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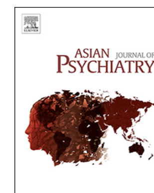

Comment on psychological interventions during COVID-19: Challenges for Iraqi Kurdistan

Dear Editor,

So far the COVID-19 pandemic has generated a plethora of papers relating to mental illness and psychiatric/psychological interventions. There is little doubt that this current crisis has not only led to the rise of mental issues (due to loss of work, income, family pressures, isolation etc.) but has also exacerbated pre-existing mental disorders. Additionally, the non-availability of psychiatric medicine due to long term and stringent 'lockdowns' may lead to relapse and deleterious withdrawal symptoms (Fiorillo and Gorwood, 2020). This is now well known to the psychiatric community.

Tandon's analysis (2020) is relevant here since he alerts us to the mental health effects of COVID-19 on Asian populations which were early epicenters of the pandemic. He also addresses the potential inconsistencies and mental health challenges regarding COVID-19 in the psychiatric profession, as well as, highlighting the ambiguity fueled by intermittent lockdowns/quarantines and substandard information which have been drivers of collective fear. Tandon's reflections nicely frame our ideas on the psychiatric challenges to Iraqi Kurds during the COVID-19 pandemic.

De Sousa et al. (2020), have proposed that low and middle income countries (LMIC) face several mental health challenges. The authors highlight 16 challenges which are beyond the scope of this letter to adequately critique. These challenges can be divided into three main categories:

1 Resource access and medical care
2 Socio-cultural factors
3 Infrastructural and social preparedness

Several of these outlined challenges are similar to those found in Iraqi Kurdistan during the COVID-19 pandemic, such as lack of resource care and facilities, socio-cultural factors and questionable health access and preparedness. Even so, Iraqi Kurdistan had until recently remarkably few infections and deaths compared to neighbouring Iran which has been a COVID-19 epicenter.

1. Social resilience and non-compliance

While we mainly agree to the content of these challenges, the authors seem to engage in making tenuous comments such as greater stress load 'will' lead to higher prevalence in depression and anxiety. This is both broad and vague and does not account for varying levels of human resilience in both individuals and communities. This connects to our next point that Iraqi Kurds have not practiced social distancing during the entire quarantine period and have freely engaged in physically close interactions. A major reason for this non-compliance could be that physical closeness reinforces strong social ties which have been very important in maintaining psychological well-being in Iraqi Kurds during ongoing oppression, civil war, conflict and mass murder over the last forty years. Furthermore, close physical interactions may offer some degree of psychological support for ordinary Iraqi Kurds in the face of massive job and income losses and future insecurity due to the COVID-19 pandemic. No amount of psychiatric counselling can substitute for this cultural habitus. We would argue that non-compliance to social distancing employed by Iraqi Kurds may reduce the adverse mental health effects of social isolation and loneliness during this crisis, even if it increases infection risk of COVID-19.

2. Questioning traditional healing concepts on mental illness

Another questionable point made by the authors relates to the issue of people in LMIC resorting to cultural myths and personalistic explanations of mental illness. First, according to the World Health Organization (WHO) approximately 80 % of African and Asian populations rely on traditional medical approaches (Oyebode et al., 2016). One reason for this is that mental illness works within the ambit of cultural beliefs that inform individual actions in understanding disease causation, symptoms and treatment methods (Jacob, 2020). There is a plethora of medical anthropological literature on the abreactive nature of various traditional healing traditions (which includes traditional Chinese medicine). On this note, one study found that health professionals and medical students in Singapore believed in superstitious beliefs akin to the supernaturalist assertions of faith healers. For example, calling certain individuals "black clouds" due to their putative ability to attract 'bad luck' during hospital shifts, as well as, refusing to utter the words "having a good call" as this could attract misfortune (Lim et al., 2007). So it seems that western medicine has not totally absolved itself from cultural myths.

The fact remains that in many LMIC access to psychiatric services are extremely limited and expensive. In 2014, 18.6 % of Iraqis (5.9 million people) were reported to suffer from mental illness (Salman et al., 2016). This number is way beyond the capabilities of current mental care services in Iraq. Consequently, the cheaper and more prevalent option has been for poor individuals to access faith healers. Unfortunately, as people in LMIC become increasingly desperate during the Covid-19 pandemic this may lead to unscrupulous individuals proffering all kinds of fake remedies, as has been the case in western social medias.

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Declaration of Competing Interest

I declare that there is no conflict of interest.

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