PSYCHIATRY IN CONFLICT ZONE — CHALLENGES IN KASHMIR

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ABSTRACT

War damages the very fabric of society. This damage relates to its physical structure, its institutions, its social fabric, its environment, its communications and the normal routine of life. Indian-administered Kashmir has been no exception and the ongoing conflict has had its toll on Kashmiri population. The impact on the physical and mental health and socio-economic functioning of region's 13 million people is alarming. The challenges faced by healthcare professionals as a result of scarce financial resources, grossly inadequate manpower and infrastructure are enormous. This article gives a brief overview of the psychosocial impact of conflict in Indian-administered Kashmir and the profile of the psychiatric services available in the region.

Key words: Conflict Zone, Psychiatric Services, Psychosocial Impact, Psychiatry Training

INTRODUCTION

Kashmir is a beautiful region of snowcapped mountains and clear lakes, covering approximately 86,000 square miles. It is nestled between Pakistan, India, and China and is dominated by the Himalayan mountains which rise to 28,000 feet. Kashmir has been at the heart of conflict between India and Pakistan since the birth of both nations in 1947. Both Pakistan and India have laid claim to the region of Kashmir over the past fifty years. The two countries have fought many wars to gain control over the entire region. After the first war between India and Pakistan in 1948, the Kashmir territory was divided into Indian-administered Jammu and Kashmir and a smaller area under Pakistani control. In Indian-administered Kashmir, from 1989 onwards, there has been a chronic strife in the region as Kashmiri's have been fighting for independence, which has taken the form of guerrilla warfare. Once a tourist destination, it has been ravaged by years of fighting and an estimated 60,000 people have died in the struggle between the two sides. The impact on the physical and mental health and socio-economic functioning of region's 13 million people is alarming.

Psychosocial impact of the conflict

War damages the very fabric of society. This damage relates to its physical structure (buildings, homes, and sanitation), its institutions (judicial, educational, medical, religious), its social fabric (families, communities), its environment (mines, defoliation, pollution, corpses, and disease), its communications (roads, railways, postal and telecommunication services, radio and television) and the normal structure (routine) of life[1]. Kashmir has been no exception and the ongoing conflict has had its toll on Kashmiri population. Nearly everybody has been affected by the violence. High levels of confrontation with violence have been reported in studies from Kashmir. People are frequently confronted with physical and psychological mistreatment. Torture, detention, threats, killings and disappearances are common. The most frequent traumatic events encountered are firing and explosions (81%) and exposure to combat zones (74%)[2].

Exposure to violence has potential implications for mental health. Poverty, low education, social exclusion, gender disadvantage, conflict and disasters are the major social determinants of mental disorders. Examination of the literature reveals a paucity of data on the impact of violence on mental health of population in Kashmir. In areas affected by chronic strife a larger chunk of population would be expected to experience mental health problems and such figures ought to apply to the people of Kashmir. There are high levels of psychological distress prevalent in the population[3]. There has been a qualitative and quantative difference in the psychiatric morbidity as a direct result of the violence. A phenomenal increase in the number of people attending the psychiatric hospital is a direct reflection of that. There is a significant increase in the number of people being diagnosed with acute stress reaction, depressive disorders, anxiety disorders, and post traumatic stress disorder[4,5]. The prevalence of post traumatic stress disorder is reported to be 15.9%[6].

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A predominantly Muslim society where death due to suicide has always been very low finds suicide as the second common cause of unnatural deaths [7]. One third of the respondents contemplate suicide, in a survey done in four districts of the region[3]. Most of the people who complete suicides are young males in the age group 25 – 34[7].There have been an increase in the number of people who attempt suicide. Law makes attempted suicide a punishable offence and help is often not sought, which leads to underreporting.

Substance misuse is an increasing public health concern. A study which compared prevalence of substance misuse pre and post conflict reveals that the use of substances is ever increasing. Use of alcohol has increased by 30% in a society where alcohol use was almost non existent. Use of opioids has increased from 9% to 73%, people using multiple substances has increased from 15% to 41%.15% of people attribute their drug use to the prevailing trauma and turmoil[8]. Misuse of non-prescription drugs is very common. Benzodiazepines, codeine and opioid based preparations are freely available in the unregulated markets.

Symptoms of anxiety and depression are common in all ages. No age group is immune from exposure to trauma and children have been severely affected in the current turmoil. The most common traumatic event experienced by children in a study was witnessing the killing of a close relative (49%), followed by witnessing the arrest and torture of a close relative (15%)[9].Parental loss, frequent displacement and exposure to violence have led to an increase in pediatric psychopathology. Behavioral changes amongst children have been reported which include isolation, aggression, drug abuse, lack of respect for elders, loss of morality/values and hopelessness. Children often complain of somatic symptoms. Children who lost their parents are often reared in orphanages. PTSD and depression are common diagnoses in children living in orphanages[10].

Psychiatric services in Kashmir

The context for the provision of mental health services in Kashmir is set by the Indian Ministry of Health's policy on mental health care, the National Mental Health Programme. Mental health resources in Indian Kashmir are few. Psychiatric services are confined to the Government Psychiatric disease hospital, an erstwhile asylum. In addition to this, there is one ward for psychiatric illness in a general hospital. More recently a private psychiatric hospital has started functioning. The total bed strength in these hospitals is one hundred and fifty. Community based mental health services are non-existent. Large parts of the region lack even the most basic of mental health facilities[11]. Families play an important and supportive role in the treatment of people with mental illness. Most of the people with mental health problems are cared by extended families and access to psychiatric services is through psychiatric out-patient services available in Government Psychiatric disease hospital and the two teaching hospitals of the region. People can attend these clinics following self referral or referral by healthcare professionals. Faith healers are also known to refer people to psychiatric services[12]. Clinicians are known to conduct private clinics in some towns and villages. As the services are mostly provided in the capital city, patients often have to travel long distances to access services. According to one of the surveys by the government of India, the state of Jammu and Kashmir had just four psychiatrists for a population of more than 10 million[11].The authors gather that there are approximately 10-15 psychiatrists working presently in Kashmir. Most of them work in urban areas.

Non-governmental Organisations

Medicins Sans Frontieres (MSF), a private humanitarian medical emergency organization, has run psychosocial and mental health interventions in healthcare facilities in rural areas as well as the capital Srinagar. MSF has also provided outreach and support to others in rural areas and assisted in the rehabilitation of the infrastructure of the psychiatric hospital in Srinagar. To increase the public awareness of mental health and reduce stigma, MSF used to operate a weekly radio program in Kashmir.

There is one non-governmental de-addiction center in the valley.

Traditional and complementary medical sector

For many people, the first person they seek out during times of crisis and need is a 'Pir' (indigenous faith healer)[12].Mental illnesses are widely misunderstood, they are often taken to be a condition brought about by supernatural forces and the stigma attached to mental disorders is widespread. Many people with neurotic disorders attribute their symptoms not to personal intrapsychic conflicts, but to the harsh and violent real world around them.

The traditional and complementary medical sector includes 'Hakims' who practice alternative healing systems such as unani medicine.

Primary care

The primary provider of health care in Kashmir is the primary health sector, with its network of community health centers and district hospitals mostly in public sector. However there are no community care facilities for patients with mental disorders.

Mental Health legislation

The Mental Health Act 1987 of India regulates involuntary detention of people with mental health prob-

lems. These stipulate that involuntary admissions can occur only in designated psychiatric hospitals on the recommendation of a psychiatrist and two medical practitioners

Given the gross inadequate facilities and resources that are available for the treatment of mental health conditions in Kashmir and given the scale of the situation there, mental health legislation is unimplementable. Compulsory care is based on the consent by a family member. Involuntary detention, managers hearing, mental health review tribunals, second opinion are not a part of the vocabulary of the mental health care professionals in the Kashmir valley.

Medical education and qualifications in psychiatry

Kashmir valley has two medical colleges, both of which have psychiatry departments. One of them offers basic specialist training in psychiatry wherein trainees work towards attaining MD in Psychiatry. The MD requires a residency of three years, written and clinical examinations and a research dissertation. Trainees who work as registrar for another three years are eligible for consultant posts. There are only two training positions available each year. Doctors who wish to train in psychiatry can apply in training schemes in other states of India through a competitive exam. In addition to MD, other Indian states offer other qualifications which include the Diploma in Psychological Medicine and the Diplomate of the National Board.

Publications

There is no professional psychiatry journal; nonetheless psychiatric research papers do find a place in the sole medical journal of the valley.

CONCLUSION

Government spending on mental health is far lower than is needed, and the burden of mental disorders far greater. Increased emphasis on mental health, improved resources, and enhanced monitoring of the situation is called for to advance mental health. Strengthening care and services for people with mental disorders is a priority; this will need additional investment in human resources and infrastructure.

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