Companion paper to *Continuing collateral damage: the health and environment costs of war on Iraq 2003*

**Mental well-being in Iraq – six months after the start of Operation Iraqi Freedom**

This paper is based on publicly available sources and discussion with health professionals in the UK, who have family, have visited or have particular interest in Iraq. We hope it will help keep mental health issues in the minds of public health specialists and policy makers. We believe the long-term issues of individual and social healing from this long period of trauma have great consequence for the region and for the world.

**Background**

By the mid 1970s Iraq had well established Psychiatric training for doctors following UK models of practice. Compared to other medical specialties psychiatry did not have high priority or prestige. Mental disorders were traditionally seen as spiritual matters requiring spiritual healers; psychological explanatory models were not common. The main support for people with mental disorders came from the family and the social stigma of such disorders was high.

During the 1980s the regime of Saddam and the war with Iran created a social and economic downturn. Psychiatry did not progress; many doctors left the country; there were few other professions in mental health, psychology was sparse and nursing had low value as a profession. There was no community based or multi-disciplinary service. The main models of psychiatric treatment remained clinic based with the family providing the basic supports. There was a long stay institution in Baghdad, Al Rashad, which had up to 1,200 beds for those people whose families could no longer cope. The major teaching hospitals in Baghdad and elsewhere had psychiatric inpatient units for short stay.

During the 1990s there were shortages of medicines and publicly funded services declined through lack of money and wages. Psychiatry, as other specialties, developed a private sector, with many doctors working mornings in the state sector and running private clinics in the evenings. There was professional isolation with limitations on communication being imposed externally and internally by the regime. Towards then end of the 1990s and leading up to the current war there had been some relaxation of sanctions and NGOs had been actively working in Iraq. However in 1999 Unicef reported “many adolescents of both sexes suffer from malnutrition and related health problems, but also from depression as they see very little hope for their future". The ICRC had been supportive of mental health services and during 2001 and 2002 had refurbished the hospital at Al Rashad, helping to develop occupational therapies there.

By the beginning of 2003 the picture was of psychiatric services being limited to Baghdad and a handful of major cities, mainly on an outpatient basis, with no access to newer medications. For a population of 25 million there were less than one hundred psychiatrists,
no community services, and a handful of psychologists. With half the population being under 18yrs there was no child psychiatry; the existence of social services and school psychological services are not known about. There seems no available epidemiological information on mental health, no prevalence rates of common disorders or of severe mental illness, no suicide rates, and no data about service usage. There is no systematic data on wider public mental health issues such as domestic violence, child abuse and substance abuse.

**Operation Iraqi Freedom**

The war started with a prolonged bombing campaign designed to create “shock and awe”. From media and medical reports there was undoubtedly an increase in acute anxiety during this period of bombing (Dyer, 2003).

There is likely to have been an increase in common mental disorders relating to anxiety and mood disturbance. Although the use of the term Post Traumatic Stress Disorder as a diagnostic category has been criticised because of its failure to take account of the social context, (Bracken et al 1995) it has value in quantifying and identifying those with particular clusters of distressing psychological experiences (Mezey and Robbins, 2001). There is no data at present on prevalence, however personal reports and the media suggest that these issues will be significant.

Separating out the impact of over twenty years of oppressive rule, two previous wars and the period of sanctions from the effects of this war will not be possible in any precise manner. The prevalence of common mental disorders is likely to be similar to other destabilised conflict areas and much greater than in stable countries (de Jong, Komproe and Ommeren, 2003). Long-term morbidity will include more suicides, greater disability, increased drug and alcohol abuse and more social and domestic violence, all major obstacles to the restoration of a stable society.

Cultural attitudes to violence, especially spiritual and other explanations of violence and social expectations influence how a population is affected by violence. The relevance of psychological models, categories and treatments to the Iraqi situation needs careful consideration.

The incidence of major psychosis is usually unchanged by war, however they are a vulnerable group. In May the Al Rashad hospital was looted, the basic services to the hospital were disrupted and the 1,200 inpatients allowed to leave. It is now reported that 600 of the former patients have returned and it is likely that those who have not returned will have perished, unless supported by their families.

Of great concern is the impact on children and young people. Half the population is under 18yrs. The incidence of conduct and emotional disorders is likely to be high however the understandings and definitions of child and adolescent mental disorders will be complex, overlapping with broader social issues of moral breakdown, violence, and educational failures (Machel, 2001). The management of these issues will also be complex and simple reductions to psychological interventions will be insufficient. Maximising the mental health of the younger generations in Iraq will require coordinated work from many sectors.
Cognitive developmental disorders are likely to be increased through association with malnutrition and poor general health.

**Post War phase and Psycho-social concerns**

The social fabric influences the course of stress disorders. Where the social order is secure and predictable then post traumatic restoration is faster and visa versa (Ajdukovic, in Press)

In some respects the economic and material fabric of society has begun to improve. Many people in state occupations, doctors, nurses, teachers etc are now receiving salaries well above the pre war level. Food security has largely been maintained. Hospitals are reporting better access to drugs, and following the initial losses through looting many are now receiving new equipment. There has not been the widespread social chaos feared by many and the family structures have largely remained in place. In many Southern cities religious and civic leaders have helped restore order.

However, continued disruption of electricity, fuel and water contribute to uncertainty, but most important is the continued uncertainty about personal security. The risks of robbery, of burglary, of kidnapping and of violence are well reported. There seems an ongoing difficulty for the responsible authorities to establish law and order. The current situation creates psychological insecurity which compounds the anxiety and mood related disorders arising from the war, from the previous repression and economic difficulty:

> “Because of the tremendous, lethal threat to schools, alot of parents forbid their children attending schools. Many children were traumatised because of the exposure to the bombing of Al-Khadra police station. More than four schools are very close to the bombing site, and the children there left their classes for the last few days, and parents are very apprehensive regarding re-attending the school.” (personal communication, 2nd November from a psychiatrist in Iraq)

The psychological effects of living under dictatorship where violence is both ruthless and unpredictable include disruption of trust in relationships, fear of betrayal and increasing violence in family and social conflicts. Concern is expressed that the moral fabric of society becomes devalued; to progress individuals must compromise themselves. Children growing up in this environment may be particularly at risk of accepting violence as the standard way of achieving status and material goods.

Poverty, uncertainty, unpredictability, poor social controls diminish the capacity for society to be “good enough” for positive child development, increases the likelihood of young people developing strategies of violence and seeking identity through fundamentalist groups that promise certainty. There is serious concern that the emergent social environment in Iraq will foster extremism, terrorism and the trans-generational transmission of hatreds.

At the same time it is essential to recall the resilience of people to traumatic events and the capacity for societies to reconstruct themselves after war and devastation. The development of non-violent coping to the events of the last two decades will be a critical issue for Iraq and for the world.

**Combatants**
There has been a growing recognition of the psychological distress experienced by soldiers and the long-term consequences of these (Jones et al, 2002). The issues of the Gulf War syndrome have yet to be resolved. Before this war started there were commitments given to the UK armed forces that adequate psychological support would be available. There is currently little data on the impact of the acute episode of fighting on the mental well being of the coalition soldiers.

The post war situation of the last four months must have its own impact. There is well documented evidence of stress on soldiers in areas of tensions where they remain targets for terrorist groups (Hotopf et al, 2003). How this is being recognised and responded to is not clear.

The impact of the war on Iraqi combatants must have been significant. This was primarily a conscription army that had little sense of loyalty to the regime. The mental health of combatants appears protected by the sense of attachment they feel to the purpose of the conflict. The shock and awe tactic was aimed at combatants and many would have known the history of the first Gulf War where tens of thousands of Iraqi conscripts died within the first few days. The levels of acute stress must have been great. These soldiers were discharged without means of support, with no occupation, with the same uncertainties faced by the rest of the population and little means of resolving the acute emotional turmoil created by the conflict. The failure to consider the psychosocial needs of several hundred thousand young men who had been conscripted into the Iraqi army may be one of the most serious and long lasting mistakes of the post conflict management.

**Key Issues for the future**

Mental health services:

The overwhelming evidence at a global level is that if the mental health needs of a population are to be met adequately then psychiatric services need to be publicly funded, driven by assessment of population needs and free at the point of delivery. Many people with serious mental disorder do not have the capacity to negotiate a private system of treatment because of innate problems, rejection by the family, or both. Some key points are:

- Restoration of the services to be used as building blocks
- Local opinion to determine the next steps for development
- Establish user and carer forums for service development
- Examine links between primary care and the specialist services
- Workforce training and development strategies for all professions
- A mental health act
- Data collection on key indicators and evaluation of interventions
- Establish relationship with the traditional health sector
- Seek partnership between the services and NGOs and sharing of information
- Establishing a Mental Health policy board with high level involvement in the Ministry of Health with clear identification of responsibilities for mental health

Promotion of mental well-being:
This needs a population approach, with multi-sector involvement and coordination at central government. Given the differing models and methods of understanding mental health there will need to be considerable discussion between different sectors, with sharing of ideas and experience as

- Discourse on models of understanding involving all sectors of society
- Definitions, Recognition and Assessment of concerns
- Discourse on models of intervention
- Pilot studies, assessments and sharing of ideas
- Clear links to mental health services
- Establishing responsibilities at a high level within the relevant ministries and high level means of inter-sector cooperation

Promotion for children and adolescents:
- Family security and fulltime education
- Educational strategies involving health sectors
- Recognition of abuse

Promotion for adults:
- Political and personal security
- Social roles and activities
- Recognition of domestic violence and gender issues

For society:
- A discourse on ways of creating social justice and reconciliation.
- The two main approaches to this are through courts to identify and punish the perpetrators of crimes and the establishment of Truth commissions that publicly acknowledge the wrongdoings and the suffering. The first step to this process is developing democratic involvement and personal security.

Actions for Medact:

- Continue monitoring health in Iraq through existing and new contacts
- Be a vital part of a network of concern for mental well being
- Continue the policy analysis of post conflict health management
- Research on post conflict mental health, models of coping, cycles of violence
- Interventions through VCH group, help to the helpers, dialogue with Iraqi psychiatrists

References


Bracken, Giller and Summerfield, 1995. Psychological responses to war and atrocity: the limitations of current concepts. Social Science and Medicine, 40, 1073-82

Dyer O (2003). British Iraqi doctors set up charity to support Iraq's mental health services. *BMJ* 327:832


