The Medicalization of Mood:

Psychiatric Uses of the Diagnosis of Bipolar Spectrum Disorder in Iran

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ABSTRACT

Western psychiatry has had a remarkable global influence on the interpretation and treatment of mental illness. The transformation of contemporary psychiatry in non-Western countries shows the dominance of Western psychiatry over the last few decades. Iran is one of many countries where psychiatric training and practice have adopted US nosology and where educators and practitioners closely follow the work of American psychiatric researchers and organizations. In the West, concerns about medicalizing normal behaviour and deviance have resulted in recurrent critiques of the DSM and psychiatric practice. Bipolar disorder has been singled out for specific criticism because, in recent years, the rates of clinical diagnosis have significantly increased in the U.S. as well as in some other Western countries. The expansion of the diagnostic categories, resulting from both contemporary psychiatry's shift from psychotherapy toward psychopharmacology and the marketing of new disorders by pharmaceutical companies has led psychiatrists to broaden the original description of manic-depressive disorder into a family of "bipolar spectrum" (BSD) or "soft bipolar" disorders—a spectrum wide enough to include much of the current territory of psychiatry and even many subclinical conditions in the general population.

Given the dominance of Western biomedicine in the world, it should not be surprising to see the rapid diffusion of changes in biomedical categories to non-Western societies. This thesis uses the example of BSD to explore how a Western medical concept of distress has been exported to a non-Western society, the conditions under which it was adopted as part of new diagnostic practices, and its impact on practitioners and patients in the social context. More specifically, this study examined: 1) how the new diagnostic category of bipolar "spectrum" disorder is understood and applied by psychiatrists in Iran; 2) factors influencing the emergence

and spread of knowledge and practices related to bipolar "spectrum" disorder among Iranian institutions and practitioners; 3) illness meanings and experiences of individuals diagnosed with BSD; 4) causal attributions and illness prototypes of individuals diagnosed with BSD; and 5) coping and help-seeking strategies and the impact of illness among individuals diagnosed with BSD in their local sociopolitical, gendered, and cultural contexts. The research design was based on a qualitative case study methodology with a focus on the emic perspective. The study involved two phases: 1a) archival research and semi-structured interviews with 25 key academic psychiatrists involved in training to clarify the history of the introduction and spread of the new concept of bipolar disorder in Iran; 1b) interviews with the same psychiatrists to explore their use of the diagnosis with patients; and 2) semi-structured interviews, using the McGill Illness Narrative Interview (MINI), with 37 patients who had received the diagnosis of BSD to explore their experience of living with the symptoms and the impact of the diagnosis.

Findings of the first phase of this study indicated that many clinicians and commentators in Iran believe there has been widespread and uncritical adoption of BSD diagnosis by Iranian psychiatrists. This appears to reflect processes beyond expanding the boundaries of psychiatric diagnoses and aggressively promoting the new diagnoses and the markets for treatment in the global scale. In addition to the influence of current practices in international psychiatry and, to some degree, the local influence of pharmaceutical companies, there are specific sociopolitical, structural, cultural, and gender-related factors associated with the widespread use of the diagnosis of BSD. Informants also highlighted the gender difference in the BSD diagnosis in Iran: women are diagnosed with BSD (i.e., subthreshold bipolar, soft bipolar disorder) far more frequently than men. Findings of the second phase of this study indicated that the high rate of diagnosis of bipolar spectrum disorder (i.e., subthreshold bipolar, soft bipolar disorder) among

women in Iran may be influenced by multiple factors, including: 1) the increasing prevalence of psychological distress—including anxiety, depressive, and somatic disorders—which is rooted in gender inequality and women's struggles with the onerous sociopolitical, patriarchal, and economic situations that they live in; 2) the reclassification of a significant number of patients who had received other diagnoses—such as anxiety, depression, complex trauma, and personality problems—which already have a higher prevalence among women; and 3) the pathologization of certain gender-related behaviours that may reflect tensions between women's emancipation and the reinstitution of conservative societal norms. Moreover, the study identified multiple factors influencing the help-seeking strategies and trajectories of patients with BSD diagnoses in Iran, including the structural limitations of the mental health care system; the modes of practice of biological psychiatry; the characteristics of the official psychology and counselling services permitted by Iran's government; popular psychology and consultation (offered remotely) by Iranian psychologists and counsellors in the diaspora; and alternative spiritual and cult-based groups.

This study suggests that in order to understand the recent widespread use and impacts of BSD in Iran it is essential to adopt an ecosocial and cultural approach that takes into account multiple processes including: the intersection and interactions between global trends in mental health; the historical, structural, cultural, and sociopolitical realities of local contexts, and the sociocultural realities of individual predicaments. The findings from this study have important clinical, research, advocacy, and policy implications—both locally and globally—and point to the need to integrate an ecosocial approach in psychiatric training and practice in order to improve conceptual, clinical, and structural competence in mental health services.

RESUME DE LA THESE

La psychiatrie occidentale a eu une influence mondiale majeure sur l'interprétation et le traitement de la maladie mentale. La transformation de la psychiatrie contemporaine dans les pays non occidentaux montre la domination de la psychiatrie occidentale tout au long de ces dix dernières années.

L'Iran est l'un des nombreux pays où la formation et les pratiques en psychiatrie ont adopté la classification venant des États-Unis et où, les formatrices et formateurs, comme les praticiennes et praticiens, suivent les travaux des chercheuses et chercheurs ou ceux des organisations psychiatriques états-uniennes. En occident, des préoccupations demeurent quant à la médicalisation de comportements normaux ou de déviance et qui ont conduit à une critique récurrente tant du DSM que des pratiques psychiatriques.

Le trouble bipolaire a fait l'objet de critiques bien spécifiques puisque ces dernières années, le nombre de diagnostic clinique s'est nettement accru tant aux États-Unis que dans d'autres pays occidentaux. Cette augmentation du nombre de catégories est dû à la fois au passage de la psychiatrie contemporaine de la psychothérapie à la psychopharmacologie et aussi à la commercialisation de nouvelles maladies psychiatriques par l'industrie pharmaceutique. Ce qui a conduit les psychiatres à élargir la description originale du trouble maniaco-dépressif à la famille du « spectre bipolaire » (BSD) ou un trouble bipolaire dit « doux ». Ce spectre est suffisamment large pour inclure une grande partie du territoire de la psychiatrie ainsi que de nombreuses conditions sous-cliniques dans la population générale.

Étant donnée la domination de la biomédecine occidentale dans le monde, il ne serait pas surprenant d'observer une rapide diffusion de changements dans les catégories biomédicales des sociétés non occidentales. Cette thèse s'appuie sur l'exemple du trouble du « spectre bipolaire »

afin d'explorer comment un tel concept médical occidental de détresse a été exporté vers les sociétés non occidentales, les conditions dans lesquelles ce concept a été adopté dans le cadre de nouvelles pratiques de diagnostic, et ses répercussions sur les praticiennes, praticiens, et les patientes dans un contexte social. Plus précisément, cette étude vise à analyser : 1) comment la nouvelle catégorie diagnostique du trouble du « spectre bipolaire » est entendue et appliquée par les psychiatres en Iran. 2) les causes influençant l'émergence et la diffusion des connaissances ainsi que des pratiques du trouble du « spectre bipolaire » au sein des institutions et près des praticiennes et praticiens iraniens. 3) les significations et expériences vécues par les personnes ayant eu le diagnostic de trouble du « spectre bipolaire ». 4) les causes et les prototypes de maladies pour les individus diagnostiqués avec le trouble du « spectre bipolaire ». 5) les stratégies d'adaptation, les mécanismes de défense et les répercussions de la maladie sur les personnes diagnostiquées avec le trouble du « spectre bipolaire » dans leur contexte socio-politique, de genre et culturel. La recherche se base sur une méthodologie d'études de cas qualitatives et met l'accent sur une perspective émique. L'étude comportait deux phases : 1a) des recherches d'archives et des entretiens semi-structurés près de vingt-cinq psychiatres clés, engagés dans la formation universitaire, pour rendre explicite l'histoire de l'introduction et de la diffusion du nouveau concept du trouble bipolaire en Iran. 1b) ces mêmes psychiatres ont également fait l'objet d'entretiens aux fins d'explorer leur façon d'utiliser les diagnostics avec les patientes; et 2) des entrevues semi-structurées, utilisant the McGill Illness Narrative (MINI) ou Entrevue Narrative sur la maladie de McGill, menées sur trente-sept patientes ayant reçu le diagnostic du trouble du « spectre bipolaire », dans le but d'étudier leur expérience de vie avec les symptômes et les conséquences du diagnostic.

Les résultats de la première phase de l'étude ont indiqué que, selon de nombreux cliniciens et commentateurs en Iran, le diagnostic de trouble du « spectre bipolaire » a été adopté de manière générale, sans formulation de critiques, par les psychiatres iraniens. Ce qui semble refléter des processus allant bien au-delà de l'élargissement des limites des diagnostics psychiatriques, de l'agressivité dans la promotion des nouveaux diagnostics et de la mise en marché des traitements à l'échelle mondiale. En plus de l'influence des pratiques actuelles en psychiatrie au niveau international et, d'une certaine mesure, de celle des entreprises pharmaceutiques au niveau local, il existe des raisons sociopolitiques, structurales, culturelles et de genre qui expliquent le recours au diagnostic de trouble du « spectre bipolaire ». Les personnes interrogées ont souligné une nette différence liée au genre dans le diagnostic du trouble du « spectre bipolaire » en Iran : les femmes le reçoivent (bipolaire atypique, bipolaire dit « doux ») beaucoup plus fréquemment que les hommes.

Les résultats de la deuxième phase de l'étude ont montré que ce taux élevé de diagnostic du trouble du « spectre bipolaire » (bipolaire atypique, bipolaire dit « doux ») chez les femmes en Iran pourrait être influencé par de multiples facteurs, en particulier : 1) la prévalence croissante de la détresse psychologique, y compris des troubles anxieux, dépressifs et somatiques, laquelle est enracinée dans l'inégalité entre les genres et les luttes des femmes contre les situations sociopolitiques, patriarcales et économiques auxquelles elles sont confrontées. 2) Le reclassement d'un nombre significatif de patients qui avaient reçu un autre diagnostic, comme l'anxiété, la dépression, des traumatismes complexes et des troubles de la personnalité, est déjà plus élevé chez les femmes; et le fait de rendre pathologique certains comportements liés au genre peuvent refléter des tensions entre l'émancipation des femmes et l'institutionnalisation de normes sociétales conservatrices. En outre, l'étude a identifié de multiples facteurs influençant

les stratégies de recherche d'aide et les trajectoires des patients atteints de trouble du « spectre bipolaire » en Iran, essentiellement : les restrictions liées à la structure même du système de soins en santé mentale; les modes de pratique de la psychiatrie biologique; les caractéristiques des services officiels en psychologie et en conseils autorisés par le gouvernement iranien; la psychologie rendue populaire et les consultations (à distance) par des psychologues et des thérapeutes iraniens issus de la diaspora; et les groupes spirituels ou de cultes alternatifs.

Cette étude propose, pour comprendre le recours récent et généralisé du trouble du « spectre bipolaire » en Iran, qu'il convient d'adopter une approche économique, sociale et culturelle prenant en compte de nombreux processus, y compris : l'intersection et les interactions entre les tendances mondiales sur la santé mentale; les réalités historiques, structurelles, culturelles et sociopolitiques dans des contextes locaux, et les réalités socioculturelles liées aux conditions difficiles des individus. Les conclusions de cette étude ont des implications considérables tant au niveau local que global, pour l'approche clinique, la recherche, la mobilisation et la politique pour souligner la nécessité d'intégrer une approche économique et sociale dans la formation et la pratique psychiatriques en vue d'améliorer les compétences conceptuelles, cliniques et structurelles des services de santé mentale.

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چشم ها را باید شست، جور دیگر باید دید.
واژه ها را باید شست.
واژه باید خود باد، واژه باید خود باران باشد،
چترها را باید بست، زیر باران باید رفت.
فکر را، خاطره را، زیر باران باید برد.
با همه مردم شهر، زیر باران باید رفت.
دوست را، زیر باران باید دید.
عشق را، زیر باران باید جست!

سهراب سپهری

One must wash eyes, look differently to things,

Words must be washed

The word must be wind itself, the word must be the rain itself

One must shut umbrellas

One must walk in the rain

One must carry the thought, the recollection in the rain

One must go walk in the rain with all the townsfolk

One must see friends in the rain

One must search love in the rain

(Sohrab Sepehri)

This research is dedicated to my dear aunt, Toktam, a beautiful woman who searched for love in the rain (1975-2011).

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CONTRIBUTION TO ORIGINAL KNOWLEDGE

Given the dominance of Western biomedicine in the world, it should not be surprising to see the diffusion or importation of biomedical categories and practices to non-Western societies. However, there remains a gap in knowledge about how a new psychiatric concept like bipolar spectrum disorder (BSD), or "soft bipolarity," which was developed mainly in the U.S., travels to a non-Western society. This includes understanding the degree to which and under what conditions a diagnostic concept and practice is adopted as well as the impact and meaning it has when deployed in another culture and context. To my knowledge, this is the first study that has explored how the new concept of bipolar spectrum disorder, and the diagnostic construct BSD, relate to Iranian culture and the Iranian healthcare system, including how this diagnosis interacts with the country's sociopolitical conditions, and what types of cultural and social structural factors encourage or discourage the medicalization of mood problems under the BSD diagnosis. This study contributes to a body of work in medical and psychiatric anthropology that examines how concepts and practices travel across cultures, and also contributes to the field of Global Mental Health by investigating how local definitions of problems can become medicalized in terms of mood disorders with social and personal consequences. Specifically, this study revealed how the use of biological psychiatry as a framework allows clinicians to sidestep or ignore underlying social, structural, and gendered causes of mental sufferings, leading to the silencing of many voices, particularly those of more vulnerable groups—such as women, children and adolescents, ethnic and religious minorities, and the poor. Psychiatric practice then marginalizes the discourse surrounding the structural, political, and social problems. Moreover, the rise of BSD has occurred at a time when enormous changes or pendulum swings have occurred in social norms, including gender roles, and psychiatric practice has struggled with the consequences of

these shifts. This occurs in a setting where political and theocratic pressures may be more important than market forces for defining the nature of psychiatric practice.

This thesis consists of five chapters. The first chapter includes the introduction and the background to the topic of this thesis. Chapters 2, 3, and 4 provide details of two different phases of this study that were conducted to examine the journey of BSD from the U.S. to Iran, the sociopolitical, structural, and cultural factors involved in the rapid expansion of this diagnosis, and the experiences of psychiatrists and patients with using and receiving BSD diagnosis in Iran.

Chapter 2, titled "The Globalization of Biological Psychiatry and the Rise of Bipolar Spectrum Disorder in Iran," was published as an original research article in Culture, Medicine, and Psychiatry (Mianji & Kirmayer, 2020).

Chapter 3, titled "Women as Troublemakers: The Hard Sociopolitical Context of Soft Bipolar Disorder in Iran," was submitted as an original research article to Culture, Medicine, and Psychiatry (Mianji & Kirmayer, September, 2019).

Chapter 4, titled "Help-seeking Strategies and Treatment Experiences Among Individuals Diagnosed with Bipolar Spectrum Disorder in Iran: A Qualitative Study," was submitted as an original research article to Transcultural Psychiatry (Minaji & Kirmayer, July 2020)

Finally, Chapter 5 presents a summary of the major findings, possible clinical and research implications for local and global mental health, and concluding remarks.

CHAPTER 1: INTRODUCTION AND LITERATURE REVIEW

1.1 Introduction

Western psychiatry has had a remarkable global influence on the interpretation and treatment of mental illness. Although German, French, and other European traditions contributed to the early dissemination of psychiatry through colonial institutions, in recent years, Anglo-American psychiatry has come to dominate the international landscape. Despite the efforts of the WHO and the World Psychiatric Association (WPA) to develop an international nosology and standardized approaches to diagnosis and treatment, in practice, international psychiatry was largely framed in terms of the delivery of biomedical services modeled on Euro-American psychiatric training, practice, and treatment (Fernando, 2014; Kirmayer, 2006). Mental health researchers and professionals trained in the West, and in Britain and the United States in particular, have contributed to the official categories of mental diseases enshrined in the DSM and ICD that circulate internationally. In addition to psychiatric nosology, American researchers and organizations run the premier scholarly journals and host the most widely attended conferences in the fields of psychiatry and clinical psychology. Western universities have trained the world's most influential psychiatric clinicians and academics. This academic influence is coupled to a powerful set of economic interests. Increasingly, much of the clinically important, evidence-based research in psychiatric training and practice—even the core training of residents in psychiatry—is controlled by pharmaceutical companies with vested interests in demonstrating the value of their new products (Angell, 2005; Kirmayer, 2006; Kirmayer & Pedersen, 2014; Watters, 2010; Lexchin, 2012). Since this evidence-based practice promotes the types of intervention that may make it much easier to standardize and scale up—that is, to provide medication and/or simple, standardized behavioural interventions rather than conducting more

complex psychosocial or psychotherapeutic interventions (Kirmayer & Pedersen, 2014)—it has been embraced widely. Similarly, the expansion of diagnostic categories has been associated both with contemporary psychiatry's shift from psychotherapy toward psychopharmacology (Mojtabai & Olfson, 2008) and with the marketing of new disorders by pharmaceutical companies (Healy, 2012; Paris, 2015). There has been a concerted effort to promote the idea that psychiatric disorders are like other medical conditions, that they can be defined in terms of neurobiological processes, and that psychiatric practice should be centered on applying expertise in neuroscience and psychopharmacology (Insel & Quirion, 2005; Kirmayer & Crafa, 2014). The expansion of the diagnostic criteria for bipolar disorder is one of the more controversial examples in psychiatry of the influence of neurobiological models and psychopharmacology treatments (Moncrieff, 2014; Mandla et al., 2017; Rhee et al., 2020).

The transformation of contemporary psychiatry in non-Western countries shows the dominance of Western psychiatry over the last few decades (Béhague, 2008; Kirmayer, 2006).

Iran is one of many countries where psychiatric training and practice has adopted the U.S. nosology and closely follows the work of American psychiatric researchers and organizations. Iran provides a particularly interesting context to examine this process of international influence because it is a relatively wealthy, well-developed country with a long history of psychiatric institutions and of universal health care with integrated mental health programs. In addition, because the state has subsidized the local production of pharmaceuticals, the influence of the pharmaceutical industry on diagnostic practices has been somewhat less direct than in the U.S. The perspectives and practice of Iranian psychiatrists in contemporary Iranian psychiatry are influenced by Western psychiatry (Mehryar et al., 1986). This influence is associated with the

Western training of the key individuals responsible for the development of modern psychiatry in Iran (Davidian, 2008; Javanbakht & Sanati, 2006) as well as ongoing knowledge exchange.

Using the case study of the emergence of new approaches to the diagnosis and treatment of bipolar disorder in Iran, this investigation examined some of the processes that maintain and extend this domination through international flows of knowledge, conceptual models, and standards in training and practice as well as through patients' experience with receiving this diagnosis and treatment.

1.2 Literature Review

1.2.1 Iranian Mental Health Infrastructure

Iran is a Middle Eastern country with a population of more than 83 million (in 2019), more than 71% of whom live in urban areas. Thirty percent of the population are younger than 18, five percent are 60 or older, and life expectancy at birth is 75.5 years for women and 72.5 years for men. Iran is an upper-middle-income country with a per capita gross domestic product (GDP) in 2019 of $5,289 and, when adjusted by purchasing power parity (PPP)[1] ,of $20,107. The total expenditure on health is 5.5% of GDP. Although neuropsychiatric disorders contribute an estimated 16.6% to Iran's global burden of disease—the second highest burden of disease in the country after injuries and external causes and before circulatory system diseases—mental health expenditures constitute only 3.6% of the total health budget, with 16.7% of the mental health budget going to mental health hospitals (Naghavi et al., 2009; Scull, 2014).

[1] https://www.imf.org/external/pubs/ft/weo/2019/02/weodata/weorept.aspx?pr.x=35&pr.y=12&sy=2017&ey=2021&scsm=1&ssd=1&sort=country&ds=.&br=1&c=429&s=NGDPD%2CPPPGDP%2CNGDPDPC%2CPPPPC%2CPCPIPCH&grp=0&a=

Since 1968, Iran's mental health services have been integrated into the primary health care system. This policy of integration of mental health aimed to create infrastructure to meet the mental health needs of all parts of the country, especially rural and remote areas (WHO, 2006). Although this program has been successful in rural areas, it did not reach its objectives in urban areas due to inadequate coverage and quality of services. For example, the program covered urban areas much less than rural (21.7% vs. 82.8% of the population, respectively, in 2004) (Sharifi, 2009).

According to a report in 2011, Iran had 855 outpatient mental health facilities (948 per 100,000), of which 40 were reserved for children and adolescents. The country had 31 day-treatment facilities (2.78 per 100,000), 46 community residential facilities, and 33 mental health hospitals (7.9 per 100,000), 3.4% of which were reserved for children and adolescents. There were 61.2 mental health workers per 100,000 Iranians—a number that far exceeded Iran's geographical neighbors—including psychiatrists (1.5 per 100,000), psychologists (2.2 per 100,000), non-psychiatric physicians (10.7 per 100,000), nurses (7.8 per 100,000), social workers (0.7 per 100,000), occupational therapists (0.06 per 100,000), and other health workers (40.9 per 100,000) (Scull, 2014). More than 90% of the country's population benefited from the national health insurance system that covers at least 80% of costs or free access to essential psychotherapeutic medications, but some medications and non-medical psychiatric treatments are not covered by the health insurance (Forouzan et al., 2011)[2] For those paying out of pocket, antipsychotics cost 4% of the minimum daily wage, and antidepressants cost 2% of the minimum; this is a relatively low cost compared with other Middle Eastern countries. All mental

[2] In 2014 Iran's president announced universal health care ("RohaniCare") for all Iranians.

health outpatient facilities had at least one psychiatric medication of each class consistently available on-site or at a local pharmacy (Scull, 2014). However, access to mental health care was unequal across the population; for instance, most mental healthcare beds were located in large cities rather than rural areas (Sharifi, 2009), and psychosocial services were not covered (Forouzan et al., 2011).

Moreover, although there are many young graduates in mental health disciplines, limitations in the budget and ineffective management systems have created barriers to the utilization of human resources in mental health settings. For instance, according to the fee schedule set by the Iranian Ministry of Cooperatives, Labour, and Social Welfare, the approximate fee per session (in USD) for seeing a psychiatrist in a university hospital was $5 in 2014 and $1.50 in 2019, and in a private setting was $11 in 2014 and $5 in 2019, per 30-minute session[3] Seeing a clinical psychologist cost $10 in 2014 (remaining at $10 in 2019) per 45-minute session (based on the fee schedule set by the Iranian Organization of Psychology and Counseling[4]). This relatively low fee for psychiatric visits and the lack of insurance coverage for psychotherapy have led many psychiatrists to reduce the duration of visits to adjust their income to meet their expectations.

A nationally representative face-to-face household survey conducted in 2011 to investigate the twelve-month prevalence of psychiatric disorders based on DSM-IV criteria in Iran found that 26.5% of women and 20.8% of men suffered from one or more psychiatric disorders (Sharifi et al., 2015). According to this study, higher socioeconomic status and having a university education were associated with lower rates of psychiatric disorders, while

[3] According to the same source, seeing a general physician in a public (governmental) setting was ~$2.70 and in a private setting was $5.50 in 2014 and ~$2 in 2019, a session which is supposed to be 15 minutes long. (http://en.ihio.gov.ir/Portal/Home/)

[4] http://pcoiran.org.ir & http://www.pcoiran.ir/fa/tarefe/tarefe_RM_98

unemployment, widowed or divorced status, and living in urban areas were associated with higher rates of psychiatric disorders. The most prevalent disorder was major depressive disorder (12.7%), followed by generalized anxiety disorder (5.2%) and obsessive-compulsive disorder (5.1%). In 2011, the most common disorders treated in mental hospitals were mood disorders (65%), followed by schizophrenia (17%) and neurotic disorders (7%).

In addition to the financial limitations of mental health care and the low numbers of psychiatric beds and psychiatrists in Iran, most psychiatrists, including psychiatric academia, lack interest in community mental health models of care (Sharifi, 2009). These factors have contributed to the prevalence of the revolving door phenomenon at most hospitals, with discontinuation of treatment, repeated relapses, and re-hospitalization of patients (Hajebi et al., 2013).

1.2.2 A Short Overview of the History of Psychiatry in Iran

The history of psychiatry in Iran is not separate from the history of medicine and psychiatry in the rest of the world (Davidian, 1995, 2008; Javanbakht & Sanati, 2006; Moharrari, 1994), with constant flows and changes across diverse geographic regions and traditions over the centuries. The oldest references to the causes and treatment of mental illnesses in Iran are found in the Avesta, the holy book of pre-Islamic Iranians written by Zoroaster (Zartusht). After the Islamic conquest of Persia (Iran) in the 7th century, the importance of philosophy and knowledge in Iranian culture led many Iranian physicians, philosophers, poets, and writers to produce psychological theories, which some consider the ancestors of modern approaches to psychology[5]. Early Persian physicians like Tabari, Razi, and Avicenna (Ibn-e-Sina) devoted long

[5] This is the view expressed in an unpublished article by Shamloo, a founder of clinical psychology departments in Iran.

sections of their texts to a discussion of mental disorders under the general title of "the diseases of the head and the brain." In *The Canon of Medicine*, written in the 11th century, Avicenna described a number of conditions, including melancholia. Since that time, Iranian physicians have perceived abnormal mental phenomena as medical illnesses caused by both physical and mental problems and have treated them in special hospitals or wards (Javanbakht & Sanati, 2006; Moharrari, 1994). The first Iranian neurology and/or psychiatric ward, called Mahfel-Almajanin ("congregation of the insane"), was built in the 11th century in the great medical center, Darolshafaa, in Yazd (a center of Zoroastrian culture). In parallel with these philosophical and medical approaches to mental illnesses, folk theories have also existed among lay people. For example, mental illness was commonly explained as possession by devils or evil spirits. However, it is worth noting that, throughout Iran's history, these folk explanations have usually not led to aggressive or neglectful behavior toward the mentally ill. In poetry and literature, any hurtful action toward the mentally ill, like throwing a stone at a person with psychotic symptoms, was viewed as childish and immature behaviour. To avoid calling the mentally ill "insane" (divaneh), poets like Rumi used the term divaneh as a positive metaphor for spiritual intoxication and creativity, and classic Iranian literature tells some positive stories about the mentally ill (Davidian, 1995).

1.2.3 A Short Review of Contemporary Psychiatry in Iran

Three years following the foundation of Tehran University in 1934, modern psychiatry in Iran began to be taught in the Department of Psychiatry at the medical school. Razi Hospital, Iran's biggest psychiatric hospital, had been established in 1918, and Roozbeh Hospital, the first modern psychiatric teaching hospital and the first university psychiatric hospital attached to the medical school of Tehran University, was established in 1951. Although a few major cities in

Iran had had asylums for psychiatric patients since the 19th century, those asylums were managed mainly by the municipalities and provided very poor conditions. In 1945, Abdolhossein Mirsepassi, Professor of Psychiatry, Tehran University, played the main role in making those asylums independent from municipalities. These pioneers in Iran's psychiatry—in effect, "the first generation of psychiatrists"—were French-trained, biologically-oriented neuropsychiatrists. The "second generation" of psychiatrists, who were the founders of the National Board of Psychiatry and who began their work in Iran in the 1950s, consisted of English-trained, biologically-oriented psychiatrists. During the 1960s and 1970s, a "third generation" of psychiatrists, who were U.S.-trained with a mainly organic and descriptive approach, returned to Iran. A group of these psychiatrists was based at the Tehran Psychiatric Institute; this institute, which is affiliated with the Iran University of Medical Science (UMS), was founded by Professor Iraj Siasi and trained psychoanalytically-oriented residents in 1977. Another group of American-trained psychiatrists started to work in private practice and in the psychiatric departments of other universities in Tehran, including the Shahid Beheshti University of Medical Science—which has had two major psychiatric training wards in the Imam Hossein Hospital and Taleghani Hospital since the 1980s—as well as at universities in other provinces, like Isfahan UMS, Shiraz UMS, and Mashhad UMS. The first program in child psychiatry was also founded in Tehran UMS during the 1970s, although training of subspecialty residents with an orientation in family therapy was begun by Professor Vali Sahami only in the 1990s (Davidian, 2008; Javanbakht & Sanati, 2006).

This modern psychiatric view—across the three generations I have described—has been successful in marginalizing pre-modern rivals such as shamans and traditional healers. For example, "[S]eeking help from traditional healers as a first help-seeking strategy has shifted from

40.2% in 1990 to … 15.6% in 2000" (Yasamy et al., 2001). These differences in psychiatrists' approaches—i.e., Iranian psychiatrists trained in the U.S. and their trainees vs. those trained in Britain and France and their trainees—have led to controversial transformations concerning the diagnosis and treatment of psychiatric disorders in Iran. For example, similar to the differences identified in research comparing psychiatric practices in the UK with those in the U.S. (Kendell et al., 1971), there was a controversy in mood disorder diagnosis vs. schizophrenia diagnosis among Iranian psychiatrists: English-trained psychiatrists (the second generation of psychiatrists), who were mostly based in the Roozbeh Hospital (Tehran UMS), were known to be more interested in the mood disorder diagnosis, whereas the American-trained psychiatrists (the third generation of psychiatrists), who were mostly based in the Psychiatric Institute (Iran UMS), were more interested in the schizophrenia diagnosis.

In the 21st century, Iran's psychiatric training and practice are no longer influenced by the European-trained (first- and second-generation) psychiatrists or the U.S.-trained (third-generation) psychiatrists, but rather, through the globalization of American psychiatry, by American psychiatric categories and textbooks, and by leading figures of American psychiatry, such as Nasir Ghaemi and Hagop Akiskal. In the first decade of the new millennium, following the expansion of the boundaries of bipolarity in the new millennium (Akiskal, 2002; Angst et al., 2003b), the diagnosis and treatment of bipolar disorder has become one of the most controversial transformations in Iran's psychiatric system, both in general and in child psychiatry.

1.2.4 The Pharmaceutical Industry & Pharmaceutical Consumerism

While physicians are still the gatekeepers for medicalization, over the past three decades, the pharmaceutical industry has played a greater role in medicalization (Conrad, 2008). According to Conrad, by sponsoring workgroups on new health conditions and promoting these

new conditions to both prescribers and consumers, pharmaceutical companies "are now marketing diseases, not just drugs"—a process in which the social construction of illness is being replaced by the "corporate construction of disease" (Conrad, 2009; Williams et al., 2011). Psychiatry provides many specific examples of the way that the research, knowledge production, and clinical practice have been redefined by pharmaceutical industry—through its regulatory, technical, and economic influence. Since the 1950s, pharmaceutical companies have provided financial support and an extremely efficient distribution system for scientific articles that promote their new psychotropic drugs (Petryna et al., 2006). A widespread expansion of the use of medication has gone hand in hand with efforts at 'pharmaceuticalization' that redefine and reconstruct health problems as having pharmaceutical solutions. The result is visible in the massive growth of drug markets not only in the USA and Europe but globally. Through the globalization of pharmaceuticals, sales in middle-income countries such as China, India, and Brazil are now increasing at a faster rate than sales in countries like the USA or the UK (Busfield, 2010). Another important dimension of this pharmaceuticalization is the changing relationship between regulatory agencies and the pharmaceutical industry. According to Williams, this change has three components: "firstly, reforms that have reduced the regulatory hurdle and increased the dependency of regulatory agencies on industry; secondly, new policies that have increased the role of regulatory agencies in promoting drug innovation; and thirdly, the globalisation of established models of governance based on the interests of the pharmaceutical industry in the developed world" (Williams et al., 2011, p. 22).

1.2.5 Iran's Pharmaceutical Market

Iran's pharmaceutical industry has undergone changes in its relationship with national regulatory agencies, which have contributed to massive growth in the drug market. In 2009, the

global pharmaceutical market value was more than $800 billion USD with a growth rate of 6.7% in the second half of the mid-2000s (Farzandi, 2011). The distribution of market value includes 40% in U.S., 30% in Europe, 12% in Asia, Africa and Australia, 11% in Japan, and 5% in Latin America (IMS, 2010). The value of the Iranian pharmaceutical market in 2009-2010 was $3.1 billion USD, showing 24% growth compared with the previous year (Drug-and-Narcotics-Monitoring-Directorate, 2009). In 2014, the top three countries from which Iran imported medications were Germany (19%), Switzerland (14%), and United Arab Emirates (13%), while the U.S. (3%) was last (Farzandi, 2011).

Countries are classified by the WHO into five levels according to the evaluation of their pharmaceutical production: 1) sophisticated pharmaceutical industry and research base; 2) innovative capabilities; 3) reproductive capabilities—active ingredients and finished products; 4) reproductive capabilities—finished products from imported ingredients only; and 5) no pharmaceutical industry (Semin, 2008). In this scheme, Iran is categorized as a level-4 country, indicating its capacity for local production of the finished products with imported material (WHO, 2004). However, in recent years, many plants have been producing pharmaceutical raw materials for local and international markets. Despite a long history and strong infrastructure in the pharmaceutical industry, Iranian pharmaceutical manufacturers are disadvantaged by the regime's poor intellectual property protection and limited investment in research and development (Farzandi, 2011). In the pre-revolution decade (1970s), about 70% of the nearly 4000 pharmaceutical products available in Iran were imported, and only 30% were formulated locally. There was no substantial investment by corporations or the government in local production of pharmaceutical products.

The Islamic revolution of 1979 changed many aspects of economic and political development, including the pharmaceutical industry. Many multinational companies left Iran, and continuing political and economic problems, such as international sanctions and eight years of war, made it difficult for the local pharmaceutical industry to access new technology and the raw materials required to produce new medications. Self-sufficiency and non-reliance on foreign intervention became the primary goal, and all the pharmaceutical companies were nationalized. The government allocated subsidized hard currency to purchase raw materials and machinery to maintain and expand the pharmaceutical industry (Cheraghali, 2013). However, due to the lack of investment in research and development, the technological capabilities of the pharmaceutical industry have been limited mainly to the areas of formulation—that is, to importing raw materials and manufacturing medications locally. Moreover, the state moved toward the production of generic medicines only and was mainly involved in the importation of medicines as finished products, raw materials, and machinery. From 1980 to 1993, the government directly supported all local pharmaceutical companies, private and public, by providing them with hard currency.

Since the mid-1990s, the Iranian pharmaceutical market has experienced marked increases both in total value and per capita consumption; the drug market has increased annually on average more than 30% between 1993 and 2003. This increase occurred in the context of the removal of government subsidies and devaluation of national currency and was driven by increasing consumption. To create a more competitive environment for pharmaceutical companies, in 2001 the Iran Ministry of Health changed its policy regarding the compulsory production of generic medications and encouraged pharmaceutical companies to produce branded medicines (Cheraghali, 2006; Dinarvand, 2009; Abdollahiasl, 2014). That reform has

changed the relationship between regulatory agencies and the pharmaceutical industry by reducing regulatory hurdles and increasing the dependency of regulatory agencies on industry. According to Iran's Ministry of Health, from 2001 to 2008, pharmaceutical expenditure as a share of health expenditure increased from USD 690 million to USD 2250 (Dinarvand, 2009). Nevertheless, the annual share of expenditure of imported pharmaceutical products has increased more than that of products produced locally in Iran. For example, from 2001 to 2008, although the sale of locally produced and imported items increased annually by 6.7% and 9.4%, respectively, the market share of expenditure of local manufacturers decreased from 82.2% to 65% (Cheraghali, 2013; Dinarvand, 2009). Despite this growth in the market share of expenditure of imported medicines, less than 5% of medicines are imported as finished products, and more than 95% of the market needs are supplied by the local pharmaceutical industry; however, because imported medicines are expensive, more than 50% of the pharmaceutical market value is accounted for by that 5% of imported medicines. To reduce outflow of valuable foreign currency and reliance on imports, which could always be affected by political turbulence, the government of Iran has continued to encourage local industry to produce "copies" of imported drugs. The lower cost of these copied biopharmaceuticals could improve the affordability of medicines; however, none of these medicines has had comprehensive evaluation according to FDA or EMA guidelines (Cheraghali, 2006, 2013).

In summary, despite a lack of intellectual property regulations that directly affects the commercialization of pharmaceuticals in Iran (Nassiri-Koopaei et al., 2014), over the past two decades, the annual growth rate of both imported and local pharmaceutical products has seen a sharp increase in Iran (Cheraghali, 2013). We could not find any published data that provide specific information on importation, production, and consumption trends for psychiatric

medications in Iran. However, the rapid growth in Iran's pharmaceutical market in the 2000s coincides with dramatic changes in Iranian psychiatric practice with the rise of depression diagnoses and high rates of prescription of SSRIs from the early 2000s (Behrouzan, 2015) and with the subsequent rise of bipolar spectrum disorder diagnosis and widespread use of "atypical" neuroleptics from the mid-2000s to date.

1.2.6 Pharmaceutical Consumerism

In addition to the role of the pharmaceutical industry in marketing new disorders and pharmaceuticalizing societies by promoting drug use as a solution for an ever-wider range of problems, the pharmaceuticalization of some disorders may be a result of popular culture more than of marketing or professional interests (Ecks, 2017).

The arenas of healthcare where drugs are bought and sold are not restricted to the official pharmacies, clinics, hospitals, and public health institutes of biomedicine. Psychiatric drugs have crept into human, social, and natural environments—such as in alternative and complementary medicine settings as well as in people's homes and workplaces—where their multiple efficacies and toxicities need to be taken into account in order to evaluate their neuro-biological impact(s) and cultural power (Oldani et al., 2014; Petryna et al., 2006). For example, in Iran, the amount of medicine stocked in patients' homes was posited as one of the reasons why the sales of pharmaceuticals usually have no direct relation to health indices (Abdollahiasl et al., 2014). Despite the efforts of the Iranian Ministry of Health to establish a center for promoting the rational use of drugs in 1995, the inappropriate use of drugs in terms of non-adherence to prescribed drugs, the overuse and misuse of drugs, and the use of needlessly expensive drugs all remain problems and require prompt attention (Mousavi et al., 2013). However, the prescription of medicines is not the only factor in the vast majority of sales as, in addition to OTC medicines,

a significant number of prescription-only medicines are available in Iran's pharmacies without the need for a prescription (Cheraghali, 2006). Some of the sociocultural roots of drug consumerism and self-medication among Iranians have been discussed before. Farid Barati[6] describes some of the factors involved in the overuse of medications as well as the public wish for medicalization of problems in Iran, including the following: the move from a traditional Iranian perspective on suffering and healing (characterized by a body and mind monism) toward a modern biomedical perspective (with body and mind dualism); dependency on physicians and the deep social faith accorded to them; and the rise of the culture of consumerism in Iran. Pharmaceutical consumerism among Iranians is also associated with ready access to medical doctors because of the availability and affordability of the healthcare system as well as the availability and affordability of essential drugs for more than 90% of the population (Cheraghali et al., 2004) due to the relatively low cost of medicines and the insurance coverage.

Although, in the past decade, the annual rate of both imported and local pharmaceutical items has significantly increased in Iran (Cheraghali, 2013), there is no evidence to show that the Iranian psychiatric system has been exclusively influenced by the pharmaceutical industry, which can be due to a lack in the intellectual property right regulations that directly affects the commercialization process of pharmaceuticals in Iran (Nassiri-Koopaei et al., 2014)

1.2.7 Iran: Social and Political Context, Gender Disparities, and Family Values

Following the overthrow of the Pahlavi monarchy in 1979, Iran became an Islamic country and theocratic republic (Priester, 2008). In 1979, a major demand of the anti-Pahlavi (Shah) revolution in Iran was promoting pluralism and developing a civil society. However, the

[6] Psychology Professor, Department, Quran and Hadith University, Qom, Tehran, Iran, Director General, Prevention and Addiction Affairs Bureau, The Welfare Organization, Iran.

Islamic Republic (IR) regime was established through eliminating opposition groups and stabilizing the regime's ideological position on political, economic, and social matters. Since the revolution, Iran's economic policy has changed hands between neo-liberals and right-wing populists; however, social policy has been determined largely by right-wing populists. In more recent times, views of classic liberalism and social democracy have been represented by less powerful institutions, which the regime mainly kept marginal (Fozooni, 2014).

The IR of Iran has had a major political influence over the social and economic situation of women's lives, exercising religious ideology at the state level to restrict women's rights and freedom within society. During and after the revolution, women have served as political symbols for the IR of Iran. How women dress and act has been interpreted as reflecting Iranian society. Therefore, establishing laws specifically concerning women has been seen an important way for the state to exercise its control and its power to express its values (Gerami, 2004). Since the revolution, while the IR regime has had its own agenda in promoting the Islamization of society through education, it has made education, including higher education, more accessible to women, who in the 21st century account for more than 60 percent of university students. Even though Iran's unstable economy and the gender discrimination that women encounter limit their participation in the job market (Rezai-Rashti & Moghadam, 2011), the high rate of education of women has increased their expectations for civic participation socially, economically, and politically. Education has also facilitated women's knowledge of diverse secular and religious worldviews on gender equality, and women have increasingly questioned legal limitations that the IR has imposed on them both within marriage and in the wider society. Women have steadily launched initiatives to expand the political space available to challenge the state and its promotion of discriminatory legal and social treatment of women (Hoodfar, 2010). Still, given its

religious commitments, it is inevitable that the IR regime enacts laws that affect women's ability to exercise life choices. Religion, tradition, family, society, and state are all key influences on women's gender roles and on their ability to articulate and pursue their goals in Iran. State and cultural gender ideology affects women's wellbeing, since not all women have equal opportunities. Thus, even though it is difficult to show the direct effect of gender ideology promoted by the state and throughout society on women's health and wellbeing, it is clear that the political setting significantly limits women's choices and results in living situations that are, at times, destructive.

Moreover, the pronatalist policy adopted by the IR regime, with the aim of increasing the Shia population to build the most "powerful" Shia country of the Islamic world, has resulted in a significant population growth, from 33.7 million in 1976 to 77.5 million in 2014 (42.4% under 25, with a median age of 28.3) (Statistical Center of Iran, 2014). The resulting increase in the number of school-aged children, the improving employment market in cities, and the lack of resources in rural areas have led to rapid urbanization; according to the Statistical Center of Iran, in 2011, 71.4% of the population were living in urban areas (Rezai-Rashti, 2012).

Due to this urbanization, globalization, technological advances in communication, and rapid changes in societal values, Iranian society has become caught in a prolonged transition from traditional values to those characteristic of modern Western societies (Shahhosseini et al., 2012). Western values, the transition from a traditional to a modern society, and the generation gap have influenced the relationship between Iranian parents and their children and in some instances have created tension between the two generations (Fatemi, et al., 2015). Iranian societal values have been greatly affected by broad access to the Internet and satellite technology, which has facilitated exposure to Western values. The younger generation is

reevaluating and questioning traditional values with regard to their freedom and their life choices, which has created tension in the parent-child relationship and has led an increasing number of Iranian parents to seek psychiatric and counseling services to address parenting and intergenerational issues (Shahhosseini et al., 2012; Fatemi et al., 2015) On one hand, Iranian adolescents view a strict parenting style as a factor that creates problems in the parent-child relationship. On the other hand, Iranian parents have consistently reported problems relating to their children who are not responding to parents' traditional cultural values (Shahhosseini et al., 2012).

Finally, a yearning by the younger generation for greater choices, gender equality, and sexual freedom, with calls to reform the restrictive bonds of religious, traditionalist, and capitalistic morality (Afary, 2009), has become an ongoing source of conflict that impacts on people's health and wellbeing. It is not surprising that a society dominated by so many fundamental challenges and contradictions—with rapid growth in the youth population rate, urbanization, social repression, gender discrimination, challenges to many traditional values, and increasing tension between modernity and traditional culture through globalization—is experiencing a dramatic increase in mental health problems (Fozooni, 2014; Priester, 2008). In response to these problems, Iran's mental health system has opted for an uncritical transfer of Western biological psychiatric approaches, mostly borrowed from the U.S. (Davidian, 1995; Mehryar et al., 1986; Javanbakht & Sanati, 2006). However, there are fundamental differences in values and epistemic assumptions between the Western scientific approach and the IR approach. In the West, there is a disconnection between religion and science, but in the IR, religion is an integral component of every aspect of life, including scientific endeavors (Priester, 2008). To address this difference, the IR's non-theocratic (reformist religious) mental health system has

been seeking its own special path or third way, which purports to transcend so-called Western secularism (which emphasizes the importance of individual choice) and Eastern theocracy (which emphasizes the centrality of religious rules and values). This third way has embraced the biological approaches that allow a kind of medicalization of those individual choices. While couched in scientific discourse, this biomedical approach may actually serve to promote religious norms, including traditionalist sexual edicts (Fozooni, 2012). It also results in the de-politicization and de-contextualization of social problems and thus may inadvertently constrain critique of and challenges and changes to social norms (Conrad, 2008).

1.2.8 The Medicalization of Mood: An Overview of the Controversy Over Bipolar Spectrum and "Soft" Bipolarity

In the West, concerns about medicalizing normal behaviour and deviance have resulted in a recurrent critique of the DSM and psychiatric practice (Youngstrom et al., 2010). Bipolar disorder has been singled out for specific criticism because in recent years, in the U.S., the rates of clinical diagnosis have increased 2-fold in adults and 40-fold in youth and children (Moreno et al., 2007; Parens & Johnston, 2010). To some extent, this reflects the current state of therapeutics. Success in managing classical bipolar cases due to the discovery of lithium in 1949 and its introduction into the marketplace in 1970 (Shorter, 2009) made it tempting to see patients with many other diagnoses as having bipolar disorder, too. Forty years later, patients with a wide variety of clinical symptoms may be considered to have variants of bipolarity and are treated with the same drugs designed and approved for classic mania (Paris, 2012).

The expansion of the diagnostic categories resulting from both contemporary psychiatry's shift from psychotherapy toward psychopharmacology (Mojtabai & Olfson, 2008) and the marketing of new disorders by pharmaceutical companies (Healy, 2012) has led psychiatrists to

broaden classic manic-depression into a family of "bipolar spectrum" (BSD) or "soft bipolar" disorders—a spectrum wide enough to include much of the current territory of psychiatry and even many subclinical conditions in the general population (Healy, 2006, 2010; Martin, 2007; Paris, 2012). Outside the formal classification system, Akiskal and others identified clinical conditions they termed bipolar II½, bipolar III, bipolar III½, bipolar IV, bipolar V, and bipolar VI disorders (Healy, 2010). Leading academic psychiatrists such as Jules Angst, Hagop Akiskal, Fred Goodwin, and Nassir Ghaemi have actively promoted this new concept of bipolarity, claiming that bipolar disorder accounts for a large percentage of the cases that clinicians see. They argue that patients diagnosed with many other disorders actually suffer from a variant of bipolarity and that all of them can be treated with the same drugs prescribed for classic bipolar disorder (Moncrieff, 2014; Paris, 2012). However, evidence from both the U.S. and European perspectives suggests that it is unclear whether the classical bipolar agents like lithium or more recent medications like lamotrigine are robustly effective in treating bipolar depression, let alone the wide spectrum of conditions including BSD either in children/adolescents or in adults (Stahl, 2013).

Nevertheless, bipolar disorder, which was considered a rare and serious mental disorder, has replaced many other diagnoses and is being diagnosed with increasing frequency in Europe and North America (Mitchell, 2012; Moncrieff, 2014). The expansion of the boundaries of bipolarity, which has continued in the new millennium, may have unintended consequences. First, the expansion of the bipolar disorder diagnosis has been accompanied by efforts to market new "atypical" antipsychotics and other drugs labeled "mood stabilizers." The wider use of the bipolar diagnosis for a spectrum of disorders appears to have allowed the use of these drugs to migrate out of the arena of serious mental disorder and into the much larger (and more

profitable) realm of everyday emotional problems (Moncrieff, 2014). Second, the cumulative effect of changes in diagnostic practice could translate into a major public health concern, as hundreds of thousands of people are prescribed medications that may have uncertain benefits for their actual clinical issues; this has clear costs in terms of expense and side effects (Paris & Black, 2015; Youngstrom et al., 2010). Finally, and most relevantly for this study, the medicalization of everyday emotional problems and the integration of psychopharmaceuticals into everyday life have played an important role in transforming everyday notions of normality, explanations for behaviour, modes of self-regulation, and sense of identity (Rose & Abi-Rached, 2013). Analysis of the rise in the diagnosis of BSD shows that it has resulted in changes in the classification of mental disorders, the advertising of drugs, and the sociocultural and political interpretations of distress (Maturo, 2010).

Given the dominance of Western biomedicine in the world, it should not be surprising to see the rapid diffusion of changes in biomedical categories to non-Western societies (Conrad, 2009). The transformation of contemporary psychiatry in non-Western countries shows the domination of Western psychiatry over the last few decades (Béhague, 2008; Kirmayer, 2006; Watters, 2010; Bemme & Kirmayer 2020). Nevertheless, there is still a gap in understanding how new concepts like "soft bipolarity" or bipolar spectrum disorder are exported to a non-Western society, the degree to which and under what conditions they are adopted, and the impact and meaning that they have not only on medical practice but also on the wider society. To address to this gap, this study aimed to examine the dynamics of the use of bipolar spectrum diagnosis and its consequences. More specifically, it aimed to explore how the new Western

concept of bipolarity, "bipolar spectrum disorder" (BSD[7]), and treatment are understood and applied among psychiatrists and how patients experience and live with the diagnosis and medication regimen in a non-Western society, Iran. This specific case study can shed light on how a Western medical concept of distress is exported to non-Western societies, the conditions under which new practices are adopted, and how their impact and meaning shift across cultures and social contexts.

1.2.9 The Prevalence of Mental Disorders in Iran

Like in many non-Western countries (Watters, 2010), the view and practice of Iranian psychiatrists in contemporary Iranian psychiatry is very much influenced by Western—particularly American—psychiatry (Mehryar et al., 1986) and is largely due to the Western training of people responsible for the development of modern psychiatry in Iran (Davidian, 2008; Javanbakht & Sanati, 2006). Consequently, all the changes, fashions, and controversies in diagnoses and treatments seen in Western psychiatry are sooner or later seen in Iran. The expansion of bipolarity—promoted as "soft bipolarity"—is only one of many examples of this influence. Following the dramatic increase in professional interest in diagnosing bipolar disorder in the U.S.—an interest reflected in a rapid growth in publications, international societies, scientific journals, and conferences focused on this condition mainly promoted by Anglo-Western psychiatrists (Mitchell, 2012)—Iranian psychiatrists also became interested in this diagnostic fashion (Abhari et al., 2013; Amin-Esmaeili, 2014; Haghighi et al., 2011; Shabani et al., 2009; Shabani et al., 2010).

[7] It is also called "soft bipolar disorder," "atypical bipolar," "dysphoric mania," and "atypical mixed depression."

A systematic review of 35 epidemiological studies in Iran showed that the prevalence of psychiatric disorders varied from 1.9% to 58.8% (Rahimi-Movaghar et al., 2014). Although findings of the first national survey on mental health disorders have never been published (Rahimi-Movaghar et al., 2014), a nationally representative face-to-face household survey conducted in 2011 to investigate the twelve-month prevalence of psychiatric disorders based on DSM-IV criteria found that 26.5% of women and 20.8% of men suffered from one or more psychiatric disorders (Sharifi et al., 2015). According to this study, higher socioeconomic status and having a university education were associated with lower rates of psychiatric disorders, while unemployment, widowed or divorced status, and living in urban areas were associated with higher rates of psychiatric disorders. The most prevalent disorder was major depressive disorder (12.7%), followed by generalized anxiety disorder (5.2%) and obsessive-compulsive disorder (5.1%). In 2011, in mental hospitals, the most common disorders treated were mood disorders (65%), followed by schizophrenia (17%) and neurotic disorders (7%) (Scull, 2014). An epidemiological study in 2005, in which substance abuse was not addressed, shows that the prevalence of psychiatric disorders in Iran was 10.81%, being more common among females than males (14.34% vs. 7.34%), with a 4.29% prevalence in mood disorders (Mohammadi et al., 2005). In another study by the same authors, the lifetime prevalence of bipolar disorder was estimated at 0.34 (bipolar I at 0.04 and bipolar at II 0.3), which was 14.5% of all mood disorders (Mohammadi et al., 2006).

The diagnostic criteria for the diagnosis of bipolar (spectrum) disorder broadened from requiring an episode of mania or hypomania to simply experiencing an episode of elevated/irritable mood or increased activity affecting social/occupational functioning. The expanded boundaries of bipolarity in the new millennium (Akiskal et al., 1999; Akiskal, 2002;

Angst et al., 2003a; Angst et al., 2010) were quickly adopted in the Iranian psychiatric system. This was reflected in research as well as practice. Until 2009, less than 8 percent of mood disorder research was allocated to bipolar disorder, with a lack of longitudinal studies (Esmaeili & Gudarzi, 2009). Soon after the BSD diagnosis was introduced to the Iranian psychiatric system, however, new diagnostic scales for bipolar disorder, such as the Bipolar Spectrum Diagnostic Scale (BSDS) (Hirschfeld, 2000), the Bipolarity Specifier Scale (Angst et al., 2003a), and the Subthreshold Hypomania Scale (Kessler et al., 2006) were translated to Farsi and used in a series of studies on both adults and children. These studies looked for "hidden bipolar patients" and indicated that bipolar disorder had been misdiagnosed and that a higher rate of psychiatric patients should have been diagnosed bipolar (Abhari et al., 2013; Amin-Esmaeili, 2014; Haghighi et al., 2011; Shabani et al., 2009; Shabani et al., 2010). An early study on BSD in Iran (Shabani et al., 2009) showed that 39% of MDD inpatients suffered from BSD by the definition of Ghaemi et. al (2002). Using the expanded criteria of bipolarity, Amin-Esmaeili, in the most recent study on subthreshold bipolar disorder in Iran, found "hidden bipolarity" in 25% of individuals with a major depressive disorder; however, the study used a very weak indicator of significance, setting the p-value to < .20 (Amin-Esmaeili, 2014). Another study of the bipolar spectrum in 2013 argued that a significant portion (53.9%) of patients previously diagnosed as having major depressive disorder were misdiagnosed because they fulfilled the criteria of bipolarity by the Bipolarity Specifier Scale, which includes all cases of bipolar I & II disorders and additional cases excluded by DSM-IV-TR criteria (Abhari et al., 2013). This study, which criticizes DSM-IV-TR for not being accurate enough to distinguish the atypical form of bipolar or "soft bipolar" patients from unipolar ones, extended the category far beyond the boundaries proposed by Akiskal and Pinto (1999) and even beyond some studies that suggested that 40% of

patients with a major depressive disorder diagnosis conform to the bipolar II pattern (Angst, 2010; Zimmermann, 2009). Although most studies on bipolar disorder in Iran have been questioned for the lack of validity of the descriptive approach in diagnosing bipolar disorder (Shaban et al., 2009), the Iranian psychiatric system has mainly accepted the creation of the expanded bipolar disorder diagnosis, assessed through the associated measures, as applicable to a large portion of psychiatric patients in the country.

In summary, following a worldwide controversy over the recent concept of bipolarity and the potential medicalization of mood (Moncrieff, 2014), Iranian psychiatrists involved in academic training and in the private sector have vigorously debated the evolving conceptualization of the conditions currently referred to as the bipolar disorder spectrum and its consequences (Mianji, 2014; Shabani, 2009). The increased tendency among Iranian psychiatrists to make a bipolar diagnosis, the discovery of "hidden" bipolar patients through the expansion of diagnostic criteria, and a lack of evidence for the efficacy of the new concept of bipolarity and its treatments have all raised concerns about the over-diagnosis of bipolar disorder in Iran.

1.3 Objectives of This Study & Research Questions

This study used a qualitative research strategy to address the following research questions:

i) How is the new diagnostic category of bipolar "spectrum" disorder understood and applied among psychiatrists?;

ii) What factors are influencing the emergence and spread of knowledge and practices related to bipolar "spectrum" disorder among institutions and practitioners?;

iii) What the illness meanings and experiences are reported by individuals diagnosed with BSD?;

iv) What causal attributions, explanations, and illness prototypes are described by individuals diagnosed with BSD?; and

v) What coping and health seeking strategies are used by individuals diagnosed with BSD in their sociopolitical, gendered, and cultural contexts and what are the impacts of the diagnosis on their lives?.

1.4 Theoretical Framework

The design, data collection, and interpretation of findings in this research project drew from two theoretical approaches: (1) a medical sociological approach of medicalization defined by Conrad and Schneider (1980) and (2) a theoretical approach to folk illness explanations developed by Allan Young (1981), which examines knowledge of prototypical illness events and knowledge embedded in action, social relations, and material equipment in addition to using explanatory models of illness.

1) "Medicalization describes a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illness and disorders" (Conrad & Schneider, 1980). Sociologists have studied medicalization since the late 1960s. The first studies focused on the medicalization of deviance (Pitts, 1968), but soon the concept was seen to be applicable to a wide range of human problems that had entered medical jurisdiction (Freidson, 1970; Illich, 1976). For nearly four decades, analysts have focused on the specific instances of medicalization, examining the origins, range, and impact of medicalization on society, medicine, patients, and culture (Conrad, 1992; Lock et al., 1988). Although in medicalization as a sociocultural process

physicians and their treatments may or may not be directly involved, many of the earliest studies assumed that physicians were the key to understanding medicalization (Conrad, 1992). According to Conrad (2008), social factors that have helped lead to medicalization include "the diminution of religion; an abiding faith in science, rationality, and progress; the increased prestige and power of the medical profession; the American penchant for individual and technological solutions to problems; and a general humanitarian trend in Western societies" (p. 8). Conrad also noted that although most sociological works in the 20th century portray the medical profession, interprofessional or organizational contests, or social movements and interest groups as the prime movers of medicalization, there has been an important shift in the 21st century, with the engines that drive medicalization now mainly biotechnology (especially the pharmaceutical industry and genetics), consumers, and managed care. The core definition of medicalization remains constant, but some of its causes and forms are changing. In particular, the availability of new pharmaceutical and potential genetic treatments are increasingly drivers for expanding new diagnostic categories (Conrad, 2008). Moreover, medicalization studies by sociologists and feminist scholars have shown the expansion of medicalization in women's lives (Riessman, 1983; Riska, 2003). This expansion has been documented in studies of reproduction and birth control, childbirth, infertility, premenstrual syndrome, fetal alcohol syndrome, eating disorders, sexuality, menopause, cosmetic surgery, anxiety, mood, and depression. To understand the emergence and spread of medicalization through the expansion of psychiatric categories, it is important to investigate social and cultural factors, which, rather than being explanatory, set the context in which medicalization occurs (Conrad, 2008).

2) Medicalization acts on and through individuals' everyday understandings of illness and affliction. Based on ethnographic work in rural Ethopia, Young (1982) developed a

theoretical framework for understanding an individual's illness narratives. According to Young, people use multiple cognitive models to perceive, reason about, and respond to their illnesses, including their coping, help-seeking, and treatment adherence (Young, 1982). He observed three specific types of knowledge structure in individuals' accounts of their symptoms, which he termed explanatory models, prototypes, and chain complexes.

Explanatory models refer to symptoms or illness schemas organized in terms of cause-and-effect relationships, referring to ideas about etiology, pathophysiology, course and treatment. This type of representation parallels the structure of physicians' biomedical knowledge. Prototypes involve salient past episodes or events, which serve as exemplars of a particular type of illness experience. The person reasons analogically from the prototype to his or her current instance of illness to understand its meaning and implications. Prototypes are based on images or events from one's own past illness experience or that of someone with whom the individual identifies in some way and can serve as models to anticipate future events and outcomes. However, they are not organized in terms of explicit causal process. Chain complexes is a form of 'transductive' reasoning which uses the meaningful linking together of salient events and sensations based on temporal contiguity. Chain complexes involve a sequence of events, drawn from memory, which led up to the current symptom or illness. In chain complexes, people reason about their symptoms in terms of this sequence but do not invoke a causal link. (Stern & Kirmayer, 2004, p. 131)

Although much medical anthropology, following the work of Arthur Kleinman (1987), has focused on explanatory models, according to Young's account, prototypes and chain complexes may be as prevalent as explanatory models in illness narratives. Moreover, the various types of knowledge structures are not mutually exclusive but commonly co-exist and

may be used to differing degrees by different people (Stern & Kirmayer, 2004; Young, 1981, 1982). Understanding illness, then, involves not only looking at how a person names it, what meanings and causal explanations are attached to it, and what help-seeking behaviours it leads to (Kleinman, 1980), but also salient past episodes or events (prototypical illness events) as well as tacit knowledge that is embedded in action, social relations or situations, and material circumstances (Young, 1981).

This study, then, employed tools developed to explore the archival and observational methods of sociology and methods designed to study illness narratives to investigate the new concept of bipolarity in Iran. The aim was to understand the factors influencing the emergence and spread of knowledge and practice related to the new concept of bipolarity (BSD) among institutions and practitioners, how the expansion of bipolarity is understood and applied among psychiatrists, and how individuals diagnosed with bipolar disorder perceive living under this diagnosis and treatment.

1.5 Methodology

The research design was based on a qualitative case study methodology with a focus on the emic perspective. This methodology is most appropriate for the objectives of this research to explore the medicalization of mood through clinician interviews and patient narratives. Qualitative research methods can allow researchers to understand the complex worlds of respondents comprehensively (Stainback & Stainback, 1988). This methodology allowed us to explore the new concept of bipolarity as a socially constructed disorder that changed over time—in terms of organizational and professional changes as well as individual perception changes—through sociopolitical and cultural transition in Iran. Semi-structured individual interviews were

used to elicit professional understandings of the emergence and the uses of this new psychiatric disorder in Iran as well as to explore Iranian patients' perceptions of living under the bipolar diagnosis and treatment.

The study involved two phases: (1) archival research and interviews with key academic psychiatrists involved in training to clarify the history of the introduction and spread of the new concept of bipolar disorder in Iran; the same psychiatrists were also interviewed to explore their use of the diagnosis with patients; and (2) interviews with patients who had receive the diagnosis of BSD to explore their experience of living with the symptoms and the impact of the diagnosis. This study was conducted with the agreement of the Iranian Psychiatric Association (IPA). Details on the methodology for each phase are presented in the following chapters. Here we provide an overview.

1.6 Study Sites

The first phase of this study took place in six psychiatric training hospitals and private offices of academic psychiatrists in the three largest cities of Iran: Tehran, Mashhad, and Isfahan. The hospital sites included Roozbeh Hospital (Tehran University of Medical Science [UMS], in Tehran), Tehran Psychiatric Institute (Iran UMS, in Tehran), Imam Hossein Hospital (Shahid Beheshti UMS, in Tehran), Razi Hospital (University of Welfare and Rehabilitation Sciences, in Tehran), Ibn-e-Sina Hospital (Mashhad UMS, in Mashhad), and Khorshid Hospital (Isfahan UMS, in Isfahan). These institutions are affiliated with the largest medical schools in Iran and are among the main psychiatric training hospitals. Most psychiatrists who were interviewed are affiliated with one of these universities and work in one of the above-mentioned cites. Moreover,

professional networking and collaboration with academic psychiatrists at those sites facilitated the recruitment of patients in the second phase of the study by referral.

In addition, interviews via Skype were conducted with two interviewees who, for professional reasons, did not live in Iran at the time of the data collection. The second phase took place in psychiatric outpatient settings and in patients' homes in four cities: Tehran, Isfahan, Shiraz, and Zabol.

All of the cities included have medical universities with psychiatric training programs which facilitated professional networking and accessing patients. Tehran, Isfahan, and Shiraz are among the five largest cities in Iran; Zabol is a smaller city on the border with Afghanistan with a large ethnic and religious minority population. By collecting data from cities with different demographics and different levels of access to the healthcare and social resources, I aimed to increase the diversity in patients' experiences with mental health problems and help-seeking strategies.

1.7 Sampling and Participants

The participants were identified through purposive sampling, with the aim of identifying individuals who were well situated to provide detailed information about psychiatric education policy and practice related to mood disorders in psychiatric departments (for the first phase of study), and with regard to the experience of living under the diagnoses and treatments of bipolar disorder (in the second phase of study).

Phase I. This phase included two components: 1) semi-structured interviews with psychiatrists; 2) analysis of archival materials and data driven from fieldwork notes during participant observation in Iranian psychiatric events.

For the semi-structured interviews (Appendix A), the study recruited 25 prominent psychiatrists (7 female and 18 male), university professors, who were influential in training and practice in the field of mood disorders working in 6 major training psychiatric settings in Iran. To find these individuals, we reviewed the Iranian psychiatric literature (mainly on mood disorders) and Iran's mental health mass media to identify the psychiatrists most involved in mood disorder research/training. After making a primary list, the researcher, who had been a member of the Iranian Organization of Psychology and Counseling and graduated with a PhD in Psychology from Iran, contacted her former professors and colleagues, shared the research aims, and asked them for a list of leading figures in mood disorders (secondary list). Then, she modified the two lists by checking with the Dean of the Iranian Psychiatric Association and her local mentor in Iran, Dr. Azarakhsh Mokri[8], and finalized a list of 25 informants. All interviews took place in a quiet office in the psychiatric ward of the related hospitals or in the participant's private office and were digitally recorded. Written and oral informed consent was obtained from all participants included in the study (Appendix C).

Documents constituted another important source of data for this study. The strengths of a documentary analysis are that documents can not only help the researcher to elicit nuanced meanings that he or she is trying to understand but also help broaden the understanding of the context surrounding the phenomenon under examination (Hodder, 2000; Rodríguez et al., 2014). Archival material thus enriched our understanding of the academic context within which contemporary psychiatry in Iran has been constantly constructed. In addition to the interviews and archival materials, additional data was derived from the fieldwork notes prepared during participant observation in Iranian psychiatric training and continuing education events and

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seminars, including the 31st Annual Meeting of the Iranian Psychiatric Association, Tehran, Iran (October 14-17, 2014), the First Iranian Psychoanalytic and Psychodynamic Psychotherapy on Culture and Psychotherapy, Tehran, Iran (October 11-13, 2014), the 4th Social and Cultural Psychiatry Conference, Tehran, Iran (May 13-15, 2015), as well as the analysis of national and social media contents about the current mental health conditions of Iranians, which provided information on relevant research and training activities and clinical practice, and both formal and informational discussions in institutional settings. Other ethnographic data collected during field visits and through social media platforms were used to clarify and interpret material derived from the interviews based on the context in which the narratives were produced and concurrent professional and public debates.

Phase II. In this phase, 37 patients (male and female, 18-55 years old) were recruited by psychiatrists who are specialized in mood disorders in Tehran, Isfahan, Shiraz, and Zabol. Patients had received a bipolar spectrum disorder diagnosis and treatment, excluding bipolar-I. Patients were identified by psychiatrists who are specialized in mood disorders, including those who participated in the first phase of the study and by the researcher's former colleagues. The project was introduced to participants first by their clinicians as "a study to better understand patients' experience with their mental suffering (emphasizing mood disorders)." Patients who agreed to participate were interviewed by the first author in their psychiatrist's office, in their homes, or in their work offices. Patients gave informed consent (Appendix D & E), either written or oral. When participants agreed to audio-recording, oral consent was recorded at the start of the interview. No quotes have been used from interviews with patients who did not agree to being audio recorded but some have been drawn from notes taken during our interviews.

1.8 Ethical Considerations

1.8.1 Approval from Ethics Boards

This research project was approved by the Research Ethics Committee at the Jewish General Hospital, McGill University, Montreal, Canada (Appendix F &G).

1.8.2 Confidentiality

The confidentiality of interviewees in the project was guaranteed. No identifying information has been disclosed or published. Electronic files have been maintained in password protected files at the Culture and Mental Health Unit, Institute for Community and Family Psychiatry, Jewish General Hospital in Montreal. To protect the identities of informants and any others mentioned in case studies, all respondents were assigned a code number, and consent forms have been kept separate from the anonymized interview transcripts. All interview audio files and transcripts will be kept under lock and key in the research unit and will be destroyed seven years following collection.

1.8.3 Dissemination of Research Results

The results from this study were submitted to and published in two scientific journals: Culture, Medicine, and Psychiatry and Transcultural Psychiatry. Results were also presented at both national and international conferences and presentations in Canada, the U.S., Japan, and Iran. In addition to academic journals and scientific conferences, I have disseminated the findings of this study via TV (such as BBC Persian and Iran-International), radio, and social media interviews with Persian-speaking media and news agencies based in Europe and North America. These media and TV channels are widely available through satellite transmission in Iran. In all dissemination activities, the confidentiality of participants has been protected: no

participant has been mentioned by name and identifying information and locations have been removed.

1.9 Data Collection

The data for this study were gathered through semi-structured individual interviews with participants and a review of secondary sources.

Semi-structured interview. For phase I, semi-structured individual interviews (Appendix A) were conducted using the semi-structured interview guidelines constructed in English and translated into Farsi.

For phase II, semi-structured individual interviews were conducted using the McGill Illness Narrative Interview (MINI) (Groleau et al., 2006). The MINI (Appendix B) is sequentially structured with three main sections: (1) a basic temporal narrative of symptom and illness experience, organized in terms of the contiguity of events; (2) salient prototypes related to current health problems, based on previous experience of the interviewee, family members or friends, and mass media or other popular representations; and (3) any explanatory models, including labels, causal attributions, expectations for treatment course, and outcome. Supplementary sections of the MINI explore help-seeking and pathways to care, treatment experience, adherence and impact of the illness on identity, self-perception, and relationships with others (Groleau et al., 2006). The interview begins with questions about the events contiguous with an illness episode (chain complexes), and then moves to questions about symptom and illness prototypes (Groleau & Kirmayer, 2004), ending with explicit inquiry about explanatory models (Kleinman, 1980). Supplementary sections at the end of the interview explore help-seeking and pathways to care, treatment experience, adherence, impact of the

illness on identity, self-perception, and relationships with others (Groleau et al., 2006). In order for the MINI to be conceptually and semantically valid for the Iran setting, the English version was translated into Farsi by a bilingual Iranian psychologist and was edited by a bilingual Iranian psychiatrist.

1.10 Data Analysis

All interviews were conducted in Farsi and transcribed by the first author. The analysis of data was an ongoing, iterative process that started at the beginning of data collection. Transcripts of the first-phase interviews were manually analyzed by thematic coding with an emphasis on identifying key terms and concepts, analogies, and explanatory models. Key passages were translated into English for discussion with the research advisor and research committee. A case-comparison method was also used to analyze the collected data; this compared the entire explanatory narrative from each participant with the explanatory narratives of the others. When participants provided similar explanations, we characterized the more general explanatory model or template in terms of its conceptual, institutional, and structural origins, anchors, and consequences. This synthesis allowed us to examine why and how the controversy over BSD has unfolded in the Iranian context (Yin, 1981).

To analyze the data gathered from the second phase of study (patient interviews), we used a thematic coding with an emphasis on identifying the underlying ideas, assumptions, metaphors or analogies, conceptualizations, and help-seeking strategies, based on three modes of reasoning about or representation of symptoms and help-seeking choices, including exploratory models, prototypes, and chain complexes (Groleau et al., 2006).

1.11 Methodological Limitations

Several design features related to sampling and the interview process may limit the generalizability of our findings. We interviewed patients who were seeing psychiatrists, who had received a diagnosis of BSD, who were selected by their clinician as potential participants, and who agreed to participate in the study and talk to the interviewer, an expat Iranian psychologist, at a time of political repression and turmoil. All of these factors contribute to potential biases in the sample and in the kinds of narratives the patients provided. The researcher's affiliation with a Western university could be perceived in different ways. For some participants, being interviewed by an expat psychologist who is not affiliated with Iranian universities and government might have facilitated building trust and feeling more secure in sharing experiences that included criticism of the system. Yet, for some participants the same position, it may have been difficult to trust a "foreigner" and share their experiences, fearing that the researcher might be a Westerner "spy." In fact, this is what my research assistant, who is a second-generation Iranian-Canadian, was jokingly called by an academic psychiatrist when I was introducing her and my project at an annual psychiatry conference in Tehran. Moreover, patients who had been referred to the study by their current clinicians might have worried that their relationship with their psychiatrist might be affected by the potential breach of confidentiality in the research interviews or, on the other hand, might have felt more eager to talk about problems that they had not had a chance to share with their clinicians due to the short length of the psychiatric visits, hoping that the researcher would pass their stories and concerns on to their psychiatrists.

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CHAPTER 2: THE GLOBALIZATION OF BIOLOGICAL PSYCHIATRY AND THE RISE OF BIPOLAR SPECTRUM DISORDER IN IRAN

2.1 Abstract

In recent years, psychiatry in Iran witnessed a dramatic increase in the use of the diagnosis of Bipolar Spectrum Disorder (BSD). This qualitative study maps the journey of the BSD diagnosis from the West to Iran, examines the controversy surrounding the diagnosis and its treatment, and explores some of the structural factors that facilitate and maintain the widespread use of the BSD diagnosis in Iran and related practices of prescribing neuroleptic and mood stabilizers. The study methods include archival research and semi-structured interviews with 25 prominent Iranian psychiatrists in the field of mood disorders. Results show the importance of factors in addition to economics in driving changes in diagnostic fashion. Most psychiatrists interviewed reported what they viewed as an over-diagnosis of bipolar disorder and over-prescription of mood stabilizers and atypical antipsychotics among Iranian psychiatrists over the past decade. In addition to the influence of leading figures of American psychiatry, the dominance of Western psychiatric classifications and textbooks in Iran's psychiatry, and indirect intervention by pharmaceutical companies, local structural and political factors have played a significant role in the Iranian psychiatric system's embrace of the new concept of bipolarity. In Iran, the medicalization of social conflict has been embraced by government, families, and psychiatrists for cross-cutting purposes. These challenges and the continued controversy over

the adoption of American psychiatric fads in a non-Western country like Iran point to the importance of elaborating a more ecosocial and cultural view of psychiatric practice to disentangle some of the complex trade-offs involved in adopting particular modes of diagnostic practice.

2.2 Keywords

Bipolar Spectrum Disorder, Medicalization, Globalization of American Psychiatry, Global Mental Health, Iranian Psychiatric System

2.3 Introduction

In the new millennium, psychiatric theory, research, training and practice have become subject to the forces of globalization. Although German, French and other European traditions participated in the early dissemination of psychiatry through colonial institutions, in the era of globalization, Anglo-American psychiatry has come to dominate the international landscape (Fernando, 2014; Kirmayer, 2006). Mental health researchers and professionals trained in the West, particularly in Britain and the United States, have contributed to the official categories of mental diseases enshrined in the International Classification of Diseases (ICD; WHO, 1992) and the Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association, 2013) that circulate internationally. In addition to psychiatric nosology, U.S. and British researchers and organizations run many of the leading scholarly journals and host the most widely attended and influential conferences in the fields of psychiatry and clinical psychology. Western universities have trained most of the world's most influential academic psychiatrists. This academic influence is coupled to a powerful set of economic interests (Applbaum, 2010; Healy, 2003). Much of the clinically important, evidence-based research in psychiatric training and practice—even the core training of residents in psychiatry—has been shaped by pharmaceutical companies with vested interests in demonstrating the value of their products (Angell, 2005; Kirmayer, 2006; Lexchin, 2012; Watters, 2010).

Iran is one of many countries where psychiatric training and practice have adopted US nosology and where educators and practitioners closely follow the work of American psychiatric researchers and organizations. Iran provides a particularly interesting context to examine the globalization of psychiatry because it is a relatively wealthy, well-developed country with a long history of psychiatric institutions, and universal health care with integrated mental health programs. In addition, the state subsidized the local production of pharmaceuticals and the influence of the pharmaceutical industry on diagnostic practices has been somewhat less direct than in the U.S. Nevertheless, the perspectives and practices of psychiatrists in contemporary Iran have been strongly influenced by Western psychiatry (Mehryar, 1986). This influence has occurred through the Western training of key individuals responsible for the development of modern psychiatry in Iran (Davidian, 2008; Javanbakht & Sanati, 2006), as well as ongoing knowledge exchange. Despite the influence of Western psychiatry, the ways that diagnostic fashions play out are also strongly influenced by Iran's local issues and institutions.

In *Writing Prozac Diaries in Tehran*, Behrouzan (2016) explored the dramatic increase in the diagnosis of depression and Attention Deficit Hyperactivity Disorder (ADHD) and in the use of antidepressants and methylphenidate (Ritalin) following the exportation of Western psychiatry to Iran, a society that has been dealing with the aftermath of military and ideological wars and ongoing sociopolitical conflicts. She traced the loops that turned depression into a common idiom for social distress, promoted by psychiatrists and embraced by laypeople, and highlights the complexity of distinguishing between social hopelessness, collective grief, melancholy, situational depression, and clinically significant major depression in the Iranian context. Imposing 'universal' psychiatric categories led to a psychiatrization of social hopelessness that

tends to downplay individual agency and replace sociopolitical discourse with a biopsychological account with troubling consequences.

The rise of the use of the diagnosis of depression in Iran, which occurred in the second half of 1990s, was followed by a dramatic increase in the use of another newly minted psychiatric diagnosis—Bipolar Spectrum Disorder (BSD) or "soft" bipolar disorder—accompanied by the widespread prescription of neuroleptics and mood stabilizers. As part of a larger study of Iranian psychiatric practice surrounding the construct of BSD, this paper aims to examine how BSD knowledge and practice have travelled from the US to Iran. This paper presents findings from qualitative interviews with key informants who are prominent Iranian psychiatrists in the field of mood disorders and consists of four sections: 1) an introduction to Iran's mental health system and to the controversy over BSD in the US and the rise of BSD in Iranian psychiatric literature; 2) an oral and archival history of the "bipolar expedition[9]" to and within Iran; 3) an exploration of some of the controversy surrounding the BSD diagnosis and its treatments in Iran; and, finally, 4) an analysis of some of the structural factors that facilitate and maintain the inflation of the BSD diagnosis and of corresponding practices of prescribing neuroleptic and mood stabilizers in the country.

2.3.1 Background

Since 1968, Iran's mental health services have been integrated into the primary health care system. This policy of integration aimed to create infrastructure to meet the mental health needs of all parts of the country, especially rural and remote areas (WHO, 2006). Although this

[9] The term is borrowed from Emily Martin's book (2007) and serves to emphasize our focus on the ways that the concept of bipolarity travels between and within societies.

program has been successful in rural areas, it did not reach its objectives in urban areas due to inadequate coverage and quality of services. Problems with the coverage and quality of mental health services in the country have been attributed to the insufficient budget allocated to mental health services[10] (Naghavi, et al., 2009), unequal access to mental health services across the country with most mental health care beds located in large cities rather than rural areas (Sharifi, 2009), relatively low fees for psychiatric visits[11], the lack of insurance coverage for psychosocial services (Forouzan, 2011), and the lack of psychiatrists' interest in community mental health models of care (Sharifi, 2009). These factors have contributed to the prevalence of the "revolving door" phenomenon seen at most hospitals, with discontinuation of treatment, repeated relapses, leading frequent re-hospitalization of patients (Hajebi, et al., 2013). The term "revolving door" refers to the frequent hospital admissions of patients who remain well for only short periods of time after hospitalization. Many of these patients live in adverse social circumstances that contribute to their repeated decompensation (Botha, et al., 2010).

Contemporary psychiatric training in Iran—and the resulting modes of clinical practice—closely follow American psychiatric textbooks, specifically those published by the American Psychiatry Association (APA) (Javanbakht & Sanati, 2006; Mehryar, 1986). Consequently, many of the changes, fashions, fads, and controversies in diagnosis and treatment seen in Western psychiatry eventually are also found in Iran. The expansion of the construct of bipolarity—

[10] Mental health expenditures constitute only 3% of the total health budget (WHO 2006) .
[11] According to the 2014 fee schedule set by the Iranian Ministry of Cooperatives, Labour and Social Welfare, the fee per session for seeing a psychiatrist in a university hospital was ~$5 USD, and in a private setting was ~$11 USD[11], per session (for a session of 30 minutes)[11]. According to the same source, seeing a General Physician in a public (governmental) setting is ~$2.70 and in a private setting is ~ $5.50, a session which is supposed to be 15 minutes long. (http://en.ihio.gov.ir/Portal/Home/). Seeing a clinical psychologist costs ~$15-25 USD per 45-minute session (based on the fee schedule set by the Iranian Organization of Psychology and Counseling in 2014; http://pcoiran.org.ir).

promoted with the term "soft bipolarity" by Hagop Akiskal and his colleagues (2003)—is only one of many examples of this influence.

The expansion of diagnostic categories has been associated with both contemporary psychiatry's shift away from psychotherapy toward psychopharmacology (Mojtabai & Olfson, 2008) and the active marketing of new medications by pharmaceutical companies (Healy, 2012). In the U.S., there has been a concerted effort to promote the idea that psychiatric disorders are like other medical conditions, that they can be define in terms of neurobiological processes, and that the role of the psychiatrist should be centered on applying expertise in neuroscience and psychopharmacology (Insel & Quirion, 2005; Kirmayer & Crafa, 2014). In this shift, psychosocial assessment and psychotherapeutic interventions have become less central to psychiatric practice (Frances, 2013; Luhrmann & Uhlmann, 2001; Paris & Kirmayer, 2016). In recent decades, newer generations of medications, with different profiles of side-effect and simpler dosage regimens, made the use of drugs easier, and not only psychiatrists but also family doctors began to prescribe them more frequently. Drug marketing and research policy have fostered the impression that breakthroughs in brain science would soon lead to effective treatment of many (if not most) mental disorders (Applbaum, 2015). In this context, bipolar disorder became a prime target since, in contrast to other diagnostic categories, it resembles a medical illness (Paris, 2012). As a result, bipolar disorder, which was once considered a relatively rare and serious mental disorder, has displaced many other diagnoses and is being applied with increasing frequency to conditions with a wide range of symptoms and severity in Europe and North America (Mitchell, 2012; Moncrieff, 2014). The expansion of the diagnostic categories of bipolar disorder in the 1990s led to a significant increase in bipolar spectrum disorder diagnosis in the US (Joel Paris, 2010). For example, over the 10-year period from

1994-1995 and 2002-2003 this diagnosis increased nearly twofold among adults (age 20 and older) and approximately fortyfold among children and youth (age 0-19) (Moreno, et al., 2007; Parens & Johnston, 2010).

The expanded boundaries of bipolarity proposed by psychiatrists in the 1990s (Akiskal, 2002; Angst J, 2010; Angst, et al., 2003) were adopted by the Iranian psychiatric system, both for research and practice, in less than a decade (Shabani 2009). An epidemiological study by Mohammadi and colleagues in 2005, based on DSM-IV criteria, found the lifetime prevalence of psychiatric disorders in Iran was 10.81%, with an overall gender difference with more females than males (14.34% vs. 7.34%, $p < .001$). The same study found a 4.29% lifetime prevalence of mood disorders, and a lifetime prevalence of bipolar disorder of 0.96 %, which comprised 22.37% of mood disorders (Mohammadi, et al., 2005). This prevalence, however, differs markedly from the findings of another study, conducted around the same time, which estimated the lifetime prevalence of psychiatric disorders to be 30.9% (Abhari et al, 2003). In a systematic review of psychiatric prevalence studies in Iran, Farhoudian and colleagues (2007) attributed the discrepancies in findings across studies to the different methodologies, study designs, and study procedures, including problems with validity and reliability of the measures and samples that were not representative of the general population in many studies.

Despite serious concerns about the methodological limitations of psychiatric epidemiological studies in Iran, the reported statistics on the prevalence of psychiatric disorders are important because they influence policy makers and psychiatrists in Iran as well as public perceptions of emotional and psychological difficulties and coping strategies (Behrouzan, 2016).

For example, according to a bibliometric analysis of research on mood disorder in Iran, until 2009 less than 8% of mood disorder research was allocated to bipolar disorder, with a lack

of longitudinal studies (Esmaeili & Gudarzi, 2009). However, soon after "soft bipolar disorder" was introduced to the Iranian psychiatric system, new diagnostic scales for bipolar disorder, such as the Bipolar Spectrum Diagnostic Scale (BSDS) (Ghaemi, Christopher & Berv, 2005; Hirschfeld, et al., 2000), the Bipolarity Specifier Scale (Angst, et al., 2003), and the Subthreshold Hypomania Scale (Kessler, et al., 2006) were translated into Farsi, and a series of studies using these scales was conducted with both adults and children. These studies looked for "hidden bipolar patients" and indicated that bipolar disorder had been underdiagnosed and that a much greater proportion of psychiatric patients should have received bipolar spectrum (BSD) diagnoses (Abhari, et al., 2013; Amin-Esmaeili, 2014; Haghighi, et al., 2011; Shabani, Koohi-Habibi, et al., 2009; Shabani, et al., 2010). An early study on BSD in Iran using the criteria of Ghaemi and colleagues (2002) reported that 39% of Major Depressive Disorder (MDD) inpatients suffered from BSD (Shabani, Zolfigol, & Akbari, 2009). More recent research on subthreshold bipolar disorder in Iran, using expanded criteria for bipolarity, using data drawn from a national survey on a representative general population aged 15-64 years in Iran, found that nearly 42% of individuals with a major depressive disorder had "MDD lying on bipolar spectrum" (Amin-Esmaeili, 2014). In this study, "MDD lying on bipolar spectrum" was defined as being diagnosed with MDD by the Composite International Diagnostic Interview (CIDI 2.1, REF), plus either having a high symptom rating on Mood Disorder Questionnaire or answering positively to either of the two mania screening questions in the CIDI, and not meeting the full diagnostic criteria for lifetime hypomania. While the twelve-month prevalence of MDD was 12.7%, using the criteria for bipolar spectrum disorder, about 42% of those MDD cases were claimed to have undiagnosed underlying bipolarity.

Another Iranian study of the bipolar spectrum in 2013 argued that more than half (53.9%) of patients previously diagnosed as with major depressive disorder were misdiagnosed because they fulfilled the criteria for bipolarity by according to the Bipolarity Specifier Scale, which includes all cases of bipolar I and II disorders and additional cases excluded by *DSM-IV-TR* criteria (Abhari, et al., 2013). This study, which criticized the *DSM-IV-TR* criteria for not being accurate enough to distinguish the atypical presentations of bipolar or "soft bipolar" patients from those of unipolar disorder, extended the spectrum far beyond the boundaries proposed by Akiskal and Pinto (Akiskal & Pinto, 1999) and others (Angst, 2010; Zimmermann, et al., 2009). However, studies of bipolar disorder in Iran have been critiqued in turn for the lack of validity of the descriptive approach used in diagnosing bipolar disorder (Shabani et al., 2009). Moreover, these studies generally use existing nosology and survey instruments without adequately addressing issues of cultural adaptation and cross-cultural validity. This limits their ability to identify cultural variations and increases the risk of both over- and under-identification of specific disorders (Kirmayer, Gómez-Carrillo & Veissiere, 2017).

Following controversy over the broadened concept of bipolarity and the medicalization of mood in the Euro-American literature (Moncrieff, 2014), psychiatrists involved in academic training and in the private sector in Iran have vigorously debated the evolving conceptualization of BSD and its clinical and social consequences (Mianji, 2014; Shabani, 2009). The increased use of bipolar diagnoses among Iranian psychiatrists, the discovery of "hidden" bipolar patients through the application of expanded of diagnostic criteria, and a lack of evidence for the efficacy of the new concept of bipolarity and its treatments have all raised concerns about the over-diagnosis of bipolar disorder in Iran.

The present study aimed to explore this transformation in psychiatric practice in Iran using a qualitative research method with key informants. The specific objectives were to: 1) describe how BSD and "soft" Bipolar Disorder (BD) knowledge and practice have emerged in Iran in the recent past; 2) explore how the new diagnostic categories of BSD and "soft" BD are understood and applied by psychiatrists; 3) clarify the content and dynamics of the controversy about the uses of BSD diagnoses in Iran; and 4) identify factors influencing the emergence and spread of knowledge and practices related to BSD and "soft" BD among institutions and practitioners in Iran.

2.4 Methods

This is a qualitative case study (Yin, 1981) of psychiatrists' understanding and uses of the diagnosis of bipolar spectrum disorder in Iran. Data were collected through semi-structured individual interviews with psychiatrists during three separate field trips each of several weeks duration, from October 2014 to June 2015, supplemented with analysis of popular media and professional publications. We used purposive sampling to select 25 prominent psychiatrists (7 female and 18 male) from six medical universities in the three largest cities of Iran, including Tehran, Esfahan, Mashhad, who were all university professors influential in training and practice in the field of mood disorders in Iran. All interviews were done in person except one via Skype. Individual interviews were conducted with 22 participants; each interview was about 75 minutes in duration. A group interview was conducted with 3 participants and lasted 2.5 hours. A semi-structured interview protocol was designed to gather data relevant to the research questions the emergence of BSD diagnoses and professional understanding of BSD and its use in clinical practice in Iran. The interview comprised 22 questions, including: "Would you tell me about the most recent bipolar patient that you saw? Was that case typical? If yes, why? If not, why not?;

Have the understandings of and practices with BD changed in recent years? How so?; Have there been any critiques about the use of the bipolar diagnosis in Iran?; Do you think bipolar disorder has been over-diagnosed or under-diagnosed in Iran? If so, since when and how?; Have any structural factors influenced the delivery and meaning of BD diagnosis and treatment of BD in Iran in clinical or psychiatric training settings? If so, how? By structural factors, I mean economics, politics, the organization of health care, the role of pharmaceutical companies, diagnostic categories and professional organizations both locally and internationally? ... ." The complete interview protocol is available on request from the authors.

Participants were chosen through purposive sampling to reflect the several generations of psychiatrists currently practicing in Iran. To recruit the participants, the first author, a clinical psychologist trained in Iran,[12] reviewed the Iranian mood disorder literature and popular media to identify those who appeared to be most involved in training and research on mood disorders. This list was refined by contacting former colleagues and educators and confirmed by checking with the Dean of the Iranian Psychiatric Association. The focus was on the main academic settings where practitioners are trained and standards of practice are set. However, this may have led to some sampling bias because of missing practitioners not affiliated with the research sites. It is also possible that the identity of the interviewer introduced some bias in the data. Living abroad and being affiliated with a non-Iranian university at the time of this study came with advantages and disadvantages in data collection. For example, some participants expressed hesitation about being critical of their institutions and colleagues to a researcher located at a Western university, however, other participants expressed feeling safer about sharing their

[12] From 2003-2013, prior to her immigration to Canada, the first author completed her undergraduate and graduate degrees in clinical and general psychology and worked in the field of mental health in Iran.

criticisms (particularly political views) with a researcher who was not currently part of the Iranian academic system.

The study protocol was approved by the Research Ethics Committee of the Jewish General Hospital, McGill University, Montreal. With the permission of the participants, the interviews were digitally recorded and transcribed. Names and other identifying characteristics of the participants have been changed to protect anonymity.

The first author conducted all interviews in Farsi. Transcripts of interviews were manually analyzed by thematic coding with an emphasis on identifying key terms and concepts, analogies, and explanatory models. Key passages were translated into English for discussion between the investigators. A case-comparison method was also used to analyze the collected data; this compared the entire explanatory narrative from each participant. When participants provided similar explanations, we characterized the more general explanatory model or template in terms of its conceptual, institutional and structural origins, anchors, and consequences. This synthesis allowed us to examine why and how the controversy over BSD has unfolded in the Iranian context (Yin, 1981).

The following sections address three broad themes that emerged from this analysis: (i) the emergence of the BSD diagnosis in Iran, including the key people and institutions; the controversy over the use of the BSD diagnosis within Iranian psychiatry; and (iii) the structural factors involved in the current knowledge and practice of BSD in Iran.

2.5 The Emergence of the Bipolar Disorder Diagnosis in Iran

2.5.1 Key People and Institutions

The bipolar disorder diagnosis came to Iran in three "waves"[13]: the first—"the wave of bipolar diagnosis vs. schizophrenia" as Dr. W termed it —followed two decades after the publication of the U.S.-U.K. Diagnostic Project, which led to an increase in the use of the diagnosis in the U.S. (Cooper, et al., 1972). The diagnosis of bipolar disorder was promoted in Iran in the early 1990s by Dr. Mohammad Taghi Yasamy, an Iranian professor of psychiatry who completed his residency in psychiatry at Tehran University of Medical Sciences (UMS) in 1981, during the period when DSM-III was being introduced in psychiatric settings in the West as well as in Iran. Apart from his work in community psychiatry, Dr. Yasamy had two key influences on Iran's psychiatric system during his time at the Kerman UMS in the late 80s and early 90s, and then at the Shahid Beheshti UMS from 1996 to 2005. In the early 1990s, he advocated for non-pharmacological treatments of psychiatric patients and, in the late 1990s, he encouraged the use of the bipolar disorder diagnosis. When Dr. Yasamy began his work with the Department of Psychiatry at the Kerman UMS in 1989, psychiatric treatment was limited to pharmacotherapy, as in most other departments, and psychologists who had no clinical training worked in administrative services. Dr. Yasamy started to train psychologists in simple techniques of Cognitive Behavioral Therapy (CBT) and then involved them in clinical work. Then, he founded a new department, the Non-Pharmacological Therapies Center, in Kerman Hospital, and organized the first national symposium on "Non-Pharmacological Therapies in Psychiatry" in

[13] The terms "wave" and "movement" were used by several psychiatrists to describe the pattern of changes in the diagnoses in general and in BSD diagnosis in particular. However, these were informal designations and, in this context, the wave or movement had characteristics of a psychiatric "fad" (Paris, 2013)—that is, an intense and widely shared enthusiasm for something, especially one that is short-lived—although the enthusiasm for the BSD diagnosis has now persisted for one decade.

Kerman in 1991 which was followed by similar events in Tehran and other cities[14]. In 1996, Dr. Yasamy went to Shahid Beheshti UMS in Tehran to pursue his academic and public health career there, where he trained psychiatrists until 2005. Following his interest in non-pharmacological treatments, mostly CBT techniques, he established collaborations with other colleagues who had expertise in psychotherapy, such as Dr. Mehdi Bina[15] and, Dr. Mohammad Sanati,[16] which led to the integration of psychotherapeutic methods into the psychiatric training curriculum. His support for psychotherapy by psychiatrists influenced psychiatric residents, some of whom became interested in non-pharmacological treatments for borderline patients and some other conditions. Dr. Yasmy's subsequent concern about not missing the diagnosis of bipolar disorder was appreciated in Iranian psychiatric community, and his work on bipolar disorder was often mentioned by psychiatrists in our study who included his former students.

Dr. Yasamy's first aim in promoting the diagnosis and treatment of bipolar disorder was to reduce the over-diagnosis of schizophrenia and facilitate the de-institutionalization of patients who had been inappropriately diagnosed with schizophrenia. However, only a few years after this first effort, a second wave of promoting bipolar diagnosis occurred around 2005, which Dr. W termed *the wave of bipolar diagnosis vs. unipolar depression*. This wave emphasized the use of the bipolar spectrum diagnosis in place of unipolar depression, suggesting that many patients with depression actually had signs and symptoms of bipolarity (Abhari, et al., 2013). Just a few years later, the use of the bipolar spectrum diagnosis was further expanded with the argument

[14]In 2005, Dr. Yasamy left Iran to pursue his career as a regional advisor of mental health at WHO EMRO (Cairo) and then senior medical officer in charge of prevention and management of mental disorders in Geneva. Recently, and after he got retired from WHO, he returned to Iran and continues his career as a professor of psychiatry at Shahid Beheshti University of Medical Science.

[15] Couple and Family Therapist and former Professor of Psychiatry at Shahid Beheshti University of Medical Science.

[16] Psychoanalyst and Professor of Psychiatry at Tehran University of Medical Science.

that cluster B personality disorders[17] could be viewed as an expression of bipolarity—*the wave of bipolar diagnosis vs. borderline personality disorder*. This shift in diagnostic practice emerged from the same medical school (Shahid Beheshti UMS) by Dr. Yasamy's students—among them, first, Dr. Shahrokh S. Gudarzi[18] and, later, Dr. Mehdi Samimi[19]. According to study participants, although the first wave was influenced by Yasamy, the wave of *bipolar diagnosis vs. unipolar depression* was mostly promoted by Gudarzi, and the last shift (*bipolar diagnosis vs. borderline personality disorder*) was promoted by Gudarzi and Samimi. Their connection with key international figures in the field, particularly Nassir Ghaemi[20]and Hagop Akiskal, and through them with the International Society for Bipolar Association (ISBD),[21] influenced the spread of the new concept of bipolar spectrum, first in Tehran universities and then throughout the medical community in the rest of the country. In addition, from 2004, Nassir Ghaemi began giving a series of talks about BSD at psychiatric departments and hospitals. His earliest presentations were organized by Shahid Beheshti UMS's psychiatric wards in Imam Hossein Hospital in Tehran, where the BSD diagnosis emerged and was promoted, and subsequent presentations were held at several psychiatric wards and hospitals in Tehran as well as other cities in Iran.

Ghaemi's talks and his book *Mood Disorder: A Practical Guide* (2007)[22], which was translated from English into Farsi and published by Tehran University, had a significant

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[17] "Cluster B involves dramatic, emotional, and erratic behaviors and includes Borderline Personality Disorder; Narcissistic Personality Disorder; Histrionic Personality Disorder; Antisocial Personality Disorder."

[18]Professor of Psychiatry at Shahid Beheshti University of Medical Science 2000-2010. Consultant Psychiatrist at Melbourne Health, Australia, since 2013.

[19] Professor of Psychiatry at Shahid Beheshti University of Medical Science.

[20] Nassir Ghaemi is an American psychiatrist of Iranian origin and professor of psychiatry at Tufts University School of Medicine in Boston.

[21] At the time, Ghaemi was a council member of the ISBD, which was influenced by Dr. Hagop Akiskal's views.

[22] http://tumspress.tums.ac.ir/books/detail.asp?bookID=162

influence on promoting the new concept of bipolarity among Iranian psychiatrists. In some cases, the impact was immediate and dramatic, as Dr N, a study participant noted: "When Dr. Ghaemi gave a talk in our center [in the mid-2000s], this view [of BSD] found its place among colleagues; we found that more than 30 percent of our patients diagnosed as MDD and treated for MDD fall into the bipolar spectrum diagnosis."

The International Conference on Mood Disorder, organized by the Mood Disorders Section of the Psychiatric Association of Turkey and held in Istanbul in 2006, was another early milestone in exporting the new concept of bipolarity from the U.S. to Iran. This conference, whose president was Akiskal and one of whose sponsors was the pharmaceutical company GlaxoSmithKline (which produces the "mood stabilizer" Lamictal (lamotrigine), hosted a group of Iranian psychiatrists, mostly from Shahid Beheshti UMS. One year later, in 2007, Gudarzi, Samimi, and some of their colleagues established the Mood Disorder Committee of the Iranian Psychiatric Association.

Of course, BSD is not the first or only diagnostic fad in psychiatry that has become widely globalized (Frances, 2013; Paris, 2013). Moreover, the importance of opinion leaders — who have high professional status, a high level of confidence in their own judgment, and a charismatic style—is not limited to those who promoted BSD in Iran. However, the dramatic influence of a few key figures in promoting the BSD diagnosis in Iran may be related to some specific local factors. First, the Iranian origins of Nassir Ghaemi, a leading figure in the field of mood disorders in the U.S., gave him special access and influence in academic and health institutions in Iran. Iranians academics and professionals highly value American cultural and scientific products (Kamalipour, 1999), and enthusiasm for American psychiatry is one example of this interest. Second, there is a lack in diversity in academic voices, which may be a result of

both the centralization of the resources in the country, which in turn leads to the allocation of more power to the institutions in the capital and to particular scholars, and patriarchal cultural values, which are reflected in the dominance of middle-aged men in shaping the history of Iranian psychiatry. This can facilitate the spread of a specific approach without encountering much criticism or resistance from the heterogeneous academic communities based in different provinces in the country. Third, the promotion of BSD diagnosis by the above-mentioned key figures coincided with the growth of residency training programs in the country. According to study participants, this led many young psychiatrists to begin their clinical work with the BSD framework as the most up-to-date academically endorsed approach. Older psychiatrists and more recent trainees have used other frameworks. As a result, less than a decade after the emergence of the BSD diagnosis, the concept of bipolarity has become a contentious issue among Iranian psychiatrists worried about the over-diagnosis of bipolar disorder in the country.

2.6 Controversy over the Use of BSD in Iran

Less than five years after the export of the new concept of bipolarity to Iran, bipolar disorder had become one of the most common diagnoses in Iranian psychiatric settings. In the present study, most participants, from different psychiatric hospitals and wards, reported what they perceived to be over-diagnosis of bipolar disorder in Iran; however, a few participants believed that bipolar disorder was "under-diagnosed"—particularly by more senior psychiatrists (*Ravanpezeshkan-e-Ghadimi*) who were still committed to psychotherapy and had not adopted new psychiatric diagnostic practices as easily as the less experienced (junior) psychiatrists (*Ravanpezeshkan-e-Javan*). In addition to this group of senior psychiatrists, neurologists who treat in psychiatric patients were identified as another group who tended to under-diagnose bipolar disorder. These neurologists were criticized not only for misdiagnosing cases of unipolar

depression that were actually soft bipolar cases, but also for iatrogenic illness—changing the presentation of symptoms (from hypomania to irritability) in atypical bipolar cases by prescribing them antidepressants.

> From the mid-1990s to the mid-2000s, Iran had an exaggerated rate of schizoaffective and depression diagnoses. The exaggeration in these diagnoses, specifically in depression diagnosis and over-prescription of antidepressants, was replaced by the over-diagnosis of bipolar disorder and over-prescription of mood stabilizers. Relying on the [bipolar] spectrum allows psychiatrists to put everything in it, like personality disorders, sub-affective forms, atypical depression, etc., and then diagnose bipolar or prone-to-bipolar and prescribe them a certain group of medications rather than making a clear diagnosis. (FGP, Dr. J, working in inpatient)

Iranian psychiatrists coined humorous or ironic expressions to capture the local embrace of the global diagnostic fashion of bipolarity (Healy, 2010; Martin, 2009). Thus, a "bipolar-minded" psychiatrist looks at everyone through bipolar lenses. The psychiatric residents at one department created a "Time until bipolar diagnosis" scale to measure the length of time before the first clinician in psychiatric rounds diagnoses any given patient as bipolar. Dr. N commented that it usually takes 1-2 minutes after the patient leaves the diagnostic interview for the psychiatrists and residents case discussion to settle on the bipolar diagnosis. He saw this as a problem in current psychiatric education which is leading to "the wrong training, the wrong diagnosis, and the wrong treatment" for many patients.

In the present study, psychiatrists reported that typical bipolar disorder cases, which were originally called "manic-depressive disorder"—i.e., someone who experiences recurrent episodes of mania or hypomania and depression (based on the DSM criteria)—are rarely seen in psychiatric settings in Iran. However, they said that up to 50 percent of psychiatric diagnoses in Iran's psychiatric settings employ the new, flexible concept of bipolarity, under labels such as "atypical bipolar," "soft bipolar," "bipolar spectrum," "dysphoric mania," "atypical mixed depression," etc. These conditions do not meet the DSM criteria for bipolar I, II, or even mixed depression—either by the length of the episodes or by the severity of the symptoms.

In our focus group interview, participants described the typical presentation of most of the cases with BSD:

> We have a bunch of patients—too many—with these features: most of them have migraines, PMS [premenstrual syndrome], panic, high reward dependency, interpersonal conflicts, movement between religiosity and modernity. They are sociable and like jobs in society such as those in the service industry. They wear harsh makeup. They think they are the most depressed people in the world, and just a day later, they come back and say that they feel better (which we assume is a mood swing). They are labeled BSD and prescribed anticonvulsants.

In the typical BSD patient, the cardinal symptom of manic euphoria is replaced by irritability, dysphoria, personality problems, and substance abuse. As Dr. L explained:

Most of the patients come with mixed features. They do not have manic or hypomanic episodes. They are angry, anxious, and dysphoric. They are irritable and their mood changes within a day. They don't have a happy mood, and they always complain about others. They pay too much attention to their appearance. Recently, we have had so many hypersexual cases: they have extramarital affairs and/or go to Facebook and social media and extend their social relationships. A woman who used to be conventional starts to get into relationships—not just virtual relationships, but in person, too. They are spendthrifts and do not care about money. Their impulse control is weak. Some of them become worse with antidepressants. In the same discussion, Dr. S. also pointed out that:

> in many patients with bipolar disorder, we do not see decreased sleep latency and grandiosity. Although they report emotional instability and/or mood dysregulation that could be considered as bipolar, the questions are whether any emotionally dysregulated person is bipolar and whether it is possible to be emotionally dysregulated but not bipolar. A clinician's interests determine the names of these wandering symptoms.

In fact, as Dr S intimated, many of the common symptoms associated with BSD can also be interpreted as ordinary variations in temperament, disruptive behaviors, or a reflection of specific personality traits. Irritability, dysphoria, emotionality, impulsivity, sexuality (extramarital affairs among women), financial instability ("being a spendthrift"), ideas of grandeur (exaggerated self-importance), oppositional behavior, talkativeness, and substance abuse are behaviors that can be readily medicalized and pathologized through the construct of

bipolarity—especially among young women[23]. Outside Iran, the new concept of bipolar disorder has also been used to replace other diagnoses such as depression or personality problems (Chan & Sireling, 2010). As Moncrieff points out, "In practice, since everyone has periods of increased energy, elevated mood, or irritability from time to time, albeit some more than others, almost anyone can come to conceive of their difficulties as fitting with the profile of bipolar disorder now being promoted; and anyone can be bipolar if they so choose" (Moncrieff, 2014). While most of the psychiatrists interviewed for this study recognized this controversy and the problem of over-diagnosis, they nevertheless have continued to make liberal use of the diagnoses. The enthusiastic embrace of BSD and its continued use in Iran therefore requires further explanation.

2.7 Structural Factors in the Over-diagnosis of Bipolar Disorder in Iran

In addition to the influence of key psychiatrists, who have played an important role in the emergence and promotion of the new concept of bipolarity in Iran, interviewees cited structural factors that contributed to the over-diagnosis of soft bipolar disorder. The following sections examine some of these factors, including: (i) the dominance of American psychiatric nosology and textbooks and the lack of exposure to psychosocial models of care in Iranian psychiatric training; (ii) the role of pharmaceutical companies; and (iii) the medicalization of the recent sociocultural transition.

[23] Gender plays a crucial role in the dynamics of medicalization in general and is a crucial factor for understanding the increase in BSD diagnosis in Iran. A gender analysis will be the focus of a later paper.

2.7.1 Psychiatric training in Iran

Psychiatric education in Iran uses an examination–based evaluation, and residents can advance to the next year of residency training only if they pass an annual exam, called Ertegha ("elevation"). At the end of the fourth year of residency, when they have already passed three Erteghas, trainees can take the national board exam. The main references used for training, Erteghas, and the national board exams are the Synopsis of Psychiatry (Sadock & Ruiz, 2015); Comprehensive Textbook of Psychiatry (Ruiz & Sadock, 2000), and, recently, Sims' Symptoms in the Mind (Oyebode, 2008). The first two textbooks are emphasized and complement articles from the American Journal of Psychiatry, the British Journal of Psychiatry, and several Iranian psychiatric journals in the Persian language. In addition, most psychiatrists in Iran are expected to use the DSM–IV–TR classification, and more recently the DSM-5 (Javanbakht & Sanati, 2006).

In this study, most interviewees pointed out that this examination-based psychiatric training makes psychiatric residents too dependent on the American textbooks as well as on the U.S. nosology (i.e., the DSM classification), which are the main references of their exams. In the case of mood disorders, using the Comprehensive Textbook for four years changes the psychiatric residents' view from a biopsychosocial approach to a "biobiobio"[24] approach. This is

[24] This critique of the shift in psychiatry from a biopsychosocial model to a "bio-bio-bio" model of mental disorders, which locates psychopathology within the individual's biological constitution and limits treatment to psychotropic medication, has also been criticized by Steven Sharfstein in his American Psychiatric Association presidential address (Big Pharma and American Psychiatry: The Good, the Bad, and the Ugly. Psychiatric News_ August 19, 2005 page 3, Published by American Psychiatric Association)

partly because Akiskal wrote the Comprehensive Textbook's mood disorder chapter, and even though it is assumed to be a milder version of his approach, the residents refer mostly to Akiskal and his allies' articles and approach in order to understand mood disorders. This approach emphasizes biological causes of mood changes and allows psychiatrists to easily relate people's behavior to a diagnostic scheme and prescribe them corresponding medication. According to Dr. U, this reflects a general problem with psychiatric nosology:

> A willingness to be up-to-date has made our young [junior] psychiatrists too dependent on the American Psychiatric references, while they are not experienced enough to know how to apply those categories in clinical practice. Psychiatry needs a holistic approach, which nosology doesn't have. Instead, nosology suggests a cross-sectional perspective on patients, which allows psychiatrists to see them in brief visits.

Mapping symptoms and signs onto diagnostic categories encourages a cross-sectional approach to characterizing patients that does not consider the temporal evolution or trajectory of illness.

Along with the role of American nosology, the quick growth in the numbers of young psychiatrists and psychiatric residents in the country (a two-fold increase in less than a decade), who are trained based on the new BSD approach, played an important role in the inflation in bipolar disorder diagnoses.

Psychiatric trainees in Iran spend most of their four-year residency in psychiatric hospitals or on psychiatric wards in general hospitals[25]. However, patients who are referred to the psychiatric hospitals and wards in Iran are mostly people with severe mental illness and are not representative of broader range of cases seen in general health care settings, who mainly have milder problems. As Dr. Z said,

> Apart from the influence of American psychiatric textbooks as the main theoretical resources of psychiatric training in Iran, four years seeing severe mood disorder cases in psychiatric hospitals helps our psychiatric residents and newly graduated psychiatrists to keep their bipolar lenses on for years after their graduation.

Experience with hospitalized psychiatric cases during four years of residency helps train psychiatric residents to treat severe cases of bipolar disorder, psychotic disorders, and substance abuse disorders, but not to deal with milder, more common "neurotic" and personality problem cases. Newly graduated-psychiatrists practice with this orientation for at least a few years until their clinical experience with common mental health problems in outpatient care gives them a better sense of the prevalence of different mental disorders in the help-seeking population.

Even though direct impact of pharmaceutical companies on psychiatric training was not reported in this study, our participants noted that by closely following the American literature, psychiatric education in Iran has been indirectly influenced by pharmaceutical companies. Healy

[25] Patients attending the outpatient psychiatric clinics of the hospitals are mostly former inpatients who are seen for follow-up or people from lower socio-economic status who have no other access to mental health care. Stigma associated with mental illness is one reason that people who have economic resources try to seek help in private clinics rather than at psychiatric hospitals, which are more public places.

(2009) examined the enormous influence that these companies have had on the APA's products, including research, clinical guidelines, and training materials. Furthermore, during psychiatric training, psychiatric residents' exposure to research may be limited to a few journals that are emphasized by the examination psychiatric board, such as *The American Journal of Psychiatry* and *The British Journal of Psychiatry,*

Lack of interest in a community mental health model of care among psychiatric academics and insufficient training in psychotherapy and in a psychosocial approach were also mentioned by participants as factors that have contributed to the increase in BSD diagnosis and in the prescription of mood stabilizers and neuroleptics. Participants pointed out that psychiatrists mostly manage their patients on their own, because mental health training and service systems put little emphasis on multidisciplinary teamwork (e.g. a team that includes a psychiatrist, a psychologist, a social worker, and a nurse). The role of psychologists and social workers in mental health care is limited, and they tend to be misused in Iran's mental health care system (e.g., social workers may work in low-level office administrative and clerical roles). Moreover, it was mentioned that although there are many psychologists and an increase in the number of graduate psychiatrists in the past decade, there are not enough clinicians—either psychologists or psychiatrists—who have been trained to deliver psychotherapy for personality problems or severe disorders such as BPD or bipolar patients. As one psychiatrist put it:

> A deficiency in the use of multiple skills and different interviews to exclude other diagnoses makes us very subjective. We see patients too fast, and the simplest thing is to give them medication, because if we do not rely on the medication, we would sink into many complex problems and have to spend so

> much time. Even if I want to use non-pharmacotherapeutic intervention, where and how is it supposed to be done? At whose cost and with which insurance? Who has received enough training to do psychotherapy? Psychiatrists? Psychologists? We do not have enough trained psychotherapists. Not every therapist who applies the bipolar diagnosis and prescribes Depakote [sodium valproate, a mood stabilizer] necessarily believes in his diagnosis and thinks that Depakote can treat a young girl who keeps escaping from home, has self-inflicted cut marks, has different cellphone numbers, dates different guys, and dishonors her family. But, at that moment, the simplest thing that a psychiatrist can think of is giving her mood stabilizers to control her emotions. We may even give her an antipsychotic to make her dull [*khamood*], stay at home, and not cause trouble for her family (Dr. L, child and adolescent psychiatrist and university professor).

A lack of training in psychosocial and community mental health perspectives and corresponding psychosocial interventions and community-based services may contribute to the over-diagnosis of bipolar spectrum disorder, but it can also result in poor quality of care for patients with classic bipolar disorder (BD). Indeed, while studies elsewhere have shown that patients with BD who receive collaborative care develop better social and work functioning, quality of life, and treatment adherence over two years (Miklowitz, 2008; Zhang, et al., 2006) recent studies in Iran show no change in the quality of life of patients with BD during follow-up (Amini & Sharifi, 2012; Shabani, et al., 2013). The ineffectiveness of routine interventions—which include mostly medication and, in some cases, occupational therapy and psychotherapy—has been noted as one potential explanation for the lack of change in the quality of life of bipolar

patients. These limitations in psychiatric training were raised by most of the interviewees as one of the factors involved in the over-diagnosis of bipolar disorder in Iran.

2.7.2 The Pharmaceutical Industry & Pharmaceutical Consumerism

Studies indicate that since 2001, the annual growth rate of imported pharmaceuticals increased more rapidly than sales of medications produced in Iran; the sale of locally produced and imported items has annually increased 6.7% and 9.4%, respectively. Moreover, the share of local manufacturers share of the pharmaceutical market has decreased markedly, from 82.2% in 2001 to 66.4% in 2008 (Dinarvand, 2009). However, the exact impact of foreign pharmaceutical marketing on the over-diagnosis of bipolar disorder was not described by participants in this study. Most of the psychiatrists interviewed believed that, unlike the situation in many countries, foreign pharmaceutical companies have no "direct" effect on the Iranian psychiatric system because there are no patent laws. As a result, most medications are quickly copied by local pharmaceutical companies and are accessible at a relatively low price. However, interviewees emphasized that, following the global market, local pharmaceutical companies have influenced the over-prescription of mood stabilizers and atypical antipsychotics in Iran. The marketing of mood stabilizers for BSD has emphasized the diagnostic construct of BSD and "off-label" uses of medications. In 2008, antidepressants, mood stabilizers, and antipsychotics were in the top four categories classes for volume of sales globally; in the U.S., 6 of the 14 prescription drugs most widely used off-label were for bipolar disorder, compared to one for anxiety, one for depression, and one for sleep disturbance (Abraham, 2010). In Iran, too, some manufacturer's marketing staff promoted their products to psychiatrists by encouraging them to add mood stabilizers to existing medication regimens saying, "There is no downside to treating your cases with a combination of antidepressants and mood stabilizers," as Dr. E quoted. Moreover, a few

companies whose main products were mood stabilizers, especially Depakote (valproate) and Lamictal (lamotrigine), sponsored symposia in Iran where broad use of the bipolar spectrum diagnosis was advocated by psychiatric "opinion leaders". As Dr. K sardonically noted:

> Therapy has become like this: we gave Depakote to a girl who was shouting a lot and was aggressive. Another girl doesn't shout as much but still shouts, so we should give her Depakote, too, to make her quiet. Well, then, why not add Depakote to the city's drinking water so that everyone can gradually take it?

Such critical statements are neither new nor specific to the use of the BSD diagnosis. Discussing the ways in which psychiatric language and statistics have shaped Iranians' experience of common forms of mental suffering, Behrouzan (2016) refers to an article published in 2010 in an Iranian Newspaper *Aftab-e- Yazd*[26], with the title "40% of anxiety disorders and depression among Tehranis." In the same newspaper article, the author claims that "Psychiatrists suggest putting antidepressants in Tehran's water." The publication of an increasing range of statistical indicators of the prevalence of psychiatric disorders in Iran's mainstream media as well as the influence on public discourse of popular lectures on mental health by psychiatrists have become important features of Iranian psychiatry in the 21st century. Although during Iran's post-war era (late-19980s and early-1990s), the contributions by psychiatrists and mental health policy makers mainstream media and public events aimed to destigmatize mental health problems and normalize psychological and psychiatric treatment, the citing of prevalence figures from psychiatric epidemiology in public discourse also has

[26] Aftab-e- Yazd newspaper; May 5, 2010 (15/02/1389 AP)

contributed to the medicalization of psychosocial and social problems, influencing how laypeople view such challenges (Behrouzan, 2016).

Despite the efforts of the Iranian Ministry of Health to establish a center for promoting the rational use of medications in 1995, the inappropriate use of psychiatric medications remains a widespread problem (Mousavi et al., 2013). This may reflect a broad acceptance of medications as a way to deal not only with physical symptoms but also emotional distress. Indeed, one participant in our study, Dr. Q, called Iran a "pharmaceutical nation," pointing to the culture of medication consumption in the country as one of the factors in Iranians' readiness for the medicalization of mood. In an article released by a national media website,[27] Farid Barati, the Head of the State Welfare Organization's Department for the Prevention and Treatment of Addiction, discussed sociocultural roots in drug consumerism among Iranians. He described factors contributing to the cultural tendency to overuse of medications as well as people's wish for medicalization, including: the move from a traditional Iranian perspective on suffering and healing as reflections of a body and mind monism to a modern dualistic perspective; dependency on physicians and the deep social faith accorded to them; a broader consumer culture; and the impact of pharmaceutical advertisements. However, in the same article, Mostafa Eghlima, Head of Iran's Social Work Society, addressed the overuse of medication in Iran from a different perspective, emphasizing social stressors: "Today there are different kinds of medications such as tranquilizers and sedative pills in everyone's bag, which is because of the many psychological pressures on Iranians today due to social and family conflicts."

The use of tranquilizers as a strategy to deal with social and family conflicts is not only a direct result of the professional practice of prescribing medications to people who seek

[27] (http://www.tebyan.net/newindex.aspx?pid=208060).

professional help for interpersonal and social distress, but also is intertwined with the public promotion of pharmacological treatments by psychiatrists. Quoting a prominent Iranian psychiatrist and professor of psychiatry in a widely-broadcast public event in Tehran, Behrouzan (2016), highlights how this psychiatrist used physiological language to explain interpersonal relationships between couples, individuals, and society at large:

> Let me be explicit [the psychiatrist said]: If you are having anxiety for no reason, please treat yourselves: take tranquilizers. I do the same [role modeling]. If you have anxiety it always has a reason, like pregnancy, marriage, etc., remember that it is normal and temporary. But I prefer that you do not even have that kind of anxiety. Before giving birth for instance, you can treat the anxiety with tranquilizers. You can become anxiety-free before an exam. Before and important meeting with a loved one. You can cut these unnecessary anxieties. Things have become so much easier in our discipline now. We can help you go to exam, anxiety-free. Like most people in the world…. … You always ask me whether exercise, prayers, alternative medicine, and things like that work; 'anything but medication, doc,' you say. This is a polite way of insulting me *[audience laugh]* because I am a doctor and it is my job to treat you with medicine, with *dāru-darmāni* [medication therapy] (Behrouzan 2016, p.67).

Similar talks and interviews were widely disseminated through public and social media, revealing the explicit ways in which the profession has worked to educate the public about

mental health, leading psychiatric diagnoses and treatments to replace the lay language of interpersonal and social distress.

Describing the rates of medication consumption among Iranians, a report by Ilia Corporation, a business consultancy firm specializing in the Iranian market, on its website (Ilia-corporation.com) states that in Iran every citizen uses on average approximately 340 units of medication per year, which is four times the global rate. Moreover, the average number of units of medication per prescription is 3.5 in Iran compared with 2 units internationally.

Participants in our study also associated pharmaceutical consumerism among Iranians with ready access to medical doctors through the health care system, and the availability and affordability of essential drugs for more than 90% of the population (Cheraghali, et al., 2004). This access reflects the relatively low price of medicines, insurance coverage, large numbers of pharmacists that "prescribe" and sell many drugs available on the market (not just the OTC drugs) by asking patients about their symptoms, and laxity in drug prescription (such as prescribing medication over the phone). The ease of prescribing medication, the economic benefits for psychiatrists through seeing more patients in a short time when the treatment is limited to the biological intervention, and the limitations in available psychosocial services reinforce psychiatrists' tendency to attribute psychiatric problems to biological rather than psychosocial causes. This causal attribution allows psychiatrists to make their diagnosis consistent with available treatments (i.e., medication), remuneration patterns, and time constraints, avoiding psychological or social explanations and interventions, that are time-consuming and that provide little economic return for psychiatrists. This attributional bias toward biological causes fits with the kind of treatment interventions that psychiatrists can offer to their patients, mainly psychiatric medications which are available at a much lower cost relative to

psychotherapy, which is not covered by insurance. To some extent, the shift in diagnostic practice therefore may be based not on strong convictions about explanatory models but on limited options. Then too, extensive engagement with mass media by biologically oriented psychiatrists encouraged the public to understand mental distress in terms of organic explanations as disorders of the brain and nervous system, which therefore warranted pharmaceutical interventions, as opposed to biopsychosocial explanations, which would support more integrative psychosocial and systemic interventions. The social, cultural, and economic context in which medicine sales and advice occur plays an important role on doctor-client interaction (Kamat & Nichter, 1998) and, in this instance, clearly has influenced the diagnosis and treatment of Post-Traumatic Stress Disorder (PTSD), anxiety, and depression (Behrouzan, 2016)—and now, as we show, BSD.

2.7.3 Political and Ideological Factors: Medicalization and Social Control

Some study participants pointed to ideological and political factors intertwined with the sociocultural transition in the country, reinforced by globalization in the 21st century, that have contributed to the way the Iranian psychiatric system embraced and applied the new concept of bipolarity. For example, Dr. D stated suggested,

> Medicalization has value in theocratic systems in general. In Iran, too, the medicalization of social conflict can be embraced by government, families, and psychiatrists for cross-cutting purposes… A decade ago, Simon Levay's studies on homosexuality [suggesting that sexual orientation has a biological substrate (LeVay, 1991)], was strongly accepted among conservatives in Iran. That homosexuality is a genetic [biological] problem, not a matter of human

> rights, human choice, etc. … Biologically-minded and genetic determinist approaches to human diversity are embraced by religious reformists [the current political mode in Iran] because it can fit with their ideological beliefs, i.e., believing in human choice, but [sometimes] the human choice contradicts their religious rules, so there is a solution for that: medicalization of that choice. For them [religious reformists], it makes better sense to say there is something wrong in the brain and that's serotonin… [In the case of embracing the soft bipolar diagnosis] the symptomatology shows itself in specific areas: too much makeup, extramarital relationships, and free sexual behaviors among women. That's not easily medicalized for men because it fits his schema of society to be a "swinger".

Studies in other countries have shown the expansion of medicalization of many aspects of experience, especially in women's lives (Ussher, 2010; Conrad, 2008). In our study, participants pointed out that the new bipolar diagnosis has been much more frequently applied to women particular to some behaviors— e.g., casual expressions of sexuality—that are seen as socially deviant or abnormal, in part because they challenge or transgress existing norms. This is an especially important issue in Iran where social norms have undergone substantial and sometimes abrupt shifts with changes in political regimes.

> Due to the lack of a context-based diagnostic approach calibrated to the social and cultural changes in norms many common symptoms and behaviors including irritability, dysphoria, emotional lability, impulsivity, sexuality (e.g. extramarital affairs among women), oppositional behavior, talkativeness, and substance abuse can be readily medicalized through the construct of bipolarity.

> The ways that these symptoms are assessed and interpreted depends greatly on clinicians' own cultural attitudes, positions and organizational contexts. As one of the study's psychiatrists, Dr S, mentioned:
>
> Psychiatrists who have strict values do not interpret their patients' behaviors based on the current norms of the society; they easily label people as being ill in the context of their [i.e., the psychiatrists'] own values and beliefs.

Of course, this problem is not limited to psychiatrists. The clinician as a person is a cultural being with a story that is reflected in his or her personal (e.g., philosophical, social, and political values) and professional attitudes about evidence-based practice, culture, gender roles, and morality that may lead to conscious and unconscious biases in clinical practice (Jackson, 2015).

More than four decades of broad sociopolitical conflicts in Iran—including the 1979 revolution, eight years of war, international sanctions, economic problems, the institution of repressive gender and social policies, and a transition in societal and cultural values have created a situation in which certain forms of distress and social problems manifest in what psychiatry may consider "atypical" behaviors, particularly among women, adolescents, youth who are asking for personal freedom and the right to choose in many domains of their lives. Many psychiatrists recognize this social-historical dilemma. However, the general mode of Iran's psychiatric system—which has involved the adoption of Western biological psychiatric approaches, mostly from the US—is to conceptualize and address the problem at the level of the individual, not society as a whole. The resultant clinical model treats the individual with

"atypical behaviors" rather than intervening in the social predicaments that produce irritability or the patriarchal family system that deems the rebellious girl troubled.

2.8 Conclusion

As a consequence of globalization, Anglo-American psychiatry has had widespread influence on the interpretation and treatment of mental illness. Mental health professionals trained in the West, and in the United States in particular, have created the official diagnostic systems and categories of mental disorders, which emphasize biomedical models of mental disorders (Angell, 2005; Perlis, et al., 2005). The transformation of contemporary psychiatry in non-Western countries over the last few decades clearly shows this domination of Anglo-American psychiatry. Although Iran is only one of many countries that have adopted the DSM nosology and that closely follow American psychiatric research and associated models of clinical diagnosis and treatment, there are specific factors that make Iran a particularly interesting site to study what happens when Western psychiatry travels. These factors include structural particularities of Iranian mental health care system, political and social constraints on public discourse, local psychiatric beliefs and practices, the role of pharmaceutical and insurance companies, and different cultural understanding of body and mind (Behrouzan, 2016).

One reflection of this engagement with U.S. psychiatry in Iran has been the rapid adoption and deployment of the diagnosis of bipolar spectrum disorder or 'soft' bipolar disorder in the new millennium, which has resulted in a significant increase the frequency of this diagnosis, particularly among women and youth, and along with that in the prescription of mood stabilizers and second-generation antipsychotics. The tendency to make bipolar diagnoses among Iranian psychiatrists was promoted by prominent American psychiatrists, in particular Hagop

Akiskal and Nassir Ghaemi, in collaboration with some of the leading figures in Iran's psychiatry who facilitated the journey of the bipolar spectrum diagnosis from the US to Iran. These 'opinion leaders' advocated for discovering "hidden" bipolar patients through the expansion of diagnostic criteria and putting them under similar medications approved for classic bipolar disorder. This was reinforced by global marketing of the new disorders.

Following subsequent controversy about the medicalization of mood in the U.K. and U.S. (Moncrieff, 2014), Iranian psychiatrists, neurologists, and general practitioners involved in academic training and in the private sector have vigorously debated the consequences of the broadened conceptualization of bipolarity (Shabani, 2009). This controversy became the focus of some important academic events in Iran such as the 31st Annual Conference of the Iranian Psychiatric Association[28] in 2014, when psychiatrists whose observations supported the argument that bipolar disorder had been over-diagnosed in the past decade invited the group of psychiatrists who believed that bipolar disorder was under-diagnosed to reconsider their use of this diagnosis.

Although the emergence and expansion of new psychiatric disorders, including bipolar spectrum disorder, in Western countries is mostly attributed to the influence of pharmaceutical industry marketing in creating diagnostic fads that are given the gloss of evidence-based practice, our study highlights the importance of factors beyond disease mongering when a new diagnosis travels from a Western country to a non-Western country, such as Iran. In addition to current practices in international psychiatry and the transnational and, to some degree, local influence of pharmaceutical companies, these factors include: (i) the response of the health care system and

[28] In the same event, one of the keynote speakers, Dr. Gudarzi, who is identified as one of the prominent psychiatrists who influenced the expansion of bipolar spectrum disorder diagnosis to Iran, questioned the uncritical adoption of American psychiatric diagnostic fads, including bipolar spectrum disorder.

local practice to the ideological values and goals of the institutions in power combined with the lack of a sociopolitical structure that protects and prioritizes human rights in health care; (ii) rapidly changing social, cultural, and gender norms that change the meaning of potentially symptomatic behaviors; and (iii) the pliability of a psychiatry that lacks a solid socio-ecological theory of mental health problems and corresponding modes of practice and that seeks pragmatic solutions for patients in situations with limited resources and heavy social structural and political constraints on action. Similar factors were identified in the extensive ethnographic study by Behrouzan (2016), who examined the rise in Iran of psychiatric discourse related to PTSD and depression.

Despite the strenuous efforts of Iranian human rights advocates inside and outside the country, Iranian organizations have not been successful in prioritizing human rights over the ideological values of those in power. Many secular psychiatrists and scientists recognize this dilemma and, in response, some have adopted biopolitical strategies of advocacy for population and individual health (Adelkhah, 1999), One example is the promotion of the treatment of transgender conditions through sex reassignment surgery (Najmabadi, 2013). Despite these efforts at advocacy, the power to make and monitor institutional regulations, including those of mental health care organizations, has been tightly controlled by the ideological arms of a regime that does not recognize and respect human rights. Moreover, in many cases, including BSD diagnosis, biomedical explanation appears to have been used less as a resource for advocacy than as a way to impose collective ideological values around "normality" both in psychiatrists' clinical practice and training and through their influence on policy making, particularly in the context of youth and women's mental health. This problem has contributed to the neglect of person-centered care and supports the tendency in the current psychiatric system to use a model

of care that focuses on a neurological notion of personhood, which conceptualizes and intervenes in patients' problems at the chemical level, while failing to address the embodied, experiential, social, environmental, and ethical dimensions of mental health and illness.

Framing a problem as a medical, psychiatric or public health issue can improve health care by informing the public of the need for care, sharing strategies for coping and help-seeking, and clarifying appropriate treatment expectations (Cataldo, 2008). Medicalization may also have broader social benefits by drawing attention to segments of the population experiencing inequities and providing a new language for expressing dissent, and exercising political agency (Bell, 2012; Behrouzan, 2015). At the same time, however, medicalization can create new avenues to extend biomedical power and may contribute to the tendency to approach public health and social problems through expedient pharmaceutical interventions (Bell, 2012). This pharmaceuticalization of public health has been seen in studies on asthma in Barbados (Whitmarsh, 2008) and AIDS in Brazil (Biehl, 2008), where the biomedical framing of problems has foreclosed other approaches to improving population health and wellbeing. The medicalization of problems of everyday life, deviant behaviors, and social problems has been described in other complex societies (Conrad, 2009). The risk of simplifying complex social problems and focusing on individualized medical solutions may be especially great in a society like Iran, which is experiencing a rapid transition from one that is traditional and religious to one that is modern and secular (Behrouzan, 2015). Instead of providing a vehicle to express dissatisfaction and concerns, the expansion of the new bipolarity in Iran may silence the voices of young people and those who live in less advantaged socioeconomic situations and belong to more traditional families. This silencing occurs in the context of medical and psychiatric

treatments that then constitute a shift to forms of *restitutive* (rather than overtly *repressive*) social control, which according to Durkheim is characteristic of complex societies (Merton, 1994).

Furthermore, although Iran has tried to improve mental health care services through the integration of mental health services into the primary health care system, due to the inadequacy of the coverage and quality of services, this reform has not led to an efficient psychosocial model of care. The under-emphasis of psychosocial dimensions and over-reliance on disease-oriented approach to mental suffering in Iranian psychiatric training, the lack of collaborative models of care and active follow-up services, and weak public-private partnership have limited services to psychiatric hospitals and private offices with little or no access to community-based outpatient services (Hajebi, et al., 2013). As a consequence of this structural incompetency, many psychiatrists have embraced diagnoses that are more attributed to biological causes, such as bipolar disorder, and reduced interventions to medications.

These challenges and the continued controversy over the adoption of American psychiatric fads in a non-Western country like Iran point to the importance of elaborating a more ecosocial and cultural view of psychiatric practice not only from the perspective of social science but as a set of conceptual tools and critique that practitioners, patients, and health systems planners can use themselves to disentangle some of the complex trade-offs involved in adopting particular modes of diagnostic practice (Kirmayer, 2015). A specific formulation and intervention plan for an individual that is tailored to the psychosocial problems and needs of the patient, rather than the ideological view of the clinician and the structural defects of the psychiatric system, must replace the general models of psychiatric frameworks (Mezzich, et al., 2016). Ultimately, it is essential to address the social determinants of mental health to avoid

reducing systemic causes of mental suffering to biological causes and to move beyond treatment to prevention.

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2.10 Conflict of Interest

The authors declare that they have no conflict of interest.

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INTRODUCTION TO CHAPTER 3

In Chapter 2, "The Globalization of Biological Psychiatry and the Rise of Bipolar Spectrum Disorder in Iran," which was published as an original research article in *Culture, Medicine, and Psychiatry* (Mianji & Kirmayer, 2020), I presented the findings of the first phase of my thesis research, which examined the journey and the dynamics of the use of bipolar spectrum diagnosis (BSD)[29] and its consequences—in other words, how the new Western concept of bipolarity, BSD, travelled from the U.S. to Iran and how this diagnosis and treatment are understood and applied by Iranian psychiatrists. The impetus for conducting this research was the gap in understanding how a Western medicalized concept is exported to non-Western societies, about the degree to which and under what conditions it is adopted, and finally about the impact and meaning it has in other cultures.

Using archival research, I described some specific characteristics that make Iran an interesting site to study the globalization of a new Western psychiatric concept in the non-Western world. These characteristics, which also contribute to the way in which BSD diagnosis is adopted and used by Iranian psychiatrists, include: Iran's complex sociopolitical systems; its being a relatively wealthy and well-developed country with a long history of psychiatric institutions; its universal health care with integrated mental health programs; Americanized psychiatric training programs; the relatively low influence of the pharmaceutical industry due to state subsidization of the local production of pharmaceuticals; a significant rate of emigration of educated and young people to Western countries, which facilitates the flow of international knowledge;[30] affordable and accessible higher education programs in different corners of the

[29] Also called "soft bipolar disorder," "atypical bipolar," "dysphoric mania," "atypical mixed depression."
[30] According to the International Monetary Fund Iran tops the list of countries losing their academic elite, with an annual loss of 150,000 to 180,000 specialists.
https://en.wikipedia.org/wiki/Human_capital_flight_from_Iran

country; wide access to global media and information despite substantial efforts at filtering and censorship by Iran's regime and, as a result, rapid social and cultural change in the new millennium.

Conducting semi-structured interviews with key academic psychiatrists, I described the controversy around the uncritical adoption of BSD diagnosis by many Iranian psychiatrists and explored some of the global and local factors involved in the rise of BSD diagnosis and the apparent over-diagnosis of BSD and over-prescription of mood stabilizers and antipsychotic medications, particularly to women. I highlighted that, in addition to the current practices that reflect the influence of international psychiatry as well as transnational and, to some degree, local pharmaceutical companies, social, political, ideological, and structural factors have played a significant role in the overuse of the BSD diagnosis in Iran and the marked gender difference.

Chapter 3, "'Women as Troublemakers': The Hard Sociopolitical Context of Soft Bipolar Disorder in Iran," (submitted as an original research article to *Culture, Medicine, and Psychiatry* in September, 2019), follows up on this gender disparity. Using semi-structured interviews with patients who received BSD diagnosis and treatment, I explore patients' experience with mental suffering, illness meaning, and attributions. Moreover, this chapter clarifies some of potential causes of the gender difference in BSD diagnosis in Iran by exploring psychiatrists' understanding of why women are diagnosed with BSD significantly more than men together with female patients' understanding of their "soft bipolarity."

CHAPTER 3: "WOMEN AS TROUBLEMAKERS": THE HARD SOCIOPOLITICAL CONTEXT OF SOFT BIPOLAR DISORDER IN IRAN

Abstract

Gender differences in the prevalence of psychiatric disorders, with higher prevalence of mood and anxiety disorders among women, have been the focus of much debate. In Iran, the adoption of the construct of Bipolar Spectrum Disorder (BSD) and of the concept of "soft bipolarity" has been associated with a large gender difference in rates of diagnosis. This paper discusses the gendered meanings of the diagnosis of BSD in Iran. In this qualitative study, we conducted 25 in-depth semi-structured interviews with prominent psychiatrists and university professors at six different universities in Iran and 37 in-depth semi-structured interviews with patients (male and female, 18-55 years of age) who had received bipolar spectrum disorder diagnosis and treatment, excluding Bipolar-I. Findings suggest that the high rate of diagnosis of bipolar spectrum disorder (i.e., subthreshold bipolar, soft bipolar disorder) among women in Iran is influenced by gender, sociocultural, political, and economic factors, as well as the diagnostic practices of biomedical psychiatry. The dominant biological psychiatry system in Iran has led many psychiatrists to frame socio-politically and culturally rooted forms of distress in terms of biomedical categories like soft bipolarity and to limit their interventions to medication. This bioreductionist approach silences the voices of vulnerable groups, including those of women, and marginalizes discussions of problematic institutional and social power. To understand the preference for biomedical explanations, we need to consider not only the economic interests at play in the remaking of human identity in terms of biological being, and the globalization of biological psychiatry, but also the resistance to addressing the sociocultural, political, and economic determinants of women's mental suffering in particular contexts.

Keywords

Bipolar Spectrum Disorders, Women's Mental Health, Sociopolitical and Cultural Determinants, Medicalization, American Psychiatry, Iran's Psychiatry

3.1 Introduction

Gender differences in the prevalence of psychiatric disorders, with higher prevalence of mood and anxiety disorders among women, have been the focus of much debate (Ussher, 2011). Depression has been the most commonly discussed disorder, with a worldwide female-to-male prevalence ratio that ranges from 2:1 to 4:1. In Iran, the adoption of the construct of bipolar spectrum disorder and of the concept of "soft bipolarity" has also been associated with a large gender difference in rates of diagnosis. In this paper, we discuss the gendered meanings of the diagnosis of BSD in the context of Iranian psychiatric practice.

3.1.1 Background

Despite the overall improvements in the health of women in Iran over the past four decades, there are still significant disparities between women and men with respect to mental, physical, and social health (Ahmadnia, 2015; Joulaei et al., 2016). Based on Disability-Adjusted Life Years (DALYs), psychological disorders ranked second among women's burden of disease in 2003 and first in 2011 in Iran (Joulaei et al., 2016). A substantial increase in psychiatric problems in recent decades has been found in several epidemiological studies (Noorbala et al., 2004; Mohammadi et al., 2005; Sharifi et al., 2011; Rahimi-Movaghar et al., 2014). This

increase has also been discussed by leaders of the Iranian Psychiatric Association in national media making the issue a topic of public debate.

The first Iranian nationwide epidemiological survey of lifetime psychiatric disorders based on DSM-IV criteria in 2005 indicated that prevalence of psychiatric disorders was more common among women compared to men, (14.34% versus 7.34) (Mohammadi et al., 2005). Gender differences in this study were consistent with the results of a nationally representative household survey (aged 15–64) on the 12-month prevalence of psychiatric disorders conducted in 2011 that indicated higher rate of psychiatric disorders among women compared to men (26.5:20.8%) (Sharifi et al., 2015). Based on this survey, while women had an overall higher rate of any mood disorder than men (17.03:11.9), bipolar type-I disorder was less prevalent among women than men. However, recent years have seen a dramatic increase in the diagnosis of bipolar disorder among women in Iran following proposals for expanded diagnostic criteria, which recognize bipolar spectrum diagnosis (BSD), as well as bipolar subtypes or "soft" bipolar disorder, treatments, which were actively promoted by leading international academic psychiatrists such as Jules Angst, Hagop Akiskal, Fred Goodwin, and Nassir Ghaemi in the 1990s (Healy, 2010; Moncrieff, 2014; Paris, 2012b).

This increase in the frequency of bipolar diagnoses occurred in North America and Europe as well Iran. The broadening of the diagnosis of bipolar disorder resulted in a category once defined in terms of the key symptom of an episode of mania or hypomania to also include people who experience only an episode of elevated/irritable mood or increased activity that affects their social or occupational functioning (Akiskal, 2002; Angst et al., 2010; Angst et al., 2003). As a result, bipolar disorder, which was previously considered a rare and serious mental disorder, has now replaced many other diagnoses—specially depression and borderline

personality disorder and is being diagnosed with increasing frequency (Basso et al., 2013; Mitchell, 2012; Moncrieff, 2014; Zutshi et al., 2011). These diagnoses were also applied to younger people and, in less than one decade, BSD diagnosis increased 40-fold among children and adolescents in the US (Moreno et al., 2007; Parens & Johnston, 2010).

Contemporary psychiatric training in Iran—and the resulting modes of psychiatric practice—closely follow American psychiatric nosology and psychiatric textbooks, particularly those published by the American Psychiatric Association (Mehryar et al., 1986; Javanbakht & Sanati, 2006). Consequently, many of the changes, trends, and controversies in diagnoses and treatment seen in the US are also observed in Iran. The expansion of bipolarity—promoted as bipolar spectrum disorder (BSD), atypical bipolar disorder (ABD), or "soft bipolarity"—is only one of many examples of this influence. In recent ethnographic research. Behrouzan (2016) has explored the use of psychiatric diagnoses such as PTSD, ADHD, and depression by both professionals and general population in Iran.

Although there are no reliable data on the rates of bipolar diagnosis in Iranian clinical settings, leading academic psychiatrists in Iran have reported a significant increase in the over-diagnosis of bipolar disorder and over-prescription of mood-stabilisers and atypical antipsychotics, particularly among young women, in the past decade (Authors, submitted). The structural factors involved in the increase of BSD and its related pharmaceutical interventions in Iran have been discussed previously (Authors, submitted). Although examining these factors is beyond the scope of this paper, it is worth mentioning that major determinants include: the academic influence of key international and Iranian psychiatrists; the dominance of American psychiatric classifications and textbooks in Iranian psychiatric training; the lack of development of and economic support for psychosocial models of care in psychiatry; the influence of

pharmaceutical companies; and a range of related political and ideological factors that affect the recognition of health problems and delivery of health care.

The gender difference in the diagnosis of BSD in Iran is consistent with the higher rate of diagnosis of bipolar subtypes among women reported in the Western literature. According to these studies, while bipolar-I has an equal prevalence in men and women, bipolar subtypes such as bipolar-II disorder and rapid-cycling, mixed episodes, dysphoric episodes with seasonal pattern, switches during antidepressant treatment (also called bipolar-III), and possibly soft bipolar spectrum disorders are all more frequent among women (Arnold, 2003; Baldassano et al., 2005; Bauer & Pfennig, 2005; Burt & Rasgon, 2004; Cassidy & Carroll, 2001; Diflorio & Jones, 2010; McElroy, 2004). Nevertheless, the existence of both clinical and epidemiological gender differences among patients with bipolar disorder as well as meaning of these differences is still a matter of controversy (Nivoli et al., 2011).

To explain reports of higher rates of psychiatric disorders particularly depression in women, biological psychiatry has focused on gender differences in reproductive hormones and temperamental factors, particularly depressive temperament (Neitzke, 2016; Studd, 2015; Studd & Nappi, 2012; Studd & Panay, 2004; Ussher, 2010). However, a substantial body of literature in social science, gender, and feminist psychological studies challenges a narrow biomedical approach to gender differences in depression and proposes more multidimensional models to explain that include psychological, social and cultural processes (Lafrance, 2009; Metzl, 2003; Ussher, 2000, 2011).

With mounting evidence that BSD is diagnosed far more frequently among women than men. Biological factors such as hormones and the impact of reproductive life events have been postulated as responsible for difference (Diflorio & Jones, 2010), Indeed, arguments against

attributing the higher rates of depression among women to their biology sometimes contrast depression with bipolar disorder, which is held to be a psychiatric disorder with equal gender prevalence across different cultures (Weissman et al., 1996). However, it remains unclear why the same hormonal differences do not lead to a higher rate of bipolar-I in women compared with men.

Overall, the role of biological factors in higher rates of both depression and BSD among women remain speculative with insufficient empirical support (Leibenluft, 1996; Leibenluft, et al., 1999; Shivakumar et al., 2008; Sit, Seltman, & Wisner, 2011; Wiener et al., 2014). The gender differences associated with a range of psychiatric diagnoses, from hysteria in the 19th century, to depression 20th century, and "soft" bipolarity the 21st century seem to reflect sociocultural processes as well as changing diagnostic fashions that extend to non-Western countries (Ussher, 2013). To some extent, this reflects a preference for biological explanations for problematic behavior and social suffering. To understand the preference for biomedical explanations, we need to consider not only the economic interests at play in the remaking of human identity as "biological being" and the globalization of biological psychiatry (Rose, 2009 & 2013; Fernando, 2017), but also the resistance to addressing the sociocultural, political, and economic determinants of women's mental sufferings in particular contexts (Kirmayer et al., 2015). The rise of BSD in Iran provides an instructive example of how gender differences in diagnosis may reflect sociopolitical issues.

3.2 Methodology

This paper is a part of a broader study on the rise of bipolar spectrum disorder diagnosis in Iran which was conducted in three periods of fieldwork from February 2014 to June 2015 in 5

cities: Tehran, Isfahan, Mashhad, Shiraz, and Zabol. The study protocol was approved by the Research Ethics Committee (REC) of the Jewish General Hospital in Montreal.

Qualitative methods of data collection included participant observation and two sets of semi-structured interviews by the first author (a psychologist trained in Iran). The interviews were designed to gather data on how bipolar spectrum disorder and its related treatments are understood by psychiatrists and patients in Iran. We collected our data within a purposive sampling method as we aimed that the participants to be rich sources of information with regards to psychiatric education policy making and influence in training and practice of mood disorders in psychiatric departments (for the first phase of study), and with regards to the experience of living under the diagnosis and medications of bipolar disorder (in the second phase of study). A first set of 25 interviews was conducted with professionals at six universities in Tehran, Isfahan, and Mashhad. All informants were psychiatrists and university professors, who were influential in training and practice in the field of mood disorders. These individuals were referred by academics and colleagues of the first author who are members of the Iranian Psychiatric Association and each provided written consent to participate in this project. Interviews were conducted in at the participants' private or hospital offices. A second set of 37 in-depth, semi-structured interviews was conducted with patients (male and female, 18-55 years old) in Tehran, Isfahan, Shiraz, and Zabol. Patients had received bipolar spectrum disorder diagnosis and treatment, excluding Bipolar-I, and were recruited by psychiatrists who are specialized in mood disorders including those who participated in the study. For semi-structured interviews with patients, we used the McGill Illness Narrative Interview (MINI) (Groleau et al., 2006). The MINI is sequentially structured with three main sections: (1) a basic temporal narrative of symptom and illness experience, organized in terms of the contiguity of events; (2) salient

prototypes related to current health problems, based on previous experience of the interviewee, family members or friends, and mass media or other popular representations; and (3) explanatory models, including labels, causal attributions, expectations for treatment, course and outcome. Supplementary sections of the MINI explore help-seeking and pathways to care, treatment experience, adherence and impact of the illness on identity, self-perception and relationships with others (Groleau et al., 2006). In order for the MINI to be conceptually and semantically valid for the Iran setting, the English version was translated into Farsi by a bilingual Iranian psychologist and was edited by a bilingual Iranian psychiatrist.

Patients were introduced to the project by the psychiatrists who participated in the first phase of the study as well as other psychiatrists who were former colleagues of the first author. Patients who agreed to participate were interviewed by the first author in their psychiatrists' office, in their homes, and in their work offices.

All interviews and conversations were conducted in Farsi and ranged from one to three hours in duration. With the permission of the participants, the interviews were digitally recorded and transcribed. To protect anonymity, pseudonyms have been used in the presentation of findings. Transcripts were analyzed by thematic coding with an emphasis on keywords, analogies, and explanatory models. In addition to the interviews, additional data derives from fieldwork notes during participant observation in Iranian psychiatric training and continuing education events and seminars, including the 31st Annual Meeting of the Iranian Psychiatric Association, Tehran, Iran (October 14-17, 2014), the First Iranian Psychoanalytic and Psychodynamic Psychotherapy on Culture and Psychotherapy, Tehran, Iran (October 11-13, 2014), the 4th Social and Cultural Psychiatry Conference, Tehran, Iran (May 13-15, 2015), and, as well as the analysis of national and social media contents about the current mental health

conditions of Iranians, which provided information on relevant research and training activities and clinical practice, and both formal and informational discussions in institutional settings. Other ethnographic data collected during field visits and through media platforms were used to clarify and interpret material derived from the interviews based on the context in which the narratives were produced and concurrent professional and public debates.

3.3 Results

3.3.1 Psychiatrists' Accounts: Constructing Soft Bipolar Women

Analysis of psychiatrists' accounts indicates that patients, who were mainly young women, 15-35 years old, received the bipolar label for a range of symptoms that psychiatrists broadly described with terms including: emotional instability, irritable mood, dysphoric mood, impulsivity, "hypersexual" behaviour, disruptive or oppositional behaviour, atypical depressive features, responding to the treatment too quickly, and treatment resistant depression.

Many of the features that psychiatrists attributed the BSD presentation in women to—such as the use of Facebook, more outgoing social behaviour, and casual sexual activity—may reflect wider social changes in Iran. However, due to the lack of diagnostic criteria which are specifically adapted to Iran's changing social and cultural norms, these behaviours can be perceived and interpreted based on the clinician's own values and institutional contexts. In other words, those psychiatrists who have strict or conservative values, will interpret their patients' behaviours based on their own norms (or those of the patient's family) and label such behaviours as symptoms of a "disorder", disregarding the norms and values of the patient and the social group to which she belongs. This diagnostic judgment is influenced not only by clinicians' personal values and local culture but also by their professional orientation. Clinicians'

commitment to either a holistic and social-contextual model of diagnosis and practice, or to a narrower biomedical model appears to influence the kind of diagnostic labels they apply to patients.

Describing one of his current patient's, Dr. L, a professor of psychiatry at a university medical school, stated:

> In our country [Iran] and [Iranian] culture, an extramarital affair for a woman is caused by specific personality traits—and because I am from the group [of psychiatrists] that doesn't believe in personality problems, I diagnose these cases as bipolar disorder.

As Dr. L explained, his professional orientation as a psychiatrist is aligned with the biomedical model and means he does not "believe in" personality disorders. He therefore diagnosed his patient with extramarital affair as having BSD, rather than treating the affair as evidence of a "specific personality trait." Consequently, he restricted his therapeutic intervention to anticonvulsant mood stabilizers rather than offering a biopsychosocial care.

The practice of rationalizing the use of the BSD diagnosis and corresponding pharmaceutical interventions based on psychiatrists' own values (and in some cases the values of patients' families) rather than the patient's own view is not limited to adult women. During this study, several psychiatrists reported a similar use of this diagnosis with adolescents.

Dr. X, who is a university professor and child and adolescent psychiatrist, pointed out:

> Not every therapist who applies the bipolar diagnosis and prescribes Depakote [divalproex sodium] necessarily believes in his justification and thinks that Depakote can treat a young girl who keeps escaping from home, has self-inflicted cut marks, has different cellphone numbers, dates different guys, and

> "dishonours" her family. But, at that moment, the simplest thing that a psychiatrist can think of is giving her mood stabilizers to control her emotions. We may even give her an antipsychotic to make her dull [*khamood*], stay at home, and not cause trouble for her family. If we do not rely on the medication, we would "sink into many complex problems" and have to spend so much time. Even if I want to use non-pharmacotherapeutic intervention, where and how is it supposed to be done? At whose cost and with which insurance?

Although not all psychiatrists believe that the new form of bipolar diagnosis is an evidence-based diagnostic construct that can be used to characterize their patients' "many complex problems," the biomedical approach is convenient and keyed to readily available therapeutics: it allows clinicians to use the diagnosis of BSD and accompanying pharmaceutical interventions as a tool to address young women's interpersonal and sociocultural problems. The biomedical approach seems to be a practical substitute for a more holistic approach and multi-level interventions, which are generally not available in Iran's psychiatric system. Financial limitations in mental health care, the lack of a public health perspective among psychiatrists, insufficient training in psychotherapy, and inadequate management systems[31] for psychosocial services are some of the factors limiting the application of a psychosocial model of care in Iran's mental health system (Authors, submitted). The lack of psychological services and the absence of social and legal support for women in Iran, such as women's shelters and youth protection

[31] Iran's mental health system does not suffer from a shortage in human resources such as social workers and psychologists but their expertise in mental health care systems has been undermined. For example, some of our participants framed employing social workers in administrative positions instead of considering them as an essential part of mental health teams as a management problem in Iran's mental health care systems.

services, may explain why some psychiatrists found it "pragmatic" to make a diagnosis like bipolar disorder, for which medication is recommended first-line treatment.

In sum, a broad use of non-specific diagnostic criteria for bipolar spectrum disorder was very common among most of the interviewees. Indeed, most of the common symptoms associated with BSD overlap with ordinary variations in temperament, behaviours that can be culturally seen as disruptive or transgressive behaviours, as related to specific (DSM cluster B) personality traits or as part of other diagnoses such as depression. This broad range of symptoms provides a gray zone where many patients' problems can be conceived of as fitting BSD.

As the analysis of psychiatrists' narratives in this study indicates, the pragmatic use of the biomedical approach may be used as a mean to control women's behaviours that cannot be tolerated by their families or the patriarchal society. Although the medical system in Iran is not generally seen as an institution associated with overtly repressive social control, like *the Gasht-e-Ershad,* (Guidance Patrol[32], also called the "morality police") or judicial system, it serves what can be called "restitutive" social control through forms of treatment and rehabilitation that enforce tacit social norms. In addition to providing clinicians with a pragmatic approach to complex psychosocial problems, biological psychiatry, thus serves patriarchal societal norms.

[32] The mission of the *Gasht-e-Eershad*, Guidance Patrol or "morality police" is to impose Islamic codes and norms of conduct and dress in public, particularly regarding women's hijab when they do not follow such codes as well as if they are accompanied by unrelated men without a male guardian. These dress codes and norms of have been viewed as a scourge and questioned and emancipated by many urban women who try to push the boundaries of dress code and similar norms. These women could be subject to the arrest, penalty, and harassment by morality police.

3.3.2 Patients' Accounts: The 'Hard' Sociopolitical Context of 'Soft' Bipolar Women

This section presents the accounts of women who received BSD diagnoses, including the metaphors and idioms they use to explain their psychiatric condition and the perceived causes of their symptoms and suffering.

Among the study participants, it was mainly those who were highly educated who were told by their clinicians that their diagnosis was "soft bipolar" or "BSD". Because of the severe stigma attached to this diagnosis—a stigma that can lead to a poor treatment compliance—most BSD patients were told that they had neurologic suffering (*narahati-asāb*), depression (*afsordegi*), or "pendular" depression (*afsordegi navasāni*; i.e. depression with mood swings). However, the most common local term attached to bipolarity was *dō-shakhsiaty boodan,* which literally means "having two personalities." Although we did not find a gender difference in local expressions for bipolar spectrum disorder, there was a clear gender difference in the factors to which patients attributed the cause of their mental health problems. Male patients mostly attributed the causes of their bipolarity to their professional, financial, and educational struggles, that could lead to failing to meet societal expectations of being a competent provider for their family. This section focuses on what female patients perceive as the cause(s) of their mental sufferings (*pendular depression, dō-shakhsiati,* depression, or soft bipolarity).

Most participants believed that their mental suffering was caused mainly by social structural and family problems which aggravated each other. The main social problems mentioned in patients' narratives include social pressures (*feshar haye ejtemaie),* patriarchal societal values (*jame'y mardsalar*), gender segregation (*tafkik-e-jensiati*), gender discrimination (*tabeez-e-jensiati*), lack of social and legal support for women, lack of job opportunities, economic problems, sexual harassment at work and in public places, and poverty.

Family problems included excessive family control, bereavement and family rejection, and different types of domestic violence and disputes (emotional, physical, and sexual abuse and humiliation), most of which were rooted in differences between young women's values and beliefs and those of their families and/or the larger society, and in gender discrimination, patriarchy, and the familist culture of "honor". Only a few participants mentioned genetic factors *(ersi boodan)* and mismanagement of their care by mental health professionals as causes of their mental health problems. While most female informants from all socioeconomic and education backgrounds attribute their mental suffering to family problems, working women who had university education emphasized social structural problems, particularly social pressures, gender discriminatory law, and patriarchal societal values, as causal factors of their mental problems. The narratives below illustrate the interplay of these factors.

3.3.3 Case Vignette 1. Struggles Over Vocational Choice

Sahar, a 35-year-old woman with a graduate degree, was originally from a small town but grew up in Tehran. She received a diagnosis of soft bipolar at age 27 and had been prescribed various mood stabilizers and neuroleptics for several years. She was a business manager and had recently married. Sahar attributed her mental health problem to both restrictive traditional family values and sociocultural issues, saying:

> … in our patriarchal society, achieving good job positions (particularly in positions such as management) for women is not easily accepted. As a female teacher or nurse, society may accept you, but being a female company manager is not tolerated. Both family and society label you as impertinent (*cheshm sefid, pa dom sabideh* or *sar ziad)* and disrespect you. They ignore all the hard study and work that are needed to become a professional woman in Iran, and when

> you become one of those, they attribute your achievement to your rebelliousness or impudent behaviours. When I entered the larger society, starting university, I learned that I could live differently [from what my parents wanted]. When I put my different ideas about who to be and what to do into action, there was conflict everyday with my parents, who didn't want me, for example, to stay out after the sunset or had problems with my choices of clothing or friends when I wanted to go to a party. I think that I was not mentally ill, but, it was the social and life environment (*mohit -e- ejtemaie va zendegi*) and cultural problems (*moshkel -e- farhangi*) which created so much tension in my everyday life.

After Iran's revolution, education, including higher education, was promoted and became more accessible to women. Indeed, university education (*tahsilat-e-daneshgahi*) for women has become a cultural norm and a value endorsed by many families, including traditional and religious ones, so that compared to the 1980s when 32% of university students were women, in the new millennium, fully 65% of university students in Iran are women. Education facilitated women's awareness of gender equality and freedom of choice in a society where the general sociocultural mode is still patriarchal and conservative. Despite all the gains that Iranian women have achieved in the past few decades, there is still a big gap between women's education and skills and the social and professional positions they can occupy—particularly when those positions are perceived as "masculine," such as management, engineering, as well as legislative, executive and judicial positions—which has an important impact on how much women can have control over their lives.

Young woman may face legal, societal, and cultural barriers if they insist on following particular professional interests. These barriers make it much harder for women than for men to both occupy and maintain equivalent occupational status. Questioning the traditional and patriarchal values and codes imposed on women by both family and society, such as Sahar has done, may lead to interpersonal conflict and distress. Because of her persistent struggle to follow her vocational choice, she has been stereotyped as a "rebellious girl." A woman's professional success and productivity, which in her view are rooted in her perseverance and resilience, may be attributed to her "rebelliousness" and "bipolarity" by her family and psychiatrists, respectively.

3.3.4 Case 2. The "Bipolar Life Space" of Indoors and Outdoors

Changes in social norms and legal codes through the Islamicization of law during the 1979 Revolution have created a life space that is itself "bipolar" in a metaphorical sense—particularly for many secular and non-religious Iranian families—and some participants perceive this as one of the main causes of their mental suffering. This factor is examined in Leila's narrative.

Leila is a 21-year-old woman from an affluent non-religious family in Tehran. She was diagnosed as bipolar at age 16, but from a "lower" type (mild) (*do-ghotbi az noe paeen*). When asked her what she thinks the cause of her "bipolarity" is, she answered, "Family and society." She continued:

> In Iran, everything is bipolar. We are one kind of person outside the home and another kind inside the home. In the school, we have 6-7 hours of religion class [per week] and have to spend our time on learning and adopting things that

> neither are important to us nor that we believe in. In school you must behave one way and in home another [opposite] way. For example, in school you must go to the prayer room, and even if you do not want to pray, you have to stay next to those who are praying and pretend to pray. At home you see that your family members are drinking wine, while in school you learn that drinking alcohol is a sin and illegal. You have to have wear hijab in public, while you can dress freely in non-public spaces. You have to pretend to believe or to do many things while outside, and those codes are so strongly dictated to you that they occupy a part of your brain. On the other hand, you live a different world while inside the home. I think these contradictions contributed to my mental problem. They affect us particularly during childhood. Now [that I am older], for example, I put a scarf over my head [outside] and realized why things are in this way [sociopolitical mandates], but when you are younger, these contradictions do not make sense to you. When you are younger, you are like dough that is getting shaped and [here] everyone shapes you in their own form. Society, including school and public, shapes you in one form, and the family [indoor people] shapes you in the opposite form. You get frayed between these polarities and can't shape your personality. Then you become bipolar or *do-shakhsiaty* [two-personalities) [if one cannot adjust to it].

In addition to the contradictions between the values of parents and those of children due to an expanded generation gap amplified by the greater access to higher level education, circulation of information through internet and social media, and globalization, there have been dramatic contrasts and contradictions between private ("indoor"; *dākhel-e-khooneh*) and public

("outdoor"; *biroon-e-khooneh*) values in many secular and non-religious Iranian families in the past few decades.

After Iran's revolution, not every family employed the religious values and codes that the Islamic Republic (IR) regime dictated in public spaces (e.g., hijab, Islamic education, banning alcohol, and heterosexual partying) in their private spaces. While some families left the country because of these restrictive sociopolitical codes, many non-religious and secular families resisted adopting religious values and codes in their private spaces. The irreconcilable public-private (commonly called "outdoor-indoor") dichotomy of values has led to a severe polarization between "who" a secular or non-religious person has to be in outdoors (e.g., street, school, workplace, and all public places in general) and "who" the same person is in his/her their private spaces. Behaviors that are prohibited by social and legal codes (such as partying or drinking alcohol) and labeled as "destructive" and illegal may be considered normal and even supported by those families who value individual choice and reject some of the religious state's policies. Given the need to respect public norms (and the danger of transgression), many people must carry contradictory personas during their everyday life. This is particularly common among the younger generation who have grown up after the revolution in the era of irreconcilable temsopms between outdoor-indoor values. This contradiction was brought up by some of our participants as one of the causes of their distress, their "two-personalities" (*do-shakhsiaty*), or their "bipolarity".

It is worth noting that the contradictory 'outdoor-indoor' codes and values impact on both young men and women in Iran; however, many facets of the religious-ideological norms which are dictated by both the state and patriarchal families (such as mandatory hijab, Islamic family law with unequal marriage and divorce rights, and an emphasis on women's sexual modesty and

purity) only circumscribe women's rights and freedoms and hence, systematically disadvantage them within both society and family.

3.3.5 Cases 3 & 4. Domestic Violence and Abuse

Finally, and of crucial importance, female participants (of all ages) most frequently attributed their mental suffering to domestic violence and family disputes—including physical, sexual, and emotional abuse. Women who had a lower education level, were financially dependent on male family members, and lived in more patriarchal families experienced more physical, verbal-psychological, economic, and sexual abuse (Vameghi, 2014).

To illustrate such conditions, we narrate two stories with many common elements which re-appeared in significant numbers of the informants' narratives.

Case 3: Zahra, in her late 40s, a married housewife with three children, was referred to her current psychiatrist with a range of somatic symptoms including itchy genitalia and headache as well as mood symptoms. Despite multiple medical tests, her somatic symptoms had not been explained by any medical condition. She was diagnosed by a series of psychiatrists, first as having depression, then as having treatment-resistant depression, and later as having bipolar spectrum disorder. She took a variety of psychiatric medications over several years without ever having a chance to disclose her life story to her clinicians. During the interview, she explained how her mental suffering [*narahati asab*] was rooted in her early marriage (she was only 15 years old) with a man from a lower socioeconomic background than that of her family. Zahra's husband accused her of not being a virgin because her hymen did not bleed when they had their first intercourse on their wedding night. Because of her husband's job, after the wedding she and her husband moved to their home in a city far from Zahra's parents, where he regularly beat and

humiliated Zahra, confining her to the home for days without allowing her contact with other people, and threatening to tell her family that she was not a virgin if she told anyone about his abuse. Zahra lived under these abusive conditions for eight years until the first time that she attempted suicide by eating opium when she was 23. When her family learned about her situation, after her suicide attempt, they came to her home and told her that nothing was as important as her marriage, that she would leave her husband's home in a white dress (shroud) as she entered it in a white dress (wedding dress). This is a very popular cultural expression that emphasizes the importance of preserving marriage for women for as long as they are alive. Zahra, who came to the interview with her 25- year-old daughter, had endured her husband's and in-laws' abuse for more than two decades.

Case 5: Akram, a 39-year-old widow from a low economic level, had studied until grade 8. She worked long hours in hard work conditions as an epilator in a beauty salon. Longstanding inflammation of tendons in her hand, which were injured during one of the many times that her father beat her with a cane, got worse with her manual job. She started visiting her psychiatrist when she was crying a lot and had sleeping problems, irritated mood, and loss of interest in daily activities. She was diagnosed with BSD. According to Akram, the root of her mental suffering began in her adolescence, when her parents learned that she had a boyfriend. She was accused of dishonouring the family. Her father beat her badly, broke her nose, called her a whore, and threatened to kill her. She escaped from home because she feared being murdered. After one night, the family found her and prevented her from going to school for one week. After that, the school did not allow her to return so that she would not "spoil" other students. Since she could not go back to school, the family arranged her marriage with her cousin when she was only 14 years old. She believes that her parents' behavior allowed her in-laws to abuse her and humiliate

her by calling her a "whore." After nine years of marriage, her husband died, leaving her with a four-year-old-son. She attempted suicide a few days after her husband died. However, she emphasized that she did not want to die but also did not want to return to her parents' home, where her family had decided that she should live after becoming a widow.

In our study, many women related stories similar to those of Zahra and Akram—detailing various forms of abuse and oppression, particularly in Mashhad, Isfahan, Zabol, and in some cases in Shiraz. In the past few years, similar stories have been shared by many women through Iranian social media and websites that aim at raising public awareness to reduce violence against women .[3334] The common element in all of these accounts is women's oppression, which is rooted in the patriarchal and honor-based cultural values that produce and are reproduced by the gender-discriminatory legal and societal codes.

In the narratives of female participants, both escaping from home (at younger ages) and suicide attempts (including pill overdose, opioid overdose, and self-immolation) occurred mainly after they were beaten, humiliated, isolated, threatened with death, and oppressed by their parents, brothers, husbands, and in-laws. Different forms of violence that women experience are because they transgress, are perceived as crossing, or simply are accused of crossing the lines of family "honor" (*aberoo*), which in patriarchal cultures is tied to "women's sexual modesty" (Vandello & Cohen, 2003). One of the values most widely shared across familist cultures is family honor. Honor has been defined in two ways—first, honor as virtuous behavior, with a great concern with generosity, hospitality, loyalty, integrity, and altruism; and second, honor as status, precedence, and reputation, based on a man's toughness and ability to protect his family

[33] http://www.khanehamn.org/

[34] http://www.bbc.com/persian/specials/162_violence

and possessions (Pitt-Rivers, 1966). Honor norms in familist culture apply to females as well, with an emphasis on modesty, shame, and the avoidance of behaviors that might threaten men's reputation and the good name of the family (e.g., sexual immodesty) (Vandello & Cohen, 2003).

A vicious cycle of patriarchal social arrangements that foster certain traditional gender roles—male honor and female chastity—and a lack of social and institutional support for women (e.g., youth protection and women's shelters) both justify and lead to a multi-layered form of violence against young women. Although different forms of discrimination and violence against women are seen at different socioeconomic levels and in different cities, women with less education and greater financial dependency are more likely to be silenced for long periods of time before seeking outside help. Lower levels of social and professional engagements limit women's access to social and medical resources and make them more vulnerable to the conditions that contribute to their physical, mental, and emotional suffering.

3.4 Discussion

Based on this study's findings, we would argue that the high rate of diagnosis among women in Iran of bipolar spectrum disorder (i.e., subthreshold bipolar, soft bipolar disorder) is influenced by multiple factors, including: (1) the increasing prevalence of psychological distress, including anxiety, depressive, and somatic disorders (Sajjadi et al., 2013; Noorbala et al., 2017)—which are rooted in gender inequality and women's struggles with the onerous sociopolitical, patriarchal, and economic situations that they live in (Piccinell, 2000; Van de Velde et al., 2010;Sajjadi et al., 2013; Joulaie et al., 2016; Noorbala et al, 2017; Kokabisaghi, 2019).; (2) the reclassification of a significant number of patients from other diagnoses—such as anxiety, depression, complex trauma, and personality problems, which already have a higher

prevalence among women; and (3) the pathologization of certain gender-related behaviours that may reflect tensions between women's emancipation and the reinstitution of conservative societal norms. Behaviors such as the use of heavy make-up, extending social relationships through social media, casual sexual behavior, extramarital affairs may be medicalized for women, while corresponding behaviors for men would not be pathologized because they fit the socially accepted schema of manhood as including being "promiscuous" *(havasbaz)*.

As in other societies, gender is a critical determinant of health and mental health status in Iran (Joulaei et al., 2016). Therefore, any mental-health-related issues among women, such as the recent increase in soft bipolar diagnosis among Iranian women, cannot be understood and treated without taking into account women's own perspectives about the causes of their mental suffering, which include the social, cultural, political, and economic contexts in which they live.

Iran has experienced intense political conflict, revolutionary transformation, regional war, and rapid societal change in the past few decades. Recognizing the diversity within the country and the female population is crucial for any discussion of women's mental suffering . Despite this diversity, however, it is still possible to identify gender issues related to the fluidity of the Iranian socio-political context and rapid changes in culture and provide a conceptual framework that can be broadly applied to a variety of forms of women's suffering from unipolar depression to BSD.

Iran's political regime has had a major influence on the social and economic situation of women's lives. Exercising religious ideology at the state level affects women's rights and freedom within that society. Both during and after the revolution, women have served as political symbols of the Islamic Republic of Iran. How women dress and act has been interpreted as a reflection of the regime's stability and its religious identity. In short, establishing laws that

specifically address women's behavior has been seen as a way for the state to exercise its power and maintain it control over the citizenry (Lind, 2012).

While the IR regime has had its own agenda in promoting the Islamization of society through education, it has made education, including higher education, more accessible to women (Hoodfar, 2010), and woman now account for more than 65% of university students. However, Iran's unstable economy and gender discrimination have limited women's participation in the job market (Rezai-Rashti & Moghadam, 2011); only 16.4% of job opportunities are assigned to females and, according to the 2013 census, the unemployment rate for females is double that of males (18.95% vs. 9.1%) (Joulaei et al., 2016). Despite this discrepancy in economic participation, the high rate of education of women has raised their expectations in terms of public participation socially, economically, and politically. Women have increasingly pushed to expand the limited political space available to challenge the state and its promotion of the discriminatory legal and societal codes that affect women's everyday lives (Hoodfar, 2010).

Furthermore, the pronatalist policy adopted by the IR regime has resulted in significant population growth rate, from 33.7 million in 1976 to 77.5 million in 2014 (with 42.4% under 25 and a median age of 28.3) (The World Bank. Iran). Together, the considerable increase in the number of school-aged children, the improving employment market in cities, and the scarcity of resources in rural areas, exacerbated by global warming, have led to rapid urbanization (Aloosh & Aloosh, 2014; Rezai-Rashti, 2012). In addition, Iranian societal values and lifestyle have been greatly affected by broad access to the Internet and satellite technology, which has facilitated Iranians' exposure to modern values. Due to this vast urbanization, globalization, and rapid changes in communication technologies, Iranian society has seen a rapid change in societal values (Shahhosseini et al., 2012). The younger generation is re-evaluating and questioning

traditional patriarchal values that restrict their freedom of choice and gender equality, resulting in tensions and conflicts in parent-child relationships and contributing to various forms of distress, for which both young women and their families increasingly seek psychiatric and psychological counselling services (Fatemi et al., 2015; Sadeghirad et al., 2010; Shahhosseini et al., 2012). These kinds of conflicts were frequently brought up by both clinicians' and patients' in our study.

Importantly, our female patients' narratives both confirm and elaborate on the quantitative findings on the high prevalence of violence against women in Iranian families, which range from 17.5% of pregnant women in Khorasan Razavi to 93.6% of women in Mazandaran province (Raisi, 2012; Vameghi et al., 2014). Studies in Iran show that the violence against women is directly related to their increasing age (with the highest frequency of domestic violence against women in their 50s and lowest frequency among women in their early 20s (Ghazi Tabatabaie, 2004) and inversely related to their educational level (especially lower in those with a university education), and to their place in the workforce (with more violence against housewives than working women)(Vameghi et al., 2014). Moreover, domestic violence and family conflicts have been found to be among the most frequently reported factors associated with attempted suicides in Iran, especially among married women (Ahmadnia, 2015; Memari, Ramim, Amirmoradi, Khosravi, & Godarzi, 2006; Shirazi et al., 2012). This is consistent with the observation in the WHO report on women's health, which notes, gender differences in social roles, social inequality, and membership in certain sociocultural units such as patriarchal families are identified as risk factors for female suicidal behavior (WHO, 2009, p. 54).

In our study, informants repeatedly stated that their families' traditional expectation of them to maintain *aberoo-e-khanevadeh*, "family honor", was one of the main sources of family

conflict and domestic violence. The complex dynamics of shame and subordination associated with family honor, which require obeying the cultural rules of family hierarchy, reflect patriarchal cultural values (Gilbert, Gilbert, & Sanghera, 2004)—a common feature of many societies throughout Central and South Asia and the Middle East, including Iran. In patriarchal "cultures of honor," it is held that the honor of the family depends in large measure on the behavior of women, who have power to "stain" the family honor through their immodest behaviors and to improve the family's reputation by adhering to the honor codes and through marrying up in the social chain. Although women have their own forms of power in patriarchal societies, in most cases, this power is constrained by social arrangements that insist on strict adherence to traditional gender roles. These norms mainly value female chastity, purity, and along with this comes male hypersensitivity to anything that can insult or threaten the family, and the man's reputation (Vandello & Cohen, 2003). Transgressing these norms then can lead to men's violence against women, justified in terms of protecting family reputation (Niaz, 2004). More broadly, "[t]he notion of family honour reinforces patriarchal power by circumscribing women's sexuality, movement in social arenas, and to some degree, economic opportunities; … [and] enhances the power of fathers, grandfathers, uncles, brothers, and male cousins over women" (Joseph & Slyomovics, 2011, p. 6).

3.5 Conclusion

We have tried to show how the recent widespread use of bipolar spectrum disorder diagnoses in Iran can be understood not only in terms of local psychiatric practice but also as result of the interaction of rapid social and cultural change, patriarchal attitudes toward gendered norms of behavior, and the limited options for more psychosocially oriented assessment and

care. Of course, the social structural and family problems that our informants perceived as the causes of their mental suffering may not be the only relevant causal factors; however, these social determinants are problems in their own right, and likely interact strongly with biopsychological factors to create vicious circles that amplify and maintain individuals' symptoms and suffering. For instance, exposure to violence and psychological trauma remains common among women worldwide (Ozer, Best, Lipsey, & Weiss, 2008; Walker, 1989). Hence, women with genetic vulnerability for depression may be more likely to experience depressive disorders (Vigod & Stewart, 2009).

Nevertheless, the narrow biomedical approach to psychiatry commonly seen in Iran reduces the complex interactions of multiple determinants to hypothetical mechanisms inside the individual's body and limits the interventions to pharmaceutical treatment. Unfortunately, this narrow view risks harming women by (1) promoting excessive use of mood stabilizers and neuroleptics, (2) foreclosing the effort to identify social, cultural and political conditions that may contribute to women's distress—namely, a patriarchal system of gender as it interacts with social, political, institutional, and economic orders; and (3) ruling out as impractical any systemic interventions or advocacy that might lead to changes in social structure, values and practices that could promote healthier, equal, and more sustainable environments for women across the lifespan. The dominant biological psychiatry system in Iran has led many psychiatrists, intentionally or not, to frame socio-politically and culturally rooted forms distress in terms of biomedical categories like soft bipolarity and to limit their intervention strategies to drugs and ECT. This model provides no place for addressing individual, familial, or broader sociocultural conflicts and/or gender oppression (Conrad, 1992, 2008).

The use of biological psychiatry as a framework allows clinicians to ignore underlying social and gendered causes of mental sufferings as upstream factors that are largely irrelevant to addressing the neurobiological final common pathways of disorder. This bioreductionist approach silences many voices, particularly those of more vulnerable groups—such as those of women, children and adolescents, ethnic and religious minorities, and poor—and marginalizes the discourse surrounding both the problematic institutional and social powers. Indeed, this approach may further disempower women by reinforcing the notion that women are more "biologically driven" than men and by delegitimizing any expression of anger, 'irritability', or discontent rooted in gender inequalities (Ussher, 2011).

In sum, multiple factors including gender, sociocultural, political, and economic factors, as well as the diagnostic practices of the biomedical psychiatry may all contribute to the apparent increase in BSD disorder among young women in Iran. Studies that take into account the interaction between biological, psychosocial, and political factors are needed to explore the perpetuating factors in women's mental health in contemporary Iran, to explain why these problems persist over time, and to suggest strategies for change. The intersection among culture, gender, class, and mental illness must be considered at all levels within policy, research, and ultimately, front-line services. Mental health practitioners and policy makers must address health system inadequacies related to gender, the barriers in creating patient-centered biopsychosocial services, and the short- and long-term burden that taken-for-granted biomedical psychiatry has on health care system and society, such as misdiagnoses, mistreatments, and medicalization.

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INTRODUCTION TO CHAPTER 4

In Chapter 3, "'Women as Troublemakers': The Hard Sociopolitical Context of Soft Bipolar Disorder in Iran," I presented the findings of the second phase of my doctoral research, which examined illness meaning and the experiences of patients, with a focus on the narratives of women diagnosed with BSD as well as the impact of illness in their sociopolitical, gendered, and cultural contexts. I explained that in the past decade, Iran has seen major social, cultural, and political changes that have had an impact on women's health and wellbeing, on the kinds of behaviours that are viewed as problematic, and on the ways in which such challenging behaviours are explained. I argued that the higher rate of BSD diagnosis among women is influenced, first, by the increasing prevalence of psychological problems—e.g., anxiety and depressive disorders—that are rooted in women's struggles with the oppressive sociopolitical, patriarchal, and economic situations that they live in; second, by bringing a significant number of patients from other diagnoses—such as anxiety, depression, and borderline personality disorders, which already have a higher prevalence among women—under the umbrella of BSD diagnosis; and third, by making BSD a gendered (feminine) diagnosis through a series of "symptoms" such as women's emancipation, harsh make-up, extending social relationships through social media, casual sexual behaviour, and extramarital affairs.

Bringing together the findings of Chapters 2 and 3, I argued that the use of the new BSD diagnosis and biomedical interventions as pragmatic tools to intervene in women's mental suffering inadvertently harms women by: 1) leading to the wider use of mood stabilizers and neuroleptics for symptoms where they may not be indicated; 2) removing the opportunity to examine and attest to the sociocultural and political conditions that surround women, which reflects a patriarchal system of gender that interacts with social, political, institutional, and

economic orders; and 3) ruling out as impractical any consideration of changes in social structure and values that could promote healthier, equal, and more sustainable environments.

In order to understand how, under such a complex sociocultural and structural system, patients diagnosed with BSD navigate the help they need to cope with and treat their mental health problems, Chapter 4, "Help-seeking Strategies and Treatment Experiences Among Individuals Diagnosed with Bipolar Spectrum Disorder in Iran: A Qualitative Study," (submitted as an original research article to *Transcultural Psychiatry* in July 2020), examines patients' coping and help-seeking strategies, barriers to treatment, and expectations of outcomes from treatment as well as the role of social, cultural, and structural factors in the choices patients make in seeking help from mental health professionals. Findings of Chapters 4 is based on semi-structured interviews (MINI) with patients who received a BSD diagnosis and treatments as well as the archival research and the analysis of national and social media contents about the current mental health conditions of Iranians and mental health services in Iran.

CHAPTER 4: HELP-SEEKING STRATEGIES AND TREATMENT EXPERIENCES AMONG INDIVIDUALS DIAGNOSED WITH BIPOLAR SPECTRUM DISORDER IN IRAN: A QUALITATIVE STUDY

Abstract

Social, cultural, and structural factors are associated with delays in seeking help from mental health professionals and poor treatment adherence among patients with mood disorders. This qualitative study examines the perspectives on the services and response to treatments of individuals diagnosed with Bipolar Spectrum Disorder (BSD) in Iran. 37 in-depth semi-structured interviews with patients who had received BSD diagnosis and treatment, excluding Bipolar-I, were conducted. The study participants identified two broad areas: 1) coping and help-seeking strategies and 2) barriers to treatment and expectations of outcomes from treatment. Multiple factors influenced the help-seeking strategies and trajectories of patients with BSD diagnoses in Iran, including: the structural limitations of the mental health care system; the modes of practice of biological psychiatry; the characteristics of the official psychology and counselling services permitted by Iran's government; popular psychology and consultation (offered remotely) by Iranian psychologists and counsellors in the diaspora; and alternative spiritual and cult-based groups. To improve the quality and accessibility of mental health services, it is essential to have structural changes within the healthcare system that prioritize human rights and the individual's values over the political and ideological values of the state and that a change in professional culture that promotes secular training of mental healthcare providers and an ecosocial model of care.

Keywords: Help-seeking, Structural and Cultural Competence, Mental Health Care System, Bipolar Spectrum Disorder, Iran

4.1 Introduction

Social and cultural variations in the experience of mental suffering, coping strategies, help-seeking behaviours, clinical presentations, and responses to interventions influence the treatment and recovery of patients with mental disorders (Kirmayer et al., 2013). Several studies in diverse settings have documented delays in seeking help from mental health professionals and poor treatment adherence among patients with mood disorders (Mojtabai et al., 2011; Eftekhari et al., 2014; Brandstetter et al., 2017). Social, cultural, and structural factors are associated with the problems in accessing appropriate interventions for patients with mental health issues. These factors include stigma, self-reliance and low perceived need for care, difference in lay explanations of mental suffering and explanations offered by biomedicine, negative attitudes towards psychiatric medications and hospitalization, confidentiality issues, lack of proper investigation and nonspecific care, lack of clinicians' cultural competence, minimal knowledge about mental health problems and existing mental health services, and costs and availability of mental health services (Clement et al., 2015; Dockery et al., 2015; Mojtabai et al. 2011; Evans-Lacko et al. 2012; Dejman et al., 2009; Efthekhari et al, 2014; Taghva et al., 2017).

For serious mental health problems, people in non-Western countries often pursue both biomedical and ethnomedical healing modalities (A. Kleinman, 1980; Hsu et al., 2009; Luu et al., 2009; Chang, 2009; Shih et al., 2010). For example, seeking help from traditional Chinese medicine practitioners and religious and spiritual practices for physical or emotional concerns are commonly reported among patients with bipolar disorder in Taiwan (Lan et al., 2018). Similarly,

studies on pathways to care among patients with mental disorders in Iran show that the majority of patients seek help from both medical and traditional healers. In a study of explanatory models of depression and pathways to care among female patients from three ethnic groups (Fars, Kurds, and Turks) in Iran, the majority of patients reported visiting several non-psychiatric physicians (such as general practitioners and other specialists) before they were referred to psychiatrists (Dejman et al., 2011). The reasons reported by patients for not visiting psychiatrists and psychologists included concern about stigmatization and the affordability of psychological services. Among those who did consult psychiatrists, some patients did not continue in treatment because of drug side-effects, concerns that medication had aggravated their illness, the long duration of treatment and the time it took for medication to be effective. Other help-seeking strategies, such as spiritual and religious support, consulting fortune-tellers and prayer-writers, and collective practices such as Zar in the south of Iran, were reported to be common among patients with mental health disorders (Dejman et al., 2009; Mianji & Semnani2015).

Across diverse contexts, patients with bipolar disorders commonly express concerns about stigma, over-medication, side effects, issues regarding the patient-clinician relationship, and the affordability and accessibility of services (Lingam & Scott, 2002; Perlick et al., 2004; Zeber et al., 2008; Thompson & McCabe 2012; Chakrabarti, 2016; Jawad et al., 2018). However, there are specific cultural, social, and political determinants that shape patients' experience and understanding of their symptoms and suffering, causal attributions, strategies for seeking help, and expectations about care. For instance, spiritual and karmic understandings of mental illness and parallel help-seeking strategies are frequently employed in Asian countries (e.g., Kleinman, 1980; Chi et al., 1995). However, these local cultural models and approaches are not uniformly endorsed within particular social and cultural settings. For example, a recent study on

explanatory models of bipolar disorder in Taiwan found generational disagreements in families regarding adherence to Daoist and Christian practice, traditional Chinese medicine, and modern psychiatry (Lan et al., 2018). Similarly, generational differences in understanding, coping with, and seeking help for mental health sufferings are reported in studies in Iran. This is associated with a move from traditional pathways towards more biomedical interventions and popular psychology methods (Behrouzan, 2016; Mianji & Kirmayer, submitted; Fatemi et al., 2015).

Despite the rise in the use of bipolar spectrum disorders (BSD) diagnoses and corresponding biomedical interventions in Iran, associated with the globalization of American psychiatric nosology in the past two decades (Mianji & Kirmayer, 2020), there has been no study of patients' experiences with the interventions. To better understand how the globalization of Western psychiatric nosology interacts with local social-cultural context in industrialized non-Western societies, this paper examines help-seeking strategies and treatment experiences among individuals diagnosed with BSD in Iran.

4.2 Method

This paper is a part of a larger study of the rise of bipolar spectrum disorder diagnosis in Iran that included three periods of fieldwork from February 2014 to June 2015 in four cities: Tehran, Isfahan, Shiraz, and Zabol. The study protocol was approved by the Research Ethics Committee (REC) of the Jewish General Hospital in Montreal. Earlier components examined institutional history, and practitioner perspectives. The present study focuses on patients' experiences of diagnosis and treatment.

We used purposive sampling to identify patients with a diagnosis of BSD, who were currently attending psychiatric practices (male or female, 18-55 years old) in Tehran, Isfahan, Shiraz, and Zabol. Tehran, Isfahan, and Shiraz are among the five largest cities in Iran; Zabol is a smaller city lied on the border with Afghanistan. Due to disparities in the distribution of the health and social resources in Iran (Chavehpour et al., 2019; Reshadat et al., 2019), there are greater barriers to accessing healthcare resources in smaller cities, rural areas, and cities along the nation's borders compared to cities with larger populations and those located in the center of the country. By collecting data from cities with different possibilities and limitations in access to the healthcare and social resources, we aimed to increase the diversity in patients' experiences with their mental health problems and help-seeking strategies. Additionally, all of the cities included have medical universities with psychiatric training programs. This facilitated professional networking and collaboration with academic psychiatrists who agreed to refer their patients for the research interview.

The study sample included 37 patients who had received bipolar spectrum disorder diagnosis and treatment, excluding Bipolar-I, both with and without a past history of hospitalization. All participants had either directly reached out or were referred to psychiatrists to treat their mental health problems. Patients had received a bipolar spectrum disorder diagnosis and treatment (excluding Bipolar-I) and were recruited by psychiatrists specialized in treating mood disorders, including psychiatrists who participated in the larger study.

Data collection was based on qualitative interviews using the McGill Illness Narrative Interview (MINI) (Groleau et al., 2006). The MINI is a semi-structured interview protocol with three main sections: 1) a basic temporal narrative of symptom and illness experience, organized in terms of the contiguity of events; 2) salient prototypes related to current health problems,

based on previous experience of the interviewee, family members or friends, and mass media or other popular illness representations; and 3) explanatory models, including labels, causal attributions, expectations for treatment, and course and outcome. Supplementary sections of the MINI explore help-seeking and pathways to care, treatment experience, adherence and impact of the illness on identity, self-perception, and relationships with others (Groleau et al., 2006). In a previous paper (Mianji & Kirmayer, submitted), we presented findings from sections of MINI, including the patients' illness experiences and explanatory models. In this paper, we focus on the findings gained from the supplementary sections of the MINI that address help-seeking history and experience. To adapt the MINI to the Iranian setting, the English version was translated into Farsi by a bilingual Iranian psychologist and was edited by a bilingual Iranian psychiatrist with experience working with Farsi-speaking patients both within and outside of the country. The interview guideline did not require modifications because of the similarity in the clinical language used by psychiatrists in Iran. This reflects the influence of American psychiatry in psychiatric training and practices in Iran (Mianji & Kirmayer 2020).

Potential participants were identified by their psychiatrists, who participated in the first phase of the study on institutional history, as well as other psychiatrists who were former colleagues of the first author (a clinical psychologist who trained and worked in Iran). The aim of this research project was introduced to participants first by their clinicians as a study to better understand patients' experience with their mental suffering (emphasizing mood disorders), Patients who agreed to participate were interviewed by the first author at their psychiatrists' office, their home, or workplace, as they preferred. All patients gave informed consent, either written or verbally. To protect participant anonymity, pseudonyms have been used in the presentation of findings.

All interviews and conversations were conducted in Farsi and ranged from one to three hours in duration. With the permission of the participants, the interviews were audiorecorded and transcribed. Transcripts were analyzed by thematic coding with an emphasis on identifying the underlying ideas, assumptions, metaphors or analogies, conceptualizations, and help-seeking strategies, based on three modes of reasoning about or representation of symptoms and help-seeking choices explored in the MINI, including exploratory models, prototypes, and chain-complexes (Groleau et al., 2006).

4.3 Results

In an earlier article (Mianji & Kirmayer, submitted), we elaborated on patients' experiences with and causal attributions of their mental suffering. Most participants explained their mental suffering as a form of neurologic illness (*narahati-asāb*), depression (*afsordegi*), or "pendular" depression (*afsordegi navasāni*; i.e., depression with mood swings). However, the most common term they used for their mental health conditions was *dō-shakhsiaty boodan,* which literally means "having two personalities." We found wide variation in patients' understanding of their BSD diagnosis. Only a few participants, mostly those with higher education and living in Tehran, named their condition "bipolar (spectrum) disorder"; participants from more traditional backgrounds and those with lower education levels mostly framed their suffering as some form of depression. Using other terms to explain their mental suffering, particularly calling it "*afsordegi"* (depression) or "*afsordegi navasāni"* (pendular depression) seemed to be associated with avoiding the stigma attached to severe psychiatric diagnoses, including bipolar disorders. There was no gender difference in the diagnostic labels or expressions used by participants with bipolar spectrum disorder. Also, the majority of

participants, both male and female patients, attributed the causes of their mental health suffering to external stressors (Mianji & Kirmayer, submitted). This paper focuses on patients' perspectives of the services and response to treatments. In this regard, two broad areas were identified: 1) coping and help-seeking strategies; 2) barriers to treatment and expectations of outcomes from treatment.

4.3.1 Coping and Help-Seeking Strategies

Coping and help-seeking strategies reported by the study participants usually included psychiatric services and, in a few cases, psychological services, social supports, and alternative sources of care. We found a discrepancy between patients' commonly expressed causal attributions (i.e., external factors such as familial and sociocultural distress) and their main help-seeking strategies (i.e., seeing medical practitioners, including psychiatrists). Participants attributed this discrepancy to the lack of affordable, professional psychological services, the lack of safe and non-intrusive social support systems, and the social stigma of mental health problems. Although all participants sought help from the medical system, patients in different cities and patients from different educational and social backgrounds reported different strategies in coping with their mental suffering, reflecting different local demography, culture and social context. The sections below illustrate the different help-seeking strategies reported by the participants in four cities in Iran: Tehran, Isfahan, Shiraz, and Zabol.

4.3.2 Medical and Psychological Services

Consulting medical doctors—which include general physicians (GPs), neurologists, and psychiatrists—was identified as the most common, but not the initial step in the help-seeking pathway of participants in the large cities—Tehran, Isfahan, and Shiraz—and one of the common pathways among participants in Zabol. Due to the stigma of mental illnesses and negative lay attitudes towards using psychiatric medications, participants expressed a preference to see a general practitioner or neurologist (*motekhases-e-maghz va asâb)* before considering visiting a psychiatrist (*ravân-pezeshk*) or psychologist (*ravân-shenas*). The lack of a referral system in Iran's healthcare allows patients to choose what specialist to see when they need medical services. This facilitates seeing a neurologist instead of a psychiatrist for psychological sufferings (Mianji & Kirmayer, 2020). Compared with *maghz* (brain) and *asâb* (nerves), in Farsi, the term *ravân* (soul, psyche) is associated with the term *ravâni*, which is used interchangeably with *divâneh,* which means "mad" or "crazy." Therefore, seeing *ravân-pezeshk* could be perceived as being *ravâni,* and that adds to the stigma of mental illness. Also, *mošâver (*counselor) is a more common term to refer to *ravân-shenas* (psychologists), the latter of which carries a stigma similar to that attached to the term *ravân* (soul, psyche) like *ravân-pezeshk* (psychiatrist). The following excerpts from interviews illustrate some of the dilemmas influencing the initial steps of seeking help within the healthcare system:

> I was agitated, nervous, and aggressive. I went to see a neurologist. I told the doctor that my head is busy [thinks too much] and I have *hojoum-e afkâr* [intrusive thoughts]. I told him that it does not make sense to have such a busy head. The doctor got an EEG (electroencephalogram) and diagnosed that I have

> migraines, too; he prescribed me a few medications including Depakote [divalproex sodium[35]]. I used them for three months and felt slightly better, but I stopped them and decided to help myself with heavy exercise, which helped, and I became fine after. A few years later, again, I became sensitive to words, felt disappointment and had thoughts of failing [negative thoughts]. This time, when I was visiting a book exhibition, accidentally, I saw a handbook of depression which recommended seeing a psychiatrist in case of having the symptoms that I was suffering from. I decided to see a psychiatrist. Despite knowing that in Iran when you talk about psychiatrists and psychologists everyone thinks you are crazy, I decided to follow that path and see a psychiatrist. I was prescribed different medications that made me like a dead body and I could not move. I meant to continue the meds, but, at some point, I decided to help myself with exercise instead of meds, which again helped. [Patient A, 34-year-old, male, technician]

Here, the patient's experience of his distress was reduced to biomedical causes and interventions, which did not seem to correspond to his psychological needs and consequently led him to stop the treatment. Describing symptoms of worrying in the context of "thinking too much" is a common idiom of distress used by local populations in different parts of the world (Kaiser et al., 2015). Exploring the individual and cultural meaning and use of local idioms of distress, such as "thinking a lot" or "thinking too much," is essential to determine how the suffering can be understood and treated (Good, 1985; Hinton and Good, 2016). The lack of an

[35] Depakote [divalproex sodium] is a drug commonly used as a "mood stabilizer" for BSD

integrative, multilevel model that takes into account the local and personal concepts of mental suffering as well as the biological, psychological and social processes may result in dismissing the patient's perspective on the causes of distress, which can undermine the clinical alliance and subsequent adherence to treatment.

Many participants reported that they saw a neurologist before visiting psychiatrists or psychologists.

> I went to see a neurologist because there is no control on [the quality of services of] counselors. I preferred to see a neurologist to get medications if needed and, if not, to get the counselling from him [the neurologist[36]]. [Patient B, 34-year-old, Female, Business consultant]

Although patients preferred to consult GPs and neurologists initially, most ended up seeing a psychiatrist, both because they did not respond well to the medications prescribed by GPs and neurologists and because they hoped that a psychiatrist might listen to their experience of mental suffering before prescribing medications. Unfortunately, according to the majority of our participants, their need for a safe space to share their experiences with mental suffering was not met by psychiatrists either. Participants reported that their psychiatric visits were too brief, (about 5-10 minutes duration), and were focused only on inquiry about some of their symptoms, which left them feeling unheard, but carrying away prescriptions for multiple medications.

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[36] In this interview, after clarifying the term "neurologist," it was apparent that the patient meant "psychiatrist" but used "neurologist" in order to reduce the stigma.

> In visiting my psychiatrist, I got to explain my symptoms briefly, then I was prescribed imipramine, amitriptyline[37], etc., [multiple medications], and the doctor kept changing the dosages of my medications. [Patient C, 39-year-old, female, physician]

In general, the most common mode of psychiatric practice was pharmacologically oriented, focusing on the symptoms and medications, with little or no attention to patients' understanding of the causes or consequences of their suffering, leaving them feeling unattended and misunderstood.

Despite frequently expressing the need and the wish to talk to a professional about their mental health experiences to be understood, and to receive help, the majority of our participants expressed dissatisfaction with and little trust in the psychological services, including psychologists, psychotherapists, and counselors. Their dissatisfaction was mainly attributed to the high costs and the poor quality of psychological services. The poor quality was associated with the problems with professional and scientific accountability of the services and with the concern that clinicians projected their own values and ideological beliefs onto patients.

> I tried counseling a few times, but what I saw was more like a business than therapy. One session they would ask me to do tests, one session to come back and get the test results. … [A]fter a few sessions back and forth, they told me that I have severe anxiety or anger issues. I told them that I know I have these

[37] Tricyclic antidepressants

> problems, and that's why I am seeking therapy. [Patient D, 27-year-old, female, MA student]

The participants emphasized the cost and inefficiency of private services, including the business-oriented aspect of the services, were among the main reasons for not pursuing psychological services. Some participants also attributed their lack of trust in the psychotherapy and counseling services to having received advice that reflected the therapists' traditional and religious beliefs instead of taking the patients' own cultural beliefs into account. Some called this way of practice "auntie-therapy," referring to traditional ways that older family members would advise them about their life struggles.

> Once, I accompanied my friend to see a psychotherapist. I think she was a physician who got a psychotherapy permit. My friend is not religious at all, and the therapist was religious. It was as if she was advising a religious person when she talked to my friend. She [the therapist] said, "I prayed to Imam Hossein[38] to get me a husband and it worked." It is ridiculous even to someone like me, who is not as non-religious as my friend, to ask Imam Hossein to give you a husband! [Patient B, 34-year-old, Female, Business consultant]

The examples given by participants in our study illustrate some of the cultural and generational tensions between young people and mental healthcare providers, such as counselors, who impose their personal views and the government's agenda in terms of social norms about

[38] Imam Hossein is the third Shia Imam, a grandson of the Islamic prophet Muhammad and an important religious figure in Islam.

romantic and sexual behaviours on their patients instead of helping patients better navigate tensions, contradictions, and rigidity in their social environment throughout the process of resolving their mental suffering.

In summary, in terms of psychological interventions, the majority of participants expressed dissatisfaction towards both psychiatrists (for not listening and just prescribing medications) and psychologists and counselors (for imposing another normative culture, consistent with their religious and ideological views). In both ways, psychological care was seen as a form of silencing the individual's own cultural and social beliefs and values—which were inseparable from how participants understood and experienced their mental suffering, symptoms, and predicaments.

4.3.3 Social Support, Stigma, and Illness Meaning

Although seeking and receiving support from first-degree family members and from close friends was identified by some participants, the stigma of mental illnesses was brought up frequently as a reason to avoid sharing their suffering with others in their social circles, particularly with extended-family members and friends. This problem was highlighted mostly by single women who were afraid of being labeled as "mad" and therefore unwanted in the context of their romantic relationships, marriage, and circle of friends, but it also was raised by men who were concerned about being labeled as weak and incompetent.

Patient F, a 27-year-old woman who reported having the support of her family throughout her treatment, said:

> Because of the respect I have for my parents [not wanting to upset them] I pretend that I have accepted my illness. But imagine that there is a girl who does not take these medications: she can meet someone and build a romantic relationship, but I cannot. I dated a guy, but I stopped it so as not to have to tell him that I am bipolar, to avoid hearing from him that I am crazy. … [I]n this society, even if a person is open-minded, when they get angry, they will tell me that "you are crazy." I will break if I hear such a thing. … I decided to never date or get married to prevent such an experience happening, even though I would really like to become a mother.

Patient G:

> I never got the right reaction from people. In my workplace and other social circles, whenever I shared that I have a mood disorder and I take medication, I noticed people's view of me changed and they took it as my weakness and judged me. For example, once, they said that she has problems and takes nerves medication (*ghors-e asâb*). At first, sharing it was not important for me until I noticed that there are negative attitudes and they can affect my career. I decided to hide it from people.

In general, we found that participants' causal attributions and seeking support from their family members were related. Those who attributed their mental suffering to their family environment, such as domestic violence, reported a lack of reliable family support and fear of being labeled and rejected by others in their social circle. Sometimes it was explicit how this social stigma and response exacerbated the problem.

Patient H:

> For example, I am discussing something with my mom, not even fighting, and she immediately turns to me saying, "Go take your pill, you are not well, go to your bedroom." This means, you are crazy, you are sick. As soon as I hear this, I become that bipolar, I explode. I know that not everyone who is angry is bipolar, but as soon as they tell me, "You are sick, you are bipolar," I remember to become bipolar [she refers to being unpredictable and having outbursts.]

Despite the dominance in Iranian culture of collectivist and familist values, the fear of receiving negative labels, of damaging personal and family social standing and reputation, and therefore becoming socially isolated may limit the safe space of family and social support that people need to rely on to cope with their mental sufferings. Similarly, a study on mental health patients' expectations for non-medical care in Tehran indicated patients' unmet need for programs that facilitate receiving peer and social supports and encourage providing safe and confidential spaces for discussion by patients, caregivers, and professionals (Forouzan et al., 2011). Studies on the caregivers' perceptions associated family members' limited support for mental health problems with the lack of social support including information, emotional, financial, and professional supports, which could empower families in providing care for their relatives with bipolar disorders (Shamsaie at al., 2010; Shamsaie et al., 2015).

4.3.4 Alternative Pathways to Care

Participants reported seeking alternatives to psychiatric medications and psychotherapy in order to both make sense of and cope with their mental suffering. Participants in different cities and from different social backgrounds reported watching, listening to, and reading pop-psychology lectures given by Iranian psychologists in diaspora (such as radio and TV shows by Dr. Holakouee[39] and Dr. Farnoudi[40]) as well as reading self-help lessons (mostly through social media and satellite TV programs) as some of the common pathways to understand their psychological and interpersonal difficulties and get advice. In their live audio and video programs (both in recorded and online format), Iranian psychologists in diaspora respond to people's questions about their relational challenges, including marital and family problems, using psychological techniques drawing from systemic, cognitive-behavioural therapies, as well as acceptance and commitment therapy. Thousands of Iranians, both within and outside the

[39] Farhang Holakouee, known as Dr. Holakouee, is an Iranian licensed Marriage and Family therapist. He holds Master's degrees in Psychology and Economy and a PhD in Sociology. Holakouee lives in Los Angeles, California, and is the founder of the Beverly Hills Center for Well-being. Since March 6, 2000, Dr. Holakouee has been hosting "Mysteries and Needs," a two-hour radio and TV program on Persian radio and TV satellite stations. His radio and TV programs, audio and video clips have become well-known and widely used by Iranians both inside and outside of Iran (https://en.wikipedia.org/wiki/Farhang_Holakouee).

[40] "Nehzat Farnoody, Ph.D., is an Iranian Licensed Clinical Psychologist with a Specialty in Cross-Cultural Psychology, based in Los Angeles, California. From 1989 to 1992 Dr. Farnoody hosted the first Iranian-American Radio and TV program on psychological topics related to the needs of the Iranian-American community. From 1995 to 2001 she hosted several radio and TV psychology media literacy programs and, since 2002, has been the host of a popular satellite TV Talk Show called, "Inner Sight (Negahi be Daroon)" on American Farsi Network (www.AFNL.com) where she has an opportunity to reach out, educate, and raise awareness on Mental Health and psychological principles of parenting and healthy families for the Iranian-Americans, as well as the Iranians living in the global community" (https://drfarnoody.com).

country, reach out to these popular media figures to ask specific questions about their relational problems, receiving general answers that are, in some cases, more in line with the consultants' values than those of the consultees or any empirical evidence. In some cases, the advice offered has no scientific evidence to back up their advice. For example, Dr. Holakouee's advice against sexual relationships before marriage, calling it contradictory to building love[41], has been criticized by people on social media to be as an old fashioned and reproducing outmoded traditional norms by many young people in contemporary Iran. However, while seeing a prayer-writer, a fortune-teller, or a traditional healer was reported by participants from more traditionacultural backgrounds, participating in *fara-darmani*[42] (mystical philosophy,

[41] https://www.youtube.com/watch?v=-EK8HntCWXw

[42] *Faradarmani* refers to a contemporary school of complementary and alternative medicine in Iran founded by Mohammad Ali Taheri, who attributed mental illness to a complex mechanism initiated by a person's worldview, radiation (energy), and non-organic/supernatural beings (*Jinn*), also called "non-organic viruses" (Taheri, 2012), that enter and occupy the human body and sabotage their sanity (http://www.asreandisheh.com/Home/Content/103). Taheri was arrested in 2010 on charges of "acting against national security" and has been in prison since 2011. He was sentenced to death in 2015 by the revolutionary court on charges of Fesad Fel Arz (corruption on earth) and establishing a "diversionary cult." However, the trial was not held and he is still in Evin Prison in Tehran. (https://www.nytimes.com/2017/08/28/world/middleeast/mohammad-ali-taheri-iran-death-sentence-mystic-healer-shiite-mystic.html)

After his arrest, the Iranian government established *Nejat Az Halghe* ("The Ring Rescue Organisation") to help "survivors" of Taheri's teachings called *erfan-e halgheh* (Mysticism of the Ring). "Abbas Ali Allahyari, head of Psychology and Counselling Organisation of the Islamic Republic of Iran (PCOIRI) and associate professor of Tarbiat Modares University has described the teachings as dangerous, predatory and exploitative, especially towards mentally ill people. Taheri's practice involves the exorcism of jinn. Dr. Nader Mahluji, a prominent psychiatrist in Tehran stated that he believed in jinn, as they are described in the Qu'ran, but that he does not believe they interact with humans because this is not mentioned in the Qu'ran, going on to state, "People who claimed to have been possessed by jinn were either charlatans, delusional, or had undergone some form of dissociation. Some may be schizophrenics and require medical treatment" (https://en.wikipedia.org/wiki/Mohammad_Ali_Taheri).

"psymentology"[43], metaphysics) workshops and using drugs (particularly marijuana) were alternative sources of help that were identified more often by younger participants in Tehran.

Patient I:

> In our society, when people cannot do anything more [feel helpless], they turn to spirituality. I got onto a path that was called metaphysics courses [refers to *faradarmani*]. This stuff per se preoccupies you. You keep thinking about how to live differently from other people—e.g., if everyone eats with the right hand, I would practice eating with the left hand. Like swimming against the stream, which after sometimes [behaving differently] will break you [isolate you].

Despite the extensive efforts from scientific (psychiatrists and psychologists), religious, and legal institutions to question, confront, and stop *faradarmani* approaches from becoming an alternative help-seeking pathway, many participants, particularly those interviewed in Tehran, heard about or personally tried joining the *erfan-e halgheh* ("Mysticism of the Ring") as an alternative strategy. Although our participants reported that this strategy did not help them in the

[43] According to Taheri (2013), "Psymentology" [a neologism he coined from 'psyche' + 'mental' + logy] or "Interuniversal Mind-Psychology" refers to an "Interuniversalist perspective on the human being with an all-inclusive approach. In Psymentology, mind and psyche are each addressed as a separate concept, comprising a specific part of an individual. The main target of Psymentology is understanding and gaining knowledge about human being, the constituent software of human existence, diagnosis and treatment of psymental(mental and psychological) disorders, as well as other related unidentified problems. Psymentology is based on the theory of "Consciousness Bond of the Parts" or "Parts Having Consciousness in Common". "Through this therapy, patient becomes connected to Interuniversal Consciousness via psymento-therapist. After this bond is established, he/she automatically undergoes Scanning stage in which all existential constituents of individual undergo scrutiny through Consciousness Bond in order to detect any manifested or hidden diseases" (p. 1534).

longer term, *faradarmani* and similar metaphysical approaches have become widely adopted in Iran as coping strategies used by mostly young and non-religious people.

The majority of participants in different cities mentioned religion and spirituality to be a strategy to cope with their emotional and psychological suffering; these strategies were identified as solitary praying, reading the Quran, and sending *salawat*[44] (salutation, sending your blessing to Allah, Mohammad, and his family). Female participants gave varied accounts of why they were reluctant or refused to seek help from religious clerics, *akhoond-ha*. One participant attributed her lack of interest in seeking help from religious clerics for mental health problems to not trusting their intentions, having been sexually approached by several clerics, and not having the power to confront them without getting into trouble.

4.3.5 Barriers to and Expectations from Treatment

Among the perceived barriers to treatment, three sets of factors were identified, which can be categorized as structural, biological, and stigma-related. The most commonly reported structural barriers that influenced help-seeking and adherence included insufficient and expensive psychotherapy and counselling services, brief psychiatric visits focused only on symptoms and medication, and the lack of a therapeutic relationship due both to the brevity of visits and the lack of culturally informed practice. Health insurance in Iran does not cover mental counseling or psychological interventions. This might explain why psychiatrists keep their visits short, stay symptom-focused, and employ pharmacological treatment as the most common intervention (Dejman, 2009; Mianji & Kirmayer, 2020). This direct barrier to care for mental

[44] There is a tradition of repeating *salawat* from five to thousands of times, which for many people has a grounding function, like repeating a mantra.

health problems has been reported to be a major factor in different countries (Jain & Jadhav, 2009; Esponda et al., 2020).

The main biological factors, which were report by the majority of our participants, including stopping therapy because of the side effects of psychiatric medications and fear of medication dependency. As well, parents or other family encouraging patients to stop using medications was mentioned as another reason to stop treatment.

The stigma surrounding psychological and psychiatric disorders and the use of psychiatric medications was reported as a social factor that led to poor treatment adherence. In contrast, no participants reported concern about stigma for receiving counseling. Instead, most participants highlighted the need to have an affordable, safe, and non-judgmental clinical space to narrate their experience. Participants identified the need for community, social, and legal supports to cope with their mental suffering, particularly those who attributed their BSD to family violence and social oppression.

4.4 Discussion

This study identified five types of influence on the help-seeking strategies and trajectories that patients with BSD diagnoses in Iran: (i) structural limitations of the mental health care system; (ii) the modes of practice of biological psychiatry; (iii) the characteristics of the official psychology and counselling services permitted by Iran's government; (iv) popular psychology and consultation (offered remotely) by Iranian psychologists and counsellors in the diaspora; and (v) alternative spiritual and cult-based groups.

The Iranian health care system promotes equal access to health care services and provides universal healthcare insurance for over 85% of the population; however, the coverage excludes non-medical interventions. Therefore, mental health services provided by the Ministry of Health, in both public and private sectors, emphasize the treatment of biomedical disease rather than mental health problems in order to benefit from insurance reimbursement policies (Fatemi, 2015). Only psychiatrists have prescription authority and can bill insurance companies for patient visits (Ghobari & Bolhari, 2001). This policy is an important contributor to disparities in the options people have in seeking help for their mental health problems. People with lower socioeconomic status and those who do not live in urban areas, where psychological and counselling services are expanding, often do not have access to psychosocial services, and the mental health interventions available to them are mostly limited to psychiatric medications prescribed by GPs or psychiatrists, which are covered by universal insurance (Fatemi, 2015).

In our study, although participants did not report any difficulties in terms of access to and affordability of seeing a psychiatrist, the majority expressed dissatisfaction with the services offered by psychiatrists because of the short visits, which focused mostly on pharmacological treatments, with little or no psychological intervention, leading to patients' feeling unheard and misunderstood. This problem was reported mainly by patients who lived in rural areas or with lower socioeconomic status, who did not have access to psychologists and counselors in their regions and who could not afford to pay psychiatrists' private fees for psychotherapy. In a previous article, we investigated psychiatrists' explanations for offering only short visits and not providing psychological interventions (Mianji & Kirmayer, 2020). They acknowledged this mode of practice was not optimal but attributed it to economic factors such as a significantly lower fee for psychiatric visits compared to other specialties, the dominance of American

biological psychiatry in Iran's psychiatric training system, and the lack of collaborative mental healthcare services to refer patients to social services, when severe problems such as domestic violence and abuse were revealed during the psychiatric visits (Mianji & Kirmayer 2020). We also described clinicians' perspectives on help-seeking pathways of patients who received BSD diagnoses. Most of the psychiatrist participants described the tendency to seek help initially from GPs or neurologists as a barrier in treating their BSD patients (Mianji & Kirmayer, 2020). They claimed that neurologists and GPs often ordered unnecessary and expensive procedures like EEGs. Referring to GPs and neurologists before psychiatrists is associated with the stigma attached to seeking help from psychiatric services (Dezhman et al., 2008; Mianji & Kirmayer 2020).

Another important influence on patients' help-seeking was the availability of counselling and psychological services offered by the official psychology and counselling sectors regulated by the Psychology and Counselling Organization of the Islamic Republic of Iran (PCOIRI). Seeking help from licensed psychologists and counsellors was reported mostly by participants who lived in large metropolitan cities—Tehran, Isfahan, and Shiraz—and by those with higher education and better economic status. Yet the majority of participants reported low levels of satisfaction from the services provided and attributed that both to the high costs of the psychological service and the therapists' lack of consideration of patients' sociocultural and personal values. Although there has been an expansion of counselling and psychological services in Iran, these services are located mostly in urban areas and they remain limited or non-existent in rural areas (Fatemi, 2015; Sharifi, 2009). Furthermore, the focus of counselling and psychological services has gone through many changes in the past few decades due to the role that the government sponsored counselling and psychological organizations play as an agent and

advocate of the regime's sociopolitical agendas—rather than as a politically neutral, professional and scientific component of the mental health care system.

Professional counselling in contemporary Iran started in the mid-1950s with a focus on improving the selection and evaluation of employees in different sectors, such as the Air Force, through the use of psychological measures developed in the Division of Psychological Research at the Ministry of Education. In the 1960s, the Iranian government sent a group of experts in education to Western countries to study counselling and psychology and transfer the knowledge to Iran. During the 1960s and 1970s, these experts, who had graduated from foreign universities, developed training programs in Iran's universities in guidance and counselling, counselling psychology, family counselling, rehabilitation counselling, educational counselling, and career counselling as independent fields (Ahmadi, 2000). After the 1979 revolution, through what was called "the Cultural Revolution", Iran's Islamic regime closed all colleges and universities from 1980 to 1982, in order to Islamicize the education system. When the schools re-opened, an individual's adherence to the ideological and political principles of the Islamic regime became an important factor in admission to higher education and employment in different sectors, particularly the academic system[45] (Sobhe, 1982). The psychological and counselling education

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[45] "To be hired, faculty members must fulfill two requirements; one is academic and the other is moral. Appropriate 'Selection Committees' are planned to monitor both. Those who already have a master's or doctor's degree can apply to fill faculty positions. However, in addition to scientific qualifications, religious and moral qualifications of these applicants will be investi- gated through examinations. In the case of deficiencies, Islamic theory and ideology courses have to be taken. Faculty employment is tentative for the first three years, after which the candidate is evaluated. If all requirements are met, tenure is granted.

Training instructors and university professors has undergone some changes. In the pre- Cultural Revolutionary period, receiving a mere graduate degree was sufficient to get a job with a college or university. Now, to study to become a faculty member, one has to fulfil four requirements: (1) general courses, (2) specialised courses, (3) practical training, and (4) thesis or dissertation. It is the first part

and services were among the fields that were significantly affected by the political and ideological agenda of Iran's regime in the 1980s. During this decade, counselors worked closely with religious Islamic clerics to provide mental healthcare services, particularly to military veterans who were serving in the Iran-Iraq War (1980-1988) (Fatemi, 2015). This influenced the type of interventions that counselors offered (Priester, 2008). Using religious concepts, such as trusting God and offering forgiveness became a common language in psychological interventions when working with veterans who suffered from PTSD (Fatemi, 2015). In the 1990s, this approach was encouraged by the Psychology and Counselling Organization of the Islamic Republic of Iran (PCOIRI), established in 1997, one of the governmental organizations mandated to follow the State's political ideology and advocate for the integration of the religious and conservative cultural beliefs in psychological interventions. The importance of psychological language and practice as a vehicle for promoting the regime's ideological and political values in society was acknowledged by the Iran's regime; hence, governmental organizations such as PCOIRI have explicitly emphasized adjusting counselling and psychological practices to conform to Islamic cultural values[46]. Emphasizing the importance of family values and

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which has changed dramatically. General education is divided into four areas as follows, (a) *Literature and Language,* which includes Persian and Arabic languages. Of those who will teach humanities, 120 hours of these two languages is required. Otherwise 60 hours will satisfy the requirement. Another foreign language (180 hours for all the fields) is also required, (b) *Islamic Ideology and Culture,* which includes history of Islam, religious thinking, present Iranian society and Islamic Revolution, (c) *Educational Studies,* which include principles of education, philosophy of education, Islamic education and psychology of education, (d) *Research Methods* which familiarise the potential faculty members with methods of conducting research [25]. Each graduate must serve at least a five-year period in teaching at the college level." (Sobhe, 1982, p# 278)

[46] "To increase heterosexual marriage success rates, the Iranian government mandated that couples who are getting married receive 16 hours of counseling prior to their heterosexual marriage. In premarriage counseling, couples participate in genetic, health, and marriage counseling (Salarvand, Bahri, Heidary, & Khadive, 2011), which can include different counseling opportunities, such as face-to-face counseling and watching psychoeduca- tional videos with other couples." (Fatemi, 2015)

heterosexual marriage through offering pre-marital counselling became one of the ways to reach this goal (Fatemi et al., 2015).

In the new millennium, however, through widespread access to the Internet and satellite technology, Iranian society has been experiencing a transition from a society that is traditional, patriarchal, and religious to one that is adopting modern and secular values and emphasizes individual rights (Mahdavi, 2007; Shahhosseini et al., 2012). This societal transition has led to a large cultural gap between generations and created interpersonal tensions at different levels, including parent-child relationships (Fatemi et al., 2015) and the relationship between social and legal authorities and ordinary people. Furthermore, these societal changes have polarized the attitudes of Iranian scholars in the field of psychology on the role of cultural adaptation in counselling and psychological practices. While some scholars and practitioners emphasize localizing psychological practices and tailoring the interventions to Islamic cultural values, such as the importance of family values and heterosexual marriage (Khalili, 2004), secular scholars have highlighted the lack in cultural adaptation in psychological interventions in order to advocate for and address the needs of individuals with less traditional and religious values, the needs of women in the context of gender disparities and inequality in social and legal rights, and the needs of LGBTQ individuals (Khoshnood, et al., 2008; Najmabadi, 2011; Dezhamkhooy & Papoli Yazdi, 2013).

Participants in our study highlighted the lack of cultural sensitivity and secular approaches in psychological and counselling services as one of their main problems with the psychological services. The importance of taking into account the differences in patient and provider perspectives and the essential impact of these differences on help-seeking, treatment

adherence, satisfaction, and outcomes has been emphasized in studies on explanatory models of illnesses (Kleinman & Benson, 2006; Tryon & Winograd, 2011). Understanding sociocultural and moral factors that are linked to patients' perspective on their suffering can guide the provision of culturally competent services which may lead to greater treatment satisfaction (Kleinman et al., 1978). Attention to culture in mental health services is also a human rights issue insofar as individuals need to be able to realize their recovery, wellbeing and aspirations in particular social and cultural contexts. However, the situation in Iran described by our participants illustrates that attention to cultural context in mental health services may also raise thorny human rights issues when individuals' values come in conflict with the State's political and social agenda centered on traditional and religious values.

Advances in technology in the new millennium—especially the Internet and satellite dishes—have connected Iranians inside the country to those in diaspora to a far greater extent than before. Over ninety percent of Iranians have satellite dishes and access to Farsi-speaking TV channels that are based in other countries[47], mostly in the UK and the US, including BBC Persian, Iran International TV, Manoto, and Farsi VOA among many other media channels. The majority of Iranians use these sources to access information and for entertainment as alternatives to Iran's national media, which is heavily censored and tightly controlled by the regime. This has influenced Iranians' social and cultural values and expectations as well as the strategies people use to address everyday challenges and overcome problems. Indeed, consulting with and receiving general advice from popular Iranian psychologists in diaspora via these media channels as well as their personal websites and social media pages has become one of the common

[47] https://www.isna.ir/news/94031307607/بیش-از-90-درصد-ایرانیان-ماهواره-دارند-شکسته-شدن-قبح-ها-با-پخش

strategies people use to address their mental health problems. Although mental health professionals encourage people not to view the pop-psychology channels as a replacement for psychiatric and psychological consultation, given the failure of psychosocial services fail to respond to the population's mental health needs—whether due to structural incompetency or cultural insensitivity—the widespread use of pop-psychology lectures and interviews is not surprising. These media influence the populace as a whole by promoting a public conception of personal, interpersonal, and social possibilities and limitations, needs, expectations, and norms, which are substantially different from the values and norms of Iran's ideological regime. In addition to Internet pop-psychology, *faradarmani*, a form of mysticism offered through series of seminars and workshops inside the country, was reported by our participants as an alternative source of help for their mental health problems. The diaspora media channels and the promotion of *faradarmani* have been criticized and suppressed by the Iranian state, which views the diaspora media as "enemies of Iran's revolution and regime" and *faradarmani* as apostasy and a threat to the Islamic ideology. The regime's critique of *faradarmani* has been supported by Iranian mental health academics who have challenged the claims made by the *faradarmani's* leaders as lacking scientific evidence and raised concerns about the danger that promoting non-scientific beliefs about mental health poses to psychiatric patients who need evidence-based interventions.

4.5 Limitations

This study has several design features related to sampling and the interview process that may limit its generalizability. We interviewed patients who were seeing psychiatrists, who had

received a diagnosis of BSD, who were selected by their clinician as potential participants, and who agreed to participate in the study and talk to the interviewer, an expat Iranian psychologist, at a time of political repression and turmoil. All of these factors contribute to potential biases in the sample and in the kinds of narratives the patients provided. While for some participants, being interviewed by an expat psychologist who is not affiliated with Iranian universities and government might have led to their feeling more secure in sharing experiences that included criticism towards the system, being referred to the study by their current clinicians might have impacted their confidence in revealing their experiences without worrying that their relationship with their psychiatrist might be affected by the potential breach of confidentiality in the research interviews.

4.6 Conclusion

This qualitative study suggests that the help-seeking strategies of people diagnosed with BSD in Iran are influenced more by the structure of the health care system and the availability and affordability of existing options than by their own illness explanatory models. Although many Iranian patients attributed their mental suffering to family and social determinants and hoped to receive psychosocial interventions, similar to other studies in Iran (Behrouzan, 2016; Ghanizadeh et al, 2008), patients reported that seeing a medical doctor and receiving biomedical intervention was a common help-seeking strategy. While the integration of psychiatric services into the public health system in Iran (Mohit, 2009) and the affordability of the psychiatric visits and pharmaceutical treatment have a strong influence on people's motivation to seek biomedical treatment, this cannot be separated from other local sociopolitical factors—including the state's

efforts to integrate religious and ideological values into the both training and practice of mental healthcare providers—and global factors, including the impact of the larger international trends towards biomedical psychiatry and rapid circulation of information as a result of the Internet and social media (Smith, 2020; Hajebi et al., 2013). Similar to other countries with a totalitarian regime (Grigorenko et al., 1997), Iran's government understands the importance and use of psychological language and practice as a means for spreading ideological and political values that are meant to facilitate social control. Serious challenges to both cultural and structural competencies in mental health services are posed by the government's role in regulating and controlling the practice of counsellors and psychologists through both non-secular training and ideologically oriented interviews that are conducted as part of the licensing and employment of healthcare providers.[48] The high costs and unequal distribution of psychosocial services in the country prevents many people from accessing other forms of care. These challenges affect the availability and quality of patient care and, especially, the respect for patient autonomy in the clinical negotiation (Forouzan et al., 2016). Given the lack of cultural and structural competence in the existing mental health services, patients turn to alternative strategies such as *faradarmani* and online pop-psychology content, which introduce other challenges, including the lack of scientific validity in the former and the risk of commercializing mental health needs and services in the latter.

[48] An ideological interview to evaluate the person's loyalty to the regime's ideological and political objectives and values, conducted by the non-scientific committees in all official and governmental organizations in Iran including PCOIRI, is one of the pre-requisites for obtaining licensure for clinical practice and for being employed by any governmental and official sectors. Although what many clinicians claim during the interview does not reflect their personal and political values, verbally committing to submit to the state's values as a way to protect their licensure and career can limit their ability to adjust their practice to the personal values of the patient.

In a globalized world, the help-seeking strategies and treatment expectations of patients with mental health problems, including BSD, cannot be understood without examining the intersection of global trends in mental health, individual predicaments, and the cultural and sociopolitical realities of local contexts. Current global mental health efforts that aim to promote care that is not confined to a narrow biomedical or psychiatric model, must be designed to be participatory and person-centered, situating patients' experiences in their cultural, social, economic, and ecological environments (SLAM and SWLSTG, 2010; Bemme & Kirmayer, 2020).

The strategies and barriers to accessing and utilizing proper mental health interventions examined in this study indicate that although incorporating psychosocial interventions into the public health system could be a positive step towards improving the accessibility and affordability of the mental healthcare services, to improve the quality of services, it is essential to have a cultural and structural reform within the healthcare system that (1) prioritizes human rights and individual's values over the political and ideological values of the state and (2) promotes secular training of the mental healthcare providers in psychological and ecosocial models of care.

There has been a growing interest on expanding the biopsychosocial model with an ecological model of care that recognizes the impact of global mental health training and policy. To realize this shift in perspective, we need clear strategies to make person-centered and ecological models of care applicable and feasible in non-Western countries under theocratic and repressive states that do not recognize or prioritize human rights values. Given the limited evidence for the cross-cultural applicability of global mental health approaches (Adeponie et al.,

2012; Bayetti, 2017; Kirmayer & Pederson, 2014), there is a need for continued research to study whether and how such models can be adapted and applied in different sociopolitical and cultural contexts in order to create greater health equity and social justice.

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CHAPTER 5: CONCLUSION

This thesis is centered on the rise of a controversial psychiatric diagnosis, Bipolar Spectrum Disorder (BSD), also called "Soft Bipolar Disorder" in Iran. I traced the origins of this diagnostic fashion, beginning with an oral history from psychiatrists about the journey from the U.S. to Iran. I then explored psychiatrists' views on the use of this diagnosis, and the patients' experiences with living with this diagnosis and its treatments. More specifically, in two separate phases, this study examined: 1) how the new diagnostic category of bipolar "spectrum" disorder is understood and applied among psychiatrists; 2) factors influencing the emergence and spread of knowledge and practices related to bipolar "spectrum" disorder among institutions and practitioners; 3) illness meanings and experiences of individuals diagnosed with BSD; 4) causal attributions and illness prototypes of individuals diagnosed with BSD; and 5) coping and help-seeking strategies and the impact of illness among individuals diagnosed with BSD in their sociopolitical, gendered, and cultural contexts.

In Chapter 2, "The Globalization of Biological Psychiatry and the Rise of Bipolar Spectrum Disorder in Iran" (published in *Culture, Medicine, and Psychiatry*, January 2020), using the case of Iran, I elaborated on a controversial global mental health topic—i.e., the domination of Anglo-American psychiatric research and clinical practice in non-Western countries. In this article, I argued that, although, in Western countries, pharmaceutical industry marketing is mostly responsible for creating diagnostic fads and the emergence and expansion of new psychiatric disorders, including BSD, the widespread and uncritical adoption of BSD by Iranian psychiatrists reflects processes beyond expanding the boundaries of psychiatric diagnoses

and aggressively promoting the new diagnoses and the markets for treatment on a global scale. In addition to the influence of current practices in international psychiatry and, to some degree, the local influence of pharmaceutical companies, there are specific factors associated with the over-diagnosis of BSD in Iran that make Iran an interesting site to study the globalization of American psychiatry. These factors, which are mostly sociopolitical and structural, include: 1) the response of the health care system and local practice to the ideological values and goals of the institutions in power combined with the lack of a sociopolitical structure that protects and prioritizes human rights in health care; 2) rapidly changing social, cultural, and gender norms that change the meaning of potentially symptomatic behaviors; and 3) the malleability of a psychiatry that lacks a well-elaborated socio-ecological theory of mental health problems and corresponding modes of practice and that seeks pragmatic solutions for patients in situations with limited resources and severe social-structural and political constraints on action.

In Chapter 3, "Women as Troublemakers: The Hard Sociopolitical Context of Soft Bipolar Disorder in Iran" (*Culture, Medicine, and Psychiatry*; submitted in September, 2019), I explored the gender factor in the use of BSD diagnosis in Iran. Although there is no significant gender difference in the rate of bipolar disorder (Hendrick, & Altshuler, 2000), the study participants highlighted the gender difference in the BSD diagnosis in Iran: women are diagnosed with BSD (i.e., subthreshold bipolar, soft bipolar disorder) significantly more frequently than men. The characteristics that most psychiatrists associated with women who receive this diagnosis—which include common symptoms and behaviors such as irritability, dysphoria, emotional lability, impulsivity, casual expressions of sexuality, extramarital affairs, oppositional behavior, talkativeness, and substance abuse—can be readily medicalized through the construct of bipolarity.

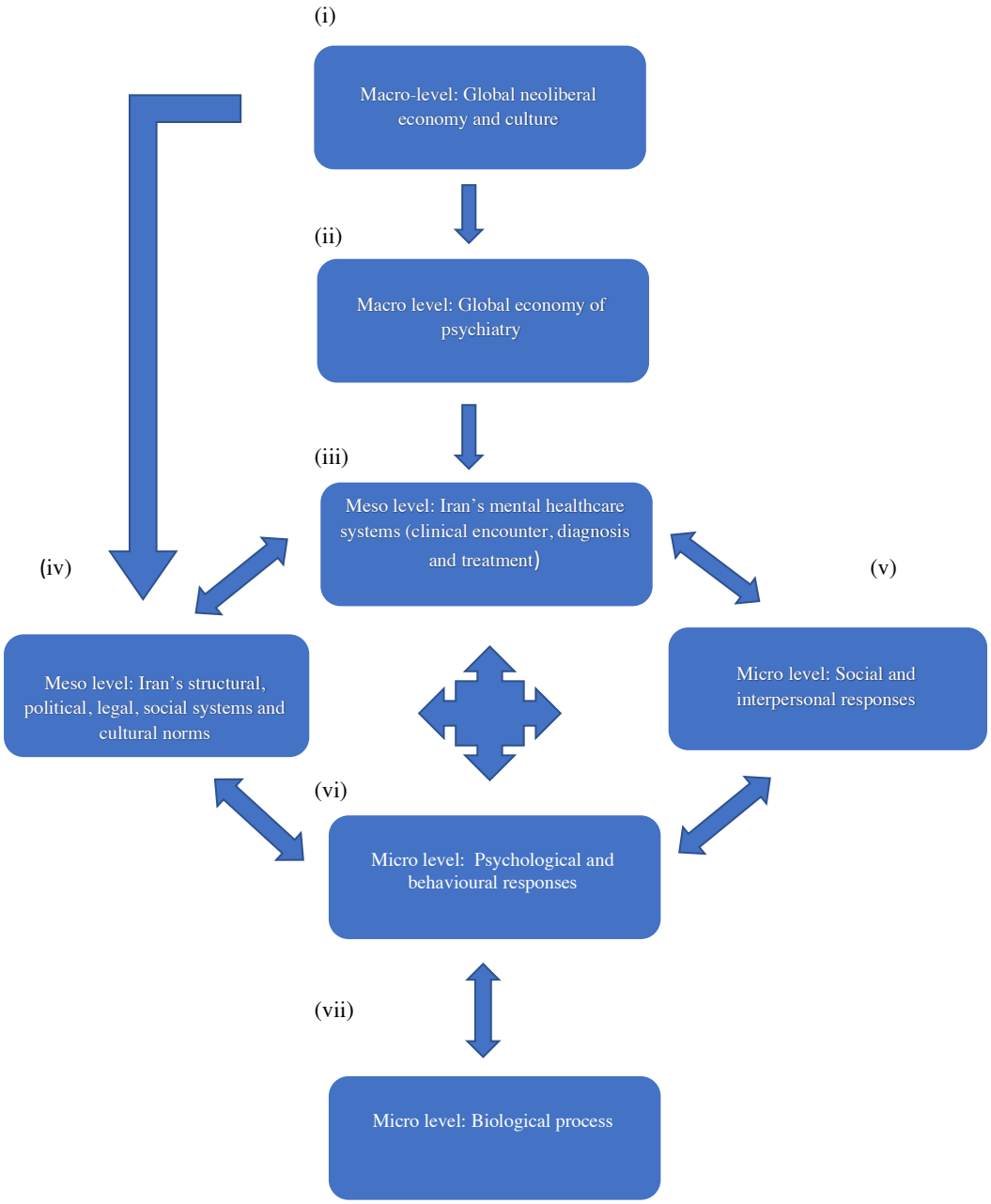
In this study, the patients—who mostly named their mental suffering as a form of depression, calling it "pendular depression*"(Afsordegi-e-navasāni),* "two-personality" (*dō-shakhsiati*) depression (*afsordegi*), though some called it soft bipolarity—believed that their mental suffering was caused mainly by social structural and family problems that aggravated each other. They identified these problems as mostly including social pressures (*feshar haye ejtemaie),* patriarchal societal values (*jame'y mardsalar*), gender segregation (*tafkik-e-jensiati*), gender discrimination (*tabeez-e-jensiati*), lack of social and legal support for women, lack of job opportunities, economic problems, sexual harassment at work and in public places, and poverty. While most female informants from all socioeconomic and educational backgrounds attributed their mental suffering to family problems, working women who had a university education emphasized social structural problems—particularly social pressures, gender discriminatory law, and patriarchal societal values—as causal factors of their mental problems.

Bringing together the views of psychiatrists and patients, I argued that the high rate of bipolar spectrum disorder (i.e., subthreshold bipolar, soft bipolar disorder) among women in Iran is influenced by multiple factors, including: 1) the increasing prevalence of psychological distress—including anxiety, depressive, and somatic disorders—which is rooted in gender inequality and women's struggles with the onerous sociopolitical, patriarchal, and economic situations that they live in; 2) the reclassification of a significant number of patients who had received other diagnoses—such as anxiety, depression, complex trauma, and personality problems—which already have a higher prevalence among women; and 3) the pathologization of certain gender-related behaviours that may reflect tensions between women's emancipation and the reinstitution of conservative societal norms.

In Chapter 4, "Help-seeking Strategies and Treatment Experiences Among Individuals Diagnosed with Bipolar Spectrum Disorder in Iran: A Qualitative Study" (*Transcultural Psychiatry*; submitted in July 2020), I examined the help-seeking and coping strategies of patients with BSD diagnosis in Iran. This study found a discrepancy between patients' illness attributions and coping and their help-seeking strategies in the sense that patients' help-seeking strategies are influenced by the structure of the healthcare system and the availability and affordability of existing options more than by their own illness explanatory models. While patients emphasized the role of family and social and cultural determinants of mental health as the main causes of their mental suffering and expected to receive corresponding psychosocial interventions, their most common help-seeking strategy was seeing a medical doctor and receiving biomedical intervention. Five main influences on the help-seeking strategies and pathways of patients with BSD diagnoses in Iran were: 1) structural limitations of the mental healthcare system in providing psychosocial services; 2) the practice of biological psychiatry with its reliance on pharmacological treatments, an intervention that is usually covered by universal health insurance in Iran; 3) the characteristics of the official psychology and counselling services permitted by Iran's government, which integrate religious and ideological values into the training and practice of mental healthcare providers; 4) popular psychology and consultation (offered remotely) by Iranian psychologists and counsellors in the diaspora as a result of the vast immigration of Iranians to Western countries in the past decade and the extensive use of satellite, internet, and social media in Iran; and 5) alternative spiritual and cult-based groups, as one of the replacements for religious coping strategies among younger generations.

Taken together, this investigation suggests that in order to understand the recent widespread use and impacts of BSD in Iran, it is essential to adopt an ecosocial and cultural approach that takes into account the intersection and interactions between global trends in mental health; the historical, structural, cultural, and sociopolitical realities of local contexts; and the sociocultural realities of individual predicaments. An ecosocial model of factors influencing the spread of the BSD diagnosis in Iran is sketched in Figure 1.

Fig 1. An Ecosocial Model of the Spread of BSD Diagnoses.



This figure maps some of the factors have that have contributed to the rise in the use of BSD diagnoses in Iran, particularly for women. At the macro level, the globalization of neoliberal economy (i) has influenced the shift in modern psychiatry towards biomedical models and pharmacological interventions, first in the U.S. (ii) and, then, as a result of the globalization of American psychiatry, in psychiatric and mental health systems in different corners of the world, including in Iran. Facilitated by advances in internet and telecommunications technology and the rapid and wide circulation of information, globalization of the neoliberal economy and culture (i) has also impacted on the cultural concept of the self and family dynamics in Iran (iv). This has led to a shift from familist and patriarchal models toward more individualist and neopatriarchal models that are reflected in structural, political, and legal systems (iv) with sometimes contradictory or countervailing effects—e.g., practicing Sharia law as a means of justifying and maintaining gender inequality and violence against women on one hand while extensively promoting and providing affordable higher education for women and encouraging women's work force on the other hand. Tensions arising from the clash between the neoliberal model, which encourages individual's choice and freedom, consumerism, and Western definitions of happiness and wellbeing and Iranian cultural and political values and rules contribute to particular social and cultural responses (v) that include efforts at emancipation by younger generations and particularly women, social and interpersonal conflicts around an individual's rights and freedoms, and family values of solidarity and conformity. Although, these social and interpersonal responses (v) have led to some reforms in the political and legal responses and changes in the cultural norms (iv), they are common causes of psychological and emotional distress that lead to biological and physiological responses (vii) in the individual's

body that shape and are shaped by psychological and behavioural responses (vi) to mental suffering, including the subjective experience and meaning of emotional distress, symptoms and illness schemas, causal attributions, psychological defences, and coping strategies. These responses are also affected by and affect mental healthcare providers' interpretation of patient's narratives (iii), which is itself influenced by not just clinicians' theoretical and clinical knowledge but the cultural and personal values of the clinicians (iv), available interventions, structural defects in the healthcare systems, as well as the trends and fashions in global psychiatry (ii).

5.1 Study Implications

> [W]ithout measuring reality against the wholly invented world of the unconditioned and self-identical, without a constant falsification of the world through numbers, people could not live.
>
> — Friedrich Nietzsche, Beyond Good and Evil, p. 7

The findings from this study have important implications for local and global clinical, research, advocacy, and policy and point to the need to integrate an ecosocial approach in psychiatric training and practice in order to improve conceptual, clinical, and structural competence in mental health services. From a clinical point of view, this study suggests that privileging biological causality—and as a result, biomedical treatments—risks ignoring the psychological, sociological, cultural, structural, and political problems that contribute to and maintain the suffering of patients with BSD. Mental health clinicians must replace the general models of psychiatric frameworks with a specific formulation and intervention plan for an

individual that is tailored to the patient's psychosocial problems, is attuned to the patient's needs, and prioritizes the patient's voice and values over the ideological view of the clinician and the structural defects of the psychiatric system (Mezzich et al., 2016; Karter & Kamens, 2019). This model emphasizes the importance of not only cultural sensitivity but also structural competency in clinical education and practice (Metzl & Hansen, 2014).

Training clinicians in this approach requires reform to allow the integration of structural and conceptual competence into clinical theories and techniques. Metzl and Hansen (2014) propose four benchmark skills for structural competency; clinicians must be able to: 1) identify and formulate not only cultural meanings but also structural barriers that impact on their patients and their clinical practice; 2) reflect on their own limitations and biases, whether they come from the clinicians' personal culture and values or from constraints that the mental health system itself imposes, including the structural barriers and organizational biases, which all are in play before the patient ever sees the clinician; 3) recognize and deliver interventions that address structural health issues; and 4) develop "structural humility" by accepting that awareness of the reality of structural factors and that acquiring advocacy and intervention skills are only the starting point for conversations in which clinicians are both speakers and listeners, leaders and collaborators, experts and students open to patients' lived experience and expertise (Metzl & Hansen, 2014; Hansen & Metzl 2019).

Furthermore, alternative psychotherapeutic approaches—such as Feminist therapy (Bem, 1981; Kaschak, 1992; Brown, 1994), narrative therapy (Morgan, 2000; White & Epstein, 1990), critical psychology (Prilleltensky, 1997; Prilleltensky & Nelson, 2002), community counseling (Lewis et al., 2003), and multicultural counseling and therapy (Ivey et al., 2002)—that directly address discrimination, oppression, and other systemic barriers can help clinicians to respond to

the extra-personal (social structural, political, and cultural) factors that shape patients' experience of suffering. Therapeutic approaches that focus on liberation, empowerment, and well-being can also help patients explore ways of resisting oppressive forces (Prilleltensky et al., 2008).

The rise of BSD has occurred at a time when enormous changes or pendulum swings have occurred in social norms, including gender roles, and psychiatric practice has struggled with the consequences of these shifts. This has occurred in a setting where political and theocratic pressures may be more important than market forces for defining the nature of psychiatric practice. Under socio-politically oppressive and ideological regimes, like Iran's, mental health practitioners face a constant challenge in finding the freedom and security needed to navigate their clinical practice according to both scientific evidence and human-rights values. Yet even under such circumstances, it is possible for clinicians to take actions toward providing person-centered care and improving cultural and structural competence in their clinical practice, through: 1) conscious effort to integrate the social determinants of mental health in case formulation, both to avoid reducing the systemic causes of mental suffering to biological causes and to move beyond treatment to prevention; 2) openness to hearing patients' voices and experiences as keys to their mental suffering; 3) creativity in planning treatment that is attuned to the patient's needs and values in a society that has gone through a rapid sociocultural transition from a traditional to a modern one; 4) educating the patient's family about the role of sociocultural as well as biological factors in the patient's suffering; and 5) engaging in advocacy for their patients in order to facilitate the patients' access to existing services.

Mental health care is an arena where disadvantaged people and those who are most vulnerable to experiencing human suffering, distress, and discrimination can voice their concerns

and reveal their predicaments (Cohen et al., 2008). Thus, mental health research and practice can be forces for good with an aim to contribute to individuals' well-being, liberation, and emancipation. This empowering and liberatory potential cannot be realized if psychiatry itself is used as a means for maintaining repressive political systems and social control (Moncrieff, 2008; Cohen et al., 2008). In order for mental health systems to move toward greater cultural and structural competency, some of the implicit assumptions of traditional research, such as the taxonomic research paradigm, must be challenged and deconstructed to avoid reducing the complex interactions of multiple determinants to hypothetical mechanisms inside the individual's body and limit the interventions to pharmaceutical treatment which can result in silencing the voices of vulnerable groups (Prilleltensky 2008, Kirmayer et al., 2012).

From conceptual and research points of view, we need studies, like the one presented in this thesis, across different sociocultural and political contexts to reveal how the use of Western psychiatric diagnoses may allow clinicians to sidestep or ignore underlying social, structural, and gendered causes of mental sufferings, leading to the silencing of many voices, particularly those of more vulnerable groups—such as women, children and adolescents, ethnic and religious minorities, and the poor—and how psychiatric practice can marginalize the discourse surrounding structural, political, and social problems. Studies that explore what happens when a clinician actually meets and works with a patient, as revealed through both providers' and clients' narratives of that encounter, can help us understand the structural problems and biases in mental health care and point to the sources of these barriers and cultural conflicts between clinician and patient (Desai et al., 2020). Qualitative studies examining clinical and professional discourse can reveal how the culture of the mental health system itself limits clinician's sensitivity to cultural and structural factors that shape the patient's experience with mental

suffering, help-seeking, and healing (Cohen, 2017). Community-based participatory research that includes the voice of participants and ensures their control over the research process, can contribute to shifting power to the community, raising people's awareness and expectations of mental health care systems, and providing them with the language and tools to resist oppressive interventions (Nelson & Prilleltensky, 2005; Wells & Jones, 2009). Clinicians need "conceptual competence"—that is, critical awareness of the assumptions, biases, and limitations of their conceptual models and theories (Karter & Kamens, 2019). Furthermore, using an ecological model of mental health problems in cross-cultural studies can facilitate discussions about solutions for reform and alternative psychiatric classification systems that aim at increasing the conceptual competence and critical consciousness in the development and application of diagnostic categories and treatments (Kirmayer & Crafa, 2014; Kirmayer, 2019). Considering the globalization of Anglo-American psychiatry in the new millennium, studies that contribute to conceptual competence play a crucial role in reforming mental health systems across the world.

Including advocacy in research and clinical practice is an essential step in bringing change to the policies that contribute to the structural defects in mental health systems and the wider society (Kirmayer et al., 2019). Clinicians and researchers can contribute to this not only by collaborating closely with mental health activists, social justice and human rights NGOs, and community councils and organizations but also by becoming advocates themselves for mental health and social justice. Mental health practitioners and researchers can educate people about the social and structural factors that correlate with their mental suffering and can challenge the systems in power by documenting and exposing structural incompetence and oppressive social and health policies that directly and indirectly cause and maintain an individual's mental suffering. However, considering the complexity of sociopolitical and structural issues and the

many challenges of advocacy, researchers and practitioners may be discouraged from adopting ecosocial and person-centered models of care. To counter this, mental health professional programs and institutions[49] can provide training and guidance on how to collaborate in partnership with different institutions, approach stakeholder communities and policy makers in specific national and local contexts, and join local, national, and international networks to share experiences as researcher-advocates and clinician-advocates to improve mental health services[50] (Kirmayer et al., 2019).

[49] Albert Einstein Medical College in New York is an example of promoting a "research-based health activism program" that bridges research with grass-roots advocacy, aiming to train future doctors how to change hats and advocate for public health, social justice, and health equality (Albert Einstein College of Medicine) (http://www.einstein.yu.edu/features/stories/1283/changing-hearts-and-minds-for-science/).

[50] My own experience illustrates this path. My doctoral training in the Division of Social and Transcultural Psychiatry (DSTP) at McGill included training at the Institute for Health and Social Policy (IHSP) (one-year graduate award) and three years of doctoral fellowship in the Global Mental Health Research Capacity Strengthening Program (GHR-CAPS). These experiences have encouraged and equipped me with theoretical and clinical frameworks to push the frontier of knowledge transfer through grass-roots advocacy. After analyzing the data gained from this study and disseminating the findings of the first phase of this research in psychiatric conferences and events in Iran in 2016, I have worked to bring together research and clinical knowledge with advocacy that targets patients' empowerment and structural changes, Through popular media, I have advocated and educated civic society in Iran and Iranians in diaspora for different mental health topics including the psychosocial needs of vulnerable girls; social, cultural, political, and gender determinants of psychiatric diagnoses and interventions in Iran; human rights in the context of mental health services; the role of systemic and structural defects in social mistrust in healthcare authorities and instructions during the current pandemic. My ongoing advocacy work has resulted in over fifty TV interviews (BBC Persian and Iran International TV channels), multiple media articles and interviews, collaboration with civic rights organizations in developing and teaching online courses that target lay audiences from lower socioeconomic and education classes, consulting Iranian children and human rights activists inside Iran as well as those in diaspora on how to address and advocate for clinical needs of psychologically vulnerable groups such as children of incarcerated parents, children in remote areas who are at a higher risk of domestic abuse and childhood marriage. (Most of this work can be found by searching Google videos for my name in Farsi فهیمه میانجی). It is important to acknowledge, however, that researchers and clinicians who wear an advocacy hat to address social and structural defects in contexts with complex political systems may face an extra layer of challenge, i.e., putting at risk their personal security and freedom.

From a local mental health policy perspective, this study suggests that intersection among culture, gender, class, and mental illness must be considered at all levels—within policy, research, and ultimately, front-line services—through addressing health system inadequacies related to gender, the barriers in creating patient-centered biopsychosocial services, and the short- and long-term burden that taken-for-granted biomedical psychiatry is on the healthcare system and society, such as misdiagnoses, mistreatments, and medicalization of sociopolitical problems and structural incompetency.

In addition to incorporating psychosocial interventions into the public health system, as a positive step towards improving the quality, accessibility, and affordability of appropriate mental health services, it is essential to have cultural and structural reforms within the healthcare system that 1) prioritize human rights and the individual's values over the political and ideological values of the state and 2) promote secular training of the mental healthcare providers in psychological and ecosocial models of care.

From a GMH research and policy standpoint, I argue that the findings of this study point to the importance of integrating a more ecosocial and person-centered model of care into psychiatric practice as well as to the need for an epistemological approach that provides a set of conceptual tools and methods that GMH researchers and policymakers as well as local practitioners, patients, and health systems planners can use to understand the intersection of multiple global and local factors in shaping patients' experience of mental suffering and their copying and help-seeking strategies. On a global scale, these factors include the globalization of the neoliberal economy, which is a strong force behind the neoliberal economy of psychiatry not only through the marketing of the pharmaceutical industry that is responsible for creating new psychiatric fads and emphasizing biomedical treatments (Moncrieff, 2006; Moncrieff, 2008) but

also through promoting a certain notion of the self that embodies and is embedded in idealized and fantasy lifestyles attached to products and consumption (Cohen, 2008; Yankovskyy, 2016; Cosgrove & Karter, 2018), the exportation of these trends from the Global North to the Global South, and the globalization of Anglo-Western social and cultural concepts, including feminist and human-rights values, through the rapid circulation of information facilitated by the advancement of technology and social media. On a local scale, these factors include the sociocultural, political, environmental, and economic conditions of each specific context. Such an ecosocial approach in producing knowledge can better equip GMH researchers to study the impact of the creation and exportation of psychiatric diagnostic categories and their influence on public discourse as well as the "looping" role (Hacking, 1993) they play in the self-narratives, experience, and expression of suffering of individuals who receive these diagnoses in different corners of the world.

Furthermore, conducting research with an ecosocial approach in non-Western countries with complex political systems—particularly those with oppressive regimes—raises ethical and safety concerns that are not properly addressed by GMH scientists and policymakers. GMH must design clear strategies for the researcher to 1) access and understand people's narratives despite systemically and culturally imposed self-silencing or self-censoring, 2) develop specific skillsets, tools, and networks that help them to understand the macro- and micro-level factors and how they interact and co-interact in such complex societies, and 3) protect themselves, their informants, their local collaborators, and the knowledge they produce from being controlled, manipulated, censored, falsified, and oppressed by the government[51]. The latter is a particular

[51] This is a major problem for researchers in Iran and in other countries with similar oppressive political system. For example, in Iran, In numerous recent cases, scholars have been arrested and prosecuted in

retaliation for scholarly work and other non-violent expression. SAR provides a horrifying list:

- On 25 May 2015, Mohammad Hossein Rafiee, a retired chemistry professor and activist, was sentenced to six years in prison and banned for two years from political and media activity, for publishing an analysis of the Iran Nuclear Agreement. He was charged with offences including membership in an illegal, anti-Iranian group, propaganda, and the use of television satellite equipment. Rafiee, then 71, faced overcrowding, poor sanitation and inadequate nutrition. He was released on medical furlough in September 2016.

- On 24 April 2016, Ahmadreza Djalali, an Iran-born citizen of Sweden and specialist in disaster medicine, was arrested and charged with espionage, accused of collaborating with scholars from 'enemy states.' He has reportedly been held in solitary confinement, denied access to a lawyer of his choosing, subjected to psychological torture, and forced to sign a confession. He has also suffered health problems. On 1 February 2017, he was sentenced to death. Djalali remains detained.

- On 6 June 2016, Homa Hoodfar, an Iran-born citizen of Canada, professor of social anthropology at Concordia University in Canada, and expert on sexuality and gender in Islam, was arrested on charges of cooperating with a foreign state against Iran. She was accused, among other things, of 'dabbling in feminism.' She fell seriously ill and was released on humanitarian grounds in September 2016.

- On 8 August 2016, authorities arrested Xiyue Wang, an American graduate student from Princeton University, who was conducting doctoral research of public records from the 19th and early 20th centuries in Iran's national archive. He was charged with espionage and in July 2017 was sentenced to 10 years in prison. Appeal was denied the following month. "He has been held in solitary confinement, and has reportedly suffered extreme stress, depression, attempted suicide, and multiple diseases," says SAR.

- On 24 January 2018, authorities arrested Kevous Seyed-Emami, an Iranian-Canadian professor of sociology at Imam Sadiq University in Iran and co-founder of the Persian Wildlife Heritage Foundation, along with several others, on charges of espionage. In February 2018, the authorities announced that Seyed-Emami had died in Evin Prison, claiming the cause was suicide. "Seyed-Emami's death follows two other recent incidents in Evin Prison in which activists' deaths were later ruled suicides. The circumstances of Seyed-Emami's death have been described as extremely suspicious."

- On 12 March 2018, Iranian authorities sentenced Sadegh Zibakalam, a prominent professor and political analyst known for his criticism of Iranian state policies, to 18 months in prison on charges of spreading false information and propaganda. "He was also banned for two years from giving public speeches, writing articles, giving interviews, and social media activity. Two months earlier, he had been dismissed without notice from a position at Islamic Azad University."

- On 14 March 2018, Iranian intelligence officials arrested Kingston University art philosophy graduate student Aras Amiri, as she was preparing to leave the country, on charges of assembly and collusion against national security, apparently in connection with her academic work. She remains detained in Evin Prison.

- On 15 April 2018, Abbas Edalat, a British-Iranian professor of computer science and mathematics at Imperial College London, was arrested based on allegations that the Campaign Against Sanctions and Military Intervention in Iran that he founded conducted espionage operations and had contact with leaders of anti-government protests. Edalat was released and returned to the United Kingdom in December 2018.

- On 1 December 2018, authorities reportedly arrested Meimanat Hosseini Chavoshi, a research fellow and demography expert from the University of Melbourne's School of Population and Global Health, and Mohammad Jalal Abbasi-Shavazi, a professor of demography at the University of Tehran, accusing them of manipulating the population and providing sensitive information to enemies of Iran.

- [In late April 2006, on his way to an international conference in Brussels, an Iranian philosopher and academic in Canada, Ramin Jahanbegloo, was arrested by the Iranian authorities. On May 3, Iran judiciary branch officials confirmed that he was arrested and sent to Evin Prison. The following day, a friend told CBC News that Jahanbegloo had been moved to a hospital.[6]Human Rights Watch expressed concern over Jahanbegloo being detained without charges and called for his immediate release.] https://en.wikipedia.org/wiki/Ramin_Jahanbegloo

- [On 14 July 2019, Persian-language media from outside of Iran reported that Fariba Adelkhah, who is a French-Iranian anthropologist and academic at Sciences Po, had been arrested in Iran. Her arrest would date back to 7 June, when she last connected to her WhatsApp account. The Iranian Human Rights website *Gozaar* stated that she had been arrested by the Islamic Revolutionary Guard Corps and was being detained at Evin Prison. French authorities stated that Adelkhah was being denied access to consular assistance,[5] and are demanding access to their citizen.] https://en.wikipedia.org/wiki/Fariba_Adelkhah

Restrictions on student expression

The SAR submission lists at least eight non-violent student protesters from the University of Tehran who were last year prosecuted on charges including anti-state propaganda, collusion against national security and disturbing public order, and were sentenced to imprisonment for up to seven years.

In December 2017, Iranian authorities acknowledged banning 27 students from graduate programmes for alleged political expression. This was reportedly part of a practice of identifying student activists by marking their names with a star in official documents, and preventing many of them from continuing at university.

"Students who receive one star may enter university after signing a document pledging not to engage in any political or social activism. Students receiving two stars are suspended and may be interrogated by the intelligence ministry. Students receiving three stars are subject to a lifetime ban from higher education," says the submission.

"Authorities have reportedly acknowledged that 151 PhD students and 398 masters students had been 'starred', but were allowed to move forward in their educational programmes after signing pledges to refrain from political activity." Notwithstanding the official statistics, says SAR, "independent rights organisations allege that as many as 150 to 200 students have been 'starred' and banned from academic activity."

https://www.universityworldnews.com/post.php?story=20190418201523148Iran is one of many countries that restricts academic freedom and oppresses and detains scientists and researchers. As indicated in Scholars at Risk Network, there are other countries with similar political systems, such as China, Turkey, Egypt, Saudi Arabia, Emarat, …, where conducting research and disseminating knowledge cannot be freely practiced. https://www.scholarsatrisk.org/action/scholars-in-prison-project/

ethical dilemma for GMH researchers from the Global North who conduct GMH research in the Global South without receiving proper training and support on how to create knowledge without relying on the resources that the official pathways, such as different sectors of government, provide[52] as well as how to protect themselves and their research findings from being oppressed in such contexts. In addition to proposing feasible and safe strategies to conduct research in such contexts, GMH needs also to suggest ways to make person-centered and ecological models of care applicable and feasible in non-Western countries under theocratic and repressive regimes that do not recognize or prioritize human rights values. Given the limited evidence for the cross-cultural applicability of global mental health approaches (Adeponie et al., 2012; Bayetti, 2017; Kirmayer & Pederson, 2014), there is a need for continued research to study whether and how such models can be adapted to and applied in different sociopolitical and cultural contexts in order to create greater health equity and social justice.

[52] Collaborating with governmentally based sections questions the accuracy and reliability of findings.

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APPENDICES

APPENDIX A. Semi-Structured Interview Guideline (Psychiatrists)

Thank you for agreeing to take part in this study. I have a number of questions to ask to explore your own reflections on the current state of psychiatric diagnosis in Iran, especially in relationship to mood and affective disorders.

از موافقت شما برای شرکت در این مطالعه سپاسگزارم. برای آشنایی با وضعیت فعلی تشخیص گذاری و درمان روانپزشکی ایران به ویژه در ارتباط با موود و افکتیو دیزوردر از نگاه شما، تعدادی سوال ازشما میپرسم.

1- Would you tell me about the types of patients that visit you?

1. میشه لطفاً بفرمایید چه تیپ بیمارانی ویزیت میکنید؟

2- Would you tell me about the most recent case that you saw? Was that case typical? If yes, why? If not, why not?

2. میشه لطفاً در مورد آخرین بیماری که ویزیت کردید بفرمایید؟ بیمار تیپیک بود؟ اگر بله، چطور؟ اگر خیر، چرا؟

3- Have you ever seen a bipolar patient? How common is this type of problem in your practice?

3. بیمار بایپولار هم ویزیت میکنید؟ در پراکتیس شما بیمار بایپولار چقدر متداول هست؟

4- Would you tell me about the most recent bipolar patient that you saw? Was that case typical? If yes, why? If not, why not?

4. میشه لطفاً در مورد آخرین بیمار بایپولاری که ویزیت کردید بفرمایید؟ بیمار تیپیکی بود؟ بله، چطور؟ خیر، چرا؟

5- What is the most typical bipolar patient? Could you give me an actual example?

5. پرزنتیشن یک بیمار بایپولار تیپیک چیه؟ میشه لطفاً با یک مثال واقعی شرح بدید؟

6- How do you distinguish between bipolar disorder and other disorders, such as borderline, schizophrenia and/or schizoaffective?

6. چطور بین بیمار بایپولار و سایر بیماران مثل بوردرلاین، اسکیزوافکتیو و اسکیزوفرنیا تمایز میگذارید؟

7- How do you treat a bipolar patient? Which medication? (If mood stabilizers mentioned) What are the mood stabilizers?

7. بیمار بایپولارتون رو چطور درمان میکنید؟ چه دارویی؟ (اگر موود استبیلایزر، مود استبیلایزر چی هست؟)

8- What is your target when you treating a BD? (Symptoms, experiences, behaviours)

8. هدف از درمان بیمار بایپولار چیست؟ در درمان چه چیزی رو تارگت میگیرید؟ سیمپتوم‌ها، تجارب بیمار، رفتارهاش)

9- How do you monitor the effects of treatment?

9. اثربخشی درمان رو چطور مانیتور میکنید؟

10- How do you know if these treatments do work?

10. چطور میفهمید که درمان موفق بوده؟

11- Are there any differences between the bipolar patients you see in the university hospital and in your (private) clinic?

11. بین بیماران بایپولاری که در بیمارستان ویزیت میکنید با مطب خصوصی تون تفاوتی هست؟

12- Do you use the same diagnoses and treatments in your university hospital as you do in your private clinic?

12. روش تشخیص و درمانتون در بیماران بایپولار بیمارستان با مطب فرقی دارد؟

13- In addition to the approaches you use, do you aware of the other approaches for the treatment of bipolar disorder?

13. آیا از سایر رویکردهای درمانی بجز رویکردی که شما استفاده میکنید اطلاعی دارید؟

14- What are the main difficulties in treating bipolar patients in Iran? (If Stigma addressed,

14-1- which one is further stigmatized in Iran, Borderline, Bipolar, Schizoaffective, and/or Schizophrenia?)

14. اصلی ترین مشکلات در درمان بیماران بایپولار در ایران چیه؟ (اگر به استیگما اشاره شد: کدام یک از اختلالات "بوردرلاین، بایپولار، اسکیزو افکتیو، اسکیزوفرنیا"استیگما بیشتری داره در ایران ؟)

15- Have the understandings and practices with BD changed in recent years? How so?

15. آیا مفاهیم و درمانهای بیماری بایپولار در سالهای اخیر تغییری کرده؟ چطور؟

16- Have any structural factors influenced the delivery and meaning of BD diagnosis and treatment of BD in Iran in clinical or psychiatric training settings? If so, how? By structural factors, I mean economics, politics, the organization of health care, the role of pharmaceutical companies, diagnostic categories and professional organizations both locally and internationally?

16. آیا عوامل ساختاری تاثیری در حرکت و مفهوم تشخیص و درمان بایپولار در ایران در هر دو ستینگهای خصوصی و بیمارستانی داشته؟ منظور من از عوامل ساختاری عوامل اقتصادی، سیاسی، سازمانهای خدمات بهداشتی، نقش شرکتهای دارویی، طبقه بندیهای تشخیصی و سازمانهای حرفه ای در هر دو سطح داخلی و بین المللی است.

17- Have there been any critiques about the use of the bipolar diagnosis in Iran?

17. در ایران، آیا هیچ انتقادی به تشخیص و درمان بایپولار وجود دارد؟

18- Do you think bipolar disorder has been over-diagnosed or under-diagnosed in Iran? If so, since when and how?

18. شما فکر میکنید اختلال بایپولار اور-دیاگنوز میشه در ایران یا آندر-دیاگنوز؟ از کی و چطور؟

19- In the past, were people with BD misdiagnosed as Schizophrenic or Schizoaffective? If yes, what proportion of the BD patients diagnosed by the recent BD "Spectrum" criteria would have been considered as Schizoaffective or Schizophrenic before this contemporary change?

19. در ایران، آیا در گذشته بایپولارها به غلط اسکیزوافکتیو و یا اسکیزوفرن تشخیص داده میشدند؟ اگر بله، چه میزانی از بیمارانی که در سالهای اخیر با معیارهای بایپولار اسپکتروم تشخیص بایپولار میگیرند قبل از این تغییرات تشخیصی ممکن بوده اسکیزوفرنیک یا اسکیزوافکتیو تشخیص بگیرند؟

20- In which direction do you think bipolar diagnosis and treatment is heading in Iran? -20 شما فکر میکنید در ایران تشخیص و درمان بایپولار به کجا داره میره؟

21- Have you heard the term "bipolar-minded psychiatrist"? If yes, what does that mean and how did this professional label originate?

21-شما هیچ وقت اصطلاح روانپزشکان بایپولار-مایندد رو شنیدید؟ اگر بله، چه معنی داره و از کجا آمده؟

22- Is there anything you would like to add?

22- چیزی هست که شما بخواهید اضافه کنید؟

Appendix B. McGill Illness Narrative Interview

McGill Illness Narrative Interview (MINI)

Generic Version for Disease, Illness or Symptom

Danielle Groleau, Allan Young, & Laurence J. Kirmayer

Section 1: Initial Narrative

*(*The aim of this section is to allow interviewees to tell their story at their own pace and in their own way.)

The introductory section of the MINI is intentionally unstructured and aims to collect a narrative organized by spatial and temporal contiguity of events. If interviewees introduce a disease label, prototype or explanatory model, it is noted, but the basic questions are repeated to encourage the narrator to return to recounting the basic sequence of events associated with their symptom or condition.

Questions 1–4 invite participants to produce an initial illness narrative in such a way as to minimize the influence of a social desirability bias. This is the least structured part of the interview. The aim here is to invite participants to tell their story in their own way. Questions 5 and 6 are probes that aim to ensure that interviewees tell the full narrative related to their pathways to care (i.e., the use of medical services). This part of the interview can be fairly long for participants with many symptoms or a lengthy illness history. Because the aim of the

unstructured interview is to allow interviewees to tell their story at their own pace and in their own way, no time limit should be imposed at this stage of the interview (Morse, 2002).

Section 1. INITIAL ILLNESS NARRATIVE

1. When did you experience your health problem or difficulties (HP) for the first time? *[Substitute respondent's terms for "HP" in this and subsequent questions.][let the narrative go on as long as long as possible, with only simple prompting by asking, 'What happened then? and then?']*
2. We would like to know more about your experience. Could you tell us when you realized you had this (HP)?
3. Can you tell us what happened when you had your (HP)?
4. Did something else happen? *[Repeat as needed to draw out contiguous experiences and events.]*
5. If you went to see a helper or healer of any kind, tell us about your visit and what happened afterwards.
6. If you went to see a doctor, tell us about your visit to the doctor/hospitalization and about what happened afterwards.

6.1 Did you have any tests or treatments for your (HP)? *[The relevance of this question depends on the type of health problem.]*

بخش ۱. روایت مقدماتی

۱- اولین دفعه ای که مساله یا مشکل سلامتتون رو تجربه کردید کی بود؟ {صطلاحی که بیمار برای مشکلش به کار میبرد از اینجا به بعد جایگزین (مشکل سلامت) در سوالهای بعدی میشود} {اجازه بدهید تا روایت به هر مقداری که ممکن هست جلو برود و فقط پرشهای ساده به موقع داشته باشید با پرسیدن سوالاتی مثل 'اونوقت چه اتفاقی افتاد؟ بعدش چی شد؟'}

۲- من مایل هستم که بیشتر در مورد تجربه تون بدونم، میشه بفرمایید کی متوجه شدید که (مشکل سلامت) را دارید؟

۳- چی شد بعد از اینکه دچار (مشکل سلامت) شدید؟

۴- چیز دیگه ای هم اتفاق افتاد؟ {تکرار سوال برای بیرون کشیدن رویدادها و تجربه های جانبی (پهلو به پهلو) اش لازم است}

۵- اگر پیش هر کس دیگری رفتید و یا هرمدل کمک دیگری گرفتید، لطفا بگید چطور بود و بعدش چه اتفاقی افتاد.

۶- اگر به دکتر مراجعه کردید، ویزیت دکتر/بستری چطور بود و بعدش چه اتفاقی افتاد؟

۶.۱ هیچ آزمایش و یا درمانی برای (مشکل سلامت) تون گرفتید؟ { مرتبط بودن این سوال به نوع مشکل سلامت بستگی دارد)

Section 2: Prototypes

(Aims to gauge whether or not participants are using prototypical experiences of self or of others, and whether they are using them to reason analogically about their own health problem and related health behavior.)

Questions in this section are more structured and aim to elicit narratives which reveal prototypical experiences of self and others, and how such prototypes are used by the interviewees to reason analogically about their health problem and related health behavior. Prototypes may be very influential for some participants and not for others. This may be because some people predominantly use an analogical way of reasoning in relation to their health problem and related health behavior; it could also be because *prototypical knowledge* is experienced-based knowledge, rather than theoretical or objective (Groleau et al., submitted). Also, it is knowledge embedded in one's own experience or that of a close one, endowing it with an emotional significance which, for some people, gives it precedence over rational or causal types of reasoning.

The purpose of this section of the interview is to gauge whether or not participants are using prototypical experiences of self or of others, and whether they are using them to reason analogically about their own health problem and related health behavior. Question 7 elicits self-prototypical experiences of participants. Questions 9, 11 and 13 aim at revealing family, social and media prototypes, respectively. Questions 8, 10, 12 and 14 invite interviewees to explore

whether they reason analogically and how they may be using prototypical experiences to explain their health problem and related health behavior.

Section 2. PROTOTYPE NARRATIVE

7. In the past, have you ever had a health problem that you consider similar to your current (HP)? [If answer to #7 is Yes, then ask Q.8]

8. In what ways is that past health problem similar to or different from your current (HP)?

9. Did a person in your family ever experience a health problem similar to yours? [If answer to #9 is Yes, then ask Q.10]

10. In what ways do you consider your (HP) to be similar to or different from this other person's health problem?

11. Did a person in your social environment (friends or work) experience a health problem similar to yours? [If answer to #11 is Yes, then ask Q.12]

12. In what ways do you consider your (HP) to be similar to or different from this other person's health problem?

13. Have you ever seen, read, or heard on television, radio, in a magazine, a book or on the Internet of a person who had the same health problem as you? [If answer to #13 is Yes, then ask Q.14]

14. In what ways is that person's problem similar to or different from yours?

بخش ۲. روایت االگوی نخستین

۷. در گذشته هیچ وقت مشکلی داشتید که به نظرتون مشابه (مشکل سلامت) اخیرت باشد؟ {اگر جواب سوال بله است، سوال شماره ۸ پرسیده شود}

۸. مشکل گذشته ات از چه نظر مشابه واز چه نظر متفاوت با مشکل اخیرت بوده است؟

۹. آیا هیچ وقت کسی در خانواده ات بیماری شبیه تو رو داشته است؟ {اگر جواب سوال بله است، سوال شماره ۱۰ پرسیده شود}

۱۰. از چه بابتی به نظرتان رسیده که مشکل آن فرد مشابه یا متفاوت با مشکل شما بوده است؟

۱۱. آیا هیچ وقت کسی در محیطهای اجتماعیت مثل دوستان و یا همکارانت چیزی شبیه به مشکل شما رو تجربه کرده است؟ {اگر جواب سوال بله است، سوال شماره ۱۱ پرسیده شود}

۱۲. از چه بابتی به نظرتان رسیده که مشکل آن فرد مشابه و یا متفاوت با مشکل شما بوده است؟

۱۳. هیچ وقت از طریق تلوزیون، رادیو، مجله، کتاب، و یا اینترنت دیدی یا شنیدی که کسی مشکلی شبیه مشکل شما را داشته باشد؟ {اگر جواب سوال بله است، سوال شماره ۱۴ پرسیده شود}

۱۴. از چه بابتی به نظرتان رسیده که مشکل آن فرد مشابه یا متفاوت با مشکل شما بوده است؟

Section 3: Explanatory Models

(Section 3 aims to elicit perceived causal attributions, local idioms, bodily metaphors, social context of the explanatory model, labeling & stigma, etc.)

This section aims to elicit explanatory model narratives of the interviewees' HP produced by a causal type of reasoning. Question 15 verifies whether interviewees use an alternative label to describe their HP. This question may, in some cases, give access to an idiom of distress or another popular cultural construct related to somatic conditions not yet documented in the literature. Question 16 elicits the perceived cause(s) of participants' HP. Question 17 may uncover new information related to attributions. Question 18 may help to clarify the bodily aspects of explanatory models, that is, how participants perceive their HP operating within their organs and body. Bodily metaphors with a cultural significance may emerge from this question. Questions 19 and 20 may stimulate an answer that gives access to a social context for the explanatory model. For example, if one of the attributions for their HP is stress, participants should be able to explain the social context of their stressful experiences in a short narrative. Questions 21 and 25 aim to reveal whether a popular label linked to participants' HP exists in their social context, and if so, how it contrasts with their own HP in terms of meaning, expected prognosis, treatment and social expectancies (e.g., stigma or access to support). Question 27 aims to clarify how participants' explanatory models apply to the story of their personal experience

Section 3. EXPLANATORY MODEL NARRATIVE

15. Do you have another term or expression that describes your (HP)?

16. According to you, what caused your (HP)? [List primary cause(s).]

16.1. Are there any other causes that you think played a role? [List secondary cause(s).]

17. Why did your (HP) start when it did?

18. What happened inside your body that could explain your (HP)?

19. Is there something happening in your family, at work or in your social life that could explain your health problem? [If answer to #19 is Yes, then ask Q.20]

20. Can you tell me how that explains your health problem?

21. Have you considered that you might have *[INTRODUCE POPULAR SYMPTOM OR ILLNESS LABEL]?*

22. What does *[POPULAR LABEL*] mean to you?

23. What usually happens to people who have *[POPULAR LABEL]*?

24. What is the best treatment for people who have *[POPULAR LABEL]*?

25. How do other people react to someone who has *[POPULAR LABEL]*?

26. Who do you know who has had *[POPULAR LABEL]*?

27. In what ways is your (HP) similar to or different from that person's health problem?

28. Is your (HP) somehow linked or related to specific events that occurred in your life?

29. Can you tell me more about those events and how they are linked to your (HP)?

بخش ۳. روایت مدل بیانی / شرحی؟

۱۵. آیا شما لغت یا اصطلاح دیگه ای دارید که (مشکل سلامت) تان را توصیف کند؟

۱۶. به نظر خودتان چه چیزی باعث ایجاد (مشکل سلامت) شما شده است؟ {علتهای اولیه را لیست کنید}

۱۶.۱. چیزهایی دیگری هم وجود دارد که از نظر شما در ایجاد (مشکل سلامت) تان نقش داشته باشد؟ {علتهای ثانویه را لیست کنید}

۱۷. چرا (مشکل سلامت) تان شروع شد؟ چه زمانی شروع شد؟

۱۸. آیا فکر میکنید که اتفاقی هم درون بدنتان افتاده که بتواند (مشکل سلامت) تان را توضیح دهد؟

۱۹. هیچ اتفاق خاصی در خانواده تان، در محل کارتان، و یا در شرایط اجتماعی تان افتاده است که بتواند (مشکل سلامت) شما را توضیح دهد؟ {اگر جواب سوال بله است، سوال شماره ۲۰ را بپرسید}

۲۰. میتوانید توضیح بدهید ربط آن اتفاق به (مشکل سلامت) شما چیست؟

۲۱. آیا تصور میکردید که ممکن است شما (علایم و اصطلاح رایج یا برچسب عامیانه که بیمار توضیح داده است) داشته باشید؟

۲۲. (برچسب عامیانه) چه معنی برای شما دارد؟

۲۳. معمولا چه اتفاقی برای افرادی که (برچسب عامیانه) دارند میافتد؟

۲۴. بهترین درمان برای افرادی که (برچسب عامیانه) دارند چیست؟

۲۵. افراد دیگر چطور به کسی که (برچسب عامیانه) دارد واکنش میدهند؟

۲۶. چه کسی را میشناسید که (برچسب عامیانه) داشته باشد؟

۲۷. (مشکل سلامت) شما از چه بابت به شبیه و یا متفاوت از مشکل آن فرد است؟

۲۸. آیا (مشکل سلامت) شما به رویداد خاصی که در زندگی تان اتفاق افتاده باشد بر میگردد و یا ربط پیدا میکند؟

۲۹. میتوانید بیشتر درباره آن وقایع بگویید و اینکه چطور به (مشکل سلامت) شما برمیگردد یا مربوط میشود؟

Section 4: Help Seeking and Service Utilization

(Section 4 aims to invite interviewees to produce, where applicable, a narrative of their experience with health services and hospitalization, and their response to received treatment.)

This section of the interview schedule is optional and should be used only if it is relevant to the research question. Its purpose is to invite interviewees to produce, where applicable, a narrative of their experience with health services and hospitalization, and their response to received treatment. This section can be omitted if the focus of the study is limited to meaning and experience of illness without paying attention to pathways to care or the impact of biomedical services. If interviewees mention in Section 1 having consulted a healer of any kind, the interviewer asks Questions 30–31 by replacing the word *doctor* with *healer*. If patients consulted both a healer and a medical doctor, the interviewer asks all questions in this section for each type of healer or help. Questions 34–36 aim to invite narrators to produce a rationalization for their health behavior in terms of incitements and deterrents to compliance with treatment recommendations. This rationalization may reveal important practical issues but, because it serves to justify the individual's actions, it may also obscure understanding of the predominant individual and cultural meanings. Questions 36–39 explore satisfaction with health care without asking the question directly to minimize potential desirability bias. At this point, it is particularly important to put interviewees at ease in order that they provide truthful answers. These questions are purposely asked toward the end of the interview to allow sufficient time to create an atmosphere of confidence. Before asking these three questions, interviewees should be reminded

that the interview is confidential and their identities will not be disclosed. This is particularly important in cases where participants may fear offending a helper or losing access to services.

Section 4. SERVICES AND RESPONSES TO TREATMENT

30. During your visit to the doctor (healer) for your HP, what did your doctor (healer) tell you that your problem was?

31. Did your doctor (healer) given you any treatment, medicine or recommendations to follow? [List all]

32. How are you dealing with each of these recommendation? *[Repeat Q.33 to Q.36 as needed for every recommendation, medicine and treatment listed.]*

33. Are you able to follow that treatment (or recommendation or medicine?)

34. What made that treatment work well?

35. What made that treatment difficult to follow or work poorly?

36. What treatments did you expect to receive for your (HP) that your did not receive?

37. What other therapy, treatment, help or care have you sought out?

38. What other therapy, treatment, help or care would you like to receive?

بخش ۴. خدمات درمانی و پاسخ به درمان

۳۰. وقتیکه به دکتر و (هر فرد دیگری که بیمار در سوال ۵ نام برده است) برای (مشکل سلامت) مراجعه کردید، دکتر (هر فرد دیگیری که بیمار در سوال ۵ نام برده است) تان به شما گفت که مشکلتان چیست؟

۳۱. آیا دکتر (هر فرد دیگری که بیمار در سوال ۵ نام برده است) تان به شما هیچ درمانی، دارویی و یا توصیه ای داد که شما دنبال کنید؟ {همه موارد لیست شود}

۳۲. شما چطور به هر کدام از این توصیه های درمانی عمل کردید؟ {سوال ۳۳ تا ۳۶ برای هرکدام از درمانها، داروها و یا توصیه های درمانی جداگانه تکرار شود}

۳۳. آیا شما قادر به دنبال کردن آن درمان بودید و هستید؟

۳۴. چه چیزی باعث میشد که آن درمان به شما اثر کند؟

۳۵. چه چیزی باعث میشد که ادامه دادن آن درمان مشکل باشد و یا اثر بخشی آن کافی نباشد؟

۳۶. چه درمان هایی انتظار داشتید که برای (مشکل سلامت) تان بگیرید که دریافت نکردید؟

۳۷. دنبال چه معالجات و درمانهای دیگری، و یا چه جور کمک و یا مراقبت دیگری رفتید؟

۳۸. مایل بودید که چه معالجات و درمانهای دیگری، و یا چه جور کمک و یا مراقبت دیگری دریافت کنید؟

Section 5: Impact of Illness

(Section 5 aims to explore the impact of health problem in patient's life and identity, sense of self, coping strategies, social supports, spiritual support, etc.)

This section aims to explore the impact of the health problem on narrators' life in general and to see if and how they believe the illness has led to changes in their identity and way of life since its onset. Questions 39–42 aim to elicit a narrative that explores possible changes in identity, roles and functioning that are linked to the health problem. This may be particularly relevant if the problem is a chronic disease or mental illness that, because of its nature, may provide a rite-of-passage or transformative experience for the narrator. As well, since health problems may require substantial adaptations or accommodations by others, a changed sense of self may originate in or be mirrored by these reactions. Questions 43 and 45 ask about ways of coping, social supports and other resources and can be tailored to the specific domains of interest. In the case of afflictions that confront patients with their own mortality, their illness experience may be embedded in a spiritual narrative.

Section 5: IMPACT ON LIFE

39. How has your (HP) changed the way you live?

40. How has your (HP) changed the way you feel or think about yourself?

41. How has your (HP) changed the way you look at life in general?

42. How has your (HP) changed the way that others look at you?

43. What has helped you through this period in your life?

44. How have your family or friends helped you go through this difficult period of your life?

45. How has your spiritual life, faith or religious practice helped you go through this difficult period of your life?

46. Is there any thing else you would like to add?

بخش ۵. تاثیر بر زندگی

۳۹. (مشکل سلامت) شما چه تاثیری روی زندگی شما گذاشته است؟

۴۰. (مشکل سلامت) شما بر برداشتی که از خودتان داشته اید و یا احساسی که به خودتان داشته اید چه تاثیری گذاشته است؟

۴۱. (مشکل سلامت) شما در نگاه شما به زندگی به طور کلی چه اثری گذاشته است؟

۴۲. (مشکل سلامت) شما چه اثری در نگاه دیگران به شما گذاشته است؟

۴۳. چه چیزی به شما در این دوره از زندگی تان کمک کرده است؟

۴۴. خانواده و دوستانتان چطور در عبور از این دوره مشکل زندگیتان به شما کمک کرده اند؟

۴۵. زندگی معنوی شما، ایمان و یا اعمال مذهبی تان چطور به شما درعبور از این دوره مشکل زندگیتان کمک کرده است؟

۴۶. چیزی دیگری هست که شما مایل باشید به اطلاعاتمان اضافه کنید؟

Appendix C. Consent Form for Psychiatrists' Interview

Over- or under-diagnosed? Looking at the professional controversy in bipolar diagnosis and treatment in Iran in the new millennium

Investigators: Dr. Laurence J. Kirmayer, Dr. Fahimeh Mianji

INTRODUCTION

This is an oral history and ethnographic project examining how the diagnostic category of bipolar disorder has been introduced in Iranian psychiatry in recent years. The study will interview leading figures in Iranian psychiatry working in academic, public and private sectors to explore their views and experiences with applying the diagnosis.
We are interested in hearing your experiences as a prominent psychiatrist involved in training the residents as well as clinical practice in this field about the way that you diagnose and treat bipolar disorder as well as your idea about the place of this diagnosis and its controversies. Your participation in this project would help us to shed light on the process of uptake of new diagnostic practices in international psychiatry.

STUDY PROCEDURES

If you accept to participate in this study, you will be interviewed and asked questions about your professional experiences and perspectives mostly regarding the bipolar disorder. During the interview, we will sit down in a comfortable and quiet place that we agree on together. For example, it could be at your office in hospital, your private clinic, or in any other place you feel comfortable in. The interview will last between 60 minutes and 90 minutes and will be audio-recorded. You will be asked question such as: How do you understand a bipolar diagnosis and treatment? 2) How have these understandings and practice emerged from the recent past and how they were different from the past? And 3) Is there any critique about the origin of this diagnosis in Iran?

BENEFITS AND RISKS

There are no direct benefits involved in participating in this interview. However, your participation includes an opportunity to contribute to the understanding of this professional controversy.

This study involves oral history from practitioners and present minimal or no risk to you.

SUBJECT RIGHTS

You may refuse to give consent and do not have to participate in this project. You may withdraw from this study at any time without consequence. In this case, we will destroy any given and recorded information. If you do agree to proceed, you may choose to stop the interview at any time. If you do not wish to answer a particular question or would like to ask me questions, please feel free to stop me.

CONFIDENTIALITY

This study involves oral history from practitioners and present minimal or no risk for them. The major concern is with the confidentiality of any patients or other individuals mentioned in the interviews. The confidentiality and anonymity of interviewees in the project will be guaranteed. No identifying information will be disclosed or published. Electronic files will be maintained in password protected files. To protect the identities of informants and any others mentioned in case studies, all respondents will be assigned a code number and consent forms will be kept separately from the anonymized interview transcripts. All interview tapes and transcripts will be kept under lock and key and will be destroyed 7 years following collection.

CONTACT

If you ever have any question or advice, we will provide you with a list of people you can contact. If you have questions or comments about the research, you can contact Dr. Laurence. J. Kirmayer (514 340 7549) – laurence.kirmayer@mcgill.ca- or Dr. Fahimeh Mianji -fahime.hmianji@mail.mcgill.ca- (+98 912 305 0917)- (+1 514 467 3389).

SIGNATURE

If you agree to participate, your consent must be documented. This can be done in two different ways: 1) I can record your oral consent, or 2) you can sign below

☐ YES to interview and recording ☐ YES to interview, NO to recording ☐ NO to both

The study has been explained to me and my questions have been answered to my satisfaction. I agree to participate in this study.

_____ _____

Signature of participant Date

I have explained the study to the participant and answered all questions. I believe the participant understood the information provided and is freely accepting to participate.

_____ _____

Signature of interviewer Date

Appendix D: Consent Form for Patients' Interview (English)

Medicalization of Mood: Impact of Professionals' Use of Bipolar Spectrum Diagnosis In Iran

Investigators: Dr. Fahimeh Mianji, Dr. Laurence Kirmayer

INTRODUCTION

This is a focused ethnographic project examining the illness meaning and experience of individuals diagnosed with bipolar "spectrum" disorder in their social, gendered, and cultural contexts. The study will interview individuals who diagnosed bipolar spectrum disorder over the past five years. We are interested in hearing your experiences as a person living under bipolar spectrum disorder diagnosis and treatment. Your participation in this project would help us to produce information to provide appropriate diagnosis and in turn intervention for patients diagnosed bipolar "spectrum" disorder. This will help improve the efficacy of treatments with psychiatric patients, and specifically for bipolar disorder patients.

STUDY PROCEDURES

If you accept to participate in this study, you will be interviewed and asked questions about your experiences and perspectives mostly regarding your psychiatric diagnosis, bipolar spectrum disorder. During the interview, we will sit down in a comfortable and quiet place that we agree on together. For example, it could be at a room in clinic, hospital, your home, or in any other place you feel comfortable in. The interview will last between 90 minutes and 120 minutes. You will be asked question such as: 1) When did you experience your health problem for the first time?; 2) In the past, have you ever had a health problem that you consider similar to your current health problem?; 3) According to you, what caused your health problem?; etc.

BENEFITS AND RISKS

There are no direct benefits involved in participating in this interview. However, your participation and the insight you provide will assist in the advancement of knowledge in the understanding of this psychiatric diagnosis and treatment. There are no expected risks involved with your participation. Sometimes it happens that a person feels uncomfortable with a question. If this happens to you, you are free not to answer the question. You will not get any personal benefit from your participation in this research project. However, the insight you provide will assist in the advancement of knowledge in this field.

SUBJECT RIGHTS

You may refuse to give consent and do not have to participate in this project. You may withdraw from this study at any time without consequence. In this case, we will destroy any given and recorded information. If you do agree to proceed, you may choose to stop the interview at any time. If you do not wish to answer a particular question or would like to ask me questions, please feel free to stop me

CONFIDENTIALITY

This study involves oral narrative from adult participants and present minimal or no risk for them. The major concern is with the confidentiality of any patients or other individuals mentioned in the interviews. The confidentiality and anonymity of interviewees in the project will be guaranteed. No identifying information will be disclosed or published. Electronic files will be maintained in password protected files. To protect the identities of informants and any others mentioned in case studies, all respondents will be assigned a code number and consent forms will be kept separately from the anonymized interview transcripts. All interview digital records and transcripts will be kept under lock and key and will be destroyed 7 years following collection.

CONTACT

If you ever have any question or advice, we will provide you with a list of people you can contact. If you have questions or comments about the research, you can contact Laurence. J. Kirmayer (+1 514 340 7549) – laurence.kirmayer@mcgill.ca- or Dr. Fahimeh Mianji - fahime.hmianji@mail.mcgill.ca- (+98 912 305 0917)- (+1 514 467 3389).

SIGNATURE

If you agree to participate, your consent must be documented. This can be done in two different ways: 1) I can record your oral consent, or 2) you can sign below

☐ YES to interview and recording ☐ YES to interview, NO to recording ☐ NO to both

The study has been explained to me and my questions have been answered to my satisfaction. I agree to participate in this study.

_____ _____

Signature of participant Date

I have explained the study to the participant and answered all questions. I believe the participant understood the information provided and is freely accepting to participate.

_____ _____

Signature of interviewer Date

Appendix E: Consent Form for Patients' Interview (Farsi)

رضایت نامه برای شرکت در مطالعه پژوهشی

عنوان پژوهش: مدیکالیزاسیون خلق و تاثیرات تشخیص طیف اختلالات خلقی در ایران

پژوهشگران: دکتر لورنس کرمایر و دکتر فهیمه میانجی

مقدمه:

هدف این پژوهش شرح تجربه افرادی است که تشخیص مشکلات سلامت روان گرفته اند. این پژوهش شامل مصاحبه با افرادی میشود که درطی پنج سال گذشته تشخیص حداقل یکی از مشکلات سلامت روان را گرفته اند.

ما علاقه مند هستیم که از تجربیات شما بعنوان فردی که مشکل سلامت روان داشته است، به ویژه تاثیر تشخیص گذاری و درمان در زندگی شما، آگاه شویم. شرکت شما در این پژوهش به ما کمک خواهد کرد تا درگ بهتری از اینکه افراد چگونه با مشکلات سلامت روان سازگار میشوند و تاثیر یک برچسب تشخیصی خاص بر زندگی آنها چیست، داشته باشیم.

مراحل مطالعه:

اگر شما با شرکت در این مطالعه موافق باشید، من با شما مصاحبه ای درباره تجربیات و دیدگاهتان در ارتباط با تشخیص گذاری-های روانپزشکی خواهم داشت. این مصاحبه بین ۹۰ تا ۱۲۰ دقیقه به طول میانجامد و آن را به صورت صوتی ضبط خواهیم کرد. از شما سوالاتی از این قبیل پرسیده خواهد شد: ۱) چه زمانی شما برای اولین بار مشکل سلامت روانتان را تجربه کردید؟ ۲) در گذشته هیچ وقت مشکل سلامت دیگری داشته اید که به نظر شما مشابه به مشکل اخیرتان باشد؟ ۳) به نظر خود شما، چه چیزی باعث مشکل سلامت شما شده است؟ و غیره.

سود و زیانها:

اگرچه شرکت شما در این مطالعه هیچ سود مستقیمی برای شما نخواهد داشت، اما از طریق آگاهی ای که در مورد مشکل سلامتتان به ما میدهید، به ارتقا دانش و درک مان از این تشخیص و درمان روانپزشکی کمک خواهید کرد.
همچنین، با شرکت در این مطالعه هیچ ریسک قابل انتظاری هم متوجه شما نخواهد شد. گاهی پیش میاید که یک شخص در مورد یک سوالی احساس معذب بودن میکند. اگر چنین چیزی برای شما پیش آمد، شما مختار هستید که به آن سوال جوابی ندهید. اگر احساس کردید که در اثر این پژوهش به استرسی وارد شد، ما میتوانیم شما را به پزشک معالجتان ارجاع دهیم.

آسیب پذیری شرکت کننده:

شما ممکن است با امضا کردن این رضایت نامه و شرکت در این پژوهش موافقت نکنید. شما ممکن است در هر مرحله ای این مصاحبه را ترک کنید. تصمیم شما برای ما قابل احترام است و هیچ پیامدی برای شما نخواهد داشت. اگر شما تصمیم به ترک مطالعه در هر مرحله ای از مصاحبه بگیرید ما همه اطلاعاتی که از شما گرفته ایم را از بین خواهیم برد. اگر شما تصمیم گرفتید که به یک سوال خاصی جواب ندهید و یا اگر سوالی از من داشتید، لطفا از بیان آن دریغ نفرمایید. چه شما در این مطالعه شرکت کنید و چه خیر، هیچ تاثیری در درمان اخیری که شما دریافت میکنید نخواهد گذاشت.

رازداری:

اطلاعات بدست آمده از این مطالعه کاملا محرمانه خواهد بود و هیچ فرد دیگری بجز تیم پژوهش به نسخه اصلی اطلاعات ضبط شده دسترسی نخواهد داشت. ما از نام و مشخصات فردی شما و هر مشخصات دیگری که منجر به معرفی شما و یا محل کار و زندگی شما بشود استفاده نخواهیم کرد. برای حفظ اطلاعات شخصی شما و هر فرد دیگری که در

مطالعه نام برده میشود، شما با یک شماره کد شناخته خواهید شد (مثلا شرکت کننده شماره ج ۲۴). فرمهای رضایت نامه از مصاحبه های دارای کد رمز جدا نگه داشته خواهد شد. فایل مربوط به شما به وسیله همان شماره رمز (کد) شناسایی خواهد شد. اطلاعات شخصی مانند سن، اصلیت، مذهب و غیره محرمانه خواهد ماند و فایل صوتی رمزگذاری خواهد شد. هیچ اطلاعات قابل شناسایی ای پخش و یا منتشر نخواهد شد.

تنها در صورتیکه من تشخیص بدهم که ممکن است سلامت شما در خطر فوری باشد، اجازه شما را برای تماس با پزشک معالجتان و یا تماس با اورژانس کسب کرده و برای کمک تخصصی به شما اقدام خواهم کرد. در غیر این صورت هیچ کدام از اطلاعاتی که شما در اختیار این مطالعه قرار میدهید حتی با پزشک معالجتان نیز در میان گذاشته نخواهد شد.

<u>اطلاعات تماس:</u>

در صورت وجود سوال و یا راهنمایی، لطفا با آدرس الکترونیک و یا یکی از شماره های زیر تماس بگیرید.

دکتر فهیمه میانجی 3389-467-1514+ / 0917-305-98912+ fahimeh.mianji@mail.mcgill.ca

<u>امضا</u>

اگر با شرکت در این پژوهش موافق هستید، این موافقت باید به یکی از این دو صورت ثبت گردد: ۱) من میتوانم موافقت کلامی شما را ضبط کنم ۲) شما میتوانید این فرم را امضا بفرمایید.

بله. با مصاحبه و با ضبط آن موافق هستم

بله. با مصاحبه موافق هستم ولی با ضبط آن موافق نیستم

خیر. نه با مصاحبه و نه با ضبط آن موافق هستم

این مطالعه پژوهشی برای من توضیح داده شد و به سوالات من پاسخ داده شد. اینجانب با شرکت در این مطالعه موافق هستم.

امضا شرکت کننده تاریخ

مطالعه را برای شرکت کننده توضیح داده و به همه سوالاتش پاسخ داده ام. بر این باور هستم که شرکت کننده متوجه اطلاعاتی که برایش فراهم آورده ام شده و با علم به آن پذیرفته که در مطالعه شرکت کند.

امضا مصاحبه کننده تاریخ

Appendix F: Ethics Approval (Phase-I)

Hôpital général juif
Jewish General Hospital

BUREAU D'ÉTHIQUE DE LA RECHERCHE
RESEARCH ETHICS OFFICE

Vasiliki Bessy Bitzas, N, PhD(C), CHPCN(C).
Chair, Research Ethics Committee
Bureau / Room: A-925
Tel: 514-340-8222 x 2445
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February 24, 2014

Dr. Lawrence Kirmayer (Dr. Fahimeh Mianji)
Department of Psychiatry
Jewish General Hospital

SUBJECT: **Protocol #14-031** entitled "Over- or Under-diagnosed? Looking at the Professional Controversy over Bipolar Diagnosis and Treatment in Iran in the New Millennium"

Dear Dr. Kirmayer,

Thank you for submitting the following documents pertaining to the above-mentioned protocol to the Research Ethics Office for review:

- Revised Protocol
- Appendix I Semi-Structured Interview Guideline
- English Consent Form (February 24, 2014)

The Research Ethics Committee of the Jewish General Hospital (Federalwide Assurance Number: 0796) is designated by the province (MSSS) and follows the published guidelines of the TCPS 2 - Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (2010), in compliance with the "Plan d'action ministériel en éthique de la recherche et en intégrité scientifique" (MSSS, 1998), the membership requirements for Research Ethics Boards defined in Part C Division 5 of the Food and Drugs Regulations; acts in conformity with standards set forth in the United States Code of Federal Regulations governing human subjects research, and functions in a manner consistent with internationally accepted principles of good clinical practice.

As this study involves no more than minimal risk in accordance with TCPS 2 article 6.12, this protocol received a delegated research ethics review. We are pleased to inform you that the above-mentioned documents are granted Delegated Approval for the period of one year.

For quality assurance purposes, you must use the approved REO stamped consent form by making copies of the enclosed one. A French consent form, as required by law, must be forwarded to the Research Ethics Office for review and approval as soon as possible. For your information, the above-mentioned protocol will be presented for corroborative approval at the next meeting of the Research Ethics Committee to be held on March 14, 2014.

Delegated Approval Date:	**February 24, 2014**
Expiration date of Delegated Approval:	**February 23, 2015**

Your "Continuing Review Application" must be received by the Research Ethics Office **one month** before the expiration date above in order to ensure timely review. Otherwise, the study will be terminated. If any modification to the study occurs (amendment) over the next twelve months, or should this study be completed during this period, please submit appropriate documentation to the Research Ethics Office. Visit our website for information www.jgh.ca/rec and to access our downloadable forms, or contact us.

Sincerely,

Vasiliki Bessy Bitzas, N, PhD(C), CHPCN(C)
Chair, Research Ethics Committee

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Appendix G: Ethics Approval (Phase-II)

Hôpital général juif
Jewish General Hospital

COMITÉ D'ÉTHIQUE DE LA RECHERCHE
RESEARCH ETHICS COMMITTEE

Dr. Vasiliki Bessy Bitzas, N, PhD, CHPCN(C).
Chair, Research Ethics Committee
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March 30, 2015

Dr. Lawrence Kirmayer (Dr. Fahimeh Mianji)
Department of Psychiatry
Jewish General Hospital

SUBJECT: **Protocol #14-031** entitled "Over- or Under-diagnosed? Looking at the Professional Controversy over Bipolar Diagnosis and Treatment in Iran in the New Millennium"

Dear Dr. Kirmayer,

Thank you for submitting the following documents pertaining to the above-mentioned protocol to the Research Ethics Office for review of your Continuing Review Application:

- Protocol
- English consent form dated February 24, 2014

The Research Ethics Committee of the Jewish General Hospital (Federalwide Assurance Number: 0796) is designated by the province (MSSS) and follows the published guidelines of the TCPS 2 - Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (2014), in compliance with the "Plan d'action ministériel en éthique de la recherche et en intégrité scientifique" (MSSS, 1998), the membership requirements for Research Ethics Boards defined in Part C Division 5 of the Food and Drugs Regulations; acts in conformity with standards set forth in the United States Code of Federal Regulations governing human subjects research, and functions in a manner consistent with internationally accepted principles of good clinical practice.

We are pleased to inform you that expedited re-approval for the above-mentioned clinical protocol and the English consent form is granted for a period of **one year**. For quality assurance purposes, you must use the approved REO stamped consent form when obtaining consent by making copies of the enclosed one. Please be informed that this study proposal will be presented for corroborative approval at the next meeting of the Research Ethics Committee to be held on April 17, 2015.

Expedited Re-Approval Date:	**March 30, 2015**
Expiration date of Expedited Re-Approval:	**March 29, 2016**

Your "Continuing Review Application" must be received by the Research Ethics Office one month prior to the expiration date mentioned-above in order to ensure timely review. Otherwise, the study will be terminated. If any modification to the study occurs (amendment) over the next twelve months, or should this study be completed during this period, please submit appropriate documentation to the Research Ethics Office. Visit our website for information www.jgh.ca/rec and to access our downloadable forms, or contact us.

Respectfully,

Dr. Vasiliki Bessy Bitzas, N, PhD, CHPCN(C)
Chair, Research Ethics Committee

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