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Northern Ireland

The victims

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Depending on one's view point, the conflict in Ireland began 80 years ago, 300 years ago or 800 years ago. The most recent civil disturbances in Northern Ireland, which began in 1969, have led to approximately 3500 deaths and 40 000 serious injuries. In a major review in the late 1980s (Curran, 1988) it was concluded that the violence had not resulted in any obvious increase in psychiatric morbidity. Over the past ten years or so there has been a significant expansion in world literature concerning post-traumatic psychiatric morbidity, and it is perhaps appropriate, given other recent developments, to examine once again the psychological impact of the civil disturbances on the population in Northern Ireland. What is the incidence of psychological victims of the Northern Ireland Troubles? Who are these victims, what are their needs, and how might these needs be addressed?

RECENT DEVELOPMENTS

Over the past three decades a number of attempts at finding political solutions to the Troubles have failed in the embryonic stages. The most recent political developments culminated in the Belfast or Good Friday Agreement. Whether this initiative will be any more successful than previous ones is not yet clear. It is certainly different from previous initiatives in that the political parties who claim to speak for the terrorist organisations have been involved. While some see this as an important and favourable part of the process, others view it as a fundamental flaw which will inevitably lead to the Agreement failing. Another aspect of the Agreement which is different from previous political initiatives is the recognition that it is "essential to acknowledge and address the suffering of the victims of violence as a necessary element of reconciliation" (Anonymous, 1998). The Agreement goes on to state that "the provision of services that are supportive and sensitive to the needs of victims will also be a critical element" and that "the allocation of sufficient resources, including statutory funding as necessary, to meet the needs of victims and to provide for community based support programmes" will be required. The Government has appointed a minister with special responsibility for victims of the Troubles.

The current regional strategy for the health and social services in Northern Ireland states that many individuals who have been bereaved or seriously affected by the civil unrest have been traumatised but have yet to be identified as victims (Department of Health and Social Services, 1997). While recent political developments were taking place, Sir Kenneth Bloomfield, former head of the Civil Service in Northern Ireland, was asked by the Government to look at ways of recognising the pain and suffering of the victims of violence over the past 30 years, with a view to recommending how these people might be helped and to suggesting possible memorial schemes (Bloomfield, 1998). Independently of Bloomfield's work, the Social Services Inspectorate at the Department of Health and Social Services in Belfast undertook a project to explore the current range of services available to individuals who have suffered psychosocial trauma as a result of the troubles, noting that it is "only relatively recently that the long-term social and psychosocial effects of the traumatic events experienced by many have begun to be recognised" (Department of Health and Social Services, 1998).

Some of the effects of the Troubles were studied recently by a group called 'The Cost of The Troubles Study' (Initiative on Conflict Resolution & Ethnicity, 1997). This group was sponsored by the University of Ulster and the United Nations. They have, somewhat damningly, commented that there has been remarkably little consistent interest shown in the specific psychiatric effects of the Troubles on the population. Their initial report examined the Troubles-related deaths over the period 1969–1994, and revealed that 90% of those killed have been male. In addition, the vast majority of prisoners and those seriously injured have been male; many of these people will have had associated psychological difficulties. The indirect psychological effects of the Troubles have been visited more upon women and children, who have often had to experience isolation and loneliness, together with associated socio-economic difficulties. It is impossible to know how many people have been affected for each person killed, imprisoned or seriously injured, but it would be surprising if a significant number of these secondary victims did not experience psychological problems as a result.

LITERATURE REVIEW

Fraser (1971) examined general practitioner (GP) prescribing patterns and found highly significant increases (26–135%) in tranquilliser prescribing rates within specific areas affected by riots. He concluded that other socio-demographic variables may well have contributed to some of the increase in consumption. O'Brien & Nutt (1998) suggested that the early use of benzodiazepines might prevent the development of post-traumatic stress disorder (PTSD). After the first few years of the Troubles, Lyons (1971) examined the number of referrals to the psychiatric services and hospitalisation rates. He found no increase in the more serious – that is, psychotic – types of psychiatric illness. This is not at all surprising, as it is exceedingly rare for psychosis to be precipitated by traumatic events except in those biologically predisposed to psychotic illness. Lyons felt that there was, however, some effect on the population, and called this an increase in 'normal anxiety'. At the time Lyons was carrying out his research the field of traumatology was in its infancy and the concept of PTSD had not been formulated. In retrospect it is, of course, impossible to know exactly what Lyons meant by normal anxiety; perhaps he was suggesting that, because the anxiety was reactive to circumstances, it could be considered normal. A more modern understanding of psychological trauma would approach anxiety as it approaches depression in that it is unreasonable to assume that, if a cause for the anxiety (or depression) can be identified,

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the condition should not be deemed pathological and worthy of treatment.

King *et al* (1982) looked at drug use between 1966 and 1980. This group found that psychotropic drug use peaked in 1975 when 12.5% of the population were taking psychotropic drugs, three-quarters of these being benzodiazepines. This rate of consumption was 25% higher than that of the rest of the UK, and the rise in consumption between 1966 and 1976 was more rapid than in the rest of Europe. However, as the peak of rioting was in 1972, the group concluded that there was no direct relationship between this and the peak of consumption in 1975. They were unable to identify any definite causal factors for the variation in drug prescribing, which was unexplained by socio-demographic and economic variables. This study, which covered the whole of Northern Ireland, may well have been unable to identify and correlate levels of prescribing with specific areas of rioting, as Fraser (1971) had done. There is no doubt that in Northern Ireland the intensity of the civil disturbances has varied, not only over time, but also between different areas. For example, over one-quarter of all those killed lived in a small part of Belfast; other areas such as Derry and parts of Armagh have seen very many Troubles-related incidents, while certain rural parts of Northern Ireland and middle-class urban areas have been much less seriously affected.

A major community-based study (Cairns & Wilson, 1984) concluded that there was some negative relationship between the violence and an individual's psychological well-being. These authors interviewed almost 800 people in two matched towns which differed in the levels of violence experienced. They found that there were more cases on the General Health Questionnaire (Goldberg, 1978) in 'Hitown' (the town with the higher level of violence), among women and among those perceiving a higher level of violence. However, they noted that the vast majority of the population were coping effectively, and postulated that this was, at least partly, due to the mechanism of denial. Eighty-five per cent of the population interviewed in 'Hitown' thought that their area had suffered only a little violence at worst. Both the towns studied were in rural areas of Northern Ireland. As mentioned above, the violence has been concentrated mostly in working-class urban areas; as yet, no similar study been carried out in such areas.

Curran (1988) commented that there appeared to be a balance of effects, in that a certain number of people showed psychological distress while some improved psychologically; he concluded that, overall, the civil disturbances had not led to any appreciable increase in psychiatric morbidity. He suggested a number of possible reasons: non-reporting of illness, migration of the ill, denial of or habituation to the disturbances, a latency period, catharsis, improvement of those already ill and improved community cohesion.

The Remembrance Sunday bombing in Enniskillen, County Fermanagh, in 1987 received worldwide publicity. Of 26 survivors examined, 13 were found to suffer from PTSD at six months (Curran *et al*, 1990). At this assessment no seriously injured victim had the specific syndrome of PTSD. At a 12-months follow-up a further two people were diagnosed as suffering from PTSD. Both these individuals had serious physical injuries. The authors suggested that the psychological symptoms could indeed be delayed, particularly in the presence of physical injury, hypothesising that the intense attention and the cossetted hospital environment may protect the physically injured from PTSD and psychological disturbance in the early stages, only to see them emerge on discharge from hospital. This would certainly suggest the possible existence of a latency period, something Curran (1988) had previously discounted as being comparatively rare.

It has been suggested that the turning in of aggression in depression can lead to suicide and that when aggression is turned outward the suicide rate decreases. Curran (1988) suggested that this was one of the reasons for the lack of an obvious increase in psychiatric morbidity. As elsewhere, it appears that the suicide rate in Northern Ireland is increasing, despite a lower rate of violence. This would lend support to Curran's argument. Curran further suggested that individuals tend to habituate to the disturbances. More recent research in the field suggests that exposure to repeated trauma tends to have a cumulative effect and that individuals so traumatised would, rather than habituate, become increasingly vulnerable to the development of psychological problems (Department of Health and Social Services, 1998).

Underdiagnosis?

There are many reasons why individuals who suffer post-traumatic psychopathology do not present for treatment. Victims can present with somatic complaints, or feelings of anger and aggressive outbursts which are not recognised as being secondary to traumatic incidents. Their symptoms can be viewed as understandable or attributed to other conditions, such as alcohol or drug misuse. Phobic symptoms and symptoms of avoidance are very common in traumatised populations and might prevent attendance. Northern Ireland is a very polarised society and many people lack trust in the authorities and are fearful of breaches of confidentiality. Such fears can exacerbate phobic and other symptoms, leading to an increased tendency for these individuals not to attend for treatment. Post-traumatic depressive illness is well recognised. Patients suffering from post-traumatic depression may have feelings of helplessness or self-blame and may be poorly motivated, with a consequent failure to attend for treatment. In a consensus statement on the recognition and management of depression in general practice it was reported that up to 50% of people suffering from depression may not have had their depression recognised at consultation with their GP (Paykel & Priest, 1993). Indeed, it has been suggested that depressive illnesses in Northern Ireland, specifically following traumatic events, are not sufficiently recognised (Kee *et al*, 1987). A related study carried out by the same group (Loughrey *et al*, 1988) found that almost two-thirds of those diagnosed as suffering from PTSD had not received psychiatric treatment. Daly (1997) referred to the way in which many individuals with post-traumatic neurosis enter the specialist services via the medico-legal system, suggesting perhaps that individuals seen by psychiatrists for non-treatment purposes were considered sufficiently unwell to be offered specialist treatment, an opinion that did not appear to be shared by the GP. In a recent study carried out at our clinic (details available from author upon request), the percentage of out-patient referrals for post-traumatic psychological problems from different group practices varied from 50% of all referrals to zero. In a short general practice consultation it can be very difficult to identify post-traumatic psychological problems. This difficulty has been recognised elsewhere. A Norwegian study of the knowledge GPs have of their patients' psychosocial problems found that under one in five were aware of patients having been subjected to threats or violence (Gulbrandsen *et al*, 1997). There is clearly wide variation in the abilities of various mental health

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professionals to diagnose any form of mental illness. It seems reasonable to suggest that the ability to identify post-traumatic mental illness – which, for the reasons stated above, may be particularly difficult – can vary considerably between different health professionals, leading to difficulties in estimating the extent of the problem.

SPECIFIC VICTIM GROUPS

The Troubles have not had a uniform effect on the population – they have tended to be concentrated upon urban districts (as mentioned above), with only a small number of rural areas experiencing major ongoing disturbances. The victims have been predominantly working class. In addition, there have been specific groups of people within the population at much greater risk of being victimised.

Security forces

Locally recruited serving and former members of the security forces have unique problems regarding accessing treatment. For these individuals and many civilian victims there is ongoing exposure to threats and danger (and this applies even to individuals never injured). Indeed, in certain areas there is a fairly constant threat. For these reasons many people who have attended for treatment do not wish their sleep disturbance or hypervigilance, for example, to be treated.

Since the ceasefires in 1994, there has been anecdotal evidence of an increase in the number of individuals seeking help for post-traumatic psychological problems. This increase could be partly due to the latency period referred to previously, and has been particularly apparent to those professionals working with members of the security forces, who have increasingly felt able to acknowledge their psychological difficulties and seek help, recent developments having led to the knowledge that effective treatments for post-traumatic neuroses are available. It is unclear how the release of paramilitary prisoners will affect the survivors and the relatives of victims of paramilitary violence. This may be particularly relevant with regard to members of the security forces, even those never seriously injured, and their relatives.

Children

Children are another group who may have particular needs which have not been met. One group studied referrals to a child psychiatry clinic in Belfast over a 12-month period in the early 1990s and found a significant increase in referrals secondary to the civil disturbances during that period (J. Lynch, personal communication, 1999). Troubles-related referrals accounted for over 10% of all referrals. The authors found that the patients had been "severely affected by the events they had experienced. While day-to-day exposure to life in a divided society may necessitate the building of some resilience, it cannot inoculate children against the profound implications of exposure to violence or death". No one now aged 30 or under has ever lived in a Northern Ireland free from civil disturbances. The possible effects of living under such circumstances on the long-term psychological health of the population in general are unknown.

The bereaved

One group of victims that has not, perhaps, received the attention they deserve are those who have been bereaved as a result of the Troubles. Parkes (1993) identified a number of factors which might increase the prevalence of psychosocial problems in the aftermath of bereavement; these factors included sudden, unexpected, untimely deaths, witnessing of horrific circumstances, threat to the life of the survivor or other loss of personal security, guilt at having survived, intense anger, and the death being caused by human agency, particularly when compensation is involved. Each of these factors is particularly pertinent to those bereaved following traumatic incidents in Northern Ireland. On the other hand, some individuals traumatised or bereaved as a result of the Troubles appear to have managed to successfully sublimate their emotions. It is unclear whether these individuals will also decompensate psychologically in the future. Regarding those individuals victimised where the perpetrator has never been caught, it is not known how the inability to identify a perpetrator towards whom anger can be directed affects the psychopathology of an individual (see Daly *et al*, 1996).

Prisoners

Some would consider terrorists incarcerated for paramilitary crimes to be victims. Certainly, they have a psychological profile different from that of those convicted of non-paramilitary-related crimes (Lyons & Harbinson, 1986). If the prisoner releases do proceed somewhat abruptly, the result may be additional psychological problems for those who have had difficulty in coping with incarceration. A local newspaper reported recently on the death of a former paramilitary prisoner who appears to have hanged himself (*Belfast Telegraph*, 26 September 1998).

WHAT ARE THE TREATMENT NEEDS?

While there is evidence that there may have been more psychopathology secondary to the civil disturbances than many have previously thought, it is none the less quite clear that most individuals do adapt to traumatic incidents without experiencing clinically significant psychopathology. It is important not to overdiagnose post-traumatic psychological reactions or to unnecessarily medicalise these reactions, thereby devaluing the concept of post-traumatic neurotic reactions.

Need to know

The decision has been taken not to hold a truth and reconciliation forum in Northern Ireland of the type that occurred in South Africa. How can we prevent the victims here being ignored and 'sacrificed', their emotional disturbances perhaps being adversely affected by further political developments? It has been suggested that victims need to be told by the police about the progress of criminal investigations; they will be informed about prisoner releases. This is one small step towards recognising the needs of victims. It has been well documented that the manner in which victims are treated by the authorities can have a significant influence upon the subsequent course of psychiatric problems (Shapland, 1984).

Effective and safe treatment

Many voluntary organisations, both generic mental health organisations and those that have evolved specifically because of the Troubles, have been engaged in treating post-traumatic psychological problems. A perceived gap in service provision by the statutory services has led to this development. A Social Services Inspectorate document (Department of Health and Social Services, 1998) recommended that these community developments should be supported with adequate resources. It is unclear what treatment is offered by many of these groups. There is as yet little evidence that

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these victim support groups are effective and are targeting the appropriate population – although, it must be said, neither is there evidence to the contrary. The same document also recommended that crisis-support teams, already in place in some districts, should be developed in all areas and adequately resourced. Many people presume that any intervention is better than none, but there is increasing evidence that interventions recommended by many, such as psychological debriefing, are of questionable benefit and may indeed be harmful (Bisson *et al*, 1997). The emphasis is often upon different forms of exposure treatment, but recent studies on Vietnam veterans have concluded that if the traumatic incident occurred more than five years previously, it is best to focus upon rehabilitation rather than on other forms of treatment such as exposure (Johnson, 1997). It must, of course, be remembered that most individuals involved in traumatic incidents do not need any form of treatment but rather require the support of their families and communities.

There is an urgent need to appraise the efficacy of the various voluntary groups. The better ones should certainly be resourced, and good relationships with the statutory services fostered. The other groups, even if peopled by well-meaning individuals, should not be publicly funded. Indeed, given the possibility of therapist-induced psychopathology, an argument could be made for some voluntary groups to be either disbanded or subsumed into the more effective ones.

Local or regional services?

For those individuals who do require treatment, a wide range of services, both voluntary and statutory, is required. Many individuals will require medium- to long-term treatment, which is best provided locally. In addition, because of the 'ghettoisation' of large parts of Northern Ireland, individuals can experience considerable anxiety when leaving their own local areas. Clearly, greater awareness as to availability of services is necessary. While the more specialist psychiatric services can endeavour to treat those most severely affected and thereby reduce the associated distress, many others, including GPs, clergy and other health professionals, can assist those less severely traumatised. Education of these other professionals and the local population is required so that the associated stigmatisation may be overcome.

It has been suggested that a regional centre be developed (Department of Health and Social Services, 1998). In view of the need for locally based, easily accessible services, this is probably not appropriate, although such a centre could perhaps be developed as a tertiary referral centre and as a focus for teaching and regionally coordinated research.

The relatively static nature of the Northern Ireland population makes it ideal for research. Unfortunately, opportunities for some very valuable research have probably been missed over the past 30 years. Prior to the development of any new services, and while examining current service provision, there is a need for a detailed epidemiological community study which specifically addresses the issue of trauma, its psychological effect upon the population and the extent of the problems here in Northern Ireland, which still remain unknown.

Finally, if there is an identified need for the development of new services, there should be a strategic plan to ensure that the appropriate services are provided, as locally accessible as possible, and that good links between the statutory and voluntary sectors are fostered. Perhaps then it will no longer be said that the various agencies are unable "to treat the multiple problems affecting the traumatised person . . . who is left to cope with a combination of physical, emotional, psychological, financial, domestic and sociological problems" (Department of Health and Social Services, 1998).

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REFERENCES

Anonymous (1998) *The Agreement*. Belfast: Northern Ireland Office.

Bisson, J. I., Jenkins, P. L., Alexander, J., et al (1997) Randomised control trial of psychological debriefing for victims of acute burn trauma. *British Journal of Psychiatry*, **171**, 78–81.

Bloomfield, K. (1998) *We Will Remember Them*. Report of the Northern Ireland Victims Commissioner. Belfast: Stationery Office.

Cairns, E. & Wilson, R. (1984) The impact of political violence on mild psychiatric morbidity in Northern Ireland. *British Journal of Psychiatry*, **145**, 631–635.

Curran, P. S. (1988) Psychiatric aspects of terrorist violence: Northern Ireland 1969–1987. *British Journal of Psychiatry*, **153**, 470–475.

—, Bell, P., Murray, A., et al (1990) Psychological consequences of the Enniskillen bombing. *British Journal of Psychiatry*, **156**, 479–482.

Daly, O. (1997) Doctors' knowledge of post traumatic neurosis. *Ulster Medical Journal*, **66**, 28–33.

—, Fleming, B. & Loughrey, G. (1996) Psychological sequelae to assassination attempts. *Medicine, Science and the Law*, **36**, 25–27.

Department of Health and Social Services (1997) *Health and Well-being: Into the Next Millennium. Regional Strategy for Health and Social Well-Being, 1997–2002*. Belfast: DHSS (NI).

— (1998) *Living with the Trauma of the Troubles*. Belfast: Social Services Inspectorate, DHSS (NI).

Fraser, R. M. (1971) The cost of commotion: an analysis of the psychiatric sequelae of the 1969 Belfast riots. *British Journal of Psychiatry*, **118**, 257–264.

Goldberg, D. (1978) *Manual of the General Health Questionnaire*. Windsor: NFER–Nelson.

Gulbrandsen, P., Hjortdahl, P. & Fugelli, P. (1997) General practitioners' knowledge of their patients' psychosocial problems: multi-practice questionnaire survey. *British Medical Journal*, **314**, 1014–1018.

Initiative on Conflict Resolution & Ethnicity (1997) *The Cost of the Troubles Study. Mapping Troubles-Related Deaths in Northern Ireland 1969–1994*. Belfast: Coleraine Printing Company.

Johnson, D. R. (1997) Inside the specialized in-patient PTSD units of the Department of Veterans Affairs. *Journal of Traumatic Stress*, **10**, 357–360.

Kee, M., Bell, P., Loughrey, G. C., et al (1987) Victims of violence: a demographic and clinical study. *Medicine, Science and the Law*, **27**, 241–247.

King, D. J., Griffiths, K., Reilly, P. M., et al (1982) Psychotropic drug use in Northern Ireland, 1966–1980: prescribing trends, inter- and intra-regional comparisons and relationship to demographic and socio-economic variables. *Psychological Medicine*, **12**, 819–833.

Loughrey, G. C., Bell, P., Kee, M., et al (1988) Post-traumatic stress disorder and civil violence in Northern Ireland. *British Journal of Psychiatry*, **153**, 554–560.

Lyons, H. A. (1971) Psychiatric sequelae of the Belfast riots. *British Journal of Psychiatry*, **118**, 265–273.

— & Harbinson, H. J. (1986) A comparison of political and non political murderers in Northern Ireland, 1974–1984. *Medicine, Science and the Law*, **26**, 193–197.

O'Brien, M. & Nutt, D. (1998) Loss of consciousness and post-traumatic stress disorder. A clue to aetiology and treatment. *British Journal of Psychiatry*, **173**, 102–104.

Parkes, C. M. (1993) Psychiatric problems following bereavement by murder or manslaughter. *British Journal of Psychiatry*, **162**, 49–54.

Paykel, E. S. & Priest, R. G. (1993) Recognition and management of depression in general practice: consensus statement. *British Medical Journal*, **305**, 1198–1202.

Shapland, J. (1984) Victims, the criminal justice system and compensation. *British Journal of Criminology*, **24**, 131–149.

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