Assessment of Psychological Status (PTSD and Depression) Among The Terrorism Affected Hazara Community in Quetta, Pakistan

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Abstract

Aim: To assess the psychological status in terms of Post-Traumatic Stress Disorder (PTSD) and Depression among the terrorism affected the Hazara community of Quetta.

Method: The study was a quantitative, cross-sectional, interview-based survey carried out at Bolan Medical Complex Hospital and Sahib-U-Zaman hospital where only the Hazara individuals were consented to be part of the study. After calculating the sample size with 95% Confidence Interval, a total of 346 individuals were interviewed for the study. A self-designed questionnaire was made from DSM-5 (PCL-5) Checklist. It was translated into Urdu language and considered for the study. The data was analyzed on SPSS version 20.

Result: The study shows that there is a high prevalence of psychiatric disorders within the Hazara Community. 68.2% of respondents were found to be PTSD positive and 51.7% were seen to be depression positive. Majority of the respondents were under the age of 25 and most of them were females.

Conclusion: It is recommended that the health departments conduct immediate surveys to assess the psychological status among the community in case of an unfortunate terrorist attack. Special psychiatric camps and depression awareness programs are also recommended to be held in Hazara specific areas along with long term follow up based counseling for the identified victims of terrorism-related mental health disorders.

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1. Introduction

During the past decades, terrorism in different regions of the world is affecting the psychological wellbeing among the populations. Unfortunately, some regions of the world are more prone to terrorist attacks and hence vulnerable to terrorism-related mental health issues. One such region is Pakistan where all aspects of life have been affected by terrorism [1]. In this study one of the most terrorism affected city of Pakistan, Quetta has been assessed particularly for community-based terrorism. No prior study has been conducted in this regard to the best of our knowledge. The two aspects of physiological assessment being judged in this study are Post Traumatic Stress Disorder (PTSD) and Depression.

Post-Traumatic Stress Disorder, as the name suggests, is a psychiatric disorder, symptoms of which appear in the wake of a traumatic event that involves the risk of serious physical injury or death. Such an event is likely to evoke feelings of terror, fear, and despair among the victim(s); when such a negative perception affects an individual's physical and mental health in the long run, it takes the form of PTSD [2]. Mental illness of this nature not only affects an individual's personal health but also accounts for truncated education attainment, poor role plays in the society and an overall unaffordable loss for the economy, thereby necessitating its proper treatment and eradication [3, 4]. Studies made on the survivors of the 1989 air crash

in Kegworth, United Kingdoms [5]; The 1988 oil platform disaster in Piper Alpha [6]; and 1995 bombings in Oklahoma, America [7]; concluded that 25 to 75% of the witnesses suffered from PTSD [8]. Related studies in Pakistan include a report of 42.6% PTSD among the survivors of the 2005 Northern Pakistan earthquake disaster [9].

Mass killings, constant fear and continued exposure to such catastrophes, are major contributors to the acquisition of Post-Traumatic Stress Disorder in a large population [2]. In this regard, terrorism is playing a significant role in the increasing number of modern-day PTSD cases, since about 28–35% of victims of terrorist attacks are prone to develop this infirmity [10]. One such population under the prospect of mass terrorism are the Hazara community of Quetta [11]. The Hazara are an ethnic minority, who descended from Afghanistan to Pakistan before partition, in the early 1890s [12], and have established themselves since then in small distinct regions of the now Quetta, Balochistan [13]. Religiously, they belong to the Shia sect of Muslims [12], owing to which, they have been subjected to the Shia Genocide prevailing in Pakistan from around 1970, that have since seen to have strengthened its roots by early 2000s [14], taking the lives of more than 2700 Shia Muslims since 2002 [15]. One of the most tragic events among all the extremist attacks include the 2013 bombings in Mariabad and Hazara Town at 2 separate occasions, each of which took the lives of over 100 Hazara individuals and left hundreds injured [11, 16]. Massacres of such magnitude have even attracted the attention of many International peace organizations [17, 18, 19] and media platforms [15, 20, 21].

Depression, however, is a complex disease that is characterized by symptoms such as low mood, loss of interests, impaired cognitive function and vegetative symptoms, such as disturbed sleep or appetite [22]. PTSD and depression have long been studied in relation to terrorism in various parts of the world due to the fact that depression itself is a part of PTSD.

A study published in 2010 in the USA indicates increased behavioral problems among terrorism-exposed preschool children in relation to conjoined maternal posttraumatic stress disorder (PTSD) and depression [23]. Another study in 2006 highlights the impact of resource loss and traumatic growth on probable PTSD and depression following terrorist attacks [24].

It drives our attention towards the deteriorating mental health of the community under the target, and so, a quantitative analysis of Post-Traumatic Stress Disorder along with depression among the individuals have been made; a study that remains novel to date.

2. Research Design and Methodology

2.1 Study setting

The study was carried out at Bolan Medical Complex Hospital and Sahib-U-Zaman hospital. Moreover, some of the data was also collected from a private coaching center in Mariabad, Quetta.

2.2 Study Population

Hazara Individuals of Hazara Town and Mariabad, Quetta who were present at BMCH and Sahib-U-Zaman Hospital respectively, were included in the study. The total sample size was 400 interviews, 200 questionnaires for the Hazara Town residents while 200 for Mariabad residents (N = 400). With a dropout rate of 13.5%, a total of 346 interviews were recorded in the end. The margin of error was set to +/-5% (Confidence level of 95%).

2.3 Study Duration

The total study duration was one year from July 2017 to July 2018

2.4 Study Tool

A self-designed questionnaire was made with the help of DSM-5 (PCL-5) checklist. It was then translated into Urdu to make it convenient for the respondents. The question-naire also included questions related to Depression.

2.5 For PTSD

The checklist consists of 20 questions and each question was scored 4, making a total score of 80. Patients who suffered any recent traumatic event were considered and further assessed for the questions. 33 scores were set as cut off out of 80 for considering it as positive for PTSD.

2.6 For Depression

Patients having low mood were screened and were ruled in for a possible presence for depression. Total 10 questions were considered from the PTSD checklist for the presence of depression, they included Questions 9-20, excluding questions 10 and 17. Each question was scored as 4, therefore the total score was 40. The cut-off score for depression as to be positive was set to 50%, therefore 20 scores were set as cut off score.

2.7 Data collection

The participants were interviewed by the research team individually. After taking oral consent the interviews were started. Any participant who was not comfortable with the questions in the questionnaire and wanted to leave the interview was permitted to leave at any point.

3. Results

3.1 Demographic Characteristics:

Table No. 1 shows the demographic characteristics of participants, according to which, most of the subjects 51.4% were below 25 years of age. 57.2% of females participated in the study. 51.4% were single, 32.1% of participants had pursued education below Matriculation, while 25.4% were qualified till Intermediate. 56.4% of the subjects were residents of Hazara Town, 43.6% subjects belonging from Mariabad, and 28% among the respondents were categorized as students with regards to the occupation.

3.2 Questionnaire Responses:

Tables 2 and Figure 1 show the details related to the Trauma. 67.6% responded that they were affected by bomb blast. 50.9% being of view that it had occurred in 2013. 92.2% reported that the event threatened serious injury and death. 47.1% participants witnessed family member as victim, 46% of the respondents had intentions to migrate from Quetta.

Table 3 shows the response to DSM-5 (PCL-5), 56.6% of the respondents expressed flashbacks of the event, 65.3% expressed it bothersome to recall the event. 32.1% expressing extreme efforts at avoiding any external reminders. 23.7% of participants were blaming themselves for the event. 43.1% emphasized that they have extremely strong feelings of fear or horror.

Among the respondents, 46.8% reported having loss of interest in activities that they previously enjoyed. 42.2% admitted that they were extremely affected by irritable behavior, angry outbursts and aggressiveness. 56.6% subjects claiming of being extremely alert and on guard. 43.6% shared of being extremely jumpy and startled and 33.5% said it was extremely difficult for them to concentrate, whereas, 20% believed they have trouble falling or staying asleep.

3.3 Score Levels:

Data for the scoring systems are included in Table 4.

PTSD: According to the aforementioned scoring criteria, the total number of individuals calculated to be PTSD positive are 236 (68.2%), while the symptoms of PTSD were absent in 110 (31.8%) subjects.

Depression: According to the above mentioned scoring system, using 20 as the cut off score; the number of subjects marked positive for the symptoms of depression are 179 (51.7%), whereas the depression negative individuals are 167 (48.3%).

Figure 2 further characterizes the presence of PTSD and Depression on the basis of the gender of the respondents.

4. Discussion

The study was conducted to focus upon the mental status of an ethnic minority of the region following extremist attacks of divergent magnitudes carried out time and again, usually on the basis of religious intolerances. A quantitative analysis of post-event psychiatric disorders such as major depression and PTSD have been made by conducting a cross-sectional study. In the light of our study we found out that among the participants of the community, 92.2% of them were affected directly by the terrorist activities involving threatened death and serious injury. Such conditions contributed to the presence of PTSD in 68.2% and Depression in 51.7% among the individuals of the study. This finding is consistent with the results of a study carried out in Manhattan, New York on September 11 terrorist attacks [25] and a systemic review study conducted on the prevalence of major depressive disorder following the terrorist attack [26]. The study showed that the participants who showed more signs of major depressive disorders, general anxiety and PTSD were females as compared as males, a finding which is consistent amongst various studies [25, 27, 28].

The participants were asked if they want to migrate from Quetta following the attacks, 54.0% of them were reluctant to do so. The major reason for not migrating was their low economic conditions. The results are like a research carried out by Axel Dreher et al. which also states that terrorist attacks do not robustly affect overall migration [29].

The results of the analysis showed that 55.5% of the contributors showing positive symptoms when asked, denied any inclination towards risk-taking behaviors and causing any self-harm which makes our results contrary to the study carried out in Israel stating; adolescents suffering from posttraumatic symptoms were reported to show more risk-taking behaviors than non-symptomatic adolescents [30].

In light of the study conducted, PTSD and Depression have a high prevalence among the Hazara community of Quetta. The participants involved in the study have limited access to the psychiatry clinics of the city. They are restricted because of the fear of attacks and bad conditions of the law and order of the city. Therefore, psychiatry camps are needed to be arranged for them in their area of living which may identify the victims, counsel/ debrief them, and keep proper follow up until they recover completely [31].

Health Department may conduct their surveys to assess the mental health among the community and arrange plans accordingly. Moreover, if any such event occurs in the future, immediate measures should be taken to relieve the victims from psychopathological burden following any unfortunate incident.

5. Conclusion

This study was aimed to assess the mental status of Hazara community status post terrorist activities in Quetta. Among the participants, 92.2% were affected by terrorist activities that lead to serious injuries and even deaths. Such incidents affected their mental health and it is reported that 68.2% were positive for PTSD, while 51.7% had Depression. Since Hazara Community is isolated and has limited access to psychiatry clinics, therefore, it is recommended

Table	1. Demographics		
Demographic Character	Frequency $(n = 346)$	Percentage (%)	
Age:			
Under 25	178	51.4	
26-35	83	24	
36-45	40	11.6	
46-55	21	6.1	
Above 55	24	6.9	
Gender:			
Male	148	42.8	
Female	198	57.2	
Marital status:			
Single	178	51.4	
Married	163	47.1	
Separated/Divorced	2	0.6	
Widowed	2 3	0.0	
Education:	5	0.9	
Matriculation	50	171	
Intermediate	27 00	17.1	
Graduata	00 65	23.4	
Graduale	03	18.8	
Masters	21	0.1	
MPhil	2	0.6	
Others (Below matric/ None)	111	32.1	
Area of residence:			
Mariabad	151	43.6	
Hazara town	195	56.4	
Occupation:			
Banker	2	0.6	
Beautician	2	0.6	
Businessman	4	1.2	
Carpenter	1	0.3	
Dispenser	4	1.2	
Driver	7	2.0	
Government employee	8	2.3	
House wife	55	15.9	
Lab attendant	2	0.6	
Laborer	13	5.8	
Mechanic	1	0.3	
NA	70	20.2	
Nurse	6	1.7	
Photographer	1	0.3	
Plumber	-	03	
Private Job	15	43	
Property dealer	1	03	
Receptionist	1	03	
Salesman	3	0.9	
Security guard	5 4	1 2	
Shonkeener	+ 11	2.2	
Student	07	28.0	
Tailor	27 10	∠0.0 2 0	
Taaahar	10	2.9 7 0	
Teacher	27	/.8	

that special psychiatry clinics are needed to be arranged in order to have psychological intervention and care for the

affected ones.

Table 2. Trauma Details				
Question	Frequency	Percentage(%)		
Identify the event that affected you the most?				
A bomb blasts	234	67.6		
Target killing	82	23.7		
Bus killing	20	5.8		
Other	10	2.9		
How long ago did it happen?				
2000	1	0.3		
2000	1	0.3		
2003	6	1.7		
2004	5	1.4		
2005	1	1.2		
2007	4	1.2		
2008	2	0.6		
2009	3	0.9		
2010	5	1.4		
2011	11	3.2		
2012	20	5.8		
2013	176	50.9		
2014	21	6.1		
2015	25	7.2		
2016	12	3.5		
2017	21	6.1		
Did not disclose	32	9.2		
Did it involve actual or threatened death,				
serious injury or violence?				
Yes	319	92.2		
No	27	7.5		
Do you want to migrate from Quetta due				
to terrorism any time soon?				
Yes	152	43.9		
No	187	54.0		
Did not disclose	7	2.0		



Figure 1. The experience of Trauma

		(/	1		
		N(%)				
In the past month, how much were you	Not at all	A little bit	Moderately	Quite a bit	Extremely	Missing value
bothered by:						
1. Repeated, disturbing and unwanted	27(7.8)	26(7.5)	50(14.5)	47(13.6)	196(56.6)	•
memories of the stressful experiences?						
2. Repeated, disturbing dreams of the	123(35.5)	53(15.3)	62(17.9)	27(7.8)	81(23.4)	•
experience?						
3. Suddenly feeling or acting as if the	52(15.0)	40(11.6)	40(11.6)	46(13.3)	168(48.6)	•
stressful experience were actually hap-						
pening again						
4. Feeling very upset when something re-	17(4.9)	19(5.5)	39(11.3)	44(12.7)	226(65.3)	1(0.3)
minded you of the stressful experience?						
5. Having strong physical reactions	93(26.9)	36(10.4)	40(11.6)	54(15.6)	123(35.5)	
when something reminds you of the						
stressful experience?						
6. Avoiding memories, thoughts, or feel-	77(22.3)	54(15.6)	49(14.2)	60(17.3)	106(30.6)	1(0.3)
ings related to the stressful experience?						
7. Avoiding external reminders of the	86(24.9)	45(13.0)	49(14.2)	54(15.6)	111(32.1)	1(0.3)
stressful experience?						
8. Trouble remembering important parts	138(39.9)	58(16.8)	54(15.6)	34(9.8)	60	2(0.6)
of the stressful experience?						
9. Having strong negative beliefs about	135(39.0)	46(13.3)	34(9.8)	32(9.2)	99(28.6)	•
yourself, other people, or the world?						
10. Blaming yourself or someone else	171(49.4)	33(9.5)	26(7.5)	33(9.5)	82(23.7)	1(0.3)
for the stressful experience or what hap-						
pened after it?						
11. Having strong negative feelings such	67(19.4)	36(10.4)	44(12.7)	50(14.5)	149(13.1)	•
as fear or horror.						
12. Loss of interest in activities that you	63(18.2)	27(7.8)	49(14.2)	45(13.0)	162(46.8)	•
used to enjoy?						
13. Feeling distant or cut off from other	135(39.0)	38(11.0)	50(14.5)	39(11.3)	83(24.0)	1(0.3)
people?						
14. Trouble experiencing positive feel-	117(33.8)	46(13.3)	44(12.7)	48(13.9)	91(26.3)	•
ings?						
15. Irritable behavior, angry outbursts,	53(15.3)	52(15.0)	45(13.0)	50(14.5)	147(42.2)	•
or acting aggressively						
16. Taking too many risks or doing	192(55.5)	26(7.5)	28(8.1)	27(7.8)	73(21.1)	•
things that could cause you harm?						
17. Being super alert or watchful or on	35(10.1)	31(9.0)	47(13.6)	37(10.7)	196(56.6)	•
guard?						
18. Feeling jumpy or easily startled?	63(18.2)	37(10.7)	51(14.7)	44(12.7)	151(43.6)	•
19. Having difficulty concentrating?	75(21.7)	47(13.6)	50(14.5)	58(16.8)	116(33.5)	•
20. Trouble falling or staying asleep?	136(39.3)	43(12.4)	53(15.3)	38(11.0)	76(22.0)	•

Table 3. DSM-5 (PCL-5) Checklist response

Table 4. Scoring of PTSD and Depression				
Score level	Frequency	Percentage (%)		
PTSD Negative	110	31.8		
PTSD Positive	236	68.2		
Depression Negative	167	48.3		
Depression Positive	179	51.7		

5.1 Limitations

As mentioned above that Hazara community has limited access to the hospitals and are isolated. We had limited access to homes of the victims and may have missed severe cases of PTSD and Depression.

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Figure 2. PTSD and Depression and its characterization on the basis of Gender.

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