



(RESEARCH ARTICLE)



Anxiety and its correlates among youth in Kashmir: A cross-sectional study

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Abstract

Introduction: The present study was undertaken to study the anxiety patterns among youth in Kashmir.

Methodology: A cross-sectional study was conducted among 400 youth of the Kashmir Valley aged 15-30 years using multistage random sampling method. Respondents were drawn from the educational institutions (Higher secondary institutions, Govt. Degree Colleges and Universities of the valley) after obtaining consent from them. Apart from the self-designed structured questionnaire, standardized anxiety scales namely “Screen for Child Anxiety Related Disorders (SCARED)” and “Screen for Adult Anxiety Related Disorders (SCAARED)” were used to achieve the objective of the study.

Results: 143(35.75%) study subjects were found to have anxiety disorder. A significant association was found between anxiety and various demographic variables such as gender, occupational status, income and victimization because of conflict. Comparatively, higher prevalence of anxiety was recorded among males, smokers, unemployed ones, lower wealth quintals, rural dwellers and victims of conflict.

Conclusion: Poor health system and non-detection/under detection of Common Mental Health disorders (CMDs) are responsible for the gap in the treatment of mental disorders. Early detection of the mental health disorders can be achieved by integrating the routine screening of mental health care with primary care. Community based mental health programmes is the need of the hour. Ensuring ample resources for youth so as to enable them to fulfill their potential and contribute fully to their individual and collective development. The gap between the allocation of resources for mental health and actual burden ought to be bridged.

Keywords: Anxiety; Disorder; Prevalence; Study subjects; Youth

1. Introduction

Anxiety disorders are among the most prevalent psychiatric conditions reported around the world, which account for about 28.68 million disability-adjusted life years (DALYs) as per the estimates put forth by one of the studies undertaken by Global Burden of Diseases (GBD) in 2019[1]. The estimates are equally significant for the adolescent group aged 10-24 years as well, ranking sixth in the global burden of diseases (GBD 2019 Diseases and Injuries Collaborators 2020) [2]. The national disease burden of India is more or less analogical with the Global Burden of Diseases (GBD), with mental disorders being the leading cause of total years lived with disability (YLDs) in 2017 at 14.5% (State- Level Disease Burden Initiative 2017)[3]. Further, among the mental health disorders, anxiety disorders were the second largest contributors to YLDs at 19% in 2017[4]. The estimates of mental health disorders in Kashmir valley are quite in line with the national and global burden with anxiety being the second most prevalent mental disorder at 23.8% after depression (Kashmir Mental Health Survey report, 2015) [5]. Though, mental disorders affect each and every stratum

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of population, however, adolescents and young people are most vulnerable to such disorders, as it is during this period that such people undergo major physical and behavioural changes [6]. Moreover, it is during adolescence that individuals prefer to be more independent from their parents and also tend to build their self-image. Therefore, the transition can lead to the increase in their stress levels, which in turn, can initiate their psychopathology.

Given the rising trend of anxiety disorders among the population in general and youth in particular, the present study seeks to determine the prevalence of anxiety disorders among youth aged (15-30 years) in Kashmir, so as to access the prevalence of anxiety disorders among this vulnerable segment of population.

2. Material and methods

A cross-sectional study was undertaken among 400 youth of the Kashmir Valley aged 15-30 years. The sample size was calculated on the basis of the formula $N = Z^2 P (1-P) / e^2$, where N=Estimated sample size; Z=Statistic for 95% level of confidence, (Z =1.96); P=Expected prevalence; e=Absolute precision/Allowable error. Assuming an overall prevalence of mental related disorders at 50% as against the national prevalence rate of 10-30% among the young people aged 10-24 (WHO report, 2011), with 5% absolute precision and a confidence level 95% plus non response rate up to 5%, the sample size calculated came to be approximately 400. Respondents were selected from all the three geographical regions of the valley- North, center and south using multistage random sampling method. To ensure the representation from all the three geographical regions, 133 respondents (approx.) each were taken from the three respective geographical zones to achieve a sample size of 400. Youth being a heterogeneous group, the study population was divided into four age groups of 15-18 years, 19-22 years, 23-26 years and 27-30 years constituting 25% (50) respondents each. Respondents were drawn from the educational institutions (Higher secondary institutions, Govt. Degree Colleges and Universities of the valley) after obtaining consent from them. In order to ensure the proper gender representation, 50 % (200) respondents each were selected from both the male and female categories.

2.1. Study tools

Apart from the self-designed structured questionnaire, standardized anxiety scales namely “Screen for Child Anxiety Related Disorders (SCARED)” and “Screen for Adult Anxiety Related Disorders (SCAARED)” were used to achieve the objective of the study. ‘SCARED’ scale was used for 15–18-year age group while as ‘SCAARED’ scale was used for 19–30 year age group. For SCAARED scale, a total score of ≥ 23 indicates the presence of an anxiety disorder. Whereas for SCARED scale, a total score of ≥ 25 indicates the presence of an anxiety disorder.

2.2. Inclusion criteria

Youth aged between 15-30 years who consented to be the part of the study.

2.3. Exclusion criteria

People falling outside the selected age group.

2.4. Statistical Analysis

The collected data was analyzed using IBM SPSS version 20. The data was presented in both proportions and percentages. To find any association between relevant variables, Chi-square test was applied. The association of <0.05 with P value was considered to be statistically significant.

3. Results

The present study included a total of 400 respondent’s aged 15-30 years. 200(50%) respondents each were taken from both the male as well as female category, so as to ensure equal gender representation. So far as the age distribution of study respondents is concerned, 100(25%) respondents each belonged to the various age groups of 15-18 years, 19-22 years, 23-26 years & 27-30 years respectively. 243 (60.75 %) study respondents were rural as against 157(39.25%) urban respondents. The occupational status of the study subjects reveals that 308(77%) were students, 54(13.5%) were employees and 38(9.5%) were research scholars. A total of 18(4.5%) study subjects confessed to be indulging in smoking. 45(11.25%) study subjects reported to have been direct or indirect victims of conflict. Further, the socio-economic distribution of the study population revealed that 161(40.25%) respondents belonged to higher class, 96(24%) belonged to upper middle class, 53(13.25%) belonged to middle class, 84(21%) belonged to lower middle class whereas, only 6(1.5 %) belonged to lower class. [Table 1].

The prevalence of anxiety among the study population was found to be 35.75% [Table 2]. As shown in the figure, most common type of anxiety noted was Separation Anxiety Disorder (38.25%) followed by Panic Anxiety Disorder/Significant Somatic Symptoms (31.5%), Social Anxiety Disorder/Social Phobias Disorder (26%), Generalized Anxiety Disorder(21.5%) and Significant School Avoidance(15%).[Figure A].

Table 1 General characteristics of the study population (N=400)

Characteristics	Total N=400	Percent (%)
Age(Year)		
15-18	100	25.0
19-22	100	25.0
23-26	100	25.0
27-30	100	25.0
Gender		
Male	200	50.0
Female	200	50.0
Dwelling		
Rural	243	60.8
Urban	157	39.2
Family Structure		
Nuclear	256	64.0
Joint	144	36.0
Education		
Pursuing Secondary& Higher secondary education	100	25.0
Pursuing Graduation	81	20.2
Perusing post-Graduation	127	31.7
Pursuing M Phil/PhD	38	9.5
Graduate (Employed)	26	6.5
Post-Graduate(Employed)	24	6.0
M Phil/PhD(Employed)	04	1.0
Occupational Status		
Student	308	77.0
Research Scholar	38	9.5
Employed	54	13.5
Socio-Economic Class		
Upper class	161	40.2
Upper middle Class	96	24.0
Middle Class	53	13.2
Lower Middle Class	84	21.0

Lower Class	6	1.5
Substance Abuse (Smoking)	18	4.5
Victims of conflict	45	11.2

Table 2 Anxiety Status of the Study Population (N=400)

Anxiety Disorder*	Frequency (N)	Percent (%)
Yes	143	35.75
No	257	64.25
Total	400	100.00

* For SCAARED scale, a total score of ≥ 23 may indicate the presence of an Anxiety Disorder; **For SCARED scale, a total score of ≥ 25 may indicate the presence of an Anxiety Disorder.

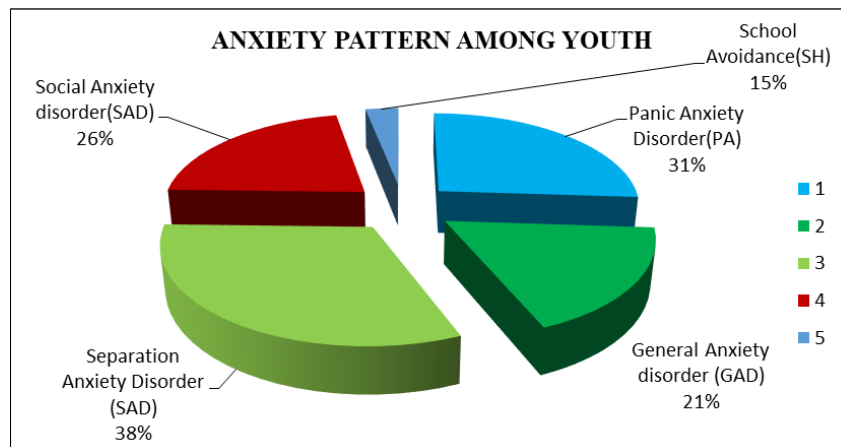


Figure 1 Anxiety Pattern of the Study Population

[Table 3] shows the anxiety pattern across socio-demographic characteristics. The tabulated data reveals a significant association between anxiety and various demographic variables such as gender, occupational status, income and victimization because of conflict. Comparatively, anxiety was found to be higher among males (23.5%) than females (12.2%). The difference was statistically highly significant ($P=0.000$). A variation in anxiety pattern was also observed with regard to the occupational status. Comparatively, anxiety was highest among scholars (55.3%) followed by employed class (35.2%), while it was least among the students (35.2%). The difference was statistically significant ($P=0.030$). Besides, a variation in anxiety patterns was also observed viz-a viz income status. Overall, anxiety showed a declining trend with an increase in the income of the respondent. The observed trend for anxiety was as: upper class (33.1%), upper middle class (24.7%), middle class (48.3%), Lower middle class (43.5%) and lower class (45.5%). The difference was statistically significant ($P=0.016$). A positive trend was also observed between the anxiety status and victimization because of conflict. Anxiety was higher among the respondents who have been the direct or indirect victims of conflict (57.8%) as against the respondents who were not the victims of conflict (33%). The difference was statistically significant ($P=0.001$).

The demographic variables which recorded an insignificant association ($P>0.05$) with the anxiety included age group, family structure, type of dwelling & substance abuse. With regard to the age group, a variation was observed in anxiety trend as: 15-18 years (36%), 19-22 years (27%), 23-26 years (35%) and 27-30 years (45%). However, the difference was statistically insignificant ($P=0.069$). Anxiety pattern among the respondents of nuclear (35.2%) and joint family (36.8%) didn't show a prominent difference. The difference was statistically insignificant ($P=0.741$). Pertinently, no prominent difference was found in the anxiety trend among the respondents of rural dwellings (35.8%) and urban dwellings (35.7%). Again, the difference was statistically insignificant ($P=0.741$). With regard to the substance abuse, it

was found that anxiety was higher among the smokers (50%) as against the non-smokers (35.1%). However, the difference was statistically insignificant ($P=0.197$).

Table 3 Anxiety pattern Across Various Socio-demographic Characteristics (N=400)

Socio-demographic characteristics	Morbidity		Total N (%)	Chi square (χ^2)	P Value	Odds Ratio
	Yes N (%)	No N (%)				
Gender				0.235	0.000	2.733
Male	94 (47.0)	106 (53.0)	200(100.0)			
Female	49 (24.5)	151(75.5)	200(100.0)			
Occupational status				0.132	0.030	-
Employed	19(35.2)	35(64.8)	54(100.0)			
Research Scholars	21(55.3)	17(44.7)	38(100.0)			
Students	103(33.4)	205(66.6%)	308(100.0)			
Socio-Economic Class				0.175	0.016	-
Upper class	51(33.1)	103(66.9)	154(100.0)			
Upper middle Class	24(24.7)	73(75.3)	97(100.0)			
Middle Class	28(48.3)	30(51.7)	58(100.0)			
Lower Middle Class	30(43.5)	39(56.5)	69(100.0)			
Lower Class	10(45.5)	12(54.5)	22(100.0)			
Victims of Conflict				0.001	0.164	2.784
Yes	26(57.8)	19(42.2)	45(100.0)			
No	117(33.0)	238(67.0)	355(100.0)			
Age group (Years)				0.133	0.069	-
15-18	36(36.0)	64(64.0)	100(100.0)			
19-22	27(27.0)	73(73.0)	100(100.0)			
23-26	35(35.0)	65(65.0)	100(100.0)			
27-30	45(45.0)	55(55.0)	100(100.0)			
Family Type				0.741	-0.017	0.931
Nuclear	90(35.2)	166(64.8)	256(100.0)			
Joint	53(36.8)	91(63.2)	144(100.0)			
Type of Dwelling				0.001	0.978	1.006
Rural	87(35.8)	156(64.2)	243(100.0)			
Urban	56(35.7)	101(64.3)	157(100.0)			
Substance Abuse(Smoking)				0.065	0.197	1.851
Yes	9(50.0)	9(50.0)	18(100.0)			
No	134(35.1)	248(64.9)	382(100.0)			

4. Discussion

The study provides the estimates of anxiety among youth in Kashmir. The empirical inputs divulge that a good chunk of youth (35.75%) possess anxiety disorders. Pertinently, a maiden mental health survey undertaken by Medicins Sans

Frontiers[7] in collaboration Institute of Mental Health and Neurosciences, Kashmir also found a high burden of anxiety (26% approx.) among the adult population aged 18 years and above in Kashmir. However, the incidence rate of anxiety in our study was comparatively higher. The difference could be because of the fact, that our study was conducted on the youth aged 15-30 years only and youth being a transitory group is more vulnerable to mental health disorders than other strata of population. Our results bear's resemblances with one of the studies conducted on adolescents of Kashmir (Tamheeda Qounsar & Amina Parveen)[8] which shows a prevalence of 35.8%. Gender based comparative anxiety trends in our study also resembles the anxiety trends of the aforementioned study as both the study found a high prevalence of anxiety among males than females. Our findings differ with most of the studies which report higher anxiety levels among females than males. This can be because of the fact that these studies are conducted on the general population whereas, our study is specified to the youth age group only. With regard to the dwelling, the prevalence of anxiety was found to be higher among rural dwellers than urban counterparts; now-a-days, youth in rural areas have almost similar access to communication and are exposed to the new ideas of living life; however, they mayn't have adequate resources to translate them into reality. This might lead to mental health problems. Our results are in line with one of the studies conducted on youth in India (Kirti Gaur & Usha Ram)[9]. Pertinently, various studies show variation in the anxiety patterns among the rural and urban youth. Therefore, this necessitates a need for undertaking more studies to understand the variations in mental health problems among the rural and urban youth before reaching to any generalisation.

Further, our study results divulge that youth belonging to lower income groups report more mental health problems as compared to the youth of higher income groups. Our results are consistent with earlier studies that have demonstrated more reported mental health problems among youth with lower socio-economic status (Hackettetal., 1999[10]; Patel et al., 2007[11]; Poongothai et al., 2009[12]; Pothen et al., 2003[13]). The study results reveal that occupational status has a significant bearing upon the mental health status. Employed youth reported lower mental health problems followed by unemployed youth who are still pursuing education and seeking job. Our findings are consistent with the observation from the available literature. Simon (2002) reported that unemployed persons and those who seek job have higher risk of depressive symptoms than individuals who are employed. Results suggest that the household and individual factors like place of residence, occupation, income, age, etc. are the most important determinants of mental health problems among Indian youth.

With regard to the association between anxiety levels and smoking, rate of smoking was found to be higher among the study participants having higher anxiety levels. Our results are consistent with many studies who report a positive association between smoking and anxiety disorder. Evidence suggests that individuals with increased anxiety are more likely to smoke (Cuijpers et al. 2007[14]; Swendsen et al. 2010[15]). Multiple factors have been proposed to explain this, including use of cigarettes to reduce anxiety (i.e., self-treatment) and an increased susceptibility of those with anxiety in initiating smoking in response to peer pressure (Patton et al. 1998[16]; Tjora et al. 2011[17]).

Conflict has a worst impact on the mental health of the people affected by it. Study Participants were asked about the various types of victimization inflicted on them or their family members such as being harassed, beaten, raped, arrested, kidnapped, handicapped & killed. Our study reports a staggering increase in the anxiety levels of the study participants directly or indirectly impacted by conflict. Our study results are in line with one of the studies conducted by Fiona Charlson and colleagues [18] which reports a high burden of mental disorders in population affected by conflict.

Limitations of the study

The present study is the maiden study which was conducted on the entire age group (15-30) of youth as specified by the national Youth Policy. However, being a cross-sectional study, it wasn't possible to look into the cause-effect relationship. Second, although, the study was conducted on 400 respondents assuming a high prevalence rate of mental health disorders, a large-scale data can present a broader and clear picture of the problem.

5. Conclusion

The present study estimated the prevalence of anxiety among the youth in Kashmir. Socio-cultural factors like place of residence, occupation, income, age, conflict, substance abuse etc. are the most important determinants of common mental disorders (CMDs) among the youth. Given the staggering number of youth which suffer from reported mental health problems in India, there is a need to improve the early detection of the disorder by integrating the routine screening of mental health care with primary care. Mental health doesn't only mean the prevention of the mental health disorders; it equally, refers to the promotion of mental health. To achieve this end, there is a dire need to aware and educate people about the importance of mental health. Further, there is a gap in the treatment which can be seen as consequence of both the poor health system and non-detection or under detection of Common Mental Health disorders

(CMDs). Community based mental health programmes is the need of the hour to do away with the attendant stigmatisation of mental health seeking behaviour. More importantly, it should be the priority of the statecraft to emphasise needs of youth by ensuring the ample resources so that they are able to fulfil their potential and contribute fully to their individual and collective development. Finally, no measure of efforts is going to fructify, unless the gap between the allocation of resources for mental health and actual burden is not bridged.

Compliance with ethical standards

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Disclosure of conflict of interest

The authors have no competing interests to declare.

Statement of ethical approval

The study was approved by the Departmental Research Committee, Department of Sociology, University of Kashmir.

Statement of informed consent

Informed consent was obtained from all individual participants included in the study.

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