original article

PSYCHOLOGICAL DISTRESS IN KASHMIRI DIASPORA DUE TO TOTAL COMMUNICATION BLOCKADE IN KASHMIR

Afifa Qazi, Mudasir Firdosi, Farida Jan, Aaliya Majeed

Abstract

On 5th August 2019, India imposed a complete communication blockade in Kashmir including telephones, mobiles, and Internet services. Kashmiris living across the world were unable to communicate with families back in Kashmir. We conducted an online study using the HADS (Hospital anxiety and Depression) rating scale to measure the psychological distress in Kashmiri diaspora due to communication blackout and conflict in their country of origin. An online survey questionnaire using the HADS rating scale was circulated to consenting Kashmiri participants over 18 years of age using social networks. A total of 465 responses were anonymously received over 4 weeks. The results show very high scores for both anxiety and depressive symptoms across the whole sample. The results on the anxiety sub-scale showed 89% of the sample scoring above the cut off for "caseness" or "abnormal". The scores on the depression subscale showed that 88% of the sample fell within the abnormal range. The consequences of conflict are far reaching and can cause significant psychological distress to the diaspora. Our study shows very high rates of both Anxiety and Depressive symptoms in the respondents, who were unable to contact their families due to information blackout. To the best of our knowledge, there is hardly any such study conducted before. Further research is needed to understand the full extent of such conflict situations and communication blackout on diaspora population.

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Introduction

Kashmir, a verdant valley nestled in the lap of the Himalayas has remained a conflict zone from many decades with resultant negative psychological effects on the local population and on Kashmiris living outside the valley. Studies suggest that more than 60% of the population has been exposed directly to trauma with high rates of Post-Traumatic stress disorder, depression and other anxiety disorders[1-2]. Community surveys by many international organisations have also shown increased rates of psychiatric morbidity with concerns around access to services and treatment for the same[3-4]. The persistent conflict situation also means that people are not able to recover due to continuous exposure to trauma and its ensuing sequelae.[5]

On 5th August 2019, Indian government revoked the Article 370 of the Indian constitution which gave the erstwhile state a special status[6]. At the same time, around 8 million people living in the Kashmir valley were completely cut off from the outside world by a total blockade of phones, mobiles, internet, and postal service. A strict curfew with restrictions on the freedom of movement resulting in difficulty accessing medical care and other essential services was imposed. Concerns were raised by various international organisations about the impending humanitarian and health care crisis [7-8]. Internet shutdowns are not new to Kashmir, but

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the complete shutdown of all communication links is the first of its kind in modern times. Reports suggest that India ranked highest on shutdowns in the world between April 2017 and May 2018 with half of all internet shutdowns reported from the Kashmir Valley[9]. As a result of the shut-down,Kashmiri diaspora settled across the globe were unable to contact their families, including aged and ailing parents, siblings and close friends with no news whatsoever of their safety and wellbeing. There was hardly any news coming out of the valley via the local media due to the curbs and international media reports suggested that people were having great difficulty in accessing emergency care; there was lack of essential medication and difficulty with travelling to hospitals[10].

This led to a situation of uncertainty for Kashmiri diaspora with huge concerns for their loved ones as they were not able to contact them. There were numerous reports of emotional distress, despondency, insomnia, and anxiety symptoms in Kashmiris living outside Kashmir on various media outlets, international newspapers and social media.[11-12] The current study was undertaken to assess the psychological impact of this communication blockade on the Kashmiri diaspora settled around the globe. There are numerous studies about the emotional impact of on-going conflict situations on populations living in war zones.[13] However total communication blockade of a whole population is new in the age of internet, and there is no published research on the psychological impact of a total communication blockade on diaspora not being able to reach their families and friends living inside the Lockdown zone.

Material and Methods:-

We devised a web based questionnaire using the Hospital Anxiety & Depression Scale (HADS). There is extensive evidence for use of HADS in various adult age groups[14] including use for assessing psychological distress among 65 to 80 year olds[15]. The questionnaire consisted of all the items on the HADS in addition to which socio-demographic information was collected. We chose the online method over paper based data collection due to its efficiency in reaching a large and geographically dispersed population and the ease and accessibility of online methods. Participants were able to complete the questionnaire on smartphones via an online link. Use of online tools is becoming increasingly popular as a method of collecting data with good reliability and validity[16].

Participants

The participants included diaspora of Kashmiri origin aged over 18 years and resident in various countries around the world. They were contacted through various social media platforms and via email, using Kashmiri diaspora organisations to facilitate contact, including the British Kashmiri Medical Association.The Kashmiri diaspora is comprised by economic migrants who are usually well settled socially and economically.

Children and young people were excluded as the HADS has not been validated for use in this age group.

Data Collection

Data was collected via an anonymous online survey which included the HADS questionnaire and demographic information including age, gender, occupation and country of residence of the respondents. The participants were informed about the anonymous nature of the data collection and use of the data as per GDPR. Submitting the data via the online link was taken as consent to take part in the study. The survey was started 2 weeks after the beginning of the communication blockade in Kashmir and responses were collected over a four week period. The respondents completed the survey online via a link.

The participants were advised to seek support from their local health care providers if they felt in need of help or felt unable to cope with the stress due to the on-going situation.

Outcome Measure

The HADS was chosen for its user friendliness and practicality. It was initially used to establish cases of anxiety and depression in non-psychiatric outpatient clinics[17]. It is a self-assessment tool with its brevity, the ability to identify both anxiety and depression and its intuitive format being the main highlights. The scale has been demonstrated to have similar sensitivity and specificity as longer questionnaires like GHQ (General Health Questionnaire)[18]. Its concurrent validity is noted to be good to very good in comparison to other questionnaires like BDI (Beck Depression Inventory) and MADRS (Montgomery-Asberg Depression Rating Scale)[19].

The HADS consists of 14 questions with 7 questions for each anxiety and depression sub- scales.Each question is rated on a scale from 0 (not at all) to 3 (worst end of the spectrum).The total score on each sub scale ranges from 0-21, and the score ranges are classified as: 0-7 = Normal, 8 to 10 = Borderline abnormal (Borderline case) and 11-21 = Abnormal (case)[16].

Analysis

Data were described using summary statistics and graphs and statistical tests were performed using SPSS.

Results

A total of 465 responses were received over a period of 4 weeks. 60% of the sample was male, 35% female and 5% did not wish to disclose their gender. The age range of the sample was 19 to 73 years with a mean age of 36.85 years and standard deviation = 10.21. Majority of the sample, 93% was in paid employment, 7% of the sample did not disclose their occupation and 2% described their occupation as homemakers. Figure 1, which presents different occupations shows that the majority of the sample were in professional occupations, with 34% working as doctors, which was the biggest professional group in the sample.

The results show very high scores for both anxiety and depressive symptoms across the whole sample (Figure 2). Majority 87% of the sample scored above the cut-off for abnormal or caseness on the HADS rating scale, 10% of the sample scored in the borderline abnormal range, and just 3% of the sample scores fell in the normal range. The mean HADS score of the whole sample was 28.6 with a standard deviation of 7.39. The mean score on the HADS-A was 15.08 with a standard deviation of 4.03 and the mean score of the group on the HADS-D was 13.55 with a standard deviation of 3.97. This indicates that most of the participants were experiencing significant anxiety and depressive symptoms.

The scores on the anxiety sub-scale (HADS-A) were slightly higher than depression (HADS-D): on HADS-A 89% of the sample scored above the cut off for caseness or abnormal compared to 87% on HADS-D, 7% of the sample scored in the borderline abnormal range on HADS-A and 1% on HADS-D, and just 4% of the scores were in the normal range on HADS-A and 11% on HADS-D. The level of anxiety symptoms was slightly higher in women, who showed a mean score of 16.24 (S.D.3.42) compared to men with a mean score of 14.64 (S.D.3.79), which was astatistically significant difference($t = -1.595$; $p < 0.001$). (Figure 3) There was no statistically significant difference in depressive symptoms (men: mean 13.53, S.D. 3.61; women: mean 14.04, S.D. 4.05) based on gender ($t = -0.512$; $p = 0.171$).

Amongst the questions on the Anxiety sub-scale (HADS-A) "I get a sort of frightened feeling as if something awful is about to happen" and "I feel tense or wound up " received the highest scores among the entire sample with a mean of 2.53 and 2.42 respectively. On the depression sub-scale (HADS-D), "I feel as if I am slowed down" was the highest scored symptom with a mean of 2.15, followed by "I feel cheerful" showing a negative mean score of 2.05 (Table 1).

Since, there were only three respondents over the age of sixty-five; the differences in presentations in older age groups could not be studied. In our sample age was not associated with any statistically significant differences in depression or anxiety. (Pearson's correlation coefficient: age and HADS Anxiety ($p = 0.913$) and HADS Depression ($p = 0.775$)).

Discussion

There is a lack of research looking into the psychological effects of conflict on diaspora living away from friends and family[20]. The research among forced immigrants, whose countries of origin are war ridden, show high prevalence of mental health problems because of previous exposure to traumatic events, war and human rights abuses[21-22]. Our study sample is likely to have such experiences among those who grew up in Kashmir and later migrated. We have not been able to find any published research looking at the extent of the psychological distress to diaspora or economic migrants during times of strife in their countries of origin. The findings from our study suggest that significant anxiety and depressive symptoms can develop in people experiencing conflict in their countries of origin even among economic migrants who may be otherwise safe, and doing well economically and socially. This current situation in Kashmir is unique due to the complete blockade of communication imposed on residents including no access to internet with resultant inaccessibility to social media. There has been internet blockade internally in Burma and Egypt in the past but not to this extent[23]. Although relatively new, the use of social media platforms in everyday life cannot be underestimated and people feel cut off from their support networks when this access is denied[24]. Connecting with families by video calling is a common phenomenon in the current times and helps people to remain connected. Sudden cessation of such practices with no way of knowing the whereabouts and well being of loved ones can be devastating[25]. The added element of uncertainty of how long the difficulty will last would also appear to be a contributory factor to the distress experienced by people.

Our findings would suggest that the distress felt is huge and more research needs to be undertaken to establish the impact of this on the causation of acute mental health crisis and reduced productivity. The need for adequate support to enable this vulnerable

group of the population to function whilst being under immense stress needs to be highlighted and more done towards identifying adequate means of support including psychological help. There is need for further research on the impact on internet and phone blockage in current age which is happening more often than before.

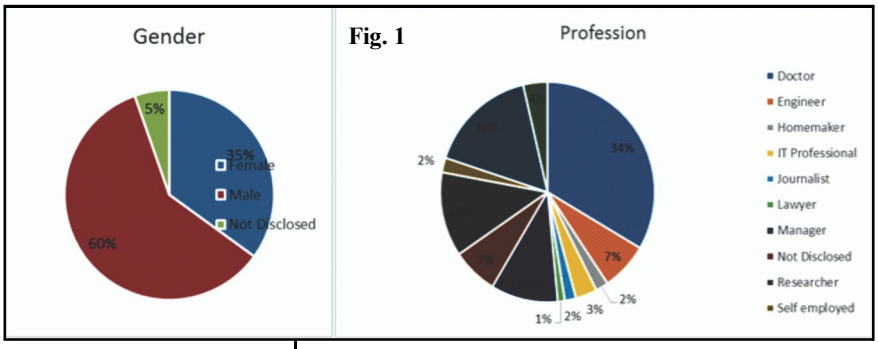

Fig. 1

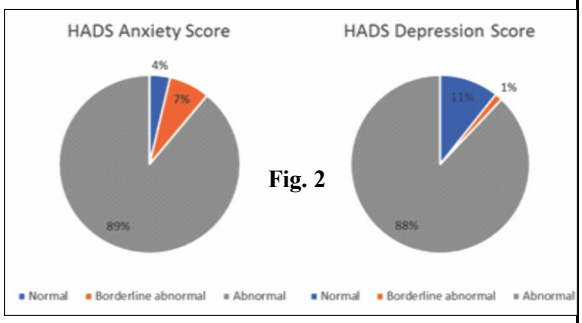

Fig. 2

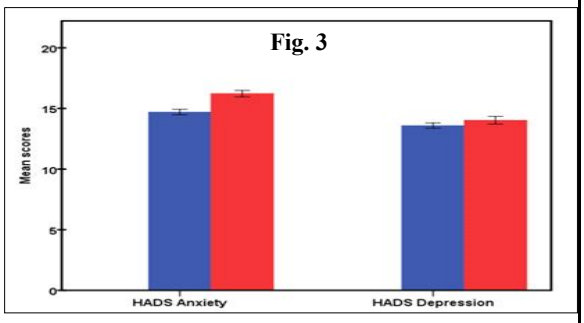

Fig. 3

HADS Anxiety/Depression	Mean	Std. Deviation
I feel tense or 'wound up'	2.4218	.74967
I get a sort of frightened feeling as if something awful is about to happen	2.5396	.71468
Worrying thoughts go through my mind	2.3448	.77445
I can sit at ease and feel relaxed	2.1991	.73607
I get a sort of frightened feeling like 'butterflies' in the stomach	1.6081	.94629
I feel restless as I have to be on the move	2.0771	.79325
I get sudden feelings of panic	1.8887	.92904
I still enjoy the things I used to enjoy	1.9850	.91451
I can laugh and see the funny side of things	1.6188	.84933
I feel cheerful	2.0578	.84843
I feel as if I am slowed down	2.1520	.83667
I have lost interest in my appearance	1.8822	.96786
I look forward with enjoyment to things	1.9251	87695
I can enjoy a good book or radio or TV program	1.9593	.94509

Limitations

Data was collected using a web based link with the sample recruited via diaspora organisations including the British Kashmiri Medical Association (BKMA). The sample is unlikely to be representative of the whole diaspora community, therefore, with a predominance of medical doctors and people in other professional occupations. This group might be expected to have lower levels of stress than others, however, and therefore the results are even more remarkable. On the other hand, online surveys may attract people who have higher levels of morbidity. HADS only indicates possible 'caseness' and does not necessarily translate into a clinical diagnosis. Nevertheless, it is widely used to assess levels of morbidity among community samples.

Conflict of interest

None

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References:

1. Margoob AM, Firdosi MM, Banal R et al. Community prevalence of trauma in south Asia: Experience from Kashmir. Jammu Kashmir Practitioner. 2006; 13(1):S14-17.
2. Margoob AM, Ahmad SA. Community prevalence of adult post traumatic stress disorder in south Asia: Experience from Kashmir. Jammu Kashmir Practitioner. 2006; 13(1):S18-25.
3. Médecins Sans Frontières (MSF), the University of

Kashmir, Institute of Mental Health and Neurosciences(IMHANS). 2016; Muntazar: Kashmir Mental Health Survey Report 2015. MSF, New Delhi, India.
4. ActionAid. Mental Health Illness in the Valley: Community-based Prevalence Study of Mental Health Issues in Kashmir, A report. 2016; Available from: https://www.actionaidindia.org/wp-content/uploads/2018/06/Mental-Health-Illness-in-the-Valley-Final-Report-Web.pdf Accessed online 24/11/2019.
5. Firdosi MM, Margoob MA. Socio-demographic profile and psychiatric comorbidity in patients with a diagnosis of Post Traumatic Stress Disorder – A study from Kashmir Valley. Acta Medica International. 2016; 3(2):97-100.
6. BBC News. Article 370: India strips disputed Kashmir of special status. BBC, August 5th, 2019. Available from: https://www.bbc.co.uk/news/world-asia-india-49231619 Accessed online 24/11/2019
7. The Lancet (editorial). Fear and uncertainty around Kashmir's future. The Lancet. 2019 Aug 17; 394:542.
8. Mahase E. Kashmir communications blackout is putting patients at risk, doctors warn. BMJ 2019; 366: l5204
9. Office of the United Nations High Commissioner for Human Rights. Report on the Situation of Human Rights in Kashmir: Developments in the Indian State of Jammu and Kashmir from June 2016 to April 2018, and General Human Rights Concerns in Azad Jammu and Kashmir and Gilgit-Baltistan. 14 June 2018. Available from: https://www.ohchr.org/Documents/Countries/IN/DevelopmentsInKashmirJune2016ToApril2018.pdf Accessed online 24/11/2019
10. Preetika Rana P and Agarwal V. India's Kashmir Clampdown Turns Hospitals Into 'Graveyards'. The Wall Street Journal. Dated 28 August 2019. Available from: https://www.wsj.com/articles/indias-kashmir-clampdown-turns-hospitals-into-graveyards-11566990962 Accessed online 24/11/2019
11. Mir A. 'Communication blackout sparks panic among Kashmiris outside J-K, states assure safety'. Hindustan Times. Dated 06 August 2019. Available from: https://www.hindustantimes.com/india-news/communication-blackout-sparks-panic-among-kashmiris-outside-j-k-states-assure-safety/story-JqS51dy8OQ1ilP6nn70LHK.html Accessed online 24/11/2019
12. Naqushbandi S. Kashmir, the Other Side of Silence: Apathy, Amnesia and Helplessness. Amnesty International India blog, 13 September 2019. Available from: https://amnesty.org.in/kashmir-the-other-side-of-silence-apathy-amnesia-and-helplessness/Accessed online 24/11/2019
13. Charlson F, van Ommeren M, Flaxman A, Cornett J, Whiteford H, Saxena S. New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis. The Lancet. 2019 Jul 20; 394(10194):240-8.
14. Cronly J, Duff AJ, Riekert KA, Perry IJ, Fitzgerald AP, Horgan A, Lehane E, Howe B, Chroinin MN, Savage E. Online versus paper-based screening for depression and anxiety in adults with cystic fibrosis in Ireland: a cross-sectional exploratory study. BMJ Open. 2018 Jan 1;8(1):e019305.
15. De Vera MA, Ratzlaff C, Doerfling P, Kopec J. Reliability and validity of an internet-based questionnaire measuring lifetime physical activity. American Journal of Epidemiology. 2010 Nov 15;172(10):1190-8.
16. Grist R, Cliffe B, Denne M, Croker A, Stallard P. An online survey of young adolescent girls' use of the internet and smartphone apps for mental health support. BJPsych Open. 2018 Jul;4(4):302-6.
17. Bjelland I, Dahl AA, Haug TT, Neckelmann D. The validity of the Hospital Anxiety and Depression Scale: an updated literature review. Journal of Psychosomatic Research. 2002 Feb 1;52(2):69-77.
18. Djukanovic I, Carlsson J, Årestedt K. Is the Hospital Anxiety and Depression Scale (HADS) a valid measure in a general population 65–80 years old? A psychometric evaluation study. Health and Quality of Life Outcomes. 2017 Dec 1;15(1):193.
19. Zigmond AS, Snaith RP. The hospital anxiety and depression scale. Acta Psychiatrica Scandinavica. 1983 Jun;67(6):361-70.
20. Stige SH, Sveaass N. Living in exile when disaster strikes at home. Torture: quarterly journal on rehabilitation of torture victims and prevention of torture. 2010;20(2):76-91.
21. Ahearn FL Jr, Noble JH Jr. Post-civil war adaptation and need in Managua, Nicaragua. Journal of Biosocial Science. 2004 Jul;36(4):401-15.
22. Jenkins JH. Culture, emotion, and PTSD. In: Marsella AJ, Friedman MJ, Gerrity ET, Scurfield RM. Ethnocultural aspects of posttraumatic stress disorder: Issues, research, and clinical applications. American Psychological Association; 1996: 165-182
23. Subramanian R. The growth of global internet censorship and circumvention: a survey. Communications of the International Information Management Association (CIIMA). 2011 Oct 31;11(2). Available from https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2032098Accessed online 24/11/2019
24. Park CS. Examination of smartphone dependence: Functionally and existentially dependent behavior on the smartphone. Computers in Human Behavior. 2019 Apr 1;93:123-8.
25. Lakshané R and Chinmayi SK. Of Sieges and Shutdowns: How unreliable mobile networks and intentional Internet shutdowns affect the lives of women in Manipur.The Bacchchao Project. 2018. Available from http://thebachchaoproject.org/of-sieges-and-shutdowns/ Accessed online 24/11/2019.