

Assessment of Anxiety and Depression among Adult Population of Kashmir, India: A Cross-sectional Study

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ABSTRACT

Introduction: Mental health in Kashmir remains a concern and is threatening to become an ever-increasing epidemic. The changing social structure and the low-intensity armed conflict have become the basis of a deteriorating state of mental health among Kashmiris. In addition to this, the other factors are widespread poverty, uncertainty, grief, oppression, fear, and high unemployment with limited employment generating sectors.

Aim: To assess the depression, anxiety, and mental distress among the adult population of Budgam district, Kashmir, India.

Materials and Methods: A cross-sectional study was conducted at the community level in Budgam district, Jammu and Kashmir, India, from December 2019 to March 2020. Total three investigators, one Senior Research Fellow (SRF) and two Junior Research Fellows (JRF) collected the data. The SRF was a Clinical Psychologist while the JRF were trained social workers. A door to door survey was conducted in the villages, which were selected randomly from the list of villages. The probability random sampling technique was used for the research purpose. Hopkins Symptom Checklist-25 (HSCL-25) was used in the study and whereby after analysing the scores of the scale,

results were derived. Chi-square and t-test were applied for statistical comparison.

Results: Out of 133 individuals, 55 were males and 78 were females. The age of the sample ranged from 18 to 45 years, with a mean age of 37 years. Total 29.32% of the adults scored above the cut-off for anxiety symptoms and 34.58% scored above the cut-off for depressive symptoms, while 39% of these adults fell above the cut-off for mental distress scores. The validated cut-off score for anxiety was 1.75 and for depression was 1.57. Feeling tense, being worried, nervousness, and low energy were reported as the symptoms of the mental distress among the people. Females, unemployed, and individuals of lower socio-economic status reported higher degree of mental distress than others.

Conclusion: Mental health issues in terms of anxiety, depression, and mental distress are found among the adult population in Budgam district. There was a significant mean difference in the mental distress levels concerning various socio-demographic variables. The study concluded that being female, having some medical condition, being unemployed, belonging to lower socio-economic status, and belonging to nuclear family predict mental health distress.

Keywords: Budgam district, Depressed individuals, Hopkins symptom checklist-25, Mental distress

INTRODUCTION

Mental disorders are widely regarded as contributing substantially to the disease load and recognised as the primary cause of Disability-Adjusted Life Years (DALYs) [1]. The World Health Organisation (WHO) recognises that mental and addictive disorders are among the most burdensome in the world and their burden is expected to increase over the next decade [2]. Anxiety and depressive disorders are frequently co-occurring conditions and are considered highly prevalent and burdensome worldwide [3]. Experts report that these conditions continue to remain largely untreated in Low and Middle-Income Countries (LMICs) because of resource-related barriers, especially in rural areas [4].

Armed conflict and violence, in particular, damage social support mechanisms and expose civilian populations to high levels of stress [5]. A positive relationship has been found between conflict and depression and anxiety disorders; 15-20% of those exposed to the conflict situation develop mild to moderate disorders like anxiety and depression [6]. Mental or psychological well-being is influenced not just by individual features or attributes, but also by socio-economic circumstances and the environment in which people live [7]. Therefore, mental health assessment and socio-demographic information is of paramount importance to devise and design context-specific intervention strategies for the affected population. Kashmir is going through public mental health challenges due to the long-term low-intensity conflict. The long-term conflict increases the incidence and prevalence of mental disorders and

reduces access to care [8-10]. Several research studies have been previously conducted in the Kashmir valley, examining the impact of the conflict on the mental health of the population. The study conducted across two districts in Kashmir reported that 33% of their sample experienced mental distress, with one-third reported having suicidal ideation [11].

Kashmir has a history of protracted political conflict, which has led to challenges in life and property and posed an immense threat to the mental well-being of the population living in the area. There are only a few studies conducted on mental health so far in Kashmir [6]. It is essential and critical to develop a knowledge base that is adequate and relevant for addressing the psychological impact of conflict on mental health. Depression and anxiety disorders are recognised as major public health problems with considerable personal, economic and social burden on those afflicted and their families [12]. In one of the studies on mental distress across 10 districts of Kashmir conducted by Medecins Sans Frontieres (MSF) in 2015 has revealed that Budgam district has the second-highest prevalence of mental distress among all 10 districts of Kashmir [13]. Furthermore, depression is far more common in rural areas (84.73%) than in urban areas (15.26%), with Budgam being a predominantly rural district. In terms of the prevalence of anxiety and depression, the proportion of the population in Budgam suffering from symptoms of probable depression in 2015 was 54%, representing 210,000 adults [13].

Thus, the research study will offer distinctive information about the mental health issues of the population in this region and further

influence the mental health policies applicable to them. Furthermore, it is anticipated that this research would add to the existing literature and validate facts in this field. Keeping the above facts in view, the investigators felt the need to conduct research on mental distress in Budgam. Hence, the present study was formulated to assess anxiety and depression symptoms and mental distress among adults of Budgam district, Jammu and Kashmir, India. The areas were selected for the study due to the significant prevalence of mental health issues as discussed above. Importantly, not many studies have been conducted at the community level on mental stress, especially in this part of the region.

MATERIALS AND METHODS

A cross-sectional study was conducted at the community level in Budgam district, Jammu and Kashmir, India, from December 2019 to March 2020. Total three Investigators, one Senior Research Fellow (SRF) and two Junior Research Fellows (JRF) collected the data. A sample of 133 individuals was taken from five villages of Budgam district. The area corresponds to economically disadvantaged areas with a low economic index also, due to the high level of prevalence of mental health. The villages where the study was conducted were Mahwara, Rezwan, Pallar, Soibugh and Bonpora. The respondents were provided assurances of confidentiality to increase their motivation and eliminate prejudice. Informed consent was obtained from all the participants prior to the study. The study was approved by the Ethical Committee of the Institution (vide No. MH/KU2019/ABW).

Sample size calculation: On the basis of the pilot study, prevalence was found to be 11% in the selected villages. Accordingly, the sample size was calculated to be 150 [14]. Out of which 17 respondents did not participate in the study. Therefore the sample of 133 was taken for the study.

Inclusion and Exclusion criteria: Individuals above 18 years of age, hailing from Budgam district and willing to participate were included in the study. Subjects with severe psychiatric illness and who were above the age of 45 were excluded from the study.

Procedure

A door-to-door household survey was conducted in the five villages, which were selected purposively. A non probability stratified random sampling technique was applied in the study. The subjects were approached personally in their own house by two JRFs and a Clinical Psychologist and interviewed using a questionnaire booklet consisting of a Comprehensive Socio-economic Questionnaire (CSEQ) and Hopkins Symptom Checklist-25 (HSCL-25) [15]. The questionnaire was orally dictated to the participants in the local language (Kashmiri) so that they could understand easily. The validity and reliability of the tool has been tested in 2015 by MSF with the Cronbach's alpha=0.92 [16].

Socio-demographic status: In order to determine the socio-demographic profile of the participants a separate socio-demographic sheet was prepared by the research team considering the sex, type of house, type of family, marital status, education level, occupation, socio-economic status, and medical condition of the participants.

- Lower socio-economic subjects constituted those who belonged to the Below Poverty Line (BPL) or Antyodaya Anna Yojana (AAY) category as per ration card.
- Upper socio-economic status were those who belong to Above Poverty Line (APL) category as per ration card.

Hopkins Symptom Checklist-25 (HSCL-25): Hopkins Symptom Checklist-25 (HSCL-25) was developed by Parloff, Kelman, and Frank at Johns Hopkins University in the 1950s [15,16]. MSF culturally adapted and validated it for the Kashmiri population, and the same was used with prior permission from the author [16]. The Hopkins Symptom Checklist-25 (HSCL-25) is made up of 10 items designed to assess symptoms of anxiety and 15 items assessing symptoms of depression in the preceding four weeks. Rating

is based on a four-point Likert scale with categories of response being: "never or no", "sometimes", "often", or "always".

Three scores are calculated from the responses:

- **Depression score:** Average of the 15 depression items
- **Anxiety score:** Average of the 10 anxiety items
- **Total mental distress score:** Average of all 25 items

The validated cut-off score for anxiety is 1.75 and for depression is 1.57 [15]. The scale has been used in other parts of the world and has been considered as a most accurate and valid tool. The score of each item is added and then divided by the total items in the scale, which provides the score of total mental distress. Similarly for anxiety, 1-10 items score is added and divided by the total items and for the depression 11-25 score is added and divided by the total items. Further the various socio-demographic factors such as native residents, gender, family type, marital status, education, and occupation were also recorded.

STATISTICAL ANALYSIS

The data were analysed with the use of relevant statistical methods. After the collection of data, it was entered in the Statistical Package for the Social Sciences (SPSS) version 19.0. Descriptive statistics, frequency, and percentage were calculated and subsequently analysed. In addition, Chi-square test was also used for categorical variables. The t-test was employed to determine the differences between the groups. The p-value <0.05 was considered as statistically significant.

RESULTS

Out of 133 individuals, 55 were males and 78 were females. The age of the sample ranged from 18 to 45 years, with a mean age of 37 years. The details of the socio-demographic dimensions of the participants are mentioned in [Table/Fig-1]. Most of the participants lived in pukka type of house and were equally living in nuclear and joint families. Majority of them were married. Total 49% of the participants were illiterate, with female mostly as housewives and male engaged in skilled work, and some of them had shops or associated with clerical work.

Variable	Category	Frequency	Percentage
Gender	Male	55	41%
	Female	78	59%
Type of house	Pukka	88	66%
	Semi-pukka	43	32%
	Kachha	2	2%
Family type	Joint	67	50%
	Nuclear	66	50%
Marital status	Single	34	26%
	Married	99	74%
Education	Illiterate	65	49%
	Primary school	9	7%
	Middle school	10	7%
	High school	19	14%
	Higher Secondary/Intermediate	13	10%
	Graduate/Bachelors	13	10%
	Postgraduate/Masters	4	3%
Occupation	Unemployed	24	18%
	Unskilled workers	8	6%
	Skilled workers	41	31%
	Clerical/Shop owner/Farmer	12	9%
	Semi-professional	7	5%
	Housewife	38	29%
	Retired	3	2%

[Table/Fig-1]: Socio-demographic details of study participants.

The validated cut-off score for anxiety was 1.75 and for depression was 1.57. Total 29.32% of the adults scored above the cut-off for anxiety symptoms and 34.58% scored above the cut-off for depressive symptoms while 39% of these adults fell above the cut-off for total distress scores [Table/Fig-2]. The anxiety symptoms, depression and mental distress were calculated based on the score assigned and the average of the same was derived. Thus, the below table confirms that mental health issues in terms of anxiety, depression, and mental distress are found among the adult population in Budgam district.

Variable	Frequency	Percentage
Anxiety symptoms	39	29.32%
Depression symptoms	46	34.58%
Mental distress	52	39%

[Table/Fig-2]: Frequency distribution of anxiety symptoms, depression symptoms, and mental distress among adults of Budgam.

In [Table/Fig-3], when combined (sometimes, often, and always) the major response in the emotional dimension reported was "feeling tense and sadness". In the cognitive dimension the major symptom of the mental distress reported was "worry". Similarly, in the behaviour dimension it was the "nervousness" and in the physical dimension it was the "low energy". The table also provides an overview of the other symptoms of mental distress as reported by the participants.

Symptom	Emotional dimension			
	Level			
	No/Never (n, %)	Sometimes (n, %)	Often (n, %)	Always (n, %)
Feeling scared	84 (63%)	32 (24%)	9 (7%)	8 (6%)
Feeling fearful	88 (66%)	35 (26%)	9 (7%)	1 (1%)
Feeling tense	73 (55%)	46 (35%)	11 (8%)	3 (2%)
Terror or panic	95 (71%)	25 (19%)	11 (8%)	2 (2%)
Crying	82 (62%)	39 (29%)	11 (8%)	1 (2%)
Sadness	62 (47%)	53 (40%)	14 (10%)	4 (3%)
Cognitive dimension				
Self blame	94 (74%)	28 (21%)	9 (7%)	2 (1%)
Hopelessness	91 (68%)	32 (24%)	6 (5%)	4 (03%)
Suicidal ideation	115 (87%)	15 (11%)	3 (2%)	0
Feeling of not being free	73 (55%)	48 (36%)	10 (8%)	2 (1%)
Worry	62 (47%)	44 (33%)	23 (17%)	4 (3%)
Inferiority feeling	87 (65%)	32 (24%)	13 (10%)	1 (1%)
Behavioural dimension				
Nervousness	75 (56%)	40 (30%)	13 (10%)	5 (4%)
Restlessness	77 (58%)	41 (31%)	12 (9%)	3 (2%)
Feeling lonely	88 (66%)	34 (26%)	10 (7%)	1 (1%)
Lack of interest in things	75 (56%)	48 (36%)	06 (5%)	04 (3%)
Everything is difficult	91 (68%)	32 (24%)	8 (6%)	2 (1.50%)
Physical dimension				
Fainting	74 (56%)	45 (34%)	11 (8%)	3 (2%)
Heart pounding/Palpitations	63 (47%)	54 (41%)	11 (8%)	5 (4%)
Trembling	85 (64%)	37 (28%)	10 (7%)	1 (1%)
Headache	49 (37%)	52 (39%)	24 (18%)	8 (6%)
Loss of sexual interest	117 (88%)	11 (8%)	04 (3%)	1 (1%)
Low energy	46 (35%)	53 (40%)	28 (21%)	6 (4%)
Sleeping difficulty	79 (59%)	28 (21%)	16 (12%)	10 (8%)
Poor appetite	99 (75%)	20 (15%)	11 (8%)	3 (2%)

[Table/Fig-3]: Frequency distribution of dimension-wise symptoms of mental distress.

[Table/Fig-4] illustrates comparison of anxiety, depression, and total mental distress between different demographic variables. It showed that male and female adults significantly differ on anxiety, depression, and total mental distress levels. This further showed that mental

distress is more prevalent in females than males. The healthy adults and adults with some medical conditions differ significantly on anxiety, depression, and total mental distress levels. There was no significant differences on these mental distress variables with respect to marital status; however, education level of the subjects showed significant results in anxiety symptoms, depression symptoms and mental distress.

Variable	Group	n	Mean	Standard deviation	df	t-value	p-value
Gender							
Anxiety symptoms	Male	55	13.13	3.93	131	4.867	0.001*
	Female	78	17.63	6.01			
Depression symptoms	Male	55	19.82	5.34	131	3.787	0.001*
	Female	78	24.37	7.71			
Total mental distress	Male	55	32.89	8.86	131	4.449	0.001*
	Female	78	41.77	12.78			
Co-morbid conditions							
Anxiety symptoms	Healthy	68	13.76	3.95	131	4.438	0.001*
	Medical condition	65	17.86	6.45			
Depression symptoms	Healthy	68	20.147	5.57517	131	4.076	0.001*
	Medical condition	65	24.9385	7.83996			
Total mental distress	Healthy	68	33.87	9.04	131	4.396	0.001*
	Medical condition	65	42.52	13.35			
Marital status							
Anxiety symptoms	Unmarried	34	15.06	4.49	131	0.841	0.2
	Married	99	16.01	6.04			
Depression symptoms	Unmarried	34	22.38	6.08	131	0.100	0.46
	Married	99	22.52	7.53			
Total mental distress	Unmarried	34	37.44	9.88	131	0.365	0.357
	Married	99	38.3232	12.82761			
Education status							
Anxiety symptoms	Uneducated	84	16.4881	6.09462	131	1.935	0.027*
	Educated	49	14.5306	4.71302			
Depression symptoms	Uneducated	84	23.3214	7.80818	131	1.769	0.039*
	Educated	49	21.0612	5.70237			
Total mental distress	Uneducated	84	39.5595	13.11152	131	1.839	0.034*
	Educated	49	35.5918	9.80204			

[Table/Fig-4]: Comparison of mean scores of anxiety, depression and total mental distress between male and female adults, medical condition, marital status and education.

Some Medical Conditions: Hypertension, Osteoarthritis, Chest congestion, Polycystic ovary syndrome; * $p < 0.05$ was considered as statistically significant; t-test used

[Table/Fig-5] shows an overview of t-values of anxiety, depression, and total mental distress, concerning the employment of adults. It was reported that employed and unemployed adults do significantly differ on anxiety and total mental distress levels. However, both groups significantly differ on depression symptoms; unemployed being more depressed. There was significant difference in the anxiety, depression, and total mental distress of adults belonging to upper and lower socio-economic status ($p = 0.014$; $p < 0.001$; $p < 0.001$, respectively). Adults belonging to joint and nuclear families significantly differed on anxiety ($p = 0.04$) and total mental distress levels ($p = 0.02$). Also, both groups significantly differed on depression symptoms; nuclear being more depressed ($p = 0.01$).

DISCUSSION

In 2015, a survey on mental health revealed that 37% of adult males and 50% of females were suffering from probable depression; 21% males and 36% females from probable anxiety related disorder and 18% males and 22% females from Post Traumatic Stress Disorder (PTSD) [13]. The purpose of this study was to look at the

Variable	Group	n	Mean	Standard deviation	df	t-value	p-value
Educational status							
Anxiety symptoms	Unemployed	24	17.46	5.77	131	1.620	0.05*
	Employed	109	15.39	5.63			
Depression symptoms	Unemployed	24	25.42	7.75	131	2.245	0.01*
	Employed	109	21.84	6.90			
Total mental distress	Unemployed	24	42.12	11.92	131	1.815	0.03*
	Employed	109	37.21	12.028			
Socio-economic status							
Anxiety symptoms	Upper socio-economic status	31	13.80	4.37	131	2.47	0.014*
	Lower socio-economic status	102	16.384	5.92			
Depression symptoms	Upper socio-economic status	31	19.00	4.82	131	3.169	<0.001
	Lower socio-economic status	102	23.57	7.44			
Total mental distress	Upper socio-economic status	31	32.80	8.38	131	2.829	<0.001
	Lower socio-economic status	102	39.74	12.64			
Type of family							
Anxiety symptoms	Joint	67	14.95	5.31	131	1.670	0.04*
	Nuclear	66	16.59	5.97			
Depression symptoms	Joint	67	21.22	6.69	131	2.076	0.01*
	Nuclear	66	23.77	7.45			
Total mental distress	Joint	67	36.13	11.44671	131	1.902	0.02*
	Nuclear	66	40.09	12.53			

[Table/Fig-5]: Comparison of mean scores of anxiety, depression and total mental distress in terms of employment, socio-economic status and family type. Some Medical Conditions: Hypertension, Osteoarthritis, Chest congestion, Polycystic ovary syndrome; *p<0.05 was considered as statistically significant; t-test used

levels of anxiety, depression, and mental distress among people in Budgam district. Following the analysis and interpretation of the data, it was discovered that about 29.32% of participants had anxiety symptoms, 34.58% had depressive symptoms, and 39% of these people had significant distress levels. This could largely be attributed to conflict situation in the region from the past many years. Additionally, the unemployment and lack of basic facilities in the area could have contributed to the mental distress. These research findings correspond with previous work done in the same area [8,10,12].

A significant difference was found among anxiety, depression, and distress levels of male and female adults. Females were found to have more anxiety, depression, and distress than male adults. The reason for such findings are due to the lack of opportunities to vent out their feelings, domestic responsibilities, and lack of exposure. These research findings are substantiated by the findings of the Iraq mental health survey [17]. In another study regarding depression and anxiety among Kashmiri women, it was stated that the prevalence of mental distress is more prevalent in females than males [18]. Also these findings are in accordance with a study, which revealed that the prevalence of depression is more in females as compared to males [19]. Also, it was revealed in the results of the present study that there is no difference in the mental distress levels of married and unmarried adults. These findings differ from the earlier findings of a study in which it was reported that in the context of conflict, married people experience more mental distress than unmarried people [20]. The results further revealed that employed and unemployed adults

significantly differ in anxiety, depression and total mental distress levels. Unemployed adults showed more depression and anxiety than employed adults. These findings are in line with a previous study, which reported that unemployed youth are at a higher risk of developing depression [20].

The overview of the results further revealed that these adults significantly differ with regard to their physical health status. The adults with some medical conditions like women with Polycystic Ovary Syndrome (PCOS), osteoarthritis, and hypertension were found to have significantly more anxiety, depression, and mental distress than healthy adults. These findings align with the earlier findings of a study conducted in 2006 [21].

The results also revealed that educated and uneducated adults differed significantly on anxiety, depression, and total mental distress levels. The findings of the present study further revealed that there was a significant difference in these variables between adults belonging to upper and lower socio-economic status. The adults from lower socio-economic status had more mental distress than those adults who belonged to the higher socio-economic status. The WHO, in 2012 also reported a similar association between mental wellbeing and socio-economic circumstances in which persons find themselves and the broader environment in which they live [22]. However, it was found that the adults who belonged to a nuclear family had more depression symptoms than those who were from joint families. In another study, which aimed to measure mental health outcomes in 390 probability sampled urban households in four administrative regions of Srinagar, 58% of households had experienced verbal violence and 32% experienced physical violence related to the conflict. The authors further reported that 46% of the sample reported anxiety and 32%, depression [11].

The outcomes of this study paint a gloomy picture of mental health in Budgam area as 29.32% of these adults scored above the cut-off for anxiety symptoms and 34.58% scored above the cut-off for depressive symptoms, and 39% of these adults fell above the cut-off level for mental distress scores. These results suggest the need for local psycho-social intervention to improve the mental health status of residents in this community.

Based on the findings of the study, there is a need for spreading awareness about mental health at the community level. The community level health workers can be trained to identify the individuals with symptoms of mental distress and can make referrals. Normally, women do not report to the hospitals due to social stigma as such. Special programmes have to be designed specifically for the women who reported depression and anxiety. Effective implementation of the District Mental Health Programme (DMHP) should be done to address the mental health problems at the community level.

Limitation(s)

The study had some limitations that suggest the need for caution in interpreting results. The probability sampling and sample size of 133 individuals limited the generalisability of the results. Hence, the replication of the study with a large sample size may make the study generalisable. Also, the study is based on self-report measures with no structured psychiatric diagnosis. However, due to social stigma related to mental distress, individuals may under-report symptoms or not agree to participate if they experience mental symptoms, making it possible that rates of mental distress are even higher than reported in the study.

CONCLUSION(S)

The findings of the present study revealed that anxiety, depression, and mental distress are present in the population of Budgam, Kashmir. There was a significant mean difference in the mental distress levels concerning various socio-demographic variables. Moreover, the

findings of the present study indicate that being a female, having some medical condition, being unemployed, belonging to lower socio-economic status, or belonging to a nuclear family predicted mental health distress. These findings of the present study have significant benefits for clinical practice, policymakers and future research.

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