



## A QUALITATIVE EXPLORATION OF VOICE ORIENTED QUALITY OF LIFE IN IRANIAN PATIENTS: A CULTURAL EXPLANATION

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### ABSTRACT

**Purpose:** The phrase "health-related quality of life" (HRQOL) refers to patients' perceptions of the influence of disease and treatment on their physical, psychological, and social function. Also, cultural aspects should be taken into account when evaluating quality of life and should be considered in related surveys. In the current study, the most prominent voice-related QOL dimensions, including culture-based items in Iranian individuals was examined.

**Methods:** A convenience sample (n= 23) of adults was interviewed addressing voice related quality of life areas. Participants consisted of 15 people (13 men and 2 women) over 18 years with voice disorders lasting at least 6 months with mean age 41.46±16.06, 3 people (2 men and 1 woman) with mean age 47.66±6.65 who worked as radio broadcasters with over 20 years of experience in the field, and 5 experienced specialists in voice disorders (3 speech therapists and 2 otolaryngologists). A semi-structured interview method was used. The components of voice quality of life based on the interviews were extracted by a fourteen stage process content analysis.

**Results:** Many of the extracted components were common to both the interviews and those found in the relevant literature and some of them are new. Some of the new components appear to fit best under the category of "cultural". Eleven cultural elements are "religious beliefs in disease tolerance and promotion of quality of life", "More support expectation from family", "Fear about pain and thinking about serious problems (such as Cancer)", "Throat strain results in more disappointment", "Fatalism in coping with problem and promotion of Quality of life", "Traditional home remediation", "Hope for spontaneous recovery", "Discrimination because of sound problems", "Pain and globus sensation as a factor in finding remediation more quickly", "Negative judgments", "Negative thoughts about people with voice disorders". These elements appear to have a potentially strong effect on health quality of life especially in the voice domain.

**Conclusions:** Relative to the development of a Quality of Life questionnaire for voice, important cultural components of Iranian patients were identified in the current study. Identifying these components may help Iranian voice clinicians obtain a more accurate understanding of health-related quality of life aspects within the Iranian culture. This may lead to more effective remediation for voice patients.

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### Introduction

Health-related quality of life (HRQOL) refers to patient- perceived impact of disease and treatment on physical, psychological, and social function [1]. Voice disordered quality of life (VDQOL) is a disease-specific construct that assesses activity limitations and participation restrictions. The use of quality of life (QOL) measures in the area of voice disorders has earned some interest in the last decade as part of routine clinical voice evaluations. A QOL questionnaire is one way to assess the overall outcome of the physical, mental, and social well-being of a patient following a health-related problem [2]. In other words, instruments for assessing HRQOL and VDQOL can be used to measure the longitudinal changes of patients' beliefs before and after intervention. Because of thoroughness of voice assessments, various quality of life instruments have been developed for voice disordered populations. Nearly all of quality of life testes in VDQOL domain were developed for Western cultures and some of them have been translated into other languages. [2]. Although the psychometric properties of translated versions have been reported, only limited information on the possible cultural differences in the perception of the impact of

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dysphonia on the quality of life are reported [3]. As is shown in Table 1, there are some general universal surveys about voice related quality of life.

**Table1.** Descriptive data of questionnaires

Measure	Target population	Number of scales	Number of items	Range of scores	Studied population	References
VHI	Patients with voice disorders	3 (functional, physical and emotional)	10	0-40	All domain of voice disorders	4
VRQOL	Patients with voice disorders	2 (physical-functioning/social-emotional)	10	0-100	All domain of voice disorders	5
VOS	Patients with vocal cord impairment	1	5	0-100	Patients with unilateral vocal cord paralysis	6
VAPP	Patients with voice disorders	5 (self-perceived severity of voice problem, effect on job, effect on daily communication, effect on social communication) and effect on emotion)	28	0-280	Patients with voice disorders	7
VoiSS	Patients with voice disorders	impairment, emotion, and related physical symptom	44	0-120	Patients with voice disorders	8
Voice-DOP	Patients with voice disorders	3 (physical, emotional, functional (job, daily communication, social communication)	32	100 mm	Patients with voice disorders	2

It is reasonable to hypothesize that people from different cultures perceive health problems differently, and in particularity the extent to which the problem impacts their lives. According to Samovar and Porter (1994), culture refers to the cumulative deposit of knowledge, experience, beliefs, values, attitudes, meanings, hierarchies, religion, notions of time, roles, spatial relations, concepts of the universe, and material objects and possessions acquired by a group of people in the course of generations through individual and group striving [9]. Also, cross-cultural differences of health, illness, and disability perceptions have been documented in the literature [10,11]. Kruschke et al. (2005) reported that the cultural background of an individual may influence the manner in which a person experiences a voice disorder [12]. Boone et al. (2013) noted that the experiences of patients across populations with different cultures may be very different[13].

Thus, there is reasonable justification to support the notion that the perceptions of a disability regarding its effect on work, social, and daily activities of an individual in the population of less-developed countries may be different from those of highly developed Western countries [2]. For example, Prakash et al. (2008) performed a survey in India (as an Eastern culture) with 400 Indian professional voice users (politicians, singers, teachers, and vendors). Results revealed that more than 50% of them do not seek consultation or remediation for their voice problems or will wait for more than one week to do so; even though 86% of the politicians, 74% of the vendors, 59% of the singers, and 49% of the teachers reported having history of voice problems. Moreover, 48% of the politicians and 44% of the vendors reported periods of voice problems at intervals of less than one week. 84% of the subjects reported that they had to use traditional home remedies such as honey, milk with pepper, ginger, or turmeric, and herbal medicines for their voice problems and did not seek treatment[14]. Another form of cultural difference between East and West cultures can be shown in pain tolerance. Nayak et al. (2000) showed that participants from India have a higher pain tolerance than those lives in the United States and possessing the ability for low expression of overt

pain expression [15]. In summary, cultural aspects should be taken into account when evaluating quality of life in questionnaires.

In this study, the most prominent voice-disordered QOL cultural dimensions in Iranian individuals as a part of East culture and as a religious country was extracted. Iran is an Eastern and Muslim country and has its own values that are very different with western countries. So, developing QOL instruments that especially measures Health related quality of life component based on the mentioned values can help specialists in Health domain to get better understanding about this important component and apply better and more effective remediation in Iranian population. These will be presented and followed by a discussion of cultural aspects of voice quality of life and other issues around the voice quality of life in this country.

### Methods

Twenty-three adult Persian-speaking individuals as a convenient sample took part in this project, including 15 people (13 men and 2 women) over 18 years old with voice disorders lasting at least 6 months with mean age  $41.46 \pm 16.06$ , 3 people (2 men and 1 woman) with mean age  $47.66 \pm 6.65$  who work as radio broadcasters with over 20 years of experience of in the field, and 5 voice disorder specialists (3 speech therapists and 2 otolaryngologists) with five years or more experience in the field. Demographic characteristics of the patients are shown in Table 2.

**Table2.** Demographic characteristics of the patients who participated in the interview

Number	Occupation	Diagnosis	Sex	Age	Duration
1	Tailor	Sulcus vocalis	Female	36 yrs	4 yrs
2	Businessman	Polyp	Male	29 yrs	3 yrs
3	Singer	Polyp	Male	40 yrs	3 yrs
4	Barber	MTD	Male	19 yrs	2 yrs
5	Shopkeeper	Polyp	Male	24 yrs	2 yrs
6	Student	MTD	Female	18 yrs	2yrs
7	Farmer	MTD	Male	52 yrs	2 yrs
8	Lawyer	MTD	Male	48 yrs	2 yrs
9	Businessman	MTD	Male	50 yrs	1 yrs
10	Army retired	Cancer	Male	51 yrs	2 yrs
11	Singer	Polyp	Male	41 yrs	7 months
12	Homemaker	Reinke's edema	Female	68 yrs	1 yrs
13	Army officer	Nodule	Male	43 yrs	1 yrs
14	Retired Teacher	Cancer	Male	72 yrs	6 months
15	Employee	MTD	Male	31 yrs	1.5 yrs

Patients were selected from the ENT ward of Hospital. Also, it should be noted that one of the limitations of the current study was samples that were dominated by male participants. This limitation has several causes: one cause was that most of the voice disorders are related to the patients' primary occupations as non-singers, but also to their second occupation as singers of religious mourning, resulting in male participants being the dominant population. In addition, most of the patients in the ENT wards are male rather than female, and this realization has a cultural aspect. In Iran, women are less likely to see a doctor only for a voice problem. For example, one of female participants who was 68 years old with a Reinke's edema diagnosis was admitted one year after her problem started. Based on the indicated limitations, we had only 2 females who had the required qualification for participation in the study. The interview framework was semi-structured. This method of interview generally has a framework of themes to be explored and is topical, information- rich conversations performed with an open framework that provides two way communications. Interviewing was done in the speech therapy office of the hospital. The duration of the interviews was variable from 45 to 60 minutes in order to reach the saturation point. All interviews were recorded using a

Samsung voice recorder. The interview recordings were transcribed. Key points in the interviews were impact of voice disorder on the patients' life, relationships (personal and social), vocational status, self-confidence, economic status and income, physiological status, family behaviors, expectations for spontaneous recovery, pain tolerance and opinion of patients about influence of fatalism and spirituality on voice problem. Questions of interview are presented in Appendix A. Thematic content analysis was performed based on a fourteen stage process as suggested by Burnard (1991)[16]. In this thematic content analysis method, the first stage is writing memos after each interview to help categorize the information later on. Stage 2: immersion into the interviews by reading through the transcripts again and again while taking notes. Stage 3: reading through the transcripts, generating headings and categories, and making notes throughout the transcripts. Stage 4: listing the categories. Stage5: developing a refined list for categories and subheadings. Stage6: validating the categories by asking two colleagues to read through the transcripts and independently determining categories. Stage 7: reading the transcripts alongside the agreed list of categories to ensure that the categories covered all aspect of the interviews. Stage 8: reviewing the transcripts against the agreed category list and subheadings by using colour highlighting pens to distinguish each category and the sections of the transcripts related to it. Stage 9: sectioning the transcripts according to the coding categories and collecting each coded section in files. Stage 10: pasting the chosen sections onto sheets with categories and sub categories headings. Stage 11: asking the selected respondents to check the appropriateness of the category system. Stage 12: checking whether the quotations fit with the categories and keeping all the complete interviews and all sections in a file together for direct reference. Stage 13: writing up the process, starting section by section. Stage 14: deciding whether or not to write the findings with or without a discussion. As Burnard (1991) suggested, thematic content analysis method aims to produce a detailed and systematic recording of the themes and issues together under a reasonably exhaustive category system and since the aim of the present study was to obtain a comprehensive and exhaustive cluster of categories [16], this method was chosen. It should also be noted, the technique has been used extensively in Health related researches [17].

**Results and Discussion**

Factors, definitions, and components of voice related quality of life based on the literature are shown in Table 3.

**Table 3.** Factors, definitions and components of voice related quality of life based on the literature

Factor		Definition	Component example	References
Physical		Physical responses to the disorder	Short breath/trouble in speaking loudly/trouble using telephone, hoarse voice, ...	2;4; 5; 6; 18;19;20
Emotional		Emotional responses to the disorder	Ashamed because of voice, frustration, upset, depression, ...	2;4;5;7; 18;19;20
Functional	Vocation	Functional responses related to vocation because of disorder	Trouble in Job, lose income, Frequent job changing, ...	2;5;7;19;20
	Daily Communication	Functional responses related to daily communication because of disorder	Avoiding speaking to people, ask to speak louder, repeat speaking, ...	2; 4; 7
	Social Communication	Functional responses related to social communication because of disorder	Trouble in social activities, restriction of personal and social life,	2; 4; 5; 7; 8;19,20

Components that were extracted from the interviews are listed in Table 4. Also, the frequency of each component in the interviews and in the literature is reported in this table. The components were categorized into 4 dimensions: Physical, Emotional, Functional (job, daily and social communication) and Cultural. Literature – based definitions of these factors are listed in table 3.

**Table 4.** Components and domains of voice related quality of life in Iranian patients

Component	Domain	Frequency	References	F*
	Physical	Professionals	5	23

Trouble in speaking using phone		Clients	15	
		Literature	2;4;5	
Trouble in speaking loudly	Physical	Professionals	5	24
		Clients	15	
		Literature	2;4;5;19	
Sore throat	Physical	Professionals	3	14
		Clients	8	
		Literature	2;19;20	
Globus sensation	Physical	Professionals	5	15
		Clients	9	
		Literature	19	
Tired sensation in speaking a long time	Physical	Professionals	5	19
		Clients	13	
		Literature	2	
Throat clearing	Physical	Professionals	5	15
		Clients	9	
		Literature	19	
Throat dryness	Physical	Professionals	5	15
		Clients	9	
		Literature	19	
Strain to produce voicing	Physical	Professionals	5	20
		Clients	10	
		Literature	2;4;6;19;20	
Short breaths	Physical	Professionals	5	24
		Clients	15	
		Literature	2;4;5;19	
Headache during speaking	Physical	Professionals	0	3
		Clients	3	
		Literature	0	
Keeping voice during speaking	Physical	Professionals	4	22
		Clients	15	
		Literature	4;19;20	
Phlegm in throat (larynx)	Physical	Professionals	4	13
		Clients	8	
		Literature	19	
Variation of voice production throughout the day	Physical	Professionals	5	23
		Clients	15	
		Literature	2;4;19	
Nervousness	Emotional	Professionals	3	14
		Clients	10	
		Literature	19	

Fear	Emotional	Professionals	0	6
		Clients	6	
		Literature	0	
Lack of self confidence	Emotional	Professionals	5	24
		Clients	18	
		Literature	2	
Lack of self-expression	Emotional	Professionals	3	12
		Clients	9	
		Literature	0	
Embarrassment	Emotional	Professionals	4	22
		Clients	15	
		Literature	2;7;19	
Lack of Calm	Emotional	Professionals	5	19
		Clients	13	
		Literature	19	
Loneliness	Emotional	Professionals	3	12
		Clients	8	
		Literature	19	
Mocked by others	Emotional	Professionals	4	18
		Clients	14	
		Literature	0	
Disappointment	Emotional	Professionals	3	11
		Clients	6	
		Literature	5;19	
Impatience and reluctance to respond to others	Emotional	Professionals	3	16
		Clients	13	
		Literature	0	
Anxiety and concern	Emotional	Professionals	4	21
		Clients	12	
		Literature	2;4;5;7;19	
No hope for the future	Emotional	Professionals	0	5
		Clients	5	
		Literature	0	
Humiliation	Emotional	Professionals	0	1
		Clients	1	
		Literature	0	
Depression	Emotional	Professionals	5	22
		Clients	13	
		Literature	2;5;7;19	
Increase of Aggression	Emotional	Professionals	3	15
		Clients	12	
		Literature	0	
Irritability	Emotional	Professionals	0	7
		Clients	7	
		Literature	0	
Inefficiency	Emotional	Professionals	5	25

		Clients	18	
		Literature	4;19	
Change of personality	Emotional	Professionals	4	7
		Clients	2	
		Literature	7	
Rejection	Emotional	Professionals	4	16
		Clients	12	
		Literature	0	
Not taken seriously by others	Emotional	Professionals	0	1
		Clients	1	
		Literature	0	
Interference in job performance	Functional (vocational)	Professionals	5	27
		Clients	18	
		Literature	2;6;7;19	
Losing job	Functional (vocational)	Professionals	5	27
		Clients	18	
		Literature	2;6;7;19	
Decreasing income	Functional (vocational)	Professionals	5	26
		Clients	18	
		Literature	2;4;20	
Job promotion obstacle	Functional (vocational)	Professionals	3	16
		Clients	13	
		Literature	0	
Loss of communication	Functional (Daily communication)	Professionals	4	18
		Clients	14	
		Literature	0	
Avoidance of speaking	Functional (Daily communication)	Professionals	4	18
		Clients	12	
		Literature	2;7	
Being misunderstood when speaking	Functional (Daily communication)	Professionals	4	14
		Clients	10	
		Literature	0	
Difficulty in understanding of speaking	Functional (Daily communication)	Professionals	4	22
		Clients	13	
		Literature	2;4;5;7;20	
Indifference to asking in various status	Functional (Daily communication)	Professionals	3	13
		Clients	10	
		Literature	0	
Given requests to speak louder	Functional (Daily communication)	Professionals	5	15
		Clients	9	
		Literature	2	
Given requests to speak more intelligibly	Functional (Daily communication)	Professionals	5	14
		Clients	9	
		Literature	0	
Inability to speak in crowded environments	Functional (Daily communication)	Professionals	5	19
		Clients	12	
		Literature	2;7	

Decrease in participating in social activities	Functional (Social communication)	Professionals	5	21
		Clients	12	
		Literature	2;6;7;19	
Annoying the audiences	Functional (Social communication)	Professionals	5	17
		Clients	10	
		Literature	2;7	
Avoid of speaking in public	Functional(Social communication)	Professionals	5	12
		Clients	5	
		Literature	2;7	
Decreasing partnership in family decisions	Functional (Social communication)	Professionals	0	4
		Clients	4	
		Literature	0	
Difficulty in finding new friends and experiencing losing old friends	Functional (Social communication)	Professionals	0	8
		Clients	8	
		Literature	0	
<b>Religious beliefs in disease tolerance and promotion of quality of life</b>	Cultural	Professionals	5	24
		Clients	18	
		Literature	2	
More support expectation from family	Cultural	Professionals	5	18
		Clients	13	
		Literature	0	
Fear about pain and thinking about serious problems (such as Cancer)	Cultural	Professionals	5	23
		Clients	18	
		Literature	0	
Throat strain results in more disappointment	Cultural	Professionals	4	16
		Clients	12	
		Literature	0	
<b>Fatalism in coping with problem and promotion of Quality of life</b>	Cultural	Professionals	5	22
		Clients	17	
		Literature	0	
<b>Traditional home remediation</b>	Cultural	Professionals	5	19
		Clients	13	
		Literature	2	
<b>Hope for spontaneous recovery</b>	Cultural	Professionals	5	19
		Clients	12	
		Literature	2,14	
	Cultural	Professionals	4	9
		Clients	5	

Discrimination because of sound problems		Literature	0	
Pain and globus sensation as a factor in finding remediation more quickly	Cultural	Professionals	5	17
		Clients	12	
		Literature	0	
Negative judgments	Cultural	Professionals	4	4
		Clients	0	
		Literature	0	
Negative thoughts about people with voice disorders	Cultural	Professionals	5	5
		Clients	0	
		Literature	0	

\*Frequency

The results of interview with specialists confirmed factors, definitions and components of voice related quality of life adding a cultural dimension that was shown in Table 5.

**Table 5.** Factors, definitions and components of voice related quality of life based on the interview with specialists

Factor		Definition	Component example
Physical		Physical Responses to the disorder	Short breath/trouble in speaking loudly/trouble using telephone, Voice hoarse, ...
Emotional		Emotional Responses to the disorder	Ashamed because of voice, Frustration, upset, depression, ...
Functional	Vocation	Functional Responses related to vocation because of disorder	Trouble in Job, lose income, Frequent job changing, ...
	Daily Comm.*	Functional Responses related to daily communication because of disorder	Avoiding speaking to people, ask to speak louder, repeat speaking, ...
	Social Comm.*	Functional Responses related to social communication because of disorder	Trouble in social activities, restriction of personal and social life,
Cultural	Cultural	Cultural elements related to the voice quality of life after disorder	Fatalism, Hope for Spontaneous recovery,....
	Judgment	Impact of disorder on the others' judgments	Negative judgments, Negative thoughts

\*Communication

Besides the viewpoints of specialists, the findings of clients' interviews are organized in Table 6.

**Table 6.** Factors, definitions and components of voice related quality of life based on the interview with clients

Factor	Definition	Component example
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Physical		Physical Responses to the disorder	Short breath/trouble in speaking loudly/trouble using telephone, Voice hoarse, ...
Emotional		Emotional Responses to the disorder	Ashamed because of voice, Frustration, upset, depression, ...
Functiona l	Vocation	Functional Responses related to vocation because of disorder	Trouble in Job, lose income, Frequent job changing, ...
	Daily Comm.*	Functional Responses related to daily communication because of disorder	Avoiding speaking to people, ask to speak louder, repeat speaking, ...
	Social Comm.*	Functional Responses related to social communication because of disorder	Trouble in social activities, restriction of personal and social life,
Cultural	Cultural	Cultural elements related to the voice quality of life after disorder	Fatalism, Hope for Spontaneous recovery, Discrimination,

\*Communication

Some of components were repeated in both the interviews and the literature and some of them are unique, as can be seen in Table 4. The unique components appear almost cultural. Thus, those components are listed under the term “cultural”.

The main focus of this study was identifying the cultural elements of voice related quality of life in Iranian people. These elements appear to have a potentially strong effect on health quality of life especially in the voice domain. Eleven cultural elements are indicated in Table 4. Four highlighted elements have deep roots in Iranian eastern culture (i.e., “religious beliefs in disease tolerance and promotion of quality of life”, “traditional home remediation”, “hope for spontaneous recovery”, and Fatalism in coping with problem and promotion of Quality of life). Also, three of these eleven components ( “religious beliefs in disease tolerance and promotion of quality of life”, “traditional home remediation”, and “hope for spontaneous recovery”) were mentioned previously in studies related to Eastern communities [2;14]. Since Iran is located in the Middle East and is influenced by Eastern culture and Islamic values. So we can expect the elements such as religious beliefs and spirituality have strong roots in Iranian culture. For example, Harandy, Ghofranipour, Montazeri et al.(2010) explored the role of religiosity and spirituality on feelings and attitudes about breast cancer, strategies for coping with breast cancer and health care seeking behaviors among breast cancer survivors in Iran[21]. They found that spirituality is the primary source of psychological support among participants. Almost all participants attributed their cancer to the will of God. Despite this, they actively engage with their medical treatment. This is an important and interesting point contrast to Western cultures in which a belief in an external health locus of control diminishes participation in cancer screening, detection, and treatment. The other eight elements are derived from the interviews of this study and may be considered Iranian-derived cultural elements that are not mentioned in previous literature. They are as follows: “more support expectation from family”, “fear about pain and thinking about serious problems (such as cancer)”, “throat strain resulting in more disappointment”, “fatalism in coping with the voice problem and promotion of Quality of life”, “discrimination against me because of my voice problem”, “pain and globus sensation as a factor in acceleration for finding remediation”, “negative judgments”, and “negative thoughts about people with voice disorders”. Some of them, like “fatalism in coping with problem and promotion of Quality of life,” have deep roots in Iranian and Eastern culture [22]. Fatalism has been shown to play a significant role in determining a vast range of individual behaviors including monetary savings decisions, occupational choices, health screening behaviors, and natural disaster preparedness [23], and it seems this component has a deep root in eastern views held by Iranians. As previously noted, Iran is in the Middle East and is heavily influenced by eastern culture. There is discussion in the medical literature of the role of fatalism in health screening behavior [24-26]. Fatalism significantly impacts both the preparation of individuals to confront natural disasters (fatalism prevents the adoption of self-protecting behaviors), and the ability to cope with the psychological consequences of natural disaster [27-30]. In this study fatalism showed an important role in coping with problems and almost all participants (professionals and clients) mentioned it.

Another cultural item was “expectation of more support from family”. In the Iranian culture, there is a strong bond among family members [31]. Thus, expecting more support from family during a problem or disease is not unexpected and this was evident in the interviews. One more main point might be related to items such as “fear about pain and thinking about serious problems (such as cancer)”, and “throat strain resulting in more disappointment”. These may seem more emotional than

cultural, but research on the relationship between culture and emotions dates back to 1872 when Darwin argued that emotions and the expression of emotions are universal [32]. While emotions themselves are universal phenomena, they are always influenced by culture [33]. On the other hand, this component, fear about pain and thinking about serious problems, has a global aspect.

However, it seems that the mentioned emotion, fear about pain and disappointment, has a strong cultural presence in Iran in comparison to the rest of the world because in Iran it leads to serious consequences. For example, Latifnejad-Roudsari, Zakerihamidi & Merghati-Khoei et al. (2014) reported high levels of cesarean in Iran (50%) compared to what has been determined by the WHO (up to 15%) [34]. They believed that fear about pain is a major factor to choose cesarean delivery. In another study, Ghooshchian, Dehghani, Khorsandi et al. (2011) reported fear about pain as one of the main causes of cesarean. Fear about pain and the disappointment resulting from it, is rooted in wrong beliefs and lack of awareness and here is where we can see the intersection of culture and emotion [35]. Smith, Caleffi & Albert et al., (2006) reported that fatalism, fear and preference for traditional healers are barriers that have strong roots in culture. Physicians also may be regarded as a source of lack of awareness for the patients [36]. They often are influenced by their own cultural and personal values [37] and these cultural and personal values are forcing them to hide the truth from their patients. Yet, truth telling to competent patients is a cardinal rule that is affirmed widely in Anglo-American medical practice [38]. In many cultures, families and physicians are readily prepared to hide the truth regarding patients' illnesses [39]. In several southern and eastern European countries, much of Asia and the Middle East, physicians and patients often feel that withholding medical information is more humane and ethical [40]. Thus, we can conclude in such stealth culture, any pain can lead patients to think about serious problems such as cancer which strongly rooted in the culture. Also, items like "Discrimination against me because of my voice problem," "Negative judgments", and "Negative thoughts about people with voice disorder," which may seem emotional or social, have deep cultural roots. Kazemi, Nasrabadi & Hasanpour et al. (2011) concluded that the culture of Iran has given rise to patients trying to conceal their disease from others which has led to social avoidance thus reducing the participants' social interactions with others [41]. The authors emphasize that patients in the Iranian culture tend to conceal their diseases from others because of a hatred of being pitied, a desire to maintain their job and social status, and a fear of negative social judgments toward the disease and its treatment. Negative thoughts, judgments, and discrimination have resulted in patients hiding their disorder which has led to social avoidance and finally, patients have become more secluded. These aspects were mentioned by all of the specialists who participated and were interviewed in the current study.

Finally, concern for quality of life is a worthwhile issue in any culture [42]. Hofstede (1984) state that "researchers approaching quality of life in Third World countries have relied too much on definitions of 'Quality' derived from North America and to a lesser extent West European values" [43]. Applying translated versions of quality of life surveys by ignoring culture would give a misleading image especially about Iran. As Hofstede noted, "countries trying to transfer Western ideas wholesale have been in trouble - Iran, for example" [43]. Thus, identifying the cultural components can help Iranian clinicians obtain a more accurate understanding of health related quality of life issues and apply better and more effective remediation. Studying and identifying these differences in any culture can help provide better insight to any dimension of health related quality of life issues in the various cultures.

## Conclusions

This study shows that culture is an important factor in investigating the quality of life. Considering it is very important for obtaining a clear and errorless judgment about patients' health related quality of life. When preparing surveys that measure HRQOL, considering the issue of culture is quite significant. Using only tests developed for Western cultures may create a misunderstanding of this important issue for clinicians and health related policy makers.

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#### **Appendix A:**

##### **Questions of Semi-structured interview:**

1. Did your voice problem affect your life? How, Please Explain.
2. Did your voice problem affect on your relationship with others? How, Please Explain.
3. Did your voice problem affect on your vocational Status? How, Please Explain.
4. What is the voice problem effect on your self-confidence? Please Explain.
5. Did your voice problem affect on your economic status and income? How, Please Explain.
6. Did your voice problem affect on psychological status? How, Please Explain.
7. What are family behaviors and reactions about your voice problem? Please explain.
8. How much do you expect your voice problem to heal spontaneously?
9. How much is your tolerance about the throat pain? Please Explain.
10. Do you think, spirituality is an effective way for coping with voice problem? How, Please Explain.
11. Do you think, Fatalism is an effective way for coping with voice problem? How, Please Explain.
12. Did you use any remediation except medical ones? If you used please explain about it.