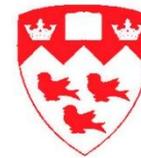


Looking at the Professional Controversy over Bipolar Diagnosis and Treatment in Iran

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Outlines

- Introduction on:
 - The globalization of Anglo-Western psychiatry;
 - Marketing “new disorders”: a new concept of “bipolarity”;
 - The controversies arising from diagnosing and treating bipolar disorder (BD) across the “bipolar spectrum” in the West
- Emergence of BD, focus on “bipolar spectrum” in Iran
 - Bipolar Spectrum (presentation, diagnosis & practice) in Iran
 - Factors influencing the delivery and practice of bipolar spectrum disorder in Iran
 - Bipolar spectrum vs. other diagnoses
 - Future of bipolar spectrum diagnosis
 - Implications

Introduction

- Globalization of the Anglo-Western Psychiatry
- An overview on bipolar disorder
- The new bipolar disorder
- Marketing bipolar disorder
- Expanding boundaries of bipolar disorder
- The shift to over-diagnosis
- A world-wide controversy over bipolar spectrum

Research Objectives

Drawing from oral and archival history & explanatory case study research among prominent psychiatrists, university professors, who are influential in training and practice in the field of mood disorders in Iran, this study examines:

- 1) how understandings and practices of bipolar disorder have emerged from the recent past and how they were different from the past
- 2) how bipolar diagnosis and treatment are understood and applied among Iranian psychiatrists today
- 3) the critiques about the origin of this diagnosis in Iran
- 4) structural factors influencing the delivery and meaning of bipolar diagnosis and pharmaceutical treatment of bipolar diagnosis in Iran's psychiatric settings

Methodology

- A descriptive explanatory case study & oral and archival history:

“This approach can be used for either descriptive or explanatory purposes as well—i.e. to describe a situation or to test explanations for why specific events have occurred. In short, the use of case studies allows one to examine the knowledge utilization process and ultimately to recommend and design appropriate policy intervention.” (Yin, 1981)

Sampling/Data Collecting

(Feb-March 2014)

- A purposive sampling (n=26)
- Semi-structured individual interview
- 25 prominent psychiatrists (18 G, 7 Ch; in person) from 6 major training psychiatric settings in Iran (4 major Tehran U, 1 Isfahan U, 1 Mashhad U)
- 1 former psychiatry professor (4 sessions Skype interview)

Data Analysis

- I transcribed all 26 interviews (about 50 hrs in total) and entered into AtlasTi (a qualitative analysis software) which allows coding the narratives and then developing thematic trees and comparative matrices

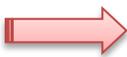
How has BD emerged in Iran?

- **First wave (90s):** Schizophrenia  Bipolar

Dr. Mohammad Taghi Yasamy

(Influenced by the Lithium Movement and the US-UK project)
mainly aimed to differentiate bipolar I from schizophrenia &
de-institutionalization of over-diagnosed schizophrenics

- **Second wave (2004-):** MDD/PD  Bipolar
(Influenced by **Hagop Akiskal & Nassir Ghaemi**)

1) **Dr. Sh. Gudarzi (2004-)** MDD  Bipolar (“Soft Bipolar”)

2) **Dr. M. Samimi (2007-)** Borderline  Bipolar (“Soft Bipolar”)

How is BD applied in Iran?

- Most psychiatrists with more than 20 years clinical experience (*Ravanpezeshkan -e-Ghadimi*) committed to the DSM criteria for bipolar diagnosis (classic bipolar)- biopsychosocial approach
- Some psychiatrists with 10-20 years clinical experience are committed to the DSM for bipolar diagnosis and some use Akiskal and Nassir Ghaemi's criteria
- Most psychiatrists with less than 10 years clinical experience (*Ravanpezeshkanus-e-Jadid*) mainly use Akiskal and Nassir Ghaemi's criteria- (a bio-bio-biological approach)

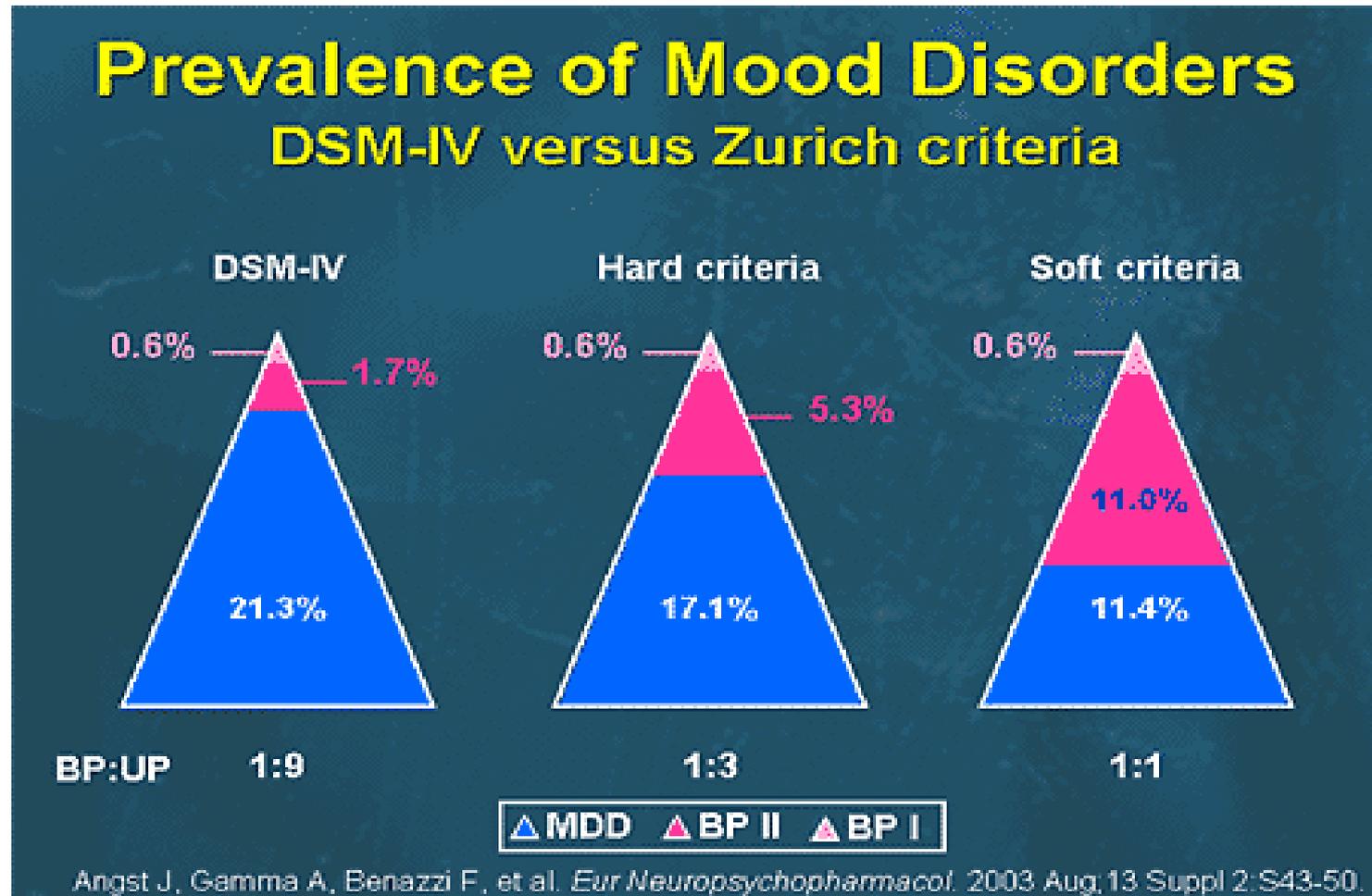
however, it is not generalized to all

How common is BD diagnosed in practice?

Hospital inpatient/outpatient & private clinics

- * Hospital inpatient: 30% amphetamine psychosis, 20% schizophrenia, 50% mood disorder (mostly BD)
- * outpatient clinic: 50% mood disorder (mostly BD)
- ** Hospital: up to 90% with BD!
- Private clinics: more neurotic cases; 30-50 % Atypical BD (BD II & soft bipolar); classic BD: 1-2%

Prevalence of mood disorders in population: MDD:BD=1 (based on Zurich criteria)



Presentation of BD cases

- Typical BD with mania and hypomania episodes (based on the DSM criteria) are rarely seen
- Most of the cases diagnosed BD are called atypical BD, soft BD, BD spectrum, dysphoric mania, etc.; they don't meet the DSM criteria either by the length of episodes or by severity
- Most of the cases are women (age 15-35)
- All socioeconomic levels

Most common presentation of atypical BD

“Most of the patients come with mixed features. They don’t have mania or hypomania 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 go to Facebook and social media and extend their social relationships). A woman who used to be ordinary starts to get into relationships—not just virtual relationships, but in person, too. They are spendthrift and don’t care about money. Their impulse control is weak. Some of them become worse with antidepressants.”

Most common presentation of atypical BD cases

- “We have a bunch of patients (who are too many) with these features: most of them have migraines, PMS, 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 after, they come and say that they feel better!
- They are a category and they come all together and bring their friends later.
 - They are labeled BD and prescribed anticonvulsants.”

Case Sample:

*Would you please tell me about the last BD case that you saw?

**I just saw a woman complaining about anger, some conversion symptoms, semi-panic attacks and depressive mood. She has had these symptoms for a few years—symptoms that are always awakened by the stressors. The recent stressor was her extramarital affair, which her husband discovered, and they were about to get divorced. I wasn't thinking about BD until her husband reported her extramarital affair to me. Then I looked for other factors and I found that she had PMS, her mother had post partum depression, and there was one case of suicide in her second degree family. I diagnosed her as having bipolar spectrum and started anticonvulsant mood stabilizers.

*Did the extramarital report change your mind to BD?

**Yes. Because in our country when a woman has an extramarital affair, it is caused by specific personality traits, and because I am from the group that doesn't believe in personality problems, I diagnose these cases BD.

Critique:

Is bipolar disorder over-under-diagnosed?

- 16/25 interviewees: in general, over-diagnosed
- 5 interviewees: in general under-diagnosed
 - by psychiatrists, over-diagnosed
 - by GPs and neurologists, under-diagnose BD
- 4 interviewees: under-diagnosed

Factors in the vicissitudes of BD in Iran

- Leading psychiatric features (Hagop Akiskal, Nassir Ghaemi, Shahrokh Gudarzi, Mehdi Samimi)
- American nosology and APA text books: Influenced by Iran's psychiatric training and policies
- Pharmaceutical companies (indirect effect)
- Lack of psychosocial model of care, referral system, and follow-up system

Pharmaceutical companies

- Pharmaceutical companies have not directly influenced bipolarity in Iran
- Pharmaceutical  American organic psychiatry  Iran's psychiatry
- Pharmaceutical  over-prescription of mood stabilizers and atypical antipsychotics (poly-pharma)
- Sponsorship for bipolar symposiums in Iran
- Sponsorship for Mood Disorder congress in Turkey (2006)

Akiskal has incidentally declared payments from marketers of most drugs now recommended for bipolar disorder (Parker et al., 2010)

Treatment of atypical BD

- Medication: (polypharma)
 - 1- Anticonvulsant mood stabilizers
 - 2- Atypical antipsychotics
 - 3- Typical antipsychotics

Valproate, Carbamazepine, Lamotrigine,
Olanzapine, Risperidone, Quetiapine, Lithium
- Psychoeducation
- ECT for very irritable cases, suicidal ideation

Why less non-medication therapy?

- 1) Psychotherapy is not the first line treatment for BD (expanded to the BD spectrum)
- 2) Not enough psychotherapists and psychologists trained to work with “atypical BD cases”
- 3) Psychological services are not covered by insurance and are expensive
- 4) Lack of psychosocial services despite the existence of many social workers and psychologists (no governmental budget)
- 5) Limited psychological services that prioritize neurotic cases (e.g. OCD)
- 6) Seeing 30-50 patients per day because of the low price of psychiatric visit

BD vs. PD, unipolar depression, and schizophrenia

Bipolar spectrum takes a larger portion of personality disorder (cluster B), unipolar depression cases and normal population than of schizophrenia cases.

BD vs. Schizophrenia

- Schizophrenia diagnosis modified by the first BD movement, called “lithium movement” by Dr. Yasami.
- BD I (classic BD) took the schizophrenia portion, not the BD spectrum
- Met-amphetamine substance abuse has taken the schizophrenic portion, not the BD portion

BD vs. Unipolar Depression

- BD has taken the portion of unipolar and anxiety disorder.
- Presentation: depressive mood, no psychosis, no response to antidepressants
- Just two choices:
 - Antidepressants
 - Anticonvulsant mood stabilizers and atypical antipsychotics (polypharma)
- Diagnosis: depression or BD spectrum

“When all you have is a hammer, everything looks like a nail.”

Predictions of interviewees for the future of this diagnosis

- 1) BD diagnosis will decrease; it has to be balanced—mostly
- 2) BD diagnosis will increase
- 3) It depends on who will write the next mood disorder chapter of *Comprehensive Psychiatry* book and how it will be written!
- 4) Due to the lack of pharmaceutical lobbies, if psychiatry doesn't modify itself, it will be replaced by other areas—like alternative medicine, herbal therapy, etc.

Implications:

- Rethinking psychiatric education and mental health policies
- Quantitative and qualitative research to understand patients' experiences and perceptions of living under bipolar diagnosis as well as its consequences in an individual and a sociocultural level

“The expansion of bipolar disorder medicalises personal and social conflicts, and profoundly affects the way in Western nations conceive of what it means to be human. At a sociocultural level, the widespread use of psychotherapeutic medication, alongside the view that its role is to correct an underlying deficiency, fosters the view that human beings are merely the incidental result of their biological makeup and not as self-determining agents. ” (Moncrieff, 2014)

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