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Psychiatry in Iraq

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In recent years there has been a wide interest in the cross-cultural aspects of mental illness. Information concerning incidence, symptomatology and attitudes towards mental illness in the developing countries may contribute to the understanding of psychological processes and psychiatric problems. Kline (1963) reported a number of surveys of psychiatry in non-Western countries. One of these surveys was conducted in Kuwait, which is culturally and geographically intimately related to Iraq. This study aims at adding to Kline's data by providing information about various facets of psychiatry in Iraq. The present data were collected through interviews with a number of practising psychiatrists and through reference to hospital statistics and other relevant literature, in addition to the authors' clinical experience.

Cultural Background and Mental Illness

Although Iraq is a predominantly Moslem country, yet the general concept of mental disorder is influenced more by superstition and pagan belief than by the teachings of Islam. The similarity between the interpretations relating to causation and treatment amongst different ethnic and religious groups would seem to indicate archaic ideas held in common.

The local Arabic word Jinoon (madness) is derived from Jinni. This is a word applied in the Moslem mythology to spirits good or evil with supernatural powers which influence peoples' lives and destinies. One common aetiological concept of psychosis upheld equally by Moslems and other religious groups is the control or possession of the patient's mind by the Jinn(plur. of Jinni). This belief is particularly firmly held in cases of major epilepsy, in which the fit is regarded as the supreme evidence of the presence of the Jinn's evil activity. Impotence is another example of the interference of the Jinn in normal behaviour. A man who proves impotent on his wedding night is said to be "knotted", or controlled by an evil spirit (Al-Alooji, 1964). The knot is a form of magical control not unknown in Western witchcraft (Cockayne, 1864, quoted by Barnett, 1965). Knotting is brought about through the mediation of a "holy" man or woman who has attained renown in the art of conjuring spirits. It is conducted at the request of a jealous man or woman who wishes to handicap the bridegroom, paying a sum of money to the holy man. The holy man is called Sayed, a word applied to the male descendants of the Prophet Mohammed who are believed to have special powers.

An equally common explanation of mental illness is the belief that extreme passion, such as an overwhelming infatuation can cause mental illness. Avicenna a thousand years ago described a condition caused by hopeless love very similar to the modern concept of reactive depression.

One last aetiological belief applied to disease in general and to mental illness in particular is that of "Hawa" which is the Arabic word for wind or air. This concept has its origin in ancient times and is deeply rooted though little understood by the average man. Hawa is supposed to produce diverse pathological conditions such as intestinal colic, asthma and various forms of arthritis and rheumatic pains. However, when it is trapped in the head, its effects are more virulent and can cause full-fledged madness. It is possible that the reason for the still common use in Iraq of cupping, a method of counter-irritation, is to reduce the tension of the air in the diseased organ.

Local treatment of mental illness consists mainly in counteracting the magic influences of the Jinn. To appease the King of the Jinn, or to chase the evil spirit, certain rituals and sacrifices are necessary. Well-known men with quasi-religious status, e.g. the Sayeds, are specialists in

this method of healing mental disorder. They recite a few sentences from the Koran, or a memorized jargon, and then decide on the method of treatment and the proper sacrifice to be offered (a chicken, a goat, or a sum of money). Occasionally a multicoloured pile of stones is thrown at random in front of the patient and the pattern formed gives the healer further indications as to the most suitable remedy. The patient is then advised to spend one or more nights in the healer's compound or in a shrine or other holy place. A talisman may be given to the patient to be worn in an effort to frighten the evil spirit out or to untie the "knot". Marriage may be advised if the healer divines that an uncontrollable passion has caused the disorder. Cautery, on the head or other parts of the body, and beating are occasionally resorted to if the condition proves resistent.

A form of group treatment found in the south of Iraq features a possessional, ritual dance (zar) conducted by the healer and performed to the beating of drums, occasionally accompanied by drinking an infusion of herbs. The ritual culminates in hysterical fits in a number of the participants. This practice was most probably introduced into Basrah and Kuwait by Africans a long time ago (c.f. Messing, 1959).

Superstitious belief in magical powers, in the evil eye, in the Jinn and their wicked designs, and many other para-religious ideas pose a problem in trying to determine normality without a thorough knowledge of the cultural background. Behaviour which to a Western psychiatrist might suggest mannerisms, preoccupation with hallucinations, or descriptions which sound delusional may well be in keeping with a particular practice (religious or otherwise) or a mystic belief. It is sometimes noted that auditory and visual hallucinations are not regarded as abnormal by the patient or his family. An explanation for hallucinations may sometimes be found in the local belief that members of the Prophet Mohammed's family may appear to give the person instructions about his affairs. It is also important to note that the recent influx of oil revenues has been one of the main factors leading to a harsh struggle for power or even for survival amongst different religious, ethnic, and political groups in Iraq. Internal intrigues, both on the public and the personal level may render misleading Western criteria for assessing delusions of persecution and ideas of reference.

People in general tolerate mental disturbance to a considerable degree as long as it is not expressed in undue violence, shameful behaviour or uncontrollable overactivity. The mental content of a patient is seldom enough to bring him to the healer or doctor; it is his behaviour that is decisive.

When a Moslem wife is finally established as mentally deranged, her husband is encouraged to take a second wife who will look after the household and the patient. If the patient is the husband, the wife will continue her previous tasks while serving her sick husband. Divorce is not encouraged if the husband and wife are even distantly related (marriage between relatives is widely practised in Iraq).

It must be emphasized here that this description applies mainly to the less educated, rural part of the population. The more urban the population, the more its concepts of illness approximate to those of the West. But some of these ideas, e.g. the evil eye, are still rife even in the main cities.

Types of Mental Illness

There is no evidence that any difference exists between the types of mental illness encountered here and in the West.

The most prevalent psychosis by far is schizophrenia, which basically resembles its counterpart elsewhere in clinical manifestations, age distribution and form. The general feeling amongst psychiatrists is that affective conditions, particularly depression, are relatively more common now in their private practice than they were a decade or two ago. This may be due to an actual increase in incidence or to a growing awareness and understanding of the nature of mental illness, as well as to a shift from the local healer to the medical doctor. Furthermore, the rise in the standard of living has made it possible for more sick people to consult psychiatrists privately, thus causing a general increase in numbers.

Depression in Iraq has a number of clinical features that distinguish it from the classical

Western description. Although the depth of the depression can reach the same severe degrees as seen e.g. in England, yet the great majority of patients remain free from self-reproach and feelings of unworthiness. Suicidal ideas are very rarely complained of. This remains the case particularly in the illiterate semi-primitive part of the population. In fact, suicide is extremely rare in Iraq, and most of the proved cases are amongst schizophrenics, or are hysterical gestures. The clinical picture of depression is often dominated by paranoid ideas that are expressed verbally or in physical attacks. The patient seldom feels responsible for his illness. He may regard it as a punishment from God or just as a bad stroke of fate. Projection of guilt and responsibility plays a very strong part in psychological processes here, in illness as well as in health (Bazzoui, unpublished data).

As compared with European patients a general observation is that the behaviour of psychotic patients in Iraq is more characterized by noisiness, as well as by verbal and physical aggression. This applies even to patients receiving tranquilizers. This behaviour may be due to the patients' premorbid disposition and their mode of upbringing in a culture that encourages aggression and assertion.

Neurotic illness seems also to be increasing at the psychiatrist's clinic. Anxiety states, hypochondriasis, phobias, and particularly obsessional neurosis are all quite common. Yet the average Iraqi regards psychiatry as the odd speciality of treating "mad people". Neurotic illness is ill-understood, often neglected, and always underestimated as a cause of morbidity. Hysterical illness is still very common in its "grand" forms amongst the naïve and uneducated rural inhabitants. It seems, however, less frequent amongst city dwellers. The change from the traditional long flowing robe (dishdasha) to Western clothes has brought about many tics whose origin can be traced to the expression of pressure discomfort.

With the exception of impotence, sexual problems in Iraq are still not within reach of the psychiatrist. Most of the impotence cases are the result of the impact of the wedding night on a sensitive or obsessional man. It is sometimes nerve shattering for the couple to find their whole extended families at the doorstep of the bedroom awaiting the consummation of the marriage. In the case of the failure of the bride to prove her virginity, she will bring on herself the family's (particularly the brother and cousins of the bride) violent revenge. Homosexuality which is widely practised in Iraq, especially in the south, is not considered to be an abnormality. The overwhelming majority of those who are homosexual are in fact heterosexual as well if given the opportunity. It is a socio-cultural phenomenon rather than a psychiatric condition, so far. The same may be said about bestiality, which is commonly practised by rural inhabitants in areas where the taboos on contact between male and female reach their strictest form.

Psychiatric Services

Psychiatric services in modern Iraq were established with the opening of the first mental hospital Dar Al-Shafa (The House of Cure) around the years 1920–21. This hospital served a limited custodial purpose, but gradually became inadequate to deal with the increased demand for psychiatric care. In 1953 Shamma'eeyah Hospital was built. It remains the only mental hospital in Iraq.

Until very recently, psychiatric services were limited to Baghdad, the capital. In the rest of the country psychiatric patients were usually seen by physicians in local outpatient departments. The more seriously disturbed patients were referred to Baghdad for specialized care, and some found their way to quacks, spiritual healers and religious men. It is fair to say that even now, almost every psychotic patient from the countryside pays a visit to a "holy" place or a "holy" man before he arrives at the psychiatric clinic.

In Baghdad there are two main Government centres for psychiatric care, apart from the neuropsychiatric unit in the Military Hospital, which is run by three psychiatrists. The first of these centres is an out-patient department attached to the Teaching Hospital, dealing with both psychiatric and neurological cases. This also is run by three psychiatrists. The average number of patients seen per day is 150. Electroplexy is given on two days each week.

Treatment is entirely at the expense of the Government. The second psychiatric centre is the Shamma'eeyah Mental Hospital already mentioned and this will now be described. more fully.

Shamma'eeyah Mental Hospital

The hospital is situated about 15 miles from the centre of Baghdad. When it was built in 1953, it had a capacity of 400 beds. In 1960–61 four new units, each of four wards, were added, bringing the number of beds to a total of 1,500. At the present time there are 2000 patients in the hospital, while the number of beds has remained the same.

Apart from a reference in the Penal Code to the diminished responsibility of those who commit crimes while suffering from a "deranged mind", there is no legislation directly relating to mental illness. Admissions to Shamma'eeyah are therefore still controlled by religious courts, i.e. the courts dealing with matters of personal status. On the application of the relatives or on the recommendation of a psychiatrist the courts commit the patient to the hospital for treatment. This committal has in many respects the binding effect of a compulsory admission under the English Mental Health Act. It is valid until the treating doctors feel that the patient is fit for discharge. Recently, voluntary admission has become more common, though far from popular. Addicts and depressive patients are those most frequently admitted voluntarily.

Table I shows the diagnostic categories of the patients. It does not reflect the incidence of these conditions among the population since only the most disturbed and the chronic are admitted. It can be seen that epileptics and mentally subnormal patients are admitted to the hospital, but only if their epilepsy or subnormality is accompanied by a severe personality disturbance or a frank psychosis. There are two wards in the hospital for these patients.

It must be mentioned here that admission to a mental hospital is still commonly regarded as cruel to the patient and a disgrace to the family, to be avoided at all cost. It is a source of embarrassment and shame for the family to have one member in the mental hospital. This can jeopardize seriously the chances of marriage for a sister or daughter, or even a brother. It explains the observation that almost all patients in the hospital are chronic and have been submitted to all possible forms of treatment privately before being finally abandoned to the care of the hospital. Once they are admitted, their families tend to forget them completely. Women are particularly shielded against the infamy of admission. Of the 2000 patients now in care in Shamma'eeyah Mental Hospital, only about 500 are women.

Table I

Distribution of Mental Illness in Shamma'eeyah Hospital 31st December, 1964

Diagnosis	No. of patients
Schizophrenia	1751
Epilepsy	92
Mental Deficiency	82
Depression (psychotic)	26
Mania	25
Senile Dementia	23
Undiagnosed (observation)	20
Psychopathy	6
Organic Psychosis	6
Hemiplegias with psychosis	6
Chronic Anxiety	5
Presenile Dementia	3
Alcohol Addiction	2
Arteriosclerotic Mental Illness	2
Drug Addiction	1
Involutional Melancholia	1
Obsessional Neurosis	1
Unspecified Mental Illness	3

Table II

Statistics of Admission and Discharge

Year	Admissions	Discharges	Deaths
1957	280	105	16
1958	653	566	17
1961	1155	1034	54
1962	1317	1183	52
1963	918	977	77
1964	1294	1128	106

Table II shows some annual figures for admissions and discharges of the mental hospital. The increase in admissions is primarily due to growth in facilities and perhaps to a slight

TABLE III

Average Duration of Stay of Patients in Shamma'eeyah Hospital

	Short-term*		Mid-term**		Long-term***		
	Months	Days	Months	Days	Years	Months	Days
Males	2	2	10	4	4	9	17
Females	1	27	12	16	4	8	10
Average	1	29·5	11	10	4	8·5	28·5

*less than 6 months
**6 months to 2 years
***more than two years

change in the public attitude towards hospitalization. Discharging a patient from Shamma'eeyah Mental Hospital can sometimes be a formidable task. The relatives have vanished without trace, and many patients have no alternative but to stay in hospital. Living alone outside the extended family is still not popular in Iraq. Early discharge has recently been encouraged. The patient is sent to his family as soon as he is well enough to manage outside hospital with their support. The discharge rate has therefore lately lagged only slightly behind that of admissions.

Table III gives the average duration of stay in hospital calculated from the hospital records in 1964. It is important to note that these figures refer mainly to psychotics.

The methods of treatment in the hospital have also recently undergone a great change. Electroplexy and insulin therapy were the only methods used until three years ago, when tranquilizers were introduced. Insulin therapy has been completely abandoned, but E.C.T. is still very frequently used and is the most popular treatment among patients and psychiatrists alike. Psychotherapy on the other hand has little appeal to the patients. This is partly due to the fact that psychotherapy usually takes a long time, unlike the quick magical effect expected from the local treatment. People seem to have transferred to some extent their belief in magical power from local treatment to E.C.T. Occupational therapy was begun in the hospital not very long ago, and it is still limited to certain handicrafts and handicapped by shortage of space and lack of trained supervisors.

OTHER SERVICES

Recently two psychiatrists have been appointed, one in Mosul for the North, the other in Basrah for the South. Preparations are being made in each of these two cities to open a unit of 100 beds for acute psychiatric cases.

Private psychiatric clinics remain the most popular and effective method of out-patient care. Although beyond the financial means of a vast number of patients, and though offering mostly palliative care, they do fill a considerable gap in the available psychiatric facilities. Neurotic adults and mentally disturbed children have no other means of treatment at their disposal. Psychiatrists at the moment number 15 only, most of them serving in the mornings in Government health services. All of these psychiatrists practise privately in the afternoons, seeing neurological as well as psychiatric patients. This small number of psychiatrists (0·2 per 100,000 population) is a far cry from what is available in modern countries (U.S.A. 6·4; U.S.S.R. 8·4 per 100,000 population) (Field, 1964). Shortage of properly trained nursing staff is even more serious; one nurse or assistant nurse is available for every 25 in-patients as compared to 1:4 in the U.S.A. and 1:1 in the U.S.S.R. (Field, 1964). Specially trained ancillary staff is literally non-existant. Facilities for community care and industrial rehabilitation have not yet been established. The medical care of the mentally subnormal is far from satisfactory. The only organized attempt at dealing with this problem was initiated about a decade ago on an educational level. Severely subnormal children with or without physical

handicaps are now attending two special schools. As intelligence testing has not yet been developed for Iraq, these subnormals are classified on clinical grounds only. Psychiatrists have recently been asked to give an occasional opinion.

Finally, a Department of Mental Health was established five years ago in the Ministry of Health. Provisions for a campaign of research and education were made, but the programme did not pass the speculative stage. In a developing country like Iraq, where malnutrition and physical illness are still serious problems, it is no wonder that mental health has not yet received proper attention.

Summary

This study is a survey of some aspects of psychiatry in Iraq, a Middle East country. An attempt has been made to describe the traditional concept of mental illness. Despite the evident influence of the Moslem religion, beliefs concerning mental illness are deeply rooted in the ancient history of Mesopotamia. It is observed that there is similarity between the incidence and classification of mental illness in Iraq and the West. Nevertheless, the manifestations of mental illness are somehow different, e.g. in depression. Furthermore it has been emphasized that in some cases (paranoid delusions, ideas of reference, hallucinations) the wholesale application of Western diagnostic criteria may be completely misleading.

Psychiatric services are mainly in Baghdad, the capital. There is only one mental hospital in the whole country (population 8 millions). There is another psychiatric clinic which is attached to a Teaching Hospital. The service of the 15 trained psychiatrists is divided between their private clinics and the Government. While private clinics give their service to the privileged few, the mental hospital remains an asylum for the unwanted outcasts. Insofar as the official and public attitude remains indifferent to the care of the mentally ill, it will be long before efficient modern psychiatric services can be envisaged in Iraq.

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