

Perspectives and Possibilities: Mental Health in post-Agreement Northern Ireland

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Mental health is considered one of the most important issues in the post-conflict reconstruction period.¹ Northern Ireland is no exception in this regard. There are numerous studies that show that the 30-year conflict has had an impact on the general and mental health of children and adults in Northern Ireland², although the poorer sections of the community were most affected. The Consultative Group on the Past (2009) notes that working class and border areas, in particular, experienced victimisation, ranging from economic and social deprivation to the oppressive presence of military and paramilitary forces. It is estimated that one in six people in Northern Ireland will suffer from a medically defined mental illness at some stage in their lives.³ In comparison to the UK average mental health needs in Northern Ireland are 25% higher.⁴ As a result of the conflict young people in Northern Ireland face a higher risk of mental ill health in comparison to young people in both England and Scotland.⁵

But how does society at large understand what the impact of the conflict has been? How do professionals and policymakers understand this legacy and what needs to be done?

In recent years, the work of victims/survivor groups supporting those affected by the political conflict has been instrumental in highlighting the ongoing impact of the conflict and the need for sustained interventions. However, this article contends that this has also, at least in part, resulted in the mental health impact of the conflict being wrongly seen as only a “victims” issue. Although it is vital to offer support services to victims, we argue, this focus has missed the wider impact of conflict on society and also belies a larger debate within the mental health profession about how to conceptualise mental health problems, i.e. as a definable and diagnosable psychopathology or a wider social problem.

These issues, among others, were the focus of a discussion at the 2011-2012 Forum for Cities in Transition conference where a panel discussion on “Conflict and Mental Health” took place.⁶ This article will highlight some of the issues raised in panel, as well as the wider literature and research focused on understanding mental health in transitional and post-conflict societies. As noted above, it will unpack debates about how best to understand and address the current mental health challenges on Northern Ireland.

Legacy

When one considers that roughly two-thirds of Northern Ireland’s adult population have had one or more experiences of trauma, and that the Troubles accounted for half of these experiences⁷, it is fairly remarkable that the society has, at least to a degree, moved significantly forward politically in the last two decades. Some communities which were devastated by conflict have gone on to be reconstructed socially and economically, and although many victims of the conflict remain on the margins of society, others now hold significant positions in government, civil society and the statutory sector. All this has led some to postulate that people are more resilient to conflict than is often thought. Experts on the “Conflict and Mental Health” Panel challenged this view and that the people of Northern Ireland were and are generally resilient to trauma associated with conflict. For the first ten or fifteen years, clinical observations highlighted the resilience of the people of Northern Ireland, and in particular, women and young people, without considering how trauma can manifest adversely in the long-term.⁸ John Alderdice notes:

Whilst it may seem that people are resilient — and indeed in some circumstances they are — one should not misunderstand that and believe that there are no serious long-term and frequently trans-generational sequelae.

David Bolton shares the view that Northern Ireland’s initial neglect of mental health issues was often predicated on the presumption of resilience, and that experiences of trauma in Northern Ireland are, in fact, much more prevalent than first believed.⁹ Bolton uses the results of an epidemiological study of the conflict in Northern Ireland carried out by the Centre for Trauma and Transformation as evidence for his view.¹⁰ The study found that fifteen percent of individuals who had experienced trauma developed Post-Traumatic Stress Disorder (PTSD), one-third of whom did not recover without access to trauma-focused therapeutic interventions.¹¹ Thus, Bolton asserts:

There is a lesson to be learned from Northern Ireland and the lesson is: don't leave it as late as we did. If you're dealing with societal conflict, one of the steps that need to be taken is to begin to put in place effective, trauma-focused mental health services that can deal with the initial trauma but also with the chronic trauma that will emerge in due course.

Muldoon and Downes (2007) also use PTSD as their yardstick. They argue that the post-traumatic stress disorder is the most common mental health problem resulting from years of war and conflict.¹² The prevalence of PTSD in post conflict societies is also thought to be normally higher than in societies where conflict is still ongoing.¹³ Nevertheless, very little research on the prevalence of PTSD in post conflict societies such as Northern Ireland is available.¹⁴ Muldoon and Downes (2007) note that “those identified as having probable PTSD represent a particularly vulnerable and disadvantaged group in terms of financial, psychological and social capital”.¹⁵ Many of the people in Northern Ireland with symptoms that may suggest PTSD do not see themselves as victims of the conflict and instead of seeking professional help some self-medicate and “treat” their symptoms with drugs and alcohol.¹⁶

But there is also a concern about narrowing the understanding of the impact of the conflict to a limited construct such as PTSD.¹⁷ Focusing on symptoms can reduce the focus on the social context that continues to create ongoing mental health challenges. Focusing on “diagnosis” can divert attention to individual symptoms instead of seeing the reconstruction of the social, economic and cultural environment as the key parts of supporting positive mental health in societies emerging from political violence.

The issue of suicide is a case in point, which is not simply a manifestation of individual depression but integrally linked to the dynamics of the social context and the political conflict in Northern Ireland. One of the main concerns of “The Promoting Mental Health Strategy and Action Plan”¹⁸ is high level of suicide among young males in the society. This has a gender dimension. Violence and aggression remain deeply ingrained in the society and manifests in violence particularly by men against others and themselves.¹⁹ Statistics from the Northern Ireland’s Public Health Agency as quoted in *The Guardian*²⁰ show that between 1999 and 2008 suicide rates in Northern Ireland have risen by 64%. In 2010, 313 deaths from suicide have been registered showing a significant increase on the previous year with a total of 260 suicide deaths registered in 2009.²¹ The majority of suicide deaths in 2010 were males between 15-34 years old, a total of 240 male deaths as a result of suicide were registered in comparison to 73 female deaths.²²

One of the public debates in Northern Ireland about suicide is the degree to which it is a legacy of the conflict, and the role of paramilitary groups in this in particular.²³ It has been argued that post-Troubles suicides and suicidal behaviour frequently occurred among young males who had not themselves participated in the violence, but who resided in areas where there had been chronic, long-term violence as a result of the conflict.²⁴ Often, these young men were the targets of intimidation, and physical and sexual abuse by paramilitary and other figures in their communities. According to Smith, Fay, Borough and Hamilton (2004) in Northern Ireland the mental health of young men is particularly affected by the conflict as they are more likely to fall victim to punishment beatings and intimidation by paramilitary groups in comparison to females. Healey explains that in her experience as a mental health practitioner in Northern Ireland, the mental health of young people in conflict is adversely affected by such diverse circumstances as: coping with the death or imprisonment of a parent(s); growing up with a parent(s) who has PTSD; living in the shadow of a brother or sister killed during the Troubles; suffering from domestic violence and various forms of physical and sexual abuse; and even being forced to relocate as a result of political intimidation.

Members of the security forces and ex-paramilitaries also seem to be vulnerable to suicide often exhibiting suicidal behaviour years after initial conflict-related incidents and experiences.²⁵ The nexus of long-term unemployment, poverty, relationship breakdown, alcohol and substance abuse, and at times the existential anxiety of the “terrible futility of the things” they were involved in can result in mental health problems.²⁶ Recent research has also begun to suggest that the impact of the conflict can become more acute with age with over 90% of ex-prisoners now being over 50 years old. A recent survey of former politically motivated prisoners found that they were four times more likely to be unemployed than others in Northern Ireland.²⁷ Mental health impacts were also present, i.e. 68.8% of respondents engaged in levels of drinking that were hazardous and 32.6 % had received prescription medication for depression in the last year.²⁸ Given that at least 15,000 people were incarcerated in Northern Ireland during the conflict, the effect on individuals and the knock-on effect onto extended families cannot be underestimated.

Perspectives

Although, as was outlined above, the individual impact of conflict can be devastating there is a tension in the psychology field about how best to understand this and the concept of resiliency. Earlier in the article the notion of resilience was challenged, but this should not be read as a total dismissal of the concept of resiliency. Rather it is a challenge to how it has been used in

Northern Ireland particularly, where its use in the 1970s and 1980s was often tantamount to the denial of the full mental health impact of the conflict. This, for example, is evident in the fact that a policy focus on victims of the conflict only developed post the 1998 Agreement. It has been argued that there was a policy silence in the areas of health, social services, education and other provisions for victims of the conflict.²⁹ This was acknowledged by the British government through Minister Des Browne in 2003 when he noted, “in all that time [thirty years of conflict] there were no policies in relation to victims”.³⁰ Since 1998, there have been numerous victim policies set in place³¹, and in 2008 the establishment of the Commission for Victims and Survivors in Northern Ireland. However, there is a danger of moving from one extreme to the next, i.e. that there is no mental health legacy of the conflict to diagnosing everyone as traumatised by the conflict. This can have the effect of pathologising resiliencies that are there and denigrating local coping mechanisms.³²

Resilience is the process of adapting well in the face of adversity, trauma, tragedy, threats, it means, “bouncing back” from difficult experiences.³³ Each individual possess protective factors that serve to support them if they experience a traumatic event, however, situations can affect these protective factors and can either support or weaken their response to a traumatic event.³⁴ According to Baker and Shalhoub-Kevorkian (1995) people in the same household react differently to the same traumatic experience. Betancourt and Khan (2008) argue that resiliency; psychological adjustment and mental health in societies that have endured years of conflict should be seen as a dynamic process instead of a personal trait. If we start to understand resilience as something that can come not only from individuals, but from the social context (e.g. community connections and cohesion, social protection) then how we can rebuild resilience and strengthen coping becomes more apparent.

Gilligan (2006) has pointed out that war can have positive aspects, for example community bonding, and that there are many social, political, economic, and cultural factors which influence how or if individuals seek help. Terms such as PTSD also run the risk of pathologising individuals, labelling them as having a disorder and skewing power relations.³⁵ It has also been argued that using medicalised language changes how people begin to describe their suffering, moving away from talking about the wider social and political context and how it links to mental health, towards framing the impact of conflict as primarily individualized PTSD as this is what gains medical and legal attention.³⁶

Many are now starting to reject an individualized mental health focus and there is a growing view that other paradigms and institutions can contribute to our

understanding of mental health in transitional and post-conflict societies more effectively.³⁷ The mental health paradigm is but one lens with which to view conflict and it is not apolitical.³⁸ Not only do structural conditions (i.e. segregation) impact upon the effective delivery of mental health services, Breen-Smyth cautions that the primacy of the mental health paradigm may actually be detrimental to victims/survivors. As in Northern Ireland, if research cannot present sufficient statistical evidence of widespread, trauma-induced psychopathologies as a result of exposure to conflict, policymakers can justify delaying, or neglecting altogether, instituting mechanisms to effectively deal with the past.³⁹ Although some feel therapeutic models do not promote passivity and patients can take control of their treatment⁴⁰, others argue the mental health paradigm inherently promotes inequitable power relationships between an expert practitioner and an inexperienced patient⁴¹. This constrains individual capacity to identify his or her needs and claim ownership of the recovery process.⁴² As a result, Breen-Smyth states, individual therapeutic interventions may be ill-fitted to patients' underlying needs:

It seems to me that it's at our peril that we look at these things solely through the lens of mental health. We also need to factor in the justice frameworks. People are aggrieved, they have not seen justice, and if we put a pill in somebody's mouth when they are grieving and the lack in their lives is the lack of justice and the lack of reconciliation, then we are storing up trouble for our own futures and for our children's futures. So, let's use mental health frameworks by all means, but let's remember that they are only one pair of glasses, and we have many more pairs of glasses at our disposal.

Hetherington concurs that justice is critically important to victims and survivors, but that in Northern Ireland, justice is contested, generally meaning law, order and security to unionists, but social justice and parity to nationalists, rendering consensus virtually unachievable.⁴³ That said, victims of political conflict from all backgrounds are unlikely to divorce the questions of truth, justice, labelling responsibility for violations, compensation and official acknowledgement of what happened to them from the healing process.⁴⁴ Although issues like justice are also not a panacea to dealing with the impact of conflict⁴⁵, research has highlighted that the legacy of conflict upon mental health cannot be dealt with solely by considering individual psychopathologies of those with direct or indirect experiences of conflict.⁴⁶

Violence committed by paramilitary groups, for example, is a group phenomenon and is not about individual psychopathologies.⁴⁷ The fact that Protestant, working-class young men are disaffected, lacking the educational resources and employment opportunities of the Protestant middle-class, and

failing more recently to attain the same level of social advancement as nationalists following the conflict, is a social problem not solely an individual one but has massive mental health ramifications.⁴⁸ Maureen Hetherington argues that violence in Northern Ireland can only be understood in terms of a collective, cultural phenomenon in which domestic violence, punishment shootings and beatings for drug-related or anti-social behaviour and political support for violence are tolerated with apathy or indifference.⁴⁹ The faith community, bystanders and politicians all have a role in changing Northern Ireland's culture of violence and that only through cultural change will victims and survivors be allowed the space to share their experiences and ultimately to heal.⁵⁰

According to Tomlinson (2007) the conflict affected everything and the society as a whole has been "traumatised" with brutalisation being common and "resistance to change engrained and depression and anxiety widespread".⁵¹ The impact and reverberations of the conflict are still being felt most acutely by the direct victims and the bereaved, but whole communities also have a collective experience of suffering making the problem personal, communal and society-wide.⁵²

Implications

The panel at the 2011-2012 Forum for Cities in Transition clearly articulated the importance of establishing effective mental health strategies even in low-level conflicts, such as in Northern Ireland. Compared with the Rwandan genocide where 800,000 people were killed in just three months⁵³, or with the conflict in Bosnia and Herzegovina which claimed the lives of more than 100,000 individuals in three years⁵⁴, it can be easy to dismiss the impact of the 3,600 people killed in the Troubles.⁵⁵ Nevertheless, as evidenced by this article and other research the impact of the conflict on mental health has been pervasive and extends well beyond the devastating impact on those most directly affected in terms of injuries or bereavement.⁵⁶

A misguided notion of resilience has in the past in Northern Ireland resulted in the full impact of the conflict being ignored until recently. Mistakenly seeing resilience as universally inherent in individuals has hindered mental health promotion in that it has affirmed the culturally defined idea that people are strong enough to deal with their own problems and this has led to many people self-medicating, taking part in risk-taking activities and various forms of violence as a means of coping with their problems. In other words, the universal presumption of resilience has led to a negative form of coping, which in turn,

has impacted negatively on the mental health of people affected by the conflict in Northern Ireland.

It is only in the last fifteen years that the assumption of resilience to the Northern Ireland conflict from a mental health perspective has been challenged. It is now also contended that the failure of society to acknowledge the complexity and pain of the past and deal with outstanding conflict-related issues in Northern Ireland politically is, at least in part, about the neglect of the massive impact the conflict has had on the society.⁵⁷

The conflict has had particularly devastating consequences for the mental health of victims, former combatants, children, and women. Further these effects have been chronic and generally manifested only after a significant passage of time. During the conflict people in Northern Ireland generally did not receive adequate support to deal with their problems.⁵⁸ Establishing effective trauma-centred therapeutic interventions is one critical avenue by which to address trauma and its often devastating sequelae.

However, therapeutic interventions are only a small part of what is needed. For example, the disproportionate effects of trauma on young people, needs to also be addressed through safeguarding and promoting the rights for children and ensuring young people feel they have a secure future. Chronic unemployment and bleak economic prospects cannot be divorced from the mental health challenges faced by a range of people in the society. Links between mental health and the social environment have been well documented, with deprivation, poverty and low educational attainment being associated with poor mental health.⁵⁹ According to Muldoon and Downes (2007) in order to better understand the impact of any specific incident in conflict situations approaches need to consider previous traumatic experiences and socio-economic background. Clearly there are linkages between trauma, anti-social behaviour, crime, poverty, substance abuse, and suicide, and therefore there is a need to define the relationship between mental health and justice both in the criminal sense but also socially. At the same time, however, we need to ensure that stigmatization of the working-class as responsible for the violence does not take place as this can be traumatizing in itself, and it fails to see that the conflict has permeated all aspects of life in Northern Ireland and is also perpetuated by attitudes across the society.⁶⁰

This sort of thinking means we need to stretch the boundaries of the mental health field to encompass the spatial territory of politics, justice and socio-economics if we are to truly understand how individuals have been adversely affected by political conflict. In other words, the mental health impact of the

conflict needs to be mainstreamed across policies aimed at health, welfare, education, justice and economic development among others. Beyond considering innovative methods of incorporating discourses of mental health and the conflict into other paradigms, this article has argued that mental health should not be discussed simply in terms of individual psychopathologies, but also in terms of shared conflict experiences across collectives and groups. This requires community-orientated interventions aimed at whole communities as part of the process of social reconstruction.⁶¹ These interventions should have psychological, social, economic, cultural and environmental elements and be aimed at ensuring human security in the broadest sense and seek to maximise the capabilities of individuals to participate in the development of their own lives and communities. Such a focus should also aim to build resilience by building on existing coping mechanisms and capabilities often seen in communities, which may be present in the community and social structure. Barsalou (2005) posits that we should reinforce the sources of resilience within our communities instead of psychopathologizing the process of social reconstruction.

For strategies to be effective the whole family should be the focus of the support in order to dampen trans-generational effects of the conflict.⁶² Even those lacking direct experiences of the conflict such as young people can continue to live with its legacy. Yet, if we focus only on the individual aspects of a young person's particular experience, we may disregard common narratives, shared experiences and the social and political conditions that detrimentally affect their mental health. Moreover, we would fail to see the implicit linkages between the mental health of parents or community leaders, and the manifestation of trauma in young people. Equally, by taking a narrow individual pathology model, or only focusing on direct victims of the conflict, the experience of many women who had to cope with enormous levels of family disruption, economic hardship and abuse in the home linked to violent conflict-masculinities⁶³, as well as alcoholism often seen in impoverished communities, can be missed. In other words, if we isolate our discussion of mental health to trauma caused by the direct participation of men in armed conflict, we would ignore the shared experience of women in the structural and physical violence associated with that struggle and its aftermath.⁶⁴

By discussing mental health solely in terms of individual psychopathologies, we also forego the pursuit of strategies to address cultural attitudes to violence. Support for violence and its pervasive nature post-Agreement cannot be reduced to an individual's particular state of mental health or pathology. Without questioning the society-wide cultural framework that perpetuates and legitimizes the pursuit of goals through violence, we not only limit alternative

courses of action, but restrict the space for victims and survivors to speak openly about their experiences of conflict at the detriment of their mental health.

In summary, violence and dealing with its mental health legacy means we need to understand violence in context and address it not only individually, but socially and politically. Although, it is extremely important to focus on the victims and survivors of the conflict, we need to simultaneously move beyond this narrow focus and consider the wider society. There is of course a danger in arguing everyone was affected by the conflict, i.e. we can fail to acknowledge the differential impact of the conflict.⁶⁵ However, if a genuinely contextual approach to dealing with the legacy of conflict is adopted, then different social, political, developmental and environmental interventions, as well as tailored individual therapeutic approaches, would be the result.

Notes

- 1 World Health Organisation, 2002; Ghosh, Mohit and Murthy, 2004.
- 2 Deloitte, 2007.
- 3 Department of Health, Social services and Public Safety, 2003.
- 4 Department of Health, Social services and Public Safety, 2004.
- 5 Harland, 2009.
- 6 The second annual Forum for Cities in Transition was held from 23rd to 26th May, 2011 in the Guildhall in Derry/Londonderry. On the closing day of the conference, participants met for a session on “Conflict and Mental Health” which was billed as “a panel discussion on the need to deal with PTSD and other mental injuries caused by conflict” (Forum for Cities in Transition, 2011). Chaired by Professor Brandon Hamber, panelists included: Lord John Alderdice, House of Lords and Executive Medical Director of South and East Belfast Health and Social Services Trust from 1993 to 1997; David Bolton, Director of the Northern Ireland Centre for Trauma and Transformation in Omagh, Northern Ireland; Marie Breen-Smyth, Chair of International Politics at the University of Surrey, England; Arlene Healey, Centre Manager and Consultant Family Therapist at the Family Trauma Centre in Belfast, Northern Ireland; and Maureen Hetherington, Coordinator of The Junction, a community relations and peacebuilding centre.
- 7 Ferry, Bolton, Bunting, Devine, McCann and Murphy, 2008, p.22.
- 8 Alderdice, panel.
- 9 Bolton, panel.
- 10 Ibid.
- 11 Ferry et al, p.28.
- 12 Muldoon and Downes, 2007.
- 13 De Jong, Komproe and Van Ommeren, 2003.
- 14 De Girolamo and McFarlane, 1996; Muldoon and Downes, 2007.
- 15 Muldoon and Downes, 2007, p.148.
- 16 Bolton, panel.
- 17 Breen-Smyth, panel.
- 18 Department of Health, Social services and Public Safety, 2003.
- 19 Alderdice, panel.
- 20 O’Hara, 2011.
- 21 Northern Ireland Statistics and Research Agency, 2011.
- 22 Ibid.
- 23 Tomlinson, 2007.
- 24 Alderdice, panel.
- 25 Ibid.
- 26 Ibid.
- 27 Jamieson, Shirlow and Grounds, 2010.
- 28 Ibid.
- 29 Hamilton, Thomson and Smyth, 2002.
- 30 Irish Echo Online, 2003.
- 31 McDowell, 2007.
- 32 Bracken, 1998.

- 33 APA Health Center, 2004.
- 34 Baker and Shalhoub-Kevorkian, 1999.
- 35 Lykes and Mersky, 2006.
- 36 See Beristain, 2006.
- 37 Breen-Smyth, panel.
- 38 Ibid.
- 39 Ibid.
- 40 Bolton, panel.
- 41 Breen-Smyth, panel.
- 42 Ibid.
- 43 Hetherington, panel.
- 44 Hamber, 2009.
- 45 Bolton, panel.
- 46 Hamber, 2009.
- 47 Alderdice, panel.
- 48 Ibid.
- 49 Hetherington, panel.
- 50 Ibid.
- 51 Tomlinson, 2007, p.109.
- 52 McAllister, 2008.
- 53 Verwimp, 2004, p.233.
- 54 Tabeau and Bijack, 2005, p.207.
- 55 Cairns and Darby, 1998; Smyth, 2001; Morrissey and Smith, 2002.
- 56 Fay, Morrissey, Smyth and Wong, 1999.
- 57 Consultative Group on the Past, 2009.
- 58 Ibid.
- 59 Department of Health, Social services and Public Safety, 2006.
- 60 Hetherington, panel.
- 61 Ghosh, Mohit and Murthy, 2004.
- 62 Thabit, Abed and Vostanis, 2001.
- 63 Hamber, 2007.
- 64 Hamber, Hillyard, Maguire, McWilliams, Robinson, Russell and Ward, 2006.
- 65 Morrissey and Smyth, 2002.

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