



Explaining Experiences of Depression in Cities Representing the Fars, Turk and Kurd Ethnic Groups of Iran: A Qualitative Study

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Abstract

Background and Objectives: Depression is one of the most important mental disorders affecting 350 million people in the world. The aim of this study was to explore the similarities and differences in the symptoms and experiences of depression in cities representing the Fars, Turk, and Kurd ethnic groups of Iran.

Methods: A qualitative study was implemented in three ethnic groups in Iran between April 2016 and March 2017 using individual interviews with 44 depressed patients, 20 people of their relatives, and three key informants in Tehran (Fars), Tabriz (Turk), and Sanandaj (Kurd) cities. The data were analyzed using directed content analysis.

Results: The analysis of the data led to the extraction of four main themes, including cognitive, behavioral, physical, and emotional/motivational symptoms.

Conclusions: The study findings would help to explore various expressions of depression and provide a multidimensional construct to develop the culturally specific measurement of depression in three different ethnic groups.

Keywords: Depression, Ethnic Groups, Symptoms, Iran

1. Background

Depression is one of the most common mental disorders affecting 350 million people around the world (1). This common, serious, and recurring disorder has a major influence on people's performance, quality of life, disability, and mortality (2). The World Health Organization predicts that depression will be one of the main causes of disease burden in developing countries after HIV by 2030 (3).

There are no detailed data on the prevalence of depression in all countries, and the review of the literature suggests a great variation in the estimations provided (2). For instance, a review study conducted from 1963 to 2015 reported the prevalence of depression in the range of 20% to 43% (28.8% on average) (4). According to a national survey on mental health in Iran in 2011 that focused on the population over age 15, the most prevalent particular disorder was a major depressive disorder (12.7%) (5). The prevalence estimated in this study was three times higher than the prevalence in a systematic review of studies carried out before

2004 in different parts of Iran, which estimated the pooled mean prevalence of 4.1% for depressive disorders, and suggested that there might have been an increase in the prevalence of depression in the country between the early 2000s and 2011. Despite the prevalence of depression, its specialized treatment is very limited in developing countries. One of the known reasons for this limitation is the failure to diagnose (or make a timely diagnosis of) the condition, which means an effective and early treatment is not given for the disorder. As a result, the cost of care may rise, especially in developing countries (2).

People have different ways of describing and prioritizing their psychosocial problems, perceiving the reasons behind them, and dealing with them. Cultural and environmental diversity affects people's perceptions of mental health and the psychosocial problems associated with unpleasant experiences. Cultural processes include physiological reactions, cognitive and emotional understandings and interpretations of particular situations, and the meaning of habits (6). Studies suggested that the language

of emotions and feelings is not commonly used in Asian countries (6-9). This information is crucial for selecting mental health problems that are important to the local people of a region and are crucial for establishing acceptable and practical interventions for them. In addition, the diagnosis of mental disorders and making decisions about them are often based on the available resources and experiences, which are both the result of studies conducted in populations (3). The diagnosis of depression is directly dependent on behavioral signs and symptoms reported by the patient. In other words, culture, religion (10), and gender (2, 11) affect the interpretation of the disease, how it is experienced, and the terms used to report its symptoms (12). For reasons that could involve both reporting style and methodological processes, the differences in depression prevalence estimations can be partly described (2).

Depressed Iranian patients, especially in cases where the depression is not severe, associate their mood symptoms with the sorrow caused by environmental factors such as economic problems, important family events, or physical illness and may regard depression as a normal reaction to a specific issue (13). In countries such as Iran, where people are inclined to present depression symptoms as normal and the direct explanation of the inner psychic world is inhibited, it is important for early detection and intervention to delineate depression symptoms and to obtain a more reliable profile of depression symptoms (14). Therefore, it is recommended for a depression assessment tool to be a patient-reported outcome measure to provide a means of gaining the patient's own perception of his or her health and illness (15). According to the above-mentioned studies and our clinical experience, we interviewed patients in three different cities to have a better understanding of the patient's perception of depressive symptoms.

2. Objectives

As part of a larger study to design a depression-screening tool compatible with the Iranian culture in Fars, Turk, and Kurd ethnicities, a qualitative investigation was conducted to better understand how patients and their relatives describe and experience depressive symptoms. In this manuscript, we report the results and discuss the differences and similarities between the concepts and symptoms expressed in these three ethnicities.

3. Methods

3.1. Design

The present study was conducted in Tehran, Tabriz, and Sanandaj, using a qualitative method, which is very useful for cross-cultural psychology and psychiatry studies (16).

3.2. Study Participants and Sampling

Study participants consisted of patients suffering from depression, as well as their families and friends and mental health service providers (psychiatrists and psychologists). A sample of 44 patients participated in this study. The patients were selected through purposive maximum variation sampling based on the following inclusion criteria: diagnosed with depression (based on psychiatrist evaluation), being an adult (18 to 65 years old), and cognitively capable to participate in the interview. Twenty patients' family members or relatives were interviewed, as well. Patients' relatives and family were supposed to live with them at least during the last year. In addition, three mental health service providers were selected purposively. Service providers were psychiatrists or psychologists with more than five years of experience (clinical psychiatric work in the three main general hospitals of each city) who were able to communicate in the ethnic language of their city.

3.3. Procedures

Data were collected between April 2016 and March 2017 using individual interviews. The interviews were held by the research assistants in Tabriz and Sanandaj. The research assistants were psychiatrists or psychologists, familiar with the culture of the intended cities and qualitative and quantitative research methods. For familiarity with and homogeneity of the interview method, a one-day training workshop was held for the interviewers in which, the researchers briefed the interviewers on the study objectives, methods and questions and gave them the necessary training for enhancing the skills needed for qualitative research. In Tehran, the interviews were performed by the first author. The interviews continued until data saturation when no new data emerged any longer. A guide questionnaire was used for directing the individual interviews, which had been developed by the research team through a review of literature and group discussions with experts. The research assistants visited the selected locations in each city (clinics, hospitals, and private doctor's offices) and fully briefed the patients deemed eligible by a psychiatrist on the study objectives and then ensured them of the confidentiality of the data and their right to withdraw from the study at any time they wished with no effects on their treatment process. The patients also gave their permission for recording the interviews. Written consents were obtained from those who agreed with all the study conditions. All the interviews were conducted in a separate and quiet room away from the other patients. The in-depth interviews with patients started with asking them to tell the story of their illness, their main symptoms, and the reasons for their visit (for example: please say about

your illness? what is your main problem? etc.). When further explanations were needed, for instance, regarding the meaning of the symptoms and terms they used in their statements, purposive questions were posed. Interviews were also held with the patients' relatives or friends who accompanied them and they were asked to discuss their patient's symptoms, how they defined their illness, and the main symptoms that made them seek healthcare. All of the emotional reactions of participants such as crying, shaking hands, etc. were written. In addition, in necessary cases, memos and reminder notes were used. At the end of each interview, the interviewer discussed the symptoms as extracted from the interviews with both the patients and their relatives and asked them to comment on their list. Each interview lasted from 30 to 50 minutes.

The research project was approved with two codes of ethics: IR.USWR.REC.1395.104 from the University of Social Welfare and Rehabilitation Sciences and Abzums.Rec.1394.48 from Alborz University of Medical Sciences.

3.4. Data Analysis

Data were analyzed using directed content analysis since it enables the identification of participants' experiences and perceived concepts and helps provide more in-depth explanations about the issue (17). All the audio tapes containing interviews with the patients and their relatives were separately transcribed verbatim in each ethnicity by one coder. After reading the interview texts, meaning units, themes, and subthemes were extracted according to the study framework and the concept of depression and then summarized as a list of symptoms for each ethnic group using content analysis (17). The list contained the main problems, symptoms, and signs of depression and the frequency of their occurrence in depressed patients in all three ethnicities. To confirm these symptoms, some interviews were also conducted with eligible key informants who were asked to talk about the main complaints and symptoms of depressed patients based on their experiences, and when further explanations were required, purposive questions were posed.

This study sought to meet the different aspects of trustworthiness. At the end of each interview, the interviewer presented a summary of the interview results to the participants (respondent validation), and the details of the method, such as the data collection and analysis methods, were clarified (transferability), and the results were assessed by a completely new assistant during the analysis (team consistency).

4. Results

A total of 44 patients, 20 patients' relatives, and three key informants from different ethnicities were studied. Ta-

ble 1 presents participants' demographic details by ethnicity. The analysis of the data led to the extraction of four main themes, including cognitive, behavioral, physical, and emotional/motivational symptoms. The symptoms related to each theme (Table 2) are addressed in the following by ethnicity.

Table 1. The Demographic Details of the Participants by Ethnicity

Participants	Ethnicity		
	Fars	Azari	Kurd
Patient			
Number	20	20	4
Men	10	10	1
Women	10	10	3
Mean age, (y)	37.6	44.3	
Mean duration of disease, (y)	6.8	5	8.7
Marital status			
Married	8	20	2
Single	9		1
Divorced/widowed	3		1
Education			
High school diploma or below	9	18	3
Bachelor's degree	6	2	2
MSc or PhD	5		
Patients' relatives			
Number	10	9	1
Men	5	5	1
Women	5	4	0
Mean age, (y)	37	42	35
Education			
High school diploma or below	6	8	1
Bachelor's degree	2	1	
MSc or PhD	2		
Key informant			
Number	3		
Men	2		
Women	1		

4.1. Cognitive Symptoms

These symptoms mostly originated from the individual's negative view of themselves, their future, and the world around them. The majority of the patients had a negative attitude mostly toward others and then toward themselves. In relation to others, this negative attitude clearly reduced their interpersonal relationships, and in relation to themselves, it reduced their self-esteem and caused humiliation as revealed by the Fars ethnic group.

"I had a bad attitude toward everyone and didn't trust anybody, especially my husband's family." "My view about myself had changed and I didn't take care of myself."

Table 2. Themes, Subthemes, and Major Codes in the Study

Theme	Subtheme	Major Codes
Cognitive symptoms	Negative attitude	Decreased interpersonal relationship
	Indecisiveness	Reduced self-esteem
	Suicidal ideation	Loneliness
		Lack of concentration
		Forgetfulness
		Frequent thoughts of death
Behavioral symptoms	Sluggish performance	Problem in performing routine activities (going to school, etc.)
		Lethargy
Emotional symptoms	Feeling sad	Sadness
	Not taking pleasure in anything	Intolerance
	Cold and dreary	Sensitiveness
		Anxiety
		Stress
		Apathy
		Crying
		Aggressiveness
Physical symptoms	Chronic pain	Insufficient sleep
	Sleep disturbance	Light sleep
	Appetite disturbance	Nightmares
	Loss of libido	Oversleeping
	Digestive problems	Increased appetite
		Decreased appetite
		Nausea
		Vomiting
		Different kinds of pain

In Azari and Kurdish ethnicities, self-pessimism and the loss of self-esteem were not obvious. Most of the participants from the mentioned ethnicities complained about feeling indifferent toward the society. Almost all of them preferred to be alone and away from others.

"I prefer staying alone, I don't like gatherings. I've become very indifferent, have no will, and don't care about it either. I avoid everyone."

In Kurd ethnicity, most of the patients were clearly skeptical about others and expressed this feeling with words such as "hatred". Feeling isolated and being excluded from the family and the community were mentioned by both the patients and their relatives. These patients felt guilty and regretful about some of their actions, and did not feel happy about themselves in general; however, they were not particularly skeptical of themselves either. The patients' relatives also complained about the patients' negative attitude toward others and found it to be

manifested in their lack of desire to attend family gatherings, their faded relationships with friends, and ultimately their reduced participation in social activities.

Indecisiveness and absent-mindedness were also discussed by some of the patients in Fars ethnicity as symptoms.

"My mind was blocked. I have trouble making even the smallest decisions that most people make them without thinking about."

In Azari ethnicity, all patients used the term "distraction" to complain about their serious lack of concentration and in Kurd ethnicity, patients complained most about being forgetful and revealed that they frequently forgot even their own words and had to constantly repeat them. Some of the patients said that they had lost their comprehension of things.

"I forget my own words and don't remember them and just keep repeating them."

Frequent thoughts of death were very bold in the patients, and suicidal ideations were more or less expressed by them, although in Fars and Azari ethnicities, the majority of them had never attempted suicide mostly due to their religious beliefs, and there was only one case of a suicide attempt by taking pills. Nevertheless, in Kurd ethnicity, most of the patients had attempted for this action.

"I found no purpose in my life, and I think about committing suicide" "crying".

"I always wish I was dead, but never think about taking my own life."

4.2. Behavioral Symptoms

This group of symptoms indicated the behavior of depressed patients and mostly showed their inappropriate and sluggish performance in routine activities. All the patients revealed that they had problems in performing routine activities such as going to work, doing the household chores, etc., and no longer did any of these activities or took very long to do them now.

"I had become very messy and dirty and couldn't be bothered with anything". "It was difficult for me to do my chores."

In Azari ethnicity, the majority of the patients expressed their inability to perform daily tasks using the term "lethargy".

"I'm always tired and lethargic. I can't do my work at all. I have no enthusiasm."

In Kurd ethnicity, also the feeling of exhaustion and the inability to perform tasks were noted by all the patients and their relatives, but none of the patients and their relatives, however, complained of the patients' lack of attention to personal hygiene.

"I did nothing at all. Just went to school and came back. It wasn't as if I didn't shower or anything like that, but didn't do anything in particular."

A patient-relative said: *“Most of the time, he is disheartened and has lost his spirit.”*

4.3. Emotional/Motivational Symptoms

These symptoms mainly included feeling sad or guilty and not taking pleasure in anything.

Emotional/motivational symptoms were manifested in the form of sadness, intolerance, sensitiveness, anxiety, and stress. Some of the patients explained that they were not able to express their sad mood *“It was difficult to explain so I kept it all to myself.”*

“Inertia, melancholy, unhappiness, and being unhappy about something obscure. I mean, you are constantly unhappy and don’t know why you are so without having received any bad news. It is very obscure, and you don’t know why.”

In Azari group, the term (sochimia) “cold and dreary” was used very often both by the patients and by their relatives to express their apathy and dullness.

“I’ve become cold and dreary, like the dead.”

Crying and feeling no joy were other common symptoms in almost all of the patients.

“I’m not happy. I’m always sad and only wish I could still laugh.”

In the Kurd group, expecting bad news and worrying about bitter events happening to loved ones were the other common symptoms in these patients.

“I felt gloomy all the time. Like, I expected that something was going to happen to my kids, my house, my relatives... That is how I felt.”

Along with other emotional symptoms, some patients also discussed feeling anxious and restless, aggressive and in a bad mood. Taking less pleasure in social networks was another emotional symptom discussed by some of the patients. A few of them considered these networks as a way of filling their time, and in some, the desire for using the virtual space had not changed.

“When he is unhappy, he gets less pleasure from eating, drinking, and resting.”

In one Kurd case, the feeling of guilt and reproach accompanied the other symptoms.

4.4. Physical Symptoms

This group of symptoms was manifested more in the form of chronic pain, sleep and appetite disturbance, and digestive problems in all participants of three ethnicities.

The physical symptoms were more manifested in the form of sleep disorders, either as insufficient sleep (in most cases) or as light sleep and nightmares and occasionally as oversleeping. Most of the patients in three ethnicities revealed that they had lost their appetite, but a few of them expressed that they had experienced increased appetites and weight gain. Among Fars patients, there were

some complaints about digestive problems such as nausea, churning stomach, etc.

In addition, among Azari patients, there was the sensation of different kinds of pain, especially a headache (which was reported in all but one patient), backache, and chest pain. Some of the Kurdish patients or their relatives used the term “change of temperament” to signify changes in the normal condition of the patients, and declared it as the reason for seeking healthcare in some of the cases. A headache was a physical symptom experienced by all these patients.

“My sleep is badly affected and I am sleepless. There has been no change in my eating, but I feel nauseated whenever I’m stressed.”

“I stay awake all night. My feelings of nostalgia trouble me and I have no sleep or life.”

In addition, the loss of libido was raised by most of the patients in all the ethnic groups. Although some of them expressed it is not easy for them to discuss this issue directly.

5. Discussion

A large literature on cross-cultural mental health revealed that the measures used by the western organizations could not be translated and easily used in other settings. Recognizing these shortcomings and with the ultimate goal of improving assessment instruments and interventions for mental health in Iran, we conducted this study to better capture cultural understanding and constructs of depression. Certain basic commonalities between the study participants understanding and experience of depressive symptoms were identified although some variations were also found. The findings of the current study were incongruence with other studies and not only showed a different language for describing symptoms, but also a different system of using a number of culturally specific symptoms among participants from different ethnicities (18-24).

Being pessimistic and loss of self-confidence were expressed more among Fars participants living in the capital city, where there is a high competition for the job, education, etc., compared to Azarie’s and Kurd participants. These may be partly described that people living in large cities feel swallowed up in a world beyond their control, which can lead to the feelings of ineffectiveness, powerlessness, and worthlessness. In addition, because of consistent experience of high competition, the residents of metropolitans are at a higher risk of experiencing inadequacy and “I am not good enough” beliefs. On top of that, experiencing more pressure for hiding real me may make them hurt more of lacking the self-confidence and complain about that as a symptom.

The terms used for expressing a number of symptoms were different in three ethnic groups. Azaries patients used the term (diyanmisham) for easy distraction because of thinking too much while Kurds used the term (Bir nekin) to explain forgetfulness or absence of mind and easy distraction. The term (sochimia) "cold and dreary" was used very often among the Azari group for expressing the apathy. This finding is congruent with other studies that verified the expression of depression varies in different cultures (25).

The tendency to express emotional dysphoria with physical symptoms and pain was common among Azari and Kurd participants. The digestive problem, stomachache, heartache, back pain, and headache, similarly, were common manifestations among patients from both genders in the three ethnic groups. This issue has also been discussed in other studies where depressive patients presenting to primary healthcare frequently mentioned somatic complaints like a headache, epigastric pain, and chest pressure instead of sadness or depression (26, 27).

Kurdish participants used the term (teşwîqê biguherinin) to describe their experience of change in temperament. We recognized that local terms that are used to describe participants' experience of suffering from depression represent not only a different language for describing symptoms, but also a system of making sense of suffering.

These findings indicate that tools developed in a particular country could only reflect the language and culture of that country, and using it in another location (even if accurately translated) may entail many problems due to the cultural incompatibility of its content (6). Standard tools are therefore required for eliminating the clear differences in the prevalence of depression between similar populations (12).

5.1. Conclusion

It is hoped the study findings will help in exploring various expressions of depression and providing a multidimensional construct to develop the culturally specific measurement of depression in three different ethnic groups. With a better measurement-screening tool, health care professionals will be more culturally competent to identify client's expressions of depression and early treatment can be provided. Moreover, researchers can also have accurate estimates of the prevalence of depression and perform meaningful group comparisons in cross-cultural or health disparities research. We believe that using a reliable and culturally valid instrument to assess depression is the first step for preventing and relieving depression because a person's culture influences his or her health, illness, and access to, and use of, health care services.

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Footnotes

Authors' Contribution: Masoumeh Dejman, Zohreh Mahmoodi and Arash Mirabzadeh collaborated in Study concept and design. Monir Baradaran Eftekhari and Katayoun Falahat collaborated in Acquisition of data. Mohsen Shati and Ameneh Setareh Forouzan collaborated in Analysis and interpretation of data. Zohreh Mahmoodi, Monir Baradaran Eftekhari, Ameneh Setareh Forouzan and Masoumeh Dejman Drafted the manuscript. Judy Bass collaborated in Critical revision of the manuscript for important intellectual content. Mohsen Shati collaborated in Statistical analysis.

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References

1. Milanovic SM, Erjavec K, Poljicanin T, Vrabcic B, Brecic P. Prevalence of depression symptoms and associated socio-demographic factors in primary health care patients. *Psychiatr Danub*. 2015;27(1):31-7. [PubMed: 25751429].
2. Kessler RC, Bromet EJ. The epidemiology of depression across cultures. *Annu Rev Public Health*. 2013;34:119-38. doi: 10.1146/annurev-publichealth-031912-114409. [PubMed: 23514317]. [PubMed Central: PMC4100461].
3. World Health Organization. *Global action plan for the prevention and control of noncommunicable diseases 2013-2020*. Geneva, Switzerland: WHO; 2013.
4. Mata DA, Ramos MA, Bansal N, Khan R, Guille C, Di Angelantonio E, et al. Prevalence of depression and depressive symptoms among resident physicians: A systematic review and meta-analysis. *JAMA*. 2015;314(22):2373-83. doi: 10.1001/jama.2015.15845. [PubMed: 26647259]. [PubMed Central: PMC4866499].
5. Sharifi V, Amin-Esmaili M, Hajebi A, Motevalian A, Radgoodarzi R, Hefazi M, et al. Twelve-month prevalence and correlates of psychiatric disorders in Iran: The Iranian mental health survey, 2011. *Arch Iran Med*. 2015;18(2):76-84. [PubMed: 25644794].
6. Kleinman A. Culture and depression. *N Engl J Med*. 2004;351(10):951-3. doi:10.1056/NEJMp048078. [PubMed: 15342799].
7. World Health Organization. *Integrating mental health into primary care: A global perspective*. Geneva, Switzerland: WHO; 2008. Contract No.: 0028-4793 1533-4406.
8. Lim N. Cultural differences in emotion: Differences in emotional arousal level between the East and the West. *Integr Med Res*. 2016;5(2):105-9. doi: 10.1016/j.imr.2016.03.004. [PubMed: 28462104]. [PubMed Central: PMC5381435].
9. Lindquist K, Gendron M, Satpute A, Barrett L, Lewis M, Haviland-Jones J. Language and emotion: Putting words into feelings and feelings into words. *Handbook of emotions*. 2016.
10. Saba Rasheed A, William Ming L, Majeda H. Islam 101: Understanding the religion and therapy implications. *Professional psychology: Research and practice*. 35. 2004. p. 635-42. doi:10.1037/0735-7028.35.6.635.

11. Douki S, Zineb SB, Nacef F, Halbreich U. Women's mental health in the Muslim world: cultural, religious, and social issues. *J Affect Disord*. 2007;**102**(1-3):177-89. doi: [10.1016/j.jad.2006.09.027](https://doi.org/10.1016/j.jad.2006.09.027). [PubMed: [17291594](https://pubmed.ncbi.nlm.nih.gov/17291594/)].
12. Lawal-Solarin FMW. Culture and depression. In: Weiner IB, Craighead WE, editors. *Corsini encyclopedia of psychology*. 2010. doi: [10.1002/9780470479216](https://doi.org/10.1002/9780470479216).
13. Davidian H. *Understand and treatment of depression*. Tehran: Academy of Medical Sciences of IR Iran; 2007.
14. Seifsafari S, Firoozabadi A, Ghanizadeh A, Salehi A. A symptom profile analysis of depression in a sample of Iranian patients. *Iran J Med Sci*. 2013;**38**(1):22-9. [PubMed: [23645954](https://pubmed.ncbi.nlm.nih.gov/23645954/)]. [PubMed Central: [PMC3642941](https://pubmed.ncbi.nlm.nih.gov/PMC3642941/)].
15. Regier DA, Kaelber CT, Rae DS, Farmer ME, Knauper B, Kessler RC, et al. Limitations of diagnostic criteria and assessment instruments for mental disorders. Implications for research and policy. *Arch Gen Psychiatry*. 1998;**55**(2):109-15. [PubMed: [9477922](https://pubmed.ncbi.nlm.nih.gov/9477922/)].
16. Ekblad S, Baarnhielm S. Focus group interview research in transcultural psychiatry: Reflections on research experiences. *Transcult Psychiatry*. 2002;**39**(4):484-500. doi: [10.1177/136346150203900406](https://doi.org/10.1177/136346150203900406).
17. Hsieh HF, Shannon SE. Three approaches to qualitative content analysis. *Qual Health Res*. 2016;**15**(9):1277-88. doi: [10.1177/1049732305276687](https://doi.org/10.1177/1049732305276687).
18. Betancourt TS, Speelman L, Onyango G, Bolton P. Psychosocial problems of war-affected youth in Northern Uganda: A qualitative study. *Transcult Psychiatry*. 2009;**46**(2):238-56. doi: [10.1177/1363461509105815](https://doi.org/10.1177/1363461509105815).
19. Bolton P, Neugebauer R, Ndogoni L. Prevalence of depression in rural Rwanda based on symptom and functional criteria. *J Nerv Ment Dis*. 2002;**190**(9):631-7. doi: [10.1097/01.NMD.0000030568.45847.AE](https://doi.org/10.1097/01.NMD.0000030568.45847.AE). [PubMed: [12357098](https://pubmed.ncbi.nlm.nih.gov/12357098/)].
20. Kleinman A, Eisenberg L, Good B. Culture, illness, and care: Clinical lessons from anthropologic and cross-cultural research. *Focus*. 2006;**4**(1):140-9. doi: [10.1176/foc.4.1.140](https://doi.org/10.1176/foc.4.1.140).
21. Snowden LR, Yamada AM. Cultural differences in access to care. *Annu Rev Clin Psychol*. 2005;**1**(1):143-66. doi: [10.1146/annurev.clinpsy.1.102803.143846](https://doi.org/10.1146/annurev.clinpsy.1.102803.143846).
22. Jordans MJ, Tol WA, Komproe IH, De Jong JV. Systematic review of evidence and treatment approaches: Psychosocial and mental health care for children in war. *Child Adolesc Ment Health*. 2009;**14**(1):2-14. doi: [10.1111/j.1475-3588.2008.00515.x](https://doi.org/10.1111/j.1475-3588.2008.00515.x).
23. Jordans MJ, Komproe IH, Ventevogel P, Tol WA, de Jong JT. Development and validation of the child psychosocial distress screener in Burundi. *Am J Orthopsychiatry*. 2008;**78**(3):290-9. doi: [10.1037/a0014216](https://doi.org/10.1037/a0014216). [PubMed: [19123748](https://pubmed.ncbi.nlm.nih.gov/19123748/)].
24. Kohrt BA, Jordans MJ, Tol WA, Luitel NP, Maharjan SM, Upadhaya N. Validation of cross-cultural child mental health and psychosocial research instruments: Adapting the depression self-rating scale and child PTSD symptom scale in Nepal. *BMC Psychiatry*. 2011;**11**(1):127. doi: [10.1186/1471-244X-11-127](https://doi.org/10.1186/1471-244X-11-127). [PubMed: [21816045](https://pubmed.ncbi.nlm.nih.gov/21816045/)]. [PubMed Central: [PMC3162495](https://pubmed.ncbi.nlm.nih.gov/PMC3162495/)].
25. Desjarlais R. *World mental health: Problems and priorities in low-income countries*. USA: Oxford University Press; 1995.
26. Sadock BJ, Sadock VA, Ruiz P. *Comprehensive textbook of psychiatry*. 2000.
27. Koroglu, E. Major depression. In: Koroglu, E, Gulec, C, editors. *Psychiatry Basic Book*. 2nd ed. 2007. p. 240-65. Turkish.