World Cultural Psychiatry Research Review
OFFICIAL JOURNAL OF
WORLD ASSOCIATION OF CULTURAL PSYCHIATRY

Original Paper

Clinicians' View of Experience of Assessing and Following Up Depression Among Women in I. R. Iran

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Abstract. ***Background:*** *Depression is a common and disabling disorder. Women suffer more than men according to surveys in Iran and other countries. Delay, misdiagnosis, non-specific treatments and lack of follow up have constituted a typical care pathway for depressed people throughout the world. One reason may be that the explanatory models of clinicians differ from those of patients in their own culture. This study explores the experiences of clinicians with a view understanding the explanatory model of depressed women from the clinician's point of view.* ***Methods:*** *A qualitative method, using data collection from individual interviews with psychiatrists, clinical psychologists and general physicians, was applied in three Iranian cities with different ethnic backgrounds. Totally 24 participants – 6 general physicians, 14 psychiatrists and 4 clinical psychologists – participated in the study. Two techniques were used: presentation of a case vignette of depression to general physicians, and an interview guide for psychologists and psychiatrists. A content analysis technique was used to develop categories and subcategories both manually and with the help of computer programs (NVivo 7 and Open Code 3 software).* ***Results:*** *Female patients visit clinicians in moderate to severe stages of the illness. Psychological symptoms usually overshadow somatic symptoms, when decide to visit psychiatrists or psychologists. The important barriers to seeking help from clinicians were stigma, beliefs that the problem will go away by itself, a desire to deal with the problem without outside help, and fear of side effects and dependency on medicine.* ***Conclusions:*** *Training and skills development for clinicians, and empowering women and alleviating the constraints on their economic and social participation at all levels, are recommended to reduce gender inequities in perceived health issues.*

Keywords: Clinician, Depression, Women, Iran, Ethnicity

WCPRR Apr 2009: 74-88. **© 2009 WACP**
ISSN: 1932-6270

INTRODUCTION Depression is a common and disabling psychiatric disorder, with an estimated lifetime prevalence of 16% and a huge impact on disability-adjusted life-years (Kravitz & Ford, 2008). A consistent finding is that women suffer depression more than men (WHO, 2004; Verropoulou & Tsimbos, 2007) due to daily stressors such as human rights issues (e.g., inequity), social isolation, lack of social support, poverty, unemployment, and loss of meaningful activity. In Iran, epidemiological surveys have shown that prevalence rates of mental disorder vary between 11.9% and 23.8%, and are higher in women compared with men (25.9% v. 14.9%) (Noorbala et al., 2004).

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Received March 15th, 2009. Accepted July 31st, 2009.

As one of the most prevalent disorders globally, depression is responsible for as many as one in every five visits to primary care doctors (Kleinman, 2004). However, delay, misdiagnosis, non-specific treatment and lack of follow up constitute a typical pathway to care for depressed people (Mechanic et al., 1994; Cooper et al., 1997). One reason could be that symptoms reported by depressed patients are embedded in multiple contexts, including the health care system, doctor-patient interaction, and explanatory models among doctors that differ from those of patients in their own culture due to the professsionals' western-based training (Kirmayer, 2005). Therefore, patients may not be diagnosed and do not receive the proper treatment for their needs (Kirmayer, 2001). The results of our earlier studies on lay people (Dejman et al., 2009a) and depressed women (Dejman et al., 2009b) showed that depressed women's perceived symptoms usually relate to their assumptions about what caused the onset of the illness. The type of complaint determined the choice of a care pathway for the patient. There was usually a marked delay before they consulted clinicians (psychiatrists, general physicians and psychologists) in the three ethnic groups. The aim of our main study was to explore the explanatory models of Iranian people on depression of women through clinicians', female depressed patients' and lay people's view in three ethnic groups. The results of our pilot study (Dejman et al., 2008) showed that depressed female patients usually seek help from alternative practitioners, such as general physicians and/or traditional healers, before consulting a psychiatrist or a psychologist. So as part of the main investigation, we also included general physicians and traditional healers in the main study. The aim of the present study was to explore clinicians' (psychiatrists, psychologists, and general physicians) experiences of understanding depressed women's explanatory model from the clinicians' point of view. In this regard, a qualitative method was chosen to understand phenomena from the viewpoint of clinicians, and to gather the participants' deeply personal experience of the conceptualization of depression among female patients (Whitley & Crawford, 2005). Our questions were:

a) In which phase of the illness's severity do female patients come to clinicians?
b) How do female patients explain their symptoms?
c) What have they done before visiting the clinicians?
d) How do they present their problems to clinicians?

Mental Health Services in Iran

The primary health care (PHC) system has led to an improvement in Iran's general health indicators (Shadpour, 1994; Yasmi et al., 2001). The network of health care now covers most parts of the country and has brought about immense changes in the promotion and maintenance of the community's health (Shadpour, 2000). According to a Ministry of Health and Medical Education Report (Ministry of Health and Medical Education, 2004), mental health facilities comprise 250 psychiatric beds, more than 100 governmental psychiatric out-patient clinics, 28 psychiatric wards in general hospitals, and 23 psychiatric hospitals. There is one mental health unit in each of 39 medical universities, one mental health unit in each of 232 districts, and 500 private psychiatric clinics (Yasmi et al., 2001).

Mental health was integrated as a component of primary care in 1989, long before many other aspects of health (World Health Organization, 2007). At present, some districts have a psychiatrist who is available to provide specialist mental health services. Otherwise, mental health coverage is provided by a specially-trained general practitioner. The district health center accepts mental health referrals from urban and rural health centers, but sometimes refers difficult cases to the provincial health center. Iran has a total of 40 health centers in 30 provinces. In some provinces there is more than one medical university, with responsibility for health services in the catchment areas as well as for medical education. The mental health units in these services are staffed by one psychiatrist and one psychologist, who are responsible for the technical, organizational, and administrative management of the services in the periphery. There are also specialist mental health services – mostly based in psychiatric hospitals or psychiatry wards of general hospitals – that provide mental health services to

patients referred from district health centers and other urban services. General practitioners in rural and urban health centers diagnose mental disorders and provide treatment as needed if it lies within their level of training and expertise. If problems are complex, general practitioners refer patients to district or provincial health centers (World Health Organization, 2007).

MATERIALS AND METHODS

The study used an exploratory design with qualitative methods for data collection by individual interviews with psychiatrists, clinical psychologists and general physicians. In-depth interview was used as a qualitative technique to understand the world from the participants' points of view, and to understand their experiences of managing depressed women (Kvale, 1996; Dahlgren et al., 2004).

Study Participants and Sampling Process

Study participants were selected from three cities with different ethnic backgrounds, located in central (Teharan, capital city, representative of the Fars ethnic group), northern-western (Tabriz, representative of the Turk ethnic group), and western (Ilam, representative of as the Kurd ethnic group) Iran. The process of data collection in each of the three selected areas was controlled by the emerging theory, and the number of interviews completed by saturation of data, that is, the point at which no new themes emerged from the interviews (Dahlgren et al., 2004). The continued selection of subjects was related to the findings that emerged in the course of the study (Sandelowski, 1986). The participants were recruited between April 2008 and July 2008. Sampling and interviewing were done by the first author with the aid of one of the researchers (a clinical psychologist) at each of the three sites. Psychiatrists and psychologists with at least five years' work experience were selected randomly from the main psychiatric hospital in Ilam and Tabriz, respectively, and from two psychiatric hospitals in Tehran. Interviews were conducted in a quiet room at the hospital or in their private office. General physicians with at least three years' work experience were selected randomly from the urban health centers affiliated to the University of Medical Sciences in each city.

Instruments

Case vignette

Two techniques were used for the study. One involved the presentation of a case vignette (Box 1) of depression to the general physicians, using individual interview technique. The respondents were then asked to diagnose the described subject, followed by questions about causes of depression and the treatment strategy they would implement for the patient. The vignette provided a uniform description of a case and definition of depression, based on the DSM-IV criteria for the diagnosis of depression. To obtain conceptual equivalence prior to the study, the research team - aided by the last author, a senior psychologist and main supervisor - reviewed the vignette to ensure that it met the diagnostic criteria (Dejman et al., 2008).

Box 1 Clinical Vignette

Major Depression without Psychotic Features

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

(Revised from Okello & Ekblad, 2006, p. 294)

Interview Guide
The other technique involved the use of an interview guide for psychologists and psychiatrists. They were asked about the chief complaints of the depressed women, their most common symptoms, their attitudes to their symptoms, and their help-seeking process before they came to the psychologist/psychiatrist.

Ethical Considerations
The nature and purpose of the study were explained to every participant before his/her consent was sought. Individual informed consent was obtained from participants. The informed consent of respondents was confirmed by signature. Participants were assured of confidentiality and informed of their right to withdraw from the study at any time during the interview. Permission to audiotape the interview session was sought orally from each informant prior to the interview. The study protocol was approved by the ethical committees at three universities of medical sciences, in Tehran, Ilam and Tabriz, as well as by the National Ethical Committee in I.R. Iran, P373, 23 July 2005; the Ethical committee at Karolinska Institutet, EPN considered the ethical questions and found since there is no research done in Sweden no evaluation was performed (2005/5:8).

Analysis
The data were analysed immediately after collection by the first author and one member of the research team (sixth author). They listened individually to the audiotapes, and corrected the transcriptions. Then they read all data repeatedly to achieve immersion and obtain a sense of the whole (Hsieh & Shannon, 2005). Data were read word by word to derive codes; as an initial coding, the exact words from the text were highlighted to capture key thoughts or concepts (Morse & Field, 1995; Jeon, 2004). The second level of analysis moved from codes to interpretation, thereby allowing us to make links and connections between different codes and patterns and between categories. This involved putting data together for new understanding; codes were then sorted into categories to organize and group them into meaningful clusters (Coffey & Atkinson, 1996). A consistent technique was used to develop categories and subcategories (Patton, 2002). Next, a definition was developed for each category. The team cross-checked their coding strategies and after detailed discussion, reached consensus. The analysis was performed with the help of NVivo 7 and Open Code 3 software qualitative data-analysis. Open Code 3 was used because it had capability to analyze Persian documents. At the next level, we transcribed the paragraphs relating to categories into English and finalized the analysis by NVivo 7 software. Credibility and internal validity were established by prolonged engagement in the field during the collection and analysis of data; triangulation by interviewing different groups of professionals to obtain different perspectives on the depressed women; member check on the development of codes and themes by the research team in Iran and Sweden; and referential adequacy by using examples of participants' quotes for themes in the text (Mays & Pope, 2000; Hsieh & Shannon, 2005).

RESULTS A total of 24 persons – 6 general physicians (2 woman and 4 men), 14 psychiatrists (3 women, 11 men) and 4 clinical psychologists (2 woman and 2 men) – participated in the study. Their mean years of work experience were 5, 8 and 7, respectively.
The findings are presented below in terms of seven themes, exemplified with relevant citations from the three cities (Tehran, Tabriz and Ilam): 1) The Stage of Illness during which the Female Patients Visit Clinicians, 2) The Female Patients' Description of Symptoms, 3) Causes of the Illness, 4) Care Pathways, 5) Barriers to Treatment, 6) Expectations of Treatment, and 7) Changes in the Form of Illness in Recent Decades.

1. The Stage of Illness During which the Female Patients Visit Clinicians

The clinicians in the three cities had similar views. According to them, patients who visit psychiatrists, general practitioners or psychologists are often in the moderate to severe stages of the illness. Since their illness is not diagnosed by other practitioners or specialists, it becomes worse and prolonged.

2. The Female Patients' Description of Symptoms

According to psychiatrists and psychologists, patients generally visit psychiatrists with both somatic and psychological symptoms, whereas when they visit psychiatrists, psychological symptoms usually outnumber and outweigh somatic symptoms. Somatic symptoms often take the form of bodily pains and problems such as headache, dizziness, backache and loss of appetite. Psychological symptoms cover a wider range; the most common are: insomnia, severe fatigue, weakness, distress/anxiety, feeling of sadness, crying, being sensitive, reduced libido (sexual desire), reduced social interaction, impatience even in dealing with children, impaired memory and increased forgetfulness, lack of interest in carrying out daily chores and activities, inability to tolerate home environment, thinking too much, inability to decide and indecisiveness, reduced ability and educational performance (among students). Psychiatrists mentioned that some patients describe their symptoms with phrases such as "I ran out of fuel on the steep road; everything has become worthless; I'm really nervous."

> "…female patients often complain about lack of appetite, impatience, restlessness. They say I can't make it anymore, I ran out of gas. The world has reached its end, I feel like I'm suffocating, I feel melancholic and through these symptoms we figure the patient is experiencing depression." (Psychiatrist, Tehran, Male)

> "Neck pains are very common. They complain of pain in the shoulder blades and aches that continually change position in the body. This is usually their first complaint. Most of the time they are uncomfortable with symptoms such as 'I'm slow' or 'I'm good for nothing. " (Psychiatrist, Tabriz, Male)

Psychiatrists and psychologists in Tabriz mentioned that female Turkish patients clearly describe their illness by referring to "Darikhma", which is generally used to describe typical symptoms of anxiety and/or depression. Such a descriptive word was not observed in the other two regions covered by the study.

According to psychiatrists in Tehran, female patients with lower levels of education often complain of psychosomatic pains and usually go to general practitioners for corporal pains, whereas those with higher levels of education understand their psychological symptoms and refer to "afsordegi" (depression).

Psychiatrists from the three cities mentioned that among patients who come to them with mental problems, depressed women usually manifest certain signs, such as avoiding eye contact, lack of interest in speaking to the doctor, unwillingness to answer the doctor's questions.

General physicians also reported that female patients usually visit them with somatic symptoms, which often include pains, lack of appetite, palpitation and insomnia. In some cases, the somatic symptoms are accompanied by psychological symptoms such as crying, impatience, loss of energy.

> "They mostly complain about made-up pains and say for instance that their hand hurts or they feel pins and needles in their hands or that they cannot do anything at home. They say they can not stand watching the television anymore or even answering their children's questions..." (General Physician, Tabriz, Male)

> "They usually say they don't have concentration or that life is really hard for them. Women mostly say that they cry a lot. They don't feel like doing anything. They can't stand their children anymore." (General Physician, Tehran, Male)

3. Causes of the Illness

According to the clinicians, a common cause of depression among female patients is external factors, issues such as economic problems, failure or loss, e.g. divorce or loss of loved ones. According to clinicians in Ilam, social stressors such as the war (between Iran and Iraq 1980–88), its consequences and the cultural texture of the city have made the area particularly prone to depression.

> "Ethnic Arab people from Ahvaz in Khuzestan province have also gone through the war but the depression rate is much lower among them due to their culture of merrymaking and their joyful musical style, while in Ilam region the native musical style is rather sorrowful and when added to the cultural texture of the region it contributes to higher rates of depression." (Psychiatrist, Ilam, Female)

Educational stresses among students, such as examinations and lack of interest in the field of study, problems at work and domestic problems (with the family) were the common causes, reported mainly by psychologists in Ilam.

> "University female students are very desperate and hopeless about unemployment (after graduation) and they ask 'we study a lot and tolerate being away from family but what is going to happen after that?' " (Psychologist, Ilam, Female)

The most important causes of the problem among married women were lack of understanding on the husband's part, problems with the husband or his family and others' lack of understanding. These issues were reported more often in Ilam than in the other two cities.

> "Women often face some problems in their father's household. They imagine that these problems would be resolved once they get married. But after their marriage, they confront marital problems with their husband and husband's family members, therefore the illness starts to manifest in them." (Psychologist, Ilam, Female)

> "At the social level, I (psychologist) have had women (who were referred to me) who stated that the main factor that led to their problems was that they were not understood at home." (Psychologist, Ilam, Female)

4. Care Pathways

According to the majority of clinicians in the three cities, female patients usually consult several doctors, such as general physicians or specialists. They tend to visit psychiatrists only when ineffective medication makes them loose their faith in doctors.

> "A majority of the patients visit a neurologist in the urban areas or a general practitioner in the rural and urban areas before visiting a psychiatrist and they might have only been examined by the rural health center doctor for 1 or 2 years. Then their problems become worse and they go to psychiatrists." (Psychiatrist, Tabriz, Male)

According to clinicians, some female patients try to deny their illness and assume it is a temporary state of affairs that will go away. They attempt to alleviate their symptoms by seeking help from psychology books and keeping themselves occupied with leisure activities, sports, walking and engaging in social

relations such as going to parties or asking for help from the family. According to the general physicians, these activities were of very little help in dealing with the illness.

> "Individuals with lower levels of education don't know what to do. They just try to attract help and support through talking about their problems and sorrows to others. However, those who are better educated try to help themselves in different ways. They try to find a way to end their loneliness and isolation." (Psychologist, Ilam, Female)

Almost a majority of the clinicians in Tabriz and Ilam considered that female patients usually go to fortune-tellers and traditional healers. They believed that depressed women with a low educational background usually go to prayer-writers or fortune-tellers. A majority of the clinicians in the three cities said that female patients went to herbalists for medicine at the same time as they were referred to psychiatrists or general physicians.

> "They (depressed women) go to certain people to write special prayers for them and they tend to go for superstition. They think they have fallen victim to evil eyes or magi. They give large sums of money to prayer-writers. They tell the patients that they have passed a certain spot alone at evenings or that fairies have cursed them. People believe in these things, especially in Ilam region. Female patients think that the prayer-writer has worked a miracle and is effective. They give handsome rewards to him/her. If they don't see any results they visit psychiatrists or psychologists. In this region (Ilam) people have more faith in prayer-writers than that they have in psychiatrists." (Psychologist, Ilam, Female)

General physicians in the three cities reported that treatment provided by general practitioners can be divided into two categories: medical treatment and psychotherapy. When they diagnose depression, they try to treat symptoms with relevant medicine. For example, for symptoms such as insomnia they prescribe relaxant medication or flouxetine. If patients do not show signs of recovery after 2-3 months, they refer them to psychiatrists. They also use treatment methods such as encouraging the patients to take up sports, change their environment, avoid listening to sad music and generally advise a change of attitude when facing problems.

5. Barriers to Treatment

The codes extracted from the interviews indicated barriers of two kinds: barriers that cause female patients to refrain from visiting psychiatrists or psychologists, and barriers that contribute to patients discontinuing treatment provided by clinicians (psychiatrists, psychologists or general physicians).

Barriers whereby female patients do not visit clinicians

According to a majority of the clinicians, there are several reasons why female patients do not visit psychiatrists or do not continue their medication. The most important reason is fear of stigmatization for being known as someone with psychopathological problems; they might lose their job and be subject to social cruelty by immediate family or friends.

> "Women especially do not trust their husbands because they fear the treatment might be used against them later. They think in the future the husband might say my wife was mentally ill and they might want to divorce them." (Psychologist, Ilam, Female)

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

According to psychiatrists and psychologists in Tabriz and Ilam, another factor that makes female patients avoid visiting psychiatrists or psychologists is the nature of treatment for mental illnesses, which requires several visits to the therapist and makes the illness visible to others.

> "If a woman visits a psychologist more than once, her husband and her family and neighbors are bound to find out. This will have negative effects on her. So, they try to describe all their problems in one session and also try to solve the problems through that single session. It is very difficult for her to visit the psychiatrists or psychologists for several sessions and keep it a secret from others." (Psychologist, Tabriz, Male)

Some psychologists and clinical psychologists mentioned that economic problems connected with payment for counseling are another reason why depressed women do not go to psychologists.

> "There is definitely the economic factor, for example the rate for an interview session with a clinical psychologist is 150,000 Rials (about US $15) and patients usually do not agree to pay these amounts. A majority of the people who come to us do not attend all the necessary counseling sessions since they don't have the financial resources." (Clinical psychologist, Tabriz, Male)

> "For depressed women there is the problem of the cost of treatment because if they need to ask the husband for the money, he will find out his wife's problem, so women usually are not willing to inform their husbands." (Psychologist, Ilam, Female)

Barriers that contribute to patients discontinuing treatment

The female patient's relatives often try to get her to stop taking medication because they are afraid she will become dependant on or even addicted to it. They blame the patient for taking psychiatric medication for long periods of time. Therefore, women are unwilling to inform their husband or family about their illness or the drugs they are receiving.

> "Family members usually tell female patients not to take their medications. Usually middle-aged women visit me without their husband's knowledge. A woman told me if she takes medication, she will be under pressure from her husband not to continue medication because she becomes addicted to the medication." (Psychiatrist, Tabriz, Male)

> "There have been cases of female patients where others interfere with their treatment. Family tells them if they take an excess of drugs, they will become dependant on the medication." (Psychiatrist, Tehran, Female)

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

> "A majority of depressed patients find the side-effects of the drugs unbearable, so they stop taking the medication." (Psychiatrist, Tabriz, Male)

For those who have a job, lack of job security and fear of losing jobs and careers is mentioned as another reason for resistance to medicinal treatment. Patients believe that the drugs cause drowsiness and might result in inability to come to work on time. That might cause the patient to lose her job.

6. Expectations of Treatment

According to clinicians, depressed women hope that their sadness, negative thoughts, somatic symptoms, like insomnia and fatigue, and inability to carry out daily chores would soon be over. The patients want to regain their energy and to be able to communicate with family members. These are among the benefits the patients expect to gain from beginning their treatment by psychiatrists, psychologists or general practitioners. Patients express their feelings about treatment through sentences and phrases like:

> "I want to recover", "have a better function at home", and "have better family relation" (with children and the spouse)." (Psychiatrist, Tehran, Female)

A majority of female patients want the kind of treatment to be appropriate to the cause of the illness. For instance, if the cause of depression is marital conflict, they would prefer to resolve their issues with their spouse. One of the psychiatrists in Tehran pointed out a difference in expectations of treatment between female patients with lower and higher educational levels. He believed that female patients with a lower educational level expect the treatment will deal with their somatic symptoms, such as lack of sleep or poor appetite, whereas those with a higher education hope to overcome psychological feelings, such as melancholy and isolation.

7. Changes in the Form of Illness in Recent Decades

Psychiatrists believe that a growing awareness among the general public is causing more patients to be referred to them than before. Women are relatively more liberated at present. They have become slightly more extroverted and talk more about their mental problems. However, the symptoms of depression have not changed much over the years. The main causes of the illness are still considered to be problems with spouse and the spouse's family. As far as treatment is concerned, female patients still go to a specialist in moderate stages of the illness. According to psychiatrists, visiting prayer-writers (mostly in Ilam) and using herbal medicines (mostly in Tabriz and Tehran) are still among the most common caring pathways undertaken by depressed women.

DISCUSSION

Female patients usually consult psychiatrists and general practitioners in the moderate to severe stages of their illness. Psychological symptoms usually overshadow somatic and other symptoms. Common somatic symptoms are complaints about corporal pains; common psychological symptoms are severe fatigue, weakness, feeling of sadness, less social interaction, impatience, easily aggravated, especially by the spouse, and impaired performance and ability. General practitioners, however, reported that patients usually go to them with somatic symptoms, such as pains, loss of appetite, tachycardia and insomnia. According to the interviews, a majority of female patients visit several doctors (general physicians and other specialists) and when medication is ineffective, they may be referred to psychiatrists. There are several reasons for patients not visiting psychiatrists, including stigmatization, economic problems and the cost of counseling. Some patients who consult psychiatrists do not continue the medical treatment due to drug side-effects, assumptions that medication has intensified the illness, long treatment periods and the time it takes for medication to be effective. Going to fortune-tellers and prayer-writers are common care pathways for depressed women.

When patients turn to psychiatrists

Results from the current study are consistent with Jacob's (Jacob, 2006) report that patients who visit psychiatric facilities often have severe and chronic illness. On the other hand, he found that depressed

patients are referred to a general physician in an early phase of their disease, and have milder and less distinct forms of illness, which is not in concordance with results from the current study. According to the clinicians in the current study, depressed women usually visit general physicians in a moderate to severe stage of their disease. This could be because depressed women often present somatic symptoms and see them as a transient condition (Dejman et al., 2009b).

Effects of disease

According to the psychiatrists and psychologists in the three cities, depression causes disruption and disorders in the ability and functionality of the female patient at work or at home. It also causes problems in social interaction and concentration. This is consistent with the perceptions of depressed women and their relatives in the recent study in Iran (Dejman et al., 2009b; Dejman et al., 2008), as well as with European American (EA) and South Asian (SA) lay beliefs in the UK (Karasz, 2005). Both of the latter groups focused on the consequences of depression for the patient's work role; SAs tended to focus on domestic role failure, while Americans referred to problems with paid work (Karasz, 2005). In addition in our study, effects of the disease according to psychiatrists and psychologists included less social interaction and familial relations, impatience and bad temper, less sexual contact and activity, and eventually conflicts with the spouse. Lack of attention to illness and timely treatment of the illness by depressed women can have major negative effects on families. Keitner (Keitner et al., 1995) related that major depression impairs family function and increases the risk of domestic violence. Considering the importance of family and the role of women in Iran, it is therefore imperative that more attention is paid to this issue.

Care pathways

The most striking cultural variation in depression concerns somatisation, which is common in non-western populations, particularly in some Asian countries (Conrad & Pacquiao, 2005). Because the diagnosis is directly connected to the reporting of symptoms by patients, clinical judgment is extremely important for a proper diagnosis. Somatisation can be seen as a cause of delay in the recognition of symptoms and in help-seeking (Conrad & Pacquiao, 2005). Findings from the current study showed that depression in women was often manifested as somatic symptoms, and treatment was sought only when symptoms were unmanageable. A majority of the women consulted various general physicians or other specialists but not psychiatrists. Not until psychological symptoms became more serious and they experienced problems with daily functions did they visit psychiatrists or psychologists. Delays in seeking initial treatment could be a factor behind the excess disability associated with depression. Kessler (Kessler et al., 2001) found that of those who seek help for affective disorder, 40% do so in the year of onset of the illness. WHO (World Health Organization, 2007) reported that the extension of primary care to include mental health care has reduced assistance sought from traditional practitioners from 40% in 1990 to 14% in 1998 and 16% in 2000. According to most of the clinicians in the current study, a majority of female patients go to fortune-tellers or prayer-writers or seek help from religion.

Female patients also go to herbalists to obtain herbal medicine. A medical text-book (Sadock & Sadock, 2007) recommends herbal medications for treatment of depression besides other treatments, such as counseling, psychotropic medication, diet, exercise, support groups, and faith-based groups. With reference to depression, concern has been expressed about the efficacy and consistency of ingredients in herbal remedies. Consultation with a naturopathic physician or trained herbalist is recommended prior to initiating therapy with herbal remedies (Sanders, 2006). So, based on Iranian culture, it is recommended that this kind of medication be included in medical guidelines and herbalists be trained to cooperate with mental health clinicians.

Seeking help from religion is a common care pathway for depressed women according to lay people, depressed women and their families in three ethnic groups in Iran (Dejman et al., 2008; Dejman et al.,

2009a, Dejman et al., 2009b). Essentially, the Islamic strategy for the promotion of mental well-being is based on the recognition of inherent human defects and emotional weaknesses and hence calls for systematic development and constructive enactment to overcome them (Pridmore & Pasha, 2004; Baasher, 2001). In daily Islamic practice, the sequence of five daily prayers, the believer recites the opening of the Quran and appeals to God to show him/her the straight path, the path of those whom He favours. This is a clear strategic line of action. The daily and seasonal Islamic practices are helpful for personality adjustment and the promotion of mental health (Baasher, 2001). For this reason, most depressed Muslim women seek help through prayer and religious practice to improve their mental problems. A study on Pakistani Muslims, Afro-Caribbean people, lay Bangladeshi Muslims, White British and Yoruba in the UK also showed that religion played an important part in healing depression (Lavender et al., 2006; Cinnirella & Loewenthal, 1999). Both Pakistani Muslims and Afro-Caribbean people valued prayer, particularly for its private nature, for healing depression. Muslim groups felt that religion could be a source of treatment, even if they were not enthusiastic about seeking help from holy persons, preferring instead to utilize private prayer (Cinnirella & Loewenthal, 1999).

Barriers to Visiting Professionals

Stigma

Findings from the present study indicate that the stigmatization attributed to mental illnesses is a major barrier on the path to early diagnosis of the illness by the female patient or her family. This is consistent with findings by Nasir (Nasir & Al-Qutob, 2005) in Jordan on health providers, who mentioned that the stigma of depression was particularly strong for women; according to health providers, the intimation of mental illness would affect their prospects of marriage – if they have depression, they will never be married. Among married women, the label of psychiatric illness might be used by the husband or his family as an excuse for him to take a second wife or as grounds for divorce (Nasir & Al-Qutob, 2005). In addition, in agreement with the current study, health providers in Jordan expressed that resistance to the diagnosis by the patient and her family, uncertainty about the diagnosis, and concerns about treatment efficacy were the dominant barriers to seeking help from medical treatment (Nasir & Al-Qutob, 2005).

Patients prefer to speak about somatic symptoms, which are more socially acceptable, in order to attract help and support. Additionally, blame by others for taking mental medication and fear of dependence on medicine were the most important reasons for discontinuing medical treatment. These results are consistent with findings among Indian Asians in the UK that depressed patients and their immediate families usually deny the illness and try to hide it; the stigma associated with mental illness prevents them from adhering to care (Conrad & Pacquiao, 2005).

Fear of mental illness stigmatization might cause female patients to refrain from consulting psychiatrists or psychologists. In small towns and areas like the city of Ilam, people do not go to local psychiatrists because, despite the principle of professional confidentiality, they fear that others will find out about their illness. Stigmatization of mental illness seems likely to be a major barrier to care and a key cause of poor recognition and treatment (Haddada et al., 2007; Kohn et al., 2004; Jorm et al., 2000).

At present in Iran, members of the patient's family and social network are seldom included in discussions about treatment. Discussions between the patient and clinicians are also rare. Therefore, involving the family in treatment management, spending enough time consulting patients and using neutral diagnostic labels may reduce the stigma associated with psychiatric disorder and also shorten the treatment lag (the time from onset of a disorder to obtaining care).

Attitudes to Illness and Treatment

According to psychiatrists and psychologists, attitudes to treatment among the female patients are of two kinds. There is one group that does not believe in the effectiveness of the medical treatment. This group seeks help from psychiatrists or psychologists under pressure from others (friends, relatives). There may be various reasons for this perception, including that the problem is not acknowledged, that treatment is perceived as ineffective, that the problem is expected to go away by itself, or that the illness is seen as a sign of weakness (Halter, 2004).
The other group comprises female patients who consult psychiatrists but discontinue their medical treatment. One of the most important reasons is the side-effects of drugs, especially drowsiness. Female patients assumed that drowsiness makes them unable to do housekeeping and manage their family. This may be because psychiatrists do not spend enough time discussing with patients and informing them about side-effects. In keeping with this result, Haslam (Haslam et al., 2004) stated that many depressed people experienced side-effects from medication and felt poorly informed about them. They believed they were not given sufficient information about mechanisms by which the medication works and its possible side-effects (Prins et al., 2008).

Cost of Treatment
Economic problems and the high cost of counseling are among the reasons why depressed women refrain from visiting psychiatrists and psychologists, or stop the treatment even if they do visit them once. Health insurance in Iran does not cover mental counseling and cognitive therapy, which have to be paid for by the patients. This might be a reason why psychiatrists prefer medical treatment as the only way of caring for depressed patients. This "direct barrier to care for depression" has been reported to be a major factor and must be taken into consideration (Aidoo & Harpham, 2001; Kessler et al., 2001)

Patient's Expectations of the Treatment
The first priorities of the female patients were regaining their energy and being able to communicate with family members. They expected to gain this by beginning their treatment.
A majority of female patients have the causes of their illness in mind and show interest in eliminating the symptoms. For instance, if the illness started on account of problems with their spouse, they are interested in settling those problems. This is consistent with the findings of Karasz on South Asians in New York city (Karasz, 2005) and the beliefs of Yoruba and Bangladeshi people in the UK (Lawrence et al., 2006). These groups believed that improving depression is dependent on its root cause. South Asians believed that if the problem could be solved quickly, there would be little effect on the women, but if underlying social problems remained unsolved, the consequences could be severe (Karasz, 2005).

Gender and depression

Gender differences in depression have been explained theoretically by chronic stress related to women's traditional role and rumination theory, which holds that women are more likely to dwell on problems and that this can lead to depression (Sanders, 2006). As social determinants of health, gender inequities damage the health of millions of women (Marmot et al., 2008). The routes whereby they influence health include lack of access to resources and opportunities, and lack of decision-making power over one's own health. Within the health sector, gender power relations translate into differential access to and control over health resources within and outside families; unequal divisions of labor and benefits in formal, informal, and gender biases in the content and process of health research (Marmot et al., 2008). In the current study, clinicians mentioned that some depressed women are dependent on their husband and/or family in finding a pathway to help, continuing medication and paying for counseling. In this regard, promoting gender equality and empowering women might be a key development strategy for better health for women. Such an approach has been embedded in the framework of the Millennium Development Goals (MDG 3) (Marmot, 2008; Marmot et al., 2008).

Expanding women's capabilities through education underpins the empowerment of women. Gender equalities can facilitate this.

The position of women has changed dramatically in Iran. Higher national priority has been assigned to the literacy and educational level of women; the proportion of women in the labor force has risen steadily in recent decades. However, much remains to be done in the way of training and skills development for the empowerment of women and to alleviate the constraints on their economic and social participation at all levels.

Limitation
Participants in this study focused on the perspective of depressed women and they explained depressed women's explanatory model as an outsider. Clinicians did not consider their own explanatory model or issues related to their perspective that may be regarded as barriers on the path to medical care for depressed women. This may be because the clinicians were not asked about these issues. It is recommended that these issues are explored in a future study to find the gap in the explanatory models of patients and doctors.

Implication
Although depression occurs universally, the manifestations and behaviors associated with depression are contextualized in the framework of patient's values and beliefs. Therefore clinicians should be informed about these issues in courses and/or guidelines. It is recommended that families and communities are also educated about mental health. The national mental health programme that has been established in Iran (Yasmi et al., 2001) needs to be revised in accordance with an evaluation of mental health systems and community needs and concepts of disease.

CONCLUSION

The important barriers to seeking help from professionals (psychiatrist or psychologists) were stigma, beliefs that the problem will go away by itself, a desire to deal with the problem without outside help, and fear of side-effects of drugs and dependency on medicine.
What is more, when patients consult specialists or general practitioners, besides obtaining medical treatment, they want to have counseling sessions to learn skills in order to confront problems that cause depression. However, counseling and psychotherapy are costly and psychiatrists tend not to use these methods for lack of time. Therefore, a medical/health insurance policy to cover the cost of mental counseling services is highly recommended.

ACKNOWLEDGMENTS

The authors are grateful to the participants for agreeing to share their experience and knowledge. We would like to express our gratitude to the Deputy for Research and Technology at the Iranian Ministry of Health and Medical Education, and to Karolinska Institutet, Stockholm, Sweden, for funding the study. We are also grateful to the research team from the Psychiatry Departments at Ilam and Iran Universities of Medical Science and the Clinical Psychology Department at the University of Social Welfare and Rehabilitation Sciences. We would like to acknowledge our special gratitude to Dr. Elialilia S. Okello, PhD, Makerere University, for her collaboration on methods in this study. We would like to thank Mr AliReza YarParvar for translating the transcripts into English and to Patrick Hort for his help in transforming the text into more readable English.

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