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Research Article:

Through the Eyes of Psychiatrists: Mental Health Services in Iraq– A Qualitative Study

Zaid Sabti Jumaah ¹ , Ali Azeez Al-Jumaili ^{2, 3, 4} , Hasan A. Shubbar ⁵ , Mohammed Yawuz Jamal ⁴ , Khalid Awad Al-Kubaissi ⁶ 

¹ Al-Rusafa Health Directorate, Ministry of Health, Baghdad, Iraq.

² Department of Public Health, School of Medicine, University of California, California, USA.

³ College of Pharmacy, University of Iowa, Iowa, USA.

⁴ Department of Clinical Pharmacy, College of Pharmacy, University of Baghdad, Baghdad, Iraq.

⁵ Thi-Qar Health Directorate, Ministry of Health, Thi-Qar, Iraq.

⁶ Department of Pharmacy Practice and Pharmacotherapeutics, College of Pharmacy, University of Sharjah, Sharjah, United Arab Emirates.

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Abstract

Background: Iraq has considerable challenges in delivering mental health services. The country has been in years of conflict and war. These events have taken a severe toll on the mental health of its people. **Aims:** This study aimed to explore psychiatrists' views on public mental health services in Baghdad, Iraq. **Methods:** The design was qualitative. Semi-structured face-to-face interviews were conducted with psychiatrists from June to July 2023. Participants were purposively recruited, and data collection continued to saturation. Interviews were audio-recorded, transcribed verbatim, and analyzed using an inductive thematic analysis. This approach assisted in identifying recurring patterns and themes. **Results:** Ten psychiatrists took part. Six interconnected themes were identified: 1) High prevalence of mental illness. 2) Delay in seeking professional care. 3) Social media, family, and relatives as sources of information. 4) Persistent challenges facing services. 5) Interventions to reduce stigma. 6) Need for improved service quality. Participating psychiatrists perceived that government mental health care could be improved with more funding and a better supply of medications. **Conclusion:** Mental health services in Iraq are confronted by structural and socio-cultural perspectives of psychiatry. These include stigma, poor mental health literacy, and workforce constraints. This results in late diagnosis and inadequate care. The solutions are multi-faceted. This includes raising public awareness, expanding access to services, developing a strong workforce, and improving the accuracy and regulation of mental health information shared publicly.

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1. Introduction

Mental health problems are common throughout the world and are a major public health challenge (1). They include depression, schizophrenia, attention deficit/hyperactivity disorder, and autism spectrum disorder that affect an estimated 450 million people worldwide (2). The four decades of war and economic sanctions and recurrent conflict in Iraq have adversely affected population health and crippled the health and social-service systems (3). Thus, the burden of mental health conditions has increased in different population

groups. In Mosul, a 2014 study found that about 40% of children under 16 years old had a mental health condition, with post-traumatic stress disorder (PTSD) being the most common diagnosis (4).

Likewise, data from Baghdad indicate a large psychological toll on adolescents and university students. Psychological trauma was reported in more than 55% of adolescent boys, and 17.1% of those aged 13–16 years and 24.7% of those aged 17–19 years were identified as having PTSD symptoms. The rates were higher among orphans and adolescents living with non-biological guardians (5). Depressive and anxiety symptoms were reported by 45.9% and 52.1% of pharmacy and medical students in Baghdad, respectively (6). In a separate study conducted in Baghdad, female participants scored higher on the Beck Depression Inventory than males. Of those with depressive symptoms, 73.7% had mild to moderate depression. The score analysis revealed 42.8% in the normative range, 20.4% in the mild range, 7.0% in the borderline range, 14.7% in the moderate range, 10.5% in the severe range, and 4.5% in the very severe range. About 63% of the participants reported some type of suicidal ideation (7).

*Corresponding author: Hasan A. Shubbar, Thi-Qar Health Directorate, Ministry of Health, Thi-Qar, Iraq.

Email: hasan.ali2200m@copharm.uobaghdad.edu.iq

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In addition to their clinical impact, mental health disorders have deep personal, social, and economic costs, especially when people delay or avoid seeking care. Stigma of mental illness and psychiatric services is a major contributor to the delay in seeking help (8). This stigma still exists in Iraq and may prevent individuals and families from accessing formal mental health services (9). Cultural beliefs also shape how mental health problems are defined and treated. In Iraq and other Middle Eastern settings, some people attribute symptoms to supernatural causes, such as evil spirits, demons, witchcraft, or the evil eye. Thus, they may resort to religious places or faith healers before seeking help from mental health professionals (10,11). For some, faith-based care may be less stigmatizing than psychiatric hospitals or psychiatric medication, which may lead to delayed presentation to formal services (10,12). The ongoing popularity of faith healing may also be indicative of a lack of public understanding of mental health conditions and treatment options (13).

Along with stigma and cultural misconceptions, there is a large gap in mental health care in Iraq, with limited funding, poor facilities and a lack of adequately trained mental health and psychosocial support (MHPSS) professionals (14,15). These constraints affect the availability, accessibility and quality of services, including the ability to develop resources and offer training programs that could strengthen delivery of care (14). While the burden of common mental health conditions and the gaps in services in Iraq have been documented, comparatively little is known about how psychiatrists perceive these challenges in everyday clinical practice. The study fills this gap by providing a clinician-centered perspective on mental health service delivery in Baghdad, with a focus on the interrelationship of stigma, informal sources of care, and health system constraints. This perspective is employed to inform the study and shed light on factors that potentially contribute to delayed care and fragmented service use. Therefore, this study aimed to explore the views of psychiatrists toward public mental health services in Baghdad, Iraq.

2. Subjects and Methods

2.1. Design of study

In this qualitative study, psychiatrists underwent semi-structured interviews to explore their views of mental health care in Baghdad, Iraq. A trained pharmacist conducted the interviews. He had 5 years of experience in health care and qualitative interviewing. Participants were recruited until data saturation was reached (16,17). Saturation was assessed iteratively during data collection and analysis by two researchers who independently reviewed the interview data and compared emerging concepts, categories, and themes. After the first 7–8 interviews, no substantially new concepts or themes emerged. A further two interviews were carried out to confirm no further relevant insights were obtained, supporting the conclusion that saturation had been reached. The final sample included 10 psychiatrists.

2.2. Settings

The interviews were conducted in several locations throughout Baghdad. This included both hospitals and private clinics. Interviews at different sites allowed inclusion of psychiatrists working in different settings. Efforts to create a comfortable environment helped

participants. Interviews were conducted solely in Arabic, the mother tongue of the participants. This created rapport and gave an open atmosphere for sharing. The substantive interview discussions lasted 20–30 minutes (mean $\pm$ SD = 23 ± 5 minutes) and provided sufficient time for in-depth discussion. Before each interview, additional time was spent introducing the study, explaining its objectives, and clarifying the interview process.

2.3. Subjects

Psychiatrists working in Baghdad were involved. A "purposive sampling" was used to get a diverse sample. This included psychiatrists of different ages, genders, and experience. Participants were recruited over 2 months from June to July 2023.

2.4. Criteria for inclusion

Participants included male and female psychiatrists aged 30 years and older who held a board certification from the Arab Board of Health Specializations or the Iraqi Council for Medical Specializations in Psychiatry. Inclusion required a minimum of three years of clinical practice experience in Baghdad, with all participants actively practicing in public hospitals, private clinics, or both. For one participant (Psy 8), total clinical medical experience exceeded three years (more than six years total), although specialty practice post-board certification was two years; all other participants met the criterion of more than three years of post-specialization practice.

2.5. Data collection

Data collection started with in-depth semi-structured interviews. Each participant was fully explained the study before consenting. The participants were assured of anonymity and confidentiality. The interviews were intended to build trust. Audio recordings of narratives were made for accuracy. A literature-based interview guides consistent with the study objectives. They included six parts: (1) mental health landscape in Iraq, (2) challenges to mental health care, (3) public perception of mental health, (4) stigma and cultural beliefs, (5) service quality and access, and (6) stigma reduction strategies. The guide included open-ended questions and probes for eliciting detailed responses. The full guide is provided in Supplementary Material File.

2.6. Thematic analyses

The study team carefully reviewed the verbatim transcripts. This enabled data processing to be accurate. Thematic analysis was then used to identify themes in the data (18–20). Themes were not predetermined, but emerged from the data. Researchers read the transcripts several times to get a general sense. Then initial codes were identified. The data were analyzed manually, without using qualitative software such as NVivo. Transcripts were coded by two independent researchers. They discussed differences to reach agreement. The researchers grouped the codes into preliminary themes. These themes were developed in the analysis. The team convened regularly to ensure rigor.

A codebook directed uniform coding and themes. The researchers considered self-reflexivity and potential bias to minimize influence on interpretation. Finally, the researchers combined the themes to provide an overall understanding of the psychiatrists' perspectives in Baghdad. Results were described narratively, supported by illustrative quotations (18). The approach was systematic and rigorous to ensure accurate interpretation.

3. Results

Ten psychiatrists participated in the study. Thirteen psychiatrists were initially approached; however, three declined to participate because of time constraints. Participant characteristics are presented in **Table 1**. Six interrelated themes emerged from the interviews: (1) perceived high prevalence of mental illness in Iraqi society, (2) delayed seeking of professional mental care, (3) social media, family, and relatives as sources of mental health information, (4) challenges facing mental health services, (5) interventions to reduce societal stigma regarding mental illness, and (6) improving the quality of mental health services in government centers. These themes and their associated subthemes are presented in **Table 2**.

Table 1. The Characteristics of the participants

Participant	Gender	Years of experience	Work setting
Psy 1	Female	3	Public
Psy 2	Male	18	Public and private
Psy 3	Female	9	Public
Psy 4	Male	4	Public and private
Psy 5	Female	8	Public and private
Psy 6	Male	11	Public and private
Psy 7	Male	28	Private*
Psy 8	Male	2	Public and private
Psy 9	Male	6	Public and private
Psy 10	Female	16	Public and private

*One participant has left public service and is now practicing in the private sector.

Table 2. Themes and subthemes identified from psychiatrists' interviews

Themes	Subthemes	Representative quote
Perceived high prevalence of mental illness in Iraqi society	Lack of awareness about mental health	"We have a high prevalence of mental illnesses, but there is no official prevalence; the patients don't receive adequate care due to lack of awareness" (Psy 6). "There is an official report from the MOH, but it doesn't reflect the whole picture because many patients don't seek medical attention" (Psy 7).
Delayed seeking of professional mental care	High social stigma	"Delay in seeking adequate care for mental illness in public health care settings because of the stigma surrounding mental illnesses, so the patients don't go to a psychiatric or any mental health provider" (Psy 1).
	Lack of awareness	"The main reason for not receiving adequate care is a lack of awareness and the culture" (Psy 5).
Social media, family, and relatives as sources of mental health information	High negative impact on mental care	"Social media has a negative impact if spiritualists and fortune-tellers provide the information" (Psy 1). "The false information provided on social media has a significant negative impact on the treatment" (Psy 3). "Social media, family and relatives hurt the treatment because they may go to spiritualists" (Psy 4 and 6).
Challenges facing mental health services	High social stigma for patients receiving mental care	"The idea of mental illness people feel ashamed of it (have a stigma), our culture, and the social factor play a big role too" (Psy 1). "The main challenges that face mental health care in Iraq are Lack of privacy, lack of trained therapists, the cost of therapy, the stigma, and lack of awareness" (Psy 4).
	Shortage in facilities, psychiatrists, and the cost of therapies	"The main gaps that face mental health care in Iraq are lack of funds, lack of centers specializing in mental health, and the diversity of drugs" (Psy 3). "Lack of privacy, lack of trained psychotherapy, high cost of therapy in private pharmacies, the stigma and lack of awareness are the main challenges that face mental health care in Iraq" (Psy 4).
	Untreatable mental conditions due to believing in some mysterious forces like ghosts, genies, and going to spiritual people	"These thoughts (believe in some mysterious) effect the treatment" (Psy 2). "These thoughts make the patient go to spiritual healers, not to a psychiatrist" (Psy 3).
Interventions to reduce societal stigma regarding mental illness	Increase awareness about mental illness	"The stigma society perceives about mental illness can be overcome by increasing mental health awareness" (Psy 1). "Having organizations that increase awareness about mental health can overcome the stigma society perceives about mental illness" (Psy 2).
	Provide centers for mental health consultation	"Providing centers for mental health consultation is the best way to overcome the stigma society has about mental illness" (Psy 9).
Improving the quality of mental health services in government centers	Improving the quality of medication and services provided in public mental care settings	"The quality of mental health services provided in government centers can be improved by improving the quality of medication provided and increasing the funding for the psychiatric department" (Psy 3). "Mental health services provided in government centers can be enhanced by providing psychological counselling and more effective treatment (drugs, electric shocks)" (Psy 1).
	Increasing the fund for the psychiatric department	"Improve the quality of mental health services by improving the quality of medication provided and increasing the funding for the psychiatric department" (Psy 3).

3.1. Perceived high prevalence of mental illness in Iraqi society

Participants consistently described mental illness as common in Iraqi society. They associated this perception with the lack of national prevalence data and with the fact that many people did not seek professional care. Therefore, they believed that the reported prevalence was probably lower than the actual number of affected individuals. One psychiatrist described the perception of the gap between the burden of illness and available information. *"No accurate data are available about this, but personally I think the prevalence is very high and the patients receive bad quality services, if any"* (Psy10). Also, another participant shared how the official numbers might not represent those who are outside of formal care: *"There is an official report from the Ministry of Health (MOH), but it's not the whole picture because many patients don't seek medical attention"* (Psy 7).

Diagnosed and undiagnosed conditions were also identified by participants, associated with access to care. They found that those with an established diagnosis were more likely to be brought into care, while those with unrecognized symptoms often remained untreated. One participant reported: *"We have a high prevalence of mental illnesses, but most of them are undiagnosed patients; the diagnosed patients receive adequate care"* (Psy 3). They linked this perception to incomplete national prevalence data and to the fact that many individuals did not seek professional care. As a result, they viewed the reported prevalence as likely lower than the actual number of affected individuals.

3.2. Delayed seeking of professional mental care

Delayed help-seeking was identified as a key barrier to accessing timely psychiatric care. Stigma, lack of awareness and cultural beliefs were cited as common barriers. Participants attributed this delay to stigma, lack of awareness of mental health conditions and cultural beliefs about the causes and management of psychological symptoms. Stigma, participants perceived, kept people from seeking early contact with psychiatrists and other mental health providers.

One psychiatrist explained, *"Because of the stigma attached to mental illnesses, patients will avoid psychiatrists or mental health providers"* (Psy 1). Another participant noted that knowledge gaps and cultural attitudes contributed to delayed care. *"Lack of awareness and the culture"* were major reasons why patients did not receive adequate care" (Psy 4). Some psychiatrists also noted that patients frequently tried non-medical options first, which delayed professional assessment and treatment. As one participant described, *"People come to spiritual people and the last thing they think about is going to psychiatrists"* (Psy 8).

3.3. Social media, family, and relatives as sources of mental health information

Social media, family members, and relatives were identified by participants as influential sources of mental health information that shaped beliefs and decisions about care. These sources were characterized as affecting public understanding of psychiatric illness, medication use and decision-making about professional care. Most participants pointed out that the effect of these sources was dependent on whether the information was coming from qualified professionals. They found unqualified online content and advice from relatives were more common and potentially

harmful. *"Family and friends, but mainly social media, have a dual effect; good when it comes from professional people, bad when it comes from unprofessional people, which is the dominant one"* (Psy 10).

Specifically, participants reported misinformation about psychotropic medication that could influence treatment acceptance and adherence. One psychiatrist reported: *"There are a lot of influencers on social media who are against medications and say that they are addictive without much knowledge"* (Psy7). Participants also described how social media and family networks reinforced non-medical explanations and directed some patients to spiritual treatment. *"Social media and relatives may refer patients to spiritualists, not psychiatric treatment,"* one psychiatrist noted (Psy 6). While some participants agreed that online information, provided by professionals, could be useful in raising awareness, the general consensus was that misinformation was having a detrimental impact on treatment-seeking and the perception of mental illness.

3.4. Challenges facing mental health services

Participants described delivery of mental health services as constrained by structural, workforce, financial and socio-cultural barriers. They stressed that these barriers constrained the availability of services and affected the patients' ability or willingness to use them. Stigma was described several times as a social barrier that limited patients' willingness to seek care. *"Mental illness is still a stigma in society,"* one psychiatrist emphasized. *"Social factors are important"* (Psy 1). Other barriers to service provision identified included workforce shortages, limited resources and low financial incentives. One participant summed up these as: *"There are too few psychiatrists, low income of psychiatry and little awareness about mental health"* (Psy 6).

Structural deficits were cited as directly constraining service deployment, with the main institutional bottleneck identified as the lack of dedicated facilities. One psychiatrist highlighted that the *"lack of facilities"* was still a major problem (Psy 5). They also reported that psychiatric services were geographically uneven. Specialist clinics were concentrated in selected urban areas, they reported, leaving smaller cities and towns with limited or no access to psychiatrists. One participant provided an example of this imbalance. *"Their clinics are not distributed well, like in Harthia there are around 14 psychiatrists, whereas in many other areas and small towns there isn't any"* (Psy 7).

Cultural and spiritual explanations for mental illness were also reported as barriers to seeking psychiatric treatment. Some patients, participants indicated, attribute symptoms to supernatural causes, which can lead to them delaying professional consultation and seeking help from spiritual healers. *"Most of the patients think they are sick because of ghosts or devils,"* one psychiatrist observed (Psy 9). Another participant explained the practical consequence of these beliefs: *"Because these thoughts make the patient go to spiritual healers, not to a psychiatrist"* (Psy 3).

3.5. Interventions to reduce societal stigma regarding mental illness

Education and awareness were identified by all participants as the main strategies to reduce stigma. They called public education essential to increasing understanding of mental illness and reducing stigma associated with psychiatric consultation. Mental health

education should start at an early age, perceived by many psychiatrists. *"Early education and normalizing the situation of mental illness" are important steps for reducing stigma*, emphasized one participant (Psy 10). Participants also talked about organized awareness activities as a means to improve public attitudes and reduce stigma. As one psychiatrist explained, *"Having organizations that increase awareness about mental health can overcome the stigma"* (Psy 2).

In addition to awareness campaigns, some participants stressed the need for easily accessible consultation centers. Visible and available services were viewed as a pragmatic way of facilitating contact with mental health professionals. As one participant pointed out: *"the best way to overcome the stigma that society has about mental illness is to have centers for mental health consultation"* (Psy 9).

3.6. Improving the quality of mental health services in government centers

At the service level, the participants offered several improvements for government mental health centers, which are related to improving the quality of treatment. These included higher funding, better infrastructure, more staff, and better quality of treatment. Funding and availability of medication were identified as key requirements for strengthening psychiatric departments. One participant proposed that *"the quality of the medication provided should*

be improved and the funding for psychiatric departments should be increased" (Psy 3).

Participants noted improvements in the treatment environment and in the day-to-day delivery of services. These included cleaner facilities, better quality of service, and more appropriate conditions for patients receiving care. One participant stressed the need for *"cleanliness, higher quality of service and more suitable treatment environment"* (Psy 8). Repeatedly, efforts to improve service quality also highlighted the need for psychological counselling and multidisciplinary care. One psychiatrist recommended that mental health services should be *"psychological counselling and more effective treatment"* (Psy 1).

Finally, several participants discussed the need for institutional reform and greater government attention to mental health care. As one participant put it, *"the whole health care system in Iraq needs to be rebuilt according to the latest standards and guidelines"* (Psy 10). This was proposed as a last step to improve the mental health services in government centers. **Figure 1** shows the relationships between the main themes identified in the interviews and illustrates how patient-, social- and health system-level factors interact to affect the use of mental health care and the provision of services in Iraq.

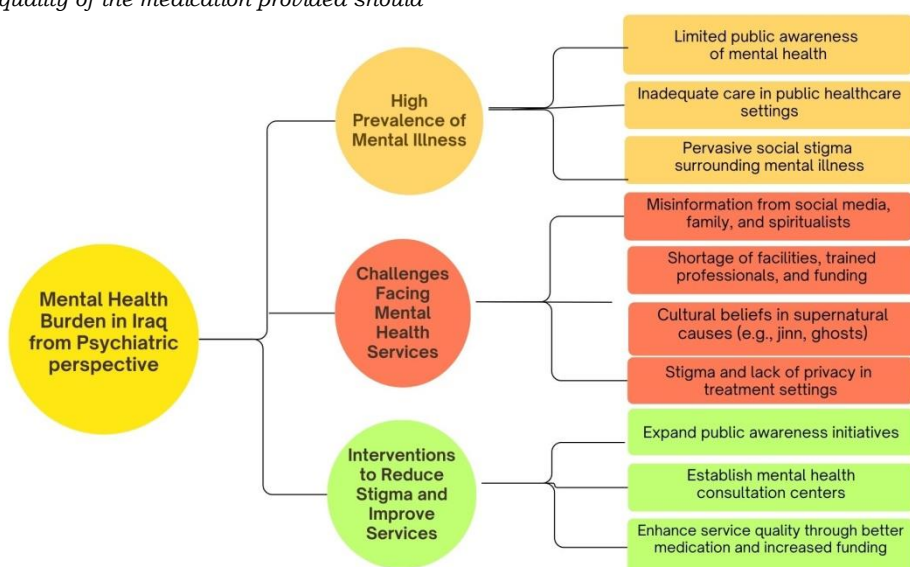


Figure 1. Mental health burden and service challenges in Iraq: a psychiatric perspective

4. Discussion

4.1. Interpreting the perceived high prevalence of mental illness in Iraq

The study reveals a high perceived burden of mental illness in Iraqi society, alongside important diagnostic and epidemiological gaps. Clinicians' perceptions of high prevalence should not necessarily be interpreted as reflecting an accurate national epidemiological estimate. Rather, these perceptions may be influenced by limited public mental health literacy, under-recognition and under-reporting of mental disorders, and weaknesses in the availability of systematic national mental health data. Similar challenges have been reported in many low- and

middle-income countries, where mental health has historically received limited attention within national health-care planning (21).

Evidence from Iraq points to a high burden of mental health issues in some groups. For example, a study from the Diyala Governorate reported high rates of depression among older patients, especially among those who were socially and economically vulnerable (22). These findings may explain clinicians' belief that mental illness is common, since these groups often have complex, untreated conditions. Other research on students in the Middle East suggests that social and lifestyle factors can also influence mental health (23). Although it is not just about Iraq, the findings suggest broader forces influencing rates of mental illness, and clinicians' perceptions about how common it is. Addressing discrepancies between clinicians' observations

and official mental health data in Iraq is vital, as these gaps may arise from limitations in the national mental health surveillance system. The lack of systematic, population-level psychiatric data hinders reliable estimates of mental health morbidity, affecting resource allocation and policy development. To improve mental health planning, it is essential to enhance national surveillance, systematically collect data, and foster collaboration among mental health professionals, academia, and health authorities.

4.2. Barriers to early help-seeking: stigma, culture, and mental health literacy

Reluctance to seek professional mental health care is more strongly related to socio-cultural factors than to individual factors alone. "Shame" and the fear of being stigmatized by family members or the wider community were cited by many of the psychiatrists we interviewed as a reason why patients often wait before getting help. The finding suggests that mental illness may not only be viewed as a health problem, but also as a source of social judgment that may damage an individual's reputation and family relationships. Stigma and misconceptions about psychiatric illness have also been identified as important barriers to seeking professional mental health care in previous research from Iraq (14,24,25). The lack of awareness of mental health problems and treatment options may also lead to a delay in seeking professional help or use of informal sources of support (14,24,25).

4.3. The role of informal information sources in shaping mental health behaviors

Participants observed a serious geographic inequality in psychiatric care, with a concentration of psychiatrists in the big cities such as Harthia and no specialist services in smaller towns. This lack of psychiatric infrastructure leads to dependence on family members, social media, and spiritual leaders for mental health information when professional services are not available. Previous work has shown that inaccurate mental health information shared through these informal channels can lead to misconceptions, stigma, delays in treatment, and inappropriate care. Misinformation is particularly harmful in the Iraqi context when it reinforces cultural beliefs that discourage seeking professional help. Increasing the availability of reliable mental health information and establishing strong referral systems in underserved areas could, therefore, reduce delays in accessing appropriate care.

the interviews revealed the negative impact of social media and family networks in the dissemination of mental health information, especially when propagated by spiritual leaders. Similar results have been reported from India, Canada and the USA, stressing that this misinformation often resulted in misdiagnosis and inappropriate treatment (26–28). The spread of misinformation contributes to stigma and treatment avoidance, ultimately leading to delayed care and worse symptoms. Unnecessary suffering and longer recovery times are caused by ineffective treatments. In conclusion, the prevalence of misinformation on mental health, especially from spiritual leaders, significantly impairs mental health outcomes.

4.4. System-level and socio-cultural barriers to mental health service delivery

Structural constraints and socio-cultural factors hinder the delivery of mental health services. Service availability and accessibility are constrained by infrastructure, workforce capacity, and financial resources. A similar study in the United States found that health care access is an important public health issue. Many Americans do not have the resources, whether physical or financial, to access essential health care services. Social prejudices and lack of services add to the burden of mental health care and worsen the problems faced by people with mental illnesses when they seek care and support (29).

A study in the Middle East shows stigma hurts those with mental illnesses. They might internalize stigma, which can impact their quality of life and social relationships. Stigma also discourages them from seeking help or finding employment. Even those who receive treatment may find it a major barrier to recovery (30). Stigma is still an issue, according to a new study from the Middle East. They are aggravated by a lack of medical education and a shortage of trained health personnel. There is also a shortage of psychiatric services and hospital accommodations. These are complex problems faced by many areas (31). Furthermore, in a qualitative evaluation of specialized substance use disorder centers in Baghdad, health care providers underscored similar systemic constraints, including severe staffing shortages, inadequate infrastructure, overcrowding, and the intensive effort required to manage behavioral health conditions (32).

4.5. Addressing mental health stigma: beyond awareness-based approaches

Most psychiatrists interviewed identified awareness-raising as an important strategy for reducing mental health stigma. This view is supported by a Singapore study. That study identified four effective strategies for reducing stigma. These include greater public awareness of mental health, increased social contact with those affected, the use of influential people to advocate for change, and the introduction of anti-discrimination legislation (33). In a previous study in Baghdad, the importance of cultural awareness in reducing social stigma and building trust in public mental health care was emphasized (34).

4.6. Enhancing the quality of government mental health services: a systems perspective

The interviewed psychiatrists point out that the quality of mental health services in the government's facilities can be improved by increasing the number of mental health clinics and allocating more funds to psychiatric departments. This recommendation is supported by a report examining the barriers to utilization of primary health centers (PHCs) in Iraq. The report identifies service quality as a major challenge and recommends improving service quality of PHCs to promote their use (35).

In order to fill these gaps, several important solutions have been proposed. First, establish psychosocial centers in each locality according to the specific needs and expand MHPSS in priority areas and affected areas. This will ensure that people have the support and resources they need. Secondly, to increase the number of mobile teams to support persons facing financial barriers to accessing centers and other health care facilities. These teams would provide direct support and services to those in need,

bridging the gap between the individual and the health care system. The solutions are prioritization of activities including psychotherapy, structured psychosocial support group sessions, and use of both pharmacologic and non-pharmacologic approaches for management of mental health conditions. These measures should improve the availability and accessibility of mental health support to those who need it (14).

4.7. Limitations

This study was limited to Baghdad, which may not capture perspectives across other Iraqi governorates. The small sample size and short interview durations may have constrained response depth. Furthermore, social desirability bias and interviewer influence related to the clinical pharmacy background cannot be ruled out. Nonetheless, a neutral, non-judgmental approach was maintained throughout. Future multi-province studies with larger samples are recommended to enhance transferability.

5. Conclusion

This study provides a qualitative, practice-based perspective on mental health services in Iraq. It shows how the psychiatrists describe their problems in the clinic. The findings suggest that the perceived high rates of mental illness are related to underreporting, delayed help-seeking and low mental health literacy rather than epidemiological data. Patients' behavior is influenced by informal sources of information, such as social media, family and spiritual beliefs, which often contribute to treatment delays. Stigma, lack of awareness, workforce shortages and service limitations are not isolated issues. These barriers together delay diagnosis and result in less effective care. This study places the social and structural factors that influence the use of mental health services in Iraq within the context of clinical perspectives and system challenges.

5.1. Recommendations

Improve mental health services in Iraq. Raise public awareness. Expand community-based services. Incentivize and train psychiatric staff. Regulate social media information about mental health.

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7. Declarations

7.1. CRediT Authorship Contribution Statement

Zaid Sabti Jumaah: Conceptualization, Investigation, Data Curation, Formal Analysis, Writing – Original Draft. Ali Azeez Al-Jumaili: Writing-review & editing, Validation, Visualization, Formal analysis, Methodology, Supervision. Hasan A. Shubbar: Project administration, Validation, Writing - review & editing. Mohammed Yawuz Jamal: Validation. Writing- review & editing. Khalid Awad Al-Kubaissi: Review & editing, Writing. All authors read and approved the final manuscript.

7.2. Consent to participate: The corresponding author confirms that all authors have participated sufficiently in the work, have approved the final version of the manuscript, and agree to be accountable for all aspects of the work.

7.3. Consent for publication: The authors give their consent for the publication of the study.

7.4. Ethics approval and consent to participate: The study was carried out following the ethical standards laid down in the "Declaration of Helsinki". The study was conducted in strict confidentiality and anonymity. All subjects gave their informed consent. The study proposal was approved by the Ethical Committee of the University of Baghdad College of Pharmacy (Approval No. RECAUBCP0625235R; approval date: 11 December 2022).

7.5. Funding: There was no funding for the study.

7.6. Data availability and materials: All data supporting the findings of this study are included in the article. The data will be made available by the authors upon reasonable request.

7.7. Conflicts of interest: The authors declare no actual or potential conflicts of interest.

7.8. AI-Assisted writing declaration: The manuscript was improved in English language, grammar, readability, and clarity using the AI-assisted writing tool Grammarly. The tool was not used to develop the study design, to analyze data, interpret results, or to draw scientific conclusions. All AI-assisted suggestions were critically reviewed, edited, and verified by the authors, who take full responsibility for the content of this manuscript.

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من منظور الأطباء النفسيين: خدمات الصحة النفسية في العراق - دراسة نوعية

الخلاصة

المقدمة: يواجه العراق تحديات كبيرة في تقديم خدمات الصحة النفسية. فقد عانى البلد لسنوات من الصراعات والحروب، مما كان له أثر بالغ على الصحة النفسية لسكانه. **الهدف:** هدفت هذه الدراسة إلى فحص وجهات نظر الأطباء النفسيين حول خدمات الرعاية الصحية النفسية العامة في بغداد، العراق. **طرق العمل:** تم استخدام تصميم نوعي. أجرى الباحثون مقابلات شخصية شبه منظمة مع الأطباء النفسيين بين حزيران و تموز 2023. تم اختيار المشاركين بشكل مقصود، واستمر جمع البيانات حتى الوصول إلى التشبع. تم تسجيل المقابلات صوتيًا، ثم نُسخَت حرفيًا، وُحِلَّت باستخدام التحليل الموضوعي الاستقرائي. ساعد هذا النهج في تحديد الأنماط والمواضيع المتكررة. **النتائج:** شارك عشرة أطباء نفسيين. تم تحديد ستة مواضيع مترابطة: (1) ارتفاع معدل انتشار الأمراض النفسية. (2) التأخر في طلب الرعاية المتخصصة. (3) وسائل التواصل الاجتماعي، والأسرة، والأقارب كمصادر للمعلومات. (4) التحديات المستمرة التي تواجه الخدمات. (5) التدخلات للحد من الوصمة. (6) الحاجة إلى تحسين جودة الخدمات. وفقًا للأطباء النفسيين المشاركين، فإن تحسين إمدادات الأدوية وزيادة التمويل من شأنهما تعزيز الرعاية الصحية النفسية الحكومية. **الاستنتاج:** تبرز وجهات النظر النفسية أن تحديات خدمات الصحة النفسية في العراق تنبع من عوامل هيكلية واجتماعية ثقافية. وتشمل هذه العوامل الوصمة، وانخفاض مستوى الوعي بالصحة النفسية، ومحدودية القوى العاملة. تؤدي هذه العناصر إلى تأخر التشخيص وعدم كفاية الرعاية. تتضمن الحلول استراتيجيات متكاملة. تهدف هذه الاستراتيجيات إلى تعزيز الوعي العام، وتوسيع نطاق الوصول إلى الخدمات، وتعزيز القوى العاملة، وتنظيم نشر معلومات الصحة النفسية.

الكلمات المفتاحية: المستشفيات الحكومية، العراق، خدمات الرعاية الصحية النفسية، الأمراض النفسية، الرعاية النفسية.