Life in Conflict: Characteristics of Depression in Kashmir

Syed Amin and Khan A.W.
*Department of *Accident & Emergency, **Psychiatry*
Sher-e-Kashmir Institute of Medical Sciences, Srinagar – 190011 (India)

Abstract:

Background: Mental, physical and social health, are vital strands of life that are closely interwoven and deeply interdependent. Mental disorders affect people of all countries and societies, individuals at all ages, women and men, the rich and the poor, from urban and rural environments. Depression is more likely following particular classes of experience – those involving conflict, disruption, losses and experiences of humiliation or entrapment. Many people living amidst the rages of conflict suffer from post-traumatic stress disorder.

Objective: To determine the characteristics of depression in the population in Kashmir where a low-intensity-conflict has been going on for the last seventeen years.

Methods: The non-combatant civilian population was surveyed. The Centre for Epidemiological Studies Depression (CES-D) Scale was used to measure symptoms of depression in community populations.

Results: Due to continuing conflict in Kashmir during the last 18 years there has been a phenomenal increase in psychiatric morbidity. The results reveal that the prevalence of depression is 55.72%. The prevalence is highest (66.67%) in the 15 to 25 years age group, followed by 65.33% in the 26 to 35 years age group. The difference in the prevalence of depression among males and females is significant. Depression is much higher in rural areas (84.73%) as compared to urban areas (15.26%). In rural areas the prevalence of depression among females is higher (93.10 %) as compared to males (6.8%).

Conclusion: Mental health is an integral part of overall health and quality of life. Effective evidence-based programs and policies are available to promote mental health, enhance resilience, reduce risk factors, increase protective factors, and prevent mental and behavioural disorders. Innovative community-based health programmes which are culturally and gender appropriate and reaches out to all segments of the population need to be developed. Substantial and sustainable improvements can be achieved only when a comprehensive strategy for mental health which incorporates both prevention and care elements is adopted.

Correspondence:
Professor S. A. Tabish
Sher-e-Kashmir Institute of Medical Sciences
Srinagar – 190011 (India).
Email: amintabish@hotmail.com

Introduction

Mental, physical and social health, are vital strands of life that are closely interwoven and deeply interdependent. Depression is more likely following particular classes of experience – those involving conflict, disruption, losses and experiences of humiliation or entrapment. World Health Organization has ranked depression as the fourth among the list of the most urgent health problems worldwide and has predicted it to become number two in terms of disease burden by 2020 overriding diabetes, cancer, arthritis etc.

The magnitude, suffering and burden in terms of disability and costs for individuals, families and societies are staggering [1-3]. Mental disorders are universal, affecting people of all countries and societies, individuals at all ages, women and men, the rich and the poor, from urban and rural environments. Mental functioning is fundamentally interconnected with physical and social functioning and health outcomes [4,5]. The mental health is influenced by displacement through conflict and war, by stresses on families, and by economic adversity. For the many persons who face uncertain futures (including those by conflict or disasters), the burden of serious emotional and behavioural disorders afflicts their lives. Many people living amidst the rages of conflict suffer from post-traumatic stress disorder [6,7].

At the dawn of a new millennium, communities and societies increasingly face situations of armed conflict. While this trend is apparent in different parts of the world, it is of particular concern to the South Asian region.

Violence is a phenomenon intrinsic to class-based societies which are inherently unequal and oppressive. Violence here may either take implicit forms in the manner of institutionalized oppression and inequality, or a more explicit form of state oppression through the use of state sanctioned institutions, such as the police, the military and courts. It could even assume a more direct form, whereby civilians manage the task of a weakened state through militia groupings. Large-scale violence may also take the form of mass uprisings against the oppression of dominant classes. Civilians are increasingly being targeted in these episodes of contemporary violence. To reduce military casualties, civilians are used as protective shields; torture, rape and executions are carried out to undermine morale and to eradicate the cultural links and self-esteem of the population. Most civilians witness war-related traumatic events such as shooting, killing, rape and loss of family members. The extent of psychosocial problems that results from this mass exposure to traumatic events can ultimately threaten the prospects for long-term stability in society.

Despite growing evidence over the past two decades of the terror – both of the physical and mental dimensions of war upon civilians – much of post-conflict activity tends to concentrate on physical reconstruction – roads, bridges and buildings. Moreover, even though psychological and psychic injuries can have more damaging, long-term consequences as other injuries from a situation of conflict, they remain undetected and distanced from any plans for rehabilitation. Partly this is because these injuries are difficult to fathom in terms of the enormity of scale and the delayed manifestation of symptoms which can sometimes take years to surface. Physical violence may be easier to identify, name and quantify than psychic or symbolic violence.

Kashmir has been regarded by many as heaven on earth. Its splendid beauty and hospitable population is legendary. Over the past 18 years Kashmir became associated with violence.

The objective of this study was to determine the characteristics of depression in the non-combatant civilian population of Kashmir where a low-intensity conflict has been going on for more than 18 years. Study was conducted during 2005-06.

Security concerns are amongst the dominant themes in the minds of people living in Kashmir. This owes to the fact that death, injury, destruction of property is the notable features of life here due to conflict, disturbances and turmoil for the last 18 years. Many have suffered tragic incidents of a war-like situation, which by their nature are beyond the endurance of common man. Many are witness to bloodshed that is characteristic of such situation. Thousands of people have lost their lives or limbs, and thousands have been rendered orphans and widows. Scores have disappeared. A colossal damage to property is evident. Many educational and healthcare institutions have suffered damages. Those who have survived all this, continue to be reminded of their vulnerability through the media of killings that make the headlines almost daily. Moreover, with disruption of development works consequent upon war-like situation, added concerns are unemployment, poverty, relationships etc.

A vicious circle of events has been created comprising torture, disappearances, displacement, killings, ballistic trauma, etc. paralleled by a state of mind wherein grieving, insecurity, oppression, poverty, uncertainties of career and relationships etc. are the major themes.

The situation in Kashmir can best be described as a “low-intensity conflict”. What predominates in such conflicts is the use of terror to exert social control, if necessary by disrupting the fabric of grassroots; social, economic and cultural relations; the main target of the combatants is often the population rather than the territory and psychological warfare is a central element. As can be expected, the consequences for mental health can be substantial. Kashmir is not merely a law and order problem but there are social, emotional, political and psychological aspects involved.

For a population of approximately 1, 10, 70,000, presently Jammu & Kashmir state has around 3800, 5000, 12300 health institutions, doctors and hospital beds respectively. Population of Kashmir Province is 57, 13,509 (2001 census) out of which 27, 07,837 are females. Kashmir province has 11 hospitals associated to Medical Colleges, 8 District Hospitals, 47 Community Health Centres, 661 Primary Health Centres/Allopathic Dispensaries, 1105 Sub Centres, 184 Indian System of Medicine (Unani) dispensaries and, 21 other healthcare institutions (Table 1,2). Health care is supported by the private sector hospitals, nursing homes, poly clinics, GP clinics, faith healers, quacks, etc. Quacks play havoc with the lives of people because of lack of implementation of regulations mechanisms. Moreover, the exodus of health care professionals from Kashmir during the early 1990s created a vacuum adversely affecting the basic health services.

The already inadequate health care infrastructure further added to the miseries making the people vulnerable to health problems and other forms of deprivation. This exodus coupled with poor governance led to malfunctioning of health sector in general but rural health facilities in particular.

Women’s health has not received proper attention for policy makers as there is a single maternity hospital catering to whole population of Kashmir.

Mental health has been neglected for far too long. In spite of eleven fold increase in psychiatric diseases due to ongoing conflict, tremendous stressful conditions, overwhelming fear and uncertainty during the last 18 years, not much attention is being paid to expand and modernize the present infrastructure.

Looking after the health of the population of the state which resides in a widely scattered mix of 6652 villages and around 75 towns, at a mean elevation of 1800 meters above sea level occupying a variegated landscape, enduring long winters and severe summers, can never be a simple task, even if we have all the resources and time as J&K is unique in more ways than can be fully explained [4,5].

Table (1). Socio-demographic parameters of J&K and India.
[Data from Census-2001 & NFHS-II] $ as per SRS vol.37 no. 2 October 2003

S. No.	Indicator / Parameter	J&K	India
1	Population (in 000) 2001	10,070	1,027,015
2	Annual Exponential Growth Rate (%) 1991-	2.55	1.93
3	Decadal growth rate (1991-2001)	29.04	21.15
4	Estimates of B.R. (Birth Rate)$ 2003	19.2*	25
5	C.D.R. (Crude Death Rate) 2003$	5.7*	8.1
6	Natural increase (CBR-CDR) 2003$	13.5*	16.9
7	Infant mortality rate 2003$	65	64
8	Sex ratio-overall (Females per 1000 Males	900*	933
9	Sex ratio in 0-6 age group	937*	927
10	Total Literacy rate (%) 7 years & above)	54.46	65.38
11	Literacy Male (%) 7 years & above)	65.75	75.85
12	Literacy Female (%) 7 years & above)	41.82	54.16
13	Child 0-6 yrs population (% of total	14.21	15.42
	Other Parameters		
14	C.P.R. (Couple Protection Rate) 2000	14.1	46.2
15	Maternal mortality rate	N.A.	407 per one lac live
16	Institutional Delivery rate (NFHS-II)	35.6	33.6
17	Total Fertility Rate (NFHS-II)	2.71	2.85

Table (2). Details of healthcare facilities in Kashmir.

District	Medical Colleges/ Associated Hospitals	District Hospitals	SDH/ CHC	PHC/ ADs	MAC/ SC	ISM Dispensary	Others*	Total	District
Srinagar	11	1	3	49	80	26	7	177	Srinagar
Budgam	0	1	9	54	115	26	1	206	Budgam
Anantnag	0	1	8	68	207	40	3	327	Anantnag
Baramulla	0	1	7	74	149	22	2	255	Baramulla
Pulwama	0	1	6	55	132	48	2	244	Pulwama
Kupwara	0	1	7	39	195	20	1	263	Kupwara
Leh	0	1	3	22	123	1	1	151	Leh
Kargil	0	1	4	13	104	1	4	127	Kargil

**Mobile Medical Units, TB centres, FP centres, Leprosy centres, Leprosy control units and Amchi centres*

Key: [SDH=Sub-District Hospital, CHC=Community Health Centre, PHC=Primary Health centre, AD=Allopathic Dispensary, ISM=Indian System of Medicine, MMU=Mobile Medical Units, SC=Sub Centre]

Within the spectrum of mental health interventions, prevention and promotion have become realistic and evidence based, supported by a fast growing body of knowledge from fields as divergent as developmental psychopathology, psychobiology, prevention, and health promotion sciences [1-3].

Many depressed patients with somatic complaints may be overlooked as ones having no real illness, once medical illnesses are evaluated and ruled out. Even in the most advanced countries more than 50 percent of the depressed individuals are neither diagnosed nor treated by their family doctors. The adequate recognition and treatment of depression is hampered by negative public attitude and gaps in professional expertise [14].

The social institutions and cultural practices have a major influence in structuring experience and in giving meaning to human lives and may be reinforced and supported by social networks that may have been severely fractured and dislocated during conflict. Social structures may provide and allow meaning in human lives. The situation in Kashmir requires prudence and modesty.

This study is an attempt to define a prevalence of mental health problems in a community exposed to conflict with special reference to characteristics of depression. However, intervention that might be used to help this population has not been studied which needs further research.

Methods

Brief psychiatric symptom scales are useful as screening instruments, because the rationale for most disease screening procedures is to provide a fast, economical method of detecting cases of suspected or potential illness in the general population. One of the most popular such scales is the Centre for Epidemiological Studies Depression Scale (CES-D Scale). This scale was developed to measure symptoms of depression in community populations [8-10]. It is a self-report scale; respondents are asked to rate the frequency, over the past week, of 20 symptoms by choosing one of four response categories ranging from “rarely” or “none of the time” to “most or all of the time”. Scores range from 0 to 60, with a score of 16 or above indicating impairment. The reliability and validity of the scale have been tested on clinical populations and on community samples [8-13].

A cross sectional study of general population was conducted to determine the characteristics of depression in Kashmir. A total of 2728 subjects were selected from different areas (both urban and rural) of Kashmir.

In order to ensure participation of different groups of people, samples were drawn from persons with different age, gender, occupation; marital status, geographical location (rural, urban), literacy, socioeconomic status, etc. All the districts (excluding Ladakh) were included in the survey. Some groups (like students) were more readily accessible than others, and the number of these participants was more in the sample than others because of their catered location in the community. Similarly, mobile persons were more accessible than those in households.

Six surveyors (four resident doctors undergoing postgraduate training and two school teachers) were assigned the job of conducting this survey individually. All were given two-week’s training of how to conduct the survey. Two school teachers who worked as surveyors for this study had an advantage of being postgraduates in educational psychology with theoretical background as well as genuine interest in such an exercise.

Three educational institutions (one each in Srinagar, Anantnag and Budgam districts) were selected including two Higher Secondary Schools (+2) that would give representation to adolescents (> 16 years of age) by conducting survey on 50 students from each school. One Srinagar-based Women’s College provided sample from a higher age group (18 plus). In addition to these three institutions, 50 university going students

(coming from both rural and urban areas) were also included in the sample to give fair representation to the youth with different academic pursuits and aspirations to exclude bias that could arise from the pursuit of more competitive branches at school and college level studies. Most of the respondents being in the young and productive age group are representative of the targeted samples.

The questionnaire was administered to the young persons after a proper explanation to them to seek their consent. Respondents were generally forthcoming and the response

was encouraging. There were no refusals from the participants and everybody cooperated in completion of the questionnaire. The number of people not located and not available was insignificant. Children below 16 were ineligible for this survey.

Similar exercise was done in other population groups. However, in these groups the approach required modification. Most of the male respondents were contacted at their work places or public places. Many women respondents were contacted at their homes or work places. The initial contacts with women were from kinship networks of the surveyors and those would further broaden the network of respondents. Such an exercise was time-consuming and laborious and took 12 months. The study was conducted in a phased manner and at times discretely to avoid any undue attention resulting from extracting information from otherwise strangers.

Results

The results reveal that the prevalence of depression is 55.72%. The prevalence is highest (66.67%) in the 15 to 25 years age group followed by 65.33 % in the 26 to 35 years age group. Females have an overall prevalence of 60 per cent while as males have 51.34 per cent. Significant difference in the prevalence of depression among males and females is in the age group of 36 to 45 years and 46 to 55 years who have p values of 0.005 and 0.013 respectively. Females have a higher prevalence of depression in all the age groups than males and it is highest in the age group 26 to 35 years (68.66%). Females in the age group of 15-25 years also have similar prevalence rate of depression (68.64%). In males prevalence of depression is highest in the age group of 15-25 years (64.61%) followed by 62.65% in the age group of 26 to 35 years (62.65%). *(Table 3, 4).*

Table (3). Age-, Gender-wise percentage of depression.

Age group (years)	Gender	No. of respondents		Depression (Score > 16)		χ^2
		No.	%	No.	%	
15-25	M	380	28.19	244	35.06	1.862
	F	472	34.20	324	39.13	
	T	852	31.23	568	37.27	
26-35	M	332	24.63	208	29.88	2.263
	F	268	19.42	184	22.22	
	T	600	21.99	392	25.72	
36-45	M	224	16.62	92	13.22	7.904
	F	252	18.26	136	16.42	
	T	476	17.45	228	14.96	
46-55	M	184	13.65	76	10.92	6.229
	F	192	13.91	104	12.56	
	T	376	13.78	180	11.81	
56-65	M	120	8.90	40	5.75	0.764
	F	124	8.99	48	5.80	
	T	244	8.94	88	5.77	
> 65	M	108	8.01	36	5.17	2.269
	F	72	5.22	32	3.86	
	T	180	6.60	68	4.46	
Total	M	1348	49.41	696	100	20.750
	F	1380	50.59	828	100	
	T	2728	-	1524	100	

M: Males; F: Females; T: Total

Table (4). Characteristics and statistical significance of depression.

Age group (years)	Gender	Depression %	p - value
15-25	M F T	64.21 68.64 66.67	0.172 (NS)
26-35	M F T	62.65 68.66 65.33	0.124 (NS)
36-45	M F T	41.07 53.97 47.90	0.005
46-55	M F T	41.30 54.17 47.87	0.013
56-65	M F T	33.33 38.71 36.07	0.382 (NS)
> 65	M F T	33.33 44.44 37.78	0.132 (NS)
Total	M F T	51.34 60.00 55.72	0.0001

M: Males; F: Females; T: Total; NS: Not Significant

The difference in the prevalence of depression among males and females is significant; p <0.05 *(Table 5).* Depression is much higher in rural areas (84.73%) as compared to urban areas (15.26%). In rural areas the prevalence of depression among females is higher (93.10 %) as compared to males (6.8%). The difference between prevalence of depression in urban and rural areas is significant i.e. p <0.05 *(Table 6).*

Table (5). Prevalence of depression according to marital status.

Marital status	No. of respondents No. %	Score > 16 No. frequency	Percentage	X2	p-value
Married	51.47	696 46.77	53.56	20.750	0.0001
Single	1324 48.53	828 53.23	64.65	34.639	

Table (6). The sex differences across urban and rural areas among individuals with depression (score >16).

Sex	Score >16	Rural	Urban	X2	p value
		No. %	No. %		
Male	692	676 97.6	16 2.31		
Female	828	612 73.91	216 26.08		
Total	1520	1288 84.73	232 15.26	164.74	0.0001

Discussion

Traumatic events can have a profound and lasting impact on the emotional, cognitive, behavioral and physiological functioning of an individual. No age group is immune from exposure to trauma, and its consequences. The effects of trauma in terms of psychopathology are well understood in the case of adults, while as in the case of children they have only recently begun to be understood. In a turmoil situation, civilian casualties have been found to outnumber military casualties by 3:1 [14]. The most common traumatic event experienced is witnessing the killing of a close relative, followed by witnessing the arrest and torture of a close relative.

Our study reveals that there is a gender difference with regards depression by locality - with men higher in rural areas / women in urban areas. The number of women suffering from depression is more (60%) as compared to men (51.34%). Women have a higher prevalence of depression in all the age groups than males and it is highest in the age group 26 to 35 years (68.66%). Women in the age group of 15-25 years also have similar prevalence rate of depression (68.64%).

Women are an integral to all aspects of society. The multiple roles that they fulfill in society render them at greater risk of experiencing mental problems than others in the community. Women bear the burden of responsibility associated with being wives, mothers and carers of others. Increasingly, women are becoming an essential part of the labour force and in one-quarter to one-third of households they are the prime source of income (WHO, 1995). Women are more likely than men to be adversely affected by specific mental disorders, the most common being: anxiety related disorders and depression.

Women in Kashmir have been closely associated with political mobilizations and continue to be victims in the ongoing cycle of violence and abuse. They continue to confront and cope with psychological and physical violence, dislocation and disillusionment of a situation of war - as women and as members of a community. Yet their voices or experience of the conflict remains absent. The invisibility of women's voices vis-à-vis the conflict emerges from the presumption that women are external, far removed from the scene of actual combat between militants and security forces. The false dichotomies of home vs. warfront were appropriately highlighted during the Kosovo conflict which brought home the social, economic and psychologically traumatic consequences of the conflict for women.

The difference in the prevalence of depression among males and females is significant; p <0.05 *(Table 5).* Depression is much higher in rural areas (84.73%) as compared to urban areas (15.26%). Lower socioeconomic status including unemployment is one of the important factors. With single people reporting higher levels of depression, locality is not a factor in rural or urban areas. There is only a marginal difference between the genders or age of married / single people.

To live in a community of total 6 million people, having more than a million depressed patients and more than 100,000 of them thinking in terms of ending their lives is a matter of great concern and a big challenge for any medical professional, working in Kashmir. The situation has become grim due to a very high percentage of chronic post traumatic stress disorder presenting with co-morbid depressive illnesses [14].

The burden of depression is rising, affecting both the working and social lives of individuals. In India, a meta-analysis of 13 psychiatric epidemiological studies (n=33 572) yielded an estimated prevalence rate of 5.8% [15].

Post Traumatic Stress Disorder (PTSD) is highly prevalent in general population in Kashmir. Most patients (67%) had co-morbid depression out of which 64.51% were males and 69.04% females [16]. According to another study [17] majority of the PTSD cases had a co-morbid psychiatric disorder most commonly depression.

A hospital-based study conducted for depression [18] revealed that depressive disorders is increasing (1971: 16%, 1980: 14% and in 1989: 32%) among the patients (N=3486) admitted in the Outpatient department of the Psychiatric Hospital of Kashmir. However, the present study reveals much higher prevalence (55.72%) among the community. The increase of depressive disorders is primarily due to continuing conflict. However, the possibility of the elevated stress in daily life as possible origin for the increase of depression can not be ruled out. Violence is

seen as the root of all evil. It does not only dislocate the life of many individuals also social and community life is affected for many rituals and events are banned for security reasons. A lingering generation conflict seems to be triggered by the violence. Family structure changes, habits disappear and respect for tradition is diminishing. The protective belt usually formed by family is eroded. Especially in the rural areas all expressions of psychological suffering are summarized by the expression of having 'tension'. The resilience of individuals, community and culture is expressed through coping and self help mechanisms.

Civilian stressors in general and conflict stressors in particular include torture, beatings, rape, life-threat; being targeted, shot at, threatened or displaced; being confined to one's home; losing a loved one or family members; financial hardship; and having restricted access to resources such as food, water and other supplies. In addition to depression other psychiatric disorders like substance misuse and suicide among young adults are on a rise.

Mental health staff is scarce. There is a single 100-bedded hospital of psychiatric diseases in Kashmir. The state of Jammu & Kashmir has only eight psychiatrists in public service and no clinical psychologists. The absences of services on primary and secondary level cause a heavy strain on the tertiary level.

There is scientific evidence that depression is 1.5 to 2 times more prevalent among the low-income groups of a population [4,5]. Poverty could be considered a significant contributor to mental disorders, and vice-versa. The two are thus linked in a vicious circle, and affect several dimensions of individual and social development. Moreover, employed persons who have lost their jobs are twice as likely to be depressed as persons who retain their jobs. Studies have shown a significant relationship between the prevalence of common mental disorders and low educational levels [19-21].

A study conducted demonstrates that, while coping strategies were to a large extent determined by social variables, there was a differential impact of violence upon civilians experiencing mass terror. For the Lebanese groups, the greater the understanding of the reason for the war the easier was the coping strategy. For Palestinians, on the other hand, the belief that their entire history was one of facing the threat of annihilation ('*for us the war has never ended*') rationalised the frequent violent assaults upon their community as inevitable and, despite higher levels of physical injury and death, enabled better coping than among Lebanese civilians. Among both groups, combatants had high rates of depression but lower levels of traumatisation. In the long term social relations were much more fractured among the Palestinians than among the Lebanese since large numbers of the former were expelled from Beirut following the Israeli invasion of 1982, fracturing once vibrant primary networks [22].

Because of the nature of social conflict in Asia, peace psychologists working in this region should focus on active nonviolent political transformation, healing protracted-war traumas, beliefs supporting economic democratization, social voice and identity, culture-sensitive political peacemaking, and psychopolitical aspects of federalizing to address a territorial conflict. The people of Kashmir must be assisted in achieving peace and safety in their own homeland. Counselors and psychologists can play a role in bringing about peace using worldview research.

There is a need for collective response from the members of all walks of life to evolve multipronged strategy with provision for immediate, short-term and long-term objectives for addressing these problems. Mental illnesses do not have only materialistic but also more powerful divine and spiritual solutions. Spiritual leaders (priest, learned scholar, etc.) should communicate with masses about the ground realities and approach to tackle issues such as social problems, drug addiction, suicide, unemployment, etc. by quoting the perfect models of prevention and control. Cultural and religious beliefs which discourage substance misuse or suicide and support self-prevention measures that enhance protective factors can play a key role in prevention of several mental disorders. Spiritual approach can be combined with evidence-based scientific methods of management of most mental illnesses. Health education in educational institutions regarding mental illnesses is essential. Programmes that support and sustain protection need to be in place.

Mental illness is not a personal failure. Science and sensibility are combining to bring down real and perceived barriers to care and cure in mental health. Strengthening mental health and resilience not only reduces the risk of mental and behavioural disorders, but also contributes to better physical health, well-being, productive life, social capital, safer environments, and economic benefits. Proper planning is at the heart of successful public policy advocacy initiatives.

Conclusion

Due to continuing conflict in Kashmir during the last 18 years there has been a phenomenal increase in psychiatric morbidity. The prevalence of depression is 55.72%.

Mental health is an integral part of overall health and quality of life. Effective evidence-based programs and policies are available to promote mental health, enhance resilience, reduce risk factors, increase protective factors, and prevent mental and behavioural disorders. Innovative community-based health programmes which are culturally and gender appropriate and reaches out to all segments of the population need to be developed. Substantial and sustainable improvements can be achieved only when a comprehensive strategy for mental health which incorporates both prevention and care elements is adopted. Health services should be able to provide the much-needed treatment and support to a larger proportion of the people suffering from mental disorders than they receive at present: services that are more effective and more humane; treatments that help them avoid chronic disability and premature death; and support that gives them a life that is healthier and richer – a life lived with dignity. Investing in mental health today can generate enormous returns in terms of reducing disability and preventing premature death.

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