ARTICLES

Medicalization as a way of life
The Iran-Iraq War and considerations for psychiatry and anthropology

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Abstract

Most debates on postwar mental health focus on clinical evaluations of veterans' and civilians' individual experiences of wartime 'trauma'. But the psychological afterlife and the social discord that wars create cannot be reduced to a clinical artifact of individual trauma or be divorced from the historical and cultural meanings that it carries. Generations of war children will continue to remember, process, and work through cultural changes that quietly inscribe past war experiences in their daily lives. This article examines one such cultural shift, namely the medicalization of the memories of the Iran-Iraq War. It illustrates how individuals' PTSD-like symptoms or alleged *depreshen* turn the seemingly desocializing act of medicalization on its head, and how diagnosis can become a cultural resource to resocialize the war in the sanitized language of biomedicine. It further suggests that moving beyond an individual and clinical rendition of trauma requires the integration of an anthropological understanding of illness and its cultural situatedness into medical pedagogies.

Keywords

trauma, memory, psychiatry, postwar mental health, PTSD

Almost three decades after the end of the Iran-Iraq War, Iranians continue to grapple with its health-related consequences. The 2014 Health Impact Assessment report published by Medact, an organization of health professionals engaged in research and activism, is among the more recent reminders of how the war lives on, and causes suffering, across generations. The report also illustrates why systematic health impact assessments, even though often focusing on epidemiological studies, should be an integral part of any attempt to assess the impact of war on civilians, if not a crucial prerequisite for preventive and interventional initiatives (Tirman 2015; Birch et al. 2014). Indeed, epidemiological data are useful, but they need to be interpreted within proper conceptual frameworks to ask what they reveal and what they mask. What is necessary is a critical examination of the cultural meanings that shape individuals' experiences of diagnostic categories and the standards and models on which they rely.

Such anthropological and cultural analysis of the experiences represented by quantitative data and standardized diagnostics is not merely a secondary investigation into a given medical construction; rather, it sheds light on how medicalized experiences (such as illness) are socially and medically constructed and inhabited, how they are made meaningful, and how life is lived around and within them. It is necessary to approach the psychological afterlife of war as both a medical and a social experience, not only in assessing the impact of war, but also in thinking about inclusive therapeutic interventions. Reflecting on ethnographic findings, I extend the question of the psychological impact of war on veterans to the impact on their children, now adults, in order to frame a set of questions, provocations, and lines of inquiry, and to revisit the conceptual frameworks of 'trauma' in the psychological sciences and 'medicalization' in anthropology.[1] These are preliminary thoughts and aim to serve as a call for dialogue.[2]

The Iran-Iraq War and the 'War of Cities'

Three decades later, the memories of the Iran-Iraq War have not left Iranians, nor has the collective feeling that the international community and Western governments abandoned them during the war, provided Saddam Hussein with arms and intelligence, and overlooked their calls for accountability in its aftermath. The Iran-Iraq War, or as it is called in Iranian

1   'Medicalization' is used to describe conditions in which previously nonmedical phenomena are brought under the purview of biomedicine and often turned into disorders. For an overview of the historical and conceptual trajectories of the term please see Conrad and Waggoner 2014.

2   The findings discussed in this article are taken in part from a larger ethnographic project that I conducted between 2005 and 2012 (Behrouzan 2016).

public culture 'the Sacred Defense', resulted in over one million deaths on both sides, with up to five hundred thousand Iranian deaths estimated.[3] Reports from the Martyrs Organization also estimate that there are over 550,000 *jānbāz* (war-disabled veterans) and over 42,000 former prisoners of war in Iran, of whom 120,000 are registered as chemically injured veterans (*Sacred Defense News*, 'Latest Statistics on Veterans' Families', 21 October 2013).[4] Figures are only reliable in so far as they represent registered veterans. But in addition to the 43,000 documented *jānbāz-e a'sāb va ravān* (psychologically inflicted veterans), and the 7,200 patients with serious psychiatric disorders, a growing number of spouses and children of veterans are experiencing psychological symptoms such as depression and anxiety. To address this situation, the Veterans Organization has recently introduced the 'endurance [*tāb-āvary*] initiative', which aims to equip families and caretakers with proper coping skills (*Basij Press*, 'New Training for 43,000 Veterans', 5 January 2015).[5] Among these relatives, spouses of veterans who suffer from posttraumatic stress disorder (PTSD) have been reported to experience severe psychological symptoms (Taghva et al. 2014), while the 'overall life satisfaction, subjective well-being … of wives of Iranian disabled veterans', is reported to have diminished due to the loss of 'their natural homeostasis' (Yousefi and Sharif 2010, 69). The children of war prisoners reportedly suffer increased rates of major depression and general anxiety (Razavi et al. 2012).

Attention to postwar psychological well-being has often focused on veterans and POWs. But the afterlife of the Iran-Iraq War is hardly limited to the experiences of returning veterans. For example, an increased rate of psychological disorders has been reported among war-displaced families in western Iran (Hashemian et al. 2006). Epidemiological studies conducted by health professionals have shed light on the often-overlapping physical and psychological conditions among veterans and civilians, particularly those exposed to mustard gas and those who struggle with chronic illness and long-term psychological conditions (Hashemian et al. 2006; Khateri et al. 2003; Falahati et al. 2010; Razavi et al. 2014). Studies suggest that in the decades since Saddam Hussein's brutal use of chemical weapons on Iran's civilian population, fertility has been hampered and the risk of congenital and developmental conditions has increased (Abolghasemi et al. 2010). There is also evidence of increased

3   *Encyclopædia Britannica Online*, 'Iran-Iraq War', accessed 26 November 2015, http://www.britannica.com/event/Iran-Iraq-War. Existing estimations and mortality reports for the Iran-Iraq War are constantly contested and vary across sources. See Murray and Woods 2014; Chubin and Tripp 1988; Khoury 2013 for historical overviews; Khoury's historical analysis of the Iran-Iraq war and the Iraqi perspective is particularly insightful for comparative evaluation.

4   http://www.defapress.ir/Fa/News/4855

5   http://basijpress.ir/fa/news-details/41691/

psychological symptoms among all civilians affected by war (Karami et al. 2013; Roshan et al. 2013). While most epidemiological studies have focused on surveys of diagnostic categories, some have examined the role of spirituality, social support, life satisfaction, and 'constructive coping strategies' in improving the psychological well-being of veterans and their families (Ebadi et al. 2009; Hassankhani et al. 2009; Aflakseir 2010).

But what forms of actual experience – lived lives – do epidemiological figures represent? In the psychological afterlife of social ruptures such as the Iran-Iraq War, an alternative history of loss or neglect is written. Iranians commonly share the perception that the international community has overlooked their suffering. These alternative histories and collective emotional states contribute to the emergence of medical as well as cultural forms that outlive wars. Similarly, the creation of compensatory structures, social categories, and cultural labels such as *'jānbāz'* (war-disabled veteran) produces both relief and restriction: while facilitating recognition and care, these forms of life also interact, in the long term, with other dynamic modes of perception and interpretation that prevail in the postwar era. Many Iranian veterans report facing resentment and neglect when returning to society; others struggle to qualify for registration and compensation. Many veterans were reluctant to claim stigmatized compensatory benefits, some lost them after hesitating too long; others found themselves ideologically distanced from their children and the society to which they returned (Behrouzan 2016). These invisible wounds escape quantitative measurements and diagnostic classifications such as those formulated in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). Indeed, we already know from the experiences of wars elsewhere that the cultural legacies of war persist across generations. But we rarely incorporate such postwar sociopolitical and cultural transformations in mental health discourses, particularly in the Middle East.

The Iran-Iraq War also transformed Iranian society by creating new forms of civilian life, and, in the longer term, new generational cultures and aesthetics among those who were children during the war. When wars are over (if they ever are), not only do their physical and psychological wounds live on, but their internalized memories too continue to return, whether in the form of perceived pathology or in other cultural expressions. They affect individual and social well-being and determine the relationship of the inflicted society with the rest of the world. For example, during what became known as the 'War of Cities', civilians in twenty-seven Iranian cities experienced, between 1984 and 1987, five episodes of missile raids that destroyed neighborhoods and livelihoods, and killed thousands of civilians, particularly in Tehran and Dezful (Khaji, Fallahdoost, and Soroush 2010). Even among those who were children during the war, these missile attacks on major cities, along with the brutal use of mustard gas and nerve agents on civilians, occupy a central place in collective memories and psychologies. The self-identified '1980s generation', in particular, repeatedly

returns in its artistic and cultural expressions to the war's sensory prompts (for example, the sound of sirens) in order to claim their cultural aesthetics, identity politics, and generational sensibilities (Behrouzan 2016).

The Iran-Iraq War, in sum, is an undeniable part of the psychological and cultural worlds Iranians continue to inhabit. Its invisible wounds still hurt. Recently, for example, commemorative ceremonies sprang up in several cities as Iranian rallied around the return of the bodies of 175 fighting Iranian divers who had been buried alive with their hands tied (Karimi 2015). Iranians' collective sentiments are today informed by the sacrifices of the war, commemorations of its losses, and an increasing awareness about its mental health impact. How can we then approach diagnoses such as PTSD or depression in this deeply wounded context? Would such diagnoses be sufficient to capture the postwar subjective experiences that mental health policies aim to address?

Reading PTSD, clinically and anthropologically: The 'I' and the 'we'

Sara, the daughter of a veteran and child of a war-refugee family, juxtaposes her generational sensibilities with those of her clinical and psychiatric diagnosis: PTSD. 'You see', she says, 'my generation strives for happiness. We are the children of the war and all its consequences. … I know I don't look *depress* or shell shocked! [laughing]. But looks can be deceiving'.

The year was 2008. In my interviews with self-medicalizing young Iranians, the term 'generation' surfaced one way or another, as did references to the Iran-Iraq War, imposed economic sanctions, and other such legacies of the 1980s. Displaced by the war from one of the southern cities, Sara and her family relocated to Tehran when she was in elementary school. Her father was an engineer who joined the front for just under a year in 1983. He lost his right leg and underwent several operations, eventually recovering and establishing a career in Tehran, but he was 'never the same person', Sara recalls her mother saying. He has, in the following years, begun to struggle with respiratory conditions that are likely caused by exposure to mustard gas, but his case has not been confirmed (and is further complicated by the fact that he is a smoker). His medical appointments, his 'PTSD' episodes, and his hospital admissions, Sara tells me, are a huge part of her childhood and adolescent memories, as is the tacit awareness of his temper, his sensitivity, his occasional anger: 'Somehow, I knew I should keep the volume down when watching the television, listening to music, or playing Atari with my cousin. Loud and bursting noises bothered him; he could lose his temper'. Sara also has very vivid memories of staying up all night praying for her father's safe return, of worrying about losing her mother, of the air raids that hit her best friend's house, and of the chaos around their move to Tehran. She remembers attending a

new school, where her cousin was already a popular student; missing their old house when they first moved into the small apartment they rented in her uncle's neighborhood; and the nights spent in the basement shelter where their neighbors shared snacks and stories and rumors and gossip, carrying on underneath the missile attacks. One neighbor was reportedly killed when visiting her mother's house that was hit by a missile; another worried whether or not to postpone their son's wedding. Myriad scenes and sounds return in her dreams, and quite frequently; it is 'a lot of *toromā* [trauma]', she admits. 'Things were happening too fast, and I was too young to process them. And remember, my experience is nothing compared to those whose houses were bombed or whose fathers were martyred'.

Yet Sara's individual childhood memories are frequently anchored in the shared experiences of a collective 'we'. Generalizations about '*nasl-e man*' (my generation), just one of the many names for the self-titled 1980s generation (*daheh-ye shasti-hā*), signify consensus on a shared experiential identity, but they can hardly be taken at face value. Nor can the Persianized terms '*depress*' or '*toromā*' be taken as the direct translation of their clinical 'equivalents'. Sara has been on antidepressants on and off for the past two years. She was diagnosed with depression after a series of losses and conflicts in the family, and began taking medicine; she stopped, but then chose to resume taking it, although without a prescription: 'It helps me go through life when I am down. I am not a victim; *depreshen* is inevitable when you are a graduate struggling with unemployment, when you still live with your parents, but your values are different from them. … I cannot change what goes on around me – people around me are angry and frustrated – but I can fix myself and the chemicals in my brain'. With her bright red lipstick and heavy makeup, Sara looks nothing like the clinically depressed patients I had known in my psychiatric rotations in the late 1990s. But that is precisely what differentiates her *depreshen* from major clinical depression as classified by the DSM.

In Iran, postwar generational forms and cultures have taken a medicalizing turn, and not solely because of the efforts of clinical practitioners or mental health awareness campaigns: young Iranians commonly interpret well-being as historically intertwined with their generational experience of the Iran-Iraq War. One of the ways they articulate this connection is in the language of psychiatry. The broader context of this medicalizing trend was a psychiatric discourse that entered the media in the 1990s and became assimilated into daily life. I have written elsewhere about the emergence of this new way of talking about life and its cultural and medico-historical trajectories (Behrouzan 2016). But, in short, during the postwar years the status of psychiatry as a medical discipline was revived, both in academia and in the media, and a public psychiatric language (Persianized terms such as '*depreshen*', '*esteress*', '*toromā*', '*depress*', and '*dep zadan*') gradually populated the national media and the Persian lexicon.

Indeed, language was both an expression and a shaper of experience; Sara's comments reflect this growing willingness among youth to identify with illness. She recalls her initial diagnosis of PTSD and depression: 'On the one hand, I wasn't sure how I felt about the stigma because it meant I was not a normal person, but on the other hand, I was relieved. I knew I wasn't crazy or weird. It made sense. After all, I grew up in the shadow of a bloody war'. I have called these modes of self-creation 'psychiatric subjectivities', and described them as a performative embodiment of the biomedical discourse as part of one's articulation and interpretation of lived life (Behrouzan 2016). When asked to explain the rising rates of psychiatric diagnoses and medication in the 1990s, it is common for young individuals to reflect on the generational sensibilities and memories of the Iran-Iraq War. In their rather diagnostic interpretations of history, one thing remains constant: the moods and psychological states of individuals are commonly anchored, articulated, and interpreted in relation to a collective 'we' and various generational labels and forms.

Sara has recurring dreams 'of crashes, airplanes crashing into our house', and of episodes of fleeing or being chased: 'once with my parents; we jumped into the car and drove off. In the dream, I knew we were driving to the suburbs during the missile raids that hit Tehran'. In other dreams, she hears screams, sirens, or explosions, 'most commonly, loud cries of a big crowd; chaos, chaos'. She describes waking with a racing heart, sweating, and a feeling of panic ('I feel it in my stomach'). When I ask her what prompts these dreams, she says they come and go without notice: 'If I think hard, I can remember some of these scenes or sounds in real life, or from television, or from school. Even after we moved to Tehran, the war was always around us. My generation is who it is today in part because of growing up during the war; we had to catch up; our parents were all too busy figuring it out and keeping us safe. … We grew up too fast. This is why we hate wars. We experienced a collective *toromā* as children'. The seamless transition from 'I' to 'we' helps her to anchor her dreams and make her experience intelligible.

Sara's reflections may not be universal, but they reveal some of the ways in which childhood memories are reconstructed, inhabited, and made meaningful. To this day, the sound of fireworks triggers in Sara very physical symptoms of panic, irritability, and shortness of breath: 'I get all these *PTSD* [in English] symptoms even if a balloon bursts next to me!' The presence of wartime cultural symbols and images in dreams and flashbacks is common among those who were old enough to remember the air raids or to be affected by the war in one way or another. Those memories create feeling states, reflexes, and symptoms that feel very real even today (Behrouzan 2016; Behrouzan and Fischer 2014).

For Sara, the war is an integral element of her identity, as well as that of her generation. On the one hand, drawing on the psychiatric language that became normalized in society since the 1990s, she clinically diagnoses and medicalizes life experiences that are socially and

historically structured. Simultaneously, she historicizes this affliction by situating it in her childhood memories of the war: 'I grew up knowing that my father could die any minute, that our house could be bombed any minute. It is a miracle that I am still a functional individual after being surrounded by death and mourning all my childhood!' Like many of her peers, Sara repeatedly sprinkles her recollections with humor. Humor is a common narrative strategy among her generation, particularly when mobilizing such memories outside the medical domain, in cultural productions and artistic expressions, and in their creation of various generational labels, identities, and cultural forms. Invariably, they create a generational theme by drawing upon songs, films, works of art, and cultural symbols that persistently underscore the experiences of 'their generation'.[6] Similarly, their narratives of 'illness' too are shaped by medicalizing desires that explicitly spring from strong memories of sociohistorical ruptures. Sara traces her PTSD, partially, to those 'shared' memories and their repeated return: 'No one understands or remembers what we went through. Unless they were there'. There is an urge to remind, to challenge the forgetfulness of a world that has moved on.

She persistently 'remembers' the war, even though she was too young to have actual memories of the battle itself. Sara's medicalization of her memories and the feeling states they create is culturally generative. In creating a generational meaning for her diagnosis, she pushes forward particular forms of sociality and kinship. Along with her generational peers, she demands recognition not only of her predicament but also of the historical injustices brought about by the war. There are lessons here not only for psychiatry in societies after such ruptures, but also for the post-Foucauldian analyses of medicalization: Sara's PTSD-like symptoms or alleged *depreshen* turn the seemingly desocializing act of medicalization on its head. In post-1980s Iran, psychiatry created a language for 'working through' and inhabiting the experience of the war. Diagnosis thus becomes a cultural resource for these youth who resocialize the war in the sanitized language of biomedicine. In medicalizing their state, they make larger generational claims for recognition and carve out spaces for agency, even if in fragments.

Medicalization as a cultural resource

Wars often result in the development of new forms of knowledge and expertise. Psychiatry thrived in Iran after the Iran-Iraq War and was advocated in the 1990s via a media-based

6   The boundaries of these generational labels remain contested, which primarily manifest in rivaling claims to these labels. I have examined these generational forms and discussed their cultural trajectories in length elsewhere (Behrouzan 2016).

discourse aimed at raising people's awareness about mental health issues. In the process, it helped to normalize a clinical language within everyday Persian. Alongside 'her generation' (wherever its boundaries are drawn), Sara makes the war's psychological afterlife meaningful by using the cultural languages available to her, one of which is the normalization of this particular clinical language and Persianized terms such as '*toromā*', '*esteress*', '*depreshen*', and 'PTSD'. As one of the many affective strategies that Sara's generation employs, her medicalization of war memories serves identity politics: her diagnosis serves as a cultural resource for historicizing her experience and creating a generational voice that demands justice and accountability.

But why would an individual willingly identify with a psychiatric illness? What is the appeal of self-naming in the language of pathology? While the DSM remains the most commonly used diagnostic tool in Iranian psychiatry, terms such as '*depreshen*' or '*toromā*' do not fit into global paradigms of mental health (Behrouzan 2016). Sara's undifferentiated translations of such clinical terms and her generational identifications with a historical etiology complicate conventional critiques of medicalization in anthropology. Rather than a top-down biomedical construction or an ideological representation (as elaborated in Young's [1997] classic work on North America), in Sara's context PTSD emerges in the juxtaposition of psychiatry with several cultural and psychological paradigms, including Shi'ism, mysticism, and its transcendental formulations of suffering, melancholic and literary resonances of an imposed war, poetic renditions of sadness, and globalized aspirations for 'happiness'. Understanding its significations thus requires cultural investigations into the symbolism that underlies civilian interpretations of PTSD. It also necessitates gaining historical insight into the emotional and cultural trajectories of the ways in which Iranians perceive their own affective structures in relation to Shi'ism, mysticism, and gnosis (Good, Good, and Moradi 1985; Fischer 1980; Fischer and Abedi 1990; Beeman 1988).

The trajectories of Iranian psychiatric mindsets are indeed too complex to be accounted for by top-down analyses of biomedical hegemonies such as those common in debates on global mental health (Summerfield 1999); such a linear analysis wouldn't account for the agency with which people inhabit their experiences of loss. Of course, there are differences between individual experiences of PTSD. Sara's was constructed in the intimate space shared by the 'I' and the 'we'. It is culturally significant in that, by being situated in relation to collective losses, Sara's invocation of PTSD tells a story of how generations are built around shared experiences, how history is psychologically reconstructed, how social anomie is perceived in the collective mind, and how, above all, pathology becomes a cultural resource for demanding justice. Her PTSD, or rather her identification with PTSD, became a way of life (one among many ways) and a channel through which to interpret and articulate emotions and memories that are indescribable. Her diagnosis of PTSD has also legitimized medical care and social relief and reduced the stigma of mental illness. Locating illness in her

individual brain, and thus seemingly desocializing her historical experience, Sara's rendition of her PTSD nonetheless creates new socialities, kinship, cultural aesthetics, and generational forms. It responds to the collective desires and forms of generational identification that are centered on remembering the Iran-Iraq War beyond institutional narratives, and on the role it plays in the identity politics of her generation. A clinical approach to Sara's PTSD would detach it from its cultural and social meanings. For Sara, medicalization matters because it helps to make sense of and connect her to the desires, claims, and hopes of a young, educated, dynamic population that now has access to the culturally legitimated language of psychiatry.

While the medicalization of historical experiences may undermine individual agency and the cultural meaning of such experiences in other settings, this is not necessarily the situation anthropology faces today in the so-called Middle East.[7] The Iranian postwar psychiatrization of generational memories illustrates how people may find in diagnosis and medication forms of clinical legitimation that may allow for historical and generational recognition (Behrouzan 2016). As such, the inscription of loss into daily life (Das 2000, 2007) and the embodiment of its cultural symbols can take a medicalizing turn, but cannot be solely captured by universalizing medicalization theories in anthropology nor the diagnostic criteria of the DSM. Medicalization can exceed these, serving as an instrumental call for justice and a creator of new socialities, generating new cultural discourses (Kleinman 1989; Kitanaka 2012; Scheper-Hughes 1992; Fischer 2003). Might we then consider pursuing a situated anthropology of the 'medicalized' (rather than of the medicalizing forces of biomedical hegemonies), one that is sensitive to individuals' historical and generational desires for justice?

Beyond trauma and the clinical encounter

To respond to the psychological afterlife and the social discord that wars create would require more than just the clinical apparatus, in that such discord cannot be reduced to a clinical artifact of individual trauma or be divorced from the historical and cultural meanings that it carries.[8] The clinical diagnosis of PTSD, itself contested in Western scholarship, is

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7   Anthropological critiques of how psychiatry operates have often either underscored the biomedical and pharmaceutical hegemonies that trivialize individuals' subjective or historical experiences (often through the prism of governmentality), or pointed to the colonial instrumentalization of psychiatry in non-Western contexts (Biehl and Locke 2010; Biehl 2005; Healy 1997; Conrad 1992; Conrad and Potter 2000; Szasz 1997; Keller 2007; Kleinman, Das and Lock 1997; Young 1997).

8   See Behrouzan 2013.

situated in its own cultural and ideological history. It regards the traumatic memory as the problem and thus aspires to remove excess memory.[9] But Sara's example reminds us that each cultural and historical setting creates its own demands, insisting on various forms of remembering, and persistently putting justice and recognition at the center of their commemoration. They urge us to engage with memory, not just individually, but also in its collective and generational forms (Behrouzan 2016).

Sara's *PTSD* is relational, and it is impossible to understand without rewinding to how the war was experienced by her father and her family. It encompasses several layers of a ruptured and unfinished experience that started with her father's injuries and stress disorder and her family's relocation decades ago. The clinical lens is not sufficient for capturing them. But these layers of experience can be traced elsewhere; they are compiled and reconstructed in a range of cultural productions and artistic expressions such as those in the 'Sacred Defense' genre of Iranian cinema, which serves as a window into her father's generational experiences of loss, solidarity, and pride (Naficy 2012; Fischer 2004; Behrouzan 2016). The complex processes of reintegration and reassimilation, particularly for veterans who were chemically injured or suffered chronic illnesses, have been depicted in postwar films such as Hatamikia's *Glass Agency* (1998) and *From Karkheh to Rheine* (1992), Panahi's *Crimson Gold* (2003), and a large body of literature, film, documentaries, and cultural productions that followed in the 1990s. In her ethnographic documentary *The Skin That Burns*, for example, Bajoghli (2012) provides a compelling account of the experience of a *jānbāz* who struggles with health issues thirty years after the war. Like filmic and artistic recollections, literature too provides entry points into the ways that life transformed across different generations: from earlier war novels such as Esma'il Fasih's *Zemestan-E 62* (1987), to post-1990s works like the award-winning novel *A Scorpion on the Steps of Andimeshk Railroad Station* (Mortezaeian-Abkenar 2006), the entanglement of faith, fear, anxiety, ambivalence, and doubt provides an alternative narrative of the psychological residues of the Iran-Iraq War. More, the creation of new institutionalized forms of personhood in the aftermath of the war (for example, *shahid* (martyr) and *jānbāz* (disabled veteran)) extended beyond veterans and martyrs to their spouses and kin. For women and children in particular, this required the assimilation of specific forms of conduct and responsibility, and later led to various cultural forms among postwar youth (Zahedi 2006; Khosrokhavar 2002, 2004).

In the 1990s, the proliferation of work in poetry, literature, and film served postwar generations as a site for subjectivity work and memory work. Reflections on the contrasts

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9   Alan Young (1997) has written about the ideological contexts that gave rise to the consolidation of
      PTSD as a diagnostic category in the aftermath of World War II and the Vietnam War. Also see
      Fassin and Rechtman 2009 for a historical trajectory of 'trauma' discourses and their limitations.

between generational experiences of the war, between 'now' and 'then', were spoken back to the recovering society. These works have been the subject of scholarly analysis in the humanities (Khorrami and Vatanabadi 2000; Khorrami and Shirazi 2008; Ghanoonparvar 2009; Rahimieh 2003; Moosavi 2015). But since they provide alternative and complementing narratives to the narratives of medicine and psychiatry, they need to be brought into a rigorous conversation with debates on postwar mental health and psychological well-being. They ought to be read not only as text, but also as the context around mental health discourses. In other words, cultural expressions should be valued and engaged with, not as mere examples, but in their capacities as projection screens that illuminate the emotional and cultural contexts in which mental health and medicalized experiences emerge and are lived through.

What is happening today in the Middle East challenges us to re-examine the boundaries of both clinical and anthropological inquiry, as well as to distinguish the myriad of conditions and issues that we have come to call 'mental health'. The fragmented nature of experiences across the region and the multiplicity of existing pedagogical and cultural discourses call for conceptual and methodological reconsiderations within anthropology. Like the other articles in this section, this one aims to problematize psychiatry's reliance on metanarratives of trauma that focus either on singular events or individual psychologies. Rather, the focus ought to be shifted to the perpetual ruptures and wounds that traumatic events create, and how these inform the micropolitics of everyday life and the cultural work involved therein. The clinical encounter and the universal paradigm of trauma in biomedical psychiatry inevitably fall short of capturing historical and generational sensibilities, in part because they individualize loss without concern for its sociocultural context and meaning, and in part because they universalize trauma and take for granted a form of pathology (for example, PTSD or depression) that privileges only certain forms of therapeutic intervention (Behrouzan 2016).

At best, when incorporating psychodynamic and psychoanalytic conceptualizations of trauma, the biomedical encounter may assume trauma as located in the event, universal and singular, and as that which is only grasped later in a coherent process of retelling (Caruth 1995, 1996).[10] Each of these formulations has its own situated trajectory and cannot necessarily be applied universally; one size, in other words, does not fit all. Significantly,

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10   I have provided an extensive critique of trauma theories and their implementations in *Prozāk Diaries* (Behrouzan 2016). Also see Laplanche and Pontalis 1988 and Radstone 2007 for a more extensive critique of dominant trends in American trauma theory, which are informed by clinical experiences and the establishment of PTSD as a diagnostic category in the third and fourth editions of the DSM.

when 'trauma' is dispersed through multiple layers of sociohistorical anomie and in attempts at inscribing loss onto everyday life – as Das (1996, 2007) has shown – it is no longer individual, but a shared, diffused, and unpolished construction of collective losses and processes of meaning making that relies on culturally available spaces of mourning and coping. Those spaces ought to be further integrated into mental health discourses.

To move beyond these understandings of trauma as either singular or sudden would require a conceptual framework that captures the diffusion and fragmentation of subjective experiences and the infusion of psychological ruptures into ordinary, postwar life. Clinical and anthropological empathy can converge in a form of listening tuned into the afterlife of memory and the cultures it creates. Indeed, macro-events such as the Iran-Iraq War continue to be invoked in people's interpretations of the feeling states in which they live. But individuals' psychological and emotional struggles to live through the afterlife of war are often overlooked in institutionalized metanarratives of war and memory. Similarly, the long-term infusion of loss and its cultural memories into the politics of daily life and of illness is hardly captured by a diagnostic category, yet those categories remain integral to how professionals and institutions assess and perceive psychological well-being.

Reflections for narrative psychiatry

I do not wish to perpetuate an overreliance on narrative at the expense of alternative forms of marking and techniques of witnessing. But in so far as the clinical encounter engages with narratives of illness, our approach to patients' narratives can benefit from a situated cultural critique. Sara's interpretation of her dreams in relation to her generational memories of the war (and to her father's experience on the battlefield) provides an example for a cultural critique of psychiatry's approach to illness narrative. Of course, the privileged position of a purely biological psychiatry has already been called into question within psychiatry itself, and the disciplinary formation of 'narrative psychiatry' and its incorporation of the humanities is certainly a step forward (Halpern and Lewis 2013; Charon 2001; Charon and Wyer 2008). But psychiatry's interest in and approach to narrative is itself culturally situated, among other things, in an essentializing formulation of the individual self and the significance of its empowerment. Narrative psychiatry in its current form requires skills in 'narrative competence' and listening, and is primarily concerned with helping patients find functional frameworks for their narrative (Lewis 2011), thus regarding narrative as an end in itself. For Sara, psychiatric medicalization as a narrative framework uses history and its reconstruction as a plot, tying together fragmented historical experiences and giving them meaning. Understanding her experience thus only becomes possible by understanding the historical and individual desires and claims behind it. Rather than regarding narrative as an end, her narratives of 'illness' are a means to historical conciliation. A primarily biomedical analysis of

her medicalized condition, her symptoms, and her identifications – without cultural insight into their historical and generational trajectories and meanings – would essentialize her illness narrative, making it static and individual. This 'diagnostic silencing' of patients' cultural experiences and generational memories erases the historical and political meanings that such narratives are built upon and mean to reflect (Biehl and Locke 2010; Biehl 2005). In other words, it is essential to understand what narratives of illness mobilize, how they shape experience, the cultural contexts in which they evolve, and the potent political and therapeutic possibilities they create. When social dis-order entrenches, individuals' living strategies entail a deep knowledge of the historical situatedness of their emotional states and psychological experiences. Individuals' narratives and experiences of illness are therefore inseparable from this tacit sense of historicity.

This is not however merely a matter of historicizing illness narratives; rather, it has pedagogical and bioethical implications. Like individual narratives of illness, medical education as an institutional form and cultural artifact is embedded in its own broader value systems and cultural assumptions that shape the professionalization of practitioners. Mental health practitioners' ways of listening must become sensitive to not only their own cultural assumptions, but also to how institutional narratives of history interact with or contradict individual and generational reconstructions of historical ruptures. Moving beyond an individual and clinical rendition of trauma thus requires the integration of an anthropological understanding of cultural situatedness into medical pedagogies, creating a clinico-anthropological approach to symptoms that acknowledges illness as both medically and culturally constructed. To listen anthropologically, on the other hand, would be to go beyond silences and stutters and incoherencies, to invite what escapes language, and to discern the fragmented narrative strategies that individuals assimilate into their lives. Investigating individuals' narrative strategies, cultural productions, explanatory models, and diagnostic efforts may lead us to situated and customized interventions and therapeutic innovations in psychiatry.

On a practical note, clinical training will need to emphasize that beyond any biological basis, medicalized conditions have a cultural, historical, and political trajectory in their conception and perception. These trajectories are constantly in the making across times and places, and are multiple in their experiences and interpretations. They can serve as cultural resources in coping strategies such as commemoration, thus underscoring the salience of remembering and its cultural and generational forms. Similarly, policy making for postwar mental health care could benefit from incorporating commemorative practices and investing in community building, not only on site but also at destinations where displaced individuals arrive (particularly necessary now for the growing numbers of refugees across the region).

This article is meant to be read as a set of provocations, as well as a call for conceptual and methodological dialogue across disciplines. Historically and culturally situated interpretations of illness narratives require combining clinical listening and anthropological listening, thereby alternating between the individual and the shared, the biomedical and the historical – not as dichotomies, but as moving fragments of life. Generational, cultural, and social wounds call for an inclusive intervention that prioritizes justice and accountability; they escape biomedical diagnostic taxonomies, and do not fit into orthodox frameworks that negate the medicalization of mental illnesses and its biomedical aspects. An interdisciplinary investigation and intervention into mental health in the Middle East would thus begin with breaking disciplinary boundaries, creating room for simultaneous explorations of anthropological and cultural forms, historical trajectories, psychoanalytical insights, and biological premises of neuroscience and epigenetics. It would also remain consistently committed to justice and human integrity, appreciate moral complexities, and endeavor to innovate in the face of the uncertainty and precarity of its time. Iran's experience provides possibilities for reconceptualizing some of these analytical and bioethical frameworks. The first step is to start from bottom up, and to let stories emerge from their own context and lead us toward theory. As they always have.

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