



POST-TRAUMATIC STRESS DISORDER (PTSD) IN KASHMIR (INDIA): A REVIEW

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ABSTRACT

Post-Traumatic Stress Disorder (PTSD) occurs due to traumatic events. The last few decades have seen various traumatic events in Kashmiri population, which has led to psychological impact on all population, especially children. PTSD is one of the psychiatric disorders occurring after witnessing of traumatic events. A review of literature regarding PTSD in Kashmir (India) has been done to assess the prevalence, causes, risk factors and psychiatric comorbidity associated with it.

INTRODUCTION

Posttraumatic stress disorder (PTSD) is a psychiatric disorder that may occur in people who have experienced or witnessed a traumatic event such as a natural disaster, catastrophe, a serious accident, a terrorist attack, war, or rape or who have been threatened with death, sexual violence or serious injury. The various predisposing factors

for trauma include multiple traumas, neurotic personalities, lower Intelligence Quotient (IQ), genetic predisposition, poor social support, past history of psychiatric illness and substance abuse.

The last few decades have seen a lot of bloodshed in Kashmir [1]. In the last few decades, a liberation struggle between India and Kashmiri extremists has led to around 20,000 deaths and 4,000 disappearances in Kashmir (India). Due to this continuous turmoil, traumatic events and political insurgency, Kashmiri population has been affected. The total lifetime prevalence for any traumatic experience in the community in Kashmir is 58.69% [2][3].

PTSD is one of the many responses that can occur after exposure to traumatic events. PTSD is defined by diagnostic and statistical manual of mental disorders IV (DSM IV TR) as a psychiatric disorder, in which there is development of symptoms of arousal, hyper vigilance and avoidance after person has experienced or witnessed or involved with an event that involves threat to self or others and patient's response occurs with fear, horror or helplessness[4].

A review of literature regarding PTSD in Kashmir (India) has been done to assess the prevalence, causes, risk factors and psychiatric co-morbidity associated with PTSD. We reviewed the published literature on PTSD in Kashmir (India) from 2006 to 2015. Further studies on Kashmiri populations exposed to traumatic events were taken. We choose 2006 to begin our review, in order to update the literature, since the study by Margoob et al., was first done in 2006. We used the DSM IV TR criteria for direct exposure PTSD to define a traumatic event and included studies published in English that measured prevalence, causes, risk factors, comorbidity on PTSD and ECT and genetic studies done on PTSD in adults, children and special population. Our search strategy for this review involved two stages. First we used MEDLINE and Google scholar databases to find various studies on PTSD in Kashmir (India). Second the citations were cross referenced to remove duplicates prior to reviewing abstracts. The articles that provided information regarding PTSD in Kashmir (India) only were marked for further review.

SOCIO DEMOGRAPHICAL PROFILE OF PTSD IN KASHMIR

Although traumatic events are found in almost every society, but prevalence of traumatic events has been studied mostly in industrialized societies. In the last few decades Kashmir has been a chronic conflict area. There has been continuous violence with political insurgency, leading to death of thousands of people, family instability, sexual abuses, damage to property and various natural disasters like earthquakes, snowstorms etc. All the above factors have thus contributed towards trauma in human lives in Kashmir (India). The children diagnosed as PTSD were detected in schools because of their deteriorating performance and behavioral changes. In all the studies, it was found that most of the cases were from rural areas compared to urban areas. The reason for this was attributed to violent and traumatic events occurring more in rural areas. Further majority (75%) of cases belonged to lower

class, followed by middle class (25%) respectively. It was also noted that most of the cases were students (80%) and belonging to joint families (33%)^{[5][6][7]}.

RISK FACTORS FOR PTSD

The various risk factors associated with PTSD include lower education, lower IQ, absence of social support, lower socioeconomic status, family history of psychiatric illness, multiple traumatic events and presence of neurotic or extroverted personality^{[5][6]}. In Kashmir, the major risk factors include violent traumatic events, due to continuous turmoil over the last few decades. Every individual had endorsed one traumatic event. Majority (49%) witnessing killing of a close relative, followed by witnessing arrest, torture of a close relative, caught up in cross firing, beaten up, and hearing about killing of a close relative. Many natural disasters like earthquakes and snowstorms also occurred during the last two decades, which also has led to the development of PTSD. There is also lower literacy rate in Kashmir (54.4%) compared to other parts of India (65%). Lower literacy rate itself is a risk factor for PTSD^{[5][8]}.

PSYCHIATRIC COMORBIDITY IN PTSD

PTSD occurs with other psychiatric disorders like depression, anxiety disorder, suicide and somatization. In Kashmir, depression and anxiety disorder are major co-morbid psychiatric disorders associated with PTSD. However, in the general population, various somatic complaints were found associated with PTSD^{[1][3]}. These somatic complaints were headache (89%), stomach ache (58%) and musculoskeletal pain (82%)^{[5][6]}.

CLINICAL FEATURES OF PTSD

In PTSD, traumatic events disclose the patient to actual or threatened death or serious injury. There are three dimensions of PTSD and all should be present for duration of more than one month. These dimensions are: (1) re-experiencing the event with distressing recollections in form of dreams, flashbacks and with psychological and physical distress; (2) persistent avoidance of stimuli associated with trauma that might recall memories or events of the trauma; (3) increased arousal in form of hyper vigilance, exaggerated startle response, difficulty in falling asleep, irritability and outbursts of anger^{[10][11]}.

In a study conducted by Margoob et al in 2010., in Department of Psychiatry, Government Medical College, Srinagar, Kashmir, India, 56 individuals diagnosed with PTSD were studied. Majority (75%) of patients in his study had witnessed number of traumatic events. Majority (85.71%) of patients in the study had a re-experiencing of traumatic event in the form of disturbing dreams/nightmares (57.41%) and distressing recollections. Most (85.71%) of the cases in the study had avoidance in the form of avoidance of people, places and activities followed by avoidance of thoughts. Majority (85.17%) of the cases in his study had sleep problems/insomnia, followed by hyper vigilance (67.85%). 92.85% of the cases in his study had an acute onset of symptoms and 7.15% had delayed onset of symptoms. Majority of the cases (71.43%) were running a chronic course. 64% of cases had more than two presenting complaints. The somatic complaints included headache, stomachache, breathlessness, palpitations, loss of appetite and insomnia. Loss of consciousness was present in 50% of individuals, followed by irritability, and decreased school performance (18%), loss of interest (4%) and stammering (3%). The presentation in the PTSD symptoms was explained by cultural variation in the presentation of anxiety or trauma related disorders^[5].

STUDIES DONE ON PTSD IN KASHMIR

PTSD in Kashmir has also been found in association with substance use disorders. Substance use disorder is very common in this part of the world, especially involving adolescents. Studies have shown that substance abuse disorder was 2-3 per 1000 for males and 2.5 -4.5 per 1000 for females associated with PTSD in Kashmir. Majority of PTSD patients were unaware of PTSD symptoms and used to do self-medication for treatment of their symptoms, resulting in addiction subsequently. Multiple drugs like benzodiazepines, opioids and cannabis were being used by the patients mostly having PTSD in Kashmir. Out of all the drugs, alcohol was least (4.8%), in contrast to the studies from rest of the world. The reason for it could be that alcohol is not a socially approved beverage, as Kashmir is a muslim majority region^[16].

Genetic studies have also been done on PTSD in children of Kashmir. PTSD patients of Kashmir were seen with lower frequencies of serotonin transporter linked polymorphic region (5HTTLPR) promoter genotypes containing the short variant (LS and SS) (68.88%) in controls, compared to cases of PTSD (77.61%), according to a study by Murtza et al., in 2006. The study also showed that in PTSD patients, there was higher prevalence of short allele, compared to long allele. These short alleles possess reduced transport capacity and had reduced uptake of 5-hydroxytryptamine (5HT) receptors or serotonin receptors than the controls. Thus, showing risk of PTSD in patients of Kashmiri population possessing short alleles^[17].

Studies showing efficacy of ECT on PTSD has also been carried out in Kashmir. Margoob et al., (2010) studied 20 antidepressant refractory PTSD patients. A total of six bilateral ECT treatments were administered twice-weekly. In a study done on PTSD patients with ECT (Electroconvulsive therapy), it was seen that there was significant improvement in symptoms of PTSD, compared to controls. The improvement was measured by CAPS

(Clinician Administered Posttraumatic Stress Disorder Scale). CAPS score decreased by a mean of 34.4% in PTSD patients. Further the improvement was seen in CAPS of PTSD patients on the third^[18].

INTERVENTIONS TO BE DONE TO PREVENT AND TREAT PTSD

Although evidence is very limited regarding best practices to treat trauma-exposed people. The various interventions to prevent and treat PTSD are Psychological debriefing, Brief cognitive behavioral therapy, Trauma – focused cognitive behavioral therapy, EMDR (eye movement desensitization and reprocessing). The various drugs used to treat individuals with PTSD include benzodiazepines (alprazolam), mono amine oxidase inhibitors (phenelzine) and selective serotonin reuptake inhibitors (SSRI'S) like setraline, fluoxetine, paroxetine and citalopram. Setraline has been FDA approved drug for treatment of PTSD^{[19][20]}.

CONCLUSION

Post-Traumatic Stress Disorder is a widespread mental disorder all over the world, remarkably in Kashmir due to it being a conflict zone. It has increased over here from last few decades and is associated with increased risk factors and psychiatric comorbidity. The results of various studies suggest that people living in conflict zones must be carefully evaluated for mental health problems. Patients in these studies presented with varied symptoms and with different comorbid disorders in different sex and age groups. Avoidance symptoms were common in subjects of these studies. PTSD is a highly prevalent disorder in the developing world as well as in the areas of conflict zone and disaster prone regions. The turbulence has affected every aspect of the life in the state of Jammu and Kashmir. There are different coping mechanisms that people can use for absorbing the daily violence and trauma like talking to friends and sharing thought. Collective social sharing decreases stress and play a key role in decreasing the sufferings and trauma. Different mental health programs should be started to help the people tackle these problems.

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