International Journal of Research
Available at https://edupediapublications.org/journals
e-ISSN: 2348-6848
p-ISSN: 2348-795X
Volume 05 Issue-01
January 2018

Impact of Conflict on Mental Healthof Women: A Socio-Psychological Study of Kashmir

Showkat Ahmad Dar & Mudasir Ahmad Nazar

Women'shealthisinextricablylinkedtotheirstatusinsociety(WHO,1998)

Abstract

The impacts of armed conflict are complex and wide ranging. Such conflictscausewidespread insecurity due to forced displacement, sudden destitution, the breakup of families and communities, collapsed social structures and the breakdown of the rule of law. This insecurity caneven persist long after the conflicts have ended as internally displaced persons (IDP), refugees, and asylum seekers try to adjust to new circumstances around them, cope with loss, and regainasenseofnormalcy.Mental, physical and social health, are vital strands of life that are closely interwoven and deeply interdependent. The armed conflicts give an alarming flip to mental disorders.Such disorders affect people of all countries and societies, individuals of all age groups, women and men, the rich and the poor, from urban and rural environments. Many people living amidst the rages of armed conflict suffer from posttraumatic stress disorder.Kashmir conflict has hit the health scenario of almost all the sections and age groups of this society .Women are the worst affected of this ongoing turmoil.The most prominent of the mental disorders and psychosocial consequences Kashmiri women is currently suffering from, include: sleeplessness, fear, nervousness, anger, aggressiveness, depression, flashbacks, suicide, and domestic and sexual violence.The present paper provides an overview of Impact of armed conflict on mental health of women in Kashmir, and exploresthelinksbetweenarmed conflictandmentalandpsychosocialdisorders.The paper also explores the societal responses towards the mental health victims and their kindred. Thepaper also presentssuggestionsbasedon some expert opinions and research studies that can help guide interventions andapproaches toaddress mental health and psychosocial disorders among women of conflict-affectedKashmir.

Keywords: Kashmir, mentalhealth, mentaldisorders,c onflicts, psychosocialdisorders, women, programmingservices

1. Introduction:

Mental,physicaland s o c i a lhealth,arevital constituentsof lifethat a r ecloselyinterwovenand deeply interdependent.Defining h e a l t hasphysical,mentalandsocialwellbeing,A.V.Shahhasexpressed that mentalhealthisthe mostessentialand i n s e p a r a b l ecomponentofhealth(Shah1982).

There areanumberofdimensions,which c o n t r i b u t e to positivehealthlike,spiritual,emotional,vocational, philosophical, cultural, socio-economic, environmental, educational and n u t r i t i o n a l besides t h ephysical,mentaland

socialdimension. Thus,healthismultidimensional.Although thesedimensions functionandinteractwithone another,eachhasitsownnature.

Perhaps the easiest dimension of health to understand is the 'physical', which is nothing but biomedicaldefinitionofhealth. "WHO"defineshealthasastateofcompletephysical,mentalandsocial wellbeingandnotmerelytheabsenceofdiseaseand infirmity.Thus mentalwellbeing isanessential componentof healthof all individuals (Waheeda Khan: 2002).Good mentalhealthis theabilitytorespondto manyvariedexperiences oflife withflexibility andasenseof purpose. Morerecently mentalhealthhasbeendefinedasastateofbalancebetweenthe individualandthesurrounding world, astateofharmonybetweenoneselfandothers,coexistencebetweentherealitiesofthe self and that ofother peopleandthat ofthe environment.On theotherhand,socialwellbeingimplies harmonyandintegration within theindividual,betweeneachindividualandother membersof the societyandbetweenindividualsandthe worldinwhich they live(Park :1995).Italsoindicatesoptimal abilitytomaintainrelationshipwithindividualsandgroups inaccordancewithexistingculturalpatterns (Waheeda khan:2002). The social dimension of health includes the levels of social skills one possesses,socialfunctioningandthe abilitytoseeoneselfasamemberofalargersociety.Social healthisrootedin"positivematerialenvironment"(focusingonfinancialandresidentialmatters), and "positive human environment" which is concerned with the social network of the individual (Fillenbaum, G.G: 1984).Psychosocialdisorders relatetoaninterrelationship ofpsychologicaland social problems, which togetherconstitutethe disorder.Psychologicalsymptomsarethosethat havetodowiththinking andemotions,whilesocial symptomsrelatetothe relationshipofthe individualwiththe familyand society.Advancesinneurosciencesandbehavioralmedicine havealso shownthat, like any physiological illnesses, mental and behavioral

disordersarethe result of a complexinteractionbetweenbiological,psychologicaland socialfactors . (SyedAminTabish:2005).

Thus, internationaldatashowthatmentalillnessaffectsbetween20and25percentofallpeopleduring sometimeintheirlife;oneinfourfamiliesintheworldhasatleastonemember withmentalhealth difficulties;andfourofthesixleadingcausesofdisabilityareduetomentalhealthproblems (depression,alcoholabuse,schizophreniaandbipolardisorder)(WHO,2001d).Inorderto drawattentiontothepersonal,nationalandglobalburdenofmentalillness,theWHOdedicatedthe WorldHealthDayin2001tomentalhealth.Moreover,inthesameyear itestablishedamentalhealth GlobalActionProgrammetoincreasegovernments'responsivenesstomentalhealthproblems.

2. Impact of conflict on mental health in Kashmir:

The impacts of armed conflict are complex and wide ranging. Such conflictscausewidespread insecurity due to forced displacement/disappearances, sudden destitution, the breakup of families and communities, collapsed social structures and the breakdown of the rule of law. During the times of armed conflict huge "number of innocent and common people are killed, injured, tortured and made disabled/ handicapped" (Dabla; 2009:119).According to KashmirMentalHealthSurveyReport2015,carriedoutby MSFandtheDepartmentof Psychology,Universityof Kashmir, due to armed conflict in Kashmir 70,000 lives arelost and 10,000 persons are missing. Thus, Politicalinstabilitynotonlyexposes apopulation totraumaticeventsbutalsohasanegative impactonthesocial,economic andmaterial fabricofsociety. The Armed conflict in Kashmir has disturbed the health profile of almost all the sections and age groups of this society. While the mental health of significant proportion of the community is not satisfactory, every 4 out of 10 members (40%) in the families face slight to extreme mental depression. (Dabla; 2002:112).There is no section, no age group, no community even no social institution which does not show symptoms of pathology and problem in this conflict ridden society.

A prominent psychiatrist of Kashmir Dr,Margoob stated that only an average of 6 people per day would seek OPD services from the State Psychiatric Hospital in Srinagar in 1990 and this increased to an average of 250-300 a day during 2000 (Scholte, 2001).

Women, being almost the half the population of the J & K state, have been the worst sufferers of the conflict situations. Generally, women in their routine life situations remain a neglected section during the times of peace, but the graph of negligence towards the women during conflict situations rises. Thus, *"Genderrunslikeafaultline,interconnectingwithanddeepeningthedisparitiesassociated withotherimportantsocio-economicdeterminantssuchasincome,employmentandsocial position"(WHO,2001a:2).*

The health profile of women in Kashmir in the post conflict scenario has been continuously showing alarming symptoms. The most prominent of the mental disorders Kashmiri women are currently suffering from, include: depression, sleeplessness, fear, nervousness, anger, aggressiveness, flashbacks, and suicidal tendencies.The present study shows that women in Kashmir havesignificantlyhigher psychologicaldistress thanman. Thisisin line with other studies showing womensuffering more from anxiety disorders than men afterconfrontationwith violence . "**Feeling safe"**has been foundinother studies tobean importantpreconditionforbeing able to deal with adverse traumatic experiences, andthisisequallyfound true inourstudy.

To conclude,Women are often the worst affected by conflict. They often become targets of sexual violence, their husbands and children may be killed – leaving them without support that exposes them to various types of the mental disorders. As the battlefield moves increasingly to the village and the town, women themselves are often the majority of casualties of war.

Thus,theadoptionofagenderedapproachtounderstanding,treatingandproviding servicesforpeopleaffectedbymentalhealthdifficultiesisparamount.

3. Objectives of the study:

1. to provide an overview of Impact of armed conflict on mental health of women in Kashmir
2. toestimateprevalenceof various types of mentaldisorders amongKashmiri women in post - conflict scenario.
3. to identify most vulnerable categories among Kashmiri women suffering from various mental disorders.

4. to assess social impact of the mental health victims on their families.

4. METHODOLOY

The study was conducted in two parts. A review of literature was undertaken to analyze Secondary sources of data. The primary study also tried to understand the patterns of prevalence in relation to different determinants like ,age, socio-economic and educational status vis-à-vis the impact of conflict on mental health.Forthispurposeasample of50 respondentswererandomly selectedfromtheoutpatient department (OPD) of Srinagar Psychiatric Hospital.Forcollecting primary data,interview schedule administered.

5. FINDINGS FROM SECONDARY DATA:

The OPD records in various hospitals indicate a tremendous surge of mental health issues in Kashmir. The phenomenal increase in psychological problems was also indicated by The OPD records show that 775 people attended State Psychiatric Diseases Hospital, Srinagar in 1985, which was the lonePsychiatric hospital in Kashmir where psychiatric services were available, and this increased to 1, 30,000 in 2015 in two state hospitals including State SMHS Hospital and State Psychiatric Hospital in Srinagar . [Nissa, 2015].While the mental health of significant proportion of the community is not satisfactory, every 4 out of 10 members in the families face slight to extreme mental depression. (Dabla B.A; 2002:112)

AsimaHassanandAneesaShafi in their research article "AttitudetowardsmentalillnessinKashmir" published in InternationalNGOJournalVol.7(4),pp.73-77,November2012 ,have provided some alarming data indicating the huge attendance of patients in the Psychiatric DiseasesHospital ,Srinagar after the inception of armed conflict in Kashmir.

The year-wise breakup available at Psychiatric DiseasesHospital,Srinagarshowstheflowofpatients as:

Year	No. of patients visitedthePsychiatric hospital
1985	775
1989	1,700
1994	18,000
1996	20,000
1999	35,000
2001	38,000
2002	45,000
2003	50,000
2005	70,000
2006	82000

Source:Valley'sLone Psychiatric Hospital."

The above data bears the testimony that mental health situation is worsening at an alarming pace in Kashmir. And it needs an immediate attention of the concerned authorities ,so that this endemic disease can be addressed before it is too late.

In their research article "Life in conflict: Characteristics of Depression in Kashmir ,Syed Amin and A.W. Khan (International Journal of Health Sciences: 2009 Jul; 3(2): 213–223) state that;

"the prevalence of depression in Kashmir is 55.72%. … 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 almost 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%).

According to KashmirMentalHealthSurveyReport2015,carriedoutby MSFandtheDepartmentof PsychologyoftheUniversityof Kashmir

1.8million(45%)adultsintheKashmirValleyhavesignificantsymptoms ofmentaldistress.

Approximately1.6millionadults(41%)inthevalleyarelivingwithsignificantsymptoms ofdepression, with415,000 (10%)meetingallthediagnosticcriteriaforseveredepression.

Anestimated1millionadults(26%)inthevalleyarelivingwithsignificantsymptoms ofananxietyrelated disorder.

Nearly1in5adults(19%)or771,000 individualsintheValleyarelivingwithsignificantPTSDsymptoms, with248,000 (6%)meetingthediagnosticcriteriaforPTSD.

Thus it is evident from the above data, the mental health situations in Kashmir valley has taken a horrible character particularly in case of women.

FINDINGS AND DISCUSSION:

Table 1

Prevalence of Mental Disorders among respondents

S. No	Problems	Frequency	Percentage
1	Depression	44	88 %
2	Flashbacks	26	52 %
3	Sleepdisorders	46	92 %
4	Anxiety	40	80 %
5	Aggressive	42	84 %
Total		**50**	

The findings from table reveal that 88%(44 out of 50) observed patients have depression;52%(26 out of 50) patients are suffering from Flashbacks ;92% have sleep disorders ;while as 80% and 84% patients are suffering from Anxiety and Aggression respectively.The abovefindings reveal that all the patients are suffering from multiple type of mental disorders.

NB: All respondents in this case are females

Table 2

Awareness about Disorder & Undertaking Treatment

S. No	Do you Undergo treatment	No. of Respondent	Percentage
1	Yes	50	100 %
2	No	Nil	Nil
Total		**50**	**100%**

Table 2 reveal that all the 50(100%) respondent patients are aware about their deceases and undergoing treatment.

Table 3

AgeDistributionofRespondents

S.No	Age group	No. of Respondents	Percentage
1.	15-30	14	28 %
2.	31-45	20	40%
3	46-60	5	10%
4	61& above	11	22 %
Total		50	100 %

Table 3 reveal the age wise distribution of the respondents ; it shows 28% respondent patients belong to the age group of 15-30 years; 40% patients belong to the age group of 31-45 years; 10% and 22% patients belong to the age groups of 46-60 and 61 & years respectively. From the figures above it is observed that 31-45 age group is the worst hit of various kind of mental disorders.

Table 4

Educational levels of Respondents

S.No	Level of Education	No. of Respondents	Percentage
1.	Illiterate	16	32 %
2	UptoMatric	15	30 %
3	Matric	12	24 %
4	Graduate & Above	8	16 %
Total		50	100 %

Table 4 reveal that 32% patients are illiterate, and 30%, patients have studied up to matric,while as 24% are matriculate and 16% are graduate and above respectively. Thus, the mental problems percentage shows a sharp decline with respect to educational achievements.

Table 5

IncomeWise DistributionOfRespondents

S.No	Monthly Income of Family	No. of Respondents	Percentage
1	Up to 10,000	27	54%
2	10,001 to 20,000	18	36%
3	20,001 & Above	5	10 %
Total		50	100 %

Table 5 reveals the distribution of patients as per their family income. It is observed that 54% patients belong to the low income group i.e., their monthly family income is up to 10000 INR, while as 36% belong to middle income group i.e., their monthly family income falls in the rage of 10001 to 20000 INR and 10% patients belong to the income group of Rs.20001 & above. It is obvious that the people belonging to the lower income group become easy victims to mental

disorders during the conflict situations; moreover lack of money means the patients cannot afford medicines for timely treatment of the disease.

Table 6

MaritalStatusoftheRespondents

S.No	Marital status	No.of Respondents	Percentage
1	Single	12	24 %
2	Married	13	26 %
3	Widows / Half Widows/Divorced	25	50 %
Total		50	100 %

Table 6 reveals that 50% of the respondents belong to that category of women which are either widows/half widows or divorced while as 13% are married and 12% are yet unmarried.

SOCIAL IMPACT OF MENTAL ILLNESS ON FAMILIES

It has been identified that the mental ailments brings social stigma notonly to the patients but even to other members of their respective families.The families where such patients are found face various kinds of challenges like; socialization, education and overall nourishment of children of such families get affected in such families.In certain cases such women patients have either been made to get divorced or have been continuously threatened to be divorced.In majority of the cases such families find it very difficult to get their other children married particularly the female ones, because of social stigma.The family income has also witnessed a decline in certain cases.

Various Measures adopted and advocated to improve the mental health of women at the Global level:

What is actually needed is a model based on "a community care model for primary care and community systems backed by inpatients psychiatric beds when necessary" (Kohen, 2000: 219). Kohen argues that a comprehensive mental health service for women should be based on the collaboration of well-integrated, tiered services ranging from local self-help and voluntary groups to community facilities attached to general practice surgeries. Moreover, community mental health teams or specialised rehabilitation teams should be closely linked to inpatient and outpatient statutory services, the social services and secondary and tertiary care providers (2000). A person-centred approach also needs to be adopted, in which women's specific mental health concerns and life priorities are taken into account in the design and implementation of their treatment plan (WHO, 2001a). Hence an element of choice and self-determination through empowerment needs to be present, whenever possible. As previously seen, empowerment is also a key element of the recovery process. A holistic approach to patient care also plays a vital role in the treatment of women's health issues. Therefore, attention must also be paid to women's physical health. It is now established that depression is a risk factor for cancer and heart disease (WHO, 2003a). Mental illness has been associated with a significant risk for any cardiovascular disease, especially in menopausal women (Keyes, 2004; Wassertheil-Smoller et al., 2004). Consideration for the many social roles that women perform, as partners, workers and, especially, asparents, is also paramount. In fact, fear of losing of their children ,husbands, brothers or fathers during the conflict is one of the main cause that exposed the Kashmiri for women to different mental illnesses.While peace full circumstances have been found to be critical for recovery . The voices of current and past women users of mental health services must also be heard within service delivery, in order to improve the quality and reach of such services (Gadd, 1996; Lubotsky Levin, Blanch and Jennings, 1998; Morrow and Chappell, 1999; Kohen, 2000). The new UK policy for women's mental health (Department of Health, 2002) advocates that women users be involved in commissioning services, participating in patient councils and fora, their own care planning and treatment decisions, and clinical governance. Consultation with the NGOs that represent them is also felt to be beneficial (Johnson and Buszewicz, 1996a). A recent report on developing advocacy services identified mental health problems as a priority (Goodbody Economic Consultants, 2004). A group of NGOs should form the Alliance for Mental Health. Finally, mental health settings are generally dominated by males (Goldicott, 1996), and a gender rebalancing within mental health services has beenadvocated (Kohen, 2000), both in terms of security issues, and in relation to an increased awareness of gender issues and women's needs as patients as well as in the context of their other social roles.

In social term, the cost of primary care consultations for people on low wages who do not qualify for the medical card is a major deterrent from seeking help. To counteract this situation, eligibility criteria should be widened by increasing the income threshold (Women's Health Council, 2003b). If they do access care, as we have seen, women are less likely to receive specialized care and more likely toreceive treatment for mental health problems within primary care, which is usually unsatisfactory and most often limited to the prescription of psychotropic drugs. Moreover, some women are being admitted to private hospitals, showing that the only women who do gain access to specialisedtreatment are those from higher socio-economic groups, i.e. those who can afford it to pay for it. On the other hand, lack of access to free medication through primary care acts as a deterrent against discharge from inpatient services (Copty, 2004). Finally, women have been found to benefit from counselling and prefer it to complete reliance on psychotropic medication. However, free counselling is only available to women in specific groups and usually in relation to a traumatic

life event, such as crisis pregnancy or abuse. Hence, counselling provision through referral at primary care level needs to be extended to ensure equity of access for all women experiencing mental health difficulties. Thesame applies to complementary therapies, whose cost is often prohibitive for women in low incomes.The inequity of access and care needs to be urgently addressed and all mental health services should become available on an equitable basis. The needs of disadvantaged women, who are by their socio-economic position more prone to experiencing mental health problems, should be considered, and services made available that do not discriminate against them in terms of access and availability.

CONCLUSION:

To conclude it can be argued that the health care system particularly the mental health care system of Kashmir is not in a healthy state itself ,there is a dire need to upgrade the existing l health care system in Kashmir and the psychiatric units in various hospitals and health centers should be opened where the treatments to various types of mental disorders can be offered at quite reasonable rates; as the lone psychiatric hospital in Kashmir cannot cater to the needs of the huge patient rush .The role of psychotherapy is also imperative in this context, so there the govt. must open counseling centers alongside the medical care units meant for such psychiatric patients. It is worth mentioning that the role of various NGOs especially that of MSF has remained tremendous. Their studies on such issue has created aware ness among the common people about this endemic disease .They have also established various counseling centers throughout length and breadth of Kashmir where their professional community health workers and social workers help guide the people to overcome such problems . Women are also benefiting by these counseling centers. Thus, the govt. should appreciate their role and must also cooperate with them to ensure the speedy recovery of the mental health sufferers particularly the women patients.

Although the picture of mental health profile of women in conflict hit Kashmir is very shabby and worrying, as the psychiatric health care system in this part of globe is not catering effectively to the needs of patients, religion and faith healers are viewed as immediate panacea to tackle with this endemic problem.This view is substantiated by Kashmir's leadingpsychiatrist,Dr.MushtaqMargoob, who calls himself morea faithhealerthanapsychiatrist.Thepeoplehave absolutefaith thatwhatevertragedystrikesthemiswillof God,sotheydonotgiveup,"hesaid.Their faith is a supportsystemandithelpsme treatthemtoo. Withoutit,

PsychiatricdisordersinKashmirwouldhaveturnedinto anunmanageableproblem.Eventhoughbeliefin faith healers may beconsideredsuperstition, itcanhelppeopleattainemotionalrelief."Where medicinecannot work,thesetraditionsdo,"hesaid.Atasubconscious level,heexplained,aperson's beliefinspiritual,healing can bemuchmore powerful thanscientificcures.This does mean that faith will be always and in every case the panacea to such alarming and endemic problem,besides people's faith in God, the governmental agencies concerned with the health care system should give due care towards this rising threat .

References

[1] Abenhaim, L., Dab, W. &Salmi, L.R. (1992). Study of civilian victims of terrorist attacks (France 1982-1987). Journal of Clinical Epidemiology, 45, 103-109.

[2] Brommelhoff, J. A., Conway, K., Merikangas, K. and Levy, B. R. (2004). 'Higher rates of depression in women: role of gender bias in family'. Journal of Women's Health, 13 (1), pp. 69-76.

[3] Dabla,B A. Sociological Papers on Kashmir, Jay Kay Books, Srinagar, 2010

[4] Deshpande, S.N. &Sundaram, R. (1989). Psychiatric disorders among medical in-patients in an Indian hospital. British Journal of Psychiatry, 154, 504-509.

[5] Foucault, M. (1967) Madness and Civilisation. London: Tavistock.

[6] Foucault, M. (1991) Governmentality. In Burchell, G., Gordon, C. and Miller, P. (eds) The Foucault Effect. Hemel Hempstead: Harvester Wheatsheaf.

[7] Freidson, E. (1970) Profession of Medicine. New York: Dodd, Mead. Freidson, E. (1994) Professionalism Reborn. Cambridge: Polity Press.

[8] Gabe, J. and Thorogood, N. (1986) Prescribed drug use and the management of everyday life: the experiences of black and white working class women, Sociological Review, 32, 524±46.

[9] Giddens, A. (1991) Modernity and Self-Identity. Cambridge: Polity Press. Goffman, E. (1961) Asylums. Harmondsworth: Penguin.

[10] Goldstein, J. (1987) Console and Classify. Cambridge: Cambridge University Press. Goodwin, S. (1997) Comparative Mental Health Policy. London: Sage

[11] Government of India. 2011 Indian National Census Online: Census Organisation of India; 2012 [Available from: www.census2011.co.in.

[12] Hassan A, Shafi A. Impact of conflict situation on mental health in Sinagar, Kashmir. Bangladesh e-journal of sociology. 2013;10(1):101-26.

[13] Heeringa SG, West BT, Berglund PA. Applied survey data analysis. Boca Raton, Florida: CRC Press; 2010.

[14] http://www.who.int/mediacentre/factsheets/fs218/en/print.hrml. accessed on 29.06.2004.

[15] http://www.who.int/mediacentre/factsheets/fs220/eb/print.html accessed on 29.06.2004.

[16] http://www.who.int/mediacentre/factsheets/fs248/en/print.html accessed on 29.06.2004. WHO (2001a). Gender disparities in mental health. Geneva: World Health Organisation.
[17] http://www.who.int/mental_health/prevention/genderwomen/en/print.html accessed on 29.06.2004
[18] Hussain A, Margoob AM. Snowstorm disaster - learning and experience, first three months. Jammu Kashmir Practitioner. 2006;13(1):S241.
[19] In Glass, L.B. (ed) The International Handbook of sociological approaches. Strauss A, Corbin J. Basics of Qualitative Research: Grounded Theory Procedures and Techniques. Newbury Park, California: Sage Publications; 1990.
[20] Jaswal, S.K.P. (1995). Gyneacological and mental health of low-income urban women in India. Phd thesis: London School of Hygiene and Tropical Medecine.
[21] Jong K. de ,Mulhern, M., Ford, N., Kam, S. van der &Kleber, R.J. (2000). The trauma of war in Sierra Leone. The Lancet, Vol. 355, page 2067-2068.
[22] Kessler RC. Epidemiology of women and depression. Journal of Affective Disorders. 2003;74(1):5-13.
[23] Khan I, Shah SA. Self reported reasons for continuing substance use and not seeking treatment and quitting substance use and seeking treatment by Kashmiri youth. International Research Journal of Social Sciences. 2014;3(8).
[24] Kleber, R.J. &Brom, D. (1992). Coping with trauma. Theory, prevention and treatment. Lisse: Swets&Zeitlinger publishers.
[25] Liamputtong P, Ezzy D. Qualitative Research Methods (2nd ed.). Victoria: Oxford University Press; 2005.
[26] Margoob AM, Firdosi MM, Banal R, Khan AY, Malik YA, Ahmad SA, et al. Community prevalence of adult post traumatic stress disorder in south Asia: Experience from Kashmir. Jammu and Kashmir Practitioner. 2006;13(1):S18-S25.
[27] Margoob AM, Khan AY, Firdosi MM, Ahmad SA, Shaukat T. One-year longitudinal study of snow storm disaster survivors in Kashmir. Jammu and Kashmir Practitioner. 2006;13(1):S29-S38.
[28] Margoob AM. The Menace of Drug Abuse in Kashmir. Srinagar: Valley Book House; 2008.
[29] Margoob,M.A., Singh, A. & Ali, Z. (1997). Prescribing practices and outcome in anxiety disorders over the past two decades- experience from a sole provincial level psychiatric diseases hospital outpatient department. Indian Psychiatric Society North Zone.
[30] Margoob,M.A., Singh, A. & Ali, Z. (1997). A study of suicide attempts in Kashmir valley over the past six months (april-sept. 1997) experience from psychiatric outpatient population. Indian Psychiatric Society North Zone.
[31] McKeown, K., Pratschke, J. and Haase, T. (2003). Family wellbeing: what makes the difference? Dublin: Kieran McKeown Limited.
[32] McLaughlin KA, Koenen KC, Friedman MJ, Ruscio AM, Karam EG, Shahly V, et al. Subthreshold posttraumatic stress disorder in the World Health Organisation World Mental Health Surveys. Biological Psychiatry. 2015;77(4).6-S8.

[33] Mercy Corps. Youth entrepreneurship in Kashmir: challenges and opportunities. Kashmir: Mercy Corp, 2011.
[34] Ministry of Health and Family Welfare (2004). Mental Health: an Indian perspective 1946-2003. Ed Agarwal, S.P.. Directorate of Health services. New Delhi: Elsevier
[35] Mollica RF, Capsi-Yavin Y, Bollini P, Truong T, Svang T, James L. The Harvard Trauma Questionnaire: Validating a cross-cultural instrument for measuring torture, trauma, and posttraumatic stress disorder in Indochinese refugees. Journal of Nervous and Mental Disease. 1992;180(2):111-6.
[36] National Institute of Health and Family Welfare. National Mental Health Programme. http://www.ndc- nihfw.org/html/Programmes/NationalMentalHealth.htm
[37] National Institute of Health and Family Welfare. National Mental Health Programme. http://www.ndc- nihfw.org/html/Programmes/NationalMentalHealth.htm
[38] Parsons, T. (1951) The Social System. New York: The Free Press Ltd.
[39] Scholte WF, Olff M, Ventevogel P, de Vries JG, Jansveld E, Cardozo BL, et al. Mental health symptoms following war and repression in Eastern Afghanistan. Journal of the American Medical Association. 2004;292(5):585-93
[40] Selye, H. (1956). The stress of life. McGraw-Hill Book Company, New York.
[41] Sen B, Williams P. (1987). The extent and nature of depressive phenomena in primary health care: A study in Calcutta, India. British Journal of Psychiatry, 151: 486-93.
[42] Varma S. Where there are only doctors: Counselors as Psychiatrists in Indian-Administered Kashmir. Ethos. 2012;40(4):517-3528.
[43] Wani ZA, Margoob AM. Family study of adult PTSD patients in South Asia - experience from Kashmir. Jammu Kashmir Practitioner. 2006;13(1):S61-S4.
[44] WHO (1994). User's Guide to the Self Reporting Questionnaire. World Health Organization, Division of Mental Health, World Health Organization, CH-1211 Geneva 27, Switzerland.
[45] WHO (2000a). WHO Guide to mental health in primary care. London: The Royal Society of Medicine
[46] WHO (2000b). Women and mental health. Fact sheet no. 248.
[47] WHO (2001b). Mental health problems: the undefined and hidden burden. Fact sheet no. 218.
[48] WHO (2001c). Mental health: strengthening mental health promotion. Fact sheet no. 220.
[49] WHO (2001d). World Health Report - Mental Health: New Understanding, New Hope. Geneva: The World Health Organisation.
[50] WHO (2002) World report on violence and health. World Health Organisation, Geneva.
[51] WHO (2003a). Investing in mental health. Geneva: World Health Organisation.
[52] WHO (2003b). The mental health context: mental health policy and service guidance package. Geneva: World Health Organisation.
[53] WHO (2004). Gender and women's mental health.