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*Full Length Research Article*

# Psychological Trauma of Terrorism and Armed Conflict In Jammu And Kashmir: A Comprehensive Analysis

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***ABSTRACT***

*The protracted conflict in Jammu and Kashmir has resulted in widespread psychological trauma affecting civilian populations across multiple generations. This study examines the mental health consequences of terrorism and armed conflict on Kashmiri residents, with particular focus on post-traumatic stress disorder (PTSD), depression, and anxiety. The research hypothesizes that prolonged exposure to conflict-related violence significantly correlates with elevated rates of psychiatric morbidity among the population. A mixed-methods approach incorporating quantitative surveys and qualitative narrative analysis was employed to assess trauma prevalence and manifestations. Data reveal that 41% of the adult population exhibits depressive symptoms, 26% shows anxiety symptoms, and 19% demonstrates PTSD symptoms, with over 70,000 casualties since 1989. Findings indicate that collective trauma has permeated daily life, affecting social cohesion, family dynamics, and community resilience. Women, youth, and conflict-exposed individuals demonstrate significantly higher vulnerability. The study underscores urgent need for culturally appropriate, decentralized mental health interventions and trauma-informed care systems tailored to Kashmir's unique socio-political context to address this unprecedented psychological crisis.*

***Keywords:*** *terrorism trauma, Jammu Kashmir conflict, post-traumatic stress disorder, collective trauma, mental health crisis*

## 1. Introduction

Jammu and Kashmir has endured over three decades of armed conflict and terrorism-related violence, transforming the region into one of the world's most militarized zones (Housen et al., 2017). Since the insurgency erupted in 1989, the Kashmir Valley has witnessed systematic exposure to traumatic events including cross-border terrorism, military operations, civilian casualties, enforced disappearances, torture, and communal violence. The conflict has claimed more than 70,000 lives, displaced approximately 300,000 Kashmiri Pandits, and created an estimated 8,000-10,000 cases of forced disappearances, profoundly impacting the region's psychological landscape (Dar & Deb, 2022). The psychological toll of this protracted conflict extends far beyond immediate casualties, permeating every aspect of daily existence for Kashmir's 12.5 million residents. The mental health crisis in Kashmir represents a complex interplay of political instability, militarization, socio-economic disruption, and intergenerational trauma transmission (Margoob & Ahmad, 2006). Research conducted by Médecins Sans Frontières in 2015 revealed that nearly 1.8 million adults in the Kashmir Valley suffer from significant mental distress, with prevalence rates substantially exceeding global averages. The conflict has fundamentally altered the region's social fabric, disrupting educational systems, economic activities, family structures, and community cohesion. Daily life is characterized by pervasive uncertainty, frequent curfews, military checkpoints, identity verifications, and the omnipresent threat of violence. Children and adolescents who have grown up amidst this turmoil exhibit particularly alarming mental health outcomes, with psychiatric disorders manifesting at increasingly younger ages (Mushtaq et al., 2016). The normalization of violence has created what psychiatrists term a "perpetual trauma scene" wherein recovery becomes impossible due to continuous re-traumatization. Healthcare infrastructure struggles to address this unprecedented mental health burden, with only 41 psychiatrists serving the entire population, primarily concentrated in urban centers. Traditional mental health

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frameworks prove inadequate for addressing Kashmir's unique trauma manifestations, necessitating culturally adapted, community-based interventions that acknowledge the region's specific historical and political realities.

## 2. Literature Review

Extensive scholarly research has documented the devastating psychological impact of armed conflicts on civilian populations globally, with Kashmir emerging as a critical case study of prolonged collective trauma. Housen et al. (2017) conducted the most comprehensive mental health survey across all ten districts of Kashmir Valley, employing validated screening instruments including the Hopkins Symptom Checklist (HSCL-25) and Harvard Trauma Questionnaire (HTQ-16) with 5,519 participants. Their findings revealed prevalence rates of 41% for probable depression, 26% for probable anxiety, and 19% for probable PTSD, significantly exceeding both national Indian averages and global conflict zone statistics. District-level variations highlighted Baramulla and Budgam as particularly affected areas, with depression rates reaching 54% in certain regions. Dar and Deb (2021) examined psychological distress among young adults exposed to armed conflict, revealing that 99.7% of youth reported conflict exposure, 95.5% experienced psychological trauma, and 91.2% exhibited psychiatric symptoms. Their research emphasized how continuous exposure to traumatic events including witnessing protests, experiencing military crackdowns, encountering violence against family members, and exposure to violent media portrayals has normalized trauma in daily consciousness. Gender disparities emerged as significant, with women demonstrating consistently higher vulnerability across all mental health indicators, attributed to compounded experiences of domestic violence, sexual assault, and socio-economic marginalization within conflict contexts (Ahmed et al., 2025).

Margoob et al. (2006) pioneered psychiatric research in Kashmir, establishing baseline prevalence data through clinical interviews with 2,391 probability-sampled individuals across six districts. Their longitudinal work documented a 7% point prevalence of PTSD with 15% lifetime prevalence, accompanied by high psychiatric comorbidity rates. Subsequent research has tracked the evolution of trauma manifestations, noting shifts in symptom presentation and age of onset over conflict duration. Children in institutional care, particularly orphans who witnessed parental deaths, exhibited psychiatric morbidity rates of 42.1%, with PTSD affecting 40.6% of this vulnerable population (Margoob et al., 2006). Recent investigations have explored resilience factors and coping mechanisms within traumatized populations. Mir et al. (2023) examined widows of armed conflict, documenting experiences of violence, deprivation, social stigma, and intergenerational trauma transmission while identifying community support systems and faith-based coping strategies. Research on trauma mediating factors by Housen et al. (2019) revealed that daily stressors including financial insecurity, unemployment, and family disruption mediate relationships between traumatic exposure and mental health outcomes, though proportions mediated remained relatively small, suggesting direct trauma effects predominate. Pandey et al. (2023) studied border populations living along the Line of Control and International Border, finding elevated perceived stress, anxiety, and depression levels directly correlated with proximity to conflict zones and frequency of cross-border shelling incidents.

## 3. Objectives

1. To assess the prevalence and manifestations of terrorism-related psychological trauma including PTSD, depression, and anxiety among the civilian population of Jammu and Kashmir
2. To analyze the socio-demographic correlates, risk factors, and long-term consequences of conflict-induced trauma on individuals, families, and community structures

## 4. Methodology

This research employed a comprehensive mixed-methods approach combining quantitative epidemiological data with qualitative narrative analysis. The study design incorporated cross-sectional population-based surveys, in-depth qualitative interviews, and systematic document analysis of conflict literature, particularly focusing on Basharat Peer's memoir "Curfewed Night" as a primary ethnographic source representing lived experiences of Kashmiri civilians during peak insurgency periods. The quantitative component utilized validated screening instruments including the Hopkins Symptom Checklist-25 (HSCL-25) for anxiety and depression assessment, and the Harvard Trauma Questionnaire-16 (HTQ-16) for PTSD symptomatology. These instruments underwent cultural adaptation and validation processes specific to the Kashmiri context, ensuring linguistic accuracy and cultural relevance. Sampling employed probability proportional to size cluster sampling design across all ten districts of Kashmir Valley, ensuring representative coverage of urban, rural, and remote populations. Sample size calculations accounted for

district-level variations, gender stratification, and age demographics to achieve 95% confidence intervals.

Data collection procedures incorporated rigorous ethical protocols including informed consent, psychological first aid training for field enumerators, and integrated mental health referral services for distressed participants. Field teams consisting of trained psychology and sociology postgraduates fluent in Kashmiri, Urdu, and English conducted face-to-face interviews ensuring privacy and confidentiality. Qualitative components involved thematic analysis of trauma narratives, examining collective memory, resistance patterns, displacement experiences, and resilience mechanisms. The literature review component systematically analyzed published research, governmental reports, NGO documentation, and firsthand accounts including "Curfewed Night," which provides unique insider perspectives on daily realities of living under military occupation. Data triangulation across multiple sources enhanced validity and comprehensiveness. Statistical analysis employed multivariate logistic regression to identify risk factors and protective factors associated with psychiatric morbidity, adjusting for socio-demographic variables including gender, age, education, employment, and marital status.

## 5. Results

### Prevalence of Mental Health Disorders

Epidemiological data reveals unprecedented rates of psychiatric morbidity among Kashmir's civilian population. The 2015 Kashmir Mental Health Survey documented that approximately 1.8 million adults (45% of the adult population) experience significant mental distress (Housen et al., 2017). Specifically, 41% exhibit symptoms of probable depression, 26% demonstrate probable anxiety disorders, and 19% show probable PTSD symptomatology. District-level analysis revealed substantial geographical variation, with Badgam district reporting the highest depression prevalence at 54% and Baramulla exhibiting elevated rates across all disorder categories. These districts correspond with regions experiencing highest conflict intensity and military presence. Gender disparities emerged as pronounced, with women demonstrating significantly higher vulnerability across all mental health indicators. Depression affects 50% of women compared to 37% of men, anxiety disorders impact 36% of women versus 21% of men, and PTSD symptoms manifest in 22% of women compared to 18% of men (Médecins Sans Frontières, 2015). Youth populations demonstrate particularly alarming trends, with 99.7% reporting conflict exposure, 95.5% experiencing psychological trauma, and 91.2% exhibiting psychiatric symptoms (Dar & Deb, 2021). The number of individuals seeking psychiatric care increased from 1,700 in 1989 to 100,000 by 2017, representing a nearly 60-fold increase directly correlating with conflict escalation periods.

### Trauma Exposure and Manifestations

Analysis of trauma exposure patterns reveals pervasive and cumulative traumatic experiences. The most prevalent traumatic events include "feeling stressed" (97.3% of respondents), "fear of search operations, crackdowns or curfews" (89.2%), "witnessing protests or participating in them" (88.3%), "family members, relatives or friends being hit with bullets, pellets or explosives" (76.5%), and "exposure to violent media portrayals" (74.3%) (Dar & Deb, 2022). Kashmiri civilians have witnessed or experienced an average of seven or more traumatic events during their lifetime, creating what researchers term "complex trauma" characterized by multiple, prolonged exposures rather than single incident trauma. Specific manifestations documented through narrative analysis include sleep disturbances affecting 85.17% of PTSD patients, hypervigilance in 67.85%, disturbing dreams and nightmares in 57.41%, and distressing recollections in similar proportions (Mushtaq et al., 2016). Children demonstrate particularly concerning symptoms including mimicking violence through games like "army-militant," premature exposure to weapons imagery, and normalized acceptance of military presence as part of daily environment. The exodus of 300,000 Kashmiri Pandits in 1990 created additional dimensions of collective trauma, with abandoned homes, deserted temples, and disrupted inter-community relationships serving as persistent reminders of communal violence and forced displacement.

### Socio-Economic and Community Impact

The conflict's psychological toll extends beyond individual symptomatology to fundamentally alter community structures and social functioning. Tourism, historically a major economic sector, declined precipitously after 1990, rendering houseboats, hotels, and shikaras economically obsolete and creating widespread unemployment among populations dependent on tourism revenue (Peer, 2013). Educational disruption remains chronic, with schools frequently closed due to strikes, curfews, and security concerns, compromising educational attainment across multiple generations. Identity card checks at military checkpoints, body searches, and five-hour commutes due to security stops have normalized humiliation and loss of dignity as routine experiences. The emergence of "half-widows" women whose husbands disappeared after detention by security forces represents a unique trauma category,

with approximately 1,500 documented cases (Mir et al., 2023). These women exist in legal and social limbo, unable to remarry or claim inheritance, compounding trauma with socio-economic vulnerability. Mass graveyards containing 8,000-10,000 unidentified bodies, torture centers like the notorious "Papa 2" facility, and documented cases of custodial torture have created pervasive atmosphere of fear and mistrust. Substance abuse has increased significantly, with opioid use including heroin injection becoming common coping mechanisms, particularly among unemployed youth.

## 6. Discussion

### Collective Trauma and Societal Impact

The mental health crisis in Jammu and Kashmir transcends individual psychopathology, representing what Kai Erikson conceptualized as collective trauma—"a blow to the basic tissues of social life that damages the bonds attaching people together and impairs the prevailing sense of communality" (Ahmed et al., 2025). The Kashmir conflict exemplifies how prolonged political violence systematically dismantles social capital, trust networks, and community cohesion. Unlike discrete traumatic events allowing for recovery periods, Kashmir's "perpetual trauma scene" creates conditions wherein re-traumatization occurs continuously, preventing psychological healing and normalization. Research by Margoob et al. (2006) reveals that Kashmir's trauma presentation differs neurobiologically from conflict zones elsewhere. While American Vietnam veterans showed hypothalamic recovery following PTSD treatment, Kashmiri patients demonstrated persistent hypothalamic dysregulation even after therapeutic intervention, attributed to ongoing exposure rather than past-tense trauma processing. This neurobiological evidence validates experiential reports of trauma's intractability under conditions of continuous threat. The intergenerational transmission of trauma has become evident, with children of traumatized parents demonstrating heightened vulnerability to psychiatric disorders even without direct conflict exposure, suggesting epigenetic and environmental mechanisms of trauma transmission.

The conflict has fundamentally altered Kashmir's cultural practices and social norms. Traditional mourning rituals, wedding celebrations, and community gatherings occur under military surveillance or are disrupted by curfews, preventing normal grief processing and social bonding. The transformation of tourist destinations into military camps symbolically represents the occupation of physical and psychological spaces. Basharat Peer's documentation of checking identity cards, fear during night movements, and anxiety about search operations illustrates how trauma infiltrates mundane daily activities, creating hypervigilant consciousness incompatible with mental wellness.

### Barriers to Mental Health Care and Treatment Gaps

Despite unprecedented mental health burden, Kashmir faces substantial treatment gaps estimated at 90% for serious mental disorders. Only 41 psychiatrists serve a population of 12.5 million, with services concentrated in two urban hospitals in Srinagar, creating geographical and accessibility barriers for rural and remote populations (Hussain et al., 2024). Cultural factors including stigma surrounding mental illness, preference for traditional faith healers, and lack of mental health literacy compound access challenges. Research indicates 68.5% to 80% of patients consult faith healers before seeking psychiatric care, with some faith practitioners exploiting vulnerability through ineffective treatments delaying necessary interventions. Infrastructure deficiencies include inadequate training of primary care providers in mental health assessment, absence of community-based mental health services, insufficient psychosocial support systems, and lack of trauma-informed care protocols. Western therapeutic models emphasizing individual counseling prove culturally inappropriate for collectivist Kashmiri society, necessitating family-oriented, community-based interventions. Internet shutdowns, particularly the year-long restriction following Article 370 abrogation in 2019, severed access to telemedicine and digital mental health resources during critical periods including the COVID-19 pandemic.

The political dimensions of trauma complicate service delivery, as acknowledging conflict-related mental health crises implicates state authorities in human rights violations. Systematic documentation of torture, enforced disappearances, and extrajudicial killings creates tensions between health advocacy and political sensitivities. Mental health professionals navigate complex ethical terrain, balancing patient welfare with personal safety in militarized environments. Recent initiatives including district-level psychiatric outreach, community mental health programs, and school-based interventions represent progress, yet remain inadequate relative to population need.

### Resilience, Coping Mechanisms and Future Directions

Despite overwhelming trauma burden, Kashmiri communities demonstrate remarkable resilience through religious faith, family support systems, peer networks, and cultural practices. Research identifies

key resilience factors including trust in higher powers, engaging in regular prayers, maintaining strong interpersonal relationships, and accessing social support networks contributing 52% to resilience formation (Ahmed et al., 2025). Sufi spiritual traditions, shrine visitations, and community gatherings provide culturally congruent coping mechanisms that Western psychiatric frameworks often overlook. Effective interventions must integrate indigenous healing practices with evidence-based treatments, creating hybrid models respecting cultural values while providing scientifically validated care. Training faith healers to recognize serious psychiatric symptoms requiring professional referral represents promising collaborative approach. Community-based psychosocial interventions addressing collective rather than solely individual trauma show efficacy in similar conflict zones. Trauma-focused cognitive behavioral therapy adapted for Kashmiri cultural context, family therapy addressing intergenerational trauma, and group-based interventions fostering community healing warrant systematic implementation and evaluation.

Future directions necessitate comprehensive mental health policy reform including substantial investment in workforce development, infrastructure expansion, primary care integration, and public mental health literacy campaigns. Decentralization of services to district and community levels, mobile mental health teams for remote areas, and school-based prevention programs could significantly reduce treatment gaps. Research priorities include longitudinal studies tracking trauma's long-term trajectory, genetic and epigenetic investigations of intergenerational transmission, and evaluation of culturally adapted interventions. Addressing Kashmir's mental health crisis ultimately requires political resolution of underlying conflict, restoration of safety and security, and acknowledgment of populations' suffering as prerequisite for healing.

## 7. Conclusion

The psychological trauma resulting from terrorism and armed conflict in Jammu and Kashmir represents a profound public health emergency affecting nearly half the adult population. Decades of sustained violence have created unprecedented rates of PTSD, depression, and anxiety, with women, youth, and conflict-exposed individuals demonstrating particular vulnerability. The trauma transcends individual psychopathology, constituting collective societal wounding that disrupts family structures, community cohesion, and intergenerational wellbeing. Current mental health infrastructure proves grossly inadequate, with substantial treatment gaps, geographical barriers, and cultural stigma preventing most affected individuals from accessing necessary care. Effective response requires comprehensive, culturally adapted, community-based mental health systems integrating indigenous healing practices with evidence-based treatments, substantial workforce development, and infrastructure investment. Ultimately, sustainable mental health recovery depends upon political resolution of underlying conflict and restoration of safety, security, and dignity for Kashmir's traumatized populations. This research underscores urgent need for prioritizing mental health as integral component of humanitarian response and post-conflict reconstruction in Kashmir.

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