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ORIGINAL PAPER

Prevalence of Childhood Mental Disorders Among School Children of Kashmir Valley

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Abstract

Prevalence of mental disorders among children is affected by armed conflict and same is true in protracted conflict of Kashmir, where the ongoing conflict has affected mental health of children badly. In order to understand mental health condition of school going children, the present study was designed to study the nature and prevalence of mental disorders among school children in Kashmir valley. The present study employed multi-stage sampling and multi-informant reporting of mental health problems in children. A sample of 1000 school children was taken from 12 schools of Shopian district through systematic random sampling method. Data was collected at different levels of screening by using Strength and Difficulties Questionnaire (SDQ) (Teacher form) and Mini International Neuropsychiatric Inventory (MINI-Kid). Socio-demographic data sheet was included to gather relevant information. The prevalence rates of mental disorders among school children were presented at different levels of screening. It was found to be 27.1% based on SDQ and 22.2% when assessed by MINI-Kid at second level of screening. The most commonly found mental disorders were of anxiety (8.5%), followed by mood disorders (6.3%) and then behavioural disorders (4.3%). Percentage of schoolgoing children with mental disorders in Kashmir is much more than in other states of India. The political conflict in the state and lack of mental health facilities give rise to high prevalence rates of mental disorders and warrant our urgent attention.

Keywords Prevalence · Socio-demographic variables · Mental disorders · School children · Kashmir

Introduction

The Kashmir Valley has been subject to continual ongoing conflict right from 1947 (Shekhawat 2007). The protracted conflict in Kashmir has affected all spheres of life. However the mental health consequences of conflict are substantial and wide-ranging (Steel et al. 2009). Globally, psychological disorders make up a large proportion of disease burden and are recognised as the leading cause of years of life lived with a disability (Ferrari et al. 2013). Number of prevalence studies has been conducted in different parts of the world so as to assess the impact of armed conflict on mental health. However there is wide disparity in the reported prevalence rates of mental disorders in such population. Prevalence estimates of mental health symptoms in youth in conflict areas range from 22.2% in Afghani youth (Panter-Brick et al. 2009) to 97% in former child soldiers in Northern Uganda (Derluyn et al. 2004). Mental disorders occur across all age groups, however children below 18 years are significantly affected. Studies have shown a strong association between children's exposure to violence and mental health symptoms (Cooley-Quille et al. 2001). In the context of Kashmir, mental disorders of children are majorly linked to their exposure to prevailing political violence from past more than two decades. The perceived threat and perpetual violence has left children living helplessly in a miserable way and has ceased their effective ways of coping and resulted in increase of various psychological problems (Jong et al. 2008). The condition of mental health in Kashmir has become bad to worse in the absence of adequate mental health facilities to children. In order to propose intervention policies for such affected children, an assessment of such problems becomes a prerequisite. The dire need of assessment and intervention of mental health problems in such conflicted areas was also felt

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by World Health Assembly who recognised mental health as a priority public health problem in 2012 and called for a comprehensive assessment of mental health issues and coordinated response from health and social sectors to address mental health disorders at the country level (Sixty-fifth World Health Assembly 2012).

Keeping in view the discrepancies in reported prevalence rates and impact of the political and social turmoil in Kashmir on mental health of children, the present study was designed to study the nature and prevalence of mental disorders among school children in Kashmir valley.

Methods

Participants

The present study includes multi-stage sampling with multi-informant reporting of childhood problems. A list of schools from Shopian district was taken from an educational authority (Chief educational officer's office) and 12 schools were chosen randomly from them. In every school, students were taken from class 5th to class 8th (both male and female sections) through systematic sampling. Equal number of male and female students was taken with total sample of 1000 students. Estimate of required sample size for the present study was made by using the formula given by Daniel (1999).

Procedure

Socio-demographic data sheet along with a consent form was sent to the parents of the selected students to get their written consent. The students who did not return with parental consent were replaced by new students from the same school and following the same procedure of inclusion. A total of 77 students dropped in the whole process. To study the prevalence of mental disorders in school children, three levels of screening were adopted and are represented in Fig. 1.

Measures

Strength and Difficulties Questionnaire (SDQ)

The SDQ is developed by Goodman (1997) and was derived from a modified version of the Rutter's scale. It includes 25 items and each of the 25 items is rated as being *not true* (0), *somewhat true* (1), or *certainly true* (2). The Total Difficulties scale is calculated by summing the scores of four problem scales (emotional problems, conduct problems, hyperactivity-inattention, and peer relationship problems) with positively valenced items reverse-scored. The Total Difficulties score can range from 0 to 40 which is also categorised into three categories viz. normal, borderline and abnormal. In the present study, only teacher form of the simple version SDQ was used. Goodman (2001) reported satisfactory reliability, whether judged by internal consistency (mean cronbach α: 0.73) or retest stability after 4–6 months (mean: 0.62). Multi-informant SDQs (parents, teachers, older children) identified individuals with a psychiatric diagnosis with a specificity of 94.6% and a sensitivity of 63.3% (Goodman et al. 2000). Cronbach alpha of 0.63 was found when calculated on the study sample.

MINI International Neuropsychiatric Inventory (MINI-Kid)

The MINI-Kid is a structured clinical diagnostic interview developed by Sheehan et al. (2010) and is designed to assess the presence of the DSM-IV and ICD-10 psychiatric disorders in children and adolescents aged 6 to 17 years. The interview is administered to the child/adolescent alone as well as along with the parent(s). The MINI-Kid is organized in diagnostic sections or modules and all questions are in binary "yes/no" format. Sheehan (2010) reported very good operating characteristics of the MINI-Kid for individual disorder diagnoses. Sensitivity ranged from 0.43 to 0.81 along different disorders; however Specificity ranged from 0.73 to 0.81.

Apart from these disorders, diagnosed cases of dissociative disorders by psychiatrists using International Classification of Diseases-10 (ICD-10) criteria given under the code F44 were also included in the study.

Socio-demographic Data Sheet

It was developed to collect information on some socio-demographic variables which are relevant in the context of mental disorders of children. It includes variables of gender, age, domicile, birth order, family type, parental education, monthly income, and exposure to political violence.

Statistical Analysis

The sample size for the study was determined by using the formula given by Daniel (1999). Descriptive statistics like frequency and percentages were used to find the distribution and prevalence of mental disorders. Data was analysed using the software package SPSS version 21.

Results

The findings of the present study are presented in percentages and prevalence rates. Sociodemographic details of the sample are given in Table 1. Further Analysis of data was

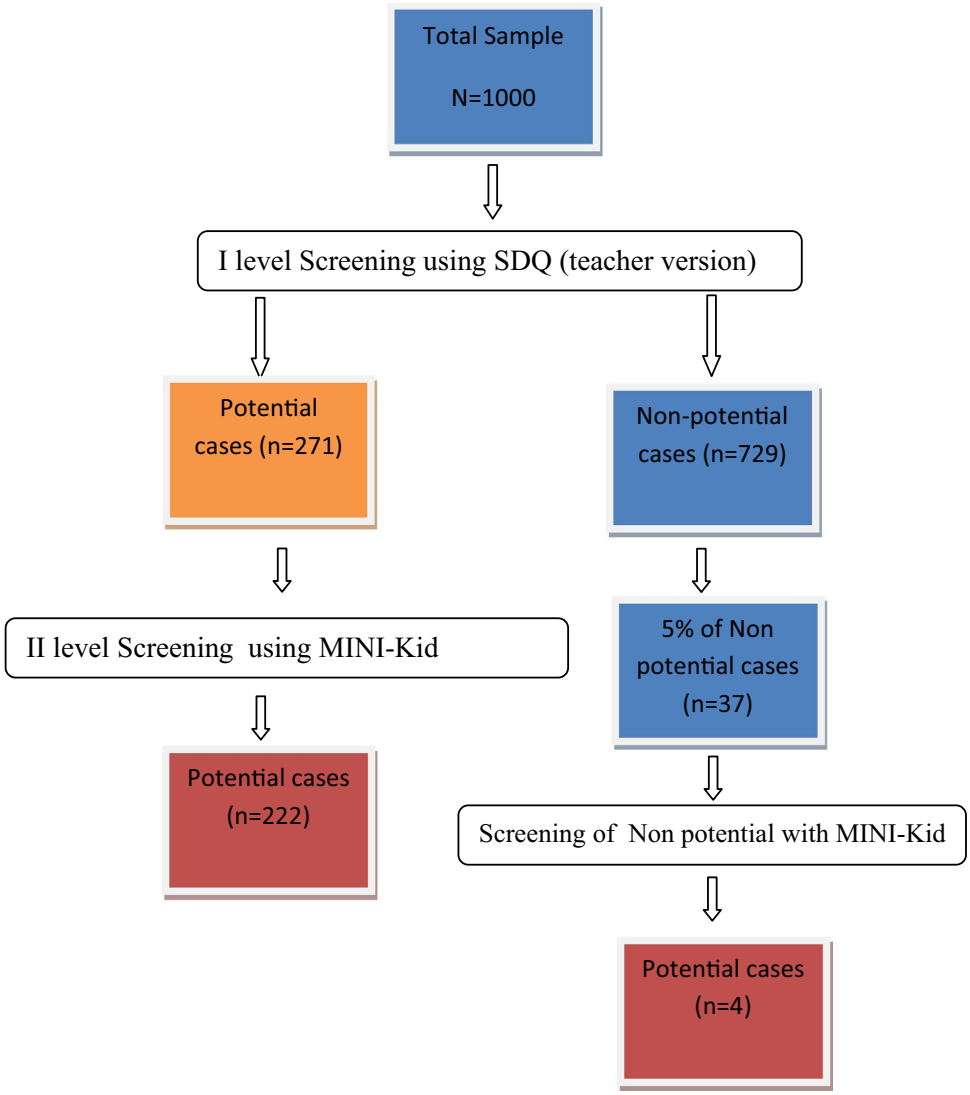

Fig. 1 Flow chart showing the screening of students

done at different stages of screening and prevalence of mental disorders among school children was reported accordingly. In the first level of screening, distribution of students across three categories of SDQ showed that 52.3% students fall in normal category, 20.6% in borderline and 27.1% students in abnormal category of SDQ categorisation. At the second level of screening, MINI-Kid was used. Out of 271 cases, only 222 cases were found potential based on MINI-Kid with any of the mental disorders. Overall prevalence rates were calculated for all the given disorders separately which are given in Table 2.

The Table 3 shows the number, percentage and prevalence of potential cases found at various stages of screening. The overall prevalence based on SDQ at first level of screening was found to be 27.1% (95%CI 24.18–30.02). However prevalence of mental disorders based on MINI-Kid was found to be 22.2% (95%CI 19.28–25.12) on second level of screening and 10.81% (95%CI 7.89–13.73) on screening non potential cases of first screening. On combining the prevalence's on second level screening and screening of non potential students, it can be said that the overall prevalence based on MINI-Kid was found to be 33% (95%CI 30.08–35.92) which is more than 27.1% as found on SDQ only.

Discussion

The results of the present study present a picture of mental health issues of school children of Kashmir valley. After regressive screening of mental problems through different stages of assessment, we found overall prevalence of mental disorders to be 22.2% (95%CI 19.28–25.12) among school children. Similar rates of prevalence were reported in study conducted by WHO in four developing countries (Giel et al. 1981) including India that showed prevalence of 21%. However few other epidemiological studies which

Table 1 Distribution of socio-demographic variables and strength and difficulties categories in total sample (N = 1000)

Socio-demographic variables	Sub groups	Total sample (N = 1000)	
		N	%
Gender	Male	500	50
	Female	500	50
Age	8–10	407	40.7
	11–12	421	42.1
	13–14	172	17.2
Domicile	Rural	648	64.8
	Urban	352	35.2
Birth order	Younger	296	29.6
	Middle	436	43.6
	Elder	268	26.8
Family type	Nuclear	613	61.3
	Joint	387	38.7
Father's education	Primary	329	32.9
	Middle	157	15.7
	Secondary	374	37.4
	UG/PG	140	14.0
Mother's education	Primary	582	58.2
	Middle	161	16.1
	Secondary	204	20.4
	UG/PG	53	5.3
Monthly income	Upto 5000	410	41.0
	5–10	335	33.5
	Above 10	255	25.5
Exposure to political violence	Direct	209	20.9
	Indirect	791	79.1

were exclusively conducted to assess the prevalence rate in the child and adolescent population of India reported prevalence in the range of 5–20.2% (Hackett et al. 1999; Malhotra et al. 2002; Anita et al. 2003; Rahi et al. 2005; Srinath et al. 2005; Bansal and Barman 2011; Bhasin and Khan 2009; Arumugam et al. 2013). On comparison with other studies, it gets clear that prevalence rate in present study is slightly higher than others. One common reason is that Shopian district is violence prone area of Kashmir as 20.9% students reported directly exposed to political violence. Systematic review conducted by Attanayake et al. (2009) also suggests a higher prevalence rate of mental disorders among children exposed to conflict than among the general population. Likewise, reduced exposure to traumatic life events have a significant impact on the psychosocial well-being of individuals living in contexts experiencing political insecurity (Housen et al. 2017). Other reasons for such differences in result findings can be attributed to differences in their methodology and sample size.

While analysing prevalence rates of various mental disorders, the most commonly found mental disorders were of anxiety disorders (8.5%), followed by mood disorders (6.3%) and then behavioural disorders (4.3%). High prevalence of these disorders among children replicate the findings of population based study by Pillai et al. (2008) in which the most common diagnoses were anxiety disorders (1.0%), depressive disorder (0.5%), behavioural disorder (0.4%) and attention-deficit hyperactivity disorder (0.2%). In twelve month prevalence study, Sagar et al. (2017) reported 3.41% having anxiety while as 1.44% having depression. Results are further validated by Kashmir based study of Dar et al. (2015) who found high prevalence of anxiety spectrum disorders followed by depression. Sarkar et al. (2012) reported comparatively low prevalence rate of depression (3.13%) in their school-based epidemiological study. On comparison, higher prevalence rates of such problems in our study can be seen in the light of socio-political conflict in Kashmir and the traumatic events children often face. The prevailing socio-political threat and lack of hope and children's state of helplessness could have given rise to high prevalence rates of anxiety and mood disorders (Jong et al. 2003). Thabet et al. (2002) in their study found that children exposed to violence related events indirectly, mainly through the media and adults, reported more anticipatory anxiety and cognitive expressions of distress. Anxiety disorders are reported most in people who are not exposed directly to violence (Jong et al. 2003) while as depression is significantly associated with the number of adverse events in last one year (Bhasin et al. 2010).

In the context of conflict and violence, commonly discussed anxiety disorders are post-traumatic stress disorder (PTSD) and conversion disorders. In the present study, prevalence of PTSD was found to be 1.3% while as dissociative disorders was 1.2%. Similar study conducted in Kashmir reported 0.86% prevalence of PTSD (Dar et al. 2015). Khan and Margoob (2006) reported somatic complaints and conversion symptoms as commonest symptoms in Kashmir. Studies report prevalence of post-traumatic stress disorder in children and adolescents to be 5–8% in Israel, 23–70% in Palestine and 10–30% in Iraq (Dimitry 2012) which is quite high than our study finding. This could be due to role of resilience which children develop after facing daily based conflicting situation in Kashmir (Justino 2012). The lesser prevalence of PTSD in our study can also be explained by transition of geopolitical conflict from armed uprising to non-violent movement (Chaudhuri 2013). Such children may also avoid going to school so as to avoid trauma related cues, resulting in less prevalence rates in our study.

Interestingly, in the present study no case of alcohol abuse, eating disorders or psychosis was found, although 0.8% prevalence of smoking cigarette was found. Alcohol is strictly prohibited in Islam. Hence it is not accepted by

Table 2 Distribution of various mental disorders (N = 222) and their prevalence rates (N = 1000) falling in diagnostic criterion based on MINI-Kid

S.No	Mental disorders	N	Percentage	Prevalence
1	Major depressive episode	54	24.32	5.4
2	Dysthymia	4	1.80	0.4
3	Manic and hypomanic episodes	5	2.25	0.5
4	Panic disorder	21	9.46	2.1
5	Agoraphobia	3	1.35	0.3
6	Separation anxiety disorder	1	0.45	0.1
7	Social phobia	5	2.25	0.5
8	Specific phobia	34	15.31	3.4
9	Obsessive compulsive disorder	1	0.45	0.1
10	Posttraumatic stress disorder	13	5.85	1.3
11	Alcohol dependence/abuse	0	0	0
12	Substance dependence/abuse	8	3.60	0.8
13	Tic disorder	2	0.90	0.2
14	Attention-deficit/hyperactivity disorder	29	13.06	2.9
15	Conduct disorder	11	4.95	1.1
16	Oppositional defiant disorder	3	1.35	0.3
17	Psychotic disorder	0	0	0
18	Anorexia nervosa	0	0	0
19	Bulimia nervosa	0	0	0
20	Generalised anxiety disorder	8	3.60	0.8
21	Adjustment disorder	5	2.25	0.5
22	Pervasive development disorder	3	1.35	0.3
23	Dissociative disorders	12	5.40	1.2
	Total	222	100	22.2

Table 3 Distribution, percentage and overall prevalence of potential cases across different levels of screening

Level of screening	Tools used	N	No. of potential cases	%	Prevalence rates (in %)
I	SDQ	1000	271	27.1	27.1
II	MINI-Kid	271	222	81.92	22.2
III	MINI-Kid	37 (5% of non potential cases)	4	10.81	10.8

society and is not easily available, leading to absence of such problem. Instead, students especially males stick to cigarette smoking. However, possibility of having substance abuse more prevalent than what was reported by children can not be denied because of tendency of children to respond in socially desirable way. Absence of eating disorders could possibly be due to different notion of beauty in Kashmir. Being very thin is not accepted as more favourable among people, rather being healthy is more acceptable. This notion of beauty was reported by most students when they were asked about it. Lack of psychosis among students could possibly be because such students do not attend school after such illness (Findling et al. 2001). Hence absence of psychosis in our sample could not be representative as there is possibility of having such cases in the community.

At the same time, in order to ascertain the specificity of SDQ based on teachers rating, screening was also conducted on 5% of non potential cases using MINI-Kid and 10.81% (95%CI 7.89–13.73) was found to have any psychiatric problem. So adding this percentage will give rise to total prevalence based on MINI-Kid to be 33% (95%CI 30.08–35.92) (Table 3). This, at the same time, shows that the sensitivity of detecting cases by MINI-Kid is better than of SDQ. Hence use of multiple measures for screening is better in detecting potential cases than single measure screening. Likewise importance of different informants is highlighted as the prevalence rates vary with different informant as well.

The findings in the study make it clear that the percentage of children with diagnosable mental disorders in Kashmir is much more than in other states of India. These problems in Kashmiri children are connected with their feelings of insecurity, violation of modesty, physical disability resulting from violence, witnessing of killing, and torture and ongoing feelings of personal vulnerability (Jong et al. 2008). Silove et al. (2014) linked psychological distress in a conflict affected population with feelings of uncertainty about the future and persistent feelings of injustice. Dimitry (2012)

reported that high levels of traumatic experiences and number of conflict-related traumatic experiences correlate positively with prevalence of mental, behavioural and emotional problems. On the other hand, lack of required mental health facilities and such professionals in valley further add up to the problem. Mental health services are largely centralised in the main city of Srinagar (Justino 2012).

The present study is a good response to World Health Assembly who recognised mental health as a priority public health problem in 2012 and called for a comprehensive assessment of mental health issues and coordinated response from health and social sectors to address mental health disorders at the country level (Sixty-fifth World Health Assembly 2012). The findings of the study may help in understanding the gravity of such problems and need for community based intervention. It highlights the need of mental health professionals in different rural and urban hospitals. It calls for urgent need of mental health counsellors in different schools of the valley, so as to improve mental health and psychosocial well-being of such children in the community.

This study had some limitations. Sample was taken from schools only, and children who live in the community were not included in the study. So findings could be seen representative of school going population only. The use of teacher rating might have failed to screen all positive cases which could have affected the real prevalence rates of second level of screening. We are only able to report associations due to the nature of our study which prevents conclusions on causes of psychological distress. So a longitudinal epidemiological study will be more informative.

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Compliance with Ethical Standards

Conflict of interest The authors declares that they have no conflict of interest.

Ethical Approval The present study is approved by Ethical Committee of Jamia Millia Islamia, New Delhi. Author has taken good care of research ethics while dealing with participants and consent of participation has been taken formally.

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