Psychological impact of long-term political violence. An exploration of community service users


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Psychological Impact of Long-Term Political Violence: An Exploration of Community Service Users

Karola Dillenburger, Montserrat Fargas, and Rym Akhonzada

Politically motivated violence has been a hallmark of life in Northern Ireland for the past 37 years. Despite the ceasefires in 1994 to 1995, violent incidents remain a relatively common occurrence. A range of community-based services developed to help people cope. In this article, the psychological health of people who use these services is assessed by means of the General Health Questionnaire, the Beck Depression Index, and the Post-traumatic Stress Diagnostic Scale. Pearson correlations indicate that 10 years after the ceasefires in Northern Ireland, the psychological health of community service users remains compromised in terms of death, individual, social, and cultural contexts. These issues are discussed in relation to questions regarding the effects of ongoing violence, resilience, and effectiveness of services.

Keywords: trauma; GHQ; BDI; PDS; D.I.S.C.; violence; Northern Ireland

Introduction

Because of increased media coverage of recent man-made and natural disasters, terms such as trauma, posttraumatic stress, victims, and survivors have become part of our everyday vocabulary. The question of whether traumatic experiences always lead to detrimental psychological effects and extreme suffering or if there can be a potential for adversarial growth have been widely discussed in the academic literature (Joseph, Linley, & Harris, 2005; Linley, 2003; Strassberg, 2006).

On a more practical level, the focus on psychological effects of violence and trauma has fuelled a rapidly growing “victim’s industry” (Omagh Support & Self-Help Group [OSSHG], 2004) of psychotherapists, counselors, and other mental health workers. This growth in services has not come without critics (e.g., Gilligan, 2006). “There is no emergency—large or small—without a psycho-trauma team rushing to the scene” (Withuis, 2005). These considerations raise a range of questions. How does violence and trauma affect the individual socially and psychologically? How long does this effect last? Does everybody who has experienced a traumatic event need therapeutic interventions? What kinds of intervention are effective? Is the concept of trauma and posttraumatic stress disorder (PTSD) appropriate or helpful?

In this article, we draw attention to the effects of trauma circumstances, individual factors, and social and cultural environment on the psychological health of people affected by traumatic events in Northern Ireland. Data show that despite the ceasefires, increased funding resources, governmental policies, and community support systems, recovery is a slow and complex process. It is essential that we understand the etiology and, consequently, the effective progression of this process. As Burrows and Keenan (2004) pointed out, “unresolved and inter-generational trauma can freeze people and groups in the past, and make transformation to more just, equal and peaceful society less possible” (p. 121).

Impact of Conflict on People’s Wellbeing

Northern Ireland has been in the grip of persistent civil unrest and violent conflict since 1969, but the
impact on people’s wellbeing has not been fully acknowledged and addressed until relatively recently. Since the beginning of the Troubles, more than 3,600 people have been killed; this means that 30% of the population lost close friends or relatives, and approximately 50% knew someone who was killed because of the Troubles (Hillyard, Kelly, McLaughlin, Patsios, & Tomlinson, 2003). More than 40,000 people have been injured, many have witnessed explosions or shootings, or have had their homes attacked (Bloomfield, 1998). Fifty percent of the population feels that the Troubles have had a significant impact on their lives (Fay, Morrissey, Smyth, & Wong, 1999).

The extent of violence fluctuated over the past 37 years, with the majority of conflict-related deaths occurring during the first decade of the Troubles. After the ceasefires in 1994/1995, the number of politically motivated homicides and bombs reduced dramatically, but paramilitary-style punishment beatings, sectarian attacks, and interparamilitary feuding continued (Healey, 2004; Monaghan, 2004).

Lack of research on the impact of violence was a hallmark of the early years. Many thought that people in Northern Ireland reacted with surprising resilience, avoidance, or denial to the continuing violence (Cairns, 1988; Cairns & Wilson, 1984). Although some early studies showed high levels of psychological distress in those who were affected by the Enniskillen bomb (Curran et al., 1990) or who were widowed as a direct result of violence (Dillenburger, 1992), it was not until after the mid-1990s that others confirmed these findings (Cairns & Lewis, 1999; Cairns & Mallet, 2003; Hayes & Campbell, 2000; Mallet, 2000; O’Reilly & Stevenson, 2003).

The Role of the Voluntary Support Groups

The significant lack of structured support in the early years (Darby & Williamson, 1978) was transformed when, in the mid-1990s, new Governmental policies led to significant local and European funds being made available to acknowledge and help the victims of the Troubles (McDougall, 2006). Consequently, there was a rapid increase in the number of voluntary organizations aiming to support people affected by the Troubles (Kulle, 2001; Morrissey & Smyth, 2002). In a survey of 107 self-help and support groups, Kelly and Smyth (1999) found that most groups were formed in 1995, the year after the initial ceasefires. More recently, Dillenburger, Akhonzada, and Fargas (in press) found that still more groups formed after the 1998 Good Friday Agreement, when the needs of those affected by the Troubles had become a political issue (Bloomfield, 1998). By and large services offered by these groups involved community-based services, such as befriending, self-help groups, respite care, and storytelling, psychology-based interventions, such as cognitive-behavioral or psycho-dynamically based psychotherapy, or Rogerian or bereavement counseling, philosophy-based interventions, for example, complementary therapies such as reflexology, aroma therapy, and Indian head massage, and education-based interventions, including information and advice or indirect services, such as computer or picture framing classes. The delivery of most of these services depended on funding cycles and, therefore, was usually provided on a seasonal basis (Dillenburger et al., in press).

Pathologizing Trauma

Clearly, not everybody is affected by trauma in the same way. Responses vary significantly depending on factors such as pretrauma life experiences, circumstances surrounding the traumatic event (i.e., type and duration of event or intensity), additional stressful life events, posttrauma social support, and cultural differences (Dillenburger & Keenan, 2005; Orsillo, Batten, & Hammond, 2001; Spates, 2003). Actually, pretrauma factors, such as age or previous trauma experiences, seem to have less effect on coping than events during or after the traumatic experience, such as trauma severity, lack of social support, and additional life stress (Brewin, Andrews, & Valentine, 2000). Hence, “it is in social environments that traumatized persons attempt to cope with the effects of their experience by talking with family or friends, participating in support groups, or seeking professional help from physicians or mental health professionals” (Follette, Ruzek, & Abueg, 1998, p. 9). In fact, even after extremely traumatic events in violent conflicts or natural disasters, most people probably do not require specific psychological or psychiatric interventions (Jones, Rrustemi, Shahini, & Uka, 2003; Sprang, 2000).

Those who require help are often diagnosed with PTSD. Although trauma-related emotional disturbance has long been recognized, for example, in war veterans and with diagnoses such as shell shock, “soldier’s heart,” or war neurosis, the term PTSD was introduced in the Diagnostic and Statistical Manual
of Mental Disorders (4th ed.) (American Psychiatric Association, 1994) only as recently as 1980 (Foa & Meadows, 1997). Symptoms include repeated flashbacks, memories, or nightmares, sleep problems, feeling detached or estranged, emotional numbness, depression, anxiety, irritability or outbursts of anger and intense guilt, and typically, avoidance of any reminders or stimuli associated with the trauma. Whereas these symptoms are common immediately after a traumatic experience, PTSD is diagnosed if symptoms are still present more than 4 weeks after the event and last long enough to significantly impair the person’s daily life.

The concept and diagnosis of PTSD is widely and critically debated. For example, Summerfield (2001) warned that PTSD combines the potent mix of legitimization of “victimhood,” moral exculpation, medical diagnosis, and access to disability pension. Moreover, he argued that the diagnosis lacks specificity, that it is imprecise especially in distinguishing between normal and pathological distress, that criteria are subjective, and that the diagnosis is frequently made without evidence of significant objective dysfunction. Gilligan (2006) maintained that the diagnosis is rooted in the assumption that the traumatic event in the past causes current symptoms without reference to context, whereas Burstow (2005) pointed out that “it is reductionist to ignore purposiveness and to assume that the behavior and orientations in question are the products of a disorder” (p. 433). Others contend that the term PTSD pathologizes common human reactions and coping strategies, ignores the significance of meaning of traumatic events for victims, and does not take into account the context in which the experience occurred (Jones & Kafetsios, 2002, 2005; Summerfield, 2000, 2001).

As such, like other DSM categories, PTSD is probably best viewed as a socially constructed diagnostic category based largely on subjective criteria (Jones, 2006). Paterson, Poole, Trew, and Harkin (2001) put PTSD reactions into a Northern Irish context when describing how Royal Ulster Constabulary officers evaluated their past traumatic experiences in relation to recent early releases of prisoners that is part of the Good Friday Agreement in Northern Ireland. These officers asked themselves “What was it all for?”. Paterson et al. (2001) point out that these reactions to traumatic events in the past cannot be analyzed without reference to present-day experiences. Gilligan (2006) agreed: “The recall of events from the past does not take place in isolation from events in the present” (p. 330).

Without a doubt, cultural, political, and economic influences on psychiatric diagnosis must be acknowledged (Kutchins & Kirk, 1999; Lee, 2001; Summerfield, 1999; Withuis, 2005; Young, 1995). In Northern Ireland, for example, violence although drastically reduced is still going on, more than 10 years after the ceasefires. In fact, Healey (2004) argued that the region should not be described as a postconflict society, but as a pre-postconflict society. “In Northern Ireland trauma can be as a result of continuous experiences, lasting weeks, months or years. For many families it is not ‘post’, but ‘ongoing’ or ‘continuous trauma’” (p. 177). On the other hand, when compared to other regions in the United Kingdom, levels of general criminal activity in Northern Ireland resemble figures in England and Wales (French & Campbell, 2005).

Recently, Dillenburger and Keenan (2005) suggested that coping with trauma, bereavement, or loss should be analyzed on at least four different contextual levels: the Death (or traumatic event), the Individual, the Social, and the Cultural (D.I.S.C.). We use this D.I.S.C. framework here to look at how service users of victims’ groups are coping in Northern Ireland today. We address the following questions:

- What is the relationship between the kinds of traumatic events experienced and long-term psychological health?
- What role do individual factors play in relation to psychological health in this population?
- How is the increase in social support and service provision affecting psychological health?
- How significant are cultural factors in relation to psychological health?

Method

Participants

The sample consisted of 67 participants (25 men and 42 women). About half of the sample were 30 to 50 years of age; the other half were older. The majority of the sample lived in the Greater Belfast area. All participants were service users of voluntary sector victims groups. These groups were selected on the basis of being core-funded by the Governmental Victims Unit. Participants had been affected by the Troubles, either through loss of a family member or
close friend, physical injured to self or family member, experiencing intimidation or threats, or having witnessed a traumatic event.

**Research instruments**

Participant information sheet and consent form were signed before completion of the four-part battery of self-report inventories.

1. The *Personal Experience and Impact of the Troubles Questionnaire* (PEIT-Q; Dillenburger, Fargas, & Akhonzada, 2005) was used to gather information about the age, gender, sociodemographic background, details of traumatic experience(s), and details of services received. The PEIT-Q also included a 7-point Likert scale to assess social validity of services (i.e., social significance of goals, social appropriateness of procedures, and social importance of intervention).

2. The 30-question version of the *General Health Questionnaire* (GHQ-30; Goldberg, McDowell, & Newell, 1996) was scored on the standard binary scoring scale of 0-0–1-1, with a maximum score of 30. Scores more than the threshold of 5 were classified as *case*, indicating that the respondent was likely to experience levels of tension, anxiety, and depression that had an adverse effect on their physical and mental wellbeing. There is a 95% probability that respondents who score 10 or more are suffering severe psychological distress, emotional, or psychiatric illness (Tennant, 1977). For comparison with previous studies that had used the shortened 12-question version, we drew out the relevant 12 questions and reported results with regard to the appropriate threshold of 4.

3. The *Beck Depression Inventory—Second Edition* (BDI-II; Beck, Steer, & Garbin, 1988) is a 21-item self-report rating inventory (each question scored between 0 and 3), using questions that reflect negative attitudes toward self, loneliness, stress, anxiety, performance and/or somatic disturbances, as well as a general depression. Scores of 5 to 9 were considered *normal* ups and downs, scores of 10 to 18 indicate *mild to moderate depression*, scores of 19 to 29 indicate *moderate to severe depression*, and scores of 30 to 63 point to severe depression (Gillespie, Duffy, Hackmann, & Clark, 2002).

4. The self-administered version of the *Posttraumatic Stress Diagnostic Scale* (PDS; Foa, Cashman, Jaycox, & Perry, 1997) gives an indication of symptoms and severity of PTSD. Scores of 1 to 10 were categorized as representative of *mild PTSD* symptoms, 11 to 20 as *moderate PTSD*, and 21 to 35 as *moderate to severe PTSD*. Scores of 36 to 50 were considered to reflect *severe PTSD* symptoms.

The GHQ-30, BDI-II, and PDS are standardized questionnaires that are extensively validated and tested for reliability across age, gender, and culture. They are widely used in Northern Ireland and other countries (Gillespie et al., 2002).

**Procedure**

Ethical approval for this research was granted from the Office of Research Ethics Committees Northern Ireland.

Access to participants was gained using a gatekeeper approach (Erickson, 1982). This meant that chairpersons of self-help groups were contacted to arrange times and places for administration of the self-report inventories. Meetings were arranged in drop-in centers, questionnaires were handed to each participant by the researcher, completed in the presence of the researcher, and collected immediately after completion. The researcher was available to answer questions and help with completion of the inventories where necessary. A small number of participants preferred to use surface mail to receive/return the inventories (*n* = 16).

**Data analysis**

SPSS for Mac OSX (Version 11) software was used to store, code, and analyze the data. Basic statistics included frequencies, means, standard deviations, and cross-tabulations. Pearson correlation coefficients (*r*) were calculated to analyze relationships among variables.

**Results**

**Overall results**

The GHQ-30 mean score for all participants was 10.99 (standard deviation, *SD* = 9.84); 64.2% of the participants were classified as *cases*, scoring 5 or more on the GHQ-30. In terms of BDI-II, the mean score was 19.85 (*SD* = 14.05). Eighteen participants scored as severely depressed, 15 as moderately to severely depressed, and 15 as mildly to moderately depressed. The PDS mean score was 25.02 (*SD* = 15.37). The PDS scores of 18 participants (about 27%) indicated...
high levels of PTSD symptom severity, whereas the scores of 21 participants indicated medium PTSD symptom severity, and 11 participants scored as experiencing moderate PTSD symptom severity.

**Traumatic event–related measures**

There were significant differences in relation psychological health and the kind of traumatic events experienced by participants (Table 1).

Nearly two thirds of the participants (61.2%) had been affected by more than one Troubles-related event. Most of the participants (82%) reported that either an immediate family member or a close friend or relative had been killed as a direct result of the Troubles. Nearly half of the participants had personally witnessed violence; 23 had been intimidated, and 15 had been injured or disabled themselves. Nearly 20% of the participants had a relative who had been injured, and 16% were carers.

Significant correlations were found for those who had been injured or disabled because of the Troubles and their GHQ-30 scores ($r = .45, p < .01$). They also scored significantly higher in terms of BDI-II scores ($r = .36, p < .01$) and PTSD symptom severity as measured by the PDS ($r = .49, p < .01$). Having witnessed a violent event was significantly correlated with PDS scores ($r = .39, p < .01$), GHQ-30 ($r = .25, p < .05$), and BDI-II scores ($r = .26, p < .05$). Having been intimidated was significantly correlated with BDI-II ($r = .32, p < .05$) and PDS scores ($r = .30, p < .05$).

**Individual measures**

In relation to gender and age, there were no statistically significant associations with the psychological measures used. However, participants who stated that they had problems in relation to their physical health scored significantly higher on all three inventories than those who stated that their physical health was good or fair: GHQ-30 ($r = .49, p < .01$), BDI-II ($r = .59, p < .01$), and PDS ($r = .57, p < .01$). The same was true for participants who visited their doctor frequently. They scored significantly higher than participants who had not visited their doctor recently: GHQ-30 ($r = .39, p < .01$), BDI ($r = .31, p < .05$), and PDS ($r = .41, p < .01$).

**Social support measures**

There were statistically significant differences in relation to social support measures. Those who reported that they were able to talk about traumatic events with their family scored significantly lower on all three measures than those who reported that traumatic events were never mentioned or discussed in their family: GHQ-30 ($r = -.36, p < .01$), BDI-II ($r = -.39, p < .01$), and PDS ($r = -.37, p < .01$). No statistically significant relationship was found between urban versus rural dwellers and inventory scores.

Those who reported suffering financial hardship scored significantly higher in relation to general psychological health, depression, and PTSD symptom severity than those who did not have to worry about their finances: GHQ-30 scores ($r = .38, p < .01$), BDI-II ($r = .52, p < .01$), and PDS ($r = .50, p < .01$). Most participants had worried that the traumatic event could happen before it did (67.2%), and 34 of the respondents blamed society, 33 blamed a paramilitary organization, 9 blamed the government, and 5 blamed an individual for traumatic events. Regardless of denominations, those who reported that their religious views had helped in the coping process scored significantly lower on BDI-II ($r = -.396, p < .01$).

<table>
<thead>
<tr>
<th>Traumatic Events</th>
<th>GHQ-30</th>
<th>BDI-II</th>
<th>PDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate family member killed</td>
<td>38</td>
<td>12.37</td>
<td>10.285</td>
</tr>
<tr>
<td>Physically injured/disabled</td>
<td>15</td>
<td>19.13</td>
<td>9.273</td>
</tr>
<tr>
<td>Close friend/relative killed</td>
<td>28</td>
<td>9.25</td>
<td>8.431</td>
</tr>
<tr>
<td>Witnessed a violent event</td>
<td>32</td>
<td>13.53</td>
<td>10.815</td>
</tr>
<tr>
<td>Intimidated</td>
<td>23</td>
<td>13.83</td>
<td>9.684</td>
</tr>
<tr>
<td>Family member injured</td>
<td>13</td>
<td>12.69</td>
<td>11.287</td>
</tr>
<tr>
<td>Caring for someone injured</td>
<td>11</td>
<td>10.55</td>
<td>11.012</td>
</tr>
<tr>
<td>Total</td>
<td>67</td>
<td>10.99</td>
<td>9.843</td>
</tr>
</tbody>
</table>

Mean Scores and Standard Deviations for GHQ-30, BDI-II, and PDS by Traumatic Event

<table>
<thead>
<tr>
<th>Traumatic Events</th>
<th>GHQ-30</th>
<th>BDI-II</th>
<th>PDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate family member killed</td>
<td>38</td>
<td>22.03</td>
<td>14.893</td>
</tr>
<tr>
<td>Physically injured/disabled</td>
<td>15</td>
<td>29.00</td>
<td>12.311</td>
</tr>
<tr>
<td>Close friend/relative killed</td>
<td>27</td>
<td>18.37</td>
<td>13.613</td>
</tr>
<tr>
<td>Witnessed a violent event</td>
<td>31</td>
<td>23.68</td>
<td>14.883</td>
</tr>
<tr>
<td>Intimidated</td>
<td>23</td>
<td>26.00</td>
<td>13.837</td>
</tr>
<tr>
<td>Family member injured</td>
<td>13</td>
<td>19.85</td>
<td>11.553</td>
</tr>
<tr>
<td>Caring for someone injured</td>
<td>11</td>
<td>17.82</td>
<td>16.086</td>
</tr>
<tr>
<td>Total</td>
<td>66</td>
<td>19.85</td>
<td>14.057</td>
</tr>
</tbody>
</table>

Mean Scores and Standard Deviations for GHQ-30, BDI-II, and PDS by Traumatic Event

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and PDS ($r = -0.368$, $p < .01$) than those who said that religious views had not helped.

There were differences in general psychological health, levels of depression, and PTSD symptom severity between those who had used the services offered by the groups and those who had not used these services (see Dillenburger et al., in press, for detailed categorization of services; Table 2). For example, those who had used indirect services, such as computer or picture-framing classes, scored lower on all three measures than those who did not use these services, and those who availed of yoga scored significantly lower in GHQ-30 ($r = -0.25$, $p < .05$), BDI-II ($r = -0.26$, $p < .05$), and PDS ($r = -0.32$, $p < .01$) than those who had not availed of yoga. However, those who used psychotherapy, irrespective of theoretical orientation, scored significantly higher on all three measures than those who had not used psychotherapy: GHQ-30 ($r = 0.32$, $p < .01$), BDI-II ($r = 0.30$, $p < .01$), and PDS scores ($r = 0.27$, $p < .05$).

In terms of social validity, participants rated the services they received generally as significant to themselves, appropriate to their case, and as helpful in the coping process. However, there were no significant correlations between these self-report data and the three inventories.

### Cultural measures

When the present research is compared with findings from general population studies in which the shortened 12-question version of the GHQ was used, substantial differences were found. Figure 1 shows GHQ-12 scores of the general population in Northern Ireland (Health Promotion Agency, 2002), and Figure 2 shows that the GHQ-12 scores for participants in the present research were much higher. In the general population, 26% of women and 23% of men scored above the GHQ-12 threshold score of 4, whereas in the present research the figures were 54.8% for women and 52% for men.

When compared with GHQ-12 scores of the general population in other cultural contexts, such as England (Health Survey for England, 1997), Scotland (Dong & Erins, 1995), and Northern Ireland before and after the Good Friday Agreement (Northern Ireland Health and Social Wellbeing Survey, 1997/2001), participants in the present study scored much higher indicating lower levels of general psychological health (Figure 3).

However, when GHQ-30 scores from the present research are compared with other studies of psychological health of people directly affected by the Troubles, figures are similar. In the present study, 10 years after the ceasefire, 67.3% of the participants scored more than 5 on the GHQ-30 ($mean = 10.7$, SD = 9.423). Before the ceasefires, Dillenburger (1992) found that 67.1% of violently bereaved widows scored more than 5 on the GHQ-30 ($mean = 9.8$, SD = 8.2) up to 10 years after the death of their husband, and 10 to 30 years after their loss, 42.9% of violently bereaved Northern Irish widows scored more than the GHQ-30 threshold of 5 ($mean = 8.1$, SD = 10.0; Dillenburger, 2002). Curran et al. (1990) found that immediately after the Enniskillen bombing in 1987, the GHQ-30 mean score of people who had lost a loved one, been at the scene of the bomb, or had been injured was 18.38 (SD = 6.5).

### Table 2. Mean Scores and Standard Deviations for GHQ-30, BDI-II, and PDS by Services

<table>
<thead>
<tr>
<th>Services</th>
<th>GHQ-30 Mean</th>
<th>SD</th>
<th>BDI-II Mean</th>
<th>SD</th>
<th>PDS Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth work</td>
<td>11.70</td>
<td>9.537</td>
<td>20.73</td>
<td>12.788</td>
<td>30.23</td>
<td>12.290</td>
</tr>
<tr>
<td>Narrative work</td>
<td>9.95</td>
<td>8.861</td>
<td>18.09</td>
<td>13.952</td>
<td>23.95</td>
<td>14.403</td>
</tr>
<tr>
<td>Counseling</td>
<td>10.11</td>
<td>9.255</td>
<td>19.05</td>
<td>14.744</td>
<td>23.94</td>
<td>17.024</td>
</tr>
<tr>
<td>Group therapy</td>
<td>10.81</td>
<td>8.530</td>
<td>18.33</td>
<td>10.253</td>
<td>26.76</td>
<td>15.175</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>29.00</td>
<td>1.414</td>
<td>43.50</td>
<td>7.778</td>
<td>48.00</td>
<td>1.414</td>
</tr>
<tr>
<td>Complementary</td>
<td>11.74</td>
<td>10.540</td>
<td>20.64</td>
<td>15.110</td>
<td>25.33</td>
<td>15.246</td>
</tr>
<tr>
<td>Indirect services</td>
<td>8.63</td>
<td>8.751</td>
<td>17.63</td>
<td>13.263</td>
<td>22.52</td>
<td>14.586</td>
</tr>
</tbody>
</table>

For detailed categorization of services, see Dillenburger et al., in press.
Using the abbreviated GHQ-12, Hayes and Campbell (2000) found that people affected by "Bloody Sunday," 25 years after the event had a mean score of 4.9 (SD = 4.27), compared with a GHQ-12 mean score of 4.92 (SD = 4.056) for the participants in the present study.

**Discussion**

Results reported here indicate that despite the fact that services for victims of community violence are now readily available, most participants scored significantly higher on measures of general psychological health, depression, and PTSD symptom severity than the general population in Northern Ireland and other parts of the United Kingdom. Whereas being able to talk about the traumatic events to one's family, using certain services offered by self-help groups, and holding certain religious beliefs seem to act as protective factors, having financial difficulties or having poor physical health were identified as vulnerability factors related to poorer psychological outcomes.

Results have to be viewed with caution. For example, for ethical reasons, sampling in the study reported here was based on informed consent and, therefore, is self-selecting. Self-selection has been acknowledged as a limitation of most social sciences and medical research (Ward et al., 2004), especially concerning studies of extreme situations (Lifton, 1983), and cannot be avoided in studies that address sensitive issues. In addition, the study reported here illustrates the psychological impact of political violence on people who do seek help. People affected by violence who do not seek help outside the family are hidden populations. Clearly, this does not mean that they are not affected, and future research should explore these effects.

However, data reported here shed light on a number of areas. With regard to the traumatic event, as expected and reported in the existing literature, there were significant differences in psychological health scores. Contrary to Holmes and Rahe's (1967) assertion that the death of a spouse is the most stressful life event, in this study, we found that personal injury, being intimidated, and witnessing a violent incident were significantly correlated with poor psychological outcome and PTSD symptom severity. A detailed and differential contingency analysis of what goes on in these situations would be necessary to inform on the reasons for this.

In line with Brewin et al. (2000), we found that pretrauma factors, such as age and gender were not
as strongly related to psychological health outcomes as factors operating during the event or afterward. However, participants who reported to have better physical health and consequently saw the doctor less often also seemed to have better psychological health. The question of whether there is a causal relationship between physical and psychological health is a chicken and egg equation. Clearly, better physical health avoids additional worry; however, obviously, better psychological health does have an impact on physical well-being. Emerging literature on correlations between physical and psychological health after trauma will shed more light on these relationships (Brunner, 2006).

Not surprisingly, our findings confirm previous research with regard to the importance of social factors for the recovery from trauma. Family communication is vital and community services are used widely. However, the effectiveness of the kinds of therapeutic approaches frequently used by community groups has been called into question (Deloitte & Touche, 2001; Dillenburger, Akhonzada, & Fargas, 2006; Hamber, Kulle, & Wilson, 2001; McDougall, 2006). Data reported here suggest that even though these services are used in the long term, many of the services may not be very effective. More research is needed to establish differential evidence of effectiveness.

When compared across cultural contexts, it becomes clear just how serious psychological health scores are for this sample. Whereas, for example, GHQ scores in England, Scotland, and the general population in Northern Ireland show that only 13% to 27% of the population attain scores of psychological ill health, depression, and PTSD symptom severity that are worrisome, for participants in this study the figure is more than 50%. Future studies should explore the effect of political and cultural changes, such as the prisoner release scheme, and investigate in detail the effect of low-level continued community violence. The need for such studies was emphasized by participants in this study, who had lost their husbands:

It’s us that has to pay the price, not them, they’re running about free, happy, laughing up and down the street with their own children. I meet them up the town, they are coming along happy, laughing. I’m not laughing. I have nothing to laugh for.

And they were never caught the ones that murdered my husband. They knew it was a loyalist because he was Roman Catholic, but they were never caught.

No-one was ever brought to justice. . . . I’d just loved them to be caught. Just the thought of maybe them walking about and enjoying life better than I’m enjoying it. And that there really gets to me. . . . I’ll never feel better no matter what they’ve done but I would love them to be caught. And there’s a lot of people like myself, that never . . . that maybe will never live to see that part.

In summary, then, the findings that the psychological health of participants who sought help outside the family circle has not improved since the Peace Process remains open to interpretation. On one hand, it is possible that there is an “extinction burst” (Dillenburger & Keenan, 2001). This would indicate that it is part of the normal process of extinction that would be expected to occur before behaviors decrease. On the other hand, it is also possible that high levels of psychological disturbance are, in fact, “reinforced” by the attention paid to victims’ issues, the availability of large amounts of money, and the growth of services. If this were the case, it would have implications for targeting of resources. Further research would need to clarify these kinds of functional relationships (Blackledge, 2004; Dillenburger & Keenan, 2005). Finally, issues of truth, recognition, and justice need to be addressed because many feel that they cannot move on unless these issues are tackled. Further research would need to look in detail at how reconciliation can be facilitated (Hamber & Kelly, 2005).

The findings reported here raise a range of questions for trauma researchers as well as practitioners. Clearly, coping with violence and trauma does not happen in isolation, and environmental factors are key in the understanding of individual coping. As Follette et al. (1998) point out “it is in social environments that traumatized persons attempt to cope with the effects of their experience by talking with family or friends, participating in support groups, or seeking professional help from physicians or mental health professionals” (p. 9). Further research on the effect of trauma or D.I.S.C. contexts, including studies of the effectiveness of support services, will shed more light on these issues.

References


Twenty-five years of evaluation. *Clinical Psychology Review*, 8, 77-100.


