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Socio-demographic Profile and Psychiatric Comorbidity in Patients with a Diagnosis of Post Traumatic Stress Disorder – A study from Kashmir Valley

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ABSTRACT

Objective: Kashmir valley has witnessed an armed conflict from last three decades, with one of the studies suggesting the prevalence of trauma exposure of 58.69% in the general population and 15.9% prevalence of Post-traumatic stress disorder (PTSD). The current study was undertaken to explore the socio demographic profile and psychiatric comorbidity in treatment seeking PTSD patients.

Methods: This cross-sectional study was conducted at Government Psychiatric Diseases Hospital Srinagar, Kashmir from January 2006 to January 2007. A total of 100 PTSD patients were interviewed and screened for psychiatric comorbidity using DSM-IV diagnostic criteria and their socio demographic details were recorded using a proforma.

Results: Most of the patients in our study had multiple comorbidities. Apart from depression and anxiety disorders, somatisation and peri-traumatic dissociation was highly comorbid.

Conclusion: Post-Traumatic Stress Disorder is a complex diagnosis with commonly associated psychiatric comorbidity. The high comorbidity in our study sample could be due to repeated exposure to trauma, cultural expression of distress and the ongoing conflict situation which makes the recovery difficult. Recognizing the comorbidities early on may help to achieve an optimal treatment outcome. Finally, the lack of appropriate service provision results in increased morbidity and probable chronicity of the symptoms.

INTRODUCTION

Post-Traumatic Stress Disorder (PTSD) is common following disasters, more so when it is man-made.[1] PTSD is not the only psychiatric disorder that develops after exposure to trauma, on the contrary, comorbidity is the norm rather than exception.[2] Kashmir valley has witnessed an armed conflict from last three decades, with one of the studies suggesting around 58.69%[3] of the general population exposed to psychological trauma and the community prevalence of PTSD around 15.9%.[4] The clinical presentation is more often complex and at times, it is difficult to come to a clear diagnostic conclusion. This study was undertaken to explore the socio demographic profile and psychiatric comorbidity in PTSD patients with an aim to understand the pattern of symptoms and likely comorbidities.

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MATERIAL AND METHODS

A total of 100 consecutive PTSD patients, attending the out-patients-department at the Government Psychiatric Diseases Hospital, Srinagar from January 2006 onwards were included in this study. The Diagnostic and Statistical Manual IV of American Psychiatric Association was used as a diagnostic tool.[5] Patients between the ages of 16-65 years were included in the

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study. Patients with prior history of other DSM-IV Axis I or Axis II disorder, substance misuse, major medical and neurological disorders, and those who did not consent, were not included. Semi-structured interview using all the relevant items from MINI PLUS (MINI International Neuropsychiatric Interview) based on DSM – IV, was used for diagnoses. Socio demographic details were recorded using a proforma.

RESULTS

The sample is comprised of 68% females, with the majority (48%) in the young age group of 16-30 followed by 32% between the ages of 31-45 years. Most were married (54%) and living in joint families (64%). The sample was predominantly from rural areas (79%), with 75% of the sample belonging to the lower socioeconomic class. Around half of the sample was illiterate (48%) and rest educated to undergraduate level (44%). Housewives formed the majority of the sample (51%) followed by students (16%) and agricultural farmers (13%) (Table 1 and Figure 1).

The results show a very high comorbidity rate (85%), with depression being the commonest comorbid condition (80%). Somatisation (56%) and Peri-traumatic dissociation (43%) also showed a very high prevalence. Anxiety disorders formed the rest of the comorbidities in addition to substance abuse in 16% and psychotic symptoms in 8% of the patients (Table 2 and Figure 2).

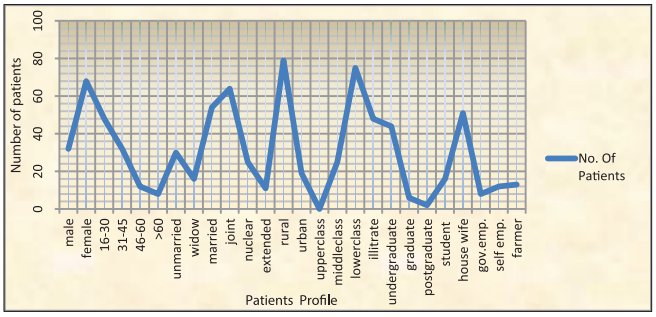

Figure 1: Sociodemographic details

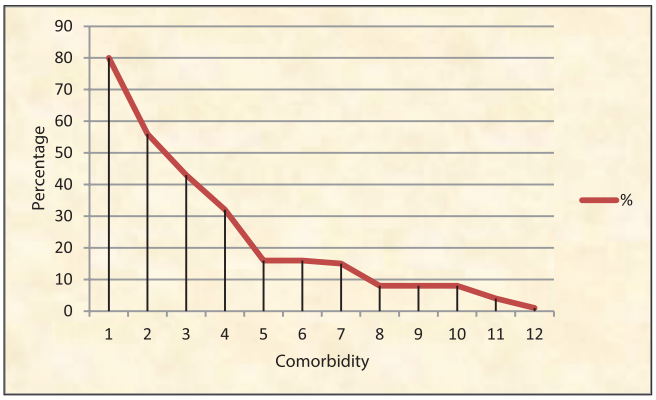

Figure 2: Psychiatric comorbidity

DISCUSSION

This study investigated the psychiatric comorbidity in treatment-seeking PTSD patients at the sole psychiatric

Table 1: Sociodemographic details

Profile	No of patients	Percentage
Gender		
Male	32	32
Female	68	68
Age range		
16-30	48	48
31-45	32	32
46-60	12	12
>60	8	8
Marital status		
Unmarried	30	30
Widowed	16	16
Married	54	54
Family		
Joint	64	64
Nuclear	25	25
Extended	11	11
Residential status		
Rural	79	79
Urban	19	19
Socioeconomic status		
Upper class	0	0
Middle class	25	25
Lower class	75	75
Education		
Illiterate	48	48
Undergraduate	44	44
Graduate	6	6
Postgraduate	2	2
Occupation		
Student	16	16
House wife	51	51
Govt. employed	8	8
Self employed	12	12
Farmer	13	13

Table 2: Psychiatric comorbidity

No	Comorbidity	%
1	Major depressive disorder	80
2	Somatization	56
3	Peritraumatic dissociation	43
4	Panic disorder	32
5	Conversion disorder	16
6	Substance abuse	16
7	PTSD (without comorbidity)	15
8	Agoraphobia	8
9	Generalized anxiety disorder	8
10	Psychotic symptoms	8
11	Obsessive compulsive disorder	4
12	Dissociative trance disorder	1

diseases hospital of the Kashmir region which has witnessed political and armed conflict for many decades.[6] The Psychiatric Diseases Hospital is the only facility in the whole region for treatment of psychological problems. Despite a huge stigma associated with the hospital, it receives hundreds of patients on the daily basis mostly from the rural areas and poor socioeconomic background. The treatment seeking is usually delayed for various reasons which may be one of the reasons for high psychiatric comorbidity in our sample.

The majority of patients in our sample were of young and productive age group, 48% between 16–30 years of age and 32% between 31–45 years. Younger people are known to have a higher incidence of exposure to the trauma compared to older people and subsequent PTSD.[7] Furthermore, majority of the sample were women (68%). Studies have reported females having 2.38–2.49 times more likelihood of developing PTSD than men.[8,9] The other reason for a higher number of women in our sample could be due to a better help-seeking attitude in women as compared to the men. The patients were mostly from ruler areas (80%) which could be explained by the fact that around 74.9% population lives in villages.[10] It is also thought that more violent incidents happen in ruler areas due to lack of oversight and media scrutiny. The situation is worsened by lack of services and accessibility to help.

Most of the patients came from a poor background, 76% from the lower socioeconomic class and 24% from the middle class. It is thought that the stigma associated with Psychiatric Diseases Hospital is the main reason why the patients from the middle and upper socioeconomic class hesitate to seek help at the hospital and usually prefer private sector.[11] Another reason could be the free of cost treatment and provision of some medications from the hospital.

The results suggest a very high psychiatric comorbidity in our sample with only 15% of the patients free of comorbidity. The results are consistent with Kessler's comorbidity survey,[8] which shows 79% of women and 88% of men meeting criteria for another psychiatric disorder in addition to a life time diagnosis of PTSD. Multiple co-morbidities were a usual finding with major depression most common comorbidity (80%). This is in agreement with the previous studies showing comorbidity rates of 78.4%,[8] 72% - 84%,[12] and 68%.[2] Anxiety disorders were the next common group of comorbidity including panic disorder (32%), agoraphobia (8%), GAD (8%) and OCD (4%). Green et al and Mc Farlane et al have reported panic disorder comorbid in 9% - 37% of PTSD patients.[13,14] Agoraphobia was comorbid in 8% of PTSD patients, which is similar to the results of 6% by Green et al.[13] Peri-traumatic dissociation was reported by 43% of our patients. Khan, in a hospital based study, has reported peri-traumatic dissociation in 68% of children suffering from PTSD.[15] Literature suggests that symptoms of dissociation are a significant risk factor for the further development of PTSD.[16,17]

Psychotic symptoms were reported by 8% of our PTSD sample. The psychotic symptoms commonly associated with PTSD are auditory hallucinations, visual hallucinations and non – bizarre delusions mostly related to traumatic experience.[18] Substance abuse was comorbid in 16% of our patient sample. Drug use or dependence in patients with PTSD may be the inadvertent result of efforts to medicate the symptoms of the PTSD.[19]

Somatization was comorbid in 56% of our sample and significantly higher than what is reported from Western literature (4%-12%).[13,12] Hussian et al, argues that somatization has a close association with trauma and culture.[20] Conversion disorder was comorbid in 16% of the sample. Studies exploring conversion symptoms and PTSD comorbidity are scarce. Khan et al have reported a 50% prevalence of conversion symptoms in children with PTSD[21] and Abu Hein et al has reported conversion fits in 25% Palestinian children in the Gaza strip.[22] Studies suggest that somatization symptoms are more common in people with PTSD in comparison to people suffering from other mental health diagnoses.[23] The results in our study may be determined by culturally acceptable variations in symptoms presentation and hence need further exploration.

Kashmir Context

Kashmir valley has witnessed an armed conflict from the last more than three decades and it has been reported that 50,000 – 10,0000 people have been killed so far.[24] Studies suggest that mental health problems have significantly increased since the start of this turmoil as people are living under ongoing conflict and trauma situation.[3] The region is catered by just one Psychiatric Diseases Hospital, in Srinagar. This hospital also receives patients from the adjoining areas of Jammu and Ladakh. The outpatients department is run as a walk in clinic, and on busy days can receive up to 300 patients. The treatment options are limited to medication as there is a lack of other allied professionals like psychologists, counsellors and psychiatric nurses.

CONCLUSION

Post-Traumatic Stress Disorder is a complex condition usually associated with co-morbid diagnosis especially depression and anxiety disorders. The high prevalence of somatisation in our study warrants further exploration in the cultural context. There is a need for appropriate service development in relation to trauma and PTSD to

prevent long-term debilitating consequences due to its high prevalence and associated comorbidity. This should be done keeping in view the demographics and majority of people living in ruler areas. Early identification can help with lessening the severity of symptoms and also improve the quality of life of many patients. PTSD can become a potential reason for drug abuse and hence timely treatment and awareness can help confronting additional health hazards. The political solution to the conflict is the key to prevent further trauma related cases and also help heal those who relapse due to ongoing trauma like situation.

Limitations

Our study sample was hospital based so results cannot be generalized to the general population.

The nature of trauma and frequency of exposure were not taken into account which could have impacted on the outcome and nature of symptoms.

Western diagnostic tools were used for diagnosis and may not be getting the representative picture due to local and cultural issues.

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