ISSN: 0975-833X

Available online at http://www.journalcra.com

International Journal of Current Research
Vol. 8, Issue, 06, pp.32728-32734, June, 2016

INTERNATIONAL JOURNAL OF CURRENT RESEARCH

RESEARCH ARTICLE

"MY COUNTRY HAD A WAR. IT WOULD BE EXTRAORDINARY NOT TO WANT TO WRITE ABOUT THAT": KASHMIR, A TAPESTRY OF VIOLENCE

***Syed Shehna and Chandra Shekhar**

P.G. Department of Psychology, University of Jammu, 180001

ARTICLE INFO

Article History:
Received 05th March, 2016
Received in revised form
27th April, 2016
Accepted 18th May, 2016
Published online 15th June, 2016

Key words:

Kashmir,
Women,
Ptsd, Health.

ABSTRACT

This paper is the result of discussions and data collection from Kashmir valley's most volatile places (districts of Srinagar, Budgam and Kupwara) and the subsequent vulnerable populations including; the half widows of Dardpora (Kupwara), Widows of police martyrs (Srinagar), Widows of the persons killed unlawfully in cross firings (Budgam), Rape victims of Kunanposhpora (Kupwara) and the Mothers of disappeared persons (Srinagar and Budgam). The study addresses post-traumatic stress and its impact on the health status of these women who continue to endure plethora hardships on daily basis. This work is a small effort in a direction which seeks to reveal how the incessant and ever-increasing violence in Kashmir has changed the lives of women forever. Results showed that PTSD significantly predicts the health status.

Citation: Syed Shehna and Chandra Shekhar, 2016. "My country had a war. it would be extraordinary not to want to write about that": Kashmir, A tapestry of violence", *International Journal of Current Research*, 8, (06), 32728-32734.

INTRODUCTION

Cradled in the lap of majestic mountains of the Himalayas, Kashmir is one of the most beautiful places on earth. This paradise is now hell for many Kashmir is due to the prolonged war between India and Pakistan since the end of the British Empire and subsequent partition of the Indian Subcontinent (Crew, 2008). The loss of human lives in Kashmir since the armed conflict began in 1989 is many times more than the combined casualties in the four wars fought between India and Pakistan. The conflict has precipitated a humanitarian crisis of tragic magnitude. Women are being the most vulnerable section of the population adversely affected (Kour, 2004). An armed conflict is a contested incompatibility that concerns government and/or territory where the use of armed force between two parties, of which at least one is the government of a state, results in at least 25 battle-related deaths in one calendar year (The Gazette of India Extraordinary, 1990). However, it should be admitted that there seems to be no universal definition in existence for the term "armed conflict", ICRC (2008) defines the term as protracted armed confrontations occurring between governmental armed forces and the forces of one or more armed groups, or between such groups arising on the territory of a State (party to the Geneva Conventions).

****Corresponding author: Syed Shehna,***
P.G. Department of Psychology, University of Jammu, 180001

The armed confrontation must reach a minimum level of intensity and the parties involved in the conflict must show a minimum of organization and have the capacity to sustain military operations. Hazen (2008) defines the term "armed conflict" as the intentional use of illegitimate force (actual or threatened) with arms or explosives, against a person, group, community or state, which undermines people- centered security and/or sustainable development. The impact of conflict in Kashmir has been experienced by people of all ages who suffered displacement, loss of home and property, loss or involuntary disappearances of close relatives, poverty and family separation and disintegration (Hassan and Shafi, 2013).

Consequences of armed conflict in Kashmir

Half widows: One of the repercussions of Kashmir conflict has been the increasing number of half widows. During the last 27 years a phenomenon new to Kashmir viz. "half widows" has surfaced engulfing a large number of Kashmiri women (Kour, 2004). Decked by thick deodar forests, terraced corn fields, apple orchards and jagged mountains, the hamlet of Dardpora tacked in the northern rim of Indian administered Kashmir looks idyllic. Dardpora which literally means "The abode of Pain" is a village in Kupwara district of Kashmir inhabited by the half widows whose husbands have disappeared but are not declared deceased (Umar, 2013).

Many women whose husbands have disappeared prefer to wait for them and do not remarry for the fear of social ostracism (Kour, 2004). The half-widows are a significant part of the Kashmiri society, and a reminder of a largely unaddressed pain and anguish of women caught in conflict (D'Souza, 2015).The social ostracism imposed on half widows is also supported by allegations on their chastity, purity and dignity. Due to the situation they are caught in, half widows have proved to be a psychological wreck as they face many psychological/ psychiatric problems related to tension, stress, strain, anxiety, emotional breakdown and trauma (Dabla, 2012).

Rape victims: Sexual violence, including rape, is one of the most significant aspects of discriminatory violence against women. The realities of rape and sexual abuse in armed conflict have been documented extensively over many years. The right to equality, including equality before the law, are violated by such crimes and the impunity that the perpetrators enjoy in the overwhelming majority of cases (Amnesty International, 2011). Despite pity for the trauma the women have suffered, society marks the victims as 'damaged goods' (Bennett, 1995). As women struggle to keep families together and care for the wounded on the margins of fragile war economies, they are the first to be affected by infrastructure breakdown, and may be forced into survival strategies that involve exploitation (UNIFEM, 2005). Women are raped in all forms of armed conflict, international and internal, whether the conflict is fought primarily on religious, ethnic, political or nationalist grounds, or a combination of all these. They are raped by men from all sides - both enemy and 'friendly' forces. The consequences of rape continue beyond the actual attack or attacks, often lasting for the rest of the women's lives. As well as the degradation, pain and terror caused at the time, the fear engendered remains long after (Chinkin, 1994). During and in the aftermath of armed conflict, it has been common for armed groups to loot, pillage and rape with impunity, treating women as the "spoil of war" (United Nations, 2008).According to Bhutalia, (2002), in situations of conflict and particularly those involving religious identities, women are targeted in specific ways. "In times of conflict, particularly religious conflict, it is women who carry the honor of the community on their backs and bodies and defiling their bodies usually through rape is a way of hitting back at the other community. Several accounts exist that describe composite and reliable accounts of crackdowns and rape which took place in the twin villages of Kunan and Poshpora (Kupwara, Kashmir) in 1991. In fact the truth of Kunanposhpora is so dangerous that it is not enough to simply dismiss it as fiction (DuttaandVij, 2013). Sexual violence has serious and multiple consequences for the mental health of women. At the psychological level, it leads to radical changes in the image that the victim has of herself, in her relations with her immediate social circle and beyond, in the community as a whole, and in the way in which the victim sees the past, present, and future. It thus has a lasting negative impact on the victim's perception of herself, of events, and of others (Josse, 2010).

Missing Persons, Disturbed survivors

Besides sexual violence, armed conflicts are characterized by the separation of men from women and children — both a voluntary and involuntary separation (Lindsey, 2000). In a cross-sectional study by Heeke *et al*. (2015) found that 23% of participants who lost a significant other to disappearance met criteria for Prolonged grief disorder (PGD) as compared to 31.5% in bereaved participants. The study also concluded that forced disappearance is related to prolonged grief reactions, particularly when those left behind maintain hope that the disappeared person is still alive. Most families with missing members have, despite repeated efforts, failed to find satisfactory explanations for the disappearances in Kashmir. In 1994, a group of these relatives formed the Association of Parents of Disappeared Persons (APDP). They have since visited security officials, police stations, politicians, courts and prisons throughout India with photographs of sons, brothers, fathers, and husbands, trying to settle the uncertainty surrounding the disappearances. The disappearance of thousands of young men has had a measurable economic impact since it is usually the earning member of the family who goes missing (Hassan and Shafi, 2013). The loss of a breadwinner and the decision maker puts multiple responsibilities on the women who are illiterate, economically unskilled and poor. They are oblivious of the masculine world outside and struggles to survive, on one hand, the anguish of searching for her missing husband/son/brother/father and on the other nurturing children in the family (D'souza, 2015). Rauchfuss and Schmolze (2008) elucidated in their study that traumatized refugees, who are survivors of serious human rights violations, suffer from persisting impunity in their home countries. Mental health problems resulting from such traumatic experiences can persist or be reactivated by certain events. In particular, family members of the forcibly disappeared suffer from an incomplete mourning due to the uncertain fate of their beloved ones.

Conflict and widowhood: The proliferation of armed conflicts, and the high levels of military and civilian casualties, have resulted in a large number of widows in many regions of the world and Kashmir is no exception. This has a major impact not only on the women themselves but on society in general. Widowhood often changes the social and economic roles of women in the household and community, besides altering the structure of the family; its impact differs according to culture and religion (International committee of the Red Cross and The Australian Red Cross, 1999). Though mostly men participate in the conflict openly, women and children are the ones mostly affected of such conflict. Their exposure to spaces of violence may sometimes have over-reaching effects on their overall social functioning. Widows of conflict suffer violations of human rights, including terrorism, torture, disappearance, rape, ethnic cleansing, family separation and displacement. Moreover, they endure lifelong social and psychological traumas. Along with children, women constitute 80% of the World's refugees and displaced persons (Qayoom, 2014). Widowhood can affect the physical safety, identity and mobility of women and children. It can also affect their access to basic goods and services necessary for survival, and their rights to inheritance, land and property, in addition to the wider impact it has on the community (International committee of the Red Cross And The Australian Red Cross, 1999).

Unlawful killings of civilians/ Cross firings: The occurrence of civilian casualties does not necessarily mean that there has

been a violation of international humanitarian law, but it is a starting point for investigators and researchers(Emerson, 2007). In recent years, much effort has been made, in different forums, to clarify some of international humanitarian law's vaguer standards. However, little attention has been given to the meaning of the concept of civilian harm (Lieblich, 2014). The women caught in armed conflicts also deal with the wrath of watching their loved ones die in many instances of unlawful civilian killings, which unfortunately is a normal course in Kashmir valley. It takes a huge toll on the lives of these women as such incidences cause indelible marks of torture and macabre leading to the invisible scars of mental harm.

Psychological trauma related to physical health

Exposure to traumatic events such as military combat, physical and sexual abuse, and natural disaster, can be related to poor physical health. A considerable amount of research has found that trauma has negative effects on physical health (Jankowsi, 2010). Seino *et al*. (2008), found that the prevalence rate of PTSD among the women caught in armed conflict was 29.8%. The most prevalent symptom was arousal (74.8%), followed by re-experiencing (54.9%) and avoidance (33.7%). People who have experienced traumatic events have higher rates than the general population of a wide range of serious and life-threatening illnesses including cardiovascular disease, diabetes, gastrointestinal disorders, and cancer. More recently, research from the field of psychoneuro immunology (PNI) suggests that traumatic life events can lead to health problems through dysregulation of the inflammatory response system which reacts rapidly to subsequent life stressors (Kendell-Tackett, 2009). Andreski *et al*. (1998) reported that, of all the psychiatric disorders, PTSD is the one with the strongest relationship with somatization and particularly medically unexplained pain. Although there is substantial literature relating somatization to PTSD, this body of knowledge is seldom referred to in the broader literature about somatization, which has largely focused on the role of depression and anxiety. Research has established that chronic stress, including traumatic events, leads to adverse health outcomes (D'Andrea *et al*, 2011). Warshaw *et al*. (1993) examined the quality of life and dissociation in anxiety disorder subjects with histories of trauma, some of whom met criteria for posttraumatic stress disorder (PTSD). Results revealed that PTSD has severe effects on quality of life in virtually all spheres of life. The high levels of depression, suicide attempts or gestures, and alcohol abuse are of particular concern and show that trauma can have long-lasting effects.

The literature has primarily used two approaches: examining the effect of acute stress in a laboratory setting and examining the link between chronic stress and negative health outcomes. However, the potential health impact of a single or acute traumatic event is less clear. The association between health outcome and chronic traumatization have been researched extensively (Irish *et al*., 2010), and concepts such as allostatic load have been elaborated to help study the connection between chronic stress exposure and health, (Jong *et al*., 2008) found that the high levels of violence confronted by kashmiri population have resulted in high prevalence of (33%) of mental health problems. Poor self rated health and likelihood of poor socio-economic functioning are also said to be associated with high levels of psychological distress.

MATERIALS AND METHODS

VARIABLES

Predictor Variable: Post-traumatic stress disorder (PTSD)

Criterion Variable: Health Status

Objectives of the Study

- To assess the impact of the dimensions of PTSD on the dimensions of Health status of women under Kashmir conflict.
- To assess the correlation between PTSD and Health status.

Hypotheses

- There will be a significant impact of the dimensions of PTSD on the dimensions of Health status of women under Kashmir conflict.
- There will be a significant correlation between PTSD and Health status.

Sample

The purposive sample consisted of 50 women out of which 11 women were half widows (Dardpora, Kupwara),12 women were the widows of police martyrs (Srinagar),10 women were the mothers of disappeared persons (Budgam), 8 women were the widows of persons killed in cross firings (Budgam) and 9 women were the Rape victims (Kunanposhpora, Kupwara). The entire sample was collected primarily from Kashmir province.

Tools

P.G.I Health Questionnaire (N-1) by Dr.S.K.Verma, Dr. DwarkaPershad and Dr. N.N. Wig, precedes the development of a completely indigenous tool(PGI.HQ N-2 by Verma, 1978).It is based on CMI-Health Questionnaire and incorporates the characteristics as envisaged by cattellP.G.I Health Questionnaire N-1 consists of 38 items divided into A(physical distress) and B(psychological distress) sections with 16 and 22 items, respectively (Verma *et al*., 1978). The PTSD checklist (PCL) by Frank W. Weathers, Brett T. Litz, Debra S. Herman, Jennifer A. Huska, and Terence M. Keane, (1993), is a self-reporting rating scale for assessing post-traumatic stress disorder (PTSD). The PCL consists of 17 items, which correspond to the DSM-III-R symptoms of PTSD, (Weathers *et al*., 1993).

RESULTS

According to Table 4.1,a significant regression equation was found, ($F(1,48)=14.101$, $p<0.05$; (0.000), with an R^2 of 0.227. The model explains that re-experiencing predicts physical distress up to 22.7%, which is statistically significant, wherein $p< 0.05$ and $F=14.101$.

Table 1. The frequency and percentages of the respondents who participated in the study

Respondents	Frequency	Percent
Half widows	11	22%
Mothers of disappeared persons	10	20%
Widows of persons killed in cross firings	8	16%
Rape victims	9	18%
Widows of (police personnel) martyrs	12	24%
Total	50	100%

Table 2. The frequency and percentages of the sample according to the districts included in the study

Districts	Frequency	Percent
Srinagar	20	40%
Kupwara	20	40%
Budgam	10	20%
Total	50	100%

Table 3. The frequency and percentages of sample according to the domiciles

Domiciles	Frequency	Percent
Urban	24	48%
Rural	26	52%
Total	50	100%

Table 4.1

Model	R	R Square	df	F	Sig.
Regression	.477[a]	.227	(1,48) 49	14.101	.000[b]

a.Criterion Variable: PhysicalDistress
b.Predictor Variable: Re-experiencing

Table 4.2

Coefficients

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	2.174	2.564		.848	.401
	Re-experiencing	.395	.105	.477	3.755	.000

a. Criterion Variable: PhysicalDistress

Table 5.1

Model	R	R Square	Df	F	Sig.
Regression	.172[a]	.029	(1,48) 49	1.457	.233[b]

a. Criterion Variable: PhysicalDistress
b. Predictor Variable, AvoidanceOrNumbing

Table 5.2

Coefficients

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	9.471	1.892		5.005	.000
	AvoidenceOrNumbing	.087	.072	.172	1.207	.233

a. Criterion Variable: PhysicalDistress

Table 6.1

Model	R	R Square	df	F	Sig.
Regression	.384[a]	.147	(1,48) 49	8.281	.006[b]

a. Criterion Variable: PhysicalDistress
b. Predictor Variable Arousal

Table 6.2

Coefficients

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	5.307	2.255		2.353	.023
	Arousal	.268	.093	.384	2.878	.006

a. Criterion Variable: PhysicalDistress

Table 4.2 indicates that re-experiencing significantly influences physical distress. The value of standardized coefficients (Beta) is 0.477, which indicates the degree of correlation between re-experiencing and physical distress. It means when re-experiencing increases, physical distress also increases and when re-experiencing decreases, physical distress also decreases. The slope of the line can be explained by the following equation:

y=.395×X+2.174

According to Table 5.1 a non-significant regression equation was found (F (1,48)=1.457, p> 0.05; (0.233), with an R^2 of 0.029. The model explains that avoidance or numbing predicts physical distress up to 2.9% which is statistically a non significant and a weak prediction. According to Table 6.1, a significant regression equation was found (F (1,48)= 8.281, p<0.05, (0.006), with an R^2 of 0.147. The model explains that arousal predicts physical distress up to 14.7%, which is statistically significant wherein, p< 0.05 and F=8.281. Table 6.2, indicates that arousal significantly influences physical distress. The value of standardized coefficients (Beta) is 0. 384, which indicates the degree of correlation between arousal and physical distress. It means when arousal increases physical distress also increases and when arousal decreases physical distress also decreases. The slope of the line is explained by the following equation:

y=0.268×X+5.307.

According to Table 7.1, a significant regression equation was found (F (1,48) =10.276, p<0.05, (0.002), with an R^2 of 0.176. The model explains that re-experiencing predicts psychological distress up to 17.6% which is statistically significant, p<0.05 and F=10.276. Table 7.2 indicates that re-experiencing significantly influences psychological distress. The value of standardized coefficients (Beta) is 0.420, which indicates the degree of correlation between re-experiencing and psychological distress. It means when re-experiencing increases psychological distress also increases and when re-experiencing decreases psychological distress also decreases. The slope of the line is explained by the following equation:

y=0.439×X+7.761

According to Table 8.1,a non significant regression equation was found (F (1,48)=1.739, p>0.05, (0.193) with an R^2 of 0.035. The model explains that avoidance or numbing predicts psychological distress up to 3.5%, which is statistically a non significant and a weak prediction.

According to Table 9.1,a non significant regression equation was found (F (1,48)=3.846, p>0.05, (0.056) with an R^2 of .074. The model explains that arousal predicts psychological distress up to 7.4%, which is statistically a non significant and a weak prediction. Table 10 shows correlation between Health status and Ptsd, with the value of 0.406, which is significant at 0.01 level.

Table 7.1

Model	R	R Square	df	F	Sig.
Regression	.420[a]	.176	(1,48) 49	10.276	.002[b]

a. Criterion Variable: Psychological Distress
b. Predictor Variable: Re-experiencing

Table 7.2

Coefficients

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	7.761	3.341		2.323	.024
	Re-experiencing	.439	.137	.420	3.206	.002

a. Criterion Variable: Psychological Distress

Table 8.1

Model	R	R Square	df	F	Sig.
Regression	.187[a]	.035	(1,48) 49	1.739	.193[b]

a. Criterion Variable: Psychological Distress
b. Predictor Variable: Avoidance Or Numbing

Table 8.2

Coefficients

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	15.294	2.383		6.419	.000
	Avoidance or Numbing	.119	.090	.187	1.319	.193

a. Criterion Variable: Psychological Distress

Table 9.1

Model	R	R Square	Df	F	Sig.
Regression	.272[a]	.074	(1,48)49	3.846	.056[b]

a.Criterion Variable: Psychological Distress
b. Predictor Variable : Arousal

Table 9.2

Coefficients

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	12.628	2.967		4.257	.000
	Arousal	.240	.122	.272	1.961	.056

a. Criterion Variable: Psychological Distress

Table 10.

Correlation

		Health Status	PTSD
Health Status	Pearson Correlation	1	.406**
	Sig. (2-tailed)		.003
	N	50	50
PTSD	Pearson Correlation	.406**	1
	Sig. (2-tailed)	.003	
	N	50	50

DISCUSSION

The present study was conducted to evaluate the impact of post-traumatic stress on the health status of Kashmiri women living in the turbulent times. The first objective of the study was to assess the impact of the dimensions of PTSD on the dimensions of Health status of women under Kashmir conflict, corresponding to which an alternate hypothesis was formulated that there will be a significant impact of the dimensions of PTSD on the dimensions of Health status of women under Kashmir conflict. The results of the present study suggested PTSD along with its dimensions as a predictor of Health status and its two components. Linear regression was performed on the obtained data which revealed that re-experiencing, the first dimension of PTSD has 22.7% variation in scores of Physical Distress, the first dimension of Health Status.

Avoidance or Numbing, the second dimension of PTSD has 2.9% variation in the scores of Physical Distress, whereas Arousal, the third dimension of PTSD has 14.7% variation in scores of Physical Distress. Subsequently, re-experiencing, the first dimension of PTSD has 17.6% variation in scores of Psychological Distress, the second dimension of Health status. Avoidance or Numbing has 3.5% variation in scores of psychological distress whereas arousal has 7.4% variation in scores of psychological distress. Thus the first hypothesis is accepted. The second objective of the study was to assess the correlation between PTSD and Health status, corresponding to which an alternate hypothesis was formulated that there will be a significant correlation between PTSD and Health status. Results revealed that there was a significant correlation between Health status and Ptsd, with the value of 0.406, which is significant at 0.01 level. Hence the second hypothesis is also accepted.

The findings of the current study are consistent with the previous researches which highlight the importance of the impact of post-traumatic stress on the various dimensions of health. Warshaw *et al.* (1993) examined the quality of life and dissociation in anxiety disorder subjects with histories of trauma, some of whom met criteria for posttraumatic stress disorder (PTSD). Results revealed that PTSD has severe effects on quality of life in virtually all spheres of life. Jong *et al*. (2008) found that the high levels of violence confronted by kashmiri population have resulted in high prevalence of (33%) of mental health problems. Poor self rated health and likelihood of poor socio-economic functioning are also said to be associated with high levels of psychological distress.

Conclusion

Overall it is concluded that living in conflict situations, especially armed conflicts can have debilitating effects on almost all the facets of one's life. Post-traumatic stress being the leading repercussion of conflicts can jeopardize the physical and psychological health of individuals confronted with the wrath of wars.

REFERENCES

Amnesty International. 2011. Rape and Sexual violence. *Human Rights Law AndStandards In The International Criminal Court.*

Andreski, P., Chilcoat, H. and Breslau, N. 1998. Post-traumatic Stress Disorder And Somatization symptoms:a prospective study. *Psychiatry Res, Vol 79*(2): 131-8.

Bennett, O., Bexley, J., Warnock, K. 1995. Arms to fight, arms to protect. Women speak out about conflict.*United States Agency For International Development(USAID).*

Bhutalia, U. 2002. Speaking Peace: women's voices from Kashmir. 11-12.

Chinkin, C. 1994. Rape And Sexual Abuse Of Women In InternationalLaw. *Symposium; The Yugoslav Crisis: New International Law Issues*.

Crew, T. 2008. "If They Are Dead, Tell Us!" A Criminological Study of The "Disappearances" In Kashmir. *Internet Journal of Criminology*http://www.internetjournalof criminology. com/Crew_Disappearances_In_Kashmir.pdf

D'Andrea, W., Sharma, R., Zelechoski, A.D. and Spinazzola, J. 2011. Physical HealthProblems After Single Trauma Exposure: When Stress Takes Root in the Body. *Journal of the American Psychiatric Nurses Association, Vol 17*(6). 378-392.

doi:10.1177/107839031145187.http://jap.sagepub.com.

D'souza, P. 2015.Vulnerabilities of half-widows of Jammu and Kashmir: Role of the Judiciary, State, Civil Society and Community. *Indian Social Institute.*

Dabla, B.A. 2012. Prime victims of violence in Kahmir.*Social Impact of Militancy in Kashmir.*

De Jong, K., Ford, N., Van de Kam, S., Lokuge, K., Fromm,S., Van Galen, R., Reilley, B. and Kleber, R. 2008. Conflict in the Indian Kashmir Valley I: exposureto violence. *Confl Health, Vol 2*(11).doi.10.1186/1752-1505-2-11.

Dutta, A. and Vij, S. 2013. Relatives of the victims of enforced disappearances. *Kafila.*

Emerson, J. 2007. Why They Died; Civilian Casualties In Lebanon. *UN Office ForThe Coordination of Humanitarian Affairs.*

Hassan, A. andShafi, A. 2013. Impact of conflict situation on the mental health in Srinagar, Kashmir. *Bangladesh e-Journal of Sociology,* Vol 10 (101).

Hazen, J.M. 2008. Armed Violence in Asia and the Pacific: An Overview of theCauses, costs and Consequences. *United Nations Development Programme.*

Heeke, C,,Stammel,N. andKnaevelsrud,C. 2015.When hope and grief intersect: ratesand risks of prolonged grief disorder among bereaved individuals and relatives ofdisappeared persons in Colombia. *Epub,* Vol 1 (173).59-64. doi:10.1016/ j.jad.2014.10.038.

International Committee of the Red Cross (ICRC). 2008."How is the Term 'Armed Conflict' Defined in International Humanitarian Law?" .*OpinionPaper.*p 3.

International Committee of the Red Cross and the Australian Red Cross. 1999. Widowhood and armed conflict: challenges faced and strategies forward. *The 27th International Conference of the Red Cross and Red Crescent.*

Irish, L., Kobayashi, I. and Delahanty, D. L. 2010. Long-term Physical Health Consequences of Childhood Sexual Abuse: A Meta-Analytic Review. *Journal of Pediatric Psychology,* Vol 35(5):450-461.

Jankowsi, K. 2010. PTSD and Physical Health. *National Center For PTSD, U.S. Department of Veterans Affairs.*http//www.ptsd.va.gov/professional/pages/ptsd-physical-health.asp.

Josse, E. 2010. 'They Came With Two Guns'; the consequences of sexual violence for the mental health of women in armed conflicts. *International Review Of the Red Cross,* Vol 92(877).

Kendall-Tackett, K. 2009. Psychological Trauma and Physical Health: A Psychoneuro immunology Approach to Etiology of Negative Health Effects and Possible Interventions. *Psychological Trauma: Theory, Research, Practice and Policy,* Vol1(1). 35-48.

Kour, R. 2004. Half Widows of Kashmir. *Journal of Institute of Peace and Conflict Studies.*

Lieblich, E. 2014. Beyond Life and Limb: Exploring Incidental Mental Harm Under International Humanitarian Law. *Applying International Humanitarian Law In Judicial And Quasi Judicial Bodies: International And domestic Aspects,T.M.C. Asser Press*, 185-218. doi http.org/10.2139/ssrn.2276814.

Lindsey, C. 2000.Women and War-An Overview. *International Review of the Red Cross.*

Qayoom, F. 2014. 'Women and Armed Conflict: Widows in Kashmir. *International Journal of Sociology and Anthropology,* Vol6(5), 161-168.

Rauchfuss, K. and Schmolze, B.2008. Justice heals: the impact of impunity and the fight against it on the recovery of severe human rights violations' survivors. *Torture,* Vol 18(1):38-50.

Seino, K., Takano, T., Mashal, T., Hemat, S. and Keiko Nakamura. 2008. Prevalence of and factors influencing posttraumatic stress disorder among mothers of children under five in Kabul, Afghanistan, after decades of armed conflicts. *Health Qual Life Outcomes,* Vol. 6. (29).doi: 10.1186/1477-7525-6-29

Umar, B. 2013. The dilemma of Kashmir's half –widows. *AlJazeera Asia.*

UNIFEM. 2005. A brief sheet for the World Summit. *United Nations Development Fund for Women, Report on the Situation of Women in Colombia,* p. 9.

United Nations. 2008. Sexual Violence Against Girls And Women During ArmedConflicts. *Annual parliamentary hearing at the United nations.*

Verma,S.K., Perishad, D. and Wig,N.N.1978. *Manual for PGI Health Questionnaire (N-1),National Psychological Corporation.*

Warshaw, M.G., Fierman, E., Pratt, L., Hunt, M., Yonkers, K.A., Massion, A.O. andKeller, M.B.1993. Quality of Life and Dissociation in Anxiety Disorder Patients With Histories of Trauma or PTSD. *Am J Psychiatry, 150*(10): 1512-6.

Weathers, F.W., Brett, Litz, Debra, S. Herman, Jennifer A. Huska, TerrenceM. Keane. 1993. *The PTSD Checklist (PCL).*

The Gazette Of India,Extraordinary.1990.*Women And The Armed Conflict In Kashmir. Part II-Section 1.*

****