Cultural Explanatory Model of Depression among Iranian Women in Three Ethnic Groups (Fars, Kurds and Turks)

Masoumeh Dejman
CULTURAL EXPLANATORY MODEL OF DEPRESSION AMONG IRANIAN WOMEN IN THREE ETHNIC GROUPS (FARS, KURDS AND TURKS)

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The cover illustration was designed by Mr. Meisam Alipour in Iran. It shows three depressed women and is a symbol of the three study locations.

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TO THE IRANIAN PEOPLE FOR A BETTER AND HEALTHY LIFE
ABSTRACT

Background: As one of the most prevalent diseases globally and as an important cause of disability, depressive disorders are responsible for as many as one in every five visits to primary care. However, the true figures are unknown, as many do not seek help or know how to access help. Women suffer more than men according to surveys in Iran and other countries. Cultural variations in clinical presentation sometimes make it difficult to recognize the disorder, resulting in patients not being diagnosed and not receiving appropriate treatment and follow up.

Purpose: This thesis explores how women’s depression is conceptualized among Iranian people in three cities located in north-west (Tabriz), west (Ilam) and central (Tehran, capital city) Iran, representative of three major ethnic groups (Fars, Kurds, and Turks) and how this conceptualization may contribute to the help-seeking behaviour of depressed women.

Methods: The thesis consists of four exploratory papers employing qualitative methods including individual interviews and focus group discussions (FGDs). Paper I reports a pilot study using a case vignette and explanatory interview guides on Iranian people (including depressed women, clinicians and lay people). Forty three adults participated in three focus group discussions (25 participants) and 18 individual interviews in the three ethnic groups. Paper II presents an explanatory model of the community (lay people) in the three ethnic groups in Iran concerning women's depression. Thirty eight men and thirty eight women from the general population, classified by level of education participated in twelve FGDs in the aforementioned cities by using a case vignette describing a woman with major depression without psychotic features. Paper III reports interview results (25 depressed women and 14 relatives) regarding how these women and their families conceptualize the patients' conditions and how their conceptualization shaped the patients’ help-seeking process. Paper IV reports individual interview results from 24 clinicians (six general practitioners [using case vignette], 14 psychiatrists and four psychologists [interview guide, both]) exploring the explanatory model of depressed women.

Results: There were more similarities than differences in the models proposed by Iranian people in the three ethnic groups. Among most of the study participants depressive symptoms were perceived as a transient reaction to external stressors. Most participants named the depressive symptoms as distress of nerve/soul “narahati asabilnarahati rohi”, problem of nerve/soul “moshkel asabi rohi”, sadness and depression “afsoordegi”. Other names were “darikhma” (deep sadness with anxiety, Turkish participants only), and “tarjoman” (sadness and nerve problems due to external events, Kurdish participants only). All connected the illness with an external stressor caused by loss (death of relatives, job loss, etc.), environmental causes (including family conflict), gender-linked stressors and internal factors caused by emotional
factors, cognition distortion and hormonal factors. Coping mechanisms involved two strategies: (1) solving problems by seeking help from family and friends, especially one's husband and neighbours, religious practice, and engaging in pleasurable activities, and (2) seeking professional support mostly from general practitioners, psychologists, family counsellors, and traditional support from herbalists and amulets (written prayer notes). The choice of medical treatment depended on the type of somatic or psychological complaints. The important barriers to seeking help from professional (psychiatrists or psychologists) were stigma and fear of dependency on medication.

**Conclusion and implications:** Rather than having a biological model, in this study participants tended to have a psychosocial explanatory model linked with preferred seeking help from informal healers (family and friends, religious practices and traditional healers) as the first treatment step. The inter-ethnic similarities could stem from common cultural and social elements, such as a common official language, legal, structural, educational and political structures, mass media, and religion in the three major ethnic groups in Iran. This finding could be useful for integrating a gender approach to health service delivery and linking gender and culture sensitivity to training of health workers, and also for education society to reduction of the stigma related to depression.

**Key words:** women, depression, explanatory model, ethnic group, qualitative method
مقدمه: افسردگی یک یکی از شایع ترین بیماری‌های مزمن و در حال حاضر مهم‌ترین علل مبتلا به پزشکی در مقایسه با سایر بیماری‌ها به نظر می‌رسد. بر اساس این وحدات تکثیر روش و وضعیت منابع مورد پیشنهادی درمان، بر اساس موانع درمانی، پیش‌بینی و دوره مراقبت از بیمار، روزگار، درمان و راهنمایی درمان باید بر اساس فرهنگ درمانی بالینی انجام شود. با توجه به کمبود مطالعات در این زمینه، هدف این مقاله است ارائه روش‌های معنی‌داری در تشخیص دادن شناسه و درمان این بیماری است.
# LIST OF PUBLICATIONS

This thesis is based on four papers. These four papers present the results of the study of an explanatory model of depression among Iranian women in three ethnic groups (Fars, Kurds, and Turks) in Iran.

The papers will be referred to by their Roman numerals I-IV in the text.

**I.**  
**Dejman M**, Ekblad S, Forouzan AS, Bardaran Eftekhari M, Malekafzali H  

**II.**  
How Iranian lay people in three ethnic groups conceptualize a case of a depressed woman: an explanatory model. (Accepted, 21 April, 2010, Ethnicity and Health)

**III.**  
Explanatory Model of Depression among Female Patients and Their Relatives in Three Ethnic Groups (Fars, Kurds, and Turks) in Iran. (Accepted, 28 April, 2010, Iranian Journal of Public Health)

**IV.**  
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LIST OF ABBREVIATIONS

WHO: World Health Organization


FGD: Focus Group Discussion

EM: Explanatory Model

DALY: Disability-Adjusted Life Year

YLL: Years of Life Lost

PTSD: Posttraumatic Stress Disorder

MDD: Major Depressive Disorder
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1 INTRODUCTION
This thesis aims to explore how depression in women is conceptualised among Iranian people in the three cities representative of three major ethnic groups (Fars, Kurds and Turks) and how this conceptualization may contribute to help-seeking behaviour by depressed women.

The project was inspired by a similar study conducted in Uganda by Dr Elialilia Sarikiaeli Okello, former PhD student of Dr Ekblad, my main supervisor. That study indicated that non-psychotic depressive symptoms in Uganda were conceptualised as a problem brought about by thought, and that illness of thought was considered to be a non-chronic condition caused by worrisome thoughts about psychosocial problems. Although the symptoms of depression were communicated as an illness, its name, causation, help-seeking behaviour and treatment differed from western biomedical medicine. Thus, as a joint project between the Karolinska Institutet and the Ministry of Health and Medical Education in Iran, we attempted to ascertain which concepts Iranian people have concerning depression. The particular focus was on depression in women, which is a prevalent disorder worldwide. We conducted the study in the three different parts of Iran which are representative of three major ethnic groups (Fars, Kurds and Turks).

The research was conducted in two phases, a pilot and a main study. The pilot study (paper I) field-tested the instruments and techniques, and assessed the applicability of conducting similar studies in Iran among different groups of informants including depressed women, lay people and clinicians. The main study was conducted in three stages, exploring the perceptions of lay people (paper II), depressed women and their relatives (paper III) and clinicians (general practitioners, psychologists and psychiatrists, paper IV) concerning female depression in the three ethnic groups.
The presentation of the thesis work begins with background information: an introduction to the global burden of depression, psychiatric disorders and depression in Iran, the concept of depression in Iran as a Muslim country, culture and depression including common features of Islamic culture and promotion of mental health and gender and depression including gender and depression in Iran. Next, a theoretical framework is presented. This is followed by aims of the studies, research questions and methods. Methods consist of the context of the study including psychiatry and mental health services in Iran and general study design. It is followed by a brief presentation of the methods used for each paper consisting of a brief summary of the study participants, the sampling process, instruments and data collection. Next, trustworthiness in four studies and ethical consideration are presented. A summary of the results of each of the four papers follows. Next, a general discussion follows which ties the four papers together and with other research. This thesis concludes with conclusions and implications for clinical practice, education, policy and further research.

1.1 TIMELINE

The individual studies took place as follows:

- July-August 2005 ethical clearances were received from the National Ethical Committee in Iran (P373, 23 July 2005), local Ethical Committees at three medical universities in Tehran, Ilam and Tabriz. Ethical Committee at Karolinska Institutet, EPN, considered the ethical questions and found since there was no research done in Sweden, no evaluation was performed (2005/5:8).
- December 2005 the author was registered as PhD student at Karolinska Institutet.
• Data for the pilot study (paper I) were collected between October 2005 - March 2006.

• Data for paper II were collected between December 2006 - March 2007.

• Data for papers III and IV were collected between April to July 2008.

• Work on data analysis and the manuscripts for the different papers were carried out between October 2005 and March 2009.

• Compilation of the four studies into an academic thesis: started in June 2009 and completed in April 2010.

1.2 THE GLOBAL BURDEN OF DEPRESSION

Depressive disorders, which are characterised by the impairment of mood regulation, most commonly include major depression (1); itself is a serious mental health disorder. It is predicted that by the year 2020, major depression will be the second important cause of disability and ranks as the fourth cause of disease in terms of DALYs and years of life lost (YLL) in the world (2-5).

The World Health Organization (WHO) has projected that by the year 2030, unipolar depressive disorders will be one of the highest causes of disease burden in middle- and low-income countries after HIV/AIDS and prenatal deaths (2, 6-9). The burden of depression among women is much higher than among men worldwide.

Depressive disorders are also highly prevalent conditions, as demonstrated by community and primary care studies. Depressed people are often high users of medical services. A fourth (23.5%) of all depressed people and two-thirds (10) of those with a lifetime history of depression an average have 15 visits or telephone calls to primary health care services. The recognition of depression by primary care physicians is
complicated by the fact that depressed patients tend not to present with psychosocial symptoms. In an international study, 69% of patients with depression reported only somatic symptoms; and 11% denied psychological symptoms even on direct questioning (11). Thus, although depressive disorder is globally responsible for as many as one in every five visits to primary care (12), many patients still don’t receive an appropriate treatment for depression and over half of primary care patients are not diagnosed (13). Furthermore, cultural causes of misdiagnosis might contribute to the problem (5, 14). There is no evidence about misdiagnosis of depression in Iran, but in the next subsection the situation of psychiatric disorders and depression in Iran will be discussed.

1.3 PSYCHIATRIC DISORDERS AND DEPRESSION IN IRAN

It is estimated that at least 7 million persons living in Iran suffer from one or more psychiatric disorders (15). The 1999 Mental Health Survey, conducted on the population of those over 15 years of age, showed that the prevalence rates of depression in the three study locations, Tehran (the capital city), Ilam (representing Kurdish ethnicity) and Western Azerbaijan (representing Turkish ethnicity) were, 18.5%, 20.3% and 30%, respectively (16).

Another survey of the prevalence of lifetime psychiatric disorders among the population of ages 18 and over showed that the prevalence of anxiety and mood disorders were 8.4% and 4.3%, respectively. Among mood disorders, major depressive disorder (3.0%) had the highest prevalence (15).

According to national data collected from 2001 to 2003, 21% of Iran’s general adult population suffered from mental illnesses, and the rate for women was 1.7 times higher than for men (25.9% versus 14.9%) (17). The higher rate of mental disorders among
women has been reported in all parts of Iran (18). Gender and marital roles were considered as possible explanations for the higher rates.

The other cross-sectional, population-based epidemiological study (age > 18) in Iran used the Schedule for Affective Disorders and Schizophrenia showed that the estimated lifetime prevalence of Major Depressive Disorder (MDD) was 3.1%, which was lower than in the United State (5-10% range) (19). The apparently low rates seen in Iran may reflect this lack of ability to detect somatically-oriented depression. It may also be that depressive illnesses may be inherently somatic in manifestation in non-Western nations or ethnic groups. Thus, the current depression criteria, which are primarily psychologically based, might be insufficient to accurately assess depressive syndromes in countries like Iran, which may tend to normalise depression (15, 19).

The next subsection is about the concept of depression among Iranian people.

1.4 THE CONCEPT OF DEPRESSION IN IRAN

In Iran, depressed patients, especially in the initial phase, will generally not complain about a disposition to depression. Patients usually blame their sadness on different causes, such as accidents or the daily occurrences of things, unfavourable living conditions, physical illness or some other reason, and therefore consider it as a natural occurrence (20).

For Turkish speaking depressed patients, the most similar word and the most prevalent initial complaints of depression is “darikhma” (anxiety with sadness). Dispersed pain, insomnia and anger were the common symptoms broached by depressed patients who sought consultation at a psychiatric centre. One important point in the evaluation of Turkish speaking patients is that some of these patients, despite displaying all the symptoms of depression, will still deny feeling “darikhma”. Some patients compare it to a feeling of restlessness (21).
In order to express the feeling of depression in the colloquial language, Iranian people usually use compound words, typically feel homesick, “delam gerefteh”; I feel gloomy “delam gerefteh”; feel bitter “oghatham talkh hast”; and it seems to me that the world is dark and gloomy. Some patients correlate homesickness to restlessness, impatience and feel like I’m being suffocated “ehsas khafegi daram” (20).

Dysphoria – sadness, grief – is central to the Iranian character, an emotion charged with symbolic meaning. Tragedy, injustice and martyrdom are central to Iranian historical experience. Dysphoric affect is thus not equated with simple unhappiness in Iranian culture; it has profound religious and personal significance (22). The experience of sadness, loss, and depression is rooted in two primary meaning contexts in Iranian culture: one associated with an understanding of the person or self, the other with a deep Iranian vision of the tragic, expressed in religion, romance and passion, and in interpretations of history and social reality. This vision is articulated through the Islamic tradition of popular mourning ritual, through the classical traditions of Persian poetry and the popular literary traditions (22). Although pathological depression is not an ideal, there is no stigma associated with expression of deep sadness; indeed, the ability to express sadness is highly valued (23).

Iranians value sadness, but they experience depression as distress “narahati”. Symptoms of “narahati” typically include feelings of sadness and grief “gham-o ghoseh”, which may be in reaction to loss or death, to ritual mourning or bereavement (22). However, it is articulated by patients in distinctive Iranian idioms and is interpreted by sufferers. A person who is severely troubled may be labelled as having mental sickness “maraz-e ravani”, which is stigmatizing. The state of “narahati” provides the boundary between one who is melancholic in a valued sense and one who is troubled or ill. They also include rumination or excessive worry of thinking “ziad fekr kardan” associated with various problems of living, poverty, and anxiety “negarani”
arising from interpersonal conflict. Distress is explained by several common etiological idioms. Distress of the nerves “narahi-e asab” usually describes a condition of irritability, weakness and tiredness, lack of patience in interpersonal relations and nervousness (20).

The conceptualization of depression is largely determined by the society’s culture and worldview. Thus, in the next subsections the relationship between culture and depression, common features of Islamic culture and promotion of mental health will be discussed.

1.5 CULTURE AND DEPRESSION

There have been a number of definitions of culture. Culture refers to the shared symbolic knowledge and attitude and customs shared by a group and transmitted to its members generationally (24). Culture is a group’s learned shared language of behaviour which through a dynamic process – is constantly changing in response to the environmental demands faced by the group (25, 26). The conceptualization of illness, as well as the manifestation of its symptoms, responses to the illness, and methods of treatment is largely determined by the society’s culture and worldview. It influences the source of distress, the interpretation of symptoms, the mode of coping with distress, help-seeking, the social response to distress, doctor-patient interactions, and professional practices (12, 27).

In mood disorders, the clinical picture of depression may differ from culture to culture. Evidence-based studies found that in some non-western societies, professional treatment is relatively rare. As a result, patients may not be diagnosed and do not receive needed treatment (28 - 29), which may add to the cost of care, especially in low- and middle-income countries (30). One suggested explanation for delayed diagnosis and treatment might be somatisation: people interpret their distress as somatic illness, or
present distress as physical illness (28). The qualitative study of depressed people in Uganda showed that a majority of the respondents gave somatic complaints as the reason for their initial help-seeking (31). Another explanation could be public's conceptual framework of illness. The illness process usually starts with personal awareness of a change in bodily feeling and continues with the labelling of the sufferer by one's family or self as “ill”; personal and family action is then undertaken to bring about recovery. Advice is sought from family members, the community, professionals or traditional healers (32). This sequence is usually not considered within the medical health system care. As an example, in Kenya, the society in general may not recommend that a depressed patient seek care at a hospital, because they consider depression to be a social problem caused by excess thinking and not by illness (33). Similarly, the study on lay concepts of depression among the Buganda of Uganda showed that common care pathways for depressive disorders were engaged in self-care or alternative and complementary treatment such as consulting with traditional healers (34, 35).

Thus, greater understanding of the attitudes, beliefs and practices regarding mental illness in the cultural context in a society and its influence on people's health is vital to the development of appropriate mental health care systems and adopting mental health policies in the country (36, 37). In the context of Iran, the religion, Islam, affects all aspects of Iranian life, attitudes and beliefs. In this regard, Islamic culture and its effect on mental health will be discussed in the next subsection.

1.5.1 Common features of Islamic culture and promotion of mental health

Islam is more than a religion, because it informs all aspects of behaviour and has been described as 'a comprehensive way of life'. A central issue is unity: the unity of
God, unity with God and unity within the Islamic community (38). Community is more important than the welfare of the individual. Although different groups experience different influences, Islamic cultures around the world share common features including family interdependence, loyalty and hierarchal societies. These societies are relatively collectivistic in which the individual’s behaviour is determined more by the norms, roles and goals of their collective, than by personal attitudes and perceived rights (38).

In general the Islam holy book deals with a number of psychosocial issues for healthy living and for the promotion of the quality of life. Essentially, the Islamic strategy for the promotion of mental well-being is based on the recognition of the inherent human defects and emotional weaknesses and hence calls for systematic developments and constructive performances to overcome them (39).

The next subsection reviews theories about the gender issue and reasons for gender differences in depression.

1.6 GENDER AND DEPRESSION

The prevalence of major depression among women in community epidemiological studies is typically estimated to be between one and a half and three times more than of men. Women present slightly more often with milder types of depression than with severe depression in outpatient settings (40). Therefore, viewing health through a gender lens necessitates steps to improve women’s equal access, affordability and appropriateness to health services (41).

Some theories about the reasons for gender differences in depression emphasised the importance of differential persistence of sex roles. Sex-role theories suggest that the chronic stresses associated with traditional female roles lead to higher prevalence of depression among women than men. Rumination theory suggests that women are more likely than men to focus on problems. Accordingly, they confront more negative
feelings of distress about the possible causes, which may allow transient symptoms of dysphoria to grow into clinically significant episodes of depression. Men, in contrast, engage in distraction, push away bad feeling by diversionary activities such as sports. Rumination intensified depressed effects and hopelessness and thus could precipitate clinical depression (42). Differences in frequency of life events, biological factors, child-care responsibilities, experience of abuse, domestic violence, unemployment, social isolation and social roles also have been considered for differences in the prevalence rate of depression among women compared with men (43, 44).

1.6.1 Gender and Depression in Iran

In Iran, the majority of women are bound to their social roles as housewives, even when women work outside the home; therefore, they may be more subject to strains and stress and more at risk of depression than men (17). In addition, Iran, as a developing country, is rapidly undergoing the process of urbanisation and industrialisation. In 1996, 61.3% of Iran’s population lived in urban areas compared to 54.3% in 1986 (45). The socio-economic changes at a societal level are expected to influence social relations at the levels of the family and household. The economic activity rate of women in Iran is still low (8.2% in 1986) but increasing (9.1% in 1996) (45). Women's recent rapid gains in the educational sphere in Iran effectively increase their chances of greater socioeconomic participation. In the highly competitive scene of higher education in Iran, female students constituted 29% of all students in 1986 rising to 36% in 1996 (45).
2 THEORETICAL FRAMEWORK

This study explored concept of people on women's depression in Fars, Kurds and Turks ethnic groups in Iran. It investigated how Iranian people conceptualised depression and their help-seeking behaviours. The study therefore drew ideas from the explanatory model below.

The explanatory model (EM) is a way of looking at the process by which illness is patterned, interpreted and treated. The concept of explanatory models is the recognition that individual patients and their families often have their own concepts and categories for illness, which may differ from those held by clinicians. How ill health is perceived and how treatment is experienced may all form part of the total picture that clinicians need to take into account. Illness is what a patient feels when going to the doctor, and disease is what one has on the way home. Both the meaning given to the symptoms and the emotional response are influenced by the patient's own background and personality, as well as the cultural, social and economic context in which the symptoms appear (46).

The EM is defined as the notions about an episode of illness, such as depression, and its treatment that is employed by all those engaged in the clinical process. “In particular, it provides explanations for five aspects of illness:

1. The etiology or cause of the condition
2. The timing and mode of symptom onset
3. The path of the physiological processes involved
4. The natural history and severity of the illness
5. The appropriate treatments for the condition” (46, p.120).

The biomedical models of depression are generally available through educational guidelines, usually written in local languages for medical doctors. On the other hand,
the patient's and the community's understanding of depression are less available to the clinicians (47).

In this regard, explanatory model can provide insight into lay beliefs about illness, the historical, personal and social meaning of the illness, expectations about what will happen as a result of illness, and identify the short- and long-term therapy goal (48). In recognition of the significance of explanatory models in psychiatric fields, the fourth edition of the DSM-IV has been supplemented by a guide in cultural formulation, which places emphasis on cultural factors related to the psychosocial environment, the explanatory models that individuals and the reference groups use to explain the illness, professional and popular sources of care (1). Although the DSM-IV includes an outline for this item, we attempted to be aware of culturally specific idioms of distress of women’s depression in order to elicit symptoms and to increase our knowledge about how to manage depression and give access for effective mental health service delivery in general. To conclude, this study is conceived as an attempt to bridge the knowledge gap exploring the explanatory models of women’s depression among the Iranian people in three ethnic groups (Fars, Kurds and Turks).
3 AIM OF THE STUDY

3.1 GENERAL AIM

To explore how Iranian people understand and talk about depression in women from three ethnic groups (Fars, Kurds and Turks).

3.2 AIM OF EACH STUDY

Paper I: To field test the method, techniques and instruments (case vignette and interview guides) in order to explore the explanatory models of depression among Iranian women through clinicians, depressed women and lay people in the three ethnic groups.

Paper II: To explore the explanatory models which Iranian lay people in the general community apply to a case vignette of a depressed woman in three major ethnic groups (Fars, Kurds and Turks).

Paper III: To describe the explanatory models of illness in women who were found to be depressed on the basis of a locally validated clinical psychiatric interview and their relatives.

Paper IV: To explore clinicians’ (psychiatrists, psychologists and general practitioners) point of view and experiences of understanding depressed women's explanatory models.

3.3 QUESTIONS:

- Would the method, techniques and instruments (case vignette and interview guides) be applicable for exploring the explanatory model of depression among Iranian people in the three ethnic groups? (Paper I)
• How do Iranian women in the three ethnic groups communicate depression and social problems? (Papers III and IV)

• How do Iranian people (including lay people and depressed women's relatives) in the three ethnic groups understand, communicate and cope with depression in women? (Papers II and III)

• When do depressed women and the other study participants (including lay people, depressed women's relatives and clinicians) in the three ethnic groups think about the treatment? What are the signals of illness? (Papers II, III and IV)

• Are there culturally specific characteristics of depression in women as a general symptom? (Papers II, III and IV)
4 METHODS

This thesis is based on four studies. This section will detail the methods used in these studies. The context of the study, psychiatry and mental health services in Iran, data analysis, trustworthiness in four studies, ethical considerations and ethical clearances have also been included in this section.

4.1 THE CONTEXT OF THE STUDY

Iran (Figure 1) is an ancient country located in the Middle East region, with an approximate area of 1,648,000 sq. km (3.6 times larger than Sweden) which makes it the 17th largest country in the world. Its population was estimated to be about 70 million in 2006. Of these 44.8 million (66%) lived in urban areas. The country ranks among those with low middle income (49). The literacy rate is 83.5% for males and 69.9% for females. The life expectancy at birth is 71.4 years on average: 72.8 for females and 69.9 for males. The official language is Persian, and the majority of the people are Shi’ite Muslims (50).

Iran is ethnically diverse; the majority ethnic groups are Fars, Kurds and Turks. The Iranian Fars, the largest ethnic group (51% of population, about 34 million), speaks Persian. They also define the “Persian ethnicity” which basically refers to anyone living in Iran who does not claim a secondary regional identity. The next largest (24 %) the Iranian Turks (Azeris: people from Iran’s Azerbaijan provinces), live mainly in northwest Iran, in the provinces of East and West Azerbaijan and Ardabil (capitals: Tabriz, Urumiyeh and Ardabil, respectively) and speak Turkish (Azeri). The Iranian Kurds (7% of the population, about 5 million) are concentrated in the western, mountainous areas of Iran, in the provinces of Kurdistan, and speak Kurdish. The majority of Kurds are Sunni Muslims. Traumatic life events and losses are two common
phenomena for the Kurds (51). The Iranian province of Kurdistan has been engaged in civil war in recent decades (1980–1988). During the Iran–Iraq war, Kurdistan was under attack and heavily bombarded (52, 53). During that time trauma and loss were a daily life experience for many individuals. Nowadays, the Kurdish population encounters many stressors including low income and unemployment (54).

Figure 1: Map of Iran showing the location of the study in Iran, Tehran, Ilam and Tabriz

The next subsection discusses the history of psychiatry, development and also the current mental health service provisions and its challenges in Iran.
4.1.1 Psychiatry and mental health services in Iran

As in the West, the history of psychiatry in Iran is as old as the history of medicine. Some early sources refer to the Islamic era. The mentally ill were perceived as patients, and there is evidence of these people being treated in special hospitals or wards (55). Modern psychiatry in Iran began in 1934. Integration of mental health into public health care system was initiated in 1986 (Figure 2). A national mental health authority advises the government on mental health policies and legislation; it is also involved in service planning, service management, coordination and monitoring, and quality assessment of mental health services (56). This integrative health care is a widely promoted model of mental health care in many low-income countries (57, 58).

Mental health services are organised in terms of catchments or service areas. Most mental health hospitals and all community-based inpatient units are run by the medical universities, some of which train psychiatry residents. All mental health outpatient facilities have access to at least one psychotropic medicine in each therapeutic class (anti-psychotic, antidepressant, mood stabiliser, and antiepileptic medicines) either at that facility or at a nearby pharmacy. All these facilities are organizationally integrated with mental health outpatient facilities. Mood/affective disorders (65%) and schizophrenia (17%) are the main diagnoses of patients admitted to mental hospitals. About 46% of the patients in mental hospitals [88,000 patients (130 per 100,000)] are female (50).

Therapeutic interventions are usually biological. Most psychotropic drugs are available in Iran (56); they include antipsychotics, anxiolytics, antidepressants, mood stabilisers and antiepileptic drugs. About 53% of the population has free access to essential psychotropic medicines. In Iran, payment takes place at all levels of health care. Patients pay 25% of the fee for a clinic consultation, laboratory investigations or medicines obtained from pharmacies. This includes expensive investigations such as
computed tomography and magnetic resonance imaging scans. For hospital in-patient
treatments, including investigations and medicines, a payment of 10% is required from
the patient (59). For those who pay privately, the cost of antipsychotic medication
averages IRR (Rials) 1500 (US 0.16) a day; antidepressant medication costs IRR 600
(US 0.07) a day (4% and 2%, respectively, of the daily minimum wage). All mental
disorders are covered in social insurance schemes, but there are limits to the duration of
a stay in hospital.

Iran has a total of 33 mental hospitals, with 5,350 beds or 7.9 beds per 100,000
people (56). The human resources at mental health facilities and private practices are
about 61.2 persons per 100,000 of the population in Iran. Their professional
composition is: 800 psychiatrists (1.2 per 100,000), 7,250 other medical doctors not
specialised in psychiatry (10.7 per 100,000), 5,280 nurses (7.8 per 100,000), 1,340
psychologists (2 per 100,000), 402 social workers (0.6 per 100,000), 325 occupational
therapists (0.5 per 100,000), and 25,900 other health or mental health workers (38.4 per
100,000), including auxiliary staff, non-doctor or non-physician primary health care
workers, health assistants, medical assistants, professional and paraprofessional
psychosocial counsellors (50). The number of psychiatric beds and the number of
psychiatrists and psychologists (7.9, 1.2 and 2 per 100,000, respectively) in Iran is much
smaller compared to Canada (80.8, 12.9, and 45.9 per 100,000, respectively) as a
developed country (60). The information about public mental health services in three
study locations (Tehran, Ilam and Tabriz) is shown in Table 1.

Iran also has a private medical sector existing alongside the public sector. All
patients can therefore choose between the public and private care, and they also have
direct access to general practitioners (GPs) and specialists without referral (59).
However, Iran still has a poorly integrated mental health program with no linkages
between the primary health care system and the private psychiatry sector (61).
Figure 2: Organizational chart for implementation of Iranian National Mental Health Program

Ministry of Health & Medical Education

National Mental Health Committee

Deputy Minister for Health Affairs

University of Medical Sciences & Health Affairs

Director General Disease Control

Provincial Mental Health Unit

Specialized Facilities

District Mental Health

Training & Research

Mental Health Unit

Rural or Urban Health Center (GP)

Family Health Technician

Multipurpose Health Worker (Behvarz)

Neighborhood Health Volunteer
### Table 1: Number of public-sector hospitals (general and psychiatric), psychiatrists and general physicians in Tehran, Ilam and Tabriz, Iran in 2008

<table>
<thead>
<tr>
<th></th>
<th>Tehran (Fars ethnic group)</th>
<th>Ilam (Kurds ethnic group)</th>
<th>Tabriz (Turks ethnic group)</th>
<th>Total in Iran</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>7,800,000</td>
<td>500,000</td>
<td>1,500,000</td>
<td>65,875,224</td>
</tr>
<tr>
<td>Total number of hospitals</td>
<td>143</td>
<td>9</td>
<td>38</td>
<td>771</td>
</tr>
<tr>
<td>Number of psychiatric hospitals</td>
<td>6</td>
<td>0</td>
<td>1</td>
<td>21</td>
</tr>
<tr>
<td>Number of general hospitals with psychiatry ward</td>
<td>33</td>
<td>1</td>
<td>7</td>
<td>151</td>
</tr>
<tr>
<td>Number of active Psychiatrists in public health sector</td>
<td>22</td>
<td>3</td>
<td>8</td>
<td>261</td>
</tr>
<tr>
<td>Number of Physicians in public health sector</td>
<td>947</td>
<td>23</td>
<td>475</td>
<td>13,469</td>
</tr>
</tbody>
</table>

### 4.2 GENERAL STUDY DESIGN

An exploratory design was used incorporating qualitative methods of data collection, such as focus-group discussion with lay people, and individual interviews with clinicians, depressed women and their relatives for the purpose of understanding an individual’s own explanation of depression (Figure 3). This was done by exploring how the study participants conceptualise the depression, the social meaning of symptoms, the metaphors of disease, the help-seeking process, and the significant role of others in the help-seeking process. The study was conducted in two phases, pilot and main phase including studies on lay people, depressed women and their relatives and clinicians (Figure 4). Given that the three major ethnic groups live in Iran, three locations, the central, western and north-western part of the country were selected to represent the Fars, Kurds and Turks ethnic groups.
A qualitative research design was chosen for data collection because:

- It helps the researcher to discover unknown aspects of people or events.
- It also facilitates obtaining in-depth knowledge of human realities and meaning as well as revealing the interdependence of the phenomena under investigation.
- It helps researchers to elicit characteristics which are culturally embedded (62).
- It is also relevant for a culture that has not been studied previously and is useful in transcultural psychiatry and psychology research (63, 64).
- It can offer insights into the prevention, phenomenology and management of psychiatric disorder (64).

In order to explore the explanatory models of depression, two techniques were used. The first involves presentation of a case vignette of major depression to non-depressed respondents (lay persons, both men and women) in focus-group discussion and general practitioners in an individual interview. Lay people were then asked to conceptualise the problem described and to answer questions regarding its causes, effects and sources of help seeking and treatment, and general practitioners were then asked to diagnose the described subject, followed by questions about causes of depression and the treatment strategy they would implement for the patient. This case vignette technique was previously used in a study in Kampala, Uganda (35).

In the second technique, explanatory model interview guides were used. Women diagnosed with major depression and their relatives were interviewed and asked about the symptoms of the illness, its causes and any treatment which had been done for the patient. In addition, clinicians including psychologists and psychiatrists were asked
about the depressed women’s chief complaints, predominant symptoms and the patient’s attitude toward their symptoms, causes and treatment.

**Figure 3: Qualitative method used for study in three cities; Tehran, Ilam and Tabriz representing three ethnic groups Fars, Kurds and Turks, respectively**

In addition to the qualitative assessment, socio-demographic data on age, marital status, education and occupation of the subjects were gathered.

### 4.2.1 Methods for each paper

#### 4.2.1.1 Paper I

The pilot study used a triangulation design comprising qualitative methods of data collection including group discussions (FGD) and individual interviews. We carried out this study to test the use of explanatory interview guides for clinicians and depressed women and presentation of a case vignette of a depressed woman for lay people across the three ethnic groups. We used these two techniques to discover how depression in women is conceptualising by study participants and how the conceptualisation shaped courses of action in the search for help. The pilot study was performed from October 2005 through March 2006.
Figure 4: Area of each study, Aim of each study, Data collection and Samples

**Study & paper I**, Pilot Study

**Aim of each study**
To field test the method, techniques and instruments (case vignette and interview guides)

**Data collection and samples based on qualitative design**
- Individual interview with depressed women
- Individual interview with clinicians
- Individual interview and FGD with lay people (women and men)

**Study and paper II**
**Lay people**

To explore the explanatory models which Iranian lay people in the general community apply to a case vignette of a depressed woman in three major ethnic groups (Fars, Kurds and Turks)

- FGD with lay people (women and men)

**Study & paper III**
**Depressed women and their relatives**

To describe the explanatory models of illness in women who were found to be depressed on the basis of a locally validated clinical psychiatric interview and their relatives

- Individual interview with depressed women
- Individual interview with depressed women’s relatives

**Study & paper IV**
**Clinicians**

To explore clinicians’ (psychiatrists, psychologists and general practitioners) point of view and experiences of understanding depressed women’s explanatory models

- Individual interview with clinicians (psychiatrists, psychologists, general practitioners)
Study participants and sampling procedures

A 3-day (July 18-20, 2005) workshop on qualitative research was held for nine assisting researchers (interviewers) from the three study locations. The interviewers in Ilam and Tabriz understood the Kurdish and Turkish languages and culture, respectively. During the workshop the participants became familiar with the project's objectives and questionnaires, and they learned the required skills for conducting qualitative research to help in conducting the study. In addition, the workshop participants were trained to raise follow-up questions about the attitudes and beliefs of the interviewees in order to access the roots of their thoughts and theories.

Study participants were selected from three locations in the central (Tehran, capital city of Iran), western (Ilam) and north-western (Tabriz) regions of the country representing Fars, Kurds and Turks ethnic groups, respectively.

Lay people were selected from public urban healthcare centres, and the depressed women were selected from the psychiatric hospitals (according to the hospital records) and the public psychiatric clinics (in the case of out-patient subjects) at the three study locations. The clinicians were selected from psychiatrists and psychologists at two public psychiatric hospitals in Tehran and the main public psychiatric hospital in Ilam and Tabriz.

The sample was purposively selected with the aim of identifying informants who would enable exploration relevant to the study. A trained research team at each of the three sites drew the sample under my supervision.

Study groups in each location included:

1- Diagnosed depressed women: Aged 20 to 60 years (in remission phase), hospitalised and/ or attending public healthcare facilities (2 patients in each location - a total of 6 patients). After the interview, the selected patients completed the Hamilton test (with
Dr. Hamilton's written permission) to verify the diagnosis of major depression. Patients with negative results on the Hamilton test were replaced by others showing positive results.

2- General (lay) population: In the pilot study we designed focus-group discussions for women and individual interviews for men and women used a vignette of a depressed woman. We used individual interview techniques for men because the research team assumed that men would talk more freely in individual interviews than in a group discussion. In order to facilitate a comparison of the men's individual interview results with women, we interviewed women in each ethnic group who fulfilled the same criteria as the men. One focus group discussion and two individual interviews (a man and woman) were conducted in each city to test the applicability of using the presentation of the case vignette via focus group or individual interview in the three study locations:

- Tehran; representing the Fars ethnic group: Aged 20-34 years with an educational level equivalent to a college diploma.
- Ilam; representing the Kurdish ethnic group: Aged 20-34 years with an education level ranging from secondary school to a high school diploma.
- Tabriz; representing the Turkish ethnic group: Aged 35-60 years with an education level ranging from illiterate to primary school.

There was one focus-group discussion (FGD) and 2 individual interviews with lay women and men at each location (a total of 3 FGDs, 25 participants and 6 individual interviews, 28 women and 3 men).

Each of the three FGDs and individual interviews consisted of individuals with a similar range of socio-demographic characteristics such as gender, age and education from public healthcare centres located in mid-level socio-economical areas from the
three locations and ethnicities. We avoided recruitment of lay people via mental health services, as our focus was on the general population's concepts.

3. Clinicians, including psychiatrists and psychologists, were interviewed individually in each location (a total of 6 persons, 4 men and two women).

The total number of participants in the pilot study was 43, of whom 36 were women (13, 11 and 12 from Tehran, Ilam and Tabriz, respectively) and 7 men (2, 3 and 2 from Tehran, Ilam and Tabriz, respectively).

**Instruments**

In order to explore the explanatory models of depression two techniques were used. The first involved the presentation of a case vignette of depression to non-depressed respondents (lay people) in focus groups and individual interviews. This case vignette technique, which describes a diagnostically unlabelled case of depression, was used in a study in Kampala, Uganda (35). It is based on the DSM-IV-TR depression categories. Prior to the study, main and local supervisors as well as the scientific committee consisting of experts in psychiatry from the three University of Medical sciences in the three study locations, reviewed the vignette with the aim of ensuring that it met the diagnostic criteria according to the Iranian culture.

The FGDs and individual interviews were used to find out which one would be appropriate for the main study. The settings for the FGDs and individual interviews were arranged in accordance with methodological recommendations (65). The FGDs' moderators and the individual-session interviewers presented the case vignette and then used an interview guide to stimulate and focus the discussion on the research topic among participants. The respondents were asked to conceptualise the problem described and answer questions regarding its causes, effects and sources of seeking help (Box 1).
The role of moderators in FGDs was to encourage participants to express a diversity of opinions, reflections and to give examples drawn from their own experiences. The observer took field notes covering group interaction and non-verbal behaviour and summarised the discussion. After each FGD, there was a debriefing in which the moderator and observer shared their experiences and validated them with what had come out at the interview. The focus group discussions and individual interviews lasted about 70 to 90 minutes and 60 minutes, respectively. The interviews were conducted in a room at a health centre. Such an arrangement ensured privacy and the integrity of the interviewee.

In the second technique, explanatory model interview guides were used for depressed women and clinicians. These are open-ended interview guides based on Kleinman’s original concepts (66) that were used in Uganda (14). The interview guides were translated from English into Persian and blindly back-translated into English and reviewed by two independent bilingual speakers. They were read by the local supervisor, me and the scientific committee to ensure that the wording of the questions and probes were culturally acceptable. Some words in the questions and some probe questions were revised and were categorised based on themes. The interview guides were first piloted on a sample of target groups. They were then revised and verified by the scientific committees at the three medical universities (Tehran, Ilam and Tabriz Universities of Medical Sciences).

Women diagnosed with major depression were interviewed about their own symptoms, their cause and any treatment they may have received. In addition, clinicians were asked about the chief complaints of depressed women, their most common symptoms and the attitude of the patient toward her symptoms. Here too, the interviews were conducted in a room at a health centre or hospital. We used convenient sampling in the pilot study, and therefore there were no drop-outs during the field test.
Box 1. Case vignette of major depression without psychotic features

A 30-year-old woman, who for the past four weeks has been feeling unhappy and no longer, enjoys her usual activities. She says her mind is closed, describes herself as feeling empty and thinks she is unable to continue her life. Also she has difficulty sleeping and has not been eating well. She complains of lack of energy and no longer enjoys sex. She says that life is not worth living. She has difficulty in concentrating and has become forgetful. During the past four weeks she has almost always been thinking about death and her dead relatives and wishes she too was dead or could kill herself (Paper I, P. 400).

1. What do you call the symptoms expressed? Do you know anybody with these symptoms? Has she any other symptoms?

2. In your opinion, what caused this situation? Probe other factors (physical, emotional, spiritual and hereditary areas).

3. In your opinion, what are the effects of these symptoms on the person's life? (Future)

4. What appropriate help should be provided for this person (probe by herself, by others)?

[Revised from Okello and Ekblad (35, p. 294)]

4.2.1.2 Paper II

The study had an exploratory design model and used (FGD) with lay people as a qualitative method of data collection. The collection of data began in December 2006 and ended in March 2007. FGD was chosen because, unlike individual interviews, it can access group norms, collective opinions and shared knowledge (63, 64). Another reason was that the pilot study (67) showed that when a case is presented individually, lay people may answer under stress; in a group discussion on the other hand, where the participants feel trust, participants feel free to talk, continue and express their opinions.

The case vignette was used for stimulating discussion, and presented a case of a woman with major depression, followed by asking explanatory questions (Box 1). This has proved to be a useful way of tracking community attitudes to a range of mental health problems and their treatments (68). The case vignette was the same as was used in the pilot study, when we found this technique to be useful for raising discussion among the group participants.
Four FGDs were conducted for each ethnic group (2 focus groups for men and 2 for women, making a total of 12 FGDs with 38 male and 38 female participants). Each focus group consisted of 5 to 8 participants. The study participants were recruited purposively (69) from the general community of the catchments areas of urban public healthcare centres in the three study locations. Participants were recruited from the defined population with the assistance of female volunteer health workers who were part of a national health program in Iran where they act as intermediaries and contact persons between households in their neighbourhoods and the health centres (70).

The participants were recruited in accordance with the variation in certain characteristics and had no self-reported diagnosis of depressive or mood disorders (Table 2). Stratification of the groups (77) was based on gender, ethnic background, and level of education (illiterate to high-school diploma and above high-school diploma). The reason for gendered focus groups was the notion that the participants would be more comfortable sharing ideas in a same-gender group (71) as well as to obtain homogenous groups and enhance group dynamics (72). To identify ethnic background we used the participants' self-definition.
Ten people were invited for each focus group (total, 120 people) to ensure a minimum participation rate of 6 people per focus group; 88 accepted the invitation and 76 actually participated in the discussions (Table 3). The most important reason for drop-out was lack of time. We avoided recruitment through mental health services because our focus was on conceptions in the general lay population.

Table 3: Characteristics of lay people in the three ethnic groups in Iran who participated in the study

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Gender</th>
<th>Below high school diploma</th>
<th>Above high school diploma</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Number of lay people who</td>
<td>Number of lay people who</td>
</tr>
<tr>
<td></td>
<td></td>
<td>accepted*</td>
<td>accepted*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Number of participants</td>
<td>Number of participants</td>
</tr>
<tr>
<td>Fars</td>
<td>Male</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>42</td>
<td>46</td>
</tr>
</tbody>
</table>

* Out of ten invitations

The process of conducting focus groups

We invited two trained psychologists and four trained psychiatrists from Tehran, Ilam and Tabriz (the three study locations) to conduct the focus groups and to help us to analyse qualitative data because they were more familiar with the local culture (62). The assistants
having received supplemental training in the data collection techniques. However, the first 
sessions produced poor quality data, so I conducted nine out of the 12 focus group 
discussions. Whenever possible these were conducted in Persian, otherwise the discussions 
were held in Kurdish and Turkish with the assisting researchers (observers) acting as 
interpreters.

There were two researchers (one moderator and one observer) for each group. One 
researcher raised the questions from the interview guide for the group to discuss, while 
the other observed the atmosphere and interpersonal interaction within the focus group. 
Permission to audiotape the interview session was sought orally prior to the interviews.

The moderator started the interviews by presenting the aim of the focus group. The 
nature and purpose of the study were explained to each participant before obtaining consent, 
which was confirmed by a signature or a left thumb-print. The participants were also 
informed (in writing) about confidentiality that participation was voluntary and informed of 
their right to withdraw from the study at any time during the interview.

After the introduction, the moderator gave an oral presentation of the case vignette of 
a woman with non-psychotic major depression without providing a definition of the 
concept of depression. The discussion started with how the vignette might be defined and 
labelled. The participants were then asked whether the problem was familiar, how they 
would label it and were encouraged to talk openly about their attitudes and experiences 
relating to the case. The moderator then asked about the causal factors of the condition. 
Probe questions were used to confirm concepts mentioned and to explore areas that the 
participants did not express. The participants’ views and beliefs were examined in detail 
about help-seeking behavior, in particular alternative non-medical sources (e.g. traditional 
healers). The observer observed the atmosphere and interpersonal interaction in the focus 
group. After each FGD, the researchers took field notes immediately and summarised the 
observed atmosphere they experienced in the groups as comprehensively as possible
through situational notes and discussions. Each FGD lasted about 70 to 90 minutes. The sessions were conducted in a room at a health centre.

In this study, to enhance credibility, we selected three different contexts, enrolled participants with different ethnicity, gender and levels of education (73). Transferability was considered by attempting to clearly detail methods of data collection. To assess dependability peer debriefing by experienced colleague to re-analyze some of the data was performed. Consistency checks between colleagues were also performed throughout the coding process (team consistency) (74).

4.2.1.3 Paper III

The study used qualitative methods for the data collection by means of individual interviews with depressed women and their relatives.

**Study Participants and Sampling Process**

Study participants were selected from the three cities with different ethnic backgrounds, Fars, Kurds and Turks. The participants were recruited purposively from April to May 2008. The research team consisted of assisting researchers including one psychologist and psychiatrist present in each city under my supervision, each having received supplemental training in the data collection techniques. The interviews were held over two days in the main public mental health clinics (n = 4, two mental public health clinics in Tehran, and one in Ilam and Tabriz, respectively) affiliated to the public University of Medical Science in each of the three cities. All depressed women (n = 30) who had been diagnosed as depressed by psychiatrists in the aforementioned clinics were referred to female members of the research team and then interviewed. After the interview, one of the assisting research team members (a psychiatrist) who had knowledge of the language of the city conducted an interview-based assessment using the Hamilton
test (with Dr Hamilton’s written permission) to confirm the diagnosis of depression. The Hamilton Depression Scale, which can be used in conjunction with clinical interviews (often in relation to patients who have already been diagnosed as having a depressive disorder), measures the severity of depressive symptoms in individuals. The 19-item version was used for the study. Scores between 0 and 6 indicate a normal or non-depressive state (75). Patients with such a score were excluded from the study. Other exclusion criteria were: mental retardation based on clinical evaluation, and any main medical condition on axis III.

Inclusion criteria for patients were: depression as an axis I diagnosis, age 18 years or older, ethnic groups (Fars, Kurds and Turks) and least 5 years residency in one of the study cities (Tehran, Ilam and Tabriz). All relatives who had accompanied the depressed women to the public clinic were also included in the study. Each interview took about 60 to 80 minutes and was audio taped. Interviews were held in private in a quiet room located in a public clinic. All patients and their relatives who accepted our request for an interview participated in the follow-up explanatory interview (Box 2) conducted concurrently in different rooms at the clinic. The Klienman’s explanatory model (76) served as an interview guide and consists of questions posed to the patients. The questions posed to the relatives were developed after the pilot study (67) by the scientific committee consisting of psychiatrists from the three study locations, a review of literature as well as the Kleinman’s explanatory model (76).

Of the total 30 depressed women who were asked for an interview, three in Tabriz and two in Ilam declined to participate because of a lack of time to participate in the interview. Among the 25 depressed women who accepted participation, 14 were accompanied by their relatives. In all these instances the relatives also participated in the interviews but separately. The relatives were husbands (n=5), children (n=5, mean age 20 years), siblings (n=3), and an aunt (n=1).
In this study, we established credibility through the main researcher's prolonged engagement with the subject matter and triangulation of data sources (interview with depressed women and their relatives) and investigators (using more than one investigator for data collection and analysing). We completed “Member Checking” by presenting of a summary of the interview to the interviewees (both depressed women and their family members) at the end of each interview as well as sending the results to some of the depressed women by convenience sampling to confirm the research findings.

**Box 2: Guide questions for depressed women and their relatives (Paper III, P. 28)**

A: Guide questions for depressed female patients:

**Theme I: Illness conceptualization & Individual experience of symptoms and cause of the illness**

**Warm up:** “It seems that you come to (hospital - clinic) because of some problems you had experienced, if you agree, let's talk about the problems”

A) “What do you call your problem?”

Probe – “Before coming here (to the clinic) what did you call your problems?”

B) “How did your problem start and what factors made it start and continue?”

Probe – (Assessing the reason for the problem) “What do you think caused your illness?”

Probe – (Others’ opinions [relatives] in this regard).

C) “What are the other difficulties that your illness has produced?”

Probe – (The discomforts the patient has experienced in this period, patient symptoms, and the main reason for these discomforts, the relationship of cause and incidence of the illness.)

D) “Do you know anybody with these symptoms in your family? (Please explain)?

**Theme II: Help-seeking process and treatment acceptance**

A/ “What did you do to get rid of this problem? What caused you make such decisions? Who had an important role in making these decisions in your family?”

Probe – (Other roles in this regard? What other interventions should be controlled for?)

B/ “What is the most important result that you hope to receive from the treatment? How do you understand that your illness has been cured? What symptoms show your remission?”

C/ “Do you think your illness will relapse? If yes, what should you do to prevent it?”

D/ “How did you decide to get here?”

B: Guide questions for relatives of depressed female patients:

**Theme I: Concept of the disease according to the patient's family members' point of view**

- “What is the patient's problem in your opinion?” Probe: (Definition of the disease in order to obtain family members' concept of disease).
- “What are the signs and symptoms that the patient has had up to now?” (i.e. the most common).
- “What do you call this problem?”

**Theme II: Cause of disease according to the patient's family members' point of view**

- How have these symptoms arisen?

**Theme III: Coping methods and help-seeking behaviour used by the patient according to the opinion of the patient's family members**

- “What reasons made your relative apply to the clinic? Reasons for referrals.”
- “What interventions have been done to make the illness better?”
- “In your opinion, what interventions should be done for patient improvement?”
- “What do you expect from the treatment?”
- “Would you like to add any further information regarding this issue?”
The assisting researchers from the three ethnic groups and I were engaged in the coding process (team consistency), with a constant comparison of the development of codes and themes. To address the issues of dependability and conformability throughout the entire research process, the main and local supervisors examined the audit trail consisting of the translated transcripts, data analysis documents and comments from the member checking (73, 77, and 78).

4.2.1.4 Paper IV

Individual interviews with clinicians were used as a qualitative technique to understand the explanatory model of depressed women from the clinicians’ points of view and their experiences of managing depressed women (69, 79).

Study participants and sampling process

Study participants were selected from the three cities with different ethnic backgrounds, in Tehran, Ilam and Tabriz in Iran, representative of the Fars, Kurds and Turks ethnic groups. The participants were recruited between April 2008 and July 2008. Sampling and interviewing were done by me with the aid of the local, assisting researchers at each of the three sites. Psychiatrists and psychologists with at least five years’ clinical work experience were selected randomly from the main psychiatric hospital, from two psychiatric hospitals in Tehran and from the main psychiatric hospital in Ilam and Tabriz. A total of 24 persons, 6 general practitioners (2 woman and 4 men), 14 psychiatrists (3 women, 11 men) and 4 clinical psychologists (2 woman and 2 men) participated in the study. Their mean work experiences were 5, 8 and 7 years, respectively (Table 4). After selecting the participants, we sent them an invitation letter and followed up with a telephone call. Then, we arranged a meeting for the interviews. All of invited clinicians, including psychiatrists, psychologists and general practitioners,
participated in the study. All interviews were conducted in Persian because all of clinicians could speak Persian fluently.

We interviewed 18 psychiatrists and psychologists but only six general practitioners. This was because we first interviewed psychologists and psychiatrists to explore their views about the common symptoms of depressed women whom they had visited, the care pathways they sought and the barriers which caused them not to visit psychiatrists or psychologists as the first step of treatment. We stopped gathering more data when we found that further interviews were not adding to the findings in each city (i.e. data saturation) (69, 80). In the next step, we interviewed general practitioners as another objective for help-seeking by depressed women. This helped to fill our data gap as well as to triangulate our data about the concept and care pathway of depressed women from a general practitioner's point of view. Through the process of gathering data, the research team agreed that after the second interview in each of the study location, the codes and themes were being repeated and that additional interviews would not add more themes.

Interviews were conducted in a quiet room at a hospital or private office. General practitioners with at least three years’ work experience were selected from the urban health centres affiliated to the University of Medical Sciences in each of the three cities.

Table 4: Distribution of the number of clinicians who were interviewed in three ethnic groups (Fars, Kurds and Turks) in Iran

<table>
<thead>
<tr>
<th>Cities</th>
<th>Psychiatrists</th>
<th>Psychologists</th>
<th>General practitioners</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>women</td>
<td>Men</td>
<td>women</td>
</tr>
<tr>
<td>Tehran</td>
<td>4</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Ilam</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Tabriz</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>
Instruments

Two techniques were used for the study. One involved the presentation of a case vignette of depression to the general practitioners using an individual interview technique. The respondents were then asked to diagnose the described subject. This was followed by questions about causes of depression and the treatment strategy they would implement for the patient. The other technique involved the use of an interview guide for psychologists and psychiatrists. They were asked about the chief complaints of depressed women, their most common symptoms, their attitudes to their symptoms, and their help-seeking process before they came to the psychologist/psychiatrist.

The credibility of trustworthiness (69) in this study was established by prolonged engagement in the field during the collection and analysis of data; triangulation by interviewing different groups of professionals to obtain different perspectives on the depressed women; peer-debriefing on the development of codes and themes by the research team in Iran and Sweden. We used the strategy of member checking by sending the summary results of data to ten clinicians who participated in our study (6 psychiatrists, 2 general practitioners and 2 psychologists) from the three cities and received their feedback. According to their responses, some descriptions of care pathways including seeking help from traditional healers have been checked. In order to establish the conformability of the research, the study’s method, sequence of data collection, data analysis, and field notes were adhered to and confirmed by local and main supervisors. As regards transferability, the study’s context and methods were described in detail. The clinicians in the three major ethnic groups in the three different parts of Iran described similar experiences and attitudes. Thus, it might be assumed that the results could be transferred to other contexts in Iran.
4.3 DATA ANALYSIS

The data was analysed immediately after collection as recommended in qualitative methodology (69, 77, and 81). Deductive content analysis was used because the purpose of the study and the structure of the analysis were based on existing theory and previous knowledge (82). All of the audiotapes were transcribed verbatim. The Turkish and Kurdish interview tapes were transcribed directly into Persian by the assistant researchers (interviewers) who had bilingual knowledge of the Persian-Kurdish and Persian-Turkish languages. Those interviews that were translated into Persian raised the issue of concept equivalency. Therefore, independent bilingual researchers from the study-site cities also listened to a sample of tapes and transcripts and translated them into Persian. There were some minor differences in the text, although insufficient to alter the results. Next, with the help of assisting researchers in each ethnic group, we read the transcripts to understand the meaning of some words and full sentences for each ethnic group.

All data were read repeatedly to achieve immersion and obtain a sense of the whole (81). To understand indirect meanings implied in the data, the assistant researchers (interviewers) in each location helped in the data coding and analysis. The meaning of the words and sentences which had a specific meaning in each ethnic group was described. The transcripts were read to derive ‘meaning units’ (covering words, phrases and/or paragraphs) (83). We developed a categorization matrix based on the Kleinman’s explanatory model on which the interview guides was based. Then all data were reviewed for content and coded for correspondence with or exemplification of the identified categories (84). The coding scheme was derived theoretically according to the framework of the study; with regard to the concept of the illness, cause and help-seeking behaviour. On the other hand, the themes and categories were identified from transcripts, providing the basis for generating new codes or modifying the codes developed by induction. The inductive codes were sorted into meaningful clusters within the theoretical themes (85).
Next, definitions were developed for each theme and category (Figure 5). Then, for each study, in a one-day workshop with all research teams in the three cities, the codes were compared between the ethnic groups to create broader categories, which linked codes across all study contexts. The analysis was performed with the aid of "NVivo 7" and "Open code 3" qualitative data-analysis software. We were able to import and analyse the Persian documents with open codes. At the next level, the paragraphs which were related to themes or categories were transcribed, and we finalised the analysis and the model.

Figure 5: Analysis steps of exploring explanatory model of depression in three ethnic groups (Fars, Kurds and Turks) in Iran (Paper III, P. 24)

1. Transcribed and translated of recorded tapes
2. Achieve immersion and identified mining unit from the text
3. Initial coding of data based on explanatory model
4. Identification of theoretical themes
5. Developed coding scheme inductively
6. Development of provisional categories and subcategories
7. Exploration of relationship between categories
8. Refinement of themes, categories and subcategories
9. Incorporation of preexisting knowledge
4.4 TRUSTWORTHINESS IN FOUR STUDIES

We established credibility through several optimization strategies including triangulation on data sources (i.e., depressed women, lay people and clinicians of various gender and work experience) and on methods of data collection (i.e., interviews and FGDs), member checks, peer-debriefing and the main researcher’s prolonged engagement with the subject matter. The subjects’ responses were validated by sending the results and citations to key informants and research groups at the three study locations, and they were invited to give their comments and opinions (73, 78).

To address transferability, the complete set of data analysis documents are on file and available upon request. This access to the inquiry’s “paper trail” gives other researchers the ability to transfer the conclusions of this inquiry to other cases or to repeat, as closely as possible, the procedures of this project. To address the issues of dependability and conformability, consistency checks were performed during the different procedural steps. The entire research process and data analysis were evaluated by main and local supervisors. Research teams from each of the three ethnic groups were engaged in the sampling and coding process (team consistency), and the design emerged throughout the entire research process (69).

4.5 ETHICAL CONSIDERATIONS AND ETHICAL CLEARANCES

The study protocol was approved by the ethical committees at the three local universities of medical sciences in Tehran, Ilam and Tabriz, as well as by the national committee in Iran (P373, 23 July 2005). In Sweden, Karolinska Institutet, EPN considered the ethical questions and found that since no research was done in Sweden, no evaluation would be performed (2005/5:8).

The nature and purpose of the study was explained to each participant prior to seeking consent. Individual informed consent was gained from participants and was confirmed by
a signature or a left thumb-print. All material was provided both in English (for the main supervisor) and Persian languages using a simple vocabulary understandable by all participants in the three cities.

Participants were assured of confidentiality and informed of their right to withdraw from the study at any time during the interview and were free to decide whether to participate in the research (autonomy) (86). Permission to audiotape the interview session was sought orally from the groups prior to the interviews. In study III, participants who suffered a problem during the interview were referred for treatment.
5 SUMMARY OF RESULTS

The results of each of the four studies are presented separately. These are the pilot study (Paper I), study on lay people (Paper II), depressed women and their relatives (Paper III) and clinicians (Paper IV). This will be followed in Section 6 with a broader discussion and Section 7 by conclusion and implications.

5.1 PAPER I, PILOT STUDY

The pilot study field-tested the method, techniques and instruments (case vignette and interview guides) based on a similar study in Uganda (35). This approach aims to test the method in a similar project in exploring the explanatory model of depression among Iranian people in the three ethnic groups. The method gathers data from clinicians (psychiatrists and psychologists), depressed women and lay people. Due to Iran's complex ethnic demographics, our study selected the three most predominant ethnic groups.

In accordance with the results of the pilot study, we changed the technique for data collection as well as the stratification of focus groups for lay people in the main study. In addition, other key informants, such as depressed women's relatives and general practitioners, were included in the main study. Therefore, we designed interview guides for relatives of patients and the use of a case vignette of a depressed woman accompanied by probe questions for general practitioners. The relatives of depressed women were included in the main study in order to explore and compare the explanatory model of family members with the depressed women. General practitioners were also included in the clinician group, because the study results showed that many depressed women first sought help there as the initial step in biomedical treatment in all the three ethnic groups.
The interview technique and the stratification criteria for lay people were also revised in the main study. In the pilot study we designed FGD for women and individual interview for men and women using a case vignette of a depressed woman. The results had shown that when a case vignette was presented individually, lay people didn't take enough time to think about the case and hence there was a risk for them answering under stress. Therefore, the research team decided to conduct group discussions for lay people both for men and women separately to increase trust and aid in helping participants feel free to talk and express their opinions.

In the pilot study the lay people (city residents) were stratified on the basis of gender, age (30-34 and 35-60 years), educational level (1- Illiterate to primary school, 2- Secondary school to high school diploma, 3- Above high school diploma) and membership in the three predominate ethnic groups (Fars, Kurds and Turks) in Iran. The pilot study results showed that stratification of participants based on the three levels of education and age did not influence the results. Therefore, the main study stratified lay people only on the basis of gender, ethnicity and two levels of education (at below high school diploma, and above).

In addition, interview guides in qualitative methods are essential for ensuring a smooth research interaction and consistent, trustworthy data. In this regard, the key points in the interview guides were discussed with colleagues at the scientific committee and also field-tested among relevant people in the pilot study. Throughout the pilot study wording of the interview guides and probe-questions were revised for both the depressed women and clinicians in order to gently ease the respondent into engaged discussion.

5.2 PAPER II, LAY PEOPLE

We explored the explanatory model which Iranian lay people in the general population applied to a case vignette of a depressed woman in three cities: Tehran, Ilam and Tabriz, representing three major ethnic groups; Fars, Kurds and Turks, respectively.
The participants' views were described within the following three themes: naming the illness, cause of the condition, and control of the illness. Under these themes, eight subthemes were identified. Naming for illness consists of a detailed description of the labelling of the case; three subthemes including “nerve problem”, “emotional problem” and “personality” were identified. Cause of conditions was divided into external factors (environmental cause and war) and internal factors (emotional factors, cognition distortion and hormonal [biological] factors). Control of illness was also categorised to deal with personality weakness, help from family and friends and biological treatment and counselling (Figure 6).

About half of the participants in the three ethnic groups mentioned similar terms for the symptoms presented in the case vignette. They labelled the illness: “distress of nerve” or soul” (“narahati asabi” or “narahati roh” in Persian and Kurdish, “asabi narahati, chilghar” in Turkish). The illness was described as a non-serious problem with nerves which, due to some recent external stressor in life, caused physical and soul problems. There were differences between nerve distress and a problem with one’s soul. When the group said nerve distress or nerve disease “narahati asabi or bimari asabi”, they meant a sickness related to nerves. But when participants called something a soul problem, they regarded it as a temporary situation due to some recent external stressor in life which put pressure on the subject and also caused sadness. Removal of these external factors would lead to an improvement. This issue was more common among participants with less education. A majority of the participants labelled the symptoms of the women as depressed, (“afsorde” in Persian, Kurdish and Turkish). Fars groups defined depression “afsorde” as feeling blue, while Turkish and Kurdish ethnic groups frequently defined it in terms of worry and soul problems (“moshkel rohi” in Kurdish and Persian, “asabi narahati chilghar” in Turkish), emphasising troubles within the mind. Some participants attributed the symptoms to personality characteristics as
weakness. Terms such as shyness, low self-confidence, sensitiveness ("hasas" in Persian, Kurdish and Turkish), pessimism ("badbin" in Persian and Kurdish), hopelessness, and low tolerance were used. The characteristics were considered to be a weakness and therefore the sufferer became sad.

The subthemes of cause of the condition were divided into external as well as internal factors. Most of the participants considered that the case symptoms might occur following a difficult external event or circumstance. Various environmental causes were mentioned. With regard to family conflicts, most participants saw conflicts and gaps between the beliefs of the women and their families as a major stress on women. Some of the participants (Kurdish and Fars) asked specifically about the subject’s marital status. When probed about the role of marriage, participants explained that if the case concerned a single woman who did not get along with parents or lived in a large family, she was exposed to stressful factors that precipitate symptoms.

MarITAL problems, such as conflicts with husband and in-laws, forced marriage and abuse were the most common phrases used for describing causes of the illness. Being in an incompatible marriage or being compelled to tolerate a partner who was not a perfect match ("hamkof" in Persian language) was also recognised as possible causes.

Regarding gender-linked stressors, environmental causes such as work conflicts or economic problems, factors such as women’s limited opportunities in families, a sense of deprivation in society, lack of attention to the needs of women and gender discrimination in the family and society, were also emphasised by most of the participants. Most women stated that working conditions as social stressors cause depression for women. Economic dependency on men, unemployment and job loss were considered to be other social stressors for women in all three ethnic groups.

War (with Iraq 1980–88) and its consequences in Ilam province was mentioned by a majority of the Kurd participants. Fear and anxiety during that time, and the war’s
consequences, such as the city’s underdevelopment and lack of facilities, were seen as major external factors contributing to problems for women in that region.

Emotional factors, cognition distortion and hormonal (biological) factors were among the most frequently mentioned sources of vulnerability depression “afsordegi” among most of the participants. Emotional factors such as weak soul (“zaaf rohi” in Kurdish and Persian, “ghalbi arir naraht de” in Turkish), low self-confidence, pessimism, inability to adjust to problems, sensitiveness “hasas” and weak nerves (“zaf asabi” in Persian and Kurdish, “asab zaieflip” in Turkish) were frequently mentioned by participants with less education.

Cognitive distortion, i.e. thinking too much about problems and negative thinking as a dysfunctional thought, were considered to be personality characteristics that may cause depression. The participants considered prolonged thinking about problems as lowering women’s tolerance levels and causing such conditions. A few of the participants with a higher education declared biological factors as a potential cause of the problem. These factors included hormonal problems and pregnancy as a precursor of feeling sad after delivery.

Participants’ opinions about the cause of the illness influenced their views about seeking help. The first step in controlling an illness was to determine the problem's cause and origin. Proper care appeared to be recommended on the basis of the etiology and duration of the symptoms. Most participants believed in the need of alternative help-seeking (prior to seeking help from biological treatment), from family and friends, dealing with personality weakness, and counselling.

Solving or coping with life’s problems was considered the best way for improvement. Most of participants in the three ethnic groups stated that the woman should empower herself to deal with life’s problems. Most women declared that the woman in the case
vignette should change her attitude and thoughts. Solutions suggested included changing a negative outlook, being more optimistic, being strong enough to challenge problems, strengthening self-confidence, diverting thoughts to other issues, and learning life skills. Consultation with a psychologist was considered as a means of expressing feelings and internal reinforcement against difficulties. The majority of the participants also suggested that the most important solution to such problems, regardless of their cause, is to strengthen the individual through reliance on and reinforcement of faith in God. Almost half of the participants (most women and some men) asserted that the absence of a relationship with God, underlined by a lack of faith, would prolong suffering and that having faith in God through prayer was of paramount importance in coping with life problems and was valued, particularly for its private nature. Praying, reading holy and spiritual books and going to holy shrines were important ways of seeking help from God in order to empower and be able to deal with her life difficulties.

In addition, friends and close family members were perceived as the main source of support. One of the main suggested strategies for dealing with the problem was changing the living conditions with the help of the family such as engaging in entertaining activities, provision of a cheerful environment by family members, travelling, and changing the monotonous rhythm of life.

The majority of participants with higher education recommended consultation with a family counsellor or psychologist, whereas a majority with less education suggested visiting psychologists only if the symptoms became worse or there was a risk of suicide. The role they assumed for these professionals was mainly counselling and listening to the patient, since their conversation is confidential and her secrets and personal matters will be respected. Most participants believed strongly in the benefits of counselling.

Medication was to be used only as a last resort. They recommended medical therapy when symptoms continued for a long time or became worse. Most of participants
generally explained that medication was unnecessary and should be considered only as a final step; most Turkish women preferred herbal medication. Most of the Kurdish participants mentioned the social stigma associated with having soul distress ("bimari rohi" in Kurdish) or a mental problem ("moshkel ravani" in Kurdish) and visiting a psychiatrist. Stigma and drug side-effects were considered as barriers to professional support.

5.3 PAPER III, DEPRESSED WOMEN AND THEIR RELATIVES

This study described the explanatory models of illness in women who were found to be depressed on the basis of a locally validated clinical psychiatric interview and on interviewing their relatives. In particular, we wished to describe the idioms of distress.
expressed by depressed women and their relatives, their view of their circumstances and how these related to their symptoms and illness.

There were similarities in the terms used for of the illness in the three ethnic groups. One theme and five categories were found in this study. The theme was: "illness meaning", including three categories: 1) perceived symptoms, 2) label of the illness, and 3) effects of the illness. Two other categories were: "the care pathway" which breaks down into seeking help from 1) clinicians, 2) traditional healers and 3) self and family, and "expectations of the treatment" (Figure 7).

Most of the depressed patients and their relatives described the illness in terms of nerve problems/illness “moshkel asabi/ bimari asabi” in Persian and Kurdish, and “ghalbim arir naraht del asabam zeif lip” in Turkish, and depression “afsordehgi” in all the three languages. They spoke of nerve problems if they experienced somatic symptoms such as body pain, headache and stomach pain in addition to sadness and thinking too much; If the psychological symptoms, especially depressed mood, sadness and crying, predominated, they labelled it as depression “afsordehgi”. The severity of depression appeared to be categorised in terms of the severity and persistency of sadness and feeling blue. Other names, used by Turkish and Kurdish participants, were “darikhma”, (deep sadness with anxiety), and “tarjoman”, (sadness with nerve distress “naraht asabi” due to transient external events), respectively. In addition, some people in all three ethnic groups used personality characteristics, such as “sensitivity” to problems and being “anxious”, both as labels as well as the cause of the problems.

The symptoms perceived by the patients were divided into two main categories: somatic and psychological. Depressed women who had been visited by the psychiatrists in the clinic in the three cities for the first time mostly focused on somatic symptoms, and depressed women who had been visited more than once (a majority of participants in the
three ethnic groups) stated both the somatic and the psychological symptoms. To some extent the patient's complaints were dependent on the reason which she or her relatives assumed was the onset of the illness. In cases where the patients attributed their problems to outside social events, most complaints were somatic. When the patient did not attribute the illness to outside events, she assumed it was a result of personal characteristics, and the main symptoms were psychological.

The most common somatic symptoms reported by the depressed women and their relatives were body pains such as headache and stomach-ache. Many of the symptoms closely resembled biomedical phenomena of depression, such as insomnia, loss of appetite and restlessness. However, with other symptoms, a potential connection with depression was less clear, such as sudden pangs of pain (resembling electric shock) in the back, a sensation of suffocation or having a lump or a tumour in the throat, blushing, pressure on the heart, a stiff neck, numbness in the back or the leg, or limb pain causing an inability to walk, a crawling sensation in the abdomen, or hot water in the head and back. These findings were similar in the three ethnic groups. It appears that even though patients had experienced psychological symptoms, they did not complain about them because they did not take them to be symptoms of an illness. On the other hand, the most common psychological symptoms reported by the patients in all three ethnic groups included sadness, crying, excessive, thinking too much, restlessness, silence and seclusion.

Common causes of their problems were marital conflicts, interference from in-laws, and pressure at work, mistreatment and abandonment by partners. Marital problems and in-law conflicts were some of the important factors that depressed women in our study repeatedly cited as a cause and aggravator of their symptoms.
The most important effects that all patients experienced as a result of their illness included loss of support from the spouse, a lower level of affection or separation from the spouse, marital conflict or a feeling of guilt originating from the patient’s inability to support her family. Such effects had arisen for patients who had been referred a second time and considered that the illness had become rather chronic. Other effects reported by relatives included seclusion, avoiding other people and an inability to handle family affairs. These issues were mostly mentioned by Turkish and Kurdish interviewees.

The process and choice of treatment appeared to depend on the type of complaints that the patient perceived if the patient’s complaints were mainly of a somatic nature. The first measures taken by the patient or relatives were to refer her to several non-psychology-related physicians and specialists, such as gynaecologists, endocrinologists, or internal medicine specialists. These visits had often entailed large expenses for diagnosis and treatment. In the absence of a somatic diagnosis or effective treatment, the symptoms, especially psychological symptoms, became more severe and the patients were referred either to neurologists or psychiatrists by their own doctors or to specialists to whom their relatives introduced them or encouraged them to visit. Many of the depressed women in the three ethnic groups stated that alongside medication-based treatments they resorted to alternative and traditional treatments. They usually did so before or simultaneously with consulting a psychiatrist and accepting medication; in other cases they did so where they found the medical treatment ineffective or experienced drug side-effects. Amongst Kurdish patients and their relatives, the primary alternative remedies included asking certain people to write prayers for the patient; Turkish patients and their relatives preferred using herbs, while Fars patients used combinations of these two methods.

Among the most important expectations stated by patients and their relatives were elevation of mood, feeling of inner happiness and increased self-confidence to make
decisions about the future. What the families also emphasised was less seclusion and reticence on the part of the patients and their ability to handle family affairs.

5.4 PAPER IV, CLINICIANS

This study explored the points of view and experiences of clinicians (psychiatrists, psychologists and general practitioners) in understanding depressed women’s explanatory models.

The clinicians’ views were described in terms of seven themes: 1) The Stage of illness during which the depressed women visit clinicians, 2) The depressed women's description of symptoms, 3) Causes of the illness, 4) Care pathways, 5) Barriers to treatment, 6) Expectations of treatment, and 7) Changes in the form of illness in recent decades.

The clinicians in the three cities had similar views. According to them, depressed women visit psychiatrists or psychologists in the moderate to severe stages of the illness. Since their illness is not diagnosed by other practitioners or specialists, it becomes worse and prolonged. Depressed women generally visit psychiatrists or psychologists with both somatic and psychological symptoms, whereas psychological symptoms usually outnumber and outweigh the somatic symptoms. Somatic symptoms often take the form of physical pains and problems such as headache, dizziness, back ache and loss of appetite.
Figure 3: Explanatory model of depression in depressed women and their relatives in three ethnic groups, Fars, Kurds and Turks in Iran, content analysis (paper III, p. 27)
Psychological symptoms cover a wider range; the most common are insomnia, severe fatigue, weakness, distress/anxiety, feeling of sadness, crying, being sensitive, reduced libido, reduced social interaction, impatience even in dealing with children, impaired memory and increased forgetfulness, lack of interest in carrying out daily chores and activities, inability to tolerate the home environment, thinking too much, inability to decide and indecisiveness, reduced ability and educational performance (among students). General practitioners also reported that depressed women usually visit them with somatic symptoms, which often include pains, lack of appetite, palpitations and insomnia. In some cases, the somatic symptoms were accompanied by psychological symptoms such as crying, impatience.

According to the clinicians, a common cause of depression among depressed women was external factors, issues such as economic problems, failure or loss, e.g. divorce or loss of loved ones. The most important causes of the problem among married women were lack of understanding on the husband’s part, problems with the husband or his family and others’ lack of understanding. These issues were reported more often in Ilam than in the other two cities.

The majority of the clinicians in the three cities mentioned that depressed women usually consult several doctors, such as general practitioners or specialists. They tend to visit psychiatrists only when ineffective medication makes them lose their faith in somatic doctors. According to clinicians, some of the depressed women try to deny their illness and assume it is a temporary state of affairs that will go away. They attempt to alleviate their symptoms by seeking help from psychology books and keeping themselves occupied with leisure activities, sports, walking and engaging in social relations such as going to parties or asking for help from the family. Almost half of the clinicians in Tabriz and Ilam considered that depressed women usually go to fortune-tellers and traditional healers. They believed that depressed women with a low
educational background usually go to prayer-writers or fortune-tellers. A majority of the clinicians in the three cities said that depressed women go to herbalists for medicine at the same time as they are referred to psychiatrists or general practitioners.

The participating clinicians mentioned two kinds of barriers for medical treatment: those that cause depressed women to refrain from visiting psychiatrists or psychologists, and those that contribute to patients discontinuing treatment provided by clinicians (psychiatrists, psychologists or general practitioners). According to a majority of the clinicians, the most important reason that depressed women do not visit psychiatrists is fear of stigmatisation for being known as someone with psychopathological problems; they might lose their job and be subject to social cruelty by immediate family or friends.

Psychiatrists in Ilam expressed that in some certain areas the psychiatrists or psychologists are natives of the area (for instance Ilam), and this causes a fear among patients of their illness being disclosed to others. So, despite the principle of confidentiality, depressed women prefer not to visit some mental health doctors.

According to psychiatrists and psychologists in Tabriz and Ilam, another factor that makes depressed women avoid visiting psychiatrists or psychologists is the nature of the treatment for mental illnesses, which requires several visits to the therapist and makes the illness visible to others. Most of the psychologists and clinical psychologists mentioned that economic problems connected with payment for counselling are another reason why depressed women do not go to psychologists.

Drug side-effects and prolonged treatment periods were other factors that contributed to the patient discontinuing the medication, according to the psychiatrists and psychologists. A majority of the clinicians believed that the nature of the illness and the time span needed for treatment must be explained to the depressed patient. However, doctors often withhold this information for lack of time. The depressed
women starts taking the medication, and because she does not see any results after a few days, gives up and consults other doctors.

Most of the clinicians described that depressed women hope that their sadness, negative thoughts, somatic symptoms (such as insomnia and fatigue) and inability to carry out daily chores would soon be over. They mentioned that the patients want to regain their energy and be able to communicate with family members.

Psychiatrists believed that a growing awareness among the general public is causing more female patients to be referred to them than before. Women are relatively more liberated at present. They have become slightly more extrovert and talk more about their mental problems. However, the symptoms of depression have not changed much over the years. The main causes of the illness are still considered to be problems with the spouse and the spouse’s family. As far as treatment is concerned, depressed women still go to a specialist in moderate stages of the illness.
6 DISCUSSION

The discussion of the four studies will start with general comments on the theoretical framework and is followed by a discussion on the methods used, their strengths and limitations. First, the findings are related to the theoretical and methodological considerations underlying the study. The discussion concludes in the last chapter with remarks about implications for clinical practice, education, policy and future research.

6.1 ON THE THEORETICAL FRAMEWORK

Some of depressive symptoms exist universally, but the experiences and expressions of depression might vary across cultures which are clinically significant (87). Psychological symptoms usually are interpreted in different ways across cultures, which may influence the treatment approach (12, 88). Therefore, the health beliefs of people suffering from mental-health impairment, such as depression, are very important and have been identified as key factors in models of health and illness behaviour that may indirectly affect clinical outcomes (88). The explanatory model is a research approach that assesses the health beliefs of people in the area of mental health.

Kleinman’s approach to the explanatory model involved asking questions through an exploratory process of qualitative enquiry. The patients’ view of their illness gives rise to a better understanding of their illness, including its personal meaning and one’s expected recovery process (66, 87).

Yet explanatory model have their limits including multiplicity of meaning, frequent changes and lack of sharp boundaries between ideas and experiences (89). The risk is that explanatory model might not gather a coherent set of social beliefs. When an individual faces problematic psychological or physiological experiences for the first time, they attempt to make sense of it. In doing so, individuals may explore and move
among a varied and complex set of beliefs. Such beliefs should not be regarded as taking the form of a coherent explanatory model but rather as a map of possibilities that provides a framework for the ongoing process of making sense and seeking meaning. Moreover, a person’s own explanatory model is likely to alter over time in response to past medical experiences and to clinician encounters in which the patient becomes acquainted with the practitioners’ explanatory models. It means, therefore, a reformulation of belief may take place among people who develop illness like depression during the time. This phenomenon is not mentioned in studies that use explanatory model of illness. Therefore, explanatory mapping for the purpose of examining both the content of health beliefs and the status of those beliefs may be of significant clinical and theoretical importance (88). Other common criticisms of explanatory model interviews include the difficulty of use in general population research, due to the considerable time needed to administer the interviews and to code and interpret the data. In addition, conducting such research requires detailed interview data collection, and much theoretical knowledge and training in qualitative methods on the part of the researchers. This model also needs participants to spend for interviews, and thus people with limited time might decline from participating (90). For that reason, some other studies, recommend new mixed-methods assessment of illness perceptions which takes much less time to administer than the current model such as Barts Explanatory Model Inventory (90). This uses a combination of interviews and checklists to assess people’s perception on illness.

6.2 ON METHOD

Would the method, techniques and instruments (case vignette and interview guides) be applicable for exploring the explanatory models of depression among Iranian women in the three major ethnic groups?
6.2.1 Strengths and limitations

Using qualitative methods, the researcher can explore areas in which little is known or can gain a new perspective in an area in which relatively much is known (91, 92). Doing qualitative research requires the researcher to have methodological skills and be able to conceptualise, communicate the goal of qualitative research, and carry out detailed description, data synthesis, and abstraction. It also requires cultural sensitivity and competence (62).

To acquire competence in culture awareness, we invited nine researchers in the field of psychiatry and psychology in the three cities to help us to obtain more information about the cultural issues in the three ethnic groups during the collection and analysis of data. We conducted one workshop for the local assisting researchers on qualitative research under supervision of my main Swedish supervisor, and the local supervisor. The aim of the workshop was to enhance the researchers' skills on collecting qualitative data, conducting interviews and following feedbacks. After conducting the pilot study, we conducted three other two-day workshops in 2006 through 2008 to train local staff how to analyze the qualitative data. Nonetheless, despite all these training courses, insufficient data-collecting skills could be considered as a limitation in gathering this “rich” data, specifically when conducting FGDs with the lay male groups who were illiterate to high-school diplomas in Ilam and lay male and female groups with illiterate to high-school diplomas in Tabriz. The assisting moderators did not ask sufficiently probing questions, which resulted in rather “shallow” data concerning the groups' concepts definitions, or “labelling” of the subject’s symptoms. We tried to deal with this problem with prompt feedback after each interview and to train them via role playing. Improvement was observed in the next individual interviews.
In addition, I moderated nine out of the 12 groups (these were four Fars, three Kurdish and two Turkish groups). All groups in Tehran were interviewed in Persian. In the Kurdish and Turkish ethnic groups, the groups were facilitated by the assistant researchers who interviewed in Kurdish and Turkish. However, in the focus groups where I was the moderator, when possible the interviews were conducted in Persian; otherwise they were held in Kurdish and Turkish with the assistant researchers (observers) interpreting the discussions.

Reflexivity and the role of language are important issues in qualitative research (92). Personal reflexivity involves reflecting upon the ways in which our own values, experiences, interests, beliefs, political commitments, aims in life and social identities have shaped the research. Therefore, the researcher is advised to constantly distinguish between another's world and one's own to prevent undue influence of researcher's ideas in an interview and data gathering (94). We tried to decrease this dilemma by conducting methodology workshops and training researchers using role-playing interview techniques and conducting a pilot study.

Critical language awareness forms part of reflexivity. Language plays a central role in the construction of meaning, and that it is the task of researchers to study the ways in which such constructions are produced, how they change across cultures and history, how they shape people's experiences and how it could be translated into other languages (95). The study was conducted in Turkish and Kurdish speaking cities, thus some of the interviews requiring translation into Persian and then English, which brought with it the issue of concept equivalency (96). In order to decrease this challenge, two independent bilingual researchers from the study-site cities translated a sample of transcripts. There were some minor differences in the text, yet these were insufficient to alter the results. In addition, in order to understand indirect meanings of the data which were understood by a native-speaking interviewer, the assisting interviewers from Tabriz and Ilam helped us to
code and analyze the data. Such meanings include cultural customs, cultural concepts and nonverbal expressions perceivable only to those familiar with the culture (62). Furthermore, crosschecking was used to increase the credibility of the results (97).

6.2.2 Using case vignette, individual interviews and focus group discussion

6.2.2.1 Case vignette

We used a case vignette for stimulating discussion among lay people, presenting a case of a woman with major depression, followed by asking explanatory questions. Vignettes are an informal kind of material, and it has been suggested that they are therefore more suitable for exploring and studying beliefs of lay participants, because lay people may not fully understand the academic criteria of the diagnoses (98). Use of vignettes has proved to be a useful way of tracking community attitudes to a range of mental health problems and their treatment (68, 99). These have been described as short stories about hypothetical characters in specified circumstances and were used here to invite interviewees to respond to these known situations (100, 101). The case vignette concept was introduced to our research group (35), and our vignette contained the criteria for depression as defined by DSM-IV (102). The name and age of the subject and some symptoms of the case were changed according to the scientific committee’s comments. We considered symptoms which were relatively characteristic of depressed women seen by Iranian clinicians.

In addition, we used a vignette for individual interviews with general practitioners to assess their experiences in caring for depressed women, and to help find an explanatory model of depressed women from a clinicians’ point of view. This technique has been widely used by health service researchers to measure processes in a wide range of practice
settings among clinicians who may care for different populations of patients (103). We presented a hypothetical case of a depressed woman and followed by asking explanatory questions to explore general practitioner’s perceptions, diagnosis and treatment based on the subject’s symptoms.

6.2.2.2 Individual interviews

The success of the interview depends on the personal and professional qualities of the individual interviewer. We tried to decrease interpersonal variability by training our researchers and observing some of their interviews in context, then provided feedback following each interview.

The interview guides for depressed women originated in a study in Uganda in 2006 (14, 104). Translating questionnaires for cross-cultural research might have methodological pitfalls related to word clarity and word meanings (96). Items must be directly and easily understood with parallel wording in the other language. However, this issue is less complicated in qualitative methods in which interviewers pose the questions to participants. We attempted to adapt the questions to the three ethnic groups’ culture. We discussed the translated guideline with research colleagues in the three study locations at the scientific committee in order to ensure similarity of meaning of each item in each culture. To enhance the conceptual equivalence of the instruments we field tested and refined the instruments with relevant people from the three ethnic groups (45). Some questions were redesigned carefully to ease the respondent gently into the encounter. We added additional probe questions as a memory aide for the interviewers to ensure coverage of all aspects of the study objectives by the interviewers.

One of our other dilemmas was that clinicians conducting a qualitative interview can sometimes fail to distinguish between their researcher role in eliciting exploratory data and their habitual role as a therapist who feels drawn to follow feedback (94). We tried to
control for this important issue by monitoring and observing their interviews, listening to the tapes or reading the transcripts with help of other research colleagues and then providing feedback (94).

6.2.2.3 Focus group discussion

Focus group discussion (FGD) in qualitative research can be used to examine the spectrum of values, norms and meanings revealed in participant discussions. We used this technique for lay people by presenting a case vignette of depressed women and asking global explanatory questions to stimulate discussion. FGD is a skill that must be acquired prior to use in research study. An FGD also differs from an individual interview in that, in addition to the reactions of the leader, all group members influence how the discussion proceeds. We wanted to create groups that would be as natural as possible for a discussion, since only persons who are capable and willing to express their opinions to others can be studied using FGDs. Therefore, the participants were selected from the general community in three catchments areas of urban public healthcare centres in the three study locations, and had no self-reported diagnosis of depressive disorders. Then, people who volunteered to participate in the study were invited to the FGD. We also formed our homogenous discussion groups using similar levels of education and gender to facilitate a free discussion and enhance group dynamics.

As to data saturation, the number of groups usually depends on the needs of the researcher, the types of individuals recruited, the cost and the available funds. In this study, we only had enough funds and time for limited focus groups. In this study, we stratified groups based on gender, and educational level and conducted four FGDs in each of the three ethnic groups (2 groups for men and 2 for women). Hence there might be a risk that full data saturation was not achieved. However, the data analysis showed that a majority of the codes and meaning units were mentioned repeatedly among the groups in
each ethnic group as well as across them, thus indicating saturation in the content of data. Similarly, resources were not available for larger samples, or for including samples from all the sizeable Iranian ethnic groups, though the selected ethnic groups were the largest in terms of population (totalling 83%).

**Gender and ethnic-related difference**

In the FGD situation, men below high-school diploma, especially in Turkish and Kurdish groups, had difficulty in finding specific words to describe the case, and their participation in the discussion took time.

The atmosphere in the interview situations varied from group to group. As we had expected, the gender-related conversational culture clearly differed between groups of men and groups of women. Women discussed their experience of meeting someone with such symptoms to greater extent than men, their sentences were longer and spontaneous discussion ensured within the groups with participants commenting on each other’s opinions. Some women, especially in Kurdish and Turkish groups, told of having such a mood of sadness. In groups of men with less than a high-school diploma, there was a feeling that the participants did not have sufficient knowledge and experience about the case to have a proper discussion, which consequently did not become very fruitful. The men were often content with short, dichotomous responses and moderators had to ask supplementary questions to elaborate the content of the responses. Disagreement also surfaced in some Fars and Kurdish groups of women and in one Fars group of men with above high-school diploma. The participants justified their opinions against others, especially on help-seeking behaviours and causes of the symptoms.

The result of the pilot study showed that the gender of the facilitator did not influence a free discussion of the issue by the participants. Therefore, I was in a position to moderate the four male group discussions in this study. We did not detect any difference in group dynamics when the gender of the moderator and the observer differed from that
of the participants. This might be because the issue was not sufficiently sensitive to prevent participants from sharing their opinions (105). Another reason could be that the moderator was trained in group dynamics and had a clinical background.

6.3 ON RESULTS

6.3.1 General comments

There were more similarities than differences between the explanations proposed by study participants from the three major ethnic groups (Fars, Kurds and Turks) in the study to describe the perception of depression in women and related help-seeking behaviour. The reason for the inter-ethnic similarities could be the common cultural and social elements, such as a common official language and common legal, structural, educational and political structures, mass media, and religion among the three ethnic groups in Iran (106).

Symptoms of depression were interpreted as problems arising from adverse social circumstances, situational terms as an emotional reaction to a pathogenic situation. In a similar study on lay people in Uganda, depression was conceptualized as an “illness of thought”, referring to a non chronic condition caused by psychological, economic and spiritual factors (35).

The model presented for help seeking of depressed women were also similar among study participants (lay people, depressed women and clinicians). Treatment and coping models involved two strategies: initially seeking social support from lay people (including family, friends), religious practice and doing pleasurable activities, and later seeking medical support from psychologists or family counsellors. Patients usually consulted doctors in various medical disciplines for their somatic symptoms and relied on expensive diagnostic approaches and medication for alleviation. They sought help from psychiatrists when the symptoms continued for a long time or became worse.
6.3.2 **How do Iranian women in the three ethnic groups communicate depression and social problems?**

Depressed women regarded their symptoms to be caused mostly by temporary situations due to some recent external stressor in life which puts pressure on them. The removal of these external factors would lead to an improvement thereby normalizing it, and thus they consider it to be a temporary situation. Common external causes of depression among women which were mentioned by study participants were economic problems, failure or loss, e.g. divorce or loss of loved ones, marital problems such as conflict with husband and in-laws or an inattentive spouse, forced marriage, being hurt by a husband (domestic violence), being married to an old person. Marital problems arising from cultural, educational and socio-economic conditions were among the most common phrases that were used, mostly by the participants in the Kurdish ethnic groups. Being in an incompatible marriage or being compelled to tolerate a partner who wasn't on the same socio-educational level “*hamkof*” was recognised as a possible cause of illness by some well-educated lay men in Fars group. There was emphasis on factors such as women’s limited opportunities in families, a sense of deprivation in society, lack of attention to the needs of women. Most lay participants saw conflicts and gaps between the beliefs of the women and their families as a major cause of sadness.

The impact of family conflicts has been found to be the main source of mental health distress in women worldwide (107). In married women in rural Ethiopia, experiencing physical violence, emotional violence and spouse control were factors independently associated with depression episodes (108). Perceived lack of opportunity in the community, discrimination and social rejection are considered as other contributors to female depression (109). In Pakistan, an Asian neighbour to Iran, women with depression also reported marital discontent, family condition, marriage-related problems, isolation,
lack of social support and experience of racism and prejudice as important causes of depression (110).

Studies in Iran show that in relation to facing other men and women in a patriarchal culture, women see themselves as lower and less valuable than men. This results in lower levels of self-respect and an assumption among women that they are imperfect, unworthy, ill and deprived; these negative characteristics and attitudes might have a relation to the depression. Such over-generalised assumptions reflect the socialization of women’s roles, because in the socialization process, girls – and later as adult women – internalise these roles and become prone to psychological illnesses, especially depression (111).

6.3.3 How do Iranian people in the three ethnic groups understand, communicate, and cope with depression among women?

Most of the depressed women, their relatives and lay people believed that the first step on the road to improvement was the acceptance of the illness by the patient. Then she can help herself by solving her problems, changing her environment, enjoying herself. This implies a negative belief that the woman is responsible for her illness, because she could not deal with her problems.

Most of participants in the three ethnic groups remarked that patients need assistance and that others must help, comprehend and listen to them. Most depressed women and lay participants in the three ethnic groups mentioned that family members would support the female patient and pay attention to her needs and maintain social contact with her. Their roles were to take care of children and support the patient during hospitalization. Lay people voiced the opinion that family can have a vital role to play in the patient’s improvement by changing the environment through being amiable and giving advice. It should be mentioned that family bonds constitute the fabric of society in Iranian culture.
Family interdependence and loyalty are strongly encouraged and can be seen as a major support for overcoming mental problems among relatives (23). The family is expected to take control of the treatment. The family is involved closely in the patient’s treatment and takes responsibility for the patient’s care (59).

Some of the clinicians in Tabriz and Ilam, lay people and depressed women’s relatives in the three cities stated that depressed women usually go to fortune-tellers and traditional healers. A majority of the clinicians said that depressed women go to herbalists for medicine at the same time that they are referred to psychiatrists or general practitioners.

Spiritual support and reliance on God were the common help-seeking behaviours used by most of the depressed women, independent of context, as a strategy to cope with their condition.

6.3.4 When do depressed women and the other study participants in the three ethnic groups think about the treatment?

Most of depressed women in the three ethnic groups mentioned trying to deny their illness and assuming it to be a temporary state. If the illness did not improve or the psychological symptoms worsened, new explanations were developed by themselves or by the relatives and other significant people, and new help was sought such as visiting psychologists or neurologists. They usually consult psychiatrists in the moderate to severe stages of their illness. Fear of stigmatisation, drug side effects and prolonged treatment period were the common reasons why depressed women do not visit psychiatrists or do not continue their medication. In agreement with studies on Indian women and depressed patients in Uganda (31, 112) psychiatric admission was seen as the last choice of treatment. This may be because in many cultures, mood disturbances are not perceived as mental health problems but as moral problems or relatively normal
reactions to social problems (28). It also might be due to fear of stigmatization as well as drug side-effects. Cinnirella and Loewenthal (98) argued that community stigma to mental disorders might lead to a preference for private coping strategies. However, attitudes are changing in Iran and some people voluntarily visit psychiatrists for neuroses, marital problems and consultations, but in general attitudes to psychiatric illnesses and treatment remain are negative and most preferred to see a neurologist for mental illnesses (38, 56). Promoting the concept of depression as a treatable medical condition might resolve this problem and help to legitimize medical help-seeking (113).

6.3.5 Are there culturally specific characteristics of depression in women within a general symptom?

Most of the depressed patients and lay people described the illness in terms of nerve problem / illness “moshkel/bimari asabi” and depression “afsordehgi. Other names, used by Turkish participants and Kurdish participants, were “darikhma”, which means deep sadness with anxiety, and “tarjoman”, which means sadness with nerve problems, respectively. In addition, some the study participants (lay people and depressed women) in all the three ethnic groups used personality characteristics, such as being sensitive to problems and anxious, for labelling as well as for the cause of the problems. Depressed women usually expressed psychological as well as somatic symptoms, although the latter predominated. Since they did not consider that psychological symptoms, such as sadness, crying to be symptoms of as illness, they did not complain about these except when these symptoms became more severe or continued for a long time. Similar study in Uganda showed that a majority of depressed patients presented their problems in term of somatic symptoms, and visit psychiatrists only when their emotional symptoms were breakdown (31).
In consistent with similar study in Uganda (31), the most common somatic symptoms reported by the patients were physical pains such as headache and body pains. In our study, when the depressed women attributed their problems to outside events, most complaints were somatic; in cases where the patient did not attribute the illness to outside events, she assumed it was a result of personal characteristics (personality characteristics), and the main symptoms were psychological.
6.4 LIMITATIONS

One limitation was the issue of participant access and recruitment; gatekeepers (staff in health centres and hospitals) may have independently and unknown to us screened potential participants. This might account for why the groups of Kurdish men and Fars women with less than a below high-school diploma had a higher mean age than other groups. Another explanation could be that these participants were simply more accessible in the city.

Focus group discussion differs from individual interviews in that, in addition to the reactions of the leader, all group members influence how the discussion proceeds and the participants may attempt to provide a desirable response. This may have been true in this study; for example, when the moderator explored participants’ opinions about help-seeking behaviours, participants did not mention traditional healers unless the moderator probed this matter. This might be because they feared exposing their idea to the group and also because the moderator was a medical doctor.

In Kurdish and Turkish focus group discussions where the discussion, for practical reasons, was held in Persian, the use of Persian might have compromised the quality of communication since Persian wasn't their first language (62). Similarly, some words and phrases were difficult to translate into Persian and English due to a lack of equivalent words or phrases in the target language; especially for labelling the illness.

Participants with less than high-school diploma education had some difficulty in distinguishing detailed aspects and talking about case vignette.

In order to explore lay people’s concepts of depressed women, the case vignette concerned a woman. The terminology, claimed etiology, and help-seeking models mentioned by the participants might not have been the same if the vignette subject had been a man. Further research is needed on this topic.
In study four, we focused on the exploring perspectives of depressed women from the clinicians' point of view. They explained depressed women’s explanatory model as an outsider. Clinicians did not consider whether their own explanatory model or issues related to their perspective might be regarded as barriers on the path to medical care for depressed women. This may be because the clinicians were not asked about these issues, since it wasn’t considered as an objective of the study.
7 CONCLUSION

Our result showed that the public's conceptual framework of depression was psychosocial as shown firstly, by their recognition of the psychological and social factorial causes of depression; secondly, by their care pathway (involving various strategies according to perceived cause and need) and thirdly by their emphasis on social and spiritual support not only of biological treatment (33).

Faith seems to provide a language to the people to describe and deal with the everyday adversities, giving people strength to deal with their problems, but religious values and seeking help from faith healers may not be mutually exclusive with seeking medical help.

The important barriers to seek help from professionals (psychiatrists or psychologists) were stigma, beliefs that the problem will go away by itself, a desire to deal with the problem without outside help, and a fear of drug side-effects and dependency on medication.

7.1 IMPLICATIONS

7.1.1 Implication for clinical practice

- These results should be considered in the diagnostic and therapeutic protocols for medical doctors and health providers in Iran when choosing an appropriate diagnostic approach and making effective decisions about treatment in a manner acceptable to patients.

- Multidisciplinary treatment meetings are recommended; all decisions concerning care and treatment should be discussed with the persons involved in the treatment
or caring process, including the patient's family and other members of her social network.

### 7.1.2 Implication for education

- Although depression occurs universally, the manifestations and behaviours associated with depression are contextualised in the framework of the patient's values and beliefs. Therefore clinicians should be informed about these issues in their medical courses and/or guidelines.

- The findings also could be incorporated in the training of health workers and their further professional development to enable them to understand the provision of culturally specific information about people's perceptions of symptoms of depression, the terms used and which treatment or help-seeking approach might be recommended.

- There is also a need to strengthen women's access to and control over resources that promote and protect health through addressing gender-based barriers to utilise services. Linking gender sensitivity to training as well as performance appraisals assures that the issue is taken seriously and translated into practice (40).

### 7.1.3 Policy implication

- Strategies for reducing risk factors related to depression cannot be gender-neutral while the risks themselves are gender-specific (40). Therefore, an inter-disciplinary action to set human rights policies to protect and promote women's autonomy and women mental health is crucial. The national mental health programme that has been established in Iran needs to be revised in accordance with an evaluation of mental health systems, community needs and concepts of disease and gender-based barriers in utilising services. It is suggested that the Ministry of Health and Medical
Education in Iran take steps to develop and integrate gender-relevant and cultural indicators in the existing national health information systems, and to find mechanisms to monitor gender sensitivity in the health system.

- These results might help national mental health planners to provide information campaigns for understanding depression based on lay people's terminology and the way they conceptualise the illness.

- More attention should be given to identifying factors that would facilitate coping with stress or distress and to design intervention programs on the communal as well as the primary health care level. In addition, it is important to review, evaluate and strengthen community services and the role of non-governmental organizations to protect and promote women's autonomy and mental health.

### 7.1.4 Research implications:

- It is recommended that the explanatory model of clinicians be explored in a future study to find the gap in the explanatory models between those used by patients and medical doctors.

- It is suggested that through epidemiological research correlation between social health determinants and depression, and also prevalence of misdiagnosis of depression in women should be explored at national level.

- The use of traditional healers for Iranian people is something that requires more research.

- Another area of research is to evaluate the gender sensitivity in the health system.
- Furthermore, it would be of value to use the explorative model in neighbour countries to study similarities and differences to the questions being raised in this study.
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9 REFERENCES


