The Psycho-Politics of Wellbeing
An Interview with Orkideh Behrouzan

Iranians have repurposed, reconfigured and transliterated the psychiatric concepts of depression and trauma as depreshen *and* toroma. *In this wide-ranging interview, Orkideh Behrouzan speaks with Sheila Carapico about the politics of Iranian mental health care policy, public discussion of the effects of 40 years of revolution and war and the ways in which a younger generation is forming identities through* depreshen*-talk. Behrouzan is a physician, medical anthropologist, scholar of science and technology and the author of* Prozak Diaries: Psychiatry and Generational Memory in Iran. *She teaches in the anthropology department at SOAS, University of London.*

Your book, Prozak Diaries: Psychiatry and Generational Memory in Iran (Stanford University Press, 2016), analyzes psychological discourses in the post-1980s Islamic Republic. What have you learned from your research?

Prozak Diaries is about three interrelated topics: one, the medicalization of life in the aftermath of the Iranian Revolution (1978–1979) and the Iran-Iraq War (1980–1988); two, the pedagogical history of psychiatry in Iran and a cultural analysis of psychiatry in terms of its dominant beliefs and mindsets; and three, memory, youth culture and generational identities. I focus particularly on the cultural and emotional formation of self-proclaimed mini-generations (such as the *nasl-e sukhteh*, or the burnt/skipped generation, and the *daheh-ye shasti-ha*, or the children of the 1980s) who define their identities, both online and offline, in relation to the psychological and cultural legacies of the 1980s.

Initially, I was curious to understand a cultural and psychological shift in post-war 1990s Iran. At that time, alarming statistics of suicide and medication with anti-depressants were circulating in the media inside and outside of Iran, and a Persianized psychiatric vernacular was becoming commonplace in ordinary talk with the use of terms such as *depreshen* and *toroma* (from the English words depression and trauma). This normalization of medication (especially among youth) and psychiatric talk was unprecedented for a society where it is common to articulate feelings in extremely concealed, private, poetic or religious terms and where melancholic inclinations are still valorized in Persian mysticism, Sufi traditions and the Shi'i ethos. Meanwhile, after the Iran-Iraq War, previously shunned psychiatrists and psychologists were given a platform to educate the public about mental health. By the early 2000s, psychiatric discussions had become public and explicit.

Based on media reports of increasing medication and self-identification with *depreshen* among youth, it is tempting to assume an epidemic of clinical depression, as if *depreshen* was a direct translation for clinical depression. But my research showed that *depreshen* could refer to a range of states, including individual or collective grief, dysphoria, anxiety, melancholy, situational depression, clinical depression and/or what psychologists call "learned helplessness." I investigated the lived experience and meaning of these clinical diagnostics in people's lives in order to understand the complexity of their choices. Our choices—of languages, concepts, quantitative standards, and the different types of knowledge and diagnostic criteria we draw upon—are never value-neutral. We choose from what is culturally and historically legitimate and available to us. My ethnography shows that *depreshen*-talk is indeed rooted in Iran's over 70-year history of modern (individual-focused) psychiatry, post-war mental health care policies and the 1990s state-promoted educational campaigns in the media.

But unlike clinical depression, *depreshen* is also situated in the social, political and economic anomie and double binds of ordinary life, uncertainties about the future, as well as the generationally specific experiences of the 1979 revolution, the 1980–83 Cultural Revolution and the Iran-Iraq War. The language of *depreshen*, and speaking about life in clinical terms in general, made it possible to publicly speak the unspeakable and to talk about the cultural and psychological experiences and losses of the 1980s without crossing the red lines of ideological propaganda or censorship. Understanding *depreshen*, therefore, requires understanding the dynamics of today's generational cultures in relation to this particular decade. In the narratives of illness that I collected, young people explained their so-called *depreshen* by persistently pluralizing and historicizing it in generational terms. For example, they

GOLROKH NAFISI
"Tehran's Nights"

would say "we are the children of the 1980s," children of the war, hence *daheh-ye shasti-ha.* Consequently, a book that was meant to be about mental health became a book about generational memories of the so-called burnt generation and the 1980s generation.

Since the early 2000s, compelling accounts of the paradoxes and anomies of the 1980s have circulated among Iranians, creating new modes of self-recognition, a new sense of voice and a new identity politics for young Iranians. After two decades of silence, there were now spaces (such as the blogosphere, which I explore in detail in the book) and vocabulary (terms such as *toroma* or *depreshen* that are borrowed from psychiatric lingo but are hardly direct translations) that made memories of the 1980s audible outside the shadow of official and institutional accounts. In doing so, they demarcated several new generational identities and labels, such as *daheh-ye shasti-ha.*

These generations are not necessarily defined through temporal junctures, but through their incommensurable aesthetics of memory that are both psychologically and politically informed. They are psychologically informed by the contradictory emotions that childhood memories of the 1980s harbor and evoke (fear, anxiety, double binds, nostalgia, dissociation, compulsive repetitions). And they are politically informed, in terms of having lived through the 1980s ideological propaganda, political oppression and genuine patriotism. As such, these generational sensibilities are often articulated, whether nostalgically or sarcastically, via the cultural symbols of the 1980s: its objects (often reminders of austerity and sanctions such as ration coupons or iconic domestic brands such as the *Darougar* shampoo), sounds (martial anthems or the sound of the siren during city bombardments) and images (children's television programs and their characters). I dedicate a significant portion of the book to a sensory reading of these material cultures to understand the compulsive returns of their memories and the socio-political meaning of such remembering both online and offline. The virtual space was both a key ethnographic site and object. I engage with it as an affective space (as opposed to a politicized landscape, as depicted in most analyses) and as a site for the reconstruction of generational memories, identity politics and new forms of sociality and kinship.

In sum, the book emphasizes the importance of thinking about the broader trajectories of illness as culturally and politically situated experiences. It also creates a conversation among anthropology, psychiatry, psychoanalysis, science and technology studies (STS) and cultural analysis. It complicates the binaries of health and illness, tradition and modernity, individual and collective, biological and psychological, and social and cultural. Scholars often tend to take for granted certain privileged conceptual frameworks (for example, medicalization in anthropology or trauma in psychology) or forms of knowledge and diagnostic categories (such as depression in Western psychiatry). My hope for this interdisciplinary conversation is to challenge the assumptions of each discipline and explore what they can offer one another.

What is medicalization?

Medicalization is a term that anthropologists use to describe situations where social, behavioral, emotional or cultural phenomena come to be defined in medical terms, turning them into a medical problem and therefore subject to medical intervention. Consider, for example, childbirth or death. In Western biomedicine, they are increasingly seen as only biological processes located in the individual body (as opposed to being understood in their sociocultural contexts).

Medicalization is a double-edged sword. It can be humanizing and therapeutically effective—think addiction, alcoholism or HIV/AIDS. On the other hand, medicalization can be de-socializing, de-politicizing and abstracting—think attention deficit hyperactivity disorder (ADHD), depression or sexuality. It can mask the sociopolitical context, trajectory or meaning of the condition, reducing it to clinical and biological artifacts and thus defining normalcy in biomedical terms and creating the impression that biomedicine is the only proper response to the problem. The history of psychiatry is fraught with instances of the latter: psychiatry has often been critiqued as a domain of power struggles, silencing and the diminishing of the patient's agency, as well as for its troubled relationship to the pharmaceutical industry, biological reductionism, colonialism and imperialism. Also, anthropology has had a long fascination with psychiatry and top-down medicalization: analyzing, for example, how Western psychiatry acts as a hegemonic system that takes away the agency of patients, reduces their struggles to neurochemical changes and masks the broader socio-political contexts of illness.

Of course, the story of *depreshen* in Iran is a story of medicalization, which raises the question of when, how, why and by whom a psychiatric discourse was legitimized and publicized among laypeople as a way of understanding emotions and as a language of talking about life. I analyzed the 1990s Iranian public campaigns around mental health from a top-down perspective, examining the way this medical way of understanding emotions was institutionalized and formalized in the domains of policy, training, state-run media and educational campaigns. I look at how this discourse obscured the sociopolitical contexts of post-war anomie and post-revolutionary disillusionment.

A top-down account, however, does not sufficiently explain why this discourse also found an eager audience among people whose wartime concerns were with post-traumatic stress disorder (PTSD), anxiety and panic attacks and were later replaced with post-war depression and dysphoria. Society was genuinely struggling and manifesting symptoms of mental illness, a condition to which the state tried to respond in technical and rational ways. But what fascinated me was how young people were actively internalizing and mobilizing this psychiatric mindset as a mode of thinking and talking and creating a bottom-up process of medicalization. In the late 2000s, many young people were self-identifying with *depreshen* and the use

of antidepressants was skyrocketing. A purely clinical reading of alarming statistics fails to explain this self-medicalization and the cultural and political import of what *depreshen* or *toroma* meant in this particular socio-political context and its specific psychological grammar. So, in order to understand the cultural meaning of these terms, I analyzed young people's own explanatory models and the meanings that they assigned to their narratives of illness. This is where I discovered the significance of their historical and political experiences and their generational memories, identities and desires.

My interlocutors were not always passive, pill-popping followers of biomedical norms. Pills did not always diminish their agency nor did diagnoses always silence them. Rather, they constructed their *depreshen* in relation to cultural discourses and historical memory. Their psychiatric subjectivity (the term I use to describe the ways in which they internalize and enact a psychiatric mode of thought) was extremely performative, despite and sometimes hand-in-hand with scepticism. Particularly when one's pain is unacknowledged and placed outside of legitimate cultural and institutional discourses, people may seek recognition and relief in the promises of biomedicine. It is important to acknowledge these very real desires for recognition and genuine attempts at dealing with psychological pain.

These ambivalences and desires suggest that medicalization could be a cultural and political resource. In the highly ideological and scrutinized public domain of post-war Iran, the sanitized, de-politicized and increasingly legitimized language of psychiatry and neuroscience provided many young Iranians with a sanctioned vocabulary for articulating life itself. This mode of speech made possible an otherwise silenced public discourse about the war and allowed an articulation of the unspeakable experiences of the present, anxieties about the future or memories of the 1980s. It was a way of raising questions about their generation's wellbeing and sense of self. Medicalization also created new forms of sociality, online and offline, making this story different from most anthropological analyses of medicalization and psychiatry. What is outstanding in their narratives is the simultaneous historicization (locating their present malaise in childhood experiences of the war, for instance) and medicalization (using biomedical diagnostics as identifiers) of what individuals perceive as *depreshen*.

Depreshen, in other words, provides a language to articulate a past filled with ruptures that could have been overlooked in the process of clinical diagnosis. I call these young narrators aspiring "historians and diagnosticians." Their urge to bear witness to a past they feel has been unacknowledged has both a psychological and a political function. In this sense, my work required going beyond conventional anthropological critiques of Western and universal diagnostic criteria. At the same time, it necessitated recognizing the multiplicity of clinical, psychiatric and psychoanalytical approaches and appreciating the complexities and nuances of clinical practice. Finally, it demanded analyzing generational memory as well as addressing the question of representation in order to critique dominant individual-centered "trauma theories" in psychoanalysis. The findings, I hope, can be relevant beyond Iran and contribute to a conceptual framework of medicalization that leaves analytical room for the desires of the medicalized individual, especially in post-war contexts.

The subject of trauma is now popular in Middle East studies, given the violence wracking the region. You lead a project called "Beyond 'Trauma': Emergent Agendas for Understanding Mental Health in the Middle East." Tell us about this project.

Prozak Diaries shows why it is important to rethink the psycho-politics of wellbeing in the Middle East. It reveals the reductive quality of clinical conceptual frameworks that are used for understanding mental health in the region. The result is that a complex set of lived experiences has been equated to the singular and universal concept of "trauma" without contextualizing and questioning the concept's historical trajectory in the West. Ignoring these issues has political and clinical implications. Even when the usage of "trauma" is critiqued, most accounts fall short of providing alternative frameworks.

In the book, when analyzing the Persian terms *toroma* or *toroma'tik*, I intentionally don't use the term trauma, in part in order to eschew disciplinary connotations that burden the term and the assumption of its universality. Living through the 1980s in Iran, for example, is not easily mapped or translated onto the term trauma. I use the word *rupture* instead, which allows Persian terminologies to emerge (as opposed to being stifled) and acknowledges the complexity, multiplicity and diffusion of historical conditions and their afterlife across generations. Trauma is universal, individual and singular. Rupture is particular, shared and fluid. It takes our focus away from the external event and toward the consequent processes of sharing, remembering and working through memory wounds that are overlooked by paradigms of institutional memory or clinical classifications.

I launched this "Beyond 'Trauma'" project as I was finishing *Prozak Diaries*. The idea of it took shape over the years amid moments that highlighted the urgency of the topic. In 2013, for instance, I was interviewed as part of an expert panel on the occasion of the tenth anniversary of the invasion of Iraq. I went in expecting a critical engagement, but I clearly had not received the memo. I was shocked to hear prominent scholars celebrate the "success" of the "operation," abstracting ruptured life-experiences to some justifiable collateral damage and what they considered normal statistics of PTSD. Of course, I was censored in the final production (though my face was still there as the only woman interviewed) and later, some senior male scholars advised me not to be emotional about the experience. This extreme experience might be rare and easy to dismiss, but it captured some of the consequential gaps in public and health care policy: namely, the opacity of the terms Middle East and

mental health, the medicalization and de-politicization of conditions that are profoundly political and require political solutions more than clinical intervention, the scarcity of interdisciplinary dialogue due to unfortunate hierarchies of expertise and finally the conceptual limitations of psychiatric concepts and diagnoses such as trauma or PTSD. Despite their limitations, particular conceptual paradigms, both in social sciences and in psy-sciences, remain institutionally and structurally central to mental health care research, practice and policy-making.

Debates about mental health in the Middle East are also deeply intertwined with a crisis of representation. In these debates, the region is often misunderstood and misrepresented, if not altogether equated with "conflict" or "trauma." Most of these debates underplay the diverse ways in which psychological wellbeing is understood, enacted and conceptualized in different cultural contexts within the Middle East. The crisis of representation in the Middle East creates a very particular context for debates on mental health: institutionalized narratives of politics, medicine and/or public health often fluctuate between the extremes of heroism and victimhood, between "trauma" and "resilience." "Beyond 'Trauma'" challenges us to go beyond such binaries and instead to explore the space in between, where individuals carve out strategies of living. What are the cultural and clinical resources that people mobilize for this purpose? What means are available—culturally, clinically, historically—to work with or through psychological pain, to sustain a moral life outside rigid clinical or cultural categories? I thought that a critical and interdisciplinary conversation was long overdue. Our 2014 London workshop was a first step towards a new dialogue that goes beyond dominant global health paradigms characterized by an individual-centered emphasis on trauma and PTSD.

Psychiatric medicalization and the universal assumptions of diagnostic criteria have already been critically analyzed in various disciplines including medical anthropology and social medicine, as have mental health and public health in practice and policy. But these conversations rarely have been brought into a serious conversation with the contributions of Middle East Studies. In the "Beyond 'Trauma'" initiative, I aim to place these debates in a conceptual and methodological dialogue, on equal footing, and to open a critical conversation about both cultural and clinical realities and experiences of psychological conditions in the region. A first step is to revisit what we assume we know and to ask what is at stake ethically, clinically and politically when mental health becomes an area of inquiry and intervention in the Middle East, and what happens to mental health paradigms as they travel.

This project is a call to re-think pedagogies and ethics of mental health care research, practice and policy. It is a multi-sited, collaborative and comparative project inviting contributions from and about different parts of the region. It also invites disciplinary engagement with art, literature, history and social sciences, which are, and should be, integral to mental health care research and policymaking. Psychiatry or psychology cannot deliver without engagement with political and cultural analysis.

Even though one of the aims of the project is to understand the region beyond the tired trope of "conflict," inevitably it must still engage with the afterlife of various states of conflict, many of which have turned from wars to prolonged states of endless chaos. From Iraq to Syria to Yemen, the condition of children alone qualifies as a humanitarian crisis. But it is also a reminder of the need for our sustained, long-term and committed attention to the psychological afterlife of ruptures for generations to come. Beyond manifesting in higher rates of physical and mental illness, war and displacement alter individuals' and communities' sense of wellbeing. In psychiatric terms, war experiences are often evaluated in terms of individual diagnoses such as PTSD and depression (themselves based on Western diagnostic standard manuals). Such a biomedical approach risks reifying these experiences into the diagnostic category of PTSD, which is treated as only something to be cured, erased and cleansed, as opposed to recognizing the experience in its sociopolitical as well as clinical entirety and as a part of lived life that people want to remember and bear witness to. The recognition of such sociopolitical and moral undertones can have therapeutic potentials. While mental health practice primarily focuses on the individual and the inner self, the social sciences and humanities often focus on the outer, the socio-historical and the political. How can clinical and cultural sensibilities be combined to make sure our health care paradigms will not reduce history to artifacts of clinical symptoms?

Since the publication of our 2015 special issue of the journal *Medicine, Anthropology, Theory* (2015), several colleagues have joined the conversation. I am also glad to announce that, together with my colleague Nora Parr, we are organizing the second "Beyond 'Trauma'" workshop in early 2019 at SOAS. So stay tuned!

Medical anthropology is a vibrant, growing field of inquiry, attracting Middle East researchers as well as undergraduate students across regional specializations. As medical practitioners-turned-anthropologists, however, you and Omar Dewachi, author of *Ungovernable Life: Mandatory Statecraft and Medicine in Iraq* (Stanford University Press, 2017), bring special insights from across a conflicted international boundary. Can you tell us how medical training and experience has informed your research findings?

In hindsight, what drew me to medicine was a profound need to engage with the human condition. Of course, it didn't hurt that I was geeky and equally fascinated with anatomy and genetics, with understanding the intelligent working of the body and with the problem-solving aspect of diagnostics. But I started medical school at age 17 while writing and publishing poems and short stories and pursuing independent studies in Persian literature. Years later, I looked

back and was struck by the extent to which my writing then was preoccupied with anthropological themes. My first encounter with anthropology happened long before I knew what anthropology was and during an extracurricular project I did with two friends when I was 14. It started with a revelation in biology class: that leprosy and tuberculosis were caused by the same bacteria, meaning leprosy was also treatable with antibiotics if diagnosed in time. The stigmatized image of the leper we had known from film and fiction was turned upside down. The real tragedy and violence, it turned out, was in the language, in poverty, in ignorance. It was a whirlwind from then on. We now had a plan for our project, starting with ploughing through medical textbooks. In those pre-Internet days, we got our hands on a copy of the 1963 documentary, *This House Is Black,* by the iconic poet Forough Farrokhzad and watched it at our biology teacher's house. We were transformed and compelled to find out more. We spent that summer commuting to a leprosy clinic on the outskirts of Tehran. We spent days interviewing patients and shadowing the attending dermatologist who ran the clinic with such grace. (Seven years later, I attended his lectures in my dermatology rotation in medical school and was elated when he said he remembered those three naïve schoolgirls.)

What has remained of that summer is a neatly bound handwritten thesis on leprosy, copies of the pamphlets and posters we made for the many presentations we gave at any venue that would have us and many poems and short stories about misunderstood leprous patients, especially women. Our de-stigmatization campaign was as rigorous as it was innocent. And that's when I decided to study medicine, after having fought the idea with all my might until that summer (my dream was to pursue literature or architecture). Fast-forward a decade. After medical training in Tehran and studying genetics in Oxford, I transitioned to anthropology and science and technology studies. I didn't see this as a departure; rather, the move still feels like going full circle to what medicine always was for me, to that leprosy project.

Though not very consciously, my medical background continues to shape me as an ethnographer in a couple of ways. First, I often think about how clinical training, internship in particular, was an entry point into ethnography long before I became an anthropologist. Clinical practice compelled and humbled me. It confronted me with the sheer reality of suffering, with what it means to acknowledge the limits of what medicine can do and with the utter complexity and fragility of life. These themes were constants during my fieldwork. *Prozac Diaries* deals with extremely intimate accounts, some of which were spoken and confided for the first time. I had to learn a lot about psychoanalytical transference beyond ethnographic empathy and recognize the courage it took for people to share with me their inner life stories. Days and nights spent on wards prepared me for remaining deeply attached ethnographically and emotionally. To pay homage to the experience, I have named four of my former patients in the acknowledgement of my book right next to my teachers and mentors in Iran because they taught me about medicalization more than any theory ever could.

The other connection between my clinical and anthropological training is clinical knowledge itself as an ethnographic and conceptual resource. On the one hand, the interdisciplinary aspect of my work relies on it. Ethnographic listening and clinical listening have a lot to offer one another. On the other hand, medicine has its own language. Speaking it helped me to bypass the early stages of building rapport with clinicians during my fieldwork and perhaps prevented some from dismissing my anthropological "musings." It also helped me read between the lines of interdisciplinary rivalries, negotiations and histories of discipline formation. But more immediately, familiarity with the nuances of biomedical explanatory models or the rites and rituals of psychiatric training helped me both to engage with practitioners' situated knowledge and to parse out elements of biomedical rationality from which anthropology can benefit or learn. The scientist in me, for example, appreciates the contributions of neuroscience and epigenetics to understating memory work, which served as a point of rapport with psychiatrists.

Finally, there is the question of positionality and reflexivity when I study medicine as an ethnographic object. Being an Iranian woman, physician, scientist, anthropologist, poet and former blogger meant that I was embedded differently in each of my field sites (such as youth culture, medicine and the Iranian blogosphere), and that people perceived me differently and in different registers. Navigating my ethnographic encounters with clinicians and non-clinicians felt like being an immigrant, code-switching between different languages and geographies, listening for signals and secrets and rumors, embodying their local norms in order to feel each setting fully. When talking to psychiatrists, I was returning to a pedagogical space that was more American than Iranian and that implied certain assumptions. But the more significant part of my ethnography was with non-clinicians and mostly with Iranian youth. Sometimes, I was made acutely aware of my position as *khanom doctor* (the deferential Persian term for addressing a female doctor) as many Iranians still call me, assigning me a place in unspoken hierarchies of expectations. My medical background was barely lost on my non-doctor interlocutors, whether they assumed an invisible clinical gaze to be reassuring or unsettling. This hybrid ethnographic relation was a learning experience particularly in relation to my gender and my generational kinship with some of the people I was interviewing. The clinical and the ethnographic gaze required management, on my part and theirs, and combining these perspectives served to soften assumed hierarchies, encouraged curiosity and allowed mutual vulnerability and trust.

I'd like to thank you for prompting this conversation and to MERIP for dedicating space to the timely topic of mental health in the Middle East. ■