

Reflections from Indigenous Psychology on Emotional Disorders: A Qualitative Study in Azeri Ethnic Group

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ABSTRACT

Objective: Depression and Anxiety literature in Iran is short of cultural/indigenous studies, especially with regard to Azeri ethnic group. This study was carried out in order to identify depression and anxiety aspects in Azeri ethnic group.

Methods: In a cross sectional qualitative design, 32 Azeri informants (14 patients, 13 lay people, and 5 professionals) recruited in the study using purposeful sampling method. Individual in-depth interviews were conducted and the collected data were analyzed through content analysis technique.

Results: Primary results indicated that 11 main theme categories exist in Azeri ethnic group: avoidance, dysfunction, arousality, disorganized personality, repetition, somatization, problematic behavior, maladaptive cognition, awareness, positive, and negative emotionality.

Conclusions: Current evidence does not support the hypothesis of "Somatizing" depression and anxiety in Iranian cultural background, 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.

1. Introduction

Conceptualization of the emotional disorders (anxiety and depression) was challenged with substantial theoretical issues in recent decades (Brown, & Barlow, 2009) and each researcher provided the different formulations for these disorders based on relevant theoretical views and principles (Brown & Barlow, 2009; Watson, 2009; Krueger & Markon, 2006; Clark, 2005; Widiger & Samuel, 2005). On the other hand, application of the theoretical perspectives and therapeutic guidelines for psychological disorders regardless of the contextual variables like culture, have resulted in ambiguities and special problems in the face of therapists (Triandis, 2007). 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, and facilitates the planning of culture-sensitive interventions for the involved people (Marsella & Yamada, 2007). Regarding these 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. Then, 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

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clinical distinction between these psychological entities. The Diagnostic and Statistical Manual of Mental Disorders (DSM), which is based on categorical approach, distinguishes between anxiety and mood disorders (depression) in multiple versions (DSM-IV-TR, 2000). Although the differentiation of two constructs has been a prevailing tradition of research and treatment in the preceding decades; several problems such as comorbidity and within category heterogeneity have questioned the usefulness of such an approach to the emotional disorders (Krueger, Markon, Patrick, & Iacono, 2005).

Classification of psychological problems has a long history in terms of the dimensional approach (Achenbach, 1966). However, Brown and Barlow's viewpoint (2009), tripartite model of Clark and Watson (1991), as well as the theory of internalization and the externalization of Kruger and Marcon (2006) have received the utmost interest. The main assumption in the dimensional approach is paying attention to common characteristics and classification of problems based on key factors like negative affect. Psychological science was generally developed to find the "common features of the human species." However, behavioral manifestations should be understood in the certain culture and ethnicity in which a person has grown and developed (Triandis, 2007).

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 (Selim, 2010; Lewis-Fernandez, Hinton, Laria, Patterson, Hofmann, & Craske et al., 2009). International epidemiological studies confirm that major depression and anxiety exist throughout the world; however, their expression, interpretation, and social responses to these syndromes are different and very versatile (Kirmayer, 2001). For instance, Selim (2010) conducted a qualitative research using case vignettes and focused group discussions with 50 individuals to study depression in Bangladesh. According to her results, participants reported somatic symptoms; however, by probing detailed explanations about the case, they started naming psychological complaints. These people associated "chinta rog" to poverty and other social issues with impacts on marriage, work, and education, and they preferred a psychosocial framework attributing the cause of problems.

In the context of Iranian culture, there are few studies which are addressed qualitatively research of emotional disorders. Dejman (2010), in her investigations on the cultural explanatory model of depression among Iranian women who suffer from depression, reported that the explanatory models are similar in three ethnic groups. She

also reported most common used terms for depression such as "Narahati Asabi," "Moshkel Asabi," and "Afsordegi" in Fars individuals. Turkish and Kurdish people also describe depression as "Darikhma" and "Tarjoman," respectively. According to Dejman (2010), Iranian people associate disorder to external stresses such as loss experience, environmental causes, gender-linked stressors, and internal factors caused by emotional factors, cognition distortion and hormonal factors.

Despite rare cases of ethnic studies in Iran regarding in emotional disorders, reports of the World Health Organization (WHO) 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 have been observed in most cultures (Jablensky, Sartorius, Ehrenberg, Anker, Corten, & Cooper et al., 1992; Sartorius, Davidian, Ehrenberg, Fenton, Jujii, & Gastpar et al., 1983). 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 in Iranian people (Kastrup, 2011).

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, Ellard, Fairholme, Boisseau, Farchione, & Barlow, 2010), 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 an interest (Triandis, 2007). With regard to these cases and emphasizing the point that the conceptual study of depression and anxiety is not much of interest to researchers working in various Iranian cultures and ethnicities (Dejman, 2010), the present qualitative study was designed to investigate the dimensions of emotional disorders (depression and anxiety) among the Azeri people in Iran.

Azeri ethnicity is one of the major ethnic groups in Iran and ranked 2nd among more than 11 recognized ethnic groups according to the population (WHO, 2008). There is little knowledge about the epidemiology of depression and anxiety in Azeri ethnic group; however, depression ranked 2nd most common mental disorder (after addiction) among Azeri people in East Azerbaijan province based on the health deputy reports (Health Deputy of

Tabriz Medical University, 2014). The increased rate of depression and anxiety, and limited knowledge about the manifestation of emotional problems in Azeri people, led research group to investigate both depression and anxiety in Azeri ethnic group, and provide much more clear picture from these disorders among Azeri people.

2. Methods

The study design of the current research is cross-sectional qualitative research. It is carried out in Tabriz, Iran. The language spoken in Tabriz is Azeri. The participants consisted of three groups who are key informants about the research question. The first group comprised 14 patients (8 males) admitted to the public or private mental health clinics in Tabriz with one or more emotional disorders. The second group was composed 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. These individuals recruited to the study because assumed that were able to provide relevant information regarding research questions.

The sampling method in all three groups was purposeful. Data were collected using in-depth individual interview. Semi-structured interview guide was developed through discussion between the authors, several individual interview experts, clinical psychologists, and a pilot study on three individuals. The participants during the interview were asked to describe the problem, individuals' experience and perception of various aspects of the problem, the local words for them, and the history and progress of the problem. Interview guide was a little bit different in three groups according to their experiences. Data collected from November 2013 to July 2014. All interviews were recorded and subsequently transcribed. Interviews in Azeri were translated to Persian. The time of interviews varied from 20 to 120 minutes, depending

on the study group. Data analyzed through conventional content analysis method.

Written informed consent was obtained from all participants before the interview. The subjects knew that the participation is voluntary 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).

3. Results

3.1 Demographic Data

The study included 32 individual in-depth interviews from 3 different groups of participants namely patients, lay people, and professionals. The demographic features of the participants are presented in Tables 1 (patients and lay people) and 2 (professionals).

3.2 Description of Psychological Problems

Individual in-depth interviews discussed the detailed descriptions of psychological symptoms that were experienced and understood by the participants. They experienced a range of mental and physical states of emotional disorders (depression and anxiety) that were categorized under 11 main themes (Table 3).

3.2.1 Avoidance

Avoidance is a general term that includes behavioral and cognitive avoidances. The dominant theme 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 communication, 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.

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

	Age, y	Gender		Marital Status	
	Mean	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, y	Specialty	Degree	Experience, y
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

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“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)

3.2.2. Dysfunction

In the present study, the various functional aspects of a variety of disorders were reported, including disturbances in interpersonal relationships, marital conflicts, and 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)

3.2.3 Arousality

It refers to the physiological and psychological state of consciousness or response to stimuli (DSM-V, 2013; p 818). The dominant aspect in the arousality theme is the appearance of physiological signs of arousal in response to distressing stimuli. This was the case in the present study, which included the physical symptoms of panic attacks, irritability, hypervigilance, impulsivity, Howl and Howoushnah (terms used 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 beats quickly. My heart is weak ...

Table 3. Themes and their frequencies in all participants (n=32)

	Theme Category	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	76
9	Avoidance	70
10	Disorganized personality	49
11	Awareness	33

* F is the frequency of codes mentioned by participants and is associated with reported themes.

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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)

3.2.4. Disorganized Personality

The disorganized personality represents a heterogeneous set of psychological symptoms that does not typically fit within the traditional definitions of anxiety and depression. 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). Other symptoms that named under the general theme of disorganized personality are 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 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)

3.2.5. Repetition

Repetition (in the content analysis of this research) is generally refer to several modes from a complex psychopathology, including thoughts, images, impulses, behaviors, and repeating customs and rituals. In the present study, the repetition involved a wide range of signs and symptoms, including a variety of repeating patterns such as thought obsession, religious obsession, Najes-Paki obsession, cleanliness obsession, checking obsession, counting obsession, washing obsession, hoarding obsession, and obsessionality, as well as various compulsions such as washing, Ab-keshi, checking, order, fear of contamination, perfectionism, procrastination, rumina-

tion, 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 toilet 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)

3.2.6. 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. This group includes the vegetative symptoms in the emotional disorders such as sleep problems, appetite problems, weight problems, eating problems, sexual problems, and psychomotor retardation.

3.2.7. Problematic Behavior

Behavioral expressions of the emotional disorders are a group of behaviors presented under the general title of problematic behavior. They are referred to visible behaviors led to self-or other-harmed behaviors, 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- or other-blame.

"If one tells me anything, I stand in front... I say to myself I have to deal with this at any cost. I will have my revenge. I have this morality."

(37-year-old male patient)

3.2.8. Maladaptive Cognition

Most of the maladaptive cognitions associated with emotional disorders and reported by the participants were as follows: 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.

3.2.9. 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, admitting or not admitting the problem, as well as being 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 until 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 consciousness and I had almost three days of sobriety.”

(42-year-old female patient)

3.2.10. 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)

3.2.11. Negative Emotionality

Negative emotionality can include emotions such as sorrow, sadness, distress, impatience, depressed mood, loneliness, melancholia, guilt, alexithymia, hopelessness, feelings 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 Sikhynthy (in Azeri language) were the most frequently reported negative emotional states.

These categories are the main themes of symptom report by participants in the present study, and apparently are able to cover almost all symptoms and signs described for emotional disorders in DSM-IV-TR (2000).

Additionally, there are aspects in the current list (e.g. disorganized personality, consciousness) that are presented in Azeri participants’ reports and might be seen as complementary aspect for clinical features of depression and anxiety. In brief, suggested schema for clinical features of emotional disorders in table 3 provides better understanding of these problems at least in Azeri ethnic group in Iran.

4. Discussion

The present research aimed to qualitatively study depression and anxiety (emotional disorders) in Azeri ethnic group. According to the results of content analysis, somatization was the most common feature of depression and anxiety in Azeri people. This finding is regular for people in non-western countries (e.g. Kleinman, 1982), and indicates that our results are in the same line with other researchers such as Dejman (2010) and Selim (2010). Although there are similarities between the current findings, however, differences exist. For instance, the present study investigated both depression and anxiety among male and female patients, while Dejman (2010) worked with just depressed women, and excluded anxiety disorders and male participants. Selim (2010) also worked with depressed participants from both genders, but she also ignored anxiety disorders.

Another issue is the frequencies of symptoms described in interviews. According to Table 3, somatization was the most common symptom cluster among all symptom reports. After somatization, there were three major themes named negative emotionality, repetition, and maladaptive cognition, which were representing main dimensions of emotional disorders in terms of emotion-cognition-behavior schema. Other psychological symptoms in Table 3 can be reduced into the above themes. Hence, the major formation of emotional disorders in current research is also in line with DSM-IV-TR (2000) structure.

In order to acquire deep understanding from findings of the research, the conclusion section can be divided into two main streams, the puzzle of somatization, and emotional disorders in Azeri ethnicity. First section, describes why somatization is much more of interest for researchers and what we can learn from current studies to conceptualize it better. In the second part, we concentrated on the specific results of the study addressing Azeri people to elaborate their ethnicity as clear as possible.

4.1-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 (1980) first described the concept of Somatization as physical symptoms that 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 (Kirmayer, 1984; & 2001); however, there are still doubts about the etiological role of this construct in explaining emotional disorders.

In line with the previous researches in the field of “Cultural Clinical Psychology”, somatization and/or in other words, “physical symptoms” were the most common symptom reported in the present study, and after that other complaints such as 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” were the most frequent ones.

The prevailing view about the commonality of somatization considers it as a representation process of physical symptoms or exacerbation of physical complaints without organic damage (Kleinman, 1982). In other words, patients other than Western cultures tend to express their psychopathological symptoms in the form of physical complaints. However, the recent studies have challenged this assumption. The evidence from studies about the explanatory models of South Asia clearly shows that although physical symptoms are the most common complaints expressed in major psychological disorders; the somatization phenomena as a “psychological process” occurs very rare (Andrew, Cohen, Salgaonkar, & Patel, 2012).

The results are consistent with recent theories in two directions: first, despite widespread reports of physical complaints by Azeri participants, other psychopathological components of emotional disorders that were more under emotional and cognitive factors were common too, i.e., the emotional complaint under the concept of “negative emotionality” and cognitive complaints under the “maladaptive cognition” having a wide range of pathological signs and symptoms, which were per-

ceived, experienced, and reported by the participants in the study. Second, many reports of physical symptoms in Azeri ethnic group and other non-Western cultures may be due to easier detection of body organs and physical pathologies 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 is reflected in the pathological reports. For instance, headaches, neck pain, back pain, stomach pain, pain in arms and legs, are all 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,” more accurately describes the nature of what happens in the Azeri participants instead of “somatization process of depression and anxiety.”

4.2 Azeri ethnicity and emotional disorders

The next issue is the terminology of Azeri participants in calling the psychological problems in the anxiety and depression arena, which shows agreement with dimensional approach. In most cases, participants were using the traditional terms of depression, anxiety, and sometimes obsession to name their psychological problems. The words used in the Azeri ethnic group were “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 “Howoush-nah” to describe their states of fear and anxiety.

The most commonly used term for negative emotional states by Azeri participants was Darykhma. In terms of expertise, Darykhma is a combination of anxiety with restlessness and somehow sadness. According to the phenomenological perspective, the emotion of fear has over in anxiety and sadness over in depression (Izard, 1972; Watson, & Kendall, 1989). Hence, the above definition clearly indicates the combined nature of Darykhma. Another term that Azeri participants used in the study to express their psychological state are Sykhynty. Sykhynty has also known to be like Darykhma and more closely resembles melancholia with feeling of restlessness. Restlessness aspect in Sykhynty includes some physical symptoms that are usually in the trunk, shoulders, and

back. Dysgynmakh as the third term was probably meant to startle as an initial reaction and is close in meaning to the concept of physiological hyper-arousality over tripartite model of Clark and Watson (1991). Houwl and Howoushnah were also two of the most frequently terms described in anxiety states, 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 led to report cautiously our findings and results.

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References

- Achenbach, T. M. (1966). The classification of children's psychiatric symptoms: a factor analytic study. *Psychol. Monogr.* 80:37.
- American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th edition). Washington, DC: (Author).
- American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed. text revision). Washington, DC: (Author).
- Andrew, G., Cohen, A., Salgaonkar, S., & Patel, V. (2012). The explanatory models of depression and anxiety in primary care: a qualitative study from India. *BMC Research Notes*, 5: 499-506.
- Brown, T. A., & Barlow, D. H. (2009). A Proposal for a Dimensional Classification System Based on the Shared Features of the DSM-IV Anxiety and Mood Disorders: Implications for Assessment and Treatment. *Psychological Assessment*, 21 (3): 256-271.
- Clark, L. A. (2005). Temperament as a Unifying Basis for Personality and Psychopathology. *Journal of Abnormal Psychology*, 114, 505-521.
- Clark, L. A., & Watson, D. (1991). Tripartite model of anxiety and depression: Psychometric evidence and taxonomic implications. *Journal of Abnormal Psychology*, 100, 316-336.
- Dejman, M. (2010). Cultural Explanatory Model of Depression among Iranian Women in Three Ethnic Groups (Fars, Kurdish, and Turkish). Karolinska Institute, Universitetsservice US-AB: Stockholm, Sweden.
- Ellard, K. K., Fairholme, C. P., Boisseau, C. L., Farchione, T. J., & Barlow, D. H. (2010). Unified Protocol for the Transdiagnostic Treatment of Emotional Disorders: Protocol Development and Initial Outcome Data. *Cognitive Behavioral Practice*, 17(1), 88-101.
- Health Deputy of Tabriz Medical University (2014). Retrieved from <http://eazphcp.tbzmed.ac.ir/?PageID=2635>.
- Izard, C. E. (1972). *Patterns of emotions: A new analysis of anxiety and depression*. New York: Academic Press, p. 33-58.
- Jablensky, A., Sartorius, N., Ehrenberg, G., Anker, M., Corten, A., Cooper, J. E., Day, R., & Bartelsen, A. (1992). Schizophrenia: manifestations, incidence, and course in different cultures: A World Health Organization Ten Countries Study (Psychological Medicine, Monograph Supplement No 20). Cambridge University Press, Cambridge/UK, p. 55-93.
- Kastrup, M. C. (2011). Cultural aspects of depression as a diagnostic entity: historical perspective. *Medicographia*, 33(2), 119-124.
- Kirmayer, L. J. (1984). Culture, Affect, and Somatization: Part 1. *Transcultural Psychiatry*, 21: 159-188.
- Kirmayer, L. J. (2001). Cultural Variations in the Clinical Presentation of Depression and Anxiety: Implications for Diagnosis and Treatment. *J. Clin. Psychiatry*, 62[Suppl 13]:22-28.
- Kleinman, A. M. (1980). *Patients and Healers in the Context of Culture*. Berkeley: University of California Press, p. 146-178.
- Kleinman, A. M. (1982). Neurasthenia and depression: A study of somatization and culture in China. *Culture, Medicine and Psychiatry*, 6: 117-190.
- Krueger, R. F., & Markon, K. E. (2006). Reinterpreting Comorbidity: A Model-Based Approach to Understanding and Classifying Psychopathology. *Annual Review of Clinical Psychology*, 2, 111-133.
- Krueger, R. F., Markon, K. E., Patrick, C. J., & Iacono, W. G. (2005). Externalizing Psychopathology in Adulthood: A Dimensional-Spectrum Conceptualization and Its Implications for DSM-V. *Journal of Abnormal Psychology*, 114, 537-550.
- Lewis-Fernandez, R., Hinton, D. E., Laria, A. J., Patterson, E.H., Hofmann, S. G., Craske, M. G., Stein, D. J., Asnaani, A., & Liao, B. (2009). Culture and the Anxiety Disorders: Recommendations for DSM-V. *Depression and Anxiety* 0: 1-18.
- Marsella, A. J., & Yamada, A. M. (2007). Culture and Psychopathology. In S. Kitayama & D. Cohen (Eds), *Handbook of Cultural Psychology: Unit 33* (pp. 797-818). New York: The Guilford Press.
- Sartorius, N., Davidian, H., Ehrenberg, G., Fenton, F. R., Jujii, I., Gastpar, M., Guibinat, W., Jablensky, A., Kielholz, P., Lehmann, H. E., Naraghi, M., Shimuzi, M., Shinkfuku, N., & Takahashi, R. (1983). Depressive disorders in different Cultures: Report on the WHO-Collaborative-Study on Standardized Assessment of Depressive Disorders. The World Health Organization, Geneva.
- Selim, N. (2010). Cultural Dimensions of Depression in Bangladesh: A Qualitative Study in Two Villages of Matlab. *J. Health Popul. Nutr.* 28(1): 95-106.
- Triandis, H. C. (2007). Culture and Psychology: A History of the Study of Their Relationship. In S. Kitayama & D. Cohen (Eds),

Handbook of Cultural Psychology: Unit 3 (pp. 59-76). New York: The Guilford Press.

Watson, D. (2009). Differentiating the Mood and Anxiety Disorders: A Quadripartite Model. *Annu. Rev. Clin. Psychol.* 5: 433-459.

Watson, D., & Kendall, P. (1989). Understanding anxiety and depression: Their relation to positive and negative affect states. In P. C. Kendall & D. Watson (Eds.). *Anxiety and depression: Distinctive and overlapping features* (PP. 3-26). San Diego, CA: Academic Press.

WHO (2008). Country profile: about Islamic Republic of Iran. WHO Country Office in Islamic Republic of Iran, http://www.emro.who.int/Iran/country_profile.htm.

Widiger, T. A., Samuel, D. B. (2005). Diagnostic Categories or Dimensions? A Question for the Diagnostic and Statistical Manual of Mental Disorders - Fifth Edition. *Journal of Abnormal Psychology*, 114, 494-504.