

Mental Health of Adolescents in Jammu and Kashmir: An Ethnographic Study of the Impact of Violence

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Abstract

Militancy-related violence and conflicts have become common causes of trauma worldwide. Jammu and Kashmir has experienced violence since 1989. Previous research on adolescent mental health in Jammu and Kashmir has focused on the prevalence of mental health disorders and the identification of their risk factors. The subjective meanings of trauma or expressions used by adolescents to describe these meanings remain largely unexplored. This paper, based on data collected using an ethnographic approach, attempts to understand the subjective experience of trauma and the mental health of adolescents exposed to violence in the social and cultural context of Jammu and Kashmir.

Key Words: *Mental Health, Social and Cultural Context Adolescents, Conflict Region, Kashmir.*

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Introduction

The World Health Organization defines adolescence as the period between the ages of 10 and 19. This period is characterized by the development of an individual's physical and psychological abilities, which affect their overall growth (Patton et al., 2016). The onset for most psychological disorders is between the ages of 12 to 24 years (Patel, Flisher, Hetrick & McGorry, 2007). A longitudinal research study carried out by Ravens-Sieberer et al. (2014) found that between the ages of 7 and 12 years and after 19 years, individuals are at a high risk of developing mental health problems. Exposure to any adverse or negative experience during this stage of life can affect the life-long functioning of an individual (Soleimanpour, Geierstanger, & Brindis, 2017). Interpersonal violence, self-harm, and depressive disorders are the prevalent causes of distress among adolescents (Ameratunga & Denny, 2016). Exposure to traumatic experiences increases the risk of developing mental health problems during adolescence (Deković, Koning, Stams & Buist, 2008). These traumatic events may range from personal experiences such as bereavement and accidents to more extensive community-based experiences such as

political and ethnic conflict. (Obermeyer, Bott, & Sassine, 2015). These findings highlight the psychological and physical factors that affect the mental health and vulnerability of adolescents.

The World Health Organization considers violent social conflict as a major health problem (Mathers and Loncar, 2005 and Krug et al 2002). Over 1.6 million lives are lost each year due to collective, interpersonal, and self-directed violence, of which nearly one-third are homicides and one-fifth are war-related fatalities (WHO, 2004). The people of Jammu and Kashmir experience violence every day. According to Kadir et al. (2019), more than one in ten children are affected globally by armed conflict. A similar study conducted by Mushtaq et al. (2016) found that Children in Kashmir are affected by constant turmoil, trauma, and political insurgency. They further reported that the experience of traumatic events has a lifetime prevalence rate of 58.69%, and violent traumatic events are a major risk factor for Post-Traumatic Stress Disorder (PTSD) among adolescents in Kashmir. The authors suggested that every child in Kashmir

suffers from at least one traumatic event. The Médecins Sans Frontières (MSF)¹ (2016) report, based on a survey conducted in 2015, found that Kashmiri youth experienced 7.7 traumatic events in their lives. A study by Dar and Deb (2021) found that 99.3% of college-going young adults narrated the effects of conflict and violence on their education in the Kashmir region. Yaswi and Haque (2008) also found that adult victims of conflict and violence in Kashmir experienced PTSD and depression. The experience of violence occurs in various forms, sometimes directly and at times through witnessing. Witnessing violence on an everyday basis in a protracted conflict- and violence-ridden region is a source of trauma for local inhabitants. In this context, we undertook research in Jammu and Kashmir to study the mental health of adolescents, as it is the protracted conflict and violence that affected earlier states and now the Union Territory in India. Since 1989, the increased spate of violence due to militancy-related incidents has led to loss of lives, including killings of civilians and armed forces personnel, and suffering for the local inhabitants (De Jong *et al.* 2008a and Varma 2012). It has also led to an internal displacement of around 160,000 members of the ethnic minority Hindu Kashmiri Pandits (Evans, 2002).

Joshi and Mir (2002), in a study conducted in Jammu and Kashmir, reported of prevalence rate of PTSD among adolescents exposed to violence. De Jong *et al.* (2008a) after conducting a survey in 30 villages in Kashmir valley found that the inhabitants are faced with high levels of violence with substantial implications for mental health.

Since Jammu and Kashmir has historically experienced multiple political upheavals, there is a history of events that have formed the collective unconscious. To study the psychological aspects of the population at a conscious or unconscious level, it would be meaningful to take into account the social and political history of the inhabitants and the region. Therefore, gaining insight into the idioms of distress becomes even more critical in order to establish an association or link between people's social and emotional accounts. Such accounts of trauma and violence are needed to understand adolescents' mental health in Jammu and Kashmir using an ethnographic approach. This paper provides an anthropological and in-depth analysis of the meaning and implications of psychological distress caused by traumatic events experienced by adolescents exposed to conflict and violence.

Objectives of the study

- To explore the nature and intensity of trauma experienced by adolescents in Jammu and Kashmir
- To study the impact of trauma and distress on the mental health of adolescents in Jammu and Kashmir.
- To understand the meaning of trauma and mental health, idioms of

¹ Doctors Without Borders/ Médecins Sans Frontières (MSF) is an international, independent, medical humanitarian organisation that delivers emergency aid to people affected by armed conflict, epidemics, natural disasters, and exclusion from healthcare. <https://www.msfindia.in/what-is-msf/>

distress, and modes of expression of distress in the local social and cultural context by adolescents in Jammu and Kashmir.

Methodology

This paper is based on data collected during an ethnographic study involving fieldwork carried out during multiple visits of one to two weeks duration between 2017 and 2019 in areas affected by daily incidents of violence in Jammu and Kashmir. The fieldwork was carried out by a team of researchers well versed with the local language and past experience of working in the same fieldwork area. To gain the insiders' perspective, the trust of the participants, and quick rapport establishment, a team of researchers was assisted by field investigators recruited from the same fieldwork area. An anthropological ethnographic research design was considered appropriate for studying the impact of psychological trauma attributed to conflict and violence. It helped to understand the subjective experiences, collective suffering, and coping shaped by the local social and cultural context when traumatic events have become a part of everyday lived experience.

Participants of Research

The total number of participants in the study was 191 adolescents in the age range of 14-19 years and they were drawn from conflict- and violence-affected areas (i.e., Srinagar, Budgam, Anantnag, Pulwama, Kulgam, Shopian, and Baramulla districts) of the Kashmir Division. These districts are highly affected by the spread of violence, as per the information reported in local and national newspapers on a daily basis. The source of information for such incidents is press releases issued by the government. Most of the participants were males from a rural background and had studied up to the 12th class level.

Measures:

Data related to basic demographics and trauma experience details were collected using a questionnaire. Narratives about the details of the nature of trauma experience, type of trauma, subjective meaning of trauma, idioms of distress, and modes of expression and impact of distress on mental health were collected through unstructured and semi-structured interviews with the participants by the first author and the field investigators.

Procedure:

During ethnographic fieldwork, the participants were primarily approached at their homes and educational institutes. The fieldwork was conducted by the first author and a team of Research Field Investigators. The research team comprised an anthropologist, sociologist, and psychologist who had experience conducting research in the areas of trauma, culture, and mental health. Participants were briefed about the study objectives and their right to withdraw from the study. Interactions with the research participants were conducted according to their convenience and comfort level in more than one sitting, and the time of each interaction also varied depending on the convenience and comfort level of the research participant. The data were recorded in the form of hand-written jottings in an attempt to record as much verbatim as could be managed and then convert those notes into more detailed and extended notes immediately after the interaction sessions when the memory was fresh. The field notes were kept in the custody of the first author.

Ethical aspects

Standard guidelines on ethical practices, as applicable and adopted by the affiliated university of the authors, were followed. Participants were clearly informed about the research objective and their right to voluntary participation. The verbal consent was taken. Given the conflict and violence-ridden nature of the field site and the security dimensions, the confidentiality,

anonymity, and privacy of the research participants were strictly maintained.

Results and Findings

The obtained data were analyzed using frequency and percentage for descriptive understanding, and thematic analysis was performed as per Braun and Clarke (2006). The data were coded after identifying similar codes and themes. The frequencies of subthemes were counted to show how frequently each subtheme was mentioned or implied in the data.

Demographic details of the participants:

Out of a total sample population of 191 participants, 63.9% (n=122) of the sample were male participants, and the number of girls was only 35.1% (n=67) of the sample. The highest number of participants, 49.7% (n=96) of the total sample (n=191), was in the age range of 17 to 19 years. Of the

sample, 28.3% (n=54) were within the age range of 14 to 16 years. The majority of participants (83.2%, n=159) were from rural areas, and 10.5% (n=20) were from urban areas. The results also indicate that most participants had studied up to the 12th class, which was 38.4% (n=73) of the total sample (n=191). Twenty% (n= 38) of the sample had studied up to the 11th standard. 9th and 10 class werethe next highest, with 16.8% (n=32) and 19.4% (n=37) participants qualified for, respectively. Only 1.6% (n=3) of the samples were not included in the study. Moreover, 3.7% (n=7) of the participants had studied till the level of 1st year of graduation. Thus, most participants were educated within the range of the 9th to 12th class. Only 0.5% of the participants (n=1) did not respond to this question.

Table 1 Presents the nature of the traumatic event as narrated by the participants (N=191).

Statement: What was the nature of Traumatic event		
Type of Response	Frequency	Percentage
Loss of family member	44	23.0
Severe injury to self	36	18.8
Witness to a traumatic event	28	14.7
Severe injury/physical torture of a family member	5	2.6
Evidence of traumatic events but reason not disclosed	78	40.8
Sub Statement: Details of Trauma Experience		
Type of Response *	Frequency*	
Personally experienced	61	
Personally Witnessed	50	
Hearing someone's personal experience	50	
Hearing someone's personal witness account	50	

* Even though the total sample was 191, the frequency reflected in the table 2 shows the responses of participants having experienced and reported more than one sub-theme.

Table 1 shows the details of the trauma exposure of the participants. 40.8 percent (n= 78) of the participants did not share details of the nature of the traumatic event. The reluctance to share such details points towards fear, sense of insecurity, and discomfort due to the prevailing atmosphere of conflict and

violence. Indeed, the interview was conducted in settings that were convenient for the participants, and the assistance of local field investigators was sought to establish rapport between the participants and the researchers. However, the non-disclosure of such details must be interpreted in the context

of the general sense of mistrust, uncertainty, unpredictability, and the lenses of suspicion through which inhabitants behave with others and try to avoid any severe reprimand or threat to their safety and security in everyday life. The interpretation of the data collected in the form of narratives through interviews is discussed under the following themes:

The everyday experiences of violence

The participants had different types of traumatic experiences in everyday life. The killings take place on a daily basis, and the recurring nature of the violence is witnessed and experienced by local inhabitants across age groups. Taking the 'exposure of trauma' as the basis, we have subdivided the themes under violence, as personally experienced violence, personally witnessed violence, indirect exposure (hearing someone's personal experiences or witness account).

Personally experienced violence

61 participants personally experienced violence, with some having any kind of violence only after 2016 and others having been used to witness it. The narratives of Participants 176 and 177 regarding the frequency of experiencing and witnessing traumatic events indicated a certain level of habituation to recurring incidents of violence. In these areas of conflict and violence, where violence is an everyday reality, the narratives of the participants reflect the development of a coping mechanism in traumatic and emotionally disturbing circumstances. A study by Mrug, Madan, and Windle (2016) showed that adolescents who had higher exposure to violence internalized it less and developed a sort of emotional desensitization towards it. The study found that due to a certain kind of habituation, adolescents had less cognitive and somatic internalization and described such numbing as an adaptive character.

Violence penetrated and impacted all aspects of the lives of participants. For

instance, Participant 152 lost the vision of one of his eyes because of pellets. He explained that because of his vision loss, he could not do anything in his life. Participant 151 almost died and was battling life when a tear gas shell hit him. Thus, in addition to the psychological impact of such experiences, there are immediate physical health consequences and disturbances in the everyday functioning of individuals. The case study of one participant illustrated the spillover impact of violence. The involvement and further arrest of Participant 176 by the police in a stone-pelting case severely affected his father. His father died after a brief hospitalization. The loss of an earning member of the family eventually had an impact on the family's financial condition. The spillover impact of violence shattered the family's support system.

Personally witnessed violence and indirect exposure

Fifty participants personally witnessed violence. Fifty participants had heard of their acquaintances' experiences of violence. Nine participants had heard of someone they knew of having personally witnessed violence. Hearing violence or witnessing violence is an immediate reminder of the violence one is surrounded by. This can set in fear and cause impact in varied forms and ways, as there may be differences in the experience of violence associated with political turmoil and conflict from inter/intrapersonal violence in the general sense.

Hearing someone's personal experience

Witnessing and hearing about incidents of violence was a common occurrence for the participants in the study, Participants 175, 174 and 173 mentioned that it was part of the mundane to hear stories of violence and traumatic events. Recurring exposure to such traumatic events may cognitively develop the tendency to normalize violence and its acceptance in everyday life as routine, but Berents and

Ten (2017) warn us against it. They argue that the expectation of violence should not normalize, because normalizing it may lead to internalizing violence. Therefore, normalizing violence can be dangerous. Thus, experiencing and witnessing trauma also becomes a lived reminder of political histories and the humanity of people who survive conflicts (Young & Rees, 2011).

Hearing someone's personal witness account

There were participants who shared that stories of violence passed on from parents to their children. Multiple participants shared their experiences of witnessing or hearing traumatic and violent incidents. Participant 187 shared that his father told him stories of violence, which disturbed him emotionally and cost him sleep during the night hours. Given the longevity of the trauma experienced by people, these heard and witnessed experiences have been passed down through generations. Research study done by Devakumar, Birch, Orsin, Sondorp, and Well (2014) examined the intergenerational effects of war and found that various events during war pass down inter-generationally. Betancourt (2015) also discussed the inter-generational effects of trauma and violence. Children living in conflict zones are vulnerable to violence at many levels, from the family to other social settings. This observation is in tandem with research findings that war affects children by breaking down community and disrupting families (Cummings, Morey, Schermerhorn, Merrilees & Cairns, 2009).

Discussion

The everyday experiences of the participants were diverse. They have been directly and indirectly exposed to diverse forms of violence, which directly impact their psychological state. Under these prevailing traumatic conditions, local inhabitants become more vulnerable to mental health problems. In the Kashmir region, from 1985 to 2006, the number of

people visiting psychiatric hospitals increased from 775 to 82000 (Hassan and Shafi, 2012). With such an increase in the number of people seeking mental health care, it shows that people are open to seeking professional help to ameliorate their mental health suffering. The following section addresses the mental health themes derived from the analysis of the collected data.

Impact on mental health

Fifteen participants reported the symptoms of depression, anxiety, and stress. Case 62 had to seek help from her mother to answer the questions, as she was unable to answer the questions. Patient 63 was emotionally disturbed. As mentioned above, there is a direct link between the experience of violence and psychological impact on an individual. While discussing the psychological state of their relatives, friends, and themselves, the participants described it as 'fearful', 'shocked', and 'abnormal'. A study conducted in Uganda found a strong link between exposure to violence and post-traumatic stress symptoms (McMullen et al., 2012). Khan and Margoob (2006) found that young children diagnosed with PTSD had witnessed killings of a close relative, arrest, torture, night raids, and cross-firing. The nature of death and violence also perpetuates a certain kind of violence, where victims project their issues to those around them. Case 72 illustrates how the death of the mother led her brother to chop two of her fingers because of the psychological impact of the death on him. There is high vulnerability to developing harmful behaviors, such as substance abuse. Case 191 mentioned how such violent experiences left the youth frustrated and many of them turned to drug abuse. Schiff et al. (2007) found that Israeli adolescents' closer proximity to violence was a predictor of higher alcohol consumption, cannabis use, and smoking. One of the more frequently mentioned psychological symptoms of emotional

disturbance due to traumatic experiences is lack of sleep. Psychological and social factors often manifest in somatic processes, one of which is the biological process of sleep. Many participants mentioned that they had not been able to sleep after the traumatic incident, resulting in nightmares and other mental health issues. Cases 190 and 188 mentioned that they had nightmares related to the traumatic event they experienced. Case 187 also had nightmares. According to participant case 188, all these incidents have had a deep impact on the psyche of people and left them sleepless. This common symptom has been found to be prevalent in other conflict zones. Bell, Mendes, Martinez, Palma and Bosch (2012) found victims of Colombian armed conflict had anxiety and arousal related symptoms like 'feelings of threat', 'sleep disorder or difficulties'. Disappearance was another form of trauma experienced by the participants. Six patients experienced the death of their parents. Thus, we can map the link between violence and trauma to the mental health of the people in Kashmir.

Perceptions of mental health

Another important theme was the various perceptions of mental health among adolescents. The data analysis shows that the youth were aware of their mental health problems, and the findings suggest that there is an urgent need to look into mental health problems. Case 188 shared that many youths suffer from trauma and distress from exposure to violence. The local language phrase "*Yeh chu sadmans manz* (S/he is in trauma) is commonly used to refer to those suffering from trauma. Trauma percolates into everyday phrases and way of life. Case 190 discussed how there is a village adjacent to the one in which he resides, called 'the land of widows.' The village has a large number of widows and children without their fathers. The responses of the participants indicated their awareness of

mental health problems and their added vulnerability. There was recognition of the fact that mental health concerns are a large-scale problem which needs attention at an institutional level. Case 191 mentioned the need for government intervention because the youth have been deeply affected by the various events of trauma. He mentioned that there is a paucity of mental health centers in Kashmir.

Mental health care is primarily provided by the psychiatry departments of government medical colleges and their associated hospitals with both outpatient (OPD) and indoor (admission) facilities, in addition to emergency services available in only two departments. Owing to the rise in the scale of mental health-related problems due to violence and conflict related trauma, most districts in the Kashmir region have been provided with the facility of mental health clinics at the district and sub-district level (Zargar 2022). Until the early 2000s, the lone department of psychiatry at Government Medical College with minimal strength of psychiatrists (3–4 psychiatrists) provided mental health care services, and the number of psychiatrists has increased to around 80 (Zargar, 2022). Besides structural problems, the participants also talked about the stigma related to mental health. Case 188 mentioned the stigma due to which youth were unwilling to deal with mental health problems openly and seek medical consultation.

Medical labeling can have consequences for individuals' social and personal lives. Jabr et al., (2013) while working on the mental health of Palestinians, found that patients of mental health are labelled using harsh words, like 'crazy' and 'lazy' and it was found to be very common in Palestine. This case is similar to that of Kashmir. Research by anthropologists suggests that imposing a diagnosis on someone's trauma is also a form of "appropriation of suffering" on various

levels. (Young & Rees, 2011). Scholarship also suggests that a psychiatric diagnosis can stigmatize individuals by transforming their lived stress into a biological, medicalized reduction (Farmer, 2004).

Conclusion

This study concludes that violence has a significant impact on the mental health of people, especially the youth. Violence, trauma, and mental health are interconnected phenomena; thus, one often has a lasting effect on another. Adolescents reported personally experiencing and witnessing violence. Research suggests that intentional and interpersonal violence such as torture is more difficult to cope with than unintentional violence such as accidents (Friborg, Emaus, Rosenvinge, Bilden, Olsen & Pettersen, 2015), and most participants reported having gone through intentional and interpersonal causes of violence. Exposure to violence and its association with a person's psychological morbidity manifests itself in the form of mental health problems like depression, suicide, post-traumatic stress disorder, and substance abuse (Auxemery, 2018 and Vermeiren, Ruchkin, Leckman., Deboutte, & Schwab-Stone, 2002).

The majority (59.2%) of the participants reported having experienced traumatic events of varied nature. While 23% of the sample had suffered the loss of their family members, 18.8% had experienced self-severe injury, 14.7% had witnessed traumatic events, and 2.6% had experienced severe physical injury, torture on themselves, or a family member. 33.5 Of the sample, 33.5% reported being a witness to cases of bomb blasts, cross-firing, killing of more than one person, interrogation/physical torture, and other events while reporting trauma. One of the main aspects of trauma is that people perceive their safety under a threat (Hobfoll, Hall, & Canetti, 2012). This was observed in the case of participants who believed their lives were unpredictable and uncertain. Moreover, their suspicion of the

researchers in their responses could also manifest this sense of feeling unsafe and under threat if sharing their trauma accounts might lead to any reprimand by the state agencies or the militants fighting against the state. Ghahary (2003) argues that the experience of traumatic events often makes it incomprehensible for victims and difficult to cope with such circumstances. Perhaps it is this incomprehensibility related to trauma that played a role in 66.5% and 40.8% of the participants who did not answer the question about trauma and the nature of traumatic events, respectively. Some participants displayed emotional numbing traits as an outcome of trauma. It was observed that violence affected the daily lives of the participants by having an adverse impact on the economy and education sector (Geelani, 2012, Dabla., 2011 and Raghavan, 2012) The socio-cultural aspects of life were also affected by the ongoing conflict. The feelings of fear prevailed among the participants, and these emotions were seen as strong forces that shaped and affected their mental health. It may be inferred that ongoing violence has become a collective socio-cultural experience for participants living in Kashmir, which needs to be further studied. Local interpretations of mental health problems in regions affected by violence and protracted conflict are needed to devise effective mental healthcare services. Anthropologists, psychologists, and clinicians need to consider the nuances of such findings and apply further in-depth qualitative approaches to understand the mental health costs of exposure to violence. Culturally appropriate intervention strategies for addressing mental health problems in violent and conflict-affected regions are needed to take care of the wellbeing and overall quality of life of people exposed to traumatic events. Future studies need to factor in resilience as a form of collective and individual coping mechanism in social and geographical

contexts in relation to recurring violence by people living in conflict zones. These findings and interpretations did not deal with the local forms of psychiatric healing or alternatives to address mental health problems that need to be explored. The dynamics of education and economic factors affecting mental health are also critical aspects that need to be addressed by future research in this field. The current study is limited to the social anthropological exploration of psychological concerns; however, it calls for clinical interpretations by psychiatrists and psychologists working in the field of trauma studies.

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NOTE: The authors have sole responsibility for the originality of the contents of this manuscript.