Explanatory Model of Help-Seeking and Coping Mechanisms among Depressed Women in Three Ethnic Groups of Fars, Kurdish, and Turkish in Iran

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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 doctors. Cultural variations in clinical presentation, sometimes make it difficult to recognize the disorder resulting in patients not being diagnosed and not receiving appropriate treatment. To address this issue, we conducted a qualitative pilot study on three ethnic groups including Fars, Kurdish, and Turkish in Iran to test the use of qualitative methods in exploring the explanatory models of help-seeking and coping with depression (without psychotic feature) among Iranian women.

Methods: A qualitative study design was used based on an explanatory model of illness framework. Individual interviews were conducted with key informant (n=6), and depressed female patients (n=6). A hypothetical case vignette was also used in focus group discussions and individual interviews with lay people (three focus groups including 25 participants and six individual interviews; n=31).

Results: There were a few differences regarding help-seeking and coping mechanisms among the three ethnic groups studied. The most striking differences were in the area of treatment. Non-psychotic depressive disorder in all ethnicities was related to an external stressor, and symptoms of illness were viewed as a response to an event in the social world. Coping mechanisms involved two strategies: (1) solving problems by seeking social support from family and neighbors, religious practice, and engaging in pleasurable activities, and (2) seeking medical support from psychologists and family counselors. The Fars group was far more likely to recommend professional treatment and visiting psychiatrists whereas the other two ethnic groups (i.e., Turks and Kurds) preferred to consult family counselors, psychologists or other alternative care providers, and traditional healers.

Conclusion: The study has educational and clinical implications. Cultural reframing of the patient’s and family’s perceptions about mental illness and depression may require community education. Family counseling, family therapy, and also religious practices can be used to empower the patient.

Keywords: Coping • ethnic group • help-seeking • nonpsychotic major depression

Introduction

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 doctors; they occur everywhere and affect members of various ethnic groups.1,2 Annually, at least 100 million people are affected by clinically recognizable depression.3 In
1990, depressive disorders ranked as the fourth cause of disability with regards to the global burden of diseases. It has been predicted that depression will be the second leading cause of disability by 2020.

Major depression is more prevalent amongst women than men. According to the World Bank, depressive disorders ranked as the fifth most significant health issue for women after maternal causes, sexually-transmitted diseases, tuberculosis, and HIV; it was ranked as the seventh most significant health problem for men.

There are no accurate statistics on mood disorder in Iran. Few studies have estimated the prevalence of depression between 2% and 46%. The National Mental Health Survey in 1999, which was conducted on those aged 15 years and over, showed that about a fifth of the population in the study (25.9% of the women and 14.9% of the men) had mental disorders. The prevalence of mental disorders was 21.3% in rural areas and 20.9% in urban regions. Depression and anxiety symptoms were more prevalent than somatization and social dysfunction. A similar study in 2001 on those aged 18 years and over estimated the prevalence of different psychologic disorders in the nation to be 17%. The rate was higher in women (23.4%) than men (10.9%). The prevalence rates of anxiety and mood disorders were 8.3% and 4.4%, respectively; major depression was the most prevalent disorder among mood disorders (2.98%).

The literature shows significant cultural variations in clinical presentation of depressive disorders, making depressed people less likely than many other health problems to be recognized and therefore be treated by clinicians. It influences the source of distress, the interpretation of symptoms, mode of coping with the distress, help-seeking behavior, the social response to distress, disability, doctor-patient interactions, the likelihood of outcomes such as suicide, and the practices of professionals. Consequently, patients may not be diagnosed and do not receive appropriate treatments. Delay, misdiagnosis, and nonspecific treatments have been typical pathway to care for people with depression. Lack of proper investigation and nonspecific care cause increased care costs, especially in low- and middle-income countries. An evidence-based study showed that professional treatment is relatively rare in many nonwestern societies due to ethnic/cultural differences in treatment seeking.

In this study, depression was defined according to the DSM-IV and ICD-10 definition of clinical depression. The study used an exploratory and triangulation design using qualitative methods of data collection by Focus Group Discussions (FGDs), individual interviews with lay people, key informants including psychiatrists, psychologists, and female patients. The qualitative research design was chosen because it is useful in transcultural psychiatry and psychology research and facilitates obtaining in-depth knowledge of human realities and meanings, besides revealing the phenomena under investigation.

FGDs were used because they make it possible to discover real concepts and experiences of participants with regard to coping with major depression. The settings for the FGDs and individual interviews were arranged in accordance with methodologic recommendations.

Study participants and sampling process
The pilot study was performed from October 2005 through March 2006. Given that three major ethnicities exist in Iran, participants in the pilot study were selected from three locations in the north-western (Tabriz), western (Ilam), and central parts (Tehran, capital city of Iran) of Iran representing Turkish, Kurdish, and Fars ethnicities, respectively.

A three-day workshop was held on qualitative
research in the presence of facilitators from the three study locations. During the workshop, the participants became familiar with the objectives of the study and the research questions and acquired the necessary skills for conducting qualitative research under supervision.

A purposive sampling technique was chosen to select cases according to variation on certain characteristics. The main characteristics which were relevant to the study included “belonging to the mentioned ethnic groups” and “the specific age group” and “educational level of interest to the study.” The process of data collection was controlled by the emerging theory. Sample size was small; subjects were being initially selected because they could illuminate the phenomena being studied. The continued selection of the subjects was related to the findings that emerged in the course of the study. Sampling was made by a trained research team at each of the three sites under the supervision of the first, second, and third authors.

At each of the three study sites, lay people were selected from public healthcare centers; the patients were selected from the mental hospitals (according to the hospital records); and outpatients were selected randomly from the private and state psychiatric clinics. The psychologists and psychiatrists were selected randomly from the psychiatrists and psychologists in the main psychiatric hospital in Ilam and Tabriz and two psychiatric hospitals in Tehran according to their work experience (at least five years).

Study groups in each location included

Patients

Diagnosed depressed women aged 20 – 60 years (in remission phase) hospitalized or attended the private or state psychiatric clinics (two patients in each location—a total of six patients).

After interview, the selected patients completed the Hamilton test (approved by the first author) so as to verify the diagnosis of major depression. The patients with negative results on the Hamilton test were replaced by others showing positive results.

Lay people

In order to compare views of different groups, and to quickly obtain a lot of information, both FGDs and individual interviews were chosen for lay people to create productive discussion. Previous studies have shown the role of gender, age, and education on mental health literacy among community. So we stratified homogeneous groups based on age, ethnic background, and educational level; then, to test the methods, one group of mentioned variables was selected as inclusion criteria for each ethnic group as follow:

- Aged 35 – 60 years with education level ranging from illiterate to primary school in Tabriz; representing the Turkish ethnic group (mean age: 38.4 years).
- Aged 20 – 34 years with education level ranging from secondary school to high school diploma in Ilam; representing the Kurdish ethnic group (mean age: 30.5 years).
- Aged 20 – 34 years with education level equivalent with college diploma in Tehran; representing the Fars ethnic group (mean age: 32.1 years).

One FGD with lay women and two individual interviews with lay women and men at each location (a total of three FGDs, 25 participants, and six individual interviews) were conducted.

Key informants

Key persons including psychiatrists and psychologists (two persons in each location; a total of six persons including two psychologists and four psychiatrists) were interviewed.

The total number of participants in the study was 43 (36 women and seven men).

Instrument

Case vignettes

To explore the explanatory models of depression, two techniques were used. The first one involved the presentation of case vignettes of depression to the nondepressed respondents (lay people) in FGD and individual interviews. These respondents were then asked to conceptualize the problem described and answer questions regarding its causes, effects, and sources of help-seeking. Box 1 is an example of the case vignette of nonpsychotic depression as it was used in this part of the study. This case vignette technique was used in the study in Kampala, Uganda by Okello and Ekblad. This subtype was based on the ICD-10 categories and DSM-IV criteria for the diagnosis of depression.

Prior to the study, the third author, a senior consultant psychiatrist, reviewed the vignette with the aim of ensuring that they met the diagnostic criteria. To ensure conceptual equivalence, all materials were translated from English into
Explanatory model interview guide

In the second technique, an explanatory model interview guide was used. This is an open-ended interview guide based on Kleinman’s original concepts which examines health and illness from an anthropologic point of view. Women diagnosed with nonpsychotic major depression were interviewed about their own symptoms, their cause, and any treatments they may have received. In addition, key informants were asked about the chief complaints of the depressed women, the most common symptom, and the attitude of the patients toward their symptoms. The questionnaire language was simple and devoid of technical words.

Ethical considerations and clearances

The nature and purpose of the study were explained to every participant before his/her consent was taken. Individual informed consent was taken from key informants, patients, and lay people. The informed consent from respondents was confirmed by signature or a left thumb fingerprint.

They were assured confidentiality and informed of their rights to withdraw from the study at any time during the interview. Permission to record the interview sessions on audiotape was sought orally from each informant prior to the interview.

The study protocol was approved by the Ethics Committees of the three Tehran, Ilam, and Tabriz Universities of Medical Sciences and also by the National Ethics Committee in Iran, P373, 23 July, 2005 and the Secretariat of the Regional Boards in

<table>
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<td><strong>Case 1: Major depression without psychotic features</strong></td>
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<td>A 30-year-old woman who had been feeling unhappy and no longer enjoyed her usual activities during the past four weeks. She said that her mind was closed and described herself as feeling empty and thought that she was unable to continue her life. Furthermore, she had difficulty in sleeping and had not been eating well. She complained of lack of energy and no longer enjoyed sex. She said that life was not worth living. She had difficulty with concentration and had become forgetful. During the previous weeks she had been almost always thinking about death and dead relatives of hers and wished she had been dead too or could have killed herself.</td>
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Stockholm for vetting the ethics of research involving humans (2005/5:8).

Data analysis

The analysis was conducted both manually by the research team at each location and with the help of the NVivo 7.0 software program (a qualitative software program used in coding and organizing the data). In Tabriz, Ilam, and Tehran, the research teams transcribed the recorded interviews verbatim. The analysis process started by gaining familiarity with the data by reading the transcripts several times, followed by open coding with the research teams. The open coding involved initial division of data into expressions lines or paragraphs. The coding scheme consisted of categories generated by participants, which were grouped into broad categories of coping mechanisms based on what key informants, patients, and lay people described as help-seeking. This phase was accomplished by the first author along with three assistants. In the first step, small subsets of the data were coded by each pair of coders. Any differences that arose were resolved by discussion.

Descriptive data were then developed as labels for meaning of issues and ideas. The second level of analysis entailed moving from codes to interpretation and reconstruction. The comparison was facilitated by the use of NVivo as the software collects all incidents coded under a category in a node. Codes were constantly compared with categories at different levels and with other pieces of data, including the literature.

Reliability and validity

In the pilot study, validity were conceptualized as trustworthiness and rigor in qualitative research and we used several strategies for optimization, such as triangulation on data source (i.e., female patients, lay people, and key experts of various gender and work experience) and on methods of data collection (i.e., interviews and FGDs), debriefing and peer examination, and respondent validation. The results and citations were sent to key informants and research groups at three study locations and they were invited to give their comments and opinions. The results were also discussed and some parts validated with members of the research group, the Transcultural Psychiatry and Psychology Section at the Karolinska Institute, supervised by the second author.
Results

In this study, we considered different age ranges and education levels in each ethnic group of lay people. The groups of patients and key informants were almost similar in age in the three ethnic groups, but key informants differed regarding years of work experience. The mean work experience was about eight, 17, and 12 years for Kurdish, Turkish, and Fars key informants, respectively.

In this article, although major depression without psychotic features was considered an illness and most of the lay people called it depression, they mentioned it in connection with an external stressor caused by loss (such as death of relatives, job loss, etc.), environmental, family pressure, and marital problems. Help-seeking and coping behaviors concerned the following themes: medical support, social support, environmental support, and religious and traditional spiritual support. These concepts have emerged from the replies of patients, lay people, and key informants to question on the cause and help-seeking based on the interview guide questions and case vignette.

Medical support

Patients were referred to a doctor or hospital, persuaded by family members such as mother, sister, or husband.

One Turkish female patient expressed that “I have done nothing, because there is nothing that I can do about it. I visited doctors ….”

Female Kurdish and Fars patients said for example “… my parents just told me to visit a doctor.” “I was very depressed; my sister found out about it and referred me to a psychiatrist.”

This view was also voiced by lay people in the three ethnic groups. They believed that family had an important role in referring patients to physicians and had to support the patients by providing medicine and advise them taking medication regularly.

This is shown in the following citation from lay persons in Tabriz: “… advised her visiting a doctor or psychologist because the family could not cope with the problems.”

Patients in Tabriz and Ilam mentioned that they were referred to psychiatrists during advanced stages of the illness when somatic symptoms had become aggravated. Usually, they had visited various physicians before hospitalization or visiting a psychiatrist. This issue was also emphasized by key informants in Tabriz and Ilam. They expressed that patients were referred to psychiatrists or hospitals when other physicians’ treatments were actually unsuccessful, or when they had experienced various medications and treatments with no remission. In addition, they preferred to visit a psychologist and family counseling as a first step in the treatment. Patients usually endeavored to tolerate or conceal their symptoms, with the result that their somatic symptoms became more pronounced when they visited a psychiatrist. However, Fars key informants mentioned that referrals to psychiatrists had increased in recent years and patients preferred to take different herbal medicines.

Hospitalization

Patients did not have a positive attitude towards hospitalization and long-term treatment in the three ethnic groups. Families believed that hospitalization often resulted in aggravating the illness. Patients also did not regard admission as therapeutic, and regardless of physicians’ opinions, they preferred to receive a comprehensive and more expensive treatment without being admitted to hospital.

Two female patients in Tabriz said that “meeting other patients on the ward affects me badly and it is better for me to be discharged as soon as possible …” “They (my parents) were unhappy about my hospitalization …”

Kurdish lay people were similar to patients of Turkish group and expressed a negative attitude toward admission. “… not to let the illness become so aggravated so as to need to be hospitalized.”

Medication

Fars and Kurdish patients worried about the side effects of medicines and expressed their negative attitudes towards long-term medication. They also complained about ineffective medication, expressed fears of becoming dependent on medication, and wanted to stop taking it if their recovery was not rapid.

One Kurdish female patient expressed her attitude in the following manner: “Medication has no effect; my problems have not been solved.”

One Fars patient said that “… I decided to continue treatment. I took a lot of pills each night but there was no improvement.”
Social support

Self care

Patients and lay people in the three ethnic groups believed that the first step on the road of improvement was the acceptance of the illness by the patient. Such acceptance led to the patient being able to help herself/himself or seek support.

One patient with Fars background said that “... I must treat myself and accept my depression.”

A Kurdish female patient said that “… I am helping myself to improve.”

All participants in the three ethnic groups remarked that patients need assistance and that others must help, comprehend, and listen.

Considering the importance of family and the role of the husband in particular, these aspects will be described separately.

Family

Turkish and Fars female patients said nothing about social support from the family or others. On the other hand, Kurdish female patients thought that family members could play an important role in encouraging patients to come into contact with physicians and continue with medication. This was regarded as an important duty of the father or brother in case of single female patients. Kurdish key informants, female patients, and key informants with Fars background mentioned nothing about the impact of family regarding to seeking medical help.

According to lay people in the three ethnic groups, family members are considered to support the woman and pay attention to her needs and maintain social contact with her. Their roles are to take care of children and support the patient during hospitalization. In this setting, lay people indicated that the family’s behavior, manner, and probable limitations may be important components in triggering the illness. A Turkish lay person reported that “some of the families are very restrictive, especially toward their daughters; these problems are going to become exaggerated when a girl marry to a man who puts the same limits on her.”

Furthermore, Turkish lay people stated that family members must understand the patient’s feelings, look for the reason for the illness, and solve the problems. They 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. Young educated members of the family, who also have normal social relationships, could be more effective in resolving the problem for the patient. It was also emphasized that patients needed individual family members, such as sister or grandmother, who could understand and listen to them as well as male members, such as a brother, with whom one can have close contact.

A Turkish lay woman gave this reflection: “Young families that are more educated and have better social relations do try to cooperate and resolve the problem.”

One lay person with Fars background gave this comment: “…if she has done her best to improve and it does not work, then she must share the problem with somebody else such as a sister, grandmother, a woman in her neighborhood, mother, anyone who understands her …”

According to key informants, the patient’s support in the family depended on the patient’s marital status. A married patient would receive support from her husband and children whilst parents and siblings would support an unmarried patient. A Turkish key informant said that “If they are married, it could be their husbands or children with whom they solve their problems; if they are single, it could be their father, mother, or sister/brother.”

Husband

Family problems, a husband’s remarriage and inappropriate behavior, misunderstanding of his wife’s needs, incompatibility and conflicts, and the negative role of in-laws in the patient’s life, were mentioned as the main reasons for illness by Turkish and Fars patients.

One female patient with a Fars ethnic background reported the following: “I think my problems are more due to my husband …”

Lay people also attributed a significant role to the husband in both causing and improving the illness. From their point of view, most men avoided becoming involved in their wife’s treatment and sometimes they rejected their wife’s illness and needs.

One Turkish lay person gave the following comments: “Most men do not cooperate in the treatment of their wives.”

One female patient with a Fars ethnic background reported that “Nobody could do anything for me; in the first place, it is only me, myself, and after that it is my husband who could...
help me with the treatment and help me carry on taking medication.”

Complementary roles of the husband were mentioned. It was thought that he should be kind and show sympathy to his depressed wife, encourage her in her treatment, accompany her on visits to the doctor, provide her medicines regularly, remind her to take her medication, take care of the children during her illness, and have a supportive role during hospitalization and ongoing treatment.

One of the Turkish lay people highlighted this “Her husband should be kind to her, talk to her kindly, look after the children, and not make her angry.”

One Kurdish lay person expressed it in the following way: “Her husband should keep her supplied with medication.”

One lay people with Fars background mentioned that “Finding a listening ear is important; her husband can provide a sympathetic ear.”

Fars key informants also mentioned the importance of the supportive role of the husband and the children, if the patient is married.

Environmental support
Having fun with others and enjoying life were key factors in getting better and were named by patients in all three ethnic groups.

In addition, trying to be happy, laughing at jokes, doing exercise, hiking, walking, and listening to music were different ways of having fun referred to by key informants and lay people in the three ethnicities.

Kurdish lay people recommended physical and mental rest, and helping patients.

Turkish lay people also emphasized having fun with children/being cheered up by the family, trying to get out of the house and a change of environment/redecorating the home as factors that may help patients to improve.

Religious and spiritual support
Female patients and key informants of Fars and Turkish ethnic background did not mention anything about religious thoughts as a way to improve. Kurdish patients believed in positive effects of prayer and invocation on the improvement process.

This was exemplified by two Kurdish female patients: “… I feel better with praying.” “… my mother told me if I pray I will get better.”

This item was emphasized by lay people in all three ethnic groups. However, lay people believed that besides medication and consultants, God’s will and faith in God were important to improvement. Keeping to the teachings of Quran and religious and holy persons, and seeking help from God, changed patients’ attitude positively toward religion. Furthermore, attending religious ceremonies was considered to be the way to seek help from religion.

Male Turkish lay people said that “If God will, it is going to be all right.”

Two Kurdish lay people exemplified: “The others should help her in studying the verses of Quran and following the teachings of great religious men. She should be improved from a religious point of view.”

Turkish key informants reported that some patients turn to fortune-tellers or writers of amulets before visiting a physician and sometimes also try to treat themselves. The reason for visiting fortune-tellers or similar traditional healers was to avoid stress and fear related to illness. Similarly, Kurdish key informants reported that some patients try to control their illness by turning to religion.

Discussion
Few studies have been carried out to identify health belief held by people on mental health problems.27,32,33 The findings are typically consistent with biomedical model, indicating that up to 20% believe depression to have biologic origins (genetic or chemical change) and 80% believe it to be primarily social (stress, bereavement, or childhood experience). However, studies that have focused on eliciting the meaning of the subjects’ experience of illness using qualitative methods27,34 have shown considerable variation between lay explanations and explanations offered by biomedicine.

The findings reported in this article, though preliminary, suggested that the cause of major depression (without psychotic feature) is conceptualized as an external stressor. All the three ethnic groups studied presented a model in which the symptoms and causes of illness were viewed as a response to an event in the social world. This model of causality impacts on their help-seeking behavior. The seeking help from family and religious practice were important sources of
support in all groups besides modern medical help. If the illness fails to respond to lay help, then one consults a traditional healer or modern doctor. Kinds of lay support were classified into three categories: emotional support, advice, and concrete help from the family, especially from husbands, and also brother or father. All groups presented a similar picture regarding these categories. These findings were same as the help-seeking behaviors of southern Asians compared with European and Americans.35

In terms of socio-demographic characteristics of lay people, data were drawn from a sample which varied by gender, age, and education in the three ethnic groups. Given such a demographically varied sample, one would expect variations in terms of perceptions on help-seeking behavior of depression. However, the findings presented above seem to indicate only a slight difference regarding source of help in the three ethnic groups studied. The Fars group was far more likely to recommend professional treatment and visiting psychiatrists whereas the other two ethnic groups (Turks and Kurds) preferred to consult family counselors, psychologists, or other alternative care providers and traditional healers, which could be due to higher educational level in Fars.

Turks and Kurds patients mentioned a marked delay in seeking professional help from psychiatrists which could be due to the stigma attached to mental illness and seeking psychiatric help in Ilam and Tabriz—a small community and minority groups compared to the Fars group living in a capital city. Besides, the social stigma attached to mental and emotional illness prompts families to deny the illness and hide the condition from those outside the immediate family. People feel ashamed to be considered mentally ill because it can affect their future; these assumptions are also supported by other reports.36,37

Most of the participants from all three ethnicities had negative attitudes towards hospitalization and had no faith in its necessity and the need for continued follow-ups. This might be due to their perceptions of mental illness and the effect of hospitalization in aggravating the illness. This was also found by healthcare practitioners in a study of Asian Indians.27

One of the most important help-seeking methods, which were reported by lay people in all groups and some patients in the Fars and Kurd groups, was focusing almost exclusively on the world of the family, particularly the husband. This reflects traditional gender roles for women and men in the society. When participants proposed that the husband could help his wife “by taking her to doctor, and buying medicine”, and “help her to follow treatment”, they in fact, reflected women’s dependency and lack of access to financial resources. Such suggestions also indicate powerful symbolic gestures of support. In taking his wife to doctor, the husband acknowledges the problem and demonstrates his willingness to allocate resources (time, effort, and treatment fees) to her.35

Spiritual support, including religion, was mentioned mostly by Kurdish and Turkish participants. It has been found that relative to other religious groups, Muslims had a greater faith in the ability of Islam and social support to help them cope with depression than mental health treatment.38 For many people, religion is a way of life, an overarching orientation that directs their thoughts, feelings, actions, relationships, and values in everyday living. Consequently, Muslim religion is more than a way of coping, and offers specific methods to help people understand and come to terms with life stressors.

Limitations of the study

The purpose of this pilot study was to test case vignettes and interview guides, aimed at exploring the explanatory models of depressive disorders among three ethnic groups in Iran. The guide questions and the vignettes, which were used in Uganda,27 were validated to explore distinctive concepts used to identify various subtypes of depression. The use of hypothetical case vignettes for lay people made it possible to access the view of nondepressed members of the community in three ethnic groups. Based on the experience of research team, FGD using case vignette was more helpful for gathering qualified data than individual interviews.

In addition, using a specific open-ended interview guide, according to the explanatory model, restricted the ability of the interviewers to explore attitudes, reflections, and needs among patients and also key informants. Qualitative research, which describes the participant’s perspective, needs the researcher to be able to distinguish between self reflection and the other’s world.

However, interviews are to focus on general questions and be followed up with reference to the
cultural model of help-seeking. Another limitation was the selection of the participants and the reliance on the gatekeepers at the three various study sites.

Conclusion and implications

The recognition of mental illness and early intervention is critical to treatment and recovery. Nonetheless, due to cultural variation in clinical presentation, depressed patients are not diagnosed and do not receive appropriate treatment. In this study, the emphasis was on the role of social support group in the management of depression without psychotic features. Treatment and coping models involved two strategies: seeking social support from lay people including family, neighbors, and religious practice as well as doing pleasurable activities, as the first step, and then seeking medical support from psychologists or family counselors. This implies that the individual patient approach employed by western-trained psychiatrists and other physicians may fall short of what the patient and their relatives expect from the intervention. This study has educational and clinical implications. Our findings assume the need for community education. In this regard, perceptions on mental illness and depression may require community education. In this regard, family counseling, family therapy, and also using religious practices can be used to empower the patient.

Cultural reframing of the patients’ and families’ perceptions on mental illness and depression may require community education. In this regard, family counseling, family therapy, and also using religious practices can be used to empower the patient.

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