Psychiatry in Kurdistan

T.P. Berney

I had come to Kurdistan because, two years ago, my wife had become the co-ordinator of an aid project led by a local GP. His family were in Qualadisa, an enclave in the south-east of the country, rimmed by the snow-covered mountains which mark the Iranian border. The project's purpose was to redevelop the area through a variety of schemes which ranged from building a hospital to re-establishing whole villages with water, sewerage and schools. The GP's brother, Osman, was a medical officer for the district and I was to help the psychiatric side of his practice.

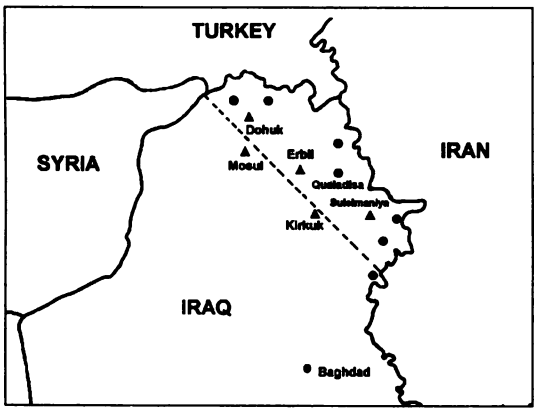

Fig. 1. The main cities of Kurdistan bordering on North East Iran

Fig. 2. Dr Osman, Medical Officer

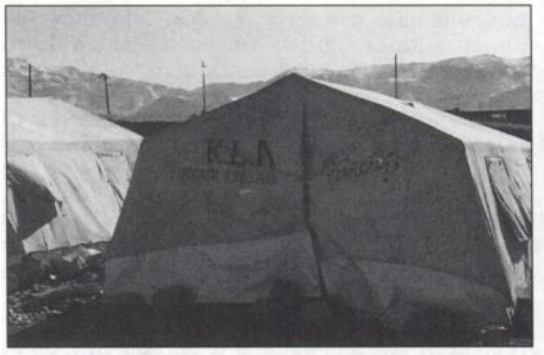

Fig. 3. Hospital stores, Qualadisa

It was spring, an English summer but blue, and I found myself involved in leisurely, formally informal discussion, broken by enquiries after health and progress, and with translation an ever-present barrier. There were omnipresent Peshmurga guerrillas with a variety of automatic arms—ever smiling, every-friendly, ever-waiting for the inevitable return of Iraqi forces. The new government, unusual in the Middle East for its degree of democracy, was hampered by a social situation that was a cross between Merrie England and the Wild West—poor roads and limited communication were compounded by a surplus of Kalashnikovs, although these were offset by feudal law-enforcement and mediaeval courtesy. Here was a society which had lived largely in rural village communities but which, with the Iraqi invasion in 1987, had either been moved into concentration camps or else had fled to the mountains and beyond. Surprisingly, family ties survived being urbanised and terrorised and were buttressed by a keen sense of Muslim values—the sense of justice and the obligation of hospitality were strong as were sexual prohibitions. I found a dishevelled society, repeatedly battered by troops and chemical weapons but slowly restoring itself. Mental health came low on the public health list, behind more fundamental priorities such as food, water and sanitation as well as the development of a nursing and medical service. The government's policy was to restore these people to their villages, making ours a popular project.

https://doi.org/10.1192/pb.18.2.104 Published online by Cambridge University Press

Dr Jameel is the director of hospital services for the north-west region and himself a psychiatrist, being one of three in the country. His story was of a psychiatric service, previously centralised on Bhagdad, which had been left without in-patient resources other than beds in a medical ward. The extended family network, which might have cared for many of his patients, had been wrecked by the population shake-up. He hoped to develop a treatment and rehabilitation unit but his whole service was short of the currency of treatment, particularly medication including antidepressants, depot neuroleptics and anti-epileptics. The lack of drugs meant that ECT, with an uncertain machine, was unmodified. Although drugs were available on the black-market for those who had the money, they were of uncertain origin and efficacy. The shortage extended to the whole medical service which lacked antibiotics, dressings and hospital clothing and equipment. They were dependent on donations for journals and books and transport was a constant problem. There were few doctors and many patients; clinics were long and the time for assessment brief. All this made it a dispiriting struggle to maintain a service, let alone develop it. And yet, in the teeth of this and with some outside help, the service was being restored.

Throughout the day and into the late evening patients arrived and silently queued until seen. Fortunately only a minority were for me as psychiatric assessment was time-consuming; a slow exploration of the mental state not just of an individual but of the family and their society. Psychosis, neurosis and marital and family problems were given a cultural twist. How does a transsexual even start to address a problem which is anathema to both his family and society? How does a family continue to care for a father who is suspected of murdering their mother? Forbearance and a resort to religion were frequent. For many the account started with the Iraqi invasion, being shelled and the subsequent move either to the camps, into the mountains or across the border. Although intermarriage led to lurid family trees of disturbance, on more careful enquiry I found that it was unusual for a disorder to breed true. The prevalence of disturbance might simply be a measure of the degree and nature of familial resilience to the high levels of stress. We discussed the possibility of setting up a formal, trained counselling service, and whether the clergy might develop their pastoral role. The recurrent question through the discussions was that of the long-term consequence?

The distance and the state of the roads meant a full day was needed for a visit to the capital, Arbil. We met Mr Jauhir Namiq, the Head of the National Assembly, who was courteous, patient and phlegmatic. The government was beginning to gain some grasp of the extent and the impact of torture on a population of which about 180,000 were immediately affected by the invasion: he spoke of the need for a sound appraisal as a preliminary to rehabilitation: his request for outside advice was passed to the College.

I left with a greater appreciation of how far a rural community, with an extended family network, can contain unhappiness and weather it; of the importance of medication to modern psychiatry; and of what a luxury it is to have the time to carry out any work with patients.

If you have any modern books, journals, drugs or equipment to donate, Kurdish Life Aid will ensure their delivery. You can contact Mrs Berney at home by phone 091-281-2608.

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https://doi.org/10.1192/pb.18.2.104 Published online by Cambridge University Press