Psychological impact of terrorism in Jammu & Kashmir

An overarching definition of mental health is the cognitive, emotional and behavioural well-being of an individual (Felman, 2020). Thus, mental health often refers to the absence of mental illness or disorder. Additionally, good mental health manifests itself as the versatility and flexibility to respond to various type of events with a sense of purpose and ability to feel in harmony with the surrounding social milieu (Hassan and Shafi, 2013). It is the capacity to adequately cope with the inevitable stresses of everyday life, use one's emotional and cognitive capabilities to overcome such demands and live a free and satisfactory life (Wani, 2014). Yet, what happens if a whole nation is collectively deprived from the possibility to have a full-fledged life and achieve psychological equilibrium and resilience due to ongoing armed insurgency, inter-state conflict and terrorism? This article will address this question in the context of the region of Indian-administered Jammu & Kashmir. While recognizing similar, if not even more acute developments of mental health problems on the territory of Pakistan-administered Jammu & Kashmir, due to the absence of available research and medical records, unfortunately this study shall be restricted only to the former area.

The Paper will first start with a brief introduction to the historical and legal background of the Jammu & Kashmir conflict. Then, it will highlight the nexus between violent conflict, war and mental illness, while providing definitions of the common mental conditions incurred. The paper will subsequently examine the existing literature on previously carried out studies in the region of Jammu & Kashmir and it will compare that analysis with the results of EFSAS' self-conducted research in the area. As a result, the article will attempt building future trajectories of the phenomenon of mental health issues and on the basis of that provide recommendations for its effective and adequate resolution.

Historical Background

The Jammu & Kashmir conflict is a territorial conflict between India, Pakistan, and to a limited degree, China. It is also a conflict that impacts the future of around 20 million people of the State of Jammu & Kashmir. The Kashmir conflict arises from the Partition of British India in 1947 into modern India and Pakistan. Both countries subsequently made claims to Jammu & Kashmir, based on the history and religious affiliations of the Kashmiri people.

The princely State of Jammu & Kashmir, which lies strategically in the north-west of the subcontinent bordering Afghanistan and China, was formerly ruled by Maharaja Hari Singh under the paramountcy of British India. In geographical and legal terms, the Maharaja could have joined either of the two new countries or remained Independent. Despite being urged by the British Viceroy, Lord Mountbatten of Burma, to determine the future of his State before the transfer of power took place, Maharaja Hari Singh demurred.

In October 1947, incursions by Pakistan took place. Faced with internal revolt as well an external invasion, Maharaja Hari Singh requested the assistance of the Indian armed forces and agreed to accede to India. He handed over control of his defence, communications and foreign affairs to the Indian government. In this milieu, war erupted between Pakistan and India, as a result of which the state of Jammu & Kashmir remains divided between the two neighbors.

The erstwhile princely State of Jammu & Kashmir consists of five regions, namely Jammu, the Kashmir Valley, Ladakh, Pakistan Administered Kashmir (Azad Kashmir) and Gilgit Baltistan. India administers approximately 43% of the region. It controls Jammu, the Kashmir Valley, Ladakh, and the Siachen Glacier. Pakistan administers approximately 37% of Kashmir, namely 'Azad Kashmir' and Gilgit Baltistan. China currently occupies Demchok district, the Shaksgam Valley, and the Aksai Chin region.

India sought resolution of the issue at the United Nations Security Council (UNSC). Following the set-up of the UN Commission for India and Pakistan (UNCIP), the UN Security Council passed Resolution 47 on 21 April 1948. The measure called for an immediate cease-fire and the first point of the Resolution called on the government of Pakistan 'to secure the withdrawal from the state of Jammu and Kashmir of tribesmen and Pakistani nationals not normally resident therein who have entered the state for the purpose of fighting'. It further asked the government of India to reduce its forces to minimum strength (after the withdrawal of Pakistani forces as stipulated in the first clause of the Resolution), following which the circumstances for holding a plebiscite should be put into effect 'on the question of the future status of State of Jammu and Kashmir'. Since then, the government of Pakistan has failed to fulfill its legal and international obligations under the said UN resolutions. This led to a situation wherein the UN Resolutions could not be implemented.

The conflict was exacerbated by the onset of terrorism in the Kashmir Valley in the late eighties, widely believed to be initiated and sponsored by Pakistan. In the wake of the terrorism, the concepts of *jihad* and Islamism emerged into the Kashmiri society, mostly expressing themselves in the outbreak of communal violence. The Kashmiri Pandits, an elite group among Hindus, became particular targets of the terrorists, thus resulting in their massive exodus in 1989-1990.

Since then, the Jammu & Kashmir conflict has remained a reason for hostility, political instability, extremism and economic malaise in the region.

On 5 August 2019, the Indian Government abrogated the special status, or limited autonomy, granted under Article 370 of the Indian Constitution to Jammu and Kashmir. The lockdown imposed following this decision created resentment among some sections of the local population, especially in the Kashmir Valley.

Conflict, War & Mental Illness

As argued by Ul Hassan, Sekar and Raj (2017), armed conflicts have a serious impact upon social determinants of mental health and well-being such as family relations, community

networks, access to healthcare, education, housing, water and sanitation. The presence of armed conflict has a harmful effect on the mental health of people by destroying the social fabric of the society and affecting people's livelihoods, often leading to unemployment and poverty (Dar and Deb, 2020). Such disasters trigger numerous losses including: *"disruption to daily routines and a sense of personal safety; damage to or destruction of homes; death or injury to family members (including parents, grandparents and siblings); loss of family income-generating activities; and closure of schools and community resources, and this may therefore arouse other psychological reactions, including grief and complicated bereavement"* (Schizoph, 2011, p. 57). As a result, individuals need to adjust to highly anxiety-triggering situations (ibid). In children and adolescents this has particularly damaging effect since it takes place within a developmental context and thus potentially disrupts the normal developmental course of the individual, later on affecting his/hers adult functioning (ibid). Thus, mistrust in others and lack of confidence in being able to exert agency in one's life could become long-lasting implications (ibid).

As defined by the American Psychiatric Association (2018), mental illness is a health condition that causes changes in emotions, thoughts, or behavior (or a combination of these). Distress and/or difficulty functioning in social milieus, employment places, or family activities are common symptoms of mental illnesses (ibid).

Some of the most commonly exhibited mental illnesses in the context of conflict are the following:

Post-traumatic stress disorder (PTSD) – a disorder that develops in some people who have experienced a shocking, traumatizing, dreadful or dangerous event (NIMH, 2019). As explained by the National Institute of Mental Health (2019, n.p.), for an individual be diagnosed with PTSD, an adult must have all of the following for at least 1 month:

- At least one re-experiencing symptom
- At least one avoidance symptom
- At least two arousal and reactivity symptoms
- At least two cognition and mood symptoms

Re-experiencing symptoms include:

- Flashbacks—reliving the trauma over and over, including physical symptoms like a racing heart or sweating
- Bad dreams
- Frightening thoughts

Avoidance symptoms include:

- Staying away from places, events, or objects that are reminders of the traumatic experience
- Avoiding thoughts or feelings related to the traumatic event

Arousal and reactivity symptoms include:

- Being easily startled
- Feeling tense or “on edge”
- Having difficulty sleeping
- Having angry outbursts

Cognition and mood symptoms include:

- Trouble remembering key features of the traumatic event
- Negative thoughts about oneself or the world
- Distorted feelings like guilt or blame
- Loss of interest in enjoyable activities

While it is normal to exhibit some of the abovementioned symptoms for a few weeks after a traumatic event, when these symptoms last more than a month, one’s ability to function is largely affected, thus could be classified as PTSD (ibid). In addition, PTSD could occur even weeks and months after an event (ibid). Oftentimes, PTSD is accompanied by anxiety disorders, substance abuse or/and depression (ibid).

Anxiety Disorders – while occasional anxiety is normal part of life, anxiety disorders are related to more protracted period of time, throughout which one’s condition could even deteriorate (ibid). As explained by the National Institute of Mental Health (2019, n.p.), there are several types of anxiety disorders including generalized anxiety disorder, panic disorder, and various phobia-related disorders.

Individuals with generalized anxiety disorder exhibit excessive anxiety or worry, most days for at least 6 months, related to their personal health, work, social interactions, and everyday routine life circumstances (ibid).

Generalized anxiety disorder symptoms include:

- Feeling restless, wound-up, or on-edge
- Being easily fatigued
- Having difficulty concentrating; mind going blank
- Being irritable
- Having muscle tension
- Difficulty controlling feelings of worry
- Having sleep problems, such as difficulty falling or staying asleep, restlessness, or unsatisfying sleep

People with **Panic Disorder** experience recurrent sudden panic attacks – short period of time marked with feelings of intense fear – which further brings about heart palpitations, sweating, trembling or shaking, shortness of breath, feelings of impending doom or feelings of being out of control (ibid).

Depression (Major Depressive Disorder or Clinical Depression), as per the NIMH (2018, n.p.) is a common but serious mental disorder, which could have severe effects that impair one's ability to cope with daily tasks. In order to be identified as such, the symptoms should be persistent for at least two weeks (ibid). Symptoms could include the following:

- Persistent sad, anxious, or "empty" mood
- Feelings of hopelessness, or pessimism
- Irritability
- Feelings of guilt, worthlessness, or helplessness
- Loss of interest or pleasure in hobbies and activities
- Decreased energy or fatigue
- Moving or talking more slowly
- Feeling restless or having trouble sitting still
- Difficulty concentrating, remembering, or making decisions
- Difficulty sleeping, early-morning awakening, or oversleeping
- Appetite and/or weight changes
- Thoughts of death or suicide, or suicide attempts
- Aches or pains, headaches, cramps, or digestive problems without a clear physical cause and/or that do not ease even with treatment

Conversion Disorder (Functional Neurologic Disorders) – the featuring of neurological symptoms, which cannot be explained by any existing conditions on the nervous system or other medical diagnosis (DSM-V, 2013). Such symptoms could be paralysis, seizures, sensory loss e.g. blindness or hearing loss, speech impediments, etc. (ibid).

The Jammu & Kashmir Context

Usually individuals are unlikely to be exposed to traumatic stressors at any given time (Rizvi and Jamal, 2017). However in the case of Jammu & Kashmir, as per the extensive Kashmir Mental Health Survey Report conducted by Médecins Sans Frontières (2016), on average, an adult in Kashmir has witnessed 7.7 traumatic events in the course of her/his life. The reported traumatic experiences included terrorist attacks, explosions, assault with a weapon, crackdowns/raids, kidnappings, imprisonment, interrogation, torture, enforced disappearances, violent death of someone known, sexual assault and physical assault (ibid).

In addition to that, apart from the direct victims of these traumatic events, emergency service workers such as medical personnel and fire fighters are also repeatedly exposed to traumatic stressors, such as accidents, killings, bomb blasts, grenade attacks, mine blasts and suicide squads (Rizvi and Jamal, 2017).

Khan (2015) further illustrates how, as an inevitable counter-terrorism measure, the prevalence of security personnel results in the militarization of society. As a result, society develops feelings of intimidation, which ultimately undermines normal interaction and community life. That coupled with the high youth unemployment rates, the fractured and uncertain economy and the breakdown of social-support systems (MSF, 2016) gives rise to stressors which negatively impact the livelihood and wellbeing of the population.

Therefore, it does not come as a surprise that large sections of the Kashmiri society began to suffer from various mental illnesses and disorders. As explained by Hassan and Shafi (2013, p. 104), from a mental health point of view, communities affected by conflict could be split up in three groups:

- those experiencing disabling psychiatric illnesses;
- those with severe reactions to trauma;
- those who are able to adapt once peace and order is restored.

While under normal circumstances only 1-3% of the general population experiences any type of psychiatric disorder (ibid), in the case of Jammu & Kashmir, as per the 2015 Survey of MSF, nearly 1.8 million adults in the Kashmir Valley are suffering from symptoms of mental health distress, with 41% exhibiting signs of depression, 26% signs of anxiety and 19% signs of Post-Traumatic Stress Disorder (PTSD), with residents from the districts of Baramulla and Budgam exhibiting the highest rates for all three. These districts are also considered hotbeds of terrorism and it was recorded that the number of people attending psychiatric hospitals rose from 1,700 in 1989 to 100,000 in 2017 (Bhat and Khan, 2018). Given the social stigma attached to frequenting mental health institutions in Kashmir, not only is this number alarming, but very likely also higher in reality due to underreporting. As argued by Hassan and Shafi (2013), doctors in the region estimate that no more than 10% of the population who are in need of psychiatric help actually visits the designated institutions. Not only due to stigma, but also due to lack of knowledge individuals shy away from treatment (ibid).

As per a study, conducted by Bhat and Rangaiah (2015), among 797 college students, nearly half (49.81%) were found to be on the diagnosable range of PTSD. In a similar study, Dar and Deb (2021), documented that among 680 undergraduate and post-graduate students, 95.4 % experienced psychological distress, 60.3% mentioned physical sickness, and 91.2% found others' mental health being affected. Amongst a sample of 200 residents of Srinagar, Hassan and Shafi (2013) discovered that 90.5% of the respondents had become fearful, 87% were having sleeping disorders, 86% were experiencing stress, depression and psychological stress, 66% had lost interest in their life, 59.5% were feeling the re-experience of the incidence, 31.5% experienced nightmares, 38.5% had become aggressive in behavior while 27% were vulnerable to suicide.

The 90.5% of respondents who became fearful expressed having anxiety and disquiet of not knowing whether they will be able to return home alive, or having an incident repeat to them or to their families (ibid). The 87% of participants who experienced sleeping disorders argued they have trouble sleeping due to re-living episodes of the incident and being afraid of getting victimized again (ibid). The 86% of respondents who suffered from psychological stress and depression explained how they found themselves in a state of mental agony and avoided social contacts due to the experienced death of loved ones (ibid). 66% argued they have lost interest in life given since they felt surrounded by death and destruction everywhere (ibid). Those 38.5% who have become aggressive argued that as a result of the incidence they have lost their self-restraint and become less stable (ibid). Alarmingly, 27% of respondents were contemplating suicide, as a means of escaping their lives which they saw not worth living any more (ibid).

The last observation is further corroborated by other surveys. As argued by Bhat and Khan (2018), the decline of mental well-being among the Kashmiri population has prompted an increase of suicide rates and substance abuse cases. De Jong, van de Kam, Ford, Lokuge, Fromm, van Galen, Reilley and Kleber (2008) conducted a study with 510 individuals in the Kashmir Valley, 33.3% of which reported contemplating suicide in the past 30 days. And indeed, it has been documented that the number of suicide attempts have increased by 250% between 1994 and 2012 (Shoib, Dar, Bashir, Qayoom and Arif, 2012). It is believed that this rise of cases in comparison to the pre-terrorism times is owing to defective coping strategies caused by the excessive external stresses (ibid). In their research amongst 201 patients admitted to the hospital after attempting suicide, Shoib et al. (2012) found that 52.7% of the sample were young people of 15-25 age, with female patients (54.7%) slightly outnumbering males (45.27%). Majority of patients were married and came from rural areas and low socio-economic background (ibid). The most preferred means of suicide was through poison (82%) (ibid). While the majority of patients had no history of self-harm (93%), some suffered from psychiatric illnesses such as depression (21.9%), adjustment disorder (9.95%) and anxiety disorders (6.46%) (ibid). As explained by Shoib et al. (2012), the high levels of comorbidity in the sample could be attributed to the high levels of violence confronted by the Kashmiri population. Other studies focusing on suicide further found that suicides amongst newly married men were also on the rise due to impotency, which doctors attribute to mental trauma from shock (Hassan and Shafi, 2013). Medical experts have discussed how ongoing terrorism has triggered depression and stress, which have occasionally translated into psycho-sexual malfunction (ibid).

The prevalence of psychiatric disorders among orphans in the region is particularly acute and alarming (Margoob, Rather, Khan, Singh, Malik, Firdosi and Ahmad, 2006). According to the authors' study that was based on an all-female orphanage, amongst the sample of 76 girls in the age group of 5-12 years, 32 children (42.10%) exhibited psychiatric morbidity (ibid). Amongst those, the most commonly exhibited psychiatric disorders were PTSD (40,62%), Major Depressive Disorder (25%), Conversion Disorder (12,5%) and Panic Disorder (9,38%). Children living under institutional care are particularly vulnerable to mental health problems, which could further deteriorate with time, and impair their long-term ability to complete their education, find employment, establish social connections and parent their own children

(ibid). As exhibited by Margoob et al. (2006) the ongoing Kashmir conflict, due to which children have lost their parents, has had a large impact on the overall high prevalence of psychiatric morbidity among orphan children in the region. This data is further corroborated by Hassan's (2021a) study on the effects of armed conflict on the widows and children of slain militants in Jammu & Kashmir, which was conducted amongst a sample of 100 families of killed militants, who died in the last 30 years. 35 families were selected from the south Kashmir districts of Anantnag, Pulwama, Shopian and Kulgam, being the epi-centre of new age militancy in the region (ibid). Equal number of participants were selected from the north Kashmir districts of Kupwara, Baramulla and Bandipora – as those witnessed a large number of killings during the 90's and 2000s, and all three areas share a border with Pakistan-administered Jammu & Kashmir, on the Line of Control (LoC). Lastly, 30 families from the central Kashmir districts of Srinagar, Ganderbal and Budgam, were interviewed (ibid).

While the precise estimate on the number of orphans and widows in Kashmir varies between different sources, stemming from the lack of comprehensive and encompassing survey carried out (Greater Kashmir, 2015), figures oftentimes range between 100,000-200,000 a year. Hassan (2021a) explains how amongst the 100 families interviewed, 94 answered that the incident (killing) had negative emotional/mental health impact on their families (ibid). 81% further argued that the emotional trauma also deteriorated their physical health (Hassan, 2021b). The majority of widows (85%) did not remarry after the incident, which is a common practice in the region especially when the woman has children; that further resulted in feelings of loneliness, lack of support at home, social insecurity, economic hardships, lack of help with the children, social apathy, ostracization and ill treatment on behalf of relatives and neighbours (Hassan, 2021a). In addition to that, 68% of respondents argued they faced stigma/isolation before and after the killing; before due to raids on behalf of security forces which distanced them from family, friends and neighbours; afterwards those feelings reduced however (ibid). Interestingly, 22% stated that they did not feel stigmatized or isolated, however given that terrorism tends to have a certain level of social acceptance in the region, this could account for the data (ibid). Although marriage with girls from militant families was not considered taboo, 37% argued that the incident has obstructed the chances of finding a suitable match for their children due to their family being avoided or deemed undesirable (ibid). In addition to that financial constraints placed an additional obstacle, with families of slain militants struggling to pay dowry (ibid). Scrutiny on behalf of security forces was another reason for families to stay away from such families (ibid).

In the majority of families the killed militant was the sole breadwinner in the family, which subsequently placed huge burden on the shoulders of the widows and their children, which were oftentimes still minors (ibid). As a result, a big number of them had to work various menial or domestic jobs, finding themselves further intimidated or underpaid (ibid). The lack of governmental programs or funds for supporting them financially as a result has made these widows and orphans socially handicapped in the Kashmiri patriarchal society (ibid). As per the study, 52% of the children of killed militants had to drop from school, while 19% could not even attend due to lack of resources (Hassan, 2012b). That is particularly worrisome given the trend of glorification of militancy in Kashmir, which was also reflected in Hassan's (2021b) study, and argued that 60% of the killed militants were seen as role models in their respective

areas and inspired others, including their close and distant relatives, friends and neighbours, to join terrorist groups before and even after their death.

Highly underexplored aspect stemming from the devotion cult towards militancy established in Kashmir is the misuse of young girls by terrorists. Relying on their hero-worshipping acquired status, militants attract young women, oftentimes maintaining affairs with multiple ones at a time, subsequently leaving them, either by choice or upon their death, which results in their marginalization considering the highly conservative nature of the Kashmiri society where sexual relations before marriage are frown upon and deemed sinful. The phenomenon remains very hushed up, due to the cultural and social stigma placed on it, alongside with the negative repercussions for one's family honour. Moreover, segments of the community who support these militants further protect their image by denying these realities not for the sake of the girls' reputation, but the militants' esteem.

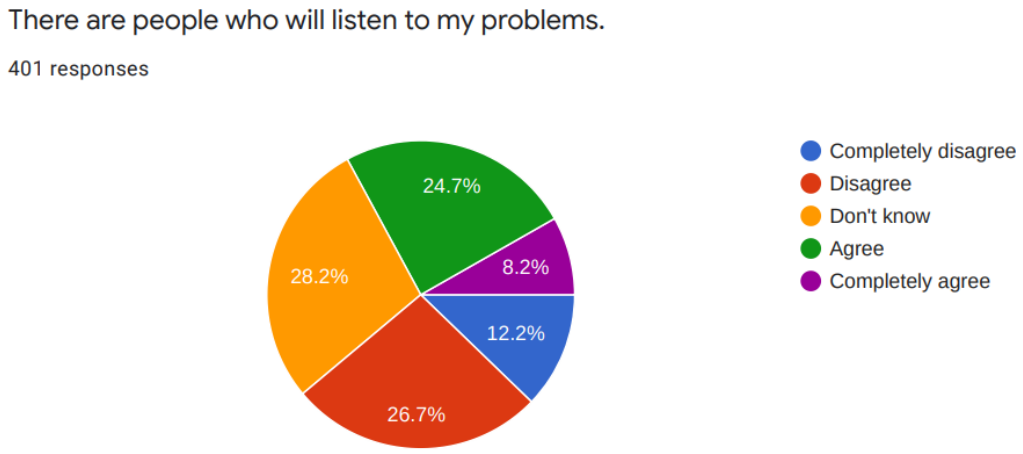
Such cases of sexual violence and harassment are unfortunately a common reality in the region of Kashmir. According to a report by Médecins Sans Frontières (2006), among 510 interviewees, 11.6% argued that they have been a victim of sexual violence since the onset of terrorism (1989). In addition, 63.9% of the respondents have heard about cases of rape while one in seven has witnessed rape (ibid). As per data provided by Bhat (2021) in 2014, 352 cases of rape in Jammu & Kashmir were recorded, 265 of which involved minors. In 2015, 2016, 2017 and 2018, 312 (251 minor), 263 (204 minor), 314 (213 minor) and 359 (273 minor) cases were registered respectively (ibid). When it comes to rapes, cases of sexual violence on behalf of security forces have been documented as well (Kazi, 2014). Given the taboo nature of the topic and the reluctance on behalf of victims to report either due to feelings of shame or fears of judgment on behalf of the community, unfortunately the number of cases of sexual violence is most likely much higher. The effects of sexual assault on (for the current study) women's mental health have been extensively studied (Campbell, Dworkin and Cabral, 2009). According to the authors, survivors of sexual abuse develop a range of psychological issues ranging from PTSD, anxiety, depression, suicidal tendencies, alcohol dependency and illicit substance abuse (ibid).

When it comes to the latter, drug addiction has become one of the fastest growing problems in Jammu & Kashmir. Before discussing statistics it is important to differentiate between the abuse of licit and illicit drugs. In the case of licit drugs, those include nicotine, alcohol and caffeine, while illicit drugs commonly include opioids, recreational, synthetic and psychedelic drugs such as cannabis, heroin, cocaine, methamphetamines, LSD, ecstasy and others (TRANSCEND, 2016). As per the latest study into drug consumption in Jammu & Kashmir, Rather, Bhat, Malla, Zahoor, Massodi and Yousuf (2021) interviewed 300 substance users and discovered the following: the majority of respondents were male (97%) in the age group of 20-29 (60.33%) and never married (69.34%). The prevalence of those have throughout their lifetime used tobacco (92.66%), opioids of any type (90.66%), cannabis (50.33) and alcohol (21.33%). When it comes to opioids, heroin was at the forefront (84.33%) followed by pharmaceutical opioids (24.33%) and sedatives-hypnotics (18.33%). While the low consumption of alcohol in comparison with other union territories in India could be explained by cultural customs given that Kashmir is a Muslim majority territory, where alcohol is taboo,

the high consumption of heroin stems from the ongoing cross-border smuggling in the region (ibid). As implied by previous studies (Bashir, Sheikh, Bilques and Firdosi, 2015) the low number of females could be explained by the stigma associated with drug use which prevents them from seeking treatment as well as the lack of appropriate facilities designed for their needs. In addition to that, as argued by Hassan and Shafi (2013), the high use of sedatives and tranquilizers emanate from the desire of quick remedies in the form of anti-depressants over long-term treatments such as psycho-therapy, that are not necessarily affordable by all of those in need. An earlier study conducted by Rather, Bashir, Sheikh, Amin and Zangeer (2013) found similar pattern amongst 198 substance abuse patients, further highlighting a new rising trend among adolescents, namely the utilization of inhalants such as glues, paint thinners, paint removers, dry cleaning fluids, typewriter correction fluids, petrol, adhesives, varnishes, deodorants, and hair sprays. As argued by the authors, the common abuse of said substances stemmed from their easy accessibility, cheap price, fast onset of action and feelings of constant 'high' (ibid). While explaining that the major reasons for engaging with drugs amongst the target group were peer pressure and the alleviation of negative moods, Rather et al. (2013) found prevalence of psychiatric disorders amongst nearly half of the group (49.5%): Bipolar affective disorder was the most common disorder (25.7%), followed by schizophrenia (9.09%), antisocial personality disorder (5.5%), PTSD (2.5%), and attention deficit hyperactivity disorder (ADHD) (2.52%). In addition to that, family history of psychiatric disorder and substance abuse were present in 23.2% and 4.04% of patients respectively (ibid).

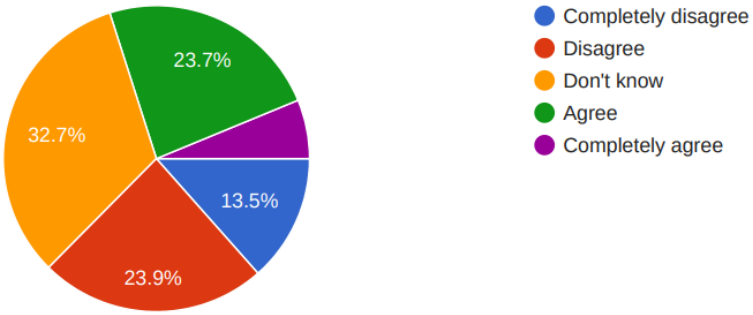
EFSAS Study

Multiple-choice questionnaires were designed and distributed among the local population in September 2020 in order to assess the living situation of members of the community, their sense of marginalization/social inclusion and opinions on the ongoing conflict. The survey received 401 answers which were subsequently analyzed and made into pie charts. The questionnaires were distributed both online and offline. The current section will analyse them in regards to the effects of armed conflict has on the mental health of individuals.



There are people who will help me change my life for the better.

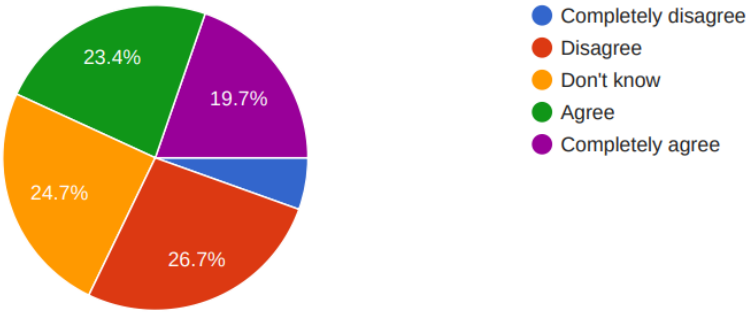
401 responses



Almost up to 40% of all participants argued that they do not believe that there are others who want to listen to their problems or help them out, as well as lacking someone to consult for advice or help. Those statistics imply a lack of support structure in the community, which could further lead to feelings of marginalization.

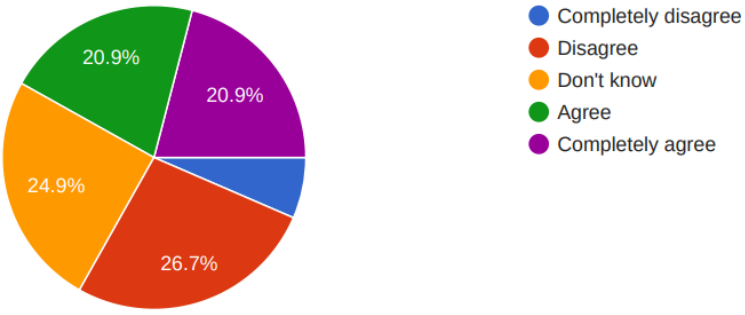
I often feel left alone with my problems.

401 responses



I often feel hopeless.

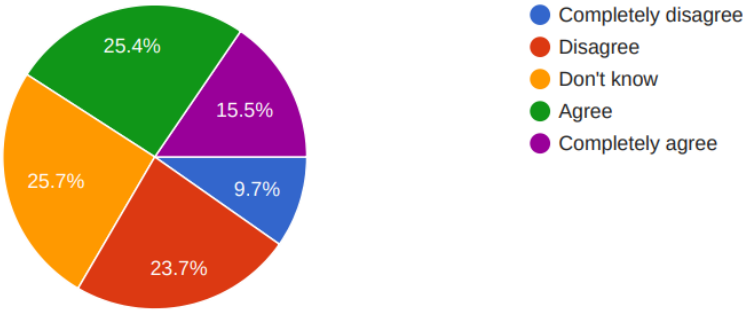
401 responses



43.1% argued that they feel left alone with their problems, while 41.8% stated that they feel hopeless. Both answers exhibit symptoms in the respondents of possible depressive states, which is imperative to address.

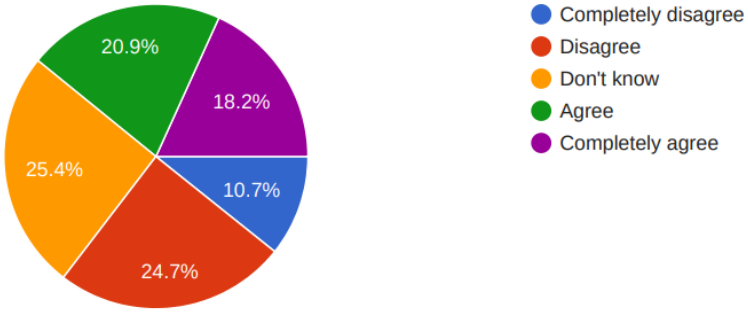
People around me often express feelings of social exclusion or discrimination.

401 responses



People around me have turned to drugs as a result of this feeling.

401 responses



39.1% of the respondents argued that they know others who have resorted to substance abuse due to feelings of social exclusion or discrimination (40.9%). Unfortunately, the type of drug was not specified, which would have been important in regards to recognizing trends in licit and illicit consumption; nevertheless, the high number is alarming signifying the utilization of drugs as a coping mechanism to feelings of social ostracization.

Future Trajectories and Policy Recommendations

Lockdowns after the abrogation of article 370 especially with the current COVID-19 pandemic, which further witnesses various lockdown measures to prevent the spread of the disease, have added to the deterioration of the mental health situation of the population (Shoib and Arafat, 2020). Imposed measures such as social distancing could contribute to feelings of loneliness or abandonment, especially for the elderly (ibid). Shoib, Arafat and Ahmad (2020) further argue that the ongoing lockdowns have increased the cases of perinatal mental health problems among pregnant women and those who have just given birth causing increased maternal anxiety, relationship conflicts, and decreased contact with healthcare professionals.

These unforeseen consequences of the pandemic could in the long-term even lead to post-partum depression (ibid). Other studies (Bhat, Khan, Manzoor, Niyaz, Tak, Anees, Gull and Ahmad, 2020) exhibit how people experience fear due to the unknown consequences of the pandemic, thus leading to heightened levels of stress which ultimately could negatively impact people's both mental and physical health. Thus, given the current situation where armed conflict and terrorism are rampant in the region of Jammu & Kashmir, coupled with the ongoing global pandemic, patterns of deteriorating mental health and psychiatric issues unfortunately remain the future trajectory.

While it is well acknowledged that people impacted by ongoing conflict are more vulnerable to psychological distress, this does not always translate into improved access to mental health care and therapy (Housen, Ara, Shah, Shah, Lenglet and Pintaldi, 2019). That is also the case in Jammu & Kashmir, where experts have identified numerous barriers to adequate treatment including: lack of awareness of psychiatric services, travel time, cost and distance to services, poor physical infrastructure, lack of understanding around the western 'counselling' or 'talk therapy' models (MSF, 2016), deficiency in mental health professionals adequately trained (especially in the understanding of somatization as an indicator of psychopathology), over-reliance on spiritual/religious healers, absence of community awareness programs (Housen et al., 2019), and others.

As a result, the present research exhibits the unmet and urgent need of ameliorating and expanding the mental health services in Jammu & Kashmir, raising awareness about the different conditions exhibited as well as reducing the stigma of seeking treatment. As summarized by the report of Médecins Sans Frontieres (2016) specific recommendations on those lines would include:

- Create more jobs for specialists in mental health facilities at all levels of healthcare.
- Establish training for personnel at mental health facilities to strengthen the competencies relevant to their posts.
- Sensitize policymakers and advocate for the development of suitable job selection criteria and the establishment of appropriate positions based on the specialization necessary.
- Encourage and establish incentives for mental healthcare staff working in rural areas.
- Develop a crisis team and a dedicated helpline for Rescue and Rehabilitation, providing services such as transport, shelter etc. for all mentally ill individuals, including those who are homeless.
- Develop models for catering to individuals who lack caretakers.
- Ensure access to mental healthcare in inaccessible rural areas through audiovisual technology.
- Formulate guidelines for the setting up of drug de-addiction central alongside with rehabilitative measures for substance abusers.

- Encourage the Education System (schools, universities etc.) on raising awareness on the topics of mental health and substance abuse.
- Make it mandatory for all schools to have a counsellor and a special needs teacher as part of schools and universities mental health programs.
- Sensitize authorities and policy makers regarding mental health issues.

Civil society organization should further launch different community awareness programs, which familiarize the general public with the spectrum of mental health issues, acquire a gendered approach by recognizing the needs of women and men, as well as promoting the normalization of seeking treatment for the purposes of reducing the stigma attached to mental illnesses.

Conclusion

Numerous studies have pointed out the causal link between armed conflict and mental health issues and associated dysfunctions (Hassan and Shafi, 2013). Apart from the psychological problems incurred, persistent dysfunctions are related to decreased productivity, poor nutritional, health and educational outcomes and curtailed ability to take part in development efforts (ibid). As a result, the adverse impact of mental health disorders in conflict-affected communities could be a major constraint in societal reconstruction and development efforts (ibid).

The current study has exhibited and described this phenomenon using as a case study the region of Indian-administered Jammu & Kashmir, focusing predominantly on the Kashmir Valley. While this is easily explainable with the fact that the Valley has in many ways become the epicenter of ongoing conflict and brewing terrorism, further research must focus also on the regions of Jammu, Ladakh as well as Pakistan-administered Jammu & Kashmir, including Gilgit Baltistan.

The effects of terrorism are multifold – loss of life, physical destruction and economic damages are unfortunately a grim reality, yet those who live to mourn their ravaged homeland are also the ones who oftentimes relive the trauma and develop psychopathological response to what have happened. It is imperative not to forget their struggle and adopt effective and considerate approaches to assist them in their daily lives.

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