



Cultural Reflections of the Expressions of the Anxiety of Patients with Generalized Anxiety Disorder

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ABSTRACT

Objective: Cultural factors in the biopsychosocial context have a significant impact on the outward reflection of the symptoms associated with mental state. One of the important characteristics of traditional societies is that they are prone to express their spiritual problems with body language. In this study, we aimed to guide the physicians in the diagnosis stage by considering the expressions of complaints of patients who have been diagnosed with generalized anxiety disorder, which is common in psychiatric outpatient clinics, in a society where traditional and cultural characteristics predominate.

Methods: This retrospective descriptive study was carried out on 50 consecutive patients diagnosed with generalized anxiety disorder referred to Harran University Medical School Psychiatric Outpatient Clinic.

Results: The patients who participated in the study stated their complaints via 33 different expressions, 15 of which were physical in nature (46%), 12 were emotional in nature (36%), and the remaining 6 (18%) were related to the cognitive field. The frequencies of the expressions were most frequent for emotional symptoms (92%), followed by physical symptoms (76%) and cognitive symptoms (44%). Although the frequency of reporting for physical symptoms was significantly higher in females ($p<0.05$), the frequency of reporting for cognitive symptoms was significantly higher in males ($p<0.05$). Reported frequency for emotional expressions did not differ according to gender status.

Conclusion: As a result, cultural factors affect the way in which anxiety is expressed in individuals with generalized anxiety disorder, especially with the diversity of somatic expressions.

Keywords: Generalized anxiety disorder, forms of expression of anxieties, cultural characteristics

Introduction

Generalized anxiety disorder (GAD) is a chronic and quite common disease characterized by uncontrolled extreme anxiety, chronic anxiety and tension (1). Generally, GAD is associated with a number of physical symptoms that cause significant deterioration in daily social and occupational functioning (2, 3). In addition to a variety of cognitive and emotional anxiety symptoms, it is characterized by autonomic nervous system (ANS) symptoms, including hot flash, palpitation, sweating, and tremors (2, 4).

GAD is common in both community and health institutions. In the epidemiological studies of national representative samples in the United States, the lifetime prevalence of GAD was found between 5.1% (5-7) - 11.9% (5, 8).

In a study reviewing epidemiological studies in Europe, the 12-month prevalence was 1.7-3.4% (5, 9) and lifetime prevalence was found between 4.3-5.9% (5, 10). Although it is common and causes many disorders, GAD is still not a well-known disease (11). Factors such as biological factors, neuropsychological factors,

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Cite this article as: Asoğlu M, Kara İ, Pirinççioğlu F, Göbelek M, Çelik H, Takatak H, et al. Cultural Reflections of the Expressions of the Anxiety of Patients with Generalized Anxiety Disorder. *Bezmialem Science* 2018; 6(4): 242-7.

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Bezmialem Science published by Galenos Publishing House.

Received: 31.07.2017

Accepted: 24.08.2017

developmental and personality factors, and excessive alarming cognitive structuring are involved in its etiopathogenesis. Major depression and other anxiety disorders are common diseases with GAD (5).

In the biopsychosocial context, cultural factors have a significant impact on the external reflection of the symptoms associated with the mental state (12). The relationship between culture and psychopathology has been a subject that has been emphasized in recent years with the development of research tools of cross-cultural psychiatry. The cultural context is considered to be effective in many areas, from the form of expression of diseases to its course and prognosis (13). One of the important features of traditional societies is to express their mental problems by body language (14). In this context, GAD patients tend to express their complaints in parallel with cultural characteristics (15). Family relationships in the eastern part of Turkey are against the individual when compared to the western part of Turkey. Mental problems cannot be expressed verbally, but are often manifested as bodily symptoms (16). Our province Sanliurfa located in southeastern Turkey has a good potential for cultural psychiatry studies being a city with its traditional family structure where different languages are spoken and different cultures live together (17).

This study was carried out in a community having dominant traditional and cultural features in order to guide the physicians in the diagnosis stage by handling the way of expression of the GAD diagnosed patients' complaints,

Methods

The ethics committee approval of this study was taken by Harran University Faculty of Medicine Ethics Committee's decision dated 01/09/2016 and numbered 07. The study was a descriptive study on the files of patients who was admitted to Harran University Medical Faculty Psychiatry Polyclinic between January 2015 and December 2016. In our outpatient clinic, an experienced psychiatrist asks the patients the question of "What are your complaints?" and the statements taken from the patients are written on the outpatient clinic file without changing the statements. After the patient's own expressions, according to the Diagnostic and Statistical Manual of Mental Disorders -5 (DSM-5) criteria, questions that are missing for possible diagnosis are asked by the same clinician and diagnosis / diagnoses are made and treatment of the patient is planned. The diagnosis of the patients was made according to the following DSM-5's GAD diagnostic criteria:

A- There is an extreme anxiety and delusion (anxious expectation) regarding most events or activities (such as success at work or school) on most days of at least six months.

B- The person has difficulty in controlling his delusions.

C- This anxiety and delusion is accompanied by three (or more) of the following six symptoms (at least some symptoms were found on most days of the last six months):

- 1- Not being able to calm down (discomfort), or feeling constantly restless,
- 2- Easily getting tired,
- 3- Difficulty in focusing or mind discharge,
- 4- Getting angry easily,
- 5- Muscle tension,
- 6 - Sleep disturbance (having difficulty of falling asleep and sleep maintenance or having a non-relaxing and non-satisfying sleep).

D- Anxiety, delusions or physical symptoms cause clinically significant distress or decline in functionality in social, work-related areas or other important functionality areas.

E- This disorder cannot be attributed to the physiology-related effects of a substance (eg an abusable substance) or another health condition (eg hyperthyroidism).

F- This disorder cannot be better explained with another mental disorder (18).

In our study, retrospective file scanning method was used and it was possible to determine the words of the applicants who expressed themselves from the file records. The complaints expressed after the questions asked by the psychiatrist were not included in this study. In the patients included in the study, the diagnosis of GAD was clinically based on the presence of an anxious mood. Patients diagnosed clinically with GAD, other DSM-5 axis-1 and axis-2 and patients with any physical disease were excluded from the study. The files of 50 consecutive patients with GAD were retrospectively reviewed and the patients' own statements were determined.

Statistical analysis

In the files of 50 patients included in the study, the statistical evaluation of the data of sociodemographic and clinical variables such as age, gender, and marital status, as well as the patient's own complaints, were made by using IBM SPSS version 23.0 Windows (IBM Statistical Package for the Social Sciences Statistics; Armonk, NY, USA). Chi-square method was used in the analyzes. Paired Sample T Test was used to compare the variables. The level of statistical significance was accepted as $p < 0.05$.

Results

Of the 50 participants, 70% were women and 30% were men. Their ages were between 18 and 55 and the mean age was 30.94 ± 8.08 years. 70% of these people were married, 26% were single and 4% were divorced. In terms of expression diversity, 50 patients who participated in the study stated their complaints in 33 different expressions and some of the complaints were common statements. Of these different expressions, 15 were related to physical (46%), 12 to emotional (36%), and the remaining 6 (18%) were related to cognitive domain (Table 1). The frequency of expressions was observed as emotional symptoms (92%) as the most frequent, somatic symptoms (76%)

as the second most frequent and cognitive symptoms (44%) as the third most frequent expressions.

The stated emotional expressions were nervousness (50%), anxiety (34%), intolerance (28%), fear (24%), distress (24%) (Table 2), anxiety (4%), crying (4%), startle (2%), tension (2%), anger (2%), remorse (2%) and restlessness (2%). The physical symptoms of the patients were insomnia (20%), tremor (12%), dizziness (10%), palpitations (8%), non-breathing (8%) (Table 2), headache (6%), loss of appetite (6%), chest pain (4%), malaise (2%), nightmare (2%), knotting (2%), sleepwalking (2%), blushing (2%), sweating (2%) and stomach pain (2%) respectively. The stated cognitive symptoms were bad thinking (20%), fear of death (10%), instability (6%), absence(4%), non-socialization (4%) (Table 2) and the desire of loneliness (2%).

As seen in Table 3, there is no significant difference between emotional, physical and cognitive expressions, marital status and age groups ($p > 0.05$). While bodily expressions were significantly higher in women ($p < 0.05$), the frequency of reporting cognitive expressions was significantly higher in men ($p < 0.05$). The frequency of reporting emotional expressions did not differ according to gender.

Table 1: Diversity of Expressions

Different Expressions	% (number)
Somatic	46 (15)
Emotional	36 (12)
Cognitive	18 (6)
33 different expressions in total	

Table 2: Descriptive frequency information for emotional, physical and cognitive expressions (n=50)

	Emotional	Somatic	Cognitive
First 5 expressions	Nervousness (50%)	Insomnia (20%)	Bad thinking (20%)
	Anxiety (34%)	Tremor (12%)	Fear of death (10%)
	Intolerance (28%)	Dizziness (10%)	Instability (6%)
	Fear (24%)	Palpitation (8%)	Absence (4%)
	Distress (24%)	Non-breathing (8%)	Non-socialization (4%)

n: number of patients, Note: Some of the expressions taken from the patients are common expressions

Table 3: Frequency of expressions according to demographic and social variables (%)

Variables	Emotional	Somatic	Cognitive
Gender			
Female	91.4	85.7*	28.5*
Male	93.3	53.3*	80*
Marital status			
Married	91.4	80	26.6
Single	93.3	74.2	22.8
Age			
Below the age of 30	90.9	77.2	50
Above the age of 30	92.8	75	39.2

* $p < 0.05$. Data are given as %

Discussion

In terms of expression diversity, 50 patients who participated in the study stated their complaints in 33 different expressions and some of the complaints were common statements. Of these different expressions, 15 were related with physical (46%), 12 were emotional (36%) and the remaining 6 (18%) were related to cognitive domain. In the GAD DSM-5 diagnostic criteria, there are only 15 different expressions of anxiety expressions (18,19). According to DSM-5, this difference of our different expression scores may be due to the influence of cultural factors.

Zhou et al. (20), in their study reported that there may be significant differences in the cultural understanding of depression and anxiety in both Chinese and Western sources. In addition to the psychological symptoms of stress, the differences in the bodily complaints are a fundamental issue in cultural psychopathology. The best-known example of this is the expression of depression in the emergence of depression by bodily symptoms in the Chinese society compared to the Western European Society. A study by Cimilli (15) and other studies on people living in societies in the process of modernization show that somatoform disorders, which are some kind of somatized form of anxiety, are widespread. Furthermore, in a study by Kleinman (14), he states that traditional societies tend to express their spiritual problems in body language.

High expression diversity, being mainly bodily expressions, supports the studies of Zhou et al. (20), Cimilli (15) and Kleinman (14). In a study by Kirmayer (21), however, contrary to the claim that non-Westerners tend to somatize their problems, recent research has indicated that somatization is everywhere.

According to the frequency of statements, patients expressed their complaints with irritability (50%), anxiety (34%), intolerance (28%), fear (24%) and distress (24%). In the Turkish Dictionary of the Turkish Language Association, the word of "irritability" is defined as "the state of being angry, act angrily, irritability" (22). In the English version of DSM-5, the closest meaning is "irritability" (19) and in the Turkish version it is "easy to get angry" (18). As can be seen, the same concept can be expressed in a different word with the influence of cultural elements.

As a matter of fact, Lee et al. (23), in a study of the multiethnic Singapore population, stated that cultural traits are likely to play a role in both the prevalence of generalized anxiety disorder and the emergence of anxiety symptoms.

In addition, in a study of Parkerson et al. (24) who examined the relationship between culture and GAD, GAD-7 scale which is a popular measure of GAD symptoms used in many cultural groups, has been evaluated in many different cultures. In this study, it is stated that the available evidence shows that the prevalence of GAD is different between the self-identifying ethnic / cultural groups, but this difference is attributed to the error of intercultural measurement rather than the actual differences in GAD rates. Again, this study showed that Black / African American participants with high GAD symptoms had lower scores of GAD-7 compared to other participants with similar GAD symptoms, and pointed out that there should be culturally sensitive GAD screening tools.

Yanik et al. (25) in the study of the people who were diagnosed with major depression in Şanlıurfa, the frequency of reporting emotional, physical and cognitive expressions did not differ significantly according to gender and age groups ($p > 0.05$). However, while cognitive expressions were significantly higher in single individuals compared to married individuals ($p < 0.05$), the frequency of reporting emotional and bodily expressions did not differ according to marital status ($p > 0.05$).

In our study, emotional, physical and cognitive expressions, do not show a significant difference according to marital status and age groups. While bodily expressions were significantly higher in women, the frequency of reporting cognitive expressions was significantly higher in men. The frequency of reporting emotional expressions did not differ according to gender. This partial difference between the two studies may be due to the fact that, in the same culture, one study was performed in depression and the other in GAD.

Besides, in a thesis study with the title "Way of Expression of Depression of Persons Diagnosed with Major Depression" conducted in İstanbul Bakırköy Dr. Mazhar Osman Mental Health and Neurological Diseases Education and Research Hospital, it was found that women expressed their complaints about emotional, physical and cognitive domains almost 6 times higher than men (26). This difference may mean that women express their complaints more comfortably in a region with a higher socio-cultural level than Şanlıurfa.

In the study of Yanik et al. (25), the most common complaints have been found to be related to the emotional field (96%); secondly, bodily expressions (87%) and least frequently (40%) related to cognitive domain (44%). Similarly, in our study, GAD patients expressed their complaints in the emotional area at a rate of 92%, in the physical area at a rate of 76% and in the cognitive area at a rate of 44%. This similarity may be due to the fact that patients with GAD and major depression having a quite high comorbidity with the same cultural characteristics express their complaints similarly.

Uluşahin et al. (27) have made the comparison of the symptom pattern between cultures by giving the same scales to the depression patients in Turkey and England. Although there were a common set of core symptoms (loss of interest, lack of pleasure, inability to work, inability to respond, suicidal ideation) among the cultures, it was found that the core symptom scores in the UK sample were high and the bodily symptom scores were low; and somatization, exaggeration of symptoms and self-pity was found to be high in Turkey sample. In addition to this, in the Turkey part of the study of "Mental Disorders in Primary Health Care" conducted by the World Health Organization it was found that while 60% of the patients with depressive disorder presented with somatic complaints, 24% of them presented with psychiatric complaints (28).

In our study, in terms of frequency of complaints the most common complaints were emotional expressions and the second most common complaints were somatic. However, in terms of expression diversity the most common complaints were somatic. Women in particular tend to somatize their complaints more than men (26). In our study, women's expressing bodily symptoms were found to be significantly higher than males.

The way of anxiety expression of people living in our region do not fully comply with the diagnostic criteria of DSM-5. Our study results, however, do not mean that the DSM-5 GAD criteria do not apply to our patient group. This study is not intended to defend such a claim. This is not the result of our study results. This study was conducted to provide guidance to physicians in the stage of diagnosis by addressing the way of expression of patients diagnosed with GAD which is frequently seen in psychiatric outpatient clinics in a society that has traditional and cultural characteristics (17). To say that "The DSM system does not apply to people in the region, unless the diagnostic criteria for these patients are established" would mean leaving clinicians without a guide. This may cause more harm than expected. In conclusion, in this study, physicians who diagnosed GAD were oriented towards DSM and diagnosis were clinically made according to DSM-5 criteria.

Limitations of the Study

This study carries the limitations of the study method of retrospective file screening. The clinical diagnosis of GAD was not supported by a test that could help with the diagnosis. Another limitation of the study is that the patient group is composed of patients presenting to the outpatient clinic. It is known that those followed in outpatient clinics are lighter in

terms of psychopathology than inpatients. Comparing the anxiety of the GAD inpatients with more severe psychopathology compared with the outpatients is a candidate for a new research topic. Another limitation of the study is that it was conducted with a small sample.

Conclusion

Our study shows that cultural factors, especially in terms of the variety of bodily expressions, have affected the way they express their anxiety in patients with generalized anxiety disorder. Physiological symptoms serve as cultural expressions of distress in many ethnocultural groups and, if misinterpreted by the clinician, may lead to unnecessary diagnostic procedures or inappropriate treatment. Culture-specific symptoms may lead to misunderstanding or misidentification of psychological distress. Clinicians should not only know the index of disease or disorder but also the meaning of somatic and dissociative symptoms, which are part of the distress language (20).

The physicians other than mental health and diseases specialists, especially the physicians who provide basic health services, should be made aware of the recognition of GAD patients because of the prevalence of generalized anxiety disorder as a problem concerning public health and since patients are admitted by non-psychiatric doctors because of the somatic symptoms of anxiety and accordingly encountering more frequently in the centers of primary health care.

It may be sometimes difficult to place the symptoms expressed by the patients into which diagnostic category when trying to diagnose the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). In this case, it will be more realistic for physicians to make a diagnosis in the DSM-5 orientations when they make a diagnosis, taking into consideration the traditional, religious and cultural orientations of the society.

It is an undeniable fact that healthcare providers should evaluate patients by taking into account their different cultural origins in order to understand the patients and help them. Due to this reality, our study is thought to guide the health service providers in the diagnosis and treatment phase. In culturally dominant regions such as Şanlıurfa (17), cultural psychiatric studies should be given more importance. This study is a preliminary study and we hope that it will inspire researchers for further studies.

Ethics Committee Approval: Ethics committee approval was received for this study from the ethics committee of Harran University School of Medicine (01.09.2016/07).

Peer-review: Externally peer-reviewed.

Author Contributions

Concept - M.A.; Design - M.A.; Supervision - M.A.; Resources - İ.K.; Materials - İ.K.; Data Collection and/or Processing - İ.K., F.P.; Analysis and/or Interpretation - H.Ç., M.A.; Literature Search - H.T., M.A.; Writing Manuscript - M.A., İ.K.; Critical Review - H.Ç., M.G., Ş.B.

Acknowledgements: Thanks to Prof. Dr. Medaim Yanık who have inspired us to making this study.

Conflict of Interest: The authors have no conflicts of interest to declare.

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