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FACULTY OF SOCIAL SCIENCES

DEPARTMENT OF PSYCHOLOGY

**PREVALENCE AND DETERMINANTS OF COMMON MENTAL DISORDER RISK
AND DEPRESSION AMONG WOMEN: CASE OF PSYCOOK**

BY

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DEDICATION

This research is dedicated to all women, special mention goes to my late mother Betty Shambare and my late mother in love Chipu Mapuke, both have had to deal with common mental disorders as both sufferers and care providers.

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ABSTRACT

Women deal with a certain level of mental stress which puts them at risk of Common Mental Disorders (CMD), particularly depression. In Zimbabwe, mental distress goes unnoticed and undiagnosed due to the current huge mental treatment gap in the nation. This study sought to identify the prevalence of CMD risk and depression as well as their determinants among women who attended a mental health communication program in Harare Central Province named Psycook. A total population sample of 140 women aged between 18 and 63 years, were investigated via a survey based, non-experimental descriptive research design. The research instrument comprising of SSQ-14 to determine CMD risk, PHQ-9 to screen for depression, and SPLQ-14 to assess for determinants was distributed. A total of (n=138) questionnaires were returned and analyzed using SPSS and STATA to provide descriptive and inferential statistics. A CMD risk prevalence of 39.9% and a depression prevalence of 29% were recorded. Age (P=0.02), relationship problems (P=0.00); interpersonal deficits (P=0.01); and sexual problems (P=0.01) were found to be strong influencers of CMD and/or depression. Money problems was the most mentioned problem; however, its ubiquitous presence did not have any significant impact on the women's mental wellbeing. These findings, being community based, carry potentially previously unrecognized CMD and depression prevalence indicating underdiagnosis where the high rates are likely to be driven by two main factors. Firstly, compared to developed and western societies, women in Zimbabwe are more likely to attribute mental illness to spiritual and personally controllable factors creating a stigma filled environment for sufferers. Secondly, the high treatment gap caused by the scarcity of mental health care providers leaves many with little or no knowledge of mental illnesses hence instead of seeking psychological help most present with somatic symptoms increasing the likelihood of CMD and depression going undetected. Future interventions to

address CMD risk and depression will do well by focusing on other communities especially rural communities to address underdiagnosis as well as to investigate relational issues among women.

TABLE OF CONTENTS

APPROVAL FORM	ii
DEDICATION	iv
ACKNOWLEDGEMENTS	v
ABSTRACT	vi
List of Tables	x
List of Figures	x
List of Appendices	x
CHAPTER ONE: INTRODUCTION	12
1.1 INTRODUCTION	12
1.2 BACKGROUND TO THE STUDY	12
1.3 STATEMENT OF THE PROBLEM	13
1.4 SIGNIFICANCE OF THE STUDY	14
1.5 ASSUMPTIONS	15
1.6 Purpose of the study	15
1.7 RESEARCH QUESTIONS	15
1.8 DELIMITATION OF THE STUDY	15
1.9 LIMITATIONS	16
1.10 DEFINITION OF TERMS	16
CHAPTER TWO: LITERATURE REVIEW	18
2.1 INTRODUCTION	18
2.2 COMMON MENTAL DISORDERS	18
2.3 DEPRESSION	19
2.4 THEORETICAL EXPLANATIONS OF DEPRESSION	20
2.5 STUDY THEORETICAL FRAMEWORK	23
2.6 WOMEN AND DEPRESSION	25
2.8 CHAPTER SUMMARY	36
CHAPTER THREE: RESEARCH METHODOLOGY	37
3.1 INTRODUCTION	37
3.2 RESEARCH PARADIGM	37
3.3 RESEARCH DESIGN	37
3.4 TARGET POPULATION	38
3.5 SAMPLE	39
3.6 RESEARCH INSTRUMENT	40

3.7	DATA COLLECTION PROCEDURE	42
3.8	ETHICAL CONSIDERATIONS	43
3.9	Data Presentation and Analysis Procedure	44
3.10	CHAPTER SUMMARY	44
CHAPTER FOUR: DATA PRESENTATION, ANALYSIS AND INTERPRETATION ...		45
4.1	INTRODUCTION	45
4.2	Response Rate	45
4.3	DEMOGRAPHIC REPRESENTATION	45
4.4	RELIABILITY OF DATA	46
4.5	COMMON MENTAL DISORDER RISK PREVALENCE	47
4.6	The prevalence of depression among women attending Psychook	48
4.7	ASSOCIATION BETWEEN CMD RISK AND DEPRESSION	50
4.8	DETERMINANTS OF CMD AND/OR DEPRESSION	52
4.9	INFERENTIAL STATISTICS	57
4.10	CHAPTER SUMMARY	60
CHAPTER FIVE: DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS		61
5.1	INTRODUCTION	61
5.2	DISCUSSION OF RESULTS	61
5.3	CONCLUSIONS	67
REFERENCES		71
APPENDICES		78

List of Tables

- Table 4.1: Response rate
- Table 4.2: Age distribution
- Table 4.3: Reliability Statistics
- Table 4.4: Marital status and CMD risk cross tabulation
- Table 4.5: Age and CMD risk cross tabulation
- Table 4.6: Marital status and depression cross tabulation
- Table 4.7: Age and depression cross tabulation
- Table 4.8: Nature of main problem frequency distribution
- Table 4.9: Nature of main problem mean scores
- Table 4.10: Nature of main problem and marital status
- Table 4.11: Chi Square tests
- Table 4.12: Nature of main problem and CMD risk
- Table 4.13: Nature of main problem and depression
- Table 4.14 Model Summary
- Table 4.15: Logistic output

List of Figures

- Figure 4.1: Study population per marital status
- Figure 4.2: CMD risk prevalence
- Figure 4.3: Depression prevalence
- Figure 4.4: Association between CMD and depression

List of Appendices

- Appendix A: Research instrument
- Appendix B: Midlands State University clearance letter
- Appendix C: Medical Research Council of Zimbabwe (MRCZ) clearance certificate
- Appendix D: Certificate of Good Clinical Practice
- Appendix E: Psycmates - Psyccook program permission letter
- Appendix F: Information sheet for participants (English)
- Appendix G: Information sheet for participants (Shona)

Appendix H: Consent/Assent Forms English

Appendix I: Consent/Assent Forms Shona

Appendix J: Audit sheet

Appendix K: Marking guide

CHAPTER ONE: INTRODUCTION

1.1 INTRODUCTION

In this chapter the background of the research as well as the problem statement are examined. The importance of the study is explored while unraveling its possible beneficiaries. Common terms are defined, the research assumptions, questions, limitations together with the delimitations are also explored.

1.2 BACKGROUND TO THE STUDY

Mental health challenges among women have remained a global public health concern especially so in developing countries (WHO, 2008). Gender and mental health research indicate a ubiquitous disproportionate prevalence of depression (Semenova, 2017), Common Mental Disorders (CMD) (Chandra & Satyanarayana, 2010) as well as co-morbidity in mental illnesses among women (WHO, 2017).

Various physical, economic and social factors operate at different life stages in shaping a person's mental health and their susceptibility to mental illnesses (Hall, 1996). Depression, in low and medium income countries, is often undertreated due to underdiagnosis thereby shortchanging the affected who seldom get to access the few available effective treatment options. (Lao, Chan, Tong, & Chan, 2016). CMD are important risk factors for suicide and other physical ailments such as cardiovascular diseases, diabetes and hypertension (Mutsatsa, 2015).

Studies in Zimbabwe, indicate that CMD such as depression and anxiety (Broadhead & Abas, 1998; January, Mutamba, & Maradzika, 2017) are highly associated with the female gender. Depression is fueled in Zimbabwe among women who have been found to experience a vicious cycle of marital stress, poverty and disability (Patel, Abas, Broadhead, Todd, & Reeler, 2001). Harare province, has a depression and anxiety prevalence of 30% (Health & Abuse, 2005), while the post-natal depression rate stands at between 30 and 34.2% (January et al., 2017).

Biologically women are pre-disposed to gender specific mental illnesses such as hormonal mood swings and post-natal depression. Women are involved in social roles like caring, which affect them mentally as they seek to juggle and balance the many roles they find themselves in. In 2016, calls were made for more to be done towards maternal mental health, after Zimbabwe had been ranked in the top six African countries that recorded highest in maternal mental illness prevalence rates (Nyanyiwa, 2016) creating a need to look into the risk factors of depression and other CMD.

Psycook, is a mental health communication program targeted at women in Harare Province. The program is meant to raise awareness on mental health and available services. Women come together and share narratives on mental wellness with culinary art as an interaction medium.

1.3 STATEMENT OF THE PROBLEM

Depression among women regularly goes undetected as primary mental health care in Zimbabwe does not allow for screening of such. (Dixon Chibanda et al., 2017; Kidia et al., 2017) Women have to juggle the multiple roles they find themselves in, which in most cases are caring roles (Rabins, 2016) These roles frequently expose them to be nurturers of others (Upreti & Singh, 2016) who will be suffering from health matters including those suffering from mental illness.

Narratives among women are shared around marital conflicts, occupational stress, in-law relationships, and financial difficulties among other issues. "Suicide Cases on the rise in Zimbabwe," (2017) contends that marital conflicts are leading to deaths of mainly women via gender-based violence or suicides and that marital stress seems to be rife among women. Women doing live videos on social media are increasing, lamenting their stress in marriages. Women are also grappling with biological gender specific mental challenges such as post-natal depression, and hormone associated mood disorders. A post-natal depression prevalence rate of between 30-34.2% has been recorded in studies done around Harare (January et al., 2017). A macro analysis of the complaints presented by women attending Psycook reveals misogynistic cultural practices, power imbalances, poverty as well as unfavorable policies that

have left most women in our societies vulnerable to mental illnesses. Zimbabwe's deteriorating economic landscape is shaping the experiences of its population (Mawanza, 2017), leaving many distressed and languishing in existential stress where depression is seemingly unavoidable.

Various programs to empower women are changing communities and making the much-needed difference, however, very few are focused and/or followed up with research that interrogates women's mental welfare. An investigation into the determinants of CMD and depression prevalence among women attending Psycook will aid in informing future interventions for women mental health care at all levels.

1.4 SIGNIFICANCE OF THE STUDY

In unravelling the prevalence and determinants of CMD risk and depression among the women attending Psycook, this study hopes to bring to the fore, the contextual risk factors, as experienced by women. The findings are expected to inform the listed stakeholders below.

- **Women:** When women are exposed to discourse on the risk factors which contribute to depression, they are more conscious and better placed to develop targeted healthy help seeking behaviors around the identified risk factors. Any trace of prevalence among women who were otherwise not seeking help will assist them in getting the much-needed help.
- **Mental Healthcare practitioners:** The design of gender sensitive, effective, specific, contextually relevant and sustainable intervention initiatives lie in the knowledge of causes and determinants of the problem to be solved. When mental health practitioners have this knowledge, it will without doubt inform intervention strategies and content.
- **Non-Governmental Organizations and civil organizations working with women:** Most donor funded initiatives will benefit from empirical evidence on areas to target in bringing solutions to women.
- **Ministry of Health and Child Welfare:** 2018 is the final year in the operationalization of the mental health policy. As the ministry converges to look back and strategize on future plans the findings will assist in informing future mental health policies.

- **Other community members:** In as much as other community members may want to assist women to cope better, they are limited as to how they can assist. Knowledge of risk factors as they are perceived by women, will help other community members to assist where they can.
- **Psycook Program:** Future interventions for Psycook program will benefit greatly from the research results as they will inform direction and content for future awareness campaigns or similar program initiatives.

1.5 ASSUMPTIONS

Women have to deal with a certain level of mental stress which puts them at risk of depression, and most may not be aware of their state in as far as screening for depression is concerned. The major source of problems that may predispose women to depression and other CMD are better identified by women themselves. The responses gathered via the investigation tools will be accepted as true and honest.

1.6 Purpose of the study

The purpose of this research is to identify the prevalence and determinants of depression and CMD risk amongst women attending Psycook.

1.7 RESEARCH QUESTIONS

- (i) What is the prevalence of those at risk of CMD among women attending Psycook?
- (ii) What is the prevalence of depression among women attending Psycook?
- (iii) What are the determinants of CMD risk and depression among women attending Psycook?

1.8 DELIMITATION OF THE STUDY

Only women attending the Psycook program will be involved in the study. The Psycook program targeted women in Harare Central province during its first season happening between July and October in the year 2018. The women are aged 18 years and above. The study will investigate the prevalence of CMD risk and depression among the sample. Possible causes of

mental distress among the women will also be investigated to examine risk factors for both CMD risk and Depression.

1.9 LIMITATIONS

The prevalence rate will be determined by use of self-report questionnaires. Self-report questionnaires are not always reliable (Fiske & Taylor, 1991) because self-perceptions may provoke biased responses from individuals who tend to be predisposed toward self-enhancement, as they try to maintain positivity about the self with the risk of being unrealistic. Collection of data will be restricted to the women attending Psycook, therefore findings may not be postulated to all women in the same geographical area. There are other women who may fail to attend Psycook and others still who may not consent though attending Psycook. Whilst the Problem List Questionnaire gives an overview of the areas in which risk of CMD may emanate from, it falls short in explaining the lived experiences of the respondents. For those individuals who may not be depressed, their responses on the problem list questionnaire may be termed perceived as they may not necessarily state with certainty where depression would emanate from.

1.10 DEFINITION OF TERMS

- **Depressed Individual:** Anyone who fits the diagnostic criteria for a depressed individual, and has been screened using validated tools to determine their state as depressed.
- **Woman:** A human being ascribing to the female gender and is equal or above the legal consenting age of 18 years old.
- **Psycook** – A mental health communication program for women meant to raise awareness on mental health and available services in Harare Province, Zimbabwe.
- **Determinants:** are those unique characteristics, red flags, variables, causes, or hazards that, if found in an individual's life may cause them to be more susceptible to a condition.

1.11 CHAPTER SUMMARY

An overview of depression among women, issues affecting women attending Psycook, study assumptions, research questions, and the issues to be addressed by the study were

stated. Benefits of the study as well as benefiting stakeholders were also established. Terms have been both defined and operationalized.

CHAPTER TWO: LITERATURE REVIEW

2.1 INTRODUCTION

The goal of this chapter is to analyze previous studies in as far as depression and its connection to women in particular are concerned. Common Mental Disorders (CMD) as baseline screening for depression are briefly explained while theoretical explanations regarding depression are unraveled. The study's theoretical framework as well as the determinants of depression in form of risk factors are explained. Additionally, gaps in existing knowledge are identified using past researches of the same phenomena.

2.2 COMMON MENTAL DISORDERS

Common Mental Disorders (CMD) represent a group of distress states that manifest with depressive and anxiety symptoms (Patel, Todd, et al., 1997). CMD are major contributors of morbidity and disability the world over (WHO, 2005). CMD of note include anxiety disorders, substance abuse disorders, mood disorders, eating disorders, personality disorders, post-traumatic stress disorders as well as depression which is regarded as one of the most common CMD (Demyttenaere et al., 2004).

Research in the area of mental health and gender shows that women are disproportionately affected by common mental disorders (CMDs) as well as co-morbid mental disorders (WHO, 2017). There is a marked gender differences in the prevalence of CMD (Hall, 1996), where substance use disorders and anti-social personality disorders predominate in men while affective and anxiety disorders predominate in women. The more severe cases that show distress, usually with multiple co-morbid mental disorders are the ones that get attention in communities thereby getting treatment while only a minority of those with seemingly less distress are attended to (Hall, 1996). Ferrari et al. (2014) cite that burden of disease attributable to mental and substance use disorders in sub-Saharan Africa is expected to increase by 130 % by the year 2050.

An unmatched case control study (Patel, Todd, et al., 1997) was done in Harare, Zimbabwe, to examine the associations for CMD among primary care attenders that visited private surgeries, traditional and medical practitioners' clinics, and primary health clinics. The study recorded

an association of CMD with the female gender ($p=0.04$ and older age ($P=0.02$). Another study (Abas & Broadhead, 1997) in Harare engaged in a community based survey revealed a CMD risk prevalence of 30.8%

2.3 DEPRESSION

Depression affects how a person feels as well as how they perceive the world around them. (Kircanski, Joormann, & Gotlib, 2012). Depression in the Diagnostic and Statistical Manual of Mental Disorders, version five (DSM-5) is characterized as major depressive episode. For one to get this diagnosis they must in the same two-week period show signs of at least either depressed mood or loss of interest or pleasure among other five or more out of the nine symptoms which include 1) depressed mood (subjective or observed); 2) Loss of interest or pleasure, most of the day; 3) Change in weight or appetite; 4) insomnia or hypersomnia; 5) observed psychomotor retardation or agitation); 6) loss of energy or fatigue; 7) worthlessness or guilt; 8) Impaired concentration or indecisiveness; or 9) recurrent thoughts of death or suicidal ideation or attempt (APA, 2013)

According to (Betrus, Elmore, Woods, & Hamilton, 1995), depression may be experienced in four basic spheres, namely physiological, behavioral, cognitive and mood. Physiological expressions may include disturbances in one's circadian rhythm caused by fragmented sleep or disrupted sleeping patterns as well as adrenaline fatigue or pituitary dysregulation. Evident in the behavioral sphere may be social isolation, increased eating, sweet cravings, general fatigue and escalated somatization. (Shedler, 2010) Cognitive interpretations of depression are symbolized by concentration difficulties, worry, rumination and in forgetfulness (Katon, Kleinman, & Rosen, 1982). Emotional indications (Katon et al., 1982) include feelings of helplessness, anger hopelessness, irritability as well as worthlessness.

While we have the DSM categories of major depressive disorder, there has been a heightened interest in other forms of depression which are less severe, thereby undiagnosed (Demyttenaere et al., 2004). Depression is compounded by the fact that most sufferers are undiagnosed hence they do not get any treatment, with the few diagnosed rarely getting remission, a status quo that has hampered the diminution of the disease burden (Slavich & Irwin, 2014). (Betrus et al., 1995) lament the underestimation of depression prevalence among women due to limited

focus given to individuals who are not in mental health systems. The result is that most women do not even get treatment or any form of intervention.

2.4 THEORETICAL EXPLANATIONS OF DEPRESSION

Various theories have attempted to explain depression, its causes and symptoms, some of the theories will be examined below.

2.4.1 Psychodynamic theory and depression

Freud's term for depression was melancholy which he characterized as feelings of dejection, inhibition of most or all activities, self-reviling, loss of capacity to love and self-reproach among other symptoms (Shedler, 2010) According to Psychodynamic theory depression is an unconscious process that emanates from loss of an object's love decreasing one's self esteem. The process frequently involves ambivalent feelings toward the lost object as one oscillates between real or fantasized internalization of the loss, or guilt feelings regarding the loss (Ribeiro, Ribeiro, & von Doellinger, 2018)

2.4.2 Biological theories of depression

The biological explanations on depression are genetic and biochemical. Several studies have linked depression to brain formation or its activity (Hollon et al., 1992) (Dunner, 2004) (Fitzgerald, Laird, Maller, & Daskalakis, 2008). Those that base depression on genetics (McClung, 2007), have proved that depression runs in families and that children of depressed parents are two to three times more likely to suffer from the disorder. Although the debate of nature vs nurture also exists in this domain there is sufficient evidence from twin studies (Boomsma, Busjahn, & Peltonen, 2002) to prove that certain genes may predispose one to depressive symptoms. Biochemical proponents; (Lingjærde, 1983; Mendels, Stern, & Frazer, 1976) argue based on the body chemistry such as noradrenalin, serotonin, dopamine, and other neurotransmitters that are key in mood arousal. It is established that if such mood related chemicals cease performing well or change in any way, they may contribute to depressive symptoms

2.4.3 Behavioural theories of depression

The reinforcement theory (Rehm, 2016) views depression as minimized rates of response to distal stimuli where behavior ceases to be controlled by once effective reinforcers. Losses in life are perceived as losses of important reinforcers. This happens through the process of chaining. Chaining involves a situation where an earlier response was dependent on a later response simply because the first response was just a pathway to the later response. For example, a woman who loses a husband through divorce may start experiencing anhedonia because her life was wrapped around her husband. She can stop all the fun activities she used to do because such previously enjoyable reinforcing activities were done to increase chances to spend time with her ex-husband

2.4.4 Cognitive theories of depression

Based on Beck's cognitive theory, cognitive theories of depression have their basis in thought processes which are involved in developing, maintaining and establishing recurring depressive episodes (Clak & Beck, 1999). Beck asserts that it is the generated negative thoughts due to dysfunctional beliefs that are the primary cause of depression or its symptoms. A positive co-relation is assumed between severity of negative thoughts and the severity of depressive symptoms. The negative thoughts are based on a negative cognitive triad which include the belief that a) the future is hopeless, b) all experiences culminate to failure or defeat, c) I am inadequate or defective.(Rehm, 2009). Hopelessness induces distal ways in which an individual may react to distress such as catastrophizing, globalizing or the tendency to view oneself as deficient (Abela, Parkinson, Stollow, & Starrs, 2009). Similarly, learned helplessness as articulated by Seligman (1975) states that an individual's repeated exposure to uncontrollable aversive events culminates to depression. When one is faced with situations in which they lack control, they face blocked goals which leads to emotional, cognitive and motivational deficits. Depression is also likely when highly desired outcomes are deemed improbable (Atherley, 1988). Consequently, it is the individual's thinking patterns that determine susceptibility to depression.

2.4.5 Social environmental theories of depression

Social environmental theories assume that depression risk factors lie in environmental issues such as lack of economic resources. Social environmental theories postulate that women's increased vulnerability lies in three main areas i.e. a) role conflict emanating from childhood socialization, b) biological factors and c) other social environmental factors. (Katon et al., 1982). Another environmental theory, Social signal transduction theory, brings insights that explain the development of depression, its recurrence and why early life stress is a strong predictor of depression. It posits a multilevel theory that link individual experiences of social environmental stress with physiological processes that trigger depression pathogens. The theory postulates that stress, real or perceived, alters affective, cognitive and social processes that promotes depression thereby upregulating inflammatory activity that then causes depression and/or anxiety. (Slavich & Irwin, 2014)

2.4.6 Feminist theories of depression

The Relational Cultural Theory (RCT) stands out in that it was developed by women who felt that the most psychological theories did not capture the uniqueness of women as far as mental wellness was concerned. (Jordan & Hartling, 2008). RCT asserts that psychological development is anchored on healthy interpersonal relationships as it assumes that individuals especially women are relational beings (Jordan & Hartling, 2008) According to RCT a sense of wellbeing as well as safety emanate from building well-meaning connections. When a disconnection in a relationship occurs, it can either be resolved amicably or otherwise. When it is solved amicably RCT, terms such relationships “growth fostering relationships” which produce five outcomes, i.e. 1) a sense of zest 2) clarity about oneself, the other and the relationship 3) a sense of personal worth 4) the capacity to be creative and productive 5. the desire for more connection. The opposite of growth fostering relationships are those relationships in which the other is manipulated and disempowered, mutuality is weakened, and empathic failures dominate. The results of such chronic disconnections are evidenced by the opposite of what comes out of growth fostering relationships evidenced by, 1) a drop in energy 2) decreased sense of worth 3) less clarity and more confusion 4) less productivity 5) withdrawal from all relationships leading to depressive episodes (Jordan, 2008)

2.5 STUDY THEORETICAL FRAMEWORK

This study uses Bronfenbrenner's (1977) ecological theory and approach in an effort to investigate the prevalence of CMD and depression and the perceived determinants among women attending Psycook. The Bronfenbrenner's ecological model challenges us to interrogate the relationships of individuals and the systems that concern them (Levine, Perkins, & Levine, 2005). The ecological model is an exploratory way of unravelling concerns about individuals at their different system levels making it a good fit for researchers interested in understanding individuals in context (Neal & Neal, 2013)

Ecological Systems Theory identifies points of intervention or contextual predictors that lie beyond the individual (Ryan, 2001). Using the ecological framework will allow the researcher to combine the understanding brought by the above-mentioned various theories hence bringing an even richer understanding of the sample. Attention is directed in a holistic approach to the wider ecological levels, that supersedes the individual personal level reaching, out to the family and community levels. This study will investigate how the different systems relate in women, through appreciating the importance of familial, environmental and situational context in relation to depression among women.

Individuals exist in networks where the size, and quality, of such networks impact and are in turn impacted by their systems making a profound influence on their mental health (Craig, 2015) Determinants of depression are said to not only include individual attributes such as the ability to manage one's emotions, thoughts, interactions and behaviours with others, but also social, cultural, economic, political and environmental factors such as national policies, social protection, standards of living, working conditions, and community support (WHO, 2018). Ecological systems theory does well in capturing all these factors via its ability to harmonize theories at the same time interrogating all the five levels or systems affecting an individual namely the *micro*, *meso*, *exo*, *macro*, and *chrono* systems (Ryan, 2001)

The ecological systems theory has the *individual* at its center who is encompassed by various systemic layers that the individual impacts and is impacted by. The biological theories of depression (Korszun, Altemus, & Young, 2006), tend to affect women at this individual level

where gender (Korszun et al., 2006), brain formation . (Hollon et al., 1992), genetics (McClung, 2007) or biochemistry (Lingjærde, 1983; Mendels et al., 1976) are used to explain the presence of depression. Behavioral theories (Rehm, 2016), also explain depression in this system where an individual's behavioral responses can be the source of one's depression.

Micro System- This is the layer which is closest to the individual where one has direct contact with the structures therein. It captures all the relationships and interactions that an individual has with their immediate surroundings. Structures in case of women may include, family, work, school, neighborhood and friends. At this level the bidirectional relationships are at their strongest where the individual affects the relationships and the relationships also affect the individual putting the greatest impact on the individual. This system is best captured by the Relational Cultural Theory's explanation of depression which asserts women are relational beings (Jordan & Hartling, 2008) hence their psychological development is anchored on healthy interpersonal relationships.

Mesosystem – this layer provides the connection between the structures of the individual's microsystem. For example, the connection between a woman's ex-partner and his children or her social circle and family. The feminist's theories explain women's experiences in this system well by showing the impact of chronic disconnections in all the relationships that affect women leading to depressive episodes (Jordan, 2008)

Exo System - This layer defines the larger social system in which the individual does not have a direct function although the individual feels the positive or negative force brought about by the interaction of this layer and other structures in the micro system. The structures in this layer impact the individual by interacting with some structure in the micro system. An example can be how schedules of close family members or workplace resources affect women's schedules. The negative forces that emanate from this system can be interpreted differently by women linking the system to cognitive theories of depression whose basis is in thought processes which are involved in developing, maintaining and establishing recurring depressive episodes (Clak & Beck, 1999).

The *Macro System* is the fourth layer which consists of cultural values, norms, customs and policies whose effects hold a cascading influence throughout the interactions of all the other layers. For example the cultural expectations for women may be the source of their depression (Keith & Schafer, 1982) as they seek to fulfil unrealistic cultural demands that do not recognize the changing roles of today's woman . Also, misogynistic culture is less likely to make provision for emancipatory policies in favor of women's mental health when some of the causes are embedded in the same culture. Social environmental theories become key in this system with their assumption that depression risk factors lie in environmental issues such as lack of economic resources. (Katon et al., 1982).

Chrono-systems encapsulates the dimension of time as it relates to an individual's environments. Factors within this system can be either external such as timing of the death of a spouse or internal such as timing of menopause. This intersection with time can be used to explain depression and its symptoms e.g. depression during adolescence was found to predict higher rates of marriage among younger women and subsequent marital dissatisfaction (Gotlib, Lewinsohn, & Seeley, 1998) yet on the other end early marriages are said to fester depression (Whitton et al., 2007). The Psychodynamic theory places emphasis on time issues such as early or childhood abuse where depression is an unconscious process that emanates from past experiences (Ribeiro et al., 2018).

2.6 WOMEN AND DEPRESSION

Symptoms of depression and its diagnosis are more prevalent in women (Goodman & Tully, 2006) This section unravels literature in a bid to explain what has been discovered about women and depression.

By virtue of gender women suffer from unique gender related depression such as premenstrual dysphoric disorder, pre and post-partum depression as well as other hormone associated mood disorders (Somerset, Newport, Raga, & Stowe, 2006). The greatest risk period for a woman to have an episode of major depression during a lifetime is during her childbearing years (Somerset et al., 2006) Women are regarded as highly relational beings hence most of their depressive symptoms emanate from broken relationship (Jordan & Hartling, 2008).

The many roles and the societal expectations of today's women could be another factor contributing to depression among women. A woman's perceptions on male and female roles and their experience of such role changes, impact on how women experience depression making them more susceptible to depression than their male counterparts. (Keith & Schafer, 1982). The women emancipation has brought more opportunities for women to make choices regarding what they want to become or who they want to be while at the same time transforming societal beliefs, standards and expectations for women. This has placed an unattainable demand for some women hence increasing the dilemma of living for them, exposing them to depressive symptoms (Betrus et al., 1995). Structural issues such as cultural beliefs, policies and general economic and political conditions within nations also affect women. As in other developing nations, Zimbabwe is characterized by poverty, economic chaos, scanty health services, civil unrest, and sex inequalities (Patel et al., 2001)

Many women are said to suffer from depression as a result of how they are socialized. This is especially key for women in that most are socialized to believe they are weaker and most women are not given the same access as their male counterparts. Religion has done its fair share in belittling women; early childhood socialization is said to have an impact and is crucial for self-esteem development (Marecek, 2006). Low self-esteem exacerbates depressive symptoms (Tabassum & Lodhi) where lack of awareness around issues of depression among common and disadvantaged population disempowers the affected as the problem is consequentially ignored.

Answers to the question of why depression is more prevalent among women remain elusive. There is a paucity of full explanations for the sex differences which available research has not cleared (Albert, 2015; Kessler, 2006; Somerset et al., 2006). Paykel (1991) suggests that the causes are likely to combine factors related to expression of distress, biology and social situation. Paykel also reports that much of depression excess happens in married women aged 25-45 years with children, strongly suggesting social causation and highlighting the vulnerable situation of young mothers. Albert (2015), posits the cause in the triggers of depression explaining that women present with internalizing symptoms and men present with externalizing symptoms where women tend to display more sensitivity to interpersonal relationships while man react more to external career or

goal-oriented factors. Jack (1991) reaffirms Paykel's position by revealing how women actively silence themselves in order to cultivate and maintain intimate relationships. Women are said to devalue their experiences, to be silent, to repress anger, and to censor themselves in order to accommodate others. Jack further demonstrates how women internalize cultural expectations about feminine goodness affecting their behavior in relationships and precipitating the plunge into depression.

Theoretical proposals as to why women are at increased risk for depression as compared to men include higher incidence of predisposing factors, greater help seeking behaviors and greater contact with clinicians (Somerset et al., 2006). (Paykel, 1991) discounts more help seeking behavior as a simple explanation for the overrepresentation of females in depression prevalence sex ratio arguing that the same ratio applies equally in studies of community prevalence.

2.6.1 Depression prevalence rates among women

Three hundred million people are said to be suffering from depression worldwide and depression has been predicted to be the largest cause of both psychological and physical morbidity or disability by 2030 (WHO, 2018). More women are affected than men. In 2010, depression in women had a global annual prevalence of 5.5% with (Whiteford et al., 2013). Community cross sectional studies have revealed varied depression prevalence rates as represented by studies in various countries. China recorded 30.7% (Cao et al., 2015), Pakistan 66% (Tabassum & Lodhi); America 36% (Price & Proctor, 2009) United Kingdom 17% (Albert, 2015), Nigeria 5.7% (A Moran, Lawoyin, & Lasebikan, 2007) Uganda 21% (Bolton, Wilk, & Ndogoni, 2004) South Africa 9.7% (Tomlinson, Grimsrud, Stein, Williams, & Myer, 2009). Specific depression prevalence rates for women were not easy to find.

In Zimbabwe approximately 30% of primary care patients present with clinically significant depressive symptoms although the actual prevalence could be hampered by somatization (Dixon Chibanda, Weiss, et al., 2016). Efforts by Friendship Bench; (D Chibanda, 2017), a community initiative to reduce the treatment gap for depression in Zimbabwe have helped in raising awareness on the subject. However, depression remains

under-diagnosed as the majority of cases are only recognized at subsequent consultations. One of the most recent Zimbabwean study (January et al., 2017), indicated post-partum depression prevalence of 34.2%. Zimbabwe at one time was among the top ten African countries rating high (Nyanyiwa, 2016) on maternal mental prevalence.

2.6.2 Demographic factors of depression

The female gender as already alluded to is in itself a demographic risk against depression. Several other sociodemographic factors such as , education, and income (Akhtar-Danesh & Landeen, 2007), against depression have been identified, however, this study has limited its investigation to age and marital status.

Age and depression are positively correlated and depression can start early on in life although it is easier to miss in the early years of life (WHO, 2018). Depression is said to be at its highest in older adulthood (Mirowsky & Ross, 1992), and it is the elderly who are more likely to be psychotic (Brodaty et al., 1991). Mirowsky and Ross (1992) attribute the rise of depressive symptoms in late life to life-cycle losses in marriage, employment, and economic wellbeing. Higher education in younger generations, is seen as a protective factor against depression.

Marital status as a predictor of depression has varied not so harmonious findings. Akhtar-Danesh and Landeen (2007) reported highest similar rates of depression in both divorced and people living with their married or common law partners. There is however, an overall prevailing perspective on the issue of depression versus marital status that says marriage may be a protective factor against depression (Whisman, Weinstock, & Tolejko, 2006)

2.6.3 Determinants of depression among women

A general scan of literature reveals a few immutable determinants for depression among women which include female gender, previous history of depression (King et al., 2008); lack of social support; accommodation issues, health issues (Cao et al., 2015; Penninx, 2006); money issues, negative life events (Tabassum & Lodhi); or self-esteem, childcare

stress; prenatal anxiety; marital conflict; maternity blues , socioeconomic status, (Beck, 2001). Some of these risk factors are further explored below.

a) Maternal causes

Childbirth can be regarded as a crisis period in some women's lives where their lives are placed at risk of major psychological disorders (Goodman & Tully, 2006). Issues of post-partum depression are a possible reality that can strike without warning at a time of physical and emotional vulnerability (January et al., 2017). New motherhood in particular is a major life event that can bring extensive adjustment challenges for some women. Same variables as in other types of depression seem to equally predict the onset of post-partum depression (Robertson, Grace, Wallington, & Stewart, 2004) The variables include relationship difficulties, low social support, previous depressive illness and life stress, with previous, non-post-partum, episodes of non-psychotic depression emanating as the strongest predictors of post-partum depression (Robertson et al., 2004)

Culturally in most parts of the world, women are expected to be natural care givers and such expectations place a combination of work overload and guilt that may be too heavy to bear (Beck, 2001). Lee (1997) advocates for more flexible work practices that leaves room for parents to care for their children as a way to alleviate the distress in early motherhood years thereby reducing the post-partum prevalence rates. A study of young mothers in Uruguay(Ardoino, Queirolo, Barg, Ciccariello, & Kordas, 2015) showed that there is a strong positive association between moderate to severe depression with high parental stress Zimbabwe has recorded a post-natal depression prevalence rate of 30.5% (January et al., 2017)

b) Interpersonal deficits

Interpersonal deficits such as low self-esteem or being a loner with an inability to socialize and relate with others constructively can be attributes of an individual's personality (Baril, 2008). Such individual dispositions can pose as risk factors for depression. There is a strong bi-directional relationship between depression and low

self-esteem as established by Sowislo and Orth (2013). Their findings showed that while low self-esteem contributed to depression, depression was also seen to erode self-esteem though the effect of self-esteem on depression was stronger than vice versa. Interventions aimed at increasing self-esteem have been found useful in reducing the effects of depression. In another study of women who were victims of gender-based violence Roberts, Williams, Lawrence, and Raphael (1999) reported that self-blame, consequentially leading to low self-esteem was significantly associated with depressive symptomatology

Loneliness is equally highly associated with depressive symptoms, hopelessness and anxiety especially in older women. In their study of homebound older adults (Han & Richardson, 2010) found a strong relationship between loneliness and depression as echoed by Cooper et al. (2003) who reported loneliness in older adults as precursor to depression.

c) Marital Issues

In a twenty year longitudinal study examining the relationship of long-term marital stress and Major Depressive Disorder, Zhang, Chen, and Zou (2014) reported that depression has a high positive correlation with marital stress, suggesting treatment interventions as a way of preventing depression in older women who would have experienced marital stress earlier in life. Women have been said to report higher levels of marital distress than man (Whisman et al., 2006) while at the same time spouses of depressed women have been shown to rate their wives more negatively suggesting a general negativity toward the women, which feeds back to their depressed states.

While a woman's marital status is said to impact on her susceptibility to depression in a negative way, some studies have found married women to have a lower prevalence, compared to divorced or widowed women (Betrus et al., 1995) .

Sexual problems

Self-reported sexual problems, especially low sexual desire, are common, among women (Mercer et al., 2003). In a study done among American women (Shifren, Monz,

Russo, Segreti, & Johannes, 2008), the prevalence of distressing sexual problems peaked in middle-age while sexual problems were more common in older women aged between 45 to 65 years. In the same study sexual problems were positively correlated with depression. Bifulco, Brown, and Adler (1991), studied sexual abuse in childhood and adolescence and recorded that sexual abuse involving contact was associated with an increased risk of depression in adulthood. Depressive symptoms on the other hand are said to cause sexual problems (Frohlich & Meston, 2002)

Age

By the teenage years, girls are much more at risk than boys to suffer from anxiety or depression while by mid-adolescence girls are more than twice as likely to be diagnosed with a mood disorder as boys (Martin, 1996). As the years progress depression is still evident as indicated by reports (Noble, 2005) that depression tends to target women at their reproductive ages. Women between the ages 40 and 59 have been found to have the highest rate of depression out of any age in America (Pratt & Brody, 2014)

At ages older than 65 years, both men and women show a decline in depression rates, and the prevalence becomes similar between them (Barg et al., 2006). Most old age-related changes, be they social, physical or biological can be expected to include losses rather than gains, depression in late life may be difficult to identify, and older adults often do not accept depression treatment offered (Penninx, 2006). Late life depression can however, lead to adverse health consequence through a sedentary lifestyle which happens to be one of the major contributors to disability and mortality in old age (Penninx, 2006)

d) Relationships

Strong and healthy relationships can be a big influence on whether a woman becomes depressed or not while simultaneously carrying the potential to help women cope with the symptoms of depression (Marshall & Harper-Jaques, 2008). Evidence suggests that people in troubled relationships are three times as likely to experience depression as compared to those who aren't endorsing unhappy or unsupportive relationships. Some

studies have found that over half of those with depression consider relationship problems to be the main cause of their illness (Gibson et al., 2016)

Familial relationships also take a pivotal role as far as depression among women is concerned. Mothers and daughters are said to have the closest, most significant yet most conflicting and potentially troubling relationship (Campbell, Kub, Belknap, & Templin, 1997). In their study Brown and Gilligan (1993) show that tension between mothers and adult children predicted depression for daughters more strongly than it did for sons. Midlife for women (Suitor, Gilligan, Johnson, & Pillemer, 2013) is another pivotal time when family relationships tend to experience more tension, more strain and more discord which are largely compounded by the fact that, children would be grown and emptying the nest while aging parents require more attention necessitating more sibling come backs to prepare for aging parents' care. Adults in the middle of their lives often react more strongly to family conflict than they do later in life.

e) Health issues

Depression is simultaneously linked to illnesses e.g. renal failure (Khaira et al., 2012), diabetes (Ismail, 2010) and several chronic illnesses (Hough, Brumitt, & Templin, 1999; Penninx, 2006) or even children's illness (Cairns & Lansky, 1980). When one is diagnosed with an illness, the knowledge may predispose them to depressive symptoms. Other psychological conditions such as insomnia, or anxiety (Hirschfeld, 2001) have a bidirectional relationship with depression causing complex comorbid conditions.

Developing a disability as an adult, whether from an injury or a chronic illness, may create challenges. Disability has been established as a risk factor for depression, and more so among disabled women (Noh, Kwon, Park, Oh, & Kim, 2016) were females with disability presented higher levels of depression scores and the female disability group showed more depressive symptoms than the male disability group.

f) Work and depression

The upward mobility of women into professional and managerial positions has posed another risk for women in the form of occupational stress. The association between work and depression can be summarized as depression coming as a consequence of unemployment, job characteristics, barrier to employment or of work and family stress (Lennon, 2006). According to Snapp (1992) trouble with superiors or subordinates has been directly linked to depression among managerial woman, agreeing with Suraj-Narayan (2005) who established that relationships at work play a significant role in terms of the stressors that women managers experience. In a longitudinal study done in Scotland (Phillips, Carroll, & Der, 2015), stressful life events predicted an increase in depressive symptomatology over a five year span. The same study refuted the notion that the symptoms only generate the perception and not actual occurrence of stress. Working women tend to experience a spill-over of work into daily family time. There is a competition of resources among, motherhood, wifehood, other domestic roles and occupational roles, consequently forcing the woman to make difficult choices (Suraj-Narayan, 2005). Compared to non-working women, working women are said to face higher levels of marital stress (Whisman et al., 2006), elevating their risk to geriatric depression (Zhang et al., 2014)

g) Major life changes

Major life events such as bereavement or legal issues may cause a homeostasis imbalance in one's psychological well-being. Stressful life events are regarded as high environmental risk factors (Zhang et al., 2014). In the event that one faces major life stressful events, the lack of or insufficient social support can make one vulnerable to depression.

h) Socio Economic Status

Low socio-economic status (SES) has been found to be associated with a higher prevalence of depression (Lorant et al., 2003). Akhtar-Danesh and Landeen (2007) reported an inverse relationship between income and the prevalence of depression ($p < 0.0001$). In their study Wang, Schmitz, and Dewa (2010), found low education and financial strain to be associated with increased risk of depressive episodes in working

participants. In those who had not worked in the previous year, financial strain was not associated with depressive episodes and financial strain was not associated at all with depression in participants who did not work. On their brief report on vulnerability to depressive symptoms (Haefffel, Voelz, & Joiner, 2007) reported that a decrease in social support is a crucial vulnerability factor for depression. When people perceive a decrease in social support, they tend to exhibit depressive symptoms.

i) Lack of Social Support

Conditions within a woman's ecology that increases their vulnerability to depression lie in the experience of major life stressors, such as social rejection and relational stress. In a local study by (Patel et al., 2001) onset of depression was attributed to severe life events, such as unwanted pregnancies, infertility, marital or other relationship matters, and bereavement. Social support after such events acted as a protective factor against the development of depression and lack of it was a risk factor. On their brief report on vulnerability to depressive symptoms (Haefffel et al., 2007) reported that a decrease in social support is a crucial vulnerability factor for depression. When people perceive a decrease in social support, they tend to exhibit depressive symptoms.

2.6.4 Policy

Policy provides the cultural narratives that organize, influence and provide significance for women dealing with depression and other CMD. In their analysis of Zimbabwe mental health system (Kidia et al., 2017) indicate that Zimbabwe is guided by the Mental Health act of 1996 and a mental health policy that was introduced in 1999. The mental health policy initiated the decentralization of mental services via the establishment of coordinators in each province however, the country's economic and political crisis (Mawanza, 2017) has derailed and hampered the establishment of meaningful community health initiatives. In a bid to operationalize the mental health policy, the Mental Health National Strategy (Kidia et al., 2017) guidelines were crafted to enable, non-governmental organizations, policy makers, mental health professionals, researchers, media, churches, individuals and communities to contribute to mental health care. The document sets a culturally acceptable direction for the implementation of a comprehensive strategy but most importantly it

emphasizes prevention of mental illnesses among other issues. The outline is broken down to specific strategies to be implemented within the 2014-2018 period.

2.7 KNOWLEDGE GAP

The concept of gender disadvantage in mental health, its correlates together with mental health outcomes has received relatively less research attention world over (Chandra & Satyanarayana, 2010). Little is known about the prevalence, severity or extent of untreated mental disorders, especially in less-developed countries (Demyttenaere et al., 2004) such as Zimbabwe. In addition, Zimbabwe does not seem to have known systematic reviews in the area of gender disadvantage and common mental disorders in recent years. In as much as previous research has been done to identify causes, and prevalence in various care giving settings in Zimbabwe, there is paucity of mere community prevalence studies.

While the above-mentioned studies contribute useful information, they however, differ significantly in context with the current study. Investigating community interventions like Psycook will help fill the community prevalence gap. Determining prevalence and causes of depression among attendants of programs such as Psycook, will further illuminate the need for such community engagement programs.

Given the non-committal nature of women to find help even when they are aware of their symptoms (Barney, Griffiths, Jorm, & Christensen, 2006), an initiative to do preliminary screening for depression in a setting such as Psycook is expected to elucidate the need for good help seeking behaviours by bringing awareness on the symptomatic presence of depression among the participants regardless of nature and size. This kind of awareness is expected to help encourage many to get the help they need.

The experience and results garnered from this study will further assist literature and future researchers in evidence-based practice. Most community engagement initiatives which are similar to Psycook end at offering preventive and awareness training but do not seek to gather empirical evidence on issues they will be addressing. The current researcher is part of the Psycook project, therefore this research will feed into the bigger vision of the Psycook project

as a possible longitudinal study. This study will also assist interventions that speak to the health belief model in as far as giving evidence toward the perceived seriousness and perceived susceptibility of depression amongst the sample are concerned.

Gender is a social construct that is greatly influenced by one's culture and ethnicity, (Chandra & Satyanarayana, 2010), an attempt to investigate the subject of depression among women using an ecological perspective is expected to highlight gender specific themes as they emerge which will hopefully provide take home messages from the study, fill in identified gaps in literature, and formulate recommendations for future research in this area.

2.8 CHAPTER SUMMARY

An exploration of literature related to women and depression together with the theoretical underpinnings of depression; theoretical framework guiding the study and findings from previous studies was done. The chapter was finalized by identifying gaps that may be filled with the current study,

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 INTRODUCTION

An articulation is made of the chosen research paradigm, research design, research instrument, target population, sampling and data collection procedures necessary to tackle this study. In addition, the statistical validity and reliability of the research instruments are discussed as well as the data analysis route and presentation.

3.2 RESEARCH PARADIGM

The study drew from a positivist approach with its underlying nature of deductive logic in an endeavor to establish the prevalence of depression and CMD risk as well as its determinants among women. The presence or absence of depression can be considered as an external unchanging reality at the time of screening, which in essence is an objective reality (Blanche, Blanche, Durrheim, & Painter, 2006). The chosen positivist approach, therefore helped in finding objective reality surrounding the research questions. Positivism on the other hand is helpful in consolidating and working with quantifiable data (Reio Jr, 2016) which best fits the design for the current study. The elements under study i.e. depression and CMD risk have standardized instruments that can measure their existence translating them into quantitative variables (Durrheim & Painter, 2006) that are best suited by a positivist approach. The determinants of depression and CMD among women were expected to fall within the same general categories, hence the findings were hoped to unearth generalizable analytical findings. This type of hypothetical testing required positivism, as it allows for hard data collection, testing and analysis (Blanche et al., 2006). The study also meant to inform on the sources of mental stress for women, which could be marred by researcher bias. Positivism allowed for the use of empirical instruments that were used to collect data via the use of a self-report questionnaire as a way of avoiding researcher bias while at the same time achieving neutrality and objectivity (Blanche et al., 2006) .

3.3 RESEARCH DESIGN

The design chosen was of a quantitative non-experimental descriptive underpinning. The mere notion of checking for prevalence denotes quantity and description of the sample findings. A

quantitative design was best suitable to quantify the number of women found to have the risk of CMD; s and those who were depressed. A descriptive quantitative design also paves way for a rich description of specific cases (Durrheim & Painter, 2006) making it suitable for a case study such as the one undertaken in this study. This design also stood as the best suited to inform the demographic description required to describe the case of women attending Psycook while at the same time describing the prevalence and its associated variables depicted by the problem list questionnaire.

Non-experimental designs are not the preferred way when trying to establish causality however there are circumstances when this is not possible for example when manipulation of either participants or variables is not possible (Reio Jr, 2016). These reasons influenced the choice of a non-experimental design in that neither participants nor variables could be controlled without causing harm to the participants in the current study. Reio Jr (2016) further recommends a broader and exploratory approach which was assumed by this design in seeking an understanding to factors that may be contributing to CMDs in women attending Psycook. This was done by availing a list of problem areas from which participants could indicate frequency thereby ascribing the weight that each variable had on them. While the data collected might not have been rich enough to explain all the complexities around the variables, it was expected to provide a general descriptive overview into the determinants of CMD's among the Psycook attendants. The design flowed from an exploratory (C. Marshall & Rossman, 1989) approach that assisted in collating appropriate data needed to delineate aspects of the problem areas linked to the risk of CMDs as well as depression among the sample. An effort was made to extract reliable, and precise data.

3.4 TARGET POPULATION

The study was targeting every woman who attended Psycook in the first season, from its inception in August 2018 to the end of the season in mid-October 2018. Psycook is a community-based health communication initiative aimed at bringing awareness to women on the importance of mental wellness and available help in Harare province. Psycook is open for women of ages from the adult consenting age of 18 and above, regardless of marital, educational or any other status. The program is advertised through notices on social media

platforms, community centers, and via word of mouth. Psycook meetings are free of charge and involve women discussing mental health whilst engaging in the recipe of the day thereby using culinary art as a medium for interaction. The total target population for the period under study was one hundred and eighty (180) women, however due to non-attendance of some registered participants, the total number of women who attended stood at 140 women.

3.5 SAMPLE

The total population sampling method was used. This method entails examining the entire population (Etikan, Musa, & Alkassim, 2016); in this case every woman attending Psycook in the first season. This sampling method was chosen because the population size was relatively small and the subjects possessed the unique characteristic of having attended the first season of Psycook (Etikan et al., 2016). The study aimed to reach the total population sample of 180 women who were expected to attend at least one of the 12 meetings scheduled for the period under study. Although every participant was a candidate, consent from those participating to be part of this research was not guaranteed neither could it be forced. Ethical practice requires research participants to give their informed consent (Honan, Hamid, Alhamdan, Phommalangsy, & Lingard, 2013) . This sampling method by virtue of falling under purposive sampling methods which are a type of non-probability sampling limited the study to make any statistical generalizations about the study population to the rest of the female gender (Etikan et al., 2016). However, it was still possible to make analytical generalizations of the study population allowing for comparisons with known patterns of the same phenomena.

3.5.1 Sampling and sampling technique

The three steps required for total population sampling (Etikan et al., 2016). were followed i.e. step one; defining the population characteristics; step two; creating the population list and finally step 3; establishing a way of contacting everyone on the list. The only defining characteristic was that the participant had to be a woman attending Psycook program. The population list was created by seeking gatekeeper clearance from the Psycook program coordinators who availed information on dates and venue of Psycook meetings as well as access time to the participants on the days they attended meetings. The Psycook program was expected to have total of twelve meetings with a maximum of 15 participants putting

the total population expected to attend to 180. Access to the participants was granted by way of addressing the attending participants on each day they came for meetings and giving them the chance to respond to the research instrument.

3.6 RESEARCH INSTRUMENT

The research was conducted using a four-part self-report questionnaire (Appendix A) as the data collection tool. It is a structured and closed ended questionnaire. The first part of the questionnaire captured the demographic details of the participant. The second part and third part of the questionnaire comprise of the Shona Symptom Questionnaire (SSQ-14) and the individual Patient Health Questionnaire (PHQ-9) respectively. The SSQ-14 assessed for the presence of risk toward common mental disorders including depression, however it is not a specific measure for depression (Dixon Chibanda, Verhey, et al., 2016). The PHQ-9 specifically screens for the presence of depression. The final part covers the Shona Problem List Questionnaire (SPLQ-14), which has the purpose of identifying the source of problems for the participant. The SPLQ-14 is a frequency ascending scale with each of the variables having four possible responses depicting a continuum. All the three questionnaires have been used (Dixon Chibanda et al., 2011) with the target population and in the same geographical location before.

3.6.1 Administration and Scoring

The research instrument (Appendix A.) was administered at the beginning of a Psychook meeting where each participant would find the research pack at their sitting position. The research pack contained a registration form an informed consent form (Appendix H or J) and the research questionnaire (Appendix A). Instructions and general procedures were communicated to the whole group then participants were given time to respond to the self-report questionnaire with an option of raising their hands to ask if they needed further assistance. Those who did not consent were asked to return the pack together with those who would have consented. This was done to ensure no one felt victimized for not consenting.

The captured data was transferred to the scoring sheet (Appendix J). The SSQ-14 was scored by adding together the number of questions to which the subject responded “yes” with a maximum possible score of 14 and a minimum possible score of zero. Any participant who scored ≥ 8 was deemed to be at a high risk of having a CMD based on the stated (Patel, Simunyu, Gwanzura, Lewis, & Mann, 1997) satisfactory specificity and sensitivity cut off score of the instrument. This was done to find the risk to CMD prevalence as baseline data to use when analyzing CMD risk factors.

The PHQ-9 was scored by totalizing all the scores with the highest possible score being 27 and the lowest possible being zero. Scoring was guided by (Kroenke, Spitzer, & Williams, 2001) who indicated scores of 5 to 9 as mild depression; scores of 10 to 14 as moderate depression, scores of 15 to 19 as moderately severe depression and scores of 20 and above as severely depressed. Moderately severe and severely depressed subjects were informed and linked to appropriate care while those who fit the category of mild and moderate were also informed and encouraged to enroll in the Psychook prevention programs. The aim of the above exercise was to describe the depression prevalence rate of the sample under study.

The SPLQ-14 has four responses for each variable. The first possible response; *Not at all* received a raw score of zero, the second possible response; *Several* got a raw score of one the third possible response; *More than half the days* was assigned the raw score of two, and finally the fourth possible response; *Nearly every day* was apportioned the raw score of three. The 14th question allowed the subject to indicate another variable which may have been missed, however it did not allow them to score it. The responses to this question, were compiled and grouped according to similarity. SPLQ-14 findings were the source of establishing the source of mental stress for women that may be predisposing them to CMD's

3.6.2 Reliability and Validity

Reliability and validity refer to the consistency and accuracy of a measuring instrument (Durrheim & Painter, 2006) The SSQ-14 (Patel, Simunyu, et al., 1997) and the PHQ-9

(Dixon Chibanda et al., 2011). have been used and validated within the same geographical location before SSQ-14 (Patel, Simunyu, et al., 1997) consists of 14 items that are believed to be the most compelling predictors of common mental disorders, with an internal consistency i.e. Cronbach's alpha reliability (α) of 0.85. The PHQ-9 when used against another validated tool in the diagnosis of depression here in Zimbabwe (Dixon Chibanda, Verhey, et al., 2016) produced a high consistency (α) of 0.8. The Shona Problem List Questionnaires has no known validity or reliability scores; however, it has been used successfully to establish the problem sources for the friendship bench program (The Friendship Bench, n.d.).

3.6.3 Pretesting

The first Psycook meeting which had a group of 12 women was used to run a pretest of the instrument with the objective of checking for any administration challenges. Average time for instrument administration was noted as 40 minutes and no exceptional challenges were eminent.

3.7 DATA COLLECTION PROCEDURE

Data was collected from Psycook meetings participants who were preregistered for the meeting. Research pack containing the registration form, informed consent form and the research instrument, was put at every participant's sitting position. The researcher would be given time at the beginning of the meeting to explain in full the research goals, benefits and risks referring to the informed consent form. The participants were given a chance to ask questions after which they were asked to sign the informed consent forms and proceed to answer the questionnaire. A copy of informed consent was given to the consenting participants for their file. After signing the consent forms the researcher gave instructions on how the self-report questionnaire works and gave room for questions. After all questions were answered and when it was clear that the respondents were ready to answer; they were given time to respond to the questions. After completion, the questionnaires were submitted back to the researchers and the respondents were freed to resume their Psycook program.

3.8 ETHICAL CONSIDERATIONS

The study's ethical considerations were as follows:

a) Ethical clearance

Permission, approval and guidance to carry out the research was granted from Midlands State University department of Psychology (Appendix B) through a dedicated supervisor who was overseeing each stage of the research process. Furthermore, ethical clearance was sought and granted from Medical Research Council of Zimbabwe (Appendix C) the country's research regulatory authority. Permission was also sought and granted (Appendix E) from Psychook program team to collect data from their participants. When collecting data of clinical nature among human subjects, it is imperative for the researcher to exercise good clinical practices (Dixon, 1999) To satisfy this end, the researcher trained for, and obtained a "Good Clinical Practice Certificate". (Appendix D)

b) Informed consent:

Informed consent was sought from all respondents who reserved the right to terminate their participation at any given time if they so wished. Verbal and research information sheets were given to participants at the beginning of the Psychook meeting. Participants were given their copies of signed consent forms to take home.

c) Autonomy

Respect and promotion of participants' rights to self-determination within their cultural and social framework (Honan et al., 2013) were guaranteed by ensuring that referrals and results dissemination to subjects who needed further care was done in a culture sensitive and respectful manner that allowed them to have an informed choice of their next steps.

d) Beneficence

The research aimed to benefit the mental health and development of participants (Tangwa, 2009). Information was availed to participants of where they could get further help if they so needed it. For those who were found to be suicidal arrangements were made for them to get immediate help while those who were categorized as depressed were linked to further help.

e) Non-Maleficence

Actions or inactions that risk harming participants were avoided (Tangwa, 2009). The fact that some of the questions on the questionnaire, especially the PQ9 could be quite intrusive hence causing possible discomfort for the respondents was noted and participants were encouraged to raise their hand if at any time they felt unable to proceed with the study, or if they needed extra support.

f) Privacy and Confidentiality

The researcher held the primary obligation and exercised reasonable precautions to protect confidential information obtained during data collection. Participants were identified on the research instrument, through a unique number to protect their identity. Whilst names were captured on the registration sheet which carried the same unique number, in order to identify those who would need further support, the actual research instrument had a unique identifying number. The registration form and the informed consent form would be detached from the research instrument upon submission. The forms were secured separately such that identifying information was to be sought from the registration sheet only when it was necessary for linking subject to further assistance. This meant that respondents' names and any identifying information were not obvious to any of the research team who were scoring and handling the research instrument.

3.9 Data Presentation and Analysis Procedure

The data has been presented in tables, graphs, and descriptive text to ensure clarity. The data was analyzed using statistical software such as SPSS and STATA by use of regression models. The analysis included descriptive, variation and inferential statistics to explain the findings and the relationship between variables.

3.10 CHAPTER SUMMARY

The chapter gave a presentation of the research methodology, design, as well as the paradigm; followed by an explanation of the data collection tool, data collection procedure, data presentation and analysis procedure, as well as the study's ethical considerations. The study population as well as the sampling procedure has been also articulated.

CHAPTER FOUR: DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.1 INTRODUCTION

This chapter shall present the results and findings of the collected data. The first section looks at the response rate as well as the demographic information of the respondents. The second section provides an analysis of the descriptive statistics that addressed each of the research questions put forward in this study. Finally, inferential statistics are presented through the use of regression analysis.

4.2 Response Rate

Table 4.1: Response Rate

Questionnaire Issued Out	Questionnaire Returned	Response Rate (%)
140	138	98.6

The table 4.1 above shows that 140 questionnaire sheets were issued out and 138 were successfully returned, therefore the response rate for this study was 98.6%. 98.6% is a very good response rate in a survey as it is adequate for a study to derive significant results and/or conclusions.

4.3 DEMOGRAPHIC REPRESENTATION

This section analyzes the demographic information of the 138 women who participated in this study namely their age and marital status.

Age

Table 4.2 below shows the age of the respondents, where the youngest respondent was 18 years whilst the oldest was 63. Most of the respondents were 38 years old, the mean age was 36.6 with a standard deviation of 10.25.

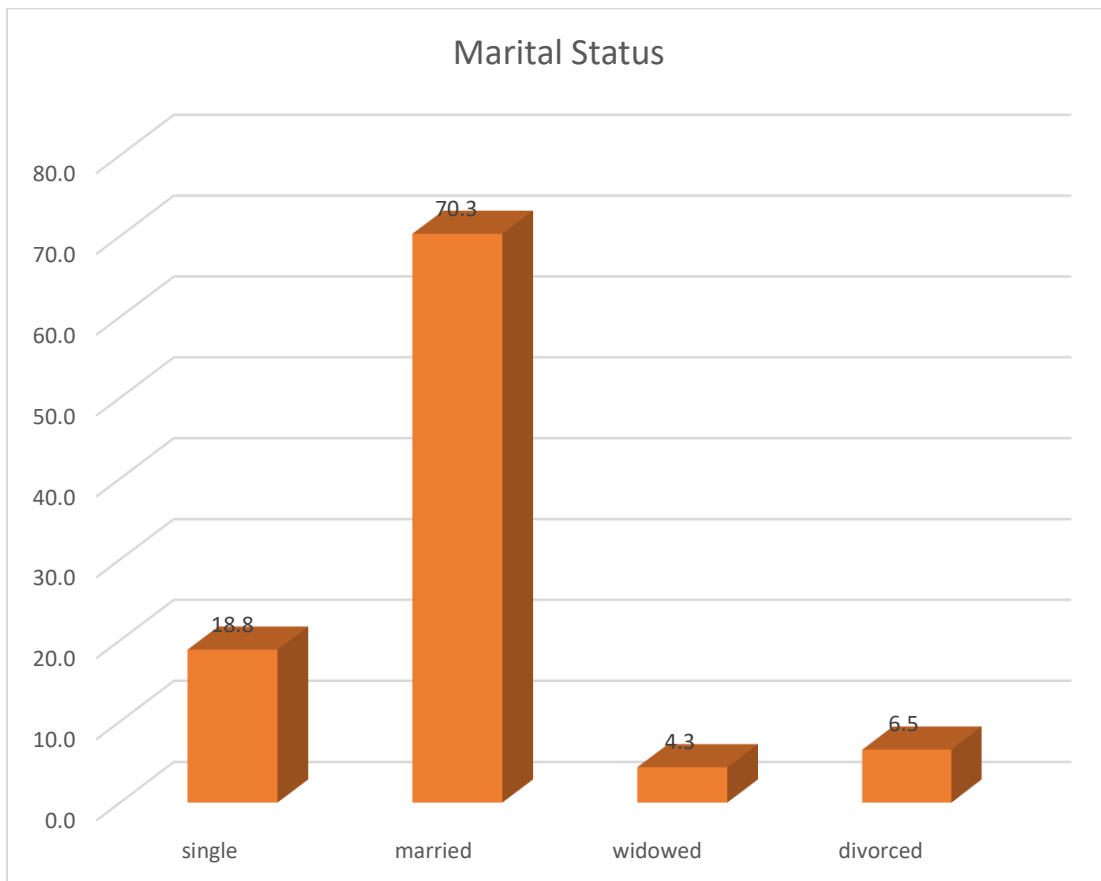
Table 4.2: Age Distribution

AGE DISTRIBUTION					
N	Minimum	Maximum	Mode	Mean	Standard deviation
138	18	63	38	36.6	10.25

Marital Status

Figure 4.1 below shows the marital status of the respondents, of which more than two thirds (70.3%) were married; while 8.8% were single; 6.5% were divorced; and 4.3% were widowed. This study could be considered somewhat wholesome as it carries the different views from married, single, divorced and widowed women

Figure 4.1 Study population per marital status



4.4 RELIABILITY OF DATA

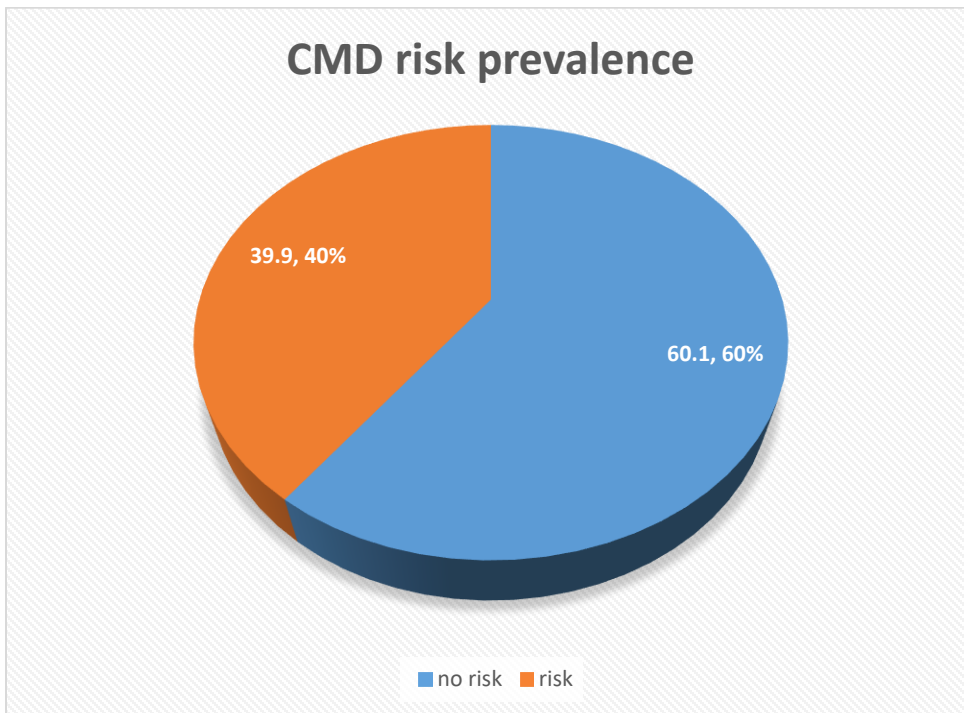
Table 4. 3: Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.717	.722	13

Table 4.3 above indicate the reliability of data. The nature of problems that were faced by the women were examined and revealed a Cronbach alpha for the data analyzed as 0.717 which is a good and acceptable reliability value.

4.5 COMMON MENTAL DISORDER RISK PREVALENCE

Fig 4.2 CMD Risk Prevalence



A CMD risk state was determined by scoring 8 or greater on the number of yes(es) on section B of the questionnaire which comprised of SSQ-14. The CMD risk prevalence of the women who participated in the study was established as 39.9% whilst the rest of the sample had minimal or no risk of CMD as depicted by fig 4.2 above

4.5.1 CMD Risk Prevalence: demographic factors

The CMD risk prevalence was further analyzed to establish the demographic representation of those who were at risk.

a) CMD Risk Prevalence as per marital status

Table 4.4 MARITAL STATUS * CMD Crosstabulation

% within MARITAL STATUS		CMD		Total
		no risk	risk	
MARITAL STATUS	single	73.1%	26.9%	100.0%
	married	58.8%	41.2%	100.0%
	widowed	50.0%	50.0%	100.0%
	divorced	44.4%	55.6%	100.0%
Total		60.1%	39.9%	100.0%

The table above indicate the proportion of those at CMD risk compared to the particular sample size in relation to marital status. The divorced had the highest proportion of 55.6% followed by the widowed at 50.0%, then the married at 41.2%. The single had the least proportion of 26.9%. The results indicate that divorced women carry the highest risk of getting depressed followed by the widowed then married, with the single carrying the least risk.

b) CMD Risk Prevalence as per age

Table 4.5 AGE * CMD Crosstabulation

% within AGE		CMD		Total
		No risk	Risk	
AGE	18-29	75.0%	25.0%	100.0%
	30-39	56.9%	43.1%	100.0%
	40-49	55.9%	44.1%	100.0%
	50+	50.0%	50.0%	100.0%
Total		60.1%	39.9%	100.0%

The table 4.5 above indicate the proportion of those at CMD risk compared to the particular sample size in relation to age. Those aged 50 years and above had the highest proportion of 50% followed by the 40-49 years band 44.1% and the 30-39 years band at 43.1%. The youngest constituting the 18-29 years band had the least proportion of 25%.

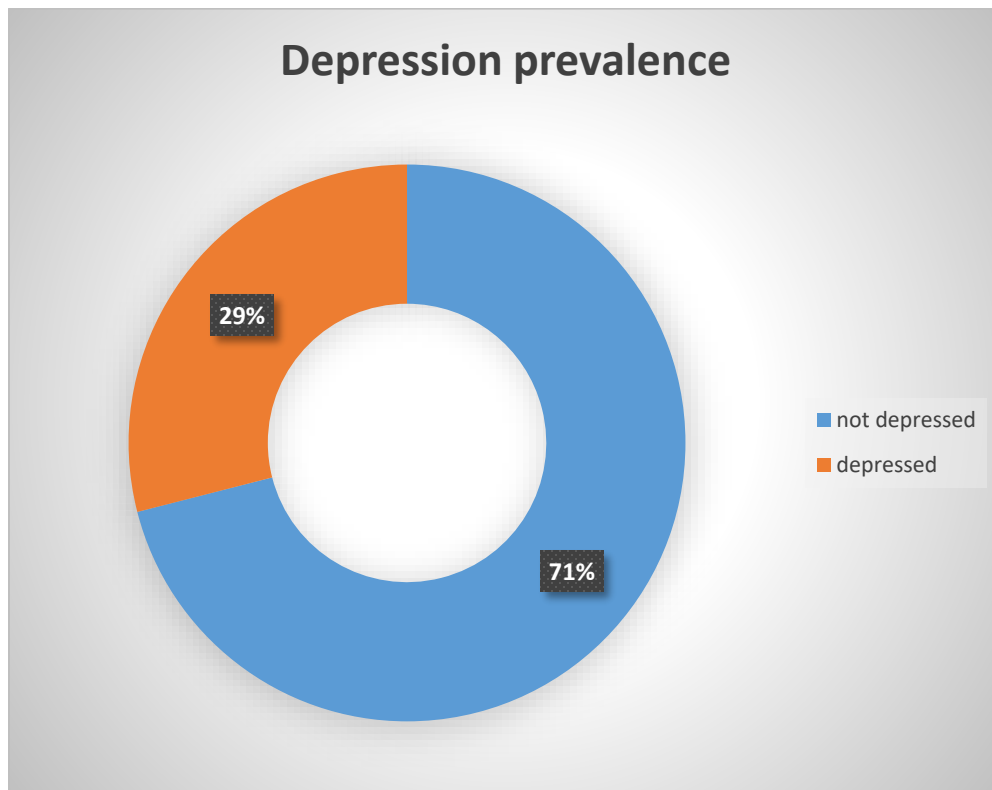
4.6 The prevalence of depression among women attending Psycook

Depression state was established by section C of the study questionnaire which used the Patient Health Questionnaire (PHQ-9). A score of 10 or greater on the total of the PHQ-9 indicated a clinical case of depression whilst a lower score of ≤ 9 indicated a case of no depression.

4.6.1 Depression Prevalence

Figure 4.3 below indicates that the depression prevalence of the sample stood at 29%. Majority of the women (71 %) from the study were rated as not depressed.

Figure 4.3: Depression Prevalence



4.6.2 Depression prevalence: demographic factors

The clinical depression prevalence was further analyzed in relation to the two demographic factors of marital status and age. Table 4.5 and 4.6 below show the prevalence rate as per marital status and age respectively

a) Depression prevalence and marital status

Table 4.6: MARITAL STATUS * DEPRESSION Crosstabulation

% within MARITAL STATUS		DEPRESSION		Total
		not depressed	depressed	
MARITAL STATUS	single	73.1%	26.9%	100.0%
	married	71.1%	28.9%	100.0%
	widowed	66.7%	33.3%	100.0%
	divorced	66.7%	33.3%	100.0%
Total		71.0%	29.0%	100.0%

The depression prevalence by marital status is tabulated in table 4.6 above. The proportion values show that divorced and widowed women have the highest proportion of 33.3% followed by married at 28.9%, with the single women having the least proportion which is 26.9%.

b) Depression prevalence and age

Table 4.7 below shows that woman aged between 50 years and above had the highest proportion (50%) followed by the 40-49 years age group (35.3%) then the 30-39 years age group (25.9%). The youngest age group (18-29years) had the least proportion of 18.8%.

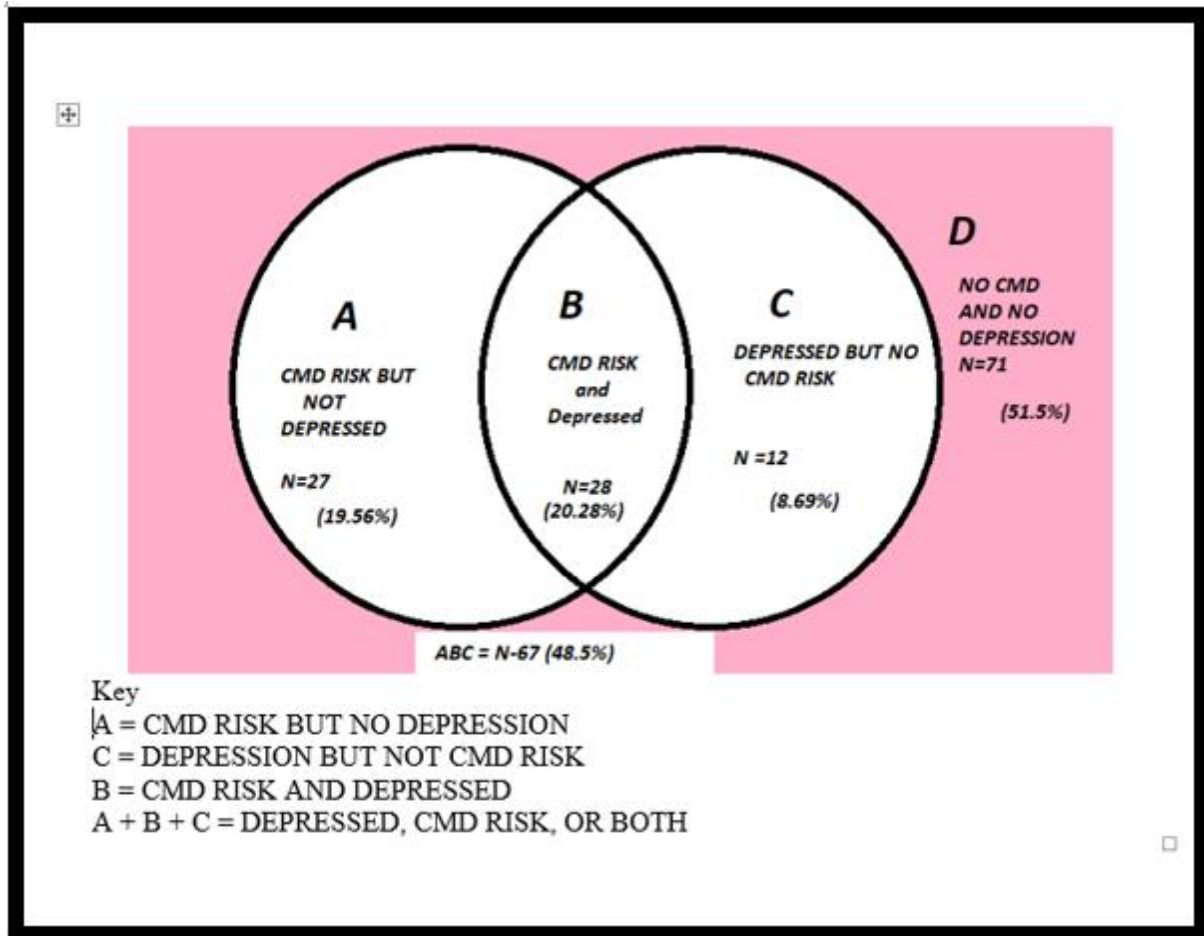
Table 4.7 AGE * DEPRESSION Crosstabulation

% within AGE		DEPRESSION		Total
		Not depressed	Depressed	
AGE	18-29	81.2%	18.8%	100.0%
	30-39	74.1%	25.9%	100.0%
	40-49	64.7%	35.3%	100.0%
	50+	50.0%	50.0%	100.0%
Total		71.0%	29.0%	100.0%

4.7 ASSOCIATION BETWEEN CMD RISK AND DEPRESSION

An analysis was done to describe the prevalence of both CMD risk and depression in association with each other and the findings are depicted in figure 4.4 below.

Fig 4.4: Association between CMD and Depression



The presentation indicates that those depressed but without the risk of CMD were 8.69% whilst those with CMD risk but with no depression were 19.6%. Of the total sample, 48.6% had either a risk of CMD, were depressed or both, presenting as the ones that needed further screening or attention to establish their exact needs. Therefore, this means that 48% of the sample are at risk of a common mental disorder of some sort. It also indicates that while others (19.6%) might not have been depressed they might have another form of common mental disorder affecting them while the 8.69% shows that when screening for mental disorders some may be missed at basic screening but may be having depression.

4.8 DETERMINANTS OF CMD AND/OR DEPRESSION

The last section of the data collection instrument comprised of the Shona Problem List Questionnaire, which on sought to answer the question of the sources of distress among the sample by establishing the nature of the main problems that the women who participated in this study had been bothered by. The responses are used to infer the possible determinants for CMD and/or depression.

4.8.1 Nature of Problem frequency

Table 4.8 Nature of main problem response frequency table

	Nature of problem	Not at all	Several days	More than half the days	Nearly Everyday
		%	%	%	%
1	RELATIONSHIP	48.6	27.5	16.7	7.2
2	MARITAL	42	31.2	16.7	10.1
3	WORK RELATED	60.1	21	15.2	3.6
4	BEREAVEMENT	74.6	10.1	10.9	4.3
5	SCHOOL	58	18.8	10.9	12.3
6	FAMILY	39.9	31.9	21	7.2
7	INTERPERSONAL DEFICITS	49.3	25.4	16.7	8.7
8	HEALTH RELATED	55.8	24.6	12.3	7.2
9	MONEY PROBLEM	25.4	31.2	22.5	21
10	ACCOMMODATION PROBLEM	74.6	10.9	5.1	9.4
11	LEGAL PROBLEM	94.2	1.4	4.3	0
12	SEXUAL PROBLEM	71.7	15.2	8	5.1
13	ALCOHOL/DRUGS	94.9	4.3	0.7	0

KEY

	Highest frequency
	Lowest frequency

According to table 4.8 above, the most cited problem with the lowest not at all frequency is the money problem which also happened to be the most mentioned factor on the nearly everyday responses. On nearly everyday responses, money problem (21.3%), was followed by School (11.8%), marital 10.1% and accommodation (9.6%). For more than half the days, the women seemed to battle with money problems (22.1%), family issues (20.6%). Interpersonal deficits (16.9%) and Marital issues 15.9%). Under several days, family problems (32.4%), money problems (31.6%), and marital problems (30.4%) were the top issues. The problems least affecting the women were 'Alcohol/drugs (94.9%); legal problems (94.1%) and accommodation (75%).

Furthermore, to elaborate on the nature of problems frequency, the mean score values of the individual listed problems were analyzed and listed (Table 4.8) below in descending order.

Table 4.9 Nature of main problem Mean values

Key: 0- not at all 1- Several days 2- More than half the days 3- Nearly everyday Nature of Main Problem	Mean
Money problem	1.40
Family	.96
Marital	.93
Interpersonal deficits (Self-esteem, loneliness)	.85
Relationship	.81
School	.76
Health related	.71
Work related	.63
Accommodation problem	.49
Sexual problem	.47
Bereavement	.46
Legal problem	.10
Alcohol/drugs	.06

For each problem listed, the lowest possible score was 0 meaning the problem did not bother the respondents at all and the highest possible score was 3 meaning the highest occurring frequency of the problem. Mean score values for each problem were used to establish the comparative frequency of the problem, where the higher the mean score value indicates a greater frequency of the problem whilst the lower the mean score value indicated a less frequency of the problem. Money problem, (1.40) family (0.96); marital (0.93), interpersonal deficits (0.85) and relationships (0.81) respectively were the top five main problems that affected the women the most. Legal problems (0.10) as well as alcohol/drugs (0.06) were the problems with the least frequency for the women who participated in this study.

4.8.2 Nature of problem frequency and demographic factors

This section establishes the association between nature of problems and demographic factors using the mean score. Thus, the higher the mean score value the greater the frequency of the problem whilst the lower the mean score value the less the frequency of the problem.

Nature of problem and marital status

Table 4.10 Nature of main problem per Marital Status

Key: 0- not at all 1- Several days 2- More than half the days 3- Nearly everyday Nature of main problem	Divorced		Married		Single		Widow	
	Mean	Mode	Mean	Mode	Mean	Mode	Mean	Mode
Relationship	1.00	0&1	.80	0	.71	0	.50	0&1
Marital	.75	0	1.18	1	.25	0	.00	0
Work related	.63	0	.72	0	.38	0	.67	0
Bereavement	.00	0	.42	0	.71	0	.83	0
School	1.38	0	.62	0	1.13	0	1.00	0
Family	1.13	2	.92	0	.96	0	1.17	0&1
Interpersonal deficits (Self-esteem, loneliness)	1.13	0	.71	0	1.08	0	1.33	2
Health related	1.50	1&2	.68	0	.63	0	.33	0
Money problem	2.38	2	1.33	1	1.25	1	2.50	3
Accommodation problem	1.63	3	.40	0	.54	0	.67	0
Legal problem	.00	0	.09	0	.04	0	.83	0
Sexual problem	.00	0	.58	0	.13	0	.67	0
Alcohol/drugs	.00	0	.05	0	.04	0	.33	0
Valid N (listwise)								

Table 4.10 above shows that all the women had a universal top most challenge being money problem. Divorced women had accommodation and health issues as their next highest problems. Married women listed family and school, divorced women listed interpersonal deficits and school while single women had interpersonal deficits and family as their next most occurring challenges. It was further confirmed that alcohol/drugs were the ones which least occurring problems for the majority of women regardless of their marital status.

Table 4.11 Chi-Square Tests- Nature of main problem per Marital Status

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	99.477 ^a	105	.034

A chi-square test was conducted and its results ($\chi=99.477$, $df=105$, $p=0.034$) showed that the p-value was less than the level of significance which indicates that there is a statistically significant association between the above views and the marital statuses of the respondents.

4.8.3 Nature of problem and CMD risk

The mean score values for the nature of problems of those at risk of CMD and of those with no risk were compared to show which of the problems were key to those who were at risk of CMD.

Table 4.12 Nature of main problem in relation to CMD risk

Key: 0- not at all 1- Several days 2- More than half the days 3- Nearly everyday Nature of main problem	CMD non-risk (mean)	CMD risk (mean)
Relationship	.61	1.11
Marital	.76	1.18
Work related	.57	.72
Bereavement	.35	.62
School	.57	1.06
Family	.76	1.26
Interpersonal deficits (Self-esteem, loneliness)	.64	1.19
Health related	.60	.87
Money problem	1.14	1.79
Accommodation problem	.29	.81
Legal problem	.04	.21
Sexual problem	.29	.75
Alcohol/drugs	.05	.08
Valid N (listwise)	83	55

Table 4.12 above captures the values showing that money problems (1.79) was the problem with highest frequency for those at risk of CMD followed by family (1.26) then by interpersonal deficits (1.19); then marital (1.18) as well as relationship problems (1.11). The

problems that least affected those at risk of CMD were legal (0.04) and alcohol/drugs (0.05). The above representation indicates that most of those at risk of CMD were most troubled by money problems, followed by interpersonal deficits, then marital problems as well as relationship problems. Legal matters, and alcohol/drugs were not areas of concern for those that had a risk of CMD.

Nature of problem and depression

Furthermore, the mean score values for the nature of problems of those depressed and of those with no depression were compared to show which of the problems were key to the specific group. Table 4.13 below captures the values indicating the nature of problem that bothered both groups.

Table 4.13: Nature of main problem in relation to depression prevalence

Key: 0- not at all 1- Several days 2- More than half the days 3- Nearly everyday Nature of main problem	Undepressed (mean)	Depressed (mean)
Relationship	.56	1.40
Marital	.76	1.35
Work related	.59	.70
Bereavement	.33	.75
School	.65	1.03
Family	.75	1.45
Interpersonal deficits (Self-esteem, loneliness)	.61	1.43
Health related	.53	1.13
Money problem	1.22	1.83
Accommodation problem	.39	.75
Legal problem	.06	.20
Sexual problem	.29	.90
Alcohol/drugs	.03	.13
Valid N (listwise)	98	40

The depressed were most bothered by money problems (1.83) followed by family issues (1.45); then interpersonal deficits (1.43); relationships (1.40) and marital (1.35). The least pressing

issue for the depressed was alcohol/drugs (0.8). Therefore, this means that money problems topped the list of what bothered the depressed followed by family issues, interpersonal deficits, relationships and marital issues respectively. Alcohol/drugs and legal problems were the least concerns for the depressed.

4.9 INFERENCE STATISTICS

4.9.1 Regression analysis

Furthermore, logistical regression analyses using STATA and SPSS were done to determine the impact or effect of the nature of problems on depression.

4.9.2 Model building

Table 4.14: Model Summary

Step	-2 Log likelihood	Cox & Snell R Square	Nagelkerke R Square
1	116.540 ^a	.302	.431

a. Estimation terminated at iteration number 6 because parameter estimates changed by less than .001.

The table above shows the **Cox & Snell R Square** and **Nagelkerke R Square** values which are used to show the variation explained by the model. Using the Nagelkerke R, about 43% of the variation is explained by the fitted model. This means that the model is a good fit for analyzing the data.

4.9.3 Model logistic output

Table 4.15 below shows the four covariates that had the most impact on depression prevalence, namely age, relationships, interpersonal deficits, sexual problem and money problems. The table will be explained using the odds ratios.

Table 4.15 Model logistic output

DEPRESSION	Odds Ratio	P>z	[95% Conf.Interval]	
AGE	1.066761	0.02	1.01009	1.12661
Relationships				
several days	4.05538	0.029	1.150764	14.29147
more than half the days	6.792848	0.005	1.79179	25.75234
nearly everyday	7.788668	0.027	1.263168	48.02476
Interpersonal Deficits				
several days	3.72916	0.045	1.028338	13.52341
more than half the days	2.795219	0.152	0.6858629	11.39185
nearly everyday	13.89336	0.013	1.73712	111.1181
Sexual Problem				
several days	0.9628775	0.959	0.2247901	4.124439
more than half the days	2.528784	0.291	0.4519598	14.14894
nearly everyday	30.9608	0.01	2.254125	425.2519
Money problem				
several days	0.562798	0.449	0.1270435	2.493175
more than half the days	0.935283	0.927	0.2216028	3.947396
nearly everyday	1.873647	0.39	0.4474175	7.846261
_cons	0.0045826	0	0.0003	0.0700021

Age

One’s age is shown as a significant factor to one’s depression susceptibility where the risk of depression increases with age. The findings show that odds are greater than one meaning the chances of one getting depressed are increasing as one’s age increases. Age also showed a significant p value of 0.02 indicating that the results are statistically significant.

Relationship problems

Relationship problems had the strongest impact indicators on depression showing that the more one experiences relationship problems the higher their chances of getting depressed. For women who responded to the frequency 'several days' the results show that they were four times more likely to be depressed than those women who did not have relationship problems at all, which is supported by a significant 0.02 p value. When one experiences relationship problems for 'more than half the days' the chances of getting depressed leap to 6.79 times more with yet another significant p value of 0.00. The chances evidently increase by 7.78 times when the relationship problems become constant i.e. 'nearly every day' as also supported by the significant p value of 0.02.

Interpersonal deficits

While interpersonal deficits clearly have an impact, they seem to have the least impact when they happen more than half the days as compared to a less frequency of several days. However, there is a large leap when they happen nearly every day where we find a likelihood of 13.89 times compared to someone with no interpersonal deficit issues. Where one experiences interpersonal deficits for several days they are 3.72 times more likely to get depressed; for more than half the days they are 2.79 times more likely to get depressed.

Sexual problems

The higher the frequency of sexual problems the more likely depression will occur. Sexual problems happening nearly every day have strong significance value of 0.01 where one is thirty times more likely to be depressed if they experience nearly every day sexual problems. When sexual problems are happening for more than half the days one is 2.5 times more likely to get depressed compared to someone without sexual problems. However, when sexual problems are at the frequency of several days, they do not depict a negative impact; showing that one is 0.04 less likely to get depressed.

Money problems

Although the results have p values that are greater than 0.05 implying that we do not have sufficient statistical evidence to conclude that money problems predict depression status, money problem was highlighted as the most affecting problem. Odds ratios for money problems also indicate that unless the problem is happening nearly every day, money problems were not key to depression prevalence. Where money problems are experienced for several days and for more than half the days the odds ratios are less than one indicating that depression is less likely forecasted at 0.44 times and 0.07 times respectively compared to where money problems are absent. However, money problems start to affect when they are experienced nearly every day, where one is 1.87 times more likely to be depressed.

4.10 CHAPTER SUMMARY

This chapter analyzed and reported on the results and findings of the data collected from the questionnaires that were distributed to the women who attended Psychook. The first section analyzed and discussed the response rate as well as the demographic information of the respondents whilst the second section provided an analysis of the descriptive statistics that addressed each of the research questions put forward in this study. Furthermore, the final section analyzed and discussed the inferential statistics, in the form of regression analysis.

CHAPTER FIVE: DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

In this final chapter, results from the study as well as conclusions are explained and discussed. Comparisons are drawn with previous similar researches. Finally, recommendations for future studies and to other stakeholders are submitted.

5.2 DISCUSSION OF RESULTS

This study was done with the intention of investigating the prevalence of Common Mental Disorders (CMD) risk, the prevalence of depression as well as the perceived determinants among women attending a community health program called Psycook. A non-experimental, total sampling survey was done which showed a prevalence of 39.9% on CMD risk and 29% on depression. These and other accompanying findings are discussed below

5.2.1 Common Mental Disorder risk prevalence among women attending Psycook

In this sample of women attending Psycook, more than one out of every three participants (39.9%) screened positive for CMD symptoms. Screening positive for both CMD risk and depression was associated with relationship problems, age, sexual problems and interpersonal deficits. The CMD risk prevalence is slightly higher than the 30.8% that was recorded by Abas and Broadhead (1997). This increase is expected in view of the mental health forecast that predicted an increase by 130% of the mental health burden in sub-Saharan Africa by the year 2050 (Ferrari et al., 2014). On the other hand, circumstances of women's lives in this setting may have overallly contributed to their mental distress. One of the reasons for investigation was the evidence of narratives among the women which included relationship and/or marital conflicts, occupational stress, and financial difficulties among other issues. Marital conflicts leading to gender based violence were said to be leading to deaths. ("Suicide Cases on the rise in Zimbabwe," 2017). A macro analysis of the complaints presented by women attending Psycook carry a potentially unrecognized CMD risk and depression prevalence indicating underdiagnosis. The high rates are likely to be driven by two main factors. Firstly, compared to developed and western societies, women in Zimbabwe are more likely to attribute mental illness to spiritual and personally

controllable factors creating a stigma filled environment for sufferers. Depression for example may be erroneously viewed as a way of seeking undeserved attention whilst culturally mental illness is attributed to spiritual forces such as bewitchment or punishment by ancestors for failing to comply with the necessary cultural protocols. Secondly, the high treatment gap caused by the scarcity of mental health care providers leaves many with little or no knowledge of mental illnesses hence instead of seeking psychological help most present with somatic symptoms increasing the likelihood of CMD and depression going undetected.

Common with previous research (Patel, Todd, et al., 1997) the never married had the lowest risk followed by the married. The divorced and widowed also matched previous research in showing that they carry the highest risk to CMD. Those aged 50 years and above had the highest proportion of having CMD symptoms. This may be due to the fact highlighted by research that reveals a significant ongoing loss in capacities and a decline in functional ability as people age. For example, experiences of reduced mobility, increased morbidity frailty, chronic pain, or other health problems, become evident in later life. In addition, a drop in socio-economic status as a result of retirement, or multiple losses necessitating bereavement, can result in loneliness, isolation, hopelessness or psychological distress in older people, for which they may require long-term care.

5.2.2 Prevalence of depression among women attending Psychook

The depression prevalence rate of the sample stood at 29% which although undesirably high, was slightly lower than the previously recorded 30% (Dixon Chibanda, Weiss, et al., 2016) in the same geographical area. While Chibanda et al., study was clinical, among people who had visited a caregiver indicating some presence already of distress the current study was a community-based investigation which comprised among others, those who were not seeking any clinical intervention. The results show a concerning high depression prevalence that indicates underdiagnosis in as far as depression itself is concerned. The expectation was to find a much lower prevalence than the previously recorded ones because the sample did not constitute people who were necessarily looking for help. This may

mean that if another broader and bigger community based cross sectional survey were to be undertaken, it might indicate a much higher prevalence rate.

The demographic representation of the depression prevalence rate was similar to that of CMD prevalence in that the proportion values indicated that divorced and widowed women had the highest proportion of being depressed followed by married women while the single women had the least proportion. The results are in line with the overall prevailing perspective that indicate marriage as a protective factor against depression (Whisman et al., 2006).

Of further concern is the combination case prevalence if both matters under investigation i.e. CMD risk and depression are considered. The total prevalence rate of those who were at CMD risk, had depression or had both was 48% which shows that almost half of the sample were battling with some mental distress of some sort that warranted attention. This also is a revelation of the prevalence rate of women who may not have known about their status revealing a state of underdiagnosis of mental illnesses among women. One is left wondering if these women were even aware of the possibility of the presence of such morbidity in their lives. As noted by (Tabassum & Lodhi) lack of awareness around issues of depression among common population disempowers the affected as the problem is consequentially ignored. The paucity of mental health practitioners, as lamented by (Kidia et al., 2017) who noted a huge treatment gap in the country's mental health service remains a nemesis. Zimbabwe's deteriorating economic and political landscape is undeniably shaping the experiences of its population as pointed by Mawanza (2017), leaving many women distressed and languishing in existential stress where depression is seemingly unavoidable.

5.2.3 Determinants of Depression

The nature of problem affecting the participants did not differ much among those found to be depressed, CMD risk or not. Money problems was the universal, most frequently cause of concern among the sample although it clearly had no impact on the mental well-being of the participants. Also, for the whole sample the least problems of concern were alcohol/drugs and

legal issues. Relationships, family issues, interpersonal deficits and marital issues also ranked high on the list of all the depressed, the CMD risk and those without risk of either CMD or depression.

All the mentioned most frequently experienced problem areas except money have a relational aspect to them validating the Feminist's relational theory (Jordan & Hartling, 2008) which places women's psychological struggles in the relational area that matters most to them. Marital, and family issues like money problems though frequently experienced did not have a statistically significant impact on depression, notwithstanding, they were mentioned as frequent areas of concern to the women. Marriage and family happen to be two of the most important relationships to a married woman as pointed by Campbell et al. (1997). Familial relationships are equally key to most women especially so because mothers and daughters although possessing the closest, most significant relationship, have the most conflicting and potentially troubling relationship (Campbell et al., 1997)

The fact that the same problems were noted by the majority of the sample irrespective of risk or not; shows that the challenges facing women in this sample are not at all divorced. This also can predict that if those not found at risk are not spared, or if the problems persist in their life; they are potential risk candidates for depression. This realization may also help to explain why prevalence for both CMD and depression were higher in the older age groups. The elder women have been probably exposed to the risk factors for longer as revealed by Zhang et al. (2014) who reported that depression has a high positive correlation with marital stress especially in older adults, suggesting treatment interventions as a way of preventing depression in older women who would have experienced marital stress earlier in life. Furthermore, following a regression analysis, the four covariates that had the most impact on depression prevalence, were age, relationships, interpersonal deficits and sexual problem.

Age

One's age ($P=0.02$) emerged as a statistically significant contributor to one's depression susceptibility where the risk of depression increased when age increased. This has been echoed

by previous studies done among the elderly (Penninx, 2006). The older citizens are especially affected by loneliness, exacerbated by a series of losses that happen in late adulthood. Suitor et al. (2013) concurred that older women experience more tension at the close of midlife that is compounded by empty nests, aging parents and consequent losses. The country's economic meltdown has seen many losing their children to the diaspora via the economic brain drain. This has left mothers without the much needed physical and psychological support that they would be otherwise getting from children and grandchildren. Such social support would be able to act as a protective factor against depression as indicated by Haeffel et al. (2007) in their brief report on vulnerability to depressive symptoms where they reported that a decrease in social support is a crucial vulnerability factor for depression. Some are probably suffering from age related chronic illnesses which may be adding to their depressive symptomology. Noh et al. (2016) report high risk of depression among the chronically ill.

Relationship problems

In agreement with the Relational Cultural Theory (Jordan & Hartling, 2008) of depression which anchors psychological development in healthy interpersonal relationships this study found relationship problems to have the strongest impact on depression. The more one experienced relationship problems the higher their chances of getting depressed increased. Healthy and strong relationships were also found to be of big influence by A. J. Marshall and Harper-Jaques (2008) who noted that people in troubled relationships are three times as likely to experience depression as compared to those who aren't. Women cherish growth fostering relationships as alluded to by Jordan and Hartling (2008) which they tend to feed off as a way of withdrawing from their otherwise selfless giving nature. When a relationship with a significant other is compromised women tend to internalize indulging in erroneous cognitive interpretations thereby exposing themselves to depression.

Interpersonal deficits

Interpersonal deficit can pose as risk factors for depression, a notion supported by this study's findings. Cultural and religious socialization has produced women who are not afforded equal

opportunities in society hence they are perceived and end up self-perceiving as weaker (Marecek, 2006). There is an undeniable strong bi-directional relationship between interpersonal deficits and depression (Sowislo & Orth, 2013). One key characteristics of depression is that it erodes one's self-esteem (Roberts et al., 1999). When this happens to an already invalidated individual it tends to crush them into further hiding or pushes them to overcompensate via people-pleasing exposing them to abusive relationships where they become victims of gender-based violence as reported by Roberts et al. (1999) further exposing them to depression. This paints a bleak idiosyncratic picture of an unending cycle of distress for some women.

Sexual problems

The higher the frequency of sexual problems the more likely depression will occur. Sexual problems happening nearly every day had a strong significance value ($P=0.01$) where one was thirty times more likely to be depressed if they experienced nearly every day sexual problems. When sexual problems were happening for more than half the days one was 2.5 times more likely to get depressed compared to someone without sexual problems. However, when sexual problems were at the frequency of several days, an unusual occurrence was depicted revealing seemingly positive impact; showing that one was 0.04 less likely to get depressed. Self-reported sexual problems, especially low sexual desire, are common, among women (Mercer et al., 2003). This could be the reason why if sexual problems are interpreted as at an average norm the women are less impacted. (Shifren et al., 2008) studied American women, and reported that sexual problems were more common in older women aged between 45 to 65 years. In the same study sexual problems were positively correlated with depression. There is also a possibility that the sexual problems could be emanating from childhood or past sexual abuse as indicated by Bifulco et al. (1991), who recorded that sexual abuse involving contact was associated with an increased risk of depression in adulthood. Sexual problems like most depressive symptoms possess a bidirectional relationship with depression where depression is also said to cause sexual problems (Frohlich & Meston, 2002)

Money Problems

Money problem was highlighted as the most affecting problem by the participants, notwithstanding the fact that it produced results with larger p values implying that there was no sufficient statistical evidence to conclude that money problems predict depression. Generally lack of resources has been found to be associated with a higher prevalence of depression (Lorant et al., 2003). Notably in this study money problems did not have any significant impact on depression yet it was the most frequently reported problem. Money problems only started taking effect when they were occurring at a frequency of nearly every day however with a poor significance ($P=0.39$) value. Where money problems were experienced less frequently i.e. for several days and for more than half the days the odds ratios for this variable actually indicated that depression was *less* likely to happen. The findings clearly indicate that money problems though an undeniable reality is not affecting the women's mental wellbeing. Zimbabwe has witnessed an oscillating economic crisis since 2008 (Mawanza, 2017) which may be the reason why the findings contradicted research findings from other countries like that of Akhtar-Danesh and Landeen (2007) who reported an inverse relationship between income and the prevalence of depression. When money problems have become expected and accustomed to, individuals seem to accept that reality and cease to be affected by lack of it as reported by Wang et al. (2010) who showed that financial strain was not associated with depressive episodes in individuals who had not worked in the previous year, and financial strain was not associated at all with depression in participants who did not work. This may be the case with women in the study, who due to the general country's economic climate may be now accustomed to money problems. Consequentially the women may have accepted the reality of money problems hence they no longer view it as an isolated, personal struggle. According to the cognitive theories of depression hopelessness, (Abela et al., 2009), is a major factor of depression that comes about when an individual interprets their circumstances as unique and devastating to one self. Money problems are probably being interpreted as a political and national challenge that the women are not catastrophizing though impacted by it hence they are not measuring their worth by it.

5.3 CONCLUSIONS

In as far as prevalence for both CMD risk and depression are concerned, the found community based CMD risk prevalence of 39.9% and depression prevalence of 29% are of major concern.

They indicate potential underdiagnosis and undetected prevalence of both. An integration of mental healthcare into primary care could provide a solution because women suffering from mental illness most often present to primary care settings with other somatic presentations. Increased frequency of healthcare visits among women could be used as an indicator among other indicators and be used to screen for CMD to avoid missing opportunities for intervention. Depression screening needs to be carried out in conjunction with a systematic approach to ensuring adequate access to mental health assessment and care. Furthermore, use of integrated care models, such as collaborative care, can improve clinical outcomes for women, as screening can also be carried out by non-specialist health workers.

On the determinants of CMD and/or depression, ‘relationship problems’ (P=0.00) was the strongest impact indicator. Other matters that showed impact were interpersonal deficits (P=0.01) and sexual problems (P=0.01). Age was also found to be a significant factor (P=0.02), showing that the chances of one getting CMD or depression increased as one’s age increased. Although ‘money problems’ (P=0.4) was the problem experienced the most, its presence did not have any statistically significant impact on women’s mental wellbeing. The determinants in this study may not necessarily mean causal agents but can be termed *perceived* causes whose presence upsurges the prevalence of depression via increasing susceptibility among those who will be experiencing them. Raising awareness among women on matters that may predispose them to mental illnesses will go a long way in mitigating against unnecessary suffering.

Limitations

The data was collected from the few women who attended Psycook which at the time of data collection was limited to Harare Central Province only, hence findings cannot be generalized to all women in the country. We have no way of knowing, empirically, to what extent the case of Psycook attendants is similar or different from other women in the community. Furthermore, because the sample was relatively small; there is no way to establish the probability that the data is representative of some larger population. The last part of the questionnaire has not been used as a self- report questionnaire before therefore its validity and

reliability are still questionable. The phenomenological experiences of the participants could not be fully captured by the study design hence there is more to be gathered especially in the area of determinants of depression. Consequentially, this research is subject to methodological criticism of multivariable studies, in that it is cross-sectional in nature. The design is obviously limited in determining the time-order relationship of variables. The assessment of the variables listed in the SPLQ-14 does not consider their possible multi-directional causal ways, together with their relative weight in influencing depression among the participants. As a result, careful considerations should be taken in making any assumptions about the relationship between and among variables in these findings.

5.4 RECOMMENDATIONS

The following recommendations are proffered to the respective agencies for consideration.

- **Parliamentarians:** To revisit the mental health act to check for relevance of content considering its now over 20years since the legislation has been relooked at. To fight for a separate budget that should be allocated and utilized for mental health from the health budget as the basis to narrow the current mental health treatment gap.
- **Ministry of Health and Child Welfare:** As the ministry converges to review the operationalization of the mental health policy which expires in 2018 in the current year and as a way of informing new strategies; a special focus to be put on gender specific issues that affect women with mental health challenges such as depression. To find ways to integrate mental health care into primary care giver settings.
- **Mental Health practitioners:** To develop strategies for early identification, management and eradication of mental health challenges facing women. To be active in the design of gender sensitive, effective, specific, contextually relevant, collaborative, and sustainable intervention programmes that address the risk factors of depression among women
- **Women:** To take an active participatory role in their mental wellbeing, through looking out for risk factors as well as taking serious note of any symptoms in order to take healthy help seeking actions that benefit them. To work on interpersonal deficits while

at the same time trying to resolve relationship conflicts which may lead to depression or any other CMD.

- **Researchers:** A need remains for an increasing number of mental health surveys to see the clear picture on a broader spectrum of the prevalence as well as the determinants of mental disorders among women. Specific attention to be given to relationships and women and their association to mental illnesses.
- **Non-Governmental Organizations and civil organizations working with women:** Promote funding towards women mental health programs, especially towards those areas where risk factors reside. To take heed of empirical findings when channeling resources.
- **Other community members:** Using the knowledge garnered in this and other studies to assist women to cope better with the challenges they face. To use the awareness raised in fighting stigma around mental health issues. Special care to be taken for the elderly as their age predisposes them to CMD by providing interventions that assist the elderly in dealing with inevitable life losses.

5.5 CHAPTER SUMMARY

A discussion of the research findings was done to elaborate on the findings and implications, relating them to differences and similarities with previous studies. Conclusions, and recommendations were availed together with any limitations of the findings.

REFERENCES

- Abas, M. A., & Broadhead, J. C. (1997). Depression and anxiety among women in an urban setting in Zimbabwe. *Psychological medicine*, 27(1), 59-71.
- Abela, J. R., Parkinson, C., Stolow, D., & Starrs, C. (2009). A test of the integration of the hopelessness and response styles theories of depression in middle adolescence. *Journal of Clinical Child & Adolescent Psychology*, 38(3), 354-364.
- Akhtar-Danesh, N., & Landeen, J. (2007). Relation between depression and sociodemographic factors. *International journal of mental health systems*, 1(1), 4.
- Albert, P. R. (2015). Why is depression more prevalent in women? *Journal of psychiatry & neuroscience: JPN*, 40(4), 219.
- Amoran, O., Lawoyin, T., & Lasebikan, V. (2007). Prevalence of depression among adults in Oyo State, Nigeria: a comparative study of rural and urban communities. *Australian Journal of Rural Health*, 15(3), 211-215.
- APA, A. P. A. (2013). *Diagnostic and statistical manual of mental disorders (DSM-5®)*: American Psychiatric Pub.
- Arduino, G. I., Queirolo, E. I., Barg, G., Ciccariello, D. A., & Kordas, K. (2015). The relationship among depression, parenting stress, and partner support in low-income women from Montevideo, Uruguay. *Health care for women international*, 36(4), 392-408.
- Atherley, C. (1988). The cognitive, learned-helplessness and hopelessness theories of depression: A review with implications for counsellors. *British Journal of Guidance & Counselling*, 16(3), 286-299.
- Barg, F. K., Huss-Ashmore, R., Wittink, M. N., Murray, G. F., Bogner, H. R., & Gallo, J. J. (2006). A mixed-methods approach to understanding loneliness and depression in older adults. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 61(6), S329-S339.
- Baril, M. E. (2008). *Psychosocial Adjustment in Adolescence: The Importance of the Family Ecology*. The Pennsylvania State University.
- Barney, L. J., Griffiths, K. M., Jorm, A. F., & Christensen, H. (2006). Stigma about depression and its impact on help-seeking intentions. *Australian & New Zealand Journal of Psychiatry*, 40(1), 51-54.
- Beck, C. T. (2001). Predictors of postpartum depression: an update. *Nursing research*, 50(5), 275-285.
- Betrus, P. A., Elmore, S. K., Woods, N. F., & Hamilton, P. A. (1995). Women and depression. *Health care for women international*, 16(3), 243-252.
- Bifulco, A., Brown, G. W., & Adler, Z. (1991). Early sexual abuse and clinical depression in adult life. *The British Journal of Psychiatry*, 159(1), 115-122.
- Blanche, M. T., Blanche, M. J. T., Durrheim, K., & Painter, D. (2006). *Research in practice: Applied methods for the social sciences*: Juta and Company Ltd.
- Bolton, P., Wilk, C. M., & Ndogoni, L. (2004). Assessment of depression prevalence in rural Uganda using symptom and function criteria. *Social psychiatry and psychiatric epidemiology*, 39(6), 442-447.
- Boomsma, D., Busjahn, A., & Peltonen, L. (2002). Classical twin studies and beyond. *Nature reviews genetics*, 3(11), 872.

- Broadhead, J. C., & Abas, M. A. (1998). Life events, difficulties and depression among women in an urban setting in Zimbabwe. *Psychological medicine*, 28(1), 29-38.
- Brodsky, H., Peters, K., Boyce, P., Hickie, I., Parker, G., Mitchell, P., & Wilhelm, K. (1991). Age and depression. *Journal of affective disorders*, 23(3), 137-149.
- Brown, L. M., & Gilligan, C. (1993). Meeting at the crossroads: Women's psychology and girls' development. *Feminism & Psychology*, 3(1), 11-35.
- Cairns, N. U., & Lansky, S. B. (1980). MMPI indicators of stress and marital discord among parents of children with chronic illness. *Death Studies*, 4(1), 29-42.
- Campbell, J. C., Kub, J., Belknap, R. A., & Templin, T. N. (1997). Predictors of depression in battered women. *Violence Against Women*, 3(3), 271-293.
- Cao, B., Jiang, H., Xiang, H., Lin, B., Qin, Q., Zhang, F., . . . Yan, W. (2015). Prevalence and influencing factors of depressive symptoms among women of reproductive age in the rural areas of Hubei, China. *Public health*, 129(5), 465-474.
- Chandra, P. S., & Satyanarayana, V. A. (2010). Gender disadvantage and common mental disorders in women. *International Review of Psychiatry*, 22(5), 513-524.
- Chibanda, D. (2017). Reducing the treatment gap for mental, neurological and substance use disorders in Africa: lessons from the Friendship Bench in Zimbabwe. *Epidemiology and psychiatric sciences*, 26(4), 342-347.
- Chibanda, D., Cowan, F., Verhey, R., Machando, D., Abas, M., & Lund, C. (2017). Lay health workers' experience of delivering a problem solving therapy intervention for common mental disorders among people living with HIV: a qualitative study from Zimbabwe. *Community mental health journal*, 53(2), 143-153.
- Chibanda, D., Mesu, P., Kajawu, L., Cowan, F., Araya, R., & Abas, M. A. (2011). Problem-solving therapy for depression and common mental disorders in Zimbabwe: piloting a task-shifting primary mental health care intervention in a population with a high prevalence of people living with HIV. *BMC Public Health*, 11(1), 828.
- Chibanda, D., Verhey, R., Gibson, L. J., Munetsi, E., Machando, D., Rusakaniko, S., . . . Abas, M. (2016). Validation of screening tools for depression and anxiety disorders in a primary care population with high HIV prevalence in Zimbabwe. *Journal of affective disorders*, 198, 50-55.
- Chibanda, D., Weiss, H. A., Verhey, R., Simms, V., Munjoma, R., Rusakaniko, S., . . . Manda, E. (2016). Effect of a primary care-based psychological intervention on symptoms of common mental disorders in Zimbabwe: a randomized clinical trial. *Jama*, 316(24), 2618-2626.
- Clak, D. A., & Beck, A. T. (1999). *Scientific foundations of cognitive theory and therapy of depression*: John Wiley & Sons.
- Cooper, L. A., Gonzales, J. J., Gallo, J. J., Rost, K. M., Meredith, L. S., Rubenstein, L. V., . . . Ford, D. E. (2003). The acceptability of treatment for depression among African-American, Hispanic, and white primary care patients. *Medical care*, 479-489.
- Craig, T. K. (2015). Community psychiatry—100 words. *The British Journal of Psychiatry*, 206(2), 115-115.
- Demyttenaere, K., Bruffaerts, R., Posada-Villa, J., Gasquet, I., Kovess, V., Lepine, J., . . . Polidori, G. (2004). Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys. *Jama*, 291(21), 2581-2590.

- Dixon, J. R. (1999). The international conference on harmonization good clinical practice guideline. *Quality Assurance*, 6(2), 65-74.
- Dunner, D. L. (2004). Pharmacotherapy of depression. *American Journal of Psychiatry*, 161(11), 2146-a-2147.
- Durrheim, K., & Painter, D. (2006). Collecting quantitative data: Sampling and measuring. *Research in practice: Applied methods for the social sciences*, 2, 131-159.
- Etikan, I., Musa, S. A., & Alkassim, R. S. (2016). Comparison of convenience sampling and purposive sampling. *American Journal of Theoretical and Applied Statistics*, 5(1), 1-4.
- Ferrari, A. J., Norman, R. E., Freedman, G., Baxter, A. J., Pirkis, J. E., Harris, M. G., . . . Vos, T. (2014). The burden attributable to mental and substance use disorders as risk factors for suicide: findings from the Global Burden of Disease Study 2010. *PLoS one*, 9(4), e91936.
- Fiske, S., & Taylor, S. (1991). McGraw-Hill series in social psychology. *Social cognition (2nd ed.)*. New York, NY, England: Mcgraw-Hill Book Company.
- Fitzgerald, P. B., Laird, A. R., Maller, J., & Daskalakis, Z. J. (2008). A meta-analytic study of changes in brain activation in depression. *Human brain mapping*, 29(6), 683-695.
- Frohlich, P., & Meston, C. (2002). Sexual functioning and self-reported depressive symptoms among college women. *Journal of sex research*, 39(4), 321-325.
- Gibson, J. L., St, C. M., Owens, M., Brodbeck, J., Dunn, V., Lewis, G., . . . Goodyer, I. M. (2016). Friendships and Family Support Reduce Subsequent Depressive Symptoms in At-Risk Adolescents.
- Goodman, S. H., & Tully, E. (2006). Depression in women who are mothers. *Women and depression: A handbook for the social, behavioral, and biomedical sciences*, 241-280.
- Gotlib, I. H., Lewinsohn, P. M., & Seeley, J. R. (1998). Consequences of depression during adolescence: marital status and marital functioning in early adulthood. *Journal of abnormal psychology*, 107(4), 686.
- Haefel, G. J., Voelz, Z. R., & Joiner, J., Thomas E. (2007). Vulnerability to depressive symptoms: Clarifying the role of excessive reassurance seeking and perceived social support in an interpersonal model of depression. *Cognition and Emotion*, 21(3), 681-688.
- Hall, W. (1996). What have population surveys revealed about substance use disorders and their co-morbidity with other mental disorders? *Drug and Alcohol Review*, 15(2), 157-170.
- Han, J., & Richardson, V. E. (2010). The relationship between depression and loneliness among homebound older persons: Does spirituality moderate this relationship? *Journal of Religion & Spirituality in Social Work: Social Thought*, 29(3), 218-236.
- Health, W. H. O. W. D. o. M., & Abuse, S. (2005). *Mental health atlas 2005*: World Health Organization.
- Hirschfeld, R. M. (2001). The comorbidity of major depression and anxiety disorders: recognition and management in primary care. *Primary care companion to the Journal of clinical psychiatry*, 3(6), 244.
- Hollon, S. D., DeRubeis, R. J., Evans, M. D., Wiemer, M. J., Garvey, M. J., Grove, W. M., & Tuason, V. B. (1992). Cognitive therapy and pharmacotherapy for depression: Singly and in combination. *Archives of general psychiatry*, 49(10), 774-781.
- Honan, E., Hamid, M. O., Alhamdan, B., Phommalangsy, P., & Lingard, B. (2013). Ethical issues in cross-cultural research. *International Journal of Research & Method in Education*, 36(4), 386-399. doi:10.1080/1743727x.2012.705275

- Hough, E. S., Brumitt, G. A., & Templin, T. N. (1999). Social support, demands of illness, and depression in chronically ill urban women. *Health care for women international*, 20(4), 349-362.
- Ismail, K. (2010). Unraveling the pathogenesis of the depression–diabetes link. *Depression and Diabetes*, 29-61.
- Jack, D. C. (1991). *Silencing the self: Women and depression*: Harvard University Press.
- January, J., Mutamba, N., & Maradzika, J. (2017). Correlates of postnatal depression among women in Zimbabwean semi-urban and rural settings. *Journal of Psychology in Africa*, 27(1), 93-96.
- Jordan, J. V. (2008). Recent developments in relational-cultural theory.
- Jordan, J. V., & Hartling, L. M. (2008). The development of relational-cultural theory. Retrieved April, 20, 2008.
- Katon, W., Kleinman, A., & Rosen, G. (1982). Depression and somatization: a review: Part I. *The American journal of medicine*, 72(1), 127-135.
- Keith, P. M., & Schafer, R. B. (1982). Correlates of depression among single parent, employed women. *Journal of Divorce*, 5(3), 49-59.
- Kessler, R. C. (2006). The epidemiology of depression among women. *Women and depression: A handbook for the social, behavioral, and biomedical sciences*, 22-37.
- Khaira, A., Mahajan, S., Khatri, P., Bhowmik, D., Gupta, S., & Agarwal, S. K. (2012). Depression and marital dissatisfaction among Indian hemodialysis patients and their spouses: a cross-sectional Study. *Renal failure*, 34(3), 316-322.
- Kidia, K., Machando, D., Mangezi, W., Hendler, R., Crooks, M., Abas, M., . . . Jack, H. (2017). Mental health in Zimbabwe: a health systems analysis. *The Lancet Psychiatry*, 4(11), 876-886.
- King, M., Walker, C., Levy, G., Bottomley, C., Royston, P., Weich, S., . . . Rotar, D. (2008). Development and validation of an international risk prediction algorithm for episodes of major depression in general practice attendees: the PredictD study. *Archives of general psychiatry*, 65(12), 1368-1376.
- Kircanski, K., Joormann, J., & Gotlib, I. H. (2012). Cognitive aspects of depression. *Wiley Interdisciplinary Reviews: Cognitive Science*, 3(3), 301-313.
- Korszun, A., Altemus, M., & Young, E. A. (2006). The biological underpinnings of depression. *Women and depression*, 41-61.
- Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: validity of a brief depression severity measure. *Journal of general internal medicine*, 16(9), 606-613.
- Lao, C. K., Chan, Y. M., Tong, H. H. Y., & Chan, A. (2016). Underdiagnosis of depression in an economically deprived population in Macao, China. *Asia-Pacific Psychiatry*, 8(1), 70-79.
- Lee, C. (1997). Social context, depression and the transition to motherhood. *British Journal of Health Psychology*, 2(2), 93-108.
- Lennon, M. C. (2006). Conceptual and Policy Issues. *Women and depression: A handbook for the social, behavioral, and biomedical sciences*, 309.
- Levine, M., Perkins, D. V., & Levine, M. (2005). *Principles of community psychology*: Oxford University Press New York.
- Lingjærde, O. (1983). The biochemistry of depression: A survey of monoaminergic, neuroendocrinological, and bio-rhythmic disturbances in endogenous depression. *Acta Psychiatrica Scandinavica*, 67, 36-51.

- Lorant, V., Deliège, D., Eaton, W., Robert, A., Philippot, P., & Ansseau, M. (2003). Socioeconomic inequalities in depression: a meta-analysis. *American journal of epidemiology*, *157*(2), 98-112.
- Marecek, J. (2006). Social suffering, gender, and women's depression. *Women and depression: A handbook for the social, behavioral, and biomedical sciences*, 283-308.
- Marshall, A. J., & Harper-Jaques, S. (2008). Depression and family relationships: Ideas for healing. *Journal of Family Nursing*, *14*(1), 56-73.
- Marshall, C., & Rossman, G. (1989). How to conduct the study: designing the research. *Designing qualitative research. Maryland: Sage publications*.
- Martin, G. (1996). Depression in teenagers. *Current therapeutics*, *37*(6), 57.
- Mawanza, W. (2017). The effects of stress on employee productivity: A perspective of Zimbabwe's socio-economic dynamics of 2016. *Journal of Economics and Behavioral Studies*, *9*(2), 22-27.
- McClung, C. A. (2007). Circadian genes, rhythms and the biology of mood disorders. *Pharmacology & therapeutics*, *114*(2), 222-232.
- Mendels, J., Stern, S., & Frazer, A. (1976). Biochemistry of depression. *Diseases of the nervous system*.
- Mercer, C. H., Fenton, K. A., Johnson, A. M., Wellings, K., Macdowall, W., McManus, S., . . . Erens, B. (2003). Sexual function problems and help seeking behaviour in Britain: national probability sample survey. *Bmj*, *327*(7412), 426-427.
- Mirowsky, J., & Ross, C. E. (1992). Age and depression. *Journal of health and social behavior*, 187-205.
- Mutsatsa, S. (2015). *Physical Healthcare and Promotion in Mental Health Nursing: Learning Matters*.
- Neal, J. W., & Neal, Z. P. (2013). Nested or networked? Future directions for ecological systems theory. *Social Development*, *22*(4), 722-737.
- Noble, R. E. (2005). Depression in women. *Metabolism*, *54*(5), 49-52.
- Noh, J.-W., Kwon, Y. D., Park, J., Oh, I.-H., & Kim, J. (2016). Relationship between physical disability and depression by gender: a panel regression model. *PloS one*, *11*(11), e0166238.
- Nyanyiwa, F. (2016). The bane of the expectant mother. *The Sunday Mail*.
- Patel, V., Abas, M., Broadhead, J., Todd, C., & Reeler, A. (2001). Depression in developing countries: lessons from Zimbabwe. *BMJ: British Medical Journal*, *322*(7284), 482.
- Patel, V., Simunyu, E., Gwanzura, F., Lewis, G., & Mann, A. (1997). The Shona Symptom Questionnaire: the development of an indigenous measure of common mental disorders in Harare. *Acta Psychiatrica Scandinavica*, *95*(6), 469-475.
- Patel, V., Todd, C., Winston, M., Gwanzura, F., Simunyu, E., Acuda, W., & Mann, A. (1997). Common mental disorders in primary care in Harare, Zimbabwe: associations and risk factors. *The British Journal of Psychiatry*, *171*(1), 60-64.
- Paykel, E. (1991). Depression in women. *The British Journal of Psychiatry*, *158*(S10), 22-29.
- Penninx, B. W. (2006). Women's Aging and Depression.
- Phillips, A. C., Carroll, D., & Der, G. (2015). Negative life events and symptoms of depression and anxiety: stress causation and/or stress generation. *Anxiety, Stress, & Coping*, *28*(4), 357-371.
- Pratt, L. A., & Brody, D. J. (2014). Depression and obesity in the US adult household population, 2005–2010. *Women*, *20*, 39.

- Price, S. K., & Proctor, E. K. (2009). A rural perspective on perinatal depression: Prevalence, correlates, and implications for help-seeking among low-income women. *The Journal of Rural Health, 25*(2), 158-166.
- Rabins, P. V. (2016). Women as caregivers. *Comprehensive women's mental health, 28-31*.
- Rehm, L. P. (2009). Cognitive Clinical Theory and Depression. *Psychological Inquiry, 3*(3), 258-260.
- Rehm, L. P. (2016). Cognitive and behavioral theories of depression.
- Reio Jr, T. G. (2016). Nonexperimental research: strengths, weaknesses and issues of precision. *European Journal of Training and Development, 40*(8/9), 676-690.
- Ribeiro, Â., Ribeiro, J. P., & von Doellinger, O. (2018). Depression and psychodynamic psychotherapy. *Revista Brasileira de Psiquiatria, 40*(1), 105-109.
- Roberts, G. L., Williams, G. M., Lawrence, J. M., & Raphael, B. (1999). How does domestic violence affect women's mental health? *Women & health, 28*(1), 117-129.
- Robertson, E., Grace, S., Wallington, T., & Stewart, D. E. (2004). Antenatal risk factors for postpartum depression: a synthesis of recent literature. *General hospital psychiatry, 26*(4), 289-295.
- Ryan, D. P. J. (2001). Bronfenbrenner's ecological systems theory. Retrieved January, 9, 2012.
- Seligman, M. E. (1975). *Helplessness: On depression, development, and death. A series of books in psychology*: New York, NY: WH Freeman/Times Books/Henry Holt & Co.
- Semenova, N. D. (2017). Women and mental health. *International Journal of Culture and Mental Health, 11*(1), 102-108. doi:10.1080/17542863.2017.1394675
- Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American Psychologist, 65*(2), 98.
- Shifren, J. L., Monz, B. U., Russo, P. A., Segreti, A., & Johannes, C. B. (2008). Sexual problems and distress in United States women: prevalence and correlates. *Obstetrics & Gynecology, 112*(5), 970-978.
- Slavich, G. M., & Irwin, M. R. (2014). From stress to inflammation and major depressive disorder: a social signal transduction theory of depression. *Psychological bulletin, 140*(3), 774.
- Snapp, M. B. (1992). Occupational stress, social support, and depression among black and white professional-managerial women. *Women & health, 18*(1), 41-79.
- Somerset, W., Newport, D. J., Raga, K., & Stowe, Z. N. (2006). Depressive disorders in women. *Women and depression: A handbook for the social, behavioral, and biomedical sciences, 62-88*.
- Sowislo, J. F., & Orth, U. (2013). Does low self-esteem predict depression and anxiety? A meta-analysis of longitudinal studies. *Psychological bulletin, 139*(1), 213.
- Suicide cases on the rise in Zimbabwe. (2017, 06/05/2017). *Pindula*. Retrieved from <https://news.pindula.co.zw/2017/05/06/suicide-cases-rise-zimbabwe-economic-challenges-infidelity-blamed/>
- Suitor, J. J., Gilligan, M., Johnson, K., & Pillemer, K. (2013). Caregiving, perceptions of maternal favoritism, and tension among siblings. *The Gerontologist, 54*(4), 580-588.
- Suraj-Narayan, G. (2005). Women in management and occupational stress. *Agenda, 19*(65), 83-94.
- Tabassum, F., & Lodhi, M. S. SOCIAL DETERMINANTS OF DEPRESSION AMONG REPRODUCTIVE AGE WOMEN RESIDING IN KARACHI, PAKISTAN.

- Tangwa, G. B. (2009). Ethical principles in health research and review process. *Acta tropica*, 112, S2-S7.
- Tomlinson, M., Grimsrud, A. T., Stein, D. J., Williams, D. R., & Myer, L. (2009). The epidemiology of major depression in South Africa: results from the South African stress and health study. *South African Medical Journal*, 99(5).
- Upreti, R., & Singh, R. (2016). A Study of Stress Perceived by the Parents of Mentally Challenged Children from Low and Middle Social Class. *Journal of Psychology*, 7(2), 101-111.
- Wang, J. L., Schmitz, N., & Dewa, C. (2010). Socioeconomic status and the risk of major depression: the Canadian National Population Health Survey. *Journal of Epidemiology & Community Health*, 64(5), 447-452.
- Whisman, M. A., Weinstock, L. M., & Tolejko, N. (2006). Marriage and depression. *Women and depression: A handbook for the social, behavioral, and biomedical sciences*, 219-240.
- Whiteford, H. A., Degenhardt, L., Rehm, J., Baxter, A. J., Ferrari, A. J., Erskine, H. E., . . . Johns, N. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. *The Lancet*, 382(9904), 1575-1586.
- Whitton, S. W., Olmos-Gallo, P. A., Stanley, S. M., Prado, L. M., Kline, G. H., St Peters, M., & Markman, H. J. (2007). Depressive symptoms in early marriage: Predictions from relationship confidence and negative marital interaction. *Journal of Family Psychology*, 21(2), 297.
- WHO. (2005). Assessment instrument for mental health. *WHO/MSD/MER/05.2*.
- WHO. (2008). The global burden of disease: 2004 update. . Retrieved 5 April 2018, from WHO Press,
- WHO. (2017). Depression and other common mental disorders: global health estimates.
- WHO. (2018). Retrieved from <http://www.who.int/news-room/fact-sheets/detail/mental-disorders>
- Zhang, N., Chen, H., & Zou, Y. (2014). A joint model of binary and longitudinal data with non-ignorable missingness, with application to marital stress and late-life major depression in women. *Journal of Applied Statistics*, 41(5), 1028-1039.

APPENDICES

APPENDIX A - RESEARCH INSTRUMENT

SHONA CMD & DEPRESSION AND DETERMINANTS QUESTIONNAIRE

SECTION A - BIOGRAPHICAL DETAILS

UNIQUE ID NUMBER _____ AGE IN YEARS: _____

MARITAL STATUS:

SINGLE MARRIED DIVORCED WIDOW other _____

SECTION B: Shona Symptoms Questionnaire (SSQ-14)

Musvondo rapfuura: <i>During the course of the past week:</i>		Ehe Yes	Aiwa No
1	Pane pamaimboona muchinyanya kufungisisa kana kufunga zvakawanda here? <i>Did you sometimes think deeply or think about many things?</i>		
2	Pane pamaimbotadza kuisa pfungwa dzenyu panwechete here? <i>Did you find yourself sometimes failing to concentrate?</i>		
3	Maimboshatirwa kanakuita hasha zvenhando here? <i>Did you lose your temper or get annoyed over trivial matters?</i>		
4	Maimborota hope dzinotyisa kana dzisina kunaka here? <i>Did you have nightmares or bad dreams?</i>		
5	Maimboona kana kunzwa zvinhu zvanzvisinga onekwe kana kunzwikwa nevamwe? <i>Did you sometimes see or hear things others could not see or hear?</i>		
6	Mudumbu menyu maimborwa dza here? <i>Was your stomach aching?</i>		
7	Maimbovhundutswa nezvinhu zvisina mature here? <i>Were you frightened by trivial things?</i>		
8	Maimbota dza kurara kana kushaya hope here? <i>Did you sometimes fail to sleep or did you lose sleep?</i>		
9	Pane pamaimbonzwa muchiomera neupenyu zvekuti makambochema kana kuti makambonzwa kuda kuchema here? <i>Were there times when you felt life was so tough you cried or wanted to cry?</i>		
10	Maimbonzwa kuneta here? <i>Did you feel run down (tired)?</i>		
11	Pane pamaimboita pfungwa dzekuda kuzviuraya here? <i>Did you sometimes feel like committing suicide?</i>		
12	Mainzwa kusafara here mune zvamaiita zuva nezuva? <i>Were you generally unhappy with the things you were doing each day?</i>		
13	Basa renyu raive rave kusarira muma shure here? <i>Was your work lagging behind?</i>		
14	Mainzwa zvichikuomerai here kuti muzive kuti moita zvipi? <i>Did you feel you had problems deciding what to do?</i>		
Scoring : Add together the number of questions to which the client responded " yes"		Total Score:	

APPENDIX A - RESEARCH INSTRUMENT CONT'
SECTION C PATIENT HEALTH QUESTIONNAIRE (PHQ9)

Over the LAST 2 WEEKS how often have you been bothered by any of the following problems? <i>MUMASVONDO MAVIRI apfuura makashungurudzwa kangani nematambudziko anotevera</i>		Not at all <i>Kwete</i>	Several days <i>Mamwe Mazuva</i>	More than half the days <i>Zviri Pakati nePakati</i>	Nearly everyday <i>Zuva rega rega</i>
1	Little interest or pleasure in doing things <i>Kusanyatsova nechido chekuita zvinhu</i>	0	1	2	3
2	Feeling down, depressed or hopeless <i>Kusanyatsonzwa chido nezveupenyu, kufunganya, zvakapfurikidza kana kushaya tariro muhupenyu</i>	0	1	2	3
3	Trouble falling or staying asleep or sleeping too much. <i>Kutadza kuwana hope kana kurara zvakapfurikidza</i>	0	1	2	3
4	Feeling tired or having little energy <i>Kunzwa kuneta uye kuve nesimba shoma rekuita zvinhu</i>	0	1	2	3
5	Poor appetite or overeating <i>Kusanyatsodya zvakakwana kana kudyisa</i>	0	1	2	3
6	Feeling bad about yourself – or that you are a failure or have let yourself or your family down <i>Kuzvizvidza pachezvako – kana kunzwa sekuti uri mukundikani muupenyu kana kutadza kuzadzikisa zvaitarisirwa nemhuri yako</i>	0	1	2	3
7	Trouble concentrating on things such as reading the newspaper or watching television <i>Kutadza kuita zvinhu zvakaita sekuverenga pepanhau nekuona chivhitivhiti pfungwa dziripamwechete</i>	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual <i>Kufamba kana kutaura zvine kunonokera mukati zvekuti zvinogona zvakaonekwa nevamwe vakakutenderedza? Kana kuti kutadza kugarisika zvekuti wange uri kufamba-famba zvakapfurikidza zvaunofanirwa kunge uchiita?</i>	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in any way	0	1	2	3

	<i>Kuve nendangariro dzekuti zvirinani kuti dai wafa zvako kana kuda kuzvikuvadza neimwe nzira</i>				
TOTAL PHQ9 SCORE/ZVIBODZWA ZVABATANIDZWA					

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people? <i>Kana muine matambudziko amakasangana nawo pamusoro, ari kukutadzisai zvakadii kuita basa renyu, kuona kuti zvinhu zviru mugwara kumba, kana kuwirirana nevamwe vanenge vakakukomberedzai?</i>	Not difficult at all <i>Kana</i>	Somewhat difficult <i>Zvishoma</i>	Very difficult <i>Zvakanyanya</i>	Extremely Difficult <i>Zvakanyanyisa</i>

SECTION D: Shona Problem List Questionnaire (SSQ-14)

Shona problem list Questionnaire

	Nature of main problem	Shona terms	Not at all	Several days	More than half the days	Nearly everyday
			<i>Kwete</i>	<i>Mamwe Mazuva</i>	<i>Zviru Pakati nePakati</i>	<i>Zuva rega rega</i>
			0	1	2	3
1	Relationship	Ukama				
2	Marital	Nyaya dzemagariro mumba				
3	Work related	Nyaya dzekubasa				
4	Bereavement	Kuchema mufi				
5	School	Zvechikoro				
6	Family	Nyaya dzemumhuri				
7	Interpersonal deficits(Self esteem, loneliness)					
8	Health related	Zveutano				
9	Money problem	Nyaya dzemari				
10	Accommodation problem	Nyaya dzepekugara				
11	Legal problem	Mhosva				
12	Sexual problem	Nyaya dzepabonde				
13	Alcohol/drugs	Nyaya dzekudhakwa				
14	Other, What??	Zvimwe, zvii??	Write on spaces provided below <i>Zvinyore pamitsetse yakatarwa iri pasi</i>			

End of questionnaire. *Mibvunzo Yaperera pano*

APPENDIX B – MSU CLEARANCE LETTER

Midlands State
University



Established 2000

P BAG 9055
GWERU

Telephone: (263) 54 260404 ext 261
Fax: (263) 54 260233/260311

FACULTY OF SOCIAL SCIENCES
DEPARTMENT OF PSYCHOLOGY

Date: 16/07/2018

To whom it may concern

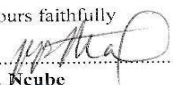
Dear Sir/Madam

RE: REQUEST FOR ASSISTANCE WITH COMMUNITY ENGAGEMENT
PROGRAMME FOR.....FATIMA MAPUKE (R1715866)

This letter serves to introduce to you the above named student who is studying for a Master of Science in Community Psychology at Midlands State University. Students in this degree programme are required to plan and implement some community engagement programme in their final year of study. We therefore kindly request your community or organisation to assist the above-named student with any information or support that they may require to do their programme.

For more information regarding the above, feel free to contact the Psychology Department.

Yours faithfully


.....
N. Ncube
Chairperson



APPENDIX C – MRCZ CLEARANCE LETTER

Telephone: 791792/791193
Telefax: (263) - 4 - 790715
E-mail: mrcz@mrcz.org.zw
Website: <http://www.mrcz.org.zw>



Medical Research Council of Zimbabwe
Josiah Tongogara / Mazoe Street
P. O. Box CY 573
Causeway
Harare

REF: MRCZ/B/1566

Fatima Mapuke
35 Honey Drive
Belvedere
Harare



04 September, 2018

RE: PREVALENCE AND DETERMINANTS OF DEPRESSION AMONG WOMEN ATTENDING PSYCOOK COMMUNITY ENGAGEMENT PROGRAMME

Thank you for the above titled proposal that you submitted to the Medical Research Council of Zimbabwe (MRCZ) for review. Please be advised that the Medical Research Council of Zimbabwe has **reviewed** and **approved** your application to conduct the above titled study. This is based on the following documents that were submitted to the MRCZ for review:

- a) Study proposal
- b) Informed Consent Forms
- c) Data collection tools

APPROVAL NUMBER : MRCZ/B/1566

This number should be used on all correspondence, consent forms and documents as appropriate.

- **APPROVAL DATE** : 04 September, 2018
- **TYPE OF MEETING** : Expedited
- **EXPIRATION DATE** : 03 September, 2019

After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the MRCZ Offices should be submitted one month before the expiration date for continuing review.

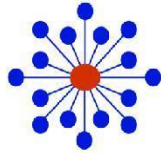
- **SERIOUS ADVERSE EVENT REPORTING:** All serious problems having to do with subject safety must be reported to the Institutional Ethical Review Committee (IERC) as well as the MRCZ within 3 working days using standard forms obtainable from the MRCZ Offices.
- **MODIFICATIONS:** Prior MRCZ and IERC approval using standard forms obtainable from the MRCZ Offices is required before implementing any changes in the Protocol (including changes in the consent documents).
- **TERMINATION OF STUDY:** On termination of a study, a report has to be submitted to the MRCZ using standard forms obtainable from the MRCZ Offices.
- **QUESTIONS:** Please contact the MRCZ on Telephone No. (04) 791792, 791193 or by e-mail on mrcz@mrcz.org.zw.
- **Other**
- Please be reminded to send in copies of your research results for our records as well as for Health Research Database.
- You're also encouraged to submit electronic copies of your publications in peer-reviewed journals that may emanate from this study.

Yours Faithfully

MRCZ SECRETARIAT
FOR CHAIRPERSON
MEDICAL RESEARCH COUNCIL OF ZIMBABWE

PROMOTING THE ETHICAL CONDUCT OF HEALTH RESEARCH

APPENDIX D – CERTIFICATE OF GOOD CLINICAL PRACTICE



NIDA Clinical Trials Network

Certificate of Completion

is hereby granted to

FATIMA MAPUKE

to certify your completion of the six-hour required course on:

GOOD CLINICAL PRACTICE

MODULE:	STATUS:
Introduction	N/A
Institutional Review Boards	Passed
Informed Consent	Passed
Confidentiality & Privacy	Passed
Participant Safety & Adverse Events	Passed
Quality Assurance	Passed
The Research Protocol	Passed
Documentation & Record-Keeping	Passed
Research Misconduct	Passed
Roles & Responsibilities	Passed
Recruitment & Retention	Passed
Investigational New Drugs	Passed

Course Completion Date: 17 July 2018

CTN Expiration Date: 17 July 2021

Tracee Williams, Training Coordinator
NIDA Clinical Coordinating Center

Good Clinical Practice, Version 5, effective 03-Mar-2017

This training has been funded in whole or in part with Federal funds from the National Institute on Drug Abuse, National Institutes of Health, Department of Health and Human Services, under Contract No. HHSN2720120100024C.

APPENDIX E - PSYCOOK PROGRAM PERMISSION LETTER



Project Leader: Fatima Mapuke
Mobile: +263782381133
Email: fmapuke@gmail.com
Address: 35 Honey Drive, Belvedere.

02 July, 2018

To whom it may concern

Dear Sir/Madam

This letter serves to confirm that Fatima Mapuke is the project leader for the Psycook Community Engagement Program. She has been granted permission to conduct any relevant research among the participants during the tenure of the project. Kindly assist her with any clearance she may be seeking in order to achieve her research goals.

For more information regarding the above, feel free to contact the undersigned

Yours faithfully



E. Nharirire

Internship Supervisor

APPENDIX F- INFORMATION SHEET ENGLISH

RESEARCH INFORMATION SHEET

STUDY TITLE: Prevalence and determinants of Common Mental Disorder and Depression among woman:Case of Psycook

RESEARCHER: FATIMA MAPUKE PHONE: +263717428082

Introduction

You are being asked to participate in the above-named study which is investigating the prevalence and determinants of depression among participants of Psycook Program. You were selected as a possible participant because you are participating in the Psycook program. We ask that you read this form and ask any questions that you may have before agreeing to participate in the study.

Purpose of the study

The purpose of this research is to identify the prevalence and determinants of depression amongst women attending the Psycook program. It seeks to investigate perceived causes of depression and their relationship with depression among the diverse women attending the program meetings

Description of the study procedures

If you agree to participate in this study, you will be asked respond to a four-part questionnaire. The first section captures the biographical details of the participant. The second part is the Shona Symptoms Questionnaire (SSQ-14) assessing for depression risk and common mental disorders. The third section is the Shona Patient Health Questionnaire (SPHQ-9) which screens for depression. The final section, is the Shona Problem List Questionnaire (SPLQ-14) which seeks to identify the problem source for the participant. Ultimately, the findings of this study will be captured in a dissertation report to be submitted to Midlands State University, and may be presented as a paper or may be published as part of any suitable publications, shared on various media; public, social or other. Please note that researcher will not and is not yet qualified to offer you treatment for depression or any other mental illness, however, depending on your score on SSQ14 and/or PHQ9 you may be contacted for the sole purpose of linking you to the necessary help you may so require.

Risks/Discomforts of Being in this Study

Although it is highly unlikely, some of the responses may evoke emotional or psychological distress.

Benefits of Being in the Study

The benefits of participating are that knowing your score may aid in self-awareness and possible beneficial help seeking initiatives.

Confidentiality

The reports and findings of this study will be anonymous as you will be identified by the unique number. All records and reports will be using your unique number. These records will be kept in a secured file, and all identifying information will be stored and secured separately. All information will be kept in strict confidence. We will not include any information in any report we may publish that would make it possible to identify you.

Payments

Participants will **NOT** pay anything to participate and they will **NOT** be paid anything for participating

Right to Refuse or Withdraw

The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* without affecting your relationship with the researcher. Your decision will not result in any loss of benefits to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely from the study at any point during the process; additionally, you have the right to request that the researcher not use any of your participation material.

Right to Ask Questions and Report Concerns

You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Fatima Mapuke at fmapuke@gmail.com or by telephone at +263717428082. If you like, a summary of the report of the study will be sent to you. If you have any other concerns about your rights as a participant that have not been answered by the researcher, you may contact Mr. S Maphosa, my supervisor, of the Midlands State University Psychology Department at +263 54 260404 ext. 261. If you have any problems or concerns that occur as a result of your participation, you can report them to the Mr. S. Maphosa at the number above.

APPENDIX G – INFORMATION SHEET (SHONA)
ZVIRI MARINGE NETSVAKURUDZO

MUSORO WETSVAKURUDZO: Prevalence and determinants of depression among participants of Psycook Community Engagement Program

ZITA REMUTSVAKURUDZI: FATIMA MAPUKE

NHAMBWA DZENHARE : +263717428082

Chekutanga

Muri kukumbirwa kuti mupinde mutsvakurudzo yakanyorwa kumusoro kwebepa rino iri kuongorora huwandu hwevanhu vane kufungisisa uye zvingadaro zvichikonzera kufungisisa pakati peavo vari pachirongwa chePsycook. Masarudzwa semumwe angapinda mutsvakurudzo ino nekuti muri muchirongwa chePsycook. Muri kukumbirwa kuti muverenge zviri pabepa rino mova nemukana wekuvhunza mivhunzo yose yamungave nayo pamusoro petsvakurudzo ino musati mabvuma kupinda mutsvakurudzo iyi.

Chikonzero chetsvakurudzo

Chikonzero chetsvakurudzo ino ndechekuogorora huwandu hwevanhu vane kufungisisa uye zvingadaro zvichikonzera kufungisisa pakati peavo vari pachirongwa chePsycook.. Iri kuzama kutsvakurudza zvingadaro zvichikonzera kufungisisa nehukama hwazvo nekufungisisa pakati pemhando dzakasiyana dzemadzimai ari kuuya kuhurongwa nemisangano yePsycook.

Zvichaitwa mutsvakurudzo

Kana matenda kupinda mutsvakurudzo iyi muchakumbirwa kupindura mibvunzo iri pabepa ramuchipihwa. Mibvunzo iyi ichange iri muzvikamu zvina. Chikamu chekutanga chinodaira maringe nezvamuri muhupenyu. Chikamu chechipiri chine mibvunzo yakanyorwa gumi nemina inonzi *Shona Symptoms Questionnaire* kana kuti (SSQ-14) muchidimbu basa rayo riri rekuogorora njodzi yekuva nekufungisisa kana kumwe kusagadzikana kwepfungwa. Chikamu chetatu chine mibvunzo yakanyorwa mipfumbamwe inonzi *Shona Patient Health Questionnaire* kana kuti (SPHQ-9) muchidimbu, inoogorora kuti munhu ane kufungisisa here. Chikamu chechina chekupedzisira chine mibvunzo yakanyorwa gumi nemina inonzi *Shona Problem List Questionnaire* kana kuti (SPLQ-14) ine chinangwa chekuzivisa panobva matambudziko emuongororwi. Pakupedzesera zvichawanikwa musarudzo ino zvichanyorwa mubumbiro richaendeswa ku Midlands State University, uye zvinogona kuiswa mubepa richaburitswa

paungano dzevadzidzi kana mabumbiro evadzidzi kana zvimwe zvinyorwa zvinoiswa pashambadziro dzakasiyana siyana. Zvakadaro munoziviswa kuti mutsvakurudzi haakwanise uye haasati aakutenderwa kurapa kufungisisa kana zvimwe zvirwere zvepfungwa, Asi maringe nezvinenge zvabuda mumhinduro dzenyu mumibvunzo yakanyorwa ye SSQ-10 kana ne PHQ-9, munogona kuzotsvagwa nechikonzero chimwechete chekukuzivisa nezveimwe betsero yamungada.

Kusagadzikana kana njodzi yekuva mutsvakurudzo ino

Kunyangwe zvazvo zvisinganyanye kutarisirwa, pamunodaira mivhunzo dzimwe mhinduro dzinogona kukukonzera kusagadzikana nekushungurudzika mupfungwa.

Zvinobatsira kuva musarudzo ino ndezvekuti zvibodzwa zvamuchawana zvinoita kuti muzive pamumire nekuzviziva imi pachezvenyu zvobatsira kuti mutsvage rubatsiro rwakaringana.

Kuchengetedzwa pakavanzika kwemagwaro

Hapana ruzivo rwuchaburitswa chero pane ripi gwaro ruchakunangai nezita renyu. Muchazikanwa nenhamba yetsvakurudzo. Ruzivo rwose ruchaunganidzwa nekuongororwa kuchishandiswa manhamba aya. Magwaro ose achachengeterwa panokiyiwa. Zvimwe zvoze zvinobatanidza manhamba emunhu anenge ari mutsvakurudzo nerumwe ruzivo rwakanangana nemunhu uyu zvichachengeterwa pakasiyana panokiyiwa, Ruzivo rune chekuita nemi ruchachengetedzwa pakavanzika nepose panogoneka.

Mibhadharo

Vachapinda mutsvakurudzo **HAVANA** chavanobhadara uye **HAVANA** chavanobhadharwa.

Kodzero yekuramba kana kubuda mutsvakurudzo

Sarudzo yekuva mutsvakurudzo ino yese iri pamuri. Munogona kusarudza kupinda kana kubuda mutsvakurudzo chero nguva ipi zvayo pasina kukanganisika kwehukama hwenyu nemutsvakurudzi kana kurasikirwa nezvakanaka zvamunofanirwa kuwana chero zvipi zvazvo. Mune kodzero zvekare yekurega kupindura mimwe mibvunze uye mune kodzero yekuudza mutsvakurudzi kuti asashandise zvamunenge mapindura musarudzo.

Kodzero yekubvunza mibvunzo kana kutura matambudziko

Mune kodzero yekuti mubvunze mibvunzo maererano netsvakurudzo ino kana gwaro retenderano rino musati mapinda mutsvakurudzo munguva yetsvakurudzo, kana kuti tsvakurudzo yapera. Kana mukazoita mibvunzo chero ipi zvayo mune ramangwana, bvunzai mutsvakurudzi Fatima Mapuke panhare dzinoti +263717428082 kana paEmail inoti fmapuke@gmail.com. Kana muchida kuzoziva

muchidimbu zvabuda mutsvakurudzo ino munozivisa zvigotumirwa kwamuri. Kana mune mibvunzo ine chekuita nekodzero dzenyu semunhu ari mutsvakurudzo, isina kupindurwa nemutsvakurudzi munogona kubata Va S. Maphosa vanova mudzidzisi wemutsvakurudzi kuMidlands State University panhamba dzenhare dzinoti +263 54 260404 ext. 261. Mukaita matambudziko anouya nekuda kwekuva kwenyu musarudzo ino munogona kubata Va Maphosa zvekare panhamba idzodzi.

Informed Consent

CONSENT TO PARTICIPATE IN A RESEARCH PROGRAM

STUDY TITLE: Prevalence and determinants of depression among participants of Psycook Community Engagement Program

RESEARCHER: FATIMA MAPUKE PHONE: +263717428082

I have read the information sheet or it has been read to me. I understand fully the risks and benefits of taking part in this study. I know that the decision to participate in this study is entirely up to me. I may refuse to take part in the study *at any time* without affecting my relationship with the researcher. My decision will not result in any loss of benefits to which I am otherwise entitled. I will be given a copy of this consent.

Participant’s Name: _____

Participant’s Signature: _____

Date: _____

Researcher’s Signature: _____

Date: _____

APPENDIX I – CONSENT (SHONA)

MVUMO

TENDERANO YEKUVA MUTSVAKURUDZO

MUSORO WETSVAKURUDZO: Prevalence and determinants of depression among participants of
Psycook Community Engagement Program

ZITA REMUTSVAKURUDZI: FATIMA MAPUKE

NHAMBWA DZENHARE : +263717428082

Ndaverenga gwaro iri riri maererano netsvakurudzo iyi kana kuti ndariverengerwa. Ndinonzwisisa njodzi nezvakanaka zvinogona kuwanikwa mutsvakurudzo iyi. Ndinoziva kuti kuva mutsvakurudzo ino hakumanikidzwi. Ndinotarudza kuva mutsvakurudzo iyi. Ndinoziva kuti ndinogona kubuda mutsvakurudzo asi ndisingarasikirwi nezvakanaka zvandinofanirwa kuwana chero zvipi zvazvo. Ndichapiwa rimwe gwaro retenderano rakafanana nerino

Zita reari kupinda mutsvakurudzo : _____

Runyoro rweari kupinda mutsvakurudzo: _____ Zuva: _____

Runyoro rwemutsvakurudzi: _____ Zuva: _____

APPENDIX J – REGISTRATION FORM

Psycook registration form - Welcome!!

UNIQUE NUMBER	PSY08181160
NAME	
TELEPHONE	
EMAIL ADDRESS	
PHYSICAL ADDRESS	

APPENDIX L – AUDIT SHEET

AUDIT SHEET

MIDLANDS STATE UNIVERSITY

SUPERVISOR- STUDENT AUDIT SHEET

DATE	TOPIC DISCUSSED	COMMENT	STUDENT'S SIGNATURE	SUPERVISOR'S SIGNATURE
02/02/18	Possible topics to be pursued	Stick to areas where there is passion so that you maintain the drive to push		
13/02/18	Topic choice	Use that as working topic		
23/02/18	Concept Note	Modify indicated areas		
07/03/18	Finalised concept note	Proceed to proposal		
25/03/18	Proposal submitted	May need to adjust topic		
14/05/18	Chapter one submission	Modify indicated areas		
19/05/18	Chapter one feedback	Proceed to chapter two		
06/06/18	Chapter one and 2 submission	Chapter one cleared		
22/06/18	Chapter 2 feedback	Research more on indicated areas for chapter two and proceed to chapter 3		
12/07/18	Chapter 3 feedback	Work on indicated areas		
11/07/18	Chapter 3	Proceed		
15/08/18	Data collection pre-test.	Adjust time and method of administering tool		
14/08/18	MRCZ application	Proceed		
01/09/18	Data collection first group	Proceed		
10/10/18	Chapter 4 submitted	Adjust indicated areas		
15/10/18	Chapter 4 feedback	Proceed		
19/10/10	Chapter 5 submission	Adjust indicated areas		
20/10/18	Chapter 5 feedback	Proceed		
22/10/18	First Draft submitted	Adjust and submit for Turn it in		
23/10/18	Final draft	Print, Bind and Submit		

STUDENT'S SIGNATURE

SUPERVISOR'S SIGNATURE

APPENDIX M – MARKING GUIDE
MIDLANDS STATE UNIVERSITY
FACULTY OF SOCIAL SCIENCES
DEPARTMENT OF PSYCHOLOGY
A GUIDE FOR WEIGHTING A DISSERTATION

NAME OF STUDENT..... REGNO.....

	ITEM	POSSIBLE SCORE	ACTUAL SCORE	COMMENTS
A	RESEARCH TOPIC AND ABSTRACT: Clear and concise	5		
B	PRELIMINARY PAGES Title page, approval form, release form, dedication, acknowledgement, appendices, table of contents	5		
C	AUDIT SHEET Clearly shown on the audit sheet	5		
D	CHAPTER 1 Background, statement of the problem, significance of the study, research questions, hypothesis, assumptions, purpose of the study, delimitations, limitations, definition of terms	10		
E	CHAPTER 2 Address major issues and concepts of the study. Findings from previous work, relevancy of literature to the study Identify knowledge gap, subtopics	15		
F	CHAPTER 3 Appropriateness of approach, design, target population, population sample, research tools, data collection procedures, presentation and analysis	15		
G	CHAPTER 4 Findings presented in a logical manner, tabular data properly summarized and not repeated in the text	15		
H	CHAPTER 5 Discussion (10) Must be a presentation of generalizations shown by results: how results and interpretations agree with existing and published literature, relates theory to practical implications Conclusions (5) Ability to use findings to draw conclusions Recommendations (5)	20		
I	Overall presentation of dissertation	5		
J	References	5		
	Total	100		

MARKER.....SIGNATURE..... DATE.....

MODERATOR.....SIGNATURE.....DATE.....

APPENDIX N – SIMILARITY REPORT



Class Portfolio

My Grades

Discussion

Calendar

NOW VIEWING: HOME > MCP DISSERTATION NOV 2018

Welcome to your new class homepage! From the class homepage you can see all your assignments for your class, view additional assignment information, submit your work, and access feedback for your papers.

Hover on any item in the class homepage for more information.

Class Homepage

This is your class homepage. To submit to an assignment click on the "Submit" button to the right of the assignment name. If the Submit button is grayed out, no submissions can be made to the assignment. If resubmissions are allowed the submit button will read "Resubmit" after you make your first submission to the assignment. To view the paper you have submitted, click the "View" button. Once the assignment's post date has passed, you will also be able to view the feedback left on your paper by clicking the "View" button.

Assignment Inbox: MCP DISSERTATION NOV 2018

	Info	Dates	Similarity	
MCP DISSERTATION		Start 26-Oct-2018 12:11AM Due 30-Nov-2018 11:59PM Post 07-Dec-2018 12:00AM	0%	Resubmit View