PSYCHOLOGICAL MORBIDITY IN A GROUP OF JOURNALISTS AFTER SIX WEEKS OF A BOMB BLAST IN KARACHI

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INTRODUCTION

There has been an increase in ethnic, sectarian, religious, political and state violence in Pakistan over the last two decades[1]. Karachi is the largest city of Pakistan and has been the centre-stage of brutal conflicts.

On May 26, 2004 a police guard was killed and at least 33 people, including police personnel and media men, were wounded when two car bombs exploded in succession near the Pak-American Cultural Centre and the residence of the United States' Consul General in Karachi. Police and media people had reached the spot soon after the first explosion. The reporters were recording details and photographers and cameramen were snapping shots when the second car blew up, resulting in casualties.

This was not an isolated incident of man-made violence. Earlier that month, two civilians were killed and two others injured in a parcel bomb explosion on the premises of Karachi Port Trust. In a separate incident a suicide bomber had succeeded in killing 14 people inside a mosque. In total 51 people have lost their lives in the month of May 2004 alone during which the city witnessed some of the worst incidents of bloodshed and violence in a decade.

According to the data compiled by leading Karachi newspaper "Dawn" (8 June, 2004) as many as 1110 casualties have been reported in about 140 blasts since 1990[2].

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Depressive, anxiety and other stress related reactions are not uncommon after exposure to traumatic events. Survivors of these incidents may carry psychological scars for a long period of time, though an acute stress reaction usually subsides within days or weeks of the exposure to trauma.

In this study we measured the persistence of anxiety, depressive and other psychiatric features in a group of young journalists who were present at the time of second bomb blast on May 26, 2004. None of these journalists required hospitalization after the blast nor they were physically injured.

SUBJECTS AND METHODS

The subjects were identified through links in journalist community. They were approached to self-administer the following screening instruments.

Hopkins symptoms checklist-25 (HSCL)

Hopkins symptoms checklist-25 provides primary care physicians, mental health practitioners and other health care providers with an instrument for detecting anxiety and depression in medical patients, psychiatric patients and in normal population. HSCL has also been used on torture and trauma victims to elicit information on anxiety and depression and is proven to be highly valid and reliable screening instrument[3-5]. This checklist has been translated for use in Urdu speaking population. The HSCL-25 has several advantages as a screening instrument. It is brief, simple in use and may be self-administered by literate patients. The HSCL does not provide a diagnosis; it allows the clinician to recognize symptoms associated with anxiety and depression[6].

Davidson Trauma Scale

The Davidson Trauma Scale (DTS), a 17-item clinician-administered scale, is a self report instrument that measures both the frequency and severity of each DSM-IV PTSD symptoms. The DTS has been shown to have good predictive properties for response to treatment and is sensitive to treatment effect[7].

This scale has also been translated in Urdu for screening people who were exposed to traumatic events. A high score on this scale indicate a diagnosis

Table 1

SCORE OF HOPKINS SYMPTOM CHECK LIST -25

Hscl25	Anxiety	Depression	Total
Range	0.3-1.7	0.2-1.3	0.03-1.48
Mean	0.47	0.31	0.36

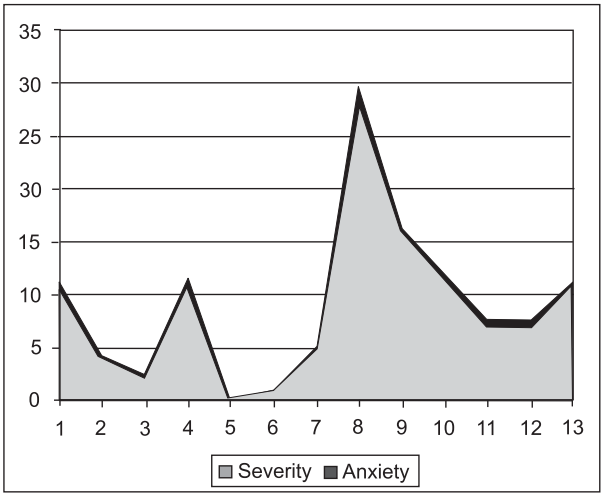

Fig. 1: Correlation of Severity of symptoms on DTS and Anxiety scores on HSCL25

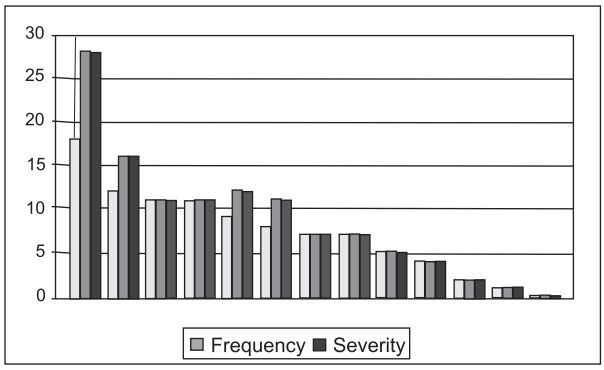

Fig. 2: Correlation of Frequency and Severity on DTS

Table 2

SCORE 0F DAVIDSON TRAUMA SCALE

DTS	Frequency	Severity
Mean	7.3	8.85
Max.Score	18	28

of PTSD. The cutoff value for the diagnoses of PTSD is 62.0 +/- 38.0 and for sub clinical presentation the cutoff value is 41.7 +/-28[8].

Subjects were requested to mail the completed questionnaires to (WAS).

A descriptive analysis has been performed to study the demographic characteristics of the subjects.

Responses on anxiety and depression clusters on HSCL were summed-up and divided by the number of answered items to generate anxiety (10 items), depression (15 items) and total HSCL scores.

Responses on sub-scales of Davidson Trauma Scale were added to generate total scale score.

RESULTS

13 subjects returned completed questionnaires. These questionnaires were completed almost six weeks after the exposure to traumatic event.

All subjects were male with an age range of 23-42 years (mean 33.3). In our sample ten subjects were married. Overall 9 subjects reported mild to moderate level of distress.

9 subjects reported residual mixed features of anxiety (group mean 0.47) and depression (group mean 0.31) on HSCL. Overall, anxiety features were more prominent. 1 subject scored 1.7 on HSCL anxiety cluster, accompanied by a high score on depressive cluster. Score of this subject on David Trauma Scale was above the cut-off point for the diagnoses of Post Traumatic Stress Disorder. 3 subjects did not report any symptoms. 2 subjects reported abuse of benzodiazepines.

DISCUSSION

This study has provided findings to confirm the persistence of mainly anxiety symptoms in a group of journalists, who were exposed to bomb blast and had witnessed the death and injury of other professionals. These symptoms were still prominent after six weeks of the incident, indicating a significant level of distressing psychological response. The general population and even the professional groups who are exposed to traumatic events remain prone to develop psychological reactions to these adverse incidents.

Most people who present with features of acute stress recover completely within a period of few weeks. Persistence of anxiety features after a six-week period may indicate future vulnerability for developing significant distress if these professionals are exposed to further trauma in future.

In the ICD -10 classification and DSM-IV it is noted that PTSD is often accompanied by anxiety depression or even obsessive – compulsive disorder but co-morbidity with other disorders including dissociative disorders is quite common along with subsequent drug abuse and dependence[9-11].

Mental health professionals and occupational health departments of relevant organizations should be able to devise individual and group support strategies to help the workforce groups, which are exposed to life threatening work situations. In addition to journalists and policemen, healthcare professionals and voluntary aid workers also constitute the vulnerable professional groups.

The bulk of research appears to be consistent with a model of PTSD that points a role for pre trauma and post exposure risk and protective factors (including biological, psychological and socio politico cultural factors), in addition to the traumatic experience, per se. Although many kinds of extreme events can cause PTSD but not all of those exposed will develop the disorder. Exposure to potentially traumatic event may be more common than once thought, and that risk factors for PTSD include personal and biological histories at the time of exposure to the extreme event, characteristics of the event itself, and characteristics of the post-exposure environment[12].

Acts of man-made violence, such as bomb blasts and wars may be intended to spread intimidation, panic, mistrust and destruction in a population in order to convey message of fear and helplessness and as a means of control and terror.

It remains for further research to identify the specific contribution of factors within each of these major domains, as well as ways in which they may interact.

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