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PREVALENCE OF PTSD SYMPTOMS, DEPRESSION AND LEVEL OF COPING AMONG THE VICTIMS OF KASHMIRI CONFLICT

BY

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A THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE DEGREE OF MASTER OF HUMAN SCIENCE IN PSYCHOLOGY

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ABSTRACT

The study examined the prevalence of Post Traumatic Stress Disorder (PTSD) symptoms, depression and coping among the adult civilian population of Kashmir. Hypothesis regarding the differences in PTSD, depression and coping were checked on 80 native Kashmiris who participated in the study. The Everstine Trauma Response Index-Adapted, Beck Depression Inventory and the Coping Resources Inventory were used to assess the three domains respectively. The study had five hypotheses: (1) Subjects who have experienced direct traumatic events will show higher levels of PTSD symptoms compared to the ones not directly affected, (2) Subjects who have experienced traumatic events will be upset due to the event for a longer duration than the ones not directly affected, (3) Subjects who have experienced traumatic events will have higher levels of depression than those who have not directly witnessed the traumatic event, (4) Subjects who suffer directly will show lower levels of coping as compared to the ones who do not suffer directly, and (5) Females will use more coping resources compared to men. Significant inter-item and inter-scale correlations were obtained. Independent Sample t-test was used between the directly traumatized and the indirectly traumatized group to explore each hypothesis. The results at $p < 0.05$ showed significant difference for all the hypotheses. Thus, the results established that direct trauma leads to increased PTSD symptoms and depression and decreased levels of coping. The study further discusses the results and future implications.

الملخص

قامت هذه الدراسة بفحص وتحليل ظهور أعراض كل من الاضطراب الإجهادي لمابعد الصدمة والمعروف باسمه العلمي Post Traumatic Stress Disorder (PTSD) ، والاكتئاب، وطرق التكيف لدى المواطنين الكشميريين البالغين. تم اختبار فرضيات البحث من خلال تجارب ميدانية أجريت على عينة من ثمانين شخصاً من ذوي الأصل الكشميري والذين شاركوا في هذه الدراسة. ولتقييم المجالات الثلاثة المذكورة، فقد تم استعمال مؤشر إفرستاين للاستجابة للصدمة، واستبيان "بيك" حول الاكتئاب، إضافة إلى مقياس مصادر التكيف المعروف باسم Coping Resources Inventory. لقد انطلقت هذه الدراسة من خمس فرضيات: ١- إن الأشخاص الذين تعرضوا للصدمة بشكل مباشر ستظهر عليهم أعراض الاضطراب الإجهادي لمابعد الصدمة بصورة أقوى من الذين تعرضوا للأمر ذاته بطريق غير مباشر. ٢-إن الأشخاص الذين تعرضوا للصدمة لفترة أطول ستظهر عليهم علامات الإحباط أكثر من الذين تعرضوا لها لفترة أقصر. ٣- إن الأشخاص الذين تعرضوا للصدمة بشكل مباشر ستظهر عليهم أعراض اكتئابية أكثر تطوراً من أولئك الذين لم يتعرضوا لها مباشرة. ٤-إن الذين عانوا من الصدمة مباشرة سيكونون أقل قدرة على التكيف مقارنة بأولئك الذين عانوا منها بطريق غير مباشر. ٥-ستكون الإناث أكثر استعمالاً لمصادر التكيف مقارنة بالذكور. وقد تم الحصول على نتائج ذات دلالة إحصائية عند قياس التداخل في الموضوعات المتعلقة بالاستبيانات، وكذا التداخل في نوعيات القياس. ولقد تم استخدام اختبار "تي" T-test للعينات المستقلة للمقارنة بين عينة تأثير الصدمة بشكل مباشر، وعينة تأثيرها غير المباشر لفحص وتقييم كل فرضية من الفرضيات الخمسة. ولقد دلت النتائج على وجود فروق ذات دلالة إحصائية بمستوى أقل من ٠,٠٥ بين نوعي العينات في كل فرضية. وهكذا فإن النتائج قد أكدت أن التعرض المباشر للصدمة يؤدي إلى ظهور أقوى لأعراض الاضطراب الإجهادي لمابعدالصدمة وللاكتئاب، بينما يؤدي إلى انخفاض في مستويات التكيف.

APPROVAL PAGE

I certify that I have supervised this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a thesis for the degree of Master of Human Sciences in Psychology.

Amber Haque
Supervisor
Date: 28/4/04

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a thesis for the degree of Master of Human Sciences in Psychology.

28/4/04
Syed Sohail Imam
Examiner
Date:

This thesis was submitted to the Department of Psychology and is accepted as partial fulfillment of the requirements for the degree of Master of Human Sciences in Psychology.

Amber Haque
Head,
Department of Psychology
Date: 28/4/04

This thesis was submitted to the Kulliyyah of Islamic Revealed Knowledge and Human Sciences and is accepted as partial fulfillment of the requirements for the degree of Master of Human Sciences in Psychology.

Mohamad @ Md. Som Sujimon
Dean
Kulliyyah of Islamic
Revealed Knowledge and
Human Sciences
Date:

DECLARATION PAGE

I hereby declare that this thesis is the result of my own investigations, except where otherwise stated. Other sources are acknowledged by explicit references and a bibliography is appended.

Name: Arooj Yaswi

Signature: Arooj Yaswi Date: 29.04.04

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DECLARATION OF COPYRIGHT AND AFFIRMATION OF FAIR USE FO UNPUBLISHED RESEARCH

Prevalence of PTSD Symptoms, Depression and Level of Coping among the Victims of Kashmiri Conflict.

Affirmed by Arooj Yaswi

Arooj Yaswi — Signature

29.04.04 — Date

To all those Kashmiris

who silently endure their fears and agonies,

and yet smile through tear laden eyes,

bringing together the shattered bits of their lives.

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1

INTRODUCTION

The roots of the present Kashmiri crisis go back long before the partition of the Indian Subcontinent into India and Pakistan in 1947; however, the conflict has intensified since 1989 when it took an armed turn. In the ensuing violence, many civilians have been killed, injured, gone missing, and been locked up or tortured. Although, the people of Kashmir are in the grips of deteriorating mental health, not much research has been conducted to study the impact of such an armed conflict on the psyche of the normal, average individual.

The people continue to suffer; and the ways in which this suffering has an impact on mental health levels gets no attention. There have, so far, been no adequate measures taken by either the government or the private sector to deal with the deteriorating mental health of the Kashmiris. The conflict has given the people misery, torture, unhappiness and deaths.

It is known that any kind of armed conflict or war entails aggression, violence and terrorism. Similarly, the conflict of Kashmir too has led to a rise in aggression, violence and terrorism. War is not a universal human phenomenon, although human aggression and individual killings might characterize all human groups, (Parrillo, 1996). War is a socially organized form of aggression that involves violent, armed conflict between nations or distinct groups of people. Violence could be defined as an intended pain or physical injury to other person or destruction of property of 'the other' (Parrillo, 1996). War is usually characterized by collective violence – organized

violence by a relatively large group of people. Terrorism, on the other hand, can be defined as the use of intimidation, coercion, threats and violent attacks to achieve the objectives of an individual or of a group (Heslin, 1990). It always involves violence and destruction.

Destruction in war is brought about by violence and aggression, as mentioned before, and violence and aggression may result in terrorism. Terrorism may be from the dominant group that oppresses the weaker group or from the group that needs to be known in order to make its grievances heard. The first category of terrorism, known as repressive terrorism, is more dangerous and severe in kind because it is organized at the government level to control citizens (Sullivan, 2003). The case of Argentina, Cambodia, Russia, Germany and many others is clear.

The other form of terrorism, revolutionary terrorism, is used by groups who are not in power but who are trying to force political and social changes. This kind of terrorism wants a lot of people 'watching' and not a lot of people 'dead'. While their acts of bloodshed appear immoral to outsiders and victims, to the terrorists they are justified and righteous acts because they are for the sake of a 'cause'. Kashmir is witnessing both forms of terrorism, where on one hand, the civilians are being terrorized to keep them under control and, on the other, a part of the civilian group, has taken terrorism as a means of rising against the perceived injustices.

War is a kind of phenomenon that is widely experienced across different individuals, cultures and contexts and categorized as traumatic (Harvey and Pauwels, 2000). But, because of individual differences, humans react differently to similar situations.

Whether as victims, perpetrators, supporters, or simply observers, most people can identify to some extent with the psychological and physical consequences produced by war. The reactions towards war also differ accordingly from pride to disgust, duty to helplessness, from essential to destruction (Briere, 1998).

This paper focuses on the psychological impact of the political, armed conflict on the native Kashmiris (as the people of Kashmir are known) from various sectors of the Kashmiri society. Since 1998, all sectors of the society have fallen prey to the malady, directly or indirectly. There might not be many who have not suffered in this conflict.

The conflict has taken its toll in terms of thousands of lives, physical material and money. Not only have people been killed, a large number of people have gone missing. This causes a greater psychological disaster to the families, who can neither bury the memories of the missing as dead, nor can they wait for and celebrate their return. The youth, in particular, are at a greater risk because they are supposed to be the active participants in the struggle. And there is no surprise that they are the ones who go missing.

Women are traumatized, many are molested and raped. Many are raped in front of the family members. The conflict has rendered many as half-widows. They are to take care of their family single-handedly, with no male counterpart to fulfil his share of the responsibilities. The situation in Kashmir is grim. No one is safe, neither physically nor mentally. The continued tension has left the people with marred mental health. Overtly or subliminally, everyone faces some kind of stress or anguish. The entire

population of Kashmir is exposed to an anticipated as well as long-lived period of threat and terror.

This paper tries to see the extent to which the Kashmiri people who have suffered, either directly or indirectly, show the symptoms of Post Traumatic Stress Disorder (PTSD) and Depression. Furthermore, it also tries to capture how the people cope and the effectiveness of their coping skills. As stated earlier, not many studies have focused on the impact of the conflict on the mental health of the Kashmiris, especially on the symptoms of depression and PTSD; this paper will, therefore, be one of the pioneering works in this field.

OBJECTIVES OF THE STUDY

This study aims at:

(i) examining the prevalence and the level of PTSD among the victims of the Kashmiri conflict,

(ii) determining the occurrence and level of depression among the victims of the Kashmiri conflict, and

(iii) analyzing modes of coping and how effectively they are used to deal with the consequences of the conflict.

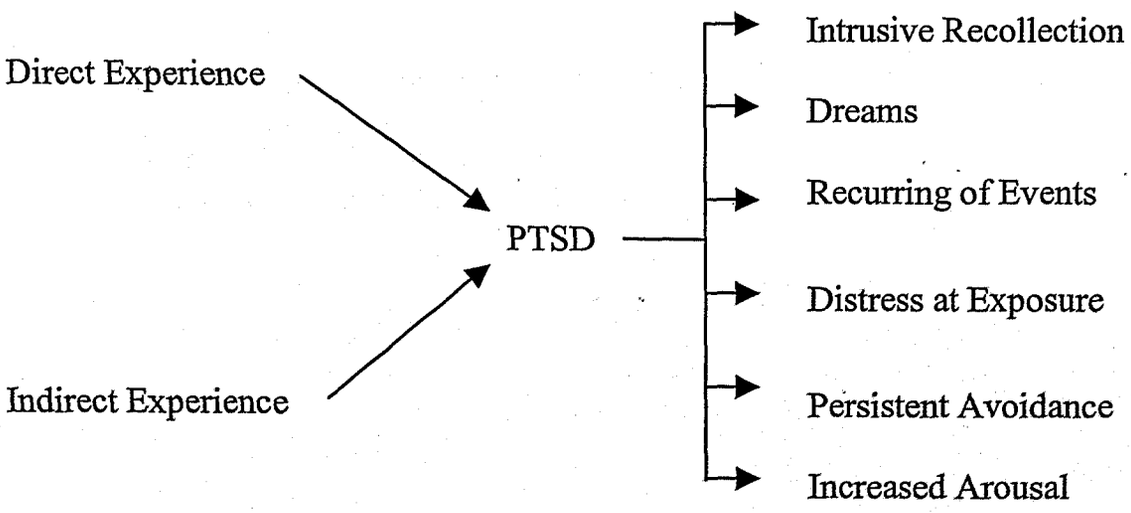
IMPORTANT DEFINITIONS

Post Traumatic Stress Disorder

Post Traumatic Stress Disorder (PTSD) is a natural emotional reaction to a deeply shocking and disturbing experience (O'Brien, 1998). It is a *normal* reaction to an *abnormal* situation. It was thought that PTSD could not be a result of normal events such as bereavement, business failure, interpersonal conflict, marital disharmony, working for the emergency services, etc, and most of the research on PTSD had been done with people who have suffered a threat to life (e.g. combat veterans, especially from Vietnam, victims of accidents, disasters, and acts of violence).

PTSD is not just 'stress'; it is associated with higher levels of physical complaints and more frequent visits to primary care physicians than most other anxiety disorders (Culpepper, 2000). It is now recognized that PTSD can result from many types of shocking experience.

Figure -1: Traumatic Event and the symptoms of PTSD



PTSD was first included among Axis I anxiety disorders in DSM III (APA, 1980). DSM IV enumerates the following symptoms to be present in the diagnosis of PTSD:

(i) The person must have been exposed to a traumatic event in which the person must have experienced, witnessed or confronted an event that involved actual or threatened death or serious injury, or a threat to physical integrity of self or others,

(ii) The person should re-experience the traumatic event in some way,

(iii) The person should persistently avoid stimuli associated with the trauma or experience a numbing of general responsiveness,

(iv) The person should experience persistent symptoms of increased arousal,

(v) The person should suffer the symptoms for at least a month, and

(vi) The disturbance should cause clinically significant distress or impairment in the social, occupational and other areas of functioning (DSM IV: American Psychiatric Association, 1994).

Based on the above definition, PTSD can result from seeing oneself or others in a life threatening position.

Depression:

Life brings with it personal ups and downs, which might greatly affect a person's mood and integrity. Changes in mood over time are a common and normal characteristic, when the changes are within the accepted level. However, among people experiencing clinical depression, the mood changes are more severe and affect daily functioning (Nevid et al., 2000). Such people may have poor sleep, poor appetite, become physically agitated or show slowing down of activity and might gain or lose a considerable amount of weight. They may lose interest in daily activities and have difficulty in concentrating and making decisions. In some cases, suicidal thoughts might also be present.

According to DSM IV (APA, 1994), a major depressive episode is denoted by the occurrence of five or more features or symptoms listed below, during a two-week period, representing a change from previous functioning; involving either a depressed mood, or / and loss of interest or pleasure. The symptoms must cause clinically significant levels of distress or impairment in at least one important area of functioning, such as social or occupational. It must also not be due directly to the use of drugs or medication, or to a medical condition, or accounted for by other psychological disorders. The symptoms should also not be accounted for by bereavement – the death of a loved one.

Symptoms:

(i) Depressed mood during most of the day, nearly every day,

(ii) Greatly reduced sense of pleasure or interest in all or almost all activities, nearly every day for most of the days,

(iii) A significant loss or gain of weight without any attempt to diet, or an increase or decrease in appetite,

(iv) Insomnia or hypersomnia nearly every day,

(v) Excessive agitation or slowing down of movement responses nearly every day,

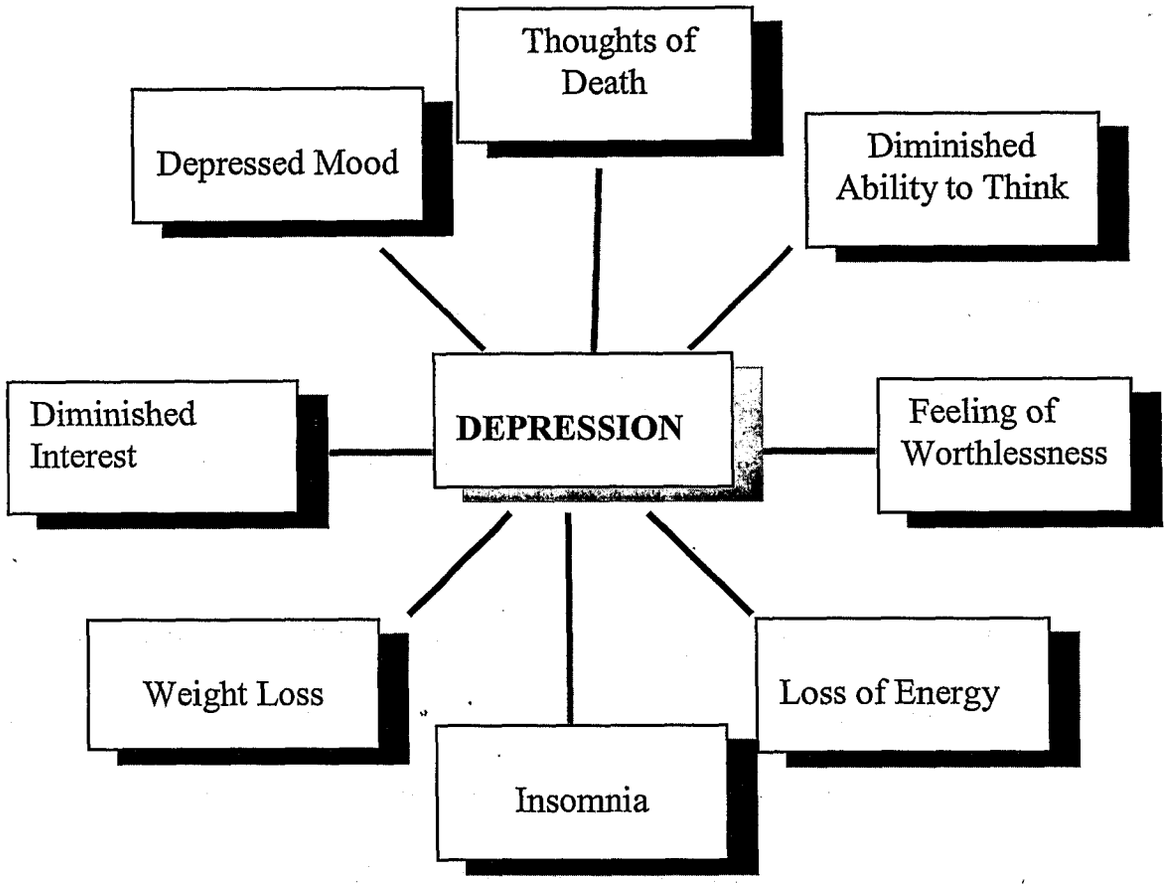
(vi) Fatigue or loss of energy nearly every day,

(vii) Feeling of worthlessness or excessive or inappropriate guilt nearly every day,

(viii) Diminished ability to think or concentrate, or indecisiveness nearly every day,

(ix) Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

Figure -2: The Symptoms of Depression



For dysthymic disorder, depressed mood should be present for at least 2 years. In the present study, depression will be classified as severe, moderate, mild and normal, based on the cut off scores set by Beck (Beck & Steer, 1993).

Coping

Coping is defined as 'dealing effectively or managing'. Whenever there is a stressful situation, people respond to it with coping. Coping may also take place in response to an anticipated stressful or traumatic event. Coping has also been defined as a process of managing taxing circumstances, expending effort to solve personal and

interpersonal problems and seeking to master, minimize, reduce or tolerate stress and conflict (Simons, Kalichman & Santrock, 1994).

There are various ways in which people cope. Generally speaking, coping can be done either directly or indirectly. When coping behavior is targeted to deal directly with the source of stress, it is called direct coping. On the other hand, when behavior may be targeted to deal indirectly with the source of stress, it is known as indirect coping. Lazarus (cited in Simons, Kalichman & Santrock, 1994) distinguishes between problem focused coping and emotion focused coping.

Problem focused coping is the cognitive strategy of facing ones troubles and trying to solve them, whereas emotion focused coping entails responding to stress in an emotional way or by using defense appraisals. While for the first, the problem is faced directly and effort is made to do something about it; in the second, people usually use defense mechanisms like rationalizations, humor, calling to religious faith etc. as modes of coping.