

See discussions, stats, and author profiles for this publication at: <https://www.researchgate.net/publication/287217330>

Psychiatric Morbidity among Chronic Low Back Ache Pateints in Conflict Zone of Kashmir

Article · February 2014

CITATIONS

2

READS

145

8 authors, including:



Hayat Ahmad Khan

Bone and Joint Hospital Barzulla Srinagar

49 PUBLICATIONS 89 CITATIONS

SEE PROFILE



Zaid Ahmad Wani

Government Medical College Srinagar

56 PUBLICATIONS 253 CITATIONS

SEE PROFILE



Nazia Hassan

Government Medical College Srinagar

14 PUBLICATIONS 24 CITATIONS

SEE PROFILE

Some of the authors of this publication are also working on these related projects:



Tight rope [View project](#)



Personality disorders [View project](#)



Original Research Article

Psychiatric Morbidity among Chronic Low Back Ache Patients in Conflict Zone of Kashmir

Abdul Wahid Khan¹, Hayat Ahmad Khan^{2*}, Zaid Ahmad Wani³, Sajad Ahmad Dangroo⁴, Majid Shafi Shah⁵, Nazia Hassan⁶, Arshaad Iqbal⁷

¹Head, Department of Psychiatry, SKIMS Medical College, Srinagar, Jammu and Kashmir, India,

²Registrar, Department of Orthopaedics, GMC, Srinagar.

³Consultant, IMHANS, Department of Psychiatry, GMC, Srinagar.

⁴Registrar, Department of Surgery, SKIMS, Srinagar.

⁵Registrar, Department of Psychiatry, GMC, Srinagar.

⁶Scholar, PGDMCH Dept. of PSM, GMC, Srinagar.

⁷CCRUM Ministry of Health, GOI.

*Correspondence Email: drhayatkhan@gmail.com

Received: 07/11/2013

Revised: 06/12/2013

Accepted: 16/12/2013

ABSTRACT

One hundred twenty seven patients of chronic low back pain patients were assessed for current psychiatric syndromes using MINI Plus (Mini Neuro Psychiatric Interview) scoring. The diagnoses included a wide range of psychiatric disorder. The main psychiatric morbidity in our study was somatoform disorder in 48 (38%) patients. Depression was the second most common diagnosis in our population with about 30% (n=39) of people suffering from depressive disorder.

The third subgroup was of PTSD (post-traumatic stress disorder) which was about 10% (n=12) of the total number of patients. This number assumes significance in the back ground of manmade conflict. High incidences of PTSD have been found in population studies in conflict zones and this was reflected here also. Somatic pains are known to be excessive in these types of patients and may actually represent a cry for help.

The authors conclude that the results imply that screening chronic low back pain patients for psychiatric comorbidity in secondary care is important since psychopathology may have serious consequences for prognosis, outcome and health care utilization.

KEY WORDS: Chronic low back ache, Psychiatric disorders, PTSD, conflict zones

INTRODUCTION

Low back pain is pain, muscle tension, or stiffness localized below the costal margin and above the inferior gluteal folds, with or without leg pain. ⁽¹⁾ Non-specific low back pain is pain not attributed to a recognizable pathology which can be

infective, tumorous, traumatic or inflammatory. ⁽¹⁾ Pain is defined as chronic when it persists for 12 weeks or more. ⁽²⁾ Back pain is a common problem with about 70% of people in developed countries experience low back pain at some time in their lives. ⁽³⁾ Each year, between 15% and

45% of adults suffer low back pain, and 5% of people present to hospital with a new episode with 1% to 3% having prolapsed intervertebral disc. ⁽³⁾ About 10% remain off work and about 20% have persistent symptoms at 1 year. ⁽⁴⁾

Symptoms, pathology, and radiological appearances are poorly correlated. Pain is non-specific in about 85% of people. About 4% of people with low back pain in primary care have compression fractures, and about 1% has a tumour. Ankylosing spondylitis and spinal infections are less common. ⁽⁵⁾ In most of the cases of chronic back pain where a definitive diagnosis cannot be made there are risk factors which include heavy physical work; frequent bending, twisting, and lifting; and prolonged static postures. Psychosocial risk factors include anxiety, depression, and mental stress at work. ⁽⁶⁾ Having a previous history of low back pain and a longer duration of the present episode are significant risk factors for chronicity. One systematic review of prospective cohort studies found that some psychological factors (distress, depressive mood, and somatization) are associated with an increased risk of chronic low back pain. ⁽⁷⁾ Individual and workplace factors have also been reported to be associated with the transition to chronic low back pain. ⁽⁸⁾ In short Back pain is a very common problem with a life time prevalence of 58-80%. ⁽⁹⁾ A study has shown that 40% of the people report LBA in a year and 15% report pain at the time of interview. ⁽¹⁰⁾

Psychosocial risk factors have been studied in patients of LBA with studies showing varying results. Major depression is thought to be four times greater in people with chronic back pain than in the general population. ⁽¹¹⁾ Patients who come to seek treatment at pain clinics, the prevalence rates are still higher with 32 to 82 percent of patients show some type of depression or

depressive problem, with an average of 62 percent. ⁽¹²⁾ Another study showed that rate of major depression increased in a linear fashion with greater pain severity and the combination of chronic back pain and depression was associated with greater disability than either depression or chronic back pain alone. ⁽¹³⁾ It has been suggested that there are various psychological factors that act as barriers to a successful outcome for patients with low back pain. ⁽¹⁴⁾ In one study, 38% of patients who reported back pain in primary care were classified as having a psychological disorder, ⁽¹⁵⁾ and in another study symptoms of psychological distress in people without back pain predicted the likely onset of subsequent back pain. ⁽¹⁶⁾ In a recent UK general practice-based study, pain was likely to persist among patients who, in addition to having more severe clinical symptoms, were smokers, were less satisfied with their employment and had higher levels of psychological distress and lower self-rated levels of general health and physical activity. Chronic pain has also been associated with increased incidence of depression, anxiety, somatoform disorders, and substance use disorders. Certain Axis II disorders are associated with chronic pain; paranoid, histrionic, dependent, and borderline personality disorders are among the most common. ⁽¹⁷⁻¹⁹⁾

Kashmir has been affected by conflict since last 22 years in which thousands have lost lives and many more have been injured. Violence has affected nearly everybody living in Kashmir. The high levels of violence confronted by the Kashmiri population have resulted in high prevalence of mental health problems. ⁽²⁰⁻²²⁾ High exposure to traumatic events in last 2 decades have resulted in increased prevalence of depression, anxiety, substance abuse and stress related disorders.

Scientific data reveals that during the continued violent conditions over the past 22 years in Kashmir, there has been a phenomenal increase in psychiatric morbidity. (23)

The present study was planned to see the association of psychiatric morbidity in patients of chronic low back pain in a general hospital setting in a chronic conflict situation since last 22 years.

MATERIALS AND METHODS

The study was done in the SKIMS medical college hospital on patients suffering from chronic low back ache without a physical diagnosable problem. The patients were referred from the orthopedics department of the hospital after evaluating them for any physical cause. All the patients had a full physical examination and investigations which included lumbar spine X rays followed by an MRI in selected patients. Patients were also evaluated and investigated to rule out any disorders like rheumatoid arthritis, Ankylosing spondylitis, spondylosis, spondylolisthesis, intervertebral disc disease or canal stenosis. Female patients were also evaluated for gynecological problems and elderly male for prostrate related symptoms.

A total number of 127 patients of chronic low back pain were taken for the study over 3 months period. The study sample included patients with CLBP not responding to treatment for last 6 months and with no history of previous psychiatric morbidity as per records and patient information. Patients with known recognizable pathology like rheumatoid arthritis, ankylosing spondylitis, osteoporosis, trauma and chronic physical conditions were excluded from the study. Patients who were pregnant were also excluded from the study.

All the patients were seen by a consultant psychiatrist. Detailed history of

the patients was taken followed by the mental status examination. Patients were administered MINI (Mini Neuro Psychiatric Interview) plus by the senior resident of department under the supervision of the consultant. MINI Plus (Mini Neuro Psychiatric Interview) scale has high validation, reliability scores and can be administered over a brief period of time. (24) Patients were grouped according to the age, sex, occupation, marital status, and education.

RESULTS

A total number of 127 patients were taken for the study which included 89 Females and 38 Males. The age of the Patients ranged from 23 to 56 years with mean age being 35.25 ± 13.12 years.

Most of the Patients in our study were married forming the largest group $n=76(60\%)$ followed by unmarried $n=31(24.4\%)$ and divorced $n=7(5.5\%)$ and separated $n=13(10\%)$ (TABLE 1).

Table 1. Marital status of patients.

| | Number | Percent |
|-----------|--------|---------|
| Married | 76 | 60 |
| Unmarried | 31 | 24.4 |
| Divorced | 7 | 5.5 |
| Separated | 13 | 10 |

Table 2. Occupational status of patients.

| Occupation | Number | Percent |
|----------------|--------|---------|
| Housewife | 60 | 47 |
| Govt. Employed | 23 | 18 |
| Self Employed | 19 | 15 |
| Unemployed | 10 | 8 |
| Student | 15 | 12 |

Majority of the sample consisted of House wives $n=60(47\%)$. Government and self-employed person formed $n=23(18\%)$ and $n=19(15\%)$ each followed by students and farmer $n=15(12\%)$ and $n=10(8\%)$ were unemployed.

$(35.5\%) n=45$ of our sample were illiterates followed by $n=48(38\%)$ who had studied to the undergraduate level. Remaining

34(26.5%) had completed their graduation. (TABLE 2)

54 %(n=69) of our Patients were from joint families and 32% (n=41) belonged to nuclear while as 17 (13%) belonged to other types of families.

Most of the Patients were from rural areas 70% (n=89) and 30% (n=38) were from urban background.

Table 3. Psychiatric Morbidity In Patients.

| Psychiatric Morbidity | Number | Percent |
|--------------------------|--------|---------|
| Somatoform disorder | 48 | 37.8 |
| Depression | 39 | 30.7 |
| Conversion disorder | 8 | 6 |
| PTSD | 12 | 9.5 |
| Substance abuse | 3 | 2.4 |
| Others | 9 | 7 |
| No Psychiatric morbidity | 8 | 6.2 |

DISCUSSION

Chronic pain is a debilitating condition with far reaching consequences. Loss of productivity, financial losses, and increased morbidity is some of the known effects of this condition. Chronic pain is associated also with significant psychiatric morbidity.⁽²⁵⁾ In the back ground of a chronic conflict situation the problem is compounded by the fact that many patients are facing stress routinely. Studies have shown that people in conflict areas have increased psychiatric morbidity as compared to people living in peaceful areas.

There is a significant association between chronic back pain and psychiatric morbidity as shown in our study and is consistent with earlier studies done elsewhere.^(25, 26) This is the first study in Kashmir, which has been an active conflict zone since last 22 years. The main psychiatric morbidity in our study has been a somatoform disorder in 48 patients which is also true for many previous studies e.g. Polatin et al reported somatoform disorder as the main psychiatric diagnosis in chronic back pain patients).⁽²⁷⁾ (TABLE 3)

Depression was the second most common diagnosis in our population with

about 30 % of people suffering from depressive disorder. This finding is consistent with studies done earlier by Poltin et al.⁽²⁷⁾

The third subgroup is of PTSD which is about 10% of the total number of patients. This number assumes significance in the back ground of manmade conflict. High incidences of PTSD have been found in population studies in conflict zones and this may be reflecting here also. Somatic pains are known to be excessive in these types of patients and may actually represent a cry for help. Kashmir has been a chronic conflict zone and people have been exposed to high incidence of traumatic events during life as compared to the other populations. The prevalence of PTSD among the population is significantly high and has been reported to be around in a community study done by Margoob et al.⁽²²⁾ This is also significant as no studies have been done in conflict zones regarding this to the best of our knowledge.

The presence of other psychiatric disorders in our patients is consistence with other studies.⁽²⁷⁾

CONCLUSION

The results imply that screening chronic low back pain patients for psychiatric comorbidity in secondary care is important since psychopathology may have serious consequences for prognosis, outcome and health care utilization.

Competing Interests: The Author(s) declare that they have no competing interests.

REFERENCES

1. Van der Heijden GJMG, Bouter LM, Terpstra-Lindeman E. The efficacy of traction for low back pain. Results of a pilot study. [In Dutch] Ned T Physiotherapy 1991; 101:37–43.)

2. Bigos S, Bowyer O, Braen G, et al. Acute low back problems in adults. Clinical Practice Guideline no. 14. AHCPR Publication No. 95-0642. Rockville MD: Agency for Health Care Policy and Research, Public Health Service, US, Department of Health and Human Services. December 1994.
3. Andersson GBJ. The epidemiology of spinal disorders. In: Frymoyer JW, Ed. The adult spine: principles and practice. 2nd Ed. New York: Raven Press, 1997:93–141
4. Chou R, Shekelle P, Chou Roger, et al. Will this patient develop persistent disabling low back pain? JAMA 2010; 303:1295-1302.
5. Deyo RA, Rainville J, Kent DL. What can the history and physical examination tell us about low back pain? JAMA 1992; 268:760–765.
6. Bongers PM, de Winter CR, Kompier MA, et al. Psychosocial factors at work and musculoskeletal disease. Scand J Work Environ Health 34. 1993; 19:297–312.
7. Pincus T, Burton AK, Vogel S, et al. A systematic review of psychological factors as predictors of chronicity/disability in prospective cohorts of low back pain. Spine 35. 2002; 27:E109–E120)
8. Fransen M, Woodward M, Norton R, et al. Risk factors associated with the transition from acute to chronic occupational back pain. Spine 36. 2002; 27:92–98
9. Jayson MI. Mechanisms underlying chronic back pain. BMJ 1994; 309:681–2.
10. Dodd T. The prevalence of back pain in Great Britain 1996. A report on research for the DoH using the ONS Omnibus Survey. London: The Stationery Office, 1996.
11. Sullivan, Reesor, Mikail & Fisher, 1992 Sullivan MJ, Reesor K, Mikail S, Fisher R. The treatment of depression in chronic low back pain: Review and recommendations. Pain. 1992; 52:249).
12. Sinel, Deardorff & Goldstein, 1996 Sinel MS, Deardorff WW, Goldstein TB. In: Win the Battle against Back Pain: An Integrated Mind-Body Approach. New York: Bantam-Doubleday- Dell; 1996:45-46.
13. Currie and Wang, 2004 Currie SR, and Wang J. Chronic back pain and major depression in the general Canadian population. Pain. 2004; 107:54-60
14. Frank A. Low back pain. BMJ 1993; 306:901–9.
15. Coste J, Schiano PJ, Leparc JM, Paolaggi JB. Clinical and psychological classification of nonspecific low-back pain. A new study in primary care practice. Rev Epidemiol Sante Publique 1995; 43:127–38.
16. Croft PR, Papageorgiou AC, Ferry S, Thomas E, Jayson MI, Silman AJ. Psychologic distress and low back pain. Evidence from a prospective study in the general population. Spine 1995; 20:2731–7.
17. Fishbain DA: Approaches to treatment decisions for psychiatric comorbidity in the management of the chronic pain patient. Med Clin North Am 1999; 83:737–760
18. Katon W, Egan K, Miller D: Chronic pain: lifetime diagnoses and family history. Am J Psychiatry 1985; 142:1156–1160
19. Koenig TW, Clark MR: Advances in comprehensive pain. Psychiatr Clin North Am. 1996 Sep; 19(3):589-611
20. DE Jong K, Ford N, Kam S, Lokuge K, Fromm S, van Galen R, Reilley

- B, Kleber R: Conflict in the Indian Kashmir Valley I: exposure to violence. *Confl Health* 2008, 2:10.
21. de Jong K, Kam S, Ford N, Lokuge K, Fromm S, van Galen R, Reilley B, Kleber R: Conflict in the Indian Kashmir Valley II: psychosocial impact. *Confl Health* 2008, 2:11
22. Margoob MA A study of the present magnitude of psychiatric disorders and the existing treatment services in Kashmir (1990-1994) *JK Practitioner* Vol 2 No 3 July – October 1995
23. Zaid A Wani, S A Dhar, Arshad Hussain , The unreported morbidity of suicidal poisonings during an insurgency: a 16-year Kashmir experience *Tropical Doctor* Vol 38, page 170-171.
24. Sheehan DV, Lecrubier Y, Sheehan KH, et al. (1998). "The Mini-International Neuropsychiatric Interview (M.I.N.I.): the development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10". *J Clin Psychiatry*. 59 Suppl 20: 22–33.
25. J.Hampton , Mark A Slater , Thomas L Patterson "Prevalence, onset, and risk of psychiatric disorders in men with chronic low back pain: a controlled study. *Pain* Volume 45, Issue 2, May 1991, Pages 111–121
26. Wong WS, Chen PP, Yap J, Mak KH, Tam BK, Fielding R Chronic pain and psychiatric morbidity: a comparison between patients attending specialist orthopedics clinic and multidisciplinary pain clinic. *Pain Med*. 2011 Feb;12(2):246-59.
27. Polatin PB, Kinney RK, Gatchel RJ, Lillo E, Mayer TG. Psychiatric illness and chronic low-back pain. The mind and the spine - which goes first? *Spine* 1993; 18: 66–71.

How to cite this article: Khan AW, Khan HA, Wani ZA et. al. Psychiatric morbidity among chronic low back ache pateints in conflict zone of Kashmir. *Int J Health Sci Res*. 2014; 4(1):149-154.

International Journal of Health Sciences & Research (IJHSR)

Publish your work in this journal

The International Journal of Health Sciences & Research is a multidisciplinary indexed open access double-blind peer-reviewed international journal that publishes original research articles from all areas of health sciences and allied branches. This monthly journal is characterised by rapid publication of reviews, original research and case reports across all the fields of health sciences. The details of journal are available on its official website (www.ijhsr.org).

Submit your manuscript by email: editor.ijhsr@gmail.com OR editor.ijhsr@yahoo.com