

The Association between Adult Mental Health Problems and Childhood Trauma: A Retrospective Community Based Study from Kashmir

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INTRODUCTION

In the context of current political instability prevalent worldwide, no age group is immune from exposure to trauma, and its consequences (Khan & Margoob, 2006). It has been long known that pathological stress response syndromes can result from exposure to war, sexual assault and other types of trauma (Lerner, Volpe, & Liddell, 2003). Evidence for post-traumatic reactions dates back as far as the Sixth century B.C.; early documentation typically involved the reactions of soldiers in combat (Lerner, Volpe, & Liddell, 2003; Holmes, 1986).

Ukpeg" ejknftgp" hqt o" c" ukipkŁecpv" rqrwncvkqp" yqtnf ykfg." recognition of psychiatric problems in children is important (Margoob et al., 2004). Approximately, 20 percent of individuals exposed to a ukipkŁecpv" vtcw o cvke" gxgp" y km" fgxgnqr" ru {ejkcvtk" o qtdkfkv {" cpf" children may be at an even higher risk (Breslau et al., 1998; Apolone, Oquepk." ("Nc"Xgee jkc."4224+0"Uvwfkgu"uw i iguv"vjcv"ur gekŁe" fkuqtfgtu" are linked to traumatic events that occur in childhood rather than later in life (Yen et al., 2002; Pole et al., 2007).

The global burden of trauma is enormous. Over the last three decades, Asia and Africa regions have witnessed the fastest increase in the incidence of traumatic events and natural disasters. India alone reported 18 major natural disasters in 2007 excluding numerous regional disasters which escaped world attention (Ferris & Petz, 2012; EM-DAT).

Kashmir has been witness to both manmade and natural traumas. After the Partition of India in 1947, the long dispute between India and Rcmkuvep" hqt" eqpvtqn" qh" Mcuj okt" jcu"ngf" vq" cp" ct o gf" eqpŁkev" dgvyggp" India and Kashmiri militants, causing deaths, disappearances, human uwhhgtkp i u" cpf" vtcw o cu" kp" vjg" kp fkc" rctv" qh" Mcuj okt" *UejqŁgnf."4222+0" A community survey done by Médecins Sans Frontières in 2005 found high levels of ongoing violence across the region, with civilians caught in the middle. The majority of people surveyed stated having been exposed vq" etquŁtg" *: 8 ' + " cpf" tqwpf/wr" tckfu" *: 5 ' +0" Jki j" pw o dgtu" qh" rgqrng" tgrqtvgf" dgkpi" uwdlgev" vq" o cmvtgcv o gpv" *66 ' +. hqtegf" ncdqwt" *55 ' +. mkfpcr rkp i" *39 ' +. vqtwtg" *35 ' + " cpf" ugzwcn" xkqngpeg" *34 ' + " *Fg" Lqpi." (2008). Beyond this manmade disaster, Kashmir has been frequently affected by natural disasters, causing heavy economic and psychological damage (Halvorson, & Parker Hamilton, 2010).

The total lifetime prevalence for any traumatic experience in the eqo owpkv {" kp" Mcuj okt" ycu" 7 :08 ; ' " kp" 4228" *Octiqqd" (" Cj o cf." 4228+0" Fcvc" tgxcn" vjcv" kp" vjg" r tgxcknkp i" eqpŁkev" ukwvcvkqp" qxgt" vjg" past thirty years in Kashmir, there has been a phenomenal increase in psychiatric morbidity, including stress related disorders (Margoob, 1995). The effects of trauma in this region are better understood in the case of adults, but in the case of children they have only recently begun to be understood (Khan & Margoob, 2006). Margoob et al. during the longitudinal follow up of snow storm children survivors hqwpf" vjcv" 56 ' " uwhhgtgf" htq o" fkuqtfgtu" kpenwfkpi" RVUF." OFF" conversion and panic disorder as in agreement with other reported studies from other parts of the world, although the follow up was not more than one year (Margoob et al., 2006).

There are no studies on the long-term outcome of childhood traumas in this region (Kashmir, India), although the trauma prevalence is quite high. The association between childhood trauma and adult mental health problems has not been studied so far. This study is an attempt to examine the long-term effect of childhood trauma.

METHODOLOGY

Study Design

The study was carried as a part of community outreach programme of Department of Psychiatry, Government Medical College, Srinagar (India) covering a population of 5,453,209 individuals were studied (Census of India, 2001). These districts were Srinagar, Anantnag, Baramulla, Pulwama, Budgam and Kupwara. Participants were selected from all the six districts of Kashmir valley. These areas were delineated as per the census report of 2001 available at the start of the study in March 2011 (Census of India, 2001). Three villages/localities were taken from each district and the care was taken to take the population of six districts proportionately. Convenience method was applied to choose the localities and the number the household was limited by availability of hilly topography, manpower, time and other resources. The study was reviewed and approved by departmental ethical committee.

Sample

Every 7th household of each village/locality was surveyed. All individuals who met the criteria for trauma at the age of 5–17 years. In each case of traumatic event respondent was asked if the trauma had happened, was witnessed, learned about, not sure, or does not apply, as per Life Event Checklist (Blake et al., 1995). Only events judged severe in intensity, according to DSM-IV-TR criteria, were included (American Psychiatric Association, 2000).

“The person has been exposed to a traumatic event in which both of the following were present:

1. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
2. The person's response involved intense fear, helplessness, or horror.
Note: In children, this may be expressed instead by disorganized or agitated behaviour”.

Those persons who had suffered trauma between 5 to 17 years of age, irrespective of sex and present age were included in the study. Persons with a psychiatric morbidity prior to trauma or severe medical morbidity or serious physical disability were not included. A proper informed consent was taken from all the participants of the study. Professional help and advice was offered to the participants. No monetary compensation was given to the participants.

Method

Those individuals who met the criteria for trauma and the age for traumatic exposure as above were further interviewed for their course of psychiatric morbidity. The schedule was delineated as per the epidemiological studies related to childhood trauma in the Department of Psychiatry, Government Medical College Srinagar. Participants were also subjected to Mini International

Neuropsychiatric interview (MINI) which has high validity and reliability scores for DSM-IV based diagnoses and have been used in a series of earlier studies among the local population (Margoob et al., 2006; Sheehan, Lecrubier, & Sheehan, 1998). Interview was carried by a member of the community outreach programme team after having received the necessary formal training for instituting MINI and the semi-structured schedule. The members included trained/qualified psychiatrists. Participants with a current psychiatric diagnosis were given appropriate treatment as required.

Data Analysis

The data was framed in an appropriate master chart and the morbidity along the different socio-demographic variables was analysed using SPSS 20.0 package. The variables were categorical and binary and hence were subjected to chi-square tests. The results with probability <0.05 were considered to show the statistical significance. The results were reported as appropriate.

RESULTS

Sample Population

A total of 18 localities/villages, comprising 2436 households were surveyed. A proportion (342) of these households was sampled which amounted to 3137 individuals, irrespective of sex and age, among them 3:4; *7:052 ' + " ygtg" o cngu" cpf" 352:4*63092 ' + " ygtg" hg o cngu" Hkxg" jwpftgf" ugxgpv{" vyq" *3:046 ' + " rgtuqpu" jcf" uwhhgtgf" vtcw o c" kp" childhood (5-17 yrs) and met the criteria for inclusion and detailed interviews were administered to this population. The sample characteristics are given in Table 1. The total males and females in the sample, there was a higher rate of morbidity in females than in males. The age ranged from 5 years to 77 years. Maximum number of cases with trauma and subsequent morbidity belonged to 20-40 year age group.

The morbidity was slightly higher in rural than the urban

- Margoob, M.A., Khan, A.Y., Mushtaq, H., & Shaukat, T. (2006). PTSD Symptoms among Children and Adolescents as a result of Mass Trauma in South Asian Region: Experience From Kashmir. *JK-Practitioner*, 13(Suppl 1), S45-S48.
- Math, S.B., Tandon, S., Girimaji, S.C., Benegal, V., Kumar, U., Hamza, A., et al. (2008). Psychological impact of the tsunami on children and adolescents from the Andaman and Nicobar islands. *Primary care companion to the Journal of clinical psychiatry*, 10(1), 31.
- OeFgt o qw." D0." (" Rcn ogt." N0L0" *3; ; ; +0" Rquv-disaster service rtqxlukqp" hqnnqy kpi" rtqcevkg" kfgpwlEecvkqp" qh" ejknftgp" ykvj" emotional distress and depression. *Australian and New Zealand Journal of Psychiatry*, 33(6), 855-863.
- McFarlane, A.C., Policansky, S.K., & Irwin, C. (1987). A longitudinal study of the psychological morbidity in children due to a natural disaster. *Psychological Medicine*, 17(3), 727-738.