EXPLORING THE INTERACTION BETWEEN DEPRESSION AND LEARNING IN SHONA CULTURE: A STUDY OF STUDENTS AND LECTURERS IN A TERTIARY EDUCATION INSTITUTION IN ZIMBABWE

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DECLARATION

I, the undersigned, hereby declare that the work contained in this dissertation is my own original work and that I have not previously in its entirety or in part submitted it at any university for a degree.

Signature ....S.Mhlanga...

Date ....31/12/2020...

OPSOMMING

Depressie is een van die mees algemene sielkundige probleme wat deur studente in hoër onderwys ondervind word. Navorsing daaroor bly egter ontoereikend, veral onder inheemse kulture. Hierdie studie ondersoek hoe studente van die Shona-kultuur in Zimbabwe depressie verstaan en hoe dit met hul leer in wisselwerking tree. Die studie het 'n gemengde metodes benadering gebruik om die versameling van kwalitatiewe en kwantitatiewe data te vergemaklik, ten einde die navorsing meer omvattend te maak. Kwantitatiewe data is aanvanklik met gebruik van Beck se Depressie Inventaris II (BDI-II) ingesamel. Die vraelys het die studie ingelig oor die voorkoms en erns van depressie in 'n steekproef van 367 vrywillige eerstejaarstudente. Kwantitatiewe data is met behulp van 'n semi-gestruktureerde, diepgaande onderhoud met 11 erg depressiewe vrywilligersstudente ingesamel, soos deur BDI-II-graderings ingelig. Onderhoude is ook met 13 vrywillige dosente van hierdie studente gevoer. Dit het die triangulering van bronne en metodes vir data-insameling vergemaklik om sterker bewys vir gevolgtrekkings deur konvergensie en bevestiging van bevindings te lewer. Kwantitatiewe data is met behulp van die Statistiese Pakket vir die Sosiale Wetenskappe (SPSS) ontleed en kwalitatiewe data is tematies ontleed. Die studie het 'n hoë voorkomspersentasie van depressie van 36% getoon, sonder enige verskil in die voorkomssyfer vir mans en vrouens. Die Shona-studente en dosente verstaan depressie in 'n groter mate as stres, te veel dink, *"kufungisisa"*, teurigheid, *"kusuruvara"*, geestelike onstabiliteit en as geestelik georiënteerd. Die studente ervaar somatiese, emosionele en kognitiewe simptome van depressie soos uiteengesit in die DSM-5. Daarbenewens is daar gevoelens van eensaamheid, gebrek aan 'n sosiale lewe, gemiste menstruele siklus, en "pyn in die hart" is ook ervaar. Depressie het optimale akademiese prestasie by die studente belemmer vanweë 'n gebrek aan konsentrasie, 'n gebrek aan motivering, versuim om aan akademiese eise te voldoen, gebrek aan dissipline, en misbruik van alkohol, dwelms en dwelmmiddele. Die studie beveel die instelling van professionele adviesdienste op die kampus aan, en programme om bewustheid en voorkoming van depressie te verhoog.

ABSTRACT

Depression is one of the most common psychological problems encountered by students in higher and tertiary education yet remains under-researched particularly in indigenous cultures. This study explores how Shona students in a tertiary institution in the Midlands Province of Zimbabwe understand depression and how it interacts with their learning. Guided by the pragmatic paradigm, the study adopted a sequential mixed-methods approach to facilitate the collection of both qualitative and quantitative data in order to make the research comprehensive. Quantitative data were initially collected through the use of the Beck Depression Inventory II (BDI-II). The questionnaire informed the study of the prevalence and severity of depressive symptoms in a sample of 367 volunteer first-year students. Qualitative data were collected using a semi-structured interview guide from 11 volunteer students exhibiting severe symptoms of depression as informed by the BDI-II ratings. Thirteen volunteer lecturers who taught these students were also interviewed. This approach facilitated triangulation of data-collection sources and methods to provide stronger evidence for conclusions through convergence and corroboration of findings. Quantitative data were analysed using the Statistical Package for Social Sciences (SPSS) and qualitative data were thematically analysed. The study discovered a 36 per cent prevalence rate of depressive symptoms with no significant differences in prevalence rates for males and females. The findings indicate that the Shona students and lecturers understand depression largely as stress, thinking too much, "*kufungisisa*", sadness, "*kusuruvara*", mental instability, and as spiritually orientated. The students experience somatic, emotional and cognitive symptoms of depression stipulated in the DSM-5, as well as feelings of loneliness, anger, lack of a social life, missed menstrual cycle and "pain in the heart". Depression inhibits optimal academic performance in the students and leads to a lack of concentration and motivation, a failure to meet academic demands, indiscipline, and alcohol, drug and substance abuse. The study recommends on-campus professional counselling services and programmes to increase mental health literacy and aid the prevention of depression.

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CHAPTER ONE

RATIONALE OF THE STUDY

1.1 Introduction

Interest in the field of mental health and, in particular, on depression has grown exponentially in a global context (Eshun & Gurung, 2009; Alonso et al., 2018; Auerbach et al., 2018; Bruffaerts et al., 2018). Depression continues to disable critical populations such as young adults in institutions of higher and tertiary learning and leading consequently in some cases to suicide (World Health Organization, 2017; Oyekcin et al., 2017; Moledina et al., 2018). Several studies have indicated that depression is more prevalent in university and college students compared to other populations (Fushimi et al., 2013; Ibrahim et al., 2013; Al-Subaie & Al-Subaie, 2019). Though social structures and available resources may make it possible to detect depression more quickly at university or college than among the same age-group in the general population, the rate of detection is slow (Hardy et al., 2020).

This research explores the complex phenomenon of the interaction between depression and learning in tertiary education students from the Shona culture in Zimbabwe. I begin by establishing the prevalence of depressive symptoms at various levels among young Shona adult students. I also explore the students' perceptions of depression and how it interacts with learning. Ultimately, the research provides a contemporary understanding of the conceptualisation of depression and its symptoms, highlighting Shona culture-specific issues in this under-researched indigenous culture. The study hopes to inform policy and improve existing operational standards in order to address the plight of students in tertiary education institutions.

1.2 Problem Statement

Students in tertiary education are vulnerable to depression as they are challenged by multiple stressors that emanate from their learning environment and socio-economic and political conditions. These students are subject to life stressors such as the transition from a more supported social life to a more independent role that involves major decision-making (Lei et al, 2016). Stressors may include poverty, conflict, family dysfunction, drug and alcohol abuse, social exclusion and constant pressure to succeed (Deb et al., 2016; Hetolang & Amone-P'Olak, 2017; Alonso et al., 2018). These experiences have a direct impact on a student's ability to function effectively in the classroom, family settings and social activities (Harper & Peterson, 2005). The numerous stressors result in unprecedented forms of psychopathological

conditions especially among this population as compared to other populations, contributing to the development of mental health problems such as depression (Nsereko et al., 2014; January et al., 2018).

Depression is differently understood and interpreted in various cultures (Shafi & Shafi, 2014; Chang, 2017; Widiana et al., 2018). Shona culture plays an intricate role in determining how to interpret depressive symptoms, in idioms used to report depression, in decisions about treatment and in the practices of professionals (Patel, 2007; Gross, 2009). The conceptualisations of depression and other mental illnesses by Shona people result in various labels being attached to a mentally ill individual. This labelling may lead to stigmatisation and discrimination of the affected individual mainly due to cultural myths that suspect a link between evil spirits and the cause of depression. The myths and stigma that surround depression in Shona culture influence an affected individual's decision about seeking medical and psychological intervention, thereby creating a vicious cycle of unwarranted pain in students (Hendler et al., 2016). Coleman et al. (2007) emphasise that an individual's response to his/her illness is dependent on the conceptualisation and explanatory model unique to his/her culture. In this research, I sought, therefore, to reveal the conceptualisations and explanatory models of depression and its symptoms by Shona learners and lecturers in the context of Zimbabwean tertiary education.

To date, little research has been conducted on the relationship between depression and academic performance in tertiary-level students from an indigenous African culture. Svanum and Zody (2001) found academic performance to be strongly associated with symptoms of depression in American students. Various studies have also discovered a significant difference between academic performance of students having low, medium and high levels of depressive symptoms (Finger, 2006 in Salami, 2008; Vankar et al., 2014; Khurshid et al., 2015; Boulard, 2015). My research fills the knowledge gap by placing into perspective the relationships between depression, depressive symptoms at various levels (minimal, mild, moderate and severe) and learning among Shona students.

1.3 Motivation

More than three hundred million persons suffer from depression at any given time and about one million people commit suicide annually across the globe (World Health Organization, Mental Health Atlas 2017; World Health Organisation, 2018a; Alonso et al., 2018). Depression is also the most common psychiatric disorder in Zimbabwe (Patel et al., 2007; Chibanda et al.,

2010). The prevalence of depression is compounded by the high HIV prevalence rate, its related social impacts and neuropsychiatric complications (UNAIDS, 2015; Piette et al., 2015). Eshun and Gurung (2009) also suggest that prevalence of depression is likely to increase as a result of worsening socio-political conflicts and unrest.

Seventy per cent of low- and middle-income African countries spend less than one per cent of their public health budget on mental health and, as a result, mental health issues such as depression go untreated (Hendler et al., 2016). There are numerous reasons why mental health, especially in Africa, does not receive sufficient attention and care. These include scarce resources and limited visibility of the burden of mental disease, leading to prioritisation in the allocation of funds being given to other sectors (Hendler et al., 2016). Most developing and some developed countries do not prioritise mental health challenges because of prevailing public health agendas that focus on physical health and common diseases of lifestyle, such as diabetes and heart disease. Consequently, mental health perspectives worldwide and especially in developing countries such as Zimbabwe need to be understood and appraised against the backdrop of these harsh realities.

As elaborated in the Mental Health Atlas of the World Health Organization, (2005), depression is an illness that affects people of all age-groups globally and young adult Shona students in Zimbabwe are not immune to this illness. In higher and tertiary education, various studies have confirmed the adverse effects of depressive symptoms and depression in students (Hysenbegasi et al., 2005; Turner et al., 2012; Boulard, 2015; Beiter et al., 2015; January et al., 2018). However, Shona culture is unique and has its own perception and management of depression which directly impacts young adult learners and their academic performance in Zimbabwean tertiary education institutions. Depression can be better understood within the culture in which it occurs (Stewart et al., 2003; Kirmayer, 2015). Various research studies have been carried out on depression and learning (Haines et al., 1996; DeRoma, Leach, & Leverett, 2009), culture and depression (Marsella, 1978; Patel et al., 2001; Mogga et al., 2006; Hedaya, 2009) and culture and learning (Ramburuth & Tani, 2009; Mantiri, 2015; Pusey, 2018). This study brings together depression, Shona culture, and learning and it analyses their associations through students' experiences in a tertiary institution in Zimbabwe.

Across the globe mental health is understood according to a western, evidence-based approach to medicine and, at times, a traditional indigenous healing approach. Patel (2007) revealed that the majority of people with mental disorders do not receive evidence-based care

and that this contributes to chronicity, extensive human suffering and increased costs of care. Hendler et al. (2016) confirm that most indigenous Zimbabweans consult traditional or faith healers for mental illnesses. This practice is likely to perpetuate a culture of labelling, discrimination and stigma associated with traditional causes of depression. The stigma stems in part from the limited knowledge and awareness of depression as a curable disease (Naeem et al., 2012). Stigmatisation of and discrimination against learners may limit their access to and full utilisation of educational resources, thereby reducing their chances of attaining their goals (Chew-Graham et al., 2003). There is, therefore, a need to promote mental health literacy to increase awareness and reduce stigmas in school settings (Kutcher et al., 2015). Addressing mental health literacy and increasing awareness are, therefore, crucial in enlightening students in educational institutions on treatment options.

By contrast, Wessely (2005) and Arie (2017) asserts that stigma may not be a key obstacle in help-seeking behaviour for depressed individuals. Stigma as an obstacle may, however, be relative to culture and the available mental health care resources (Clement et al., 2015). Whilst depression as an illness that can be medically and psychologically diagnosed and treated may not be readily accepted in Shona culture as a result of traditional belief systems, understanding depression and pathways to care are central to educational success for university and college students. This is especially important in Zimbabwe as students' success in achieving their educational goals is of paramount importance because it is believed that education is a key to economic emancipation.

Although the majority of the world's population lives in non-western countries on continents such as Africa and Asia, most research on depression has been done in western societies such as North America, Europe and Australia (Haroz et al., 2017). This contributes to the homogenisation of cultures and reduces cultural pluralism which human survival depends on (Marsella, 2003). Notably, the international classification systems for mental illness such as depression have been criticised for assuming that the diagnostic categories have the same interpretation or meaning in different cultures (Haroz et al., 2017). The panels responsible for constructing the diagnostic categories (such as the WHO Diagnostic System) have also been unrepresentative of the global population. Of the 47 psychiatrists who contributed to the first draft of the WHO Diagnostic System, only two were from Africa, and none of the 14 field trial centres was located in Sub-Saharan Africa (White, 2013). This suggests that most treatment options are informed by western conceptualisations that may not holistically reflect depression in other, non-western cultures. This indicates how little research has been carried out in African

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indigenous cultures, particularly the Shona culture in Sub-Saharan Africa, to explicitly reveal the conceptualisations, expressions and experiences of students during the course of their studies.

In a study in Zimbabwe by Patel et al., (2001), it was discovered that there is no Shona term equivalent to "depression" and that Zimbabweans express the equivalent of depression in somatic forms that result in an underestimation of its prevalence. The study elaborated that Zimbabweans may use a cultural metaphor such as "*kufungisisa*", "thinking too much", to describe depression, although it is not equivalent to depression. The word "depression" may be used to represent an illness that rarely presents with cognitive and emotional symptoms (Patel et al., 2001), thereby creating incongruity between the term "depression" and the way in which it is understood by mental health workers.

Psychological conditions are not clearly represented in Shona vocabulary and are not grouped but rather placed in a single cluster from minor to severe psychological and psychiatric conditions. Various explanations of behaviour are used when describing depression because there is no specific term in the Shona language to describe depression. These cultural explanations and the grouping together of psychological conditions may have led to ignorance in the formulation of specific vocabulary in the Shona language to distinguish the various existing psychological conditions. The lack of specific Shona vocabulary to describe different mental illnesses may affect the conceptualisation of depression in students. This research therefore clarifies the Shona students' conceptualisation of depression.

1.4 Aims

The research aimed at establishing the prevalence of depression among Shona students, their perceptions of it, and its interaction with their learning in tertiary education.

1.5 Research Question

The research question that guided the study is:

How are depression and the interaction between depression and learning understood by young adult students in Shona culture?

1.5.1 Sub-research questions

The sub-research questions are a guide to answering the main research question.

a. What is the rate of prevalence of depressive symptoms among young adult Shona students in a tertiary education institution?

b. How are the symptoms of depression experienced by young adult Shona students in a tertiary education institution in Zimbabwe?

c. How do young adult Shona students in a tertiary education institution understand depression?

d. What are the relationships between learning and depression among Shona students in tertiary education?

1.6 Definition of key terms

- Learning – the process in which there is a permanent change in behaviour that results from an individual's interaction with the environment, (Hough, 2007). Learning can also be viewed as the process of seeking understanding and information from being educated.

- Acculturation – the "transition in which individuals gradually accommodate and eventually take on some of the values and beliefs of a new culture" (Eshun & Gurung 2009, p. 9). Acculturation may be intentional or unintentional.

- Indigenous – having originated in, living or occurring naturally in a particular region.

- Student – undergraduate, postgraduate person who is studying at a college, polytechnic or university or anyone who studies to acquire knowledge.

- Achievement – attainment or accomplishment of a goal after an effort.

- Culture – the integrated pattern of human knowledge, belief and behaviour that depends upon the capacity for learning and transmitting knowledge to successive generations.

- Indigenous – having originated in, living or occurring naturally in a particular region.

- Stigma – the devaluing, disgracing and unfavourable treatment by a community or general public of persons with mental illness (Abdullah & Brown, 2011). Stigma may also be referred to as a set of negative and often unfair beliefs that a society or group of people have about something.

- Academic performance – the extent to which a student has achieved his/her educational goals.

- Higher Education – education beyond the secondary level especially education provided by a college or university. Higher Education maybe used interchangeably with Tertiary Education in this research.

1.7 Methodology

1.7.1 Research Paradigm

My research was guided by the pragmatic paradigm. Pragmatism emphasizes the research problem and makes use of all approaches available to understand the problem. Pragmatism results in a problem-solving, action-orientated inquiry process based on a commitment to democratic values and progress (Biesta, 2010; Haight & Bidwell, 2016; Koenig et al., 2019). Creswell (2009) also asserts that pragmatism as a worldview arises out of actions, situations and consequences. As I focused on a particular culture, that of the Shona, Denzin and Lincoln (2011, p. 93) advise that "the open ended nature of cultural studies projects leads to a perpetual resistance against attempts to impose a single definition over the entire project". Pragmatism thus enabled me to select methods, techniques and procedures that best answer the research question and make the research more comprehensive (Glogowska, 2011; Molina-Azorin, 2016).

Denzin and Lincoln, (2011, p. 290) state that "there is an affinity for pragmatism as the paradigm of choice for many mixed methodologists". Since pragmatism does not prescribe any one philosophy and reality, researchers draw liberally from both qualitative and quantitative approaches (Creswell, 2009; Creswell, 2014). The use of different approaches generates different outcomes, reveals different connections in social patterns, between actions and consequences, so that our knowledge claims are pragmatic, that is in relation to the processes and procedures through which the knowledge has been generated (Biesta, 2010). Scholars are therefore drawn to historical realism and relativism as their ontology, to transactional epistemologies (Denzin and Lincoln, 2011).

I initially gathered quantitative data in order to establish the prevalence and severity of depressive symptoms among first-year students at a tertiary education institution in Zimbabwe. A closed-ended questionnaire, The Beck Depression Inventory (BDI-II) was employed to collect data, thereby developing numeric, primary data from the behaviour and experiences of the students. The responses to the questionnaire were scored and rated, and an overall score revealed the presence and severity of depressive symptoms in students. The BDI-II questionnaire responses revealed the prevalence of depression based on the participants'

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recollections of past experiences of depressive symptoms. I applied statistical procedures to compute the prevalence rate of depressive symptoms at various levels in the Shona students.

The questionnaire also revealed the type of symptoms experienced by the Shona students as the questions are based on the emotional, physical and psychological state of a depressed individual. The knowledge developed was based on careful observation and measurement of reality that exists in the participants' world. Information gathered may, however, be exaggerated, falsified or inaccurate, although I encouraged participants to be as honest and truthful as possible. In this scenario knowledge was, therefore, discovered. As part of the goal of seeking to affirm the presence of universal properties, quantitative data produced objective and generalizable knowledge about experiences and social patterns (Willis, 2007).

I then proceeded to establish the Shona learners' understanding of depression and its relationships with learning by means of more nuanced qualitative co-created data gathered during interviews with the Shona students who scored high in their responses on the BDI-II questionnaire. Lecturers of these students were also requested to participate and give their experiences with students who exhibited depressive symptoms. The inclusion of lecturers allowed for data triangulation and corroboration of findings as students self-reported on their experiences of depressive symptoms and learning in class and in the educational community. I, as the researcher, participated in the research process to ensure that knowledge produced is reflective of reality. With an understanding of the social context and culture in which the data were produced, I was able to accurately reflect on meanings from data gathered. Knowledge was, therefore, constructed as I sought understanding of the participants' experiences of depression and the world in which the students and lecturers live, work and learn. "Social reality is a construction based upon the actor's frame of reference with the setting'' (Guba & Lincoln, 1985, p. 80, as cited in Denzin and Lincoln, 2011).

Data produced from interviews were treated as knowledge that constitutes the social reality of the narrator. Complex patterns were revealed to expose descriptions of construction and reconstruction of identities and also to show the impact of a person's knowledge creation from specific cultural standpoints (Etherington, 2004). Qualitative data from interviews produced socially constructed, co-created subjective knowledge by the participant and me, while quantitative data enabled the discovery of objective knowledge. The gaps between theory and practice are filled because scientific generalisations may not solve all problems. Human

beings are multifaceted creatures – hence the need to understand and interpret the meaning of phenomena in order to improve practice.

Pragmatism thus opened doors to multiple methods, different world views and different assumptions, as well as different forms of data collection methods and analysis (Creswell, 2009; Molina-Azorin, 2016). I initially began with a broad survey that made use of questionnaires and produced results that can be generalized to a population; thereafter, I proceeded to collect detailed views from interviews that enabled the creation of qualitative data. I used the Statistical Package for Social Sciences (SPSS) to analyse quantitative data and a thematic analysis for qualitative data. I assumed that collecting diverse types of data is ideal for providing a better understanding for the research problem. Kalolo (2015) confirms that the idea of a one-dimensional construct in educational research may present a limited measure that may not do adequate justice to highly complex systems. In this study, re-linking paradigms and designs best met the needs and purposes of this research (Creswell, 2014; Biddle & Schaft, 2015).

1.8. Research Approach

This study was exploratory in nature, so a mixed methodologies approach allowed for the collection of both quantitative and qualitative data that led inevitably to a thorough analysis of the phenomenon under study. Creswell (2009) defines mixed methodologies as an approach to inquiry that combines or associates both qualitative and quantitative forms. The approach involves the use of both methods in tandem so that the overall strength of a study is greater than that of studies that use only qualitative or quantitative research (Creswell and Plano Clark, 2011; Creswell, 2014; Shannon-Baker, 2016). Recognising that all methods have limitations, biases inherent in a single method can be neutralized or cancelled by the other method. Denzin and Lincoln (2011) assert that the two methodological approaches are compatible and can be fruitfully used in conjunction with each other.

Denzin and Lincoln (2011, p. 285) define mixed methods research as a type of research in which a "researcher combines elements of qualitative and quantitative research approaches (e.g., use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the broad purpose of breadth and depth of understanding and corroboration". Denzin and Lincoln further elaborate that this definition includes an essential characteristic of methodological eclecticism that involves selecting and then synergistically integrating the most appropriate techniques from a myriad of qualitative, quantitative and mixed methods in order

to more thoroughly investigate a phenomenon of interest. Significantly, I emphasised methodological eclecticism to select the best techniques available to answer the research questions and consequently the main research question.

I adopted sequential mixed methods as I sought to elaborate on and expand on the findings of one method with another method. The breadth and depth of inquiry was expanded by making use of different methods for different inquiry components (Kivunja & Kuyini, 2017; Ghiara, 2020). A study may begin with a quantitative method in which a theory or concept is tested, followed by a qualitative method involving detailed exploration with a few cases or individuals (Creswell, 2009). In this study, I initially collected quantitative data to enable statistical analysis of results from the BDI-II questionnaire that provided information on the prevalence and severity of depressive symptoms amongst Shona learners. The questionnaire was rated on a scale in which the higher the score, the greater the severity of depressive symptoms. Lower scores indicated lower levels of depressive symptoms. Students who scored high were identified for further inquiry in the qualitative phase of the study.

Qualitative data were then gathered through interviews to enable a deeper understanding of the Shona learners' perceptions of depression and its interaction with learning. Responses from interviews added meaning to the statistical data. I used a semi-structured interview guide to gather data in the form of life stories on depression and learning. This facilitated the triangulation of methods and sources and provided stronger evidence for conclusions through convergence and corroboration of findings.

Riessman (2008) contends that combining methods forces the investigator to confront troublesome philosophical issues and educate readers about them. Diversity of methods is required in order to provide a more detailed picture and fully understand the active self-shaping quality of human thought (Shorten & Smith, 2017). Oliver (2002) is of the view that events in society can be understood in different ways by different people, thereby making human society very complex, and this should be taken into account when carrying out research in order to give a complete picture of complex issues. The fundamental principle is combining methods that have complementary strengths and non-overlapping weaknesses. Mixed methodology may also advance the timeline of a debate by offering more data for future discussions and research, thereby facilitating greater scholarly interaction (Shorten & Smith, 2017).

Mixed methodologies have, however, been criticized as they require the researcher to be familiar with both qualitative and quantitative forms of research in order to utilize their

strengths for the benefit of the study (Molina- Azorin, 2016; Fetters & Molin-Azorin, 2017). The research design also requires extensive data collection and analysis of both numerical and text data, which may be time consuming (Creswell, 2009). For the success of this study, I assumed the necessity of familiarizing myself with both qualitative and quantitative methods as a means of strengthening the research as a whole and enabling a deeper appreciation of the problem at hand. I selected a manageable and recommended sample size of 24 participants and interviewed them to ensure in-depth data were efficiently collected and effectively analysed within the recommended time frame. Hagaman & Wutich (2017) suggest that 20 to 40 participants are ideal for research interviews. Merriam (2009) is also of the view that one person's experience is not necessarily less reliable than the experiences of many.

1.9 Population

The study was carried out at a tertiary education institution in Zimbabwe operating under the Ministry of Higher and Tertiary Education, Science and Technology Development. The institution is located approximately 300km south of the capital city, Harare, in the Midlands Province. The country comprises 10 provinces. The Midlands province is centrally located in the country and is inhabited by people from different ethnic backgrounds overlapping from other provinces to form a diverse population.

The students at the institution in which the research was conducted come mainly from low to middle socio-economic status and from both rural and urban backgrounds. The students and lecturers originate mostly from Shona and Ndebele cultural backgrounds, with the majority being Shona. Their first language is Shona, although some students speak different Shona dialects. The majority of the population practise Christianity, though Shona traditional beliefs and practices are also common.

The institution had an entire student population of N=2,646 from first- to fourth-year students. This study targeted a population of N=513 first-year students to allow for continuous monitoring and provision of psychological support during their second, third and fourth years of study.

The institution also had a population of N=156 lecturers who taught all the students from first to fourth year. Lecturers were part of the study as they were believed to have vital information about students who exhibited depressive symptoms in their classes. This study targeted a population of N=23 lecturers who taught first-year students only.

1.9.1 Sample

For the purposes of the study, a smaller group of participants was selected from the students and lecturers as it was not possible to study the whole population. The smaller research group selected was considered typical of the target population. This study selected a sample of n=367 first-year students for the quantitative component of the study and established the prevalence of depressive symptoms amongst the n=367 volunteer first-year students.

A total of 438 students out of a population of 513 volunteered to take part in the study. However, n=367 met the inclusion criteria for the study. Therefore 72% of the targeted population of first-year students participated in the study.

The study then proceeded to the qualitative component, which included n=11 volunteer students, 73% of the targeted 15 students who had exhibited severe levels of depressive symptoms. Qualitative data were also gathered from 13 volunteer lecturers, 57% of the targeted n=23 lecturers who taught the students.

A total of n=24 volunteer participants, 63% out of a targeted 38 participants, constituted the sample for the qualitative data component.

1.9.2 Sampling procedures

1.9.2.1 Purposive Sampling

The study employed a non-probability sampling technique, namely, the purposive sampling technique, to select a sample of students and lecturers. I purposefully selected participants because they contributed significantly to the topic under study (Lyons & Coyle, 2007; Sharma, 2017). Merriam (2009) says purposive sampling is based on the assumption that the researcher wants to understand and gain as much relevant information as possible; therefore, a sample must be selected from which the most can be learned. Patton (2002, p. 230) argues that "the logic and power of purposive sampling lies in selecting information – rich cases for study in depth". This sampling technique enabled me to purposefully select volunteer Shona students and lecturers who are known to have information relevant to the study. I selected first-year students to allow for continuous monitoring of participants during their second, third and fourth years of study.

I sought assistance from lecturers who taught Health and Life Skills to recruit volunteer students from a population of 513 first-year students to take part in the study. Permission was sought from the Health and Life Skills lecturers to access students and introduce the research

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during their lecture time. I provided a flyer for the lecturers to distribute to students during their lecture time. The lecturers initially introduced the research briefly and explained the objectives of the research to students in class. The flyer also explained the objectives of the study and the students' role as participants, and requested them to take part in the study. The flyer contained mycontact details, telephone number, e-mail address and my physical location on campus. Potential participants could decide whether to participate in the study or not. Some students who decided to take part in the study contacted me by e-mail, WhatsApp and others physically visited the office. I gave students who were interested in taking part in the study a date, time and venue (classroom) where we met and I issued them an informed consent form to read and complete. I encouraged students to ask questions.

After completing the informed consent form, I gave students the BDI-II questionnaire to complete. A clinical psychologist was present in the classroom during the completion of the BDI-II in case any participant exhibited signs of distress. They would then be able to receive professional attention. I distributed the questionnaire to students during their lunchtimes and during their breaks when they were free from lectures. I physically issued the questionnaires to students and collected them on the same day after completion. I also requested the students to voluntarily write their first names, surnames and contact details for the purposes of referring counselling to those who might require it and for inviting them to take part in the interviews for the qualitative data collection phase.

I asked the participants who scored high on the BDI-II to volunteer for participation in the narrative component of the study interviews. A limited number of 11 students out of a targeted 15 volunteered to participate. The students were identified based on the results of the BDI-II. Students with a Shona cultural background were also identified based on their Shona surnames. Students who scored high on the BDI-II and met the criteria for depression but did not meet the inclusion criteria for the research were offered counselling services and referred by the clinical psychologist for further assessment and treatment at the Gweru Provincial Hospital.

Lecturers of student participants were identified through the students. I requested the participant student to give the names of their lecturer and give consent for them to be part of the study. The lecturers were then invited to volunteer to be part of the study though they were not informed of the name of the student who had recommended them in order to ensure that the identity of the student remained anonymous. Objectives of the study were clearly explained

to all the lecturers before they completed a consent form. Thirteen lecturers out of a targeted 23 who taught the student participants volunteered to be part of the study.

1.10 Research Instruments

1.10.1 Questionnaire

A questionnaire may be defined as a form of inquiry which contains a systematically compiled and organized series of questions that are distributed to research participants for the purposes of gathering data.

This study employed the Beck Depression Inventory-II (BDI-II). This is a 21-item self-report questionnaire that measures the presence and degree of depressive symptoms in adults (Beck, 1995). The questionnaire contains a series of structured, definite, concrete and direct questions which require participants to select from responses offered. I explained the objectives of the research to first-year students and these volunteers were given the questionnaire and asked to respond to it. The responses were rated on a scale where a score of zero to three is assigned to each response. A total score of zero to nine indicates minimal depressive symptoms; 10 to 16 mild; 17 to 29 moderate; and 30 to 60 severe depressive symptoms. The questionnaire established the prevalence and severity of depressive symptoms while also revealing the emotional, physiological, psychological and cognitive symptoms of the students' depression.

The BDI-II questionnaire was ideal for this study as its items were modified to be equivalent to the items from the *Diagnostic Statistical Manual of Mental Disorders* (DSM-IV and -V) of the American Psychiatric Association (APA) of 1994 and 2013 (Garcia-Batista et al., 2018). The APA provides a defined, culturally informed diagnostic criterion of depression that stipulates that a depressed individual experiences 5 or more of the depressive symptoms in 2 weeks (American Psychiatric Association, 2013). The presence of depressive symptoms as stipulated by the BDI-II therefore reflects the possibility of a depressive disorder in an individual with recommendations for further psychological and psychiatric evaluations.

According to Beck et al. (1996) the internal consistency of the BDI-II is good, with a Cronbach's alpha coefficient of 0.85. The items on the questionnaire are highly correlated with one another. The BDI-II has been successfully used in many western and non-western studies (Stewart et al., 2003; Carmody, 2005; Nwobi et al., 2009; Chen et al., 2013; Smojver-Ažić et al., 2015). Makhubela (2015) confirms in a study of South African university students that the BDI-II provides an assessment of severity of depressive symptoms that is equivalent across

culture, race, gender and time in university students. A study at the University of Nigeria by Nwobi et al. (2009) employed the BDI-II and reported a high prevalence rate of mild to moderate symptoms of depression and that only a minimal proportion of students sought medical advice. Dere et al. (2015) also reported that the BDI-II showed strong measurement invariance among college students across culture and gender through a multi-group confirmatory factor analysis. The BDI-II provided a standardised tool for data collection for this study.

The limitations of the BDI–11 are that scores can easily be exaggerated or minimized by the respondents as it is a self-report questionnaire. To reduce the probability of exaggerated or minimised scores, I encouraged the students to respond honestly. Participants were also encouraged to give factual information, which was paramount in ensuring valid and reliable findings that could be generalised to similar contexts. There was also the risk of some students not returning the questionnaire, which might have affected the validity of the research. In this view, I physically administered the questionnaires by hand and collected them after completion on the same day to ensure a 100% response rate.

1.10.2 Interview

I made use of interview guides to elicit narratives from student and lecturer participants. The interviews revealed the cultural perceptions of depression and its interaction with learning among the Shona learners. The goal was to gather in-depth data from depressed students and their lecturers in the form of stories of life experiences. DeMarrais (2004, p. 55) defines an interview as "a process in which a researcher and participant engage in conversation focused on questions related to the study". An interview may be described as verbal interaction between two or more people with a specific intention of obtaining and giving information that is relevant to a research question under investigation (Kabir, 2016). Interviews are one of the most common primary data collection instruments used to collect a special kind of information. Patton (2002) explains that interviews are held to acquire information we cannot observe, such as feelings, thoughts and intentions. In this research interviews were ideal as they revealed students' and lecturers' feelings, intentions and perceptions with regard to depression and learning in Shona culture.

Esin et al. (2014) assert that the material gained through interviews (such as spoken words, paralinguistic communications, other sounds and non-verbal communications) has multiple meanings that are further expanded by the changing interactions between research

participant and researcher. Respondents' responses are not limited to what they are asked but instead complex interactions between responses are formed. The interview process thus turns into a collaborative meaning-making process rather than simply the imposition or reception of the interviewer's or interviewee's framework of meaning.

I employed a semi-structured, open-ended interview schedule to ensure coverage of important issues whilst maintaining focus on the research questions (Polit & Beck, 2008). The semi-structured-interview schedule enabled me to elicit information about past events and how people interpret the world around them – information that is impossible to replicate (Merriam, 2009). The semi-structured interview also enabled meto gather detailed information that could not have been conveyed by any other means, such as facial and bodily expressions, evasiveness and attitudes. Merriam (2009, p. 90) further explains that "the researcher would be able to respond to the situation at hand, to the emerging worldview of the respondent and to new ideas on the topic". The open-ended nature of the semi-structured interview allowed the interviewee some freedom to share various experiences and allow an in-depth understanding of the different variables that contribute to the problem.

I scheduled appointments to meet with each of the student and lecturer participants on dates and times that were convenient to both the interviewer and the interviewee. The appointments were diarised to ensure they were all honoured and adequate attention was given to each of the respondents. A room for carrying out the interviews was identified to ensure privacy and confidentiality. The open-ended semi-structured interview guide ensured that focus on the research objectives remained key in the discussions. I personally requested each student participant in the study to tell his/her life story with regard to depression and learning experiences and to be guided by the interview questions. Responses were recorded and then transcribed. I also requested the lecturer participants to narrate the learning experiences of students who exhibited depressive symptoms in class. To ensure the students 'anonymity, the lecturers were not informed of the names of the students who were participating in the study. The participants were interviewed until saturation point was reached, that is, until no new themes emerged.

The semi-structured interview has its shortcomings, Fraenkel and Wallen (2003) point out that an interview session can be lengthy and time-consuming. Data can also be difficult to analyse as the respondents are free to answer questions in their own ways. To counter such challenges, I was guided by some pre-set questions. These controlled the amount of flexibility

in participants' responses and resulted in a reasonable amount of time spent on each session. I held interviews with all the research participants from the 3rd of August 2018 to the 9th of February 2019. A thorough thematic analysis was carried out to ensure a deep understanding of the complexity of the human psychological nature.

1.11 Data Presentation and Analysis

1.11.1 Statistical Analysis

Quantitative data from the questionnaires was presented in tables, graphs and pie charts, and a descriptive, interpretative analysis was also given. Analysis of data was based on descriptive statistics where the researcher employed frequencies, standard deviations, averages and ranges. The statistical analysis from the participants' biographical data was given to enable the reader to fully understand the participants' demographic background. The SPSS software program was employed for data presentation and analysis. The program has highly interactive syntax and dialogue boxes that facilitated sorting, defining and analysis of variables. The software enabled accurate analysis of numerical data and was able to perform categorical or ordinal analysis and regression analysis. The SPSS computed the prevalence and severity of depression and other relationships within emerging social patterns.

Relationships between levels of depression and group descriptors such as gender, marital status and religion were determined using the Pearson correlation. The analysis sought to establish the prevalence of depressive symptoms at various levels according to the student group descriptors. The statistical analysis also established the relationships between levels of depression and the 21 items on the questionnaire. The analysis initially used the Varimax-Kaiser normalisation rotation method factor analysis to extract variables with the largest association with depression. The Pearson correlation was then done to assess statistically significant relationships between the dependent (levels of depression) and independent (items from questionnaire) variables. The statistical analysis enabled a comprehensive understanding of relationships between variables and responses to research sub-questions.

1.11.2 Thematic analysis

I prepared and organised qualitative data from interviews for a thematic analysis. Each data source was transcribed and read repeatedly in a search for meanings and patterns. Codes were generated from the data. According to Creswell (2014) coding is the process of segmenting and labelling text to form descriptions and broad themes in the data (to try to make sense of the data). I analysed the depressed students' stories and then "restoried" them into a framework

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that made sense. I then wrote a detailed analysis for each theme. Clear and distinct themes emerged from the data gathered. The themes answered research sub-questions posed in this chapter and the overall research question.

1.12 Scope of the research

The study was conducted at a state-run tertiary educational institution in the Midlands Province of Zimbabwe. The study focused on young adult Shona first-year students, between the ages of eighteen and thirty. College students below eighteen years and those above thirty years and in their second and third year of study were not included in the study. College students who did not have a Shona cultural background were also not included in the study.

Lecturers who taught the participants were also included in the study. Lecturers at the institution who did not have a Shona cultural background and did not teach any of the participants were not included in the study.

Both males and females were considered for the study.

1.13 The Researcher

By virtue of having been a Dean of Students at the institution where the research was carried out, I was a subjective and integral part of the research process. I had a strong personal background understanding of the context, the phenomena under study and the entire research process. This included my direct primary role in the research process pertaining to the collection and generation of data and its eventual analysis. My personal beliefs, values and assumptions, therefore, played a pivotal role in shaping this research. This placed me, however, in a potentially compromising position that could have influenced the research process and outcome. As a result, it was my obligation to establish counter approaches that included adhering to all research procedures to ensure that researcher biases did not affect the outcomes of the research. My deep understanding of the process could also have contributed valuably to the research. I nevertheless put procedures in place to minimise bias.

In establishing counter approaches to reduce biases, I had to critically self-evaluate, reflecting on the aims and objectives of the research. I consulted with my professional colleagues and my supervisor to keep me focused. I also triangulated data sources and collection methods as another counter approach. Over and above, I also declared my personal interest in the research as I had been Dean of Students at the site of research. This placed me in a position where I encountered cases of depressed students in my line of work. This

background prompted me to embark on the study in the hope of improving awareness and hopefully attitudes of the community and mental health practitioners, and further to instigate policy formulation in the provision of mental health care in tertiary institutions in Zimbabwe.

1.14 Assumptions of the Study

I made various assumptions before the data collection phase of the research. These are discussed below.

The first assumption was that I would face challenges in recruiting volunteer research participants. This was mainly because I offered no incentive to prompt them to volunteer. Surprisingly, after being introduced to the research concept, the students were curious to understand their experiences and levels of depressive symptoms that were going to be revealed by the BDI-II. Going through the BDI-II became an enlightening experience that brought a new awareness about themselves they had not anticipated. This prompted the participants to volunteer for and be eager to participate in the study which was vital to the completion of this research.

I also assumed that the college culture did not view depression as a serious illness that deserves attention. In Zimbabwe's tertiary institutions various international and national organisations have carried out research and programmes such as awareness campaigns on HIV-AIDS, breast cancer, drug abuse, cholera and typhoid. Over the years these have been given due attention. Mental health challenges such as depression, on the other hand, have not been given much attention in higher and tertiary education and might, therefore, not carry equal weight and be considered a trivial issue in this educational context. However, the cooperation I received from the college authorities and students was resounding testimony to their view of depression as an illness that required equal attention.

I also assumed that I might not be able to meet all participants and complete data collection due to my demanding work schedule and that of the participants. Research participants had class timetables that occupied most of their time while at college. However, diarising and honouring appointments ensured the collection of data from all research participants though some appointments had to be cancelled and rescheduled until data collection was complete.

1.15 Ethical considerations

This section presents a summary of the main ethical issues that I was confronted with in carrying out this educational research. Ethics address the question of how to conduct research in a moral and responsible way (Blumberg, 2011). Human beings should not cooperate in any research that may result in a sense of self-degradation, embarrassment, or a violation of moral standards and principles. Ethics are said to be "situated" and have to be interpreted in a specific location (Simons & Usher, 2000, as cited in Cohen et al., 2011). I focused on the following ethical issues: permission to carry out research, researcher positioning, access to context and participation, voluntary participation, informed consent, anonymity, confidentiality and data storage (Campbell & Groundwater-Smith, 2007). I was also guided by the Stellenbosch University code of research.

1.15.1 Permission to carry out research

Permission to carry out the research was sought and granted from the Research Ethics Committee at Stellenbosch University (ethics approval number: 0762).

The researcher also sought and was granted written permission from the Polytechnic College in Zimbabwe.

1.15.2 Researcher positioning

I was the Dean of Students at the Polytechnic College, the site of study, for five years. Though my professional position placed me in a more powerful position, being a woman in a patriarchal community placed me in a less powerful social position. Some students have higher societal positioning in terms of their social class positioning, age and maleness. I, however, established a rapport that was conducive to building respect and democratic relationships irrespective of the dynamic societal positioning and divergent views that facilitated a mutually meaningful data collection process (Bold, 2012). The participants' responses were of primary importance in both the questionnaire and the interview process. My line of questioning allowed the participants to tell their story, which was constructed through the interview.

The qualitative component of this research required that I pay attention to the "positioning" of the tellers of the stories and the listeners, as their personal, social, cultural and political worlds came together and interact within the narrative process, (Esin, Fathi & Squire, 2014). I also analysed my own personal, social and cultural positioning as well as the methodological and theoretical frameworks I applied. Researcher positioning encouraged and influenced the way that an account is presented. Hence a collaborative and conducive

environment that allowed for negotiation of meanings within the context of the interview was facilitated.

1.15.3 Access to context and participants

I gained official permission to carry out research by contacting the college authorities in person with a written request to which they responded. I had reasonably easy access to the context and participants as I had been previously employed at the site of study. A good working relationship already existed among the researcher, the lecturers and the college administration, so gaining access to the context and participants was not a challenge. Cohen et al. (2011) are of the view that achieving goodwill and cooperation is especially important and a researcher should best present him/herself as competent, trustworthy and accommodating.

Students completed the questionnaire during their free time, such as during lunchtime while on campus. Appointments for interviews were also scheduled and honoured during the participants' free time and a private room was acquired for the interview sessions.

1.15.4 Voluntary participation and informed consent

The principle of informed consent arises from the "subject's right to freedom and self-determination" (Cohen et al., 2011, p. 77). Informed consent respects and protects the right of self-determination and places some of the responsibility on the participant. In this research, participants were presented with an opportunity to weigh risks and benefits of being involved in the research before they agreed to participate. I had an obligation to respect the rights of human participants and protect them from any form of harm which might result from this study. Informed consent ensured, therefore, that participants were aware of the purposes and procedures of the study, risks, benefits, discomfort, and how these were to be handled during and after the study.

To ensure voluntary participation, I asked students and their lecturers to volunteer to partake in the study. Volunteer participants were informed that they were free to withdraw from the study at any time. The participants were requested to give their names and contact details to enable the researcher to contact them and recommend any necessary social and psychological support during and after the study. I focused only on the first-year students as this enabled continuous monitoring and the opportunity to offer the necessary psychological support during the course of their studies.

I also sought consent from lecturers who volunteered to participate in the study. The participating students' consent was sought for their lecturers to give an account of the students' depression and learning experiences. All participants completed and signed informed consent forms.

1.15.5 Non-maleficence, Anonymity and Confidentiality

I ensured that participants were not harmed physically, psychologically, emotionally or professionally. Any perceived risks were pointed out in the informed consent form and explained when briefing participants. Careful thought was given to the possible consequences of the research. A clinical psychologist was available during and after the research to ensure that any signs of distress exhibited by the participants were dealt with professionally. Anonymity and confidentiality were upheld in order to ensure participants were protected from harm.

The identities of participants were kept confidential and any information divulged to a third party was given only with the consent of the participant. Denzin and Lincoln (2011) are of the view that a participant is considered anonymous when he/she cannot be identified by the information provided. In this research, participants were informed and assured that anonymity and confidentiality would be maintained as no information pertaining to their identities was revealed. Participants were requested to write their names and contact details on the questionnaire; however, pseudonyms were attached and used during data analysis. A private room was used for interview sessions to ensure confidentiality and no invasive interruptions. The lecturers who gave accounts of students' depression in class were not privy to the specific student participants' identities in this study. In case of any perceived risk, the researcher and clinical psychologist's contact details were given to the respondents.

1.15.6 Data storage

With the consent from participants, data were audio-recorded and notes were also written during interviews. Data were transcribed and stored in a password-protected computer accessible only to the researcher and her supervisor. The data from questionnaires were analysed using the SPSS and saved in the researcher's password-protected computer. The questionnaires will be shredded five years after the completion of the research. The hard copies are secured in the researcher's office in a lockable drawer. The keys to the office and those to the lockable drawer are kept by the researcher and access to the office will only be in the presence of the researcher.

Denzin and Lincoln (2011) emphasize accuracy of data as the cardinal principle in social science research. Fabrications, fraudulent materials and omissions are unethical and were not accommodated in this research.

1.16 Chapter Summary

This chapter provided the reader with an overview of the entire thesis. Initially, the background of the study illustrated the context of the research, followed by the aims of the study, its purpose and how these aims would be achieved. A brief outline of the research design and methodology presented how the research aims could be achieved. The chapter also outlined the scope of the study and the participants included in the research. The significance of the study was presented to justify why the research had to be carried out. The research question "How are depression and the interaction between depression and learning understood by young adult students in the Shona culture?" guided the execution and focus of the study. Key terms were also defined to enable the reader to better understand the research. The next chapter will discuss the theoretical framework of the study.

CHAPTER TWO

THEORETICAL AND CONCEPTUAL FRAMEWORK

2.1 Introduction

Depression is a complex phenomenon with no single definition. Various culture-based idioms are used in describing symptoms to report the illness. This complexity, therefore, called for engagement of relevant theoretical approaches in order to guide me when exploring the interaction between depression, culture and learning. In this research, the Transcultural Approach and Beck's Cognitive Theory of Depression were used to frame the study. These approaches bring together the social, cultural and individual aspects of depression and learning which are discussed in this chapter.

2.2 Transcultural Psychiatry

Transcultural psychiatry is a branch of psychiatry that concentrates on the cultural context of mental illness. It involves social and cultural factors that trigger and influence the experience of depressive disorders and other mental illnesses (Moldavsky, 2004). Beck (2016) says the transcultural approach is based on the notion that beliefs and values of different cultural groups should be understood so that effective service provision that reflects the distinct conceptualisations of mental health can be provided. The transcultural approach guides this research as it places into perspective the beliefs, values and conceptualisations of mental health, particularly depression, in the indigenous Shona culture. Understanding depression in Shona culture is paramount as it demystifies the illness, consequently enabling provision of effective mental health interventions and care.

The foundation of transcultural psychiatry was, however, characterised by colonial ideologies that assumed the universal applicability of western psychiatric and psychological diagnostic categories. During the colonial and postcolonial eras, mental illness particularly in Africa was fuelled by scientific racism which alleged that mental illness such as depression was uncommon and therefore accorded low priority (Whitley 2015). In 1977 Arthur Kleinman proposed a "new cross-cultural psychiatry" that respects cultural differences and did not export western psychiatric theories and diagnostic categories that were themselves culture bound (Kirmayer, 2006). Transcultural psychiatry, also known as cross-cultural psychiatry or cultural psychiatry, is understood as a way in which a medical symptom and diagnosis reflect social and cultural aspects (Kirmayer, 2006; Kumar et al., 2015).

According to the Global Mental Health report of 2014 (cited in Whitley, 2015), developing nations have also made the epidemiological transition from not according mental illness the relevant attention to acknowledging its existence. Whitley confirms that this adjustment towards recognising mental illness in developing countries has contributed to the increase of the burden of mental health and depression in particular. Indigenous communities in developing countries have specific cultural, historical and political factors that define categories of identity. These social factors contribute to the development of social stressors that may lead to depression and affect access to resources and coping strategies (Kirmayer et al., 2017). Moldavsky (2004) further asserts that transcultural psychiatry's interests range from biology, statistics, anthropology, philosophy, epidemiology to spirituality in mental illnesses.

Moldavsky (2004), explains that transcultural psychiatry historically focused mainly on making comparisons between psychiatric and psychological disorders across different cultures whilst retaining the universal validity of theoretical frameworks of mental illness developed in western countries. The new transcultural psychiatry, on the other hand, asserts that the western-constructed theoretical models are applicable mostly to western populations. Kleinman (1997, p. 3) states that "the chief failing of the old transcultural psychiatry is its total reliance on external western psychiatric categories which are applied by clinicians and epidemiologists as if they were independent of cultural bias, but which in fact are culture specific categories". The concentration was on universals instead of cultural differences as mental illness is influenced and culturally shaped. Models for the diagnosis and treatment of mental health illness should, therefore, be culture specific in order to be applicable to the mentally ill from any culture, ethnic group, race, etc. – hence the focus on cultural syndromes.

2.2.1 Cultural Syndromes

Researchers and mental health practitioners' focus and attention on culture-bound syndromes (CBS) in transcultural psychiatry are an illustration of transformation in the approach to cultural dimensions of psychopathology (Cheung, 1998, as cited in Bhui & Gavrilovic, 2012). Recently, the term *cultural syndrome* has replaced CBS in the Diagnostic and Statistical Manual (DSM-V) as culture in the contemporary world is no longer 'bound' but in constant flux as thinking patterns are exchanged due to globalisation (American Psychiatric Association, 2013; Kirmayer, 2019). Cultural syndromes are understood to be culture-reactive syndromes, implying that psychopathology is rooted in social variables. Symptoms of depression arise through interactions of psychophysiological, cognitive-affective and social processes including culture-specific explanations (Hinton & Lewis-Fernandez, 2010; Kirmayer, 2019). Patients'

symptoms are, therefore, a reflection of an attempt to adapt to challenges they face in their social circles. Different cultural and historical traditions frame depressive experiences and disorders within their contexts, thereby limiting certain symptoms, and shaping different conceptualisations (Marsella, 2003). Culture shapes illness first by shaping the explanations in the local language that describe the illness.

In light of these circumstances, several cultural syndromes are considered to be indigenous illnesses as they are composed of localised diagnostic categories (Dowrick, 2013). These categories include Koro in Eastern Asia, Latah in Malaysia and Susto in Latin America and in other countries where they are a result of population movement (Henderson et al., 2010). These diagnostic categories are now included in the DSM-IV and -V in a move to urge clinicians to be more inclusive and culture-sensitive in their diagnosis and treatment options as there are no specific diagnostic procedures for assessing cultural syndromes (American Psychiatric Association, 2013). Latah experienced in Malaysia is described by Osborne (2001) as a possible emotional outlet for a stifling culture where an individual mimics others and experiences trancelike behaviour after a sudden fright. Whilst some physical symptoms such as sweating and increased heart rate are experienced, there is no clear physiognomic source for the condition and instead of latahs being shunned they are celebrated for their oddity (Osborne, 2001). Koro is also a mental state that arises when an individual believes their sex organs are retracting, a belief that leads to anxiety attacks and sometimes suicide (Mattelaer & Jilek, 2007). Susto, on the other hand is conceptualised as a spirit attack caused by losing someone close, witnessing a frightening incident such as a death or experiencing an accidental fall or scare (Olivo, 2013). An individual is rendered helpless as biological responses that prepare the body for action against fear may be absent owing to social norms or cultural inhibitions (Olivo, 2013).

Gross (2009) holds the view that if depression is currently defined in western culture and this psychiatric diagnosis is not found in non-western cultures, depression will inevitably be regarded as merely a western folk concept analogous to other cultural syndromes. However, recent research in non-western cultures, especially in low- to middle-income countries, has enabled an epidemiological transition towards positioning mental illnesses such as depression as a global burden (Global Mental Health, as cited in Whitley, 2015). Though cultural syndromes are a product of mental illness, they are induced by one's environment and culture, and not necessarily by any bodily pathology. It is culture, therefore, that shapes the illness behaviour and help-seeking behaviour (Hinton & Lewis-Fernandez, 2010; Kirmayer, 2019).

Nichter (2010, p. 405), defines CBSs as "socially and culturally resonant means of experiencing and expressing distress in local worlds". Cultural syndromes or idioms of distress in the Zimbabwean context are represented by the Shona idiom, *kufungisisa,* translating as "thinking too much" (Patel et al., 2001). *Kufungisisa* is linked to social isolation, withdrawal and feeling panicky (Kaiser et al., 2015), which are among the depressive symptoms experienced by Shona people (Patel et al., 2001). "Thinking too much" has also been recently included in the DSM-V as one of the cultural concepts of distress among other universal symptoms of depressive disorder (American Psychiatric Association, 2013, p. 834). The concept of thinking too much is also associated with depressive disorder in Asia, Australia, North America, Europe, and African countries such as Uganda, South Sudan, Kenya, Ghana, Malawi, Eritrea and Tanzania (Kaiser et al., 2015). Transcultural psychiatry, therefore, plays a pivotal role in its advocacy role for cultural syndromes to be incorporated into research and mental health intervention programmes. This assists in understanding forms of suffering in order to improve communication (Kirmayer et al., 2017) and reduce stigma in communities (Hinton & Lewis-Fernandez, 2010).

Dowrick (2013) argues that depression can be understood as a set of localised diagnostic categories operating at a larger scale than other cultural syndromes. Cultural syndromes may be minimised or exacerbated by culture as it is culture that determines which symptoms are normal or abnormal (Kirmayer, 1984) and defines what constitutes health and illness (Al Busaidi, 2010; Kumar et al., 2015). Though depression is universal, some of its symptoms are culturally unique and hence are supported differently in different cultures. Some conditions are universal and some culturally distinct, but all are meaningful within a particular context (Kleinman, 2004; Altweck et al., 2015). This research explores the perceptions and experiences of depression and its symptoms in Shona culture as exhibited by Shona students.

2.2.2 Acculturation

Furthermore, ever-increasing global travel and globalisation have led inevitably to cultural mixing, integration and ultimately acculturation. This process has changed what constitutes depression in any one community. Cross-cultural psychiatry becomes crucial as psychiatrists and psychologists are pressured to provide mental health diagnoses and treatment for people from different and mixed cultural backgrounds. Acculturation involves the transitional process when an individual gradually accommodates and eventually takes on some of the values and beliefs of a new culture (Eshun & Gurung, 2009; Wilson & Thayer, 2018). Such a person's

definition of depression becomes an assortment of different cultural syndromes and other universal symptoms of depression.

Acculturation is a result of contact with a culture group other than one's culture of origin where changes in cultural practices, after contact and immersion, can be described at individual and group level (Eshun & Gurung, 2009; Erten et al., 2018). Berry (1997) notes that acculturation often involves maintaining connection with the original culture and continuing acculturative contact with other cultures. Berry (1970) (as cited in Eshun & Gurung, 2009) conceptualised a model for acculturation which includes strategies for acculturation, namely, separation, assimilation, integration, and marginalisation. These may not necessarily be chosen by the individual but by the group in the dominant society.

Berry's model of acculturation (as cited in Eshun & Gurung, 2009) and Truong (2019) describe separation as involving individuals focusing more on adopting the cultural norms of the host society and disregarding their own culture, whereas assimilation involves individuals focusing more on maintaining their own cultural heritage. Integration is when someone adopts and adapts the host culture while also maintaining their own cultural norms and values. Marginalisation, on the other hand, refers to a person who adopts neither their own culture nor that of the host culture, which may lead to adjustment challenges. An individual may wish to assimilate but may not be fully permitted to do so, while another may wish to remain separated but may be coerced into assimilation by the dominant society. Hence the process of acculturation may be manipulated by the dominant society. Acculturation may, therefore, result in various degrees of shift in beliefs and behaviour which are to be accurately conceptualised for effective diagnosis and treatment of mental illnesses (Gui et al., 2019).

Studies among students in higher education have also highlighted that they often experienced acculturation stress which led to depressive symptoms during their transition on campus owing to conflicting cultural values and the adoption of varying coping strategies (Ma, 2017). Students are predisposed to negative mental health outcomes when stressful events intensify and lack social support, especially from faculty advisers. (Falavarjani et al., 2019). Gui et al. (2016) discovered that international students perceive a low level of discrimination, which appears to endorse integration as a coping strategy in Canada, thereby reducing the occurrence of depressive symptoms. The integration of both cultures may serve as a resource and reduce the risk of depression whereas the rejection of one or both of the cultures might increase the risk of depression (Nguyen, et al., 2017).

Cultural studies assert that our conceptualisations of the world around us are always unstable as culture is dynamic and influenced by context (Kirmayer et al., 2014). Cross-cultural psychiatry does not restrict itself to one approach but deploys any suitable model or method to better understand relationships between culture and mental health. The scientific data discovered and the acceptance of the limitations of our knowledge have been among the sources of controversy among psychiatrists and psychologists studying culture and mental health (Bhui & Gavrilovic, 2012). Kleinman (1977) recommends detailed local phenomenological descriptions of depression along with the behaviours they exhibit, independent of a unified framework, in order to address the problem of depression.

2.2.3 Perceptions of mental health workers

Transcultural psychiatry is also concerned with how mental health workers socialised in dominant cultural frameworks treat people from different cultural and ethnic groups (Bhui & Gavrilovic, 2012; Beck, 2016). Disease or illness relates not only to the biological and psychological changes exhibited but also to health workers' constructions and conceptualisations of clinical realities and the treatment models deployed. The argument is that a cultural perspective to mental illness can assist mental health workers and researchers to become aware of hidden assumptions and limitations they are faced with during practice. The risk is high that a health worker may decontextualise depressive symptoms and assign his/her own ethnocentric conceptualisation to the problem independent of the context in which those symptoms emerge (Marsella, 2003).

The idea is to identify cross-cultural approaches that are most appropriate for treating the diverse populations around the world. An approach to cultural assessment may include cultural consultation that involves cultural interpreters and brokers in the development of cultural conceptualisations and treatment plans to assist mental health workers (Kirmayer et al., 2014). Cross-cultural psychiatry thus challenges the assumptions of well established "good clinical practice" and raises theoretical, cultural, philosophical and technical challenges for mental health practitioners (Bhui & Gavrilovic, 2012). Earlier explanations of depression and possible options for its diagnosis and treatment, such as Sigmund Freud's psychodynamic theory and the theories of Behaviourists, have been discovered more recently to incorporate in some respects Aaron Beck's cognitive theory of depression. These theories saw a breakthrough in psychology as some recommendations for diagnosis and treatment models provided clinicians with viable options.

2.3 Aaron Beck's Cognitive Theory of Depression

Beck's Cognitive theory of depression rose to prominence during the 1960's after his unsuccessful attempts to prove the psychodynamic theory that viewed depression as a manifestation of supressed anger and aggression (Rosner, 2014a, b in Ruggiero et al., 2018). Beck's cognitive theory of depression also modified the behaviourist theories that concentrated on stressful negative life events and lack of positive reinforcement as the major causes of depression (Beck, 1967). The behaviourist did not take into account an individual's thoughts (cognition) and feelings (emotions) as causes of depression. The cognitive perspective does not, however, reject behaviourist principles but seeks to integrate mental events into the behavioural framework. Cognitive theory assumes that automatic negative thoughts generated by dysfunctional beliefs and the way in which an individual interprets events were the cause of depressive symptoms (Beck, 1967). Cognitive theories may also be referred to as cognitive behavioural theories as they focus on cognition, emotions and behaviours that manifest into depression.

2.3.1 The Cognitive triad

Psychiatrist Aaron Beck (1967) theorised that people with depression look at the world through a cognitive triad: a person develops negative views (1) of him-/herself, (2) of the world and (3) of the future. The cognitive triad comprises dysfunctional belief themes or schemas that cause an individual to believe he/she is defective or inadequate, that all experiences result in failure and that the future is hopeless. These negative schemas subsequently lead to many types of errors in thinking and information processing (Soflau & David, 2017). Beck et al. (1979) as cited in Nevid (2009, p. 538) believe that "people who adopt a negatively slanted or distorted way of thinking become prone to depression when they encounter disappointing or unfortunate life events. Negative thinking becomes a kind of mental filter that puts a slant on how people interpret their life experiences".
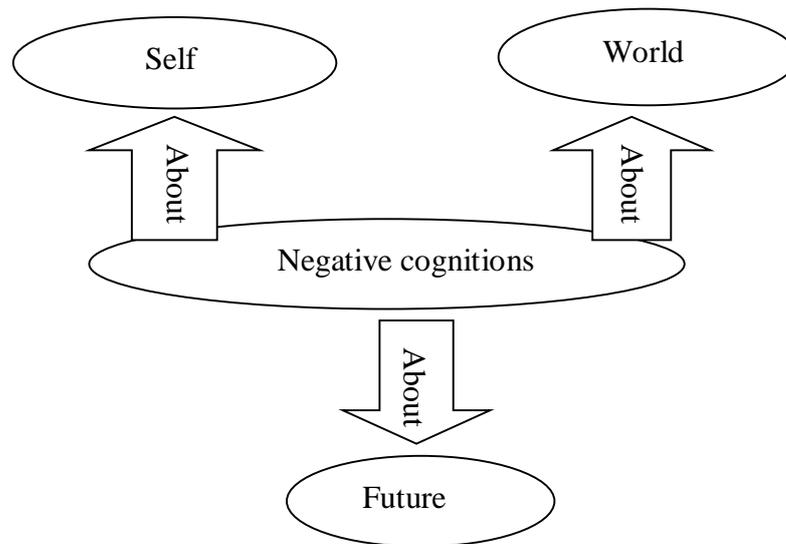
Figure 1: Beck's cognitive triad for depression (Durand & Barlow, 2009, p. 234)

The assumption is that, our cognition determines our emotions and behaviour, subsequently altering our schemas. As a result, the interaction of the three when faced with a negative life event such as failing an examination may be distorted, leading to depression. An individual focuses mainly on negative events and pays little attention to positive events; this state of mind then sustains and builds justifications for depressive symptoms. Beck (1967) says that automatic thoughts cannot be totally controlled since they are reflexive reactions based on beliefs individuals hold about themselves. A depressed individual thinks differently from an individual who is not depressed. Since these errors in thinking are automatic, they may not be aware of their negative views. Depressed people are, therefore, more likely to recall negative events than non-depressed individuals (Durand & Barlow, 2009).

2.3.2 Cognitive Distortions

The thinking of depressed individuals is consistently more negative than that of individuals who are not depressed in all dimensions of the cognitive triad (Nwabuko et al., 2020). For example, a student may perform poorly in one aspect of an examination and conclude that he/she is a total failure in life and that his/her peers and school see him/her as incapable of meeting the academic goals; hence the future is bleak. Beck (1967) asserts that this is a case of an over-generalising distortion applied to the self: one instance is generalised to all other instances. An individual may even stop trying to be better in the belief that he/she is a failure in life, thereby creating a self-fulfilling prophecy that eventually manifests into a repetitive cycle of cognitive distortions. Minor events may lead to major depressive episodes. Negative

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thoughts, generated by dysfunctional beliefs, typically lead to depression (Burkhouse et al., 2019). A person's overall view of the environment, the stressor and the self may be negative and will likely lead to maladaptive coping strategies (Beck, 1967).

Beck (1976) examined other cognitive distortions such as arbitrary inferences, catastrophising and personalising. Arbitrary inferences refer to when an individual reaches a negative conclusion even when evidence does not support it. Cognitive distortions are applied quickly to the information from daily life and outside of immediate awareness resulting in a stream of negative thoughts that affect an individual's feelings and behaviour (Beck, 1967). Catastrophising is when an individual believes that the worst will always happen, in the process exaggerating the magnitude of the negative event. Nevid (2009, p. 539) describes catastrophising as "exaggerating the importance of negative events or personal flaws (making mountains out of molehills)." Personalising is the assumption that everything bad that happens is one's own fault (Bhaumik, 2019). An individual is also likely to attribute the negative feelings of others to him- or herself. For example a teacher may walk into class looking unhappy and a student then assumes that he/she is probably responsible for the teacher's unhappiness.

Table 1: Cognitive distortions interact with the cognitive triad in a depressed individual.

Information processing about:

	The self	The world	One's future
Overgeneralising	"I received bad grades on this paper. I just can't seem to do anything right."	"If anything can go wrong with this project, it probably will."	"Why bother trying? Everything I do turns out to be a failure."
Arbitrary inferences	"The teacher didn't have time to see me today. She probably doesn't like me."	"This teacher doesn't care. Probably none of the teachers care about students."	"I'm sure all the teachers I'll have will be lousy, just like this one."

Personalising	"My softball team lost today, and it's all my fault."	"This reminds me of all the times my team lost when I was in grade school."	"I'll probably never be on a winning team."
Catastrophising	"Failing this exam means I'm incapable of learning."	"Failing this exam probably means I won't get into medical school."	"Since I probably won't get into medical school, I should just quit college right now."

Adopted from Larsen & Buss (2008, p. 448)

Beck's cognitive model of depression shows how distortions are applied to processing information about the self, the world, and one's future. These cognitive distortions promote depression (Larsen & Buss, 2008, p. 448).

2.3.3 Negative schemas

Beck also theorized that after a series of negative events in childhood, individuals may develop a deep-seated negative schema, an enduring negative cognitive belief system about some aspect of life (Gotlib & Macleod, 1997; Durand & Barlow, 2009; Ku, 2017). These childhood negative events may include abuse, bullying and or loss of a parent or guardian (Burkhouse et al., 2019). Beck in Ku (2017) argues that these critical events activate dysfunctional beliefs that then create automatic negative thoughts about oneself. Beck and Bredemeier (2016) assert that though there are several biological and psychological mechanisms that define a depression-prone individual, the depressive disorder emerges in the wake of a "precipitating loss of the investment in a vital resource" (p. 601). The importance and meaning placed on negative events is magnified whilst the importance and meaning placed on positive events is minimised. An individual pays particular attention to information that matches his/her negative expectations and selectively pays little attention to information that contradicts these expectations. A relationship exists, therefore, between the severity of depression and the extent of someone's negative thoughts: the more negative thoughts an individual has, the more depressed he/she becomes. "The more these distorted thinking patterns dominate an individual's cognitions, the greater the vulnerability to depression" (Nevid, 2009, p. 538).

In their study on college admissions Abela and D'Alessandro (2002) found that a student's negative view about the future influenced the interaction between dysfunctional attitudes and the increase in depressed mood. These findings confirm Beck's theory as students who were not enrolled into their college of choice would doubt their futures and this would lead in turn to symptoms of depression. The students would focus on advantages they could have had if they had been enrolled in a particular college and not pay attention to what advantages their particular college is offering. These negative schemas would help them feel hopeless about their self-worth, their college environment and the future, even when there was evidence that their college would offer alternative and probably equal opportunities to make their future bright. Depression impacts the students' belief system to produce pessimistic and illogical thoughts about themselves, the world and their future (Pierce & Hoelterhoff, 2017).

Alloy et al. (1999) criticised Beck's cognitive theory of depression by asserting that the precise role of cognitive processes is yet to be determined; hence the maladaptive role of cognitive schemas may be a consequence rather than a cause of depression. Contrary to the assertion, an earlier study by Moilanen (1993) evaluating college students discovered that the students' depressive states were consistently related to the negative processing of their personal information. The study revealed that, as theorised by Beck, students were affected by their cognitive thoughts and consequently developed depressive symptoms. The study then recommended that Beck's theory be used in future research with college students as the close examination of students' cognitive thoughts by counsellors and college psychologists would inform treatment options. A number of other studies support Beck's cognitive theory of depression (Goodman & Gotlib, 1999; Reilly-Harrington et al., 1999; Mazure et al., 2000; Segal et al., 2006, as cited in Durand & Barlow, 2009; Hetolang & Amone-P'Olak, 2017; Ezeudu, et al., 2019).

2.3.4 The Beck Depression Inventory

From Beck's cognitive theory of depression, the Beck Depression Inventory (BDI) was developed. Initially developed to measure the existence and severity of depression in clinical populations, it has been successfully employed in non-clinical populations (Beck, 1995). The BDI was empirically constructed from pre-selected items of Beck's observations in psychotherapy with depressed patients (Steer et al., 1986). The BDI was later upgraded to the BDI-II; this is a 21-item self-report questionnaire containing a series of structured questions (Beck et al., 1996).

The BDI-II inventory was upgraded to make its contents more comparable to items from the diagnostic criteria for major depression of the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM – IV) (American Psychiatric Association, 1994). Symptoms of depression measured by the BDI-II must have appeared for at least two weeks for a diagnosis of depression (American Psychiatric Association, 2013). The BDI-II is one of the measures of depression most frequently used by researchers and clinicians (Brantley et al., 2004; Lobakeng & Plattner, 2019). More than 2,000 empirical studies have employed the instrument (Richter et al., 1998).

In a study on the validation of the BDI-II, Beck, Steer and Brown (1996); Steer et al. (1999) found that the BDI-II has moderately stable psychometric properties in different populations. These findings are also supported by a more recent study in South Africa by Makhubela (2015). Though the BDI-II is also commonly used in South Africa by researchers and clinicians, the probability that the assessment instrument may not measure the same constructs in exactly the same way across cultures should be considered; consequently, the instrument may not be measurement equivalent. The risk of validity of the BDI-II remaining indeterminate, particularly when applied in cultural groups other than those where it was originally developed should not be overlooked (Swanepoel & Kruger, 2011). Studies have determined, however, that the BDI-II provides an assessment of severity of depressive symptoms that is equivalent across race, gender and time in university students (American Psychiatric Association, 2013; Makhubela, 2015; Dere et al., 2015).

Boury, Treadwell and Kumar (2001) studied Beck's theory by monitoring students' negative thoughts using the BDI-II. The investigation discovered the existence of a direct relationship between negative thoughts and the severity of depressive symptoms, despite their predictions that the negative feelings would eventually improve with time. The BDI-II scores correlated significantly with the number of automatic thoughts, the number of core beliefs, and different types of core beliefs in both time periods. This supports Beck's assumption that "negative thought content characterises depression" (Boury et al., 2001, p. 34). The effects of negative cognitive thinking or information processing were, therefore, proven to prolong depressive symptoms and depression in college students (Nwabuko, et al., 2020).

2.4   Chapter Summary

This chapter spelt out that depression is a universal phenomenon that has been alluded to by various researchers, psychiatrists and psychologists. It is, however, prudent to acknowledge

that culture plays a critical role in the perception, interpretation, diagnosis and treatment of depression. Depression therefore becomes a social construct with various culture-specific idioms used to report the illness. To gain a deeper insight into depression, culture and how it interacts with learning, some theoretical frameworks guided this research. These included the Transcultural Psychiatry and Aaron Beck's Depression theory.

The Transcultural Society's background was elaborated by giving the reader an insight into the inception of the new Transcultural Psychiatry, which respects cultural differences in mental illnesses. The chapter elucidated the social and cultural factors that create and influence the experience of depressive symptoms in individuals from different cultures. The significance of CBS, acculturation and the importance of the view of the mental health workers on depressed individuals was emphasised in order to identify cross-cultural approaches that are appropriate for diagnosing and treating diverse populations around the world.

The chapter also discussed Aaron Beck's cognitive theory of depression as it offers one of the most prominent practical explanations of depression and includes an assessment tool in the form of the Beck Depression Inventory (BDI) and finally the Beck Cognitive Behavioural Therapy (CBT). Beck's theory is a combination of cognitive and behaviourist perspectives and hence gives a comprehensive overview of the emotional, cognitive, physical and behavioural attributes that manifest as depression.

CHAPTER THREE

REVIEW OF RELATED LITERATURE

3.1 Introduction

This chapter explores the perspectives of various researchers on depression, culture, Shona culture, and depression. This provides a clear perspective and enables arguments to be constructed around the variables under study. The chapter also focuses on the research questions in a bid to shed light on the main research question. Ultimately, the review of related literature engaged with and critiqued other authors' views while building a discussion around the research questions.

The questions on which the research focused include the following:

➢ What is the prevalence rate of depressive symptoms among young adult Shona students in a tertiary educational institution?

➢ How are the symptoms of depression experienced by young adult Shona students in tertiary education in Zimbabwe?

➢ How do young adult Shona students in a tertiary education institution understand depression?

➢ What are the relationships between depression and learning among Shona students in a tertiary education institution?

3.2 Depression

"The term 'depression' is based on a bodily metaphor of being 'pressed down', which is a phenomenon of having low mood, being slumped and bowed by burdens, slowed down, and depleted of energy" (Kirmayer et al., 2017, p. 165). It is derived from the Latin word *deprimere* meaning "to press down" (Jackson, 1986). With the passage of time the term gained popularity in English, French and German medical fraternities. Depression can also be defined in various ways based on the cultural or local meanings that influence physiology, cognition and behaviours. Marsella (2003) notes with concern the semantic confusion surrounding the term "depression" and points out that depression denotes a mood, symptoms and several syndromes of disorder and illness. It simultaneously represents a broad spectrum of affective experiences and social consequences. It is not similar to other medical conditions as it does not have a clear-cut aetiology and pathology that are defined by a specific and definite set of symptoms (Lim et

al., 2018). Descriptions of depression are usually complex stories that require expertise for accurate diagnosis, as for example in Yi's story outlined below.

> Yi, a young U.S.-born Hmong woman, is seriously distressed. She is having difficulty sleeping; she has lost her appetite; and she lacks interest in her studies. Yi also says that she has little energy and is having a difficult time balancing school and family obligations. Although she does not spontaneously use emotional terms to describe how she feels, when asked she agrees that she is unhappy and anxious. All these symptoms are consistent with DSM criteria for major depressive disorder (American Psychiatric Association, 2013). And yet Yi reports other symptoms that are not typically associated with major depression. She describes bodily aches and pains, especially in her stomach and liver. She has become particularly concerned about what other people think of her, making it hard for her to get along with her family. Finally, she reports that at night, the spirit of a disgruntled ancestor visits her, right before she is about to fall asleep. These encounters sap her energy. Although she says that she knows other people who have been visited by spirits, she is nonetheless concerned about experiencing these visits herself. (Yulia et al., 2016, p. 337)

Such experiences raise more questions about what depression is and how it is conceptualised in different cultures across the globe, questions that are important for assessment and effective intervention strategies. In Yi's case, depression can be viewed as a psychological, neurological phenomenon embedded in socio-cultural experiences that affect the well-being of an individual (Marsella, 2003). Marsella clarifies that cultural variations exist in all variables leading to depression, such as the meaning of depression, perceived causes, onset, and epidemiology, expression of symptoms, and the course and outcome of the illness. While depression is one of the commonest mental disorders and it is known that cultural, biological and psychological factors contribute to is manifestation, its complex pathogenesis still remains poorly understood (Gross, 2014; Menard et al., 2016). For this reason it is critical for clinicians and researchers across the relevant disciplines to improve their understanding of the complex cultural knowledge related to depression.

According to the DSM-5 (American Psychiatric Association, 2013), depression is a period of prolonged dysfunction that is characterised by symptoms of depressed mood anhedonia. The DSM-5 takes cognisance of the uniqueness and importance of personal experiences embedded in a particular society, demonstrating that it is culture sensitive

(American Psychiatric Association, 2013). Kessler et al. (2005) define depression as a mood disorder exhibited by a prolonged emotional state that affects a person's feelings, thoughts and behaviour. Depression is often chronic and substantially impairs an individual's occupational potential and quality of life (Lim et al., 2018; Liu et al., 2019). Depression affects the way individuals feel about themselves and others, and the way they eat, sleep and carry out their daily activities. In general, depression involves a pattern of sadness, fatigue, anxiety, agitated behaviour and a reduced ability and willingness to function and interact with other people. It ranges from mild feelings of sadness to severe episodes that may require medical and/or psychiatric attention, and in severe cases even hospitalisation. Hinrichs (2002) says the advantage of depression is that it frees a person from the pace of life and this total withdrawal from conflict with oneself is a measure of the seriousness of the disorder.

3.2.1 Types of Depression

Depression presents itself in several forms that exhibit similarities, though there may be some unique symptoms associated with a particular type of depression. A depressive episode can be categorised as mild, moderate and severe depending on the number and severity of symptoms experienced (World Health Organization, 2020). There are various types of depression and major depressive disorder, recurrent or persistent depressive disorder (dysthymia), bipolar affective disorder, seasonal affective disorder, and depression types unique to women are the most common types amongst others.

3.2.1.1 Major Depressive Disorder

This is one of the most common types of depression characterized by a minimum of 5 diagnostic symptoms from the DSM - 5 of the American Psychiatric Association (2013) including the experience of either an overwhelming feeling of sadness or loss of interest and pleasure in usual everyday activities. Other symptoms that are associated with major depression include insomnia or hypersomnia, an increase or decrease in appetite, psycho motor agitation or retardation, constant fatigue or a lack of energy, feelings of worthlessness and inappropriate guilt, recurrent suicidal ideation with or even without any specific plans for committing suicide, and cognitive difficulties, such as, diminished ability to concentrate and make decisions. These symptoms should persist in an individual for at least two weeks and should represent a significant change from their previous functioning. Their daily lives such as educational, social, or other important functions are also negatively impacted as they may abscond from school,

perform poorly in academic endeavours or not show up for work and if they are present may not be productive (Anxiety and Depression Association of America (ADAA), 2018; World Health Organization, 2020).

3.2.1.2 Recurrent or Persistent Depressive Disorder (Dysthymia)

Dysthymia is a chronic condition that involves repeated depressive episodes with feelings of deep sadness most days over periods of up to two years or more (Anxiety and Depression Association of America, 2018). An individual also experiences insomnia or hypersomnia, poor appetite or overeating, fatigue, low self-esteem, and poor cognitive ability, leading to a lack of concentration, difficulty in making decisions and feelings of hopelessness (American Psychiatric Association, 2013). The symptoms may not be as severe as those of major depression: symptom-free intervals may be shorter in duration than two-months. However, major depressive episodes may also occur during a persistent depressive disorder episode (World Health Organization, 2020). Grohol (2019) asserts that a persistent depressive disorder is very difficult to treat as a patient may have tried different treatment regimens over years.

3.2.1.3 Bipolar affective disorder

Bipolar disorder is sometimes known as a mood disorder as it is characterised by mood swings ranging from depression to mania. An individual experiences extreme high moods characterised by an excessive amount of energy and an inclination to do anything; then the individual experiences very low mood swings (Grohol, 2019). Bipolar disorder is characterised by elevated or irritable moods, inflated or high self-esteem, pressure of speech and hypersomnia (World Health Organization, 2020). These changes in mood swings may be gradual or sometimes rapid, with no clear explanation for the change in behaviour. A diagnosis is, therefore, critical to manage the erratic fluctuations in behaviour.

3.2.1.4 Seasonal affective disorder (SAD)

Seasonal affective disorder consists of symptoms similar to those of a major depressive disorder but usually occur during the winter season. The lack of sunlight and shorter days of winter may cause a mood change as the body's natural daily rhythms may alter in response to the reduction in light or the functions of serotonin (Merz, 2018).

3.2.1.5 Depression types unique to women

Various studies have indicated that women are more vulnerable to depression than men (Lim et al., 2018; World Health Organization, 2018). In addition, they are also at risk of premenstrual dysphoric disorder (PMDD) and postpartum depression. Postpartum and PMDD depression are both influenced by the female reproductive hormones that are active during the menstrual cycle and the process of childbirth (Grohol, 2019).

PMDD may be an extension of premenstrual syndrome and is characterised by emotional and behavioural symptoms such as hopelessness, sadness, extreme moodiness, changes in sleep or eating habits, irritability, anger, tension and anxiety (Grohol, 2019). Physical symptoms such as breast tenderness and bloating may also be experienced (Merz, 2018). These symptoms are likely to appear during ovulation and end during the menstrual period when oestrogen and progesterone levels fluctuate and the mood changes are severe and can disrupt educational, occupational and social life (Anxiety and Depression Association of America, 2018).

Postpartum depression is usually experienced after childbirth when hormonal changes trigger depressive symptoms. During pregnancy, the female hormones, oestrogen and progesterone, increase and soon after childbirth the hormones rapidly decrease to the levels of a woman who is not pregnant. These drastic changes are linked to the onset of depressive symptoms (Grohol, 2019). Postpartum depression if not diagnosed may have severe effects on women, their infants and families, and their general social functioning may be negatively affected (Merz, 2018). Research has also indicated that women who suffer from postpartum depression are at risk of experiencing a second episode during their subsequent childbirth experiences (Grohol, 2019).

3.3 Culture

Culture is that "complex whole which includes knowledge, belief, art, law, morals, custom, and any other capabilities and habits acquired by man as a member of society" (Taylor, 1974, as cited in Eshun & Gurung, 2009, p. 3). Eshun & Gurung (2009) acknowledge that lay people often define culture as a way of life of a group of people. Culture may also be understood to comprise beliefs, norms, values and behaviours that are acquired and transmitted from generation to generation by a group of people. Kirmayer (2019) says culture is the many ways

in which the social world is configured by meanings and traditions. Culture also changes constantly as people learn and appreciate new ways of life from other cultures. Cultural traits and norms play a pivotal role in influencing how an individual thinks, responds to distress and expresses emotions (Eshun & Gurung, 2009).

Marsella (2003) similarly defines culture as shared learnt meanings and behaviours that are transmitted through social activity for the purpose of individual and societal development and growth. Culture consists in shared internal and external representations. External representations may include activities, roles, and institutions. Internal representations are composed of beliefs, values and attitudes, and patterns of consciousness. These shared meanings and behaviours are dynamic, subject to continuous change in the perceived internal and external circumstances. Meanings and behaviours perceived in a particular group of people are therefore determined by culture. Marsella (2003) further asserts that culture becomes the lens or template used in constructing, conceptualising and interpreting reality. People from different cultures would, therefore, define and experience reality differently. In this view, the conceptualisation of mental disorders such as depression varies across cultures as they are embedded in cultural experiences (Kumar et al., 2015).

3.4 Shona Culture

The Shona people are the largest cultural group in Zimbabwe, constituting more than 75 per cent of the population, whereas the Ndebele account for just over 20 per cent of the population (United Nations Population Estimates and Projections, 2019). The remaining small fraction of the population consists of white Zimbabweans, who account for less than one per cent, and mixed race groups at less than 0.5 per cent (United Nations Population Estimates and Projections, 2019). Other ethnic groups such as Venda, Tonga, Shangaan and Nambya account for the remainder. Zimbabwe has an estimated population of about 14.6 million people, of whom more than 70 per cent live in rural areas. The country's diverse ethnic groups have various norms and values. This is true of the largest group, and Shona culture is unique in many ways. Shona people live mostly in Zimbabwe, with smaller populations in parts of Mozambique, Zambia, Botswana and South Africa (Chemhuru & Masaka, 2010).

The Shona people speak the Shona language, which consists of a number of related dialects. The dialects unique to the Shona culture include but are not limited to *Zezuru, Karanga, Tonga, Manyika, Korekore,* and *Ndau* (Muchinako et al., 2013). These dialects are paramount in identifying specific geographical origins and ethnic groups of people and also

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play a significant role in the vocabulary available to express various medical and psychological ailments. The idiom *kufungisisa*, the closest translation of which is "thinking too much" and which is the closest translation of depression (Patel, 2001), is a standard Shona term that is understood in all dialects. A standard Shona exists across the various geographic locations for effective communication, standardisation of teaching and learning, and execution of national examinations. At present, the country has 16 official languages with 75 per cent of the population speaking the Shona language (Jarus, 2017). If someone speaks the Karanga dialect it means they come from the Karanga ethnic group and respect the norms and values of the Karanga people. English is, however, the official medium of communication in the academic, private and public sectors.

The Shona people identify themselves by totems, *mutupo*, which represent clans that historically formed dynasties during the ancient civilisation of the Shona. The totems have been used in some instances as surnames since the initial inception of the culture. People from the same clan use the same totem, which is usually an animal or body part, such as, *Shumba* ("lion"), *Gumbo* ("leg"), and *Nzou* ("elephant"). People who share a totem are descendants of one ancestor and are not allowed to have intimate relationships or get married. This poses a challenge, however, for the orphaned, abandoned and adopted children who may not be aware of their founding roots and hence are afraid that in violating rules they may be subject to punishment by ancestors. Furthermore, there are also complications for child adoption as strong belief systems with regard to identity clans guide the Shona people and consequences such as withdrawal of ancestral protection are threatened. Shona people use totems to connect and communicate with ancestors when faced with challenges such as persistent mental illnesses – an adopted child with an unknown totem becomes a risk that many families would prefer to avoid.

The Shona people practise Christianity and acknowledge God, *Mwari*, as a dynamic presence in their everyday lives, although traditional beliefs and the worship of ancestral spirits are also very common. The concept of afterlife does not exist as in Christianity, with its view of another life in heaven or hell. Rather it is seen as another form of existence in this world here and now. Attitudes to and beliefs about the dead are that they are similar to living parents and guardians. Shona culture places emphasis on ancestral worship, and rituals to contact the dead ancestors are often held (Gelfand, 1982). Rituals called *bira* ("ceremonies") are held to contact the dead. The rituals more often than not are held when there are problems in the family

or when people celebrate an event such as a good harvest. The Shona people honour ancestral spirits and pray to them for good health, rain and success in an enterprise.

Bad spirits, *shavi*, are often used as explanations for disasters, misfortunes and some illnesses, especially psychological and psychiatric ailments. Ancestral spirits are then consulted through traditional ritual ceremonies. Mental illness is believed to have its roots in disgruntled ancestors who are punishing a clan or family for not respecting certain norms and values. The individual and sometimes family of mentally ill persons may be subjected to stigma and discrimination that may lead them to be reluctant to seek medical and psychological help. Traditional healers are consulted when illness is persistent or psychological and when spiritual causes are suspected (Gelfand, 1982; Mawere & Kadenge, 2010). Traditional healing is believed to be effective in dealing with psychological conditions whereas modern medical diagnoses and treatments are suitable for other ailments.

3.5 Culture and Depression

Cross-cultural studies in psychology, psychiatry, anthropology and other disciplines have been consistent in their conclusion that there are variations in depressive disorders across cultures (Kleinman & Good, 1986; Marsella et al., 2002; Marsella, 2003; Kumar, Ongeri et al., 2015; Kirmayer, 2019). The argument is that culture and mental health are embedded in each other (Sam & Moreira, 2002, as cited in Eshun & Gurung, 2009). Understanding the role of culture is, therefore, of paramount importance to the diagnosis and treatment of mental illnesses. Culture influences mental health such as depression in several ways:

1. An individual's experience of depression and associated symptoms;
2. How an individual describes his/her symptoms within the cultural norms;
3. How the symptoms described are understood, interpreted and diagnosed;
4. The treatment and treatment options for depression and outcomes (Castillo, 1997, as cited in Eshun & Gurung, 2009).

The United States (U.S.) Surgeon General's Report on mental health (1999) summarised the role of culture in mental health illnesses by explaining that the cultures that individuals come from inevitably shape their conceptualisation of their mental health and affect their choice of mental health services. The cultures of the mental health service providers also affect diagnosis and treatment (Marsella, 2003). In support of the U.S. Surgeon General's Report, the World Health Organization (WHO), sponsored an extensive study that confirmed that respondents from various countries reported a mood of sadness, tension, anxiety and lack of energy as

universal symptoms of depression. The study noted, however, that western respondents reported additional emotional symptoms such as guilt, whereas non-westerners reported somatic symptoms such as headaches and stomach aches (Draguns, 1990). Such revelations are an indication that although some symptoms of depression are universal others are related to varying cultural factors.

Marsella (2003) highlighted that one of the relationships between culture and depressive experience and disorder is the concept of selfhood assumed by certain cultural traditions. Cultures are believed to socialize individuals with metaphorical languages and mediations of reality that promote context-based orientations that in turn persuade an individual to be attached to others. This socialization mitigates the perceived loneliness and isolation associated with various cultural traditions. Marsella further explains that because western culture usually values individual autonomy, personal control is closely related to depression. On the other hand, Asian culture emphasises selfless subordination to family. (Maercker et al., 2015). These differences in perceptions of depression and other mental illnesses across the globe created an opportunity for the development of an interdisciplinary field of cross-cultural or transcultural psychiatry.

3.6 Prevalence of Depression in Higher and Tertiary Education

A growing body of research suggests that psychological conditions among students are numerous and increasing in higher and tertiary education institutions (DeRoma, et al., 2009; Asante & Andoh-Arthur, 2015; Auerbach et al., 2018a; Van der Walt et al., 2020). The prevalence rates of depression and depressive symptoms in students at higher institutions are higher than in the general population (Leino & Kisch, 2005; Herman et al., 2009; World Health Organization, 2018; Cassady, et al., 2019). Kessler et al. (2005) noted that most lifetime mental disorders have their first onset during or shortly before college. Universities and colleges are, however, well positioned to promote mental health amongst students as they encompass important aspects of student life such as health services, catering, accommodation, extra-curricular activities and other social networks. An improved understanding of depression in a higher education setting might be translated to multiple campuses and reach a large proportion of the young adult population. Mental health in early adulthood is crucial as it has lasting implications including academic success, future employment, successful relationships and the ability to set and achieve lifelong goals (Auerbach et al., 2018).

3.6.1 Prevalence of Depression in Western Societies

Eisenberg et al. (2007) contend that mental health among university students in western societies represents an important and growing public-health concern for which epidemiological data are required. In a web-based study on mental health among university students in the USA, an estimated prevalence rate of 15.6 per cent for undergraduates and 13 per cent for graduate students was established. The study reported that students with financial challenges are most likely to report depression and anxiety disorders and more likely to have suicidal thoughts compared to those with a stable financial background.

Eisenberg et al. (2009) also revealed that students from well-to-do families were more likely to report suicidal thoughts. The study recommended the need to address mental health challenges in young adult populations, particularly among those of lower socio-economic status. A more recent study discovered a depression prevalence rate of 23 per cent amongst students in the USA (Beiter et al., 2015). These results indicate an increase in the number of depressed individuals, and Weinberger et al. (2017) attribute this increase to the rapid increase in drug use and drug overdose, in some cases leading to death. Results for mental health prevalence from a university population are illustrated in Table 2.

Table 2: Prevalence of mental health problems in a university population (Eisenberg et al., 2007)

	Undergraduates				Graduates		
	Female N=677 %	Male N=604 %	All N=1181 %		Female N=819 %	Male N=843 %	All N=166 %
Any depression (PHQ-9)	13.8	13.8	13.8		12.5	10.3	11.3
Major depression	6.5	3.9	5.2		4.2	3.9	4.1
Other depression	7.3	9.9	8.6		8.3	6.4	7.2
Any depression or anxiety (PHQ)	6.1	2.2	4.2		5.4	2.6	3.8

Missed academic obligations due to mental health	22.4	14.3	18.4		18.2	10.8	14.1
Mental health affected academic performance	51.1	37.4	44.3		49.5	34.6	41.2

In a similar study, Bayram and Bilgel (2008) unveiled a prevalence rate of depression among Turkish university students of 27.1 per cent. The variation in prevalence rates was explained as being due to cultural differences, different measurement tools and different methods. The prevalence rate of depression in university students was reported to be higher than in average non-university populations. Such statistics are, however, not available in Zimbabwe and there is a need for more research in this area in order effectively to address the problem of depression.

Arslan et al. (2009) also studied the prevalence of depression and its correlates among students in a Turkish university. The study noted that psychological problems such as depression have significant implications for student lives, academic performance and behaviour. The Turkish version of the BDI was employed to reveal a prevalence rate of 21.8 per cent (one in every five students had a likelihood of experiencing depressive symptoms). The Turkey Mental Health Profile Report confirmed that depression was amongst the most frequently experienced mental illnesses (Erol et al., 1998, as cited in Arslan, et al., 2009).

Eisenberg et al. (2007) recommend that it is imperative to study depression among students in higher education. This is especially true for developing countries such as Zimbabwe where the majority of students are from low socio-economic backgrounds. Such study would indeed facilitate improvements in understanding and addressing mental health problems in young adult learners. A major concern is that depression still does not receive the attention required and remains one of the major causes of disability (World Health Organization, 2011). Unfortunately, individuals with moderate to severe mental illnesses including depression have a life expectancy of 10 to 20 years less than the general population (World Health Organization, 2018a). Depression impedes the economic development of a country as production is slowed down by affected persons who do not receive the required attention and whose lives may be cut short.

3.6.2 Prevalence of Depression in Non-Western Societies

Among Chinese university students the prevalence of depression was estimated to be 11.7 per cent, and socio-demographic factors were associated with causing depression in students (Chen

et al., 2013). This study also employed the BDI-II scale to measure the severity of depressive symptoms among university students. The study found no differences in depressive symptoms between male and female students. It was assumed that this could be because Chinese female students experience the same pressures and face the same job opportunities as their male counterparts. An increase in the prevalence rates has been recently noted, Lei et al. (2016) carried out a meta-analysis of 39 studies with a sample of 32,694 Chinese university students and discovered a 23.8 per cent prevalence rate of depressive symptoms. It was discovered, however, that students did not seek help as they did not perceive the need for it and also did not have any appropriate mechanisms to solve their depressive disorders (Zou et al., 2020).

Chen et al. (2013) further established that older students were more susceptible to depression than younger students and this was attributed to greater stress from factors such as employment, and financial and marriage pressures. The study also discovered that students from poor families had higher depression than those from well-off families. A person's mental health is influenced by economic conditions as one's self-esteem and self-confidence are affected, leading inevitably to depression (Weinberger et al., 2017). Similar to Weinberger et al.'s analysis, students in Zimbabwe's tertiary institutions at great risk of depression owing to the poor economic conditions prevailing in the country.

Sarokhani et al. (2013) also analysed results from studies of depression among students in various Iranian universities. The study revealed an average prevalence rate of depression among Iranian university students of 33 per cent. The study alluded to the fact that students are a special group of people who are transitioning from adolescence to adulthood, a stressful period in one's life. Most students were also reported to have left their homes for the first time to attend university, a situation similar to that of university and college students in Zimbabwe and that may entail a loss of traditional family social support. This transition period may include challenges of trying to fit into a new environment and making new friends. Being away from home generally causes anxieties (Alim et al., 2017, as cited in Islam et al., 2020). Alim et al. further assert that the pressure of academic achievement in a competitive environment, is also a determinant in one's future success and to the onset of depression. The BDI was the common assessment tool in the studies: several studies support its usefulness in measuring the presence and severity of depression in nonclinical populations.

Depression has been discovered to be highly prevalent among university students in several other non-western countries.

PREVALENCE OF DEPRESSION AMONG UNIVERSITY STUDENTS FROM DIFFERENT COUNTRIES
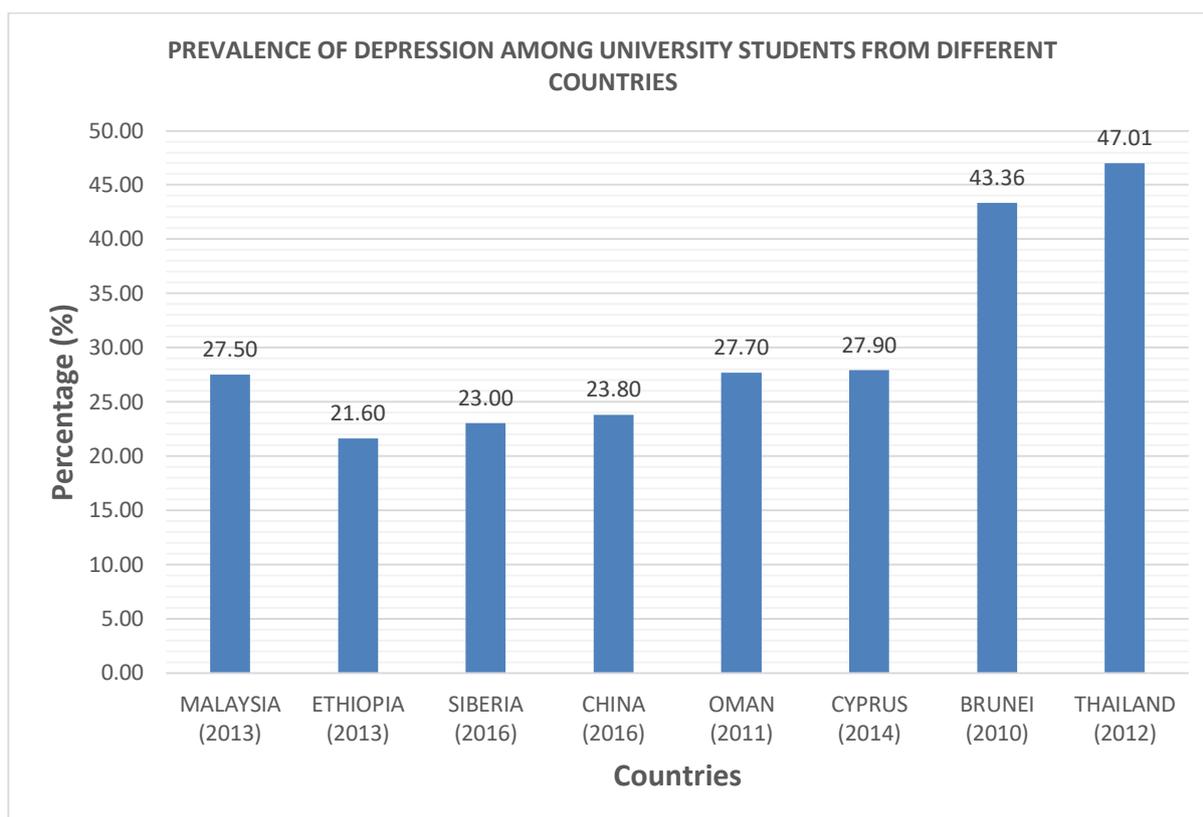
Figure 2: Prevalence of depression among university students from different countries (Lei, Xiao, Liu, & Li, 2016).

3.6.3 Prevalence of Depression in African Societies

Nwobi et al., (2009) discovered that students at the University of Nigeria were exposed to various academic, psychosocial and health-related stressors that predisposed them to mental health challenges. The study employed the BDI-II scale and revealed a prevalence rate of 61.9 per cent for minimum depression, 27.6 per cent for mild depression, 8.9 per cent for moderate depression and 1.6 per cent for severe depression. The study also discovered that factors related to the academic environment were associated with depression in students and a minimal number sought medical advice. In a more recent study of Nigerian university students, Dabana and Gobir (2018) discovered a 58.2 per cent prevalence rate with no proven statistical relationship between depression and academic factors. Depression was found not to affect academic performance, nor did it affect students' interest in their studies. Asante and Andoh-Arthur (2015) discovered a 39.2 per cent prevalence rate of depression among university students in Ghana, with similar predictors of depression to those discovered in Nigerian students by Nwobi et al. Ahmad et al. (2007) noted that psychosocial problems were often

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ignored for intervention and where there was lack of mental health services. Academic underachievement and antisocial behaviour were notably increased.

A limited number of prevalence studies have been carried out in South Africa and other African countries (Peltzer et al., 2013; Othieno et al., 2015). Bantjes et al. (2016), carried out a survey of undergraduate and postgraduate South African university students in which a prevalence of 11.2 per cent of moderate to severe symptoms of depression was reported. Depressive symptoms were reported to be most common among female students, students with disabilities and students with atypical sexual orientations (Bantjes et al., 2019). In another study, Pillay et al. (2020) discovered a 20.3 per cent prevalence of depressive symptoms among first-year students at a rural university in South Africa.

Mental illness was reported to have adverse effects on U.S. students' adjustment to university social life and academic achievement (Eisenberg et al., 2009; Alonso et al., 2018). Barriers to seeking treatment for mental health issues included stigma, low mental health literacy, financial challenges and inadequate social services, all of which contributed to increased rates of depressive symptoms and illnesses in students (Moosa & Jeenah, 2007). Prince (2015) and Castillo and Schwartz (2013) recommend effective prevention programmes, early detection of mental illness and novel treatment approaches among university students.

3.7 Understanding Depression in Different Cultures

Contemporary developments such as migrations of huge populations and globalisation have focused attention on the mental health of minority populations as the process of acculturation necessitates a different approach to mental health diagnosis in a single community. In reaction to globalisation, acculturation and other factors, the DSM-IV TR saw fit to include a list of culture-bound disorders that should be considered during diagnosis of depression in people of various cultures. Diagnosis of depression is, therefore, strongly viewed as a social practice unique in different cultures. DSM-IV of the American Psychiatric Association (1994) modestly states:

> Culture can influence the experience and communication of symptoms of depression. Under-diagnosis or mis-diagnosis can be reduced by being alert to ethnic and cultural specificity in the presenting of complaints of a major depressive episode. For example, in some cultures, depression may be experienced largely in somatic terms rather than with sadness or guilt. Complaints of nerves and headaches (in Latino and Mediterranean cultures), of weakness, tiredness, or imbalance (in Chinese and Asian cultures), of

problems of the "heart" (in Middle Eastern cultures), or of being "heartbroken" (among the Hopi) may express depressive experiences. (p. 324)

Dowrick (2013) highlighted that the DSM-IV postulates that CBS or culture syndromes of depression are considered to be "illnesses" limited to specific indigenous cultures, composed of localised diagnostic categories and used to frame coherent meanings for certain repetitive, patterned and troubling sets of experiences and observations. Examples commonly cited include *koro* in eastern Asia, *latah* in Malaysia, and *ataque de nervios* in Latin America (American Psychiatric Association, 2000). Dowrick further asserts that depression is a set of localised diagnostic categories, albeit currently operating on a larger scale than other cultural syndromes. Cultural syndromes maybe generic terms for mental disorders without a definite meaning but broad explanations ranging from healing rituals to supernatural causes of mental illness. However, over the years, a number of terms from indigenous languages have been accepted into the psychiatric literature such as the DSM-IV and DSM-V to denote depression and other mental illnesses: "To avoid stagnation in this field, it is essential to apply the concepts of clinical psychopathology to the analysis of these disorders, to integrate them into recognised classifications of diseases if possible or to broaden the classification if necessary" (Cheung, 1998 p. 3, as cited in Bhui & Gavrilovic, 2012).

3.7.1 Depression in the American Context

Major depressive disorders were reported to affect 17.3 million Americans from the age of 18 years and above, with more women being affected with the disorder than men (National Institute of Mental Health, 2017). In defining its form of depression, western culture places emphasis on individual thought, achievement and well-being (Kanazawa et al., 2007). Presentations of depressive symptoms among Americans are in terms of "internal disturbances, where an individual's needs take precedence over those of the group" (Kanazawa et al., 2007). Americans were reported to be autonomous and self-sufficient, hence the symptoms expressed as internal disturbances. As one focuses on personal successes and gratification and when people fail to achieve their objectives and with minimal social support, this may increase the likelihood of the development of a depressive disorder (Nemade et al., 2016). Therefore, the understanding of depression by individuals in a particular culture can be exacerbated by cultural expectations. Stewart et al. (2003) noted that culture influences the prevalence and expression of depression, with members of a culture receiving different levels of support.

3.7.1.1 Depression in the Amish culture in the United States of America (USA)

Nolen-Hoeksema (2007) conducted research on the Amish cultural group of the USA. The Amish were reported to lead a simple agrarian lifestyle with an emphasis on family and community well-being. The Amish were said to be religious and to maintain a simple lifestyle orientated around farming and the church. Their culture rejects modern conveniences such as telephones, electricity and cars. This rejection reduces their vulnerability to depression because competition and pressure to keep up-to-date with modern technology are minimal. The prevalence rate of depression in this culture was found to be less than one-tenth of that in the mainstream populations of the United States. Such variations in the prevalence of depression may be attributed to their simple lifestyle with its emphasis on interpersonal relationships, thereby providing a social-support system that protects members from depression.

3.7.1.2 Depression in African Americans

Eshun and Gurung (2009) revealed varying attitudes and beliefs about depression among African Americans. The study revealed that 30 per cent of African Americans believed that they could "handle" depression, as they believed that prayer and faith alone would successfully curb depression. One third of the sample also revealed that they would not take medication for depression if it were prescribed by a medical practitioner. Depression was perceived as a normal part of life that could be dealt with according to their norms and traditions. Such tendencies may cause individuals to minimise their experiences of depression and underestimate its impact on production. Bailey et al. (2018) also discovered that African Americans' strong sense of ethnic identity was a protective factor against depression.

Depressive experience has been associated with individual strength of character and willpower. Depressive experience has been conceptualised in a "moral" context. Common phrases such as "It's up to you!", "You have got to pull yourself out of it" or "It's your choice" imply that African American's thinking converts various dysfunctions and expressions into a battleground within an individual between "good" and "evil" (Marsella, 1980 in Marsella, 2003). Depressive experience therefore becomes a normal personal responsibility, in which guilt, failure and worthlessness are the "immoral" characteristics that denote a deficit or inadequacy in personal determination.

3.7.2 Depression in Asians

Some cultures are known to be organised so as to protect their members from depression. Kleinman (2004) says culture affects the interaction of risk factors and protective psychological

factors that contribute to depression. Eastern cultures operate on collectivism, which focuses on the group and the interdependency of its members, thereby creating a strong social support system. In such a scenario the group is more important than the individual and personal happiness is sacrificed for the stability of the group (Kleinman, 2004). According to Honghong (2016), Asians describe their symptoms as "interpersonal disturbances" that are mainly attributed to their emphasis on interdependence and interconnectedness of members in communities. Similar scenarios are found in Shona culture where the family and extended families are interdependent and provide social support for members. The collectivism of such cultures may, however, produce many stressors that can lead to depression. Nemade et al. (2016) highlighted that group obligations that are demanding and non-negotiable may cause an individual to feel restricted, powerless and limited.

Chinese culture is unique, with Confucianism and Taoism being at the core of the traditional Chinese value system (Honghong, 2016). Chinese tradition advocates for the rejection of individuality and self-assertion, and the maintenance of balance among natural, human and spiritual entities (Ryan, 1985). Taoism places emphasis on self-control and interpersonal harmony, while Confucianism is concerned with fulfilling social expectations and conforming to norms such as maintaining family reputation through individual achievement and respecting parents and elders (King & Bond, 1985). These belief systems play an integral role in experiences and the expression of emotion, and in cognition and mental health. Chinese people are believed to somatise their depressive symptoms as they view the body and the mind as integrated with each other and inseparable. The harmony of this combination is considered as well-being (Honghong, 2016). Somatic symptoms are described in connection with bodily pains, such as heart pain and fatigue. In some instances, after a thorough physical check-up some patients are referred to a psychiatric clinic (Lee et al., 2007).

Chinese tradition's emphasis on interpersonal relationships and the pressure to maintain these relationships play an integral role in the stigmatisation of mental illness when an individual fails to meet social obligations. Chinese peoples' well-being is greatly influenced by harmonious relationships in the social and cultural context (Hsiao et al., 2006; Maercker et al., 2015). Disharmony is thereby brought by mental illness when one is unable to meet societal expectations. Hsiao et al. (2006) suggest that this brings about a sense of guilt and shame in patients, their families and care-givers. Depression may as a result not receive adequate psychiatric attention as individuals and families try to avoid the labelling and stigmatisation associated with mental illness.

3.7.3 Depression in Aboriginal Populations

Depression in Australian Aboriginal men is understood as both a contributor to and a consequence of displacement, disconnectedness, distortion or injury of the spirit (Brown et al., 2012). Emotions were understood within the construction of the spirit, *kurunpa,* which was vulnerable to repetitive and powerful negative forces, loss, and stress across the life course. *NgangkariTjuta* (or traditional healers) are essential protectors of the community's well-being in times of trouble, sickness and sadness. The role of *NgangkariTjuta* in contemporary Aboriginal life is that of conduits or guides for community members to link to, understand, and transition between spiritual worlds and physical expressions of depression. Brown et al. (2012) elaborate that all visible, cognitive and emotional manifestations of depression were a direct consequence of the impact of worry and sadness on the health and vitality of an individual's spirit. Such revelations highlight the significant role of *NgangkariTjuta* in the preservation of mental health and healing of depression in the indigenous culture.

Brown et al. (2012) further explain that though symptoms of depression were common in Aboriginal men, the term *depression* was not frequently used in the communities. A narrative by an Aboriginal man revealed: "'Cause you can't put a word on it for Aboriginal people... We understand stress. But depression ....it's a word that is not ... even in our vocabulary" (Brown et al., 2012). Just as in findings by Van Niekerk et al. (2008) who reported that university students understand and refer to depression as "stress". There is very little recognition of depression in Aboriginal culture as either a medical diagnosis or as a cluster of affective or emotional symptoms. The study noted that there was a hesitancy to talk about emotional symptoms of depression among the participants. A weakened, displaced or misaligned *Kurunpa* was the primary explanation and expression of depression in Aboriginal men. *Kurunpa* exists in physical, emotional, and spiritual forms that could be injured, manipulated, moved, lost, felt, seen and replaced (Brown et al., 2012).

3.7.4 Depression in the Zambian Context

Zambia is a low-income country in sub-Saharan Africa with high poverty and unemployment levels (World Health Organization, 2005), a situation similar to that prevailing in Zimbabwe. The lifetime risk of developing depression is higher for women than for men (Paul et al., 2015). In Zambia, mental health is perceived as the ability to cope with demands of life and equated with a stable mind. An individual is required to meet societal expectations (Eshun & Gurung, 2009). In this context, mental illness such as depression is considered to be a regression into childhood and depressed persons are considered to be dangerous to themselves and society.

Mental illness is ridiculed and labelled with derogatory terms such as *kufunta, ukupena* and *usilu*. An individual may be considered an invalid as he/she is not able to be financially independent (Eshun & Gurung, 2009). Persons with a mental health condition are often humiliated, condemned and considered to have a form of spirit possession or social punishment as a consequence of witchcraft. The risk of mortality is increased because of stigmas attached to mental illness (Manolova, 2017). As such, depressed students in higher institutions of learning may be at risk of being labelled, discriminated against and stigmatised, all of which are major determinants in the decision to seek medical and psychological interventions.

The majority of Zambians practise Christianity and believe in prayer as a method of treatment for mental illnesses, whereas other Zambians believe in traditional practitioners who administer traditional medicines through spiritual healers. An estimated 70-80 per cent of people with mental health problems consult traditional practitioners (Eshun & Gurung, 2009; Manolova, 2017). According to Mayeya et al. (2004), acupuncture is also practised as a treatment option. In such a culture, depressed young adult students may not seek professional interventions for depression as their culture supports traditional and spiritual interventions. This scenario may perpetuate a cycle of untreated depression that has an impact on academic achievement and general interpersonal relationships.

3.7.5 Depression in the Zimbabwean Context

Doctors and mental health practitioners from western societies regarded mental health as a condition (Rosenberg, 2019). One example is J.C Carothers, a psychiatrist and consultant for the World Health Organization. In 1953, Carothers published a paper, "The African mind in health and disease: a study in ethnopsychiatry", in which he argued that the African continent's inhabitants did not possess the psychological development or a sense of responsibility to experience depression (Carothers, 1953). This contributed to several international mental health organisations not prioritising mental health in non-western societies. Research in Zimbabwe by Patel et al. (1997) revealed both that depression is a fundamental human experience and that the nature of emotional pain is not different from physical pain. Patel et al. argued that the way Zimbabweans seek help may be different from that of the western societies but human beings feel depression the same way.

The Shona culture in Zimbabwe does not have an equivalent term for depression or for most other mental illness. The idiom *kufungisisa* ("thinking too much") is used to denote depression (Patel, 2001). Zimbabweans express their depression as thinking too much,

attributing it to social stressors and to supernatural causes. Like Patel, Willis et al., 2018 also discovered that idioms of distress such "thinking deeply" (*kufungisisa*) were used to describe depression. Social stressors that are known to lead to thinking too much are, inter alia, poverty, limited public health services, civil unrest and sex inequality (Patel, 2001). Experiences of depression are also attributed to relationships and interactions with close family members and friends, stress, darkness or a lack of hope and an ambiguous future (Willis et al., 2018).

At 12.7 per cent, Zimbabwe has one of the highest prevalence rates of HIV and AIDS in sub-Saharan Africa (UNAIDS, 2019). This rate is a major contributing factor to the high prevalence of depression because of the stigma associated with HIV and AIDS (Kim et al., 2015). Adherence to treatment regimens is poor and individuals are less likely to be treated successfully (Chibanda et al., 2016; Rosenberg, 2019). The psychological and social effects of HIV and AIDS, such as stigma and labelling of an individual, render them more susceptible to depression so that the provision of holistic care presents various unique challenges. In people experiencing both depression and HIV and AIDS, negative automatic thoughts were reported to be associated with depressive symptoms and vice versa (Riley et al., 2017), thereby perpetuating the cycle of untold pain.

The Zimbabwe National Association of Mental Health (ZIMNAMH) (2019) estimates that 300,000 Zimbabweans suffer from various mental health ailments, including depression. Despite the burden of mental illness in communities there is still no provision of psychological treatment in primary care across the country. There are nine mental health institutions in the country and fewer than 20 psychiatrists in government practice. This situation is mainly due to the ailing economy as qualified personnel prefer to work outside the country for better remuneration and working conditions (ZIMNAMH, 2019). These institutions are also subject to shortages of food and drugs and mainly cater for severe mental health challenges, such as schizophrenia, without much consideration of depression (Rosenberg, 2019).

Zimbabwe's mental health policy, introduced in 1999, has attempted to decentralise mental health services but the prevailing economic situation has slowed down the effective implementation of the policy (Mangezi & Chibanda, 2010). Other issues such as HIV and AIDS, cancer, food shortages and national disasters have taken precedence and mental health continues to fall down the priority list (Chibanda et al., 2016). The mental health policy currently provides for universal access to psychiatric care and drugs (Liang et al., 2016) and safeguards the rights of a patient although it still emphasises the institutionalisation of the

mentally ill (Mangezi & Chibanda, 2010). Institutionalisation is intended to contain the illness rather than treat it, as there is a lack of appropriate modern drugs and the institutions are manned by underqualified personnel and also understaffed (Rosenberg, 2019).

In response to the critical shortage of manpower and health facilities to offer counselling services to patients suffering from depression and anxiety, Chibanda, a psychiatrist in Zimbabwe, decided to "take it to the community" (Rosenberg, 2019). In 2007, Chibanda set up a bench outside a clinic that had one of the highest rates of depression in the high-density suburb of Mbare in the capital city of Harare. He called it "the friendship bench". He then trained elderly women in how to diagnose depression using a simple questionnaire and how to do a form of problem-solving therapy. The elderly women took into consideration the patient's belief system: for instance, if the patient wanted to pray, they would pray together in a way that encouraged problem-solving (Chibanda et al., 2016). By 2015 the friendship bench was a common feature in all primary health centres in Harare and was being introduced in other cities. The introduction of friendship benches in tertiary institutions would introduced a scarce resource that would be accessible to most students who exhibit depressive symptoms.

In a study of depression, Liang et al. (2016) reported that Zimbabweans were noted to visit health services frequently and when illness was persistent or when they were not satisfied with the services, they visited providers of traditional care . General health practitioners were reported to treat symptoms of depression without addressing the root cause leading to a cycle of chronic pain as symptoms recur (Liang et al., 2016). When illness is not cured, African traditional medicines provide an alternative solution that uses spiritual power and rituals that meet patients' cultural expectations (Kajawu et al., 2015). African tradition medicines identify mental problems as supernatural, such as those associated with witchcraft or the spiritual realm (Kajawu et al., 2015) and this association leads to the stigmatisation and discrimination of an individual. In their study in Zimbabwe, Liang et al., (2016) quoted a participant's view of mental illness:

"They believe this person who is mentally sick, if I take this person to my house, what he has will come for me. That's why you find that many of our patients here are shunned. Once they suffer mental illness no one wants to take responsibility because they feel like probably the spirits are against them, or something, so if I take responsibility that same thing will come to me as well. So, once it's like that people don't want to be responsible. That's one major problem that we have in terms of

psycho-social support. Some just come and dump their relatives and disappear. They give wrong phone numbers and wrong addresses and they disappear for good because they don't want to have anything with this person anymore" (Liang et al., 2016, p. 23).

African traditional healers, faith healers and mental health practitioners rarely cooperate in the treatment of depression and other mental illnesses (Liang et al., 2016). In some cases cooperation is important, especially where the patient believes in supernatural forces as the cause of the illness. The practice of traditional healers may have a positive role in the treatment of mental ailments (Kajawu et al., 2015) though more research is required to confirm the effectiveness of their methods. Bu (2019) emphasised that depression is more than just a random "chemical imbalance in the brain". Current psychiatry should not rely only on anti-depressants, which may be a temporary solution, because there are bigger forces at work that should be resolved in order to curb depression.

3.8 Stigma in mental health

Stigma in mental health can emanate from (1) institutional barriers and (2) attitudinal barriers.

3.8.1 Institutional barriers

Abdullah and Brown (2011) describe the stigma of mental illness as the "devaluing, disgracing and disfavouring by the general public of individuals with mental illness". Stigma is often associated with discrimination or unequal treatment of people, thereby denying them resources such as access to a job and their rights as a citizen. A fear of stigmatisation may prevent mentally ill individuals from speaking out about their condition and seeking access to mental health care, ultimately leading to continued suffering as they may choose to remain silent and avoid discrimination. Hence, a culture of silence is inculcated. Though every individual has a unique experience of illness, stigma presents disadvantages at social, economic, legal and institutional levels. The World Health Organization (2001) asserts that stigmatisation of and discrimination against mentally ill persons are barriers that need to be overcomeas victims will be unable to live successfully in a community. DeFreitas et al. (2018) also discovered that stigma is an obstacle in the treatment of depression.

Parker, Gladstone and Chee (2001) noted with concern the stigma associated with mental illness in Chinese culture where depression may be viewed as a sign of weakness in an individual's character and may be a cause for family shame. This may cause a family to deny that a relative has mental illness. Most Asian cultures place emphasis on conformity to norms, emotional self-control and family recognition and respect through goal accomplishment

(Abdullah & Brown, 2011). Mental illness becomes a source of shame for the family. Some cultures do not stigmatise mental illness at all, whereas other cultures stigmatise certain forms of mental illness and yet others stigmatise all mental illness. The causes of mental illness may also influence stigmatization. WonPat-Borja et al. (2012) revealed that genetic causes of mental illness reduced willingness to marry and reproduce among Chinese American populations. In Malaysia, the belief that mental illness and suicidality stem from spiritual forces and moral weakness is rife and may be a major cause of stigmatisation of mentally ill individuals (Ibrahim et al., 2020). Stigmatisation of mental illness is reported internationally to various extents, an indication that stigmatisation of mental illness is common globally.

3.8.2   Attitudinal barriers

Attitudes toward depression vary among individuals, families and cultures. In Shona culture, the phrase "thinking too much" that is used to describe depression may not lead to stigmatization as it may not in some instances be interpreted to mean depression. In the Buddhist culture "thinking too much" is also often stigmatised whereas in other cultures it is less stigmatising (Le Touze et al., 2005; Eberhardt, 2006). In Uganda, anti-depressants were discovered to reduce the experience of "thinking too much" (Okello et al., 2012), suggesting that depression and the process of thinking too much were similar. The concept "Thinking too much" also represents a focal point for intervention before a patient progresses to a more severe form of mental illness potentially leading to higher stigmatisation.

Vankar et al. (2014) discovered that stigmatising attitudes about depression and mental health services presented a barrier to seeking help among Indian medical students. Depressed students revealed that they felt if other students learnt of their depression they would not respect their opinions. The students felt that staff members and fellow students would view them as unable to handle their responsibility and cope with academic demands. The study highlighted that depressed students were insecure about teachers, counsellors and their friends' ability to maintain confidentiality when they sought help. Behere et al. (2011) also elaborated that students may feel embarrassed and ashamed, and may turn a blind eye to their depression.

In Taiwan and Boston's Chinatown, the presence of depression in a family may lead to the labelling of particular family members as unfit for marriage (Kleinman, 2004). Such labels label depressed individuals as sick, which frees them from obligations and responsibilities. Sartorius (2007) elaborates that the stigma of mental illness is the main obstacle in the provision of professional care. A mark is attached to the patients and their families across generations

and even institutions that provide mental health care. Such labelling inhibits individuals with mental health challenges and depressive disorders from seeking treatment because the label communicates an inability to function fully that may have its roots in ancestral and traditional beliefs.

Similarly, a study by Wong et al. (2011) revealed that mental illness and high prevalence rate of depression is associated with high stigma in non-western cultures. The study revealed that symptoms of depression were simply regarded as a part of the struggles of life that do not require medical attention. It also revealed that mental distress is regarded as weak faith in God and in oneself; therefore, in order to avoid shame and gossip, depressed individuals did not seek medical attention. An individual would be viewed with low regard and as not useful in the community. Such stigmatisation leads to discrimination and reluctance to invest resources in mental health care. Individuals would consequently resort to reporting somatic symptoms that are easily accepted and diagnosed. As a result, depression would remain undiagnosed and untreated owing to fear of gossip and shame.

3.9 Genetics of Depression

Family history and twin studies globally suggest that mood disorders such as depression can be transmitted genetically within family members over generations (Viktorin et al., 2016). This implies the influence of genes that render certain individuals more vulnerable than others to depression (Chirita et al., 2015). Genetic factors contribute immensely to the cause of depression, although the exact mechanism is still unclear. The development of DNA microchip technology has enabled numerous genome-wide association studies (GWASs) to explain depression pathogens in thousands of patients with depressive disorders. These studies have, however, not been able to clearly identify specific loci responsible for depression (Shadrina et al., 2018). Depression is therefore a complicated heterogeneous disorder and a coordinated action of many genes and conducive environment are most likely responsible for depressive disorders (Chirita et al., 2015; Shadrina et al., 2018).

Genetic predisposition to depression constitutes of a configuration of dysfunctional (multifactorial) genes in an individual, and varies from one family to another (Nolen-Hoeksema, 2007). Kendler and Karkowski-Shuman (1997) (as cited in Nolen-Hoeksema, 2007) suggested that genetic factors are confirmed to increase an individual's biological sensitivity to environmental stressors by altering the neurotransmitter and neuroendocrine systems responsible for responding to stress. Kendler and Karkowski-Shuman further explain

that genetic factors were also likely to influence individuals' selection of high- versus low-risk environments for the development of depression through the creation of social relationships such as where they live and type of occupation.

Genetic Factors

Dysfunction in neurotransmitters and neuroendocrine systems

Personal characteristics that increase stress response and exposure to stressors (e.g neurotocosim)

Heightened vulnerability

Encounters with new stressors
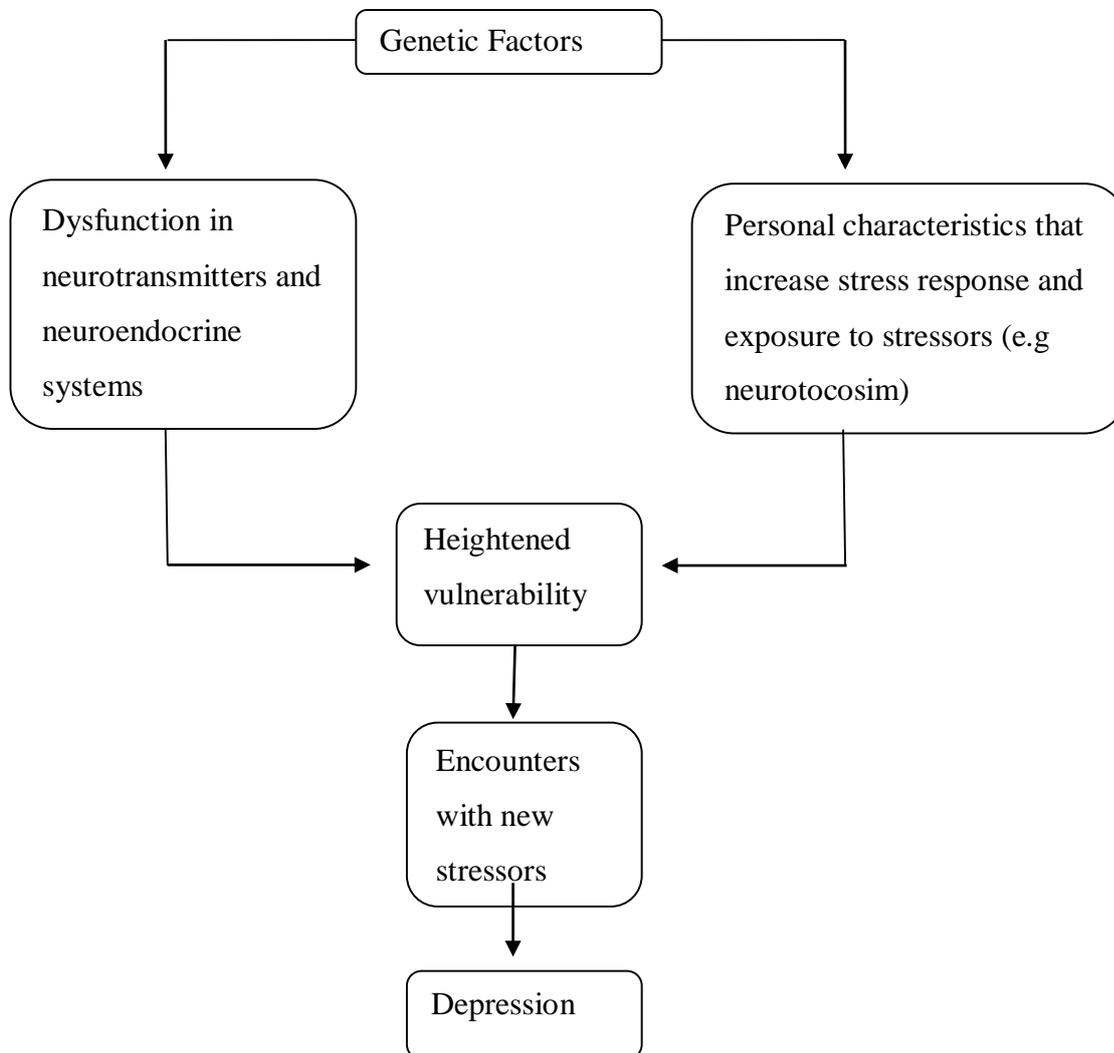
Depression

Figure 3: An Integrative Model of Depression, Proposed by Kendler and Karkowski-Shuman, (1997) (in Nolen-Hoeksema 2007)

Several neurotransmitters such as serotonin, norepinephrine and, in lesser concentrations, dopamine are responsible for increasing a person's vulnerability to depression. These neurotransmitters are located in the limbic system of the brain responsible for regulating emotional processes such as appetite and sleep (Nolen-Hoeksema, 2007). Studies confirm the serotonin transporter gene is involved in genetic abnormalities that render a person vulnerable to depression (Southwick et al., 2005). Depression may, therefore, be a result of an abnormality in the serotonin transporter gene which leads to a dysfunction in regulating serotonin. Individuals with abnormalities in the serotonin transporter gene were discovered to be at an

increased risk for depression when confronted with negative life events. Other studies confirm that in depressed individuals receptors for serotonin and norepinephrine were reported to be insensitive or too few receptors were present (Kujawa & Nemeroff, 2000).

Research on twins conducted by Breen et al. (2011) identified an area of the DNA, the chromosome 3 (called 3p 25-26), that is linked to severe recurrent depression. The region of chromosome 3 is characterised by 214 genes identified as being linked to severe recurrent depression. This region of the DNA consists of genes that contribute to an individual's vulnerability to severe recurrent depression. Approximately 40 per cent of the variation in liability to major depressive disorders and recurrent depression in studies of twins is attributed to additive effects and may be greater for early onset of depression (Viktorin et al., 2016). Studies of twins have found higher concordance rates for monozygotic twins than for dizygotic twins, whilst other studies discovered that the depression gene is more common in women than in men (Kendler et al., 2001). Other studies of twins discovered, however, that there was no gender difference in genes causing depression (Eaves et al., 1997; Kendler & Prescott 1999; Rutter et al., 1999).

Non-genetic factors such as environmental factors may be required to act as a catalyst in the cause of depression even in people with a genetic vulnerability to depression. The influence of the environment cannot be minimised because an individual inherits depression genes as well as families that provide social support to protect or expose an individual to depression. Families struggling with mental or behavioural disorders may be a haven of dysfunction (Kendler et al., 2001), which may greatly influence the onset of depression. An individual with a depression gene may be more reactive to environmental stressors that exist within the family set up and less likely to respond to treatment owing to their persistent contact with a dysfunctional family.

Matthews et al. (2015) tested the hypothesis that social isolation, loneliness and depression share similar or common genetic influences. The study reported a high correlation on the heritability of loneliness and isolation, and the genetic correlation accounted for an estimated two-thirds of the phenotypic overlap. This indicates that the co-existence of social isolation with loneliness is to a large extent driven by similar heritable characteristics of depression. Individuals with social isolation heritable traits may be predisposed to maladaptive responses to their disconnectedness, inevitably perpetuating a cycle of loneliness, social isolation and depression. Environmental factors reflected in socioeconomic and cultural factors

may also influence and shape the context in which social and personal relationships are created (Berkman et al., 2000).

3.10 Symptoms of depression experienced in various cultures

Cultural groups possess varying attitudes to and beliefs about depression, and hence experience depression in different ways. Each cultural group seems to have its own way of communicating and expressing symptoms of depression. Previously it was believed that depression affected people only in developed western nations and that people from developing nations did not experience depression (Whitley, 2015; Rosenberg, 2019). Ethno medical studies suggest that this perception may have more to do with cultural perceptions about which symptoms become labelled as depressive disorder, how occurrences of depression are recorded for statistical purposes and how depression is viewed within a particular culture (Nemade et al., 2016).

3.10.1 Symptoms of depression according to the Diagnostic Statistical Manual of Mental Disorders (DSM-MD)

The *Diagnostic and Statistical Manual of Mental Disorders* (*DSM–5*) (American Psychiatric Association, 2013) offers a standardised manual used worldwide to identify, classify and diagnose mental disorders across different cultures. Five or more of the following symptoms should be present in a depressed individual during the same two-week period. The symptoms represent a change from previous functioning.

- Persistent sad, anxious or empty feelings
- Feelings of hopelessness or pessimism
- Feelings of guilt, worthlessness, helplessness, or self-hatred
- Irritability, restlessness
- Loss of interest in activities or hobbies once pleasurable including sex
- Fatigue
- Difficulty in concentrating
- Insomnia or excessive sleeping
- Overeating or appetite loss
- Thoughts of suicide attempts
- Aches or pains, headaches, cramps, digestive problems that do not cease even with treatment

The symptoms do not meet the criteria for depression if they are due to the direct physiological effects of substance abuse or drug abuse, medication or a general medical condition. The symptoms should also not be a result of bereavement unless the symptoms persist for longer than two months, (American Psychiatric Association, 2013).

According to the American Psychiatric Association (2013), the current updated DSM-5 reflects cross cultural variations in presentation and gives more detailed and structured information about cultural concepts of distress. The manual seeks to address the fact that different cultures and communities exhibit and explain symptoms of depression in various ways. The manual's recent inclusion of cultural concepts assists mental health practitioners in recognising how people from different cultures think and talk about psychological problems. The cultural formulations assist practitioners to assess cultural factors influencing patients' perspectives of their symptoms and culturally accepted treatment options. The manual also offers a sensitive method of cultural formulation. There is, however, little research demonstrating that culturally informed approaches affect treatment outcomes. There is thus a need for research that focuses on incidences of depression in their cultural context.

Earlier, the DSM-1V classified depressive symptoms into emotional, cognitive and physiological symptoms as depression is said to take over the whole person encompassing their behaviour, thoughts and bodily functions (Nolen-Hoeksema, 2007, p. 303).

3.10.1.1 Physiological Symptoms of depression

Physiological symptoms may also be referred to as somatic or bodily symptoms and are experienced when many bodily functions are disrupted while an individual is depressed. According to Nolen-Hoeksema (2007) physiological symptoms include changes in appetite, sleep patterns and daily activity levels. An individual may experience psychomotor retardation, which may mean that he/she is quieter than before, and talks and walks more slowly than before, with their energy levels generally appearing to be depleted. On the contrary, some individuals may be agitated or hyperactive and their behaviour may become unpredictable. Appetite may also change. A depressed person may overindulge or even binge eat or eat much less than before, practically not finding any type of food appealing. Changes in sleep patterns may also be experienced. These changes may include early morning awakening and general restlessness and/or disturbances during sleep, with failure to go back to sleep being common (Bekhuis et al., 2016; Schlarb et al., 2017).

3.10.1.2 Emotional Symptoms of Depression

Beck (as cited in Halgin & Whitbourne, 2007) explains that emotional symptoms involve a dysphoric mood of an intensity that outweighs the normal disappointments of everyday life. The dysphoria may present as a loss of interest in previously pleasurable activities without a clear explanation. This is also referred to as anhedonia and occurs when the usual reactions to previously pleasurable activities are not experienced. In some cases this may be due to a loss of a loved one or any negative event in life. Feelings of sadness, however, extend beyond the normal expected periods. An individual feels a deep sense of sadness rendering one miserable and incapable of joy (Fernandes et al., 2017). One may also become easily irritated by minor events that normally just pass without an intense reaction causing an individual to feel overwhelmed.

3.10.1.3 Cognitive symptoms of depression

Cognitive symptoms are characterised by an intense negative self-view, normally reflected by low self-esteem and feeling that one needs to be punished. Nolen-Hoeksema (2007) explains that a depressed individual's thoughts may be filled with feelings of worthlessness and guilt. These feelings may also lead to thoughts of suicide, suicidal ideation and even to the actual act of suicide. A student may experience trouble concentrating in class, slowness in processing and in making decisions and good life choices (Wang et al., 2019). In severe cases one may experience hallucinations and/or delusions; this is a reflection of people losing touch with reality. Hallucinations affect sensory experiences and may be auditory, visual, and tactile and may have an impact on taste. The content of hallucinations is contextual and cultural.

3.10.2 Symptoms of depression in university and college students

Symptoms of depression in university and college students are similar to symptoms experienced by the general population as listed in the DSM-V (American Psychiatric Association, 2013). However, Ehmke (2020) in his study of college students discovered that symptoms of depression in college students may be difficult to detect especially when the student lives away from home. Ehmke further explains that some symptoms such as crying and uncharacteristic sadness were said to be easier to detect, whereas other symptoms such as poor concentration and irritability may be more difficult to detect. Other symptoms such as self-isolation and taking less interest in activities previously enjoyed were common in students and peers or staff members at the institution may notice the change in behaviour and be able to detect symptoms of depression (Ehmke, 2020).

Turner et al. (2012) are of the view that using depressive symptoms as a proxy for depressive disorder might not be as precise as using a diagnosis of depression, but doing so is more economical and can identify undiagnosed depression and at-risk students for follow-up. Students and staff members in tertiary institutions should be made aware that even mild symptoms of depression may be associated with lower grades. Studies by Backels and Wheeler (2001) noted that although university staff members see mental health problems as having an effect on academic productivity, they may not know just how prevalent these symptoms are and how they affect students. Various studies have also demonstrated that other demographic factors such as socio-economic status (Shadowen et al., 2019) and religion influence the types of symptoms experienced.

Khawaja et al. (2013) in a cross-cultural investigation of university students' depression discovered that country, gender and level had effects on the depressive symptoms of students. The study revealed that Australian students were more depressed than Iranian and Portuguese students. The Australian and Iranian students reported a significantly higher level of cognitive and affective symptoms than the Portuguese students. Demographic variables also revealed variances in cognitive/emotional, lethargy and motivation levels. It was noted that Portuguese male students had lower levels of motivation than the female students, whilst the Australian females reported higher levels of lethargy symptoms. These differences in symptoms of depression experienced across cultures are an indication that depression is common but symptoms vary and mental health practitioners should consider these variations when designing treatment programmes for students.

3.10.3 Symptoms of Depression in the Asian context

Although the DSM criteria for mood disorders are used worldwide, recent research in different cultures has resulted in new diagnostic categories of culture-bound syndromes such as the third edition of the Chinese Classification of Mental Disorders (CCMD-3). The CCMD-3 is also known as *Shenjingshuairuo* or neurasthenia (Chinese Psychiatric Association, 2001, as cited in Eshun & Gurung, 2009). The Symptoms of depression in *Shenjingshuairuo* include fatigue, dizziness, headache, joint and muscle pain, loss of concentration and gastrointestinal complaints. Earlier studies by Kleinman (1982) revealed that major depression and *Shenjingshuairuo* are similar. The symptoms of neurasthenia are reported to unfold according to a sequential script; for example, an individual may initially complain of circadian dysfunction in which he/she would be kept awake by too many thoughts and be exhausted during the day. Emotional symptoms are not entirely absent but are described as consequences

of fatigue even though they might be the main problem (Kleinman, 1982; Dere et al., 2015). The study found that 87 per cent of a sample of Hunan Chinese diagnosed with *Shenjingshuairuo* met the criteria for major depression and responded satisfactorily to anti-depressant medications.

However, perhaps due to globalisation and changing roles in Chinese society, the feelings of neurasthenia are receding while depression-like presentations are becoming common (Ryder et al., 2012). In Chinese samples in North American clinics, the emotional and cognitive symptoms were relatively deemphasised in favour of somatic symptoms such as insomnia, chronic fatigue and bodily aches and pains (Lee et al., 2007). Possible explanations for such a scenario could be that physical symptoms enable one to gain access to health-care resources which might be scarce (Yen et al., 2000). Other major symptoms associated with depression among the Chinese include reduced interest in previously pleasurable activities, hopelessness, poor concentration and suicidal ideation (Zhang et al., 2016).

Nemade et al. (2012) (as cited in Ineme & Osinowo, 2016) emphasize that cultural identity influences the degree to which individuals show somatic (physical) symptoms of depression. Some cultures are more comfortable reporting physical symptoms of depression rather than mental. Chinese students in American universities would complain about bodily discomfort, feelings of inner pressure, pain, dizziness and fatigue. Similarly, Japanese students in American universities would complain about abdominal pains, headache, and neck symptoms. In such cultures, traditional medicines to address the symptoms are more prevalent than medical and psychological interventions. Nemade et al. (2012) (as cited in Ineme and Osinowo, 2016) elaborated further that an individual may reject explanations from clinicians and prefer explanations that are favoured within the patient's culture. The key symptom of low energy is explicable in and fits with Chinese traditional medicines and is described as "life force" or "energy". These traditional medicines were treatment options for persistent mental and physical fatigue neurasthenia. A student from China in an American university may favour an explanation in terms of a flawed energy flow and reject a chemical imbalance as an explanation for the depression which is normally accepted in an American culture.

3.10.4 Symptoms of depression in Aborigines

Young adult Aboriginal men in Australia were reported to experience and describe depression in somatic forms such as insomnia, tiredness and gastrointestinal complications (Brown et al., 2012). Mood symptoms such as excessive sadness, irritability and the terms "depressed" or

"feeling depressed" were used directly by a few participants to explain subjective feelings. The study noted the recurring and intrusive nature of excessive "worry", in particular recurrent thinking about issues that caused sadness and concern. Feelings of guilt and self-reproach, which are common in western societies, are virtually non-existent in young Aboriginal men. The study revealed hidden or masked depressive symptoms, undifferentiated somatic complaints, lethargy and vital exhaustion and the strong interplay among mood, anger, impulsive acts of violence and substance misuse. Balaratnasingam and Janca (2019) also reported similar findings on symptoms of depression that include weakened spirit, irritability, homesickness, excessive worry, rumination, homesickness and drug or alcohol use amongst young Aboriginal men.

UNESCO (2002) confirmed that participants from different countries reported sad mood, anxiety, tension, and lack of energy as common symptoms of depression. Respondents from western countries reported additional symptoms of feeling guilty, whereas non-westerners reported more somatic complaints. This observation suggests that Shona learners in Zimbabwean institutions are more likely to use their somatic symptoms to describe depression. The feelings of guilt, self-blame, loneliness and anxiety commonly reported by depressed people in western societies did not seem to be part of the experiences of people living in non-western societies. Symptoms and reactions to depression are experienced differently in different cultures and can also vary between men and women.

3.10.5 Symptoms of depression in the Zimbabwean context

In Zimbabwe, similarly to various other indigenous cultures in developing countries, there are no direct equivalents in the Shona language for the term depression, (Patel et al., 2001). Multiple somatic or physical symptoms such as headaches, stomach aches and fatigue are the most common presentations of depression. Patel et al. (2001) assert further that in addition to somatic symptoms, most Shona patients, after further inquiry, would then admit to experiencing cognitive and emotional symptoms of depression. Shona models such as *kufungisia,* and the belief that supernatural factors contribute to the cause of depressive symptoms are major indicators that the role of culture in understanding depression is crucial. It is therefore important to understand the culture-specific terminology used by persons in order to assess mood in those who present somatic symptoms in order to detect depression.

Kleinman and Good (1985) are of the view that there is no universal conceptualisation of depression and that the experience and expression of depressive experience varies according

to the function of the cultural context within which it occurs. Recent studies by Patel et al. (2001) recommend, however, that methods developed in other cultures be employed to identify depression in individuals and that these methods be used in Zimbabwe owing to the universal nature of depressive symptoms. They urged that adequate attention be paid to conceptual translation. A study of depressive symptoms specifically among the Shona Zimbabwean College students has not been carried out. Hence this study will provide a contemporary analysis of symptoms experienced in light of the rapid globalisation and challenges learners are faced with in tertiary institutions of learning.

3.11 The Relationships between Depression and Learning.

Learning and acquiring an education involve an investment that is highly regarded in most cultures, especially the Shona culture where families sacrifice their meagre resources to give their children an opportunity to enrol at a learning institution. Guardians and parents have high expectations for learners to attain their educational goals. However, several factors such as depression may affect the process of learning and have a significant impact on students' ability to meet expected educational outcomes. Depression has been shown to manifest from or affect cognitions, emotions and the physical well-being of an individual, all of which are paramount in the process of learning. The relationships between depression at its various levels and learning is therefore imperative as they inform clinicians and educationists about when it is crucial to intervene to ensure learning is not interrupted.

3.11.1 Depression and learning in the United States of America

Hysenbegasi et al. (2005) reported on the impact of depression on academic productivity and its treatment among university undergraduate students in the USA. The study compared the grade point average (GPA) of students who had a diagnosis of depression and the GPA of a control group selected from the overall population. The GPA is an internationally recognised and standardised calculation used to establish the average result of grades achieved throughout a course (Warne et al., 2014). Grades may be assigned letters (for example, from A to F) or figures ranging from 1 to 6 and may be used by employers and educational institutions for the purposes of assessing an individual's capabilities and or comparing them with other applicants (Warne et al., 2014).

According to studies by Hysenbegasi et al. (2005) and Ruz et al. (2018), diagnosed depression was associated with a decrease in student GPA, whereas treated depression was not associated with a significant difference in GPA. The study further reveals that the negative

effect of depression on academic performance is reflected on a reduction of learning opportunities and a decreased capacity to demonstrate learning. Furthermore, depression is said to cause delays or inhibit students' employment searches, ultimately affecting their careers and future. Many college students have been reported not to have developed effective problem-focused coping strategies to manage the myriad of stressors they are faced with (Heller & Cassady, 2017). Especially relevant, Hysenbegasi et al. (2005) highlighted the importance of the availability of mental health services on college and university campuses in order to reduce the effect of depression on academic performance.

In their study, Hysenbegasi et al. (2005) reported on the pattern of impairment of school performance reported by undergraduate students in the six months before and six months after diagnosis of depression. Figure 4 illustrates that before diagnosis the impairment was at a minimum of 28 per cent and that after diagnosis the pattern significantly reduced to a minimum of 11 per cent.
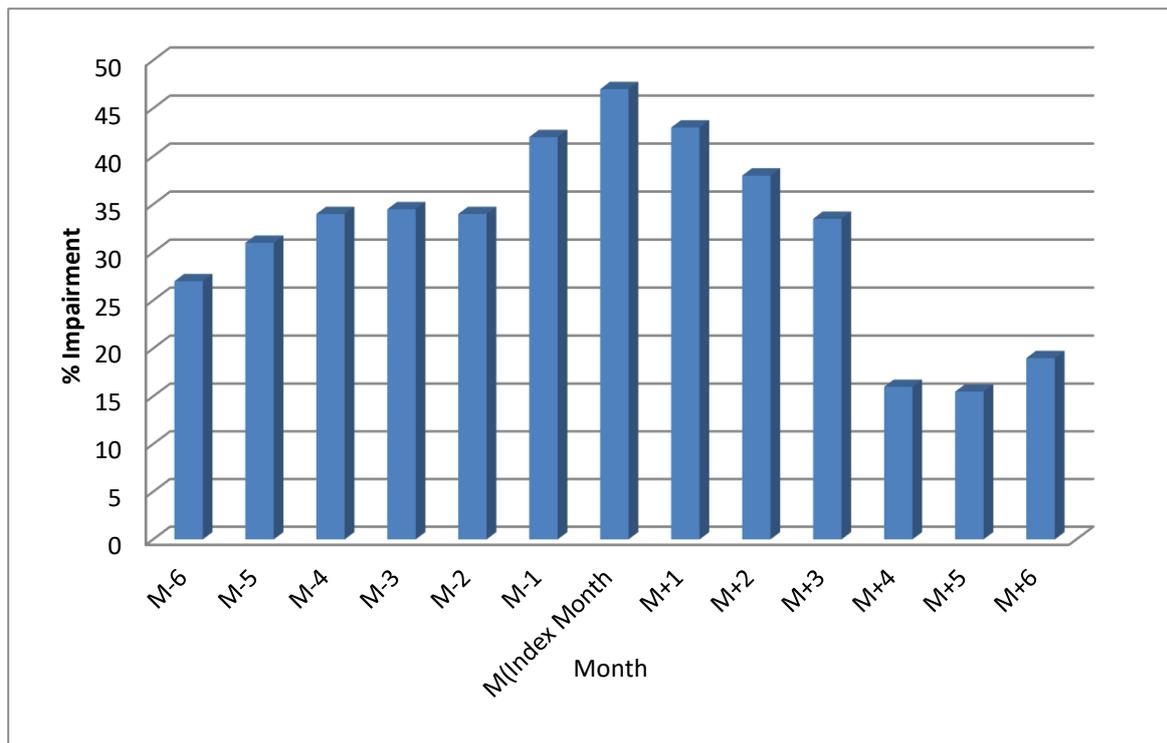
Figure 4: Self-reported impairment of school performance caused by depression in the six months before and after diagnosis of depression (Hysenbegasi, Hass & Rowland, 2005, p. 149)

On another note, the interrelatedness of depression and academic performance claims low performance as one of the causes of depression (Hysenbegasi et al., 2005). The study revealed that students claimed low school performance as one of the causes of their depressive

symptoms. None of the depressed students claimed that low school performance was the only cause of their depression; they claimed an additional two other causes. Brain and Mukherji (2005) also emphasise that the consistent use of dysfunctional problem-solving strategies and learning styles leads to an increase in frustration levels in the learner and eventually to depression. A student's learning ability may therefore be a source of depression as he/she struggles to grasp concepts and meet academic demands. Khurshid et al. (2015) are of the view that college life presents a new lifestyle, roommates and exposure to new cultures. When a student fails to manage these first experiences they may become depressed. Wechsler et al. (2000) also note that students who experience depressive symptoms are more likely to experience academic problems. Depressive episodes during learning affects an individual's concentration and learning ability. A sudden fall in grades may be associated with depression (Bernal-Morales et al., 2015).

3.11.2 Depression and learning in Pakistan

Students at a Pakistan university also exhibited a significant negative effect of depression on academic performance (Khurshid et al., 2015). Findings by Turner et al. (2012) elaborated on a significant difference between the academic performance of students with low, medium and high levels of depression. This revelation, therefore, implies that depression at any level may have an effect on academic performance though it may require different intervention strategies for effective learning to take place. The study recommended that mental health professionals should be sensitised to the effects of depression in learners and that teachers need to be vigilant and identify depressed individuals during lectures so as to recommend the most suitable treatment options.

3.11.3 Depression and learning in adolescent scholars

The current study focused on college students from the age of 18 years, which is within the adolescent age range to young adults of 30 years of age. Depression during adolescence is increasing with a tendency to continue into adulthood (Aalto-Setälä et al., 2002; Uslu et al., 2008; Costello et al., 2011; Bernal-Morales et al., 2015). Harrington et al. (1990) also reported that about 60 per cent of depressed adolescents experienced one or more episodes of depression in adulthood. Depression in adolescents becomes of interest in this study as this stage leads into young adulthood. Hence the transitional period may contribute to the onset of depressive symptoms in college students.

According to a study by Boulard (2015), many adolescents' primary concern is their education and this leads to a tendency to overinvest in the school sphere. The characteristics in his sample of adolescents may in fact continue into early adulthood and when young people fail to meet their educational expectations after overinvesting in school, they may succumb to depression. The study reported that the adolescent finds it difficult to place issues into perspective and to cope with difficult circumstances. The adolescent focuses on the professional future, which is perceived as a cognitive investment, and is hopeful of a bright future as he/she is unable to control and derive satisfaction from their present environment. The adolescent may, however, be unable to make the effort to succeed because of symptoms such as poor concentration and insomnia and may, then, plunge into a deeper depression as academic achievement is compromised (Jaycox et al., 2009; Da Fonseca et al., 2009).

Studies of secondary-school pupils in Nigeria reveal that depression slows down academic performance (Salami, 2008). Pupils with high levels of depression are less able to complete complex academic tasks. Depression was also reported to be associated with adverse short-term memory functioning in tasks requiring information processing (Dearden et al., 2005; Finger, 2006 in Salami, 2008). There was reported evidence suggesting that impaired information-processing skills affect the study habits making it difficult for pupils to accomplish academic tasks. Counsellors are recommended to design therapeutic interventions for reducing pupils' psychopathology in order to improve their study skills and performance (Salami, 2008). The studies indicate that depression disrupts the process of learning. Similar studies are yet to be carried out among Zimbabwean college tertiary students.

Turner et al., (2012) report that several studies have shown a relationship between academic performance and depression, although the relationship may not be linear. The study found that those experiencing a moderate level of depression perform worse academically than those with mild or severe depressive symptoms. By contrast, DeRoma et al. (2009) postulate that students experiencing moderate depression do not necessarily perform worse academically than those with mild depression. Earlier studies by Heiligenstein et al. (1996) discovered that severely depressed individuals are the most functionally impaired. Recently, Vankar et al. (2014) noted that Indian medical students with moderate to severe depression had a significantly higher need for psychological and academic help. The research conducted for this thesis provides a contemporary perspective on the relationships between depression at its various levels and learning among Shona students.

Heiligenstein et al. (1996) reported that depression at all levels that was exhibited in affective impairment, distress and lack of interest in school became among university students more prevalent than academic impairment. The study revealed that the risk of academic impairment became likely at only moderate to severe levels of depression. Students with impaired information-processing skills are likely to have problems in the acquisition, storing and recall of academic materials to be learned. The impact of academic impairment at various levels of depression require further investigation in order to recommend strategies that reduce the impact on productivity and academic successes. The significance of intervention before depression symptoms are severe cannot be over-emphasized in order to enable optimum performance by students.

Boulard (2015) compared life narratives of depressed with those of non-depressed adolescents in Belgium. The study revealed that life stories differed as a function of psychopathology. The adolescents presented factual information only about what happened to them. Similarly, in findings by Clarke et al. (2006), depressed adolescents spoke about their illness and defined themselves by their depression, as being sad, or having a low morale: the disease was part of their identity. Their experience of time was reported to have "stopped", to being without a future and with the past emerging from the present. Adolescents in school concentrated on school achievements, while the non-depressed group defined themselves by their social relationships. According to Üstün et al. (2004), two-thirds of adolescents do not receive medical and/or psychological treatment owing to the lack of knowledge regarding the identification of depressive symptoms as the adolescents stage is characterised by different mood swings.

3.12 Chapter Summary

This chapter discussed conceptualisations of and studies on depression, the meaning of culture in general, and Shona culture specifically to elaborate on the beliefs, norms and values for a clear understanding of the link between culture and depression.

In order to give the reader some background to the culture central to the study, the chapter also highlighted those traditions in Shona culture that shape people's perceptions of depression. The chapter reveals Shona culture's unique traditional belief systems, which originated from the inception of the culture and are still prevalent in spite of rapid globalisation. The Shona people blame bad spirits, *shavi*, especially for psychological and psychiatric illnesses. Mental illness is said to have its roots in disgruntled ancestors, implying a unique

conceptualisation of depression that cannot be holistically understood using conventional screening and diagnostic tools.

Literature related to the study was also reviewed in an attempt to address research questions. The prevalence of depression among students in various institutions of higher learning globally was illustrated. Of concern are reports of the high prevalence rates of depression, which require aggressive intervention strategies. The symptoms of depression exhibited by persons from different cultural backgrounds were key in this research as they illuminate the way symptoms are experienced and expressed. Various unique culture-bound syndromes were discovered to play a pivotal role in expressing and conceptualising depression. Of importance was the revelation of how depression at various levels affects the learning process.

CHAPTER FOUR

RESEARCH METHODOLOGY

4.1 Introduction

This chapter focuses on providing a comprehensive research methodology that guided me in exploring the relationships between depression and learning in Shona college students. I embraced a mixed-methodology design that allowed me to explore both quantitative and qualitative research methods. The chapter outlines and justifies the research methodology, which includes the research paradigm, population and sample, data-collection procedures, quality standards adhered to in this research, data management and the data analysis plan that ensured the success of this study.

4.2 Research Paradigm
4.2.1 The Pragmatic Paradigm

In this research, I acknowledge that philosophical ideas influenced the practices of this study. With this in mind, this section introduces the research paradigm from which most decisions were made (Guba & Lincoln, 2005). A research paradigm is defined as a comprehensive belief system, worldview or framework that guides a researcher and his/her practices (Willis, 2007). Owing to the study's exploratory nature, I was guided by the pragmatic paradigm, which enabled the exploration of the practices best suited to address the research question. This entailed that I make use of both qualitative and quantitative techniques. Several scholars have disagreed about combining both methods, resulting in others referring to "paradigm wars" (Muijs, 2004; Maxwell, 2013). The argument rests on the fact that qualitative and quantitative methods are underpinned by different worldviews that recommend different research techniques and quality standards and cannot, hence, be applied in one study.

By contrast, Plowright (2011) rejects the single-method approach and is of the view that an integrated methodological approach is best for answering complex issues in research, prompting the adoption of the pragmatic paradigm for this study. This paradigm allowed me to explore and select the most suitable approaches for an in-depth understanding of the research problem. The paradigm draws liberally from quantitative and qualitative approaches, paving the way for a mixed-methodology approach. Qualitative methods are said to produce subjective data, whereas quantitative methods are inclined to produce data which is objective (Muijs,

2004). Data gathered were, therefore, indicative of different outcomes reflecting the diversity and complexity of the matter under study. The pragmatic paradigm lead to an action-orientated process that sought to solve challenges faced by Shona students.

In selecting the research paradigm, I considered my knowledge of and past experiences with depression among Shona students and how I was made aware of the challenges faced by students during the process of learning. I also considered my knowledge on theoretical perspectives and literature that explained the concepts of depression, culture and learning. I also considered the value placed on the issues under study by the community I sought to investigate and the possible risks and benefits from this research. It was, therefore, important to consider "what works" in bringing out the reality (Parvaiz et al., 2016; Fetters & Molin-Azorin, 2017b) of depression in Shona students. Nguyen (2019) illustrated the factors influencing the choice of a paradigm:
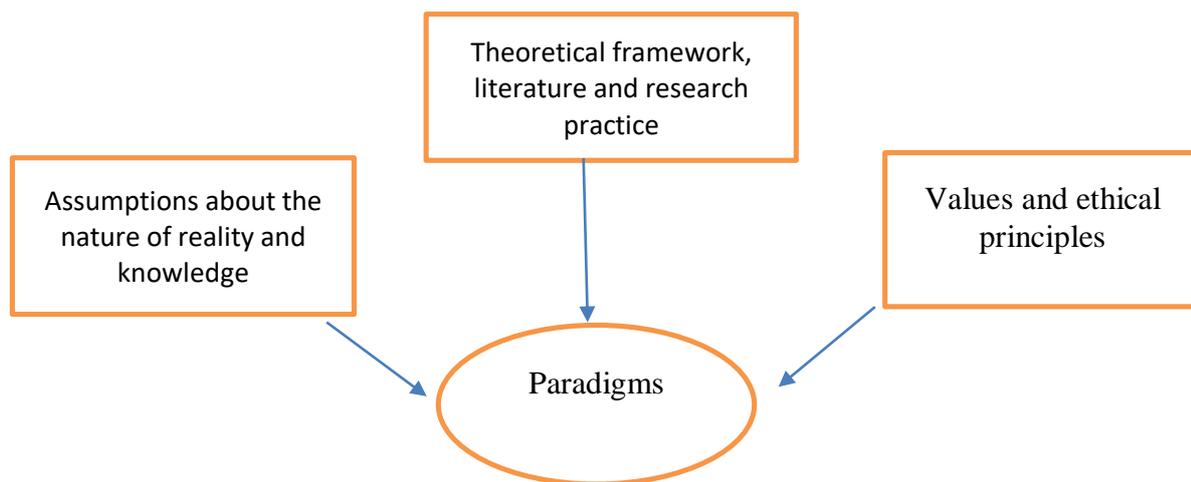
Figure 5: Selection of research paradigms in social sciences (adapted from Nguyen, 2019)

Taylor and Medina (2013) also elaborated on the composition of a research paradigm that includes the ontology, epistemology, axiology and methodology of the research. **Ontology** refers to the view of the nature of reality, which may be internal or external. A consideration of its form and nature should be made and if it exists in singular or multiple forms (Taylor & Medina, 2013). A paradigm also constitutes a related view of the type of knowledge that can be generated and standards for justifying it, also referred to as **epistemology**. The epistemology of research concerns itself with the relationships between the researcher and reality. Knowledge is derived from participants' experiences and the researcher maintains the subjectivity and objective meanings of actions (Zukauska et al., 2018)

The research paradigm also includes the **methodology** as a disciplined approach to generating knowledge (Taylor & Medina, 2013), explicitly illustrating how the researcher eventually reaches that which should be known. This includes the research design, data-collection methods, population, sample and sampling techniques, quality standards adhered to and methods used to analyse data. The nature of ethical behaviour and values constitute the **axiology** of the research; these are the values that shape the research and phenomena under study. Axiology is the requirement that research should maximise good outcomes and minimise or avoid any form of perceived or real harm that could occur to participants during research (Mertens, 2015). It was imperative to respect the rights of participants and ensure that they were not subject to any form of harm that might arise from participating in this research.
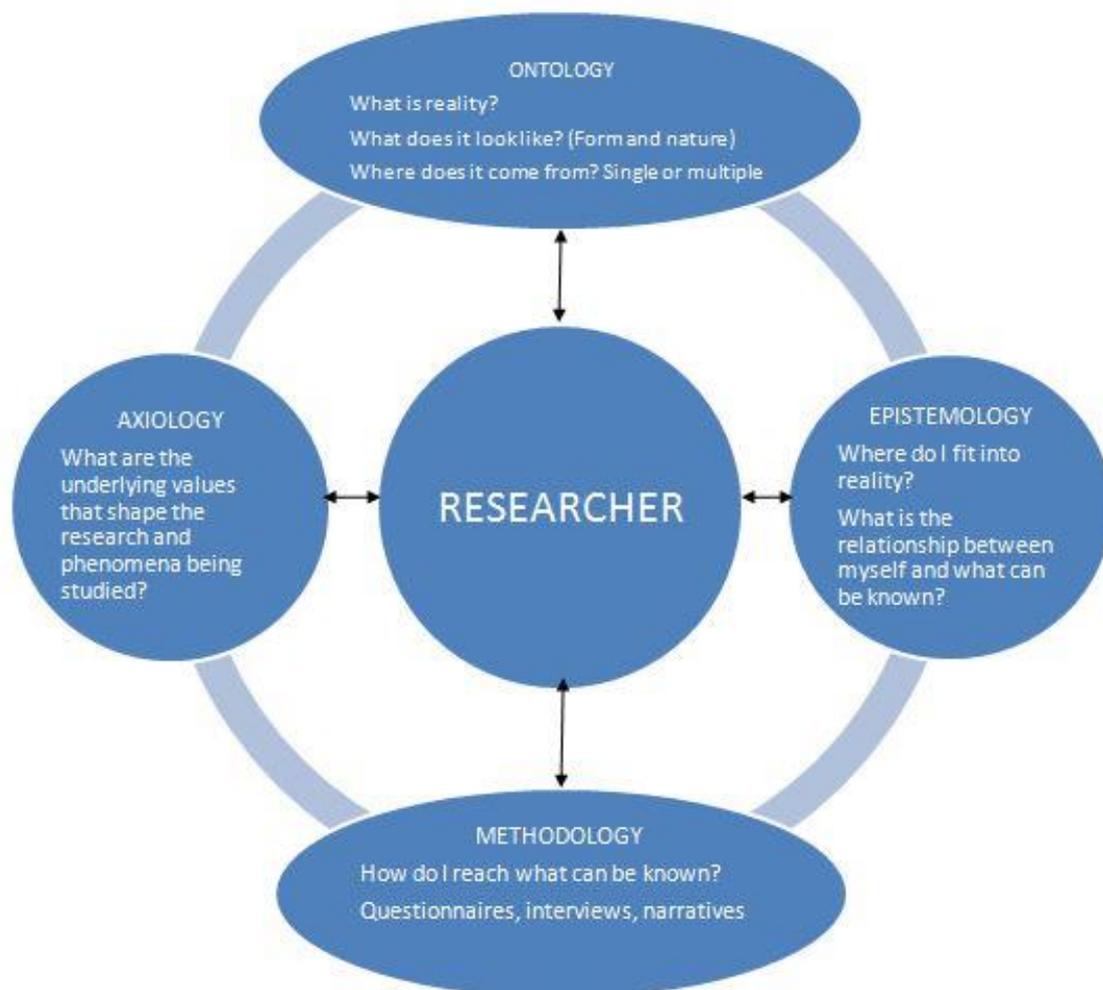
Figure 6: Questions leading to the definition of research paradigms (Nelson & Prilleltensky, 2010)

4.3 Research Methods

4.3.1 Mixed Methodologies

As outlined in the first chapter, mixed methodologies combine methods that have complementary strengths and non-overlapping weaknesses. In adopting the **mixed-methodology** approach, I initially gathered quantitative data in order to establish the prevalence and severity of depressive symptoms among 367 Shona first-year students at a polytechnic college. I collected quantitative data using a closed-ended questionnaire, the BDI-II, on the prevalence and severity ranging from minimal, mild, and moderate to the severe form of depressive symptoms. Symptoms of depression among the Shona students were identified by use of the comprehensive BDI-II questionnaire as it was formulated based on items from the DSM-IV of the American Psychiatric Association (2013). Demographic details of participants were also established to give important background information about the Shona participants. These quantitative data facilitated the selection of information-rich participants, 11 students exhibiting severe symptoms of depression and 13 lecturers who taught the students. I held interviews with 11 student participants who had severe symptoms of depression as revealed by the BDI-II rating scale. Quantitative data were collected from all 24 participants by means of a semi-structured interview guide. Interviews with lecturers were also held to corroborate findings from students on the students' experiences of depression and learning.

The mixed-methodology approach allowed triangulation of data-collection techniques, sources and theoretical frameworks, inherently validating, ensuring credibility, trustworthiness and dependability of findings which represent the underlying values that shaped this research (Kabir, 2016). Re-linking paradigms and designs best met the needs and purposes of this research. Figure 7 outlines the sequence followed in the mixed-methods design of this study.

Quantitative data collection	
Participant recruitment, volunteer Shona students	BDI-II questionnaire

Quantitative results	
SPSS for statistical data analysis	Prevalence rate and severity of depression

Qualitative data collection	
Quantitative results to determine sample for qualitative data collection (students and lecturers)	Interviews - narratives of depression from students and lecturers

Qualitative results	
Emerging depression themes from data	Thematic analysis

Figure 7: Stages illustrating the Sequential Mixed Methodology Design

4.3.2 Quality standards

Given the diverse types of data collected and methods used in the pragmatic paradigm, there is no consensus on the quality standards employed although various approaches were employed to cater for both qualitative and quantitative data. Quantitative techniques advocate for objectivity, validity, reliability and generalisability, whereas qualitative techniques recommend confirmability, credibility, transferability and dependability, which can be modified with the use of triangulation of data sources, methods and theoretical frameworks (Taylor & Medina, 2013). The collection of quantitative and qualitative data called for careful consideration in ensuring that quality standards for both types of data were observed.

4.3.2.1 Objectivity

Because objectivity in quantitative data is an essential component of competent inquiry, methods in this research were examined for bias (Creswell, 2009). In this research objectivity was assured by collecting primary data from students and making use of a structured questionnaire. The questionnaire comprised a series of closed-ended questions that are highly correlated with one another and have good internal consistency (Beck et al., 1996; Makhubela,

2015). Responses were scored and analysed using the Statistical Package for Social Sciences research (SPSS) to ensure objectivity. Patton (2002) argues that ensuring objectivity is difficult as tests and questionnaires are designed by humans, so the intrusion of researcher biases is inevitable. Objectivity and confirmability in this research significantly countered the element of researcher biases as participants completed the questionnaire and summed up their scores independently. I entered the data into the computer using Microsoft Excel and a colleague verified to minimise biases or errors and to ensure the highest level of objectivity was attained before the SPSS analysis.

4.3.2.2 Confirmability

The concept of conformability is comparable to objectivity although it is usually applied in qualitative research. Confirmability is assurance that steps taken in research ensure that findings are the result of experiences and the ideas of the research participants rather than the preferences and characteristics of the researcher (Shenton, 2004). Findings of the research should be confirmed by other researchers (Korstjens & Moser, 2018). Miles and Huberman (1994) recommend that researchers reveal their predispositions and methods adopted and that decisions made should be adequately justified and acknowledged. Weaknesses in techniques should also be revealed and methods to counter these should be clearly stated. Miles and Huberman (1994) further explain that a detailed methodological description should be outlined so that the reader determines how far the data and emerging constructs may be accepted. In order confirm research findings, an "audit trial" (p. 72) may enable the reader to retrace the course of the study step by step from how the data lead to conclusions to how the research question leads to all procedures. This research outlined all steps taken to ensure that the reader is able to understand the research step by step, enabling an acceptable level of confirmability of research findings.

4.3.2.3 Validity

The nature of validity seems clear in quantitative studies but is debated in qualitative studies. Validity in mixed-methodology studies is mainly applied to quantitative data that can be an approximation of reality and can be studied and analysed using statistical tests (Denzin & Lincoln, 2011). Valid research measures what the researcher intends it to measure. In this research, the use of well-established research methods ensured that the construct of depression was effectively measured in students of the Shona culture. Employing well-grounded research methods, I was able to demonstrate that the results of the study can be applied to a wider population provided the reader decides that their circumstances are similar to those portrayed

in this research. Maxwell (2005, p.105), says that "validity is relative". It has to be assessed in relationship to the purposes and circumstances of the research rather than as a property independent of context, methods or conclusions.

To ensure **content validity**, the research instruments in this research were scrutinised by a panel of experts so that the instruments capture what the study seeks to discover (Eshun & Gurung, 2009). Sekaran and Bougie (2013, p. 226) are of the view that "a panel of judges can attest to the validity of the instrument", in order to ascertain that the instrument measures what it purports to measure. Peer scrutiny also enabled me to refine the construction of research instruments such as the open-ended interview guide in light of the comments made. The BDI-II's content validity is also ensured as most of its items are equivalent to the DSM-1V and DSM-V standardised criteria for depression (Garcia-Batista et al., 2018). The instruments employed therefore included an adequate and representative set of items that measure the concept of depression.

The BDI-II ensured **construct validity** as it has been used successfully in several studies across cultures (Bosscher et al., 1986; Beck et al., 1988; Steer & Clark, 1997; Richter et al., 1998; Aalto et al., 2012; Abubakar et al., 2016; Lee et al., 2016; Garcia-Batista et al., 2018). An instrument becomes valid when it correlates with other instruments that measure the same construct. The BDI-II has been proven to correlate highly with other measures (Steer & Clark 1997) such as the Hamilton Depressive Rating scale with a Pearson (r – 0.71) showing good agreement (Beck et al., 1996). Construct validity testifies to how well the results garnered from the use of the instrument fit the theories around which the test is designed (Sekaran, 2003).

In this research, qualitative data validity was ensured by the use of appropriate tools, methodology, data analysis, results and conclusions (Leung, 2015), and these were presented before a panel of experts to assess their appropriateness for the research. This study also triangulated data-collection instruments in the form of questionnaires and interviews. Data-collection sources involved students and lecturers and theoretical frameworks included the Aaron Beck Cognitive-behavioural theory of depression and transcultural perspectives to ensure findings were valid.

4.3.2.4 Credibility

Equivalent to validity in qualitative research is the concept of credibility that poses the question, "How congruent are the findings with reality?" (Merriam, 2009) Credibility establishes that the findings are a correct interpretation of the participants' original views

(Korstjens & Moser, 2018). Lincoln and Guba (1985) emphasize that ensuring credibility of findings is one of the most important ways of establishing trustworthiness. It is, therefore, prudent to adopt established research methods that have been successfully employed in similar circumstances. Yin (1994) recommends the adoption of correct operational procedures for the variables under study. These may include the data-collection process and techniques, methods of data analysis, sampling techniques. Key is the process of triangulation, which establishes trustworthiness as methods and/or techniques employed corroborate findings.

In this research, I employed tactics that ensured participants gave honest and accurate responses by selecting volunteer participants so that data were collected from those who were genuinely willing to participate in research (Shenton, 2004). Individuals were given an opportunity to refuse to participate in this research and were educated on their unconditional right to withdraw from the study whenever they wished. Shenton (2004) further emphasises the importance of iterative questioning techniques, especially during interview sessions where the researcher has an opportunity to probe and to elicit detailed data. The researcher was also open to scrutiny from colleagues, peers and supervisors in order to refine methods and strengthen arguments so as to facilitate the credibility of findings. The BDI-II has been proven to have high one week test-retest reliability (Pearson r-0.93) suggesting that it is not overly sensitive to daily variations in mood (Beck et al., 1996).

4.3.2.5 Reliability

Reliability assumes, with particular reference to quantitative data, that there is a single reality and studying it repeatedly will yield the same results (Merriam, 2009). Human behaviour is not, however, static, so repeating a study may not reveal the same results. To ensure reliability, it is important to note that the results of this study are consistent with the data collected. Open-ended semi-structured interviews were held with students and lecturers in order to corroborate findings. With the aid of the Cronbach Alpha, the reliability of the questions from the questionnaire was determined whilst the SPSS ensured the reliability of the analyses.

4.3.2.6 Dependability

In addressing issues similar to reliability in quantitative research, qualitative techniques lean on the dependability of results. The argument is that owing to the ever-changing nature of phenomena scrutinised by qualitative research (Marshall & Rossman, 1999), it is not guaranteed that if the research were repeated in the same context, using same methods and participants, similar results would be obtained (Shenton, 2004). Dependability involves the

stability of findings over time (Korstjens & Moser, 2018). Lincoln and Guba (1985) stress that in order to achieve dependable results, overlapping methods such as various data-collection techniques for the same participants can be adopted. Such in-depth coverage allows the reader to assess the extent to which proper research practices were followed and to develop a thorough understanding of the methods and their effectiveness (Shenton, 2004). Furthermore, the researcher gave a clear description of the research design and how it was implemented, including details of the data-gathering process.

4.3.2.7 Transferability

After taking into account sufficient contextual information considerations, a practitioner or readers may believe that their situation is similar to that portrayed in the study and it is prudent for them to relate it to their position. Firestone (1993) says that in such a scenario transferability of research findings becomes plausible. Firestone further points out that the researcher is in no position to make transferability inferences since they are in the "sending context" (p. 70). The reader or practitioner has an obligation to pursue the description of the research report and the context within which the study was undertaken and then determine how far they can be confident to transfer results and conclusions of the research. In order to provide sufficient contextual information for transferability, thick descriptions of the phenomena under study are provided to enable understanding and comparisons of the readers' instances and those in the study (Korstjens & Moser, 2018). Thick descriptions also included boundaries of the study such as geographical locations, data-collection methods, the time within which data were collected, the number of participants and those not included, the number and length of data-collection sessions and the organisations taking part in the study (Pitts, 1994).

4.3.3 Triangulation

Triangulation in this research involved the use of different data-collection techniques, sources and theoretical frameworks so as to ensure rigour (Shenton, 2004) in procedures and strengthen the results (Patton, 2002). The idea was to gain richer insights into the interaction between depression and learning in Shona culture. Merriam (2009) says the process cross-checks data for credibility and reliability in research. This study triangulated data-collection techniques by making use of a questionnaire and interviewing participants. The BDI-II questionnaire, which consists of closed-ended questions, was employed and revealed symptoms of depression experienced by students. The students who exhibited severe symptoms of depression according to the BDI-II were further interviewed and gave in-depth explanations of symptoms experienced. In addition, a few symptoms which were not included in the BDI-II were also

revealed. The students' lecturers were also interviewed and they corroborated the students' experiences of depressive symptoms and learning while at college. Data-collection sources were thus triangulated by the collection of primary data from students and lecturers. Theoretical frameworks were also triangulated as Beck's cognitive-behavioural theory of depression and views from transcultural psychiatry assisted in the exploration of complex human behaviour and offered a more balanced explanation to readers (Noble & Heale, 2019). Evidence from different data sources, techniques and theoretical frameworks was examined to build a coherent justification for themes, a process that adds to the validity of the research (Creswell, 2009, p. 191) and the trustworthiness of findings (Shenton, 2004).

Triangulation thus ensured that data were comprehensive and provided a deeper understanding of the complex phenomenon of depression in Shona culture and learning environments. As a result, the quantitative and qualitative data collected in this research complement each other by providing a deeper understanding of variables presented through results of an analysis of students' and lecturers' life experiences with depression and the statistical data gained from student questionnaires.

4.4 Population

The institution chosen for the research had a total population of N=2,646 students in their first to fourth years of study at the time of data collection. This study focused on N=513 first-year students, in order to facilitate continuous monitoring of and psychological support for those who might require such services. Of the 513 first-year students, 218 were male, constituting 42 per cent of the study population, whereas 295 were female, constituting 58 per cent of the study population. This indicated that the institution had more female than male first-year students at the time of data collection. Two hundred and eighty-five students were between the ages of 18 and 21, and constituting 55 per cent of the population. One hundred and fifty-eight were between 22 and 25 years, constituting 31 per cent of the population, and 70 were between 26 and 30 years of age, representing 14 per cent of the study population. The population was therefore composed of young adults who were in most cases probably attempting to establish solid professional and social foundations.

The institution also had a total population of N=156 lecturers who taught all classes from first-year to fourth-year students. This study targeted N=23 lecturers who were in contact with and taught first-year students; of these, N=13 were female, constituting 57 per cent of the population, and N=10 were male, constituting 43 per cent of the study population. The

population showed that there were more female students and lecturers than male at the institution. This is a reflection of the country's population, which has more females than males (World Population Prospects, 2019).

The lecturers were between the ages of 27 and 63 years, and two were between 27 and 30 years of age, representing 9 per cent of the population. Eight lecturers were between 31 and 40 years of age, 35 per cent of the population. Seven of the lecturers were between 41 and 50 years of age, representing 30 per cent of the population. Four lecturers were within the 51 to 60 year age range, constituting 17 per cent of the population, while two of the lecturers were in the 61 to 70 year age range, representing 9 per cent of the study population.

4.5 Sample

Of the 513 first-year students, n=438 (85 per cent of the student population) volunteered to participate in the study. I physically distributed and collected n=438 BDI-II questionnaires from the volunteer participants and a 100 per cent return rate was achieved. However, n=67 (15.3 per cent) of the volunteer participants did not meet the inclusion criteria for this research. The valid sample under study for the quantitative component of the study constituted n=367 participants, which was 72 per cent of the targeted population.

For the qualitative component of the study, n=15 students were discovered to have severe symptoms of depression according to the results of the BDI-II. N=4 of the students were not interested in taking part in the second phase of the research. The sample thus constituted of n=11, 73 per cent of the volunteer student participants

The sample also consisted of n=13 volunteer Shona lecturer participants. Of the n=23 lecturers who taught the student participants, 17 per cent, n=4, were not included as they were from the Ndebele culture, while 17 per cent, n=4, were not available to participate and 9 per cent, n=2, declined to participate in the study.

The sample for the qualitative component of the research thus constituted n=13 lecturers and n=11 students, a total of 24 participants.

4.5.1 Sample size

The valid sample under study thus constituted n=367 participants, which was 72 per cent of the targeted population.

4.5.1 Sampling Procedures

This section describes the process used to select the sample for the study.

4.5.1.1 Purposive Sampling

I purposely selected students and lecturers who contributed significantly to the topic under study. The 513 first-year students were a priority in this study as they agreed to continuous monitoring during the rest of their study period. Volunteer student participants were recruited through assistance from Health and Life Skills lecturers during their lecture time. Flyers were also distributed with information about the research and my contact details. Out of the n=513 students, n=367, 72 per cent of the students were eligible to participate in the study. I asked students to voluntarily write their names, surname and contact details on the questionnaire for the purposes of recommending counselling to those who might require it and to enable me to contact them for the following data-collection phase.

In order to select those who had symptoms of depression, I physically distributed and collected the BDI-II questionnaire on the same day as they were completed by students. I went through all the questionnaires and classified them according to the BDI-II scores. I then selected the questionnaires with scores ranging from 29 to 63 as these represented students with severe symptoms of depression. During the completion of the BD1-11, a clinical psychologist was present in the classroom: in case any participant exhibited signs of distress, they were assured of receiving professional attention. However, in this case, no student reported or exhibited signs of distress. Fifteen students fitted into the category of those with severe symptoms of depression, of whom 11 agreed to volunteer to participate in the second phase of data collection. Their lecturers were also purposefully selected and asked to participate by virtue of their direct contact with the students.

4.6 Research Instruments

Instruments recommended in mixed methodology research and employed in this study included a questionnaire and the semi-structured interview schedule. The different ways of gathering data supplemented each other and boosted the validity and dependability of findings (Zohrabi, 2013). I designed a semi-structured interview guide to do qualitative interviews and also made use of the BDI-II questionnaire to collect quantitative primary data from students and lecturers.

4.6.1 Questionnaire

The BDI-II was successfully adopted for this study: the 21-item questionnaire established the prevalence and severity of depressive symptoms while also revealing students' emotional, physiological, psychological and cognitive symptoms of depression. Those who volunteered to be part of the study were issued with and requested to respond to the questionnaire. The responses were rated on a scale where a score of zero to three is assigned to each response. A total score of zero to nine indicates minimal depressive symptoms, 10 to 16 mild, 17 to 29 moderate, and 30 to 60 severe symptoms of depression. The items on the BDI-II were modified to match those of the DSM-IV and -V. A diagnosis of major depressive disorder includes establishing symptoms as per the DSM criteria and their duration, though further clinical judgement is needed (Sharp & Lipsky, 2002; Freeman & Joska, 2013).

Earlier studies by Patel et al. (1997) developed the Shona Symptom Questionnaire (SSQ), a 14-item questionnaire, written in the Shona language, to measure common mental disorders. Though the SSQ provides a sensitive method of identifying depression, the lack of conceptual and lexical equivalents to depression in the Shona language that adequately represent depression and its symptoms may pose the risk that the SSQ will not comprehensively cover all elements of depression. Whilst language and culture are strongly intertwined (Eshun & Gurung, 2009), the SSQ has not been effectively used in other studies, so it may not assure quality measurement that enable the comparison of prevalence rates of depression in students across cultures in higher and tertiary education institutions. Patel et al. (2001) observed that symptoms of depression experienced by people in Zimbabwe are fairly universal, so methods developed in another culture may be successfully applied in Zimbabwe.

This study employed the BDI-II as it has been successfully used in many other cultures in sub-Saharan Africa (Oyugiet et al., 2007, as cited in Byakika-Tusiime et al., 2009; Hamad et al., 2008; Kagee, 2008; Deribe et al., 2008) and more than 2,000 studies have employed it globally (Richter et al., 1998). Makhubela (2015) says clinicians and researchers can use the BDI-II with confidence considering the generalizability of the instrument's properties among black, white, male and female university students and its stability across time. The revised BDI-II was developed in response to the American Psychiatric Association publication of the Diagnostic Statistical Manual for Mental Disorders (4th edition), which took into account cultural variations of depressed individuals and clinicians (Beck et al., 1996). Consequently, it is more comprehensive as it addresses more items related to depression across cultures.

The BDI-II was also designed for low literacy populations ranging from adolescents of 13 years to adults of 80 years (Whisman et al., 2000). Clients require a 5th to 6th grade reading level to understand the questions (Groth-Marnat & Schumaker, 1990). Most noteworthy, the population in this study were students in a tertiary institution of learning who were highly literate and who used the English language in their academic writing and oral communication. Language was therefore not a barrier to understanding the questions posed on depression and its symptoms on the BDI-II questionnaire. In fact, using the English version of the BDI-II questionnaire was advantageous as the lexical equivalents to represent depression and its symptoms in the Shona language are scarce and may not be used on day to day practical discourse.

To ensure that the BDI-II was appropriate for the Shona participants the clinical psychologist who was present during the administration of the questionnaire requested the first class of 34 and second class of 37 students to report any ambiguous, inappropriate or irrelevant questions. The students did not report any need to edit any item on the questionnaire. However, one participant indicated that the item on loss of interest in sex was private and it was embarrassing to share that type of information though it is very important in determining depression in an individual. The clinical psychologist assured the students that their responses would remain private and confidential and be used for research purposes only. The BDI-II was therefore successfully employed in this study without adaptation.

4.6.1.1 Reliability Coefficient of the BDI-II

The Cronbach Alpha of the BDI-II questionnaire used in this study was 0.916. The Cronbach Alpha is "a reliability coefficient that indicates how well the items in a set are positively correlated to one another" (Sekaran & Bougie, 2013, p. 292). The internal consistency gets higher as the Cronbach Alpha gets nearer to 1. Values of alpha which are in the 0.70 and 0.80 range are considered acceptable and good respectively, while those less than 0.60 indicate unacceptably low reliability (Cohen et al., 2011; Sekaran & Bougie, 2013). Carmody (2005) asserts that with a Cronbach Alpha of 0.916, the BDI-II is a suitable screening tool for depression in college samples of diverse ethnic groups.

The BDI-II questionnaire has proven to possess adequate internal consistency with a coefficient alpha of 0.84 to 0.92 in previous clinical and non-clinical samples in many countries (Makhubela, 2015; Chen et al., 2013; Beck et al., 1996; Richter et al., 1998). In another study on depression among Chinese university students, Chen et al. (2013) employed the BDI-II and

a reliability coefficient of 0.851 was realised. Test re-test reliability of the BDI-II is modest with a range of r=0.60 to 0.83 in non-clinical samples (Makhubela, 2015). The BDI-II items also possess high construct validity as items correlate highly in other measures of depression (Beck et al., 1996).

4.6.2 Semi-structured Interview

I made use of a semi-structured interview guide to elicit responses from 11 students who exhibited severe symptoms of depression and from 13 lecturer participants to solicit information on their perceptions of depression and its interaction with learning in the Shona students. I gathered in-depth data as the participants narrated their stories of life experiences with depression. I was able to collect a special kind of non-verbal primary data such as the participants' facial expressions, feelings, thoughts, and intentions with regard to depression and learning. The semi-structured interview schedule provided a guide during the interview process to ensure important aspects were covered. Respondents were, however, not limited to the questions asked and this allowed complex interactions to emerge between the interviewees and me on how depression is understood and interpreted. This collaboration provided for a meaning-making process towards a comprehensive understanding of depression and learning in Shona culture.

I made individual appointments to meet with the student and lecturer participants on dates and times convenient to both the interviewer and interviewee. I diarised the appointments and the interviews were held in a private room at the college. I established a good rapport to ensure participants were free to discuss their life experiences with depression until no new themes emerged and data gathered were comprehensive.

4.7 Data Presentation and Analysis Plan

4.7.1 Statistical Analysis

The SPSS version 22.0 software programme and Microsoft Excel were used to present, analyse and interpret the quantitative data on the prevalence and severity of depressive symptoms. The program was used to ensure a thorough and precise data presentation and analysis. The program is reliable with highly interactive syntax and dialogue boxes that efficiently facilitated the sorting and defining analysis of variables. The software package enabled objective and accurate analysis of quantitative numerical data and performed crucial categorical or ordinal analysis

and regression analysis. Descriptive statistics were computed for exploratory purposes and to establish the mean, standard deviations, percentages, skewness and kurtosis in order to provide an overall comprehensive picture of the population under study.

The SPSS enabled me to obtain accurate statistical results on the prevalence rate of depression and demographic data of participants. Data screening, cleaning and vetting to capture mistakes were also carried out. I presented the quantitative data on tables and graphs and a descriptive interpretative analysis was also made so as to give a holistic analysis of the data.

Data were also analysed using the Pearson correlation method to ascertain relationships between demographic variables, depression factors and depression levels. An analysis of depressive symptoms and other emerging relationships within social patterns was made. Relationships among various variables were computed to gain a deeper insight into depression factors in this population.

4.7.1.1 Factor analysis

The first step towards the development of the linear model that predicts levels of depression as a result of changes in the 21 factors that were assessed as independent factors (of depression) was to reduce the number of factors by selecting those with the largest variance with depression-related latent variables. Factor analysis, specifically principal component analysis using the Varimax-Kaiser Normalization rotation method, was used to extract factors with the largest variance with a latent variable associated with depression. Nine components with eigenvalues above one were selected and for each of these nine components, one factor with the highest correlation with that latent variable was picked. This resulted in the extraction of nine independent variables and the elimination of factors that caused very little or no variation in the data.

4.7.1.2 Pearson correlation

Pearson correlations established the relationships between the Shona students' levels of depression and demographic data. Pearson correlations (r) between levels of depression and the nine variables were also done to assess if they had any statistically significant relationship with the dependent variable. Statistically significant correlations at $p < 0.05$ meant that there was a relationship between the dependent variable and the independent variable in question, making it possible to further test if this relationship was predictive as part of a model.

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4.7.1.3 Model building

The next step was to extract a linear regression model and test if it conformed to the general linear model in the form below:

$$Y = \beta 0 + \beta x^1 + \beta x^2 + \beta x^3 + \beta x^4 + \beta x^5 + \beta x^6 + \beta x^7 + \beta x^8 + \beta x^9$$

Where:

y:	levels of depression
$\beta 0$:	Constant
βx^1:	agitation
βx^2:	punishment feelings
βx^3:	crying
βx^4:	concentration difficulty
βx^5:	loss of energy
βx^6:	indecisiveness
βx^7:	changes in sleep patterns
βx^8:	pessimism
βx^9:	loss of interest in sex
E:	error margin

This model is an extension of the simple equation for a strength line: $Y = \beta x + c$. In the model above, levels of depression can be predicted from changes in any of the nine dependent variables with a change in any of the independent variables being expected to predict a change in the participants' level of depression.

4.7.1.4 Model testing

Finally, several tests were done to test if the model produced was able to reliably predict the above-discussed relationship and to test if the model met the assumption required for its reliability. These tests were:

1. Multiple regression correlation: to test for model fitness
2. Multiple regression correlation squared: to test for the model's power of prediction of the dependent variable in percentage terms
3. ANOVA: To test the model's fitness
4. Tolerance and Variance Inflation Factor (VIF): to test for the non-existence of correlation among the nine independent variables (multicollinearity assumption)

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In all the tests, a 5 per cent level of significance was used to determine statistical significance.

4.7.2 Thematic analysis

Data were analysed thematically in two stages that involved thematic experience analysis and a process analysis (Bold, 2012; Gubrium & Holstein, 2012). Thematic analysis is defined as a method of identifying and analysing emerging patterns in qualitative data (Clarke & Braun 2013). The data from interviews were audio recorded, then transcribed. The transcriptions were read and reread to establish codes and themes from the data (Gubrium & Holstein, 2012) with the aim of answering the research questions. The coding process involved dividing written texts into smaller segments that were in turn reassembled into a related theme. Consequently, no pre-existing codes were imposed on the data as data were examined for emerging themes.

Thematic analysis is theoretically flexible and can be applied across various theoretical frameworks and can be used to analyse different types of data (Clarke and Braun, 2013). Clarke and Braun describe six stages that were employed to analyse data in this research. The initial stage involved **familiarisation** with the data through reading and re-reading the data. Data were then analysed and labels were generated for important features through **coding**. The process of coding captured the semantic and conceptual meaning of data. I then proceeded to search for **themes** by collating the coded data relevant to each theme. Themes were also **reviewed** to ensure the story told was convincing in relation to coded extracts and the entire data set. The themes were also **defined** and **named** by identifying the "essence" of each theme and constructing an informative name that was concise for each theme. Finally, the stage of **writing up** involved weaving together the data extracts to produce a coherent and persuasive story about the data in relation to existing literature.

Features and symptoms of depression symptoms were coded based on content from the participants' interview responses and guided by the reviewed literature. As pointed out by Ryan and Bernard (2003), I kept in mind factors such as metaphors, local expressions used (in English and in Shona), analogies and where items were repeated. Features with similar meaning were grouped together (Haroz et al., 2017) to form codes, for example "social isolation" (Bolton, 2012), "social withdrawal" (Okello et al., 2012) and "lonely" (Abdur-Kadir and Bifulco, 2010, as cited in Haroz et al., 2017) were grouped together under social isolation (theme). A descriptive coding was executed in two segments as follows: (1) responses from students followed by (2) the responses from their lecturers.

The descriptive coding was validated by the use of themes from literature reviewed and I also requested two colleagues to code some of the data sets in order to compare results. These were discussed and in some instances new themes emerged. I then presented and interpreted raw data as it could not be presented as findings (Boeije, 2010). The process of presenting and interpreting data may however pose a possible risk of researcher bias and misunderstanding of the data (Babbie & Mouton, 2001). To counter this challenge, I carried out a process of member checking to ensure that participants verified that the transcribed data indeed represented their views.

The second stage involved the posing of numerous process questions, a route distinctively preferred in a constructionist analysis. This involved an analysis of research positioning: the interview process was a collaborative meaning-making process between myself (the interviewer) and the interviewee and within the cultural contexts of the interview (Bell, 2010; Esin et al., 2014). As an interviewer, I was not a neutral bystander (Stephens and Breheny, 2013) and hence my direct contribution to shaping the data from to stories narrated cannot be minimised. I am a part of the Shona community and possess an understanding of depression in Shona culture. This facilitated the building of the necessary rapport to enable the collection of sensitive data about an individual's illness. I was also able to comprehend the stories told and weave coherent thematic data sets.

4.7.3 Inclusion criteria

Data from volunteer Shona students who exhibited severe symptoms of depression according to their BDI-II responses and data from volunteer Shona lecturers who taught the student participants were included in the study.

4.7.4 Exclusion criteria

Data from students who scored below 29 out of 60 (the severe symptom range of depression) on their BDI-II test result scores and data from lecturers who belonged to other ethnic groups such as Ndebele and did not teach the student participants were not included in the study.

4.8 Scope of the research

This research was conducted at a tertiary education institution in Zimbabwe. The institution is a government institution and operates under the Ministry of Higher and Tertiary Education, Science and Technology Development and is mandated to provide Technical and Vocational Education and Training (TVET) for the education sector, industry and commerce.

The study focused on first-year young adult Shona students between the ages of eighteen and thirty as they constitute the majority of the population in the institution. The study excluded students below the age of eighteen and those above thirty years and students in their second, third and fourth years of study. This research was influenced by Shona cultural norms and values and its perception of depression, so students who were not of the Shona culture were not included in the study.

By virtue of their direct contact with depressed students, Shona lecturers who taught the student participants were information-rich participants and thus were included in the study. This decision meant that lecturers at the institution who did not teach the students or had no Shona cultural background were not included in the study.

The study included both male and female volunteer participants.

4.9 Ethical Considerations

This section presents a synopsis of the research ethics issues that I encountered during this project. As elaborated in the first chapter, ethics provided guidance in carrying out research in a moral and responsible way that befits human participants. I ensured that the participants were not subjected to any form of self-degradation, embarrassment, or violation of moral standards and principles. The ethical standards that guided me were suitably "situated" in the Shona cultural context of a tertiary education institution. Guided by the Stellenbosch University code of research ethics, I focused precisely on the following ethical principles before data collection: permission to carry out research, researcher positioning, access to context and participants, voluntary participation, informed consent, anonymity, confidentiality and data storage.

4.9.1 Permission to carry out research

Permission to carry out research was sought from and granted by the Stellenbosch University Research Ethics Committee for Human and Social Sciences (ethics number 0762). Permission was also granted by the Zimbabwean Ministry of Higher and Tertiary Education, Science and Technology Development at the Polytechnic College.

4.9.2 Researcher positioning

I was the Dean of Students at the Polytechnic College, the site of study, from 2012 to 2017. Though I was no longer employed at the institution at the time of data collection, I still held a powerful position in the college community. However, some students held a higher societal positioning with regard to their social status such as social class positioning, age and maleness.

I established a constructive rapport to ensure that participants were able to share their experiences and that my objectives were achieved. Though my societal positioning was not on a par with the participants' positions, I was able to elicit comprehensive data on depression and learning in Shona culture.

I paid particular attention to the positioning of the participants and the listeners, as sharing personal information regarding an individual's illness involved their personal, social, cultural and political worlds to collectively interact within the interview process. I also analysed various aspects of my own personal, social and cultural positioning. Having a Shona cultural background enabled me to understand and connect with participants and to negotiate meanings during the interview process. Methodological and theoretical frameworks were also aligned with the context of this research.

4.9.3 Access to context and participants

After I was granted permission by the Stellenbosch Research Ethics Committee to carry out research, I contacted the college authorities with a written request. I was granted permission by the college authorities in a written reply. Since I had been recently employed at the institution, I enjoyed a reasonably easy access to the context and participants as we previously shared a good working relationship. I nevertheless presented the letters granting me authority to carry out research to the heads of departments despite the goodwill and trust that already existed between us.

The students completed the questionnaire during their free time while on campus; they visited a designated room where the clinical psychologist and I were stationed. The interviews were also held during the participants' free time and a private room was acquired for the interview sessions.

4.9.4 Voluntary participation and informed consent

To ensure voluntary participation and informed consent, the objectives of the research and role of participants were clearly explained. I also distributed a flyer with details on the research to ensure that potential participants had the opportunity to read and to fully understand the demands of the research. This also gave them an opportunity to weigh the risks and benefits of participating before agreeing to take part in the research and inevitably placed some responsibility on the participant. I respected their human rights and ensured that a clinical psychologist was present in case the participants were confronted with any form of harm which might result from the study.

The participants contacted me of their own free will, so their participation in this research was voluntary. I informed them that they were free to withdraw from the research at any time and they would not be prejudiced. I gave the participants an opportunity to read the consent form and ask questions before signing it. The student participants who participated in the interview process also gave consent for their lecturers to participate in the research and contribute their experiences of and observations on the depressed students while in class.

4.9.5 Non-maleficence, anonymity and confidentiality

In this research, I asked participants to write their names and contact details to enable me to make a follow up and recommend professional attention to those who might require it. Though I had access to their names and contact details, these were kept confidential and pseudo-names were attached to the data for analysis. The participants were, therefore, anonymous and could not be identified from data in the final document. I acquired a private room for interview sessions and privacy was maintained. My contact details and those of the clinical psychologist were readily available to the students on the flyer and on the consent form they signed.

In addition to the presence of the clinical psychologist, I gained authority from Gweru Provincial Hospital to refer the participants free of charge to ensure they were protected from any form of harm by having access to medical and psychological attention. Nonetheless, perceived risks were pointed out in the informed consent form to ensure participants were well informed about the perceived risks and benefits of participation.

4.10 Data Storage

During the interview sessions, data were audio-recorded and notes taken. The recordings were then transcribed and the data were stored in a password-protected computer accessible only to me and my promoter. The hard copies of the completed BDI-II questionnaires were locked up in a drawer in my office and will be shredded after a minimum of five years subsequent to the completion of the research. The keys to my office and those to the lockable drawer are in my custody and access to the office will only be in my presence. I analysed the data from questionnaires using the SPSS and saved the analysis in my password-protected computer.

No fraudulent materials or unethical practices were tolerated in this research as its results and recommendations seek to address a critical, life-threatening and disabling condition that affects vibrant young adults in tertiary educational institutions in Zimbabwe.

4.11 Chapter Summary

This chapter discussed the research methodology that guided the execution of this study. The chapter illustrated how the pragmatic paradigm places emphasis on application of the most suitable methods to answer the research question. The paradigm enabled the use of mixed methodologies, which paved way for the collection of qualitative and quantitative data. Data-collection methods in the form of semi-structured interviews to gather narratives of depression and the structured BDI-II questionnaire were also discussed. The data collection methods were justified as they provided the requisite data for the research as well as permitted triangulation of data-collection methods and sources. Triangulation of data collection procedures and sources also ensured that quality standards in research (such as validity, reliability and credibility) were adhered to.

The population of this study was described as first-year students and their lecturers in a tertiary educational institution in Zimbabwe. A sample drawn using the purposive sampling technique availed the information rich participants for the success of the study. The chapter presented the SPSS as the plan employed for analysing quantitative data and a thematic analysis for the qualitative data. Research ethics, which includes permission to carry out research, researcher positioning, access to context and participants, non-maleficence, anonymity and confidentiality, voluntary participation and informed consent, was described so as to show how the researcher carried out the research in a moral and responsible way. The chapter finally described how the data collected and all research material would be stored during and after completion of the research.

CHAPTER FIVE

DATA PRESENTATION, ANALYSIS AND DISCUSSION

"WHAT IS THE PREVALENCE RATE OF DEPRESSION AMONG SHONA ADULT STUDENTS IN A TERTIARY EDUCATION INSTITUTION?"

5.1 Introduction

This chapter lays out the procedures that were followed in the data presentation, analysis and discussion on the prevalence rate of depressive symptoms among young adult Shona students in a tertiary education institution. I conducted the analyses in two stages: the statistical analysis for the quantitative, followed by a thematic analysis of the qualitative data. Quantitative data were presented in tables, graphs and descriptive form.

5.2 Quantitative Data Analysis

5.2.1 Socio-demographic data of participants

The socio-demographic data collected for this study included a comparison of gender differences for depression among men and women, the presence of depression among students in an age range of 18 to 30 years, and ethnicity groupings comprising various Shona dialects, including Zezuru, Manyika, Tonga and Ndau. The marital status (single, married, divorced or widowed) and Shona language proficiency of the participants were also determined and analysed. Socio-demographic characteristics such as gender, age, marital status and ethnicity affect an individual's predisposition to stressful situations (Noh et al., 2012) and thus influence their susceptibility to depression. An analysis of socio-demographic characteristics gives a comprehensive picture of the population under study.

Table 3: Distribution of students' demographic characteristics showing levels of depression

		Level of depression				Total
		Minimal depression	Mild depression	Moderate depression	Severe depression	
Gender	Male	93 (25.3%)	25 (6.8%)	21(5.7%)	6 (1.6%)	145 (39.5%)
	Female	142 (38.7%)	44 (12%)	30 (8.2%)	6 (1.6%)	222 (60.5%)
	Total	235 (64%)	69 (18.8%)	51 (13.9%)	12 (3.3%)	367 (100%)
Age	18 to 21	115 (31.3%)	38 (10.4%)	32 (8.7%)	5 (1.4%)	190 (51.8%)
	22 to 25	81 (22%)	20 (5.4%)	14 (3.8%)	5 (1.4%)	120 (32.7%)
	26 to 30	39 (10.6%)	11 (3.0%)	5 (1.4%)	2 (0.6%)	57 (15.6%)
	Total	235 (63.9%)	69 (18.8%)	51 (13.9%)	12 (3.4%)	367 (100%)
Shona dialects	Shona	219 (59.7%)	62 (16.9%)	50 (13.7%)	10 (2.7%)	341 (93%)
	Zezuru	13 (3.5%)	2 (0.5%)	1 (0.3%)	1 (0.3%)	17 (4.6%)
	Tonga	0 (0%)	1 (0.3%)	0 (0%)	0 (0%)	1 (0.3%)
	Ndau	2 (0.5%)	3 (0.8%)	0 (0%)	0 (0%)	5 (1.4%)
	Manyika	1 (0.3%)	1 (0.3%)	0 (0%)	1 (0.3%)	3 (0.8%)
	Total	235 (64%)	69 (18.8%)	51 (14%)	12 (3.3%	367 (100%)
Shona language proficiency	Very good	131 (35.7%)	28 (7.6%)	20 (5.4%)	5 (1.4%)	184 (50%)
	Good	71 (19.3%)	26 (7.1%)	20 (5.4%)	1 (0.3%)	118 (32.1%)
	Average	33 (9%)	13 (3.5%)	10 (2.7%)	5 (1.4%)	61 (16.6%)
	Poor	0 (0%)	2 (0.5%)	1 (0.3%)	1 (0.3%)	4 (1.1%)
	Total	235 (64%)	69 (18.7%)	51 (13.8%)	12 (3.4%)	367 (100%)
Marital status	Single	201(54.8%)	60 (16.3%)	48 (13.1%)	10 (2.7%)	319 (87%)
	Married	33 (9%)	8 (2.2%)	2 (0.5%)	2 (0.5%)	45 (12.3%)
	Divorced	0 (0%)	0 (0%)	1 (0.3%)	0 (0%)	1 (0.3%)
	Widowed	1 (0.3%)	1 (0.3%)	0 (0%)	0 (0%)	2 (0.5%)
Total		235 (64%)	69 (18.8%)	51 (13.9%)	12 (3.3%)	367 (100%)

5.2.2   Prevalence and severity of depression

The descriptive data in Table 3 reveal a 36 per cent prevalence rate of depression among college students of the Shona culture. The prevalence rate is composed of 3.3 per cent of the participants with symptoms of severe depression, which was determined by a score ranging from 29 to 63 on the BDI-II scale; 13.9 per cent with moderate depression with scores ranging from 20 to 28; and 18.8 per cent with mild depression with scores ranging from 14 to19. Students with minimal to normal scores of depression constituted 64 per cent of the study with scores ranging from 0 to13. The prevalence rate was thus calculated from scores indicating severe, moderate and mild depression ranging from 14 to 63 on the BDI-II scale.

5.2.8.1 Discussion

A depression prevalence rate of 36 per cent among young adult Shona students is relatively high compared to results from other institutions of higher learning. Studies by Arslan et al. (2009) employed the BDI-II and revealed a prevalence rate of 21.8 per cent amongst Turkish university students. Chen et al. (2013) also employed the BDI-II and estimated a depression prevalence rate of 11.7 per cent amongst Chinese university students. In South Africa, research suggests that about 12 per cent of university students experience moderate to severe symptoms of depression. Furthermore, a study at 26 university campuses in the United States of America showed that at least 17 per cent of students suffered from depression (Bantjes et al., 2017). Earlier studies in a western university by Eisenberg et al. (2007) discovered a 15.6 per cent prevalence rate among undergraduate students and a 13 per cent rate for graduate students. Although depression is a common mental health challenge in institutions of higher and tertiary learning, few studies have been conducted in universities and colleges in Africa to enable comparisons from similar socio-economic, cultural and political backgrounds to the situation in Zimbabwe.

Communities globally are generally faced with various challenges: the differences in support an individual gets from close social and family relationships may play a pivotal role in the onset of depressive disorders and hence determine the prevalence rate of different regions. Kleinman (2004) contends that culture affects the interaction of risk factors and protective psychological factors that contribute to the onset of depression. Differences in prevalence rates of depression across the globe can also be attributed to the employment of different measurement tools and to varying cultural expectations in different regions that are likely to trigger the onset of depression (Chen et al., 2013). A universal standardised measurement of depression thus becomes critical in assessing the depth of the prevalence of depression and

may also provide a basis for comparison with other communities globally though it may be adapted to suit the demands of different cultures.

In results that are similar to those in this study, Sarokhani et al. (2013) analysed results of depression among Iranian university students and discovered an average prevalence rate of 33 per cent after using the BDI-II as the common assessment tool. Studies in Nigerian university student populations also employed the BDI-II scale and discovered a high 38.1 per cent prevalence rate of depression, although a reported minimum number of students sought treatment (Nwobi, Ekwueme & Ezeoke, 2009). In another study, in Uganda, Nsereko et al. (2014) discovered a prevalence rate of 34.8 per cent, which was generally higher among students than in results from other studies in the general population. Of concern, Leino and Kisch (2005) confirmed that the prevalence rates of depression in students at higher and tertiary education institutions are higher than those of the general population. These high depression rates in university and college students are attributed to the assertion that students are subject to additional life stressors that emanate from the college environment and that are likely to result in unprecedented forms of psychopathological conditions as compared to other populations (Nsereko et al., 2014).

Unfortunately, owing to the worsening socio-economic and political climate in Zimbabwe, the depression prevalence rate is likely to increase as students' woes in higher and tertiary education continue to intensify. This inevitably places students in tertiary education in a dire situation due to the effects of depression. The World Health Organization (2011, 2018a) points out that depression is disabling and detrimental to students' social and academic goals. Such a high prevalence rate becomes an obstacle to achieving developmental goals for the local, national and international community.

5.3 Relationships between levels of depression and demographic data

The relationship between levels of depression and demographic data (including gender, age, ethnicity, marital status and Shona language proficiency) were determined using the Pearson correlation. The analysis sought to gain a deeper understanding of the effects of demographics on levels of depression among the Shona students.

Table 4: Correlations

		Levels of Depression
Pearson Correlation	Gender	-0.014
	Age	-0.098
	Ethnicity	0.018
	Shona language proficiency	0.181
	Marital status	-0.074

The data above present the Pearson Correlation for the Shona students. The data show the relationship between levels of depression in students against demographic variables. Gender indicated a -0.014, translating to a low negative relationship that suggests gender negatively relates to depression in students. Age at -0.098 indicated a low negative effect on levels of depression in students. Ethnicity indicated a 0.018, which is a low negative relationship with levels of depression. Marital status indicated a -0.074 which suggests a low negative effect on levels of depression in students. The students' Shona language proficiency, with a 0.181, suggests that it positively influences the students' relationship with depression.

5.3.1 Model Summary

Table 5: Model summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	0.197[a]	0.039	0.023	0.84774

a. Predictors (Constant): marital status, ethnicity, Shona language proficiency, gender, age

The model suggests that marital status, ethnicity, Shona language proficiency, gender and age have a 19 per cent explanatory power on how depression is expressed amongst students in tertiary institutions. Therefore, unaccounted for variables explain the 81 per cent, meaning

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that a deeper analysis of depressive factors and is needed in order to explore the deep-seated aspects of depression among Shona students within the tertiary institution.

5.3.2: ANOVA

Table 6: ANOVA

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	8.650	5	1.730	2.407	0.037[a]
	Residual	214.163	298	0.719		
	Total	222.813	303			

a. Predictors (Constant): marital status, ethnicity, Shona language proficiency, gender, age

b. Dependent Variable: levels of depression

The findings from the study suggest that marital status, ethnicity, Shona language proficiency, gender and age have a relatively low effect on levels of depression. Such findings suggest that a combination of these variables may have no significant influence on levels of depression among students in tertiary institutions.

5.3.3: Coefficients[a]

Table 7: Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	T	Sig.
1	(Constant)	1.435	0.248		5.780	0.000
	Gender	-0.006	0.105	-0.003	-0.052	0.958
	Age	-0.047	0.071	-0.049	-0.659	0.511
	Ethnicity	-0.008	0.066	-0.007	-0.124	0.901
	Shona language proficiency	0.183	0.061	0.173	2.974	0.003
	Marital status	-0.078	0.153	-0.038	-0.511	0.609

a. Dependent Variable: levels of depression

The findings demonstrate differences in the levels of influence among the demographic variables against the levels of depression among students in tertiary institutions. The data reveal that for gender P = 0.958, for age P = 0.511, for ethnicity P = 0.901, for marital status P = 0.609 and for Shona language proficiency P = 0.003. These findings suggest that marital status, ethnicity, gender and age had no significant influence on depression at its various levels amongst tertiary institution learners. However, Shona language proficiency had a slightly significant influence on depression at its various levels among students in a tertiary education institution.

5.4 Tests for normality

Tests for normal distribution of the independent variables of the study, i.e. gender, age, language proficiency, ethnicity and marital status were also carried out. Results of tests with statistically significant variables appear in Table 8.

Table 8: Tests for Normality

	N	Min	Max	Mean	Std. Deviation	Skewness		Kurtosis	
	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Std. Error	Statistic	Std. Error
Gender	367	1	2	1.60	0.490	-0.431	0.127	-1,824	0.254
Age	367	1	4	1.69	0.857	1.142	0.127	0.574	0.254
Ethnicity	367	1	6	1.20	0.772	4.348	0.127	19.600	0.254
Shona Language proficiency	367	1	4	1.69	0.784	0.751	0.127	-0.539	0.254
Marital status	367	1	4	1.14	.403	3.374	0.127	14.838	0.254
Valid n	367								

The standard deviations on the data ranged from 0.403 on marital status to 0.857 on age. These differ from the standard deviation of a normally distributed sample, which is 1. The Kurtosis scores of the sample ranged from -0.539 to 19.6, while the Skewness statistic ranged from -0.431 to 4.348. The above scores show that the data from the sample were not normally distributed and presented a skewed range. The data could not, therefore, be analysed reliably using parametric tests, i.e. tests that were based on central tendencies of that data. The Kruskal-Wallis test, which is the non-parametric equivalent of one-way ANOVA, was therefore used to assess variances of scores on depression across the study's independent variables.

5.4.1: Variations in depression based on gender

Table 9: Variations in depression based on gender

		Level of Depression				Total
		Minimal depression	**Mild depression**	**Moderate depression**	**Severe depression**	
Gender	Male	93 (25.3%)	25 (6.8%)	21(5.7%)	6 (1.6%)	145 (39.5%)
	Female	142 (38.7%)	44 (12%)	30 (8.2%)	6 (1.6%)	222 (60.5%)
	Total	235 (64%)	69 (18.8%)	51 (13.9%)	12 (3.2%)	367 (100%)

According to the statistical data in table 9, females constituted 60.5 per cent and males 39.5 per cent of the sample under study. This data indicate that Shona female students are more likely to volunteer to participate in research than their male counterparts. Of the n=145 male participants, n=52 (35.9%) had depressive symptoms with BDI-II scores ranging from 13 to 63. Male participants with severe symptoms of depression constituted 1.6 per cent of the entire sample under study, while those with moderate symptoms of depression constituted 5.7 per cent, and 6.8 per cent of the sample had mild symptoms of depression. Of the n=222 female participants, n=80 (36%) had depression symptoms with depression scores ranging from 13 to 63 on the BDI-II scale. Among the female participants, 1.6 per cent of the entire sample under study had severe depression, while 8.2 per cent had moderate depression and 12 per cent had mild depression.

Table 10: Independent samples test for differences in depression based on gender

		Levene's Test for Equality of Variances		T-test for Equality of Means					95% Confidence Interval of the Difference	
		F	Sig.	T	Df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Levels of depression	Equal variances assumed	0.727	0.394	0.249	302	0.804	0.02608	0.10484	-0.18024	0.23240
	Equal variances not assumed			0.241	181.441	0.810	0.02608	0.10821	-0.18744	0.23959

The T-Test above was administered at a 95 per cent degree of confidence interval, with the test assessing for differences in levels of depression amongst the participants on gender dimension. The findings from the study illustrated that the data distribution had equal variances. The finding demonstrated that there were no significant differences between the experiences of depression from the participants based on gender differences (P Value = 0.394). These findings imply that the experiences of depression are not gender-polarized but rather the phenomenon affects Shona male and female college students in a similar fashion. These findings also suggest that variables that influence depression cut across males and females similarly and as a result intervention strategies should target both men and women equally. Therefore, the findings suggest that gender alone does not have a significant influence on levels of depression in the targeted Shona population.

5.4.2 Discussion

The data suggest that male and female Shona students exhibit similar depression prevalence rates with slight differences in severity of depression rates particularly in the mild depression range where more females had slightly higher rates. The similar prevalence rates of depression may be attributed to equal pressures to succeed in educational goals placed on both males and females. Traditional Shona culture would have placed more pressure on the male students to succeed as they were socialised to believe that they would be the head of the family and hence should ensure that they were able to provide for their families. However, due to the influence of acculturation (Eshun & Gurung, 2009) indigenous cultures are shifting from the belief that education priority should be given to males rather than females. The female student is now faced with equal pressure to succeed in her academic endeavours. Shona male and female students in colleges are, therefore, likely to have similar prevalence rates of depression.

This observation is similar to that made by Chen et al., (2013). Chinese male and female students had similar depression prevalence rates and these may be attributed to their experience of the same pressures to achieve academically and place themselves in the job market. The pressure to achieve is embedded in families, especially in developing nations where in most cases parents and guardians sacrifice their meagre resources to send their children to higher education. This prompts a sense of indebtedness to achieve and be able to financially support the parents and guardians into old age. The emphasis in Shona culture on collectivism and maintaining a social balance is similar to Chinese culture, in which peoples' wellbeing is influenced by harmonious relationships within families and in the social and cultural context (Hsiao et al., 2006). In their analysis of several studies, Sarokhani et al. (2013) also found no differences in depressive symptoms between male and female university students in Iran. A different perspective from Eisenberg et al. (2007) discovered slightly higher prevalence rates of depression in female undergraduates and lower levels for female graduate students.

In the general Zimbabwean population, Patel et al. (2001) found depression to be significantly higher in females than in males. The research established that females were more susceptible to depression when faced with challenges that involve loss of primary sources of self-esteem. In other studies across various nations and cultures, women have been discovered to have a twofold increased risk of depression compared to men (Van de Velde et al., 2010). Kessler et al. (2003) report that the prevalence of depression in the general population is approximately 12-20 per cent, with women scoring higher than men. An academic setting may,

however, present more complex scenarios that may influence the prevalence rates of depression in males and females and across gender as compared to the general population.

Furthermore, Zimbabwe is attempting to comply with the United Nations Development Programme's (UNDP's) Sustainable Development Goals 4 and 5 (SDG 4 & 5), in which countries are urged to "Ensure inclusive and equitable quality education and promote lifelong learning for all, and to achieve gender equality and empower women and girls" (UNDP 2015). Striving to ensure that the SDGs are met by 2030 has influenced equal access to education and a drive to empower women and girls in the public and private sectors.

5.4.3 Analysis of variance in association with gender

The Kruskal-Wallis test on the variance by gender in expressions and views of depression showed statistically significant results amongst the Shona student population, as set out in Table 11.

Table 11: Kruskal-Wallis test by gender

	Chi-Square	Df	Asymp. Sig.
Pessimism	3.979	1	0.046
Punishment feelings	4.599	1	0.032
Suicidal thoughts or wishes	6.091	1	0.014
Crying	15.404	1	0.000
Irritability	7.355	1	0.007
Changes in appetite	6.740	1	0.009

The tests showed that there were statistically significant variances at $p<0.05$ across gender in the above variables. The mean rank in Table 12 further describes these statistically significant differences.

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Table 12: Mean ranking by gender

	Gender	N	Mean Rank
Pessimism	Male	145	193.02
	Female	222	178.11
	Total	367	
Punishment feelings	Male	145	196.28
	Female	222	175.98
	total	367	
Suicidal thoughts or wishes	Male	145	194.24
	Female	222	177.31
	Total	367	
Crying	Male	145	161.21
	Female	222	198.89
	Total	367	
Irritability	Male	145	198.82
	Female	222	174.32
	Total	367	
Changes in appetite	Male	145	168.34
	Female	222	194.23
	Total	367	

Males generally had higher scores on pessimism than females (mean rank of 193.02 and 178.11, respectively). This is an indication that males are more pessimistic than females. Males also scored higher on the variable feelings of being punished (Male =196.28, Females =175.98), indicating that males were more likely than females to feel that they were being punished.

On suicidal thoughts, the mean rankings were higher for males (194.24) than for females (177.31), showing that males experienced suicidal thoughts more than females. Males were, therefore, more suicidal than females, according to the results from the sample.

On crying as a variable, females had a higher mean ranking of 198.82 compared to 174.32 for males. Females also scored a higher mean rank of 194.23 than males (168.34) on changes in appetite as an indication of depression. Thus females were more likely than males to cry and to experience appetite changes as an indication of depression.

5.4.4 Depression levels based on age

Table 13: Depression levels based on age

		Level of depression				Total
		Minimal depression	Mild depression	Moderate depression	Severe depression	
Age	18 to 21	115 (31.3%)	38 (10.4%)	32 (8.7%)	5 (1.4%)	190 (51.8%)
	22 to 25	81 (22%)	20 (5.4%)	14 (3.8%)	5 (1.4%)	120 (32.6%)
	26 to 30	39 (10.6%)	11 (3.0%)	5 (1.4%)	2 (0.6%)	57 (15.6%)
	Total	235 (63.9%)	69 (18.8%)	51 (13.9%)	12 (3.4%)	367 (100%)

The mean age of the participants under study was 24 years. The students in the 18 to 21 years age-groups had a depression rate of 39 per cent, the 22 to 25 age-groups had 33 per cent and the 26 to 30 had 32 per cent. The prevalence rates in this category were calculated within the particular age range due to skewness of the population. A comparison between the age-groups may not adequately represent all the age-groups as the study concentrated on first-year students who were mostly in the 18 to 21 year range. Although the prevalence rates are in the same range, the results of this study indicate a slightly higher prevalence rate for the younger Shona student age-groups and a lower prevalence rate of depression for the older population.

The younger Shona student participants may possibly be facing challenges of adjusting to college life and these may contribute to the slightly higher prevalence rates than those for the older population, who may have already adjusted to the environment. The younger age group enrolled from high school where they may have experienced a more supportive academic and social life. They may find challenges adjusting to their new and more independent lifestyles at college more demanding. These adjustment challenges may include, amongst others, the beginning of a new life where they are expected to fit into a new environment, making new friends and decisions that shape the course of their futures.

5.4.5 Variations in levels of depression by age

Table 14 : Variations in levels of depression
by age

	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	2.756	3	0.919	1.252	0.291
Within Groups	220.057	300	0.734		
Total	222.812	303			

Table 14 shows the Analysis of Variance Test (ANOVA) administered at a 95 per cent degree of confidence interval. The test checked for variations in levels of depression among the participants according to age differences. The findings demonstrated that there were no significant differences in the experiences of depression among the participants based on age differences (P Value = .291). These findings imply that experiences of depression are not age-polarized but rather that the phenomenon affects Shona college students of all ages in a similar fashion. These findings also suggest that variables that influence depression cut across all ages similarly. Although slightly more attention may be paid to the younger age groups, intervention strategies should target all categories. Such findings suggest that age alone does not have a significant influence on depression in the targeted population.

5.4.6 Analysis of variance based on associations between age and depression

The Kruskal-Wallis test on the variances by age in expressions and views of depression showed the statistically significant results set out in Table 15.

Table 15: Kruskal-Wallis test by age

	Chi-Square	Df	Asymp. Sig.
Loss of interest	9.3394	2	0.009375

The only variable that differed across the three age-groups that were assessed was loss of interest in activities. These differences are described using mean ranking.

5.4.7 Mean ranking by age

Table 16: Mean ranking by age

	Age	N	Mean Rank
Loss of interest	18 to 21	190	188.30
	22 to 25	120	158.33
	26 to 30	38	156.57
	Total	348	

Higher loss of interest in everyday activities was experienced more in the 18 to 21 year age-group (mean rank = 188.30), followed by the 22 to 55 (mean rank = 158.33) and finally the 26 to 30 year age-groups (mean rank = 156.57). A decreasing mean-ranking pattern by age-group was noted. Younger age-groups exhibited a higher loss of interest in activities than older age-groups.

On the other variables that were not statistically significant (viz., p>0.05), it can be concluded that the sample experienced the listed symptoms or expressions more or less in a similar fashion regardless of age.

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5.4.8: Discussion

The results of this study indicate a slightly higher prevalence rate of depression for younger Shona student age-groups than for older students. This is an indication that regardless of age the students experienced depression in more or less a similar fashion. The marginal difference may be attributed to challenges for younger students in adjusting to college life compared to the older population who may find it easier to adjust to the environment. The younger age-group enrolled from high schools, which offer more support for academic and social life, and this may explain why they find it challenging to adjust to their new and more independent lifestyles. These adjustment challenges may include, amongst others, the beginning of a new life where they are expected to fit into a new environment, and to make new friends and decisions that shape the course of their futures. The decrease in social support and higher social expectations from family and from themselves increase their vulnerability to depression. Steptoe et al. (2007) assert that most students who move from their homes for the first time may be subject to loss of their accustomed social support from friends and family members.

Contrary to the findings of this research, Chen et al. (2013) established that the older generation was more vulnerable to depression than the younger age-groups owing to challenges such as marriage and employment pressures. Some communities silently prescribe that when young adults reach a certain age they should be married and / or financially stable, thereby putting pressure on a student who has not met those demands. King and Bond (1985) established that in Chinese traditional culture, Taoism and Confucianism place emphasis on fulfilling social expectations such as marriage and conforming to norms such as maintaining family reputation through individual achievement, which includes academic achievement.

Kessler and Bromet (2001) also noted a decrease in the prevalence rate of depression among older students as was established in this thesis. They state further that episodes of major depression are most common in late adolescence or early to middle adulthood and that the peak risk period for the onset of depression is late adolescence to the early 40s. This conclusion places college students at the centre of the depression peak risk period as they are not only faced with adjusting to college pressures but also experience a transition that must lay the foundation of a successful career and social life. Kessler and Bromet (2001) also discovered that the link between age-group and the onset of depression varied significantly in different countries. They also found no significant association between age and the onset of depression in five countries in the middle- to low- income range. This analysis indicates that depression may not necessarily be associated with a particular age-group.

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5.4.9: Depression levels based on Shona dialects

Table 17: Depression levels based on Shona dialects

		Level of depression				Total
		Minimal depression	Mild depression	Moderate depression	Severe depression	
Shona dialects	Shona	219 (59.7%)	62 (16.9%)	50 (13.7%)	10 (2.7%)	341 (93%)
	Zezuru	13 (3.5%)	2 (0.5%)	1 (0.3%)	1 (0.3%)	17 (4.6%)
	Tonga	0 (0%)	1 (0.3%)	0 (0%)	0 (0%)	1 (0.3%)
	Ndau	2 (0.5%)	3 (0.8%)	0 (0%)	0 (0%)	5 (1.4%)
	Manyika	1(0.3%)	1 (0.3%)	0 (0%)	1 (0.3%)	3 (0.8%)
	Total	235 (64%)	69 (18.8%)	51 (14%)	12 (3.3%	367 (100%)

The results indicate that 93 per cent of the participants speak the standard Shona dialect and had a 33.3 per cent prevalence rate of depression. The Zezuru dialect constituted 4.6 per cent of the population with a 1.1 per cent prevalence rate; 0.3 per cent of the participants speak the Tonga dialect had a 0.3 per cent prevalence rate. The Ndau dialect was represented by 1.4 per cent with a prevalence rate of 0.8 per cent, while 0.8 per cent use the Manyika dialect and have a depression prevalence rate of 0.6 per cent. The sample under study was thus largely composed of standard Shona-speaking students with a smaller fraction (7 per cent) who speak a different Shona dialect. The Shona people originate from various geographical locations across the country, where different dialects of Shona are spoken. These dialects provide varying linguistic support and an in-depth picture of the various lexical items used in describing, conceptualizing and expressing depression. A comparison of depression prevalence rates amongst students who speak the different Shona dialects was, however, not possible as the sample in this study was not an adequate representation of all Shona dialects.

5.4.10: Variations in levels of depression based on Shona dialects

Table 18: Variations in levels of depression based on Shona dialects

	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	3.918	5	.784	1.067	.379
Within Groups	218.894	298	.735		
Total	222.812	303			

The Analysis of Variance Test (ANOVA) above was administered at a 95 per cent degree of confidence interval. The test assessed differences in levels of depression among the participants according to differences in Shona dialects used. The finding demonstrated that there were no significant differences in the experience of depression among the participants based on Shona dialect differences (P Value = .379). These findings imply that experiences of depression are not dialect-polarized but rather that the phenomenon affects speakers of all Shona dialects and that this applies equally to Shona college students. These findings also suggest that variables that influence depression cut across all dialects similarly and that intervention strategies should target all categories. Therefore, the findings suggest that Shona dialect differences alone do not have a significant influence on levels of depression among the Shona college students.

5.4.11 Analysis of variance based on associations between Shona dialects and depression

The Kruskal-Wallis test on variations according to Shona dialects in expressions and views of depression showed that how students expressed depression indicators was not differentiated according to dialect. The tests on all the variables did not indicate statistically significant variations on these expressions. It can, therefore, be concluded that in this study, Shona dialect did not influence how they scored on the depression indicators provided.

5.4.12 Discussion

The data indicate that the standard Shona language and the various related dialects have similar words to describe their experiences of symptoms of depression. Therefore, the Ndau, Tonga or any other Shona dialect did not provide a term which is semantically equivalent to depression hence the various dialects did not influence different understandings and experiences of

depression. The fact that the Shona language lacks explicit vocabulary to express depression leads to the conclusion Shona culture does not fully embrace depression as a disease entity. Patel et al. (2001) acknowledge the absence of diagnostic labels for depression in non-European languages as a major challenge in understanding and expressing depressive symptoms.

In their study, Abubakar et al. (2016) reveal that the Swahili or Kigiryama languages have no direct term for depression. Possible suggestions of terms meaning deep sadness and thinking too much were used to represent depression. In the absence of specific indigenous language for terms for depression, it can only be identified through reporting a set or cluster of related symptoms that occur over a period of time. It is, therefore, important that mental health caregivers be familiar with the indigenous language and culture of their patients in order to diagnose depression.

5.4.13 Depression levels based on Shona Language proficiency

Table 19: Depression levels based on Shona language proficiency

		Level of depression				Total
		Minimal depression	Mild depression	Moderate depression	Severe depression	
Shona language proficiency	Very good	131 (35.7%)	28 (7.6%)	20 (5.4%)	5 (1.4%)	184 (50.1%)
	Good	71 (19.3%)	26 (7.1%)	20 (5.4%)	1 (0.3%)	118 (32.1%)
	Average	33 (9%)	13 (3.5%)	10 (2.7%)	5 (1.4%)	61 (16.6%)
	Poor	0 (0%)	2 (0.5%)	1 (0.3%)	1 (0.3%)	4 (1.1%)
	Total	235 (64%)	69 (18.7%)	51 (13.8%)	12 (3.4%)	367 (100%)

The results as illustrated in table 19 indicate that 50 per cent of the students had a very good level of proficiency in the Shona language, with a depression prevalence rate of 14.4 per cent, while those with a good level of proficiency constituted 32 per cent of the population under study with a 12.8 per cent prevalence rate of depression. Sixteen per cent of the population were average proficiency Shona speakers with a prevalence rate of 7.6 per cent, and 1.1 per cent were poor proficiency Shona speakers with a prevalence rate of 1.1 per cent. This may be an indication that though Shona is a first language for most students, some students may

communicate in other languages such as English and Ndebele, compromising their proficiency in spoken Shona. This study was carried out at a tertiary education institution where the medium of communication is English. The students' Shona language proficiency did not hamper effective communication and data gathering in this research.

5.4.14 Variances in levels of depression based on Shona language proficiency

Table 20: Variances in levels of depression based on Shona language proficiency

	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	10.073	3	3.358	4.735	0.003
Within Groups	212.739	300	0.709		
Total	222.812	303			

The Analysis of Variance Test (ANOVA) above was administered at a 95 per cent degree of confidence interval. The test assessed differences in levels of depression among the participants based on their Shona language proficiency differences. The finding demonstrated that there were significant differences between the experiences of depression of the participants based on Shona language proficiency differences (P Value = .003). These findings imply that the Shona college students' experiences of depression at it various levels are affected by their Shona language proficiency. These findings also suggest that variables in Shona language proficiency that influence depression are unique to the level of proficiency. Therefore, such findings suggest that Shona language proficiency alone does have a significant influence on levels of depression in the targeted population and as such has an impact on experiences, knowledge and understanding of depression as a clinical pathology.

Fenta, Hyman and Noh (2004) assert that personal resources such as language fluency, ethnic pride and positive attitudes towards acculturation exert beneficial effects on mental health. A good language proficiency is important as it provides the necessary vocabulary that enables an individual to express their experiences of depressive symptoms. As the data indicate that most of the students in this study were proficient in their first language, Shona, this is an indication that their ability to articulate their depressive symptoms was not limited by their vocabulary or knowledge of the language.

Though the students were proficient in their language, the scarcity of vocabulary in Shona to describe depression and its symptoms influences their understanding of the illness and even the attitude they adopt towards it. An illness that is not talked about in a society's daily discourse may be regarded as non-existent or even taboo, especially if its cause is related to negative spiritual forces that bring shame to the family. This may lead to stigmatisation and discrimination against persons with depression and may influence their decision to seek treatment.

5.4.15 Depression levels based on marital status

Table 21: Depression levels based on marital status

		Level of depression				Total
		Minimal depression	Mild depression	Moderate depression	Severe depression	
Marital status	Single	201(54.8%)	60 (16.3%)	48 (13.1%)	10 (2.7%)	319 (86.9%)
	Married	33 (9%)	8 (2.2%)	2 (0.5%)	2 (0.5%)	45 (12.3%)
	Divorced	0 (0%)	0 (0%)	1 (0.3%)	0 (0%)	1 (0.3%)
	Widowed	1 (0.3%)	1 (0.3%)	0 (0%)	0 (0%)	2 (0.5%)
Total		235 (64%)	69 (18.8%)	51 (13.9%)	12 (3.3%)	367 (100%)

The study revealed that 87 per cent of the 367 participants were single with a depression prevalence rate of 36.9 per cent, while 12.3 per cent were married with a prevalence rate of 26.6 per cent. The population under study also consisted of n=1, 0.3 per cent divorced student who was depressed and hence a 100 per cent prevalence rate in that category. Of the n=2, 0.5 per cent widowed students, n=1 was depressed, hence a 50 per cent prevalence rate. Owing to the skewed population under study, results of divorced, widowed and married students may not adequately represent their population.

The depression prevalence rates were calculated within each category. The results indicate a high prevalence rate among single students. Since most first-year students are single, the other categories may not be adequately represented to compare results. The results show that most first-year students at the college are single and if we consider the dominant age-groups, it is logical to assume that most students enrol in college soon after high school and before committing themselves to marriage; therefore, they are mostly single. Kessler and

Bromet (2001) discovered that separated or divorced persons had a significantly higher rate of major depression than married persons. This can be attributed to the lack of accustomed social support and in some cases financial support from a partner, thereby increasing an individual's susceptibility to depression.

5.4.16 Variances in levels of depression based on marital status

Table 22: Variances in levels of depression based on marital status

	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	1.623	2	.812	1.104	.333
Within Groups	221.189	301	.735		
Total	222.813	303			

The Analysis of Variance Test (ANOVA) above was administered at a 95 per cent degree of confidence interval. The finding demonstrated that there were no significant differences between the experiences of depression from the participants based on marital status differences (P Value = .333). These findings imply that the experiences of depression are not polarized according to marital status but rather that the phenomenon affects Shona college students of any marital status in a similar fashion. These findings also suggest that variables that influence depression cut across all marital statuses similarly and, as such, intervention strategies should target all categories. Therefore such findings suggest that marital status differences alone do not have a significant influence on levels of depression in the targeted population.

5.4.17 Analysis of variance based on associations between marital status and depression

The Kruskal-Wallis test on the variance of depression expressions and views by marital status showed the statistically significant results depicted in Table 23.

Table 23: Kruskal-Wallis test by marital status

	Chi-Square	Df	Asymp. Sig.
Self-dislike	9.602	3	0.022
Suicidal thoughts or wishes	9.647	3	0.022
Changes in sleep patterns	9.051	3	0.029
Loss of interest in sex	9.192	3	0.027

The tests showed that there were statistically significant variances at p<0.05 across marital status categories in the above variables. The mean rank on table 24 further describes these statistically significant differences.

5.4.18 Mean ranking by marital status

Table 24: Mean ranking by marital status

	Marital Status	N	Mean Rank
Self-dislike	Single	319	187.18
	Married	45	159.77
	Widowed	2	133.00
	Divorced	1	362.50
	Total	367	
Suicidal thoughts or wishes	Single	319	185.67
	Married	45	169.57
	Widowed	2	158.00
	Divorced	1	352.00

	Total	367	
Changes in sleep patterns	Single	319	180.91
	Married	45	199.97
	Widowed	2	356.00
	Divorced	1	108.00
	Total	367	
Loss of interest in sex	Single	319	183.22
	Married	45	179.71
	Widowed	2	331.00
	Divorced	1	331.00
	Total	367	

Because there were only two widowed persons and one divorced person in the analysis, these categories were excluded from the interpretation of the Kruskal-Wallis test mean ranks above. First-year students arrive mostly straight from high school and are not yet married or widowed. They were not adequately represented to enable the computation of meaningful statistics to represent their category.

There was a statistically significant variance by marital status on the variable "self-dislike" as an expression of depression. Single persons feel or experience self-dislike more than married persons (mean ranking for single = 187.18, for married, 159.77). Such a revelation may lead to the notion that marriage is a sanctuary that brings about self-appreciation due to the confirmation of commitment from a partner.

Single persons also experienced suicidal thoughts or wishes more than married people (mean ranking 185.67 versus 169.57 for married persons). This may be an indication of the importance of social support, although married people may experience marital problems that can also lead to depression.

On the variable "changes in sleep patterns", married people experienced this phenomenon more than single persons. Married persons had a mean ranking of 199.97 compared to 180.91 for single persons.

Finally on the variable "loss of interest in sex", single persons felt this phenomenon more than married persons. They had a higher mean ranking of 183.22 compared to 179.71 for married persons on this variable.

5.5 Relationships between symptoms of depression and levels of depression

Pearson correlation was used to establish the relationship between depression level (dependent variable) and items on the BDI-II questionnaire (independent variable). The results determined the factors that predicted changes in levels of depression in the Shona students.

5.5.1 Factor analysis

Using principal component analysis extraction sums of squared loadings, nine independent variables had eigenvalues above 1 and were identified as causing 60 per cent of the variance in the data set with levels of depression being the dependent variable. These tests are shown in Table 25.

Table 25: Principal component analysis – factor extraction

Component	Total	Initial Eigenvalues % of Variance	Cumulative %	Extraction Sums of Squared Loadings Total	% of Variance	Cumulative %
1	2.461	11.721	11.721	2.461	11.721	11.721
2	1.699	8.089	19.810	1.699	8.089	19.810
3	1.434	6.829	26.639	1.434	6.829	26.639
4	1.381	6.574	33.213	1.381	6.574	33.213
5	1.297	6.175	39.388	1.297	6.175	39.388
6	1.179	5.614	45.002	1.179	5.614	45.002

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7	1.114	5.305	50.307	1.114	5.305	50.307
8	1.066	5.076	55.383	1.066	5.076	55.383
9	1.007	4.794	60.177	1.007	4.794	60.177
10	0.977	4.652	64.830			
11	0.942	4.487	69.317			
12	0.908	4.326	73.643			
13	0.803	3.822	77.464			
14	0.772	3.676	81.140			
15	0.753	3.585	84.725			
16	0.651	3.102	87.827			
17	0.612	2.915	90.742			
18	0.564	2.684	93.427			
19	0.509	2.426	95.853			
20	0.487	2.318	98.171			
21	0.384	1.829	100.000			

Extraction Method: Principal Component Analysis

a. Only cases for which levels of depression = minimal depression are used in the analysis phase.

Thus the process ruled out the remaining 12 factors owing to their little variance with the latent variable – depression. The next step of the PCA identifies the individual nine factors.

Table 26: Factor analysis – final 9 extracted factors (independent variables)

Variables	1	2	3	4	5	6	7	8	9
Concentration difficulty	0.794								
Pessimism		0.785							
Indecisiveness			0.718						
Agitation				0.799					
Loss of energy					0.790				
Loss of interest in sex						0.758			
Crying							0.728		

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| Punishment feelings | | | | | | | | | 0.828 | |
| Changes in sleep patterns | | | | | | | | | | 0.764 |

5.5.2 Correlation coefficients

Table 27: Pearson correlation between level of depression and the nine independent variables

Variable	N	Levels of depression	Sig. (2-tailed)
Agitation	304	0.524**	0.000
Punishment feelings	304	0.517**	0.000
Crying	304	0.482**	0.000
Concentration difficulty	304	0.465**	0.000
Loss of energy	304	0.443**	0.000
Indecisiveness	304	0.432**	0.000
Changes in sleep patterns	304	0.389**	0.000
Pessimism	304	0.335**	0.000
Loss of interest in sex	304	0.204**	0.000

There was a statistically significant Pearson correlation among the nine factors and levels of depression leading to the conclusion that all nine factors are positively related to level of depression. The above factors could, therefore, be used in the model because of this proven relationship.

5.5.3 Building the model

Table 28 shows the coefficients of the model extracted from the data as well as the p-values of these coefficients.

Table 28: Multiple regression coefficients

Model	Unstandardised coefficients		Standardised coefficients			Collinearity statistics	
	B	Std. error	Beta	t	sig	Tolerance	VIF

(Constant)	0.713	0.044		16.155	0.000		
agitation	0.208	0.029	0.250	7.150	0.000	0.828	1.207
Punishment feelings	0.222	0.030	0.258	7.432	0.000	0.844	1.185
Crying	0.151	0.025	0.209	6.046	0.000	0.849	1.178
Concentration difficulty	0.139	0.035	0.143	3.975	0.000	0.783	1.277
Loss of energy	0.224	0.045	0.175	4.989	0.000	0.829	1.207
indecisiveness	0.152	0.029	0.181	5.286	0.000	0.862	1.160
Changes in sleep patterns	0.140	0.032	0.148	4.362	0.000	0.876	1.141
pessimism	0.208	0.051	0.136	4.100	0.000	0.918	1.089
Loss of interest in sex	0.055	0.032	0.056	1.715	0.087	0.936	1.069

The above model shows that a unit change in agitation can predict a 20.8 per cent change in the level of depression if all other factors are constant. Other factors predicted the following percentage changes in the level of depression: feelings of punishment (22.2%); the frequency of crying (15.1%); concentration difficulties (13.9%); loss of energy (22.4%); indecisiveness (15.2%); negative changes in sleep patterns (14%) and increased pessimism with life (20.8%). While all the above variables had statistically significant coefficients ($p<0.05$), only loss of interest in sex did not have a statistically significant coefficient. The standard errors for each of the above coefficients were very low, ranging from 0.29 on indecisiveness to 0.51 on pessimism. This enhances the view that the individual factors (independent variables) can be highly reliable in predicting changes in levels of depression.

Overall, from this relationship, the following model can be extracted using unstandardized beta coefficients:

$y=0.713+0.21x^1+0.22x^2+0.15x^3+0.14x^4+0.22x^5+0.15x^6+0.14x^7+0.21x^8+0.06x^9+E$

Where:

y:	levels of depression
β_0:	constant
βx^1:	agitation
βx^2:	punishment feelings
βx^3:	crying
βx^4:	concentration difficulty
βx^5:	loss of energy
βx^6:	indecisiveness
βx^7:	changes in sleep patterns
βx^8:	pessimism
βx^9:	loss of interest in sex

This model was based on the general structure of a multiple linear model: $y = \beta_0 + \beta_1 x_1 + \beta_2 x_2 + \ldots + E$ and can be used to predict changes in levels of depression in response to changes in the nine variables in the population of interest.

5.5.4 Model fit tests

To conclude on the fitness of the model in predicting the above relationship, model fit tests were done. Table 29 shows the summary of the preliminary multiple linear regression model generated using level of depression as a dependent variable and the nine factors extracted through principal component analysis (and confirmed through Pearson correlation).

Table 29: Model Summary

model	R	R Square	Adjusted R Square	Std. error of estimate	Change statistics					Durbin-Watson
					R Square change	F Change			Sig. F Change	
1	0.038	0.702	0.693	0.47536	0.702	76.895	9	294	0.000	1.668

a. Predictors: (constant) loss of interest in sex, pessimism, loss of energy, indecisiveness, punishment feelings, changes in sleep patterns, crying, agitation, concentration difficulty

b. Dependent variable: levels of depression

The multiple correlation coefficient (R) of 0.836 shows that the model is highly reliable in predicting changes to the dependent variables as a result of changes to the nine independent variables. An R square (squared multiple correlation coefficient) of .702 shows that the independent variables in total explain 70.2 per cent of changes in levels of depression. This indicates that the model is powerful and predictive. The other 29.8 per cent is explained by other factors outside the model.

In addition to the confirmation by the multiple regression correlation, ANOVA tests before also confirm the goodness-of-fit for the model.

Table 30: ANOVA to test model fit

ANOVA[b]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	156.379	9	17.375	76.895	.000[a]
	Residual	66.433	294	.226		
	Total	222.812	303			

a. Predictors: (Constant), lossofinterestinsex, pessimism, lossofenergy, indecisiveness, punishmentfeelings, changesinsleeppatterns, crying, agitation, concentrationdifficulty

b. Dependent Variable: levels of depression

The ANOVA score of F(9)=76.895, p<0.05 shows that the model can reliably predict changes in levels of depression as a result of changes in any combination of the nine independent variables.

5.5.5 No multicollinearity

There was no multicollinearity between each of the nine independent variables in the model. The tolerance on each of the variables ranged from 0.783 to 0.936 while variance inflation factors (VIFs) ranged from 1.069 to 1.277 indicating significantly low collinearity on all nine factors. The assumption was that the independent variables were not correlated among themselves.

In conclusion, out of 21 symptoms of signs of depression, multiple linear regression shows that nine of these factors can be used to predict changes in levels of depression among the students in the population. The factors can explain a total of 70.3 per cent of changes in depression levels in the population. The model was deemed reliable considering that it met the major assumptions of multiple linear regression and had a high level of fitness.

5.6 Chapter Summary

This chapter presented, analysed and discussed quantitative data on the prevalence of depression and its symptoms amongst young adult Shona students. A high depression prevalence rate of 36 per cent was revealed among the Shona students with similar prevalence rates in males and female. The severity of depression amongst students was also established. SPSS was used to present and analyse the quantitative data. These data were then further analysed using the Kruskal-Wallis test, which is the non-parametric equivalent of one-way ANOVA, to analyse variances of scores on depression across the study's independent variables. The analyses established percentages, mean, standard deviations, skewness and kurtosis in order to provide a comprehensive picture of the demographic data obtained. The demographic data were also analysed in detail as the variances provided information that was key to understanding depressive symptoms, depression and its prevalence rate in Shona culture.

CHAPTER SIX

HOW DO SHONA YOUNG ADULT STUDENTS IN A TERTIARY EDUCATION INSTITUTION UNDERSTAND DEPRESSION?

6.1 Introduction

This chapter seeks to explore depressed Shona students' understanding of depression through a thematic analysis of data obtained from responses to interview questions. The chapter will initially provide a layout of demographic details of students and lecturers included in the sample that participated in the qualitative component of the study. The various conceptualisations of depression from the depressed Shona students and their lecturers will then be presented and analysed. Some of the data will be presented as direct quotations from the participants in order provide a clear and comprehensive picture of depression as understood by Shona students.

The ultimate goal was to answer the main research question which reads as follows: How is depression and the interaction between depression and learning understood in Shona culture by young adult learners in a tertiary education context?

The qualitative analysis was done under research sub-headings from the research sub-questions which sought to answer the main research question. The following are the research sub-questions:

How are symptoms of depression experienced by the young adult Shona students in a tertiary education institution?

How do the young adult Shona students in a tertiary education institution understand depression?

What are the relationships between learning and depression among Shona students in tertiary education?

6.2 Sample size

Out of the n=15 students who exhibited severe symptoms of depression with scores ranging from 29 to 63 on the BDI-II scale, n=11 (91.7%) agreed to speak about their illness. The sample size therefore constituted n=11 Shona student participants who were prepared to be interviewed.

The sample also consisted of n=13 volunteer Shona lecturer participants. Of the n=23 lecturers who taught the student participants, 17 per cent (n=4) were not included as they were from the Ndebele ethnic group, 17 per cent (n=4) were not available to participate and 9 per cent (n=2) declined to participate in the study.

The sample size constituted n=24 lecturers and students.

6.3 Demographic data for student participants

Table 31: Demographic data for student participants

Gender	Male 5 (45%)	Female 6 (55%)	
Marital status	Single 10 (90%)	Married 1 (10%)	
Ethnicity	Shona 11 (100%)		
Religion	Christian 11 (100%)		
Household income	0-$500 10 (90%)	$500-$1000 1 (10%)	

Of the 11 students who took part in the second phase of the study, 45 per cent (n=5) were males and 55 per cent, (n=6) were females. Ten of the participants were single, 90 per cent, and 10 per cent was married. All the participants were from the Shona culture and practised Christianity. Most of the participants, 90 per cent, (n=10) were also from very low - income households with an income ranging from US$0 to US$500 per month while 10 per cent were from families that earned between US$501 and US$1000 per month. The data indicate that students from low-income households are more susceptible to depression than those from a more financially stable background.

Studies by Steptoe et al. (2007) and Bayram and Bilgel (2008) also discovered that students from poor backgrounds had higher levels of depression than those from economically stable backgrounds. The studies also reported that students from poor families experienced low self-esteem, feelings of hopelessness and low self-confidence, leaving them more susceptible to depression. In a country such as Zimbabwe where most families live below the poverty datum line (PDL), poverty may be a contributor to high rates in the prevalence of depression. According to the report by Zimbabwe National Statistics Agency (ZIMSTAT) and UNICEF (2019), the PDL in April 2019 was US$873, placing all students, 100 per cent, of students in this study below the PDL. Zimstat defines the PDL as the cost of a given a standard of living that must be attained if a person is deemed not to be poor. PDL represents the minimum

consumption expenditure necessary for an individual to consume a food basket of approximately 2,100 calories. This indicates that students face financial challenges increasing their vulnerability to depression as they are not able to meet their minimum food requirements. Addressing the mental health challenges of people of low socio-economic status should therefore be prioritized (Eisenberg et al., 2007; Hendler et al., 2016).

6.4 Demographic data for lecturer participants

Table 32: Demographic data for lecturer participants

Gender	Male 5 (38%)	Female 8 (62%)	
Marital status	Single 1 (8%)	Married 11 (84%)	Widowed 1 (8%)
Age range	31-40 6 (46%)	41-50 6 (46%)	61-70 1 (8%)
Ethnicity	Shona 13 (100%)		
Religion	Christian 13 (100%)		
Language proficiency	Shona 13 (100%)	English 12 (92%)	Ndebele 1 (8%)
Years' experience as a lecturer	0-10 7 (54%)	11-20 5 (38%)	21-30 1 (8%)

Data were also collected in the form of interviews from n=13 Shona lecturers who taught the Shona students who exhibited severe symptoms of depression. Interview questions were also used to maintain focus on the aims of the research. Of the n=13 lecturers, 38 per cent (n=5) were males while 62 per cent (n=8) were females. Similar to the picture portrayed in the student population, females are more likely to volunteer to participate in research than their male counterparts. Most of the participants were married (84%, n=11), while 8 per cent (n=1) were single and 8 per cent (n=1) were widowed. Their ages ranged from 31 to 70 years and 46 per cent (n=6) were in the 31 to 40 year age range while another 46 per cent (n=6) were in the 41 to 50 range. Eight per cent (n=1) were in the 61 to 70 year range. Unlike the students, lecturers were mostly middle-aged and married, a result of their being older and at a different stage of life.

The participants were all from the Shona ethnic group (100%, n=13) and they all practised Christianity. The lecturer participants' years of teaching experience were varied: 54

per cent (n=7) had between 0 and 10 years' experience, while 38 per cent (n=5) had 11 to 20 years and eight per cent (n=1) had 21 to 30 years' lecturing experience. This is an indication of different levels of experience in dealing with students. On language proficiency, 100 per cent (n=13) were proficient in the Shona language, while 92 per cent (n=12) were also proficient in English and eight per cent (n=1) were proficient in Ndebele. This revelation indicates that most lecturers are fluent in two languages (bilingual), namely, Shona and English, while one lecturer is fluent in three languages, Shona, English and Ndebele.

6.5 Responses from participants

6.5.1 Depression as stress

Depression is of major concern in higher and tertiary education institutions and its conceptualisation in the young adult Shona student populace plays a major role in the alleviation of its effects. During the interviews with depressed Shona college students, it emerged that depression is highly prevalent, though an analysis of their stories indicates that students rarely refer to their condition as depression unless the term is brought to their attention. Students understand their depressive states as a higher level of "stress", as indicated by 64 per cent of the student participants. Students describe their stressful life events, the effects of stress on their persons and their efforts in coping with stress. Similar to the students' conceptualizations, 46 per cent of lecturers also conceptualise students' depression as a form of stress that emanates from social situations that the student finds difficult to cope with.

> "Depression is when I am stressed because something happened which I don't like and I feel sad and unhappy because I am stressed." – Student 1

> "Depression is like being stressed. You can have things that are stressing you and you are not very happy about your situation." – Student 7

> "Depression is when students fail to manage their stressors in life. It could be a relationship or schoolwork or even peer pressure." – Lecturer L

> "A state in which a student is experiencing excessive stress and ends up being withdrawn, unmotivated and not interested in different activities. At times the student might have suicidal thoughts due to stress." – Lecturer F

The stress was reported to emanate from social challenges that the students struggle to cope with and eventually they develop depression. Students are faced with numerous stressful

situations, including pressure to succeed, the effects of drug and alcohol abuse, relationship problems, financial challenges and family dysfunction. These stressful situations may then lead a student to experience psychopathological conditions that contribute, especially among young adults, to the development of mental health problems such as depression (Nsereko et al., 2014).

> "When stress levels are too high because of poverty, death or illness of a close family member and other adverse situations in their life this normally causes depression in students." – Lecturer K

Though being stressed does not automatically lead to depression, certain "levels of stress" are interpreted as such and are believed to cause depression in the Shona culture. Depression and stressful life events are, although stressful life events are not absolute predictors of depression (Gotlib, 2000). It is the individual's ability to cope with environmental stressors that determines whether or not he/she will be depressed (Murbery & Bru, as cited in Haligin, 2007). Depression is, therefore, a result of an individual's inability to cope with negative life events. The ability to cope with negative life events may result in some economically disadvantaged individuals or societies not to suffer from depression. Some economically disadvantaged African American communities in the US were discovered to have lower depression rates compared to some of the economically stable European Americans (Saluja et al., 2004, as cited in Nolen-Hoeksema, 2007; January et al., 2018).

Population studies have also confirmed that depression is likely to be experienced in families where abuse, financial crisis and conflict are persistent and the individual is less likely to respond positively to treatment owing to the depression-conducive living environment (Meaney, 2015). Some individuals are more vulnerable and reactive to stressors in their environment, rendering them more susceptible to depression. Meaney (2015) further asserts that some individuals faced with severe stress may nonetheless remain resilient while others faced with less severe stress become depressed.

The word stress was commonly used by both the lecturers and students to denote depression in students. The reported stress presented itself at various levels, evidenced by the use of the phrase "excessive stress". A certain level of stress would, therefore, be regarded as alarming and as requiring some form of intervention, especially as the possibility of suicide was believed to be high among stressed individuals. Van Niekerk et al. (2008), in their study, indicated that university students use and understand the term stress to describe depression as the students reported that they were stressed and described the source of stress but in fact

exhibited and revealed symptoms of depression. Brown et al. (2012) also discovered that Aboriginal people do not frequently use the word "depression", but instead used "stress" to describe their depressive symptoms.

Since the term *depression* does not have a direct translation in the Shona language, depression was also represented by its symptoms during conversations with research participants. This is likely, therefore, to contribute to high prevalence rates as depression may not be diagnosed in its holistic form. Symptoms of depression emerging as a result of encountering a stressful situation would be addressed independently as and when they were presented. Similarly, Chinese people facing severe stress complain of "neurasthenia", palpitations, nausea and pain in the joints (Nolen-Hoeksema, 2007). A stressed individual and a depressed individual experienced similar psychological challenges and reference to depression amongst the Chinese was rare. It is, however, prudent to note that not everyone who encounters a stressful life event develops depression.

6.5.2 Depression as sadness

Depression was also conceptualised as a state of intense sadness as reported by 55 per cent of the students; in some cases it was conceptualized as being unhappy (*kusuruvara*), emanating from life events that do not turn out as planned or when one grieves. The DSM-5 of the American Psychiatric Association (2013) identifies persistent sadness that extends beyond expected periods as one of the major symptoms of depression. The Shona students' understanding, however, suggests a blurred and simplified representation of a serious illness as being unhappy. Sadness does not adequately represent depression and may not be interpreted to mean the same by clinical practitioners. A similar term *kunetseka*, meaning deeply troubled or bothered, was used when Student 4 indicated that "*handina mufaro ndiri kunetseka nehupenyu hwangu*", which translates as "I am unhappy as I am deeply troubled in my life". The Shona terms *kunetseka* and *kusuruvara* are used along with other symptoms to describe depressive disorders, though *kunetseka* ("troubled") and *kusuruvara* ("unhappy") may be both a cause and a symptom of depression.

> "Depression is feelings of hopelessness and sadness in students. This can come as an emotional state of the mind and can be hereditary." – Lecturer K

> "Someone can be very sad, but they really don't talk about depression because depression is a serious mental problem and you will be going 'mad' (*unenge wava kutopenga)*. I once told my mother when I was feeling very sad and I couldn't even eat

or sleep and she told me that it was going to get better with time and we never discussed it again" – Student 1

The lecturers also understood depression as a form of sadness, as indicated by 39 per cent of the population. The feelings of sadness were described as a certain state of mind which goes deeper than the normal sadness that occurs when one is faced with an adverse situation. The data also indicate that sadness and hopelessness were believed to be inherited in some cases. This may be an indication of a noted pattern of recurring depressive episodes in members of the same family. Cultural and contextual factors affect how individuals understand and conceptualise depression; in fact, racial and ethnic minorities are less likely to understand depression as resulting from biological factors (Cardemil et al., 2015). Though a depression gene may exist (Bulik-Sullivan et al., 2015; Levinson, & Mostaafavi, 2014; Okbay, 2016; Sullivan et al., 2018; Wray and Ripke, 2018), it has not been scientifically documented in Shona communities.

The stories told in this research reflect that the communities in which the students live rarely talk about depression as a disease that requires professional attention. The community talks about being unhappy (*kusafara)* or about a deep sadness (*kusuruvara*) that is normally a reaction to social challenges. *Kusafara* and *kusuruvara* represent an emotional state of dissatisfaction that emanates from an unpleasing life event. These experiences of deep sadness are believed to be normal experiences that an individual should learn to go through in life. Abubakar et al. (2016) also report that in Kenya depression was understood as *simanzi* ("deep sadness or sorrow") or *kugandamizwa, kutsanganyikiriwa* ("getting mixed up"), as there is no direct term to represent depression in Swahili or Kigiryama. Some researchers have also suggested that most indigenous cultures tend to associate depression with somatic rather than psychological symptoms of depression, such as sadness (Tsai et al., 2002)

Brown et al. (2012) elaborate on cognitive and emotional symptoms of depression as a manifestation of the impact of worry and sadness on the vitality of an individual's spirit. When individuals feel sad because of an event such as poor academic performance or even loss of a loved one, their emotions may be unstable and affect their cognitive capabilities and behaviour as they try to come to terms with their loss. Beck (1967, as cited in Nolen-Hoeksema, 2007) explains that individuals develop dysfunctional beliefs that cause them to believe that they are inadequate and hopeless. Feelings of sadness and hopelessness may be temporary, though they may be an indication of depression if they persist for more than two weeks after a negative life

event. Feeling sad and hopeless is a normal response to a negative life event in the Shona culture and thus may not holistically represent depression as a serious mental illness.

6.5.3 Depression as "thinking too much"

The study reveals that 36 per cent of the student participants understood depression as a state when an individual thinks a lot about challenging social and personal issues. Students emphasized that they worried a lot about their situations. The idiom 'thinking too much' and worrying represented similar processes as data reveal that students tended to think too much when they were worried. "Thinking too much", troubled thoughts and being worried may, however, be interpreted differently in various circumstances and may not adequately represent depression as a whole but may in some instances be one of the symptoms of depression.

Patel (2001) states that Zimbabweans may use words such as *kufungisisa*, which translates as "thinking too much". The concept of "thinking too much" is popular in several other countries and is associated with a depressive disorder in which individuals report on social isolation and withdrawal (Kaiser et al., 2015). In recognition of its common use, it has been included in the DSM-V (American Psychiatric Association, 2013). These localised diagnostic categories such as 'thinking too much' are believed to frame coherent meanings of experiences that describe depression. It becomes critical, therefore, that mental health caregivers understand the cultural backgrounds of a patient in order to accurately interpret patterned experiences. In Shona culture, depression may be understood as a set of localized categories that describe a person's emotions, cognition and physical well-being. It is essential to apply the concepts of clinical psychopathology to the analysis of depressive disorders in order to integrate and broaden them into recognised classifications of diseases, if possible (Cheung, 1998, as cited in Bhui & Gavrilovic, 2012).

> "Depression is the same as when someone is very unhappy or sad and they think a lot about their problems and they need to pray about them so that God intervenes." – Student 1

Thinking too much was associated with life stressors: an individual becomes worried and exhibits a prolonged change in mood that becomes detrimental to health and social life. As revealed by Student 1, "when someone is unhappy or sad they think a lot about their problems". The idiom "thinking too much" was used to describe a reaction to sadness and being unhappy. The process of thinking a lot is noted as manifesting from negative events encountered by the student, consequently affecting daily social and academic interactions. Beck's cognitive theory

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of depression also explains that an individual then pays particular attention to negative events. Thereafter, this negative state of mind leads to the automatic manifestation of negative schemas, thereby sustaining and justifying the depressive symptoms (Beck, 1979). The idiom "thinking too much" may, however, not explicitly describe depression in Shona culture and may, therefore, be less stigmatizing than in other cultures where this phrase is used. In the Buddhist culture, for example, "thinking too much" is often stigmatised (Le Touze et al., 2005; Eberhardt, 2006).

> "Depression is when you have a lot of stress and worry so much about things in your life that are not alright and you end up thinking a lot about the bad stuff that makes you sad." – Student 8

> "I'm not 100 per cent sure as people don't normally talk about depression but I think they relate it to when one thinks too much because of problems; then you don't operate like you normally do because of constant thinking (*unenge uchingofunga*)." – Student 3

However, only 8 per cent of the lecturers conceptualized students' depression as a process involving thinking too much about one's predicament, while 8 per cent believed depression was a consequence of having unresolved issues that one was worried about. From the data gathered, it can be assumed that the process of thinking a lot may be selectively revealed by a depressed individual as lecturers mostly report on students' overt behaviour while at school. Thinking a lot may, therefore, be difficult for the lecturers to confirm as an indicator of depression amongst Shona students.

6.5.4 Depression as spiritually orientated

The conceptualisation of depression was significantly linked to spirituality and deeply rooted in both traditional ancestral origins and Christianity as a source of and an explanation for the depressive state of an individual. Depression was understood as a reaction to some form of misfortune that was brought about by a negative life event manifesting from the spiritual realm and then leading to a state of deep sadness. The negative life event has a spiritual connection which then triggers a chain of reactions, including mental illness such as depression and other negative events that one may encounter.

> "I'm not very sure what depression is but I think it's being unhappy or sad when evil spirits play a role in bringing misfortunes in your life and everything just goes wrong.

Your ancestors will have turned their back on you, *mudzimu inenge yakufuratira*. I have also witnessed traditional cleansing ceremonies held by family members so that the bad omen is cast out and brain can function normally". – Student 3

Of the 11 students interviewed, 27 per cent understood depression as a manifestation of evil spirits, 18 per cent stated that misfortunes had a role in their depression, and 18 per cent indicated that God sets the course of their lives. The data indicate that supernatural explanations denote a situation beyond an individual's control ("Your ancestors would have turned their back on you"). This is an indication of individual helplessness. The students believe that an individual maybe exposed to evil spirits when spiritual ancestors withdraw their protection owing to some apparent wrongdoing in the family and not necessarily a wrongdoing by the depressed individual. Traditional ritual ceremonies such as *bira* ceremonies are sometimes held to communicate with or appease the ancestors (Gelfand, 1982). The family unit is responsible for appeasing the ancestral spirits to ensure that its members continue to enjoy protection by their ancestors from ailments and misfortunes. Life is believed to be pre-planned by supernatural forces; hence mental illness may be a fate that one is not fortunate to escape from. This belief raises concerns about the degree of acceptance of practical or scientific solutions to curb depression amongst Shona students.

"There is a myth that views depression as an evil spirit which will be affecting an individual."– Lecturer K

In contrast to the students' conceptualisation of depression, only 8 per cent of the lecturers acknowledged the relationship between depression and any form of spiritual forces. The comment from the lecturer, "There is a myth that views depression as an evil spirit …", shows that lecturers are distancing themselves from the belief even though they are aware of the myth. This distancing may be attributed to the fact that lecturers may have adopted a more middle-class lifestyle and may be reticent about sharing spiritual beliefs because of their higher level of education, greater experience in life and the high probability that "indigenous" beliefs may not be universally acceptable. The lecturers may also not have been privy to background information about students' illnesses that might have been known by family members. The belief systems of the students' families and the familial support play a fundamental role in shaping the students' conceptualisations of their illness. Another assumption could be that students may strongly feel that there is more to their illness than biological or other scientific explanations, hence their conceptualisation of depression as related to spiritual forces.

The Shona students' conceptualisation of depression as spiritually orientated is analogous to Zambians who practise Christianity and believe in prayer while at the same time turning to spiritual and traditional healers for treatment of mental illnesses (Eshun & Gurung, 2009). Depression and spirituality are thus interconnected and deeply rooted in an individual's belief system and it may be difficult to adopt a purely scientific approach to its treatment. According to a report from the Mental Health Foundation of (2006), spirituality can make a positive contribution to mental wellbeing as faith and belief in a transcendent being are associated with a decrease in depressive symptoms. Zimbabweans have been reported to seek African traditional medicines that mainly used spiritual powers when faced with mental ailments such as depression (Kajawu et al., 2015).

Similarly, depression in Aboriginal men is understood as emanating from negative life events that cause distortion of the spirit. Traditional healers are consulted for the protection and healing of the spirit in order to address depression (Brown et al., 2012). Depression is understood as a mental state that is a consequence of lack of protection from supernatural powers, leading to an inability to cope with the demands of life. The perceived relationship between depression and spirituality is therefore significant in influencing the action taken to treat the illness.

6.5.5 Depression as a form of mental instability (madness)

Depression was also believed to be a serious mental problem by 18 per cent of the student participants and labelled as "madness" or "mentally disturbance". These labels present a dysfunctional individual who is not capable of making rational decisions and will hence not be fully functional and appreciated in a community. Mentally disturbed individuals are therefore freed of responsibilities that enable them to be totally independent and respected by the community they live in. When individuals are said to be mad, they are relieved of their duties as society loses confidence in their ability to cope with life's demands. The word *mental* in Shona Culture is associated with severe mental disorders and in some instances asylums. Patients and mental health care providers become reluctant to stigmatise depressed individuals as "mental cases" (Patel, 2001). In some cultures, especially in non-western societies, mental illness brings about shame for the family (Abdullah & Brown, 2011; Parker et al., 2001).

"Depression is a mental problem that affects the brain, *unogona kutopenga* ("you can go mad if it is serious"). Diseases that affect the brain are usually difficult to cure so if

you go mad they put you at Ingutsheni Hospital [a psychiatric hospital in Bulawayo, Zimbabwe] because you will not be your normal self." – Student 11

"Depression is a state when individuals show signs that they are mentally disturbed or they might be withdrawn." – Lecturer F

The Shona students' understanding of depression as "madness", *kupenga,* which is believed to be an extremely high magnitude of mental illness, is a sign of ignorance of what constitutes depression. Madness also describes someone who has "lost their mind". These derogatory labels indicate that depression is misrepresented and misunderstood to the extent that the undesirable discriminatory labels attached to the illness lead to stigmatisation. Congruent with findings in this study, Vankar et al. (2014) discovered that stigma towards depression made Indian medical students believe that other students would not respect their opinions, a belief that negatively affected their confidence levels and also presented a barrier to seeking professional help from mental health practitioners. A depressed student may not reveal his/her illness or seek help out of fear of being labelled and stigmatized (Behere et al., 2011).

This revelation is a reflection of the grouping together of mental challenges and the labelling of a depressed individual as a "mad" person. The assumed inability to function as a "normal" person inevitably leads to discrimination and stigmatisation of the affected individual. Though the labelling that leads to stigmatisation may be unintentional because of the common use of the term, it is likely to discourage affected individuals from seeking treatment from professionals. The association of Ingutsheni Hospital and a "mad" person with depression is also likely to deter depressed patients from seeking treatment as they may fear being grouped together with "mad" persons. Ingutsheni Hospital is a psychiatric institution well known for housing acute psychiatric patients who may cause harm to themselves or the community, thus making it an institution that people shun and do not want to be associated with.

In contrast to students' conceptualisations, lecturers in this study did not view depression as a form of madness. This difference in understanding of depression may indicate that lecturers are conscious of and sensitive to the effects of labelling and stigmatisation of mentally ill individuals. The labelling of depressed individuals may be attributed to Shona Culture's various explanations about the causes of depression that bring about shame to the

family. The labelling and stigmatisation stem from limited knowledge about depression as a curable disease (Naeem, et al., 2012; Ibrahim et al., 2020).

6.5.6 Perceived ignorance of depression

Eighteen per cent of the students could not explain depression as it was said to be "not a real disease', as 'no scientific explanation" was available in their culture. The fact that depression does not exist as a disease entity in Shona culture may make it difficult for the student to conceptualise it as a disease that can be treated. This scenario may possibly cause depression to be labelled as a disease for other people in other cultures and not necessarily in Shona culture.

"*Chinonzi chii ichocho, ukaenda kuchipatara unotiunozwei*? ("What really is depression? If you go to the hospital what do you say you are suffering from?"). Depression cannot be easily explained because there is no real disease to point at. So it's someone just describing their feelings like feeling very sad; it's not a disease, maybe a weakness." – Student 5

"People don't really understand the existence of depression, [and] hence care less about the situation." – Lecturer C

"People don't understand depression. They think you are not being serious, you are deliberately not being cooperative or you are just moody and boring." – Student 2

This lack of recognition of depression clearly places students in a quagmire, as depression may not be reported, thereby creating a vicious cycle of pain that can otherwise be prevented. A condition that is described as moody (as reported by Student 2) may not propel an individual to seek treatment, though Patel (2001), points out that depression in medicine is closely linked to mood swings. Among African Americans depression was perceived as a normal part of their daily life experiences that could be dealt with according to their cultural norms and traditions (Eshun & Gurung, 2009: Bailey et al., 2018). Compared to other diseases depression is a unique ailment as symptoms of depression may differ from individuals in different regions and across the globe. Symptoms of depression, such as sadness, crying, lack of appetite or insomnia, may be reported to parents and guardians and considered as normal experiences that do not require professional attention. From the data, it emerges that some Shona students may not be socialised to embrace the existence of depression as an illness that requires attention. Shona Culture, therefore, provides a lens or template used in constructing,

conceptualising and interpreting reality as it is embedded in cultural experiences (Marsella, 2003: Kirmayer, 2019).

Owing to their reluctance to acknowledge their depression, some students would discuss their issues after probing and spending moments of silence reflecting on their conflicting thoughts of whether to talk about their problems or not. Other questions on their conceptualisation of depression (such as symptoms of depression and whether depression affected their learning) yielded more comprehensive responses.

 "I don't know what to say. Too many things are bothering me in my mind and I don't think it's good to talk about them to anyone. I am a man. I should not just behave like I am weak. I should just find a solution to my problems." – Student 5

"I don't think I can really talk about it. It makes me very sad even to think about it. It's too much. I know this meeting is confidential but I just feel I will be exposing my very personal self. Maybe if I keep your phone number and think about it I will call you and talk over the phone." – Student 11

To a lesser extent the data suggest that socialisation in Shona culture places more emphasis on somatic symptoms as exposure of emotions maybe considered as weak especially in males. Evidently some individuals found it difficult to reveal their emotions as they felt they would be exposing their "inner self". Some students resorted to being silent about their emotions which are likely to lead to increased levels of depression. Student 11 proposed a telephone interview and during the brief conversation the student was unable to make eye contact with the interviewer. This was a reflection of feelings of shame and possibly guilt normally associated with self-blame about their current predicament. It was also sad to note that even after the proposal of a telephone interview and attempts to reach him, the student was still not willing to discuss what caused his depression. Of primary concern, Patel (2001) also asserts that the role of culture in the experience of common symptoms of depression is limited but volunteering of these symptoms may be influenced by stigma and lack of awareness of depression as an illness.

"Depression is not viewed as a serious problem; more often than not it is viewed as a deliberate action by the victim or a sign of the victim's weakness in terms of character." – Lecturer I

"The Shonas do not really accept the fact that one can go through depression. It is somehow viewed as stubbornness or being ill-mannered. The community does not accept the fact that one can be in a state of feeling withdrawn from the rest." – Lecturer J

From the data, depression is also understood as a deliberate ploy by an individual to become uncooperative and not perform as expected. Fifteen per cent of the lecturer participants highlighted that Shona culture does not understand depression and believe that individuals are just moody and boring to be around because they are not interested in participating in the daily activities. This view is in line with responses from Student 5, who did not relate to depression as a disease and hence there believed there was "no disease to report". These uncertainties in the conceptualisation of depression may lead to inaction, decreased productivity and loss of lives through suicide. Fifteen per cent of the lecturers also indicated that depression was considered a normal experience in life that does not require any special attention.

Shona culture's lack of awareness of the existence of depression accounts for the use of descriptors such as "ill mannered", "stubborn" or "arrogant" to describe individuals presenting with various symptoms of depression. Depression is thus misconstrued as an attitude problem, which may even prompt a negative response from friends and family. This is also an indication of Shona culture's lack of awareness about emotional well-being, with a bias towards physical symptoms such as headaches and stomach aches which can be referred to a medical practitioner for treatment. Expressing one's emotions may be viewed in Shona culture as a sign of weak character; hence depressed individuals may opt not to talk about their illness out of fear of being labelled as weak and incapable of handling challenges they are faced with.

Eshun and Gurung (2009), in their research, discovered that, 30 per cent of African Americans believed that they could "handle" and curb depression through prayer and faith. A depressed individual would be encouraged to "pull themselves out of it". Depression becomes a normal personal responsibility that may be construed as a deficit or inadequacy in character (Marsella 2003; Bailey et al., 2018). The Shona community's stance on depression is deep rooted in their cultural beliefs, which also determine the course of action taken when one is faced with such a mental health challenge. Important to note, in some instances depression can pass without treatment and even without long-term consequences. However, depressed individuals' ways of thinking and how they view themselves and their social relationships may be negatively affected even long after the depressive episode (Boland et al., 2002).

6.5.7   Depression as social isolation

Lecturers understood depression as a state when one is withdrawn, lonely or isolated from one's peers, as indicated by 39 per cent of the population. Students' social lives may become more solitary as they progressively shift from being interested to losing interest in the company of peers and friends and even in social activities. Whilst being isolated may not exclusively denote depression, a significant change in behaviour from a social to a more solitary life may be interpreted as symbolising an unhealthy state of the mind that may require attention. Young adults who are socially isolated were said to experience greater feelings of loneliness and were most likely to be depressed at a later stage, suggesting that social relationships confer benefits for mental well-being (Matthews et al., 2015). It is important to note that loneliness may be experienced without social isolation (Masi et al., 2011; Cacioppo et al., 2015). Lonely individuals are more vulnerable to depression and social contact may be inadequate to protect them from depression.

> "A state of feeling withdrawn and spending most of their time alone leading to low self-esteem due to some circumstances beyond their control." – Lecturer J

> "Depression in females is viewed as mood swings and withdrawing from activities and from friends or attitude problems." – Lecturer K

As stated by Lecturer J, when a student is withdrawn, his/her self-esteem may also be lowered owing to loss of self-confidence as social challenges overwhelm social judgment. Depression may start as or consist of a chain of negative emotions that deter productive social integration amongst students. Fifteen per cent of the lecturers understood depression as involving low morale that leads one to prefer spending time by oneself. Depression was also conceptualised as a mood disorder by eight per cent of the lecturers. A mood disorder would see an individual being reported as displaying inconsistent moods; hence other students would find it difficult to relate to that person, possibly leading to isolation.

Twenty-seven per cent of the student sample indicated that they did not feel like doing any activity at school, while 31 per cent of the lecturer population indicated that the students exhibited behaviour that showed that they were not interested in school activities. Since depression may potentially incapacitate an individual causing loss of focus on schoolwork, this view poses a risk of misconceptualisation of a serious illness. Such misconceptualisations are likely to portray an individual's depression as a deliberate action of not conforming to societal educational expectations. Lack of interest in school activities and social isolation may therefore

inherently be linked to depression since an affected individual pays less attention to school activities while their peers are actively involved. This may leave depressed individuals alone and lead to their eventual isolation.

Being considered as anti-social may cause people to reciprocate that behaviour towards the depressed individual as they may not understand that an individual has no interest in socialising. This outcome may further aggravate the crisis as a depressed individual may already feel undesired and unappreciated. The depressed person is, therefore, unlikely to receive the social support required to overcome the depression. Some lonely young adults tend to adopt negative perceptions and expectations of their peers, which in turn can have negative implications on their social interactions, driving others away and increasing their isolation (Cacioppo & Hawkley, 2005; Cacioppo & Hawkley, 2009; Matthews et al., 2015).

Depression in females was also interpreted as mood swings that were attributed to the fluctuation of female hormones. Females were reported to display inconsistencies in moods especially during the period of their menstrual cycle. Significant hormonal changes in oestrogen and progesterone during the menstrual cycle, postpartum period and at menopause increase vulnerability to depression (Whiffen, 2002, as cited in Weis, 2008; Grohol, 2019). This belief results in little attention being paid to depressed females as they are believed to be going through a natural biological process that will pass. The DSM-5 of the American Psychiatric Association (2013), however, lists examples of depressed mood that occur over a period longer than two weeks. The depressed mood should be a change from previous functioning, as one of the symptoms of depression. Depressed moods were reported as common amongst Shona female students compared to their male counterparts.

6.5.8 Depression as a manifestation of lack of social and financial support

The data reveal that 36 per cent of the Shona student population cited socio-economic challenges as their major cause of depression. The socio-economic challenges were associated with their parents' or guardians' unemployment and / or a traumatic life event such as the death of parents, abandonment by parents or the divorce of parents earlier in their childhood. After such a life-changing event, the student would then experience challenges in coping with financial needs owing to lack of financial support to meet the demands of tertiary education. The loss of a parent or guardian may not only mean the loss of a person whom they were attached to, but may result in years of instability and disruption of a secure life pattern. Orphans and students from broken families tend to lack financial, social, moral and emotional support

and hence were likely to become vulnerable to depression. Eisenberg et al. (2007) highlighted that students experiencing financial challenges are more likely to report depression and have suicidal thoughts than those from financially stable backgrounds.

> "... we have very little money to live on and meet my school requirements; sometimes I don't even say what I need for school because I know there is no money. We generally live on handouts and we don't know where the next meal will come from. The future of my studies is not bright; I may not be able to complete my studies." – Student 4

A student saddled with so many financial constraints may find it difficult to concentrate in class and may end up dropping out of school due to non-payment of tuition fees. The cycle of poverty may be perpetuated. Such uncertainties about fundamental aspects of life such as education may instil a sense of hopelessness about life in general and the future. The data from Student 4 also reveal a learned culture of silence about fundamental educational needs due to the pattern of expected negative responses from guardians. This may also bring about a lack of confidence and lowered self-esteem as a student may fail to fit in socially with their peers. Decision-making skills are also affected by poverty. A person's mental health is strongly influenced by economic status as self-esteem and self-confidence are affected (Bayram & Bilgel, 2008).

> "The lack of support from loved ones leading to non-payment of tuition fees and other college requirements." – Lecturer B

> "Students struggle to meet their daily financial requirements as some come from extremely poor families where parents or guardians are not employed. Most of them are vendors who struggle to put a meal on the table. Meeting educational needs becomes strenuous for parents, guardians and the students." – Lecturer G

Forty-six per cent of the lecturers also thought that students were depressed because of financial problems. That financial demands of tertiary education represent a significant burden to an already struggling family unit raises the probability of succumbing to depression. In cases where families struggle to afford food and other basic commodities, meeting the financial obligations of tertiary education may not then be a priority. Zimbabwe is a developing nation with socio-economic and political challenges. These unfavourable economic conditions were commonly expressed among students and in the general population. As Todd et al. (1999) reported, economic deprivation is strongly associated with the incidence of depression in

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Zimbabwe. In other populations, as Chen et al. (2013) discovered, Chinese students from poor families exhibited higher levels of depression than those from well-off families. Depressive episodes were also reported amongst the poorest populations experiencing household food shortages and also amongst the wealthiest populations (Duthé et al., 2016).

> "Depression is mainly caused by low support due to loss of loved ones including parents and spouses or rejection by other students." – Lecturer F

The research I conducted revealed that a lack of social support was a major contributing factor in students' depression. Fifty-four per cent of the lecturers view social support from peers and family members as fundamental to students' ability to maintain mental stability. Society plays a significant role in its members' wellbeing through the provision of social support for the life challenges encountered. The loss of a loved one, who might be a parent, guardian or spouse, may lead to a lack of social support as an individual may depend on loved ones for social support. This loss increases the risk of depression as an individual may be socially and financially dependent on family and friends.

6.5.9 Depression as hereditary

This study also revealed that other than social challenges as major vehicles for depression, 15 per cent of the lecturers alluded to the fact that depression in the Shona population might be hereditary. Members of the same family may be predisposed to depression owing to similar personality traits that make them more vulnerable to depression. In some cases, maladaptive depression-coping strategies such as eating disorders, or substance and alcohol abuse may actually be emulated by family members because siblings idolise each other. Adoption of coping strategies by members of the same family as they battle with socio-economic challenges may have adverse implications as reported by Student 3. The literature available to confirm these findings, particularly in indigenous cultures, is scarce. The data in this study indicates that owing to the experience of similar negative life events, depression and its coping strategies may be common and may run in the immediate family and even extended family members.

> "My brother committed suicide when I was 19 years old. That was three years ago; he was 25. I felt very sad. I now understand why he did that: life can be unbearable. He was very unhappy, rude to everyone and violent. He used to drink a lot and take drugs. When I was much younger I could see him do that [abuse drugs] and I used to admire him but he refused to give me some but I eventually got connections to get my own

dope. It makes me feel better but I don't want to be violent, and now I don't think a lot about my situation the days just go faster than before." – Student 3

"...This can come as an emotional state of the mind and can be hereditary." – Lecturer K

Environmental factors may play a pivotal role in protecting individuals from depression and also provide the necessary support in availing treatment options. However environmental factors may also provide fertile ground for the onset and development of depression. Families with mental or behavioural disorders are usually characterised by considerable dysfunction, which increases the chances of family members suffering from depression (Meaney, 2015). In some cases, depression may be hereditary, rendering some individuals and families more vulnerable to the illness. Genetic factors have been proven to place individuals at higher risk of depression (Weis, 2008; Viktorin et al., 2016). However, the exact mechanism of inheritance is not yet clearly defined and may vary from family to family (Nolen-Hoeksema, 2007).

6.5.10 Depression as a manifestation of chronic illnesses

Chronic illnesses were also cited by 18 per cent of the students as their cause of depression. Chronic illnesses such as HIV-AIDS were reported amongst this young adult population. The stigma surrounding HIV-AIDS, coupled with the stigma associated with depression in most indigenous societies such as the Shona community, also plays a major role in the acceptance of and adherence to treatment, both of which collectively contribute to the well-being of a student. The burden of a chronic illness has the potential to incapacitate or slow down activity levels in students. Studies have indicated that depression is significantly associated with chronic illnesses, particularly HIV and AIDS (Kim et al., 2015; Chibanda et al., 2016), and subsequently associated with risk of early death (World Health Organization, 2018b).

"Ma'am, I'm very sick and I was born with this terrible illness. Both my parents died from it. I take tablets every day. If I don't my health will deteriorate and I will die. My health once deteriorated while I was in high school. At that time I had refused to take tablets. I almost died, ma'am. I basically don't have a life, so that's why I am probably depressed. I really never talk about this to anyone and I don't like talking about it. I have AIDS, so I take ARVs. I ask myself why me, what did I ever do to deserve this? I wish I was never born because I have been suffering for a long time. This is all I can say about my situation because the details of my life are too sad." – Student 2

Student 2 also "fears death", believing that the illness has no cure and death is inevitable and fast approaching. Living in such fear increases anxiety and robs an individual of the motivation to work towards a certain goal. Life becomes a struggle to survive and the focus on education becomes limited. Depression is also significantly associated with non-adherence to treatment regimens as reported by Student 2 and confirmed by Breitbart et al. (2000) and Cluley and Cochrane (2001). Such circumstances give an individual a pessimistic view of life that is detrimental to health and social and academic endeavours.

"I know I will die soon because I feel my condition getting worse. Every time a new symptom develops I get very anxious and even get a runny stomach because I think maybe tomorrow could be the day I will die." – Student 2

Chronic illnesses are likely to increase students' vulnerability to depression, which will further disable them and result in their being less able to cope with their daily activities. HIV-AIDS is sexually transmitted, though in some cases children are infected at birth from infected mothers. It is not unusual for school-going young adults to be taking life-long HIV-AIDS treatment. Treatments of such chronic illnesses are known to extend lifespan and even improve quality of life but owing to lack of information and the stigma surrounding HIV-AIDS an individual may become anxious and feel hopeless. Unfortunately, the stigma associated with HIV-AIDS may contribute to defaulting on treatment especially if students do not fully understand and accept the nature of their condition.

Illnesses were also believed to cause depression in students, as suggested by 31 per cent of the lecturers. Illnesses included chronic and non-chronic illnesses involving a close relative or the student's own illness. Depression being caused by an illness may also depend on the severity of the illness and its effects on students' daily lives. If the illness is prolonged, coupled with financial constraints from having to adhere to medical regimens, students may be vulnerable to depression. Unfortunately, research indicates that depression interferes with prolonged physical health, consequently reducing an affected individual's lifespan (Lyness et al., 2004).

6.5.11 Failure to cope with college life

Depression was also described by 15 per cent of the lecturers as emanating from failure to cope with college life particularly among the first-year students. The transitional period from high school to college may bring about mixed feelings and challenges that one may find difficult to adjust to. Students may experience acculturation stress leading to depressive symptoms during

their transition to campus life as their cultural values may conflict with those of the college and in some instances they may fail to adopt effective coping strategies (Ma, 2017). Twenty-three per cent of the lecturers also mentioned that depression was caused by poor performance. A student may fall victim to depression if he/she fails to attain the desired educational goals. Owing to family pressure to achieve and the competitiveness of a very limited job market, students may feel hopeless and foresee a bleak future. This feeling may possibly lead to depression. The lecturers confirmed that poor performance causes depression though in some cases depression may also lead to poor performance.

> "Some students simply fail to cope with college life as it is different from their high school experiences where their daily activities are guided and supervised and [they] experience school work pressure and they may also fail to handle peer pressure; other students experience marital problems." – Lecturer L

Failure to cope with college life may be explained as a case of overgeneralising distortion mainly applied to the self (Beck, 1967, as cited in Larsen and Buss, 2008). A student may fail in one aspect and generalise that he/she is not good enough and may even recall other incidences of failure in order to justify the belief of not being good enough. He/she may even stop trying to improve, believing that life has been a total failure and thereby creating a self-fulfilling prophecy that eventually leads to depression. There is also a tendency to magnify failures whilst paying little attention to successes. A student may be overwhelmed by negative thoughts, fail to adjust to the new demands of college life and become depressed.

6.5.12 Relationship problems

Marital problems accounted for nine per cent of the causes of depression amongst the young adult Shona population. Marital problems were also associated with physical abuse, feelings of not being appreciated, feeling rejected and fear of judgment by society. Several studies have reported that marital dissatisfaction is strongly associated with depressive symptoms (Culp and Beach, 1998; Whisman, 1999) and victimization through physical violence in marital relationships are strongly associated with depression (Stith et al., 2004).

> "... my marriage is not going on well at all. I think he wants to divorce me because he is having an affair with another woman. He treats me badly. Sometimes he disappears and I don't even know where he is; sometimes he beats me in front of my children. My children cry, then I also cry. We are all not happy at home ..." – Student 5

Student 5 also explains that she has to endure the pain as she and her children are financially dependent on her husband. She fears what society would say if she left her abusive husband. An unsupportive life partner in such a scenario becomes a catalyst to serious health risks that may prevent individuals from fulfilling their life goals, though other studies have shown that depression may be a risk factor for marital dysfunction (Whisman, 1999; Stith et al., 2004). The fear of societal judgement further cultivates a culture of silence as individuals in abusive environments fear being labelled.

Relationship problems were cited by 31 per cent of lecturers as causes of depression among students. These young adults are at a stage in their lives where they are trying to establish lasting relationships. However, when their expectations are not met this can lead to emotional instability and eventually they may become depressed.

Unplanned pregnancy was also an issue of concern as nine per cent of the students reported it as their cause for depression, while 15 per cent of the lecturers also identified unplanned pregnancy as a cause of depression amongst students. Falling pregnant without actually planning to raise a child may be challenging as the woman may not be financially and psychologically prepared to meet the demands of raising the child. The pregnancy becomes an obstacle to achieving their goals and hence becomes an "unwanted pregnancy". The student may consider abortion as the only solution as putting up the child for adoption is not a common practice in Shona culture. Cases of unwanted pregnancies pose a life threat to mother and child as abortion is illegal and conducted in unsafe conditions.

> "... it's tough. Nothing in my life is going as planned; sometimes I really think about killing myself.... I'm pregnant and my boyfriend does not want to get married to me. It was a mistake. I don't know what to do; I have no money to take care of a child and my parents would certainly kill me if they discover this." – Student 10

> "A student can be depressed due to unwanted pregnancies; they may not be able to accept early responsibilities of parenthood." – Lecturer J

Being scared about the uncertain outcomes of the situation and feeling unappreciated were also mentioned as instrumental in causing depression. Though tertiary institutions provide platforms for Sexual Reproductive Health (SRH) education, some students still find themselves in regrettable circumstances where they contract sexually transmitted diseases, including HIV-AIDS, and sometimes have unplanned pregnancies. Unplanned pregnancies among young

adults or even in adolescents in a country such as Zimbabwe where abortion is illegal may lead to fatalities as some individuals commit suicide and others die while attempting abortion. Legalising abortion would possibly provide safe options for young adults who are not ready to take up the responsibilities of parenthood.

Eight per cent of the lecturers also narrated that domestic violence was a cause for concern as some students would report experiencing physical, verbal and emotional abuse from their spouses, friends and family members. Domestic violence is also an indication of relationship problems though it carries far reaching legal implications that reflect on gender-based violence. Fifteen per cent of the lecturers also disclosed that some students might be depressed owing to sexual harassment. Any form of abuse perpetrated on an individual has detrimental effects on psychological well-being and sexual relationships which in turn negatively affect other social relationships and academic performance. An abused student may lose self-confidence, suffer from low self-esteem or feel hopeless about future prospects.

"Students are subjected to domestic violence and all forms of abuse from those they expect to get support from especially spouses." – Lecturer B

Unreported sexual harassment that might have occurred at the college and during childhood may have dire implications for the victim, who might experience anger and in some cases feelings of self-blame that have not been resolved. Psychodynamic theorists postulate that unhealthy childhood relationships may prevent an individual from developing a strong and positive sense of self, which may result in self-blame and plunging into depression (Feldman, 2009). Such an individual may succumb to depression as the violation of self becomes unbearable.

6.6 Chapter Summary

This chapter presented, analysed and discussed data obtained from Shona students and lecturers on their understanding of depression. Themes emerging from the data reveal that depression is understood and represented as stress, thinking too much, sadness, social isolation, mental instability, or as being spiritually orientated. Ignorance of the existence of the disease within the Shona community was also noted. Depression was also understood in relation to its causes, which include chronic illnesses, socio-economic challenges, relationship problems, failure to cope with college life and an inherited susceptibility. The data show that Shona students and lecturers in a higher education institution in Zimbabwe are to a great extent aware of the existence of depression. They were, however, unable to holistically present their

conceptualisation of the illness as Shona culture does not provide semantic support for the equivalence of depression. Depression was mostly represented by a cluster of related symptoms, a scenario that may potentially lead to treatment of symptoms that may result in chronicity of symptoms.

CHAPTER SEVEN
SYMPTOMS OF DEPRESSION EXPERIENCED BY SHONA STUDENTS

7.1 Introduction

This chapter will present, analyse and discuss symptoms of depression experienced by Shona students in Zimbabwe. The symptoms of depression experienced by Shona students are similar to those experienced in other cultures. Shona students experience a range of somatic, emotional and cognitive symptoms of depression featuring all 11 diagnostic features for depression as stipulated in the DSM-5 (American Psychiatric Association, 2013) including additional associated features. This is a clear indication of the presence of common or universal symptoms of depression that are not influenced by Shona culture.

7.2 Somatic symptoms of depression

Somatic symptoms of depression experienced by the Shona students included a general disturbance in sleep patterns, headaches, diarrhoea, tiredness, lack of appetite, fainting spells, missed menstrual period, pain in the heart (*moyo unorwadza),* no interest in daily activities and laziness. Amongst the somatic symptoms experienced, pain in the heart and delayed and/or missed menstrual period are not present in DSM-5 (American Psychiatric Association, 2013) which provides standardised diagnostic criteria for depression. Although data reveals delayed and/or missed menstrual period as a symptom of depression experienced by some students, it may not be a result of other factors such as pregnancy and illnesses associated with reproductive health.

> "My life is miserable. Sometimes I am so sad. When it's serious I even miss my period and sometimes it comes later in the month. I told my aunt once and she thought I was pregnant, but I don't even have a boyfriend. I don't sleep [have sex] with anyone, I hope this will not affect my ability to have children one day. What will people say about me (with tears in their eyes)." – Student 5

Symptoms reported by Student 5 are likely to aggravate the worry that causes the student to experience severe levels depression. The recurring and intrusive nature of excessive worry, especially recurrent thinking about issues that cause an individual to be sad, exacerbates the experience of depressive symptoms (Brown et al., 2012). As the student contemplates the possibility of infertility in future, new fears and anxieties develop and further deepen the depression crisis.

"I think a lot about my situation, my life, *ndinonzwa moyo wangu uchirwadza* ("my heart is in pain"). Sometimes I just faint. Only God knows my destiny." – Student 5

Symptoms of "pain in the heart", *moyo unorwadza,* reported by the Shona students, may exacerbate the development of other chronic conditions such as heart disease that may be detrimental to one's quality of life even after the depression episode (Kessler & Bromet, 2013). The descriptor "pain in the heart", *moyo unorwadza*, may be an indication that an individual is experiencing physical pain felt in the heart and accompanied by fainting spells. The student also seemingly projects a picture of a situation that is beyond control and with no alternative form of relief as "fate" is determined by God. Depression becomes a way of life and accomplishing their everyday activities becomes a struggle as both physical and emotional well-being is compromised.

"I don't sleep as much as I should so I am always tired during the day; then I get headaches. I just lie awake at night thinking and fantasising about what my life and my future can be like." – Students 5

"I worry so much I have no appetite for anything really and sometimes I forget to eat. I eat to survive when I feel faint and dizzy and then sometimes I get a runny stomach." – Student 10

As individuals become preoccupied with worries about life, they may neglect physiological needs such as eating, which may lead to eating disorders. This was indicated by 27 per cent of the population. Thirty-six per cent of the students reported feeling lazy, 45 per cent reported disturbance in sleep patterns and 27 per cent narrated that they felt tired. Such symptoms may cause a chain reaction as one may feel tired from lack of sleep, which may also lead to feelings of laziness and subsequently a lack of appetite and a general lack of energy. Patel et al. (2001) acknowledge that Zimbabweans report multiple somatic symptoms as presentations of depression, as well as emotional and cognitive symptoms. Some cultures have been reported to be more comfortable reporting somatic symptoms (Nemade et al., 2012, as cited in Ineme & Osinowo, 2016) rather than emotional and cognitive symptoms. This was noted as being common among Chinese samples in North American clinics (Lee et al., 2007).

Unfortunately, presentation of somatic symptoms may lead to treatment of symptoms such as eating disorders, headaches and stomach aches without addressing the underlying causes of the illness. It may be possible for depression to go undiagnosed as treatment of

somatic symptoms may provide temporary relief of bodily pains. Depression may then progress to unbearable levels, in some cases leading to suicide or other severe challenges of mental illness. In some instances presentation of somatic symptoms may be used to gain access to health care (Yen et al., 2000). The presentation of somatic symptoms may be common particularly when individuals are not able to state in their first language that they are depressed, and other symptoms may be disclosed upon further interrogation (Patel et al., 2001).

Though somatic pains are common in depressed individuals, they may also be a cause for depression and provide a simple and culturally acceptable way of expressing psychological distress in the absence of suitable terminology. The somatic pains may be persistent and if left untreated may possibly lead to other health complications in addition to depression. The presentation of depressive symptoms as a proxy for depressive disorder may not be as precise as using a self-diagnosis of depression, but it can assist in identifying both depression and those at risk for developing depressive symptoms. The early identification of depressive symptoms is especially pertinent as the disease may be treated in its early stages before incapacitation, prompting higher chances of a prompt and full recovery thereby reducing the cost of health care (Turner et al., 2012). Presenting depressive symptoms may be particularly useful in Shona culture where depression does not have a precise term in the indigenous language.

7.3   Emotional symptoms of depression

The emotional symptoms of depression reported by the Shona students include an intense sense of sadness, bad moods, crying, general unhappiness, irritability, lack of excitement in previously enjoyed activities, loneliness, the absence of a social life and anger. Common amongst the Shona students and notably absent from the DSM-5 are loneliness, the lack of a social life and anger. Loneliness and social isolation are significantly determined by the culture's role in supporting individuals socially through the interconnectedness of family and friends. In this instance, Shona culture supports social interconnectedness through immediate and extended family and friends who are in some cases even considered to be family. However, when students enrol at college and leave these social-support structures they may experience challenges in establishing their own social-support structures at the institution.

Sadness as a core symptom of depression was reported by 73 per cent of the students, and bad moods were also reported by 27 per cent of the female students who felt sad. This possibly indicates a strong relationship between feelings of sadness and bad moods, particularly in females. Experiences of sadness coupled with a general lack of motivation were also noted

amongst students in class by 31 per cent of the lecturers. Feelings of sadness may overwhelm a student, possibly leading to lack of motivation and inability to accomplish daily tasks. Being sad also influences judgment as an individual maybe pessimistic and fail to be objective in daily decision-making.

"I'm generally sad most of the time because of my problems ... I'm always in a bad mood even when something good happens and my friends are excited." – Student 1

"... and when I feel sad, I smoke and drink all sorts of stuff, so it helps me to be happy ..." – Student 6

The data in this research reveals that students with depressive symptoms are abusing drugs and alcohol as coping strategies in the belief that such substances provide relief from the overwhelming feelings of sadness. Drug and alcohol abuse poses an enormous hazard, which may lead to various health complications that may extend into periods even after one has recovered from depression. It is likely that an individual who is sad for some reason may be susceptible to drug and alcohol abuse and other forms of prohibited activities. Substance abuse was noted amongst depressed students by 31 per cent of the lecturers. The use of prohibited drugs and alcohol, especially by male students, is believed to make them "happy" and forgetful of their worries. However, the abuse of drugs is not only a criminal offense but also has health implications that may affect the student for life.

"Some students easily break down even when they face small challenges. They would cry and feel helpless; other students, especially males, seek comfort in taking drugs to make themselves feel better." – Lecturer J

Twenty-three per cent of the lecturers indicated that truancy was of concern whilst 15 per cent narrated that depressed students are undisciplined. Drug abuse, truancy and a lack of discipline may be associated with each other as the abuse of drugs may lead to truancy and indiscipline which are all inimical to academic achievement. Eight per cent of the lecturers notes that students tended to drop out of college. In some cases truancy may be an indication that a student is losing focus on academic work before dropping out of college.

"Students become truants; [there is] increased undisciplined [behaviour] and failing to do assigned work and not associating with other students." – Lecturer D.

"Students absent themselves from lectures, submit their assignments late and they end up performing poorly. Some even end up dropping out of college and we lose track of the student and unfortunately without education life may not be very good." – Lecturer M

The data from lecturers also revealed that hopelessness and being helpless were observed amongst the depressed students in class. Students were also reported to be overly emotional when faced with situations that they would normally overcome without emotion. This usually took the form of crying and mood swings

"I have experienced students who are anxious, who look very fatigued in class even before any activity; they even fail to hand in assignments on time and show no hope in their life." – Lecturer L

The lecturers' observations and experiences with depressed students indicate that students' feelings of helplessness and hopelessness are associated with depression amongst the Shona students. These may be attributed to an individual feeling trapped in a situation and sensing that there is no hope for liberation from the current state of illness. The student may then fail to come up with solutions to change the *status quo* and become helpless. This could be attributed to a persistent pattern of negative thinking that inhibits creative thinking to produce solutions to life's challenges. Eight per cent of lecturers also indicated that some students even display confusion as they find it difficult to organise themselves and present concepts in a logical manner. This could be attributed to a diminishing lack of focus on academic work owing to social challenges.

"Some students become confused; they don't know what they want; they fail to express themselves logically. This also reflects in their submitted work as their usual presentation drastically changes, and their performance deteriorates." – Lecturer J

7.4 Cognitive symptoms of depression

A range of cognitive symptoms were also experienced by the Shona students. These included, thinking too much, worrying, lack of trust, a sense of worthlessness, pessimism, poor concentration, suicidal thoughts and wishing one was not born. Thinking too much was the most frequently reported cognitive symptom of depression amongst young Shona adults, as revealed by 56 per cent of the population.

"I think a lot about my uncertain future as I may not complete my studies, I am also worried about my siblings' welfare as I have not seen them for a long time." – Student 9

Thinking a lot about adverse situations and challenges would occupy a student's thoughts, though not necessarily aid in solving the challenges being faced. Students may be burdened with negative thoughts that may ultimately distract from the achievement of academic goals. This is congruent with Beck's (1995) cognitive triad, in which a triad of effect occurs when an individual produces recurrent negative patterns of schemas and distorted information processing. The student is preoccupied with much negative and recurrent thinking about the situation, which subsequently influences both feelings and actions. Thinking a lot can also be interpreted in multiple ways as it may be both a symptom and a cause of a student's depression. The idiom "thinking a lot" becomes a complex phenomenon as its interpretation is based on its social and cultural representation. Cognitions play a central role in sustaining dysfunctional behaviour, and, therefore, depression manifests from cognitions (Beck, 1995).

Students also reported a lack of concentration and absent-mindedness during lectures (36 per cent and 27 per cent, respectively). Students report, further, on being preoccupied with other thoughts while in class, and, hence, dedicating less time to learning activities while in class.

"I don't sleep very well so sometimes I fall asleep in class and at times I just sit there without listening; my mind just wonders off." – Student 5

From the data, it emerges that a lack of concentration and absent-mindedness in class are related to other depressive symptoms such as lack of sleep. A series of symptoms may be responsible for poor academic performance as students miss out on concepts taught. Depression may stem from poor performance due to a lack of concentration, though in some instances poor performance may be due to depression. Consistent failure to control and affect the environment leads to negative beliefs about oneself and eventually to depression (Bandura, as cited in Hayes, 2000). Poor academic performance may thus lead to depression. Thirty-one per cent of the lecturers stated that students perform poorly in class as a result of depression.

"The student is withdrawn from their classmates and other activities; they do not participate in class and generally lack concentration and motivation." – Lecturer C

Lecturers of depressed students also described the experiences the students go through while in class and the symptoms they witness in students' class behaviour. Thirty-nine per cent of the lecturers noted that depressed students were withdrawn during class activities and 31 per cent indicated that students lacked concentration. Being withdrawn during class activities and a lack of concentration are an indication of a mind-set that is preoccupied with other issues that are taking precedence in one's life. The process of learning is undoubtedly disturbed as the student focuses on other issues instead of academic work.

Crying was also a common symptom of distress as 36 per cent of students reported crying, especially during the night-time when they were alone, and even crying at college during the day over issues that they would not normally cry over. Symptoms of depression such as crying, sadness and bad moods may be associated with a range of emotions and their occurrence may be triggered by various social situations. Feelings of anger and irritability, reported by 36 per cent and 27 per cent of the participants respectively, were also common amongst the Shona population. The students narrated that they would later realise that they could make an effort to control their emotions as their social lives and relationships were affected by their actions. Excessive irritability often leads to over-reacting to negative life events as an individual finds it difficult to regulate emotions (Campas, Connor-Smith and Jaser, 2004, as cited in Halgin, 2007). Depressed students may simply experience more frequent intense levels of negative affect compared to their peers. These negative cognitive distortions may be automatic and difficult to control since they are reflexive reactions to their lives and the world (Beck & Beck, 1995).

> "I feel angry about the situation that my father put us in and I easily get irritated and this affects my social life. My friends tell me about it and I sometimes regret what I would have said and done. Sometimes I look back and think that there was no reason for me to be so irritated." – Student 3

Anger and irritability in this instance are a reaction to a past event that one had no or little control over but that was detrimental to one's social interactions. The type of symptom experienced depends on the historical, social and cultural context. Symptoms of depression emanating from undesirable past events may not be easily generalised as common symptoms of depression.

Students who were depressed were reported by 8 per cent of the lecturers to be aggressive and to display bullying tendencies towards other students. Some behaviours, such

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as bullying and aggression, may be compensatory in nature with the possibility that an individual may not even be aware of the hurtful actions towards peers. Undiagnosed depression may not only be harmful to the sufferer but may also affect peers and family members, who may not understand how a depressed individual conceptualises the surroundings.

Feelings of worthlessness and self-hatred were also reported by students and lecturers (36 per cent and 27 per cent, respectively). Such feeling may in turn affect an individual's self-confidence and self-esteem. These symptoms may lead to problems in daily functioning and are detrimental to one's ability to maintain social relationships that are beneficial to personal development. In most academic institutions students seek to be recognised and respected by excelling academically and in other disciplines. Creating social relationships boosts self-esteem and provides support both academically and socially. Self-hatred may even affect the ability to show affection to other people and, hence, affection may not be reciprocated, prompting the development of other social challenges.

Suicidal ideation was of major concern in this sample as 36 per cent of the sample reported suicidal ideation and half of the group indicating suicidal ideation (18 per cent) wished they had never been born.

> "I wish I was never born. Maybe if I were dead things would be better for everyone as I am constantly sick and in a lot of pain and obviously a burden to my guardians." – Student 9

Suicidal ideation among the Shona students was associated with trauma in their lives, such as a life-threatening chronic illness, death of a loved one or financial challenges. Individuals become hopeless and pessimistic about all aspects of their lives and suicidal thoughts provide an escape route from their perceived uncontrollable situation. Reports of suicidal thoughts among students were also noted by 8 per cent of the lecturers. Suicidal ideation is common amongst depressed individuals since an individual may contemplate ending his/her life as an exit route from the challenges of life. It is important to ensure that students have the necessary social-support systems at institutions of learning to mitigate effects of depression such suicide. Mutambara (2016) noted that hopelessness was related to suicidal ideation in university students in Zimbabwe. Whilst suicidal ideation does not always lead to suicide, data published by the World Health Organization (2017) report an alarming 1,641 deaths by suicide, which accounted for 1.3 per cent of total deaths in Zimbabwe.

7.5 Chapter Summary

The Shona students exhibit and express their experiences of somatic, emotional and cognitive symptoms of depression. Symptoms of depression have a dual role as some of the reported symptoms represented depression as an illness category, whereas in other cases they were reported in related clusters to describe depression. The symptoms reported by the students and lecturers were common symptoms across various other cultures and are included in the American Psychiatric Association, DSM-5 (2013), with the exception of loneliness, anger, lack of a social life, delayed or missed period and pain in the heart. In addition to structured methods, it is important to use an unstructured data-collection tool in order to elicit diverse responses that represent the historical and cultural experiences of depression among the Shona students.

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CHAPTER EIGHT

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WHAT ARE THE RELATIONSHIPS BETWEEN LEARNING AND DEPRESSION AMONG SHONA STUDENTS IN TERTIARY EDUCATION?

8.1 Introduction

This chapter will unravel how depression affects the process of learning and its impact on academic performance among the Shona students. Depression affects a student's learning and consequently academic performance in various ways. Shona culture plays a pivotal role in influencing learning through the expectations and values it places on students' academic performance.

8.2 How depression affects learning and academic performance

This study reveals how depression affects learning and academic performance in the Shona young adult learners. Sixty-four per cent of the Shona student population revealed that depression negatively affected their learning and academic performance, while 100 per cent of the lecturers indicated that depression adversely affected students' learning. Several studies confirm that students who experience depressive symptoms have a higher probability of experiencing academic challenges (Wechsler et al., 2000; Khurshid et al., 2015).

Thirty-six per cent of the students stated that they perform well regardless of their depressive symptoms. Other studies have demonstrated a relationship between academic performance and depression though the relationships may not be linear (Turner et al., 2012). Regrettably, 18 per cent of the students indicated that they were not sure if depression affected their academic performance, which suggests that they might not be motivated to seek help. This lack of clarity on the effects of depression on academic performance may be a result of some students' lack of awareness of or failure to recognise depression as a disease that requires attention. The data in this research indicate that students with severe depressive symptoms are at an increased risk of poor academic performance as their learning process is negatively affected by depression.

> "...yes! Depression affects my learning. Most of the time I don't feel like coming to school but I'm afraid of failing because I know that will make my situation worse. I don't like school because I don't make friends easily; I think people don't like me. I

submit my assignments on time and I pass but I know I can do better if I don't think about too many things, such as my situation." – Student 1

The data also indicated that depressive symptoms interfere with the process of learning, a position confirmed by various studies (Turner et al., 2012; Boulard, 2015).

Eighteen per cent of the students in this study indicated that they perform well in their academic endeavours despite being depressed. This is an indication that whilst students may be suffering from depression, they remain focused and motivated to achieve their academic goals. The data reveals that students experiencing depressive symptoms feel they are under pressure from family and society to meet their academic demands. The pressure to succeed induces in them a fear of failure and thereby instilling the willpower to meet academic goals regardless of their depressive symptoms. King and Bond (1985) also acknowledged that prioritizing achievement to maintain family reputation and fulfilling social expectations in Chinese culture is more important than acknowledging the depression. Depressive symptoms may inhibit maximum academic performance as individuals may not have the full capacity needed to bring about success. Countries with recorded high prevalence rates of depression also report low academic performance from the depressed individuals (Kessler & Bromet, 2013).

"I pray every day that I complete my programme because it is my only solution to my problems; otherwise I will continue to be miserable in my poverty." – Student 5

More and more, due to the ailing political and socio-economic climate, the emphasis on academic performance as the key to social and financial emancipation is a motivating factor in the students' performance. Students evidently learn to live with their depressive symptoms or believe they are a normal part of life. Achieving academic goals supersedes their health needs. Overcoming depression may, therefore, be considered as a secondary goal, while achieving academic targets is a primary goal. Prioritising academic achievement at the expense of mental health may result in prolonged untreated depression and the development of other health complications that may become chronic. The pressure of academic achievement as a determinant of future success in a competitive environment (Steptoe et al., 2007) dictates the course of action a student takes with regard to mental health.

8.2.1 Failure to meet academic demands

Depressed students also reported that their learning was affected: 27 per cent admitted to submitting their assignments late, while 73 per cent indicated that they submitted their assignments on time and were able to meet their academic obligations. Various justifications were given for not meeting academic demands, such as simply feeling like not attending class, a response that may also be a consequence of depression. Submitting assignments after the due date may have unfavourable consequences for a student's final grade, worsening the student's already compromised position. Hysenbegasi et al. (2005) also discovered that these negative effects of depression on students' academic performance lead to missed learning opportunities and consequently decreased capacity to demonstrate learning.

"Sometimes I can't come to school because the situation at home is not good as I sometimes I don't have bus fare. I am always submitting my assignments late and my marks are low but in high school I was good in class and I performed very well." – Student 5

The reported absenteeism was also of great concern as the process of learning is interrupted by financial challenges faced by the student in travelling to college every day. The student is likely to lag behind in academic work, which may intensify or trigger other depressive symptoms, such as worry.

Forty-six per cent of the lecturers indicated that low grades were common among depressed students. Evidence of effective learning is usually measured by attaining good grades in an examination or in assignments, and depressed students have been reported to perform poorly at the end of an assessment period. Studies in Nigeria have reported that students with high levels of depression have limited capacity to complete complex academic tasks and their academic performance slows down significantly (Salami, 2008). Hysenbegasi et al. (2005) also discovered that untreated depression was associated with low GPA whilst there was no significant difference in GPA among students on depression treatment.

Twenty-three per cent of the lecturers indicated that depressed students have difficulties in grasping taught concepts. This observation suggests that depression has adverse effects on the actual process of learning as a student's mind may be preoccupied with problems. The students' ability to grasp concepts is negatively affected thereby making it difficult to achieve academic goals. Undiagnosed depression not only affects an individual's well-being, but may

also affect all facets of life as academic performance plays a fundamental role in a person's social standing during and after college life.

8.2.2 Lack of concentration

Related to the students' depression, 72 per cent of the student group reported that the process of learning was affected by a lack of concentration in class. Eighteen per cent also reported day-dreaming and sleeping in class. Being unable to pay attention in class may affect optimum absorption of knowledge as the student misses out on important content being taught.

> "I think a lot about other issues during lectures; sometimes I fall asleep during the lecture and it's embarrassing." – Student 11

> "Sometimes I can't concentrate. I just day-dream during lectures, I am just so stressed. I end up just copying notes from my friends without understanding what was taught during the lecture." – Student 4

> "Depression affects my learning because I know I will die soon. It's a waste of time so I don't like doing school, but when I write assignments I pass so I think I'm intelligent but it's no use, then what? So sometimes I write my assignments and sometimes I just don't, especially when I feel very low." – Student 9

Such scenarios may potentially further plunge an individual into deeper depression as they may not be able to perform according to expectations. Owing to the feelings of hopelessness experienced by some depressed students, nine per cent of the Shona learners also reported that they did not like school. From the data, it is evident that a student may believe that attending lecturers is a waste of time as they may not benefit from their hard work in the long run. This is evidence of lack of motivation on an important aspect in life that is considered key to one's future success.

This sense of hopelessness is due to chronic illnesses and may be harmful to an individual's attitude towards their longevity and affect their ability to execute daily activities that support the achievement of lifelong goals. A chronic illness coupled with depression may be predominantly detrimental to one's livelihood and a cause of premature death. Chibanda et al. (2016) noted a high prevalence rate of depression among Zimbabweans living with HIV and AIDS.

"Yes! Depression seriously affects learning because it affects the well-being of the student in terms of emotional health and an emotionally unstable student cannot perform optimally in their academic endeavours. They obviously get distracted by their emotions." – Lecturer I

"Depression affects a student's concentration levels. Maximum attention is required so that one is able to understand what is taught, and some of the concepts are complex and a student may not be able to understand on their own in order to be ready for exams." – Lecturer K

"Because of depression, a student lacks concentration and fails to comprehend taught concepts leading to poor grades." – Lecturer D

The lecturers revealed that lack of concentration was the major effect of depression on learning. Seventy-seven per cent of the lecturers observed that depressed students fail to concentrate on their studies in class. The process of learning is complex as a student should not only listen but also understand in order to transfer knowledge and relate to the outside world. In order for learning to take place, a healthy emotional, physical and cognitive state is essential for an individual to perform optimally. Psychosocial challenges affecting students have a direct impact on their ability to function effectively in class (Nsereko et al., 2013) and often result in study burnout among students (Kitzrow, 2003; Harper & Peterson, 2005).

8.2.3 Lack of motivation and low self-esteem

Low self-esteem was also noted amongst depressed students. Possible effects include loss of confidence and questioning one's self-worth, which may also lead one to feel hopeless. Fifteen per cent of the lecturers alluded to lack of confidence and low self- esteem as a cause of depression among students. In some cases, low self-esteem is associated with some undesirable event that may have bruised one's ego. A low self-esteem and lack of confidence in an individual may also affect social relationships. Lecturers revealed that college students who exhibited emotional distress were less engaged in classroom and campus activities resulting in less desirable academic outcomes.

"Depression takes away a student's self-esteem and motivation, which I think is the drive that enables them to work hard. With low self-esteem students feel they are not worth it or they can't do it so they end up giving up in their studies." – Lecturer J

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> "I don't want other students to look at me as the dull guy who always fails their assignments. It's not good for my image. I don't look forward to my classes. I just don't like school." – Student 6

Continued poor performance in schoolwork may bring about numerous consequences in students such as shame, negative attitudes towards school and consequent perceived or real labelling and discrimination. Poor academic performance further compromises their confidence as the manner in which they express themselves socially amongst their peers and on academic forums may be affected. The picture portrayed by Student 6 one in which poor academic performance leads to depression whilst depression can also lead to poor performance. Hysenbegasi et al. (2005) confirm the interrelatedness of depression and academic performance. Continued failure to achieve academic goals may lead to depression whilst depression may also lead to failure to achieve academic goals.

The lecturer participants also reported that due to depression, a student may lack motivation and not be interested in schoolwork. Lack of interest in school work has dire consequences as an individual may not fully embrace the process of learning and the principles governing the school structure. Depression among university students was identified as leading to poor attendance, difficulties in concentration, and lack of motivation and interest (Dusselier et al., 2005). The entire process can actually be a waste of time as one may not benefit from attending class, eventually resulting in an undesirable outcome at the end of a learning period. When students are not motivated to learn they may fail to concentrate and hence may not grasp concepts taught. Lack of motivation may result in continued failure in academic tasks and students may stop trying as they expect to fail (Brain & Mukherji, 2005). Ultimately their frustration levels increase. Depression hinders the process of effective learning. Motivation becomes a major driving force in attaining academic goals. The data also revealed that some students may eventually drop out of school owing to depression as both their academic goals and their social life may not live up to their desired expectations.

8.2.4 Indiscipline

From the data, it emerged that 23 per cent of the lecturer participants disclosed that bad behaviour sometimes leads to depression and in some instances depression promotes ill behaviour in students. Another Twenty-three per cent of the lecturer participants also mentioned that some students developed bad attitudes towards authorities, leading to

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undesirable consequences that may then trigger depressive symptoms. Confrontations with college authorities were reportedly due to behaviours fuelled by drug and alcohol abuse and general indiscipline. Writing about students in India, Ahmad et al. (2007) noted with concern the effects of psychosocial problems that included increased academic underachievement and antisocial behaviour among university students.

> "In my view, depression affects learning in that it lowers concentration levels, which may prompt absenteeism. Depression creates tension within the learning environment and other ill behaviours such as substance abuse." – Lecturer K

> "Depression affects learning in a number of ways, such as causing low grades, non-attendance of lectures, school dropouts, and students develop bad attitudes towards authorities." – Lecturer B

Based on lecturers' views, it may be assumed that indiscipline and its consequences may trigger depressive symptoms while depression may also drive one to drug abuse and other undesirable habits. A student who adopts undesirable habits and antisocial behaviour is likely to generate repeated multiple problem behaviours such as substance abuse, truancy, conduct issues, authority conflict problems and aggression (Smart et al., 2004; Loeber & Farrington, 1998). Such behaviour on college campuses may not be tolerated and students involved may pose a burden to their parents, guardians and college authorities. The consequences of indiscipline such as conflicts with authorities may lead a student to experience feelings of isolation and rejection from the college community, further compounding the depression (Nsereko et al., 2013).

8.3 Chapter Summary

Whilst depression has been proven to affect many facets of life, Shona students in an educational institution are not immune to the effects of depression. Depression inhibits maximum academic performance as some students are able to successfully complete their tasks while others struggle and are not able to achieve their goals. This chapter revealed that the Shona students were negatively affected by depression in several ways, including failure to meet academic demands due to absenteeism caused by socio-economic challenges. Students failed to concentrate and even fell asleep in class owing to depression, thereby losing out on taught content. Depression was also associated with lack of motivation, low self-esteem and indiscipline. Other students were reported to drop out of college owing to loss of interest in academic work and possibly succumbing to pressure from environmental stressors.

CHAPTER NINE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

9.1 Introduction

This chapter is a summary of findings and conclusions from both qualitative and quantitative data. The findings emerge from the research question that guided the study: how are depression and the interaction between depression and learning understood by young adult students in Shona culture? The chapter lays out recommendations for key stakeholders, including the Ministry of Higher and Tertiary Education, Science and Technology Development, the college administration, lecturers and students. Recommendations are aimed at reducing or alleviating symptoms of depression and their effects on students' academic performance. Implications for future research and limitations of the study are also highlighted.

9.2 Summary of Findings

A prevalence rate of 36 per cent for depressive symptoms was discovered amongst first-year Shona students in a tertiary education institution in Zimbabwe. The breakdown of the prevalence rate showed 3.3 per cent with severely depressive symptoms, 13.9 per cent with moderately depressive symptoms and 18.8 per cent with mild symptoms. Sixty-four per cent of the participants had minimal to normal scores for depressive symptoms. These prevalence rates were discovered to be high in comparison with results from other institutions of higher learning (Chen et al., 2013; Sarokhani et al., 2013; Lei et al., 2016) and even with those of the general population (World Health Organization, 2018a; Cassady et al., 2019).

The high prevalence rate of depressive symptoms described in this study is of concern as social factors associated with depression are on the increase, especially among students in higher and tertiary education who are confronted with additional unique challenges. The socio-economic environment presents unfavourable conditions for students to fully exploit their potential. A student may succumb to experiences of negative life events and develop negative thoughts; the more the negative thoughts, the greater the vulnerability and severity of depressive symptoms experienced. As explained in Beck's cognitive theory of depression, the relationship between the severity of depression and the amount of someone's negative thoughts is determined by the from life events experienced (Nevid, 2009; Beck & Bredemeier, 2016). Life experiences brought about by negative events play a pivotal role in the occurrence and severity of depression.

Symptoms of depression exhibited by Shona students were similar to those stipulated in the DSM-5 (American Psychiatric Association, 2013) with a few additional experiences. Earlier studies in Zimbabwe by Patel et al. (2001) revealed that Zimbabweans exhibit similar symptoms of depression to those encountered in many other industrialised and non-industrialised nations, suggesting that culture plays a limited role in the experience of some common symptoms of depression. The Shona students reported experiencing somatic, cognitive and emotional symptoms of depression. These findings are in line with Beck's cognitive theory of depression, which focuses on cognitions, emotions and behaviours that manifest into depression (Beck et al., 1979). Depression is, therefore, a result of the interaction of negative cognitions, emotions and behaviours stimulated by negative environmental conditions. Honghong, (2016) indicates that non-westerners frequently report somatic symptoms of depression as compared to cognitive and emotional symptoms. The findings in this research however provide no evidence that somatic symptoms are more common than emotional and cognitive symptoms among Shona students.

The somatic symptoms of depression exhibited by Shona students included headaches, a general disturbance in sleep patterns, diarrhoea, lack of appetite, missed menstrual period, laziness, pain in the heart, loss of interest in daily activities and tiredness. It should be noted that some of these symptoms are additional to the experiences stipulated in the DSM-5, namely, missed menstrual period, and pain in the heart. Pain in the heart was also noted amongst the Swahili population of Kenya (Abubakar et al., 2016). A symptom such as this may lead to the development of other chronic conditions that may affect an individual even after the depression episode. Transcultural psychiatry advises on the possible risk of decontextualising unique depressive symptoms and of mental health workers assigning their own ethnocentric conceptualisation (Marsella, 2003). Cultural conceptualisations of depressive symptoms are, therefore, important for a holistic diagnosis of depression.

Patel et al., (2001) discovered that chronic somatic symptoms were initially presented in most cases and after a few questions that revealed other psychological symptoms the mental health worker was led to a diagnosis of depression. Somatic symptoms provide culturally acceptable ways of expressing depression in the absence of Shona equivalent semantics. The somatic symptoms reported included headache, stomach pain, loss of appetite and poor sleeping habits. The Shona student participants in this research reported a cluster of somatic, emotional and cognitive symptoms of depression. The students' use of English language during

data gathering in this research provided the linguistic support which may not have been achieved in the Shona language.

Emotional symptoms of depression reported by young adult Shona students included crying, general unhappiness, irritability, sadness, loneliness, bad moods, lack of interest in previously enjoyed activities, isolation and anger. Notably absent in the DSM-5 (American Psychiatric Association, 2013) and common amongst the Shona students were social isolation and loneliness. Shona culture assumes a significant role in providing the social support to protect individuals from depression through the interconnectedness of family, extended family members and the community. This social support offered by family members may not be available when a student enrols for college; hence they suffer from adjustment challenges as they try and build new social circles. An individual may, however, be lonely even when not socially isolated. Matthews et al. (2015) argue that lonely individuals are more susceptible to depression irrespective of any social support that surrounds them.

The findings also reveal relationships between depressive items on the BD-II questionnaire and severity of depression among the Shona students. Out of the 21 items on the BDI-II questionnaire, 9 items emerged to have a significant impact on the severity of depression experienced. These included; pessimism, changes in sleep patterns, indecisiveness, crying, agitation, punishment feelings, concentration difficulty, loss of interest in sex, and loss of energy. These findings indicate that certain symptoms of depression are significant in influencing the level of depression the Shona student experiences. These symptoms should therefore be key in intervention strategies that aim at reducing the impact of depressive symptoms on Shona students

The sample comprised 60.5 per cent female and 39.5 per cent male participants. There were no significant differences in prevalence rates of depressive symptoms for both sexes. Severe depressive symptoms were experienced by 1.6 per cent of both male and female students. Students with moderate symptoms of depression comprised 5.7 per cent male and 8.2 per cent female, whilst 6.8 per cent of males and 12 per cent of females had mild symptoms of depression. These findings indicate that whilst symptoms of depression were evident for males and females, the severity of depression varied slightly as females had higher rates in the mild to moderate range. These findings may be an indication that both male and female students face similar social and academic challenges that lead to the manifestation of depressive symptoms.

Variances of depression expressions and symptoms by gender showed that males had significantly higher scores on pessimism, feelings of being punished and suicidal thoughts than females. Females, on the other hand, exhibited a higher mean ranking on changes in appetite, mood swings and crying. Female students who felt sad and unhappy also experienced mood swings, which might be attributed to hormonal changes. Female students were also discovered to cry more than their male peers over issues that they would not normally cry over in their day-to-day lives. This tendency to cry may be attributed to a lesser ability to control emotions when faced with adverse conditions. Another possible explanation may be the fluctuation of the female reproductive hormones during the menstrual cycle and the process of childbirth which causes premenstrual dysphoric disorder (PMDD) and postpartum depression (Grohol, 2019). These experiences specific to females may have contributed to confirmation in various studies that women are more susceptible to depression than men (Lim et al., 2018; WHO, 2018a). These revelations are important when designing prevention programmes that are effective in reducing targeted specific symptoms that affect males and females differently.

Thinking too much, worrying, a sense of worthlessness, pessimism, suicidal ideation, poor concentration and lack of trust were reported cognitive symptoms of depression by the Shona students. Thinking too much and poor concentration were the most commonly reported cognitive symptoms of depression among the students. Students were faced with challenging situations such as financial constraints leading to poverty, chronic illnesses coupled with poor health-care services, and death of parents or guardians leading to loss of social and financial support amongst other challenges. These social stressors cause students to worry and think a lot about their seemingly bleak future and result in a lack of concentration in class. Beck (1979) confirms that critical negative life events activate dysfunctional beliefs that cause depression. An individual's view of the environment, the future and the self may be negative and this is likely to lead to maladaptive coping strategies (Burkhouse et al., 2019).

Suicidal ideation was also noted with concern. Some students lamented that they wished they had never existed in the first place as their existence was filled with challenges and misery. Thoughts of suicide provide an escape route from the challenges they believe cannot be overcome. Suicide ideation is also associated with several other depression indicators such as pessimism, hopelessness, feelings of worthlessness and self-hatred. Suicidal ideation has been noted to be prevalent in Zimbabwean university students (Mutambara, 2016). Shona culture's traditional values and Christian values condemn suicidal ideation and the act of committing suicide, thereby possibly deterring some students from revealing their actual views on suicide.

The study concentrated on first-year students who were mostly within the 18 to 30 year age-group. Prevalence rates were, therefore, calculated within a particular age range. The findings reveal that most of the first-year students were single. Married, divorced and widowed persons were not adequately represented to make a comparison. Symptoms of loss of interest in previously enjoyed activities were experienced more significantly in this young age-group. The findings also revealed that single persons experienced more significant feelings of self-dislike, changes in sleep patterns, loss of interest in sex and suicidal thoughts. Other symptoms and experiences of depression were experienced more or less in a similar pattern regardless of age among the Shona students.

Shona students speak different Shona dialects that provide varying linguistic support for the conceptualisation and expression of depression. The findings reveal no significant difference in experiences of depression due to Shona dialects. The Shona language dialects provide similar linguistic support for the conceptualisation and expression of depression. The Shona student participants were also highly proficient in the Shona language and therefore adequately capacitated with available Shona vocabulary to understand and express their experiences of depression and its symptoms. Their proficiency in the Shona language, however, influenced the students in the manner in which they experienced symptoms of depression. Symptoms of depression are believed to be a product of historical traditions and culture-specific explanations that frame depressive experiences through the use of a local language that describes the illness (Marsella, 2003; Kirmayer, 2015).

Depression was mostly represented by its symptoms. For an individual socialised in Shona culture, depressive symptoms are characterised by a mixture of spiritually orientated traditional explanations and Christian-based conceptualisations. Though there is no term for depression in Shona culture, the symptoms exhibited by Shona students that were used describe depression were presented in a cluster reflecting an acknowledgement of depression as a disease entity. In light of the unique conceptualisations, transcultural psychiatry advocates for the understanding and consideration of beliefs and values of different cultural groups for effective mental health service provision (Beck, 2016).

The findings reveal that the Shona students understand depression as "stress". The term "depression" was not commonly used amongst the Shona students and instead they used the term "stress" to describe a cluster of depressive symptoms. Stress was also noted to be associated with stressful life events such as financial problems leading to poverty, relationship

challenges, chronic illnesses, death of a parent or guardian leading to loss of social and financial support and failure to meet academic demands. These associated psychosocial challenges often manifested into psychopathologies such as depression often referred to as "stress" by university and college students.

Depression was understood as intense sadness (*kusuruvara*), which was also a reaction to environmental stressors. In some cases, intense sadness was believed to be inherited and some families had more than one member who occasionally experienced sadness that led to suicide. Sadness had a dual role as it was presented as one of the most common emotional symptoms and as a term that represents depression. This dual role may contribute to misunderstandings of depression as an individual can be sad without being depressed. Closely related were general feelings of unhappiness as unhappy students experienced sadness and a lack of interest in previously enjoyed activities. The intensity and duration of sadness are, therefore, critical in diagnosing depression to avoid medicating normal sadness while minimising the risk of suicide due to its dual presentation with sadness.

The phrase "thinking too much" (*kufungisisa*) was also used to represent depression. The process of thinking a lot was due to adverse life events that an individual was worried about. The idiom "thinking too much" was noted as representing depression and in some cases as a symptom of depression among the Shona students. Thinking too much has also been included in the DSM-IV and V of the American Psychiatric Association, of (2013) as a cultural syndrome of depression. Transcultural psychiatry advocates for such cultural syndromes to be incorporated in research and mental health intervention programmes in order to improve understanding of mental health in various cultures (Kirmayer et al., 2017).

Depression is believed to have its roots in supernatural causes associated with traditional beliefs or Christianity. Depression and spirituality are interconnected and deeply rooted in the Shona students' belief system. Depression and other mental illnesses are believed to be a form of misfortune that has befallen a family or a form of punishment for the family from disgruntled ancestors. The family would need to contact and appease the spiritual being. This traditional conceptualisation of depression as a misfortune or form of punishment for a wrongdoing in the family brings shame to a family leading to labelling, stigmatisation, discrimination and associated with not seeking medical attention. Research in this regard suggests that spirituality is indeed associated with positive contributions to mental well-being

as faith and belief in a transcendent being are associated with a significant decrease in depression (Mental Health Foundation, 2006; Kajawu, 2015).

The Shona students and lecturers understood depression as a form of mental instability, with labels such as "mad", "madness" and "*kupenga*" being attached to an individual. These labels such as "madness" are mostly due to the grouping together of mental illnesses from minor psychological conditions to severe psychiatric conditions in Shona culture. The labels were associated with persons who were totally out of touch with reality and were freed of responsibility as members of the community. A student is most likely to feel stigmatised when labelled "mad" and believe that other students do not respect his/her opinions. This labelling in consequence affects a student's confidence levels and also presents a barrier to seeking professional assistance (Vankar et al., 2014). In some instances students even stop trying to improve their capabilities as they believe they are failures (freed of responsibility), thereby creating a self-fulfilling prophecy that perpetuates a cycle of cognitive distortions (Beck, 1967).

Ignorance of depression as a disease is also noted among a small number of the Shona students. Depression as a disease entity is not holistically acknowledged in Shona culture and the lack of explicit Shona vocabulary to describe depression may contribute to this ignorance. Shona cultural socialisation does not fully embrace the existence of depression; hence the partial lack of understanding of depression as a curable disease. Culture determines social norms and inevitably shapes behaviour around illness that induces help-seeking attitudes in Shona students (Hinton et al., 2016). Cultural inhibitions and limitations in vocabulary may lead to the identification of depression through its symptoms and possibly contribute to undiagnosed cases of depression.

The majority of Shona students acknowledge the negative effects of depression and depressive symptoms on their learning and academic performance, a position also confirmed by Hysenbegasi et al. (2005) whilst a minority were able to achieve their academic objectives despite being depressed. A few students were not sure if depression did in fact affect their learning and academic performance. Academic achievement is of paramount importance to Shona students and their families as it brings hope that when they successfully complete their studies they will be able to secure employment and raise their family's standard of living. Achieving academic goals in some instances supersedes the attention given to depression as a student is motivated to achieve despite enduring the pain and suffering of their illness, as in

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some cases and depending on the severity of the symptoms, Shona students continue with their studies without undergoing any form of treatment.

Findings reveal that some students were not able to meet academic demands by not submitting assignments on time or missing lectures as they sometimes did not feel like attending lectures. Absenteeism was also noted and ascribed to challenges of illness and the cost of travel to college. This failure to meet academic demands inevitably affects their grades as students lag behind and fail to master concepts taught during their absence. Students who exhibit depressive symptoms suffer low self-esteem, which in turn affects their confidence and raise questions about their self-worth. Low self-esteem and a lack of confidence affect both academic performance and a student's social life. Feelings of hopelessness and worry then increased, plunging them further into a deeper depression. Failure to meet academic obligations and poor social relations led students to believe that they are incapable, that the school and their peers see them as incapable and that their future is bleak (Beck, 1967, as cited in Larsen & Buss, 2008). Depression has, therefore, a negative impact on students' belief systems, consistently producing pessimistic and illogical thinking patterns about themselves, the world and their future (Pierce & Hoelterhoff, 2017).

Depression was also characterised by considerable lack of concentration during the process of teaching and learning. Students report on being absent-minded and falling asleep during lectures, thereby missing out on taught content. Negative thoughts about their lives and to a lesser extent fantasies about a good life they wish to live consume their cognitive processes during the day and cause lack of concentration and insomnia. Depression therefore results in a reduction in learning opportunities, a probable decrease in levels of information absorbed and a decrease in the ability to demonstrate that learning has taken place (Hysenbegasi et al., 2005). Social isolation, withdrawal from peers and previously enjoyed social activities were preferred as an escape route from social activities. Leading a solitary lifestyle which deters productive social integration affects an individual's self-esteem and is construed as depression by the Shona students.

Lack of motivation was cited by students with depressive symptoms and their lecturers as a major obstacle in achieving academic goals and also cause them to lose interest in their academic work and fail to apply maximum effort towards the achievement of their academic goals. Lack of interest in academic work was reported to lead to indiscipline when students sought an outlet for their frustrations. Findings in this research established that some students

engage in drug and alcohol abuse and subsequently run into confrontations with college authorities. These dysfunctional belief themes or negative schemas cause students to believe they are defective or inadequate, leading them to adopt a distorted way of thinking (Soflau & David, 2017) and consequently leading to poor decision-making.

9.3 Conclusions

In conclusion, it is evident that the prevalence of depressive symptoms was relatively high among the first-year Shona student population in comparison with prevalence rates from other institutions of higher and tertiary education and those of the general population. The Shona students experienced common cognitive, somatic and emotional symptoms of depression as experienced by the general population and those listed in the American Psychiatric Association DSM–IV and V of 2013. In addition, experiences of pain in the heart, missed menstrual period, anger and loneliness were also revealed. A cluster of depressive symptoms including feelings of punishment, agitation, crying, concentration difficulty, loss of energy, pessimism, changes in sleep patterns, agitation and indecisiveness were prominent in influencing levels of depressive symptoms. It is therefore prudent for intervention programmes to focus on reducing these symptoms and thus curbing their effects among Shona students.

Demographic characteristics such as sex, marital status, religion, ethnicity and age were not significant risk factors for depressive symptoms. This may be a result of the traits not predisposing the participants to depressive symptoms. The depressive symptoms were, however, influenced by the adverse socio-economic conditions the students were confronted with. These included financial challenges, death of parents or guardians, chronic illnesses, lack of social support, relationship challenges, poor academic performance, and drug and alcohol abuse. These challenges were the foundation of the students' excessive worry about the possibility of not completing their studies and inevitably believing their futures were bleak, leading to the manifestation of depressive symptoms.

The students understood their depression as "stress". The word "depression" was rarely used in their daily discourse, though they presented with a cluster of depressive symptoms. This may be the rationale for some participants' reluctance to acknowledge depression as it did not exist in their Shona culture as a disease entity. They also understood depression as "thinking too much" (*kufungisisa)* and "troubled thoughts" (*k*), which was a reflection of their excessive worrying over challenges faced in their daily lives. Depression was also conceptualised as spiritual, with its roots in the Shona traditional practices, and in some instances depression was

believed to be God's plan on an individual's life therefore religious interventions were sought. Students conceptualised depression as "madness", depending on the types and severity of symptoms experienced. The Shona students acknowledged that depression was hereditary and affected family members for generations, in most cases leading to suicide.

The impact of depression on learning was significant: the Shona students reported they were unable to optimally concentrate and participate in learning activities in class, leading to poor academic performance. Depression affected attendance as some days an individual would not feel like attending school, thereby missing out and lagging behind on taught content, in some cases eventually leading to dropping out of college. Depression also negatively impacted social life as interactions with peers were minimised or avoided owing to loss of interest in social life. Some students noted, however, that despite their feeling depressed, their academic performance was not affected as they were motivated to complete their programmes, secure employment and alleviate their family's poverty.

9.4 Recommendations for the Ministry of Higher and Tertiary Education, Science and Technology Development

The Ministry of Higher and Tertiary Education, Science and Technology Development should introduce a mental health policy that implements a robust on-campus mental health care facility. This is to facilitate effective prevention, timeous detection, and novel and comprehensive treatment approaches that are cost effective and accessible to all students. Included in the policy, as recommended by the World Health Organization, there should be a model that can be modified and tailored to suit the Shona cultural context in order to address mental health in students.

Table 33: Model of support for university students

Level of support	Type of support	Examples	Severity of students' mental health problems
Level 5	External specialist support	Specialist mental health services	Severe problems requiring specialist care
Level 4	University support services	Counselling	Students with more severe or

			diagnosable problems
Level 3	Structured university support	Personal tutors Study and well-being skills Peer support or buddy system	Students with varying levels of distress
Level 2	Informal university/personal support	Friends Social support via university societies with some offering talks on mental health issues Family	Students with varying levels of distress
Level 1	Self-care – or readiness for university	Budgeting and cooking skills Friendship skills Coping with academic demands (e.g. time management, essay skills, sleep) Emotional coping skills	Students with varying levels of distress

Adapted WHO model in Brown (2018).

9.4.1 The Ministry of Higher and Tertiary Education, Science and Technology Development should also adopt cost effective intervention programmes that are accessible to students on campus such as "the friendship bench" recently introduced in clinical settings by Psychiatrist, Dr D. Chibanda in 2007 (Chibanda et al. 2016). "The friendship bench" is a Zimbabwean innovation that offers culturally informed problem-solving therapy aimed at mitigating depression and its symptoms and other mental health challenges. The friendship bench's focus on problem solving therapy can be highly recommended for the Shona students as their depressive symptoms are mostly a reaction to external factors such as financial challenges,

illness, drug abuse and failure to cope with college demands amongst other factors elaborated in this study.

9.5 Recommendations for College Administration

The college administration should compile a localised college mental health policy, with particular focus on depression and guided by the ministerial mental health policy. The college policy should suit the specific mental health needs of the students. The findings of this research can also be used to inform policy so that intervention strategies can focus on addressing challenges that lead to depressive symptoms and depression in students.

The policy should focus on programmes that increase awareness and mental health literacy with the aim of reducing the stigma and discrimination associated with depression in order to promote professional help-seeking behaviours. Programmes should also focus on preventing depression for high-risk populations such as students with mild or moderate symptoms of depression, students with learning difficulties and those from financially disadvantaged backgrounds. Students can be empowered with problem-solving strategies such as ways of overcoming negative thinking.

The college should create a supportive social and physical environment that seeks to address depression and other mental-health challenges. Information on support services and resources on mental-health services should be made available to students so that they are aware of available help options.

Workshops and in-service training should be held for college administrators and lecturers to improve mental-health literacy and enable them to impart the knowledge and identify students who need assistance. Other research studies highlight that lecturers were usually the first port of call for students experiencing depressive symptoms but 60 per cent felt they were underequipped to provide support (Hughes et al., 2017; Gulliver et al., 2018). The lack of mental health literacy among lecturers and other college administrators suggest the importance of training to empower staff members to offer assistance to students.

9.6 Recommendations for Lecturers

Lecturers should offer lectures on mental health, particularly depression, and enlighten students on support services available as part of their health and life-skills curriculum. The goal would be to improve mental-health literacy and help-seeking behaviours amongst students. Low mental-health literacy especially in people from poor socio-economic backgrounds is due to

lack of access of information through education, which exacerbates the likelihood of developing mental-health problems such as depression (Ibrahim et al., 2020).

Lecturers should play an active role in identifying students experiencing various social and academic challenges and those who are depressed in class and should recommend that they seek help. These students can be identified by paying attention to attendance, academic performance, general behaviour, attitudes towards peers, learning and learning activities while in class.

9.7 Recommendations for Students

Students should expound on their mental health literacy to facilitate a better understanding of depression and other mental illness. This would reduce stigma associated with mental illness and promote help seeking behaviours so that their academic and social lives are not negatively impacted.

Students should adopt a caring attitude towards one another so that they provide the necessary social support for their peers and minimise vulnerability to depressive symptoms associated with lack of social support and isolation.

9.8 Implications for future research

9.8.1 Variances of depressive symptoms and depression expressions by gender showed that males had significantly higher scores on suicidal thoughts, pessimism and feelings of being punished. Female students, on the other hand, exhibited a higher mean ranking on changes in appetite, sadness, mood swings and crying. Future research should focus on gender differences in depressive symptoms and depression in order to come up with interventions that circumvent risks associated with depression and gender. While there were no significant differences in prevalence rates of depressive symptoms based on gender, male and female students experienced different symptoms that affected their daily lives differently. Cognitive behavioural interventions aimed at alleviating specific symptoms for females and males may also be particularly helpful

9.8.2 Research should focus on the effectiveness of traditional healing practices in indigenous populations that believe in traditions as a cause of depression. As was highlighted in this research, some students believe the root cause of their depression is linked to their traditions; hence modern medical and psychological interventions may not be readily accepted. The significance of understanding Shona students' conceptualisation of depression should not be

undermined in an effort to come up with effective holistic solutions to their challenges. A combination of contemporary interventions and traditional healing practices may also be advocated for intervention programmes.

9.8.3 Further research is required to clarify academic performance as a cause for depression or if depression causes poor academic performance in students, especially those with low socio-economic status. This research noted that some students with severe depressive symptoms continue to perform well in their academic work whilst others perform below their expected standard. Further research can clarify whether Shona cultural expectations to succeed play a pivotal role in students' academic performance.

9.9 Limitations of the Study

There were a number of limitations that may influence the interpretation of findings from this study. These possible limitations are elucidated below.

The reliability of the research may have been affected as the data-collection process involved a self-reporting questionnaire. Because participants themselves reported on their past and present experiences of depression, the possibility of minimised or exaggerated scores may be high. To minimise the impact, the research opted for volunteer participants, as those who were willing to participate were more likely to give a true reflection of events. The participants were also encouraged to be honest in their responses. This may be highly likely on the item on interest in sex especially considering that most of the participants were single and Shona culture insists on abstinence until marriage. Students who were sexually active and single might not have been willing to reveal their sexual thoughts and behaviour.

The generalisability of the findings of this research may be limited as it was carried out at a single college and there may be regional differences in depression at other institutions. The sample was drawn from volunteers in a single tertiary institution of learning. Variables involved in the manifestation of depression may change in different settings. These variables may include students' socio-economic status; some higher and tertiary education institutions may have more students who have stable economic backgrounds that alleviate some challenges faced by students in other institutions.

9.10 Chapter Summary

Depression is a serious, highly prevalent mental condition among Shona students in higher and tertiary education. Culture plays an integral part in understanding depression in students of this

indigenous culture. Depression is associated with poor academic performance, substance abuse, low self-esteem, reduced productive social interactions, and general detrimental effects on productive time. Depression, if left untreated, has the potential to rob individuals of their future careers as it affects a person's ability to enter and compete in the job market and live productive and meaningful lives. Early identification of depressive symptoms and depression may avert a potential crisis and interventions employed may be more scalable in institutions of higher and tertiary learning, thereby minimising its impact on academic performance and the student's social life.

Recommendations highlighted included policy formulation by the Ministry of Higher and Tertiary Education, Science and Technology Development and the preparation of localised policies by institutions of higher and tertiary education. A policy should aim to provide a standardised method for circumventing depression and its effects on students. Mental-health literacy programmes, such as the inclusion of mental health in the curriculum, were also recommended to increase awareness of depression as a curable disease and improve help-seeking behaviours. Generalisability of these findings may, however, have been affected by the limited targeted population studied, although the reader may decide to benefit from this research due where settings are similar.

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APPENDIX 1

Beck's Depression Inventory (BD1-11)

On this questionnaire are groups of statements. Please read each group of statements carefully. Then choose the one statement in each group which best describes the way you have been feeling in the past two weeks, including today. Circle the number next to the statement you chose. If several statements in the group seem to apply equally well, circle each one. Be sure to read all statements in each group before making your choice.

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

Name and surname ....

Phone number and address ....

....

Please tick in the appropriate box

Sex   male ☐ female ☐

Age (years) 18-21 ☐ 22-25 ☐ 26-30 ☐

Ethnicity Shona ☐ Ndebele ☐ Zezuru ☐

   Tonga ☐ Ndau ☐ Manyika ☐

Other (specify)..

Shona language (spoken) very good ☐ good ☐

      average ☐ poor ☐

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Marital status   single [ ]   married [ ]   divorced [ ]

widowed [ ]

Please circle the number beside the statement you pick

1. Sadness

0. I do not feel sad.

1. I feel sad much of the time.

2. I am sad all the time.

3. I am so sad or unhappy that I can't stand it.

2. Pessimism

0. I am not discouraged about my future.

1. I feel more discouraged about my future than I used to be.

2. I do not expect things to work out for me.

3. I feel my future is hopeless and will only get worse.

3. Past failure

0. I do not feel like a failure.

1. I have failed more than I should have.

2. As I look back I see a lot of failures.

3. I feel I am a total failure as a person.

4. Loss of pleasure

0. I get as much pleasure as I did from the things I enjoy.

1. I don't enjoy things as much as I used to.

2. I get very little pleasure from the things I used to enjoy.

3. I can't get any pleasure from the things I used to enjoy.

4. Guilty feelings

0. I do not feel particularly guilty.

1. I feel guilty over many things I have done or should have done.
2. I feel guilty most of the time.
3. I feel guilty all the time.

6. Punishment feelings

0. I don't feel I am being punished.
1. I feel I may be punished.
2. I expect to be punished.
3. I feel I am being punished.

7. Self dislike

0. I feel the same about myself as ever.
1. I have lost confidence in myself.
2. I am disappointed in myself.
3. I dislike myself.

8. Self criticalness

0. I don't criticise or blame myself more than usual.
1. I am more critical of myself than I used to be.
2. I criticise myself for all my faults.
3. I blame myself for everything bad that happens.

9. Suicidal thoughts or wishes

0. I don't have any thoughts of killing myself.
1. I have thoughts of killing myself but I would not carry them out.
2. I would like to kill myself.
3. I would kill myself if I had the chance.

10. Crying

0. I don't cry any more than I used to.
1. I cry more than I used to.
2. I cry over every little thing.

3. I feel like crying, but cannot.

11. Agitation

0. I am no more restless or wound up than usual.
1. I feel more restless or wound up than usual.
2. I am so restless or agitated that it's hard to stay still.
3. I am so restless or agitated that l have to keep moving or doing something.

12. Loss of interest

0. I have not lost interest in other people or activities.
1. I am less interested in other people or activities.
2. I have lost most of my interest in other people or things.
3. It's hard to get interested in anything.

13. Indecisiveness

0. I make decisions as well as ever.
1. I find it is more difficult to make decisions than usual.
2. I have much greater difficulty in making decisions than I used to.
3. I have trouble making decisions.

14. Worthlessness

0. I do not feel I am worthless.
1. I don't consider myself as worthwhile and useful as I used to.
2. I feel more worthless as compared to other people.
3. I feel utterly worthless.

15. Loss of energy

0. I have as much energy as ever.
1. I have less energy than I used to have.
2. I don't have much energy to do very much.
3. I don't have enough energy to do anything.

16. Changes in sleep pattern

0. I have not experienced any change in my sleeping pattern.

1. I sleep somewhat less than usual. – or – I sleep somewhat more than usual.

2. I sleep a lot less than usual. – or – I sleep a lot more than usual.

3. I sleep most of the day. – or – I wakeup 1-2 hours early and can't get back to sleep.

17. Irritability

0. I am no more irritable than usual.

1. I am more irritable than usual.

2. I am much more irritable than usual.

3. I am irritable all the time.

18. Changes in appetite

0. I have not experienced any change in my appetite.

1. My appetite is somewhat less than usual. – or – My appetite is somewhat greater than usual.

2. My appetite is much less than usual. – or – My appetite is much greater than usual.

3. I have no appetite at all. – or – I crave food all the time.

19. Concentration difficulty

0. I can concentrate as well as ever.

1. I can't concentrate as well as usual.

2. It's hard to keep my mind on anything for very long.

3. I find I can't concentrate on anything.

20. Tiredness or fatigue

0. I am no more tired or fatigued than usual.

1. I get more tired or fatigued more easily than usual.

2. It's hard to keep my mind on anything for very long.

3. I find I can't concentrate on anything.

21. Loss of interest in sex

0. I have not noticed any recent change in my interest in sex.

1. I am less interested in sex than I used to be.

2. I am much less interested in sex now.

3. I have lost interest in sex completely.

INTERPRETING THE BECK DEPRESSION INVENTORY

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circled zero on each question. You can evaluate your depression according to the table below.

Total score   levels of depression

0 - 13...minimal depression

14 – 19 ....mild depression

20 – 28 ....moderate depression

29 – 63 ....severe depression

Total score ....

A SCORE OF 20 0R ABOVE INDICATES THAT YOU MAY NEED MEDICAL TREATMENT. YOU WILL BE REFERRED FOR AN ASSESSMENT AND TREATMENT.

APPENDIX II

Interview guide for student participants

Date ....

Sex   Male   ☐   Female   ☐

Age   18-21   ☐   22-25   ☐   26-30   ☐

Marital status   single   ☐   married   ☐   divorced   ☐

               widowed   ☐

Ethnicity   Shona   ☐   Ndebele   ☐   Tonga   ☐

Other (specify) ....

Religion   Hindu   ☐   Christianity   ☐   Islam   ☐

Other (specify) ....

Household income   low   ☐   medium   ☐   high   ☐

1. What you understand by the term depression?

2. How do the people in your community and in your institution understand depression?

3. Can you explain some of the symptoms of depression you experience?

4. Can you tell me what you think caused your depression?

5. Do you think depression affects your learning, and if so how?

6. What are your preferred intervention strategies in order to curb depression and its effects?

APPENDIX III

Interview guide for lecturer participants

Date ....

Sex   male   ☐   Female   ☐

Age (years)   20-30   ☐   31-40   ☐   41-50   ☐

               51-60   ☐   61-70   ☐

Marital status   single   ☐   married   ☐   divorced   ☐

               widowed   ☐

Ethnicity   Shona   ☐   Ndebele   ☐   Tonga   ☐

               Other (specify) ....

Language proficiency   English   ☐   Shona   ☐   Ndebele   ☐

               Other (specify) ....

Religion   Hindu   ☐   Christianity   ☐   Moslem   ☐

Other (specify) ....

Number of years' experience as a lecturer   0-10 ☐   11-20 ☐

21-30 ☐   31-40 ☐   41-50 ☐

1. Can you tell me what you understand by depression in students?
2. How do people in your community and in your institution understand depression?
3. How do students experience and exhibit symptoms of depression?
4. Can you tell me what you believe led to your student being depressed?
5. How, in your view, does depression affect students' learning?
6. How best do you think we can curb depression in students in order to reduce its effects on learning?

APPENDIX 4

Consent form for students

UNIVERSITEIT·STELLENBOSCH·UNIVERSITY
jou kennisvennoot • your knowledge partner

STELLENBOSCH UNIVERSITY

CONSENT TO PARTICIPATE IN RESEARCH TITLED:

EXPLORING THE INTERACTION BETWEEN DEPRESSION AND LEARNING IN THE SHONA CULTURE

You are invited to take part in a study conducted by Songile Mhlanga who is currently studying for a PhD in Educational Psychology at Stellenbosch University. You were approached as a possible participant because you are a student at a higher educational institution and the study aims to improve the psychological wellbeing of students in higher educational institutions of learning, hence, the importance of your contribution to this study.

1. PURPOSE OF THE STUDY

The purpose of this study is to identify the role played by the Shona Culture in influencing the level of recognition of depression in learners at tertiary institutions. Depression as an illness in

the Shona context is not easily recognised as there is no vocabulary to describe it. This study therefore seeks to increase awareness of depression as an illness that can be medically and psychologically diagnosed and treated in the Shona Culture, thereby, reducing the stigma associated with the condition. The study also hopes to bring to light the relationships between academic performance and depression amongst Shona learners in order to influence policy formulation on mental health in Higher Education in Zimbabwe.

2. WHAT WILL BE ASKED OF ME?

If you agree to take part in this study, you will be asked to respond to a questionnaire which will be scored to reveal the existence and level of depression in an individual. The questions will be rated on a scale and the higher the score indicates the greater the level of depression. If your score is high you may be requested to participate in an interview. You may also be referred for counselling. A private room within the institution will be sought for the interview session. You may respond to the questionnaire during the Health and Life Skills lecture or any free time while at school.

3. POSSIBLE RISKS AND DISCOMFORTS

The recollection of experiences that may have led to depression may evoke emotional and psychological feelings that could lead to discomfort. The researcher would ensure a clinical psychologist is available during and after the research to ensure any signs of distress are dealt with professionally. Contact details of the clinical psychologist are; Dr Julia Mutambara, Midlands State University, Faculty of Medicine, P Bag 9055 Gweru, phone number +263772937136.

4. POSSIBLE BENEFITS TO PARTICIPANTS AND/OR TO THE SOCIETY

As a participant, you may benefit directly or indirectly as increased awareness of depression as an illness that can be treated would reduce stigma associated with the illness as students would be more confident to seek medical and/or psychological interventions. Treatment of depression would also reduce its impact on academic performance and improve the quality of student life

on and off campus. The study also hopes to influence policy formulation on mental health in order to adopt best practices in Higher Education in Zimbabwe

5. PAYMENT FOR PARTICIPATION

Participation will be voluntary and participants will not be offered any payment.

6. PROTECTION OF YOUR INFORMATION, CONFIDENTIALITY AND IDENTITY

Any information you share with the researcher during this study and that would possibly identify you as a participant will be protected. This would be done by ensuring that the researcher and her supervisor are the only people with access to the research data. The information will be stored in a password protected computer and hard copies will be stored in lockable drawers. The information gathered will be used for future publications and any identifying information will not be included. The name of your institution will also not be published. You are advised to write your names on the questionnaire to enable follow up interviews for the study. Your name will not be published and pseudonyms will be used during data analysis and in the final report. You are allowed to withdraw your participation from the study whenever you feel you are not able to continue participating without any consequences. Information gathered will be destroyed after 5 years of completion of the study, research data in the form of hard copies will be shredded and soft copies will be permanently deleted from the computer.

7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you agree to take part in this study, you may withdraw at any time without any consequence. You may also refuse to answer any questions you don't want to answer and still remain in the study. The researcher may withdraw you from this study if for any reason you are no longer available to take part in the study.

8. RESEARCHERS' CONTACT INFORMATION

If you have any questions or concerns about this study, please feel free to contact;

Songile Mhlanga at no 1700 Thomas Hill, Riverside, GWERU, phone number 0772840945 and/or the supervisor;

Professor Ronelle Carolissen at room 2024 GG Cillie Building, Ryneveld Street, Stellenbosch, South Africa, phone number 0218082738.

Clinical Psychologist – Dr Julia Mutambara, Midlands State University, Faculty of Medicine, P Bag 9055 Gweru, phone number +263772937136.

9. RIGHTS OF RESEARCH PARTICIPANTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research participant, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

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DECLARATION OF CONSENT BY THE PARTICIPANT

As the participant I confirm that:

- I have read the above information and it is written in a language that I am comfortable with.

- I have had a chance to ask questions and all my questions have been answered.

- All issues related to privacy, and the confidentiality and use of the information I provide, have been explained.

By signing below, I _____agree to take part in this research study, as conducted by Songile Mhlanga.

_____   _____

Signature of Participant   Date

DECLARATION BY THE PRINCIPAL INVESTIGATOR

As the **principal investigator,** I hereby declare that the information contained in this document has been thoroughly explained to the participant. I also declare that the participant has been encouraged (and has been given ample time) to ask any questions. In addition I would like to select the following option:

*	The conversation with the participant was conducted in a language in which the participant is fluent. Lectures and examinations in Higher Education in Zimbabwe are conducted in the English Language, hence, students and lecturers converse fluently in English, before, during and after data collection.
	The conversation with the participant was conducted with the assistance of a translator (who has signed a non-disclosure agreement), and this "Consent Form" is available to the participant in a language in which the participant is fluent.

_____   _____

Signature of Principal Investigator   Date

APPENDIX 5

Consent form for lecturers

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jou kennisvennoot • your knowledge partner

STELLENBOSCH UNIVERSITY

CONSENT TO PARTICIPATE IN RESEARCH TITLED:

EXPLORING THE INTERACTION BETWEEN DEPRESSION AND LEARNING IN THE
SHONA CULTURE

You are invited to take part in a study conducted by Songile Mhlanga who is currently studying for a PhD in Educational Psychology at Stellenbosch University. She is also the Dean of Students at Gweru Polytechnic. You were approached as a possible participant because this study aims to improve the psychological wellbeing of students in higher institutions of learning, and you as a lecturer who is in direct contact with the students are assumed to possess the requisite information that can assist in achieving the objectives of this study.

1. Purpose of the study

The purpose of this study is to identify the role of the Shona Culture in influencing the level of recognition of depression in learners. The study seeks to increase awareness of depression as a disease that can be medically and psychologically diagnosed and treated in the Shona Culture, thereby, reducing the stigma associated with victims of depression. The study hopes to bring into light the relationships between academic performance and depression amongst Shona learners in order to influence policy formulation on mental health in Higher Education in Zimbabwe.

2. What will be asked of me?

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If you agree to take part in this study, you will be asked to respond to interview questions that seek to reveal the experiences of depression in learners in higher education. The interviews will be carried out by the researcher in a private room on campus to ensure privacy and confidentiality are maintained.

3. Possible risks and discomforts

No possible risks are anticipated for lecturers in this study. Any risks that may arise during the study will be dealt with promptly with guidance from my research supervisor who is also a Clinical Psychologist.

4. Possible benefits to participants and/or society

Increased awareness of depression as a disease that can be treated will most likely reduce stigma associated with the disease as learners would be more confident to seek medical and/or psychological interventions. Treatment of the disease would also reduce it's impact on academic performance amongst learners and enhance desired learning outcomes. The study also hopes to influence policy formulation on mental health in Higher Education in Zimbabwe.

5. Payment for participation

Participation will be strictly voluntary and participants will not be offered any payment.

6. Protection of your information, confidentiality and identity

Any information you share with the researcher during this study and that would possibly identify you as a participant will be protected. This would be done by advising you not to write your names on any information you release for this study. The researcher will be the only person with access to the information you release pertaining to this study. The information gathered will be used for future publications and any identifying information will not be included. The name of your institution will also not be published. Information gathered will also be destroyed by shredding and deleting soft copies after the research is complete.

7. Participation and withdrawal

You can choose whether to be in this study or not. If you agree to take part in this study, you may withdraw at any time without any consequence. You may also refuse to answer any questions you don't want to answer and still remain in the study. The researcher may withdraw you from this study if for any reason you are no longer available to take part in the study.

8. Researcher's contact information

   If you have any questions or concerns about this study, please feel free to contact;

   Songile Mhlanga at no 1700 Thomas Hill, Riverside, GWERU, phone number 0772840945and/or the supervisor;

   Professor Ronelle Carolissen at 2024 GG Cille Building, Ryneveld Street, Stellenbosch, South Africa, phone number 0218082738.

9. Rights of research participants

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research participant, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

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DECLARATION OF CONSENT BY THE PARTICIPANT

As the participant I confirm that:

- I have read the above information and it is written in a language that I am comfortable with.

- I have had a chance to ask questions and all my questions have been answered.

- All issues related to privacy, and the confidentiality and use of the information I provide, have been explained.

By signing below, I _____agree to take part in this research study, as conducted by Songile Mhlanga.

_____   _____

Signature of Participant   Date

DECLARATION BY THE PRINCIPAL INVESTIGATOR

As the **principal investigator,** I hereby declare that the information contained in this document has been thoroughly explained to the participant. I also declare that the participant has been encouraged (and has been given ample time) to ask any questions. In addition I would like to select the following option:

*	The conversation with the participant was conducted in a language in which the participant is fluent. Lectures and examinations in Higher Education in Zimbabwe are conducted in the English Language, hence, lecturers converse fluently in English, before, during and after data collection.

	The conversation with the participant was conducted with the assistance of a translator (who has signed a non-disclosure agreement), and this "Consent Form" is available to the participant in a language in which the participant is fluent.

_____   _____

Signature of Principal Investigator   Date

Appendix 6

Flyer

REQUEST FOR YOUR PARTICIPATION IN A STUDY

Title: Exploring the interaction between depression and learning in the Shona Culture.

 Aims: To establish the prevalence of depression and explore the meanings that students (and lecturers) make of the relationships between learning and depression.

Objectives: to establish the prevalence of depression in Shona Learners.

 To determine how Shona learners experience symptoms of depression

 To establish the Shona learners understanding of depression

 To determine how depression influences the learning experience

Role of participant: To answer questions asked by the researcher by responding to a questionnaire.

 Some students may also be requested to respond to some interview questions.

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