Hope and Resilience as Protective Factors Against Depression Among Adolescents: Implications for Counselling Psychology in Zimbabwe

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DOI: https://doi.org/10.47772/IJRISS.2026.101000628

Received: 24 October 2026; Accepted: 29 October 2026; Published: 12 November 2026

ABSTRACT

Adolescent depression is a significant global public health concern, with consequences for psychological well-being, academic functioning, interpersonal relationships, and future development. Globally, approximately one in seven adolescents aged 10–19 years experiences a mental health condition, and depression is among the leading causes of illness and disability during adolescence. The burden is particularly concerning in sub-Saharan Africa, where adolescents face multiple social, economic, educational, and family-related stressors while access to specialised mental health services remains limited. Evidence from the region indicates substantial levels of depression and other common mental health difficulties among young people, although considerable variation exists across countries and measurement approaches. In Zimbabwe, population-based evidence similarly demonstrates a significant burden of common mental health problems among young people, highlighting the need for contextually appropriate prevention and intervention.

While traditional approaches to adolescent depression have frequently focused on identifying symptoms and risk factors, increasing attention has been directed towards protective factors that may reduce vulnerability and promote psychological well-being. This review focuses specifically on hope and resilience as potentially important protective factors. Drawing on Snyder's Hope Theory, hope is conceptualised as the combination of agency, or goal-directed motivation, and pathways thinking, or the perceived ability to identify routes towards desired goals. Resilience is understood as a dynamic developmental process through which adolescents adapt positively despite adversity. The review examines the relevance of these constructs to adolescent depression and considers their implications for Counseling Psychology practice in Zimbabwe, with particular attention to strengths-based assessment, culturally responsive interventions, school-based counselling, and the development of psychological resources that can support adolescents in navigating adversity. This paper is a narrative critical review rather than a systematic review. It synthesises the evidence thematically, identifies where evidence for Zimbabwean adolescents is missing, and labels its practice recommendations as inferences from related African and international research.

Keywords: adolescent depression; hope; resilience; protective factors; Counseling Psychology; Zimbabwe; strengths-based practice; adolescent mental health

INTRODUCTION

Adolescence is a critical developmental period marked by substantial biological, psychological, cognitive, emotional, and social change. During this period, young people increasingly develop their identities, establish relationships outside the immediate family, gain greater independence, and begin making decisions that shape their educational and occupational futures. Adolescence can therefore offer important opportunities for growth and positive development, but it can also be a period of heightened vulnerability to mental health difficulties. Academic pressure, interpersonal conflict, bullying, poverty, family instability, violence, discrimination, social exclusion, and uncertainty about the future can all influence adolescent psychological well-being. The World Health Organization (WHO) identifies adolescence as a formative period during which healthy coping, emotional regulation, interpersonal, and problem-solving skills have important implications for mental health across the life course (World Health Organization, 2025).

Depression is particularly important within this developmental context. Unlike temporary sadness or normal fluctuations in mood, depressive disorders involve persistent disturbances in mood and/or loss of interest or pleasure, accompanied by other psychological, cognitive, behavioural, and physical symptoms that result in significant distress or impairment. Current WHO estimates indicate that approximately one in seven adolescents aged 10–19 years experiences a mental health condition globally, and that depression, anxiety, and behavioural disorders are among the leading causes of illness and disability in this age group (World Health Organization, 2025). Importantly, mental health difficulties that emerge during adolescence may persist into adulthood when they are not identified and appropriately addressed, potentially affecting educational attainment, employment, relationships, physical health, and overall quality of life.

Adolescent depression should therefore not be understood exclusively as an individual psychological problem. It is embedded within broader developmental, relational, social, cultural, and economic environments. For adolescents living in low- and middle-income countries, these environments may include additional challenges associated with poverty, limited access to mental health services, educational inequalities, family unemployment, community adversity, and exposure to violence. In sub-Saharan Africa, depression and other common mental health problems constitute an important but frequently under-recognised concern. A systematic review of adolescent mental health studies across the region identified substantial levels of depression, anxiety, emotional and behavioural difficulties, post-traumatic stress, and suicidal behaviour among adolescents across multiple countries (Jörns-Presentati et al., 2021). More recent meta-analytic evidence has estimated a pooled prevalence of depression of approximately 15.27% among young people in sub-Saharan Africa, although substantial heterogeneity exists between studies (Gosse et al., 2026).

The significance of this burden extends beyond the presence of depressive symptoms. Adolescents experiencing depression may show reduced concentration, diminished motivation, social withdrawal, hopelessness, academic difficulties, interpersonal problems, and reduced engagement in activities that previously provided meaning or enjoyment. Where symptoms are severe, depression may also be associated with suicidal thoughts and behaviours. The consequences therefore extend beyond the individual adolescent to families, schools, health systems, and wider communities.

Within this context, there is a growing need to complement approaches that focus primarily on psychological difficulties with approaches that also identify and strengthen the resources that enable young people to cope with adversity. This has contributed to increased interest in strengths-based and positive psychological approaches, which seek not only to reduce psychological symptoms but also to promote adaptive functioning, meaning, agency, connectedness, and psychological well-being.

Burden of Adolescent Depression Globally and in Sub-Saharan Africa

The global burden of adolescent mental health problems provides a strong rationale for early prevention and intervention. WHO estimates that 14.3% of adolescents aged 10–19 years experience a mental health condition, while many of these difficulties remain unrecognised and untreated (World Health Organization, 2025). Depression is among the leading causes of illness and disability during adolescence. WHO further reports that mental health difficulties during adolescence can have consequences extending into adulthood, particularly when young people do not receive appropriate support.

Sub-Saharan Africa is of particular concern. A systematic review covering 16 countries and more than 97,000 adolescents found considerable variation in the prevalence of mental health problems, reflecting differences in study populations, instruments, definitions and social contexts, but a substantial burden overall (Jörns-Presentati et al., 2021). A more recent meta-analysis of 63 studies and 55,071 participants estimated a pooled depression prevalence of 15.27%, again with marked heterogeneity between studies (Gosse et al., 2026). Section 3.1 examines these data in more detail.

The African context matters because adolescent mental health cannot simply be understood through evidence generated in high-income countries. Adolescents in sub-Saharan Africa may experience unique combinations of socioeconomic disadvantage, family responsibilities, educational pressures, community adversity, gender-based violence, infectious disease burdens, and limited access to specialised psychological services. A

regional review has highlighted severe shortages of specialised adolescent mental health services, inadequate integration of mental health into primary healthcare, stigma, and insufficient attention to the social determinants of mental health (Gosse et al., 2026).

Zimbabwe illustrates these challenges. In a population-based study of young people aged 13–24 years in Harare and Mashonaland East, 37.4% screened positive for probable common mental disorders and 11.2% reported suicidal ideation (Doyle et al., 2023). These figures concern common mental health problems rather than diagnosed depression, but they show considerable psychological vulnerability among Zimbabwean young people (see Section 3.1.2).

These findings reinforce the need for interventions that are not only accessible but also developmentally appropriate and culturally responsive. In settings where specialist mental health resources are limited, prevention and early intervention strategies that can be implemented through schools, communities, primary healthcare, and counselling services may be particularly valuable.

From Risk-Focused to Strengths-Based Approaches

Historically, much mental health research and clinical practice has focused on identifying risk factors associated with psychological disorders. In the context of adolescent depression, these may include adverse childhood experiences, family conflict, social isolation, academic difficulties, poverty, trauma, bullying, chronic illness, and negative cognitive patterns. Identifying such factors remains essential, because understanding vulnerability helps professionals develop appropriate prevention and intervention strategies.

However, a predominantly risk-focused approach may provide an incomplete understanding of adolescent mental health. Two adolescents may experience similar adversity yet show very different psychological outcomes. One may develop persistent depressive symptoms, whereas the other may maintain psychological functioning, seek social support, adapt to changing circumstances, and continue pursuing meaningful goals. This difference raises an important question: what psychological and environmental resources enable some adolescents to cope more successfully with adversity?

This question has contributed to a broader shift towards strengths-based approaches. Rather than asking only "What is wrong with this adolescent?", strengths-based practice also asks "What is working, what resources does this young person possess, and what can be strengthened?"

This does not mean minimising depression or ignoring risk. Rather, strengths-based practice complements risk assessment by recognising that psychological functioning is influenced by both vulnerability and protective processes. In counselling, this perspective allows practitioners to assess symptoms while simultaneously exploring an adolescent's strengths, relationships, values, goals, coping skills, sense of meaning, and sources of support.

Hope and resilience are particularly relevant within this framework because both constructs focus on how individuals respond to challenges and maintain or regain adaptive functioning. Hope emphasises the ability to formulate meaningful goals, identify possible pathways towards those goals, and maintain motivation to pursue them. Resilience focuses on positive adaptation in the context of adversity. Together, they offer a framework through which counselling psychologists can move beyond symptom reduction towards the development of psychological capacities that support long-term functioning.

This approach is especially relevant for adolescents, because adolescence is a period during which beliefs about the future, identity, competence, relationships, and personal agency are actively developing. Supporting adolescents to develop realistic goals and confidence in their ability to navigate obstacles may therefore have implications not only for current psychological well-being but also for their transition into adulthood.

Defining Hope: Snyder's Theory

Hope is often used in everyday language to describe a positive expectation that something desirable will happen. Within psychological theory, however, hope has a more specific meaning. Snyder's Hope Theory conceptualises hope as a cognitive-motivational process involving two interconnected components: agency thinking and pathways thinking (Snyder, 2002).

Agency thinking refers to an individual's perceived capacity to initiate and sustain movement towards desired goals. It can be understood as the motivational component of hope; the belief that "I can act towards achieving this goal." Pathways thinking, in contrast, refers to the perceived ability to identify routes or strategies through which desired goals can be achieved.

Consider, for example, an adolescent who wishes to improve academic performance. A hopeful adolescent may identify the goal of passing an examination, develop several strategies such as creating a study timetable, joining a study group, asking a teacher for assistance, or accessing additional learning materials, and maintain motivation despite setbacks. Hope, therefore, is not simply positive thinking. It involves goal-directed thinking, planning, perceived agency, and the capacity to generate alternative pathways when obstacles arise.

Snyder's framework is particularly relevant to adolescents because young people are increasingly required to make decisions concerning education, relationships, career aspirations, and future identity. When adolescents perceive that they have no meaningful goals, or no possible routes towards achieving them, they may become vulnerable to feelings of helplessness, discouragement, and hopelessness. Conversely, the ability to identify meaningful goals and alternative pathways may support adaptive coping.

The Children's Hope Scale, developed for children and adolescents aged approximately 8–16 years, operationalises the two dimensions of agency and pathways thinking and provides evidence for assessing hope during childhood and adolescence (Snyder et al., 1997). The broader Hope Scale has similarly been developed to measure these dimensions in older populations (Snyder et al., 1991).

Importantly, hope should not be interpreted as unrealistic optimism. An adolescent can acknowledge difficult circumstances while still believing that alternative routes towards meaningful goals exist. From a counselling perspective, this distinction matters. Effective hope-oriented counselling does not require the psychologist to tell an adolescent that "everything will be fine." Instead, it involves helping the young person identify achievable goals, recognise existing strengths, generate realistic alternatives, and develop confidence in taking purposeful action.

Hope may therefore represent an important psychological resource for adolescents experiencing depression. The relationship between hope and depression is particularly meaningful because depression may involve negative expectations about oneself, one's circumstances, and the future. Strengthening agency and pathways thinking may provide one avenue through which counselling can challenge helplessness and support renewed engagement with life goals.

Defining Resilience: A Developmental Perspective

Resilience is another central concept within strengths-based psychology. Although resilience has sometimes been described as an individual's ability to "bounce back" from adversity, contemporary developmental perspectives conceptualise it more broadly as a dynamic process of positive adaptation in the presence of significant adversity or stress (Luthar et al., 2000; Masten, 2001).

This distinction is important because resilience should not be understood as an innate personality trait that some adolescents simply possess while others lack. Rather, resilience develops through interactions between the individual and their environment. Personal characteristics, family relationships, peer networks, schools, communities, cultural values, and access to supportive services can all contribute to resilient adaptation (Ungar, 2011).

From a developmental perspective, resilience may change across time and circumstances. An adolescent may cope effectively with one challenge but struggle with another. Similarly, resilience can be strengthened through supportive relationships, opportunities for competence, emotional regulation skills, problem-solving abilities, positive identity development, and access to meaningful social resources.

Protective factors associated with resilience may therefore exist at several levels (Fergus & Zimmerman, 2005). At the individual level, these may include self-efficacy, emotional regulation, problem-solving skills, positive self-concept, optimism, and adaptive coping. At the family level, supportive parenting, family cohesion, communication, and emotional availability may contribute. At the school level, supportive teachers, positive peer relationships, belonging, and opportunities for achievement may provide protective resources. At the community level, safe environments, social connectedness, cultural identity, religious or spiritual resources, and accessible mental health services may promote adaptive functioning.

This ecological understanding is particularly relevant in Zimbabwe and other African contexts, where individual well-being is often strongly embedded within family, community, cultural, and relational systems. Consequently, resilience-oriented counselling should avoid placing the entire responsibility for adaptation on the adolescent. Instead, it should examine both individual strengths and environmental resources.

Resilience should also not be confused with the absence of distress. A resilient adolescent may experience sadness, fear, disappointment, or significant psychological pain while still being able to seek support, adapt to changing circumstances, maintain meaningful relationships, and gradually regain functioning. Resilience therefore represents adaptive functioning in the context of difficulty, rather than immunity from emotional suffering.

Rationale for Focusing on Counseling Psychology

Counseling Psychology provides an appropriate framework for examining hope and resilience because the discipline traditionally emphasises human development, psychological well-being, strengths, prevention, coping, interpersonal relationships, and the promotion of adaptive functioning.

Although the treatment of adolescent depression may involve clinical assessment, psychotherapy, psychiatric intervention, and multidisciplinary care, Counseling Psychology can make an important contribution at the level of prevention, early intervention, psychological support, and strengths development.

For adolescents, counselling can provide a structured and confidential environment in which young people explore emotional experiences, identify personal strengths, develop coping strategies, clarify values and goals, improve problem-solving skills, and strengthen supportive relationships. Within a strengths-based approach, the counsellor does not ignore depressive symptoms. Rather, assessment of symptoms is combined with exploration of protective resources.

This perspective is particularly relevant in Zimbabwe, where access to specialist mental health services remains an important challenge. Evidence from sub-Saharan Africa indicates shortages of specialised adolescent mental health services and barriers associated with stigma and limited service availability (Mushonga et al., 2025). Research examining school-based psychological interventions in the region also suggests the potential value of delivering mental health interventions within accessible settings such as schools (Osborn et al., 2020).

Counseling psychologists may therefore have an important role across multiple levels of intervention. At the individual level, counselling may strengthen agency, coping, emotional regulation, and goal-setting. At the family level, psychologists can promote communication, supportive parenting, and understanding of adolescent mental health. At the school level, counsellors can facilitate psychoeducation, early identification, peer-support initiatives, group counselling, and referral. At the community level, counselling psychologists can contribute to mental health promotion, stigma reduction, community education, and culturally responsive psychosocial interventions.

A focus on hope and resilience also aligns with the preventive orientation of Counseling Psychology. Rather than waiting until depressive symptoms become severe, practitioners can identify and strengthen protective resources before or alongside the emergence of significant psychological difficulties.

Rationale for a Zimbabwean and Culturally Responsive Perspective

Although much of the literature concerning hope, resilience, and depression has emerged from Western contexts, psychological constructs cannot automatically be assumed to operate identically across cultures. Adolescents' understanding of identity, family, responsibility, success, spirituality, community, and the future is influenced by their sociocultural environment.

In Zimbabwe, concepts of well-being may be strongly influenced by family relationships, community belonging, spirituality, cultural identity, educational aspirations, and expectations regarding social responsibility. Interventions that seek to strengthen hope and resilience should therefore be sensitive to the meanings adolescents attach to these experiences.

A culturally responsive counselling approach does not mean assuming that all Zimbabwean adolescents share the same beliefs or experiences. Zimbabwean adolescents represent diverse socioeconomic, religious, linguistic, educational, urban, peri-urban, and rural contexts. Instead, culturally responsive practice requires psychologists to explore how each adolescent understands their circumstances and what sources of strength are meaningful within their particular context.

This is especially important when working with constructs such as hope. For one adolescent, hope may be closely connected to educational achievement or future employment; for another, it may involve family relationships, spirituality, creative aspirations, sport, community belonging, or personal independence. Similarly, resilience may be expressed through individual coping but may also be supported by family, peers, schools, churches, community structures, or other social networks.

A Zimbabwean Counseling Psychology perspective should therefore seek to integrate evidence-based psychological principles with locally meaningful understandings of adolescent development and well-being.

Aim and Scope of the Review

The primary aim of this review is to examine hope and resilience as protective factors against depression among adolescents and to consider their implications for Counseling Psychology practice in Zimbabwe.

Specifically, the review seeks to:

- Examine the burden and significance of adolescent depression globally and within sub-Saharan Africa, with particular attention to the Zimbabwean context.
- Explore the theoretical conceptualisation of hope, particularly Snyder's Hope Theory and its components of agency and pathways thinking.
- Examine resilience from a contemporary developmental perspective, including individual, family, school, and community protective resources.
- Review empirical evidence concerning the relationship between hope, resilience, and depressive symptoms among adolescents.
- Explore how hope and resilience may interact to support adaptive coping and psychological well-being.
- Consider the relevance of strengths-based approaches to adolescent counselling in Zimbabwe.
- Identify gaps in existing African and Zimbabwean research and highlight directions for future research and practice.

The review does not suggest that hope and resilience alone can prevent or treat depression. Rather, these constructs are considered as protective resources within a broader biopsychosocial and ecological understanding of adolescent mental health. Severe or persistent depression requires appropriate assessment

and, where indicated, multidisciplinary intervention. The purpose of focusing on protective factors is therefore to complement, not replace evidence-based assessment and treatment.

Structure of the Review

The remainder of the paper is organised as follows. Section 2 describes how this narrative review was conducted and its limitations. Section 3 synthesises the literature thematically: the burden of adolescent depression (3.1), the evidence for hope (3.2) and resilience (3.3) as protective factors, their interaction (3.4), and how both may be expressed in Shona and Ndebele cultural contexts (3.5). Section 4 draws out implications for Counseling Psychology in Zimbabwe and critically examines the risks of importing interventions and measures without local adaptation. Section 5 sets out research priorities, and Section 6 states what the review adds.

METHOD

Search Strategy

This paper is a narrative critical review. It does not claim to be a systematic review and does not follow PRISMA reporting standards. Its aim was to identify, appraise and synthesise empirical and theoretical literature on the relationship between hope, resilience and adolescent depression, with particular emphasis on evidence relevant to Zimbabwe and the wider sub-Saharan African context, and to develop implications for Counseling Psychology practice.

A structured and documented search was used so that readers can see how the evidence base was assembled, but the search was designed to build an informed, critical account of the field rather than to retrieve every eligible study.

Four electronic databases were searched: PubMed, PsycINFO, Scopus and Google Scholar. The search ran in two phases. The first phase targeted the core constructs of the review, using Boolean operators and controlled vocabulary with the primary search string: ("adolescent" OR "youth" OR "teenager") AND ("depression" OR "depressive symptoms" OR "major depressive disorder") AND ("hope" OR "resilience" OR "protective factors" OR "strengths-based"). The second phase added a targeted string to capture context-specific literature: ("Zimbabwe" OR "Sub-Saharan Africa" OR "Africa") AND ("adolescent" OR "youth") AND ("depression" OR "mental health" OR "prevalence").

In addition to the database searches, the reference lists of included articles and of relevant systematic reviews were hand-searched to identify further sources. The search was limited to peer-reviewed journal articles, books and book chapters published in English between 2000 and 2026, a period chosen to capture the main theoretical developments in positive psychology and developmental psychopathology since the turn of the millennium.

Because the search was iterative and aimed at building a critical narrative, the numbers of records identified, screened, excluded and included were not logged at each stage. For this reason no PRISMA flow diagram is presented, and the review should not be read as an exhaustive or exactly reproducible count of the literature. The English-language restriction and the limited use of grey literature are discussed in Section 2.4.

Inclusion and Exclusion Criteria

The following criteria guided the selection of sources for the narrative, so that the evidence discussed is relevant and of adequate quality.

Inclusion criteria

- **Population**; Studies were included if their sample consisted of adolescents (broadly defined as individuals aged 10–19 years, consistent with the World Health Organization definition) or young adults

(up to age 24) where findings were disaggregated for the adolescent subgroup (World Health Organization, 2025).

- **Constructs**; Studies were required to measure or conceptually analyse at least one of the following: depression (or depressive symptoms), hope, or resilience.
- **Design**; The review included quantitative studies (cross-sectional, longitudinal, cohort, and intervention designs), qualitative studies, and theoretical or review articles that contributed to the conceptual understanding of the protective factors.
- **Context**; Priority was given to studies conducted in sub-Saharan Africa, with specific attention to Zimbabwe. However, given the paucity of Zimbabwean-specific research on hope and resilience, high-quality studies from other low- and middle-income countries and seminal global research were also included to provide a comparative evidence base.

Exclusion criteria

- Studies focusing exclusively on clinical populations with a primary diagnosis other than depression (e.g., schizophrenia, bipolar disorder) were excluded unless depression was a secondary outcome of interest.
- Articles that were not peer-reviewed (e.g., opinion pieces, editorials, conference abstracts) were excluded, with the exception of authoritative reports from organisations such as the World Health Organization or UNICEF.
- Studies that did not provide sufficient methodological detail to assess quality, or whose findings were not reported in a way that could be meaningfully synthesised, were excluded.

Data Extraction and Synthesis Approach

Key information was extracted from each included source into a structured form: author(s), year of publication, study location, design, sample characteristics (size, age range, gender distribution), measures of depression, hope and resilience, and the main findings on the relationships between these constructs. These data underpin the thematic synthesis in Section 3. The characteristics of the studies that contribute most to it are summarised in Supplementary Table S1 (after the References), so that the text can synthesise across studies instead of describing them one at a time.

Given the heterogeneity of study designs, measures and populations, a meta-analytic approach was not feasible. Instead, a narrative synthesis was adopted, guided by the framework of Popay et al. (2006). This allowed quantitative and qualitative findings to be integrated, patterns and divergences across studies to be explored, and a coherent narrative to be developed in relation to the review's aims. The synthesis was organised thematically: first the context and burden of adolescent depression (Section 3.1), then the evidence for hope and resilience as protective factors (Sections 3.2 and 3.3), their interaction (Section 3.4), and their expression in Shona and Ndebele cultural contexts (Section 3.5), and finally implications for practice (Section 4).

A particular focus of the synthesis was on identifying the mechanisms through which hope and resilience may confer protection against depression, as well as the cultural and contextual factors that may moderate these relationships in Zimbabwean and African settings. Throughout the synthesis, gaps in the literature were noted; these are consolidated and discussed in Section 5 to inform future research directions.

Limitations of the Review

Several limitations of the review itself should be kept in view. First, it is a narrative review, so the selection of sources involved judgement and no formal risk-of-bias tool was applied. Selection bias cannot be excluded, and because no PRISMA flow diagram is available, readers cannot see how many records were considered at each stage. Second, the search was restricted to English-language publications. This excludes work published in Shona, Ndebele or other languages, and work in French or Portuguese from other parts of Africa, and may under-represent locally produced knowledge.

Third, the review drew mainly on peer-reviewed literature. Grey literature such as government reports, programme evaluations and theses was used only selectively, even though much Zimbabwean evidence on

adolescent mental health sits in these sources. The Zimbabwean material cited here therefore rests on a small number of studies, some of which are a preprint, a master's thesis or an implementation brief and have not been through journal peer review. Fourth, most of the hope and resilience measures and intervention trials discussed were developed and tested outside Zimbabwe. Their findings are used as comparative evidence, and the conclusions about Zimbabwean adolescents rest on inference and not on direct testing. Finally, the review covers the literature only up to the date of the last search and may miss more recent studies.

FINDINGS

Because the same studies bear on several themes, this section synthesises findings by theme and reports individual study details only where they matter to the argument. Supplementary Table S1 (after the References) lists the main characteristics of the studies that contribute most to the findings.

Adolescent Depression: Prevalence and Correlates

Global Prevalence

Depression is among the most significant contributors to the global burden of disease in young people. A meta-analysis of 96 studies from 29 countries and more than 528,000 participants estimated the pooled prevalence of mild-to-severe depression among children and adolescents at 21.3%, moderate-to-severe depression at 18.9% and major depression at 3.7%, with prevalence rising between 1989 and 2022 (Lu et al., 2024). WHO estimates of 1.3% for adolescents aged 10–14 years and 3.4% for those aged 15–19 years (World Health Organization, 2025) are much lower because they concern clinical depressive disorder, whereas the meta-analytic figures include elevated symptoms. Where broader screening tools are used, one review put the global point prevalence of elevated self-reported depressive symptoms in 2001–2020 at 34% (Shorey et al., 2022). Taken together, these estimates suggest that between one in five and one in three adolescents worldwide report significant depressive symptoms at any given time, while a much smaller proportion meet criteria for a depressive disorder.

The burden is not evenly distributed. It is greater in lower-middle-income countries than in higher-income settings (Lu et al., 2024). In sub-Saharan Africa about one in five adolescents is estimated to have at least one mental health problem, and depression prevalence has been reported at between 15.27% and 26.9% depending on the instrument and population (Gosse et al., 2026). Heterogeneity is substantial, so these ranges indicate a large burden and are not precise estimates.

Context in Zimbabwe and Africa

Evidence from Zimbabwe is growing but fragmented, and much of it comes from studies with methodological limitations. The strongest population-level data come from a general-population sample of young people aged 13–24 years in Harare and Mashonaland East, in which 37.4% screened positive for probable common mental disorders, 15.8% had abnormal emotional symptom scores and 11.2% reported suicidal ideation. The odds of probable common mental disorders rose with age and were higher among those neither in school nor working (Doyle et al., 2023). These figures describe common mental disorders and not depression specifically, so they indicate vulnerability and not depression prevalence. Studies of particular groups point the same way: 18.5% of adolescents in the juvenile justice system in Bulawayo and Matabeleland North screened positive for depression (Marufu, 2024), and one study of adolescents living with HIV found that 57% screened positive (Zvandiri, 2021). A national survey recorded depression in only 2% of adolescents aged 15–17 years (ZIMSTAT & UNICEF, 2019), a figure widely considered an underestimate because of stigma and underreporting.

Zimbabwean adolescents also face a cluster of risk factors that precipitate and sustain depression: adverse childhood experiences, food insecurity, sexual and emotional violence, and the chronic stress of poverty, HIV and political instability. In one study, 28.4% of adolescents and youth reported mental distress in the previous 30 days, and cumulative adverse childhood experiences were associated with higher odds of distress (Chipalo,

2024). These conditions are not background variables. They shape how depression is experienced, expressed and treated, and they are the setting in which any protective role of hope and resilience has to be judged.

Academic, Social, and Health Impacts

Untreated adolescent depression has far-reaching consequences. In a 21-year longitudinal study, depression in mid-adolescence (ages 14–16) predicted later major depression, anxiety disorders, nicotine dependence, alcohol abuse or dependence, suicide attempt, educational underachievement, unemployment and early parenthood, for girls and boys alike (Weavers et al., 2021). Academically, depression is linked to impaired concentration, reduced motivation and absenteeism, and among school-going adolescents in Uganda even mild depressive symptoms were associated with a two-fold higher risk of behavioural impairment affecting academic and social life (Anguzu et al., 2025). Where education is a main route out of poverty, as in Zimbabwe, this is a threat to individual and national development. Socially, depression is associated with withdrawal, impaired peer relationships and family conflict, which can deepen isolation and in turn worsen symptoms.

Suicide risk is a particular concern. Suicidal ideation was reported by 11.2% of young people in the Harare study (Doyle et al., 2023), and the risk of suicidal behaviours among adolescents living with HIV has been estimated at 47.4% (Zvandiri, 2021). Depression is also associated with substance use, risky sexual behaviour and poorer physical health, and the global economic cost of adolescent anxiety and depression has been put at US$340 billion a year, mostly through lost productivity and healthcare costs (UNICEF, 2021). In Zimbabwe, services are concentrated in urban hospitals and few trained professionals serve most of the population (Mushonga et al., 2025), so the human and economic costs of inaction are considerable.

Against this background of high prevalence, functional impairment and contextual risk, the protective potential of hope and resilience becomes important. Understanding how these strengths can be assessed and nurtured in Zimbabwean adolescents is a clinical and public health priority.

Hope as a Protective Factor

Conceptualisation and Measurement

Hope, as conceptualised by C. R. Snyder, is a cognitive-motivational construct rooted in goal-directed thinking (Snyder, 2002). It comprises two reciprocal components: agency thinking (the perceived capacity to initiate and sustain the motivation necessary to achieve goals) and pathways thinking (the perceived ability to generate workable routes to desired goals). Unlike related constructs such as optimism or self-efficacy, Snyder's theory equally emphasises both the motivational ("willpower") and strategic ("waypower") dimensions of goal pursuit (Snyder, 2002). A goal, in this framework, can be anything an individual desires to experience, create, get, do, or become. For adolescents navigating the developmental challenges of identity formation, academic pressures, and shifting social landscapes, the capacity to set goals and generate pathways to achieve them is particularly salient (Marques et al., 2011; Snyder, 2002).

The theoretical distinctiveness of hope becomes clearer when it is contrasted with neighbouring constructs. Optimism, as conceptualised by Scheier and Carver (1985), refers to a generalised expectancy that good outcomes will occur, but it does not specify the mechanisms through which those outcomes are to be achieved. Self-efficacy, by contrast, refers to the belief in one's capability to execute specific behaviours, but it does not inherently include the generation of alternative routes when obstacles arise (Bandura, 1997). Hope uniquely integrates both the motivational and strategic components, which is why it has been described as a "cognitive-motivational" resource rather than merely an affective disposition (Snyder, 2002). In high-adversity contexts such as Zimbabwe, this distinction carries practical weight. An adolescent may remain optimistic that life will improve while possessing no viable pathway to that improvement, and it is the pathways component of hope, the ability to generate alternative routes, that may be most protective when structural barriers constrain options (Ciarrochi et al., 2007).

The measurement of hope in adolescents has evolved considerably since Snyder's original formulations. The most widely used measures include the Children's Hope Scale, a six-item self-report instrument that captures

pathways and agency thinking (Dew-Reeves et al., 2012; Snyder et al., 1997), and the Dispositional Hope Scale, which has been validated for use with adolescents in diverse cultural contexts (Snyder, 2002). The Children's Hope Scale has demonstrated robust psychometric properties across diverse populations: a large-scale validation with 171,052 Australian students aged 8–18 years confirmed that it is a unidimensional scale with good internal consistency (Cronbach's $\alpha = .86$) and sensitivity to age and gender differences (Richter et al., 2024). Critically for the present review, the scale has also been validated among South Sudanese refugee children displaced in Uganda (N = 1,118), where confirmatory factor analyses supported its underlying factor structure and demonstrated measurement invariance by sex and developmental stage (Tumwebaze et al., 2023). In South Africa, the Children's Hope Scale has similarly shown scalar invariance in adolescent samples (Guse, 2016), providing preliminary evidence that hope is not culturally bound to Western populations but is measurable and meaningful among African adolescents, including those exposed to significant adversity.

The Comprehensive Child and Adolescent Hope Scale offers a broader, four-dimensional assessment (attachment, survival, mastery, and spirituality), demonstrating strong internal reliability ($\alpha = .95$) and correlation with measures of anxiety and depression (Scioli et al., 2025). This instrument represents a significant theoretical expansion of Snyder's original model, incorporating attachment, survival, and spirituality alongside mastery. Such a multidimensional framework may be particularly well suited to African contexts, where spiritual and relational dimensions of hope are culturally salient. The scale has demonstrated stability over a three-month test–retest period ($r = .77$), suggesting its potential utility for both assessment and outcome monitoring in clinical and school settings (Scioli et al., 2025). Importantly, higher hope scores have been consistently linked to lower symptom severity at baseline in clinical samples of adolescents (Dew-Reeves et al., 2012).

Empirical Evidence Linking Hope to Lower Depression

Cross-sectional, longitudinal and experimental evidence converges on an inverse relationship between hope and adolescent depression. In a latent class study of Chinese adolescents, those in a high-hope class (32%) reported lower depression and higher life satisfaction and self-esteem than those in average-hope (47.5%) and low-hope (20.5%) classes. This suggests that the benefits of hope are not confined to Western settings, and that roughly one in five adolescents may have low hope even in an academically driven, collectivist context (Li et al., 2023). Longitudinal evidence speaks more directly to direction. A meta-analysis of 22 studies with 10,682 adolescents found that lower hope was associated with higher depression ($r = .16$, $p < .001$) and predicted later depressive symptoms even after controlling for baseline anxiety. Hope also buffered the effect of negative repetitive thinking on depressive symptoms, although the relationship was reciprocal, with depression predicting later reductions in hope (Yao et al., 2024). Hope contributes beyond related constructs too: in a longitudinal study it predicted school grades and emotional well-being after controlling for self-esteem and attributional style, and it explained variance in depression beyond optimism (Ciarrochi et al., 2007).

Two points qualify this picture. First, the pooled association between lower hope and depression is modest ($r = .16$), whereas the association with hopelessness is larger ($r = .34$), which suggests that building hopeful thinking and reducing hopeless thinking are related but separate therapeutic targets (Yao et al., 2024). Second, the reciprocal relationship implies a negative cycle in which depression erodes hope and low hope sustains depression, a cycle that hope-based intervention might interrupt.

Experimental evidence is limited but supportive. In a randomised controlled trial of a five-week hope intervention delivered by paraprofessionals to adolescents aged 13–17 years, the treatment group showed greater increases in hope, more use of social coping and self-acceptance strategies, and a significant reduction in depression compared with a waitlist control (Scioli et al., 2025). Delivery by trained advanced psychology students suggests scalability where specialists are scarce, which is relevant to Zimbabwe, but the trial was not conducted with Zimbabwean adolescents.

Mechanisms: Goal-Setting, Coping, and Problem-Solving

The protective effect of hope is thought to operate through three linked mechanisms. The first is goal-setting. High-hope individuals pursue more goals, so that blockage of one goal is less devastating, whereas low-hope

individuals may experience a cascade of dysphoria, loss of agency and reduced pathways that can end in depressive symptoms (Cheavens et al., 2006; Snyder, 2002). Zimbabwean adolescents face many potential blockages, among them educational disruption caused by economic hardship, limited employment prospects, family separation through parental migration, and food insecurity. Diversifying goals across life domains may therefore be an especially relevant protective strategy.

The second mechanism is coping. Hope theory treats most non-biological depression as a deficiency in hopeful thinking that can be treated by systematically raising hope (Cheavens et al., 2006). Hopeful adolescents are more likely to use social coping and self-acceptance strategies (Ciarrochi et al., 2007; Snyder, 2002), to appraise stressors as challenges rather than threats, to persist, and to seek support, so that transient distress is less likely to consolidate into clinical depression. These coping advantages are proposed by theory, and the evidence cited here does not show which of them carries the link between hope and depression.

The third mechanism is problem-solving, which pathways thinking facilitates by equipping adolescents to navigate obstacles without becoming immobilised (Snyder, 2002). The trial by Scioli et al. (2025) explicitly targeted pathways thinking by asking adolescents to identify multiple routes to their goals, and school-based programmes elsewhere have reported benefits. A year-long positive psychology intervention with Australian secondary students lowered depressive symptoms and raised well-being and hope relative to controls (Lim et al., 2025), and the Hopeful Minds programme in Malaysian secondary schools reduced overall and somatic depressive symptoms (Abdul Kadir et al., 2026). These results suggest that hope-based problem-solving can be taught in groups within existing school structures, and that it could be feasible in resource-constrained Zimbabwean schools if teacher-counsellors are trained to deliver manualised programmes, although such programmes have not been tested in Zimbabwe.

Resilience as a Protective Factor

Conceptualisation and Sources: Individual, Family, School, and Community

Resilience is understood from a developmental perspective as the capacity for positive adaptation in the context of significant adversity (Luthar et al., 2000; Masten, 2001). It is not a static trait but a dynamic, evolving process rooted in meaning-making and the mobilisation of resources across multiple systems (Ungar, 2011). In the adolescent developmental period, resilience resources span individual, familial, school, and community domains (Fergus & Zimmerman, 2005). Contemporary resilience scholarship emphasises that resilience is not merely the absence of psychopathology following adversity but the presence of positive functioning across multiple developmental domains (Masten, 2001). This distinction is particularly important for adolescents in Zimbabwe, where baseline levels of adversity are high and where "positive adaptation" must be understood relative to the normative context of adversity rather than to a universal standard of thriving.

At the individual level, resilience is supported by personal strengths such as self-efficacy, problem-solving skills, and enabling values (Fergus & Zimmerman, 2005). Familial resources include parental monitoring, secure attachment, and responsive caregiving; a cohort study of U.S. adolescents found that parental monitoring and youth problem-solving skills were prospective resilience factors against depression susceptibility (Theron et al., 2023). School environments contribute through supportive teacher–student relationships, school connectedness, and structured opportunities for autonomy and competence (Theron, 2023). Community and cultural resources include peer support, faith-based networks, and communal values of interdependence and spirituality (Theron, 2016; Ungar, 2011).

In African contexts, the socio-ecological model of resilience articulated by Ungar (2011) requires expansion to account for culturally specific relational structures. Recent conceptual work has proposed that Western resilience frameworks systematically undervalue the intergenerational care networks and indigenous knowledge systems that are central to African societies, and that resilience in African adolescents must be understood through the lens of Ubuntu philosophy; the African worldview that emphasises interconnectedness, interdependence, and communal responsibility (Mhaka-Mutepfa & Mpofu, 2026; Theron, 2016). An Afrocentric model of resilience developed from research with Black rural adolescents in South Africa identified Ubuntu and respect for elders as core cultural resources that support positive adaptation (Mahwai

& Ross, 2026). This framework adds depth to the relational and cultural-spiritual layers of the socio-ecological model and suggests that resilience-promotion efforts in Zimbabwe should include preserving traditional practices, promoting cultural pride, and fostering African values such as Ubuntu.

The school context merits particular attention in the Zimbabwean setting, where schools are often the most accessible institutional resource for adolescents. A longitudinal Australian study of 3,512 adolescents found that greater resilience predicted lower depression and anxiety, and greater happiness, life satisfaction, and positive affect one year later, with school climate and school identification emerging as important contextual contributors (Allen et al., 2025). In rural Zimbabwe, a qualitative study with 15 students aged 13–18 identified that resilience pathways were supported by community collaboration and personal strengths, and that school–community partnerships were critical for promoting adaptive coping and improved mental health care (Chidakwa, 2026). The study highlighted peer influence, mentorship, and experiential exposure as important but often underexplored mechanisms supporting rural resilience (Chidakwa, 2026). Community-based organisations also play a role: research in Zimbabwe has shown that such organisations provide platforms for young people to express themselves, build resilience, and develop coping mechanisms for the challenges they face (Bindura University of Science Education, 2025). These findings align with the growing recognition that resilience in African contexts is fundamentally relational and communal rather than individualistic, and that resilience-promotion efforts must engage families, schools, and communities as interconnected systems.

Empirical Evidence Linking Resilience to Lower Depression

Longitudinal evidence supports resilience as a predictor of lower depression. In a three-wave study of 333 secondary vocational school students assessed at one-month intervals, resilience and depression were reciprocally and negatively related across waves, and resilience, rather than meaning in life, was the active ingredient: meaning in life did not directly predict depression, whereas resilience reduced depressive symptoms and promoted later meaning in life (Zhou et al., 2026). This challenges the assumption that meaning-making alone is protective and suggests that practical coping skills and adaptive capacities deserve priority in interventions for adolescents in high-stress educational settings. A three-year prospective clinical cohort of 717 adolescents with anxiety or depressive disorders found that higher levels of promotive factors, including structured style, personal and social competencies, family functioning and social resources, were associated with a lower probability of anxiety or depression three years later, and that personal competence beliefs and social competence reduced the persistence of depression and its spread to anxiety (Ranøyen et al., 2025).

African evidence points the same way. Among 1,972 Kenyan youth aged 14–25 years, depression and hopelessness were strongly and negatively associated with resilience (Ndetei et al., 2025), and a study across four sub-Saharan African countries found that higher resilience was associated with less suicidal ideation and fewer depressive symptoms, with the strongest protective effect among adolescents exposed to the highest adversity (Cortina et al., 2021). This suggests that resilience acts as a compensatory resource that matters most for the most vulnerable adolescents. Few of these studies come from Zimbabwe, and associations of this kind cannot by themselves show that increasing resilience would reduce depression in Zimbabwean adolescents.

Cultural Considerations in African Adolescents

Resilience in African adolescents must be understood through a socio-ecological and culturally grounded lens. A narrative scoping review of 59 studies across 18 sub-Saharan countries found that the resilience of children and adolescents is a complex, social-ecological process supported by relational, personal, structural, cultural, and spiritual resilience-enablers (Theron, 2023). Crucially, relational and personal supports matter more or less equally, and the capacity for positive adjustment is complexly interwoven with African ways of being and doing (Theron, 2023). The review identified that resilience-enablers in sub-Saharan Africa cluster into five categories: relational (family, peer, and community support), personal (self-efficacy, problem-solving, and emotional regulation), structural (access to education, healthcare, and economic resources), cultural (values of interdependence, respect for elders, and communal responsibility), and spiritual (religious faith, ancestral connection, and transcendent meaning). These enablers do not operate in isolation but interact dynamically, such that the protective effect of any single enabler depends on the availability of others. For example, personal

self-efficacy may be less protective in contexts where structural barriers systematically block goal attainment, unless it is accompanied by relational support that helps the adolescent navigate those barriers (Theron, 2023).

A South African mixed-methods study with 223 adolescents identified four depression trajectories and found that resource constellations characterised by within- and across-system diversity and cultural responsiveness were most protective (Theron et al., 2023). The stable-low and declining depression trajectories were characterised by diverse personal, relational, contextual, and culturally valued resources, with an emphasis on relational supports (Theron et al., 2023). This finding aligns with traditional African valuing of interdependence and spirituality (Theron, 2023).

In Zimbabwe specifically, a study of left-behind adolescents found that resilience was expressed through varied adaptive forms; from spiritual belief and symbolic connection to inward dialogue and outward service and that coping strategies were largely internally driven and rooted in future-oriented meaning-making (Fisher et al., 2023). Adolescents in the study demonstrated varying forms of adaptive resilience, including reliance on faith as a meaning-making framework that enabled them to endure emotional hardship, the use of emotional withdrawal as a protective strategy, and the articulation of strong agency in rejecting the notion that parental absence must dictate their future (Fisher et al., 2023). One adolescent's narrative demonstrated resilience as active meaning-making rooted in future orientation rather than emotional fixation, while another found strength in transcendence and spiritual framing that transformed isolation into sacred endurance (Fisher et al., 2023).

These findings illustrate that resilience in Zimbabwean adolescents is not a single, uniform construct but manifests through diverse pathways shaped by individual temperament, cultural resources, and the specific nature of the adversity faced. This heterogeneity reinforces the need for culturally grounded, individualised approaches to resilience assessment and intervention rather than one-size-fits-all programmes.

The Interaction Between Hope and Resilience

How They Reinforce Each Other

Hope and resilience are conceptually distinct but functionally linked: hope supplies the cognitive-motivational drive for goal pursuit, and resilience supplies the adaptive capacity to sustain that pursuit under adversity (Masten, 2001; Snyder, 2002). Studies that have examined the two together suggest a sequential process in which hopeful adolescents engage in goal-directed coping that builds resilience, and resilience in turn sustains hope through successful coping. In a study of secondary school students, psychological resilience mediated the relationship between hope and mental health (Scioli et al., 2025), consistent with the idea that hope works partly by building resilience. If this is right, programmes that target both constructs may achieve more than programmes that target either one, but this has not been tested directly.

The pattern is not uniform across studies. In a structural equation modelling study of 355 Chinese migrant adolescents, positive teacher relationships increased hope, and hope in turn reduced depression, whereas peer and teacher relationships enhanced resilience but resilience alone did not significantly reduce depression (Li et al., 2023). Hope may therefore be the more proximal route through which relational resources reduce depressive symptoms, while resilience may work through other pathways or need components that target depressive cognitions directly. The authors recommended giving adolescents more autonomy and applying clear school rules so that academic goals are easier to reach and hope is strengthened (Li et al., 2023). The evidence comes from China, but it identifies teacher–student relationships as a plausible lever in Zimbabwean schools.

A serial mediation study found that hope and resilience fully mediated the association between disadvantaged family socio-economic status and probable depression, through three two-step paths (via hope alone, resilience alone and loneliness) and two three-step serial paths (via hope and resilience in sequence, then through loneliness and school refusal functions) (Li et al., 2025). Read cautiously, this implies that economic disadvantage may lead to depression partly by eroding psychological resources, so that strengthening hope and resilience may interrupt the pathway from disadvantage to depression even where structural conditions

cannot quickly be changed. Two cautions apply. A mediation model of this kind does not by itself establish causal order, and the finding should not be taken to mean that poverty is a problem of individual psychology. The presence of loneliness and school refusal in the model also underlines the importance of social connectedness and school engagement.

Gaps in Combined Research

Three gaps stand out. First, few studies have examined hope and resilience simultaneously in adolescents, and fewer still have tested their interactive or sequential effects on depression over time (Theron, 2023). Most treat them as separate protective factors. The mediation studies above (Li et al., 2023; Li et al., 2025) are informative, but few studies have used moderated mediation or latent interaction approaches to test whether the two amplify each other (Scioli et al., 2025; Theron, 2023). Whether high hope combined with high resilience protects more than the sum of its parts remains largely untested. The answer matters for intervention design, because synergy would favour integrated programmes and would bear on how components should be sequenced. Longitudinal studies that measure both constructs at several time points are needed.

Second, the hope–resilience–depression nexus has hardly been studied in Africa or Zimbabwe. Zimbabwean research on adolescent mental health is limited and has mostly examined risk and distress, with qualitative work such as that of Fisher et al. (2023) among the few studies to describe resilience, and resource diversity and cultural responsiveness have been identified as key to advancing sub-Saharan adolescent mental health (Theron, 2023; Theron et al., 2023). Local developments are encouraging but are not yet evidence of effect. The Zvandiri Character Strength (ZCS) scale study identified connectedness, happiness, hope, motivation, optimism and perseverance as key constructs for measuring wellbeing among adolescents living with HIV, and found wellbeing to be relational, contextually situated and often co-occurring with distress (Zvandiri et al., 2026). The Youth Friendship Bench emphasises empathy, active listening and fostering realistic hope (Chibanda et al., 2026), and the Y-MIND programme is adapting the Friendship Bench for young people with depression in Ghana and Zimbabwe (King's College London, 2025). Together these suggest that hope is already a working therapeutic target in Zimbabwean practice even though it has not been studied as a protective factor.

Third, hope and resilience measures have not been validated in Zimbabwe. The Children's Hope Scale has shown measurement invariance across sex and developmental stage among South Sudanese refugee children in Uganda (Tumwebaze et al., 2023) and scalar invariance in South African adolescents (Guse, 2016), and the Dispositional Hope Scale has been validated in Chilean and Korean samples (Snyder, 2002; Scioli et al., 2025), but comparable work in Zimbabwe is absent. This limits comparability and the cultural appropriateness of tools used in counselling practice (Theron, 2023).

The ZCS study found that imported positive psychology instruments showed ceiling effects and weak internal structure when applied without cultural adaptation (Zvandiri et al., 2026), which underlines that adaptation, including formative qualitative work, cognitive interviewing and psychometric evaluation, must come before routine use. Without culturally appropriate tools, counsellors cannot reliably assess hope and resilience, and researchers cannot build the local evidence base that policy and practice need.

Hope and Resilience in Shona and Ndebele Cultural Contexts

Most of the evidence reviewed above was generated in Western, Asian and Australian settings, and the constructs themselves were defined within individualist traditions. Snyder's hope theory defines hope as an individual's own goal-directed agency and pathways (Snyder, 2002). A question for Zimbabwe is whether, and how, this account fits the two main language communities, Shona and Ndebele speakers. We found no study that has examined hope in Shona- or Ndebele-speaking adolescents, so this section is an analytical discussion that draws on the African resilience literature and on Zimbabwean work on distress, and its propositions should be treated as hypotheses to be tested.

The first issue is the tension between individualistic and collectivistic understandings of hope. Hope theory emphasises personally chosen goals pursued through personal agency. In African contexts, scholars describe

well-being and resilience as relational and communal, grounded in interdependence and Ubuntu (hunhu in Shona, ubuntu in Ndebele) and supported by intergenerational care and respect for elders (Mahwai & Ross, 2026; Mhaka-Mutepfa & Mpofu, 2026; Theron, 2016, 2023). For an adolescent who is expected to contribute to the wellbeing of the family, a goal such as staying in school may be pursued for the family as much as for the self. A counsellor who treats autonomous goal pursuit as the only sign of hope may therefore miss shared goals, or may unintentionally set the adolescent against family expectations.

This produces a tension that counsellors are likely to meet in practice. Where a personal aspiration, such as further study away from home or a career the family does not favour, conflicts with obligations such as caring for relatives or contributing to household income, the pathways component of hope may be constrained by the very relationships that also provide support. The Children's Hope Scale operationalises personal agency and pathways and does not capture goals held jointly with family. The Comprehensive Child and Adolescent Hope Scale, which adds attachment, survival and spirituality to mastery (Scioli et al., 2025), may fit better, but it also needs testing in Zimbabwe. Hope-focused counselling may therefore need to include family members in goal-setting where the adolescent agrees, and to treat negotiation between personal and family goals as part of the work and not as resistance.

The second issue is how hope and resilience are expressed and named. Distress in Zimbabwe is often described through local idioms such as kufungisisa ("thinking too much") in Shona, documented in Harare primary care (Patel et al., 1995), and the Shona Symptom Questionnaire was developed from such idioms (Patel et al., 1997). It is plausible that hope and resilience are likewise expressed through faith, endurance, family and community ties, and spiritual framing, as in the Zimbabwean left-behind adolescents who described faith as a meaning-making framework and found strength in transcendence (Fisher et al., 2023). Spiritual and ancestral connection is also one of the resilience enablers identified across sub-Saharan Africa (Theron, 2023). English-language items may not capture these meanings. We found no published evidence on how hope is expressed in Ndebele-speaking communities, so differences between Shona and Ndebele speakers, and between urban and rural adolescents, can be neither assumed nor ruled out.

These considerations do not weaken the case for hope and resilience as protective factors. They suggest that Zimbabwean practice should treat agency and pathways thinking as a starting framework to be adapted, ask adolescents what hope means to them and whom it involves, and test whether relational and spiritual dimensions add explanatory power beyond individual agency. Sections 4.4 and 4.6 consider the practice implications.

Implications for Counseling Psychology in Zimbabwe

The evidence in Section 3 indicates that hope and resilience are modifiable resources rather than fixed traits, which makes them legitimate targets for counseling. This section translates that evidence into recommendations for counseling psychologists in Zimbabwe. Because no trial has yet tested hope- or resilience-focused counseling with Zimbabwean adolescents, the recommendations below are inferences from related African and international evidence, and are labelled as such. Evidence quality is uneven, so the section also examines the risks of importing interventions and measures without local adaptation (Section 4.6).

Assessment of Hope and Resilience in Clinical Practice

Strengths-based assessment should sit alongside, not replace, assessment of symptoms and risk. A sensible sequence is to screen for depression and suicidal ideation first, since 11.2% of young people in the Harare and Mashonaland East sample reported suicidal ideation (Doyle et al., 2023), and then to assess hope, resilience and available supports to shape the formulation and treatment plan.

Table 1 lists instruments that counselors can draw on. None has been validated for Zimbabwean adolescents in the studies reviewed here, a gap noted in Section 3.4.2, so scores should be treated as prompts for conversation rather than as diagnostic cut-offs.

Domain	Instrument	Format	Practice note
Depression	Patient Health Questionnaire for Adolescents, PHQ-A (Johnson et al., 2002)	9-item self-report	Brief screen with a suicide-risk item; needs local translation and piloting
Common mental disorders	Shona Symptom Questionnaire, SSQ-14 (Patel et al., 1997)	14-item yes/no	Developed in Harare; used as the outcome measure in the Friendship Bench trial (Chibanda et al., 2016)
Hope (children and younger adolescents)	Children's Hope Scale (Snyder et al., 1997)	6-item self-report	Separate agency and pathways scores; designed for ages of about 8 to 16
Hope (older adolescents)	Hope Scale (Snyder et al., 1991)	12-item self-report	Eight scored items cover agency and pathways; check wording for English-language comprehension
Resilience	Child and Youth Resilience Measure, CYRM-28 (Ungar & Liebenberg, 2011)	28-item self-report	Built through cross-cultural mixed-methods work and covers individual, caregiver and context resources, so it suits an ecological reading of resilience

Three practical points follow. First, instruments should be translated into Shona and Ndebele by back-translation and checked through cognitive interviews with a few adolescents before use. Second, hope scores need to be read alongside symptom severity. In a clinical sample, high initial youth hope combined with elevated baseline symptoms predicted poorer treatment outcomes (Dew-Reeves et al., 2012), so a high score is not automatically reassuring. Third, structured questionnaires should be paired with interview methods. Asking an adolescent what goals matter to them, what routes they can see, what has helped before, and who they would turn to gives richer and more culturally grounded information than a total score, and does so without requiring any additional resources.

Evidence-Based Interventions: Hope Therapy, CBT with Strengths, and Resilience Training

Three intervention families fit the protective-factor evidence in Section 3, and they can be combined in a stepped way. Table 2 summarises them, and the paragraphs below note where the evidence is strongest and where it is thin.

Approach	Core elements	Evidence base	Relevance for Zimbabwe

Hope therapy	Clarifying goals, generating several pathways, building agency, planning for blocked goals (Snyder, 2002)	Pilot study in a community adult sample (Cheavens et al., 2006); school programme for middle-school students (Marques et al., 2011); randomized trial of a hope intervention for adolescents delivered by paraprofessionals (Scioli et al., 2025)	Goal-based and brief; can be taught to non-specialists
Strengths-based CBT	Identifying strengths first, building a personal resilience model, applying it to the presenting problem (Padesky & Mooney, 2012)	Clinical model with growing practice use; trials with adolescents are limited	Suits individual counseling in schools and clinics
Problem-solving therapy	Structured problem-solving delivered by trained lay health workers (Chibanda et al., 2016)	Randomized trial in Zimbabwean primary care showing lower symptoms of common mental disorders at six months	Locally developed, task-shifted; adaptation for adolescents is a logical next step
Resilience training in groups	Skills such as cognitive restructuring and problem solving (Brunwasser et al., 2009); brief lay-delivered group sessions (Osborn et al., 2020)	Penn Resiliency Program meta-analysis; randomized trial of the Shamiri group intervention in Kenya	Low cost; shows that group formats can work in an African school setting

Hope therapy. Hope therapy works by helping a young person name a goal that matters, build more than one route to it, and rehearse responses to blockage, which mirrors the mechanisms described in Section 3.2.3 (Snyder, 2002). A counselor might, for example, help an out-of-school adolescent whose goal is paid work to list three routes (a vocational course, an apprenticeship, informal trading) and to plan what to do if the first is blocked. The supporting evidence is encouraging but uneven. Much of it comes from adults or from non-clinical youth samples (Cheavens et al., 2006; Marques et al., 2011), and the paraprofessional-delivered adolescent trial (Scioli et al., 2025) is the most relevant to low-resource settings. We found no hope-therapy trial with Zimbabwean adolescents.

Strengths-based CBT. Cognitive behavioural therapy is the best-established psychological treatment for adolescent depression, and strengths-based versions add an explicit focus on what the young person already does well. Padesky and Mooney (2012) propose four steps: finding strengths, building a personal model of resilience, applying that model to the presenting difficulty, and practising it in daily life. Behavioural

activation and problem-solving components of standard CBT overlap with Snyder's pathways thinking, so counselors need not choose between the two frameworks. Where CBT is used, hope and resilience measures (Table 1) can track change in protective resources as well as in symptoms.

Resilience training. The Penn Resiliency Program, a school-based cognitive-behavioural programme, showed a small but significant reduction in depressive symptoms in a meta-analysis (Brunwasser et al., 2009), and a later review found that school-based resilience programmes can help but vary widely in quality (Dray et al., 2017). The most relevant African example is the Shamiri intervention, a brief group programme delivered by lay providers, which reduced depression and anxiety among Kenyan adolescents in a randomized trial (Osborn et al., 2020). Zimbabwe's own Friendship Bench shows that task-shifting to trained lay workers can work in this setting (Chibanda et al., 2016).

Taken together, the evidence supports offering hope- and resilience-oriented work as part of a stepped model. Universal group sessions and psychoeducation can serve most adolescents, individual strengths-based CBT or hope therapy can follow for those with persistent symptoms, and referral for medical and psychiatric assessment is needed for severe or high-risk presentations.

The strength of this evidence should not be overstated. None of the hope-focused studies cited was conducted with Zimbabwean adolescents. The hope-therapy evidence includes a pilot study with adults and non-clinical youth samples (Cheavens et al., 2006; Marques et al., 2011). School-based resilience programmes have produced small average effects and vary widely in quality (Brunwasser et al., 2009; Dray et al., 2017).

The Zimbabwean Friendship Bench trial tested problem-solving therapy for common mental disorders in adults in primary care, not hope or resilience in adolescents (Chibanda et al., 2016). It is reasonable to pilot and evaluate these approaches in Zimbabwe, but not to assume that effects reported elsewhere will transfer.

School-Based and Group Counseling Applications

Schools reach most adolescents and are already where counselors and teachers meet young people, so they are a natural base for hope- and resilience-oriented work, as the Kenyan Shamiri trial also suggests (Osborn et al., 2020). Three levels of activity are practical.

Universal. Classroom-based life-skills sessions can teach goal-setting, generating alternative routes to a goal, and handling setbacks, which are the core skills of hope theory (Snyder, 2002). Teacher behaviour matters too. Among Chinese migrant adolescents, positive teacher relationships raised hope, which in turn lowered depression (Li et al., 2023), so brief training for teachers on supportive, goal-oriented interaction is a low-cost addition. This evidence comes from another context and should be tested locally.

Selective and group-based. Small groups offer a way to build both hope and resilience at once. A short group programme might run for about six to eight weekly sessions with six to ten adolescents, moving from personal strengths and valued goals, to routes and obstacles, to identifying sources of support in family, peers, church and community. Group work also uses peer support, which the resilience literature identifies as a resource for African adolescents (Theron, 2023). Peer-led models already exist in Zimbabwe. The Zvandiri programme uses trained young people to support adolescents living with HIV (Mavhu et al., 2020), a group in which 57% screened positive for depression in one study (Zvandiri, 2021). Adding a structured hope and resilience component to such platforms is a promising option, although we did not find evidence that this has been tested.

Indicated and referral. Adolescents with persistent or severe symptoms need individual assessment, a written safety plan where there is suicide risk (Stanley & Brown, 2012), and referral pathways to clinics or specialist services. Every group programme should have these arrangements in place before it starts, with clear rules on confidentiality and its limits.

Three adaptations need emphasis. First, adolescents who were neither in school nor working had higher odds of probable common mental disorders in Harare and Mashonaland East (Doyle et al., 2023), so groups should run not only in schools but also in youth clubs, places of worship and community centres.

Second, because stigma and other barriers to help-seeking are reported among Zimbabwean youth (Mushonga et al., 2025), groups may be better framed around goals, skills and success than around depression. Third, groups should run in the participants' preferred language, and facilitators should check that examples and activities are relevant to the participants' lives.

Culturally Responsive Practice in Low-Resource Settings

Protocols should be adapted, not simply transferred. Sub-Saharan resilience research describes resilience as a social-ecological process that depends on relationships, culture and belief (Theron, 2023). South African work found that adolescents with diverse support systems were better protected from depression (Theron et al., 2023), and a Zimbabwean study found resilience expressed through spirituality, symbolic connection with absent family members and positive coping (Fisher et al., 2023). Four lessons follow.

Ask about meaning, in local terms. Distress is often described through local idioms rather than the word "depression". The Shona idiom kufungisisa, or "thinking too much", is one example documented in Harare primary care (Patel et al., 1995). Counselors can ask how the adolescent and family understand the problem before introducing clinical language, and can ask the same open question about hope, such as "What do you want your life to look like, and who is part of that?"

Let hope and resilience be relational. For many adolescents, goals are shared with family, such as helping siblings stay in school or caring for relatives, and sources of strength include church, peers and elders (Sections 1.6 and 3.5). Counselors should therefore invite caregivers or other trusted people into the work where the adolescent agrees, and should treat faith leaders and community figures as possible partners, not as obstacles. Where spiritual or traditional explanations are important to the family, the counselor can respect them while keeping the adolescent's safety and access to care in view.

Do not read structural adversity as individual failure. Hope and resilience fully mediated the effect of socio-economic disadvantage on probable depression in one study (Li et al., 2025), which shows that these constructs can be intervention targets, but it does not mean that poverty is the fault of individuals. Counselors who work with food insecurity, unpaid fees or violence should combine counseling with practical action, such as referral to social protection, school fee assistance or child protection services (Theron et al., 2023).

Designing for scarcity. Specialist and urban hospital services are out of reach for most adolescents (Mushonga et al., 2025). Simple structured approaches, group delivery, low-cost materials and trained lay workers under supervision are practical responses, and the Friendship Bench shows that this model can work in Zimbabwe (Chibanda et al., 2016). Counselors should also be clear about consent and confidentiality for minors, including when caregivers must be informed.

Training and Supervision for Counselors

If hope- and resilience-oriented practice is to reach Zimbabwean adolescents, it has to be built into how counselors are trained and supervised, because the work will be delivered by a mix of counseling psychologists, school counselors and trained lay supporters. We suggest that training for all three groups cover the following competencies.

- Strengths-based assessment, including how to use and interpret the instruments in Table 1 with caution and alongside interview.
- Core hope-therapy skills: goal clarification, generating pathways, building agency and planning for blocked goals.
- Foundations of CBT and problem-solving therapy, including strengths-based adaptations (Padesky & Mooney, 2012).
- Screening for depression and suicide risk, safety planning and referral services (Stanley & Brown, 2012).
- Group facilitation with the associated issues of confidentiality, disclosure management and diverse age ranges.

- Cultural humility, namely examining local expressions, religiosity and thinking through assumptions about adolescents and their beliefs (Section 1.6).

Supervision is important as much as the initial training received. In the implementation of the Friendship Bench initiative, unqualified lay health workers were providing problem-solving therapy by applying a properly supervised approach (Chibanda et al., 2016). It implies that training with appropriate supervision works in the case of task shifting. Counseling psychologists are to supervise school counselors and lay health workers, holding regular discussions on the cases and performing consultations. Supervision will also pay attention to the well-being of the counselors.

Finally, training institutions have a role. Counseling Psychology programmes in Zimbabwe could add modules on strengths-based and culturally responsive practice and on adolescent depression, and could place trainees in schools and community programmes. Local studies of how well these approaches work should be built in from the start, since the review has shown that the evidence for Zimbabwean adolescents is still missing.

Risks of Importing Interventions and Measures Without Local Adaptation

The practice recommendations in this section draw mostly on evidence from outside Zimbabwe, and importing them without adaptation carries risks that counseling psychologists and programme planners should weigh. Most hope and resilience instruments and manualised programmes were developed in Western or high-income settings, and the Zimbabwean evidence that exists points to caution.

Measurement risks. In the ZCS scale development study with adolescents living with HIV in Zimbabwe, imported positive psychology instruments showed ceiling effects and weak internal structure, and did not capture the relational, culturally embedded and fluctuating nature of wellbeing (Zvandiri et al., 2026). A ceiling effect means that an instrument cannot separate adolescents with high hope from those with moderate hope, and a weak internal structure means that subscale scores, such as agency and pathways, may not mean what they are assumed to mean. Used uncritically, such tools could misclassify adolescents, hide need, or produce reassuring scores that lead to missed risk. Scores from the instruments in Table 1 should therefore be used as prompts for conversation, with formative qualitative work, cognitive interviewing and psychometric testing before any routine use or cut-off scores.

Conceptual and intervention risks. A programme that teaches individual goal-setting and personal agency may sit uneasily with family obligations and communal values (Section 3.5). It may place responsibility for coping on the adolescent when the main problems are structural, such as poverty, unpaid fees or violence, and it may use examples, language or session formats that do not fit local life. Group formats that name depression may increase stigma (Mushonga et al., 2025). Evidence of benefit from Kenya, China, Australia or Malaysia is relevant but is not proof of benefit in Zimbabwe, because effects may differ with delivery, language, dose and context.

Safeguards. Instruments should be translated, back-translated and piloted with adolescents. Shona- and Ndebele-speaking adolescents, caregivers, teachers and community or faith figures should help adapt content. New programmes should be piloted with routine outcome monitoring before they are scaled up, safety planning and referral pathways should stay in place, and practical support for structural problems should be treated as part of the response. Reports of adaptation should document what was changed and why, so that the Zimbabwean evidence base can accumulate.

Directions for Future Research

Six directions follow from the gaps identified:

- Longitudinal, multi-construct designs; Studies that assess hope and resilience simultaneously, at multiple time points, and model their interactive effects on depression trajectories. The question of whether the two constructs operate synergistically remains largely untested (Theron, 2023).

- Zimbabwean prevalence and protective-factor studies; Population-based work that measures protective factors alongside symptoms, extending the approach taken by Doyle et al. (2023) to include hope and resilience.
- Cultural validation of measures; Translation, back-translation, cognitive interviewing, and invariance testing for the Children's Hope Scale, the CYRM-28, and the PHQ-A in Shona- and Ndebele-speaking adolescent samples.
- Culturally grounded conceptual and qualitative work; Studies of how hope and resilience are understood, expressed and negotiated by Shona- and Ndebele-speaking adolescents and their families, including how personal goals and family obligations interact (Section 3.5).
- Intervention trials; Pilot and feasibility trials of hope therapy, strengths-based CBT, and group resilience programmes delivered in Zimbabwean schools and communities, including task-shifted delivery by trained lay workers under supervision.
- Implementation research; Studies of how school counsellors, teacher-counsellors, and community cadres can feasibly deliver these programmes within existing resource constraints, and of the supervision structures required to maintain quality.

CONCLUSION

This narrative review set out to read the evidence on hope and resilience together, to examine it critically from a Zimbabwean counselling perspective, and to be explicit about where inference replaces evidence. Its contribution is therefore less a summary of what is known than a critical map of what is known, what is not, and what follows for practice.

Four insights emerge from reading the evidence together. First, hope and resilience may protect through different routes. In one study of Chinese migrant adolescents, hope was the more proximal link between relational resources such as supportive teachers and lower depression, whereas resilience alone did not significantly reduce depression, so the two should not be treated as interchangeable targets (Li et al., 2023). Second, both constructs may lie on the pathway between socio-economic disadvantage and depression (Li et al., 2025). This makes them plausible counselling targets in a high-adversity setting, but it also warns against locating the problem in the adolescent when poverty, violence and weak services are structural. Third, whether hope and resilience reinforce each other, and how a combined programme should be sequenced, remains untested. Fourth, the individual, goal-focused form of Snyder's hope theory may need adapting for settings in which goals and strengths are relational and shared with family, faith and community (Section 3.5).

The review also shows how thin the Zimbabwean evidence is. We found no trial of hope- or resilience-focused counselling with Zimbabwean adolescents, no validated hope or resilience measure for Shona- or Ndebele-speaking adolescents, and no study of how these constructs are expressed in either language group. The recommendations in Section 4 for stepped, school- and community-based, task-shifted counselling are therefore inferences from related African and international evidence, and imported measures and programmes carry specific risks of ceiling effects, weak internal structure and poor cultural fit (Zvandiri et al., 2026).

For practice, the most defensible position is that counsellors in Zimbabwe can reasonably add strengths-based assessment and hope- and resilience-oriented work alongside, and not instead of, assessment and treatment of depression and suicide risk, provided that tools are adapted, families and communities are involved, structural problems are addressed practically, and outcomes are evaluated. For research, the priorities are culturally validated measures, longitudinal designs that test the two constructs together, and pilot trials with Zimbabwean adolescents (Section 5). Until that evidence exists, hope and resilience should be treated as promising and plausible protective resources and not as proven treatments.

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APPENDIX

Supplementary Table S1

Supplementary Table S1. Main characteristics of the studies that contribute most to the findings in Section 3. Figures are those reported by the original authors as summarised in the text.

Study	Context and design	Sample	Main finding relevant to this review
Lu et al. (2024)	Global; systematic review and meta-analysis	96 studies, 29 countries, >528,000 children and adolescents	Pooled prevalence: mild-to-severe depression 21.3%, moderate-to-severe 18.9%, major depression 3.7%; increasing 1989–2022
Shorey et al. (2022)	Global; systematic review and meta-analysis	Adolescents, studies from 2001–2020	Point prevalence of elevated self-reported depressive symptoms 34%
Gosse et al. (2026)	Sub-Saharan Africa; meta-analysis	63 studies, 55,071 participants	Pooled depression prevalence 15.27%; reported range up to 26.9%; high heterogeneity
Doyle et al. (2023)	Harare and Mashonaland East, Zimbabwe; population-based prevalence study	Young people aged 13–24 years	37.4% probable common mental disorders; 15.8% abnormal emotional symptoms; 11.2% suicidal ideation; higher odds with age and among those out of school and not working
Chipalo (2024)	Zimbabwe; adverse childhood experiences and distress	Adolescents and youth	28.4% reported mental distress in past 30 days; cumulative adverse experiences linked to higher odds
Marufu (2024)	Bulawayo and Matabeleland North; juvenile justice system (master's thesis)	Adolescent offenders	Depression prevalence 18.5%; 7.6% comorbid depression and anxiety
Weavers et al. (2021)	Longitudinal, population-based, 21 years	Adolescents aged 14–16 at baseline	Later depression, anxiety, substance use, suicide attempt, lower educational attainment, unemployment, early parenthood

Anguzu et al. (2025)	Uganda; school-going adolescents	School-going adolescents	Even mild symptoms associated with two-fold higher risk of behavioural impairment
Li et al. (2023)	China; latent class analysis	1,688 adolescents	High-hope class (32%) had lower depression and higher life satisfaction and self-esteem
Li et al. (2023)	China; structural equation modelling	355 migrant adolescents	Teacher relationships raised hope, which lowered depression; resilience alone did not significantly reduce depression
Yao et al. (2024)	Meta-analysis of longitudinal studies	22 studies, 10,682 adolescents	Lower hope related to higher depression (r = .16); hopelessness r = .34; relationship reciprocal
Scioli et al. (2025)	Randomised controlled trial; five-week hope intervention by paraprofessionals	Adolescents aged 13–17 years	Greater hope, more social coping and self-acceptance, and less depression than waitlist control
Lim et al. (2025)	Year-long school-based positive psychology intervention, Australia	Secondary students	Lower depressive symptoms; higher well-being and hope than controls
Abdul Kadir et al. (2026)	Hopeful Minds programme, secondary schools, Malaysia	Secondary students	Reduced overall and somatic depressive symptoms
Zhou et al. (2026)	Three-wave longitudinal study	333 secondary vocational students	Resilience predicted lower depression and later meaning in life; meaning in life did not directly predict depression
Ranøyen et al. (2025)	Three-year prospective clinical cohort	717 adolescents with anxiety or depressive disorders	Promotive factors associated with lower probability of anxiety or depression at three years
Ndetei et al. (2025)	Kenya	1,972 youth aged 14–25 years	Depression and hopelessness negatively associated with resilience
Cortina et al. (2021)	Four sub-Saharan African countries	Adolescents	Higher resilience linked to less suicidal ideation and depressive symptoms, most strongly under high adversity
Allen et al. (2025)	Australia; longitudinal, one-year follow-up	3,512 adolescents	Greater resilience predicted lower depression and anxiety; school climate and identification contributed

Theron (2023)	Sub-Saharan Africa; narrative scoping review	59 studies, 18 countries	Resilience a social-ecological process; relational, personal, structural, cultural and spiritual enablers
Theron et al. (2023)	South Africa; mixed-methods study	223 adolescents	Four depression trajectories; diverse, culturally responsive resources most protective
Fisher et al. (2023)	Zimbabwe; qualitative study of left-behind adolescents	Adolescents with migrant parents	Resilience through faith, symbolic connection, inward dialogue and service; future-oriented meaning-making
Chidakwa (2026)	Rural Zimbabwe; qualitative study	15 students aged 13–18 years	Resilience supported by community collaboration, personal strengths and school–community partnerships
Li et al. (2025)	Serial mediation analysis	Adolescents of disadvantaged socio-economic status	Hope and resilience fully mediated the link between disadvantage and probable depression
Zvandiri et al. (2026)	Zimbabwe; scale development (preprint)	Adolescents living with HIV	Imported instruments showed ceiling effects and weak internal structure without cultural adaptation
Tumwebaze et al. (2023)	Uganda; Children's Hope Scale validation	1,118 South Sudanese refugee children	Factor structure supported; invariance by sex and developmental stage
Guse (2016)	South Africa; Children's Hope Scale validation	Adolescents	Scalar invariance shown