportive role of "social agency" also featured in the narratives as promoting overall well-being, relieving the emotional burden and minimising the potential for relapse. In this theme, both spiritual and relational agency were found to have good benefits, which suggests the

need for care from mental health services alongside a more inclusive role for religion and relational agency in the "spiritual recovery" of people with BD in Malaysia.

The latter theme of "establishing a positive sense of self" may well suggest that the majority of the participants are moving forward with a positive approach to life, such as handling problems and managing prejudice or self-discrimination in living with the society. Nonetheless, a minority do not share this positive adaptation, thereby suggesting the presence of obstacles to living positively. These include a lack of emotional control and support, having family and sociability issues and being locked in a state of spiritual struggle (i.e. as for two negative cases).

Overall, these narratives capture a shift of positive mind or inner motivation in those reporting having religious faith and practising religion in at least half of this sample with BD. Though the spiritual contributes to a positive mindset, this does not appear directly in most of the narratives in this chapter as the participants themselves cited their religious faith and practices as part of their life satisfaction. In this regard, while accounting for a positive adjustment to BD, the narratives suggest an interplay between religion and the psychological domain (as considered in the Discussion chapter).

6.5 Summary of the findings

The findings reveal the spiritual recovery approaches of people diagnosed with BD in Malaysia. Three themes were identified in the data: "restoring hope, meaning and purpose", "maintaining a positive sense of self" and "adapting to live with BD".

The first theme of "restoring hope, meaning and purpose" consists of three themes: "experiencing spiritual despair", "engaging in spiritual meaning-making" and "orienting the spiritual life". In the theme of "experiencing spiritual despair", the narratives of people with BD demonstrated a loss of hope and meaning, along with a distancing or alienation from their religious tradition and spiritual practices. This loss of hope was associated with perceived suffering and adverse life events that often spurred their initial diagnosis with BD. The narratives feature negative remarks on the fated experience by God (i.e. the effects of BD symptoms and life tragedies), which suggests that such participants were "experiencing spiritual despair".

Later, as recounted in the next theme of "engaging in spiritual meaning-making", the participants began to understand their fated experiences in terms of spiritual interpretations. This spiritual meaning-making was facilitated by community support and guidance towards religion, which highlighted the role of close family members, in alignment with medicinal efficacy, in recovering from BD symptoms. In this sense, the "spiritual recovery" of the participants with BD in Malaysia is aligned with medicinal efficacy and the supportive role of family members (with clear instances of pharmaceutical interventions enabling spiritual practices). Further on this theme, the theme of "orienting the spiritual life" uncovered articulations of life goals, aims and purpose set against the experience of losses and despair associated with BD. The majority of the participants featured were

keen to move towards spiritual recovery, and this drives them towards religious faith and devoting oneself to God.

The second theme, "maintaining a positive sense of self", mainly consists of the religious element in the participants' everyday lives: faith in God, religious practices and a sense of spiritual harmony (i.e. peacefulness and connectedness). "Keeping faith in God" (first theme) was suggested as a foundation for "devoting oneself to God" (second theme). Faith in God is individualistic and dynamic, and a loss of faith suggests a reduction in religious practices according to some narratives. The spiritual recovery in this theme featured religious faith and practices as central to inner resilience, helping the participants move on from traumatic life events, as in the previous theme of experiencing spiritual despair.

Subsequently, life is viewed with joy and contentment and perceived as a blessing from God. The spiritual aspects foreground the positive or pleasant thoughts and emotions about the participants' devotion to God, including "peacefulness" and "connectedness". The symbiosis of medicinal and spiritually efficacious practices was reiterated in this theme, as BD symptoms interfere with religious devotion in their everyday life. In this theme, the spiritual way of life consisting of keeping faith and religious devotion to God contributes to maintaining a positive sense of self, whereby the participants conceptualised themselves as good believers, thus removing the tendency towards negativity and suicidal ideation. In this theme, the role of religion and social agency as captured in the narratives were both inclusive in promoting the spiritual recovery of people with BD in Malaysia.

The last theme of the finding – "adapting to live with BD", through the two themes of "improving a sense of self-control" and "establishing a positive life adaptation" – highlighted the sense of self-control and positive approach to life in living with BD. This theme offers a further understanding of spiritual recovery, including taking control of the emotions associated with BD symptoms by spiritual means in daily life. These narratives capture a shift of positive mind or inner motivation from those who reported having religious faith and practising religion in at least half of this sample with BD.

Though the spiritual contribution to a positive mind shift does not appear directly in most of the narratives, the participants' inclusion in religious faith and practices may well suggest an interplay between the religious and psychological domains. In other words, the narratives suggest that developing self-efficacy by taking spiritual approaches in their daily life management enables the participants to handle emotional or life challenges. The supportive role of "social agency" is also featured in the narratives as promoting overall well-being, relieving the emotional burden and thus minimising the potential for relapse. In brief, these findings call for a more inclusive role of religion and social agency in the "spiritual recovery" of people with BD in Malaysia.

While the majority of the participants highlighted the positive role of religion and family members for "spiritual recovery", two young female participants reported having negative perceptions of both aspects (i.e. loss of faith and no guidance). Clearly, in this instance, these dimensions can represent a major setback in "spiritual recovery". Some non-spiritual approaches such as biomedical intervention and social agency were revealed to play a significant role in the promotion of "spiritual recovery", as considered in the Discussion chapter. The dominant power of mental health services in Malaysia within the traditional biomedical paradigm,

particularly the hegemony of pharmacological treatment, is also considered in the Discussion chapter to provide the basis for understanding the efficacies of contemporary psychiatric treatment in managing BD symptoms in the Malaysian context. Though social agency assists in maintaining the overall aspect of well-being and recovery, the presence of a gender barrier for men in Malaysian culture may warrant the introduction of gender targeting for psychotherapy and psychological intervention in the Malaysian context.

Upon summarising the findings, the current study provides a basis for understanding the key salient resources inclusive of spiritual matters and practices of the study sample living with BD. Moreover, the matter of spirituality and practices was embedded within the Malaysian social-religio-cultural context, in which can be included the conceptualisation of spirituality – this pertains to the aim of the current study. Hence, the researcher applies the Bourdieusian approach in conceptualising the key salient resources as spiritual capital, thus marking a methodological divergence from ConGT in conceptualisation work (see The combination of ConGT and sociological theory, p.65). The application of a Bourdieusian approach in conceptualising spirituality is based on Bourdieu's sophisticated theory on symbolic capital, which was interpreted by his scholar, i.e. Verter, as spiritual capital. This is presented in the following Chapter 7: The theoretical foundation for discussion.

Chapter 7: The theoretical foundation for discussion

7.1 Introduction

This chapter marks a departure from constructivist grounded theory (ConGT) as the methodological approach adopted, as outlined in Chapter 3, in favour of applying the theory developed by Pierre Bourdieu, that is, Bourdieusian Theory (BT). Firstly, Bourdieu's theory will be introduced and discussed in the context of the work of other prominent sociologists to justify the choice of applying BT to the theorisation of spiritual capital, which is referred to as symbolic capital in BT.

As demonstrated in the findings chapters (Chapters 4, 5 and 6), the resources of religion, interpersonal relationships and medicine were particularly salient for the people with BD included in this study. In making sense of the three different resources with BT's symbolic capital, this chapter proceeds with the presentation of the conceptual tools of BT, i.e. capital, field and habitus.

This study will then introduce the three key salient resources as capitals with reference to the participants' habitus in exhibiting the presence of spiritual capital – understood in relation to meaning, values and practice and practical utilisation within the Malaysian social setting. For each capital, explanations will also be offered with regard to how each habitus and disposition (integral to cultural norms and practices) might typify the individuals with BD included in this study. For the purposes of this study, the alliance of key salient resources in the findings (as presented in eight themes) are termed capital clusters: capital cluster A (comprising religion,

interpersonal relationships and medicine) and capital cluster B (religion and interpersonal relationships). These capital clusters or interrelated capitals will be used to relate to the complementarities between capitals and their competitiveness in both a positive and negative way.

The current study will then highlight how the presence of spiritual capital moves beyond psychological resilience to offer insight on spiritual capital as potentially increasing access to social capital, which provides life chances and opportunities to individuals with BD, e.g. access to social support for living and stability, or perhaps employment. The next section serves as an introduction to BT.

7.2 The background to Bourdieusian sociological theory

This section demonstrates how Bourdieu's ideas were informed by other notable classical theorists, including Karl Marx, Emile Durkheim, Max Weber and Levi-Strauss.

Bourdieu entered the sociological field as an anthropologist during the structuralist movement in the 1950s (Jenkins, 1992). Structuralism is a broad theoretical movement that interprets and analyses society within a system of signs and symbols, thus promoting multidimensional interpretations in which all social components come together (O'Byrne, 2011). Bourdieu's form of sociology relates to the sociology of symbolic processes and was developed along with his orientation of structuralism, hermeneutics (i.e. in the dimension of the meaning) and a historical pragmatism (Halas, 2004). Bourdieu is also a symbolic interactionist (based on George Herbert Mead); he analyses the meaning of the group and its representatives through their relations to actions (Halas, 2004).

However, for Bourdieu, structuralism had little or no explanatory or predictive power concerning value judgements in the interpretation of social reality (Jenkins, 1992; Sim & Loon, 2012). Bourdieu thus became one of the major theorists in the post-structuralist movement, with his social theory bringing a theoretical explanatory power to the understanding of the social world. Scholars such as Halas (2004) and Jenkins (1992) accorded merit to Bourdieu as he unveiled the complex nature of society with regard to structures and social practices. Bourdieu's ideas gained prominence in the mid-1970s, along with those of other contemporary theorists such as Michel Foucault (Dillon, 2010).

As mentioned above, Bourdieu developed a powerful explanatory theory with his use of the dialectic approach, which addresses the dichotomy between subjectivity and objectivity in social life (Dianteill, 2003; Given, 2008). The word 'dialectic' is derived from the Greek word *dialegein*, meaning '*to argue*' (Dillon, 2010, p. 37). Bourdieu (1990) studied the dialectical aspect in the interpretation of objective structure from Levi-Strauss, who is the figure most commonly associated with the dialectical relationship between individuals and social structures (Jenkins, 1992; Ritzer & Goodman, 2004). Bourdieu (1977a) explains that humans' 'lived experience' is one of the areas for the subjective interpretation of objective structure. By taking the dialectic approach, Bourdieu highlights the notion of 'taken for granted' as relating to knowing the general implicit as opposed to explicit nature of objectivity (Sim & Loon, 2012).

As well as Levi-Strauss, Bourdieu developed his own social theory influenced by the great classical founders Marx, Durkheim and Weber (Jenkins, 1992; Sapiro, 2015). Bourdieu sheds light on ideas within religious power and structure, particularly in relation to the work of Weber and Durkheim on religio-spirituality (Abrahamson, 2010). Bourdieu

(1987a), in a critique of Weber's analysis of the religious domination (i.e. charisma) of the priest, contended that Weber failed to include the structure of the religious field and the relationship between structure and the religious habitus of the laity. Similar to Durkheim, Bourdieu emphasised the social nature of social life and the way in which a particular social order comes to be maintained (Dillon, 2010). Bourdieu diverged from Durkheim's thinking as he incorporated social structure in the application of symbolic order and highlighted the role of social agents (Nicolaescu, 2010).

As mentioned previously, Bourdieu's sociological theory evolved from the old theories, albeit with a more sophisticated understanding that concerned the dichotomy between objectivism (i.e. materials or resources) and subjectivism (i.e. concern with meanings) (Urban, 2003). Bourdieu developed a symbolic interpretation of meaning with regard to the material aspects of social life and between structure and human agency (Swartz, 2004). In this respect, Bourdieu follows the Marxian tradition in terms of examining the material aspect of social life via the means of production, distribution and exchange (Ritzer, 2008; O'Byrne, 2011). In so doing, Bourdieu offers a potentially satisfactory synthesis of Marxian theory and structuralism (Jenkins, 1992).

A further aspect of Bourdieu's social theory is his prominent contribution to the understanding of culture regarding its dominant influence on symbolic interpretation, which, as an understanding, can also be applied to religion (Swartz, 2004). The dialectic approach, i.e. as applied by Bourdieu, offers explanatory power with regard to the theoretical understanding via two components, namely the diachronic (i.e. concern about the trajectory) and the synchronic (i.e. the interrelationship between components) (Ritzer, 2008). Another advantage of the dialectic approach is that it is applicable across a wide range of disciplines, including spirituality. This is because the

dialectic approach rejects any specific focus that limits the context (Ritzer, 2008). The rationale for the choice of BT over ConGT for the purpose of theorising is presented in the next section.

7.3 The rationale for applying the Bourdieusian Theory of symbolic capital

To reiterate, the hybrid form of ConGT and BT has been presented in Chapter 3. The researcher in this study deems BT to be useful for understanding the concept of spirituality from the salient resources identified in the findings (i.e. religion, interpersonal relationships and medicine). The value of resources can be inscribed as symbolic capital, defined as follows:

> *any form of capital when it is perceived by social agents endowed with categories of perception which cause them to know it and recognise it, and give it value* (Bourdieu, Wacquant and Farage, 1994, p. 8).

From the above, Bourdieu et al. (1994) make the additional point that symbolic capital depends on the shared belief of people in perceiving and appreciating certain things. This is because the salient resources in the findings characterise forms of values and thus are appreciated for participants' recovery in the context of BD, which empirically indicate that these resources can be built into a concept of spiritual capital (with reference to BT's symbolic capital).

The study also reviews how the concept of spirituality, referred to as symbolic capital in BT, fits with the views of other scholars in the field of spirituality such as Clarke (2006), McSherry and Cash (2004), Pesut et al. (2008) and Swinton (2010). They have suggested that the concept of

spirituality should be considered in the context in which it is expressed and should be congruent with the cultural values of the society. In this vein, spiritual capital, as with the application of BT, corresponds to the concerns of those scholars who hold a shared belief that people perceive and appreciate certain things (Bourdieu, Wacquant & Farage, 1994).

In considering the congruity of cultural values in the study sample with BD, this study then focuses on the (shared) meaning and values of the salient resources from the findings. The first key salient resource in this study sample is religion, in which religious values were commonly shared within the religious paradigms of being Muslim, Christian or Hindu. The commonality is evident since, for most of the study sample, their perception of loss is associated with the religious notion of 'takdir' or fate, as demonstrated in the participants' subjective accounts. This was most prominent in the way most of the participants regarded their world, living with BD, in terms of the benefits of religious faith and practices for their psychological well-being and resiliencies (in reference to the findings). These aspects are summarised as follows: a sense of safety, cultivating a positive sense of self and having good self-control, as opposed to a tendency to engage in impulsive behaviour.

Following the religious values, the next key salient resource is interpersonal relationships, particularly within the family unit, where it highlights the advantages that the participants receive in relation to their 'resiliencies', which can heighten their sense of self-worth and belonging. Moreover, support from others was appreciated as a source of strength for living with BD. The appreciation of support extends to family members providing advice on religious matters and taking the participants to a mental health service at a time of crisis. This then highlights the

participants' accounts of the aspect of medicinal efficacy, as shared by almost all of the study participants.

The advantages of medicine or biomedical intervention were perceived in this study sample with BD in terms of controlling their symptoms and addressing the potential for recurrence. This resource is also integral to spiritual aspects in the context of BD as the study sample appraised modern psychiatric treatment as being related to their spiritual conditions; they attained a sense of calmness from medication as a symptoms-based form of treatment. One of the prominent highlights revealed by the participants related to the benefit of medication in the sense that it controls the symptoms of BD, which subsequently enables the participants to perform their religious practices. The healing effect of religious worship was identified as being able to promote a sense of 'peace' and a feeling of tranquillity, which clearly refers to devoutness as distinct from biomedical intervention for these participants with BD.

Following this, in order to theorise spiritual capital as per BT symbolic capital in terms of spiritual resources, the next section presents the conceptual tools of BT.

7.4 The conceptual tools of Bourdieusian Theory: capital, field and habitus

Advancing the presentation of symbolic capital (other than the recognition and appreciation of the value of resources) from the previous section, this section presents the key conceptual tools in the application of BT for the salient resources or forms of capital in the findings.

Bourdieu's conceptual tools can be usefully applied to the theoretical understanding in the area of meaning-making between subjectivity and objectivity (Calhoun, 2006; Costa & Murphy, 2015). Theoretical understanding in BT hinges on a trinity of key concepts, i.e. habitus, capital and field, which are to be understood as functioning complementarily to each other in an interdependent manner. This is according to BT scholars including Robinson and Robertson (2014), McKinnon, Trzebiatowska and Brittain (2011) and Swedberg (2011), wherein for the purpose of social analysis, it makes sense to treat all three elements as one concept. For instance, religion as capital, or religious capital, can be explained from the perspective of its corresponding habitus, within the religious field. The BT terms used as conceptual tools are explained in the following sections.

7.4.1 Capital

Bourdieu uses Marx's language of 'capital' as a reference of objectivity to illustrate the resources in society (Guest, 2007). Bourdieu (1986, p. 241) defines capital in relation to social practice as the:

> *accumulated labour (in its materialised form or its 'incorporated', embodied form) which, when appropriated on a private, i.e. exclusive, basis by agents or groups of agents, enables them to appropriate social energy in the form of reified or living labour*.

Here, BT offers the simplified form of one unified concept of capital to explain the structure (i.e. in its embodied and material states) in the social world (Tittenbrun, 2016). Moreover, the distribution of the different types of capital at a given moment represents the immanent structure of the social world and governs its functioning in a durable way, thus determining the chances of success for practice (Bourdieu, 1986). This study therefore adopts the term 'capital' in reference to those salient resources for

spirituality that the participants with BD in this sample disclosed. This is according to the different capitals present in the findings which could be perceived as having a practical utilisation by this study sample through their spiritual journey. Hence, the presence of different resources also reflects the participants' social world and their society in Malaysia.

Thus, the term 'capital' is a key term in this study, used for the understanding of salient resources, not only in the form of advantages but also the deployment of facilities and resources available to people with BD within their social context. The social context in which capital is disclosed is explained via the BT term 'field', as presented in the next section.

7.4.2 Field

Moving on from the previous section, that which can be counted as capitals depends on the particular field (McKinnon, Trzebiatowska & Brittain, 2011). Hence, field links to capital where it designates arenas of production, circulation and the appropriation of goods, services, knowledge or status (Swartz, 2004). Even so, Bourdieu (1986) sees resources for symbolic benefits within the social field and the presence of resources is included in his definition of social capital as follows:

> *Social capital is an aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance and recognition.* (Bourdieu, 1986, p. 21)

Viewed this way, the notion of social capital is able to explain that the social field is enriched with the establishment of a durable network of social relationships, and the availability of institutions that orient people for social reinforcements such as customs, rituals and regulations (Bourdieu, 1977a).

As resulting from social enforcement and investment, Bourdieu (1986; 1997) explains that it is represented through the habitus, which is an integral part of the person established by the society. Capital thus depends on the quality of the social field that serves as the area in which the social actions and engagement take place (Swedberg, 2011; Pileggi & Patton, 2003). The habitus is further explained in the next section.

7.4.3 The habitus

Habitus is a complex concept and it could comprise many aspects of human beings within the shared social context. Bourdieu (1987b, p.811) explains that habitus is:

> *the habitual, patterned ways of understanding, judging, and acting which arise from our particular position as members of one or several social fields, and from our particular trajectory in the social structure (e.g. whether our group is emerging or declining; whether our own position within it is becoming stronger or weaker)*.

In addition to the above, Bourdieu (1977a; 1989) always emphasises that the habitus is common to all members (in the specific context), comprising the schemes of perception, conception and action. The habitus is also perpetually reinforced by the social group (which is linked to the individual's dispositions and interest) (Bourdieu, 1977a), and hence, it is a form of collective enterprise (Bourdieu, 1977a).

Continuing from the above, Bourdieu (1986) acknowledges that habitus is integral to culture in the form of long-lasting dispositions of the mind and body. Cornelissen (2016) supports Bourdieu's view on the influence of

culture as he explains that habitus comprises the individual's disposition from the earliest years of life, acquired in specific contexts.

Other than the dispositions of culture, habitus can transform in response to changing experiences and social circumstances (Edgerton and Roberts, 2014). Bourdieu (1977a) goes further in asserting that people's responses (words or actions) are defined in relation to their mechanism of problem solving, or they set goals that they want to achieve (Bourdieu, 1977a). For Bourdieu (1990), the form perception, thought and action, according to the socially structured situation, can be more reliable than the examination of only formal rules and explicit norms.

Habitus brings logic to the practical congruity of dispositions in utilising capital to its interest and advantage (Cornelissen, 2016; Wacquant, 1989). In this regard, Bourdieu sees habitus as potentially generating a wide behavioural repertoire that is transformed according to social condition (Reay, 2004). This is why Bourdieu (1977a; 1990) viewed habitus, despite its complexity, as also being able to anticipate the trajectory of capital as envisioned by its potential profits or interests for people.

In summary, the BT tools of capital, field and habitus, in their interdependency, offer structural insights into the theorisation of symbolic capital. Further to this, it is crucial that this study establishes the value of Bourdieu's symbolic-spiritual capital by aligning the key salient spiritual resources congruent with the shared habitus in this study sample with BD, and this is presented in the next section.

7.5 Spiritual capital with the key salient resources in the findings

This section applies the BT trinity concept, i.e. habitus, capital and field, with the purpose of introducing religion, interpersonal relationships and medicine as forms of capital in terms of BT. The presentation of each different capital within spiritual capital in the context of the application of the BT concepts in this study sample with BD will take into account the following:

1. Habitus in considering a shared belief, dispositions and ways of seeing the world, and habitus in the exercise of religio-cultural norms and practices that might typify the individuals included in this study.

2. An assessment of the utility of the capitals in the Malaysian study sample.

Religious capital is prominent in Malaysian cultural society, with the definitions given in the next section.

7.5.1 Religious capital

The definition of religious capital begins with the version put forward by Bourdieu (1991, p. 22) as follows:

> *… the generative basis of all thoughts, perceptions, and actions conforming to the norms of religious representation of the natural and supernatural world*.

Following the above, in this study, the researcher defines religious capital as the dispositions of religious faith (in the Malaysian context of being Muslim, Hindu and Christian) and the religious practices undertaken by the people with BD in this study. This includes that they have taken a position of religious membership in a practising religious institution. As part of

being a member, they are able to seek support from their religious leaders and other members for religious guidance within the society. Hence, the study sample reveals the exercise or orientation of the religious habitus as being contextually bound to their religion within Malaysian society (i.e. the social field).

Religious habitus is typically presented by this study sample with BD related to their views on losses in the midst of adverse events as fated by God. This could typically be influenced by the way society views such events through a religious lens. Specific to the interests of this study sample with BD, the religious capital that they mobilise manifests in seeking improvement in religiosity via meeting clerics, joining communal gatherings and worshipping as part of a congregation.

Added to this, there is a relative prevalence of spiritual guidance in Malaysian society, wherein the participants have access to religious figures in support of religious knowledge within religious institutions in Malaysia, i.e. to 'imams' and 'Ustaz' as teachers (fem. 'ustazah'), Christian 'priests' or Hindu clerics. Moreover, the religious institution as a cultural artefact, in the form of a mosque, temple or church (as mentioned by them), is made available to them as a member of a religious group for religious assembly and worship as part of a wider congregation.

Following the presentation of religious capital among the participants in this section, this study reiterates that the participants in this Malaysian sample were purposely included as they fulfilled the criterion of having a religion. Relational capital is closely aligned with religious capital for the majority of the study participants and is presented in the next section.

7.5.2 Relational capital

The researcher defines relational capital as the participants in this study having contact available to supportive interpersonal relationships, in particular with family members. In Malaysia and in the context of mental health problems in general, family in particular, but also friends, are the main source of support. Moreover, values and beliefs (i.e. religion) are dynamically shared amongst members of the group, thus giving patients a sense of belonging and trust (Deva et al., 2008). In a similar vein, van der Gaag (2005) justified relational capital as a distinct concept on its own, as it is a form of resource in terms of enabling durable access to relationships.

In addition to the above, the habitus (of this relational capital) orients the individuals with BD to make use of it for support and guidance within close and trusting relationships. This is because this capital mostly relates to their family members or spouses (for the study participants). The findings also revealed that the family unit in this study sample with BD could play overlapping roles in facilitating the participants' access to both medicinal and religious capital. This is evident in the participants' subjective accounts that their families are the people closest to them and who thus enable them in terms of religious matters, such as by providing advice and guidance. A very small number of participants (2 out of 25), however, revealed a weak reliance on relational capital, as demonstrated in the lack of positive roles among their families.

Having said that, the families, within the context of relational capital, could be regarded as central agents in promoting the two capitals, i.e. religious and medicinal. As such, relational capital, while being independent, also exists interdependently alongside the other capitals. Hence, this capital

neatly informs us about the important involvement of family in facilitating participants' recovery.

In considering the BT concept of 'field', relational capital is situated within the broad social relationship, or social capital. It is always discussed at the level of the collective characteristics of the society while typically being assessed by the level of community participation, volunteerism and membership of community-based or social organisations (Koenig, 2012). Moreover, in the context of BD, it should be considered that the individuals may feel disempowered or stigmatised by particular others, or by members of the wider community (Tew et al., 2011), and this phenomenon is also observable to patients in Malaysia (Deva et al., 2008).

Therefore, this capital, as a means of relating to the study sample, needs to be accorded a status in this study. This is due to the extent to which it has been appraised by the participants with BD in the findings, having been cited as channelling positive emotional resources such as love, care and happiness, and perhaps being important for their sense of belonging. This sense therefore justifies the status of using relational capital in this study in terms of the inclusion of patients living close to their family members. However, the study sample also very clearly indicated that medicinal efficacy is another resource, and this is presented next.

7.5.3 Medicinal capital

In this study, the researcher defines medicinal capital as pharmacological interventions or regimes that are required by or made available to people with BD for the management of their symptoms. These include consultancy with their psychiatrist as well as their adherence to the regimes prescribed to them. Hence, the habitus of medicinal capital is analysed in the findings of this study that orient the participants' expression on medicinal efficacy,

which indicates their position of being a user of MHS. This medicinal capital in the context of BD provides the participants with access to meet their psychiatrists on a regular basis for checks on the efficacy of treatment for their stability, especially medication (see Chapter 1, Section 1.8.1. for details).

It is therefore important to consider the context of having BD, and the fact that the participants in this study are in favour of scientific explanations of BD and the hierarchical position of psychiatrists (in Malaysia) in authorising medicinal aspects. This is because medicine is rooted within a larger social system and brings with it an accepted culture of prioritising scientific knowledge that dominates healthcare (Balboni, Puchalski & Peteet, 2014). From a more socially justified perspective, scholars such as Rottman et al. (2016) and Shah and Mountain (2007) suggest that service users are beginning to appreciate the value of medicine for their well-being. In this respect, a number of scholars – Balboni, Puchalski and Peteet (2014), Miles (2009) and Puchalski et al. (2014) – have highlighted the medicinal benefit of promoting spirituality in people with health problems.

Additionally, medication and spirituality combine to help the participants maintain their positive sense of self, with no case identified of participants avoiding medication on the grounds of religious beliefs. The dominant hierarchical position of psychiatrists in Malaysia was also reflected in the case of a curtailment of religious practices, such as daily prayers, due to the side effects of medication. Here, psychiatrists were sought in order to change or adjust medications to open up the route to spiritual practices (i.e. religious capital) via medicinal intervention, and therefore the individuals can return to their family members (i.e. relational capital).

Moreover, despite the role of the medicinal aspect being seen as managing symptoms, medicinal efficacy emerged strongly as being complementary to enabling religious practices. According to Puttini (2007), the scientific habitus of health makes and sustains the link between medical and religious practice. Despite this, empirical evidence linking the medicinal and spiritual aspects remains scarce. A recent study by Vanderpot, Swinton and Bedford (2017) reported that the participants in their study valued medication that supported spirituality, and this perception was highly correlated with reports of greater wellness. Hence, it can clearly be stated that the participants in the study sample hold medicinal capital as part of their integrated repertoire of spiritual resources, and it is therefore accorded status in the study.

7.5.4 Summary

Based on the analysis of habitus/es in the study sample for the respective capitals and the assessment of the utility they offer, spiritual capital in the context of BD comprises spiritual resources. It includes the central roles of supportive relational agency (i.e. family members) and encompasses the other, i.e. religion with the support of medication. Thus, it is important for this study to make the distinction that spiritual capital, as grounded in the findings, although it can be part of cultural capital, should be confined to the interest of this study for the context of BD and Malaysian society.

7.5.5 Introduction to the capital clusters shaped by the findings

This section presents the capitals in alliance, or clusters, according to the eight themes in the findings, as different capitals can offer complementary potential benefits to this study sample with BD. Table 7.1 presents an overview of the mobilisation of the types of capital according to the

different points in the participants' spiritual journey (as captured in the findings according to the eight themes).

Table 7.1: Overview of capitals according to theme

Theme	The capitals mobilised by the study sample
Theme 1: Experiencing spiritual despair	religious, relational and medicinal capital
Theme 2: Engaging in spiritual meaning-making	religious and relational capital
Theme 3: Orienting the spiritual life	religious, relational and medicinal capital
Theme 4: Keeping faith in God	religious capital
Theme 5: Devoting oneself to God	religious, relational and medicinal capital
Theme 6: Having a sense of spiritual harmony	religious capital
Theme 7: Improving a sense of self-control	religious, relational and medicinal capital
Theme 8: Establishing a positive life adaptation	religious, relational and medicinal capital

Table 7.2 presents the clustering of the capitals into two models in order to view them as complementary spiritual resources for the participants with BD (as indicated via the themes in the findings).

Table 7.2: Categories of capital clusters

Name of capital cluster	Capitals involved	Theme(s) involved
Capital cluster A	all three capitals: religious, relational and medicinal	1, 3, 5, 7 & 8
Capital cluster B	religious and relational capital	2

To summarise Table 7.2, capital cluster A contains all three capitals (i.e. religious, relational and medicinal) as they were found in Themes 1, 3, 5, 7 and 8. Capital cluster B contains two capitals (i.e. religious, relational), as found in Theme 2. Religious capital in its singularity was present in Theme 4: Keeping faith in God, and Theme 6: Having a sense of spiritual harmony. The concept of the capital cluster in spiritual capital will be considered in the Discussion chapter.

The next section presents the application of BT by other scholars, whereby BT is applied to produce the evolution of the concept of religious-spiritual capital.

7.6 The evolution of the Bourdieusian concept of religious-spiritual capital

This section alters the focus to identifying the empirical literature that utilises BT in the context of religious and spiritual capital.

BT is a significant and evolving body of work in its own right in which Bourdieusian scholars (i.e. those who follow Bourdieu's social theory) have synthesised many conceptual currents (Halas, 2004). Hence, this study does not attempt a comprehensive exploration of BT as a whole, but rather focuses on the literature pertaining to religious/spiritual capital. A systematic search of studies was conducted in a bid to identify those relevant to the development of BT and this focus. The following relevant keywords were used: Bourdieu AND (religion OR faith OR spiritual) AND capital AND English; 'Bourdieu' AND 'religious capital'. The databases searched included the International Bibliography of the Social Sciences (IBBS), ScienceDirect, JSTOR, Applied Social Sciences Index & Abstract (ASSIA), CINAHL and Google Scholar (for hand research).

This section recapitulates Bourdieu as the scholar who initiated the discourse of religious capital in his novel association with symbolic capital. Bourdieu (1989) specifically claimed that symbolic capital is closely associated with religion, particularly in declaring the meaning of consecration. However, it was Verter (2003) who adapted Bourdieu's concept of symbolic capital into spiritual capital. Verter is acknowledged as producing the most prominent work offering a rich theoretical insight into spiritual capital (Guest, 2007).

Verter's (2003) version of spiritual capital was developed on the basis of the individual, as part of a cultural production, and the relative autonomy of the involved fields. Spiritual capital is in fact actively negotiated within the lives of individuals, and amongst the networks in which they are active (Verter, 2003). Moving on, Verter (2003) identified a weakness in Bourdieu's theorisation on the relative autonomy – that Bourdieu did not discuss the interaction between the fields of power (Verter, 2003). This is the contribution with regard to the theoretical insight from Verter (2003); that spiritual capital offers a model that is subject to change, while taking into account social power relations and one's position within the broader social field. Using the metaphor of finance, Verter (2003) briefly mentioned that spiritual capital 'is not a stable currency' (p.159).

Despite the above, Verter's (2003) investigation of the symbolic power of Bourdieu's cultural capital equates the appreciation of art with the appreciation of faith. In this vein, Verter (2003) concludes that spiritual capital is a form of cultural capital – it can be amassed or accumulated and exchanged. Nonetheless, it is important to return to Bourdieu's original idea, by which he mentions that all interactions in different capitals (other than cultural capital) can be reduced to symbolic exchanges (Bourdieu, 1977).

In addition to Verter (2003), this study considers the empirical work of other Bourdieusian scholars, all of whom have used the concepts of symbolic capital (i.e. using properties of symbolic power, and/or exchange, habitus) in their empirical work on religious-spiritual studies (e.g. Arat, 2016; Franceschelli & O'Brien, 2014; Grace, 2010; Green, 2012; Peñalva, Coggin & Medina, 2014; Puttini, 2007; Skousgaard, 2007). In addition, Streib and Hood (2013) used BT in a study on the construction of the religious field.

Empirical studies on religion and spirituality, in particular, have used different lenses from Bourdieu, including those by Urban (2001), Shanneik (2011) and Mellor and Shilling (2014). Urban (2001), in his work on 'sacred capital' in colonial Bengal, used Bourdieu's concept of 'symbolic capital' to interpret religion and the religious sacred. Shanneik (2011) analysed the change in religious habitus among religious converts in his sample, and Mellor and Shilling (2014) later explicated the process of religious habitus as not being fixed for all time.

Guest (2007) claimed to have gone beyond Bourdieu's original framework for setting out how religious capital evolves into a spiritual version. Guest (2007) developed his theory of spiritual capital in the form of cultural traits; these were derived from a case study based on understanding the transmission of spiritual capital as emanating from the clergy to their children. Here, Guest (2007) attempted to emphasise religio-cultural influence in spiritual capital as compared to total individualised experiences. In a similar vein, a study on Islamic capital by Fransceschelli and O'Brien (2014) added to the specificity of BT by focusing on how parents pass values on to their children. These two studies suggest that the negotiation of spiritual capital begins with the household.

Overall, Bourdieusian scholars have employed concepts of BT's symbolic capital and power within their work on religious/spiritual capital. Among them, Verter (2003) is particularly helpful in terms of providing the example that symbolic-spiritual capital is a form of exchange from a variety of resources subsumed under cultural capital. The current study follows Verter's (2003) spiritual capital and is embodied in what Bourdieu calls the 'habitus' – interpreted on the basis of the symbolic gain or advantage of different spiritual resources. Hence, by reviewing the literature from Bourdieusian scholars, especially that by Verter, spiritual resources (as brought by the study sample) fit within the theoretical lens of BT's symbolic capital. The next section presents the explanatory model of the symbolic capital of BT.

7.7 The explanatory model of symbolic capital

In this section, this study examines Bourdieu's conception of different capitals as being transformed into one single symbolic capital. Bourdieu (1984) stated that *'different capitals can be aggregated or converted into a single capital'* (p. 71). Specifically in relation to symbolic capital, other than social and cultural products, Bourdieu (1984) gives an example whereby in economic capital, all capitals can be exchanged into symbolic goods (i.e. symbolic capital).

The epistemological operation of BT enables the social scientist to delve beneath the surface of the world sociology and challenge what is found; indeed, this is the strength of BT in terms of enabling the revelation of unrecognised social mechanisms that can tend to sustain the reproduction or transformation (i.e. of symbolic capital) (Bourdieu and Wacquant, 1992). As such, this section presents the explanatory power of symbolic capital through the social lens, which provides a far clearer indication of the

benefits of spiritual capital for individuals' prospects in terms of social life aspects.

7.7.1 Habitus in empowering spiritual meaning-making

In taking the conceptualisation of spiritual capital with the BT approach, this study acknowledges that the production of symbolic capital lies in the examination of the habitus (Bourdieu, 1985; 1989). Pickel (2005) and Rhynas (2005) regarded spiritual capital as falling within the psychological process of human beings, with the task that habitus involves regulating the capital internally (Pickel, 2005). Put simply, the habitus indicates how people react to, and actively handle, their social circumstances (Korp, 2008).

Following a deliberate reading of the available literature on spirituality, the current study acknowledges that the psychological dimension of habitus is bound by two concepts in the literature – spiritual intelligence and self-transcendence.

Spiritual intelligence or quotient (SQ) is moral intelligence, defined as *'the intelligence with which we access our deepest meanings, values, purposes, and highest motivations'* (Zohar & Marshall, 2010, p. 3). SQ enables one to reinforce relations and connections (Holmes, 2009) and to transcend the gap between the self and others (Zohar & Marshall, 2000). Thus, SQ generates spiritual capital and complements the capacity for self-transcendence.

Self-transcendence is when a person expands their personal boundaries that are external to them (within the environmental context), driven by the meaning and values that the individual is going to fulfil (Frankl, 1985; Reed, 2014). Reed (2014) conceptualised transcendence in reference to

relativism; thus, it is all-encompassing, including the social, cultural or other contexts in which an individual could be understood. In this sense, Belzen (2009) contended that there should be some limits rather than an innate all-inclusiveness. Reed's (2014) theory of self-transcendence is contradicted by the former's theological lens, i.e. as being profoundly linked with God or a higher power in most of the literature on spirituality (Unruh, Versnel, & Kerr, 2002).

Therefore, in this section, the study provides an understanding of transcendence in relation to the capital(s) within the aspects of the social field that promote and facilitate recovery. This is pertinent to the findings revealed by the study participants in light of their experience of living with BD and controlling the symptoms via medicinal aspects. This study justifies the need to afford spiritual capital a status beyond its coherence within the thinking and feelings of human beings. This is in the context of the fact that people relate their meaning to their social world and practices.

Having said this, the current study acknowledges the concept of psychological capital as comprising various resources that themselves may be expressed, in their own right, as capitals – as in the case of spiritual capital. The psychological aspect of human beings is broad and complex, as per Bandura's lens (2006, p. 177):

> *Psychology is the one discipline that uniquely encompasses the complex interplay among biological, intrapersonal, interpersonal, and socio-structural determinants of human functioning.*

From the above, the current study does not consider the use of the term 'psychological capital' to be useful due to its broad descriptions, together with its complexities. In brief, psychological capital is the individual's

internal resource (Song, 2010). Within this view, it is therefore argued by this study that it is time to give spiritual capital a status while also acknowledging that it falls into the category of a human psychological mechanism.

Despite such a view, the current study regards the BT version of spiritual capital as adding to the debate, in that its conception depends on people's perceptions of giving meaning, which in turn relates to their social world view. This is the strength of using BT's tool of habitus in particularising the concept of spirituality within people's social framework in this study. Therefore, this study is going to move to the discussion chapter with the psychological aspect of habitus, taken with the concept of SQ and transcendence, that relates to spiritual capital within the broader social relations of the study sample with BD. The transformation of capitals in the next section assists in illustrating how the salient resources are converted into symbolic capital.

7.7.2 The transformation of capitals for symbolic capital

Bourdieu (1977a; 1984; 1985; 1991) uses the metaphor of 'gift exchange' and symbolic domination as elements that build symbolic capital in relation to the social field. Here, Bourdieu refers to the field (i.e. social setting) of symbolic capital as a market of symbolic goods. Concerning this field of a symbolic goods market, Bourdieu specifically mentions that agents have access to cultural goods. Bourdieu (1985) explains that the market of symbolic goods *'consists of a set of inter-related agents and institutions, functionally defined by their role in the division of labour (of production, reproduction and diffusion or access of cultural goods)'* (p. 13).

In this regard, symbolic capital is a form of exchange from cultural and social capital. This also points to the fact that spiritual capital is a particular form of social capital (Boettke, 2011) while also being a form of cultural capital; as such, it can be amassed or accumulated and exchanged (Verter, 2003). This, in return, relies on the conception of habitus that is instantiated by social and cultural backgrounds (history, institutions, social relations and biographies) that are internalised within us as matter of knowledge, dispositions and practices (Leyton, 2014).

7.7.3 The power of society to symbolic capital through the BT lens

Moving on, the basis of exchange is through the manipulation of symbolic power, violence and efficacy, which are elements of symbolic domination that can guarantee symbolic capital in relation to the social settings. The following contains details concerning what Bourdieu means by the terms symbolic power, symbolic violence and efficacy in his theory of symbolic domination (Bourdieu, 1977a).

Symbolic power *'is a power to make things with words'*, *'or reveal things that are already there'*. Symbolic efficacy refers to meaning, and it *'depends on the degree to which the vision proposed is founded in reality'* (Bourdieu, 1989, p. 23). Furthermore, in this respect, symbolic power itself can be a form of 'symbolic violence' *'which the dominated (i.e. the people) cannot fail to grant to the dominant'* (Bourdieu, 2002, p. 35). Here, the domination can be guaranteed, as the symbolic power is guaranteed by societal influence (Bourdieu, 1986).

Moreover, the cycle of the social reproduction of symbolic power continues. This is illustrated by Bourdieu (1989) as the way that the objective relations of power tend to reproduce themselves in relation to symbolic

power, as evident in the following explanation of symbolic capital by Bourdieu (1989):

> *Symbolic capital is nothing other than economic capital or cultural capital when it is known and recognized, when it is known through the categories of perception that it imposes, symbolic relations of power tend to reproduce and reinforce the power relations that constitute the structure of social space.* (p. 21)

In addition to the above, Bourdieu (1991) closely symbolises the structure of relations of symbolic power as belonging to a social relationship and expectations. This means that people's actions are then subjected to either social obligations or preference (Bourdieu, 1986; Grusendorf, 2016). Accordingly, the symbolic exchange value of capital (or symbolic power) may be continuously appraised by every individual who comes into contact with the capital resource (or social power relation) (Bourdieu (1977a).

However, the concept of 'gift exchange', as appreciated or valued by people, again depends on the interests and expectations which motivate them to use the capital (Bourdieu, 1991). Another perspective to consider is that people also vary their investment in terms of their obedience to the respective capitals, which can be attributed to the conflicts of power held by the capitals (Bourdieu & Wacquant, 1992).

Therefore, for Bourdieu (1989), the social field is constructed in such a way as to illustrate that agents, groups or institutions are situated close to people and are readily accessible through either choice or necessity. For this reason, capital is the outcome of social relationships (Bourdieu, 1986). Taking into consideration one's relationships within the broader social field, however, spiritual capital depends on the constraint of the social power

relation (Boettke, 2011). Hence, the critical aspect of symbolic capital is that the power that comes with social position confers on the bearer prestige, honour and recognition granted by diverse social groups (Bourdieu, 1986, 1977a).

7.7.4 The role of social positioning

Spiritual capital is an incessant recalculation of one's position within a framework of human relations (Verter, 2003), as the habitus acts to assume the social position that enables the the formation of relationships between individuals and societies (Leyton, 2014). Bourdieu (1987) developed the notion of the habitus for its trajectory in the social structure, in terms of whether one's position within it becomes stronger or weaker. For instance, the habitus acts to state that the adopting of a position in which one obeys a social command can improve an individual's status as a good person, while a decision to disobey such a command could result in the opposite. Here, an individual's position (within a particular field) reflects their habitus and the capital they can mobilise in that field (Edgerton and Roberts, 2014). Hence, improving one's position within the field means gaining access to capital where individuals build their power relations with the society through their status of having the capital (Rhynas, 2005).

For Bourdieu, capital is always a resource (symbolic or material) that can be used to maintain or improve one's position in a given field (McKinnon et al., 2011). Following this, Bourdieu (1977a) directed the investigation of the symbolic power of the (salient) capital to the position of agents that prescribe or sustain the beliefs. In his other work, Bourdieu (1977b) provided an example of how to imagine the social power relation; thus, when the authority exerts power to command the practical mechanisms,

the receivers acknowledge that power through their acceptance, submission or obligation and practicality. This is because the members of the authority are responsible for empowering the practical function attached to the capital by endowing the laypeople with practical works (Bourdieu, 1985; 1986; 1989).

From the above, symbolic power exemplifies that certain values can be constantly reinforced via social mechanisms of actions and interactions, which involves the roles of agents, authorised members and institutions within the particular society. Moreover, the existing institutionalisation (attached to capital) can guarantee a particular form of social relationship in a lasting way (Bourdieu, 1986). For Bourdieu (1990), an institution is complete and fully viable, capable of transcending the individual agents of a particular field, and has durable dispositions to recognise and comply with the demands in the field.

Here, Verter offers a more critical appraisal of 'social positioning' as influencing the dynamicity of spiritual capital: Spiritual capital is identified not as a steady accumulation along a linear path, but rather as a never-ending shifting of one's position within a framework of human relations (Verter, 2003). Verter (2003) then continues to highlight that the value of spiritual capital is determined not just by professionals but also by laypeople. In addition, the shifting framework of an individual's dispositions (or habitus), which determines the position he or she will take in a particular field, is the aggregated product of multiple inputs and is what gives an individual identity (Verter, 2003). Similarly, Bourdieu was not proposing that individuals are in the same social position, as the positions in every field are hierarchical (Leyton, 2014).

Continuing from the above, if we consider the similarity between an individual taking a social position, invested to amass new spiritual capital, and the investment in economic and social capital, then the work devoted to its accumulation through devotional practice indirectly becomes a function of the work devoted to amassing the economic or social wealth exchanged (Verter, 2003). Thus, when strategically invested, spiritual capital can become a valuable asset that may yield social and economic advancement (Verter, 2003). This is why, for Bourdieu (1987), such symbolic capital can be readily convertible into the more traditional form of economic capital.

This critical point on the social power relation within spiritual capital therefore goes beyond psychological resilience as an endpoint of the benefits of spiritual capital – in alignment with how the trading of capitals to increase social position or status (in individuals with BD) may generate other benefits such as employment, social status and access to other capitals which extend beyond only 'psychological resilience'. In this regard, Verter offers a sophisticated scheme that is both rich in theoretical insight and multifaceted in its scope (Guest, 2007).

Moving on, the social structure has the power to constrain and model the life of individuals, in addition to the power to exclude particular social positioning (Leyton, 2014). In a negative way, the enduring habitus (in struggling to preserve the values and utilisations of the capitals) forces the social obligation on to individuals who do not have the power to act in their own right (Leyton, 2014). In brief, the power of social structures constitutes individuals' subjectivities and materiality, regardless of their will (Leyton, 2014). Hence, people are bound to fulfil their needs since behind the formation of many social relationships there is also an element of necessity (van der Gaag, 2005). Additionally, not all social relationships are

based on the voluntary selection of the most rewarding or comforting persons from a population. In this sense, although spiritual capital may be amassed and exchanged, it can also be wasted and may lead to personal ruin (Verter, 2003).

7.7.5 Complementarities between capitals

Verter (2003), and Pini and Previte (2013) made the assumption that scales of spiritual capital can vary widely among people. This can be explained by the role of the habitus (in reflecting people's interest and subjective motivations of their practices) in bringing the interrelationship of different components (Ritzer, 2008). Hence, the different capitals brought together by an individual could potentially be regarded as complementary (Adler and Kwon, 2002).

In view of this, in this study, the complementarity between capitals derived from the findings should be perceived along with the critical view of Bourdieusian scholars such as Verter (2003) and Guest (2007), in particular on the potential exploitation that occurs in the interrelatedness of capitals. This is because spiritual capital depends on the practices and schemas of perception and the classification of the capitals that people deploy, which produces unequal symbolic power (of the capitals) (Leyton, 2014).

Additionally, as people occupy multiple fields simultaneously, changes in one field may affect another (Verter, 2003), potentially in a negative way. Hence, not all complementarities among the capitals (i.e. in spiritual capital) are symmetrical or balance (Adler and Kwon, 2002). This relates to how they contribute extra features to (someone or something) in such a way as to either improve or emphasise their qualities (good or bad, positive or negative). From here, Bourdieu goes on to implicate the

potential negative complementarity among capitals in his notion of competition and trading aspects, as outlined in the next section.

7.7.5.1 Competition and trading among differing capitals

Moving on, Bourdieu (1989; 1985; 1977a) specifically uses the term 'competition', whereby different capitals exist as a result of competition as each one attempts to impose its symbolic power. Bourdieu (1977b) further explains that different modes of production coexist according to the scope of their legitimacy or their function in society. Here, the assessment of capital (in its value) is always in flux (Verter, 2003).

Indeed, capitals reflect how their social agents could have obtained a high degree of autonomy when laypeople obey the enforcement (Bourdieu, 1985; Bourdieu & Wacquant, 1992). In this sense, certain capitals can be placed into their respective hierarchical (social) positions of value (i.e. above other capitals), thus undermining the other capitals (Bourdieu, 1985; 1989). Here, the habitus, since it carries the social presentation that struggles to preserve the values and utilisations of the capitals, reproduces random hierarchies (Bourdieu, 1987; Leyton, 2014).

Other than the aspect of competition emphasised by Bourdieu, another key point that needs to be considered in taking habitus to the broader social system is 'trade'. Ewing (2012) explains that trade in the context of social life means that there is a tendency to manoeuvre and negotiate for one's advantage at the expense of others. Similarly, because of the accumulated spiritual capital, certain things (e.g. spiritual capital) can be traded that help to maintain (or improve) their position within the field of social production. Additionally, one form of capital may be traded with or converted to another (let us say, religious capital converted into spiritual

capital), which also means that it is not traded equally (Pini and Previte, 2013).

In the context of benefit derived from social life, individuals are seen to invest in social relationships as a way of creating a good life and improving their life chances, and in doing so they employ their resources accordingly (van der Gaag, 2005). Hence, spiritual capital in the context of living with BD may be traded solely for the purpose of improving an individual's social position, and in order to gain good recognition from the society.

Overall, Bourdieu (1977b; 1989) invites others to view the symbolic power of capital in terms of its power dynamic related to the interrelatedness of the capitals through the notion of competition and trading. The related notion of competition, that of trading between capitals, is referred to in the context of this study – such trading may nevertheless be under duress (constraints) or directed by a powerful state, organisations, professions or individuals (such as medics or religious leaders), rather than simply in the form of an individual choosing to trade one capital for another. Here, this could limit an individual's choice over what they think or desire. Therefore, BT brings critical social aspects in considering human living within the constraint of society, and this could influence the habitus for spiritual meaning-making. This will be critically examined in the next section, by considering the complementarities of capitals (in the findings) in positive and negative ways.

7.8 Critical view from BT's symbolic capital in bringing the complementarities of capitals in positive and negative ways

Following the BT explanatory model of symbolic capital, this section presents critical views and presuppositions in making visible the complementarities and competition among the salient capitals in this study in positive and negative ways. In doing so, this section also illustrates that people trade in capitals as much as one exchanges things as a basic rule of economy.

On the surface, the findings appear to suggest a positive complementarity in the relatedness between capitals. The elements of power relation, competition and trading of capitals will be illustrated along with the findings that suggest a positive complementary interplay among the key salient capitals. Such positivity can be understood due to the advantages to these individuals with BD in the Malaysian context (as suggested by the participants in the eight themes in the findings).

In this context of BD, despite the key capitals being made available to the participants, an important element here is how they compete with each other. In this sense, it is considered how they may oppose or undermine the other capitals as they can be removed from some individuals in society, which applies even to spiritual capital. In this study, what marks the aligning of the key capitals in a negative way is the disempowerment or social positioning of the individual in such a way as to be disregarded by others. From the sociological point of view, this represents a powerful act, where the availability or possession of capitals in individuals with BD in this study is all about power.

Here, social positioning is a critical perspective on this implication of spiritual capital in this study sample as it can mean the difference between a person having or not having a quality life and being socially positioned as more or less powerful than others in the society. This is perhaps why some people have access to these capitals (while others do not) as it conveys their social status (through social positioning).

This will be revealed through an analysis of the different services and resources commonly deployed in this study sample as shaped by individuals' experiences of BD and recovery. Henceforth, the current study returns to the findings against which the capitals were aligned complementarily in supporting the spiritual journey of this study sample with BD.

In Theme 1 – 'Experiencing spiritual despair', the participants' experiences of social- or illness-related loss(es) prompted their negative appraisal in perceiving such an event as a punishment from God (i.e. their religious capital, in 11 out of the 25 study participants). Here, the participants undermined the religious capital once they questioned the fated event and abandoned religious practice. This is because the habitus (i.e. of religion) was transformed through the socially situated process, with the effect of lowering the individuals' interest (Reay, 2004).

At this point, the participants highlighted that family members took them to their psychiatrist as their symptoms of BD were exacerbated by the adverse event. From this finding, the participants in the study sample suggested that they appreciated the support of both family and biomedical intervention as they needed to recover from the despair event and its associated symptoms.

However, this appeared to manifest as circumstances in which the participants were positioned as being less powerful than others in Malaysian society, in that they had no choice but to rely on biomedical treatment in order to return to their families. Here, the negative social constraint on what seemed to be spiritual capital lay with the limited choices made by the participants themselves in order to please their family members, i.e. the relational capital. Moreover, the participants appeared to trade medicinal capital for being a stable individual with BD in order to access the other capitals, such as relational capital and perhaps social and religious capital.

Moving on from spiritual despair, in Theme 2, 'Engaging in spiritual meaning-making', the participants suggested their greater utilisation of religious capital as they took their positions as religious devotees in appraising the loss event through the religio-cultural lens typical in Malaysian society. Thus, they found acceptance of the fated event through religious belief as they began to value both the reward they were gaining for the afterlife and the strengthening of their faith. At this point, a greater mechanism for utilising spiritual resources was apparent compared to previously, which involved the participants' social relations with relational and religious agency. This was via interactions within the family for motivational advice, in addition to seeking the religious support services available from religious institutions.

Here, it is deemed that people with BD could have modified their religious habitus so that they viewed such events in line with the idea of reward from a religious perspective as well as for their psychological well-being. This study also draws a similar conclusion to that of Mellor and Shilling (2014), wherein religious habitus is not fixed for all time. Moreover, the quality of such relational connections also guides or brings the individual

access to religious capital in their quest for religious guidance, i.e. by meeting religious scholars. Here, the participants continued to suggest the importance of family as an emotional resource as well as its role in heightening their sense of self-worth. As such, both religious and relational agencies were perceived as positive and complementary resources in facilitating meaning-making in this study sample with BD, and in helping them recover from spiritual despair.

Yet it could also be the case that the participants had no choice but to adopt the positive religious ideas enforced by their families or religious leader. In doing so, they come to be accepted by and are able to live together with family members who share a similar religious stance. Thus, they can continue to obtain support from these two capitals, i.e. religious and relational, in order to live in the Malaysian society.

Moving on, the individuals with BD in this study continue to make use of religious, relational and medicinal capitals as evident in Theme 3, 'Orienting the spiritual life'. Here, the participants used a metaphor for the significance of life goals in dealing with motivational drive while living with BD. This theme features the habitus oriented to the future with the expression of life goals in order to become a useful person who is able to cope with the BD symptoms.

The majority of the participants focused on the fact that they had to take responsibility for their family members, which is thus aligned with the relational capital for motivational drive in maintaining their mental health. Less prominent, meanwhile, was the orientation towards the subject of religious life goals (featuring among only a minority), whereby religious capital led them to be religious, directing them to a righteous path, and to be strong. Further to this, the participants suggested that they might need

to rely on their medication as a way of controlling their BD symptoms and achieving what they had planned for their life. As such, the key salient capitals, as taken by the individuals with BD in this study, both compete with and complement each other to support what the individuals want to pursue in a positive way.

Considering the positive complementarity of the three capitals (i.e. religious, relational and medicinal) in the above, it seems the relational capital restricts the participants' choice for living, given their conditions with BD, thus meaning they need secure attachment as they are dependent on their families. This is perhaps why many of the participants who possess relational capital in a strong bonding have few choices available but to formulate such life goals congruent to their needs (to be with their families). This circumstance in securing their needs to be with their families could undermine the religious capital in reference to their life goal.

Here, in the formulation of life goals, it seems that they trade medicinal capital in a negative way as a means of securing their needs. It also seems that, once they disregard their medicine, or become non-compliant, the spiritual capital may be taken away from the individuals with BD in this study, which can then preclude membership of possibly their family, or society, or perhaps result in them losing greater social or economic benefits, such as employment.

Continuing from the above, the religious capital is secured among the participants in this study in Themes 4, 5 and 6 ('Keeping faith in God', 'Devoting oneself to God' and 'Having a sense of spiritual harmony'). Supporting this finding, in Islamic belief (i.e. the religious capital of being a Muslim, which almost carries a similar ideology to other dominant

religions), there is only one principle that guides behaviour, namely obedience of God and His laws (and, by extension, one's parents) (Ewing, 2012). Here, the participants seemed to improve their position as being a good religious servant as they can be close to religious leaders in Malaysian society; thus, they enjoy access to religious institutions and a congregation. This is evident in the finding that the participants can make an effort to reach religious scholars such as imams, priests and gurus via their religious agency.

The finding suggests that the participants' involvement in religious society was less prevalent in this context of BD as they are able to pursue religious practice in private; indeed, only a minority (6 out of 25) mentioned interactions with fellow believers for religious information and in congregations. Looking at the social positioning, in religious practice, being a good religious member can yield a certain social status; again, this is a power issue as some people are socially positioned as having higher status in this regard than others – notably the *imam* or the priest over the lay members, yet a pecking order can even apply among the lay members in terms of who stands closer to the esteemed leader. Here, the spiritual capital of being in the Muslim religion, for example, can be removed by the *imam* (i.e. religious leader) or religious community by expelling the individual from religious practices and communities (literally banished), thus potentially excluding them from the religious capital.

Together with taking a religious devotee position (albeit in more individualistic and private ways among the majority), the participants continued to suggest the positive aspect of medicine (i.e. medicinal capital) that enabled them to perform religious practices. The participants differentiated the effect of medicinal efficacy for emotional calmness from the feeling of peace gained from spiritual activities. In fact, much of the

spiritual experience could commonly be viewed within the religio-cultural lens of the Malaysian society. This spiritual expression could show that the participants are forced to express a type of spiritual peacefulness and calmness that is pleasing to others with a similar religious lens in order to be accepted as, perhaps, a religious person.

The finding within the three themes suggests that relational capital is less referred to, as it is based on the individual being a good religious person who devotes their time and obligation to the attaining of spiritual benefits. Therefore, with regard to the aspect of religious practices in this study sample with BD, the positive complementary interplay between the religious and medicinal capitals channels advantages to them.

Given that the participants use such religious and medicinal capital in a positive way (to improve their status as good religious devotees), this study is aware that a form of socio-cultural enforcement of the conception of religious faith may limit the choice of these individuals so that they are not excluded from the religious society. These individuals with BD could have used religious capital and shown their devotion in such a way as to convey the cultural image of what is accepted by others, especially their families. Moreover, the use of religious capital could serve to protect them from the engagement in destructive behaviours that is associated with BD, e.g. self-harm and suicidal tendencies, so they can continue to please their families (i.e. relational capital). In this case, spiritual capital among this study sample with BD is not neutral from the family or perhaps a societal agenda in terms of constructing what the participants have to manipulate in order to gain the opportunity to lead a good or satisfactory life.

Moreover, the participants suggested that their reliance on the medicinal aspect as a means of enabling them for religious practice also manifests as a form of exploitation that limits their choices as individuals. Even if we were to agree that all psychiatric services, including medical capital, were of 100% benefit to people with BD (and we know that this is surely not the case), only then might we consider how only some people in society can access that 'medicinal capital' in the first place. They may have to demonstrate that they are following a medication regime in order for their families to allow them to reach religious society. Again, spiritual capital given in this way can also be taken away from these individuals with BD if they fail to comply with their regimes and are hospitalised due to a worsening of their BD symptoms, in which case they also lose access to the relational, social and religious agency that they had outside hospital.

Moving on to Theme 7 – 'Improving a sense of self-control', this current study perceives that spiritual capital resources were captured with their benefits in terms of minimising any relapse of BD. Here, in this context of BD, the participants highlighted a mutual reliance on spirituo-religious and relational aspects, as well as medical assistance, for the treatment of their BD. In this instance, the participants' religious capital is credited with the notion of promoting good self-control over destructive behaviour that is a particular symptom of BD. Meanwhile, medicinal capital is found to be complementary to promoting symptom control. In addition, the relational capital also acts as a complementary resource for the emotional channelling of stress(es), with the exception of a minority of the male participants who highlighted the missing element of trust in their relational capital.

The complementary interplay between the three capitals in positive ways is continued in the next theme (Theme 8 – 'Establishing a positive life adaptation'). This theme relates to the aspect of recovery as it highlights a positive shift in mindset among the participants with BD that links to an adjustment or adaptation in their social life. This theme brings together the positive complementarity of relational, religious and medicinal capital in co-supporting a positive mindset. Moreover, some of the participants revealed that they were stable (in terms of their BD) and were thus ready and open to joining religious groups for assembly and congregational prayers, or even socialisation. This was in contrast to other participants who had low levels of self-esteem and positivity and who limited themselves to spiritual resources in the form of socialisation.

Pertinent to BT, improving a sense of self-control and positive life adaptation are regarded as a symbolic gain in the exchange of spiritual resources for the building of spiritual capital. Here, the finding suggests that the presence of spiritual capital, particularly with regard to improving the sense of control and adapting positively to live with BD, could potentially inform the participants' interest for utilising spiritual resources over time. This is informed by Bourdieu's (1977a) assertion that this capital undergoes continuous changes in value as appraised by every individual who comes into contact with it. Bourdieu (1977a; 1990) also stated that habitus, envisioned for its potential profits or interests, is able to recognise the trajectory of capital.

Nonetheless, the researcher is aware of the potential for darker or more negative interplay over the longer term, e.g. a disempowering or socially manipulative side to the connectivity between capitals; indeed, they can combine or relate to one another in both positive and negative ways in relation to the Malaysian social capitals. This may be because some people

are given preferential access to other kinds of capital as they are encouraged to join religious or other organisations, while this preferential access may also be denied to them if they are rejected or made to feel so uncomfortable about joining that they make no attempt to do so.

In this regard, the spiritual capital taken from this study sample with BD with the key salient capitals is neither an innocent nor neutral phenomenon, nor is it simply positive. Moreover, there is a possibility in this study that the individuals may be heavily constrained and commanded by more powerful others or the powerful system to do this; thus, to trade capitals in particular ways. Moving on, a person may trade a strong affiliation with a spiritual life/religion (spiritual capital) as a means of gaining favour with the family and being supported (relational capital), or else agree to medication (medicinal capital) as a way of securing other capitals (e.g. cultural capital, access to family or community (relational capital)). In supporting this, religious capital may be important for entry into other fields (McKinnon et al., 2011).

As suggested by the findings in this study, the element of relational support and trust did emerge particularly in the sense of social inclusion, thus eliminating the sentiment of being discriminated against by the society, as had been perceived by some of the study participants in this group with BD. A person may, for example, align themselves with or agree with a spiritual capital in order to activate family support and relatedness. This is because ties with kin are strongly embedded in a normative system in most cultures, and good contact with kin could help in times of need (van der Gaag, 2005). Furthermore, helping family members is a normative obligation, which stabilises these relationships and makes them very reliable for individuals (van der Gaag, 2005).

Another way of seeing this is perhaps that each person operates to maximise his or her advantage (or that of his or her family) vis-à-vis others in order to realise personal or familial wishes and goals. In this regard, this may have nothing to do with the choice and wishes of an individual – they can be socially positioned higher or lower but still, effectively, be overpowered by others to adopt this position, role or status within families or the Malaysian society. Hence, in terms of family or relational capital, this may or may not be good. Indeed, such a capital (relational) may be a powerful force working against an individual's rights and their place in society (social position). Moreover, across societies, there are far too many cases of families abusing members, demanding unacceptable roles and lives from them; as such, family or other relatedness as a capital can be both positive and negative.

Moving on, in this study, people may say they agree with or align with 'medicinal capital' as a way of accessing other capitals, let us say 'cultural capital' or 'family relations/relational capital'. Thus, they can go home because they have followed the medical view of what it is to be a good patient. However, compliance – where available – does not equate with acceptance of the spiritual values, although it may well be a defence mechanism; indeed, the status of symbolic capital can be challenged (Kamoche and Pinnington, 2012). A patient who agrees to take 'the tablets', or an individual who states that 'medicinal capital' helps them in their 'spiritual life' may state this because they wish to convince the psychiatrist or family of their progress. In such cases, they find medicine is in favour and also aligned with a spiritual world view, and they may also demonstrate this view to a researcher in case a report gets back to the psychiatrist or their family.

Continuing from the above, the spending of medicinal capital on others (as a way of getting back to family) technically constitutes relationship costs, although this is generally not seen as a burden when applied to pleasant relationships: contacting others is often seen as pleasant, but it can also be perceived to be manipulative or opportunistic (van der Gaag, 2005). This sits in parallel to the argument put forward by Boettke (2011) related to how individuals constrain themselves (for they will), which can determine how they interact with one another to engage with the societal network. For example, an individual who fails to accept the general and powerful view that medicine is the best intervention may be denied access to other capitals and be socially positioned as a 'non-compliant' patient who may then also potentially be denied access to family or the wider community (and have to remain in hospital), or be denied another capital that they value, in this case 'relational capital'.

Hence, we can perceive a case where spiritual capital is accessed before being manipulated and then traded in order to obtain something that goes entirely against spiritual ideas and values. The meaning here is that spiritual capital can be traded in society for both good and ill. Moreover, this can also extend to the potential trading of spiritual capital in this study; thus, by demonstrating approval of 'medicinal capital' and its positive effects, an individual may be trying to get out of hospital and thus have access to the other capitals that they value – perhaps the freedom to access the library, cinema or another asset such as sporting facilities or simply open space, as something that is not available to them in hospital. The next section examines the criticism of BT.

7.9 Criticism of Bourdieusian Theory

Although there is explanatory power within Bourdieu's theory, his sociological analysis of religious capital in a social order can also be considered problematic (Urban, 2003). Pertinent critiques include the limits of the social context of the Catholic Church, from which the analysis of religious capital is derived (Grusendorf, 2016; McKinnon, Trzebiatowska, & Brittain, 2011; Rey, 2007).

Also in this respect is the uncritical cognisance of the evolution of religion in society over time (Baker & Miles-Watson, 2010; Iannoccone & Klick, 2003; Urban, 2003; 2005). Bourdieu's definitions of such conceptual tools as capital and habitus seem to always be in flux and ambiguous; as such, Bourdieu has a tendency to merely characterise them as opposed to tightly define them (DiMaggio, 1979; Grusendorf, 2016). In response, Bourdieu and Wacquant (1992) asserted that the concepts were always intended to be open to improvisation and creative modification in response to changing historical circumstances.

Another critique is that Bourdieu has turned every human into a capitalist (Urban, 2003). A counterargument put forward by Verter (2004) is that the term *capitalist* (i.e. an investor) makes no sense when applied to symbolic forms; thus, it should be fundamentally understood as a medium of social relations in a social economy (i.e. of power) rather than a material economy (i.e. of money and goods). Bourdieu is also regarded as a reductionist and his social theory has been viewed as having a political agenda. Urban (2003), for example, argued that Bourdieu's works reduces the dimension of 'transcendence' and the sacred only to the material and the pursuit of profits. Urban (2005) also contended that Bourdieu extended what is perceived as personal interest into a larger social concern.

Nonetheless, Bourdieu's theory of symbolic capital can be viewed as being 'political', based on the notion of the power held by the society. This is because a capital/resource is shaped by the community itself (Montemaggi, 2011). In supporting this, one can refer back to Bourdieu's (1990) account of habitus that contains sufficient explanation of the social influence on people's subjectivity in terms of perceiving meaning and values. Even so, Montemaggi (2011) drew particular attention to the need for social action as one of the resources for spiritual capital, stating that what counts as spiritually motivated social action is distinct from that which constitutes politically motivated action.

Despite the critique put forward by Urban (2003), he also acknowledged the importance of Bourdieu's work and the advantages it brings to the study of religion, particularly in terms of theorising spiritual capital from material resources. Other scholars also acknowledge Bourdieu's sophisticated social model that merits the scientific modes of inquiry (Nicolaescu, 2010; Vandenberghe, 1999). The scholars' view thus supports the relevance of using BT for theorising spiritual capital in this study. The next section highlights the strength of BT's symbolic capital in critically viewing the participants' spiritual capital.

7.9.1 The strength of BT's symbolic capital in informing the spiritual capital of people with bipolar disorder

Overall, the view of spiritual capital as symbolic capital through the BT lens critically brings the insight that the participants with BD are able to enjoy the benefits of aligning different capitals, i.e. religious, medicinal and relational capital, in particular for their recovery and social life adjustment within the Malaysian society. It could also be perceived that the potency of spiritual capital in aligning or activating associated resources is especially

beneficial for those needing access to a support system in order to lead a good life. Moreover, spiritual capital in this study sample with BD works with the medicinal aspect, as recognised by the participants and their families, to assist in stabilising the symptoms of BD. With that, spiritual capital for the interest of people with BD, which matches the model for their spiritual care, should be reduced from Bourdieu's theory of symbolic-cultural capital.

With regard to the above, the spiritual capital lies within the power issue in relation to patients being either overpowered or disempowered by others. Hence, spiritual capital could also be taken away from patients with BD with regard to power issues in having access to the associated capitals. While taking symbolic capital as per BT, spiritual capital could also be viewed as an exchanged form of social capital for patients with BD – it could also be traded for their freedom and open access to other benefits within the broader social system in Malaysia, which may include access to things such as education, art, vocations and employment, wealth and entertainment. In this sense, spiritual capital is worthy of attention by MHS in terms of considering the spiritual model of care that could maximise the benefits to patients. This particularly emphasises the central role played by relational agency in supporting patients' recovery within the society as this is the form closest to them.

7.10 Chapter summary

This chapter has presented the rationale for theorising spirituality as spiritual capital through the application of BT as encouraged by the ConGT approach. The theoretical understanding of spirituality in this study adopts the term spiritual capital as drawn from the evolution of BT's symbolic-spiritual capital as found in the prevailing literature. The application

incorporates the BT-based theoretical tools, i.e. capital, field and habitus, and the BT mode of theorising symbolic capital. Hence, the key links in the application of BT symbolic capital to spiritual capital in this study, which will be further extended in the Discussion chapter, took into account the following aspects:

1. The concept of habitus brings the aspect of meaning-making and practices for spirituality, thus rendering discernible the values of the salient capitals of the individuals with BD within the norms and view(s) of what is acceptable of the Malaysian society, i.e. religious, relational and medicinal capital.

2. The alignment of the different capitals, i.e. religious, relational and medicinal, through the capital clusters model, brings theoretical insight of a spiritual model of care which could be of interest to the MHS in supporting the recovery of patients.

To conclude, the aspect of meaning-making imbued with the BT elements of the habitus in relation to social life for this study sample with BD will be considered against the relevant literature in the following Discussion chapter. In so doing, the current study will examine the claims regarding the strength of using BT for the purpose of theorising spirituality into spiritual capital.

Chapter 8: Discussion

8.1 Introduction

In this chapter, the discussion mobilises the eight themes from the findings that highlight the salient capitals, i.e. religious, relational and medicinal capitals, either alone or in terms of their interrelatedness, i.e. capital clusters (A or B). Following on from the mobilisation of the eight themes, the current study will discuss the habitus as it is linked to the salient capitals, bound by two concepts in the prevailing literature in psychology and spirituality – spiritual intelligence (SQ) and self-transcendence. The current study then links the understanding of SQ and transcendence in relation to empowerment of the habitus to mobilise the capital(s) within the social field.

The current study will highlight the strength of the conceptualisation work using a BT approach with the arguments that the aspect of meaning-making imbued with habitus relates to the participants' social world view, specifically in relation to BD. Within this argument, the view on the spiritual model of care for promoting recovery in patients with BD, along with the potential activation of integrated spiritual resources, will be highlighted as one of the implications for mental health services.

Despite this, the claims made by the current study will be moderated based on the study context; however, the conception is dependent on the context of interest which, in this case, is living with BD and religion. Moreover, the sample size places a limit on the generalisability of the findings in the context of BD elsewhere. The discussion in this chapter begins with the first theme, as in the following section.

8.2 Experiencing spiritual despair

This theme relates to the participants' spiritual despair and frustration over adverse social events losses (expressed as a sense of religious doubt and loss of religious faith), as experienced by the majority of the study sample with BD (19 out of 25). Hence, the discussion of this theme focuses on the spiritual capital of being religious in a negative state – with the condition of losses being negatively appraised against the participants' religious faith, i.e. religious capital, among the study sample. As such, the arguments of the current study will focus on spiritual capital in a negative state (in the event of losses and despair) because the religious habitus in this sample with BD alters to to reflect a loss of interest or deviation from their religious faith matters.

Later, the current study highlights the implication of the medicinal capital in capital cluster A (as assisted by relational agents), which appeared to assist the study sample in this phenomenon of spiritual despair. Hence, the current study will highlight the function of MHS for medicinal assistance, especially in the face of spiritual despair for people with BD.

In the theoretical vein of BT, the religious habitus of the study sample gives way to the viewing of spiritual capital in a negative state as this is linked to the social circumstances in the experience of loss. In this regard, the current study refers to Hobfall's (1989) theoretical view that social and environmental circumstances often threaten people's resources. Agreeing with this, Bourdieu and Wacquant (1992) strongly emphasise that the researcher must consider situations that are not favoured and which may influence the subjectivity of the habitus in the opposite direction. In addition, Brown et al. (2014) highlight that emotional state can influence the expression of the meaning of the habitus. As such, the current study

claims that the disempowerment of religious capital should be viewed in conjunction with the psychological disadvantages brought about by adverse social events in this study sample with BD.

Continuing from the above, the empirical evidence obtained from other study samples with BD highlights their psychological disadvantages, albeit not directly under the phenomenon of spiritual despair. For instance, research by scholars such as Fletcher, Parker and Manicavasagar (2013; 2014) and Nitzburg et al. (2016) concluded that these BD populations tend to have maladaptive coping mechanisms. As pertaining to this literature, maladaptive coping could also be the case in this Malaysian study sample while they were expressing the religious habitus. This links to Pickel's (2005) explanation that the habitus acts as a psychological process when coping with an adverse event. As the current study focuses on the BT concept of habitus, it argues that the psychological dimension of spiritual capital is responsible for the devaluation of religious capital in light of the phenomenon of spiritual despair.

Despite the above, the current study acknowledges the prevailing literature that includes terms used by scholars that are similar to the phenomenon of spiritual despair. These are 1) spiritual struggle (Ano & Pargament, 2012) and 2) existential crisis (Josephson & Peteet, 2007). Ano and Pargament (2012) describe spiritual struggle as the reflection of an individual's tension within their perception of the religious system. Presenting a similar meaning, Josephson and Peteet (2007) specifically highlight their notion of 'existential crisis' and its impact on individuals' relationships with God. Nonetheless, the current study brings further insight to the role of the psychological dimension of habitus pertinent to the disempowerment of religious capital through the concept of self-transcendence.

In addition to the above, the notion of 'self-transcendence' has been used when describing spiritual struggle as an impairment of one's ability to transcend oneself (Ano & Pargament, 2012; Agrimson & Taft, 2009; Ellison & Lee, 2009). Accordingly, Pargament et al. (2005) suggested that this impairment in transcendence has two fundamental aspects: intrapersonal and interpersonal. Ellison and Lee (2009) explained that intrapersonal struggles involve feelings of spiritual alienation, guilt and lingering religious doubt, whereas interpersonal struggles involve a problematic relationship with God and external religious communities (Ellison & Lee, 2009). Yet, the literature has not been direct with regard to its use of this term as a form of psychological disadvantage that can disempower religious capital, as one of the spiritual resources, in a meaningful way. Hence, the current study has a direct point in relation to the psychological dimension of spirituality through the lens of habitus which has disempowered religious capital among the study sample.

Another aspect of psychological disadvantage for spiritual capital in a negative state is SQ, which can decline in relation to an individual's consciousness in every aspect of life (Bensaid, Machouche & Grine, 2014). Along with this notion, for this theme, slightly more than half of the interviewees (14 out of 25) had experienced suicidal ideation during a time of spiritual despair, which is classed as one of the symptoms experienced during the depressive phase of BD. This contradicts the studies by Durà-Vilà and Dein (2009) and De Fazio et al. (2015) in which spiritual struggle as a conflict in faith does not necessarily suggest or cause depression or suicide. Nonetheless, when viewed through the lens of habitus via BT, the study participants, at the time of their interviews, reflected only on their past experiences, whereby the context offered an understanding of the habitus in relation to religion and loss events.

Hence, this study accords merit to the power of a situational analysis of the habitus according to adverse social events and loss experienced in the context of life despair. It is important to note that habitus is centred on contexts (Cornelissen, 2016) and '*is not a stable currency'* (Verter 2003, p. 159). Furthermore, emotional reactions are among the most powerful experiences of everyday life (Baumeister et al., 2007). However, the current study places a limit, in particular, on the negative state of spiritual capital within the Malaysian sample with BD with a religion. Therefore, this situational analysis of habitus in an adverse event may differ from the spiritual capital in a population with no religion elsewhere.

Continuing from the above, in relation to the particular context of BD wherein events exacerbate the symptoms, the current study invites others to look at the role of medicinal capital in resolving spiritual despair, thus to be connected as spiritual capital. This is a particular implication for MHS that captures the interest and involvement of psychiatrists in promoting the spiritual model of recovery. In this regard, while the disempowerment of religious capital resulting from psychological disadvantage is obvious in this theme, medicinal capital with support from family agency, i.e. relational capital, appeared to assist the study sample. This is because the study sample expressed the habitus as pointing to relational capital (supportive family members) in terms of help in seeking medical intervention to moderate the distress associated with a worsening of BD symptoms, such as thoughts of or attempts at suicide. In this sense, BT offers a structural view of the role of agents for the capital in moderating the impact of spiritual despair through biomedical intervention for the study sample with BD.

Viewed conventionally, medicine is the first line of treatment for BD (Fletcher et al., 2013). Nonetheless, Skeggs (2004), from her sociological stance, elaborates on the mechanism by which an individual can gain access to social resources through the assistance of others. Hence, the current study captures the attention placed on the supportive role of relational capital in terms of access to medicinal capital. In this respect, the individuals with BD refer to their conditions as requiring treatment wherein the access to medicinal capital is facilitated by their families.

Nonetheless, the findings from the inclusion of medicinal capital cease to be the same once the context of having BD is altered to one outside of MHS or perhaps outside Malaysia. Hence, the findings are also limited to a context of living with BD in which medicinal capital is expressed as being of great importance, while this may not necessarily also be the case in healthy people, or among the non-compliant.

To conclude, the religious-spiritual capital of being religious may be in a negative state when related to a loss event. Yet, medicinal capital was deemed helpful in remedying the spiritual despair of this study sample with BD and favourably highlights the role of MHS in promoting spiritual recovery. Moreover, the phenomenon of spiritual despair in this sample with BD was understood due to the insight into BT's habitus within the context of living with BD and in relation to loss events. The transition from despair into an experience of hope and meaning in life is described under the next theme of 'engaging in spiritual meaning-making'.

8.3 Engaging in spiritual meaning-making

Despite the religious doubt and frustration experienced as part of the impact of losses in the previous theme, in this theme, a majority of the participants (18 out of 25) adopted a positive view of God, which activated their contact with their religious capital. In addition, this majority appreciated the supportive relationships they had with their family members, despite the adversities they were experiencing. Hence, capital cluster B (i.e. religious and relational capital) is linked to the aspect of meaning-making associated with religious or relational capital and follows on from viewing the impact of losses by this study sample with BD. The arguments in this theme will focus on the psychological dimension of humans that empowers the habitus for meaning-making that links to capital cluster B.

To begin the discussion, the current study looks to others in considering the temporality of habitus as brought by BT that captures the transition from despair to meaning-making by the study sample with BD. Jenkins (1992) posited that life and subsequent experience is a process of adjustment between subjectivity and objective reality. In agreement with this, Hobfoll (1989) believes that people could merely alter their interpretation of adverse events and their consequences as a focus on what they might gain. In this vein, Cohn et al. (2009) reported that participants who frequently experienced positive emotions made use of resources that helped them deal with a broad range of challenges. In this respect, the habitus of the study sample focuses on the positive values of what they could stand to gain from social loss events in the past.

Such a focus on positive values may also refer to the renowned psychological theory of coping and appraisal by Lazarus and Folkman (1984). They explained that individuals react to stressful situations through both primary and secondary appraisals: 1) in a primary appraisal, people tend to focus on the magnitude of the stress; and 2) as people move towards a secondary appraisal, they begin to evaluate their ability to handle the stressful situation. This is in accordance with the meaning-making in the study sample with BD highlighted in the current study as they were situated between appraising the aspect of the living experience in the past and present. It is thus a strength of using the concept of BT's habitus that it sheds light on the transition between the past and present state of the participants' spiritual capital.

As in the above, the transition of habitus could be explained through the fundamental role of SQ for positive meaning-making. This is because SQ helps people discover life values (essentially the value of existence) (Zohar & Marshall, 2000) and self-transcendence contributes to their positive thoughts at the same time as enabling them to let go of life's adversities (Greenway et al., 2007; Reed, 2014). Through the lens of spirituality, Durà-Vilà and Dein (2009) and Greenway et al. (2007) made a nebulous assumption that spiritual meaning-making can indicate growth in the aftermath of spiritual struggle. While spiritual growth is metaphysically unseen, it is nonetheless the focus of the current study to argue the point that it is the habitus that enables people to value and appreciate spiritual resources and this, therefore, is fundamental to meaning-making.

The current study would further argue that the study sample is able to see a loss event through the religious habitus that they share with other religious members in terms of appraising the adverse event positively. In a similar vein, many scholars have mentioned that religious believers are

capable of deriving positive meaning from negative life events within the religious faith orientation (Dyess, 2011; Emmons, 2005b; Tuck & Anderson, 2014). It is therefore argued by the current study that the psychological dimension of spiritual capital can be attributed to the participants' contact with religious capital. This is done by them adopting their religio-cultural lens in appraising the adverse event at the same time as being facilitated by the individuals submitting to religious belief (within the Malaysian religio-cultural lens) together with contacting religious agents and agency (as mentioned by them).

The reference to the attachment system can assist in explaining the positive meaning appraisal as it is associated with religion, thus referring to the utilisation of religious capital among the Malaysian study sample. The attachment system is defined in the literature as follows: *'a type of affective bond which the individual forms with a specific person who is approached in times of distress'* (Brandt, 2014, p. 762). From this perspective, religion entails people forming an attachment to a spiritual figure, e.g. God, as a secure base (Granqvist 2014; Granqvist & Kirkpatrick, 2013). In addition, Cassibba et al. (2014) refer to the 'God attachment' as a functional strategy for coping with disease, whereas Granqvist (2014) refers to it more generally in terms of emotional regulation. Up to this point, the current study has maintained that the participants in this study sample with BD come into contact with religious capital in the context of their spiritual recovery from despair.

Continuing from the above, the current study relates to the literature on religion and spirituality, which has similarly described the use of religion in people's coping. For example, Desai and Pargament (2015) found 'positive religious coping' to be the strongest predictor for resolving spiritual struggle. In a similar vein, De Castella and Simmonds (2012), in their

qualitative study of participants experiencing trauma, highlighted the process of meaning-making in strengthening their religious and spiritual beliefs. Despite this, the notion of spiritual capital for this study sample with BD presents their habitus of being religious and its mechanism of social relations through religious agents and agency. In other words, religious appraisal should consider the religious information and guidance offered by other people to study participants.

As referred to from the findings, a majority in the study sample perceived relational capital to be meaningful. Thus, it is important for this study to consider that spiritual meaning-making is multidimensional; it can be psychological, religious or spiritual (Park, 2007). For instance, some scholars employ the term 'existential meaning of life' in its broadest sense (Cour & Hvidt, 2010; Frankl, 1985; Stillman et al., 2009). McSherry (2002), favouring this term, agrees that the meaning of life does not necessarily have a religious connotation. Granqvist (2014) mentioned that the family can serve as a spiritual resource for the attachment system aside from religion. It is thus time to acknowledge that the habitus for spiritual capital allows for an understanding of meaning-making as per the lived human existence that people can relate to others.

A further argument concerning the habitus for spiritual capital may reduce the bias towards religious spirituality and open up an understanding of a non-religious form of spirituality. This is contrary to the stance of Koenig et al. (2012) and Pesut et al. (2009), who point out that existential meaning may not be suitable for a religious population. Despite this, the habitus of the participants in the Malaysian sample clearly expresses the inclusion of relational capital together with spiritual meaning-making in terms of enabling them to move on from an adverse event. Similarly, Swinton (2010) situated the role of relational qualities within families and

communities when discovering the transcendence trait, as it can potentially be found in an individual’s family and community. Hence, while deploying the concept of ‘spiritual capital’ with its capital cluster, the current study has revealed valuable insights into relational capital as one of the spiritual resources for the study participants with BD.

Up to this point, the current study has outlined a theoretical route to considering the complex issue of non-institutional religion, i.e. with relational capital as one of the spiritual resources positioned within the context of living with BD in Malaysia. It may however be the case that relational capital is not found in other contexts, as reported by Stillman et al. (2009), or that a decline of meaning in life amongst the Western adult population is due to social exclusion. In a similar vein, Crescioni and Baumeister (2013) argued that people are a less stable source than religion when it comes to seeking meaning in life. Nonetheless, it should be noted that the literature concerning individualism versus relativism has been predominantly accepted only by Western society (Albertsen, O’Connor & Berry, 2006; Bandura, 2006; Braam, 2009). The current study further argues for the need to look at the context of the study population in Malaysia, where the habitus specifically reveals the symbolic meaning of relationships with family members.

In furthering the argument, it is worth examining the literature written from an Eastern perspective, such as that from Ho and Ho (2007). They proposed the broad inclusion of transcendence where it captures the relationship of oneself with others and society, nature and the cosmos. Moreover, relational quality is a form of long-lasting contact relationship characterised by trustworthiness and where there is a steady expectation for the future (van der Gaag, 2005). It is thus a strength of using the habitus of BT that the current study can highlight the inclusion of relational

capital as a positive aspect, as per this theme, since it was expressed as such by a majority of the study sample.

Viewed through the BT lens, the symbolic view of both religious and relational capital in the study sample is clearly manifested in a form of symbolic exchange for positive emotion accompanying spiritual meaning-making. This therefore highlights the positive gains from these two capitals of securing a position in the aspects of the meanings and values in this study sample. This is supported by the literature; positive emotions are brought to the fore during meaningful appraisal and are an antidote to negative emotions (Emmons, 2005a; Fredrickson, 2001). The current study thus intends to focus on the positive emotion accompanying spiritual meaning-making that sheds light on a form of spiritual recovery. Moreover, the spiritual capital specific to the participants with BD is highlighted in their habitus, which renders their religious and social values promotive for their recovery.

Overall, spiritual meaning-making (in this theme) sheds light on the dynamic state of spiritual capital as the habitus of the study sample changes their view with regard to life adversities and existential concerns. Moreover, the habitus of this study sample highlighted the importance of capital cluster B, which includes religious capital and relational capital bound within the Malaysian contextual view. The finding therefore limits its contextual derivation and leaves it open to scholars as to whether they are interested in the phenomenon of habitus in its temporality according to the context. The discussion on habitus for the inclusion of capital cluster A will continue in the next theme of 'orienting the spiritual life'.

8.4 Orienting the spiritual life

The finding of this theme indicates that life goals were formulated either with a religious vision or variously formulated according to what the participants envisioned for their future. Of the non-religious life goals, most were related to the participants' family members. The life goals were variously formulated. The determination to maintain well-being was found to be moderately prevalent in the Malaysian sample, with the participants clearly asserting the need for medication (i.e. medicinal capital) and removing other disruptive behaviours and maintaining well-being.

As such, the current study provides arguments that the expression of life goals may be broad as it captures the habitus concerns for the future while utilising capital cluster A, i.e. religious, relational and medicinal capital. Later in this theme, the current study continues to present findings on the medicinal aspect as an implication for MHS to formulate a spiritual model of recovery integrated with the aspect of medicine.

It is arguable whether the term 'life goals', which provides spiritual orientation of the habitus(es) of this study sample, could be accepted in its broad sense as this could explain the formulation of life goals that varied among the majority in the study sample (n=16), including a commitment to families, and personal ambition. In the literature, scholars such as Gorelik (2016) and Reed (2014) associate the expression 'life goals' with human growth in only a more metaphorical sense. Yet, what matters most is that, according to Bourdieu and Wacquant (1992), people will pursue a pre-envisioned future. This is also highlighted by Jenkins (1992), who states that aspirations will change the habitus. Keyes (2011) describes the value of life goals as a sense of aliveness or a reason for one's existence, whereas Basset et al. (2008) perceive life goals and the purpose of life as

an 'inner motivator'. Hence, with the application of BT in the current study, the habitus of BT reveals the concerns or inspirations of the study sample for the future.

As in the above, the psychological dimension of spiritual capital through the idea of self-transcendence is helpful in understanding its fundamental structure (for spiritual capital) that empowers the habitus of the study sample. In a similar view, some scholars have proposed that the idea of transcending life goals creates a positive indicator of psychological well-being, including maintaining a positive attitude, orienting life perspectives more broadly and allowing people to rise above life's challenges (Delgado, 2005; Emmons, 2003; Reed, 2014; Starck, 2014). The current study, however, highlights the fundamental role of the habitus in reference to religious capital as the inspiration for religious-oriented goals.

Regarding the Malaysian sample, religious capital through religious-oriented goals features strongly in the participants' accounts of returning to a religious, righteous path and the removal of suicidal thoughts. Supporting this, Abu Raiya, Pargament and Krause (2016) reported that people who dedicate their lives to religion could see a reduction in their spiritual struggles. Hence, the current study argues that religious capital remains relevant as a reference for meaningful life orientation, as is evident among the minority of participants in the Malaysian sample. This sits in parallel to the commentary review by Park (2007), who posited that a sense of ultimate (i.e. religious) purpose may provide the motivation for maintaining one's mental and physical health. Nevertheless, only a minority of the participants (9 out of 25) expressed their life goals in respect of a religious aim to life.

Religious capital in this study sample should be understood in terms of a psychological explanation. Schnitker and Emmons (2013) highlighted the psychological function of religion as one of the precursors to providing the meaning of life which then serves as an adaptive approach against life's adversities. Religious goals can impart a sense of control in relation to transcendence (Hill & Pargament, 2008; Schnitker & Emmons, 2013). Pargament and Mahoney (2005) claimed that this is because people view themselves in the context of their relationship with God, as being sacred or having significant qualities. Again, this means that religious capital, as seen through the participants' religious habitus, is mobilised because it offers psychological advantages to the Malaysian sample.

As in the above, the current study puts forward the need to further highlight the habitus in the participants' visions about the future, notably in the context of this study sample with BD when recovering from spiritual despair. The current study refers to the notion of 'self-transcendence' in the interpretation of the habitus that conveys the idea of the relationship between participants and their spiritual resources.

Scholars such as Delgado (2005), Emmons (2003), Reed (2014) and Starck (2014) make a specific link between transcending life goals and positive indicators of well-being, as characterised by a positive attitude and the ability to rise above life's challenges. Emmons (2005b) briefly asserted that individuals could transcend their life goals in order to grow (either spiritually or psychologically). Nevertheless, while adhering to BT, the current study offers an interpretation of the habitus of this study sample with BD in their vision of the future, which encompasses their inspiration for well-being.

In addition to the above, what is interesting about the expression of life goals by the study sample with BD here relates to their well-being, which in turn links to the use of medicinal capital. Emmons (2003) suggests that one way of clarifying the impact of goals on well-being is to differentiate those goals into either intrinsic or extrinsic. Thus, intrinsic goals facilitate well-being, while extrinsic (materialistic) goals do not support well-being. Moreover, Emmons (2003) believes in the importance of 'life goals' in terms of their ability to link individuals with resources and improve well-being. As such, it may be that an account of a strong will or determination to maintain well-being can be understood as an intrinsic goal. Moreover, this links well with an understanding of the advantages of medicinal capital to support determination among the participants in this study sample with BD.

Continuing from the above, the habitus's vision of life goals overstates the advantage of medicinal capital amongst the other capitals in capital cluster A, i.e. religious and relational capital. Currently, mental health recovery is only thought to be achieved by adding meaning to life and by engaging in meaningful activities (Best, McKitterick, Bestwick & Savic, 2015; Stickley & Wright, 2011). Here, it is perhaps useful to add the complementary interplay between spirituality and medicine from the findings of this study to the paucity of literature pointing to the fact that medicine (i.e. medicinal capital) promotes spirituality for people with BD.

Following this, the medicinal aspects need to be highlighted among the other spiritual resources, i.e. religious and relational capital, in terms of supporting spiritual practices and well-being in the Malaysian study sample. According to the conservation of resources model by Hobfoll (1989), even when people are not immediately confronted with stressors, they still strive to develop resources to protect themselves from future losses.

This study in applying BT symbolic capital, however, is aware that medicinal capital may possibly be traded for spiritual capital (in a positive or negative way) with an eye to securing more social gains in the future. This trading of spiritual capital could be viewed as the participants in this study sample complying with their medication regime in order to secure their freedom to live outside MHS. This especially entails the Malaysian participants being positioned as the service users under the dominant psychiatrist's scientific knowledge. Hence, the current study affirms that an understanding of spiritual capital along with the inclusion of medicinal capital can allow psychiatrists in Malaysia to offer spiritual care in conjunction with the prescribing of a medicinal regime.

To conclude, all people are different in terms of their life purpose (despite a minority of the sample perceiving theirs as being for religious purposes). This theme has highlighted the psychological explanation regarding spiritual capital, along with religious- or non-religious-oriented goals (including family-oriented goals). The inclusion of medicinal capital was dominant among the other capitals in support of the participants' pursuit of their life goals. Moreover, this theme indicates the need to review the approach to mental health recovery with the conception of spiritual capital from this study sample with BD. Nevertheless, the context in which the notion of spiritual capital is considered alongside the medicinal aspect is limited to the population with BD within the bounds of mental healthcare in Malaysia. The next theme of keeping faith in God discusses the psychological dimension of spiritual capital in relation to religious capital.

8.5 Keeping faith in God

In this theme, the discussion focuses on forms of religious capital that can be immediately recognised in the expression of faith among the majority of the Malaysian sample. This is because the religious habitus is revealed among the majority in this study sample with BD through the notions of gratefulness, submission, reliance, trust, blessing and thankfulness to God. The current study, however, provides an argument for using religious capital for a healthy psychological state when viewed through the lens of the participants' religious habitus, as in the case of those living with BD.

As in the above, the religious habitus of this study sample recognises the value and benefits of religious faith in contributing to a healthy psychological state, despite them having to live with BD. Levin (2009) briefly outlined how keeping faith in God is a type of psychological act. Montemaggi (2010) attempted to relate religious faith, which reflects the intra-subjective processes of the individual's religious identity, to an understanding of it being psychological in nature. Nonetheless, the current study perhaps brings additional insight about the religious-spiritual form of recovery – this is by understanding the religious habitus of the study sample in that the participants need to position themselves as being religious in order to be part of the religious group.

In this respect, the current study has merit in its application of the habitus of BT that leads to the participants viewing religion as one of the attributes of their psychological well-being. This is supported by the idea that a belief in God who gives a sense of security is associated with lower levels of psychiatric symptoms (Flannelly & Galek, 2010; Pargament & Lomax, 2013) and, thus, it becomes a functional strategy for coping (Cassibba et al., 2014). Nonetheless, Granqvist (2014) offered a critique of the

methodological limitations among those studies attempting to provide evidence of the interplay between religion and mental health as it is difficult to draw any real conclusions. With the interpretation of the habitus of BT, it is therefore a strength of the current study that it is able to understand the interrelationship between religion and a healthy psychological state; this is in such a way that it implies a relationship with God through religious beliefs.

In addition to the above, religious capital in the Malaysian sample irrefutably defines the faith or beliefs of the members of the study sample as directing the understanding of the symbolic power of religion within the sample. This is because religion forms the basis of faith in God (Belzen, 2009; Palmer & Wong, 2013; Zinnbauer & Pargament, 2005). In the same vein, Radford (2012) advocated that the notion of faith can help clarify spiritual conceptions in the context of being religious. Yet, the current study also embraces the views of others when considering the importance of an individual's psychological state in empowering the religious habitus in the context of a realisation of God in selected areas of life.

In supporting the argument of this study, the expression of faith is concerned with an individual's self-consciousness in relation to understanding God (Montemaggi, 2010; Radford, 2012; Ronel, 2008), which can then strengthen their overall faith in God (Ronel, 2008). Reed (2014) posited that maintaining faith in God carries a transcendent trait, while Ronel (2008) related faith to SQ. Viewed in this way, the current study offers an understanding of the psychological dimension of habitus to empower this study sample in contact with religious capital in terms of keeping faith in God.

The current study sets out the concept of spiritual capital a little differently from the way it was presented by Malloch (2010). Malloch briefly built up the idea of spiritual capital as the capital of belief understood through a religious tradition that attaches people to a transcendent resource. This study suggests that faith in God, i.e. religious capital, should be highlighted in conjunction with the social influences in Malaysia that reinforce faith in God for this study sample with BD. This is captured from the habitus which highlights the supportive role played by religious members in reinforcing their religious faith in God through a sharing of their ideas of God. Furthermore, the social influence of faith in God in this study sample aligns with the BT view on social power relations in society. Hence, BT offers structural insight that the expression of religious faith stems from the participants' religious habitus they have in common with the religious members, even their families.

In this regard, Radford (2012) strongly suggested that scholars need to look at the system (religious, secular or both) in which people's world views are influenced in order to construct meaning and value. Within the BT perspective, the current study emphasises that the concept of religious faith should always be viewed as the social element of reinforcement through interactions. This is because religious capital prescribes faith-based engagements involving cooperation and communication (Baker & Skinner, 2006; Baker & Smith, 2010). In the same vein, much of the literature highlights faith in the context of a relationship with God and families, as well as interactions with the wider society and cultural context (Belzen, 2009; Dyess, 2011; Heywood, 2008; Malloch, 2010; Vaillant, 2013). While the literature acknowledges the form of socio-cultural enforcement on the conception of religious faith, the current study, with its application of BT,

enables the enrichment of this concept of spiritual capital with the form of social enforcement.

This study also acknowledges the contradictory view of scholars on religious capital as an element of faith viewed under social reinforcement. For instance, Iannaccone and Klick (2003), drawing their observations from U.S. society, posited that religion is an individual choice. Aligned with this, Pesut (2009) also observed that many modern societies have experienced a decline in their levels of institutional religious participation and influence. This contradicts the earlier assertion in Western literature that social capital is one of the resources for faith in God (Belzen, 2009; Malloch, 2010).

Following on from this, Montemaggi (2010) critiqued the interpretation by Iannaccone and Klick (2003) based on the observation that it does not offer a theory of spiritual capital with value due to the authors' failure to acknowledge the influence of religious membership and culture (Montemaggi, 2010). Thus, the current study favours the view that spiritual capital nevertheless comprises underlying social aspects that should be considered along with religious empowerment in a religious study sample. The finding on religious capital is thus limited only to a population which follows religion as this theme carries only the aspect of keeping faith in this study sample with BD in Malaysia.

Overall, religious capital as per this theme enforces the theory of spiritual capital as being contextually bound to religious study among participants in Malaysia. Nonetheless, the current study continues to highlight the role of the psychological dimension (of spiritual capital) in the expression of faith, by linking it to the concepts of self-transcendence and SQ. Despite the dominance of religious capital for this theme, the next section of the study

will highlight the role of medicinal capital in advancing the well-being of the study sample for their religious practice.

8.6 Devoting oneself to God

The discussion of this theme raises the religiously interpreted commitment to faith in God as expressed by a large majority of the participants in this study (23 out of 25), thus depicting the BT element of practice in religious capital. The argument brought to the discussion of this aspect of religious practice focuses on the social interactions that reinforce religious practices in Malaysia and which thus limit the interpretation among the non-religious population. This theme, however, involves the participants' responses to appreciating the benefits of medicine that enable their religious practice. As such, the current study will highlight the medicinal capital integral to the spiritual capital of being religious for the aspect of enabling religious practices in this study sample with BD.

For the purpose of discussing the finding in this theme, religious practices among the study participants in Malaysia can be viewed together with the previous theme of 'keeping faith in God'. This reflects Radford's (2012) explanation that the context of faith helps to expound the dialectic relationship between one's faith in God and an individual's religious practices. In general, Jenkins (1992) mentioned that practices, as per BT, are the product of the habitus, as well as serving to reproduce it (the habitus) to confirm its symbolic efficacy. In other words, BT's practice can lead to a continuous acknowledgement of the capital to amass spiritual capital. Hence, the concept of religious habitus helps this study to understand the participants' accounts of religious practices that build spiritual capital.

The current study brings forward the spiritual capital from the religious habitus and the position of being religious (in this study sample with BD) in order to have contact with the religious capital. In line with this thought, scholars such as Ahmad and Khan (2015), Belzen (2009), Krause (2011) and Reed (2014) affirmed that one's engagement with religion implies the attribute of self-transcendence. This may clarify why certain spiritual scholars, e.g. Swinton (2010), have strongly suggested that rituals, prayers and worship in religion are forms of spirituality. Nevertheless, the current study claims the importance of the role of religious habitus as per BT that motivates individuals for religious practices within the Malaysian social framework of the study sample.

In addition to the above, the current study identifies the habitus of the relational form of religiosity in assisting or encouraging religious practice, as understood within the participants' accounts of interacting with others (i.e. religious members). Furthermore, this finding seems to support the study by Skousgaard (2007) that explored how participants select their investment strategies for the accumulation of spiritual capital. As such, the current study maintains the idea of social influences on religious practices. Hence, the current study contradicts the notion of individualistic spirituality as derived from Western social perspectives as per Paley (2009) and Pesut et al. (2008). In this sense, spiritual capital as theorised with the BT element of habitus and practices recognises the social influence within religious practices while also acknowledging the individual religious practices for spiritual capital.

Nevertheless, the current study moderates the claim on the social influences since, according to the participants' accounts of their relational religiousness in this theme, only a small number of the participants (6 out of 25) suggested that their interactions with fellow believers were

conducted for the purpose of religious information and participation. This low level of positive response could serve to identify those who are willing to socialise in spite of how it may open them up to the possibility of being discriminated against by the religious community. In this regard, Pesut et al. (2008) pointed out that scholars tend to overlook the role of the community in supporting the spiritual needs of service users. Nonetheless, in the context of BD (based on the relatively small number among the study participants), it is conceivable that the participants could have faced discrimination or been disregarded by other religious members, thus limiting their access to the religious community.

Another argument highlighted by the current study concerns the integration of medicinal capital as an intriguing resource for spiritual capital that can capture the interest of psychiatrists for promoting their spiritual care plan. This is aligned with the BT perspective, whereby the habitus of medicine responds to the benefits derived from the medicinal aspect for managing symptoms and enabling religious-related practice. Hence, the current study slightly contradicts the findings from Cruz et al. (2010) and Mitchell and Romans (2003), wherein a study sample with BD used religion only for the management of their BD symptoms and this became the indicator for mental health outcomes.

A further perspective requiring consideration is that adherence to medication is potentially a process of learning based on the users' own experiences (Rottman et al., 2016). Moreover, to date, little direct research has been conducted looking at the perceived impact of psychiatric medication on spirituality (Vanderpot et al., 2017). This is why Vanderpot et al. (2017), in their phenomenological study, introduced the concept of spiritual side effects and took the view of psychiatric medication as being spiritually helpful and enhancing, as well as hindering and harmful.

However, the current study has shed light on the habitus as per BT in a way that acknowledges the experience of those study participants with BD in perceiving the efficacy of medication. Hence, it is time to alter the mentality that religious belief encourages people to discontinue medical care, as was put forward by Mueller, Plevak and Rummans (2001). Instead, the current study argues that it is time for scholars to be open-minded about medicinal aspects as one of the spiritual resources with the ability to enable religious practices, especially in the case of those living with BD.

Hence, it can be assumed that there are two practices involved in this theme; one involves a combination of religious practices, with the other practice related to the taking of medication. Despite this, the current study has limited findings as it reflects only the power and position of the participants in the study sample as they are bound by the authority of the psychiatrists in Malaysian MHS. Moreover, Pesut et al. (2011), while highlighting an over-reliance on the biomedical model in the study of BD, also failed to account for the role of the medicinal aspect with regard to how the participants in their study sample maintained their spiritual aspects. Therefore, the notion of a capital cluster that includes medicinal capital, as proposed by the current study, is effective in illustrating the conflict of interest among the psychiatrists who treated them.

Overall, this study recognises the inter-relation between the capitals in this finding, i.e. religious and medicinal capitals, as used by the study participants with BD through BT's element of habitus and practice. Nonetheless, the finding is limited to the context of this study sample in Malaysia, where there may be obligations towards the psychiatrist, and which may differ from that found in other MHS settings elsewhere. Hence, the finding might be different once the context of the psychiatrists'

involvement is removed from the understanding of spiritual capital. In the next theme of 'having a sense of spiritual harmony', religion is the dominant resource for discovering the meaning of spiritual acts.

8.7 Having a sense of spiritual harmony

The discussion of this theme concerns the monopoly of religious capital among the subjective feelings associated with religious practice. This is the case due to the sense of connectedness and peacefulness that was expressed by a majority of the participants (19 out of 25); as such, the subjective nature of these narrative accounts is commonly associated with devoutness in performing religious practices that removes the logic of medicinal efficacy. This applies to BT's symbolic exchange of religious capital that builds on spiritual capital attributed by the religious habitus and practices of this study sample. Despite this, the current study will assert the reflection of religious habitus whereby the study sample with BD acknowledged the symbolic meaning of religious practices within the religious-social framework in Malaysia.

In the literature on spirituality, many scholars include notions of 'connectedness' and 'inner peace' as the common constructs of spirituality (D'Souza, 2007; Puchalski et al., 2014; Swinton, 2010; Weathers et al., 2015). Accordingly, Braam (2009) asserted that many spiritual activities facilitate a fundamental sense of connectedness to oneself, God and others. Moreover, scholars such as Carson and Stoll (2008) and Culliford (2007) have suggested that spirituality derives from its connection to religious activities such as prayer, meditation or contemplation. However, BT provides a slightly different view in that people view the logic of practice (of religion) as being in accordance with their goals or interests, termed symbolic goods in BT (Jenkins, 1992). Despite the symbolic meanings of

religious practice, which forms part of spiritual capital, it comes with the assistance of the medicinal aspect, as in the case of living with BD in this study sample.

With particular reference to validating the symbolic meaning or subjective feelings of religiousness, the current study refers to the context of being religious as conveyed by the Malaysian study sample within the expression of spirituality. Zohar (2010) explained that religious devotion, in terms of its symbolic meaning to devotees, builds spiritual capital. In addition to this, Sheer (2012) highlighted the importance of the potential of habituation and social context for enriching the cognition of meanings and emotions.

Nevertheless, the current study relates to Zembylas (2007), who asserted that positive emotions are generated by the habitus. From a psychological perspective, people learn to anticipate emotional outcomes and behave so as to pursue the emotions they prefer (Baumeister et al., 2007; Fredrickson, 2001). Up to this point, the current study has offered a further understanding of the potency of spiritual capital to this study sample with BD as perceived through their habitus within the Malaysian context. The current study thus identifies subjectivity (as viewed through the habitus lens) accompanying religious devoutness, expressed by the study participants as derived from the context of being religious. In taking this view, the current study emphasises the construction of meanings that situates the religio-social world view of the study sample in Malaysia.

The claim in the above returns to the notion of self-transcendence whereby it refers to the innate subjective experience of having an interaction with transcendent resources (i.e. God) (D'Souza, 2007; Fallot, 2007; Pesut, 2008). From a psychological perspective, Baumeister et al. (2007) pointed

out that emotion exists in part to influence behaviour. Similarly, Heywood (2008) specifically posited that positive emotions are often derived within and from religious devotion. The current study thus argues for the fundamental role of religious habitus to express a sense of connectedness (with God) in this study sample.

Another way of understanding spiritual capital refers to the capacity of SQ to look for connections (i.e. transcendence) that link the individual with God or to others and reveal the meaning behind this connection (Collins, 2010; Hanefar et al., 2016; Zohar & Marshall, 2000). Lending support to this view, Hanefar, Sa'ari and Siraj (2016) asserted that only a person with a high SQ (i.e. purification of mind) would be able to achieve a feeling of closeness to God through solemn prayer. In this regard, working with BT's element of habitus provides a structural perspective wherein the psychological dimension comes into play in recognising and hence expressing the value of religious practices in this study sample with BD in the context of religiosity.

While the psychological element, i.e. SQ, is recognised by the current study in terms of its attribution to the religious habitus of the study sample with BD, it is also acknowledged that SQ was subject to a measure of criticism in its initial development owing to a lack of scientific explanation; hence, it was considered to be mysterious (Kwilecki, 2000; Mayer, 2000). In this respect, Emmons (2000) countered the critics by asserting that SQ brings psychological benefits (salutary effects) both to and from religion.

Despite the criticism, scholars began to acknowledge SQ as one of the study variables for predicting psychological benefits. In this regard, Karimipour et al. (2015), in their review of the existing literature, concluded that religious practices produce SQ with emotional recognition,

where the feeling of peacefulness is a form of emotional quotient (EQ). Further supporting this, Levin (2010; 2009) recognised positive emotions resulting from the psychodynamic play of religion. As such, SQ was fundamental in recognising the symbolic meaning behind religious practices that also removed the logic of medicinal efficacy as differentiated by the study sample.

Nonetheless, within the frame of being religious, as in the sample with religion, the current study limits the claim that the above SQ empowers the habitus that is not suited to the secularist and atheist population elsewhere. This can be contradicted in terms of the mainstream secular world view whereby the population may often refer to themselves as being spiritual but not religious (Reimer-Kirkham et al., 2012). This is due to the fact that spirituality in a modern view is about being connected to the physical, material and secular aspects of life at the same time as being disconnected from those perceived as being religious (Huss, 2014).

Additionally, Ammerman (2013), in his study of the American non-religious population, found that the participants' broad descriptions of spirituality included an all-encompassing life orientation. Moreover, spirituality is commonly described as a positive emotional response to lived experiences, which is very general (Best, Aldridge, Butow et al., 2015; Greenway et al., 2007; Van Cappellen et al., 2014). As such, the current study acknowledges the need to consider the different spiritual resources at the same time as highlighting the context of religiosity in this study sample with BD with regard to the expression of positive emotions such as a sense of connectedness and peacefulness. This refers back to the BT element of habitus in understanding the context of religiosity in this study sample of people who are religious within the Malaysian religio-social framework.

Continuing from the above, the current study agrees with Van Cappellen et al. (2014) that positive emotions are not only linked within religion or spirituality but are also more common in religious contexts. The current study also challenges Paley's (2008) dismissal of the notion of spirituality applied to human beings. He argued that a perceived relationship with God serves merely as a cognitive strategy for coping with and reducing emotional distress. Consequently, the current study invites others to adopt the concept of spiritual capital as one that is not attached solely to religion but as one that also focuses on the dynamic role played by religion for psychological benefits, especially in the case of the world view of religious people. Thus, scholars can still confidently use the term spirituality, or spiritual capital, as presented in this study if they focus on the interpretation of the habitus according to the social construct of the population of interest.

In summary, the current study reiterates the important aspect of medicine, in particular its function of enabling religious practice among the study sample with BD. Despite this, the subjective feeling of religious devotion reintroduces the monopoly of religious capital, which could be dominant for spiritual capital in this study sample in Malaysia. This reinstates the element of the social construct in perceiving the symbolic meanings of religious practice in this study sample with BD, thus pushing medicinal capital into a position below religious capital in this theme. The next theme, however, focuses on the aspect of the complementary interplay among the capitals in terms of emotional stability in the context of BD.

8.8 Improving a sense of self-control

For the discussion of capital cluster A (i.e. religious, relational and medicinal) in this theme, the current study will highlight the habitus(es) in associating the different capitals in the subjective expression of improving the sense of control. The current study perceives the symbolic gains of the salient capitals for the well-being of this study sample with BD as the participants showed their expression of an improving sense of self-control. As such, the current study continues to assert the strengths of using the habitus as per BT for an understanding of the symbolic gains of the salient capital for this study sample with BD.

The current study refers back to SQ, which empowers the habitus in capital cluster A in acknowledging the symbolic gain offered by these capitals – improving a sense of self-control. This is aligned with the concept of spirituality in the literature which has been described using psychological connotations. In this regard, spirituality can foster self-control and self-worth (Ahmad & Khan, 2015; Kavar, 2015; McCullough & Willoughby, 2009) and trigger better self-management in overcoming challenges (Reed, 2014).

Continuing from the above, the theorisation of spiritual capital with the salient capitals is due to its symbolic gains in this study sample with BD. This is because the sense of control relates well to the literature in the field of psychology, which is pertinent to emotional or self-regulation. The theory of self-regulation is defined as follows:

> … *Any process that operates without the need for conscious supervision or explicit intentions, and which is aimed at modifying the quality, intensity, or duration of an emotional response. Implicit self-regulation can thus be investigated even when people do not realise that they are engaging in any form of emotion regulation and when people have no conscious intention of regulating their emotions.* (Koole & Rothermund, 2011, p. 390)

In this regard, Bandura (2003) acknowledges the process of self-regulation that has the capacity for symbolisation, such as a recognition of the value of religious activities. In addition to this, some scholars have mentioned that self-regulation requires resources in a broad sense that are not limited only to religion (Baumeister & Vohs, 2007; Koole et al., 2010; 2011; Tice et al., 2007). Providing further support, Acevedo, Ellison and Xu (2014), in their study of adults in Texas, suggested that secular engagements such as social activities, education and humanistic services can act as a buffer against psychological distress. While the presence of broad spiritual resources may indeed be the case in a Western social context, the current study has at least brought the salient capitals as spiritual resources for this study sample with BD derived from within their social framework.

In this theme, the current study suggests that the religious capital must secure symbolic power in order to be continuously utilised (by being religious) and perceived its symbolic gains in this study sample with BD. As the context of the current study specifically includes people with religion, this automatically favours the literature asserting that religion promotes emotional or self-regulation (Koole et al., 2010; Laurin & Kay, 2016; McCollough & Willoughby, 2009). In accordance with this, religion could be seen as a psychological resource (Van Cappellen et al., 2014), with the act of being religious perceived as a psychological act that is free of

apprehension (Andreescu, 2011). Furthermore, there is limited evidence to provide a contrasting perspective that religion contributes to poor self-control (Laurin & Kay, 2016). In this respect, religious capital is exceptionally salient for a sense of control in the case of living with BD for this study sample.

Even if religious capital is perceived to be advantageous to this study sample with BD, the current study refers to Laurin and Kay (2016) in their assertion that attention should be given to the intrinsic and extrinsic forms of religiosity. Intrinsic religiosity is more closely associated with self-regulation than extrinsic religiosity (Koole et al., 2010; Laurin & Kay, 2016). Allport and Ross (1967) explained that intrinsic religiosity refers to people internalising their religious values and then using those values to guide their behaviour, while extrinsic religiosity refers to people valuing religion for benefits other than solely a personal religious aim; for instance, for status, sociability or security. Nonetheless, the religious aspects attributed to a sense of control are limited only to this study sample and other populations with religion. Moreover, this depends on the social power of religious capital in a certain population that could influence the habitus to acknowledge the sense of control associated with religion.

Following on from the above, it is important for the current study to highlight the differing responses in terms of acknowledging the respective advantages offered by medicinal and religious capital over the sense of control. Baetz and Toews (2009) argued that medicine is not restricted purely to a materialistic perspective, but that it is part of the biopsychosocial-spiritual model approach to treatment. Darling et al. (2008) highlighted the importance of adhering to the medication prescribed for mood stabilisation related to BD; specifically, those who adhere are significantly more likely to report lower levels of health-related stress and

greater life contentment. Hence, the current study specifically highlights the mutual reliance on spirituo-religious practices and medical assistance in controlling mood, as suggested by the study sample with BD as the Malaysian service users.

Despite the above, relational capital is also associated with spiritual capital as the interviewees relied on others as a common source of emotional channelling. For Scheer (2012), the management of emotion requires the ongoing learning and maintenance of an emotional repertoire whereby it is carried out in conjunction with both other people and its resources. According to Tew et al. (2011), relationships are central to recovery and all relationships or forms of social inclusion are necessarily good for people. Hence, the finding for the habitus with respect to the relational aspect brings forward the idea that the participants with BD in this study are socially or relationally included as part of others, particularly their family members. Thus, the conception of spiritual capital in the context of participants' exclusion by family members could have been different to that found in this study.

Nevertheless, a minority of the males in the study sample expressed insecurity in their relational capital in terms of trust when seeking emotional support in the Malaysian context. Hence, as constructed by the men in the study sample with BD, the current study deems that relational capital for support among men is less significant where the person, referred to by BT as the social agent, experiences a lack of trust. As such, in the case of living with BD, the supportive role of others could serve to relieve the emotional burdens of the participants, with the consideration of them not being disregarded by others.

In addition to the above, the current study specifically focuses on the group with BD, whereby they expressed an improvement in their sense of control – as psychological gain along with the utilisation of spiritual resources. According to the literature, a strong sense of psychological well-being is one of the characteristics of psychological resilience (Cohn et al., 2009; Haddadi & Besharat, 2010; Ong et al., 2006). Resilience was presented by Reich, Zautra and Hall (2010) as implying a continuation of the recovery trajectory, which itself depends on strength, resources and capacities. In reference to this, an understanding of the characteristics of resilience is conveyed through the symbolic gains of the salient capitals as brought with the vision of BT.

Moving on from the above, the current study argues that scant attention has been paid to the forming of a line between spirituality and mental well-being. This is since these elements are routinely treated as overlapping constructs in most quantitative research, thus leading to a lack of precision in the conception of spirituality in the literature (Reinart & Koenig, 2013; Weber & Pargament, 2014). However, in theorising spiritual capital as per BT, the current study attempts to improve the precision of the conception of spirituality in the understanding of habitus as part of spirituality (in that it links to the participants' utilisation of spiritual resources) and its symbolic gain of mental well-being, as suggested in the study sample with BD.

To summarise, this theme has discussed an expansion of the salient capitals that are associated with spiritual and psychological gains in terms of improving a sense of self-control among this study sample with BD. Despite this, the current study highlights the limited application of the conception of spiritual capital with religious capital to only the religious members of the study sample, while medicinal capital is limited to those living with BD who are obliged to resort to medical assistance for help with

their BD symptoms. Meanwhile, relational capital was particularly salient in terms of supporting the emotional aspects of this study sample with BD as they are not disregarded by their families. The next theme also sheds light on the symbolic gains of capital cluster A for envisaging spiritual recovery in the sample with BD in terms of establishing a positive life adaptation.

8.9 Establishing a positive life adaptation

Similar to the previous theme, the discussion of this theme focuses on capital cluster A for spiritual capital, in particular for portraying the positive adaptation to living with BD found among a majority of the study sample (19 out of 25). The form of positive adaptation as seen in this study sample is referred to in the literature as one of the characteristics of resilience. Hence, the discussion of this theme continues to argue that the understanding of capital cluster A sees it as spiritual capital attributed to resilience.

In claiming that capital cluster A comprises resources attributable to the benefits of resilience, the current study sought an explanation of resilience from the literature. The term adaptation is notably included as one of its characteristics (Folke et al., 2010; Wong, 2011). Essentially, according to Richardson's (2002) resilience model, resilience depends on the individual and his or her external resources, which can begin at any point in time. In a similar vein, several scholars believe that resilience requires multidimensional resources as these can increase the flexibility and efficiency of human adaptation (Baumeister & Vohs, 2007; Fletcher & Sarkar, 2013; Folke et al., 2010; Koole et al. 2010). This includes multi-level attachments involving families, schools and communities (Greene, Galambos and Lee, 2004). Behind the literature's initial focus on resilience,

however, Greene et al. (2004) argued that the resources for resilience are linked to spirituality.

Referring to the above, the common characteristic of the positive adaptations captured in the findings for this theme relates to the positive thoughts and emotions of the majority of the sample with BD in the current study. Hence, for the population of BD with religion, the current study would emphasise the benefit of religion in the long run for both spiritual capital and resilience. The current study refers to the view of psychological resilience taken by Sanderson (2008) as being a by-product of religion. Nevertheless, through the BT lens, the current study relates back to the aspect of the social empowerment of religion by religious institutions and agencies in Malaysia in terms of its empowerment towards the habitus and practice of the study sample. Hence, merit is accorded to the interpretation of religious habitus in this study sample with religion and in the participants with BD in terms of their resiliencies.

Other than religious habitus, the current study also considers the construction of narratives on medicinal efficacy which make way for medicinal capital to account for resilience. This is supported by Richardson (2002), who suggested that resilience requires an interdependent homeostatic balance of bio-psycho-spiritual elements; as such, it is less likely to be disruptive when the practical application of resources becomes routine as part of everyday living. Richardson (2002) assumed that a disruption of the bio-psycho-spiritual elements can occur if an individual has insufficient resources to create protective resilience factors. In this respect, Richardson (2002) assumed that people who have greater self-control over their illness management will rely less on medical support. However, this is not the case for this study sample with BD as they expressed the medicinal aspect in terms of perceiving its benefits for them.

While religious and medicinal capital were perceived in terms of their clear contribution to resilience, relational capital was barely mentioned by this study sample with BD. This is because only a minority among the study sample referred to having a positive attitude towards socialisation as opposed to expressing the quality of relationships for their contribution to resilience. Nonetheless, the limits to the understanding of resilience claimed by the current study in the above correspond to a review of the literature by Fletcher and Sarker (2013), wherein the understanding of it varies contextually. Lending support to this, Clauss-Ehlers (2008) asserted that an understanding of the resilience process requires a critical examination of the contextual perspective. In this regard, the current study provides an example of the understanding of resilience with the capital cluster as its resources that are contextual to the Malaysian study sample living with BD and which could prompt the interest of other scholars to further examine the protective resources of resilience in their context of interest.

However, the current study further invites scholars to critically view the spiritual resources attribute as extending beyond merely psychological resilience as spiritual capital provides access to a broader social system and increases participants' social capital. This is accompanied by the argument that the habitus and its motivation for practice as per BT's spiritual capital offers the potential for trading, perhaps by improving a participant's social status as a recovered individual and thus providing chances for them to improve their social capital, e.g. opportunities for employment, education, social or club memberships. Lending support to the above, individuals with good psychological well-being are able to interact with resources for resilience which, in turn, can be attributed to

positive attitudes to a good life and mental health (Emmons, 2000; Fletcher & Sarkar, 2013; Slade, 2010; Wong, 2011).

Further, social inclusion functions in the context of mental health and promoting recovery for people with mental health problems. Tew et al. (2011) placed specific emphasis on social inclusion and its ability to build positive identities, reduce stigma and increase the self-confidence of those with mental health problems. In addition, Leamy et al. (2011) suggested that resilience comes under empowerment, whereby individuals exercise personal agency in self-management. Nevertheless, in the context of BD in Malaysia, the social support network was not always relevant for all those in the study sample. Yet, the current study offers perspective on the integration of salient capitals that could be viewed as the spiritual resources needed for resilience and possibly for improving the quality of social life in this study sample with BD. Moreover, the insight on spiritual capital can promote mental health recovery and social adaptation, as suggested in this study.

Despite this, the current study limits the understanding of spiritual capital to potentially extend beyond psychological resilience, owing to the fact that the subjective data focus only on spiritual aspects (in response to the research aim – to provide a conceptual understanding of spirituality). Moreover, the study data were derived solely from qualitative analysis comprising only 25 study participants with BD, thus limiting its generalisability to the whole population with BD in both Malaysia and elsewhere.

To summarise, the idea of this theme of psychological resilience captured from the interpretation of habitus perceives the symbolic gains in the expansions of salient religious capital for psychological well-being. The

spiritual capital in this context of BD may also potentially extend beyond only psychological resilience in that the participants may have increased opportunities to lead a good life and enter recovery by way of expanding their social capital. Regardless, this study maintains the argument that the vision of spiritual capital comes with a specific contextual lens for examining Malaysian participants living with BD. This raises a suggestion for future work that scholars in the field of mental health should be open to identifying all possible resources for spiritual capital and its potential strength for their population of interest. The current study's contribution to the field of knowledge is highlighted in the next section.

8.10 Chapter summary

In summary, this study has discussed the findings on different salient capitals for spiritual capital from the study sample with BD in Malaysia; these comprise religious, relational and medicinal capitals. This points to the key understanding of spiritual capital as it is linked to the Malaysian social context with reference to habitus according to BT, which situates these particular salient capitals in relation to social structure. Hence, its particularity is asserted in the context of individuals who are religious, receive support and who are service users diagnosed with BD and who are bound to the authority of their psychiatrist.

In addition, the current study provides a vision of spiritual recovery in this Malaysian sample with BD as involving the interest of MHS in determining a model of spiritual care that includes promotive agents and the agency of relational and religious capital. Despite this, the evidence given in the current study on spiritual recovery does not prove that service users have recovered or can recover from BD. The next chapter will highlight the implications of the current study for the body of knowledge, particularly in

relation to the view that spiritual resources can include many resources and thus are not limited only to religious spirituality.

Chapter 9: Conclusion

9.1 Introduction

The purpose of this chapter is to discuss the overall contributions of the present study and to acknowledge its limitations. The latter section presents the study's recommendations for future research and mental health service (MHS). Lastly, the researcher provides her reflective account regarding her influence on the data collection and analysis process.

9.2 Summarising the findings in response to the research aim

The present study aimed to understand the concept of spirituality from the subjective account of service users with BD affiliated with religion in Malaysia.

The research aim responds to the issues raised in Chapter 1, which highlighted the need to comprehend service users diagnosed with BD in terms of their spiritual lives, going beyond the concerns of medical tradition. The present study also responds to the Malaysian study sample with religious affiliation and provides a rich understanding of spirituality. Furthermore, the present study acknowledges the lack of spiritual care within the explanatory model from the service users in Malaysia.

In responding to the literature review (i.e. Chapter 2), the research aim was also raised by the ongoing debatable concept of spirituality which cannot be the standard guide for spiritual care in MHS. The findings of this study then built upon the literature review, in particular on the resolutions suggested by other scholars such as McSherry and Cash (2004) and Swinton and Pattison (2010). These scholars raised the need to particularise the concept of spirituality by examining the context of service

users. The present study thus focused on the Malaysian context to provide a contextual understanding of the concept of spirituality. In order to derive an understanding of this concept, and due to the problematic study measurements offered by the existing literature, the present study chose to employ a qualitative approach.

The findings were derived from a thematic analysis and were presented in the following eight themes: 'experiencing spiritual despair', 'engaging in spiritual meaning-making', 'orienting the spiritual life', 'keeping faith in God', 'devoting oneself to God', 'having a sense of spiritual harmony', 'improving a sense of self-control', and 'establishing a positive life adaptation'. This study found that the participants strongly identified with the different salient resources of spirituality, which are religion, interpersonal relationships and medicinal efficacy. As such, the current study points to the case that spiritual resources are not limited to one, i.e. religion, but in fact involve many resources, as seen in the sample of people living with BD.

In making sense of the findings, the present study applies the Bourdieusian Theory (BT) of symbolic capital in the context of his sociological approach to conceptualisation work for the particular context of living with BD in Malaysia. The conceptualisation work applied mobilises the salient resources (in their respective themes in the findings) into capitals that can be exchanged for spiritual capital in the form of symbolic value or gain to this study sample.

In this approach, the term symbolic value must be understood from the social perspective on power and social positioning of the individuals –in which social obligation and enforcement influence symbolic value from the habitus (i.e. subjectivity), which is congruent with the social practice of the

study sample in the expending of spiritual resources. While adopting a BT lens, a further review of the literature demonstrates that habitus falls within the psychological process of human beings, which can be bound with the relevant concepts; spiritual intelligence or quotient (SQ) and self-transcendence. The current study then links the understanding of SQ and transcendence in relation to empowerment of the habitus to mobilise the capital(s) within the social field.

In addition, the salient resources were aligned in groups, or, as termed by this study, capital clusters. The current study recognises the unequal number of capitals in the groups in accordance with the aspects and experiences of living with BD which can be linked to the eight themes. This led to the modelling of capital cluster A (comprising religious, relational and medicinal capital) and capital cluster B (religious and relational capital). In addition, this study highlights the complementarity between the different capitals in both a positive and negative way in line with BT's critical view of symbolic power and symbolic capital.

In a positive way, the complementary interplay between the different capitals in the context of BD and the presence of spiritual capital offers a support mechanism in terms of enabling recovery in the study sample with BD. This support mechanism is enacted via religious and social agency, through relational connections, religious guidance and professional expertise, i.e. via the psychiatrist who authorises a medicinal regimen. The integrated spiritual resources also encourage certain behavioural repertoires that are conducive to the participants' well-being, via the seeking of emotional support and taking of medication that can enable religious practices. In the event of a crisis, where an individual can lose the spiritual capital in their life as a result of religious doubt and frustration, the relational agency, i.e. the family, comes to play a central role in taking

the individual to meet their psychiatrist to resolve the symptoms exacerbated by the event.

The current study then exposes that beneath spiritual capital lies a power issue, which functions in a negative way. Spiritual capital, with its resources, consists of power that urges individuals to comply with the social enforcement (of those spiritual resources) in line with their social needs. Hence, knowing about having BD, this, combined with the taking of another social position, could be one attempt to improve one's status within the Malaysian society. Examples may cover inclusion as a member of their family, being religious in order to gain memebership of a religious group, and being compliant with a medicinal regime – all are necessarily attributed to empowering the participants' attempt to amass spiritual capital, regardless of their choices.

Moving on, with regard to BT's symbolic capital, spiritual capital may also become a subject of manipulation and exploitation by the individuals with BD; as such, they may trade spiritual capital for an improvement in their social status as a good and obedient person, possibly in the eyes of their psychiatrist and family members. The potential win for the individuals with BD could be that they trade their medicinal capital by demonstrating their compliance, or even spiritual capital, in order to gain other capitals such as social or economic, although these may go against the spiritual values. In doing so, the individuals may perceive the chance to resume a good life outside of hospital, together with social and economic wealth.

Having said this, the assessment of habitus, capitals and the power issues in Malaysian society illustrate the dynamic form of spiritual capital as individuals become socially positioned to access and utilise the resources. The current study concludes that the conception of spirituality with the

application of BT ultimately removes the ambiguity of this concept; its applicability can thus be matched to mental health care with the vision of enabling recovery in society. Moreover, the vision of spiritual capital with BD brings a combination of medical (i.e. medicine) and non-medical approaches (i.e. religious, interpersonal relationships) capable of complementing the MHS agenda in supporting a spiritual care approach. The next section discusses the contribution of this study in relation to the previous literature.

9.3 Relationship with previous literature

This section contains an overview of the findings of the study and their relationship to previous work in this area of spirituality.

First of all, the current study embraces the salient capitals for spiritual capital in the small population with BD in Malaysia. With the application of BT, the understanding of spiritual capital with its resources comes with empirical data and not a review of conceptual ideas as per the work of other scholars on religious or spiritual capital (e.g. Bosch et al., 2013; Finke, 2003; Palmer & Wong, 2013; Verter, 2003).

While the contemporary concept of spirituality attempts to detach religious understanding as one of the constructs, the study in Malaysia with a BT perspective takes into consideration religion, i.e. religious capital, as one of the resources for spiritual capital in alliance with other resources, i.e. relational and medicinal, in this context of people with BD. The current study, in using the term spiritual capital, removes the ambiguity of the concept of spirituality, thus confirming that it is not synonymous with religiousness.

Instead, being religious is a form of BT practice that reproduces spiritual meaning and the values associated with religious capital. In this way, religious practices are deemed to become spiritual along with those mentioned by Swinton (2010), Carson and Stoll (2008) and Culliford (2007). The current study thus affirms that religiousness is inseparable from spirituality in the religious sample, in line with scholars such as Ahmad and Khan (2015), McSherry and Cash (2004) and Reinert and Koenig (2013).

Despite the findings derived from the religious sample, spiritual capital that takes the form of interpersonal relationships and medicinal efficacy reflects how spirituality can be multifaceted and multidimensional, as highlighted by Cook et al. (2011) and McSherry (2007) and Swinton (2012). This means that spirituality can be diffused beyond only being religious as per Baetz et al. (2009), Koenig (2009) and Swinton and Pattison (2010). The concept of spiritual capital with the vision of a capital cluster in this study sample with BD complements the idea in Pesut et al. (2008) where it is contended that spirituality is built from individual and social elements.

Additionally, the theory of spiritual capital illustrates Swinton's (2001) idea on the intra- and interpersonal experience in the matter of spirituality that the individual has with the community. Added to this, the present study is similar to that of Vanderpot et al. (2017) in terms of presenting the biomedical element, i.e. medicine, as promoting spiritual activities and the participants' well-being.

Nonetheless, this study acknowledges that the spiritual capital in Verter's (2003) version, in the example given of symbolic-spiritual capital subsumed under cultural capital, is helpful in clarifying that a variety of resources could be traded for spiritual capital. However, the version of

spiritual capital here, in the context of mental health care for people with BD, especially with the inclusion of medicinal capital, should be distinguished from spiritual as a form of cultural capital as per Verter (2003) and Guest (2007).

The current study acknowledges that spiritual capital in this study runs parallel to Palmer and Wong's (2013) definition, in that meaning and value are generated from both the individual and any collective resources in a social setting. This study also acknowledges other scholars who specifically highlight the idea of the combination of resources/capitals in different areas, despite not applying BT directly. Holt et al. (2012), for instance, examined social, spiritual and religious capital as variables that were correlated with each other. Whereas Stoke, Baker and Lichy (2016), in their study, refined their conceptual framework of spiritual capital with the inclusion of a post-secular ideology. They did this by exploring the interrelationship between human, social and spiritual capital in the corporate sector (Stokes et al., 2016).

In addition to the above, Tew et al. (2011) introduced the idea of having a combination of capitals (i.e. economic, social and identity) in terms of them serving as recovery capital for mental health. This is because different forms of capital may have a profound difference in terms of how a person is able to achieve sustainable recovery (Tew et al., 2011). Nonetheless, the understanding of capital clusters as spiritual capital is set to offer insight into the complementary interplay between the different capitals, in either a positive or negative way, with the critical aspect of the power issue and social status of individuals. Hence, in contrast to other studies, the current study has applied BT's symbolic capital and power that links individuals with BD to the social context.

9.4 Contribution of the study

The central contribution of this thesis is the conceptualisation of spirituality as spiritual capital as a novel and distinct construct for patients with BD as per the BT theoretical vein. It involves how the conceptual understanding was claimed as being constructed with social elements that underlie the aspect of meaning-making, in particular from the subjective data of 25 interviewees with BD. Moreover, the empirical data came from Malaysia, a country in South East Asia in which religion, i.e. Islam, Hinduism, and Christianity, is presented as a way of life of the society.

Through BT, the current study offers an interpretation of the clustering of salient capitals (i.e. religious, relational and medicinal) in a dynamic alliance, focusing specifically on what the participants gain from these salient capitals for their recovery. Hence, the presence of spiritual capital in this study sample highlights its attribution to the participants' psychological well-being and resiliencies in the context of BD. Moreover, with its BT perspective, the current study brings a further view on the potential of spiritual capital to go beyond psychological resilience; that is, by considering the social or economic gains, trading with this spiritual capital may bring other benefits such as employment, social status and access to other capitals. Hence, spiritual capital could be the key that enables individuals with BD to live a good life within their broader social system.

Overall, spiritual capital (in this study) is linked with particular resources, i.e. religion, interpersonal relationships and medicine, as demonstrated in the particular context of a small sample of Malaysian participants living with BD, which can serve as an empirical guide for a model of spiritual care in MHS.

9.5 Implications of the study

This study contributes to the preliminary theory of spiritual capital with three salient capitals, i.e. religious, relational and medicinal, as per BT in its sophisticated theoretical vein, as derived from this small sample diagnosed with BD. In this present study, the spiritual resources are not limited to religion but they do, in fact, involve many resources or capitalsworking in dynamic alliance, as shaped by the participants' interest in their life journey. Moreover, the study participants were logically concerned with these capitals in terms of aiding their recovery.

Overall, in promoting the recovery of the study sample with BD, spiritual capital is linked to integrated spiritual resources within the social framework of Malaysia and the function of the Malaysian MHS. Further to this, the spiritual capital of the participants offers a support mechanism in terms of enabling recovery in the study sample with BD. This support mechanism is enacted via religious and social agency, through relational connections, religious guidance and professional expertise, i.e. via the psychiatrist who authorises a medicinal regimen.

Furthermore, BT is useful in bringing forward the provisional reality in considering that the alliance of many of the resources or capitals is dynamic in nature, as characterised by their positive complementary interplay – that is, one capital enables the other capitals through its own support mechanism. However, the important aspect is perhaps that this alliance of many resources can also work in a negative complementary way due to the issue of power. This has the effect of undermining access to resources, particularly for those at a disadvantage and especially for individuals with mental health problems, who may be disregarded by others, excluded or denied access to their spiritual resources.

As such, the current study raises a concern regarding spiritual capital, not as an individual agenda but rather for the whole society and MHS. Hence, MHS in Malaysia can integrate spiritual resources into more or less a formal, integrated form of spiritual care in clinical practice in Malaysia with an emphasis on the involvement of families and religious agency. In doing so, spiritual capital can be something that is promoted by MHS, together with the families. Following this implication, the next section presents the limitations of the study as acknowledged by the researcher.

9.6 Limitations of the study

It should be stressed that this study has been primarily concerned with an understanding of the concept of spirituality in the context of living with BD, and with religion. The findings of the current study do not claim to offer either a comparison of different religions in Malaysia or a distinction between religion in the East and West. Moreover, the vision of spiritual capital reflects only the contextual world view of the service users with BD in Malaysia with religion in general. In addition, this theory may not be directly transferable to the non-religious population.

Moreover, the integration of medicinal capital for spirituality as derived from the study of the sample with BD is also meant to be contextually bound; however, this depends on the social obligation of the study participants with regard to the power of their psychiatrist for biomedical treatment, which may not be the same elsewhere. Moreover, the social and relationship qualities brought by the study sample may also not apply to the healthy population or individual Western people.

Additionally, there are limitations to the making of claims related to the theory built from a qualitative study. This is because the nature of subjective data means that it provides a theoretical understanding of the

phenomenon (i.e. at the level of meaning) as opposed to an explanation of cause and effect as seen in a quantitative study (Ritchie et al., 2013). Unfortunately, the theory generated from this qualitative study using the present small study sample, i.e. 25 participants from Malaysia, is not generalisable to a wider population (Carson & Gilmore, 2006; Eisenhardt & Graebner, 2007).

Furthermore, the data obtained using the interview method capture only a part of the reality in the form of subjective expression (Sandelowski, 2010). For instance, this study takes forward only an understanding of the meanings, life goals and subjective improvement over the sense of control that is relevant only to a particular point in time. Hence, this finding reflects only a snapshot of the subjectivity of those individuals with BD that was taken during the interview session. What we do not know is whether their views have remained or will remain consistent over time.

In addition, in reference to the positive life adaptation (refer to p. 282), the current study knows little about the resilience brought with the understanding of spiritual capital. Thus, the understanding of resilience offers limited knowledge for predicting the adaptability of the sample living with BD over time. Moreover, the overall vision of spiritual recovery with the spiritual capital in this Malaysian sample with BD is not going to prove that the service users have recovered or indeed can recover from BD.

To sum up, there are some limitations to the use of a qualitative approach that need to be addressed in order to reflect the impact of this study within its scale. By addressing the constraints of this study, the next section contains recommendations for future research for a better understanding of spiritual capital in clusters.

9.7 Professional recommendations

This section contains professional recommendations for future research and actions to be considered by both MHS practitioners and policymakers.

9.7.1 For future research

With the vision of spiritual capital as per BT brought by this study, future research into spirituality in mental health problems should usefully focus on the various resources that can explain spiritual capital.

It is thus hoped that there will be different versions of spiritual capital, i.e. manifold and integrated spiritual resources, in other world paradigms, i.e. from both other religious and secular perspectives. This study thus suggests the need for a more theoretical understanding of the spiritual capital of secularist- or atheist-drawn perspectives in people with a mental health problem. This is because the vision of spiritual capital may also be plausible in non-faith populations. Therefore, this study invites future scholars to study the spiritual resources within their population of interest to develop more contextually bound theories of spiritual capital. Furthermore, other than focusing on BD, future work can also focus on providing robust empirical data to support the concept of spiritual capital for various types of mental disorders.

The findings on medicine as being integral to other spiritual resources are tempting for future studies. It implies that the recovery approach can include both medical and non-medical resources. It may be the case elsewhere that users rely on a coming together of medicine and the spiritual form of practices to control the symptoms, i.e. in any mental disorder. Future study may seek to use a longitudinal research approach, for example, to examine the role of medicinal capital along with other capitals in the capital cluster for their effects on psychological resilience or

spiritual recovery over time. Another way would be to view spiritual and psychological resilience as one. Therefore, future scholars can study spiritual capital together with the understanding of psychological resilience in their study sample.

Another avenue for further study would be to conduct research into the specific understanding of spiritual recovery from the spiritual capital in a negative state as this relates to the participants' response to adverse social events as seen through their religious lens. In this case, future studies may also wish to understand the spiritual capital or spiritual despair in adverse social events from the context of a non-religious perspective.

Moreover, by taking BT's symbolic capital and with the examination of symbolic power, future scholars may also bring more critical insight on the complementary interplay between many spiritual resources – potentially in both positive and negative ways. It would be interesting to explore how the issue of power contributes to the understanding of spiritual capital in other populations elsewhere in the world and the ways in which it further adds to the body of knowledge.

Despite this current study lacking any Hindu or Buddhist perspectives, it is recommended that future studies seek to include a large representation of Eastern religious world views. This is in light of the lack of literature on spirituality from Eastern world views such as Buddhism, Taoism and Sikhism.

9.7.2 For future action or policy of MHS

The current study specifically offers empirical data on spiritual capital to support the integration of spiritual resources, particularly with MHS in Malaysia. Based on the findings discussed, MHS should focus on various

spiritual resources such as interpersonal relationship quality and medicine, as opposed to presuming that only one acts as the dominant resource, such as religion. The theory of spiritual capital also reflects the spiritual model that requires MH practitioners to promote the active involvement of all members of society; most importantly, the families and other people who are involved in religious and emotional support. Along with this, MH practitioners can also suggest to service users with BD, or with other types of mental health problems, the benefits of medicine alongside their spiritual approaches.

However, the agenda of promoting spirituality for recovery with the evidence of spiritual capital should depend not only on the role of MHS, the users and the society. The spiritual capital of the service users with BD (in the current study) might also be used to encourage further dialogue between policymakers, MH practitioners and service users on the consideration of spirituality as one approach to MH recovery. Policymakers should thus begin acknowledging the role of spiritual resources other than medicine in promoting the recovery process, including religion and interpersonal relationship quality. Policymakers should therefore undertake continuous mental health promotion to educate people on the need to support the religious and psychological needs of users. In this sense, policy can empower service users to seek essential spiritual resources that can support their recovery.

The current study suggests that close and long-term relationships, such as those with family and close friends (relational capital), provide psychological support that can contribute to psychological resilience. Given this, the interrelationship between these capitals warrants support from mental health practitioners and policymakers to continuously promote a healthy and supportive relationship with users, their families and society.

At the same time, this will empower users with mental health problems to exercise their mechanisms of seeking support from others to promote their mental well-being.

Following the recommendations contained in this section, the researcher next provides her reflexive account to make readers aware of her values and roles within the data enquiries and the theoretical development of capital clusters.

9.8 Researcher's reflexive account

Firstly, the qualitative researcher is the primary instrument for data collection and data analysis (Watt, 2007). To reiterate, the researcher needs to expose her value and influence as part of the research inquiry (see Creswell & Miller, 2000; Ortlipp, 2008). This is particular to data analysis and is not a neutral approach, in that the researcher brings her assumptions to the shaping of the findings (Mauthner & Doucet, 2003).

Normally, the researcher's guided reflexivity practices are based on 1) the researcher's reflection on her social, cultural and religious background (Cresswell & Miller, 2000), and 2) the researcher's reflections on the data analysis, which are typically recorded in a research journal (Mauthner & Doucet, 2003). This section on reflexivity, however, provides a summary of the researcher's thoughts on her background in terms of the influence she brought to shaping the data. The researcher then outlines her thoughts and strategies in dealing with difficulties during the data collection and analysis.

To describe the researcher's reflection on herself throughout the research journey, the researcher will refer to herself in the first person, 'I', in this section.

Reflexive account on personal background

The essential element of reflexivity is to reflect on the interview where the information is bound by the social characteristics and emotions of the participants (Mauthner & Doucet, 2003). Therefore, this section provides a reflection on the researcher's thoughts on being the interviewer in collecting the subjective data from the study participants. It begins with the researcher's thoughts on being a female interviewer.

<u>Being a female interviewer:</u>

I acknowledge that my identity as a female researcher influenced the way the male participants shared their thoughts and emotions in dealing with stressful occasions. On one occasion with a male participant, I was aware that he was guarding his emotional expressions or had not revealed his emotional burden while discussing adverse events. Despite being a female interviewer, however, I was comfortable talking with the male participants, and the conversations went well.

<u>Being a Muslim interviewer:</u>

The preconceptions that I brought as a researcher in the interviewing process revolved around my identity of being born a Malay Muslim. *Hence, I could understand and discuss well the Malay and Muslim cultural and religious connotations. When communicating with participants, I was able to comfortably and easily ask them about the meanings behind their religious accounts, and the participants were comfortable with sharing their thoughts in detail.*

Moreover, in this respect, I feel that religion is one of the protective resources for people with mental health problems, and therefore I was pleased to listen to the religious accounts of the study participants.

<u>Being a Malay interviewer:</u>

However, it may not always be convenient for me to converse in English, particularly with non-Muslim participants, as English is a second language in our country. As I do not have an extensive knowledge of non-Muslim religious practices (these varied from Muslim to Christian to Hindu in this study), I was curious to learn about the details of religious practices amongst the non-Muslims. I felt that using English as a spoken language among the non-Malays limited their thoughts and emotional expressions, which are not always expediently expressed compared to when using our mother tongue. I noticed this from the conversations in English, which tended to be around an hour in length, shorter than when using the Malay language.

<u>Being a mental health professional:</u>

Another preconception that I brought to shaping the data is that I am qualified as a mental health nurse, in addition to being a nurse lecturer in the subject of mental health. In this regard, I have a biomedical conception of the symptoms and treatment of BD. I realised that because of this, I tended to be interested in listening to the participants discussing the symptoms of BD and would tend to ask how they dealt with these. *I also noticed that my identity as a mental health nurse became an interference when the participants began sharing their thoughts on their prescribed medication. I began taking an interest in asking more about their thoughts about medication, as it was primarily mentioned by the participants. My*

identity may have been influenced by the nature of the study setting, which was within a hospital. Thus, the participants tended to see me as part of the healthcare personnel or as a trainee, rather than as a researcher first.

<u>Problems during data collection:</u>

During the early stages of data collection, I encountered difficulty in recruiting potential participants. This may have been because I was not familiar with the outpatient setting, and I took the time to build a rapport with all of the mental health practitioners there. The first two days of data collection ended with no service users wanting to participant in my study.

My strategies were revised, as advised by some of the psychiatrists in the outpatient setting. They suggested identifying the service users diagnosed with BD who would come for follow-ups by looking at medical records, then tracing them through the psychiatrist in charge of looking after each case. I found that service users with BD were easily identified and were not left out during their follow-up visit.

Another problem I faced was when Chinese service users rejected the invitation to participate in this study because they did not converse very well in either Malay or English. Sometimes, service users were fed up with waiting for extended periods before they could see a psychiatrist, so they would rush to get their medication and then go home. Furthermore, I felt that the setting was not conducive to approaching and briefing the service users to participate in my study as they were tired of being interviewed by medical students before or after meeting their psychiatrist.

Reflexive account on the analysis stage

Conducting preliminary data analysis:

The preliminary analysis stage is when I began to analyse the interview transcript soon after the first interview, before I searched for the next participant. I began keeping a research journal to record my thoughts.

In the beginning, I felt that the analysis process was overly technical as opposed to emphasising the subjective meanings of the data. This is because I began using NVivo prior to conducting my third interview. I feel that this software was very good in the beginning as it helped me become more organised, enabling me to develop categories from the codings I had in NVivo.

My categories kept changing as I began thinking back to the old versions and comparing them to the new codes. With the data obtained from just three interviews, I had almost 30 categories. I had to create an Excel file to display all of the categories and try to make sense of them. I discussed this process with my supervisors and shared my thought that it was rather too technical for analysing the data at the preliminary stage. Therefore, I convinced myself, with the agreement of my supervisor, to analyse without using NVivo for the preliminary analysis. The analysis approach was then conducted manually without the use of NVivo.

Categories and themes changing from time to time:

When reflecting on the data analysis in the earlier stages, I realised that the categories would remain subject to change until the completion of a data interview.

To be confident with the data that I had obtained up to that point, I needed to both understand and remain open to the data. In response to my concerns, I followed the advice of my supervisor: to read and re-read the interview transcripts two to three times before beginning the analysis.

Delaying the literature review while analysing the data:

Another concern raised by the supervisors focused on my lack of theoretical reading to aid in my understanding of the data while performing the analysis. My thoughts on this were that I may not be giving justice to the data with an early reading of the theory as I should be examining their subjectivity before allowing the existing theory to shape my understanding of the data. After discussing my concerns about the influence of existing theory in the data analysis with my supervisors, we came to a consensus to delay the literature review, as per Glaserian grounded theory.

Feeling detached from the data:

However, as I proceeded with the analysis and generation of themes, I tended to look back at the codes and categories. I found the process of analysis difficult at the outset. It was full of chaotic thoughts, meaning that the data from many interviews became highly disorganised.

My response to this was that I needed to thoroughly check the interview transcripts for each participant and thus decided to use different coloured pens to manually underline the codings falling under different categories in the interview transcript.

Reaching confidence in the data analysis:

The whole analysis of 25 interviews using the colour coding approach gave me some confidence in the direction of the outcome, which concerned the spiritual matters of the study participants.

During this period of analysis, the research journal entries most often consisted of idea maps and data displays, rather than thoughts in narrative writing.

While completing this step, I produced seven overarching themes and presented these to my supervisors. Their feedback left me with the impression that they were quite satisfied with the themes, with a condition to merge some into smaller themes.

Writing the findings report:

From March to June 2016, while writing the report, I found that I had to re-check and re-categorise or merge a few of the categories.

I found the writing-up process of the findings to be compelling. This is because I supported the themes with relevant excerpts and wrote the findings with a satisfying flow.

Re-checking the patterns in themes:

In June 2016, while finishing the writing up of the findings report, my supervisors suggested double-checking the patterns of coding and categories.

Therefore, I decided to import all of the interview transcripts into NVivo after completion of the analysis with 25 interviews. This required me to look at the data and codings all over again.

I became slightly frustrated with this step as I began to fear that the length of time taken to complete the analysis and produce the findings reports would increase. Nonetheless, it was quite a short process of coding and categorising the data in NVivo according to the eight themes that I had developed thus far.

I also needed to check which of the participants were excluded from any of the themes. Despite this hurdle, I came to realise and was certain that the eight themes were finalised. In the end, I came up with three overarching themes which grouped the eight themes together.

Theorising approach:

Following the completion of the data analysis, I was ready to move on to the theorising work. I started theorising in September; that is, after completing the writing up of the findings chapters. The initial approach was to follow the ConGT theorising approach with the eight themes.

I began to relate my findings which noted that religion, relationships and medicine in participants with BD could be understood as the spiritual resources when put together.

The initial reading on spiritual capital in the work of Zohar (2010) moved my interest more in the direction of this topic of inquiry as I had never previously heard of this theory on spiritual capital. Zohar, however, never mentioned any theory of capital. Nonetheless, encouraged by ConGT, I sought out the social theory on capital, at which point I found Bourdieu's theory to be compelling in terms of assisting me in theorising.

Early thoughts on applying Bourdieusian Theory:

I became lost with regard to comprehending the forms of capital from Bourdieu's writing as I was unable to locate any work by Bourdieu on spiritual capital. I then specifically searched for any of Bourdieu's work related to religious capital. To my disappointment, there was not much writing on religious capital by Bourdieu.

However, Verter's (2003) version of spiritual capital based on Bourdieu's perspective encouraged me to read further. With advice from my supervisor, I read further and then wrote a section about Bourdieu's theory of symbolic capital and how this could assist me to theorise on the spiritual capital drawn from my findings.

The hurdle in theorising with Bourdieusian Theory:

I never found it easy to understand how I could relate my findings to the resources contained within Bourdieu's work. This is because Bourdieu's terminology was originally written in French and has been translated by various English scholars for the purpose of academic reading.

When theorising using Bourdieu's theory, I was confused as to what habitus is and needed to understand this along with Bourdieu's work on symbolic capital and mode of domination.

The term "capital" is rather straightforward, as it refers to resources. This required me to read the work of other scholars on Bourdieu's theory. I then came up with my own terminology of the religious, relational and medicinal capitals as their own entities.

Added to this, I needed to examine the influence of society and the psychiatrist as the agents promoting these capitals. Bourdieu views that different capitals need to compete for their hierarchical position of value as promotion by agents and agencies in social capital. This aspect required me to return to the findings and I struggled with illustrating the interplay of these capitals found in the findings.

Writing the theory of spiritual capital:

The final challenge I faced was putting the theory into writing and discussing this in line with the existing literature. In the beginning, the theory was not all clear; for example, psychological capital was not used in relation to other capitals. Even the term "psychological capital" has replaced the early use of individual capital.

Moreover, playing with the term "capital" was never straightforward in the form of writing the discussion. It was not until I had re-read and revised the different capitals countless times that I was able to highlight the elements of aggregation and competition as per BT.

Further, in writing the theory on spiritual capital, I struggled to grasp that spirituality and psychology are the same. This is because I was advised to keep the term psychological capital aside and focus on the psychological dimension of spiritual capital, which focuses on meaning-making. Nevertheless, further thought and revision convinced me of the logic that spirituality in the form of meaning-making is a psychological thinking process.

I was too lost in the middle of theorising spiritual capital with BT to critically think about spiritual capital in terms of its broad social relation. I was struggling to figure out that spiritual capital could be traded based on

an individual's interest, which could go entirely against the spiritual values, such as people might trade their spiritual capital for social profits? Viewing it in this way went against my own value in judging what spirituality is and its purest and natural way based on my own religious insight. This is why I continued to struggle with conceptualising spiritual capital right up to the time of the thesis submission.

Overall, the research outcome as per the thesis and the actual research process have been reflected in this section.

9.9 Chapter summary

To summarise, this study makes a novel contribution by conceptualising the spiritual capital as per the BT theory and as first applied in this study with evidence from the sample of those with BD in Malaysia. The theory of spiritual capital, as derived from the empirical evidence in a Malaysian context in the study sample with BD, increases the confidence in the originality of this study.

The present study has made two major contributions:

> Firstly, it contributes to the debate on the need to consider the multidimensional resources for spirituality according to the context of living in the population of interest.
>
> Secondly, this study fills a gap in the knowledge whereby there remains a paucity of literature on spirituality with religions outside a Western world view.

Last but not least, it is hoped that the viewpoint of spiritual capital as per BT could attract other scholars to also fill in gaps in the understanding of

multiple resources for spiritual capital in the context of their own academic interests.

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Appendices

Appendix A: Study timeline

Main tasks	Month of study as per academic calendar											
Year 1/ 2013-2014	Oct	Nov	Dec	Jan	Feb	Mac	Apr	May	Jun	Jul	Aug	Sep
Literature review for PhD Topic	√	√	√									
Writing research proposal				√	√	√	√	√	√			
Reviewing methodology and methods					√	√	√	√				
Proposal defence (first attempt)										√		
Seeking ethical approval											√	√
PhD upgrade	√											
Year 2/ 2014-2015	Oct	Nov	Dec	Jan	Feb	Mac	Apr	May	Jun	Jul	Aug	Sep
Obtaining ethical approvals			√									
Data collection, transcribing and analysis			√	√	√	√						
Data analysis & adding 2 topics for subsequent interviews							√					
Continuing data collection, transcribing and analysis								√	√	√	√	
Sending transcripts for translation into English									√	√	√	√
Finishing all transcribing												√
Year 3/ 2015-2016	Oct	Nov	Dec	Jan	Feb	Mac	Apr	May	Jun	Jul	Aug	Sep
Data analysis: categorising codings for themes	√	√	√									
Managing translations of transcripts	√	√	√									
Validation of the translated transcripts				√	√							
Reviewing Chapter 1, 2 and 3						√						
Writing finding chapters: Chapter 4, 5, & 6						√	√	√	√	√		
Double-checking of patterns across themes with NVivo									√			
Literature review for discussion											√	√
Year 4/ 2016-2017	Oct	Nov	Dec	Jan	Feb	Mac	Apr	May	Jun	Jul	Aug	Sep
Writing Discussion chapter	√	√	√		√	√	√	√				
Extensive reading of Bourdieu's theory			√	√	√							
Writing Chapter 7: Theoretical foundation for discussion			√	√	√	√		√				
Revising Chapter 3					√	√		√	√			
Revising Chapter 1 & 2							√	√				
Revising Chapter 7 & 8									√			
Writing Chapter 9: Conclusion chapter									√			
Submission of first thesis draft to supervisor										√		
Receiving feedback on first draft										√		
Revising thesis draft											√	

Submission of thesis to School of Health Science												√

Appendix B: Ethical approvals

Ethic approval from Faculty of Medicine and Health Sciences Research Ethics Committee

Direct line/e-mail
+44 (0) 115 8232561
Louise.Sabir@nottingham.ac.uk

6th August 2014

Faculty of Medicine and Health Sciences

Research Ethics Committee
School of Medicine Education Centre
B Floor, Medical School
Queen's Medical Centre Campus
Nottingham University Hospitals
Nottingham
NG7 2UH

Nurasikin Mohamad Shariff
PhD Student – Nursing
B33, School of Health Sciences
QMC Campus
Nottingham University Hospitals
NG7 2UH

Dear Nurasikin

Ethics Reference No: OVSa10072014 SoHS
Study Title: Spiritual journey in recovery among patients living with bipolar disorder in Malaysia: a grounded theory study.
Chief Investigator/Supervisor: Dr Aru Narayanasamy, Associate Professor, Dr Nigel Plant, Associate Professor, Nursing, School of Health Sciences.
Lead Investigator/Student: Nuraikin Mohamad Shariff, PhD Student, Nursing, School of Health Sciences.
Duration of Study: 1/10/14-30/06/15 6-8mths **No of Subjects:** 30

Thank you for your letter dated 6th August 2014 responding to the issues raised by the Committee and the following revised documents were received:

- Patients Information Sheet V2.0: 06.08.2014
- Consent Form V2.0: 06.08.2014

Documents previously received and reviewed:

- FMHS Research Ethics Application form dated 6/25/2014
- Research Proposal dated 25/6/2014
- Patients Information Sheet V1.0: 10.06.2014
- Consent Form version 1.0: 10.06.2014
- Interview Guide version 1.0: 10.06.2014

These have been reviewed and are satisfactory and the study is approved.

Approval is given on the understanding that the Conditions of Approval set out below are followed

1. Please can you submit copies of approval/agreement letters when these have been obtained from:
    a. Ethical Committee of University Malaya Medical Centre (UMMC).
    b. Hospital Kuala Lumpur (HKL).
    c. National Medical Research Research Register.
    d. Ministry of Health Malaysia
    e. Clinician Leads in Psychiatry at HKL and UMMC

2. A Favourable opinion is given on the understanding that all appropriate ethical and regulatory permissions are respected and followed in accordance with all local laws of the country in which the study is being conducted and those required by the host organisation/s involved.

3. You must follow the protocol agreed and inform the Committee of any changes using a notification of amendment form (please request a form).

4. You must notify the Chair of any serious or unexpected event.

5. This study is approved for the period of active recruitment requested. The Committee also provides a further 5 year approval for any necessary work to be performed on the study which may arise in the process of publication and peer review.

6. An End of Project Progress Report is completed and returned when the study has finished (Please request a form).

Yours sincerely

Dr Clodagh Dugdale
Chair, Faculty of Medicine & Health Sciences Research Ethics Committee

Approval from Economic Planning Unit

NURASIKIN MOHAMAD SHARIFF
Kulliyah Of Nursing, IIUM, Jalan Hospital Campus
25150, Kuantan
Pahang
Email: nurasikin@iium.edu.my

UPE: 40/200/19/3147

23 September 2014

APPLICATION TO CONDUCT RESEARCH IN MALAYSIA

With reference to your application, I am pleased to inform you that your application to conduct research in Malaysia has been *approved* by the **Research Promotion and Co-Ordination Committee, Economic Planning Unit, Prime Minister's Department.** The details of the approval are as follows:

Researcher's name	:	**NURASIKIN MOHAMAD SHARIFF**
Passport No./ I.C No	:	**830714-06-5184**
Nationality	:	**MALAYSIA**
Title of Research	:	**"SPIRITUAL EXPERIENCE IN RECOVER : A GROUNDED THEORY STUDY OF PEOPLE WITH BIPOLAR DISORDER"**
Period of Research Approved	:	**3 YEARS**

2. Please collect your Research Pass in person from the Economic Planning Unit, Prime Minister's Department, Parcel B, Level 4 Block B5, Federal Government Administrative Centre, 62502 Putrajaya, Malaysia and bring along two (2) colour passport size photographs.

Ethic approval from University Malaya Medical Centre

UNIVERSITI MALAYA
PUSAT PERUBATAN UM

MEDICAL ETHICS COMMITTEE
UNIVERSITY MALAYA MEDICAL CENTER
ADDRESS : LEMBAH PANTAI, 59100 KUALA LUMPUR, MALAYSIA
TELEPHONE : 03-79493209 FAXIMILE : 03-79492030

NAME OF ETHICS COMMITTEE/IRB Medical Ethics Committee, University Malaya Medical Center	**MECID.NO**: 20148-517
ADDRESS : LEMBAH PANTAI, 59100 KUALA LUMPUR	
PROTOCOL.NO(if applicable) :	
TITLE: Spiritual journey in recovery among patients living with bipolar disorder in Malaysia: A grounded theory study	
PRINCIPAL INVESTIGATOR : Assoc Prof Ng Chong Guan	**SPONSOR** -

The following item [✓] have been received and reviewed in connection with the above study to conducted by the above investigator.

[✓] Application to Conduct Research Project(form)	Ver.No :	Ver.Date : 30-08-2014
[✓] Study Protocol	Ver.No :	Ver.Date :
[✓] Patient Information Sheet	Ver.No :	Ver.Date :
[✓] Consent Form	Ver.No :	Ver.Date :
[ ] Questionnaire	Ver.No :	Ver.Date :
[✓] Investigator's CV / GCP (Assoc Prof Ng Chong Guan,NURASIKIN BINTI MOHAMAD SHARIFF , Nigel Plant,)	Ver.No :	Ver.Date :
[ ] Insurance certificate	Ver.No :	Ver.Date :
[✓] Other Attachments		
1) Patient Information Sheet and Consent_Malay	Ver.No : -	Ver.Date :
2) Patient Information Sheet and Consent_English	Ver.No : -	Ver.Date :
3) Interview guide	Ver.No : -	Ver.Date :

and the decision is [✓]

[✓] Approval

[ ] Rejected(reasons specified below or in accompanying letter)

Comments:

The researcher has addressed the issues raised.

Investigator are required to:

1) *follow instructions, guidelines and requirements of the Medical Ethics Committee.*
2) *report any protocol deviations/violations to Medical Ethics Committee.*
3) *provide annual and closure report to the Medical Ethics Committee.*
4) *comply with International Conference on Harmonization – Guidelines for Good Clinical Practice (ICH-GCP) and Declaration of Helsinki.*
5) *obtain a permission from the Director of UMMC to start research that involves recruitment of UMMC patient.*
6) *ensure that if the research is sponsored, the usage of consumable items and laboratory tests from UMMC services are not charged to the patient's hospital bills but are borne by research grant.*
7) *note that he/she can appeal to the Chairman of MEC for studies that are rejected.*
8) *note that Medical Ethics Committee may audit the approved study.*
9) *ensure that the study does not take precedence over the safety of subjects.*

Date of approval : 23-11-2014

This is a computer generated letter. No signature required.

Gatekeeper at University Malaya Medical Centre

Assoc. Prof. Dr. Ng Chong Guan
Email: chong_guan@um.edu.my
Phone: +60124318913

2 December 2014

Jalan Universiti, 50603 Kuala Lumpur, Wilayah Persekutuan Kuala Lumpur

To whom it may concern,

Name: Nurasikin Mohamad Shariff
Student ID: 4204382
Study title: Spirituality in recovery: a grounded theory study among people with bipolar disorder in Malaysia.
Study setting: psychiatric clinic, department of psychological medicine, University Malaya Medical Centre (UMMC).

With regard to the above matter,

1. I, Assoc. Prof. Dr. Ng Chong Guan hereby confirm that I accept this student to be under my clinical supervision throughout her recruitment period in the study setting.

2. The active recruitment period commenced on 1st December 2014 until the approved study period.

3. The student has attained an ethical approval from the ethic committee before she commences her data collection in UMMC.

Yours truthfully,

Profesor Madya Dr Ng Chong Guan

Assoc. Prof. Dr. Ng Chong Guan,
Consultant Psychiatrist,
Department of Psychological Medicine,
University Malaya Medical Centre,
Kuala Lumpur.

Ethic approval from Medical Research and Ethics Committee, Ministry of Health Malaysia

JAWATANKUASA ETIKA & PENYELIDIKAN PERUBATAN
(Medical Research & Ethics Committee)
KEMENTERIAN KESIHATAN MALAYSIA
d/a Institut Pengurusan Kesihatan
Jalan Rumah Sakit, Bangsar
59000 Kuala Lumpur

Tel : 03 2282 0491
Faks : 03 2282 8072 / 03 2282 0015

Ref : (8) dlm.KKM/NIHSEC/ P14-1140
Date : 30th Disember 2014

NMRR- 14-1091-21353 (IIR)
Spirituality In Recovery Among Patients Living With Bipolar Disorder In Malaysia: A Grounded Theory Study.

Principal Investigator: Nurasikin Binti Mohamad Shariff, University of Nottingham.

Documents received and reviewed with reference to the above study:

1. Study Protocol Version No 5 Version Date 21-12-2014
2. Patient information sheet (English) & Informed Consent Form (English) Version No 3, Version Date 21-12-2014.
3. Patient information sheet (BM) & Informed Consent Form (BM) Version No 4, Version Date 21-12-2014.
4. Questionnaire version 2 date 25-06-2014.
5. CV and IA-HOD-IA form of
   I. Nurasikin Binti Mohamad Shariff

The Medical Research & Ethics Committee, Ministry of Health Malaysia operates in accordance to the International Conference of Harmonization Good Clinical Practice Guidelines.

Project Sites: **Hospital Kuala Lumpur**

Comment:

Please note that the approval is valid until **30th Disember 2015**. To renew the approval, a completed 'Continuing Review Form' has to be submitted to MREC at least 2 months before the expiry of the approval. You are required to report occurrence of all serious and unexpected adverse events and a Study Final Report upon study completion to the MREC. The required forms can be obtained from the MREC website (http://www.nih.gov.my/mrec

Gatekeeper at Hospital Kuala Lumpur

Versi 2.0 Tarikh: 15 Feb

INVESTIGATOR'S AGREEMENT, HEAD OF DEPARTMENT'S AND INSTITUTIONAL APPROVAL

PERSETUJUAN PENYELIDIK, PENGESAHAN KETUA JABATAN DAN INSTITUSI

This document is intended for online submission for purpose of formal research review and approval. It is to be used in lieu of other equivalent manually printed document such as Borang JTP/KKM 1-2 and Borang JTP/KKM 3. After completing the form below and obtaining the required signatures, please scan this document and submit online.

Dokumen ini adalah untuk penghantaraan atas talian (online) mengikut prosedur rasmi semakan dan persetujuan penyelidikkan. Borang ini dikeluarkan sebagai gantian dokumen kebenaran manual yang serupa seperti Borang JTP/KKM 1-2 dan Borang JTP/KKM 3. Selepas melengkapkan borang di bawah dan mendapatkan tanda tangan yang diperlukan, sila imbaskan dokumen ini dan hantar atas talian.

Unique Research ID : *[Nombor Pendaftaran]*	21353
Research Title : *[Tajuk]*	Spiritual journey in recovery among patients living with bipolar disorder in Malaysia: a grounded theory study
Protocol Number if available : *[Nombor Protokol jika ada]*	

Investigator agreement ***[Persetujuan penyelidik]***

I have understood the above titled proposed research and I agree to participate in the research as an investigator.

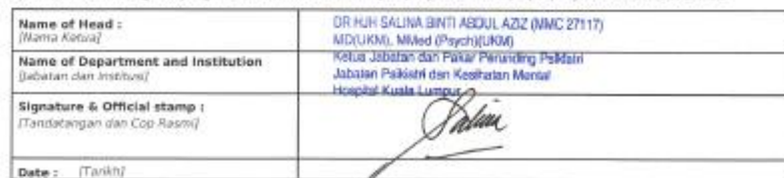
Saya faham cadangan penyelidikan yang bertajuk di atas dan saya bersetuju mengambil bahagian dalam projek tersebut sebagai penyelidik.

Name of Investigator : *[Nama Penyelidik]*	Nurasikin Binti Mohamad Shariff
IC number : *[Nombor KP]*	830714065184
Site Institution : *[Institusi]*	Kuala Lumpur Hospital
Signature & Official stamp : *[Tandatangan dan Cop Rasmi]*	
Date : *[Tarikh]*	7.8 - 2014

Head of Department Agreement ***[Persetujuan Ketua Jabatan]***

I agree to allow the above named investigator to conduct or to participate in the above titled research.

Saya membenarkan pegawai yang bernama di atas untuk menjadi penyelidik dalam projek penyelidikan tersebut di atas.



Name of Head : *[Nama Ketua]*	DR HJH SALINA BINTI ABDUL AZIZ (MMC 27117) MD(UKM), MMed (Psych)(UKM)
Name of Department and Institution *[Jabatan dan Institusi]*	Ketua Jabatan dan Pakar Perunding Psikiatri Jabatan Psikiatri dan Kesihatan Mental Hospital Kuala Lumpur
Signature & Official stamp : *[Tandatangan dan Cop Rasmi]*	
Date : *[Tarikh]*	

Institutional approval ***[Pengesahan Institusi]***

This section maybe omitted if one of the NIH institute is authorized to approve on behalf of institution. Refer NIH for details.

[Bahagian ini tidak perlu jika salah satu daripada institusi NIH diberi kuasa pengesahan bagi pihak institusi tersebut. Rujuk NIH untuk maklumat lanjut]

I agree to allow the investigator(s) named above to conduct or to participate in the above titled research. Where applicable, I further agree to allow my institution to be one of the sites participating in the research.

Saya membenarkan pegawai yang bernama di atas menjalankan penyelidikan selaku penyelidik dalam projek penyelidikan tersebut. Jika berkenaan, saya juga membenarkan institusi ini mengambil bahagian dalam projek tersebut.

Name of Director : *[Nama Pengarah]*	
Name of Institution *[Institusi]*	
Signature & Official stamp : *[Tandatangan dan Cop Rasmi]*	25/8/14 DR. DING LAY MING (MPM: 27280) Timbalan Pengarah (Perubatan) II b.p. Pengarah Hospital Kuala Lumpur
Date : *[Tarikh]*	

Appendix C: Participant information sheet

University of Nottingham, School of Health Sciences

B Floor, South Block Link

Queen's Medical Centre

Nottingham

NG7 2HA

Title of Project: Spirituality in recovery among patients living with bipolar disorder in Malaysia: A grounded theory study.

Name of Investigators: Nurasikin Mohamad Shariff

Patients Information Sheet

Dear participant:

You are invited to take part in a research study on spirituality in recovery among patients living with bipolar disorder in Malaysia.

Before you decide whether to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with friends and relatives if you wish to. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether

you wish to take part or not. If you decide to take part you may keep this leaflet. Thank you for reading this.

What is the purpose of the study?

This study is part of a PhD in Nursing Studies, at the Faculty of Health Sciences, University of Nottingham, England. The aim of this study is to provide a conceptual understanding of perspective and practices of how people with bipolar disorder account for their spirituality in recovery in Malaysia.

Why have you been chosen?

You have been selected to take part in this study because you are a patient diagnosed with bipolar disorder. I would like to collect information about your spiritual experience in your recovery period since you have been diagnosed. This information will be used to improve the way spiritual care is provided for all patients. Your views are very important to help nursing staff and other health professions and to help in understanding your own difficulties and challenges.

Do you have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. However any information collected about you up to the point of withdrawing cannot be erased. This is because the data that has been entered onto the University computer system has been made anonymous, and the data analyses will draw together the information provided by all participants. Thus, it becomes impractical to extract your individual data from the system without tampering the analyses that has been made.

What do I have to do?

With only one interview in our next meeting, I would like you to share your spiritual experience by asking some questions. The interview will take about 45 minutes to 1 and a half hour. There is no right and wrong answer. All answers are based from your own perspectives. With your permission, our conversation will be audio-taped by an audio-recorder.

What are the possible benefit of this participation?

Your views in spiritual experience in your recovery period will provide a useful and a deep understanding of how spiritual dimension is important in providing protective coping in spite of living with your illness. This understanding will inform mental health professionals to provide care sensible to your needs.

What are the possible disadvantages and risks of taking part?

Any disadvantages or risk related to taking part in this study is extremely unlikely.

Will your participation in this study be kept confidential?

Anything you say will be treated as confidential, no names will be mentioned in any reports of the study and care will be taken so that individuals cannot be identified from details in reports of the results of the study. However, exclusion from confidentiality and anonymity could ensue based upon legal or ethical code, that your words or actions involving potential harm to self or other, or any criminal activity would likely be reported to clinician or authority.

Who has reviewed the study?

This study has been reviewed and approved by the University of Nottingham Medical School Ethics Committee, and from the Medical Research and Ethics Committee, Ministry of Health.

For further enquiries regarding your rights as participants in this study, you can contact:

Medical Research and Ethics Committee,

Ministry of Health, Malaysia,

Jalan Rumah Sakit, Bangsar,

59000 Kuala Lumpur

Phone number: 03-2282 0491

Contact for Further Information

Miss Nurasikin Mohamad Shariff (researcher)
Mobile: 6019-6925160
Email: ntxnm4@nottingham.ac.uk

Dr Aru Narayanasamy (Main supervisor)
Tel: +44 0115 82 30808
Email: ntzan@exmail.nottingham.ac.uk

Dr Nigel Plant (co-supervisor)
Tel: +44 0115 74 84303
Email: ntznp@exmail.nottingham.ac.uk

Thank you for help and support in taking part in this study.

The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

Consent form

Title of project: Spirituality in recovery among patients living with bipolar disorder in Malaysia: A grounded theory study.

Study Number:____________
Participant ID no.: ____________

Name of Investigators: Nurasikin Mohamad Shariff

Please tick the box

1. I confirm that I have read and understand the information sheet dated ____________ (Version no:__) for the above study and have had the opportunity to ask questions.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis.	☐
3. I understand that I can be excluded from confidentiality and anonymity based upon legal or ethical code, that my words or actions involving potential harm to self or other, or any criminal activity would likely be reported to clinician or authority.	☐
4. I understand that the results of the study may be published in peer reviewed journals and presented at conferences, but the data will be anonymous and there will be no means of identifying participants.	☐
5. I understand that the interview will be recorded which will be kept for 7 years following completion of the research after which time it will be destroyed.	☐
6. I agree to take part in the above study.	☐

_________________________ _________________ _______________________

Name of Participant Date Signature
(I/C no:)

_________________________ _________________ _______________________

Name of Person taking consent Date Signature
(I/C no:)

Three copies: 1 for participant, 1 for project notes and 1 for the medical notes

Appendix D: Example of questions were asked in the interviews

- **View on Illness experiences.**
    - How long you have bipolar? Since when you seek psychiatric services?
    - How about your own experiences? (early diagnosis, now)
    - How do you come to know about BD?
    - Can you share your view about BD?
- **Views on well-being and healing.**
    - Tell me how would you describe your life now?
    - What is your view about life?
    - What does being well means to you.
    - How about healing? From where you can get sources of healing? What about traditional/ religious healing?
- **View on treatment and services from HCP.**
    - Tell me about what the services had offer to you?
    - Tell me more about medications that you take? How does that affect you?
    - Could you share your thought about changes in medication?
    - Tell me more about services you received from your doctor/ nurses?
    - What do you wish from the services?
- **Own coping/ source of strength.**
    - How do you draw your strength?
    - How do you cope? Hong long did you do that? Why you prefer to do that?
    - How does these affect your life?
    - Tell me about your religious view? Your view of God/ supernatural power?
    - Religious practices that you do? Why?
- **Hope, Purpose and direction of life.**
    - What do you wish for/ hope for in this life?
    - Can you describe your purpose or life direction?
    - What if people lose their life direction? How can we help them?
    - Do you have similar experiences? Tell me more about it?
    - Tell me about your view on spiritual matters?
- **Views on families, friends and significant others.**
    - Tell me about them? How is your relationship with them? To what extend? What do you do together? What do they mean to you?
    - Tell me about how does having them affect your life?
- **Views on community networking.**
    - Can you share your view about making connection/ contact with community? Who? Why? How?

- If you do not prefer doing it, why?

Appendix E: Report on double-checking for the inclusion of the participants in eight themes

Re-examining of the data was carried out using NVivo software version 10 after the preliminary analysis of eight themes, i.e. researcher coded manually and sorted the coding with colour coding approach. The objective of this report is to illustrate the inclusion of the participants in each theme in the findings following the re-examination of the data with NVivo. Table 1 in this report presents the total inclusions of participants in each of the themes. Each theme was supported with the typical or leading codes, derived from the analysis of the participants' narrative account. Table 2 gives the overall snapshot of the inclusion of each participant across eight themes.

This report also presents the negative cases analysis. As illustrated in Table 2: Three female participants: A Chinese and two Malays (P01, P05, P08) showed in their narrative expression of having a reduction of faith in God towards the issue of experiencing spiritual despair, then they were excluded substantially from the number of themes. This is because in the following of all the positive aspects in the latter sub-themes (as in Table 2), these participants expressed the least positive aspects in God, religiousness, human support and meaning in their lives. Though these narratives are less inclusive across all the themes, they highlighted issues on potential setbacks for spiritual recovery where positive aspects of life had been missing in the life of people with BD. The gap in these negative cases could be that these participants are young and in their early stages of living with BD (having been diagnosed not more than 4 years ago).

A summation of this report is that not all participants in this sample with BD are positively included across all sub-themes in this spiritual recovery. Nevertheless, the report shows the inclusion of a substantial presentation of participants in the study sample, and this has been reported in the finding chapters, i.e. Chapter 4, 5 and 6.

Table 1: Patterns of inclusion of participants with the typical or leading codes

Themes	**The inclusions of participants**	**Total**	**Typical or leading codes**
Experiencing spiritual despair	P01, P08, P09, P14, P15, P16, P19, P21, P22, P23, P24	11	*Do not accept the fate from God, express anger and frustration towards God, question God's unfairness, neglect prayers, do not perform solah regularly, have a weak faith in God.*
Engaging in spiritual meaning-making	P02, P05, P06, P09, P11, P15, P16, P19, P20, P21, P22, P23.	18	*BD as a test from God, acceptance of fate, reviving faith, perceive BD as a blessing from God, God's love.*
Shaping life direction	P02, P03, P04, P06, P09, P10, P11, P12, P15, P16, P17, P18, P19, P20, P21, P22, P23, P24, P25.	19	*Won't give up, have aim to survive, having a desire or need to stay normal or mentally healthy, having a determination or life goals, need to find ways, Assign meaning to own life, assign meanings for the family members, stay happy, seeking for happiness, love as a reason to live*
Keeping faith in God	P02, P03, P04, P05, P06, P07, P09, P11, P12, P13, P14, P15, P16, P17, P18, P19, P20, P21, P22, P23, P24.	21	*Have faith in God, believe or trust in God, believe in God's will, Feeling grateful to God, gain God's blessing in life, thank God, alhamdulillah (Praise God).*
Devoting oneself to God	P02, P03, P04, P06, P07, P09, P10, P11, P12, P13, P14, P15, P16, P17, P18, P19, P20, P22, P23, P24, P25.	21	*Pray and worship, meditate, reliance, selfless and charity, feeling of connectedness, closer to God, relationship with God, religiousness during episodes, religiousness increases with ageing, increasing religious understanding and practices.*

Themes	**The inclusions of participants**	**Total**	**Typical or leading codes**
Having a sense of spiritual harmony	P02, P06, P07, P10, P12, P13, P14, P15, P16, P19, P20, P21, P22, P23.	19	*"Peacefulness": Seeking peace from God, healing in the Church, gain peace and calmness in religious practices, a peace of mind in reciting the Koran, cleanse from negative thoughts, religion promotes peace.* *"Connectedness": feel connected with God, approaching or near to God, God is accompanying me, God is always with us, shows relationship with God, taking care of relationship with God.*
Improving a sense of self-control	P02, P03, P04, P06, P07, P09, P10, P22, P12, P13, P14, P15, P16, P17, P18, P19, P20, P21, P22, P23, P24, P25.	22	*Controlling BD and mood, control anger, self-control from negative behaviour, Be patient and calm, stabilise or manage mood, less suicide, mood is important.*
Establishing a positive life adaptation	P02, P03, P04, P06, P07, P09, P10, P11, P12, P14, P15, P17, P18, P19, P20, P22, P23, P24, P25.	19	*Positive mind, stay positive, have self-confidence, a strong mind, be brave to socialise, able to socialise, enjoy life, can handle the disorder, close-knit with neighbour, success, maximising resource (P14), maximising own potentials (p18), striving for success (P24)* *Brought up children properly despite of having BD (P02, 12: 6-11)*

Table 2: Patterns of data across the participants and index total

		Experiencing spiritual despair	Engaging in spiritual meaning-making	Shaping life direction	Keeping faith in God	Devoting oneself to God	Having a sense of spiritual harmony	Improving a sense of self-control	Establishing a positive life adaptation	(n=8)
P01	Cindy	√	0	0	0	0	0	0	0	1
P02	Kasthri	0	√	√	√	√	√	√	√	7
P03	Tan	0	√	√	√	√	√	√	√	7
P04	Ahmad	0	0	√	√	√	√	√	√	6
P05	Siti	0	√	0	√	0	0	0	0	2
P06	Asiah	0	√	√	√	√	√	√	√	7
P07	Zakaria	0	√	0	√	√	√	√	√	6
P08	Melati	√	0	0	0	0	0	0	0	1
P09	Suraya	√	√	√	√	√	0	√	√	7
P10	Kumar	0	0	√	0	√	√	√	√	5
P11	Normah	0	√	√	√	√	√	√	√	7
P12	Muthu	0	0	√	√	√	√	√	√	6
P13	Lucy	0	√	0	√	√	√	√	0	5
P14	Chong	√	0	0	√	√	√	√	√	6
P15	Umar	√	√	√	√	√	√	√	√	8
P16	Rohani	√	√	√	√	√	√	√	0	7
P17	Osman	0	√	√	√	√	0	√	√	6

P18	Shimala	0	√	√	√	√	0	√	√	6
P19	Dollah	√	√	√	√	√	√	√	√	8
P20	Aminah	0	√	√	√	√	√	√	√	7
P21	Mahmud	√	√	√	√	0	√	√	0	6
P22	Jamal	√	√	√	√	√	√	√	√	8
P23	Nora	√	√	√	√	√	√	√	√	8
P24	Robert	√	0	√	√	√	√	√	√	7
P25	Sofia	0	√	√	0	√	√	√	√	6

Appendix F: Reports on translation work

Report on Translation Work

Translation done by Nurasikin binti Mohamad Shariff

Translation review by:

Norzaiha Norhan

norzaiha@gmail.com

B.Ed TESL (Hons), Dip Translation (BM-English-BM) Persatuan Penterjemah Malaysia, Dewan Bahasa dan Pustaka

[Abstract]

This report is on the translation work done on an interview transcript that was done in Malay, then translated to English, and subsequently back-translated to Malay. This report will look at the overall meaning that was done from the original language to English and also from English back to the original language. This report also covers the use of language, particularly that which involves cultural and religious terms.

Documents:

- p9M Original Version
- p9E Translated Version
- p9M Back-translated Version

In general, between the two documents (original version in Malay and the translated version in English), meaning has been translated very well. The translation work has managed to capture the essence of the interview.

There are several grammatical discrepancies throughout the translated document. The grammatical discrepancies however do not affect the overall meaning.

Example:

Original version in Malay	Translated version in English	Suggested translation
Page 2 Kami jarang dijaga oleh mak.	Page 2 – line 5 Our mom rarely took after us.	Our mom rarely took care of us.

Page 4 Saya sendiri nak jadi strong.	Page 4 – line 14 I alone had be strong…	I myself want to be strong…

In terms of choice of words, the translated work sometimes reflects direct translation instead of more appropriate translation.

Example:

Original version in Malay	Translated version in English	Suggested translation
Page 2 Jadi berpindah-randah.	Page 2 – line 7 And so, we shifted places a lot.	So, we moved around a lot.
Page 2 Dari segi taraf hidup, macam mana?	Page 2 – line 8 So, how was it in terms of socio-economic status?	So how was your standard of living?
Page 3 …dirumah tu…	Page 3 – line 23 …at there.	…there.

There are instances where the translated sentence is given an added detail that was not present in the original transcript.

Example:

Original version in Malay	Translated version in English	Suggested translation
Page 2 …dan pernah datang rumah.	Page 2 …came over to the house **once**.	

As for the use of cultural or religious language, they have been translated appropriately and sufficiently. Instances where words were not translated into English were also appropriate so as to retain the original essence of the word that does not have an English equivalent.

Documents:

- p9M Original Version
- p9E Translated Version
- p9M Back-translated Version

In general, between the two documents (translated version in English and the back-translated version in Malay), meaning has been translated very well. The back-translated work has managed to capture the essence of the translated transcript.

Instances where discrepancies exist could be due to the translator using more formal phrasing of Malay sentences instead of the conversational tone present in the translated version.

Translation review by:

Norzaiha Norhan

norzaiha@gmail.com

Report on Translation Work

Translation done by Nurasikin binti Mohamad Shariff

Translation review by:

Norazmi bin Danuri

B.Ed TESL (Hons), M.Ed TESL (Hons) 12 years of teaching experience in University Tun Hussein Onn Malaysia.

[Abstract]

This report is on the translation work done on an interview transcript that was done in Malay, then translated to English, and subsequently back-translated to Malay. This report will look at the overall meaning that was done from the original language to English and also from English back to the original language. This report also covers the use of language, particularly that which involves cultural and religious terms.

Documents:

- P21M Original Version
- P21E Translated Version
- P21M Back-translated Version

In general, the translation process has been carried out very well. The writer managed to interpret words, sentences and linguistic and cultural contexts successfully. As a result, the translation has managed to deliver the essence of the interview.

There are several grammatical discrepancies throughout the translated document. The grammatical discrepancies however do not affect the overall meaning.

Example:

Original version in Malay	Translated version in English	Suggested translation
Page 12 Ada orang pula mungkin sebab terlampau stress ke.	Page 10 There are even those who do it because of having to face stressful situations in their lives.	Some people do it because they are stressed.

In terms of choice of words, the translated work sometimes reflects direct translation instead of more appropriate translation.

Example:

Original version in Malay	Translated version in English	Suggested translation
Page 2 Jadi berpindah-randah.	Page 2 And so, we shifted places a lot.	So, we moved around a lot.
Page 2 Dari segi taraf hidup, macam mana?	Page 2 So, how was it in terms of socio-economic status?	So how was your standard of living?

There is an instance where the translated and back-translated sentences have different meaning from the original text where 'stress' that was referred to as a state of being has been translated to describe 'situations' in the translated and back-translated to 'situasi hidup' (life situation).

Example:

Original version in Malay	Translated version in English	Back translation
Page 12 Ada orang pula mungkin sebab terlampau stress ke.	Page 10 There are even those who do it because of having to face stressful situations in their lives.	Page 10 Ada juga yang buat disebabkan situasi hidup yang menekan.

Words and expressions that have religious or cultural reference have been translated appropriately and effectively. Certain words were not translated as they might not have the translated

equivalents. Yet, overall understanding can still be achieved and the intended meaning has not been changed.

Documents:

- P21M Original Version
- P21E Translated Version
- P21M Back-translated Version

In general, between the two documents (translated version in English and the back-translated version in Malay), meaning has been translated very well. The intended meaning of the original text has been successfully retained throughout the process.