Political Unrest and Mental Health in Srinagar

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This paper reports on the impact of the on-going political unrest in Srinagar on the mental health of low-income urban people in Srinagar. The Kashmiri translation of the Self-Reporting Questionnaire 20 (SRQ-20) was used to assess current psychiatric morbidity in the respondents in Baramulla. The SRQ-20 was validated against the ICD-10, which was used as a gold standard. A cut-off of 11/12 was arrived at by testing for sensitivity and specificity. The findings of the study indicate high mental health morbidity in the respondents, especially in homemakers and in unskilled workers as a result of the on-going long-term unrest and the consequent trauma in the region.

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INTRODUCTION

The *World Development Report* (World Bank, 1993) estimates that minor psychiatric morbidity (mainly anxiety and depression) constitutes 90 per cent of the mental ill health in community settings in developing countries. Moreover, mental health problems are grossly underestimated in these countries not only due to lack of reporting of their prevalence, but also due to underplaying of the significance of these diseases (Harpham and Blue, 1995).

There is increasing recognition that mental ill health is a problem in developing countries and that it causes a great deal of suffering and places a considerable burden on national budgets. A review of a cross-section of studies from developing countries, recognising increasing mental ill health associated with, among other things, urbanisation, has advocated more attention to mental ill health in rapidly urbanising developing countries (Harpham and Blue, 1995).

Recent literature on mental health in developing countries (Blue, Ducci, Jaswal, LedermirandHarpham, 1995;Ekblad, 1995;Marsella, 1995; Srinivasa Murthy, 1997; World Health Organisation, 1992) highlights the vulnerability of the low-income communities to mental ill health. The studies conclude that the cause of illness in the respondents is due to the socio-political environment in which they live. The environment is responsible for mental health deterioration rather than misconceived biological factors. The fears experienced by low-income groups include losing esteem, income, love and employment. These fears cause insecurity and incapacity to deal with everyday problems (Blue and others, 1995).

The relationship between mental health and chronic conflict situations, such as political unrest, is poorly researched in developing countries (especially in low-income urban groups). This paper reports on the findings of a study which explored the impact of political unrest and mental health in low income urban households in Srinagar by studying the prevalence of minor psychiatric morbidity in the people and by seeking to understand the experience of the on-going political unrest on peoples' lives. The study also explored the peoples' response (coping) to minor psychiatric morbidity.

Violence has become an integral constituent of Kashmiri life. The reins of terror are in the hands of gunmen. Through kidnappings, bombings, assassinations, religious blandishments and press censorship, the secessionists have virtually achieved administrative and psychological severance of the valley from India. The indiscriminate killings and the panic and fear gripping the hearts of Kashmiris has become a way of life. More than 90,000 Kashmiri Pandits have fled their homes due to fear and the threat of impending danger and political unrest (Ali, 1997).

The low-income urban community in Kashmir is perhaps the most vulnerable not only in terms of overall economic deterioration but also in terms of social security and the constant threat they face from both the militants and the security forces by becoming 'soft targets' of various atrocities (Ali, 1997).

THE STUDY

The study was conducted in the Baghat Barzulla area in Srinagar district. This area has a population of around 10,000 and is situated at a distance of 3 kms. from 'Lalchowk', the heart of the city. The area is primarily residential with people from both high and low income groups living here.

The majority of the low income groups are small-scale businessmen and daily wagers. Some of the residents are teachers, others government employees and some are unemployed. In order to study the impact of political unrest on the mental health of the community, men, women and children as well as young adults and older people were included in the study. A total of 25 households were selected for the study.

Households, which had at least four members across three age groups (children, young and older adults), a monthly income of Rs. 3000/- or less and were willing to participate in the study, were included in the sample. Respondents were further selected only if they had faced no major life event in the previous year, that is death in the family, accidents, trauma, and so on, as these factors could contribute to mental ill health and, hence, act as cofounders in the interpretation of the results (mental health and political unrest).

Thus, respondents were selected purposively based on the above criteria. A rough map of the whole area was prepared and the area was surveyed so as to select the households based on the criteria outlined above. A total of 100 respondents, across 25 households, were selected for the study. Of these, 27 were children and young adults in the age group of 12-19 years, 51 were adults between 20-49 years and 22 were older adults in the age group of 50 years and above (see Table 1).

The study was conducted in two phases using a combination of quantitative and qualitative methods. As no data was available on the current prevalence of minor psychiatric morbidity in Srinagar, a quantitative study was initially undertaken to assess the prevalence of minor psychiatric morbidity in the low income urban households.

The Self Reporting Questionnaire 20 (SRQ-20) was used as a screening instrument or more precisely as a case finding instrument for minor psychiatric morbidity. In the framework of a collaborative study on strategies for extending mental health care (coordinated by the World Health Organisation), the SRQ-20 was developed as an instrument designed to screen for psychiatric disturbance in primary health care settings, especially in developing countries (Harding, De Arango, Baltazar, Climent, Ibrahim, Ladrigo-Ignacio, Srinivasa Murthy and Wig, 1980). In recent years, the SRQ-20 has been used in some 30 studies from which its psychometric properties can be assessed. The SRQ-20 is an instrument with proven reliability and validity consisting of 20 items which question the respondent about symptoms and problems likely to be present in those with neurotic disorders. The SRQ

20 consists of 20 close ended questions which have to be answered by a 'yes' or 'no'.

The SRQ-20 was translated into the local Kashmiri language and the questions put forward to the respondents. An attempt was made to translate the questions in Kashmiri as accurately as possible so as to retain the validity of the data. Each respondent in the household was interviewed separately. A cut-off score of 11/12 was arrived at after measuring the sensitivity and specificity of the tool in the Kashmiri community. The sensitivity and specificity figures for the validity sample were calculated for various cut-off points using the decision matrix advocated by the World Health Organisation (WHO)(1994). A sensitivity and specificity of 84 per cent and 100 per cent were obtained using 11/12 as the cut-off point. The sensitivity figure (84 per cent) for the study is high indicating that the probability of testing positive if the disease is truly present is good. Specificity for the study (100 per cent) is very good and indicates that the probability of screening negative if the disease is truly absent is high.

The responses from the SRQ-20, were validated against the Internationa] Classification of Diseases-10 (ICD-10) using it as gold standard. The ICD-10 was applied by a trained psychiatrist in the field on the respondents selected by the researcher. The psychiatrist was blind to the SRQ-20 score of the patients, so as to avoid researcher bias.

In the second part of the study there was purposive selection of households, based on their willingness to participate in the study, experience of mental ill health by at least one member in the household and the respondents' ability to reflect and communicate on the subject. The interviews were conducted in the homes of the respondents with the help of an interview guide.

RESULTS

Socio-Demographic Profile of Respondents

The table below shows that most of the respondents (52 percent) were in the 20-50 years, followed by those in the 12-19 years age group (27 per cent) with 21 per cent in the older age group. Among the men, 69.6 per cent had studied beyond matriculation, with some of them being even graduates and post-graduates. Thirty per cent were not able to complete their education up to the tenth class and 30 per cent of the respondents had not received any formal education. The last group comprised mostly the older male population.

TABLE 1: Socio-Demographic Profile of Respondents

Variable		*Male*	*Female*	*Total N=100*
Age	12 to 19 years	13	14	27
	20 to 50 years	20	30	52
	50 years and above	18	3	21
Education	Above Matric	16	7	23
	Under Matric	21	10	31
	Uneducated	16	30	46
Marital Status	Married	37	32	69
	Unmarried	16	15	31

In the female respondents, only about 15 per cent had passed matriculation, 21.3 per cent had some sort of formal education, but could not complete matriculation, and a large proportion of about approximately 64 per cent had no formal education. This major group comprised mostly middle-aged homemakers. About 69.2 per cent of the respondents were married.

Further, six per cent of the respondents were skilled professionals like tailors, craftsmen (carpet weaver), *wazas* (cooks), carpenters, masons, shawl weavers, plumbers, and so on. Twenty per cent were in the semi-skilled category: gardeners, bread-makers, teachers, cycle mechanics, painters, caterers, and so on. The unskilled category comprised labourers, preachers, businessman, clerks, peons, daily wagers, shop owners, and so on. Homemakers, students and the unemployed contributed comprised 28, 15, and five per cent respectively.

Incidence of Minor Psychiatric Morbidity

Thirty-seven per cent of the respondents reported minor psychiatric morbidity, on using 11/12 as the cut-off point. Table 2 shows that of the 37 cases reporting minor psychiatric morbidity, 21 per cent were in the 12-19 years age group, 62.2 per cent in the 20-49 years age group and 29.7 per cent in the age group of 50 years and above.

Among the children and teenagers/adolescents (12-19 years) and young adults, of the 27 members interviewed, 24 (that is 88.9 percent) did not report morbidity, and three (11.1 per cent) reported minor psychiatric morbidity. In the age group 20-49 years, a very high incidence of minor psychiatric morbidity was reported. The total number interviewed in this group was 52, including both males and females of which 23 (that is, 44.2 per cent) reported minor psychiatric morbidity. In the older age group (50 and above), of the 21 individuals

interviewed, 11 respondents (52.9 per cent) reported minor psychiatric morbidity, thereby indicating the presence of very high minor psychiatric morbidity in this age group.

Of the 53 males interviewed, 22 (41.5 per cent) reported psychiatric morbidity. In females, 15 of 47 respondents (31.9 per cent) reported minor psychiatric morbidity. Thus, males reported higher incidences of minor psychiatric morbidity than females.

On looking at the marital status and the SRQ-20 score, it is evident that in the married group, of the total respondents, 31 (that is, 45.6 per cent) reported minor psychiatric morbidity. In the unmarried group, of 31 respondents, five (16.1 per cent) reported minor psychiatric morbidity. One widow, who was interviewed, reported minor psychiatric morbidity.

Some respondents in the matriculation category were graduates and post-graduates. In this group, the total number of population interviewed was 23. Of these, 10 (that is 43.5 per cent) reported minor psychiatric morbidity. In the below matriculation group, consisting of mainly young adults, children and women, of the 31 respondents interviewed, seven (22.6 per cent) reported minor psychiatric morbidity. In the group with no formal education, most of the respondents consisted of the older persons and homemakers. In this group of 46 respondents, 20 (43.5 per cent) reported minor psychiatric morbidity.

It is evident from the above that both the respondents who had completed their matriculation as well as those with no formal education, the reporting of minor psychiatric morbidity was surprisingly equal, that is 43.5 per cent, thus indicating that education was no buffer for psychiatric morbidity or that the impact of political unrest was similar on both groups. Reporting of psychiatric morbidity was lower in the 'below matriculation' group.

Under 'occupation' homemakers and unskilled workers reported the highest psychiatric morbidity. In the group where the approximate income was between Rs. 500-1,500, the SRQ-20 was administered to 18 respondents. Of these, five (that is 17.8 per cent) had SRQ-20 scores of 11 and above, indicating minor psychiatric morbidity. In the income group of Rs. 1,500 and above, a high incidence of minor psychiatric morbidity was found. Of the 30 respondents interviewed in this group, 15 (50 per cent) had a score of 1 1 and above, indicative of mental illness, that is minor psychiatric morbidity. Of the total respondents having minor psychiatric morbidity, 23.2 per cent were in the Rs. 500-1,500 income group and 71.4 per

cent were in the Rs. 1,500 and above income group. Thus, people with comparatively higher incomes reported higher minor psychiatric morbidity. Respondents with two or more children also had higher psychiatric morbidity.

TABLE 2: Presence of Minor Psychiatric Morbidity

Variable		*Absence of Current Psychiatric Morbidity (1-10) N = 63*	*Presence of Current Psychiatric Mobidity (11 & above) N = 37*	*Row Total*
Age	12 to 19 years	24	3	**27**
	20 to 50 years	29	23	**52**
	50 years and above	10	II	**21**
Sex	Male	31	22	**53**
	Female	32	15	**47**
Marital Status	Married	37	31	**68**
	Unmarried	26	5	**31**
	Widow		1	**1**
Educational Qualification	Above Matric	13	10	**23**
	Under Matric	24	7	**31**
	No formal education	26	20	**46**
Occupation	Skilled	3	3	**6**
	Semi-skilled	13	7	**20**
	Unskilled	14	11	**25**
	Housewife	16	12	**28**
	Student	12	3	**15**
	Unemployed	4	1	**5**
Income (in rupees)	Income Nil	1	1	
	500-1,500	13	5	**18**
	1,500 and above	15	15	**30**

Effect on Mental Health

Respondents reported that the on-going political unrest affected their mental health by impacting on their daily lives, on the children's education and on the economic condition of the valley. Figure 1 shows the cycle of deteriorating economic condition on the mental health of the respondents.

FIGURE 1: Viscous Cycle Of Deteriorating Economic Conditions and Mental Health

DECREASED PRODUCTIVITY

Implications for Day-to-Day Life

Case Illustration 1

A 50 year old man, married with three children, with no formal schooling and a *waza* by profession.

> Difficulties! Our whole life has become one big difficulty. I swear by God that since this gun [unrest] has come my life has become chaotic. My work [earnings] is almost zero. I had to sell my small piece of land in order to feed my family. I do not know what will happen when that amount finishes. My daughter is no more a child. I have to get her married. This is my concern. I am always preoccupied as to how I will fulfill my responsibilities.
>
> Tension is the only problem. I know it will kill me. I am not scared of bullets whether of the CRP [Central Reserve Police] or the militants; my own tension will kill me. When my children go to work in the morning, I do not know whether I will see their faces again. The whole day I have headache and when they come back I feel relieved. Last year my neighbour's son was kidnapped and they (militants) took 20,000 rupees for his exchange. I have told my children so many times to go out of the State and work, but they do not agree. When your life is like this how can they progress in life!
>
> These problems are not only with us; my whole neighbourhood feels like me. But whom to tell! Sometimes in a crackdown [by state defense forces] we get beaten by CRP, sometimes militants threaten

> to kill us if we do not provide space in our houses — we are caught between two guns. You won't believe I just sleep 2-3 hours at night. If there is a small noise at night I get shaken. I have to shift my children to my room to provide them [defense personnel] space. Even my youngest child is getting influenced by them. When he sees guns and money with them, he wants to become like them. My wife is a patient of blood pressure [suffers from hypertension] and will definitely die if this continues.

The above views about the present political turmoil are expressive of the difficulties people face in their day-to-day life in Kashmir. One family in Barzulla, whose house is close to a bunker, said, 'We are never sure what is going to happen next. The thought them firing at us always hangs over us'. In a totally uncertain environment, these helpless residents of Barzulla live under a constant threat. The prime fear for women and people belonging to the older age group is for the the well-being of their children. As a mother said, 'The whole day I am on thorns as I do not know whether I will see the faces of my children again when they leave for work'.

Bus travel is also an ordeal for working women. Militants and defense forces stop vehicles and order the men to come down and start frisking women. As some women reported, 'Search is only a pretext, they begin fondling our bodies and we cannot do anything'. Women are also forced to unveil themselves, as a female teacher reported this:

> One day I was travelling in a bus. The army stopped it and ordered the men to come down. Then they started frisking women and forced them remove their Burkhas. I requested that they bring lady police for searching women. But they turned down my request and unveiled me at gun point.

'The militants have used their increased militancy and political power to engage in abuses against the civilian population,' reflected an engineering student. 'We are crushed between guns. Our days begin with fear and end with fear.'

'Pick' was a local term widely used by respondents to indicate kidnapping. The word was used to communicate that somebody had been kidnapped for a ransom by one group or the other. Respondent stated,

> Last year my neighbour's son was 'picked' and they (militants) took 20,000 rupees for his exchange. I have told my children so many times to go out of the state and work, but they do not agree. When your life is like this how can they progress. These problems are not confined to us, our whole neighbourhood feels like this, but whom

> to say this to. Sometimes in crackdowns which are there every alternate day, we get beaten, our children get beaten and at the same time militants threaten to kill us, if we do not provide space in our houses. We are caught between two guns.

A Human Rights Report by Justice Tarkunde (substantiates the terror and misery of the Kashmiris. According to this report, the people in the Valley are terror stricken. In their daily life, they are constantly haunted by the fear high handedness of the security forces and barbarity and repression of the militants. Even the literate class and persons of conscience who can raise a voice against the repression, cannot do so for they fear reprisal.

Implication for Education

An old man related the segregation of the pen to segregation of Kashmir from India as he argued that if their children remain uneducated, then they cannot have access to reputed national institutes in the country and blend with its (Indian) culture. Thus, they have no alternative but to get entangled with the gun culture, which will remain their prime source of income. On the other hand, some women even considered the closure of schools a blessing in disguise as their children were safer at home. But most of the parents, with some educational background, said that the closure of educational institutions had crushed their hopes of seeing their children prosper.

A school teacher revealed that the political turmoil had not only led to increase in drop-out rate from schools, but had also degraded the quality of education. While revealing his experiences, he expressed that examinations were a mockery, 'Open market sale of question papers has put forth a new challenge before us. If this trend continues, a day will come when the edifice of educational system in the valley will crumble. By remaining a mute spectator to this ongoing assault on our educational set up, we will be pushing our future generation into a whirlpool of agony and misery'. The implication of political unrest on education and the vulnerability of the students to constant stress and strain is clear from the high reporting (43 per cent) of psychiatric morbidity in matriculates and above.

Implication for Economic Condition

Preoccupation with the economic crisis was an important issue brought out by the respondents. The businessmen were of the opinion that ever since the political turmoil, they had lost their *zehni tamadan* (mental

peace) as they were always preoccupied about how to sustain themselves. Among them, the businessmen who solely depended on the tourist industry were the worst affected. A businessman who had a carpet weaving business and who also owned a a little shop stated, 'Those who can afford have left and started business somewhere else, but what about us, we are crushed. Even if *we go* out just to sell some items we will be called 'Indian agents' and 'they' will kill us. I wish I was a government employee who gets his pay even if he does not work'.

On the other hand, government employees complained that as the government machinery has collapsed, their day-to-day work and lives were guided by militants and this had brought them to a stage where some of them were even prepared to leave their jobs. The direct influence of militants in terms of threats left them with no alternative, but to quit their jobs. As one government employee said, 'A job is meant for earning to live, not losing your life'.

'Money has finished', and 'how are we going to eat' were the statements spontaneously stated by many respondents. A teacher expressed how, in the existing economic crisis, even students have stopped paying the fees. 'You cannot stop teaching them. I have started to spend what I have saved for my daughter's marriage. What will happen next when it finishes? With this preoccupation, it is a torture. It is better that they kill us once and for all, rather than dying a little everyday like this'.

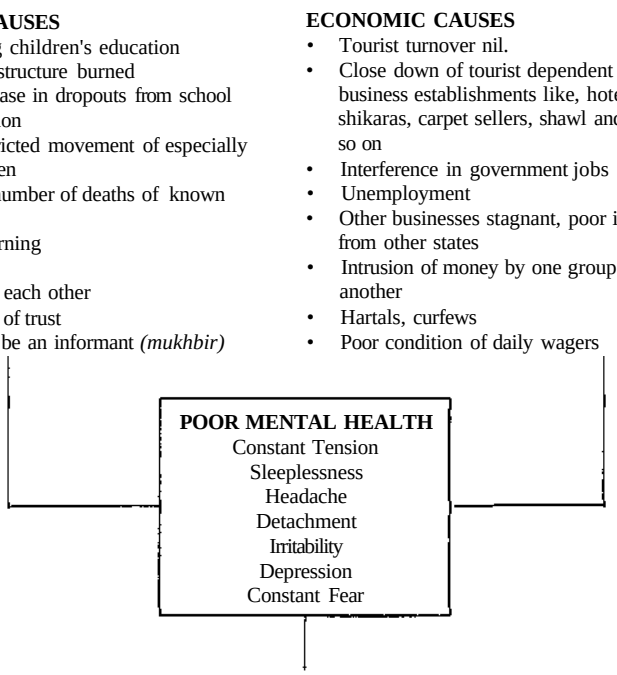
Implications for Mental Health

'We are forever ill', commented a middle-aged housewife. 'How can we remain happy and healthy when our *zehan* is constantly worrying for our men and children who go out in this turmoil. Money can come again, but if a life is lost can it come again'? Constant recurring symptoms like headaches and sleeplessness were reported very frequently by the respondents. Local terms like *pharat* (fear/threat) were commonly used. Complaints of 'sleeplessness were found not only in adult men and women, but also in teenagers and children. On probing for the possible reasons for such complaints, the researcher found that the *pharat* of the midnight knock was reported as the main cause. Some related their ill health to preoccupation with deteriorating economic conditions, while others associated it with worry for children. However, the overall cause was enmeshed in the present political turmoil.

Accessibility to health services was a major problem reported. Some respondents reported that in case of sudden illness at night, no health services were available to the patient until morning, as the security forces did not let anybody come out of their homes at night. 'After evening, our life is a hell. It is not only physical torture for the ill person, but mental anguish for all of us'.

Figure 2 clearly outlines the social and economic factors impacting on the mental health of the respondents.

FIGURE 2: Effect of Political Unrest on the Mental Health of Urban Kashmiris

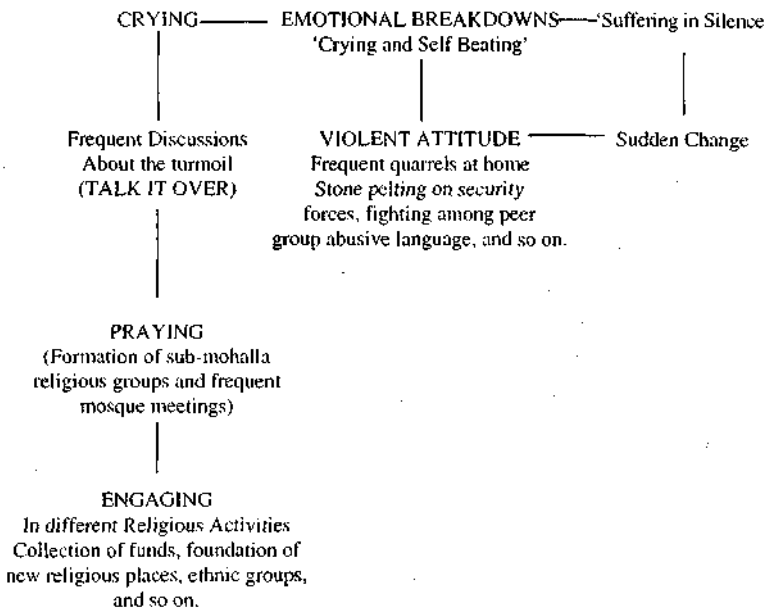


COPING WITH THE 'TENSION'

To understand the people's response to the current political unrest in Kashmir, the different coping strategies used by respondents were

probed (Figure 3). The responses varied and were not always clearly defined. One reason for this could be that due to chronic stress faced by the respondents in the last seven years, these coping strategies have become a part of their day-to-day life and the respondents cannot distinguish them as strategies to cope with the current stress.

FIGURE 3: Nature of Coping Strategies Used by Respondents



Respondents used mainly two types of coping strategies: internal strategies (such as praying, crying, suffering in silence, emotional breakdowns like crying and self-beating, thinking it over, day-dreaming, and fantasising); and external strategies (such as talking it over, violent attitude, frequent quarrels at home, engaging in different activities such as formation of mohalla groups, committees, "and so on).

Apart from these strategies, some used a combination of both external and internal strategies. Harari and Kaplan (1977) also suggested that avoidant thinking is a way to cope with stress. People can avoid uncomfortable situations by turning their attention away from it or by thinking about other things. Coping, as a concept, is process

oriented. Coping is directed towards what the Kashmiri actually thinks and does within the context of the experience of political turmoil, and how these thoughts and actions change as the experience unfolds itself.

Due to varied responses about the coping strategies used, no clear coping strategy could be identified for specific situations by a particular group of respondents. However, various methods such as 'talking it over', 'praying and crying' and 'suffering silently' were reported by almost all the respondents. There was not much of a difference between the number using internal methods of coping and those using external methods.

Comparison of other variables like education with the coping strategy did not reflect a difference between those who received formal education and those with no formal education. This could be due to the fact, that both the educated and uneducated are being exposed equally to the impact of political unrest in their day-to-day life. 'Talking it over' was again a commonly used coping mechanism in the educated group, but combination of other coping strategies like 'suffering silently', 'praying and crying' were also used.

Talking it Over

A majority of the respondents in the adult age group affirmed use of the coping strategy which involved 'talking it over with others': the 'others' included close friends, family members and relatives. A point to be emphasised is that in one of these 'talks' observed by the researcher, the discussion revolved round the day-to-day incidences related to political unrest like crackdowns, killings, bomb blasts, and so on. This type of coping strategy was observed both in male as well as female adults, irrespective of sex, education, and so on. These discussions were confidential and only took place with utmost care with close and trusted individuals.

Praying and Crying

This was another popular coping mechanism observed in a majority of adult females and elderly respondents. Interestingly many of the female respondents quoted, 'After we finish our household chores, we sit on the *Jai Namaz* [prayer mat] the whole day, praying and crying for the return of our men from work and for forgiveness of our sins that has led to the present political turmoil'.

Suffering Silently

This was a response which could not be measured quantitatively. Almost all the respondents reported that this coping strategy had been used in the beginning years of political unrest, but now 'suffering silently' was not possible as 'water had gone over their heads'.

To illustrate the combination of coping strategies used, a case study of a middle aged Kashmiri woman is given here. Farida Begum, wife of a daily wager, married for the last 20 years, and a mother of two, living in a three room hut in urban Srinagar expressed her views regarding the political turmoil and a reflection on the combination of coping strategies used.

> *Tabahi* [destruction] is the only thing we are seeing for the last seven years in Kashmir. Kashmir is burning, we have lost our children, our livelihood. So many lives have been destroyed. Those who are living are in constant *pharat* and pain. I have seen a mother whose four sons were killed by security forces. If this continues Kashmir will be a desert, and not a single soul will survive.
>
> I do 'cry' often on seeing what is happening. I 'pray' day and night for the day when I see the military [security forces] going back and *Aman* in the valley. Sometimes, I feel like 'bursting open'. I cannot restrain myself, at times and 'cry and beat my chest' hours together whenever I see faces of young boys who are massacred by the security forces in the newspaper.
>
> My husband is a member of the 'mohalla action committee'. There they discuss whatever is happening and all of us have to contribute 25 Rupees per month, which is given every month to a family like us on rotatory basis, because how else can we survive, if this continues.

DISCUSSION

Measurement of Mental Health in Low-Income Urban Groups

It is currently estimated that at least 500 million people in the world suffer from mental disorders and that only a small proportion of them receive appropriate care. In Kashmir, in the present turmoil, various reports published by social organisations like the People's Union for Civil Liberties (PUCL) highlight the alarming rise of minor psychiatric morbidity and their neglect in terms of non-identification, treatment and referral.

In the current study, the cut-off point for minor psychiatric morbidity by using SRQ-20 was found to be 11/12. This, in itself, reveals a

very high cut-off. Recent studies in India in low income urban groups (Jaswal, 1995, 2000) have used 7/8 as the cut off point for measuring minor psychiatric morbidity. The cut-off scores in countries such as Brazil, Chile, Columbia, Ecuador, Ethiopia, Guinea-Bissau, Hong Kong, Kenya, Malaysia, Spain, South Africa, Sudan, United Arab Emirates, the United Kingdom and Zimbabwe, have been found to be in the range of 3/4 to 10/11 (WHO, 1992). Earlier studies in India which have used the SRQ-20 (Deshpande, Sundaram and Wig, 1989; Dhadphale, Ellison and Griffin, 1982; Harding and others, 1980; Sen, 1987) have also used a cut-off of 10/11, 7/8, 5/6, and 7/8 and 1 1/12 respectively. The cut-off of 11/12, thus, signifies a relatively high threshold for minor psychiatric morbidity.

Further, an overall morbidity of 37 per cent was reported by the respondents indicating a high prevalence of minor psychiatric morbidity. Jaswal (1995) reports a prevalence of 17.9 per cent in a general population of low-income urban women in Mumbai. The prevalence increased to 27.5 per cent for women reporting gynaecological morbidity. Older women and women who were isolated reported the highest psychiatric morbidity. In another study (Jaswal 2000), of low-income urban women reporting to a health facility and facing different forms of violence, 55 per cent of the women reported minor psychiatric morbidity when 7/8 was taken as the cut-off point.

In the current study, amongst those reporting psychiatric morbidity, respondents between 20-50 years reported 52 per cent of the morbidity. Further, married respondents reported higher morbidity as well as those without any formal education. It is also seen that homemakers and unskilled workers report high psychiatric morbidity. Thus, respondents in the employable age group with fewer alternatives (unskilled workers and homemakers) and those with dependants (married) are seen to report higher morbidity. Figure 2 clearly outlines the social and economic causes leading to poor mental health in these respondents. This profile of psychiatric morbidity is different from findings of other studies in low-income urban groups in India.

Mental Health And Political Unrest

Srinivasa Murthy (1997) recognises that 'the need of the population arises from the uncertain and threatening situation which changes from day to day with associated decreased feelings of security and mental tension'. He reiterates that 'the stress arises from lack of control day

to day activities and lack of predictability and inability of the individuals to take or initiate action at their own level'.

A renowned psychiatrist from Kashmir (Beigh, 1992) also reports that the preliminary enquiry conducted by the PUCL about tension related diseases, torture related mental imbalances, militancy related deaths, and excesses committed by the paramilitary forces presents a very gloomy picture. It reveals that the turmoil in Kashmir, marked with brutal violation of human rights, has injured a large number of Kashmiris, physically and mentally. Beigh (1992) further reports that a large number of patients can be seen queuing outside psychiatric clinics and the social life in Kashmir is under the shadow of the militants and Khaki clad men. This has made deep impressions on the minds of people. The dances of death in and around the bunkers have made life miserable for the people and many inhabitants of 'pressure areas' (where the military operations are carried frequently) in Srinagar now complain of mental ailments.

An investigation by the PUCL into the rise of psychiatric problems also reveals the severity of the problem in the valley. They reported that in the last two years there was an increase in depressive disorders by 20 per cent, anxiety related disorders by 30 per cent and hysteria by 10-20 per cent. The cause of such an increase in minor psychiatric morbidity was related with the political turmoil in the valley.

The PUCL explained that the causes of mental ill health are either embedded in unnatural life events like untimely death of a friend or a relative, loss of life and property in firing, constantly perceived threats and fear in interrogations, crackdowns, and so on. These findings are strikingly similar to the findings of the current study. Beigh (1992) also reports that many people, young and old, are found to be carrying sedative strips like valium and calmpose in their pockets and complain of insomnia (sleeplessness), headaches and fatigue.

Striking similarities to the above study are found in the current study. Respondents reported that *pharat* revolved around the survival of oneself. Social isolation, in terms of restricted movements after the office/work hours, was an important factor brought out by some of the male respondents. 'We feel we live in jail' and 'Our life is tied by a rope' were some of the analogies used by the respondents in explaining the amount of stress and constraints they faced in their day to day life.

CONCLUSION

Strengthening of Mental Health Care Components in the Public Health Care System

In India, in the public health care delivery system, mental health has the least priority. This holds true for Kashmir too. Community mental health or primary mental heath is not recognised as it may not always elicit physical morbidity. In Srinagar, the main mental health care delivery system has remained within the four concrete walls of the psychiatric hospital run by government medical college. There is an urgent need to reach mental health care services to primary health care facilities such as urban health posts and clinics in various parts of Srinagar as well as in the state as a whole. It is universally known that in conflict situations, health professionals see people experiencing distress more than any other group. Thus, sensitisation and training of general practitioners as well as other health personnel to mental health, particularly minor psychiatric morbidity is essential. Besides this, specialised psychiatric services for those experiencing bereavement, physical harm, terrorism, hostage and related experiences should be available.

Social and Psychological Support

Since the Kashmiris are leading a life under constant threat and fear, certain preventive measures need to be taken in order to stop further social and emotional ramification in the present turmoil in the valley. One of the most essential services that should be made available at public dispensaries is that of a social counsellor. The researchers realised this during the interview sessions, when the respondents were sharing their personal experiences, that fear of their condition and inability to express and share their feelings was an important factor contributing to minor psychiatric morbidities.

. One of the most vulnerable groups in the present situation in Kashmir are the unemployed youth and daily wagers. Due to the on-going political unrest, labour intensiveness in the private sector and other industries is receding leading to more unemployment. Instability in day to day life has made the survival of daily wagers difficult. This frustrating experience, along with the political turmoil, if allowed to continue may not only lead to major psychiatric morbidities, but may also lead to psychosocial problems such as drug addiction and alcohol

abuse. Social workers/counsellors are required, to counsel these youths in vocational guidance as well as to provide information and support.

Social organisations need to provide support to the homemakers, through formation of local support groups as they mostly spend the whole day in mental anguish, waiting and praying for the return of their husbands and children. Constant fear has become a part of the daily routine of these women. To break this vicious circle of fear and despair, self-help groups can be formed, which provide both psychological support as well as some economic help. This would help to decrease the feeling of helplessness and isolation and not being part of the larger social situation.

Concept of Mental Health

There is growing evidence from both developed and developing countries that the prevalence of common mental disorders or minor psychiatric morbidity is high and that certain groups such as urban low-income populations and women are particularly vulnerable. However, programmes such as Structural Adjustment Programmes and other forces of globalisation have put the populations of developing countries and particularly these populations at risk of mental ill health. Increasing conflict between neighbouring countries and ongoing political unrest within the country are also putting more and more people at risk of mental ill health. This study clearly highlights the impact of chronic/long-term conflict on the mental health of the population.

In view of larger numbers of people requiring mental health services, especially in the light of decreasing community and family support (due to migration and decreasing resources), the need for integration of mental health into primary health care is essential.

Further, the need to recognise and integrate the widening concept of mental health such that illness related to conflict, trauma and long-term stressors is identified and diagnosed by mental health professionals is imperative.

NOTE

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