The Psychotherapeutic Treatment of Trauma in Northern Ireland in 2012

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Abstract

The aim of the present study was to explore the ongoing psychological impact of the “troubles” in Northern Ireland and the psychotherapeutic treatment of trauma, fourteen years after the signing of the Good Friday Agreement in 1998. The thirty years of conflict punctuated by random acts of bloodshed and violence have impacted significantly on the emotional and psychological wellbeing of most in Northern Ireland and continue to this day, with regular, ongoing dissident and sectarian based incidents. Using five qualitative interviews the study evaluates the psychological impact of the “Troubles” on therapists/counsellors, those working with the security forces and clients who were affected. Both content and thematic analyses were conducted.

Analysis from the qualitative research found that PTSD was the most prevalent presenting issue. Cognitive Behavioural Therapy and EMDR were deemed to be the most successful interventions for its treatment supported by other complementary therapies such as family therapy. Trans-generational historical trauma was also found be significantly impacting on the population across Northern Ireland. Results obtained are discussed in the context of academic research in the literature review. Methodological limitations of the research and future recommendations were also made.
1. Literature Review

1.1 The History behind the “Troubles” in Northern Ireland

For more than a generation Northern Ireland was the site of one of Europe’s most bloody and protracted recent conflicts. Between 1969 and 2007, the “Troubles,” as the conflict became euphemistically known, claimed the lives of about 3,700 people, with thousands injured in countless bomb and gun attacks (Edwards, 2011). The sectarian nature of the conflict along with the indiscriminate character of the violence entrenched the bitterness and hatred that continues to this day in Northern Ireland. Although the conflict between Protestant Unionists and Catholic Nationalists has its roots in the 17th century, the most recent phase can be traced to the partition of Ireland in the 1920s and the hold of the Ulster Unionist Party until the collapse of the Stormont administration in 1972. In the 1960s, a conglomerate of Catholics, nationalists and Republicans opposed to the Ulster Unionist Party established the Northern Irish Civil Rights Association (NICRA). In 1969, the Royal Ulster Constabulary attacked and open fired on one of NICRA’s marches sparking violence. Counter-demonstrations by Protestant loyalists - so called for their "loyalty" to British rule - lead to escalated violence. Emerging from civil unrest the Irish Republican Army (IRA) was formed as the cutting edge of Catholic defenderism (McKittrick and McVea, 2011).

Few actions were as momentous in the Troubles as the interventions of the British troops ordered into the province in 1969 to provide military assistance to the civil power. Despite its initial peacekeeping posture the British army were quickly thrust into the violence (McKittrick et.al, 2011). “Operation banner” as the intervention became known,
became the longest campaign in military history. The knee jerk reactions of the Security Forces, made up of the RUC and the British Army served to generate controversy and high profile inquiries such as Saville Inquiry were the British Army were deemed responsible for the death of thirteen men during a Civil Rights march in Derry known as Bloody Sunday. In response to this in November 1974 twenty-one people were killed in Birmingham by IRA bombings. The British government as a result responded by introducing the Prevention of Terrorism Act, which allowed suspects of these crimes to be held without charge for up to seven days (Edwards, 2011). A bomb was also planted in the House of Commons in London, injuring eleven people. In December 1974, the IRA finally called a ceasefire in the belief that the British troops were about to pull out of Northern Ireland however this was not the case and armed violence resumed.

The 1980s will be most remembered for the hunger strikers in the Maze prison lead by the IRA leader Bobby Sands where ten died of starvation. Violence resumed right up to 1998 when the Good Friday Agreement was signed including a devolved parliament and a role for the Republic of Ireland in Northern Ireland affairs. This, however, did not put an end to the violence with the Omagh bombing happening just four months after the agreement killing twenty nine people (Edwards, 2011). Power sharing institutions were finally devolved by the British Government to the local Stormont Assembly in a deal between Ian Paisley’s Democratic Unionists Party and Gerry Adam’s Sinn Fein in May 2007. At the same time due to winding up of the IRA’s campaign and in the spirit of normalization, the British Army would retract its troops and terminate Operation Banner in 2007.
These thirty years of conflict punctuated by random acts of bloodshed and violence have impacted significantly on the emotional and psychological wellbeing of most in Northern Ireland impacting not only on the survivors of the “Troubles” but also their children and grandchildren.

1.2 Impact of the Conflict on Northern Ireland

It is difficult to quantify the numbers of people affected by conflict related trauma in Northern Ireland due to the lack of systematic information (Hillyard, Rolston and Tomlinson, 2005) however Muldoon et al. (2005) found that over thirty years of political violence, Northern Ireland witnessed 3,500 deaths, over 35,000 injuries, 16,000 charged with terrorist offences, 34,000 shootings and 14,000 bombings. Muldoon et al. (2005) suggested that 12% of the Northern Ireland population were diagnosable with PTSD and 6% of those within the Border Counties were also impacted. O’Reilly and Stevenson (2003) concluded it is “probable” that the mental health of the entire population has been significantly affected by the conflict. For instance, in the Poverty and Social Exclusion Survey (Hillyard et al., 2003), half of the respondents reported knowing someone who had been killed due to the Troubles, and 30% stated to have lost close friends or relatives related to the “Troubles” (Daly 1999).

Taking into consideration these shocking figures it is not surprising that Northern Ireland has the highest level of twelve month and lifetime Post Traumatic Stress Disorder (PTSD) across the world with 61% of the Northern Ireland adult population having experienced a traumatic event at some point in their lifetime and 39% having had one or
more traumatic experiences linked to the conflict resulting in direct service costs (those that availed of trauma therapeutic services and medication) of £33million (Ferry et al., 2011). According to the DSM IV (APA, 2000) and NICE (2005) there are three categories of symptoms which characterize PTSD, re-experiencing of the event such as nightmares or flashbacks; avoidance of things that remind the person of the event and numbing of emotions and responsiveness; and hyper-vigilance symptoms such as jumpiness, irritability and sleep disturbance. The diagnosis requires that three of these symptoms be present. Ferry et al. (2008), Shalev and Yehuda (1998) and Kessler, Sonnega, Bromet and Nelson (1995) also found that individuals who met the criteria for PTSD were more likely to experience a wide spectrum of mood, anxiety or substance abuse disorders or suffer chronic physical conditions.

According to Healey (2004), although Northern Ireland is often described as a post-conflict society, for many, especially families living in the areas most affected by the Troubles, many continue to be impacted by targeted violent attacks. Similarly although many suffer from PTSD, the name, in a sense fails to describe and minimizes the continuity of the traumatic events which spanned over thirty years, consigning the traumatic event to the past (Becker, 1995). Thus how does one provide effective treatment for those exposed to continuous trauma, where the individual may be re-traumatised between therapeutic sessions? According to Healey (2008) psycho-educational material can be useful as the client can develop at least, an understanding of what is happening to them and they in turn can learn some coping mechanisms. As the traumatic events are ongoing, Continuous Traumatic Stress Syndrome (Straker, 1987)
may be a more meaningful descriptor of what went on and continues to go on in Northern Ireland, where ongoing threat and violence sets a baseline of fear for individuals, families and communities becoming part of their life response template (Stewart and Thompson, 2005). This fundamental lack of safety ripples in and out between families and community to create a series of “unsafety zones” (Stewart, 2000) where existing and potential support structures are compromised through exposure to chronic fear and threat. The impact of trauma can often shatter the beliefs that one holds about the world (Janoff-Bulman, 1985) and can impact on coping mechanisms and no longer being able to make sense of the world. For others the preferred coping mechanism was fear and silence or as Coulter, Healey and Reilly (2007) deemed it a stoicism and silence. As Kapur (2001) puts it Northern Ireland society has until recently remained in the distress and denial phase of the troubles, with many feeling a sense of isolation in their trauma, and is only now beginning to realise the destructive impact.

1.3 Trans-generational Trauma

Trans-generational trauma is evident across many cultures, from the Aborigines in Australia, the victims of the holocaust to Northern Ireland where historical trans-generational trauma is ripe. One could argue historical trauma is defined as the subjective experiencing and remembering of events in the mind of an individual or the life of a community, passed from adults to children in cyclic processes as ‘collective emotional and psychological injury ... over the life span and across generations’ (Muid, 2006; 36).

The trans-generational effects of trauma can impact in a number of ways, including the effect on the attachment relationship with caregivers, which in turn effects the parenting
style and the parents physical and emotional disconnection from his or her family and society (Milroid, 2005). The child witnesses the on-going impact of the original trauma which a parent or family member has experienced which in turn is transmitted to the child. This theory is supported by the Irish Peace centre (2010) who believe the art of traumatic story-telling is destructive to other generations often resulting in a range of social and psychological pathologies, such as self-harm, suicide, anti-social behaviour, anomie and inter-personal violence.

Duran and Duran (1995) suggested that historical trauma becomes embedded in the cultural memory of people and is passed on to the next generation becoming normalised within that culture. This model of historical trauma provides a link between the intergenerational transmission of trauma and ‘Dysfunctional Community Syndrome’ (DCS) which is defined as a situation whereby multiple violence occurs and appears to increase over generation, both increasing in number and intensity (Duran, Duran, Brave Heart Yellow-Horse Davis, 1998).

Memmott, Stacey, Chapters and Keys (2001) suggested that the typical cluster of violence types in a dysfunctional community would include male-on-male violence, female-on-female violence, child abuse, substance use-related violence, male suicide, pack rape, infant rape, rape of grandmothers, self-mutilation, spousal assault and homicide. They further argued that when a community deteriorates to the point of DCS, it has devastating immediate and generational effects on the members of that community, particularly the children. Exposure to community violence results in dangerously high
levels of emotional distress and antisocial behavioural problems, and has been identified as an independent risk factor for problems such as depression, anxiety and aggression in youth (Scarpa, 2001). This is supported by Simpson’s (1998) study on conflict in South Africa, Winship (1996) study on victims of the holocaust support and Shevlin and McGuigan (2003) study on 73 family members of those killed in Bloody Sunday, who found high levels of intrusion, avoidance and hyper arousal particularly in the victims children.

1.4 Treatment of Conflict Related Trauma

According to Healy (2004) there was an-all prevailing silence that extended to all levels of society within Northern Ireland, from those involved in Health and Social Services to those planning Health and Social Care provision within the Department of Health and Social Services. The culture of silence equally extended to the therapeutic context, with many mental health specialists ill equipped to speak about the atrocities, unsure what was the most effective means of treating continuous trauma due to little structured support for those affected.

With the beginning of the Peace Process in the mid-1990s, the Government in Northern Ireland began to pay considerable attention to those who had been bereaved and injured through the Troubles (Dillenburger, Akhonzada and Fargas, 2007). Reports such as the Bloomfield Report (1998) were commissioned, a Victims Unit was set up as part of the Office of the First Minister and Deputy First Minister and a Victims Strategy (Reshape, Rebuild, Achieve, RRS, 2002) was developed. The Good Friday Agreement in April
1998 stated that it was critical that the suffering of the victims of the violence should be acknowledged and addressed as part of reconciliation (Northern Ireland Office, 1998) and committed government to take steps to address their needs.

Since 1998, £44 million of central government and European funding has been allocated to a variety of organisations, with the aim to support victims and survivors of the conflict in Northern Ireland (McDougall, 2006; Dillenburger, Akhonzada and Fargas, 2005; Kulle, 2001; Morrissey and Smyth, 2002). These groups provide a range of interventions and services aimed to improve the quality of life of those most acutely affected by the Troubles and/or have an advocacy role. The Pave Report (2007) attempted to categorize services available into four categories; Community-based services included self-help projects, befriending and respite, often initiated by people who had themselves experienced bereavement and Troubles related trauma; Philosophy-based services carried out from a certain philosophical stance, such as complementary therapies based on Eastern Philosophy (meditation, yoga, aroma therapy); Education-based services that were primarily concerned with education, such as advice and information, or indirect services, such as specific skills courses in information technology or cookery classes and Psychology-based services were interventions that were carried out by professionally trained and accredited therapists who worked from a clear psychological, theoretical and methodological basis. Overall the report found that psychological services achieve their aims of helping people gain improved mental health and to cope with trauma but it was community based services such as befriending, self-help groups, which enabled people to break the silence.
1.5 Psychotherapeutic Evolution of Care: Early, Middle and Later Interventions

In recent years there has been increasing evidence about the effectiveness of certain psychological and pharmacological treatments for Post Traumatic Stress Disorder in Northern Ireland (Crest, 2003). Research would suggest however that the most effective treatment strategies combine patient education; pharmacologic interventions, such as selective serotonin reuptake inhibitors and psychotherapy (Lange, Lange and Cabaltica, 2000; Melman, Clark and Peacock, 2008). For the purpose of this research we will focus on the psychotherapeutic interventions and divide them into early, middle and later interventions.

1.5.1 Early Psychotherapeutic Interventions

Creating safety is a critical initial phase of the therapeutic process (Coulter, 2001). It may involve discussion with potential clients about where best to be seen, openness around how the records are kept and significant effort is exerted to ensure there is a high degree of control regarding the timing, methods and pacing of the therapeutic work, seeking to avoid the unpredictability which is at the heart of traumatic experiencing (Healey, 2004). There should be concern for the patient’s physical safety, and education and reassurance regarding the individual’s psychological symptoms should be provided, with appropriate pacing (Rothschild, 2000). Rothschild (2000) and Turnbull (2011) both allude to the importance of the therapist knowing when to “apply the brakes” using safe place imagery, body awareness and anchoring if the client becomes hyperaroused. It is fundamental that the therapist can adequately attune to the client to ensure that they as therapists are aware of this so as to not cause any harm to the client (Herman, 1992).
Therapeutic witnessing also plays a critical role in the initial stage of therapy. Blackwell (1997) believes that for many the therapist acts as a witness to their realities, witnessing the impact of the Troubles much of which still remains invisible to the rest of society, allowing the client to feel they are being heard.

Psycho-education is also increasingly used following trauma. The term covers the provision of information about the nature of stress, posttraumatic and other symptoms, and what to do about them. The provision of psycho education can also occur before possible exposure to stressful situations or, alternatively after exposure (Wessely et al., 2008). The intention is to ameliorate or mitigate the effects of exposure to extreme situations.

1.5.2 Middle Psychotherapeutic Interventions

Once the relationship of trust has been established, Cognitive Behavioural Therapy (CBT) and Eye Movement Desensitization and Reprocessing (EMDR) have been clearly shown to be effective in treating Post Traumatic Stress Disorder, with the exposure and cognitive restructuring elements of treatment being the most significant components (Ehlers and Clarke, 2000).

Ehlers et al. (2000) propose that PTSD develops if and when the traumatised person makes maladaptive interpretations of the event(s) and of the consequences those event(s) have for them. Therefore, an essential component of the treatment focuses on identifying all possible maladaptive interpretations maintaining the dysfunctional meaning of the
traumatic event. A narrative of the incident is produced in order to reconstruct the event with as many details as possible. The model puts emphasis on the emotion of fear as the main affective component with the individual often experiencing highly emotive vivid flashbacks and memories which result in them engaging in maintaining safety behaviours such as avoidance in an attempt to manage their high levels of anxiety. This prevents the processing of the memory and often leads to misinterpretations of the traumatic experience (Westbrook, Kinnerly and Kirk, 2011).

In CBT, strategies are often introduced to diminish the very high levels of arousal associated with the vivid troublesome images so they can be processed and contextualized. This means that they form memories which are subject to rational appraisal. The sense of present threat is eliminated by placing the image in context of time, place and longer-term outcome often achieved using cognitive restructuring while “reliving the trauma” (Grey, Young and Holmes, 2002) or cognitive processing therapy (Resick and Schnicke, 1993) where the client writes a detailed account of the traumatic experience for cognitive review. Along with constructing more helpful interpretations of the traumatic memory, clients are also encouraged to expose themselves to real-life situations linked to the trauma so that they might challenge their anxiety provoking cognitions in vivo (Foa and Rothbaum, 1998). Safety behaviours can be reduced by reviewing unhelpful beliefs and field-testing new possibilities. Many trauma victims are also encouraged to engage in pleasurable activities by being given homework and also completing weekly activity schedules to boost mood as well as activity levels (Westbrook et al., 2011).
Eye movement desensitization and reprocessing (EMDR) in comparison is an integrative psychotherapeutic approach that emphasizes the role of the brain's information processing system in ameliorating the somatic and psychological consequences of distressing events. It is a highly controversial therapy for trauma survivors and evolved from Shapiro (1995) noticing that her troubling thoughts were resolved when her eyes followed the waving leaves during a walk in the park. She suggested that lateral eye movements facilitate the cognitive processing of trauma and developed EMDR from this hypothesis.

According to Nolen-Hoeksema (2010), during a session of EMDR, a client attends to the image of the trauma, thoughts about the trauma and the physical sensation of anxiety aroused by the trauma. At the same time the therapist quickly moves a finger back and forth in front of the clients eyes to elicit a series of repeated, side to side eye movements called saccades. During the session the client provides ratings of his or her anxiety level and how strongly he or she believes negative thoughts pertain to the trauma (Rothbaum, 1997; Shapiro, 1996). Davidson and Parker (2001) believe it has similar effects to those of behavioural therapies focused on exposing people to their traumatic memories and cognitive behavioural therapies however Resick and Calhoun (2001) believe it is this exposure and habituation to the trauma and the cognitive restructuring not the eye movements which are effective for treatment of PTSD.
1.5.3 Later Psychotherapeutic Interventions

When the client has acknowledged and continues to work on a number of the issues, other interventions such as group and family therapy are useful interventions. The special characteristics and curative factors that groups bring in particular to psychotherapeutic treatment apply to the treatment of trauma also (Klein and Schermer, 2000). Because isolation is such a powerful effect of trauma, the ability of groups to provide support and reconnections for members is particularly important for trauma treatment. According to Klein et al., (2000) and Herman, (1997), there are four types of trauma groups; Acute Debriefing typically immediately after a disaster or trauma with the goal of helping participants talk of the immediate trauma experience; Time-Limited Supportive Educational Group designed to help patients manage the overwhelming affect of trauma, decrease isolation and alienation; Cognitive-Behavioral Groups designed to provide an opportunity to share the trauma experience, develop a narrative, and teach coping skills to manage recurrences of PTSD and other symptoms and Psychodynamic groups designed to help the individual make meaning of his/her experience, examine his/her view of themselves and their relationships as they integrate their experience into a more general view of themselves in society.

Supportive group therapy, psychodynamic group therapy and cognitive behavioural group therapy have all proved promising in research (Foy et al., 2000) however the available evidence does not presently favour one type over another. Of particular importance is that individuals have shared similar traumatic experiences and that due consideration is given to gender, sexual orientation, ethnicity, culture and religion. The latter requirements would suggest that group therapy might present intrinsic difficulties in
Northern Ireland due to the sectarian nature of much of the conflict. The therapist must also be observant of the dance between vicarious traumatisation and countertransference that occurs immediately once the group comes together and the detrimental impact that this can at times have for the group (Klein et al., 2000).

Figley (1986) specifically discusses the importance of the healthy family system in the process of recovery for individuals suffering from PTSD. As an intimate social system, family members promote recovery by detecting traumatic stress, confronting the trauma, urging recapitulation of the catastrophe and facilitating resolution. By viewing the family as a system and individual members and their various relationships within the family as subsystems, psychotherapists develop interventions to improve presenting problems both at an individual and family level.

1.6 Impact of the “Troubles” on those in the Security Forces

The “Troubles” in Northern Ireland has made policing a high-risk profession, with Ryder (1989) stating that Interpol statistics show that a Police Officer in Northern Ireland (at that time called the Royal Ulster Constabulary and later renamed the Police Services of Northern Ireland) is at more personal risk than in any other police service in the world. In some areas ‘normal’ policing duties are carried out but in other areas policing has consisted mainly of security and anti-terrorist duties depending on the situation in the surrounding communities. Police officers have frequently been caught between two fractured communities (Catholic and Protestant). During the Troubles, the RUC was strongly identified with the protestant community and officers were highly committed to
its identity (Mulcahy, 2006). Wilson, Poole and Trew (1997) showed that PTSD was only present in 5% of serving RUC officers during the Troubles involved in critical incidents over a six-month period whereas Daly and Johnston (2002) reported 67% of those held at gunpoint in a bar towards the end of the ‘troubles’ experiencing PTSD as their social identity was less strong as they saw the troubles as over. Another study (Paterson, Poole, Trew, and Harkin, 2001) examined the physical and psychological health of recently retired RUC officers demonstrating that 16% of those medically retired and 6% of those normally retired have PTSD relating to critical incidents experienced during their police service. The Police Rehabilitation and Retraining Trust was established in 1999 treating retired RUC officers’ psychological needs which have arisen in the face of adversity and conflict. All treatment offered is short-term, usually lasting for 12 sessions and each of the therapists is Cognitive Behavioural Therapy (CBT) and Eye Movement Desensitisation and Reprocessing (EMDR) qualified.

Similarly for those who served in the Army, although post-combat psychological conditions do not require any treatment that differs from those offered in civil practice (both CBT and EMDR are used), it is important to remember that soldiers are, or have been, part of a sub-culture different from most therapists in which concepts such as shame and guilt are important in modifying behaviour, including help-seeking. Thus they were seen to kill for a purpose with no shame attached (Palmer, 2003). It is important to address the therapist’s and clients cultural differences if engagement in therapy is to be effective and not a ‘block’ - the ‘you don’t understand you weren’t there’ syndrome.
1.7 Dealing with Therapists/Practitioners

The therapist themselves can often be perceived of being at risk. A study by Smyth, Morrissey and Hamilton (2002) evaluated the experiences of staff employed by North and West Health and Social Services staff providing services to the population of Belfast most affected by the Troubles. The study gave expression to the disturbing experiences of many staff, some of whom had faced personally dangerous situations. Another study (Luce, Firth-Corzens, Midgley and Burges, 2002) provided a useful insight into vicarious trauma in Omagh and the impact the bombing had on the medical service staff that were faced with treating many neighbours and friends.

As a whole, trauma-focused treatments can be emotionally difficult and taxing for therapists and care-givers leading to vicarious traumatization, burnout, secondary stress disorder and compassion fatigue. Such distress is exacerbated by the fact that some 30% of psychotherapists have experienced trauma during their own childhood (Brady, Guy, Poelstra and Fletcher-Brokaw 1999; Kohlenberg, Tsai and Kohlenberg, 2006). Vicarious Traumatization (VT) which is the cumulative transformation in the inner experience of the therapist that comes about as a result of empathic engagement with the client’s traumatic material, can also have a negative impact on feelings and relationships of the therapist sometimes leading to poor decision making, social and professional withdrawal, substance abuse and clinical problems (Pearlman and Saakvitne, 1995; Rothschild, 2006). Burnout in comparison is often defined as a prolonged response to chronic emotional and interpersonal stressors on the job which consists of three components: Exhaustion, depersonalization and diminished feelings of self-efficacy in the workplace. Secondary Traumatic Stress or what Figley (1995) calls Compassion Fatigue, refers to the adverse
reactions of helpers who seek to aid trauma survivors. Countertransference in comparison implies that the helper’s response is influenced by the helper’s own unresolved issues (for example the lingering impact of the helper’s victimization experiences) (Kahn, 1997). This may lead to avoidance and overidentification with the client.

In order to prevent any of these from happening to the therapist, self care is fundamental for the psychotherapist. It is important that the therapist engage in physical and mental well-being rituals such as adequate exercise and rest and have some outlet for emotional discharge outside of their clinical role.

1.8 Conclusion

Society in Northern Ireland has been wrought by sectarian conflict for three decades. The conflict punctuated by random acts of bloodshed and violence from paramilitary groups, police and British military had been the predominant model for conflict resolution in Northern Ireland until 2008. As a result Northern Ireland now bears witness to the highest levels of PTSD in the world and psychotherapeutic and community based interventions are fundamental to address this trans-generational issue.
2. Methodology

2.1 Aim of the Study

The aim of this research was to explore the ongoing psychological impact of the “Troubles” in Northern Ireland and the psychotherapeutic treatment of trauma, fourteen years after the signing of the Good Friday Agreement in 1998. The thesis focused on the evolution of care for Post traumatic stress disorder in Northern Ireland directly related to the “Troubles” for three target groups:

- Professional therapists dealing with other professional therapists;
- Professional therapists dealing with those in the security forces (Army or Police);
- Professional therapists dealing with the general public and community.

2.2 Methodological Approach

In order to assess the evolution of care within these three target groups, a qualitative methodological approach was undertaken and five in-depth interviews were conducted. Interviews were conducted with the following professional therapists:

1. **The Founder and Senior Counsellor within Community Counselling Centre in North Belfast** close to the Ardoyne, Shankill and Falls Road; The centre has been home to numerous clients both Catholic and Protestant presenting with Post-Traumatic Stress Disorder symptoms resulting from the Troubles. The centre also does a significant amount of work with schools in the locality including the Holy Cross whose children were subjected to daily abuse from protesters in 2001.

2. **Chief Counselling Psychologist working in a Department of Psychological Therapies for Retired Security Force Veterans**; The Department was set up to
meet the needs of officers in the security forces who have been impacted by emotional and physical trauma predominantly resulting from the “Troubles.”

3. **Senior Psychotherapist and Supervisor in Northern Ireland who has practiced in Belfast for over twenty years:** Interview with a senior psychotherapist who has worked in Belfast for over twenty years, particularly focused on working with people from East and North Belfast during the Troubles. Being from Belfast herself and having worked in the Health Services, this interview provided an insight into the evolution of care both from a therapist perspective in dealing with community/individual clients as well as the impact of the Troubles on other therapists from the supervisors eyes.

4. **Founder of the Northern Ireland Centre for Trauma and Transformation:** This interview provided an insight into the new models being developed in Northern Ireland to deal with PTSD but also enabled one to gain an insight into the interventions that worked following the aftermath of the Omagh bombing and how resultant trauma continues to this day to manifest itself.

5. **Founder, Centre Manager and Consultant Family Therapist at the Family Trauma Centre:**

   The Family Trauma Centre is a community based treatment service for children, young people and their families established in 1998. This interview provided insight into the main function of the centre and the psychotherapeutic interventions used.

Their names have not been disclosed to maintain anonymity.
2.3 Research Questions

Five research questions were set out to investigate the evolution of care within each of the target groups.

Research Question 1: How has conflict in Northern Ireland impacted on the emotional and psychological wellbeing of people who have lived through the troubles (within the relevant target group)?

Research Question 2: What are the most successful psychotherapeutic interventions used for treatment (of this target group) especially in relation to trauma?

Research Question 3: How does the historical impact of conflict in Northern Ireland continue to manifest itself today in clients within the target group presenting for psychotherapeutic treatment?

Research Question 4: How have the “Troubles” impacted on family members of the target group?

Research Question 5: How has therapy in Northern Ireland evolved in dealing with trauma since 1998?

2.4 Materials

Prior to the interviews a standard introduction was prepared and the interview questions sent to the interviewees in order for them to be able to prepare for the interview (see Appendix 1). Permission was requested of each interviewee to allow the interview to be taped. The interview format was kept as open and flexible as possible to allow for the flow of conversation.
2.5 Procedure

Each interviewee was interviewed using the tape recorder. Typically each interview lasted between 45 minutes and one hour. Tapes will be held in a secure place for seven years and then destroyed. Anonymity was assured.

2.6 Data Management and Analysis

Once the interviews were conducted, interview transcripts were immediately typed up (Appendix 2) and a thematic analysis conducted. The transcripts were coded and connections were established between discrete pieces of data. The transcripts were also coded for themes, categories, patterns and relationships. Other emergent codes that became apparent on review of the data included enabling the emergence of crucial but previously uncovered issues and connections. Similarities and differences were also uncovered in the analysis of the data. Outlying data was also discussed and explanations of why they do not fit the thematic patterns are discussed in the findings and conclusions of this thesis. The full analysis is presented in Appendix 3.
3. Results-Qualitative Analysis

Once the interviews were conducted, interview transcripts were immediately typed up (Appendix 3) and a thematic and content analysis conducted. The main themes were identified and coded as illustrated in Table 1 below. Similarities and differences were also uncovered in the analysis of the data. Outlying data was also discussed and explanations of why they do not fit the thematic patterns are discussed in the findings and conclusions of this thesis. Full detail of the analysis is included in Appendix 2.

Table 1: Coding for Interview Transcripts

<table>
<thead>
<tr>
<th>Clients</th>
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</thead>
<tbody>
<tr>
<td>Evolution of care of Professional therapists dealing with other therapists</td>
<td>(TT)</td>
</tr>
<tr>
<td>Evolution of Care of Professional therapists dealing with those in the services</td>
<td>(TS)</td>
</tr>
<tr>
<td>Evolution of Care of Professional therapists dealing with the general public and community.</td>
<td>(TPC)</td>
</tr>
<tr>
<td>Early interventions</td>
<td>(E)</td>
</tr>
<tr>
<td>Middle interventions</td>
<td>(M)</td>
</tr>
<tr>
<td>Later interventions</td>
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<td>The importance of the therapeutic relationship</td>
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<td>Trans-generational impact of trauma</td>
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3.1 Clients

One of the services specifically offered psychotherapeutic services for retired veterans who had served in the security forces. Three of the services offered supervision and support for other therapists. Two of the services offered family therapy and two also
offered services specifically for children. Three of the services offered psychotherapeutic services to individuals over 18.

3.2 Presenting Issues

All five of the services indicated that PTSD, anxiety and depression were the main presenting issues. One of the services reported OCD as a presenting issue, one reported complicated grief while suicide ideation, anger management and trauma related to childhood abuse were reported once respectively.

3.3 How conflict has impacted on emotional and psychological wellbeing?

“Silence” and “Fear” were very prevalent themes apparent from the interviews, both appearing three times during the qualitative research. The silence and fear were closely correlated in that typically people who had been subjected to traumatic events as a result of the conflict were fearful to speak out for fear of being victimised as evident in the below quotations.

“They never talk about the conflict but silence is beginning to lift. There was a huge fear about speaking out due to fear of victimization from sectarian attacks.”

“We also have a number of clients who did not access therapy before we opened because they feared to enter areas where they expected to be killed like the Ballysillan Road, Shankill or Falls. We see our clients typically deal with trauma by using avoidance techniques; very often they are afraid to talk of what they experienced…”
Normalisation and trivialization were also prevalent themes appearing three times in the qualitative research. Due to the level of exposure to conflict particular in some of the more targeted areas, clients began to normalize the conflict and in a sense became desensitised to what was going on, merely seeing it as a way of life.

“In a sense as well they had no time to process the trauma due to the repeated exposure to the conflict night on night, day on day resulting very often in desensitisation.”

“…there is a subtlety in how people in NI discuss their trauma and the troubles. For outsiders they will say “Ah sure it wasn’t that bad”

Other themes that emerged were that of the ongoing impact of trauma (reported twice), loss of identity, avoidance and attachment issues evident in parents and children (all reported once during the qualitative research).

3.4 Successful psychotherapeutic interventions

At this stage it may prove useful to divide effective psychotherapeutic interventions into three categories to best illustrate the evolvement of care:

- Early Interventions (Initial sessions)
- Middle Interventions (Session 4-8)
- Later Interventions (Session 8 onwards when the client has resolved a number of initial presenting issues)
In terms of early interventions, psycho-education and assuming a person centered approach were deemed particularly useful means of establishing trust and creating awareness with the individual during the formation of the therapeutic alliance and were reported twice in the interview transcripts.

“I adopt my therapy to suit the clients needs. Each intervention is different. You can’t just tick a box and say CBT worked for them. What client presents with and my clinical judgment certainty with person centred at the foundation and critical at the beginning of the relationship.”

“I take a multifaceted approach using whatever techniques are required from Cognitive Behavioural therapy to EMDR dependent on whatever the presenting factor is. I continually think systematically, encouraging the parents to first look to themselves and then working with the child. Charles Figley has done a lot of work on family trauma and it typically relates to the fact that the parent can’t identify a stressor with a particular problem, thus psychoeducation is really important.”

Art therapy was also reported once as an effective early intervention.

“The art therapy was particularly successful as it enabled the high traumatized client really express what they could not speak about through picture.”
The most effective psychotherapeutic interventions for the treatment of trauma related symptoms was reported to be Cognitive Behavioural Therapy, in particular Trauma Behavioural therapy, reported to be used by all five services. All reported its success using it at the middle part of formulating the therapeutic relationship, once the initial trust had been established between the therapist and the client. CBT along with EMDR were the therapy of choice particularly for those who had served in the security forces.

“We use CBT and EMDR specifically as recommended via the NICE and CREST guidelines. It is however up to the therapist to determine what clinical interventions make sense for the client. We are very problem and goals focused and we deal very much with the here and now using a 12 session model however we do have the discretion to be able to extend this at times to 16 sessions.”

EMDR was also reported being used in the Family trauma centre.

In terms of later interventions family therapy was presented twice in the interview transcripts, as it appeared to help the client transition back into family life.

“We found family therapy also be particularly useful at the end of therapy work when people had recovered enabling them to readjust and engage in an activity which assisted them in rejoining family life.”
Group therapy was also discussed in two of the interviews but there was a sense that it can lead to more harm and possible re-traumatisation if not used with caution.

“After the Omagh bomb for example, the health services offered a group session to the staff however they found it unhelpful because they felt it was enough to have to deal with their own trauma without carrying the trauma of others. They found the entire experience quite distressing. Thus for the treatment of trauma, it needs to be treated on an individualized basis. The group however may have some part to play at the end of treatment in the consolidation of the traumatic event but would suggest limited usage.”

In terms of evolution of care for the therapist, three of the services offered peer supervision, while one was an actual supervisor. In terms of care, both the services and the supervisor spoke of the importance of self care and taking time to recuperate in order to prevent vicarious traumatisation amongst the therapist themselves.

“In order to lower the risk of vicarious traumatisation amongst our therapists we encouraged our therapists to disclose and be honest and authentic if there was anything they found particularly difficult.”

“When it comes to supervision and self care especially when working as a supervisor and dealing with clients who are very traumatized I ensure I take time between the sessions and am not overworked. If I personally am not well enough I cannot cope with their
issues. Also with my supervisees I ensure they feel really supported particularly around some of the horrific stories they share with me. “

3.5 The impact of the “Troubles” on clients

The prevalent theme in terms of the historical impact of the conflict in Northern Ireland, was the difficulty that was apparent in terms of quantifying the true extent of the conflict across Northern Ireland (reported twice in the qualitative research). There was a sense in these interviews that perhaps everyone had been impacted in one sense or another but was difficult to contextualize the true extent of the conflicts impact.

“It is difficult to quantify the number of people affected by Troubles related trauma. We have little or no idea of the specific numbers who may have developed PTSD or traumatic bereavement as a result of the conflict. When we consider children in Northern Ireland we also have little understanding of the consequences of growing up in a society exposed to civil conflict for more than 35 years where violence was often the backdrop to their entire childhood.”

Emotionally stunted development was another theme presented twice in the transcripts, the fact that the clients themselves as a result of the traumatic events they witnessed, found their emotional development was stunted impacting on their ability to become fully actualized individuals.
“We haven’t looked at the legacy we have left to our children in the north. Those that have been impacted by the conflict can’t even get past it themselves so in a sense they are emotionally children themselves”

Other ways that the impact of the conflict appeared to manifest itself were in delayed traumatic response to multiple traumas, symptoms of Obsessive Compulsive Disorder, loss of identity, normalization of conflict related events and attachment issues (all reported once in the interview transcripts).

3.6 The impact of the “Troubles” on family members

The prevalent theme in terms of the impact of the conflict in Northern Ireland on family members was trans-generational trauma (appearing in all of the five interviews). It appeared to manifest itself in many different ways including anxiety symptoms and hyperarousal similar to parents becoming apparent in children (reported three times), individuals reliving their parents stories (reported three times) and attachment issues evident in children as a result of insecure base and avoidant parenting styles.

“More recently we have begun to consider the concept of trans-generational trauma, how trauma which occurred in one generation can have a profound impact on future generations. Given the troubles started roughly in 1969, over 40 years on we are seeing children from third generation struggling to come to terms with the impact on their families of trauma that happened to their grandparents. Studies by Hayes and Campbell and Muldoon found that family members were significantly affected by Troubles related trauma.”
“Most clients have several family members who have been seriously affected by The Troubles, whether through physical or psychological traumas, economic hardship or being forced to leave Northern Ireland. It continues to manifest in many of the children who had an insecure base growing up and whose lives were shrouded in violence and continual looking over ones shoulder-continually in a state of hyperarousal”

“There is also an anthropological dimension of trauma. The narrative experience of communal violence is transmitted to the next generation but it was not a feature we were really aware of until later on, a number of years after the bombing in Omagh. Very often we found that those who were impacted by the Troubles were highly avoidant of anything that would remind them of the traumatic event so they believed the trauma to be secondary to whatever was impacting on their everyday life for example relationship issues.”

Spouse stress was also reported within the security forces, along with complicated grief if the wife of the serving officer was bereaved.

“It particularly impacted on the spouses of those living with one who was suffering from PTSD. They often come just to talk to discuss how their husbands symptoms are impacting on their marriage and relationship and the ongoing stress that was created in the family. The family members were also subject to SPED, where the family members were moved around from house to house and very often those is the services had to sell
their houses for protection. For example if they got word of a specific threat they would immediately be evacuated. There was also the ongoing stress of whether the husband would return home. For those family members who lost someone during their service in the conflict, they often presented with complicated grief about the murder whereas when it happened they maybe did not grieve properly.”

3.7 The Evolution of therapy dealing with Trauma related issues since 1998 in Northern Ireland

There were two prevalent themes evident from the analysis of the qualitative research. Firstly there was a sense that counselling as a whole has become more acceptable with less of a stigma attached to it meaning and as a result the relationship between those in medical profession and counsellors / psychotherapists has improved significantly with the two professions working more collaboratively.

“Relationship between Psychotherapists/counsellors has significantly improved and they are quick to refer people to us. I have also established a strong relationship with the GP’s so we avail of much more of these services.”

The second theme (reported in three of the interviews) related to the Mental Health services which were perceived in Northern Ireland to under-resourced and ill-equipped to deal in a targeted way with trauma. Similarly there was also a sense that too much money was being invested in research rather than in clinical treatment itself resulting in ill-equipped mental health service provision.
“Treatment of trauma has not really developed since 1998 as the system has not made up its mind in terms of what types of services we want. NI PLC and health services wasted so much time and money without determining what the most effective use of therapy was. Now we know that Trauma focused cognitive therapy if very effective.”

“We have created a victims industry in NI however we cannot sustain as things are not targeted in a particular way. A lot of money is spent on research and not enough money on the treatment which is really wrong. For me I have invested on the clinical work and am critical of spending too much time on research. While there has been much research on transgenerational trauma, the service planning of the DHSSPS has not been influences. We know that clinically a significant number will require psychological services in the country and that many existing mental health services are ill equipped to treat complex trauma. In addition to the traumas of the past, violence is still at large in Northern Ireland.”
4. Discussion

The aim of this research was to explore the ongoing psychological impact of the “Troubles” in Northern Ireland and the psychotherapeutic treatment of trauma related to the conflict, fourteen years after the signing of the Good Friday Agreement in 1998. As a result of thirty years of civil unrest, neighbours and friends have become enemies because of religious and political ideologies leading to death, injury, and a deeply divided society, not to mention the psychological unseen cost of the conflict; the immeasurable toll the conflict had taken on the mental and emotional health of people in Northern Ireland who had lived their whole lives in turmoil and continual fear since the 1960s. The rationale for this research assignment was to explore how the “Troubles” in Northern Ireland continue to manifest themselves in clients presenting for therapy to this present day with regular, ongoing dissident and sectarian based incidents and high prevalence of clients presenting with trauma related symptoms such as PTSD. The research also examined the most successful psychotherapeutic interventions currently being used in Northern Ireland and the evolution of psychotherapeutic care for a number of audiences, the therapist providing supervision to another therapist, the therapist providing therapy to those in the security services such as the army and police forces and the therapist who provides psychotherapy to a client presenting with continuous stress disorder or PTSD.

The first research question evaluated how conflict in Northern Ireland impacted on the emotional and psychological wellbeing of people who have lived through the troubles. On analysis of the five interviews conducted, PTSD, anxiety and depression were the most reported presenting issues of those that came to therapy within these services. Ferry
et al. (2011) appear to be in support the finding suggesting that Northern Ireland had the highest level of twelve month and lifetime PTSD across the world. Other secondary issues such as suicide ideation and loss of identity were also reported in the interviews supporting Kessler’s (1995) findings which indicated that whose suffering from PTSD were likely to experience a spectrum of mood disorders, which could in turn impact on their sense of self. Straker (1987) also suggested that due to acute community trauma many present with what resembles “continuous traumatic stress syndrome” due to the fact that violence becomes a normal way of life. This again is supported by the findings from the research where “silence” and “fear” were prevalent, creating a series of “unsafety zones” (Stewart, 2000) where support structures were compromised due to chronic fear of victimisation. Clients were often re-traumatised between sessions, thus psycho-education (Healey, 2008) was deemed as particularly important, so at least the client could recognize the symptoms of PTSD and trauma.

Normalisation and trivialization were also reported as common themes evident amongst the therapeutic client base reported on. This finding would support the DSM IV (APA, 2000) which states that one of the categories of symptoms characterising PTSD is avoidance of things that remind the person of the traumatic event and numbing of emotions and responsiveness. Loss of identity was also evident as a theme from the analysis, particularly within the security forces which would support Mulcahy’s (2006) findings that retired RUC officers reported being highly committed to their social identity. In the literature review Wilson et al. (1997) found that PTSD was only present in 5% of servicing RUC officers during the Troubles but on retirement PTSD became
significantly most prevalent as a result of losing their sense of purpose and identity while trying to transition to a new way of life (Paterson et al., 2001).

The purpose of the second research question was to determine what the most successful psychotherapeutic interventions were which are currently being used for the treatment of conflict related trauma. In order to best illustrate the evolution of psychotherapeutic care, the psychotherapeutic interventions were divided into three categories: early interventions (those most effective during the initial few sessions), middle interventions (main body of the sessions) and later interventions (used towards the termination and phasing out of the psychotherapy).

In terms of early interventions, forming a therapeutic alliance with the client was of fundamental importance and was reported twice in the analysis of the interview transcripts. According to Coulter (2001), the importance of creating a safe place for the client to disclose his/her story is critical to the therapeutic process. Both Healey (2004) and Rothschild (2000) equally stress the importance of creating this safe environment and particularly stress the importance of pacing and knowing when to apply the brakes should the client become overwhelmed at any time during the initial therapeutic sessions. Blackwell (1997) also emphasizes the importance of therapeutic witnessing, the fact that the client can emerge from his or her silence and isolation and fear of disclosing, by being heard in a safe environment where there is trust and the client is protected.
On analysis of the qualitative research Cognitive Behavioural therapy and Eye Movement Desensitization and Reprocessing (EMDR) were mentioned as being particular effective in treating symptoms of PTSD once the therapeutic alliance has been embedded during the middle phase. This is supported by research conducted by Ehlers et al. (2000) which proposed that CBT conditions the client to introduce strategies to diminish the high levels of arousal associated with traumatic images or memories so they can rationalize and place the potential threat in the past where it belongs. Thus Cognitive Behavioural Therapy enables the client to construct more helpful, rational interpretations of traumatic memories whilst also challenging anxiety provoking cognitions. Eye Movement Desensitization and Reprocessing (EMDR) in comparison used within the security forces, the family trauma centre and the regionalized trauma centre, is a highly controversial therapy used with trauma survivors and developed by Shapiro (1996). Although there is much debate as to how the lateral movements of the eye can prove an effective treatment for trauma, Davidson et al. (2001) believe it has similar effects to behavioural therapies enables the cognitive processing of trauma.

In terms of later interventions family therapy was presented twice in the interview transcripts, as it appeared to help the client transition back into family life. According to Foy et al. (2000) the curative impact comes from the ability of family group to provide support and reconnections thus assisting with the isolation which most clients face as a direct result of the trauma witnessed. According to Figely (1986) by seeing the family as a system and individual members of the family as subsystems, it is possible to develop
interventions at both levels, initially with the client and then afterwards with the family as a whole.

According to Foy et al. (2000) supportive group therapy, psychodynamic group therapy and Cognitive Behavioural group therapy have all proved promising treatments for Post Traumatic Stress Disorder however the findings from this qualitative research does not support this position. From the interviews there was a sense that it could actually prove detrimental as there was a sense from experiments conducted in two of the centres that participants who did partake in group work actually found “it was enough to have to deal with their own trauma without carrying the trauma of others.” This finding is in support of Klein et al. (2000) study which found that vicarious traumatisation along with countertransference are immediately at play within the therapeutic group which can sometimes be of harm to the members of the group. However there was a sense that the group may have some part of play at the end of the treatment in the consolidation of the traumatic event.

The qualitative analysis also found that many of the services offered group supervision for its counsellors, along with counselling, as vicarious traumatisation was highly prevalent amongst many of the counsellors. This supports Smyth et al. (2002) study and Luce et al. (2002) study on vicarious traumatisation evident amongst those in the Health and Social Services section in areas most affected by the conflict in Northern Ireland.
The third research question was focused on examining how the historical impact of the conflict in Northern Ireland continues to manifest itself today in clients presenting for therapy. The prevalent theme was the difficulty that was apparent in terms of quantifying the true extent of the conflict across Northern Ireland (reported twice in the qualitative research). There was a sense in these interviews that perhaps everyone had been impacted in one sense or another but was difficult to contextualize the true extent of the conflicts impact. This finding in itself supported Hillyard et al. (2005) findings around how difficult it was to assess the impact of the conflict on people living in Northern Ireland due to a lack of systemic information however the Poverty and Social Exclusion Survey (Hillyard et al., 2003) would suggest that half of the respondents would have known someone killed during the conflict. O’Reilly et al. (2003) similarly stated that it was probable that the mental health of the entire population in Northern Ireland had been impacted. The findings from the qualitative research also indicated that the issue of conflict related trauma was far from being resolved and was ongoing which would also support Straker (1987) position on continuous traumatic stress syndrome in “unsafe zones” of Northern Ireland.

The fourth research questions explored the impact of the conflict on family members of those who were directly or indirectly affected by the Troubles. The prevalent emergent theme was that of trans-generational trauma, trauma which spread across three generations over thirty years. The interview transcripts speak of children reliving their parents traumatic stories via the art of “traumatic storytelling” (Irish Peace centre, 2010), the net effect being destructive leading to a number of pathologies such as self harm,
anxiety and hyperarousal. In a sense it is as if the trauma becomes embedded in the cultural memory and becomes normalized within the culture as per Duran and Duran (1985) study on historical trauma, and the symptoms of PTSD such as intrusion, avoidance and hyperarousal are passed from one generation to the next, supported by Shevlin and McGuigan’s (2003) study. Other resultant factors emerging from the qualitative analysis included the impact on the attachment relationship with caregivers, with parents appearing avoidant and both physically and emotionally disconnected from his or her family, impacting on their children who may develop anxiety or other social or psychological pathologies (Milroid, 2005).

The final research question evaluated how the treatment of PTSD had evolved since 1998 Good Friday Agreement of which there were two central themes emerging from the analysis of the qualitative research. Firstly there was a sense that counselling as a whole has become more acceptable with less of a stigma attached to it significantly improving the relationship between those in medical profession and counsellors. Secondly however there was a prevailing sense that the Mental Health services in Northern Ireland were under-resourced and ill-equipped to deal in a targeted way with trauma related to the Troubles. Since 1998 however £44million has been allocated to organisations supporting victims of the Troubles, £33million of which was spent on trauma therapeutic services and medication according to the Pave report (2007). From the qualitative research there was a sense however that many of the services are not targeted enough with a substantive proportion of the money being spent on research instead of treatment and as a result many of the existing mental health services are ill equipped to deal with complex trauma.
Thus from this research it is recommended that the Department of Health in Northern Ireland does not underestimate the significant of investment in the clinical treatment of conflict related complex trauma and potentially re-evaluates the Pave report (2007) to determine the impact of existent spend on such services.

In terms of limitations of the present study, due to time limitations, only five qualitative interviews were conducted and considering the range of trauma related services in Northern Ireland, this is only a small sample. If repeating the study on a grander scale, it would be recommended to interview at least five representatives within each sector, for example therapists in community and trauma centres, other psychological services for security forces, psychological services within the hospitals and more than one supervisor to obtain a wider cross-representative sample. Future research could also evaluate the beneficial impact of the different types of interventions depending on the client grouping and presenting issue. Due to the fact that the research was for an undergraduate degree I could not get access to client files or a client group to assess the impact of the different interventions. In order to assess the successfulness of the interventions a longitudinal study would have needed to be completed. Future research could also explore the concept of historic trans-generational trauma in Northern Ireland, specifically focused on its impact on the children of Northern Ireland today.
References


Victims Unit, Office of the First Minister and Deputy First Minister of Northern Ireland (2002). *Reshape, Rebuild, Achieve. Delivering practical help and services to victims of the conflict in Northern Ireland.*


Appendix 1: Interview Questions

An exploration into the ongoing psychological impact of the “Troubles” in Northern Ireland and the psychotherapeutic treatment of Post Traumatic Stress Disorder

Introduction:

As part of my BA in Counselling and Psychotherapy in Dublin Business School which is IACP accredited, I am presently conducting a study into the impact of the Troubles in Northern Ireland and the evolution of care of three groups:

• Professional therapists dealing with other professional therapists;
• Professional therapists dealing with the police services;
• Professional therapists dealing with the general public and community.

My research methodology is purely qualitative and I am engaging in five in-depth interviews with representatives from the three groupings. You/your organisation has been recommended as influential in the treatment of trauma resulting from the “Troubles” having spoken with other therapists in Northern Ireland.

The interview should take no longer than an hour and your confidentiality is assured with your name not being disclosed in the thesis. The questions are set out below so you can prepare in advance to our meeting on x February at x time in x location.

• Who is your main client grouping?
• What are the main presenting issues you come across?

• How has conflict in Northern Ireland impacted on the emotional and psychological wellbeing of people who have lived through the troubles (within the relevant target group)?

• What are the most successful psychotherapeutic interventions used for treatment (of this target group) especially in relation to trauma?

• How does the historical impact of conflict in Northern Ireland continue to manifest itself today in clients within the target group presenting for psychotherapeutic treatment?

• How have the “Troubles” impacted on family members of the target group?

• In your opinion how has therapy in Northern Ireland evolved in dealing with trauma since 1998?

Thank you for taking the time to review the questions and I greatly look forward to meeting with you.
Appendix 2: Interview Transcripts

Interview 1

Who is your main client grouping?
Our main client grouping are mostly retired members of the RUC and their family
members who were impacted by the conflicts as a result of their family members
devotion to the service.

What are the main presenting issues you come across?
They vary from one to the next and a lot of the trauma related to conflict based issues are
somewhat masked. Others are more aware of what these symptoms are. Very often they
come in with one issue but soon you find it related to traumatic event they witnessed. It
can often be a delayed response to a horrific scene they came across however they
managed to cope with these scenes at the time. They often present confused as to why
they cannot cope now. One of the main triggers however is retirement as they lose that
sense of identity and camaraderie. In a sense as well they had no time to process the
trauma due to the repeated exposure to the conflict night on night, day on day resulting
very often in desensitization.

Very often we have the complicating factor of multiple trauma and the fact that often it is
cो-morbid with depression and anxiety. It is never that they will speak about a single
incident as they has been long term exposure.
They often also present with OCD and they are very often obsessed with vigilance and
security. Many of them have a ritual they perform before they go to bed at night and first
thing in the morning, checking under their cars for example for bombs however it is when this checking behaviour becomes problematic that there becomes a problem.

**How has conflict in Northern Ireland impacted on the emotional and psychological wellbeing of people who have lived through the troubles (within the relevant target group)?**

Very often the client who typically has retired a number of years ago knows there was a issues but they just get on with it. However they lose their identity and hence that sense of protection when they retire which significantly impacts on them.

**What are the most successful psychotherapeutic interventions used for treatment (of this target group) especially in relation to trauma?**

We use CBT and EMDR specifically as recommended via the NICE and CREST guidelines. It is however to the therapist to determine what clinical interventions make sense for the client. We are very problem and goals focused and we deal very much with the here and now using a 12 session model however we do have the discretion to be able to extend this at times to 16 sessions. We don’t typically do group work as most officers do not want others to know they are attending for fear of losing that sense of machoism that goes with the job. There is also a certain stigma they at times present.

Also they typically did not go out on stress leave or take sick days due to fear that their contract may be removed which was the risk that a number of full time reserve people were subjected to.
How does the historical impact of conflict in Northern Ireland continue to manifest itself today in clients within the target group presenting for psychotherapeutic treatment?

How have the "Troubles" impacted on family members of the target group?

It particularly impacted on the spouses of those living with one who was suffering from PTSD. They often come just to talk to discuss how their husbands symptoms are impacting on their marriage and relationship and the ongoing stress that was created in the family. The family members were also subject to SPED, where the family members were moved around from house to house and very often those is the services had to sell their houses for protection. For example if they got word of a specific threat they would immediately be evacuated. There was also the ongoing stress of whether the husband would return home. For those family members who lost someone during their service in the conflict, they often presented with complicated grief about the murder whereas when it happened they maybe did not grief properly.

We see the Troubles also impacting on adult children of those who’s fathers were in service, impacting on their sense of security about whether their father would come home. Those retired officers also often present a lot of guilt of not being with their kids when they were growing up and this often surfaces with their inability to be able to cope with their grandchildren.

In your opinion how has therapy in Northern Ireland evolved in dealing with trauma since 1998?

Counselling back in the day when the forces were involved in the conflict, was not really something that was available to them at the time. However the huge trigger was
retirement and there was a huge sense of isolation associated with retirement. They found a lot of other families did not want to socialize with them and they could not even go into certain parts of Belfast for fear of being recognised.

The importance of supervision has also become significantly more important. In here we are a very close team and we have immediate debriefs after particularly traumatic events. We also have a debrief lunch once a month and have ongoing supervision and personal therapy.

People in politics very much keep the conflict alive today plus there is also the continued threat of dissidence activity. It is not as peaceful as what people think
Interview 2:

Who is your main client grouping?

Up to the 1990s there were no services. The Family Trauma Centre was established within the statutory sector in 1999 by the DHSSPS as a regional specialist treatment service for children, young people and their families who are adversely affected by the Troubles. It opened originally because Mo Mowlem really pushed for it. After the Good Friday Agreement, suddenly it was –how much money do you want for the service and when do you want it. In October 1998 we go the building and on 1st January 1999 we were fully staffed and up and running. The centre is a specialist, psychotherapy led children and young people’s service that is part of the CAMHS network and has a regional remit in relation to psychological trauma. The primary function of the centre is to assess severe, complex and enduring psychological trauma in children, young people and their families in Northern Ireland. The service is trauma specific and family centred. It is a culturally sensitive practice using systemic therapy with an emphasis on the impact of trauma on family systems and is focused on creating a model to make space for all sides of the story to be told. Initially children were referred from families where a family member had been murdered or seriously injured at times witnessed by the child. We focused on offering a service open to children residing in high intensity Troubles affected areas, residing in interface areas, children who were subjected to intimidation or affected by paramilitary actions and punishment attacks.

Following an independent review of the FTC commission by DHSSPS in 2002 the FTC were asked to widen its remit to other forms of trauma. As a result we developed a Child
Psychotherapy service to respond to the needs of Looked After Children (LAC) and pre- and post adoption. We also extended our remit to look after homicides and accidental deaths, post suicide, serious assault, robbery and kidnapping and refugees and asylum seekers.

We provide clinical treatment services, systemic family therapy, child psychotherapy, psychological services and a range of trauma treatments and have outreach centres across Northern Ireland including Fermanagh, Omagh, Dungannon, Derry, Ballymena, Newtownabbey, Portadown, Downpatrick, Newry, Banbridge, Belfast and Ards.

**What are the main presenting issues you come across?**

They are mainly trauma related but dependent on the level of intercommunity violence, it is whether spoken about openly or not. For example if it is between community such as violence as a result of being Protestant or Catholic, well that’s speakable about however if its intercommunity, in their own community then I am often met with silence for fear. We are presented with everything from families whose children are devastated by childhood abuse to children who have lost their father due to his involvement in paramilitary activity to families who present with complicated grief because the body of a murdered family member has never been found.
How has conflict in Northern Ireland impacted on the emotional and psychological wellbeing of people who have lived through the troubles (within the relevant target group)?

There is a subtlety in the trauma of people in Northern Ireland particularly in the hot spots up in Ardoyne. There are 1.78 million people in Northern Ireland. A recent study indicated that 1 in 10 are directly affected by Trauma however that does not include those who witnessed events or whose family members were impacted. If this were to be included, nearly everyone in Northern Ireland would be impacted. However there is a subtlety in how people in NI discuss their trauma and the troubles. For outsiders they will say “Ah sure it wasn’t that bad” but for those who grew up and came from NI they expect you to know the detail. They will say simple things like “My father was never the same after the bomb” and then silence and onto the next thing. For example most recently I was working with a family whose house had been burnt down by a paramilitary group. I asked had any of them been affected by the Troubles before and they said no. I then said something and noticed the father straining to hear me. I asked him had he a hearing deficit and he said “O that was the bomb.” I then said “I thought you said you weren’t impacted by the troubles before.” His response was “Ah that was different-we weren’t directly targeted, it was just a bomb!” It took me to come to Dublin to work and then go back to Belfast to realize just how silent we are about trouble related traumas and what amazing coping mechanism we developed.
What are the most successful psychotherapeutic interventions used for treatment (of this target group) especially in relation to trauma?

Unlike many of the community, although they do great work, they are very often not providing proper mental health treatment. The Government spent a lot of money on conflict related trauma but to what avail I often ask. In the community based interventions, much of the activity if spent talking about the trauma, but that doesn’t help, in fact it just engrains the trauma, going over and over it again and again. Where community groups do help is where they provide employment schemes and support groups however they are very dismissive of statutory agencies like ourselves. Our service is one of the only NHS services specifically targeted at trauma. A lot of our work is about psychoeducation, so the mother may present with a traumatized child. I will also say “You the parent need to look at yourself and then your child will improve.”

My family interventions typically find that trauma is at the heart of most difficulties within families. So a couple will come with a concern for their son and then you find the couples relationship is shakey. I will then ask how has their life as a couple changed since dealing with their son. I take a multifaceted approach using whatever techniques are required from Cognitive Behavioural therapy to EMDR dependent on whatever the presenting factor is. I continually think systematically, encouraging the parents to first look to themselves and then working with the child. Charles Figley has done a lot of work on family trauma and it typically relates to the fact that the parent can’t identify a stressor with a particular problem, thus psychoeducation is really important. For example I am working with a mother who suffered from Generalised anxiety disorder, and am
now seeing that trait develop in her three children. Thus its about educating her how to
deal with her anxiety as this is modeled onto her children. We know from numerous
studies that people impacted by trauma are typically more aroused and anxious, for
example the recent study of the babies born in and around 9-11 in the USA where they
found the babies cortisol levels were higher than norm group born a year later (as their
mothers had been in an anxiety state). What we also know is that Psychotherapy does
improve matters however NI spends so little more on children. We don’t invest in them.

**How does the historical impact of conflict in Northern Ireland continue to manifest itself today in clients within the target group presenting for psychotherapeutic treatment?**

It is difficult to quantify the number of people affected by Troubles related trauma. We
have little of no idea of the specific numbers who may have developed PTSD or
traumatic bereavement as a result of the conflict. When we consider children in NI we
also have little understanding of the consequences of growing up in a society exposed to
civil conflict for more than 35 years where violence was often the backdrop to their entire
colorhood.

**How have the “Troubles” impacted on family members of the target group?**

More recently we have begun to consider the concept of trans-generational trauma, how
trauma which occurred in one generation can have a profound impact on future
generations. Given the troubles started roughly in 1969, over 40 years on we are seeing
children from third generation struggling to come to terms with the impact on their
families of trauma that happened to their grandparents. Studies by Hayes and Campbell
and Muldoon found that family members were significantly affected by Troubles related trauma.

In your opinion how has therapy in Northern Ireland evolved in dealing with trauma since 1998?

We have created a victims industry in NI however we cannot sustain as things are not targeted in a particular way. A lot of money is spent on research and not enough money on the treatment which is really wrong. For me I have invested on the clinical work and am critical of spending too much time on research.

While there has been much research on transgenerational trauma, the service planning of the DHSSPS has not been influences. We know that clinically a significant number will require psychological services in the country and that many existing mental health services are ill equipped to treat complex trauma. In addition to the traumas of the past, violence is still at large in NI.
Interview Three

Who is your main client grouping?
Clients from a variety of different backgrounds and those who have been subjected to the trauma related to the conflict. At the time during the conflict many did not come forward with PTSD but since then they have come forward now with trauma related issues and discussing issues which previously they were afraid to discuss due to fear of paramilitary activity. What I am now finding is when the historical inquiry teams call to families they become retraumatised during the investigation with the team. I also act as a supervisor for other therapists.

What are the main presenting issues you come across?
Very often stuck at age of the trauma and traumatized emotionally so they stay at 18 years old emotionally.

How has conflict in Northern Ireland impacted on the emotional and psychological wellbeing of people who have lived through the troubles (within the relevant target group)?
It is amazing as there is so much normalization and trivialization of the events. They never talk about the conflict but silence is beginning to lift. Huge fear about speaking out due to fear of victimization from sectarian attacks. At the beginning of conflict not as much evidence based research around PTSD, but the interventions around its treatment has grown.
What are the most successful psychotherapeutic interventions used for treatment (of this target group) especially in relation to trauma?

Not a believer in introducing them to group. I adopt my therapy to suit the clients needs. Each intervention is different. You can’t just tick a box and say CBT worked for them. What client presents with and my clinical judgment certainty with person centred at the foundation. Take a very gentle and flow approach with PTSD. Very often you will find a large amount of avoidance which manifests itself in the form of dissociation and day dreaming.

When it comes to supervision and self care especially when working as a supervisor and dealing with clients who are very traumatized I ensure I take time between the sessions and am not overworked. If I personally am not well enough I cannot cope with their issues. Also with my supervisees I ensure they feel really supported particularly around some of the horrific stories they share with me.

I can recall one time when I really experienced vicarious retraumatisation. I was looking into the face of one of my clients and was just haunted by the pain and grief I saw in his face. I saw so much pain and anger in his eyes and spent a lot of time thinking about him. With other clients just the graphic details of clients scooping up body parts with their shovel.
How does the historical impact of conflict in Northern Ireland continue to manifest itself today in clients within the target group presenting for psychotherapeutic treatment?

We haven’t looked at the legacy we have left to our children in the north. Those that have been impacted by the conflict can’t even get past it themselves so in a sense they are emotionally children themselves.

How have the "Troubles" impacted on family members of the target group?

The trans-generational impact of trauma is evident with most of the clients I have worked with. You see it in some of the Jewish studies what were conducted but in Belfast it is also evident how the trauma is passed through the generations. As the individual tells their parents stories they relieve it at times.

In your opinion how has therapy in Northern Ireland evolved in dealing with trauma since 1998?

Relationship between Psychotherapists/counsellors has significantly improved and they are quick to refer people to us. I have also established a strong relationship with the GP’s so we avail of much more of these services. Once clients can put a name to what they are experiencing, there is a sense of relief and therapy can begin.

With the services, trauma is also very complex. They do not know who to trust and in the therapeutic relationship it often takes them a long time to build up the trust. Initially much of these early conversations are about checking your credentials and your access NI status and they fundamentally conduct a deep search of you as a counselor. Both PSNI officers and army have a tendency to stick very closely to their own little family and they struggle to transition to normality and socialize with those outside their community. For
example there are certain towns they live in the North and other areas they won’t even go into. Numerous bus drivers have also been impacted via bus hi-jackings.

My believe however in terms of how therapy has evolved is that every professional person has a role to play, the impact of the trauma is so great, there is room for all of us. One thing however I would stress is the fact that NICE documentation does not truly reflect what is going on in Northern Ireland. We have a different culture, a different dialect and a different way of viewing the world. They try to put their world into our world but often this does not work.
Interview 4

Who is your main client grouping?

We opened our doors back in 2010 so are a newly established community counselling centre, based in North Belfast, providing a safe place for people in North Belfast to talk through their issues. At present we work principally with disadvantaged adults and disadvantaged primary school children. Many of our clients come from both the Falls and the Shankill and surrounding Ardoyne area.

What are the main presenting issues you come across?

Presenting issues range from everything from depression, anger management to Suicidal ideation and PTSD. In the case of children, we work both in the schools in the locality and on a one to one basis and typically we see them presenting with stress caused by suicides and violence which they have witnessed or are acutely aware of in the area, for example a close family friend. Interestingly most adults present with relationship issues or work issues but scratch beneath the surface and you will find that almost everyone we see has been impacted by the troubles.

How has conflict in Northern Ireland impacted on the emotional and psychological wellbeing of people who have lived through the troubles (within the relevant target group)?

It is hugely evident in most of our client base who often present with symptoms of PTSD and anxiety related disorders. This is particularly apparent, for example, in ex-paramilitaries who seek our help. Being based in one of the hot areas during the Troubles
we see a large proportion of ex-paramilitaries or those who are or were “connected.” We also have a number of clients who did not access therapy before we opened because they feared to enter areas where they expected to be killed like the Ballysillan Road, Shankill or Falls. We see our clients typically deal with trauma by using avoidance techniques, very often they are afraid to talk of what they experienced and we are always conscious to apply the breaks to prevent the client from becoming too traumatized. We also have a large proportion of clients who present with suicide ideation as a result of having been victimized because of their religion or may have been subjected to significant violent attack impacting on both their emotional and psychological wellbeing.

It also impacts from an attachment perspective and often we see in the schools, heavily traumatized childrens whose mothers are avoidant and as a result of not having the secure base as a result of violence they may have been witness to these children are often highly sensitive and anxious.

**What are the most successful psychotherapeutic interventions used for treatment (of this target group) especially in relation to trauma?**

My theoretical approach is eclectic and person-centred. As a person who grew up close to a notorious flash-point area, I value my understanding of the local culture and language. I recognise that people have particular difficulty in talking about traumas and that patient, non-judgemental listening may be required, over many sessions. In some cases particularly of abuse we also use art to open up the client or do picture work. CBT also assists but no matter what I always ensure with trauma work that I do no harm to the client.
How does the historical impact of conflict in Northern Ireland continue to manifest itself today in clients within the target group presenting for psychotherapeutic treatment?

In my catchment area, where so many families were involved in The Troubles as victims and/or activists, the conflict continues to cast a long and dark shadow, affecting clients' sense of identity, their memories and their expectations. Spanning so many decades, much of the troubles became almost normal way of life for many—ask anyone and they could identify one bomb from another or one gun from another. Today in clients they will speak about it at a surface level and then move on to an issue impacting on them today as it is so deeply engrained.

How have the "Troubles" impacted on family members of the target group?

Most clients have several family members who have been seriously affected by The Troubles, whether through physical or psychological traumas, economic hardship or being forced to leave Northern Ireland. It continues to manifest in many of the children who had an insecure base growing up and whose lives were shrouded in violence and continual looking over ones shoulder—continually in a state of hyperarousal.

In your opinion how has therapy in Northern Ireland evolved in dealing with trauma since 1998? This is hard for me to answer because I have only been in practice for two years. I am learning all the time. The biggest problem I face is finding ways of providing therapy for the many trauma victims who simply cannot afford to pay the full cost of therapy
Interview 5

Who is your main client grouping?
The NICCTT was set up initially directly after the Omagh bombing in 1998. Between 1998 and 2001 almost all of the clients were exclusively Omagh bombing victims. From 2002 onwards many of the clients were non Omagh bomb and we began to offer a service across the West of Northern Ireland and across Northern Ireland. It became a regional service predominantly concentrating on providing counseling support for affected by the Troubles.

What are the main presenting issues you come across?
Most of the people we saw were referred either by themselves, by mental health services or by their GP. The main presenting issues were Post Traumatic stress, Depression and anxiety related disorders all directly related to the trauma that the Troubles in Northern Ireland had caused. We conducted a randomised control trial in the centre with 58 of our patients and found that the majority of the people presented suffering from multiple traumas. They presented with alcoholism, family and relationship breakdowns and most of those who had been impacted by the Troubles also presented with depression, anxiety —the typical symptoms you find often co-morbid with PTSD. The BMJ study illustrates our findings in greater detail.

How has conflict in Northern Ireland impacted on the emotional and psychological wellbeing of people who have lived through the troubles (within the relevant target group)?
It continues to impact significantly as evident in my response above and it is imperative that we continue to realize the significance of this time.
What are the most successful psychotherapeutic interventions used for treatment (of this target group) especially in relation to trauma?

Originally the trauma centre provided art therapy, cognitive therapy, group therapy and we had the luxury of being able to put in place a highly specialist trauma team. The art therapy was particularly successful as it enabled the high traumatized client really express what they could not speak about through picture. After 2002 the work became more focused on trauma cognitive therapy.

We found family therapy also be particularly useful at the end of therapy work when people had recovered enabling them to readjust and engage in an activity which assisted them in rejoining family life.

In terms of group work we did try it but the view was it was not a good way forward as people could hide in the group, thus CBT was the main model we adopted. Trauma is so highly idiosyncratic and impacts everyone so differently for example put 10 people who have witnessed the same traumatic event in a room and five may suffer severe PTSD whereas the other five due to its highly individualized nature. Similar the context of how the person had experienced the traumatic event also impacted for example someone who was in the middle of it, picking up limbs from bodies versus one who was at the top of the road who ran in the opposite direction to the bomb.

After the Omagh bomb for example, the health services offered a group session to the staff however they found it unhelpful because they felt it was enough to have to deal with their own trauma without carrying the trauma of others. They found the entire experience quite distressing. Thus for the treatment of trauma, it needs to be treated on an individualized basis.
The group however may have some part to play at the end of treatment in the consolidation of the traumatic event but would suggest limited usage. Community interventions are also useful playing a psychoeducational role. People we found looked for guidance and reassurance. These interventions enabled people to find support in the reactions of their neighbours and friends. Both Supervision and Group supervision was also offered to all of our therapists and we operated in a supportive open plan office with no sense of hierarchy. Everyone multi tasked doing a variety of roles. In order to lower the risk of vicarious retraumatisation amongst our therapists we encouraged our therapists to disclose and be honest and authentic if there was anything they found particularly difficult. For all volunteers we encouraged this honesty, all work was valued within the centre. We would also do informal things for our employees such as away days, giving the people time off to go to get their hair done or go for a massage. Particularly in the years after the bomb there was a high level of distress, so it was crucial we pulled together.

**How does the historical impact of conflict in Northern Ireland continue to manifest itself today in clients within the target group presenting for psychotherapeutic treatment?**

Anecdotally, the transgenerational transfer of trauma was evident in many of the clients we saw. For example children who live with a father who is suffering from PTSD and depression as a result of the troubles may suffer adversely. Some of the referrals who were parents were so focused on struggling with getting their own needs met in counselling that they would find it very difficult to be there for their children.
How have the “Troubles” impacted on family members of the target group?

There is also an anthropological dimension of trauma. The narrative experience of communal violence is transmitted to the next generation but it was not a feature we were really aware of until later on, a number of years after the bombing in Omagh.

Very often we found that those who were impacted by the Troubles were highly avoidant of anything that would remind them of the traumatic event so they believed the trauma to be secondary to whatever was impacting on their everyday life for example relationship issues.

In your opinion how has therapy in Northern Ireland evolved in dealing with trauma since 1998?

Treatment of trauma has not really developed since 1998 as the system has not made up its mind in terms of what types of services we want. NI PLC and health services wasted so much time and money without determining what was the most effective use of therapy. Now we know that Trauma focused cognitive therapy if very effective.

Appendix 3 Analysis

The transcripts were coded illustrated in the table below.

<table>
<thead>
<tr>
<th>Clients</th>
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<tbody>
<tr>
<td>Evolution of care of Professional therapists dealing with other professional therapists</td>
<td>(C)</td>
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<tr>
<td>Evolution of Care of Professional therapists dealing with those in the services</td>
<td>(TT)</td>
</tr>
<tr>
<td>Evolution of Care of Professional therapists dealing with the general public and community.</td>
<td>(TS)</td>
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<td>(TPC)</td>
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Early interventions (E)  
Middle interventions (M)  
Later interventions (L)  
The importance of the therapeutic relationship (TR)  
Trans-generational impact of trauma (TGT)  

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<tr>
<th>Interview ID No.</th>
<th>Interviewee Name</th>
<th>Received</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Psychotherapist for Service veterans</td>
<td>Yes</td>
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<tr>
<td>2.</td>
<td>Family Trauma Psychotherapist</td>
<td>Yes</td>
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<tr>
<td>3.</td>
<td>Supervisor and Psychotherapist</td>
<td>Yes</td>
</tr>
<tr>
<td>4.</td>
<td>Community Based Centre Founder/Counsellor</td>
<td>Yes</td>
</tr>
<tr>
<td>5.</td>
<td>Founder of Trauma Centre</td>
<td>Yes</td>
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</tbody>
</table>

Questions for Coding

1. Who is your main client grouping?

2. What are the main presenting issues you come across?

3. How has conflict in Northern Ireland impacted on the emotional and psychological wellbeing of people who have lived through the troubles (within the relevant target group)?

4. What are the most successful psychotherapeutic interventions used for treatment (of this target group) especially in relation to trauma?

5. How does the historical impact of conflict in Northern Ireland continue to manifest itself today in clients within the target group presenting for psychotherapeutic treatment?

6. How have the “Troubles” impacted on family members of the target group?
7. In your opinion how has therapy in Northern Ireland evolved in dealing with trauma since 1998?

Using the codes assigned the following template was populated for each interview question.

<table>
<thead>
<tr>
<th>ID No.</th>
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<th>Response</th>
<th>Data Code</th>
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<tbody>
<tr>
<td>1.</td>
<td>1.</td>
<td>Our main client grouping is mostly retired members of the RUC and their family members who were impacted by the conflicts as a result of their family members devotion to the service.</td>
<td>CGS</td>
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<tr>
<td>2.</td>
<td>1.</td>
<td>The centre is a specialist, psychotherapy led children and young people’s service that is part of the CAMHS network and has a regional remit in relation to psychological trauma. We offer supervision support to our therapists too.</td>
<td>CGC/F/CGT</td>
</tr>
<tr>
<td>3.</td>
<td>1.</td>
<td>Clients from a variety of different backgrounds and those who have been subjected to the trauma related to the conflict. At the time during the conflict many did not come forward with PTSD but since then they have come forward now with trauma related issues and discussing issues which previously they were afraid to discuss due to fear of paramilitary activity. What I am now finding is when the historical inquiry teams call to families they become retraumatised</td>
<td>CGI/CGT</td>
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during the investigation with the team. I also deal with therapists

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<tr>
<td>4.</td>
<td>1.</td>
<td>We opened our doors back in 2010 so are a newly established community counselling centre, based in North Belfast, providing a safe place for people in North Belfast to talk through their issues. At present we work principally with disadvantaged adults and disadvantaged primary school children. Many of our clients come from both the Falls and the Shankill and surrounding Ardoyne area</td>
<td>CGI/ CGC</td>
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<td>5.</td>
<td>1.</td>
<td>The NICTT was set up initially directly after the Omagh bombing in 1998. Between 1998 and 2001 almost all of the clients were exclusively Omagh bombing victims. From 2002 onwards many of the clients were non Omagh bomb and we began to offer a service across the West of Northern Ireland and across Northern Ireland. It became a regional service predominantly concentrating on providing counseling support for affected by the Troubles. We also offered family therapy. We also offer supervision support to our therapists</td>
<td>CGI/CGF/CGT</td>
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<td>1.</td>
<td>2.</td>
<td>They vary from one to the next and a lot of the trauma related to conflict based issues are somewhat masked. Others are more aware of what these symptoms are. Very often they come in with one issue but soon you find it related to traumatic event they witnessed. It can often be a delayed response to a horrific scene they came across however they managed to cope with these scenes at the time. They often present confused as to why they cannot cope now. One of the main triggers however is retirement as they lose that sense of identity and camaraderie. In a sense as well they had no time to process the trauma due to the repeated exposure to the conflict night on night, day on day resulting very often in desensitization. Very often we have the complicating factor of multiple trauma and the fact that often it is co-morbid with depression and anxiety. It is never that they will speak about a single incident as they has been long term exposure. They often also present with OCD and they are very often obsessed with vigilance and security. Many of</td>
<td>PTSD Depression Anxiety OCD</td>
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</table>
them have a ritual they perform before they go to bed
at night and first thing in the morning, checking
under their cars for example for bombs however it is
when this checking behaviour becomes problematic
that there becomes a problem.

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|   |   | PTSD
|   |   | Complicated Grief
|   |   | Depression
|   |   | Anxiety
|   |   | Childhood Abuse

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<td>3.</td>
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|   |   | PTSD
|   |   | Depression
|   |   | Anxiety

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<tr>
<td>4.</td>
<td>2.</td>
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|   |   | Depression
|   |   | Anger
|   |   | Management
|   |   | Suicide Ideation
|   |   | PTSD
|   |   | Anxiety

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<tbody>
<tr>
<td>5.</td>
<td>2.</td>
</tr>
</tbody>
</table>
|   |   | PTSD
|   |   | Depression
|   |   | Anxiety

78
depression, anxiety – the typical symptoms you find often co-morbid with PTSD. The BMJ study illustrates our findings in greater detail.

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<tr>
<th>ID No.</th>
<th>Q No.</th>
<th>Response</th>
<th>Data Code</th>
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</thead>
<tbody>
<tr>
<td>1. 3.</td>
<td></td>
<td>Very often the client who typically has retired a number of years ago knows there was a issues but they just get on with it. However they lose their identity and hence that sense of protection when they retire which significantly impacts on them. Very often they come in with one issue but soon you find it related to traumatic event they witnessed. It can often be a delayed response to a horrific scene they came across however they managed to cope with these scenes at the time. They often present confused as to why they cannot cope now. One of the main triggers however is retirement as they lose that sense of identity and camaraderie. In a sense as well they had no time to process the trauma due to the repeated exposure to the conflict night on night, day on day resulting very often in desensitization.</td>
<td>Loss of Identity Loss of security Desensitisation No time to process</td>
</tr>
<tr>
<td>2. 3.</td>
<td></td>
<td>There is a subtlety in the trauma of people in Northern Ireland particularly in the hot spots up in Ardynoe. There are 1.78 million people in Northern Ireland. A recent study indicated that 1 in 10 are directly affected by Trauma however that does not include those who witnessed events or whose family</td>
<td>Everyone impacted Minimisation Normalisation Silence</td>
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</table>
members were impacted. If this were to be included, nearly everyone in Northern Ireland would be impacted. However there is a subtlety in how people in NI discuss their trauma and the troubles. For outsiders they will say “Ah sure it wasn’t that bad” but for those who grew up and came from NI they expect you to know the detail. They will say simple things like “My father was never the same after the bomb” and then silence and onto the next thing. For example most recently I was working with a family whose house had been burnt down by a paramilitary group. I asked had any of them been affected by the Troubles before and they said no. I then said something and noticed the father straining to hear me. I asked him had he a hearing deficit and he said “O that was the bomb.” I then said “I thought you said you weren’t impacted by the troubles before.” His response was “Ah that was different-we weren’t directly targeted, it was just a bomb!” It took me to come to Dublin to work and then go back to Belfast to realize just how silent we are about trouble related traumas and what amazing coping mechanism we developed.

| 3.3. | It is amazing as there is so much normalization and trivialization of the events. They never talk about the conflict but silence is beginning to lift. Huge fear about speaking out due to fear of victimization from sectarian attacks. At the beginning of conflict not as much evidence based research around PTSD, but the interventions around its treatment has grown. |
| ----- | Normalisation Trivialisation Silence Fear |

| 4.3. | It is hugely evident in most of our client base who often present with symptoms of PTSD and anxiety related disorders. This is particularly apparent, for example, in ex-paramilitaries who seek our help. Being based in one of the hot areas during the Troubles we see a large proportion of ex-paramilitaries or those who are or were “connected.” We also have a number of clients who did not access therapy before we opened because they feared to enter areas where they expected to be killed like the Ballysillan Road, Shankill or Falls. We see our clients typically deal with trauma by using avoidance techniques, very often they are afraid to talk of the what they experienced and we are always conscious to apply the breaks to prevent the client from |
| ----- | Fear Avoidance Silence Attachment issues Ongoing effect |
becoming too traumatized. We also have a large proportion of clients who present with suicide ideation as a result of having been victimized because of their religion or may have been subjected to significant violent attack impacting on both their emotional and psychological wellbeing.
It also impacts from an attachment perspective and often we see in the schools, heavily traumatized childrens whose mothers are avoidant and as a result of not having the secure base as a result of violence they may have been witness to these children are often highly sensitive and anxious.

5. 3. It continues to impact significantly as evident in my response above and it is imperative that we continue to realize the significance of this time. Ongoing effect

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<th>Response</th>
<th>Data Code</th>
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<tbody>
<tr>
<td>1.</td>
<td>4.</td>
<td>We use CBT and EMDR specifically as recommended via the NICE and CREST guidelines. It is however up to the therapist to determine what clinical interventions make sense for the client. We are very problem and goals focused and we deal very much with the here and now using a 12 session model however we do have the discretion to be able to extend this at times to 16 sessions. We don’t typically do group work as most officers do not want others to know they are attending for fear of losing that sense of machoism that goes with the job. There is also a certain stigma they at times present. Also they typically did not go out on stress leave or take sick days due to fear that their contract may be removed which was the risk that a number of full time reserve people were subjected to.</td>
<td>CBT (E)/(M) EMDR(E)/(M)</td>
</tr>
<tr>
<td>2.</td>
<td>4.</td>
<td>Unlike many of the community, although they do great work, they are very often not providing proper mental health treatment. The Government spent a lot of money on conflict related trauma but to what avail I often ask. In the community based interventions,</td>
<td>Psychoeducation (E) CBT (M) EMDR (M) Family therapy</td>
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much of the activity if spent talking about the trauma, but that doesn’t help, in fact it just engrains the trauma, going over and over it again and again. Where community groups do help is where they provide employment schemes and support groups however they are very dismissive of statutory agencies like ourselves. Our service is one of the only NHS services specifically targeted at trauma. A lot of our work is about psychoeducation, so the mother may present with a traumatized child. I will also say “You the parent need to look at yourself and then your child will improve.” My family interventions typically find that trauma is at the heart of most difficulties within families. So a couple will come with a concern for their son and then you find the couples relationship is shakey. I will then ask how has their life as a couple changed since dealing with their son. I take a multifaceted approach using whatever techniques are required from Cognitive Behavioural therapy to EMDR dependent on whatever the presenting factor is. I continually think systematically, encouraging the parents to first look to themselves and then working with the child. Charles Figley has done a lot of work on family trauma and it typically relates to the fact that the parent can’t identify a stressor with a particular problem, thus psychoeducation is really important. For example I am working with a mother who suffered from Generalised anxiety disorder, and am now seeing that trait develop in her three children. Thus it’s about educating her how to deal with her anxiety as this is modeled onto her children. We know from numerous studies that people impacted by trauma are typically more aroused and anxious, for example the recent study of the babies born in and around 9-11 in the USA where they found the babies cortisol levels were higher than norm group born a year later (as their mothers had been in an anxiety state). What we also know is that Psychotherapy does improve matters however NI spends so little more on children. We don’t invest in them.

3. Not a believer in introducing them to group. I adopt my therapy to suit the clients needs. Each intervention is different. You can’t just tick a box and say CBT worked for them. What client presents with

4. Person Centred (E) CBT (E) Supervision
and my clinical judgment certainty with person centred at the foundation. Take a very gentle and flow approach with PTSD. Very often you will find a large amount of avoidance which manifests itself in the form of dissociation and day dreaming. When it comes to supervision and self care especially when working as a supervisor and dealing with clients who are very traumatized I ensure I take time between the sessions and am not overworked. If I personally am not well enough I cannot cope with their issues. Also with my supervisees I ensure they feel really supported particularly around some of the horrific stories they share with me.

I can recall one time when I really experienced vicarious traumatisation. I was looking into the face of one of my clients and was just haunted by the pain and grief I saw in his face. I saw so much pain and anger in his eyes and spent a lot of time thinking about him. With other clients just the graphic details of clients scooping up body parts with their shovel.

| 4. | 4. | My theoretical approach is eclectic and person-centred. As a person who grew up close to a notorious flash-point area, I value my understanding of the local culture and language. I recognise that people have particular difficulty in talking about traumas and that patient, non-judgemental listening may be required, over many sessions. In some cases particularly of abuse we also use art to open up the client or do picture work. CBT also assists but no matter what I always ensure with trauma work that I do no harm to the client. |
| 5. | 4. | Originally the trauma centre provided art therapy, cognitive therapy, group therapy and we had the luxury of being able to put in place a highly specialist trauma team. The art therapy was particularly successful as it enabled the high traumatized client really express what they could not speak about through picture. After 2002 the work became more focused on trauma cognitive therapy. We found family therapy also be particularly useful at the end of therapy work when people had recovered enabling them to readjust and engage in an activity which assisted them in rejoining family life. In terms of group work we did try it but the view was it was not a good way forward as people could hide |
in the group, thus CBT was the main model we adopted. Trauma is so highly idiosyncratic and impacts everyone so differently for example put 10 people who have witnessed the same traumatic event in a room and five may suffer severe PTSD whereas the other five due to its highly individualized nature. Similar the context of how the person had experienced the traumatic event also impacted for example someone who was in the middle of it, picking up limbs from bodies versus one who was at the top of the road who ran in the opposite direction to the bomb.

After the Omagh bomb for example, the health services offered a group session to the staff however they found it unhelpful because they felt it was enough to have to deal with their own trauma without carrying the trauma of others. They found the entire experience quite distressing. Thus for the treatment of trauma, it needs to be treated on an individualized basis.

The group however may have some part to play at the end of treatment in the consolidation of the traumatic event but would suggest limited usage.

Community interventions are also useful playing a psycho-educational role. People we found looked for guidance and reassurance. These interventions enabled people to find support in the reactions of their neighbours and friends.

Both Supervision and Group supervision was also offered to all of our therapists and we operated in a supportive open plan office with no sense of hierarchy. Everyone multi tasked doing a variety of roles. In order to lower the risk of vicarious traumatisation amongst our therapists we encouraged our therapists to disclose and be honest and authentic if there was anything they found particularly difficult.

For all volunteers we encouraged this honesty, all work was valued within the centre. We would also do informal things for our employees such as away days,
They vary from one to the next and a lot of the trauma related to conflict based issues are somewhat masked. Others are more aware of what these symptoms are. Very often they come in with one issue but soon you find it related to traumatic event they witnessed. It can often be a delayed response to a horrific scene they came across however they managed to cope with these scenes at the time. They often present confused as to why they cannot cope now. One of the main triggers however is retirement as they lose that sense of identity and camaraderie. In a sense as well they had no time to process the trauma due to the repeated exposure to the conflict night on night, day on day resulting very often in desensitization.

Very often we have the complicating factor of multiple trauma and the fact that often it is co-morbid with depression and anxiety. It is never that they will speak about a single incident as they has been long term exposure.

They often also present with OCD and they are very often obsessed with vigilance and security. Many of

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<td>them have a ritual they perform before they go to bed at night and first thing in the morning, checking under their cars for example for bombs however it is when this checking behaviour becomes problematic that there becomes a problem.</td>
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<td>2.</td>
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<td>It is difficult to quantify the number of people affected by Troubles related trauma. We have little or no idea of the specific numbers who may have developed PTSD or traumatic bereavement as a result of the conflict. When we consider children in NI we also have little understanding of the consequences of growing up in a society exposed to civil conflict for more than 35 years where violence was often the backdrop to their entire childhood.</td>
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<td>3.</td>
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<td>We haven’t looked at the legacy we have left to our children in the north. Those that have been impacted by the conflict can’t even get past it themselves so in a sense they are emotionally children themselves.</td>
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<td>4.</td>
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<td>In my catchment area, where so many families were involved in The Troubles as victims and/or activists, the conflict continues to cast a long and dark shadow, affecting clients’ sense of identity, their memories and their expectations. Spanning so many decades, much of the troubles became almost normal way of life for many-ask anyone and they could identify one bomb from another or one gun from another. Today in clients they will speak about it at a surface level and then move on to an issue impacting on them today as it is so deeply engrained.</td>
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<td>5.</td>
<td>5.</td>
<td>Anecdotally, the transgenerational transfer of trauma was evident in many of the clients we saw. For example children who live with a father who is suffering from PTSD and depression as a result of the troubles may suffer adversely. Some of the referrals who were parents were so focused on struggling with getting their own needs met in counselling that they would find it very difficult to be there for their children.</td>
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<td>It particularly impacted on the spouses of those living with one who was suffering from PTSD. They often come just to talk to discuss how their husbands symptoms are impacting on their marriage and relationship and the ongoing stress that was created in the family. The family members were also subject to SPED, where the family members were moved around from house to house and very often those is the services had to sell their houses for protection. For example if they got word of a specific threat they would immediately be evacuated. There was also the ongoing stress of whether the husband would return home. For those family members who lost someone during their service in the conflict, they often presented with complicated grief about the murder whereas when it happened they maybe did not grief properly. We see the Troubles also impacting on adult children of those who’s fathers were in service, impacting on their sense of security about whether their father would come home. Those retired officers also often present a lot of guilt of not being with their kids when...</td>
<td>Spouses stress and anxiety Complicated grief Anxiety in children of those in services Transgenerational trauma Guilt with grandchildren</td>
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they were growing up and this often surfaces with their inability to be able to cope with their grandchildren.

2. 6. More recently we have begun to consider the concept of trans-generational trauma, how trauma which occurred in one generation can have a profound impact on future generations. Given the troubles started roughly in 1969, over 40 years on we are seeing children from third generation struggling to come to terms with the impact on their families of trauma that happened to their grandparents. Studies by Hayes and Campbell and Muldoon found that family members were significantly affected by Troubles related trauma.

3. 6. The trans-generational impact of trauma is evident with most of the clients I have worked with. You see it in some of the Jewish studies that were conducted but in Belfast it is also evident how the trauma is passed through the generations. As the individual tells their parents stories they relieve it at times.

4. 6. Most clients have several family members who have been seriously affected by The Troubles, whether through physical or psychological traumas, economic hardship or being forced to leave Northern Ireland. It continues to manifest in many of the children who had an insecure base growing up and whose lives were shrouded in violence and continual looking over ones shoulder-continually in a state of hyperarousal.

5. 6. There is also an anthropological dimension of trauma. The narrative experience of communal violence is transmitted to the next generation but it was not a feature we were really aware of until later on, a number of years after the bombing in Omagh. Very often we found that those who were impacted by the Troubles were highly avoidant of anything that would remind them of the traumatic event so they believed the trauma to be secondary to whatever was impacting on their everyday life for example relationship issues.
Counselling back in the day when the forces were involved in the conflict, was not really something that was available to them at the time. However the huge trigger was retirement and there was a huge sense of isolation associated with retirement. They found a lot of other families did not want to socialize with them and they could not even go into certain parts of Belfast for fear of being recognised. The importance of supervision has also become significantly more important. In here we are a very close team and we have immediate debriefs after particularly traumatic events. We also have a debrief lunch once a month and have ongoing supervision and personal therapy. People in politics very much keep the conflict alive today plus there is also the continued threat of dissidence activity. It is not as peaceful as what people think.

2. We have created a victims industry in NI however we cannot sustain as things are not targeted in a particular way. A lot of money is spent on research and not enough money on the treatment which is under-resourced and ill equipped.
really wrong. For me I have invested on the clinical work and am critical of spending too much time on research. While there has been much research on transgenerational trauma, the service planning of the DHSSPS has not been influences. We know that clinically a significant number will require psychological services in the country and that many existing mental health services are ill equipped to treat complex trauma. In addition to the traumas of the past, violence is still at large in NI.

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<th>Relationship between Psychotherapists/counsellors has significantly improved and they are quick to refer people to us. I have also established a strong relationship with the GP’s so we avail of much more of these services. Once clients can put a name to what they are experiencing, there is a sense of relief and therapy can begin. With the services, trauma is also very complex. They do not know who to trust and in the therapeutic relationship it often takes them a long time to build up the trust. Initially much of these early conversations are about checking your credentials and your access NI status and they fundamentally conduct a deep search of you as a counsellor. Both PSNI officers and army have a tendency to stick very closely to their own little family and they struggle to transition to normality and socialize with those outside their community. For example there are certain towns they live in the North and other areas they won’t even go into. Numerous bus drivers have also been impacted via bus hi-jackings. My believe however in terms of how therapy has evolved is that every professional person has a role to play, the impact of the trauma is so great, there is room for all of us. One thing however I would stress is the fact that NICE documentation does not truly reflect what is going on in Northern Ireland. We have a different culture, a different dialect and a different way of viewing the world. They try to put their world into our world but often this does not work.</th>
<th>Relationship between GP’s/health professionals significantly improved NICE documentation does not truly reflect what is going on in Northern Ireland Place for everyone</th>
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<td>3.</td>
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<td>This is hard for me to answer because I have only been in practice for two years. I am learning all the time. The biggest problem I face is finding ways of providing therapy for the many trauma victims who simply cannot afford to pay the full cost of therapy</td>
<td>Therapy costings</td>
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5. Treatment of trauma has not really developed since 1998 as the system has not made up its mind in terms of what types of services we want. NI PLC and health services wasted so much time and money without determining what the most effective use of therapy was. Now we know that Trauma focused cognitive therapy if very effective.

| 7. | No main developments as Health services has not made up their mind what they want |