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Making sense of depression within the Shona culture: Perceptions of tertiary students in the Midlands Province of Zimbabwe

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ABSTRACT

This research paper sought to provide a deeper understanding on the conceptualisation of depression and its symptoms in students of the Shona Culture in a higher education institution. Vulnerability to depression is increased as students adapt to the university culture and the Shona Culture provides a unique template for the conceptualisation and expression of depressive symptoms. A constructivist world view was adopted facilitating a qualitative approach to gather in-depth data from a non-random sample of students and their lecturers at a university in Zimbabwe. Results indicate that Shona students understand depression as stress; *'kufungisisa'*, thinking too much; madness; *'kusuruvara'*, sadness and as something which was spiritually oriented. In some cases, it was difficult for the students to come up with a Shona word which directly translates to depression. Students believed depression was caused by failure to cope with demands of college life, chronic illness, relationship problems, financial challenges and as hereditary. The study therefore recommends that mental health practitioners in education institutions adopt problem-solving strategies to enable students to cope with challenges emerging in their socio-economic environment. Research and mental health intervention programmes should incorporate Shona cultural syndromes of depression such as *'kufungisisa'*, *'kusuruvara'* and any other terms that are suggestive of depression in order to facilitate a better understanding and diagnosis of depression. Mental health practitioners and traditional healers should collaborate to foster the development of tailor-made intervention strategies that considers both the scientific and spiritual pathology of depression.

KEYWORDS:
depression, madness, Shona Culture, perceptions

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1. Introduction

Depression is one of the most common psychological problems experienced by tertiary students worldwide, yet it seems to be an under-researched area, particularly as it relates to the Shona culture. According to World Health Organisation (WHO) (2017) cases of depression are on the rise, particularly among tertiary students. The Zimbabwe National Association of Mental Health (ZIMNAMH) (2019) estimates that more than 300 000 Zimbabweans suffer from various mental health ailments out of a population of about 14 million, and depression was reported to be the most prevalent. Zivin et al. (2009) lament the high prevalence of mental health problems among higher education students and indicate that these problems may be growing both in number and severity.

Students in universities and colleges are particularly vulnerable to depression due to the demands and pressures associated with higher and tertiary education. These demands and pressures cumulate to psychosocial challenges which include financial challenges, fear of failure, relationship challenges, drug abuse and pressure to succeed from family. They also have to cope with challenges connected to identity development and adjustment challenges amongst others. These psychosocial challenges may lead to stressful situations which manifest into more severe psychopathological challenges such as depression (Alonso & Mortier et. al., 2018). This paper explores how tertiary students of the Shona culture in the Midlands Province of Zimbabwe conceptualise depression, its perceived causes and symptoms. The intention is to facilitate a deeper understanding of the mental disorder as it affects tertiary students of the Shona culture so that effective culturally informed interventions can be adopted to reduce its impact on the students for their improvement well-being.

Depression is found worldwide, across all racial and ethnic groups, with culture and society playing a pivotal role in an individual's overall mental health. The way individuals view the world, express their emotions and respond to stressful situations is influenced by their culture (Eshun & Gurung, 2009). This is because culture acts as the lens or template which is used in the construction, conceptualisation and interpretation of reality (Marsella, 2003).

Baldwin, Faulkner, Hecht and Lindsey (2006) view culture as an elusive term. They suggest that although there is no single, eternal definition of the word 'culture' because of the multidisciplinary nature of the concept's usage and divergence of opinions within a single discipline, many authors treat it as

some set of elements that are shared by people who belong to the same society. In this paper culture is viewed from Goodenough's (1981) interpretation of culture as it refers to "a mental framework involving models for perceiving, relating and interpreting things, people behaviour or emotions" (p. 167) within people in any particular society.

Cultural variations exist within societies (Baldwin et al., 2006), even among the Shona culture. These variations are important because they bear upon how different students conceptualise depression. They also account for how the students communicate their symptoms and which ones they seek help for. Gross (2014) purports that cultural, biological and psychological factors contribute to the manifestation of depression. Culture also bears upon on whether the students even seek help in the first place, what type of help they seek, what coping styles they adopt and the social supports they have at their disposal (The US Department of Health & Human Services, 1999). Eshun and Gurung (2009) express the same view that culture influences mental health such as depression in several ways which include:

- The individual's experience of depression and depressive symptoms;
- How the individual expresses their symptoms within their cultural norms;
- How the symptoms expressed are understood, interpreted and diagnosed;
- The treatment options of depression and outcomes. Understanding the role of culture is therefore of paramount importance in conceptualising, diagnosis and treatment of depression.

According to Marsella (2003) cultural variations are present in all variables that lead to depression. These include the meaning of the term, the perceived causes, its onset, expression of the symptoms, the course and ultimately the outcomes of the disorder. The presence of these cultural variations make depression to be perceived as a unique mental condition since it does not have a precise aetiology and pathology that are defined by specific and definite symptoms (Lim et al., 2018).

Different perspectives of depression and its effects on individuals of various cultures have also been presented by researchers worldwide (Patel, 2007; WHO, 2018). These researchers have portrayed depression in various forms of clustered depressive symptoms which can be a manifestation of genetic and environmental factors. The varying symptoms account for the culturally distinct characteristics of its conceptualisation and presentation. The Shona culture

is no exception, as both scientific and traditional perceptions of depression contribute to its complex conceptualisation. The fact that it is a representation of broad spectrum of affective experiences which are significantly associated with social consequences underscores the uniqueness and importance of personal experiences as they are embodied within a particular society and culture.

Cross-cultural studies in psychology, psychiatry and other disciplines have been consistent in their conclusions that there are variations in the conceptualisation of depressive disorder across cultures (Kleinman & Good, 1986; Marsella, 2003; Kumar et al., 2015; Kirmayer, 2019). The argument is that culture and mental health are embedded in each other, (Sam & Moreira, 2002 in Eshun & Gurung, 2009). Cultures are believed to socialise persons with metaphorical languages and mediations of reality that promote context-based orientations of depression.

Marsella (2003) emphasises that one of the relationships between culture and depressive experience is the notion of selfhood assumed by some cultural traditions particularly noted within the Western cultures. Marsella further alludes to the notion that some Western cultures may value individual autonomy. As a result, personal control is closely related to the experience of depression or other mental challenges. On the other hand, various non-western cultures emphasise selfless subordination to family and non-personal control hence the aversive consequence of person-hood is not similar (Maercker et al., 2015).

The conceptualisation of depression by Shona students in tertiary institutions is undoubtedly embedded in their Shona cultural experiences. The strong belief of the Shona people in ancestral descendancy places expectations on individuals to consistently connect with their ancestors through their family elders within the clan. The Shona culture also emphasises ancestral worship. Rituals and ceremonies to contact, honour and worship the ancestors are often held (Gelfand, 1982), especially when problems are experienced and for general success in life. The belief is that if the ancestors are, for any reason, disgruntled, they will punish an individual, family or clan, particularly if certain cultural norms have been disrespected. The resultant scenario is whereby the affected individuals are stigmatised or suffer from mental disorders or depression.

Research in Zimbabwe by Patel (1998) reveals that depression is a global experience in humans, and Zimbabweans' experience of emotional pain and physical pain is not felt differently. Patel (1998), however, discovered that the way Zimbabweans seek help with regards to depression is different from that

of the Western societies though there were similarities in the experiences of depression.

With regards to Zimbabwe, Iliescu (2017) purports that depression has been found to be expressed in ways that are different from those typical in the Western world. According to Iliescu (2017) qualitative studies based on exploratory interviews have shown that, while somatic complaints such as headaches and fatigue were often present in cases of depression, these were attributed by Shona speakers in Zimbabwe to cognitive and emotional causes. Iliescu (2017) explains that the construction revolves around the indigenous concept of '*kufungisisa*' meaning the habit of 'thinking too much'. According to Patel (2001) and Willis et al. (2018) Shona speaking people use the term '*kufungisisa*' which translates to 'thinking too much' to represent depression. Various research has also shown that the concept of 'thinking too much' is popularly used to represent depressive disorder in several other countries (Kaiser et al., 2015).

Thinking too much, is usually a reaction to social stressors and in some instances suspected to be triggered by supernatural powers. These social stressors may include poverty, death in the family, illness, civil unrest, failure to achieve academic goals, sex inequalities, relationship problems and an uncertain future amongst several other challenges. The stressful encounters may then lead the individual to experience psychopathological conditions which contribute to the development of mental health problems such as depression especially among young adults (Nsereko, Musisi, Nakigudde & Ssekiwu, 2014). Experiencing stressful events may not automatically cause depression; however, certain 'levels of stress' were believed to lead to depression amongst the Shona students. Gotlib et al. (2020) asserts that depression and stressful life events are strongly related though stressful life events may not be absolute predictors of depression. It is the individual's ability to cope with stressful situations that determines their vulnerability to depression (Murbery & Bru, in Haligin 2007). Patel et al. (2001) also established through interviews with Shona speakers that multiple somatic complaints such as headaches and fatigue were the most common presentations of depression.

In addition to social stressors, Zimbabwe has one of the highest HIV and AIDS prevalence rate of 12.7% in sub-Saharan Africa (UNAIDS, 2019) which is a major contributing factor to high prevalence of depression due to the stigma associated with HIV and AIDS (Kim et al., 2015). The psycho-social effects of HIV and AIDS such as stigma and labelling on individuals make them more susceptible to depression. The experience of both depression and HIV and

AIDS, results in consistent reports of negative automatic thoughts associated with depressive symptoms (Riley et al., 2017), thus perpetuating a myriad cycle of emotional and physical pain.

Due to an acute shortage of primary mental health care facilities, depressed people in Zimbabwe are reported to visit general health services frequently presenting with various somatic symptoms and when illness is persistent, they visit traditional care providers (Liang, 2016). General health practitioners, in most cases, are reported to treat symptoms of depression without addressing the source of the problem which leads to a cycle of chronic pain as symptoms recur (Liang, 2016).

Traditional healers are often consulted when the depression condition becomes persistent or psychological (Mawere & Kadenge, 2010). The general belief among the Shona people is that when an illness does not have a clear trajectory or cannot be cured by scientific medicine, African traditional medicines provide an alternative solution that uses spiritual powers to fulfil their cultural and spiritual expectations (Kajawu et al., 2015). African traditional care providers explain the causes of mental health problems as supernatural, and in some instances mental illness as a result of witchcraft. Unfortunately, this assertion leads to stigmatisation and discrimination of an individual due to its association with 'dark forces' (Kajawu et al., 2015).

African traditional healers, faith healers and professional mental health practitioners rarely cooperate in treatment of depression and other mental illnesses (Liang, 2016). In some cases, cooperation is important, especially where the patient believes in supernatural forces as the cause of their mental illness. Kajawu et al., (2015), emphasise that the practice of consulting traditional healers may be helpful in the treatment of mental ailments. Such views are consistent with Bu (2019) who asserts that depression is not a mere random 'chemical imbalance in the brain', hence the need to consider resolving the bigger forces that may be responsible, in order to curb its severity.

The causes of depression are both genetic and environmental (Stange, Oyster & Sloan, 2011). Stange et al. further argue that genetic factors pre-dispose individuals to particular personality traits such as shyness and low mood which may contribute to the development of depression. Similarly, the cognitive style, such as propensity to ruminate on problems, being a perfectionist as well as sensitivity to criticism make one prone to depression. These predispositions are only possibilities that are given shape within a social context. Stange et al. (2011)

also state that one's life experiences have been shown to have a major impact on the aetiology or study of the causes of depression. They reason that the presence of long-term problems helps to explain one's vulnerability to depression. Such problems include child abuse or neglect, ruptured attachments, living with an abusive or uncaring spouse, long term unemployment, poverty or insecurity and a history of physical or sexual abuse.

According to Stange et al. (2011) recent research suggests that individuals who are vulnerable to depression may produce adverse events through their interactional style that may trigger further depressive episodes. In addition to this, long term substance abuse which is often intended to ease depressive symptoms, typically perpetuates depression and creates additional problems. In developing countries, the confluence of absolute poverty, poor health services, gender inequality and chronic daily stress can produce a vicious cycle of depression. Severe life events such as death of a loved one also prove to be constant triggers of depression.

Depression presents itself through numerous forms of symptoms and some unique symptoms are mostly associated with a type of depression. A depressive episode can be categorised as mild, moderate and severe depending with the number and severity of symptoms experienced (WHO, 2020). These include the experience of overwhelming feelings of sadness, loss of interest and pleasure in previously interesting and pleasurable everyday activities, insomnia or hypersomnia, fluctuating appetite, psycho motor agitation and retardation, constant fatigue, feelings of worthlessness and guilt, recurrent suicidal ideation with or even without any precise plans for committing suicide. Major Depressive Disorder (MDD) is also associated with cognitive difficulties especially in learners, which may include, diminished ability to concentrate and make decisions. These symptoms of depression are usually persistent in an individual for a continuous duration of at least two weeks and denote a significant change from their previous daily functioning.

Persistent depressive disorder or dysthymia is a chronic condition that is characterised by repeated depressive episodes with persistent feelings of deep sadness most of the days over periods of up to two years or even more. Short symptom-free intervals may also be experienced. An individual is likely to experience insomnia, an increase or decrease in appetite, fatigue, low self-esteem, poor cognitive ability and feelings of hopelessness (APA, 2013). The symptoms experienced in dysthymia may not be as severe as those experienced in major depression. It has also been discovered that major depressive episodes

may occur during a chronic and persistent depressive disorder episode (WHO, 2020).

Bipolar disorder is commonly known as a mood disorder as it is characterised by extreme mood swings. An individual may experience severe high moods with excessively high amounts of energy to do anything and sometimes experiences very low mood swings with loss of energy and may not want to be involved in any activity (Grohol, 2019). Bipolar disorder is also characterised with elevated or irritable moods, deflated or inflated self-esteem, pressure of speech, insomnia and hypersomnia (WHO, 2020). These changes in mood swings maybe experienced gradually and, in some cases, rapidly with no clear explanation to the causes in change of behaviour.

Seasonal affective disorder is identified by symptoms similar to those experienced in major depressive disorder but usually occurring during the winter season. This is due to the limited amount of sunlight available as days filled with sunshine are normally associated with happier mood experiences. Research has shown that the shorter days experienced in winter may cause a mood change as the body's natural every day rhythm such as sensitivity to light and other functions of serotonin maybe altered (Merz, 2018).

Research has discovered that women are more vulnerable to depression as compared to men (Paul & Dave, 2017; Lim et al., 2018; WHO, 2018) due to social challenges they encounter in their daily lives. In addition, they are also at risk of premenstrual dysphoric disorder (PMDD) and postpartum depression which men may not experience. PMDD, in some instances, may be experienced as an extension of premenstrual syndrome and the symptoms include emotional and behavioural symptoms such as extreme moodiness, hopelessness, sadness, changes in sleep patterns, variations in eating habits, irritability, anger, tension and anxiety (Grohol, 2019).

The influence of culture on individuals' perceptions of depression and the cultural variations that exist as evidenced by previous researches prompted this study which sought to explore how tertiary students of the Shona culture in the Midlands Province of Zimbabwe conceptualise depression, its perceived causes and symptoms. The overall aim was to bring to light the mental disorder as it affects tertiary students of the Shona culture, so that effective interventions that are culturally informed can be used to reduce its impact on the students and enable them to function effectively and lead a more fulfilling life both at the campus and in society.

2. Methodology

This study was carried out at a state-owned tertiary educational institution in the Midlands Province of Zimbabwe. Shona speaking students of both sexes were selected for the study. Lecturers teaching the participants were also included in the study. Lecturers were considered to be a wealthy source of information since they were in constant interaction with the students and would probably have noticed any symptoms of depression among some students.

The constructivist paradigm guided the study. Constructivism is associated with establishing meanings of phenomenon from participants' views; thus, knowledge is constructed (Creswell, 2009). Wheeldon (2012) also views constructivism as a worldview which implies that individuals have their own unique interpretations or subjective perceptions about a single real world and these are often based on their experience of the phenomenon. It was for these reasons that the researcher considered the paradigm best suited for the study.

The qualitative approach was used, considered suitable because the aim of the study was to generate and interpret information in an attempt to appreciate how Shona students at a tertiary institution conceptualise depression. Adopting this approach, therefore, was expected to enable the researchers to explore meanings and gaining insight into the subject under study (Levitt et al., 2017).

The case study design was chosen because of its ability to reveal an in-depth understanding of a case or a bounded system (Creswell, 2018). The design allowed the researchers to capture the views of the participants. Out of a population of 513 first year students 11 students who had scored high on the Beck's Depression Inventory-11 (BDI-11) questionnaire were chosen. Because of their scores, these students were considered to have reported moderate to severe symptoms of depression and were, therefore, purposively sampled.

Qualitative data was also generated from 13 volunteer lecturers who taught these students. Purposive sampling of the participants was likely to lead to the generation of valuable information that was required to fulfil the objectives of the study (Lyons & Coyle, 2007).

A semi-structured, open ended interview schedule was used, because it gathered in-depth data of participants' feelings, intentions, and perceptions of depression (Kabir, 2016).

This instrument served to elicit narratives of depressive experiences from student and lecturer participants. The interview revealed how the Shona speaking learners conceptualised depression and the perceived causes of the state.

A number of ethical considerations were followed in the data generation process. For instance, permission to carry out the research was sought and granted and a written authorisation was issued from the tertiary education institution. Written authority was also granted from the Provincial Hospital to refer students who required psychological or psychiatric support. Anonymity and confidentiality were upheld in order to ensure participants were protected from any form harm.

The data from interviews was audio recorded, transcribed then thematically analysed. The transcriptions were read and re-read to establish emerging codes and themes from the data (Gubrium & Holstein, 2012) As emphasised by Ryan and Bernard (2003), during interview sessions, the researcher noted factors such as emerging metaphors, local expressions used (in English and in Shona), analogies and instances where items were repeated. Codes were created as features with similar meanings were discovered, (Haroz et al., 2017). The descriptive coding was executed in two segments as follows: (1) responses from students followed by (2) the responses from their lecturers.

Of the 13 lecturers interviewed, 38%, (n=5) were males while 62%, (n=8) were females, an indication that females volunteered more to participate in research as compared to males.

3. Results

Shona tertiary students' conceptualisation of depression

Findings showed that the students' conceptualisation of depression included the following:

- depression as stress
- depression as sadness
- depression as thinking too much
- depression as spiritually oriented
- depression as madness
- some professed ignorance of depression

Each of these views are explored in detail in the next section, as they were presented by the students.

Depression as stress

Data generated from the Shona speaking students indicated that though depressive symptoms were highly prevalent in this sample, students rarely referred to their illness as depression, but rather as 'stress'. This was indicated by 64% of the students and 46% of the lecturer participants. Stress was described as occurring and felt at different intensities. The data revealed that experiences of stressful life events, effects of stress on individuals and their efforts in coping with stress were largely described as depression. This could be due to the unavailability of a Shona word that directly translates to depression. The stressful encounters may then lead the student to experience psychopathological conditions which contribute to the development of mental health problems such as depression, especially among young adults (Nsereko, Musisi, Nakigudde & Ssekiwu, 2014).

Experiencing stressful events may not automatically cause depression; however, certain 'levels of stress' were believed to lead to depression amongst the Shona students. Gotlib et al. (2020) assert that depression and stressful life events are strongly related though stressful life events may not be absolute predictors of depression. It is the individual's ability to cope with stressful situations that determines their vulnerability to depression (Halgin & Whitbourne, 2007). Participants reported that:

> 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).

> 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).

> 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).

Depression as sadness

An intense sadness was reported as depression by 55% of the students and in some instances described in Shona language as kusuruvara (being sad). Sadness which is persistent is, however, recognised in the DSM-5 of (2013) as one of the major symptoms of depression. The sadness is usually a result of grief which could be due to a death of a close person and the sadness continues beyond the expected periods. The conceptualisation of sadness as a representation of

depression may lead to misinterpretation and inaccurate diagnosis by mental health practitioners. A similar term 'kunetseka' (deeply troubled or bothered) was also used to denote depression as indicated by one of the students that, 'I am unhappy as I am deeply troubled in my life'. In the absence of a Shona word for depression, the students adopted various Shona words such as, *'kunetseka'* and *'kusuruvara'* to describe depressive disorder along with other terms for depressive symptoms.

Depression as 'thinking too much'

Depression was understood as 'thinking too much' by 36% of the students. When an individual was burdened with problems or social challenges they would 'think too much' and not be able to function normally. The idiom '*thinking too much'* and worrying were also reported to represent similar processes as the students tended to 'think too much' when they were worried. Similarly, earlier studies by Patel (2001) established that Zimbabweans sometimes use a cultural metaphor, '*kufungisisa*' (thinking too much) when describing depressive disorder.

Various research has also shown that the concept of 'thinking too much' is popularly used to represent depressive disorder in several other countries (Kaiser et al., 2015). In recognition of its common use, the metaphor was then included in the DSM-V (APA 2013) as a depiction of depressive disorder. This localised diagnostic category existing in the Shona culture frames a coherent meaning of experiences that define depressive disorder. It, therefore, becomes prudent for the mental health care giver to understand the cultural background of an individual in-order to accurately interpret such unique metaphors and patterned experiences of depression.

Depression as spiritually oriented

Depression was also believed to be spiritually oriented and originating from Shona traditional beliefs as indicated by 27% of the students and 8% of the lecturer participants. The data revealed that participants believed that depression was a result of misfortunes that befell an individual emanating from evil spiritual forces. The misfortune would be in the form of a negative life event or subsequent negative life events which were believed to be a creation of spiritual forces. The inability to cope with these traditional evil spiritual

forces induced negative life events which would then lead an individual into depression. One student had this to say:

> *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,* 'midzimu inenge yakufuratira' (ancestors would have looked the other side). *I have also witnessed traditional cleansing ceremonies held by family members so that the bad omen is cast out so that the brain can function normally*".

Supernatural causes of depression in this case were reported to signify a situation beyond a person's control, as participants highlighted that; '*your ancestors would have turned their back on you'*, a probable indication of a state of helplessness. Evil spirits responsible for mental illnesses were believed to be a result of withdrawal of protection from spiritual ancestors. The withdrawal of protection was a consequence of ancestors' disgruntlement over some apparent wrongful doing by an individual or the family. In order to appease the avenging spirits, traditional ritual '*bira*' ceremonies are sometimes held as a medium to communicate with the ancestors (Gelfand, 1982). Mitigating the occurrence of mental illness becomes the family unit's responsibility to ensure that its members continue to enjoy protection from ancestors.

Eshun and Gurung, (2009) and Kajawu et al., (2015) confirm that the Shona people in Zimbabwe, similar to Zambians understand depression as spiritually oriented whilst they also practice Christianity. The people believe in prayer and also turn to traditional healers when mental illness persists. Depression and spirituality are, therefore, interconnected and embedded in the Shona cultural belief system, adopting purely scientific treatment approaches may not holistically address depression in students. Previous research also concurs with the findings presented in this paper because spirituality, it has been reported to have a positive influence to mental wellbeing as faith in a transcendent being has been greatly associated with a reduction in depressive symptoms (Mental Health Foundation, 2006).

Depression as madness

Depressed individuals were in some instances believed to be 'mad', 'mentally disturbed' or labelled other derogatory Shona words such as '*kupenga'* (going mad). These labels denote a dysfunctional individual who is not able to make rational decisions in order for them to be useful and appreciated in their

community. This would lead the individual to being relegated of their duties, responsibilities and independence as family and community would have lost confidence in their capacity to deal with everyday life demands. Mental illness, due to its misconception, especially in some non-western societies may bring about shame for the family (Abdullah & Brown 2011; Parker, Gladstone & Chee, 2001).

The word *madness* can be interpreted in various terms but mostly describes someone who is insane or has 'lost their mind'. This is an indication that depression is misunderstood and its meaning distorted as these undesirable discriminatory labels may lead to stigmatisation. Unfortunately, research among depressed Indian medical students revealed that stigmatisation often led them to believe that other students do not respect their social opinions and academic contributions, which in turn affected their confidence, self-esteem levels and became an obstacle to seeking professional help (Behere, Yadav & Behere 2011; Vankar, Prabhakara & Sharma, 2014). Stigmatisation and labelling of depressed students may, therefore, have long lasting undesirable consequences.

Perceived ignorance of depression

At least 18% of the participants failed to understand depression as it was said to be, '*not a real disease*' with claims of there being, '*no scientific explanation'* in the Shona culture. Due to the absence of depression illness in the Shona language, its conceptualisation maybe saddled with multiple challenges such as a lack of awareness or ignorance of its existence. Depression in students was misinterpreted as an act of being, '*ill mannered*,' '*stubborn'* or '*arrogant'* especially due to the experience of depressive symptoms such as mood swings and lack of interest in previously pleasurable activities.

Ignorance of depression may also be an indication of the Shona people's obliviousness of general emotional well-being with a bias towards physical symptoms such as headaches and muscle aches which are referred to a general medical practitioner for treatment. Expressing emotions or being emotional was viewed as a weakness in character and inability to handle life challenges. Depression may therefore be understood as a foreign ailment experienced by people in other cultures and not necessarily the Shona culture. Students 2 and 5 narrated that:

> *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).

> What really is depression; if you go to the hospital, what do you say you are suffering from, '*Chinonzi chii ichocho, ukaenda kuchipatara unotiunozwei*', 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).

This lack of awareness of depression subjects students to a cycle of needless suffering that may be prevented as depression may not be reported and diagnosed. Similarly, some African American societies perceive depression as a normal experience that does not require specialised attention (Eshun & Gurung, 2009; Bailey, Mokonogho, & Kumar, 2018). This research shows that the socialisation of some Shona students does not acknowledge the existence of depression as a medical or psychological ailment. This is an indication that the Shona cultural socialisation is responsible for the provision of a lens or template for the students to construct and conceptualise mental illnesses (Marsella, 2003; Kirmayer, 2019).

Depression as social isolation

Almost 39% of the participants understood depression as social isolation, an individual was reported to be withdrawn, isolated and lonely. This behaviour was understood to denote depression and involved a noted change from being social to losing interest in social relationships and school activities. Depression was reported as "*a state of feeling withdrawn and spending most of their time alone leading to low self-esteem due to some circumstances beyond their control*." Matthews et al., (2016) assert that socially isolated young adults experienced loneliness and were most probably depressed, suggesting that mental well-being was closely associated with good social relationships. In some instances, loneliness can be experienced without being socially isolated (Cacioppo et al., 2015). As a result, social contact alone may be inadequate to protect an individual from depression illness.

Depression as mood swings

Depression especially in females was understood as mood swings and associated with the fluctuation of female hormones. A participant reported that "*depression in females is viewed as mood swings and withdrawing from activities and from friends or a display of attitude problems."* A depressed student is likely to be treated as having a negative attitude towards their academic and social activities.

Research has shown that changes in oestrogen and progesterone levels during the menstrual cycle and postpartum period have been proven to increase vulnerability to depression (Whiffen, 2002 in Weis, 2008; Grohol, 2019). Consistent with findings in this study, mood swings were most commonly reported by female participants as compared to their male counterparts. However, if depression in females is generalised to fluctuation in hormones which is a natural biological process, depression may be trivialised and left undiagnosed. The DSM-5 of (2013) lists mood swings which occur for more than two weeks as a symptom of depression. Mood swings that are persistent and last for more than two weeks are a probable indicator of depression and necessitate further inquiry.

Perceived causes of depression

Depression as a manifestation of chronic illnesses

The Shona speaking students perceived chronic illness as the cause of depression as cited by 18% of the participants. The illnesses included HIV-AIDS with either the student or care-giver being infected with the virus. Depression emanated from the stigma associated with HIV-AIDS, undependable health care service provision for treatment and the notion of a probable early death. Depressed individuals were also likely not to adhere to treatment regimens as negative thoughts about life lead to hopelessness. Kim et al., (2015) and Chibanda et al., (2016) have also indicated that depression is significantly associated with HIV and AIDS. The student's focus and motivation to accomplish educational goals is then compromised as attention to health and wellness gain priority. Student 2 narrates:

> 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 ask myself why me, why was I born with AIDS, what did I ever do to deserve this, I wish I was never born because I have been suffering for a long time.

Feelings of hopelessness overwhelm the student to a point where they lament over their very existence.

Failure to cope with college life

Findings also indicated that students encounter various challenges during the transitional period from high school to college. The campus culture was reported to be unique with a new independence that brought about responsibilities which directly influenced one's future. This new independence was different from their high school experiences and peer influence was rife. Decisions made were ought to be carefully thought out as the consequences had the potential to permanently mar an individual's future. Failure to make the right choices would compromise the ability to cope with college demands and subsequently lead to depression. Effective coping strategies for students were therefore key to a productive social and academic success.

A narrative from Lecturer L illuminates that "*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 may also fail to handle peer pressure.*"

Relationship problems

Personal relationships were also cited as a source of depression with reports of physical and emotional abuse experienced particularly from spouses. The experience of abuse made students feel unappreciated in their relationships which in turn lead to a myriad of negative emotions and experiences including lowered self-esteem and lack of confidence. This emotional instability adversely affected their social and academic achievement which subsequently led to depression.

Earlier studies by Whisman, (1999) and Stith et al., (2004) also reported on marital dissatisfaction as closely linked to depression. Shona students dissatisfied in their marriages exhibited depression symptoms and Student 5 reported that:

> *…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 also elaborated that despite the ill-treatment from her husband, she was not able to leave him as she and her children were financially dependent on him hence, she had no choice other than to endure the abusive treatment. Feelings of helplessness and hopelessness play a pivotal role to the onset of

depression as negative perceptions about the future dominate the individual's thoughts.

Unplanned pregnancy was also indicated to be an issue of concern which led students into depression. Falling pregnant while in college was a challenge as the financial implications would entail that they suspend studies and focus on raising the child. Options of abortion and adoption were not a common practice in the Shona culture. Lecturer J narrated that, "*a student can be depressed due to unwanted pregnancies; they may not be ready to face responsibilities of parenthood.*"

Unresolved experiences of sexual abuse which occurred during their earlier years of life were also reported to haunt students as they felt violated, angry and self-blame. Psychodynamic theorists posit 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 them into depression (Feldman, 2009). These un-dealt with negative personal experiences may therefore lead a student into depression as reminiscence of abuse resurface and become unbearable.

Financial challenges

Financial challenges were also noted to lead an individual into depression. Eighteen percent of the students were facing financial challenges and struggling to secure funds to meet school demands. Students from financially disadvantaged backgrounds were more susceptible to depression (Alonso & Mortier et. al., 2018) as they constantly worried about the possibility of not being able to complete their academic programmes. A student experiencing financial challenges worries about an uncertain and possibly bleak future.

Depression as hereditary

The Shona speaking participants believed depression was hereditary as the depression gene was passed on amongst family members from generation to generation. This assertion has not been proven in the Shona speaking people though various research has proven that genetic mechanisations place individuals at greater risk of depression (Weis, 2008; Viktorin et al., 2016). The exact mechanism of inheritance of the depression gene is not yet scientifically defined and variations exist in different families (Nolen-Hoesksema, 2007; Viktorin et al., 2016).

The findings reveal that similar personality traits amongst family members predisposed family members to depression. For example, a family of introverts may prefer to self-isolate themselves and may not easily seek social or professional interventions to their challenges. The family members' experiences of similar negative life events such as financial challenges or death of a loved one were also a factor that increased their vulnerability of depression. These environmental factors were pivotal in causing depression and determination to seek help. Maladaptive depression coping strategies such as eating disorders, substance and alcohol abuse were reported to be emulated by family members as siblings tended to idolize each other. Student 3 narrates:

> *My brother committed suicide when I was 19 years old that was 3 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).

5. Conclusion

An analysis of data from Shona speaking students and lecturers on their understanding of depression revealed various perspectives on their conceptualisation of depression. Depression is understood and represented as stress, thinking too much, sadness, social isolation, mental instability, spiritually oriented, and an ignorance of the existence of the disease was noted within the Shona community. Though participants presented with common depressive symptoms, the word depression was substituted with terms such stress, madness or thinking too much, '*kufungisisa*'. Whilst the data showed that Shona speaking students and lecturers in tertiary education in Zimbabwe were to a greater extent aware of the existence of depression. They were, however, not able to holistically present their conceptualisation of the illness as the 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 without a depression diagnosis which may result in chronicity of symptoms.

Spiritual orientations and traditional explanations of depression were an unquestionable reality in the Shona culture socialisation. The belief that the current life on earth was dependent on the transcendent being is a key element

to an individual's mental well - being. This dependency on the transcendent being played a pivotal role in the choice of intervention strategies. 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).

Depression was also understood in relation to its causes which included chronic illnesses, socio-economic challenges, relationship problems, failure to cope with college life and as inherited depression. These challenges causing depression in Shona students, if addressed are a key element in the reduction of the occurrence of depression. However, in spite of the various challenges encountered by many students, a lesser number developed severe symptoms of depression. This then illuminates on other factors as contributing to the onset of depression regardless of similar negative environmental experiences. These factors may include coping strategies adopted or the lack of a coping strategy employed in the face of socio-economic challenges.

These findings were also in congruent with Beck's cognitive theory of depression which focuses on cognitions, emotions and behaviours that manifest into depression (Beck et al., 1979). Participants in this study understood depression as a consequence of the interaction of their cognitions, emotions and behaviours stimulated by negative environmental experiences.

6. Recommendations

The lack of a Shona word equivalent to depression poses the risk of undermining its presence leading to a misdiagnosis of the illness. Research and mental health intervention programmes should therefore incorporate Shona cultural syndromes of depression such as '*kufungisisa*', which translates to 'thinking too much' and/or '*kusuruvara*' which means 'sadness'. This would provide a clearer, common expression for a better understanding of depression. The cultural syndromes would also assist mental health practitioners diagnose depression particularly in the Shona indigenous culture.

More research in various indigenous cultures should consider the role of spirituality on mental well-being. This would deepen our understanding of the illness for the development of tailor-made effective intervention strategies. Transcultural psychiatry is of the opinion that understanding and consideration

of cultural beliefs and values are fundamental principle in effective mental health service provision (Beck, 2016).

Tertiary institutions should advocate for and prioritise the recruitment of professional mental health practitioners to improve access to mental health care for students on campus. The presence of mental health practitioners on campus is likely to increase the awareness of the illness. This would inevitably promote a better understanding of depression, facilitate early identification and diagnosis of the disease.

Depression in Shona students was mostly a reaction to the socio-economic challenges emerging from their volatile environment. The coping strategies or lack of effective coping strategies adopted to mitigate challenges faced by the Shona students exposed them to depression. Mental health practitioners attending to students in tertiary institutions should therefore consider problem solving strategies as an integral part of the intervention methods employed to minimise the occurrence of depression in students.

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