

Trauma-induced distress and behavioural problems among children and adolescents in Kashmir: a descriptive study

D R Dar, G Lakshmana, F A Paul, R Mahanta

Abstract

Background

Research show that the youth of Kashmir have mental health issues secondary to being exposed to political conflicts and violence. However, this area is under-researched among school children and adolescents living in this region.

Aims

The study aimed to examine and understand the psychological distress and behavioural problems among school children aged between 10 to 18 years living in conflict-affected areas in Kashmir, India.

Methods

A mixed model was used to collect the required data. Quantitative information was obtained using a semi-structured interview and the DASS- 21 questionnaire. The qualitative information was obtained by conducting interviews with randomly selected participants from the group.

Results

Of the 112 children and adolescents, 73.2% were males and 47.3% were from the age group of 10-12 years. Out of the total, 85.7%, 76.8%, and 54.9% had some level of depression, anxiety, and stress respectively as per the DASS- 21.

Conclusion

Trauma, and stress, increased the risk of depression, anxiety, and behavioural problems among children and adolescents in complex ways. Our findings highlight the importance of examining trauma and distress at early life cycle stages across age cohorts of children and adolescents in school populations.

Keywords: children and adolescents, political conflict, trauma, stress, depression.

SL J Psychiatry 2023; 14(1): 44-49

Introduction

High rates of mental health issues are reported among people exposed to political conflicts and children and adolescents are no exception (1). Depression, anxiety, behavioural and emotional problems (BEPs) are commonly reported among children and adolescents exposed to conflicts and war (2). Childhood and adolescence are considered vulnerable periods due to the many biological and psychosocial changes taking place in a person's life during these periods (2). Political instability, social/ ecological fragility, and the growing gap in accessing education have been shown to modify the response of children and adolescents to trauma (4). Existing literature shows that trauma can be passed down generations and children and adolescents may develop psychological issues due to them being directly exposed to trauma and or due to that passed down generations (indirect exposure) (5). The deleterious psychological effects of political conflicts among children and

adolescents are well established (6). However, research is scarce in this area among school children and adolescents in Kashmir.

The study aimed to examine and understand the psychological distress and BEPs among children and adolescents aged 10 to 18 years in Kashmir who have been either directly or indirectly affected by political conflicts.

Methods

The present study used a mixed research design in which data was collected with a sequential explanatory procedure. The final database represented both quantitative and qualitative information.

The data was collected from secondary and higher secondary school students after obtaining assent/ informed consent depending on their age as well as the

consent from their parents or guardians. Five secondary and six higher secondary schools were selected from a list of 138 schools by simple randomisation and 112 children and adolescents were randomly selected from this cohort (55 students from secondary grades, and 57 from higher secondary grades). The study included participants who could read and write English. Client-Oriented Practical Evidence Search (COPEs) interview guidelines were used to conduct the interviews (7). A convenient sampling method was employed to identify teachers, children, parents, clinical psychologists, psychiatric social workers, faith healers, and community leaders who participated in the qualitative phase of the study and three children, two teachers, three parents, two clinical psychologists, two psychiatric social workers, one faith healer, and one community leader were interviewed.

The English version of the DASS-21 which has been validated among Kashmir children and adolescents was used in the study (8). The DASS-21 is a self-report instrument designed to assess stress, anxiety, and depressive symptoms. It has a 4-point Likert scale with answers ranging from 0 ("Did not apply to me at all") to 3 ("Applied to me very much, or most of the time") and is drafted to evaluate each of the 21 items (9). The ratings are classified as: normal, mild, moderate, severe, and

profound. In both clinical and non-clinical samples, the DASS-21 has been shown to have excellent internal consistency and reliability (10).

Quantitative data were analysed using the SPSS version 25.0. The relationship among the DASS-21 variables scores was determined using Pearson correlation analysis (significant at the probability level <0.05).

Prior to the commencement of the study, an information session was conducted for all the participants. The ethical clearance to conduct the study was obtained from the Chief Education Office of Kulgam District, Jammu and Kashmir.

Results

Out of the sample, 73.2% of students were male and 47.3% were from the age group of 10-12 years. Just above half of the group (50.9%) were higher-secondary students and 42.0% were directly or indirectly affected by conflict-related trauma (Table 1).

Out of the total 85.7%, 76.8%, and 54.9% had some level of depression, anxiety, and stress respectively as per the DASS- 21 (Table 2).

Table 1. Demographic details of participants

Variables	Characteristics	N	%
Gender	Male	82	73.2
	Female	30	26.8
Age	10-12 Years	53	47.3
	13-15 Years	39	34.8
	16-18 Years	20	17.9
Education	Secondary	55	49.1
	Higher-Secondary	57	50.9
SES	Lower	45	40.2
	Medium	41	36.6
	High	26	23.2
Religion	Islam	112	100.0
Family type	Nuclear	68	60.7
	Joint	44	39.3
Conflict trauma: whether affected directly or indirectly	Yes	47	42.0
	No	65	58.0
	Total	112	100.0

Note: SES = Socio-economic status.

Table 2. Prevalence of depression, stress and anxiety among children and adolescents		
Variable	Frequency (n)	Percent (%)
Depression		
Normal	16	14.3
Mild	26	23.2
Moderate	54	48.2
Severe	14	12.5
Profound	2	1.8
Anxiety		
Normal	26	23.2
Mild	26	23.2
Moderate	35	31.3
Severe	21	18.8
Profound	4	3.6
Stress		
Normal	27	24.1
Mild	13	11.6
Moderate	55	49.1
Severe	15	13.4
Profound	2	1.8
Total	112	100.0

Conflict-related trauma showed a significant mean association with stress, $t(40) = 1.76, p < 0.05$, where children and adolescents exposed to conflict exhibited higher scores in the stress subscale ($M=5.83, SD= 1.76$) compared to those who were not exposed to such conflicts ($M=5.23, SD= 1.78$) (Table 3).

Depression ($r= 0.026, p < 0.05$) and stress ($r= 0.134, p < 0.05$) had a significant relationship with age (Table 4).

Table 3. Mean comparison of conflict trauma (whether affected directly or indirectly) and DASS 21						
Variables	Yes		No		t (40)	p
	M	SD	M	SD		
Depression	5.28	1.85	5.48	1.79	-0.58	0.56
Anxiety	6.02	2.03	5.58	2.15	1.09	0.28
Stress	5.83	1.76	5.23	1.78	1.76	0.05

Table 4. Descriptive statistics and correlation coefficients of age variable

Variable	Age	Depression	Anxiety	Stress
Age	–			
Depression	0.026*	–		
Anxiety	0.127	-.218	–	
Stress	0.134*	0.013	-0.035	–

Note: * $p < 0.05$, & ** $p < 0.01$ (2-tailed)

The verbatim from the informal discussions with parents, teachers, psychologists, social workers, etc.

“The father of one of my students died due to the political conflict in Kashmir. The child started missing classes continuously, and even when he came to a class, he was always silent and isolated” – **Teacher 1.**

“The psychological effects of the political conflict among the children are quite distressful for us to see. The effects of trauma on our kids are apparently visible. I find it difficult to listen and share their feelings and emotions about their suffering. Fear and anxiety have engulfed them. Few of our children joined orphanages after parental deaths” – **Teacher 2.**

“Our clients usually come with complaints of constant sobbing, crying, and not being able to sleep during the night. Some have stories of parental deaths and have vivid dreams of those deaths. They find it difficult to go to bed alone. Sleep is disturbed. School performance and grades have gone down, they have lost interest in studies and can’t concentrate due to the trauma.” – **Clinical psychologist 1.**

“I see my child confused, fearful, sad and distressed. During the day he appears normal, but as soon as it is dark I cannot leave him for a single. This happened after a traumatic death of a friend of his during the conflict. He has repeated nightmares and sleepless nights.” – **Parent 1.**

“I am fearful of the political violence. I get easily scared when I hear any bad news on my way to school. I feel numb and I am worried to tell about my emotions to the teacher and parents because they may scold or beat me for revealing my fears and anxieties.” – **Child 1.**

“I can’t get well along with my peers. I find myself down and lonely in class, in the playground and during school activities. My sadness looks so different from others. I was brought up in a disturbing

environment. My friends don’t like me. My emotions get disturbed when my friends ignore me. I hate myself.” – **Child 2.**

“I have been smoking for the last six months. I started smoking with my friends. I am distressed. I find all my friends growing up in a chaotic political environment. My parents beat me and scold me even for small mistakes. My parents don’t bother about my disturbed emotions.” – **Child 3.**

“It’s not safe to be outside during late evenings in Kashmir. My son comes home late in the evening. I know he is smoking. But he keeps the room locked from inside and doesn’t come out for hours. I am suspicious of his behaviour. I suspect he takes weed or charas.” – **Parent 2.**

“I see children in small groups sitting behind the ruined buildings and puffing cigarettes. It smells of heroin and charas. They run away when they see me approaching them.” – **Community leader 1.**

“Our field observations show a trend of increasing substance abuse among children and adolescents. Teenagers get easily involved with these. Morning newspapers are usually filled with such news. Even, doctors have recently declared that heroin abuse is alarmingly high now among Kashmir kids.” – **Social worker 1.**

“Poor and middle-class families are constantly coming to me for prayers or any spiritual help for their problems. Many families with their children do come with disturbed sleep, loneliness, social isolation, or even jinn possessions. The families of the children see psychological problems as a Godly curse. God only would save them.” – **Faith healer 1.**

“I believe in my Peer Baaba (faith healer). My daughter has had this problem for two years. She apparently behaves fairly normal when Peer Baaba gives her Taweez (amulet) and water to drink.” – **Parent 3.**

“Our observation describes that families believe that supernatural powers cause mental illness and reach out to traditional healers to seek out treatment. In Kashmir, faith healers are the primarily preferred source of obtaining treatment, which could also be due to sparse psychiatric facilities and social stigma.” – Psychiatric social worker 2.

Discussion

We found high rates of psychological issues among our study population where more than 70% of the sample had some level of depression, stress and anxiety according to the DASS -21. A Ukrainian study conducted under similar circumstances reports much lower levels of depression among their population (11). A previous study conducted among adolescents above the age of 16 years, reports that depression was prevalent among 55.72% of the population (12).

The prevalence of anxiety among the children and adolescents in our sample was higher than reported in a recent systematic review (13). We also found that the stress levels were higher among those who were exposed either directly or indirectly to political conflicts than those who have not been exposed to trauma. A previous report suggests that anxiety and stress as the most common psychological issues seen among children and adolescents exposed to political violence (14).

Charlson, et al., highlight that children and adolescents living in regions where there are political conflicts experience higher incidences of psychological distress (15). They also mention that, when global figures are considered, one in five children and adolescents affected by political conflicts may encounter mental health issues (15).

In our study, depression and stress had a significant correlation with age. A previous study reports that children and adolescents as the most vulnerable group to develop psychological issues during political conflicts (16).

Some of the other factors that have been bound to have an association with psychological effects among individuals of this age group include low social support, traumatic events, perceived threats to life, and dysfunctional families (17). Stress caused by political conflicts is reported to also cause a significant negative impact on their social and scholastic functioning (17,18). The cohesion and integrity of families are gravely threatened in political conflict regions (19, 20).

We observed that some individuals in our study group tended to reach out to faith healers for psychological support when distressed. Engrained cultural and religious beliefs, low levels of mental health literacy and scarcity

of mental health resources may have also contributed to this finding. A previous review on psychological issues in war-torn areas also reports similar findings (21).

More than 85% of low- and middle-income countries (LMICs) including those with active political unrest, lack access to adequate mental health care (22). Traditional faith healers and community leaders are identified as potential resources for support in our type of settings in the WHO mental health action plan 2013-2020 (23, 24). However, in India, collaborations between mental health services and faith healers are rarely observed. It is our opinion that inclusion and working together with faith healers and community leaders may promote the early recognition and treatment of BEPs, depression, and anxiety disorders. Singh in his paper, “Comprehensive mental health action plan 2013-2030” highlights the need for the integration of mental health care with primary healthcare services which may also apply to other countries in our region (25).

Limitation

We used the validated English version of DASS-21, and some cultural psychological connotations may not have been captured in this version. Our study population was restricted to one district in Kashmir and therefore the results may not be generalizable.

Conclusion

We report high levels of depression, anxiety and stress among the study population who have been exposed to political conflicts. We highlight the importance of strengthening the support systems, mental health literacy as well as the mental health services in order to treat this group of vulnerable people.

Acknowledgment

The author would like to thank all the participants who participated in the study.

Author contribution

DRD formulated the study, conducted the data analysis and prepared the final draft. LG, FAP and RM edited the draft. All authors approved the final manuscript.

Conflict of interest

None.

Funding

None.

D R Dar, F A Paul, R Mahanta, Department of Psychiatric Social Work, LGB Regional Institute of Mental Health, Tezpur, Assam, India

G Lakshmana, Department of Social Work, Central University of Karnataka, Kalaburagi, India

Corresponding author: D R Dar

E-mail: danishwarrasool@gmail.com

 <https://orcid.org/0000-0001-9636-1705>

References

- Samara M, Hammuda S, Vostanis P, et al. Children's prolonged exposure to the toxic stress of war trauma in the Middle East. *BMJ*. 2020; 371: 1-6.
- Peel AJ, Armour C, Buckman JE, et al. Comparison of depression and anxiety symptom networks in reporters and non-reporters of lifetime trauma in two samples of differing severity. *J Affective Disord Rep*. 2021; 6: 100201.
- Panther-Brick C, Leckman JF. Editorial commentary: resilience in child development-interconnected pathways to wellbeing. *J Child Psychol Psychiatr*. 2013; 54(4): 333-6.
- Bashir A, McDonald M, Egan J, Hawk ME. Protocol of a Community-based intervention on Mental Health in Kashmir. *Indian J Psychol Med*. 2020; 42(6): 68-72.
- Kadir A, Shenoda S, Goldhagen J. Effects of armed conflict on child health and development: a systematic review. *PloS one*. 2019; 14(1): 1-37.
- De Jong K, Van De Kam S, Ford N, et al. Conflict in the Indian Kashmir Valley II: psychosocial impact. *Confl health*. 2008; 2(1): 1-8.
- Shlonsky A, Gibbs L. Will the real evidence-based practice please stand up? Teaching the process of evidence-based practice to the helping professions. *Brief Treat Crisis Interv*. 2004; 4(2).
- Singh K, Junnarkar M, Sharma S. Anxiety, stress, depression, and psychosocial functioning of Indian adolescents. *Indian Journal of Psychiatry*. 2015; 57(4): 367.
- Ahmed O, Faisal RA, Alim SM, Sharker T, Hiramoni FA. The psychometric properties of the depression anxiety stress scale-21 (DASS-21) Bangla version. *Acta Psychol*. 2022; 223: 103509.
- Tran TD, Tran T, Fisher J. Validation of the depression anxiety stress scales (DASS) 21 as a screening instrument for depression and anxiety in a rural community-based cohort of northern Vietnamese women. *BMC Psychiatry*. 2013; 13(1): 1-7.
- Martsenkovskyi D, Napryeyenko O, Martsenkovsky I. Depression in adolescents exposed to war trauma Risk factors for development of depression in adolescents exposed to war trauma: does PTSD matter? *Glob Psychiatry*. 2020; 3(2): 227-240.
- Amin S, Khan AW. Life in conflict: Characteristics of Depression in Kashmir. *Int J Health Sc*. 2009; 3(2): 213.
- Lim IC, Tam WW, Chudzicka-Czupala A, et al. Prevalence of depression, anxiety and post-traumatic stress in war-and conflict-afflicted areas: A meta-analysis. *Front Psychiatry*. 2022: 2136.
- Devakumar D, Birch M, Osrin D, Sondorp E, Wells JC. The intergenerational effects of war on the health of children. *BMC Medicine*. 2014; 12(1): 1-5.
- Charlson F, van Ommeren M, Flaxman A, Cornett J, Whiteford H, Saxena S. New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis. *Lancet*. 2006; 5(1): 25.
- Trickey D, Siddaway AP, Meiser-Stedman R, Serpell L, Field AP. A meta-analysis of risk factors for post-traumatic stress disorder in children and adolescents. *Clin Psychol Rev*. 2012; 32(2): 122-38.
- Samara M, Hammuda S, Vostanis P, El-Khodary B, Al-Dewik N. Children's prolonged exposure to the toxic stress of war trauma in the Middle East. *BMJ*. 2020; 371.
- Hart J, Boyden J, De Berry J, Feeny T. Children affected by armed conflict in South Asia: a review of trends and issues identified through secondary research. *Hb Int Disaster Psychol Interv Sp Needs Popul*. 2006: 61-76.
- Schiff M, Fang L. Adolescent substance use in Israel: The roles of exposure to political traumas and posttraumatic stress symptoms. *Psychol Addict Behav*. 2014; 28(2): 453.
- Murthy RS, Lakshminarayana R. Mental health consequences of war: a brief review of research findings. *World Psychiatry* 2006; 5(1): 25.
- Demyttenaere K, Bruffaerts R, Posada-Villa J, et al. Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys. *JAMA*. 2004; 291(21): 2581-90.
- Musyimi CW, Mutiso VN, Nandoya ES, Ndeti DM. Forming a joint dialogue among faith healers, traditional healers and formal health workers in mental health in a Kenyan setting: towards common grounds. *J Ethnobiol Ethnomed*. 2016; 12: 1-8.
- World Health Organization. Comprehensive mental health action plan 2013-2030. 2021
- Singh OP. Comprehensive mental health action plan 2013-2030: We must rise to the challenge. *Indian J of Psychiatry*. 2021 Sep 1; 63(5): 415-7.