Orginal Article

Reflections from indigenous psychology on emotional disorders: a qualitative study from iran

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Abstract

Introduction: Depression and Anxiety literature in Iran is suffering from the lack of culture/indigenous studies in assessment, diagnosis, and treatment of emotional disorders especially in Azeri ethnic zone, and still there is no comprehensive research on how Azeri speaking individuals percept and experience depression and anxiety. Current study is carried out in order to identify depression and anxiety dimensions in Azeri ethnic group.

Methods: In a cross sectional qualitative design, 32 informants from Azeri ethnicity (14 patients, 13 lay people, and 5 professionals) participated in the study from September 2013 till December 2014. Individual in-depth interviews had been conducted with regard to highlighted themes of explanations, reporting the experiences and perceptions of the participants from emotional disorders. Data were analyzed through content analysis technique.

Results: Primary results indicated that 11 main theme categories identified in Azeri ethnic group which are dimensional constructs related to emotional disorders: Avoidance, Dysfunction, Arousality, Disorganized Personality, Repetition, Somatization, Problematic Behavior, Maladaptive Cognition, Awareness, Positive, and Negative Emotionality.

Conclusion: In the same line with related researches in the field, Somatization had the highest frequency of symptom report by participants. However, current evidences are not supporting the hypothesis of "Somatizing" depression and anxiety in non-western people including Iran, and perhaps other psychological processes are involved in somatic symptom report. Theoretical advantages and implications of the study in the framework of clinical and indigenous studies are discussed.

Declaration of Interest: None.

Keywords: Emotional disturbances, Azeri ethnic group, Cultural characteristics, Qualitative research.

Introduction

The conceptualization of emotional disorders (anxiety and depression) was challenged with substantial theoretical issues in recent decades (1) and every researcher has provided the different formulations of these disorders based on relevant theoretical views and principles (1,2,3,4,5). On the other hand, the application of theoretical perspectives and use of therapeutic guidelines for psychological disorders regardless of the contextual variables such as culture, have put ambiguities and special problems in the face of therapists (6). Hence, the study of psychological problems from the perspective of people's perceptions and definitions of each culture and ethnicity can be an appropriate basis for a more detailed understanding of the cultural and ethnic characteristics of mental disorders,

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and it facilitates the planning of culture-sensitive interventions for involved people (7). Taking into account the above assumptions, the current study was carried out based on qualitative methodology to study the theoretical dimensions of depression and anxiety as indicators of emotional disorders in Azeri ethnic group, and it introduces the cultural dimensions arising from the content analysis of the data.

Anxiety and depression have long been of interest to the researchers in the field of psychopathology, and several researchers have tried to build a conceptual and clinical distinction between these psychological entities. Diagnostic and Statistical Manual of Mental Disorders (DSM) which is based on categorical approach, distinguishes between anxiety and mood disorders (depression) in multiple versions (8). Although the differentiation of two constructs has been a prevailing tradition of research and treatment in the preceding decades; however, several problems such as comorbidity and within category heterogeneity have questioned the usefulness of such an approach to the emotional disorders (9).

Classification of psychological problems has a long history in terms of the dimensional approach (10). However, the viewpoint of Brown and Barlow (1), tripartite model of Clark and Watson (11), and the theory of internalization and externalization of Kruger and Marcon (3) have received the most interest. The main assumption in the dimensional approach is paying attention to common characteristics and classification of problems based on key factors such as negative affect. The development of psychological science is generally to try to find the "common features of the human species." However, it is necessary that behavioral manifestation should be understood in certain culture and ethnicity in which a person has growth and developed (6).

Culture plays an important role in shaping the symptoms of depression and anxiety, awareness of the problem severity and its impact, and help seeking behavior (12,13); Although international epidemiological studies confirm that major depression and anxiety are seen throughout the world, however, symptom expression, their interpretation, and social responses to these syndromes is different and very broad (14).

While Iran suffers from lack of ethnic studies in emotional disorders, World Health Organization (WHO) reports confirm the remarkable cross-cultural similarities in symptomatology of depression such as low mood, anhedonia, anxiety, loss of energy, and loss of interest to the environment that has been observed in most cultures (15,16). However feeling guilty is one of the depressive symptoms which is seen in western societies. WHO study has reported the highest frequency of guilt in Switzerland's patients and the lowest rate for Iranian people (17).

In general, theoretical and practical defects of categorical approach to the issue of the study and treatment of emotional disorders have been apparent in recent years more than any other period. Although the dimensional approach has made significant progress in conceptualization of emotional disorders (Unified Protocol for the Transdiagnostic Treatment of Emotional Disorders, 18), however, it requires the precise well-controlled studies. On the other hand, it seems that dealing with cultural and ethnic considerations in the assessment, diagnosis and treatment of emotional disorders has become a necessity rather than being interest (6). With regard to these cases and emphasizing the point that the conceptual study of depression and anxiety is not much of interest to researchers among Iranian various cultures and ethnicities (19), the present qualitative study was designed to investigate the dimensions of emotional disorders (depression and anxiety) among the people of Azeri ethnic group in Iran, and it examines the cultural dimensions of the disorders with the use of qualitative research methods and techniques.

Methods

The study design of the current research is cross-sectional qualitative research. Study is carried out in the city of Tabriz, Iran. The speaking language in Tabriz is Azeri. The participants consisted of three groups: The first group; consisted of 14 patients (8 males) admitted to public and private mental health clinics in Tabriz with one or more emotional disorders. The second group was of 13 individuals (5 male) of Tabriz lay people who provided information on the experience of emotional disorders in Azeri ethnic group. The third group included Azeri experts (n=5) who were specialized

in the field of psychiatry and/or clinical psychology and had a history of clinical practice for over 10 years with patients with emotional disorders in the city of Tabriz.

The sampling method in all three groups was purposeful. Data were collected using in-depth individual interview and from November 2013 to July 2014. All interviews were recorded and subsequently transcribed. The Interviews were held in Azeri were translated to Persian. The time of interviews varied from 20 to 120 minutes, depending on the study group.

Written informed consent was obtained from all participants before the interview. The subjects knew that the participation is voluntarily and they can leave the research in any time during the interview. Ethical approval for this study was obtained from Department of Psychology at Shahid Beheshti University (Tehran, Iran) and the Department of Culture Studies at the University of Tilburg (Tilburg, The Netherlands).

Results

Demographic Data: The current study includes 32 individual in-depth interviews from three different groups of participants namely patients, lay people, and professionals. The demographic features of the participants are presented in tables 1 (patients & lay people) & 2 (professionals).

Table 1. Demographic feature of patients and lay people (n=27)

	Age	Gender		Marital Status	
	M	Female	Male	Single	Married
Patients	35.92	8	6	7	7
Lay people	35	8	5	5	8
Total	35.46	16	11	12	15

Table 2. Demographic feature of professionals (n=5)

	Gender	Age	Specialty	Degree	Experience
N. 1	Female	43	Psychiatry	MD	12
N. 2	Male	50	Clinical Psychology	PhD	23
N. 3	Male	50	Clinical Psychology	PhD	21
N. 4	Male	34	Clinical Psychology	MA	11
N. 5	Male	38	Psychiatry	MD	12

Description of psychological problems

Individual in-depth interviews included the detailed descriptions of psychological symptoms that were experienced and understood by the participants. Participants experienced a range of mental and physical states of emotional disorders (depression and anxiety) that were collected in eleven main themes after summarization (see Table 3).

1. Avoidance: Avoidance is a general category term that includes behavioral and cognitive avoidances. Dominant aspect in the reports of patients, lay people, and professionals was behavioral avoidances such as isolation, withdrawal, avoidance of group, passivity, leaving the situation, lack of communi-

Table 3. Theme names and frequencies in all participants (n=32)

	Theme Categories	F
1	Somatization	572
2	Negative Emotionality	440
3	Repetition	316
4	Maladaptive Cognition	270
5	Problematic Behavior	133
6	Positive Emotionality	117
7	Arousality	83
8	Dysfunction	79
9	Avoidance	70
10	Disorganized Personality	49
11	Awareness	33

cation, not going out, self-entertainment and taciturnity. In rare cases, the participants were referring to cognitive avoidances such as watching TV, internet games and entertainment with Facebook and mobile.

> I love to be even more alone ... on the time the dinner and lunch carried upstairs, I had never gone down. I loved to sit up. I was busy looking at the movie and this kind of things... Then came one of my friends introduced me to the Facebook… I became member and wrote some notes… We gaped and laughed with peers...
>
> (37 year old male patient)

2. Dysfunction: In the present study the various functional aspects of a variety of disorders reported, including disturbances in interpersonal relationships, marital conflicts, communication problems with a partner, sabotage, disruption of daily activities, lack of personal hygiene, academic failure, changes in lifestyle, and lack of discipline.

> Depression can cause disruptions in our daily routine ... I was very comfortable in doing my work, during a couple of hours …now that I come –before I do the works, I say wow! Who wants to do these works?
>
> (32 year old lay woman)

3. Arousality: It refers to the physiological and psychological state of consciousness or response to stimuli (20, p 818). The dominant aspect in the arousality theme of is appearance of physiological signs of arousal in response to distressing stimuli. This was the case in the present study includes the physical symptoms of Panic attacks, irritability, hyper vigilance, impulsivity, Houwl and Howoushnah (in Azeri language), externalization of problems and physiological hyper arousality.

> I cannot sleep some nights because of being terrified (Dysgynmakh). A kind of fear (Khouf) is there in my body. I'm afraid of everything. I'm sensitive to noise. If the clock ticks and tocks, I cannot sleep. If something happens, my heart rates quickly. My heart is weak ... When I'm anxious, my body shakes from inside, my heart beats, and I'm breathless. As if there is something in my throat and squeezes me. Also my eyes are blurry at the moment...
>
> (54 year old male patient)

4. Disorganized Personality: the disorganized personality represents a heterogeneous set of psychological symptoms that does not fit within the traditional definitions of anxiety and depression typically. For instance, dissociative experiences such as depersonalization and dissociative amnesia are sometimes seen as merely a single symptom in the patients, or some psychotic symptoms such as delusions, hallucinations, or illusion that are seen in some forms of depression (e.g., Depressive Disorder with Psychotic Features). Of Other cases in the present study named under the general chaos of the disorganized personality, following characters can be pointed to the irritable mood, experience of internship syndrome, nerve disorder, instability, and some general problems of the character.

> After the childbirth of my daughter I had a similar case. For example I remember ... I do not know what ... comes and carries the baby out. Such thing - I really saw it deemed illusion. But I totally remember that my grandmother was along with me. We sat down and I went to bed and the Baby was new born. I felt that the door opening. A very tall man bent his head and came in. I could not see his face, but I felt the sound of his breath breathing too scary. I even saw his hands that taking the child. He had... nails. I cried a moment. It felt collapsed and I rose via a bad mood ... I woke up and saw my body is completely soaked with sweat and the kid is in my next. I was afraid afterward (Dysgynirdim)…
>
> (42 year old female patient)

5. Repetition: repetition in the content analysis of this research is intended to refer generally to several modes from a complex psychopathology including thoughts, images, impulses, behaviors, and repeating customs and rituals. In the present study, the repetition includes a wide range of signs and symptoms that can be named some of them: a variety of repeating patterns, such as thought obsession, religious obsession, Najes-Paki obsession, cleanliness obsession, checking obsession, counting obsession, washing obsession, hoarding ob-

session, obsessionality, and various compulsions such as washing, Ab-keshi, checking, order, fear of contamination, perfectionism, procrastination, rumination, control, preoccupied with details, and stereotyped behaviors.

> I've met with many families, who have accepted to wash the feet after each time of going to WC as a normal behavior, and no matter how hard you actually try to show him that this is an extra or extreme behavior... That person does not accept...
>
> The story of women in Azerbaijan is washing and cleaning up from the morning and it is one of the characteristics of a good woman in this area, that her house should be extremely clean...
>
> (Specialist in Clinical Psychology)

6. Somatization: The signs and symptoms include a substantial number of physical symptoms such as headaches, palpitations, blood pressure problems, breathless, choking sensation, muscle contraction, red face, hot-headedness, restlessness, sweating, body pain, shaking limbs and so on, and it is a group that includes the vegetative symptoms in the emotional disorders such as sleep problems, appetite problems, weight problems, eating problems, sexual problems, and psychomotor retardation.

7. Problematic Behavior: behavioral expressions of the emotional disorders are a group of problematic behaviors that are presented under the general title of problematic behavior. It is referred to a visible behavior led to a self-or other-harmed behavior, with negative consequences. Some of the major classes of problematic behaviors include aggression, suicide, addiction, disinhibition, lack of social support seeking, and a number of negative behaviors, such as jealousy, lying, crying, self-harm, casting blame and self-other- blame.

> If one tells me anything, I stand in front... I say to myself I have to deal with this with any cost. I will have my revenge. I have this morality.
>
> (37 years old male patient)

8. Maladaptive Cognition: Most of maladaptive cognitions associated with emotional disorders were reported by the participants such as the nihilism, traumatic experiences, uncontrollability of thought, worry, uncertainty, negative thoughts, and some cognitive symptoms such as impaired attention and concentration , overvalued ideation, being skeptical of decision, forgetfulness, preoccupation, disturbing thoughts, confusion and cognitive disability.

9. Consciousness (Awareness): Sub-categories in this section are to some degree heterogeneous and include various modes of consciousness, problems of consciousness, clouding of consciousness, unconsciousness, coma, admission or not to admit the problem, as well bring informed about the signs and symptoms of the disorder, prevalence, course, prognosis, heterogeneity of symptoms, and treatment for their problems.

> I had attempted suicide several times to year 1996. I told once I ate imipramine. I ate it all in one time. I ate Imipramine and Nortriptyline, which the doctor had prosecuted me all together. My husband came and saw that for example, I had no certain consciousness and I had almost three days of sobriety.
>
> (42 year old female patient)

10. Positive Emotionality: The Signs and symptoms were identified and grouped into the following experiences: lack of positive affect, lack of motivation, anhedonia, lack of comfort, loss of interest, lassitude, malaise, listlessness, lack of enthusiasm, lethargy, lack of interest, lack of energy, lack of willingness, and low reinforcement.

> It seems I am in the water of a river that goes into every direction. I'm on the same side. There is no that sense, passion, interest in my inside at all...
>
> (27 year old female patient)

11. Negative Emotionality: Negative emotionality can include emotions such as sorrow, sadness, distress, impatience, depressed mood, loneliness, melancholia, guilt, alexithymia, hopelessness, feel-

ings of failure, low self-esteem, fatigue, anger, nervousness, fear, stress, types of anxiety (generalized, social , phobia, agoraphobia), and depression (major, postpartum). Also the categories of Darikhma, Dysgynmakh, and Sikhynty in Azeri language were the most frequently reported of negative emotional states.

Conclusion

The aim of the present research is a qualitative study of depression and anxiety (emotional disorders) in Azeri ethnic group. The conclusion section can be divided into two main streams, the puzzle of somatization, and emotional disorders in Azeri ethnicity.

"The puzzle of "Somatization

The investigations associated with explanatory models of emotional disorders which addressed the impact of cultural and ethnic factors, refer to the concept of "Somatization" as a common finding in cultural studies of Eastern societies. Kleinman (21) first described the concept of Somatization meaning that physical symptoms are presented in place of personal or social problems. Several studies have addressed the role of somatization phenomena as the most significant cultural component of depression and anxiety in the East (22,14); however, there are still doubts about the etiological role of this construct in explaining emotional disorders.

In line with previous research in the field of "Cultural Clinical Psychology", somatization and/ or in other words, "physical symptoms" was the most common symptom reported in the present study, and respiratory problems, bodily pain, palpitations, sweating, blood pressure problems, digestive problems, trembling limbs, redness of the face, difficulty in speaking, and restlessness were frequent. After somatization, the component of "negative emotionality" was the most common symptom and then "repetition", "dysfunction" and "problematic behavior."

The prevailing view about the commonality of somatization is that it is a representation process of physical symptoms or exacerbation of physical complaints without organic damage (23). In other words, patients of non-Western cultures tend to express their psychopathological symptoms in the form of physical complaints. However, the recent studies have challenged this assumption. Thus the evidence from studies about the explanatory models of the region of South Asia clearly shows that despite physical symptoms are the most common complaints expressed in major psychological disorders; however, the somatization phenomena as a "psychological process" occurring very rare (24).

The results are consistent with recent theories in two directions: The first is that, despite widespread reports of physical complaints by Azeri participants, other psychopathological components of emotional disorders that were more under emotional and cognitive factors are common enough, means that emotional complaint under the concept of "negative emotionality", and cognitive complaints under the "maladaptive cognition" included a wide range of pathological signs and symptoms were perceived, experienced, and reported by the participants in the study. Second, probably the reason of many reports of physical symptoms in Azeri ethnic group and overall non-Western cultures may be that the identification of body organs and physical pathologies are more easily detected than psychological signs and symptoms. The Azeri clients report a significant number of physical symptoms not because of the extensive and severity of physical symptoms, or the "somatization" process of symptoms, but of ease of reporting and paying attention to details.

There is a point that the ease of dealing with components and sub-groups of the body symptoms reflected in the pathological reports. For instance, headaches, neck pain, back pain, stomach pain, pain in arms and legs, these all are summarized in the sub-components of physical pain. But perhaps it is very difficult for Azeri patients to report the micro components of "feeling guilty". Hence it seems that "many reports of physical symptoms," is more accurate to describe the nature of what happens in the Azeri participants instead of "somatization process of depression and anxiety".

Azeri ethnicity and emotional disorders

The next issue is terminology of Azeri participants in calling the psychological problems in the anxiety and depression arena which shows being in line with dimensional approach. In most cases, participants were using the traditional terms

of depression, anxiety and sometimes obsession naming their psychological problems. However, the words used in the Azeri ethnic group were including "Darykhma", "Sykhynty" and "Dysgynmakh". These words were used both alone and together with the word "Urah" means heart (as "Urah Darykhma", "Urah Sykhynty", and "Urah Dysgynmakh"). Sometimes the participants drew the words "Houwl" and "Howoushnah" to describe their fears and anxiety states.

The most commonly used term for negative emotional states for Azeri participating was Darykhma. In terms of expertise, Darykhma is a combination of anxiety feeling with restlessness and somehow sadness. According to the phenomenological perspective, the emotion of fear has over in anxiety and sadness over in depression (25,26). Hence, the above definition clearly indicates the combined nature of Darykhma. Another term that Azeri participating people used in the study to express their psychological state is the word Sykhynty. Sykhynty concept has also been known to be like Darykhma and more closely known as melancholia with feeling of restlessness. Restlessness aspect in Sykhynty includes some physical symptoms that are more in the trunk, shoulders and back. Dysgynmakh as the third term was probably meant to startle as initial reaction and is close in meaning to the concept of physiological hyper arousality over tripartite model of Clark and Watson (11). Houwl and Howoushnah were also two of the most frequently described in anxiety states which drawn by participants to describe their state of anxiety.

The present study has some conceptual and methodological limitations such as limited number of samples, the heterogeneity of group, and using content analysis technique that lead findings and results reported cautiously.

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