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# Nobody's Health is Forgotten: I Am Nobody!

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Editorial

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The medical professional's health is endangered by known physical and mental risks. In recent years in Iran, medical doctors have been facing waves of public mistrust expressed via the mass and social media. These irritations seem to be triggered by social events like the death of a celebrity in a hospital or a TV comedy series showing the malpractice of doctors and them jeopardising patients' lives for their own benefits.

Hostility and mistrust toward doctors can increase the effort-reward imbalance which is already affecting many Iranian doctors. Moreover, for many doctors who work in crowded clinics and offices, the demand-control balance -as another determinant of professional health- is also disturbed as a consequence of inequity in distribution of health care and absence of a well-established country-wide system of patient-referral management (Riley, 2004).

Doctors' health is a necessity in any country if it pursues the improvement of the public health indices. Doctors are known to be hesitant in seeking help for their own health-concerns, and also for those of their children and family members. Very often, doctors deal with their own health concerns only by asking some colleagues' advice via phone and their medical examinations are often missed. Appropriate strategies have been determined and successfully applied by the health system of some countries to help doctors overcome health seeking barriers and to meet their specific social care needs.

The Iranian health system is going through a national health reform to increase public health care indices and to decrease the existing inequity in distribution of health care facilities. The national family physician program is part of the reform project.

We require locally-appropriated and effective health care strategies to ensure real health care delivery to all Iranian medical doctors and their families. Surveys and studies need to be integrated into the national family physician project to provide accurate estimations of the current health status of this population as well as their health concerns, needs, and threats.

The note below is a short statement to attract attention to some of the health risks, concerns, and hazards threatening Iranian doctors and their families.

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*"My job is talked about more than most other jobs in the mass media and TV. Quite often I appear in social talks, educational movies, stories of kindness and crime, and legends of humanity and brutality. My public image usually takes the extreme form of one character or the other, angel vs. devil, sacrificing vs. opportunistic, life–saver vs. killer, punctual vs. neglective, money-hoarder vs. selfless and in-debt, parent of spoiled children vs. that of intellectual ones, and many others. I am never sure which image I am in your eyes, or feel certain about who I really am. I am greatful to the great teacher Dr. Michael Balint, for articulating my perplexity in the smart term of "Doctor Nobody".*

*However, those professional stigmas feel rather light compared to all the burdens of prejudices one could ever carry in life, but then, this letter is not intended to be about my identity, but to claim for health care and social support.*

*Everybody is a sworn responsibility of mine. I am that of nobody, so is my family. The health system of my country seems committed to deliver care to all. Moreover, people are frequently re-assured of being safe-guarded against the doctor's negligence through public media, as through a few public speeches by the health care minister-a kind doctor himself.*

*But am I also considered as the audience of his speeches? Perhaps not.*

*Let me illustrate it through a fictitious job story in my own psychiatry practice. Part of the story will feel familiar, very close to a popular recent event in my country. Yet it is going to be fiction.*

*Suppose I once happened to examine the severely traumatized wife and children of a doctor in my office. The doctor and his family had been widely rejected and isolated after the broadcasting of the TV news report about the doctor's misdeed followed by the widespread reflections in the public media. The mother and children came to me several months after the malpractice news was broadcasted. When I examined them for the first time, the son's school refusal condition had already been neglected by both the health and education systems for two months. Indeed, his school refusal was of a delayed onset. It began only when a new student joined the school, heard the news, and readily remembered the story of "Doctor Evil" who was now a classmate's father. And the son perceived that a new wave of rejections will be coming.*

*The doctor's misdeed was toward a child with a mild injury. He left the child's medical care procedure unfinished when the child's father declared he was not going to pay the due hospital payment. There is no justification for the doctor's misdeed, of course, Never, Ever!. But, I doubt that the neglected patient was the main victim of this story.*

*After the rapid countrywide and even global news spreading, the health authorities further demonized the doctor by promising the public his severe punishment. What remained far from the public imagination was that all those waves of hate and blame did not touch any demon, but severely harmed two innocent children and their mother, as well as everybody else in a nice big family. My point is to re-induce awareness of the fact that strong attitudes-both positive and negative ones- are readily adopted by the public toward medical professionals. And my question is: Am I not excluded from the protection and care which is granted to all by the health care system of my country, as the doctor of my story and his family were?! Then, am I not taken for granted and viewed as invulnerable?! While I am among the vulnerable, so is my family!! If nobody is free of health-care needs, then I am definitely Nobody. A multi-labeled Dr. Nobody! Then, beware! Nobody's health care is forgotten."*

## References

Riley, G. J. (2004). Understanding the stresses and strains of being a doctor. *Med J Aust*., 181(7), 350-353. doi:ril10433_fm [pii]. Retrieved from PM:15462646

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# A Sociopragmatic Contrastive Analysis of Compliment Responses between Native American and Native Persian Chatters – A Web-Based Study

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Empirical Study

## Abstract

**Background:** Online social networking has reduced the distance between people with different languages and cultures through allowing individuals in distant geographical locations to form interpersonal relationships. Adopting the Internet as the medium for online interactions, the current study aimed to compare and contrast Native American and Persian speakers' compliment responses (CRs) in this environment.

**Methods:** Data were collected from online social networks by saving archived conversations of 15 chat participants who were selected through snowball sampling from each group of English and Persian chat users. The conversations were produced from January 2009 to May 2012. The compliment exchanges made by the two groups were examined and contrasted with each other in terms of CRs strategies.

**Results:** Chi-square test and z-score results indicated that the two groups of participants differed significantly in adopting strategies for responding to compliments.

**Conclusion:** American speakers employed acceptance significantly more than Persian speakers. This is while Persian chat participants used self-praise avoidance significantly more than their American counterparts. Comparing the results of the study with other studies on CRs realization, it is suggested that communicative acts which take place in anonymous social networks mirror the cultural values of the language community of text-talk users and the medium of interaction did not restrict participants' cultural preferences in complimenting responses. However, they used some text-talk features in the online environment which indicates the need for using compensatory strategies due to the mode of interaction.

**Keywords:** Compliment responses, Medium of interaction, Cultural values, Text-talk features

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## Introduction

Over the past decades, the development of modern technology has brought about dramatic changes in social interactions in terms of channels of communication. With the advent of the new technology known as Internet, the online environment and online interaction was viewed as a separate realm from the face-to-face interactions that take place in daily life. However, as more people come online, online interaction and electronic

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communication are more increasingly viewed as normal channels for communication. Online social networks have become a popular way for users to connect, express themselves, and share content with people from all over the world.

When compared to face-to-face interaction, online interaction may seem impoverished because it lacks paralinguistic features such as gaze, tone, hand gestures, facial expressions, and etcetera. This is especially evident in text-based chatting in various chat rooms, social networks, instant messaging, emails, and so on. This may influence the communication; in other words, communication may deviate from the way it occurs in face-to-face interaction. Werry (1996) asserts that this relatively new medium provides grounds for analysis since it makes possible interesting forms of social and linguistic interaction, brings into play a unique set of social interaction, and shows some parameters that determine how communicative acts are structured in the new medium of electronic communication. Similarly, Anderson, Beard, and Walther (2010) noted that participants adapt new forms of communication creatively and use different sets of resources to successfully convey their messages and achieve interactions online.

Moreover, it is now well documented that linguistic competence alone is not sufficient for effective communication, and online communications may not be an exception in this respect. Speakers of a language must also master sociopragmatic norms of the language to achieve communicative purposes appropriately in their face-to-face interaction. Among the many speech acts to investigate, the compliment act is deemed as a particularly suitable speech act to examine when comparing cultures or sociopragmatic norms underlying a given language since we can view what is valued in a particular culture through it (Wolfson & Manes, 1980).

According to Holmes (1988), a compliment is defined as "a speech act which explicitly or implicitly attributes credit to someone other than the speakers, usually the person addressed, for some 'good' (possession, characteristic, skill, etc.) which is positively valued by the speaker and the hearer". Holmes (1988) considered compliments to be positively affective speech acts on the one hand, and potentially face-threatening acts on the other. Downes (1998) defines compliment as a supportive action associated with offers, gifts, and congratulations which is sequentially expected to be followed by an acceptance or rejection as the second part. Similarly, Herbert (1990) explains that a compliment event consists of a two unit exchange in which the second utterance as the compliment response is conditionally relevant and sequentially dependent on the first utterance which is the compliment offered.

Compliment responses (CRs) patterns vary greatly across cultures. It has been reported that, in non-western languages, the acceptance rates are much lower than those in English speaking communities (Baek, 1998). While acceptance of the compliment is reported to be used by native English speakers (Chen, 1993; Herbert, 1986; Holmes & Brown, 1987), downgrading and rejection were usually used by speakers of other languages, especially those from Asian countries such as China, Taiwan, Japan, and Vietnam (Chen, 1993; Baba, 1996; Tran, 2006; Yu, 2004). According to Ye (1995), CRs are intricate acts since they are ubiquitous and multifunctional.

Thus far, the results of other studies have shown that compliments and CRs' realizations are varied across cultures in face-to-face interaction. There is a debate whether or not CRs are realized in online environments in the same way they are realized in face-to-face interaction. In other words, it is worth discussing how the medium of interaction influences or restricts speakers' cultural preferences in complimenting and responding to compliments. To do this, an etic contrastive analysis between two distinct cultures is more beneficial than emic comparisons to shed light

on cultural preferences of a given language community within any social setting.

## Review of the literature

There is a lack of research on contrastive analysis studies on how Persian speakers achieve different speech acts, including complimenting, through distant communication compared to speakers of other languages. On the other hand, a majority of the previous studies on speech acts were not based on speakers' communicative performance adopting Discourse-Completion Tasks (DCTs). The studies on compliment speech act, and speech acts in general, made use of many data collection methods such as role playing, natural ethnographic method, use of interviews, and films; however, the online medium has been neglected for speech act realization, especially in the Persian language. Complimenting behavior, seemingly a very simple act, is in fact very intricate in different speech communities because it indicates the emphasis of different cultures on their values.

The act of complimenting requires the addressee's response. Socially preferred structures divide the second part of the speech act, which is response to the compliment, into preferred and dispreferred social acts (Wang & Tsai, 2003). By preferred, it is meant socially and structurally accepted and expected acts, and by dispreferred it is meant socially and structurally unexpected acts.

It can be implied that acceptance of, or agreement with requests, assessments, invitations, and offers is preferred, while rejecting or disagreeing with them is dispreferred. It seems that acceptance or agreement occurs more frequently than rejection or disagreement. It is expected that acceptance be usually given without delay and clearly, while rejections are given with hesitation (Levinson et al., 1983; Pomerantz, 1985). However, Pomerantz (1978), in her study on CRs in English conversations, found that most of the respondents hesitate to accept and agree with the compliment as well as disagree with it. Generally, the recipients' internal conflict was between agreeing with compliments on the one hand and avoiding self-praise on the other. Pomerantz's conclusion shows that compliment response production is the result of multiple constraint systems. This finding is highlighted when considering that, according to Brown and Levinson (1987), compliments can be regarded as face-threatening acts. Therefore, due to the fact that complimenting is both a positive politeness device as well as a face-threatening act, its appropriate realization is deemed as complex. Besides, compliments may also threaten the face of interlocutors. For instance, if the complimentee feels that the compliments are insincere or exaggerated, have some hidden intentions, intrude into the private space of the complimentee, or compel the complimentee to share the object complimented on, they may provoke negative reactions. Therefore, compliments are very complex speech acts and may lead to misunderstanding in intercultural encounters.

Yousefvand (2010) conducted a research to examine CRs across gender among Persian university speakers using DCT. Her findings showed that Persian speakers generally tend to respond to compliments with agreement and modesty. The results she obtained indicated the significant effect of gender on CRs. She reports that men tend to reject a compliment by using formulaic expressions, whereas females in her study preferred to accept compliments or show surprise when complimented. Heidari-Shahreza, Vahid Dasjerdi, and Marvi (2011) investigated the discoursal variation of CRs among male and female Iranian Persian speakers through the use of DCT. Their findings showed that the two groups of speakers mostly prefer to use acceptance strategies in almost all of the four situations mentioned. However, female speakers tended to use evasion strategies when they were complimented on their possessions.

This study explores how one particular

speech act, compliment and CRs, is realized in the two languages of Native American English and Persian by social network users, and how their realizations contrast with those in face-to-face interaction. Theoretically, it might shed light on the communicative strategies related to compliments and CRs among Persian and American speakers in online electronic environments. The findings of this study might also be helpful in understanding the nature of electronic communication and comparing it with face-to-face interaction.

**Compliment responses taxonomies:** CRs have been one major focus for research on the issue of compliment speech act. According to Pomerantz (1978), CRs represent the recipient's resolution of conflict between two conversational constraints. She explains that the preferred second part in a compliment speech act would be in an agreement with what the compliment giver has said. This puts pressure on the recipient of the compliment to be in agreement with the complimenter. Paradoxically, accepting the compliment or agreeing with the compliment may be regarded as self-praise. Pomerantz found that her American participants did not follow her acceptance model of CRs as was expected, but rather they tended to disagree with compliments or reject it to avoid self-praise. She believes that this is due to another constraint system that functions to minimize self-praise (1978, p. 81). Therefore, Pomerantz (1978) classifies CRs into three main categories of acceptance, rejection which deals with disagreement tokens, and self-praise avoidance which aims to minimize positive evaluation of the compliment (as cited in Jucker, 2009). Other taxonomies include those of Holmes (1988, as cited in Jucker, 2009) and Herbert (1989, as cited in Tran, 2006).

## Methods

Using snowball sampling, 15 Native American and 15 Native Persian profile users on the social network, Facebook, were selected regardless of their gender, age, educational background, and social status. Snowball sampling was used as a guarantee that all the participants were native speakers and all of them logged into the network with their real identities. With the consideration of ethical issues, the 15 profile users' archived conversations with their friends were saved for later analysis. Referrals or mutual friends helped reveal other chat users' native language when necessary. The corpus of the study consisted of text-based written conversations which contained compliment speech act sequences in the two languages of American English and Persian. The two data sets were obtained from naturally occurring conversations which had taken place among chat participants in Facebook from January 2009 to May 2012, the time of data collection. Such data was not elicited by the researcher for the purpose of research. Therefore, although in written form, it can be counted as naturally occurring data as it was originally produced to a communicative end (Jucker, 2009). For coding the data, a modified version of Pomerantz's (1978) taxonomy of CRs was employed. However, some other categories were added to Pomerantz's model to fit all the patterns observed in the data.

The data were analyzed both qualitatively and quantitatively. The quantitative analysis was employed for examining complimenting behavior in terms of compliment strategies, functions they serve, and compliment response patterns. Qualitative analysis of the data was used to discuss the nature of online interaction and its effect on the complimenting behavior of chat participants.

## Results

Having examined the compliments, the patterns of (explicit) acceptance, self-praise avoidance or deflection, and rejection were identified at a macro-level (their distribution is displayed in figure 1).

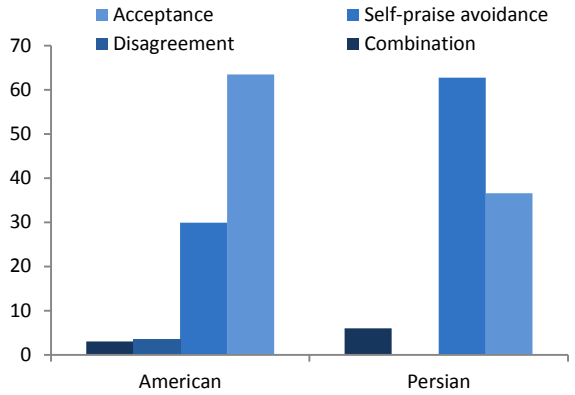


**Figure 1.** Distributions of compliment response strategies at macro-level

The results of chi-square test shows that there exists a significant difference between the two groups' use of CR strategies at significance level or alpha level of 0.05 ($\chi 2$ (3) = 127.561, P < 0.05; asymptotic significance < 0.001), and the effect size of 0.345 (Cramér's V = 0.345).

Further examination was conducted by z-score to see which particular strategies at the macro-level significantly differ in terms of frequency between the two groups. The z-score computation shows significant difference in adopting all four strategies between the two groups of participants at the alpha level of 5%. This means that acceptance, disagreement, and combination strategies are more likely to be used by American speakers, and Persian speakers are more likely to use self-praise avoidance strategies (Table 1).

The results indicate that American speakers are more likely to use acceptance category to respond to the compliments (Z = 8.79) which is larger than the critical value 1.96 at confidence level of 95% (P ≤ 0.05). All the subcategories of the category of acceptance (appreciation token, agreeing utterance, praise upgrade, informative comment, and non-verbal clues) share the feature of acceptance of the offered compliment, not necessarily agreeing with the compliment force. In contrast, Persian speakers tended to make more use of avoidance strategy (Z = 10.77). It should be mentioned that the shared characteristic of self-avoidance strategies (including praise downgrade, return, deprecating expressions, shifting credit, humorous comment, disregard, and legitimate evasion) is lack of positive elaboration in responses. Z-score also shows that speakers made use of combination strategies and disagreeing utterance significantly less than their American counterparts (P ≤ 0.05).

Glancing at figure 2, one can grasp the tendency of the two groups to use strategies at the micro-level. However, to find significant differences between the two groups and the relationship of language and culture, z-score and chi-square test were conducted.

Chi-square testing on CR strategies at the micro-level showed a significant relationship between the language used and the compliment response adoption ($\chi 2$ (13) = 446.621; P < 0.05; asymptotic significance < 0.001; Cramér's V = 0.543). The z-score also showed which cells contributed more to the chi-square value (Table 2).

**Table 1.** Distributions of compliment responses strategies at macro-level and results of significance testing of individual cells

| Compliment response strategies | Persian n (%) | American n (%) | Z-score |
|---|---|---|---|
| Acceptance | 185 (36.6) | 359 (63.5) | 8.79* |
| Self-praise avoidance | 317 (62.8) | 169 (29.9) | 10.77* |
| Rejection | 0 (0.0) | 20 (3.5) | 4.27* |
| Combination | 3 (0.6) | 17 (3.0) | 2.91* |
| Total | 505 (100.0) | 565 (100.0) | ---- |

* Significant difference

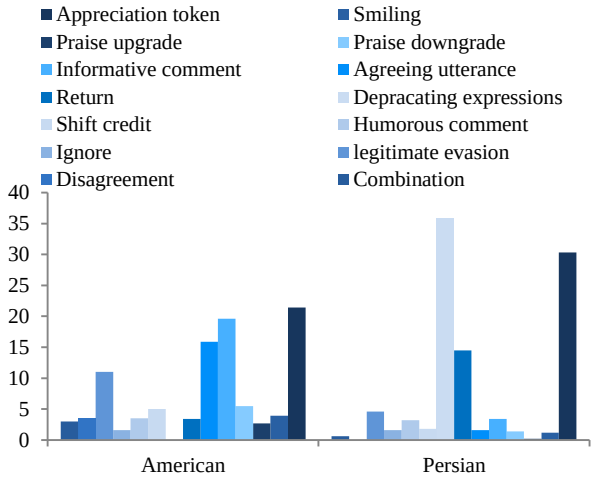


**Figure 2.** Distributions of compliment response strategies at macro-level

The results suggest that American speakers tend to use all four subcategories of acceptance category, except smiling and appreciation token, significantly more than Persian speakers. Informative comment ($Z = 8.19 > 1.96$, $P \leq 0.05$) and agreeing utterance were used with the highest significant difference by American chatters.

The two next strategies with the highest significant difference between the groups were praise upgrade ($Z = 3.3 > 1.96$, $P \leq 0.05$) and smiling ($Z = 2.77 > 1.96$, $P \leq 0.05$). It should be mentioned that in smiling category, complimentees choose to respond to the compliment offered by smiling in their conversational turns. Due to the restrictions of the medium, this strategy was realized through the use of emoticons. Within the self-praise avoidance category, the highest significance was observed in the use of deprecating expressions ($Z = 15.61 > 1.96$, $P \leq 0.05$) and returns ($Z = 6.46 > 1.96$, $P \leq 0.05$) which were used by Persian speakers in a very high frequency compared to their American counterparts. By using deprecating expressions, the compliment recipient humbles himself/herself and exalts the compliment giver. The significant differences also show that American speakers are more likely to use praise downgrade ($Z = 3.62 > 1.96$) and shift credit ($Z = 2.83 > 1.96$) to deflect a compliment at alpha level of 5% when compared to Persian speakers. However, legitimate evasion was the most significant strategy used by American chatters in deflection category ($Z = 3.88 > 1.96$, $P \leq 0.05$). In this strategy, compliment recipients attended to other moves which had come with the compliments, such as requests, questions, and comments.

**Table 2.** Distributions of compliment response strategies at micro-level and results of significance testing of individual cells

| Compliment response strategy | Persian n (%) | American n (%) | Z-score |
|---|---|---|---|
| Appreciation token | 153 (30.3) | 121 (21.4) | 0.32 |
| Smiling | 6 (1.2) | 22 (3.9) | 2.77* |
| Praise upgrade | 1 (0.2) | 15 (2.7) | 3.3* |
| Agreeing utterance | 8 (1.6) | 90 (15.9) | 8.12* |
| Informative comment | 17 (3.4) | 111 (19.6) | 8.19* |
| Praise downgrade | 7 (1.4) | 31(5.5) | 3.62* |
| Return | 73 (14.5) | 19 (3.4) | 6.46* |
| Deprecating expressions | 181 (35.8) | 0 (0.0) | 15.61* |
| Shift credit | 9 (1.8) | 28 (5.0) | 2.83* |
| Humorous comment | 16 (3.2) | 20 (3.5) | 0.34 |
| Disregard | 8 (1.6) | 9 (1.6) | 0.011 |
| Legitimate evasion | 23 (4.6) | 62 (11.0) | 3.88* |
| Disagreement | 0 (0.0) | 20 (3.5) | 4.27* |
| Combination | 3 (0.6) | 17 (3.0) | 2.91* |
| Total | 505 (100.0) | 565 (100.0) | |

* Significant difference

Considering the results, the null hypothesis was rejected both at the macro-levels and the micro-levels of CR strategies at alpha level of 5% ($P \leq 0.05$). It can be concluded that the two groups of chat participants culturally preferred different strategies to respond to compliments.

## Discussion

The findings on CRs showed significant differences between the two groups of speakers. Generally speaking, American chat participants used acceptance strategy almost twice as much as Persian participants, while the latter group was likely to use self-praise avoidance strategy almost twice as much as the former group.

Although significant differences were observed in most CR subcategories at the micro-level, the cells were contributed more to the overall significant difference related to informative comment and agreeing utterance (favored by American participants), deprecating expressions and returns (favored by Persian speakers), and disagreement (favored by American participants), respectively. American speakers also used a combination of these strategies significantly more than Persian speakers.

It can be implied from the findings that Persian speakers' responses to preferred compliments lack positive elaboration. Although no significant difference was observed, Persian chatters used appreciation token in the acceptance category slightly more than their American counterparts. Seemingly, acceptance of compliments in the American language is characterized by positive elaboration, while the very low acceptance responses in Persian were in the form of ritual *thank you*. Compared to other subcategories of acceptance, appreciation token has the least force and is the most conservative strategy in accepting the compliment; it rather equals with seemingly agreeing with the compliment. It does not show whether the complimentee has actually accepted the compliment or just superficially expressed his/her acceptance. Interestingly, Persian chatters were very conservative in other strategies in the acceptance category. In cases of praise upgrade and agreeing utterances, which were low in frequency, Persian chatters often used some emoticons like winking which seems to minimize the force of their acceptance. Even in respect to informative comments, Persian speakers mainly made use of neutral comments, while American participants tended to utilize more positive comments on the compliments. This shows American participants' enthusiasm to give detailed, often positive, comments on the topic of the compliments to be certain that the complimenter is informed of all the aspects of the topic.

Praise downgrade is the second most frequent strategy used by American speakers in the deflection or self-praise avoidance category. The first distribution belongs to legitimate evasion which is related to the procedural function of the compliments, and thus, intentional or unintentional neglecting of the compliment acceptance. Praise-downgrading used by American speakers is the negative elaboration of the compliment by the recipient.

However, praise downgrading is the least used strategy among Persian chatters. It seems that Iranians even evade from negative elaborations when avoiding compliments. In contrast, they use two other strategies (self-deprecating expressions and returns) which do not endanger the face of the complimenter (to minimize the compliment he/she has offered) and endanger their own face to the least possible extent.

(Self)Deprecating expression, the most frequently used strategy among Persian speakers, belongs to the category of deprecating expressions or self-denigrating expressions. To be specific, no sign of disagreeing or downplaying the complimentary force is observed using these expressions. It seems that adopting such expressions is mostly a modest way to agree with the complimentary force. Furthermore,

the recipient lowers or downgrades himself/herself not the complimentary force. To be specific, the recipient humbles himself/herself and exalts the complimenter by giving credit to him/her in most of such expressions. Three patterns of deprecating expressions were observed in the Persian data. The first pattern is when the complimenter asks the complimentee not to continue complimenting, like when they say *ekhtiar darin* (literally means the choice rests with you), *khahesh mikonam* (literally means you are welcome), and *sharmande mifarmayin* (literally means you are embarrassing me). The second type are expressions of affections which can be regarded as self-lowering returns such as *ghorbanat* or *fadat sham* (literally means I am ready to sacrifice my life for you), *dar khedmatam* (I am at your service), and *chakerim* or *mokhlesim* (I am your humble servant). The third type of these expressions is when the compliment recipient attributes the compliment to the complimenter, that is, when they say *cheshmat ziba mibine* [it is your eyes that see beauty (I am not as beautiful as that which your eyes see)], and *lotf darid* [it is kind of you; complimenting me is a sign of your kindness (that you pay attention to me)]. Even offering expressions given in response to a compliment on possession is in this category. In such situations, recipients usually offer the object to the compliment giver by saying *ghabeli nadare* (it is not worthy of you, take it). This means that although the object is good or acceptable for me, your position requires you to have a better object of this kind.

Return was the second most frequently utilized strategy by Persian speakers; the frequency of its use was significantly higher than that among the American participants. Returns occur when the complimentary force is shifted to the complimenter by returning the same compliment offered or by offering another compliment.

Both of these most used strategies offer something to the complimenter. It seems as if Iranians feel indebted when complimented. Therefore, they pay back their debt by equal gifts through return acts [*to khodet zibatari* (you yourself are more beautiful than me)] or more expensive ones in case of self-deprecating expressions. It is worth noting that most of the acts used for this category are frozen expressions which are the least face-threatening for the complimentee.

The two groups were almost equal in terms of using the disregard strategy. However, this cannot be regarded as a cultural scheme due to the asynchronous environment in which the conversation has taken placed and its multilogue nature, it is very probable that some have missed the comments that others have posted. However, in some cases the complimentee had shifted the topic of the compliment, for instance, to greet the complimenter [*chetoriyayi*? (how are you?), *che khabar* (what's up?)].

As for the third category, it appears that Persian speakers do not use disagreement strategies to reject compliments. In the Persian culture, disagreeing with others is a sign of rudeness and regarded as a threat to the audience's face. Disagreeing is not the expected acceptable response for compliments. Disagreeing with compliments conveys the message that the complimenter is a liar and ruins the relations as opposed to what the complimenter intended – as the broader research by Motamedi et al. (2013) showed that compliments function as phatic communion in the Persian culture significantly more than the American culture.

Moreover, Persian speakers are concise in responding to the offered compliments, since any elaboration other than positive extension is also considered as recipients' seeking or waiting for more compliments. This may be the cause of Persians' lack of use of the combination category.

Seemingly, CRs pattern schemes in the Persian language include:

1. One pattern is self-humbling and other-exalting. Using returns, the compliment recipient also gives credit to the compliment giver. It seems that exalting and giving credit

to the compliment giver is the most prominent characteristic of Persian CRs.

2. It seems also that Persian speakers face a dilemma when they want to respond to a compliment. This may be partially due to the fact that the boundary between sincerity and insincerity of compliments in the Persian culture is rather blurred and not clear-cut. Thus, Persian speakers take the middle stance by adopting deflection strategies, mostly through the use of deprecating expressions and returns, and lack of use positive elaborations. This is a conservative way they adopt to minimize the threat to their own face and, at the same time, to the relationship existing between the complimenter and complimentee.

3. They also choose the strategies with the most minimal degree of endangerment of their own face and that of the complimentee in order not to be rude and also maintain the solidarity between them.

The findings of this study on CRs showed the same preferences that Sharifian (2005) and Yousefvand (2010) reported. Sharifian found that Iranians used formulaic expressions to avoid the acceptance of compliments. The present study's data show a similar preference among Persian speakers. Yousefvand (2010) also found that speakers rarely reject compliments with negative answers, but rather utilize formulaic expressions such as "I have done nothing" and "You make me feel ashamed". Examination of the Persian data showed the same preferences. Persian speakers did not use disagreeing utterances at all. However, the current study findings are in contrast with those reported by Heidari-Shahreza et al. (2011), who claimed that Persian speakers, both men and women, mostly prefer acceptance strategies. However, the findings cannot be compared with other studies in details since other variables may have contributed to their results. For instance, Heidari-Shahreza et al. and Yousefvand examined the impact of gender on the use of CRs, a variable which was not considered in this study.

In respect to strategies used by chatters to realize compliment speech acts in online settings, the influence of the online medium on speech act realization can be discussed at two levels. The first level was participants' way of complimenting which is explained in detail by Motamedi & Biria (2013). For the purpose of this study, it suffices to say that the findings of the mentioned study showed the same cultural schemes as those of this study in the two speech communities.

Secondly, it was revealed that the main difference between face-to-face compliments and online compliments is in the mode of interaction. Two general patterns were found in the two corpuses of online compliments as text-talk features. The first pattern was that of *shorthand* which works as a system of using shortened forms and logograms to increase the speed and brevity of typing. The second pattern of text-talk features is related to *compensatory strategies* which tackle the lack of paralinguistic features and non-verbal clues in the offline environment. Compensatory strategies consist of punctuations and pictograms which create interpersonal engagement between the interlocutors.

Seemingly, pictograms are not only used to intensify or color the messages or show the attitudes or feelings of the participants, but also to have an illocutionary force of their own. In the two data sets, the participants sometimes took their turns to talk in the form of pictograms. As such, a smiling emoticon may mean I am happy with what you have said, uploading a heart shape ♥ may mean I love you, or thumbs-up may mean that I agree with you.

The chat participants also made use of word intensifiers and sentence punctuation to convey their meaning. This means that without such practices, the complimentary force was not conveyed or the intention of the speakers' compliments was misunderstood. These include exclamation marks with written compliments which are associated with rising intonation showing

surprise. Using multiple dots show the same tendency to intensify the act which they come with. Capitalization has the intensifying function in compliment exchanges, like the functions repetition and quotation marks serve. In this sense, the words, including verbs or adjectives, that are responsible for conveying the complimentary force are capitalized, put in quotation marks, or repeated in different ways.

The other interesting pattern was that Persian speakers used roman typography to write Persian words, or write their messages in English or a combination of English and Persian. This may mostly be due to keyboard characteristics. Using a Farsi keyboard, they cannot use logograms such as :) and :P.

## Conclusion

The examination of the complimenting behavior of the two groups of participants from two distant cultures showed that no single universal model is representative of compliments and their responses in the two languages since different cultural norms and scripts cause variation in realizing the speech act in different languages. It seems that cooperative manners are realized culturally, that is there are variations from culture to culture. While a certain way of complimenting or responding to a given compliment is considered as cooperative or the sign of agreement in one culture, it may be regarded as discordant in another.

The results on compliment speech act suggest that communicative acts realized in social networks do not differ from their realization in offline face-to-face interactions. Seemingly, it is the culture of a given speech community which is framed in the new mode of conversation. Online interaction, as a new form of communication, occurs within the native language of participants with all its features and norms. However, in online text-based chat, people are able to express online what is nonverbal in offline face-to-face conversation. This causes an emergence of a text called hybrid text by Crystal (2001). Furthermore, using these features show participants' proficiency in text-based conversation.

## Limitations

There exists a methodological constraint in online research. This shortcoming is the inability to retrieve findings for verification which consequently leads to the lack of generalizability of the research findings. The other shortcoming relevant to computer mediated communication (CMC) studies is that it is impossible to guarantee participants identities; in the current study, it was attempted to mitigate this problem through the use of snowball sampling to select those people who log into their profiles with their real names or those who have offline, real life relationships with each other. The results obtained examining chat style through analyzing the corpus of this study is not generalizable to other online environments either, since text-talk features may vary from one online environment to the other. In addition, literature on speech acts suggests that there are several variables influencing the use of compliments by participants, among them are gender, age, educational level, and social statue, which were neglected in this research.

## Conflict of Interests

Authors have no conflict of interests.

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# The Impact of Clinical Gaze Techniques on the Emergence of Psychology: Revisiting Michael Foucault's History of Madness

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Theoretical Study

## Abstract

When we talk about observation, an abundance of theories in science come to our mind whose discussions are on how observation of natural sciences is susceptible or non-susceptible to observers' objectives and their previous experiences epistemologically, semantically, psychologically, or socially. The objects of observation in these schools are natural objects and phenomena the subject matter of which is something other than the human being. However, it is not merely natural objects which are the human being in the history of development and evolution of knowledge; the human being has also become his own object and has been studied. The body has become the object of human being in medicine and psyche, and individual and social behaviors the object of research of the human being himself in human sciences. As the object of observation is the psyche of the human being, the characteristics of observation are examined in this article from Foucault's view since its object is also the psyche of the human being. It is also shown that observation in this domain is not only a political act but an identity-making one. Due to this characteristic, "observation" was used as a technique for the treatment of psychological diseases, especially in the case of madness, until the 19th century. This led to the emergence of psychology.

**Keywords:** Observation, Gaze, Madness, Object, Subject, Power techniques

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## Introduction

Many know the objective of Foucault's works as analyzing the phenomena of power or building foundations for such an analysis. This is while Foucault's works can be known to be the genealogy of the modern subject and describing the formation of subject as an object of knowing. He says that "it is not power but the subject which is the general theme of my research" (Foucault, 1982, p.778). However, since "the human subject is placed in relations of production and of signification, he is equally placed in power relations which are very complex" (Foucault, 1982, p.778). Power has a considerable role in Foucault's analysis. *"History of Madness"* is one of the most important books dealing with such relations by Foucault. In this book,

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Foucault explains various possible conditions for medicine and psychology in terms of an individual's subjectivity. He says, in "*Histoire de la Folie*", "the question was how and why, at a given moment, madness was problematized through a certain institutional practice and a certain apparatus of knowledge." (Foucault, 1988, p.257). From Foucault's point of view, "Problematization doesn't mean representation of a preexisting object, nor the creation by discourse of an object that doesn't exist. It is the totality of discursive or non-discursive practices that introduces something into the play of true and false and constitutes it as an object for thought (whether in the form of moral reflection, scientific knowledge, political analysis, etc.)" (Foucault, 1988, p.257). He stated that "when I was dealing with madness I set out from the 'problem' that it may have constituted in a certain social, political, and epistemological context: the problem that madness poses for others." (Foucault, 1988, p. 258). The description Foucault gives in the "History of Madness", as the genealogy of the modern subject, shows what he calls "surfaces of emergence" of a specific set of knowledge and a set of functions about madness and the mad person in his "the archaeology of knowledge". This is to show "where these individual differences, which, according to the degrees of rationalization, conceptual codes, and types of theory, will be accorded the status of disease, alienation, anomaly, dementia, neurosis or psychosis, degeneration, etc., may emerge, and then be designated and analysed." (Foucault, 2002, p.45). Peter Miller believes that Foucault's work in the "History of Madness" has four important features:

- Foucault shows historicity of the modern subject as the object of psychiatry knowledge.
- He shows that it was through madness that the truth of human being as the subject could become a scientific object. The important point is that the object of this knowledge is also the subject. But it is the knowledge of the subject which is merely possible because this subject changes to the object of scientific perception. This was an event based on the correlated formation of subject and object.
- Describing possible conditions for emergence of psychiatry, Foucault proposes the issue of managing populations.
- He shows that managing madness as a field that has to be dealt with is ultimately based on a set of obtained knowledge from the subject (Miller, 1987).

From Foucault's perspective, psychiatry was not the result of a project of madness manifestations discovery lasting several decades. The subject which psychiatry of the 19th century gave rise to its knowledge was the invention of the late 18th and the early 19th century; the time when mandatory residential centers were established for housing unemployed, poor, madmen, and basically for anyone who had no roles in working and building wealth. If we regard establishing these centers as "an economic measure and a social precaution, it was an invention" (Foucault, 2006, p.77). As a result of the involvement of physicians in these centers, madness was regarded as disease and possible conditions for emergence of psychiatry as a profession which deals with madmen was prepared.

Fear was the dominant climate in these centers which later changed to asylums. The dominant fear in the asylums was so deep that it directly influenced the patient without using any corporal punishment. The objective was to awaken and appreciate the simple and instinctive sense of responsibility in patients, i.e., the part of their being in which any manifestation of madness was associated with imagination of punishment. The madman was seen as a mad person who was not regarded as faulty in the framework of this disease, saw himself as responsible for those conducts which disturbed ethics and society, and considered himself to be deserving of punishments and blame. In other words, he had to become aware of his madness. In this way chain and bars in

mandatory residential centers were replaced with more direct and unmediated confinement. In asylums, they "substituted the stifling responsibility of anguish for the free terror of madness; the fear was no longer of what lay on the other side of the prison door, but what raged instead beneath the seals of conscience" (Foucault, 2006, p.485). What happened was that Samuel Tuke and Philip Pinel – practitioners of psychiatry in the 19th century – established asylums and "The secular terrors in which the alienated found themselves caught up were transferred … to the heart of madness." (Ibid, p.485). But, "Through what methods and techniques did they do this?"

## "Gaze" as a treatment technique

In these centers, the madman was regarded as a guilty person who had to be punished. However, "the asylum no longer sanctioned the guild of madman,… it organized it. It organized it for the madman as self-consciousness, in a non-reciprocal relation with his keeper, and it organised it for men of reason as a consciousness of the other, and a therapeutic intervention into the madman's existence. Through this guilt, the madman became an object of punishment always offered to himself and the other; and from that recognition of his status as object, and his consciousness of his own guilt, the madman was to return to his consciousness as a free, responsible subject, thereby regaining reason. This movement where, by becoming an object for another, the alienated person returned to his own freedom, was a process to be found in Work as well as in the Gaze." (Foucault, 2006, p. 485).

Working in asylums was by no means productive. It was merely imposed as a moral code on the patients. The regularity of the hours, the attention needed for their attention and accuracy and the necessity to reach favorable results prevented the freedom of thought and soul of the patient which was fatal and constrained him to a series of responsibilities. Nevertheless, "gaze" had a more effective function. It was through gaze that the fear of responsibility was put in the heart of the madman. How was gaze applied? In other words, what techniques were used for gazing which caused fear?

### "Gaze of others" technique: "desire of esteem"

The technique based on observing others which was called "desire of esteem" by Tuke (1732–1822) was known to be more effective than the technique of working to treat the madman. To perform this technique, Tuke held ceremonies in which madmen had to imitate social life with all its formal conducts and rituals while others gazed at them to catch the smallest inappropriate conduct, disorder, or ineptness which were signs of madness. Directors and keepers of asylums regularly invited them to parties. The invitees would wear their best clothes and compete for good behavior. They were provided with the best food and they were treated as if they were guests. These parties were usually organized to the most possible order, were extremely favorable for the guests, and created a climate in which patients tried to control their conducts and propensities to the most possible extent.

The important point is that these ceremonies did not lead to intimacy, dialogues, or reciprocal knowing. These ceremonies provided the madman with an environment that was realistic and accessible, but to which he was perpetually an outsider. They had to play roles which their environment demanded rather than being themselves. Any kind of ineptness in role playing was evaluated and judged by gazers, and therefore, the madman became an object who was evaluated and judged by normal people in the role of a subject. In this way, his attention was turned to his own surface by imposing the form and mask of the social, and thus, he recalled his empty roles through the gaze. The madman tried to behave in a way which conformed to normal behavior acceptable by his society. Using this method, Tuke and his colleagues attempted to

normalize the behaviors and conducts of the madman. Through these procedures, the madman was treated or, more precisely, they would treat the madman. Although shackles, bars, and chains were absent and there seemed to exist an intimacy between madmen and gazers, no reciprocal interaction was established between them. "The proximity that comes into being … is simply that of a piercing gaze, observing, scrutinizing, moving pitilessly close the better to see, while remaining sufficiently distant to avoid any contamination by the values of the Stranger." (Foucault, 2006, p. 487).

"In classical confinement too the madman had been exposed to the gaze, but it had little power of penetration, going no deeper than the monstrous surface of his visible bestiality; and it had a degree of reciprocity, as healthy men could read there, as in a mirror, the imminent movement of their own fall. The gaze that Tuke instituted as one of the primary components of life in the asylums was at once more profound and less reciprocal. It was to track the least perceptible indications of madness in patients, hunting for the point where madness was secretly attached to reason, and barely began to drift apart from it; …" (Foucault, 2006, p.486). "What at first glance seemed to be a simple negative operation that loosened bonds and freed the profound nature of madness turned out to be a positive operation that enclosed madness in a system of rewards and punishments, including it into the movement of moral consciousness. It was the passage from a world of Censure to a universe of Judgement." (Foucault, 2006, p.487).

"It is judged on its actions alone; its intentions are not put on trial, and no attempt is made to plumb its secret depths. It is only answerable for the part of itself that is visible." (Foucault, 2006, p.487). In this way, the psychology of madness became possible, "for before the gaze, on its own surface, madness is constantly made to deny its own dissimulation" (Foucault, 2006, p.487). "The science of mental illness, such as it was to develop in the asylums, was only ever of the order of observation and classification. It was never to be a dialogue." (Foucault, 2006, p.487).

### "Recognition as mirror" technique

In mandatory residential centers, the physician imposed care and judgment on the madman from outside or in the form of intrinsic moral judgment. A sample of this method through an extrinsic approach was mentioned above. Tuke mostly adopted this method. However, Pinel designed a method termed "recognition in mirror" which made judgment and care intrinsic to the madman. "Here the movement is of a quite different nature. It is not that error is dissipated by the imposing spectacle of truth, or its counterfeit; the aim is to attack the arrogance of madness rather than its aberration." (Foucault, 2006, p. 499).

In this method, a play was organized to bring doubt and distress inside the patient through his claims being ridiculed by other madmen. In this way, the patient would observe himself through the other's mirror and know and judge himself morally. This method is performed in two ways:

The first way was exaltation in which the madman was called upon to observe madness. Pinel brings about a case which shows how this method works. He talks about three alienated men who claimed to be Louis XVI and were arguing about their rights to royalty. The guard approached one of them and told him that everyone knew he was a king and there is no reason to argue with the two obviously mad people. Being flattered by the guard, the patient withdrew proudly. This tactic was used for the second patient. In this way, all arguments were ended.

Reflection on this method shows that when the madman observed others disdainfully, he became certain that he was justified and that his delirium conforms to reality. "The cleavage between presumption and reality can only be recognised in the object. It remains entirely veiled in the

subject, who becomes immediate truth and absolute judge; …" (Foucault, 2006, p. 498). Exalted sovereignty of one of the three madmen unveiled the fake sovereignty of the other two and negated their sovereignty, thereby confirming his own presumption. In this phase, "madness, as simple delirium, is projected onto others, and as perfect unconsciousness is entirely accepted" and "the complicitous mirror becomes a means of demystification." (Foucault, 2006, p. 498).

The second way was abasement; "presumptuously identified with the object of his delirium, the madman recognised himself in the mirror of the madness whose ridiculous pretension he had already denounced" (Foucault, 2006, p. 499). Pinel gives an instance of this in which "another Bicêtre patient still believed himself to be king, and still expressed himself 'with the commanding tone of supreme authority'. One day when he was less agitated, the guard approached him and asked him, if he was king, why he didn't bring his detention to an end, and how it was that he allowed himself to be kept together with the other inmates. Repeating this speech day after day, he gradually caused him to see the ridiculous nature of his exaggerated pretensions, showing him another alienated patient who had also long been convinced that he was invested with supreme power and yet had become an object of derision. The maniac felt shaken at first, and soon began to doubt his own title as sovereign, and finally managed to recognise the chimerical nature of his imaginings." (Foucault, 2006, 499). He was treated through this method.

In this method, "the solidity of his sovereign subjectivity crumbled in the object that he had demystified by taking it as his own identity. He found himself the unpitied object of his own gaze, and faced with the silence of those who represented reason and did nothing other than hold out a dangerous mirror, he recognised himself as objectively mad." (Foucault, 2006, p. 499).

Rescuing the madman from the grip of madness was possible in the case that he was the observer of his disdained non-rationality and, while trapped in absolute subjective deliriums, he found a ridiculous and objective image of the same deliriums suddenly in another madman identical to him. In the reciprocal play of gazes in which the madman only saw himself, the truth was suggested through surprising the madman. Moreover, "… the asylum, in this community of madmen, ensured that mirrors were positioned in such fashion that eventually the mad could not fail to see themselves for what they were." (Foucault, 2006, p. 499). They became responsible for the truth they had known of themselves and became imprisoned in their own gaze, which was continually directed toward themselves, and "…finally chained to the humiliation of being an object for itself." (Foucault, 2006, p. 499). "It saw itself and was seen by itself – as both pure object of spectacle and absolute subject." (Ibid, p. 498).

### Silence technique: not being exposed to the gaze

Compared to the dialogue between reason and madness in the Renaissance, confinement of the classical era was to impose silence. However, this silence was not total since language was not absent, but was expressed through objects. The silent dialogue between reason and non-reason – that is struggling – was set up through confinement, prison, dungeons, and even torture. In Pinel's time, this dialogue was extinguished, there was absolute silence, and reason and madness had no common language; "… all that answered the language of delirium was an absence of language." (Foucault, 2006, p. 457), because not only was delirium not a part of the dialog with reason anymore but it was not counted as language at all.

Pinel talks about a priest who was defrocked and expelled from the church because of madness. Suffering from delusions of grandeur, he thought he was Jesus Christ. His proud and eloquent speeches amused those people in the hospital, but as he

believed he was experiencing the Passion of Christ, he tolerated others' continuous sarcasms patiently. Pinel freed him of chains and behaved very differently toward him. He neither encouraged him nor extracted a promise. Without saying a word, he removed his chains and ordered others to avoid talking to him. This prohibition for a man so proud of himself had a deeper and more tangible effect on him than chains and dungeons. Being excluded and isolated in his total liberty – which was new to him – caused him to feel humiliated. Eventually, after a long period of hesitation, his thoughts became more reasonable and rational and he joined other patients.

Dungeons, chains, and being the constant subject for the amusement and sarcasm of others were the factors that led to the free expression of patient's delirium. These indicated that the madman had accepted his delirium. However, being freed of chains and being ignored by others and their silence imprisoned him and deprived him of meaningless and formal liberty. Through the silence of others, he was left alone with his own truth which was no longer acknowledged. Although he again showed the truth before others several times, his attempts were useless because he was not exposed to the gaze of others, and because he was not humiliated, this truth did not give him grandeur and magnitude. "It was the man himself, and no longer his projection into delirium, who now found himself to be humiliated." (Foucault, 2006, p. 496).

Foucault emphasizes that gaze has an inevitable and important role in building one's identity. This gaze is not necessarily the gaze of others who are in accord with the person, but is that of those who are discordant with him. In the case of the defrocked priest, Foucault notes that "… he no longer experienced their presence as a gaze, but rather as a refusal to pay any attention to him, a gaze averted" (Ibid, p. 497). The disagreement of others with the person had created a boundary which illustrated the territory of his identity. In confinement, this boundary was totally recognized. Sarcasm, disdain, exhortation, chains, and dungeons were among the things which had created his boundary of identity. Approaching them, he would find his identity again. A fragment of this identity-creating boundary vanished by removal of the chains and it collapsed totally by the silence of others. Thus, "…for him others were now nothing but a limit that constantly retreated as he advanced. Freed from his chains, he was now truly a prisoner, by virtue of silence, in sin and shame." (Foucault, 2006, p. 497). "His torture had been his glory: his deliverance was his humiliation" (Foucault, 2006, p.497). The sense of guilt, shame, and sin led the patient to become conscious of his disease and join the others. In this way, "… a common language was once more possible, after guilt had been recognised and acknowledged." (Foucault, 2006, p.497).

Establishers of asylums knew that being gazed at by others – being conspicuous – has a very fundamental and important role in building one's identity. Therefore, they made the madman identity-less by preventing him from being gazed at or at least by ruining a fragment of his identity which was his madness. In this way they could treat madness.

## Conclusion

It seems that gazing was used as a technique for treatment of madness. It is worth mentioning that each of the gazing techniques was based on a specific feature of gaze. One of the features common in all the three techniques is the politicality of gazing. Gaze as a political act is a technique for the rule of a group of people (physicians) over another group (mad people). Until the late 18th century, the only existent power in the world of madmen was an abstract and formless power which imprisoned them; a keeper without arms, chains, and bars which acted merely by gazing and language. He encountered madness not as a specific person, but in the position of a reasoned

being; he gained his authority due to his not being mad. Prior to this period, reason's imposing power on non-reason was through chains, bars, and imprisoning. Since then, due to his being reasoned, the director had power and authority over mad people, and could decide on the fate of patients and execute it and in this way could deal with "guiding the possibility of conduct and putting in order the possible outcome." (Foucault, 1982, p.789). In other words, there was the director-physician at one extreme due to their being wise and there were madmen at the other extreme whose being non-reasoned subordinated them to the reasoned, and thus, they became the object of their gaze.

The science of mental illness in the manner which evolved in asylums was merely involved with observation and classification. This science never established a dialog between itself and the mental patient. Even when in the 19th century, the power of the language between patient and physician was used and the patient-physician relationship began to be deemed as important, this science did not transform into a dialogue. Later, psychoanalysis added the observed person's speech to visual observation of the observer. However, this was not a mutual dialog, but always a recorded monologue of the observed person, "… thus keeping in place the old asylum structure of a non-reciprocal gaze, but balancing it out, in a non-symmetrical reciprocity, with the new structure of a language without response." (Foucault, 2006, p.488).

As we have seen, Foucault shows that very deep transformations in mechanisms of power have occurred in the West since the classical era. Functions of these mechanisms including "reinforce, control, monitor, optimize, and organize the forces under it: a power bent on generating forces, making them grow, and ordering them, rather than one dedicated to impeding them, making them submit, or destroying them." (Foucault, 1978, p. 136). Through establishing the asylums, madness became "visible" and was regarded as a deviation from "health" – i.e., mental disease. Foucault believes that all these sub-deviations from "health" which were classified entomologically and named oddly formed a knowledge termed psychology. The objective of the mechanism of power which created such knowledge was "to give it an analytical, visible, and permanent reality." (Foucault, 1978, p.44). Exercising this form of power needed continual, conscious, and curious presence which functioned "through examination and insistent observation" (Foucault, 1978, p.44).

## Conflict of Interests

Authors have no conflict of interests.

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# Health Anxiety Disorder and Its Impact on Health Services Utilization: A Narrative Review Article

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Review Article

## Abstract

Health anxiety disorder (HAD) is defined as anxiety about having a serious illness or fear of a serious illness, despite the assurances of doctors to the contrary. The purpose of this study was to review HAD, its diagnostic criteria, and its impact on health services utilization in a review article in 2018. For this aim, articles in ProQuest, ScienceDirect, PubMed, Scopus, Embase, and ISI Web of Science databases were selected without a publication time limit, and then, data on the nature, diagnostic criteria, and the effect of HAD on health services utilization were extracted. HAD is a relatively common disorder that persists in the absence of suitable management and results in excessive utilization of health services, avoidance of health care, and disruption of the function of individuals. Therefore, with early diagnosis, repetition of counseling, clinical trials, and the use of health services is avoidable and will prevent cost increases. Consequently it is better to have consensus on the diagnosis criteria of this disorder and, if diagnosed, the person is treated.

**Keywords:** Health anxiety disorder, Utilization, Health services utilization, Psychosomatic disorders

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## Introduction

With regard to the important role of health in people's lives, it is no surprise that most people have concerns about their health. Health concerns occupy most people, especially after experiencing unfamiliar physical symptoms. This state of affairs is most commonly resolved and eliminated with the disappearance of symptoms or the assurances of doctors. However, in some cases, even though the evidence does not indicate a specific illness or problem, the patient's concern is not resolved and may even become more severe and lead to a phenomenon called health anxiety disorder (HAD) (Panahi, Asghari

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Moghadam, Shaeeri & Eghtedar Nejhad, 2010; Karimi, Homayuni, & Homayuni, 2015). HAD is a condition in which an individual interprets his symptoms or physical complaints as a serious illness. This disorder is often a spectrum that has mild concerns on the one hand, and on the other hand, fear and extreme anxiety about the health status and obsessive thoughts about physical sentiment. Health-related concerns may emerge both in people with disease and those who suffer from serious medical conditions and illnesses, leading to stimulation of people, and thus, further elucidated physical symptoms. To this end, different types of health and diagnostic services are used (Melli, Carraresi, Poli & Bailey, 2016; Hosseini Ghomi, Salimi Bajestani, & Zakeri, 2014; Abramowitz, Olatunji, & Deacon, 2007). People with various levels of HAD show different health services seeking behavior compared to those who are not affected by the disorder and their decision to utilize health services is altered. This decision may take the form of health services overutilization or avoidance of health services utilization. As a result, the differences in the treatment behavior of people with this disorder can have a significant effect on health services utilization (Koszegi, 2003; Nasri, Shakari & Haidari, 2015; Elshaug et al., 2017). This study aimed to understand HAD and its criteria, diagnostic criteria, and its effect on health services utilization.

## Methods

This narrative review study was conducted in 2018. This study was conducted by searching for the keywords "Anxiety", "Health Anxiety", "Hypochondriasis", "Health services utilization", "Health care utilization", and "Psychosomatic Disorder", in valid databases such as ProQuest, ScienceDirect, PubMed, Scopus, Embase, and ISI Web of Science. From among the 101 sources found according to the relationship with the topic of this study, 51 articles were selected. Then, data regarding the nature, diagnostic criteria, and impact of HAD on health services utilization were extracted.

## Results

**Introduction to Anxiety Disorder:** One of the important factors leading to medical attention is complaints of physical symptoms. Some of these problems seem to be rooted in the psychological pressures of everyday life. Thus, in recent decades, new diseases have been identified as psychosomatic disorders that are associated with emotional and psychological factors. According to the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), psychosomatic disorders are a large group of diseases the physical signs of which constitute their main component, but the root cause of these diseases is psychological problems. Psychosomatic disorders fall into several major groups. One of these disorders in the group of Somatic Symptom and Related Disorders (SSD) is HAD or hypochondriasis. Although the DSM-5 mentions this disorder in the group of SSD, it is also referred to in the Illness Anxiety Disorder (IAD), which indicates that the core of the disorder is anxiety (Shabbeh, Feizi, Afshar, Hassanzade Kashtali, & Adibi, 2016; Noohi, 2013; Rahmaniyan, Sarvarian, & Zamani, 2016; American Psychiatric Association, 2013; Gropalis, Witthoft, Bailer, & Weck, 2018; Huang et al., 2016; Ahmadzadeh, Malekian, Afshar, Maroufi, Arbabi & Nejatisafa, 2012).

People with SSDs have multiple physical symptoms that affect their daily lives and are most often a strong sign of their pain. Symptoms may or may not be specific localized pain. These symptoms sometimes indicate a natural feeling of the body or discomfort that is generally not a sign of serious illness. Nevertheless, people with IAD continuously think about having a serious illness. In these cases, there are no bodily signs or very mild signs. The person has severe anxiety for his health and is easily excited about his health. These individuals

display excessive health behaviors, including excessive treatment behavior and avoidance behavior (American Psychiatric Association, 2013). Individuals with HAD may illustrate excessive curative behavior in order to ensure their health status. Such people, especially if they have illnesses, frequently use diagnostic tests and visit doctors at various specialized levels. These frequent and unproductive visits displease both the individual and doctors. Sometimes even a sense of frustration is felt by physicians or even the entire person's health system. Perhaps even the individual feels that doctors do not believe him/her or see his/her complaints as figments of his/her fancy. In contrast, some people avoid any action that exacerbates their health concerns. This behavior involves avoiding people (medical team, and friends or relatives with illness), avoiding places (hospitals and doctors' offices), and avoiding activities (taking into account medical advice, and thinking about death and illness) (Anderson, Saulsman, & Nathan, 2011).

An individual with hypochondriasis is actually afraid of being ill. A person with this disorder has a persistent urge to have or is unlikely to have a serious illness. Although concern may be due to a non-physical sign or symptom, an individual's discomfort is not primarily a physical complaint, but rather anxiety about the meaning, importance, or cause of a complaint. In other words, the person's concern is that he may be diagnosed with a disease. If there is a physical sign or physical symptom, often a natural physiological sensation such as dizziness, or a physical discomfort that usually does not signify the presence of a disease, is caused in the individual. If there is a recognizable medical condition, the anxiety and mental involvement of the individual are clearly extreme and disproportionate to the severity of the disease. People who have been diagnosed as hypochondriasis according to previous version of DSM, now are categorized mostly as Somatic Symptom Disorder and sometimes as HAD cases in the DSM 5. Therefore, if the symptoms are not noticable and anxiety is severe, the person has HAD, and if the symptoms are severe but anxiety is low,the patient suffers from Somatic Symptom Disorder (Hosseini Ghomi et al., 2014; Abramowitz et al., 2007, American Psychiatric Association, 2013; Weck, Richtberg, & Neng, 2014).

Hypochondriasis is not merely a psychological disorder that involves health-related concerns. Additionally, self-diagnosis depends on the observation of the DSM criteria, while the spectrum of health anxiety involves both continuous and mild-to-relational anxiety concerns and fleeting concerns until the complete diagnosis of hypochondriasis. In recent years, this problem has been addressed by psychiatric health professionals to a large extent because, according to the advice of these professionals, it is better to use the term health anxiety to diagnose this disorder, and only use the term hypochondriasis in the case of an extreme HAD. Therefore, there are many reasons to extend the continuous measurement of health anxiety, which indicates that the scales used for this measurement should be sensitive to normal levels of health concerns as well as hypochondriasis (Hart & Bjorgvinsson, 2010; Salkovskis, Rimes, Warwick, & Clark, 2002; Bobevski, Clarke, & Meadows, 2016).

HAD is usually characterized by anxiety and fear of having a serious illness. The disorder may be seen in a healthy person, in a person experiencing symptoms without medical justification, or in someone who is really ill. In people with a disease, such concerns are adaptive and cause them to pay particular attention to their physical symptoms so that they can treat any symptoms they may have. In other cases, severe physical health concerns occur in the absence of any clear symptoms of disease, such as when people find that they are ill on the basis of a misinterpretation of their physical symptoms. However, the relationship of health anxiety with the

presence of any non-communicable disease has not yet been proven. These thoughts are usually reinforced by mental and emotional imagery, and thus, people experience anxiety with continuous health (Karimi et al., 2015; Weck et al., 2014; Sunderland, Newby, & Andrews, 2013; Dibajnia, Panahi, & Moghadasin, 2012; Deirdre Kehler, 2006).

In general, there are several theories for HAD:

- Psychodynamic theory
- Biological theory
- Behavioral theory
- Cognitive-behavioral theory

Researchers believe that the cognitive-behavioral theory of health anxiety specifically contains useful information that illustrates its underlying (vulnerabilities), revealing, continuing, and exacerbating factors. This model has also been empirically verified (Deirdre Kehler, 2006). The cognitive-behavioral theory (CBT) about HAD shows that the mild form of this disorder is more common among ill people or those who are worry about their health in a long term. In addition, severe anxiety has prolonged and significant effects on individual performance, and in its severe and enduring form, it affects individuals' quality of life (QOL) and ability to work, and may even have the risk of dismissal from work and disabilities (Hosseini Ghomi et al., 2014; Fink, Ornbol, & Christensen, 2010; Tang, Salkovskis, Poplavskaya, Wright, Hanna, & Hester, 2007; Eilenberg, Hoffmann, Jensen, & Frostholm, 2017; Hedman et al., 2011).

HAD is rarely recognized in clinical studies because it is considered as a secondary illness or condition for other psychiatric disorders. Evidence suggests that multiple physical symptoms or concerns about diseases may be related to the disorder and are very debilitating if this disorder is accompanied by other mental disorders. Therefore, the diagnosis of health anxiety is necessary to prevent severe disabilities (Bobevski et al., 2016; Fink et al., 2010, Newby, Mahoney, Mason, Smith, Uppal, & Andrews, 2016; Hadjistavropoulos & Lawrence, 2007).

**Criteria for diagnosis of health anxiety disorder:** The DSM-5 diagnostic criteria for HAD include:

1. Continuous thinking about having a serious illness
2. The absence of physical symptoms (If physical signs are present, they are very mild. In the case of a previous illness in the person, there is a great likelihood of other medical conditions.)
3. Lack of certainty about the results of the treatment and the doctor's affirmation of the patients' health
4. Severe health concern easily led to distress and fear regarding health
5. Great concern about a particular disease that had already existed in the individual's family
6. Great concern about the illnesses that make it hard for the individual to work
7. Repeated searching for some of its physical symptoms on the Internet
8. Exhibition of severe health-related behaviors (such as controlling and testing physical symptoms) or abnormal avoidance of certain situations (such as avoiding referral to a doctor and hospital)

Based on the criteria of the Diagnostic Criteria for Psychosomatic Research (DCPR), HAD is classified as "Abnormal Illness Behavior (AIB)" and the following criteria are used to identify it:

- General concerns about illness, concern about pain, and addressing physical symptoms (desire to exaggerate physical sentiment) for at least six months
- Concerns and fears that are even triggered by the confidence of the medical group, maybe even after a while new concerns arise (Porcelli & Rafanelli, 2010).

HAD has two forms:

- Health service seeking behavior: Too frequent usage of medical and diagnostic services, including visiting physicians or performing diagnostic tests
- Avoiding Health Services: Avoiding Getting Health Care (American Psychiatric

Association, 2013).

Many studies have pointed out that there are no significant gender differences in the incidence of health anxiety; it also seems that there is little relation between demographic variables such as level of education, social status, and marital status and this disorder. However, based on these studies, physical symptoms disorder has a direct correlation with health anxiety. Physical symptoms include one or more physical symptoms that are annoying and excessive thinking, emotions, or behaviors that are related to physical symptoms caused by health concerns. Physical symptoms are more common in patients with severe HAD or hypochondriasis than in others. About 20 percent of people whom received first level of healthcare services and experienced bodily syndromes might have HAD. People who suffer from physical impairment and health anxiety are subject to poor physical health, increasing disability, excessive use of health care, and dissatisfaction and discontent with physicians' interpretation of their symptoms and disease management. Therefore, in this situation, the relationship between the patient and the physician will be confused (American Psychiatric Association, 2013; Lee, Creed, Ma, & Leung, 2015; Solem, Borgejordet, Haseth, Hansen, Haland, & Bailey, 2015; Shahidi, Molaie, & Dehghani, 2012; Toussaint, Lowe, Brahler, & Jordan, 2017).

**Approach to health anxiety disorder in the health services seeking-behavior:** In some health systems around the world, when there is no referral system, people who have good access to health care are encouraged to increase their use of health services. This is particularly the case with insurance, low cost of receiving services, or free services, such as services provided to covered individuals at the social assistance centers of the Social Security Agency. In such a situation, consumers are not motivated to save money on the use of services because they do not incur all medical expenses, and this will lead to moral hazard (Keshavarz & Zomorrodi Anbaji, 2010). Therefore, there are several reasons for using health services more than needed or less than needed that should be distinguished from the category of health anxiety. In addition to a form of health anxiety that is treated as avoidance of care, there are many other factors that can lead to lack of access to health care. One of the factors that lead to avoiding care is the lack of access to affordable services. Geographic, financial, and physical access are determinants of whether people are benefiting or not benefiting from health services, and individuals' reluctance to receive health services may be due to lack of access to them in various ways (Rezapoor et al., 2015).

The next factor that can be considered in receiving or avoiding health care is the health literacy of individuals. Health literacy refers to the individual's capacity to obtain, interpret, and understand the basic information that is appropriate for deciding on health services. It also includes a set of reading, listening, analysis, and decision making skills and their ability to apply these skills in different situations, which do not necessarily correlate with their degree.. Although it is still unclear how health literacy affects health outcomes, there are many reasons that health status, hospitalization, self-care skills, preventive care, and inappropriate use of health services are greatly impacted by the health literacy of people. Indeed, a low level of health literacy can lead to undesirable physical and mental health that affects the quality of health care services, especially if someone is struggling with disabling circumstances, such as anxiety disorders. Therefore, moral hazards, access, severe illnesses and health literacy are among the factors affecting the inappropriate use of health services, and when considering HAD, these items should be rolled out. (Reisi, Mostafavi, Hasanzadeh, & Sharifirad, 2011).

Figure 1 depicts different types of inappropriate healthcare seeking behavior, the factors affecting it, and the proposed treatment method for each one.

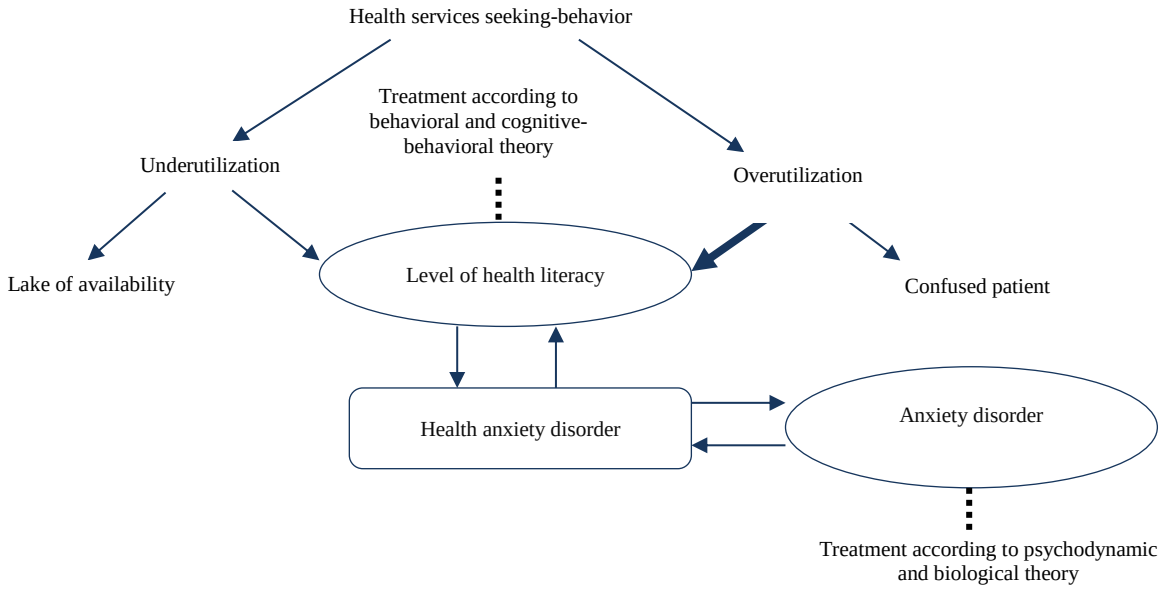


**Figure 1.** Types of inappropriate treatment-related behaviors that affect the inappropriate treatment behavior and the way each one treats them

Various studies suggest that, in contrast to people who use health services more than usual because of HAD, some people refrain from receiving any specialized medical care by showing avoidance behaviors. This problem can reduce the level of anxiety in the short term, but may have long-term irreversible effects on the individual and society. Therefore, identifying people with this form of HAD can reduce irreparable complications for the health of the individual and society in the long run (Anderson et al., 2011). Various studies have suggested that patients with anxiety disorders, especially at high levels, are significantly more likely to use all types of health care, especially if their access to healthcare is facilitated by insurance coverage and other factors, than those who have a real medical condition and have a good health record. The burden of health anxiety is significant for the community and individual, and it leads to an increase in the rate of use of general or specialized health services. People with health anxiety may seek to see physical symptoms even at mild levels, seek screening tests, diagnostic tests, referral to doctors at various levels of expertise, and the use of paraclinical services. In these cases, their concern, even after consultation with the doctor, may still be at high levels and, by repeating tests and referrals to the doctor, may result in high medical expenses (Fink et al., 2010; Shahidi et al., 2012; Scott, Mackenzie, Chipperfield, & Sareen, 2010; El-Gabalawy, Mackenzie, & Sareen, 2016; Roberge, Fournier, Duhoux, Nguyen, & Smolders, 2011; Rimes & Salkovskis, 2002).

Patients also exhibit protective behaviors designed to reduce health anxiety, such as avoiding information related to illness or seeking to ensure their health through clinical guidelines and body checks. However, in the long run, these behaviors may intensify and add to the severity of HAD, instead of reducing its severity (Hadjistavropoulos & Lawrence, 2007).

Individuals with health anxiety may not only reveal an abnormal set of behavioral patterns of response to disease information, but may also act inadequately and ineffectively in the use of protective anxiety strategies. This issue in people with health anxiety may have a negative effect on their satisfaction with the advice of the physician. Some people with health anxiety may be reluctant to seek medical advice and receive diagnostic and therapeutic services, especially mental health services, in the face

of their physical symptoms. Some people also avoid referrals because of fear. Others may also prefer not to see a physician to get ensurance about their physical condition, and only consider their relatives' comments.. While the cognitive-behavioral theory of health anxiety anticipates active avoidance behavior in relation to disease-related information, the question is whether people with health anxiety use cognitive strategies of suppression and distraction during exposure to information related to the disease. They remain in ambiguity and uncertainty. Such strategies are ineffective and may lead to excessive use of healthcare through deterioration (Weck et al., 2014; Tanis, Hartmann, & Te, 2016; Hadjistavropoulos, Craig, & Hadjistavropoulos, 1998; Issakidis & Andrews, 2002).

Given that health services are currently provided for people with physical and psychological illnesses, not for people with unexplained physical symptoms or health anxiety, excessive use of care services heavily influences health in contemporary times. In addition, health anxiety at its extreme levels has led to economic burden and significant negative effects on the individual and society. Furthermore, the use of the health care system at different levels of health care services (such as frequent visits to professionals, medical tests, unnecessary hospitalizations, and the use of medications) will increase if this disorder intensifies. In the hypochondriasis, which is a vigorous form of health anxiety, radical estimates of the medical conditions tends to medical service overuse, all of which in turn create high health care costs. Therefore, trying to cure this issue is important (Abramowitz et al., 2007; Elshaug et al., 2017; Bobevski et al., 2016; Prochaska, Le, Baillargeon, & Temple, 2016).

## Conclusion

Investigating research related to the present study showed that HAD and its severe form, hypochondriasis, are relatively common disorders that persist in chronic non-treatment and lead to overutilization of the health care system and disruptions in the daily routine of people. Moreover, this disorder can have a significant impact on the QOL of individuals. These characteristics have caused HAD and hypochondriasis to impose many costs on the health system and society (Panahi et al., 2010; Karimi et al., 2015).

Regarding the high prevalence of psychological disorders, there are several valid instruments for measuring anxiety disorder that are based on the criteria of the DSM-4 and DSM-5 and cognitive-behavioral theories. Among these tools, the Health Anxiety Inventory-Short Form (HAI-SF) is a useful tool for measuring this disorder among different demographic groups. Although the study of health anxiety disorder among patients and hypochondriasis cases is important, but its review in other samples seems to be effective in assessing how they benefit from health care services. (Elshaug et al., 2017; Dibajnia et al., 2012).

Given that people's strong concerns about their health status are not usually overcome by reassurance,, over time, the concerns of individuals have been transferred from one disease to another, and ultimately, have created many problems for the individual, family, and health system. However, studies have shown that this disorder can be effectively treated with the use of psychotherapeutic interventions and cognitive-behavioral interventions. Moreover, if health concerns and the likelihood of them are diagnosed as anxiety in the early stages, repeated counseling, clinical trials, and other health care services and their economic burden on the limited resources available to the health sector can be avoided. Besides,given that the funds allocated to the health sector are limited, there is a need for consensus on the diagnostic criteria of this disorder. Evidently, the timely detection of this disorder and its prevention will lead to the efficient management of health care resources and

prevent financial risks for consumers and healthcare providers (Lung-Cheng, Ho, Weng, Hsu, Wang, & Wu, 2015; Saneei et al., 2016).

## Conflict of Interests

Authors have no conflict of interests.

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# Psychocultural Factors Affecting HIV/AIDS Infection among Iranian Women: A Grounded Theory

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Quantitative Study

## Abstract

**Background:** Previous studies have shown that adversity, sexual violence, prostitution, and addiction can increase the risk of HIV/AIDS infection. Providing an overview of the risk factors of this disease is significantly important in preventing its spread. It was therefore decided to focus this research on the determination of cultural and social factors that increase the risk of HIV/AIDS among women in Tehran, Iran.

**Methods:** The present study was a qualitative research. The study group consisted of 13 women with HIV/AIDS infection who are members of the HIV Positive Club of the Iranian Welfare Organization, their sexual partners, and 10 experts and specialists of HIV/AIDS in Tehran. The qualitative approaches of interviewing the infected women and holding group discussion with experts and politicians were applied for data gathering. The analysis of data was carried out using grounded theory based on basic concepts, organizational concepts, comprehensive concepts, strategies, and consequences.

**Results:** As a result of data analysis, 73 basic concepts, 61 organizational concepts, and 151 comprehensive concepts (73 social and 78 cultural factors) were obtained.

**Conclusion:** The most important factors are lack of information and sexual awareness within the mentioned group, the educational level of parents and children, unprotected sexual intercourse among polygamous partners, prostitution, homosexuality, divorce, cultural shift in women's role in the family, discrimination, poverty, marginalization, men's dominance in the intercourse, and unprotected sexual intercourse. Increasing women's awareness through training in order to affect their sexual behavior is suggested as a solution in this regard. Moreover, welfare and wellbeing must be improved in the society so that low-cost health care is available and accessible to all members.

**Keywords:** Cultural factors, Social factors, HIV/AIDS, women

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## Introduction

The first case of AIDS was reported almost 30 years ago, and its spread had started by then and is still a challenge for modern societies. AIDS is an infectious disease with a certain way of transmission that differs from that of other infectious diseases. AIDS has no frontier like nationality, age, and gender (Shojaei Therani, 1998). It can have negative physical, mental, social, and economic effects on individuals' wellbeing. It is noteworthy

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that the majority of infected people are younger than 25 years of age (Sadrizadeh, 1976; Ministry of Health and Medical Education, 2014).

Up to two-thirds of the healthcare budget in some African countries are allocated to HIV/AID cases (UNAIDS, 2007).

HIV/AIDS has been categorized as a behavioral disease due to its transmission ways such as shared injection needles, blood, unprotected sexual intercourse, and etcetera (Ministry of Health and Medical Education, 2014).

Based on the Ministry of Health and Medical Education report in 2015, 29,414 individuals were diagnosed with HIV/AIDS among which 88% were men and 12% were women. Until today, 6,990 cases of HIV/AIDS have been reported and 6,202 have been reported as dead. In addition, 45.6% of the infected group were 25-34 years old (Ministry of Health Indonesia & statistics, 2007). In Iran, the recorded transmission rate from 31 years ago until today related to shared injection needles, sexual intercourse, transmission from mother to child, and unknown methods are 66.6%, 14.5%, 1.14%, and 16.7%, respectively (Sadrizadeh, 1976; Ministry of Health and Medical Education, 2014). Furthermore, in 0.8% of cases, transmission was related to infected blood donation which dated back to the period in which there was not a complete blood bank health check plan (Ministry of Health and Medical Education, 2014).

According to the Iranian National Center for AIDS Prevention website, the number of HIV cases registered is 30727; however, the estimation is 110459 in Iran [25632 men (85%) and 4551 women (15%)] and 36900000 globally. According to studies, women are at a higher risk of exposure than men. The origin of this risk is the fact that it is a taboo topic in society and this is also the underlying reason for the unreported number of infected cases and the acceleration of its spread especially among women (Rave, Gapta, and Jana, 1997). It has also been shown that sexual intercourse was the transmission method in more than 90% of all affected adults in developing countries (UNAIDS, 2004).

It is estimated that at least 50 million women are affect by HIV because of their sexual partners (IHRA/WHO/AHRN, 2004). These women are either married or sex partners of men who are present high-risk sexual behaviors. The United Nations Office on Drugs and Crime (UNODC) estimates that 75% of HIV positive women in Eastern Europe and Central Asia have been infected by their injecting addict partner through injecting drug use or sexual relations. Women now account for 56 to 76% of injecting drug users in Eastern Europe and Central Asia, for example, 56 to 76% of injecting drug users in Russia are women and they are increasing every day. However, none of the countries in the region provide appropriate services that reflect the needs of women who are drug users (Asian Development Bank, 2009).

The United Nations Programme on HIV/AIDS (UNAIDS) estimated that 85% of women were affected by HIV in Eastern Europe and Central Asia through shared needles or sexual intercourse (UNAIDS, 2005).

There is a close relationship between poverty and HIV/AIDS. Studies have shown that in Africa poverty has increased the incidence of HIV/AIDS, especially among girls and women (Scott, 2010).

The lack of equal income opportunities for African men and women causes them to migrate from small towns and villages to larger urban and metropolitan areas; this in turn results in an increase in HIV/AIDS. When men return to their city and village and to their families, they are more likely to transfer HIV/AIDS to their women (Crush, Williams, Gouws, & Lurie, 2005).

The study of poverty, migration, social inequality, marginalization, and other social factors can play an important role in health policy planning. Studies show that in Africa,

cultural values and norms are associated with the spread of HIV/AIDS. Some of these values and norms include gender inequalities, sexual facts, sexual commitment, polygamy, sexual violence among couples, and prostitution and health reproduction (Lagarde et al., 2001).

Today, women comprise up to 30% of injecting drug users in Eastern Europe and Central Asia. Russia is an example with up to 30% prevalence of injecting drug use reported among women which is increasing. However, there is no effective social service in these areas to control drug use (Hernandez et al., 2004).

The fight against AIDS requires comprehensive effort. Along with health and sanitation, correction of cultural and social approaches is essential for the management of this disease. Today, scientists' efforts to discover AIDS are now more than ever. Evidently, the study of cultural and social factors is useful in the prevention of this disease through future planning and policy-making. Thus, the present study aimed to elaborate on this issue in a qualitative study of women's own language.

It is obvious that a study of social and cultural factors can be effective for futuristic planning for the prevention of the spread of HIV/AIDS infection. The following research tried to clarify the issues by gathering information from affected persons.

## Methods

The present research is a qualitative study. The study group consisted of affected women in Tehran, Iran, who have been members of the HIV Positive Club since 2015 (13 individuals), their partners (13 individuals), and 10 experts. The participants were selected through purposive sampling method from among the residents of Tehran. The women were between 25 to 50 years of age and were influenced by cultural and social factors. The interview method was applied to gather data until saturation, i.e., lack of any new information and repetition of the same information.

Data gathering was performed in this study by carrying out 2 group discussions with non-governmental organizations managers, psychologists, specialists, and people who are working with the HIV infected group. The feedback provided by experts in the group discussions assisted us in reviewing and filtering the collected data. The participants were HIV infected persons who were registered in one of the HIV centers that are supervised by the Iranian Welfare Organization (Yaran Mehr, Khaneh Khorshid, Simaye Sabze, Rahaei, Ahange Rahaeye, Shargh, and Andishemandan Raya health centers).

All the efforts in this research were toward avoiding personal interpretation and bias through using recommended research methods. For example, comparison method is a research method in which the comparison is between the data gathered from the research, the participants' thoughts, similar experiences, and other existing data. The collected data were also verified by the interviewee; the interviewer's interpretation of the interview outcomes was presented to them. Moreover, interviewees were provided with a detailed explanation of the research method (descriptive method). Finally, the triangle method was used to accumulate data from the available documents and sources, and interviews of experts in order to verify the research results.

## Results

**Descriptive statistics:** The average age of the participants was 34.9 ± 6.3 years. The average number of siblings was 5. Their average marriage duration was 11 years. The average age of marriage of the subjects was 21 years. In addition, the average number of children was 1. The length of acknowledgment of the infection was 22 months and their average disease duration was 2.4 years (Table 1).

Thus, 73 basic concepts, 67 organizing concepts, and 151 pervasive concepts with 73 cultural and 78 social factors were obtained (Table 2).

**Table 1.** Demographic data

| | Age | Brothers and sisters | Marriage years | Marriage age | Children count | Duration of acknowledgment (Months) | Duration of disease (Years) |
|---|---|---|---|---|---|---|---|
| Mean ± SD | 34.940 ± 6.266 | 4.560 ± 2.159 | 10.600 ± 9.240 | 21.330 ± 3.922 | 1.070 ± 1.100 | 21.690 ± 3.197 | 2.360 ± 1.286 |
| SE of Mean | 1.566 | 0.540 | 2.922 | 1.013 | 0.284 | 7.549 | 0.388 |
| Median | 35.00 | 4.00 | 5.50 | 20.00 | 1.00 | 11.00 | 2.00 |
| Minimum | 25 | 2 | 14 | 16 | 0 | 2 | 2 |
| Maximum | 50 | 9 | 30 | 30 | 4 | 120 | 5 |

SE: Standard error; SD: Standard deviation

## Discussion

The present research reviewed the cultural and social factors which impact the transmission of HIV/AIDS to women.

**Table 2.** Demographic data of the clients and their parents

| Variety | Indicator | Women with HIV (%) | Her mother (%) | Her father (%) |
|---|---|---|---|---|
| Education | Pre-diploma degree | 68.75 | 87.5 | 75 |
| | Diploma | 25 | 12.5 | 18.75 |
| | University degree | 6.25 | 0 | 6.25 |
| Occupation | Employed | 6.3 | | |
| | No income | 93.8 | | |
| | 300000 tomans | 68.8 | | |
| | 300000-500000 tomans | 7.1 | | |
| | Higher than 1 million tomans | 7.1 | | |
| Marital status | Married | 12.5 | | |
| | Divorced | 87.5 | | |
| Housing | Without a house | 6.3 | | |
| | Renting a house | 25 | | |
| | Other | 68.8 | | |
| The way of learning about the disease | Triangle clinics | 12.5 | | |
| | Laboratory | 43.8 | | |
| | Symptoms | 25 | | |
| | Sexual partner | 6.3 | | |
| | Friends | 12.5 | | |
| Reflection after the disease | Suicide | 6.3 | | |
| | Depression | 75 | | |
| | Impatience | 18.8 | | |
| Knowledge about the disease transmission way | Knew | 37.5 | | |
| | Did not know | 62.5 | | |
| Function after knowing disease | Without any function | 12.5 | | |
| | Went to the doctor | 87.5 | | |
| Extramarital relation | Had | 66.7 | | |
| | Did not have | 33.3 | | |
| Using prevention tools in sex | Used | 18.8 | | |
| | Did not use | 81.3 | | |
| Addiction background | Had | 62.5 | | |
| | Did not have | 37.5 | | |
| Sexual aggression | Had | 56.3 | | |
| | Did not have | 43.8 | | |
| Effective sociocultural factors in women's view | Family limitations | 21.4 | | |
| | Lack of information | 25.7 | | |
| | Lack of family support | 7.1 | | |
| | Sexual relations | 14.3 | | |
| | Personal hygiene habits | 21.4 | | |

**Table 3.** *Social and cultural Indicators*

| Social indicators | Pervasive concepts<br>Cultural indicators | Organizing concepts | Basic concepts |
|---|---|---|---|
| Neglect or inattention toward the following among women is effective on HIV infection in Iran. | | | |
| Visible sexual problems/having more than one wife/sexual jobs/lack of obligations in family/lack of real social supports in marriage/lack of social connections in nuclear families/lack of trend to be in social groups/Unjust sexual relations/low safety in society and poverty/release of bad sexual cases in media and satellite/lack of placement plans in prisons/lack of knowledge about media/hall- marking/lack of legal and financial supports for divorced women/lack of emotional divorce training/preservation of the legal and regulatory dimension of marriages outside the customs/lack of sexual training for men/fear in women/lack of training in sexual desires cognition in men and women/lack of legal support for divorced women/lack of support for divorced mothers to keep their children/lack of living skills training for women of different ages/lack of health training (physical-sexual, mental, behavioral and social) for women/lack of education for women/lack of financial support and insurance/lack of training for men to support women of different ages/lack of availability of free social consultation for women/lack of clinics in every part of the country and Tehran/lack of public and legal supportive organizations/lack of recognition of damages regarding the changes in women's role and its results in scientific and academic cases and media/consultation before divorce/encouragement to build a family/preparation of living areas/increase the | lack of training about sexual health/knowledge of the personal identity of women/lack of attention to the role of husband and individual relations/difficulty in marriage/lack of training of sexual relations in men/lack of training of sexual relations for women/women's lack of belief in sexual training for young people/lack of extended family advantage's training/sexual culture for women employees/sexual aggressiveness/enjoyment of men in sexual relations/men who do not use prevention tools when visiting other countries/women's lack of values and beliefs in only having sexual relation with their husbands/elimination of sexual problems in prisons/acceptance of social connections for the development of knowledge/emphasis on sexual behavior training in society/people's tendency toward sexual knowledge/lack of cultural support for divorced women/emphasize on religious cases like extramarital relations and polygyny /fear in sexual aggression/lack of legal support for women/acceptance of living with HIV and maintaining the marriage/acceptance of men's aggression in the family/difficulty in establishing a relationship between mothers and children/lack of knowledge about their own physical-mental-behavioral and social condition/lack of knowledge among women/lack of education among women/lack of financial independency among women in the family because of lack of occupation and personal income/communication difficulty for women in the family/fear of disease/lack of money | acceptance of multiple sexual relations by women/disbelief in active sexism among women/social acceptance of increased age of marriage for women/lack of decision-making power in sexual relations by women/willingness to accept a nuclear family style/increased HIV infection prevalence among women due to poverty and low income/ increased likelihood of sexual assault and violence among marginalized women and those living in deprived areas /norm of free sexual relations between women/prison experience in women/reinforcement of sex outside the norms of society through the use of social networking sites and internet porn/stigma is one of the reasons for women not to refer women to health systems/lack of attention to women's sexual and emotional needs in relationships/tendency toward concubinage in economic and social issues/lack of attention to women's sexual demands /lack of attention the lifestyle of a generation of women by their parents and the community/ lack of awareness of personal and social skills in women/protecting experts against HIV/women's avoidance of treatment due to its high cost/delayed action by women due to the lack of social and psychological support/discouragement of women by the long healing process from entering into or continuing treatment/the absence or lack of health services as a barrier to treatment in women/lack of sufficient income to deal with health problems/replacement of social roles | unprotected sexual intercourse/injection needles/drugs and alcohol use/ lack of sexual health education /sex outside the marriage /polygamy/white wedding/lack of alignment in sex with the spouse/multiplicity in sex/ prostitution/adultery/forced to perform high-risk sexual behaviors/women's lack of freedom in the use of condoms/increased marriage age/ patriarchy in sexual relations/negative attitudes of men toward the use of condoms/changes in the family structure/poverty/economic status/ social gap /emigration/marginalization /transit drivers/sexual tourism/shift work/values/custom and culture/prison/internet and social network/stigma and discrimination failure in marriage/sexual problems/family problems/ sexual violence/imposed lifestyle /defects in life skills/lower vulnerability of experts/cost of treatment/length of treatment/social and mental support/lack of access to health services /inability to obtain medicine/the changing role of women /divorce/homelessness/lack of leisure programs /depilation/lack of support /individualism/sub- |

**Table 3.** Social and cultural Indicators (continue)

| Social indicators | Pervasive concepts<br>Cultural indicators | Organizing concepts | Basic concepts |
|---|---|---|---|
| positive places/lack of planning for women's free times/ women's lack of social connections/lack of control over sub-societies/people's lack of certainty regarding treatment systems/lack of attention to HIV/living skills training/inadequate access to health services/free consultation/making a related film/lack of training media/lack of attention to media knowledge/lack of social happiness/possibility of global connection in HIV training and treatments/attention to the changes in family structure/people's tendency toward group activities/social development and use of expert staff/local treatment model that is suitable for the Iranian culture/local treatment structures/increased social justice regarding the distribution of social resources/reduction of poverty/social distance/women's economical ability/income for women/hall-marking/education/development of women's knowledge/lack of social comparison/lack of social connections/social hall-mark/lack of access to health care/lack of attention to the national and traditional custom and culture/ planning and consultation before and after the divorce/financial support for women/legal support/lack of living skills training for men and women in social and educational systems/lack of hall-marking for homosexuality/lack of firmness in the family/lack of obligation to have one wife | for themselves/lack of promotion of national, Iranian, and religious beliefs in the family/lack of cultural values among women in choosing a husband/lack of group activity training/lack of sexual training for women according to the culture/lack of training of women regarding the disease process/lack of parental role training in the family/lack of training for children/lack of knowledge of desires/lack of comfort for citizens/lack of media use for cultural training/lack of attention to happiness in life/lack of attention to cultural democracy/lack of attention to culture making in the family and school/using intelligent people for training and curative planning/changing the attitudes of managers to change the organizational structure/cultural democracy/using culture to cope with social damages/lack of attention to HIV treatments in society/production of cultural need for knowing and understanding/lack of attention to the results of drug and alcohol use/lack of social and personal rules for women/sexual health training/personal skills training for a parental relationship/ training for children /living skills training/ healthy sexual relations/sexual aggression/healthy sexual behavior and safety training for husbands/lack of attention to the rules and national, Iranian, and religious beliefs of the family and women/lack of healthy sexual training for women/lack of safety and healthy sexual relation's training | for women after divorce and family breakup/homelessness as a cause of AIDS among women/women's sexual activity due to lack of leisure/exclusion and rejection by family and society/lack of group activities and immigration/avoidance of treatment by women due to the psychological and social damages of HIV/effectiveness of family education on women with AIDS/training employees and stakeholders /psychological and social support to prevent HIV in women/attention to the movies mostly watched by girls/motivating women to seek treatment/international experiences/individuality/scientific update/reforming of health structures /poverty/social exclusion/drugs use/replacement of problematic social roles for women/length of disease and expense of medicine avoid women to treat/nuclear family/failed marriage and separation as the cause of multiple sexual relationships to reduce the divorce rate /gender preferences in sex/earning money through prostitution /strict parents' traditional beliefs and lack of acceptance of youth lifestyle/ women's lack of knowledge of personal skills/violence in sex and lack of attention to women's sexual and emotional needs/inattention to educational systems for adulthood/impact of traditional or religious values and beliefs on HIV prevention /homosexuality/polygamy | cultures/damages/family education/training employees and stakeholders/attention to audience in film making/increased expectancy/utilization of international experiences/ scientific update/educated elite/reformation of the health structures/education /homosexuality/lack of knowledge about the way of disease transmission/shame in talking about sexual issues |

It was revealed that lack of information and sexual awareness within the mentioned group, educational level of parents and children, unprotected sexual intercourse of polygamous partners, prostitution, homosexuality, divorce, cultural shift in women's role in the family, discrimination, poverty, marginalization, men's dominance in intercourse, and unprotected sexual intercourse by the partner are the most important sociocultural factors (Table 3).

These results were verified through comparison with similar research conducted by the Preventive center of HIV in USA in Today world and the HIV groups who were infected by share needles and unprotected sexual intercourse and its relation with social- cases in Gorgan and Gonbad Kavoos (Etemad, Heydari, Eftekhar, Kabir, & Sedaghat, 2010). It seems that men are typically the dominant partner in Iran and are aggressive toward their partner, and women are the victims of this aggression. This domestic aggression combined with the lack of rules and regulations render women insecure in the society. Thus, this may propel them toward drug use in order to forget and free their mind (Table 2).

Lack of knowledge about HIV transmission ways among women is another cause of HIV infection. Lack of knowledge of the interviewees showed that there is a large gap in sexual behavior training. Early marriage (teenage girls are forced to get married) is one of the cultural issues from which some regions in Iran are still suffering. In some subsections of the Iranian society, divorce is not a norm; hence, a divorced woman must get into a religious contract with another man after divorce in order to secure her life. Since these contracts are not regulated, women are vulnerable to aggression and sexual intercourse with multiple sex partners (HIV) (Table 2).

Having HIV is another problem in Iran. This is due to increasing life expenses, unsuitable jobs, and preference for polygamy instead of monogamy. This combined with unprotected sex will result in the transmission of HIV virus among youngsters (Table 3).

The experts' and physicians' statements regarding lack of knowledge about safe sex, level of education, and divorce among women, which are effective cultural factors, were confirmed by the participants. The experts believed that cultural changes in women's role in the society, family structure, male dominance in partnership and sex, the lifestyle imposed by parents, dependency, low availability and accessibility of social benefits, health insurance, and consultancy affect the risk of HIV infection among women (Table 3).

In addition, similar social factors were reported in other researches. For example, the research by Stephani Scott (2010) in South Africa revealed that polygamy, men's negative attitude toward condom use, preference of having a large number of children in the society, and gender discrimination are the possible influencing factors. Factors such as poverty and prostitution of HIV infected women, which increase the chance of infection, can be added to the abovementioned factors (Table 3).

Homelessness, poverty, obsolete and old traditions, immigration from rural areas to cities, unemployment, consideration of sexual matters as a taboo subject within families, social discrimination and unfair distribution of social benefits, and homosexuality increase the risk of infection. Moreover, it was shown that the lack information and training for different HIV transmission ways play a pivotal role in the risk of infection. Another influencing factor was the studied women's level of education; the majority had a high school diploma or pre-diploma degrees (Table 3).

Poverty and low financial status are often accompanied by prostitution as a solution to earning money; this also increases the risk of HIV infection. Poverty can play a key role in this regard because they take on MSP to earn money (Table 3).

The results of the interviews with the experts and women were in agreement in terms of the mentioned factors. Furthermore,

homosexuality among HIV infected women, and drugs and alcohol abuse increase the risk of infection. In addition, any type of discrimination (social) may cause social frustration, and consequently, result in vulnerability toward MSP and the risk of HIV infection (Table 3).

From the experts' point of view, sexual tourism is an influencing factor in this respect. Moreover, the lack of knowledge about HIV transmission ways is a reason for unprotected sexual intercourse. Another influencing factor is unregulated marital contracts, which render women vulnerable to MSP. Ultimately, women play an important role in reducing vulnerability to HIV. Therefore, providing them with training and a secure social system will decrease the risk of HIV spread among them. This will also help to decrease this risk permanently for future generations through parents educating their children (Table 3).

## Conflict of Interests

Authors have no conflict of interests.

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# Investigating Cognitive Behavioral Therapy in Decreasing Depression in Women Suffering from Postpartum Depression in an Obstruction Office in Ahvaz, Iran

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**Quantitative Study**

## Abstract

**Background:** This study was performed to determine the effect of cognitive behavioral therapy (CBT) on decreasing the rate of postpartum depression (PPD) in two women referred to one of the obstraction offices of Ahvaz, Iran. Two women with PPD and their husbands were selected through a clinical diagnostic interview and the Edinburgh Postnatal Depression Scale (EPDS) and based on the study inclusion and exclusion criteria and lectures in health center in Ahvaz.

**Methods:** This study was a single-subject and non-congruent multiple baseline experimental study. Data analysis was conducted using visual depiction, reliable change index (RCI), and recovery percentage. In this study, two women with PPD underwent CBT and data were collected at baseline, during therapy, and at the one-month follow-up, and they completed the Beck Depression Inventory (BDI-13).

**Results:** The findings indicated 24.17% and 20.92% recovery percentage in depression in the first and second woman, respectively, as a result of CBT.

**Conclusion:** The results of the present research illustrate the efficacy of CBT in improving depression in women with PPD.

**Keywords:** Cognitive behavioral therapy, Postpartum depression. Women

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## Introduction

Parturition is a natural phenomenon and in the absence of any unexpected event, it will pose no threat to the mother and fetus and will take place without any complications. Sometimes, parturition is accompanied with complexities and difficulties which can affect the mother and fetus's life and endanger their life. The parturition mechanism is difficult in humans

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due to increment in brain size and shape of the pelvis. These factors create problems in the case of mismatches between the size of the embryo's skull and mother's pelvic outlet (Scott, Gibbs, Karlan, & Haney 2009).

Parturition is sometimes accompanied by a mood disorder which results in feelings of disappointment, incompetency, sin, fear, and worthlessness. These disorders can be the result of pregnancy period stresses or continuation of prenatal depression, sudden hormonal imbalance, physiological changes, and mental problems related to the pregnancy and parturition period (Kani Ahmadi Golzar, 2012). The symptoms of postpartum depression (PPD) persist for at least for 2 weeks and often occur 4 or 6 weeks after birth; in addition, it continues until 3 months after parturition in 50% of cases (Cooper, Champbell, Day, Kennerley, & Bond, 1988; Cox, Murray, & Chapman, 1993). PPD has a significant negative effect on all dimensions of quality of life (QOL) of the mother (Wewerinke, Honig, Heres, & Wennink, 2006; Posmontier, 2008). Interpersonal psychotherapy (IPT) and cognitive behavioral therapy (CBT) are among the treatments used for women suffering from PPD; however, there is much discussion regarding the best therapy approach. The highest therapeutic efficacy has been observed in psychological treatments (Cuijpers, Brannmark, & Van Straten, 2008) and an average amount of efficacy in pharmaceutical treatments (Bledsoe & Grote, 2006). CBT includes a series of psychotherapy interventions with the aim to decrease the level of mental problems. Moreover, it has been more effective than any other psychological intervention (Beck, 2001).

Previous researches on the prevalence of PPD have concentrated on the level and severity of depression semiology (Ohara, 1982; Paykel, 1980; quoted by Rajabi & Khoda Rahimi, 2000) rather than its diagnostic evaluation, although depression semiology is important for diagnosis in this period. However, the research results were based on signs which may have been misleading. To treat PPD, most often anti-depression drugs are used, but studies have indicated that patients undergoing pharmacotherapy have a two times greater risk of disorder recurrence compared to those undergoing cognitive therapy (Kani Ahmadi Golzar, 2012). PPD is a multifactorial disorder; therefore, the possibility of PPD can be decreased and women's mental health can be increased through identifying and decreasing each of these factors. Due to the sensitivity of this period and the higher risk of depression during this period, this research was conducted to investigate that the efficacy of CBT on the elimination of the symptoms of PPD among women referred to the Midwifery offices in Ahvaz, Iran.

## Methods

This non-congruent multiple baseline experiment was performed with a single-subject design. In this kind of study design, the experimental condition is controlled carefully and the independent variable is applied for a regular basis. This design makes possible the comparison of symptoms improvement level during the study period among the subjects, and after the intervention and at baseline. Single-subject experimental designs are similar to group designs and investigate the effect of an intervention by comparing different given conditions of the subject. The performance of subjects is used in the pre-intervention stage or baseline stage in order to predict subject behavior in the future (Kim & Lee, 2003; quoted by Imani, 2012).

The multiple baseline design of CBT was as follows. At the first stage, the baseline of the first couple was performed for 2 weeks. At the next stage, intervention therapy was undertaken continuously. Moreover, composition of the baseline behavior for the second couple was conducted for 3 weeks, then, the treatment was undertaken continuously. CBT was implemented in 10 sessions lasting 1.5 hours twice a week (Table 1).

**Table 1.** The multiple baseline design of cognitive behavioral therapy for two couples

| First Couple | Baseline | Baseline | Intervention | Intervention | Intervention | Intervention | Tracking | |
|---|---|---|---|---|---|---|---|---|
| Second Couple | Baseline | Baseline | Baseline | Intervention | Intervention | Intervention | Intervention | One-month tracking |

In addition, the Marital Satisfaction Scale (MSS) and Beck Depression Inventory (BDI-13) (short-form) were completed by the couples in the second, fifth, eighth, and tenth sessions and one-month follow-up was conducted. The study population included all women suffering from PPD referred to a midwifery office in Ahvaz in 2014. Two individuals were chosen through purposive sampling and a clinical interview by a clinical psychologist with ≥ 12 cut-off points in the Edinburgh Postnatal Depression Scale (EPDS) and considering the study inclusion and exclusion criteria. Both participants and their husbands provided informed consent to take part in the study. Cox et al. (1993) reported 0.78 as the characteristic score and 0.73 as the positive predictable value for the EPDS in a sample of adult mothers using 12.13 cut-off points and 0.86 sensitivity. The reliability of this scale has been determined to be 0.92 using Cronbach's alpha and 0.8 using test-retest method. Its characteristic score has been reported at 0.96 and its sensitivity as 100% (Montazeri, Torkan, & Omidvari, 2007). Furthermore, Cronbach's alpha of the BDI-13 was acceptable (0.81) in the whole sample and its simultaneous validity coefficient with Minnesota Multiphasic Personality Inventory (MMPI-D) on 50 people is 0.57 and significant ($P < 0.001$).

## Results

As can be seen in table 2, the depression level in the two women decreased from the baseline stage to the stage before CBT. The level of depression improvement was 24.17% at the end of the treatment stage of the first woman and 24.36% at the tracking stage. Moreover, it was 20.92% at the end of the treatment stage of the first woman and 20.87% at the tracking stage. These results indicate that CBT was more effective on decreasing depression in the first woman compared to the second woman, i.e., this treatment was more effective on the first woman than the second woman (24.17%).

**Table 2.** Depression level changes in the first and second woman during the treatment

| Dependent variable | Depression level | |
|---|---|---|
| Woman | First woman | Second woman |
| Treatment stages | | |
| First baseline | 25 | 25 |
| Second Baseline | 25 | 24 |
| Third baseline | - | 25 |
| Baseline stage mean | 25 | 24.66 |
| Second session | 24 | 23 |
| Fifth session | 22 | 21 |
| Eight session | 19 | 18 |
| Tenth session | 17 | 16 |
| Treatment stage mean | 20.5 | 19.5 |
| Reliable change indicator | 30.4 | 3.26 |
| Depression improvement level | 24.17 | 20.92 |
| Total improvement level after treatment | 22.54 | |
| One-month follow-up | 16 | 18 |
| Depression improvement level (follow-up) | 24.36 | 20.87 |
| Reliable change indicator | 6.08 | 5.37 |
| Total improvement level after follow-up | 22.61 | |

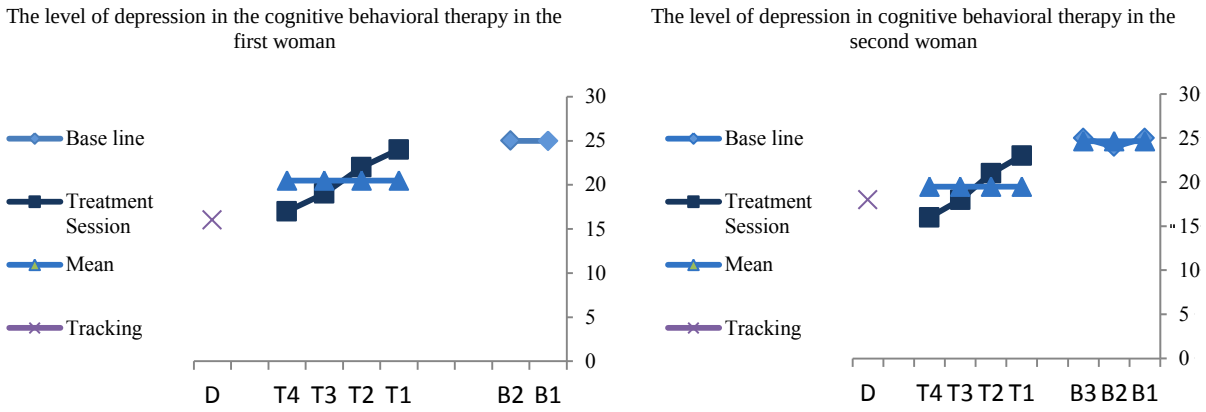


**Figure 1.** The changes in cognitive behavioral therapy scores of depression level in women at baseline (B), treatment (T), and follow-up stages (D)

In figure 1, the rate of depression in the first and second women decreased from the baseline stage to the post CBT stage. The findings indicate that CBT had a greater effect on reducing depression in the first woman than in the second woman. The total level of depression improvement after the treatment (22.54%) indicates the effectiveness of this treatment on improvement of depression among women. Moreover, in the 1-month follow-up phase, the two women were in the same range of interventions. Furthermore, reliable change index (RCI) after the treatment stage were significant in the first (3.04) and second (3.26) woman (more than z = 1.96). RCI was 6.08 in the first woman and 5.37 in the second woman at the one-month follow-up which are significant. However, according to the total level of depression improvement in both women during CBT, it can be said that this treatment was successful based on the Blanchard classification (Poppen, 1989; quoted by Hamidpour, 2008). The depression improvement level of this treatment was 22.61% in the follow-up stage; thus, it can be said that the effect of the therapy persisted.

## Discussion

The aim of this research was to investigate the efficiency of CBT in decreasing PPD in women. The findings indicate that in the two women suffering from PPD, changes were observed in the depression dependent variable. In relation to the use of CBT for the treatment of depression, it can be said that depression level in the first and second woman decreased in the post-treatment stage compared to the baseline stage. The level of depression improvement was 24.17% at the end of the treatment stage in the first woman and second women 20/92 which indicates that CBT decreased the depression level in the first woman more than the second woman. The total level of improvement in depression after the treatment (22.54%) indicates the effectiveness of this treatment on women. The results of this research are similar to that of the study by Rajabi, Karjo-Kasmaie, and Jabbari (2011), Thomas et al. (2012), and Leichsenring, Hiller, Weissberg, and Leibing (2006). In explaining the above findings, it can be said that the cognitive vulnerability assumption is based on individuals' ability to understand, interpret, or evaluate occurrences and conditions that result in denying negative or stressful mental occurrences; however, this may exacerbate the depression symptoms (Metalsky, Halberstadt & Abramson, 1987; quoted by Rajabi & Khoda Rahimi, 2000). Chabrol et al. (2002) presented the prevention and treatment combined approach for the treatment of women with PPD using the EPDS; in addition, they reported that cognitive–behavioral consultation resulted in a significant improvement of depression symptoms in comparison to the control group.

A limitation of this research was its small sample size; therefore, result generalization should be done cautiously. Moreover, it is recommended that several psychologists provide the treatments in future researches since this will result in higher trust in the results and prevent bias. Considering the importance of the treatment of PPD, more extensive research should be carried out in this field and the risk factors of PPD should be examined closely in appropriate cultural and social environments to ensure that appropriate programs are designed to prevent this health problem.

## Conflict of Interests

Authors have no conflict of interests.

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