



Southern Health & Social Services Board

Trauma Advisory Panel

IN THEIR OWN WORDS

**The effects of the Troubles on
health and wellbeing as
told by people themselves**

June 2006

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FOREWORD

The Southern Health and Social Services Board (SHSSB) Trauma Advisory Panel (TAP) recognises that the Troubles have had a far-reaching impact on the physical and psychological health and wellbeing of the population. Exposure to high levels of violence and death has adversely affected individuals, families and eyewitnesses and resulted in varied and complex responses.

The TAP commissioned a study to gather information and record the needs and experiences of individuals affected by the Troubles in order to inform policy and service development. It was of primary importance to plan the study so that it would record the stories of participants in their own words. This report reflects the needs and issues as told by those who were interviewed.

The outcomes of the study were, at all times, secondary to the needs of those who participated in the process. By engaging a researcher with therapeutic skills and adhering to agreed protocols, it was possible to ensure clear ethical guidelines for the study. Feedback from the pilot and subsequent interviews was positive and affirming. Those interviewed reported that they felt acknowledged and respected. The Trauma Advisory Panel is grateful to all participants who were interviewed and to the groups who facilitated the contacts.

The evidence of unmet need and of ongoing pain is a challenge to policy makers and service providers in the statutory, voluntary, self help and private sectors. We would like to thank the Victims Unit at the Office of the First Minister and Deputy First Minister for giving us the financial support to undertake this valuable work.

A handwritten signature in black ink, appearing to read 'Tom Smith', with a stylized flourish at the end.

Tom Smith

Chair of Southern Health and Social Services Board,
Trauma Advisory Panel

ACKNOWLEDGEMENTS

Thanks goes to the people who participated in this study about how their health was affected by the Troubles and how they manage ongoing health challenges. They shared their experiences of trauma and stress, they described what life was like for them living with the health issues that have arisen out of those times, and expressed hopes for the future. Their identities are preserved to respect their privacy.

While the focus of the study was on personal pain, disability and needs, many respondents asked that people who have cared for them be acknowledged. Thanks goes on their behalf to those GPs, employers, former colleagues, ministers of the churches and friends who continued to extend a helping hand, keep in touch and visit. They are grateful to the victims groups, community groups and individuals who work to empower people affected by the Troubles by promoting new friendships, developing skills and offering support. They acknowledge those agencies which have provided services to them, and appreciate the SHSSB Trauma Advisory Panel for commissioning this study.

Thanks to the carers who helped improve the mental, emotional and physical wellbeing of those interviewed and provided support and made a difference to their quality of life.

This report is the result of combined goodwill and effort of several people whose input at practical and participatory levels is much appreciated.

They include those who made the interviews possible, their families and members of the Trauma Advisory Panel. Thanks to the readers who made editorial contributions and to those who gave administrative support. The support of the TAP Coordinator in giving encouragement to tread softly has given the author scope to hear the peoples concerns and write it in their own words. A personal “thank you!” to Theo, Aisling and Sorcha for their endless encouragement.

Julie-Anne Mullan



INTRODUCTION

This report reveals in their words how people's lives continue to be affected by day-to-day physical, mental and emotional challenges. It gives a broad indication of the health services they depend on. It also highlights specific gaps in health service provision relevant to victims and survivors who now form part of the ageing population. What is of particular interest here are the specific additional needs they continue to have that arise out of trauma and cumulative stress experienced during the Troubles.

It is hoped that this document will bring awareness of the areas of need and give insight into the complexity of managing health issues arising from trauma and cumulative stress. The simplicity of the language belies the complexity and depth of the process. This work is for everyone who may hear their story told between these lines.

BACKGROUND TO THE STUDY

The Trauma Advisory Panel (TAP) wanted to become more informed directly and in detail about the health concerns and challenges experienced by victims and survivors of the Troubles living in the Southern Health and Social Services Board area. The Trauma Advisory Panel will in turn use these findings to inform statutory agencies and influence policy. They agreed to commission a study to gather this information.

Methodology

In the preparatory phase of the study a lot of time was given to careful planning, discussion and testing the methodology within the Trauma Advisory Panel steering group. This was with a view to protecting respondents from being re-traumatised and in this it was successful. It was felt inappropriate to take a strictly scientific quantitative approach, opting instead for quality personal evidence that would give a picture of what life is like for victim/survivors living with health management issues. (See Appendix 1 for more information on methodology.)

The steering group agreed that a range of respondents would be accessed and would be interviewed with a view to obtaining representative data for the Southern Area Health and Social Services Board. Interviews would be semi-structured so as to give people scope to tell their story in their own way, at the same time being guided to provide comparable data on health issues.

The data gathered would indicate their perception of the main issues and assess to what extent health needs are (or are not) met by the statutory, voluntary and private sectors. The Trauma Advisory Panel would ensure that the facts are conveyed to health providers and policy makers.

Objectives

The main objectives were to:

- ❖ utilise a format for gathering data that would facilitate people to speak of their health needs in a way that would be beneficial to them and avoid re-traumatisation,
- ❖ describe the type and extent of health issues which are ongoing and challenging,
- ❖ point to services that are experienced as satisfactory or underutilised and pinpoint unmet needs and/or gaps in services,
- ❖ make recommendations that will improve future quality of life.

The Scope of this Study

The study set out to explore the validity of the following statements.

- ❖ People affected by the Troubles need physical, emotional, mental and spiritual support above and beyond their previously held expectations associated with natural physical decline.

- ❖ People have access to the services they need to ease mental, emotional and physical pain caused by their experiences.
- ❖ Experiences of the Troubles continue to have an impact on the wellbeing of the immediate family of those involved years, even decades, after the event.
- ❖ A solid ethical framework and well-prepared methodology could result in quality information without re-traumatising participants.

The Interviews

Semi-structured interviews were held with 19 respondents in mid-2005. Interviews took place at a venue of their choice e.g. in their home, at a victim/ community group office or other venue. Interviews lasted approximately an hour and a half. Respondents were invited to tell how their health was affected by trauma or cumulative stress during the Troubles. (For details on the model used see Appendix 2). The first part of the interview explored the health issues with which they were confronted; physically, mentally and emotionally. They were then invited to talk about their present health status and, finally, to express their hopes for the future. It was considered too intrusive to ask for specific details about financial support and services accessed. Patterns did emerge which are highlighted below. (See semi structured questionnaire, Appendix 3).

Respondents

Represented here are members of the public who during 30 years of the Troubles experienced one or several traumas e.g. the death of a relative(s), or, cumulative stress from multiple traumas in the course of their life and work. Also represented are those who were caught up in and witnessed shocking events. Their experiences resulted in long-term consequences that include personal injury, loss of employment and onset of chronic conditions. The participants are an indicative sample of the people the Trauma Advisory Panel has been supporting. Those interviewed were representative of the population in respect of age, gender, religion geographic location in the SHSSB area. It was acknowledged that not only were these people directly affected but so also were their families through two generations, their colleagues and their communities who suffered with them.

The age of respondents ranged from 31 to just over 70 years of age. Most of those interviewed were in the age range 51 – 60yrs. The older people interviewed were parents whose child, teenage or adult son/daughter was killed in the Troubles. Others were hurt or injured or experienced their siblings being killed, injured or imprisoned. The younger people interviewed were young when events put their whole family into turmoil. Families were displaced, family members were interned, or they lost a parent due to the Troubles. (For more details of respondents see Appendix 5)

SYNOPSIS OF THE FINDINGS

The people interviewed were challenged by shock and trauma, or were caught up in a series of events that led to cumulative stress. They spoke about how they had to cope with physical injuries, thoughts, and emotions throughout the months and years that followed with the support of their families. In managing their health issues, they were also supported to varying degrees by the statutory, voluntary and private services.

When asked how they or their loved ones were injured or killed, 14 respondents attributed the death of a relative to paramilitaries and/or security forces. Five respondents were personally affected by ongoing stress over the years, and recounted how they had been caught up in bomb explosions or hijacking. Four respondents said they were not injured physically but experienced emotional trauma. (For information on the Troubles-related experiences of individual respondents see Appendix 6).

Immediate Impact on the Individual

Two respondents spoke of sustaining a range of injuries in an attack i.e. bullet and grenade damage leading to kidney, bowel and leg problems, while the other suffered injuries to the lower back, head and face. Five were treated for insomnia. Three people experienced the onset of symptoms such as high blood pressure and night sweats or chronic conditions such as arthritis, psoriasis, eating problems.

“Fear dominated me.”

Fear was the main manifestation of emotional stress in the immediate aftermath of traumatic events. Eight respondents spoke of fears for their personal safety, or the safety of other family members who were under threat. Some feared certain places, their home or hospital, or passing near the site where a loved one was killed. One woman said that when young she felt she had to “fight back, fight to shut out the fear”. People described themselves then as “constantly jumpy”, “distraught”, “up and down all the time”, or very angry. Reference was made also to “blinking out” painful memories of e.g. funerals.

Many spent time thinking and ruminating, trying to figure out ways of making sense of what happened. Counselling or professional support was not available or offered at the time. Nine respondents spoke about having constant negative thoughts in reaction to what happened.

Those interviewed suffered circular thoughts of blame and constant anxiety about being under threat. They reported being so stressed that one respondent found herself driving on the motorway with no memory of how she got there. Memory loss arising from injuries caused confusion and frustration.

“Before this happened I thought this could not happen: now I know it can.”

Several women in this study spoke of having to cope with stress by using self encouragement - not to give in to what was happening, even when they had “difficulty concentrating, experienced tiredness and were worn out. There didn’t seem to be any way to get over it”. Men who were interviewed tried to keep working as a means of distracting themselves from painful emotions. A man injured in a bomb explosion explained that coping meant rationalising the situation in order to stay sane. “You think you’ll never be in a bomb – it’s not as bad as for others. I’m lucky”. Another man tried to feel better by telling himself “a lot of people were worse off than me.”

The experience of having been injured or stressed had an effect on people’s sense of purpose and beliefs. Respondents grappled with the meaning of it all, asking why did this happen? One respondent maintained that her belief in God and religious practice kept her going, but another said it was hard to maintain religious practice: but “it didn’t stop me praying.” Identity was affected too: “I felt useless. I felt 16 years were totally wasted. I couldn’t get work.” Another respondent became involved in local community action; “I thought I had a right to participate actively on behalf of the local community.

When their personal health status changed through loss of limb or sensory impairment, the ripple effect was outwards to family members, colleagues and friends. An inward impact within families of forced re-location, reduced income particularly impacted on the emotional life of those who were children at the time. Everyone spoken to depended on family for support.

One respondent to this study became permanently housebound due to injuries that were extensive and severe. A particular poignancy lies in the hidden suffering of the housebound person; hidden because in their isolation only a small number of people share in their lives long-term. These are mainly family, members of the church, close friends and victim/survivor group members. Another respondent, who was typical of those injured, experienced temporary periods of inability to leave the house, due to ill-health, physical incapacity, fears/phobias, and lack of ability to trust.

Effects on Family

It was confirmed that to be forced to move house put extra emotional and financial demands on families. Among the 19 people interviewed respondents spoke of having to relocate; moving from one town/city to another, moving away only to return to their home area in later years, or going to a different location in the same area. Through time all of these respondents have become settled where they now live. However not being able to stay in the family home, having terrible memories of what happened there, not being able to stand the pain of loss, made it such that two respondents had to leave and never to return to their home again. The main explanation given for relocation was for safety and security reasons.

“I never went on a holiday since 1976.”

These moves resulted in social isolation through loss of contact with the local community and friends.

Fear governed a decision to withdraw from society. One man found himself avoiding social gatherings like football matches and never went away on holiday again. Another said that only close family and friends would call to visit. Fear of being seen while moving about in the community was a factor in withdrawing from community life for a member of the security forces.

Two respondents spoke of the positive effect that events they experienced had on their support network. One remembered that family and neighbours rallied round, another said that the local social network was “brilliant” especially, in the absence of statutory service support.

Family members and relatives experienced serious changes in personal health status in the aftermath of the death of a loved one. Four respondents talked about the sudden deterioration in health of parents, a wife, a mother, a father and a sister-in-law. They spoke of sudden changes, broken hearts, and of one parent’s health rapidly deteriorating a year after their child was killed. These were the hidden victims of the Troubles.

“My mother lost her heart when my brother died.”

During the interviews the extent to which remaining family members suffered also became apparent. Siblings were as affected as parents by loneliness, grief and loss. Where there was extreme need and faced with tragedy in the community, neighbours, friends and colleagues played an important role in keeping people connected and grounded as they supported them in their struggle to adapt through offers of emotional and practical support.

Sources of Support

Respondents described how family helped out in time of need. In one instance relations who were also injured when a respondent's parent was killed, moved house to provide support. For others it was noticeable that family and neighbours helped, even when threatened: "family stood their ground and wouldn't let anyone push us out." For others family was a lifeline as friends and family gathered round. "They felt hurt by how I was treated. They saw the hours I spent, the effort I made." Children supported their parents despite their own suffering and loss.

“My wife’s my anchor, my rock.”

Other respondents experienced a lack of support at the time it was needed most. People of all ages had difficulty learning to cope with stress on their own. Finding people to talk to whom they could trust would listen and understand them was difficult. One woman said she was grateful to have a friend to talk to on the phone. Another's distress continued after the trauma through intimidation. For security reasons, one respondent could not attend family events and had to miss important family celebrations. Two respondents spoke of feeling abandoned on the one hand by their employer and another found that the statutory services "never offered help" at that time.

Unforeseen Effects

Traumatic experiences during the Troubles had a major impact on income and life chances. People lost jobs, careers, chances of a better life. Their expectations of normal life had to be let go suddenly, without warning. According to one respondent life changed in every way; “I was cut down at a young age. I can do nothing. I can’t work now with the pain”. Two respondents lost their businesses. Two others could no longer hold down a full-time job, and another admitted it was a massive adjustment to have little or no disposable income. Low income and the extra burden of finding money for treatments was a problem. A sense of injustice existed amongst those who received compensation when they discovered that people in a similar position had been awarded more than them.

While four respondents lost their jobs directly or indirectly as a result of the Troubles others had to continue working regardless of stress. Three said they kept working, sometimes with the help of friends and neighbours. Reduced income was a problem and they found themselves having to survive on pensions, benefits and/or families pulling together to pool resources.

Women coped with a change of roles within the family. They had to take on the role of breadwinner when income was reduced and had to learn new skills. Only one respondent reported having savings to tide the family over for a time.

The attitude of respondents to educational attainment was affected by living through the trauma and stress of the Troubles. Those who were teenagers at the time either continued with their education with even better results than expected, or they dropped out. Others made up for missing out on their own education by making sure that their children did well at school. There were those who as adults embarked on a degree or other skills training course. Some reported that their inability to concentrate at school affected their early academic achievements.

CURRENT STATE OF HEALTH

All 19 respondents answered this question in great detail; they were keen to share information on physical, mental and emotional aspects of their health status. Only five people interviewed could say that they felt fine on the day of the interview. Three said that they felt reasonably fit and average for their age and were medication free. Two said they lived a simple life and took medication if required.

***“There was a gradual build up.
I had no history of these things.”***

The following describes current symptoms which indicate the level of chronicity and deterioration caused by injuries, trauma and the ageing process.

- ❖ Three people have high blood pressure. One described himself as having ‘heart trouble’. Others said they had been taking sleeping pills long-term since the death of a husband or child. Others were on anti-depressants or managed by taking tablets when the need arose. Changes of medication produced side effects that had recently kept one respondent in bed for a number of days.
- ❖ One respondent came to the interview on crutches another person used an electric wheelchair, and a third had limited mobility.
- ❖ It was remarked that pain in joints and muscles increased with age.

Back problems, aches and pains in the neck and head were reported as being continuous. Respondents regretted it kept them from doing DIY work or gardening. They felt that their pain was directly linked to injuries and trauma and not to their age.

- ❖ Ongoing stress and depression and associated physical discomfort was a complex and debilitating factor as evidenced by a respondent who had intended to continue work but retired early on account of extreme stress. Extreme jaw pain developed which required a visit to a dental specialist. Depression was so bad that their appetite was reduced and being on four different kinds of medication affected the liver.
- ❖ They experienced fatigue, burnout, weight loss, and tiredness. Discomfort was a major factor: three people said they had soreness in the lower back and legs, or were very tired and others had symptoms of depression.
- ❖ People said they were still preoccupied by what happened even though some of them had experienced trauma up to thirty years ago. They said they continued to take one day at a time, that they were wary about driving anywhere for fear of losing concentration, or found themselves thinking about what happened. “I’m not the same” said a respondent “I don’t notice until I look back how life has changed.” There were regrets, thinking about what and who was lost.

But there were also those who thought they were now coping better, who said the family and the grandchildren kept them going. Reflection on the past brought feelings of sadness: “I think a lot about how it affected my mum. She suffered.” Not only did respondents have regrets, they thought about what might have been if their parent, brother or spouse had not been killed. Others thought about how different their own lives might have been.

- ❖ Respondents reflected on the daily experience of the effects of trauma, and that even if things appeared to be going well in the province that hypervigilance continued, as did reliving the fear, constantly checking security and reacting to unexpected noises.
- ❖ Other ongoing concerns included functioning with impaired memory, financial insecurity, and low income.
- ❖ Emotional highs and lows were described as constant and nearly half the respondents regularly experienced anger or bursts of temper. They spoke of deadened feelings, exhaustion, feeling demoralised and drained. One woman said: “I lost my heart the day he died.” Many of the men became emotional when they spoke of their experiences of grief and loss during the Troubles. They simply couldn’t hold back the tears when talking about what happened. They reflected that they couldn’t stop crying even after all these years.

- ❖ There were those whose family kept them going on a daily basis. A couple of people said that they had a hopeful outlook thanks, ‘to job satisfaction, taking it easy, changed priorities and not blaming any more’. Others said they felt as if something beyond their control influenced their ups and downs.
- ❖ Some respondents felt positive about being engaged in community work, doing whatever they can, placing some trust in people, joining in victim/survivor work and visiting the sick. Many respondents said they wanted to be happy again, when the Troubles are resolved and healing takes place.

“I would like to be able to look forward to waking up.”

Current Needs

Asked how their needs were being met at the time of the interview, respondents spoke about support they obtained from a variety of sources, i.e victim/survivor groups, good neighbours, ministers of religion, spouses, children, grandchildren and in-laws. The family, particularly grown-up children, met most of their needs. Community associations, voluntary groups and self help groups were mentioned. Two respondents in employment got helpful support through work. Friends were important. Active participation in sports, exercise and outdoor activities were valued by three respondents.

Victim/survivor groups met needs in several ways. They offered an opportunity for isolated people to get help away from home and to meet and socialise with people who had similar experiences. Two respondents were seeing a counsellor employed by their victim/survivor group. Some groups helped by providing training courses and complementary therapy treatments. They complemented and supplemented the roles played by GP, hospital, church, pub, or community group and family and friends.

“GPs are on the front line but are they adequately trained for this?”

The professionals most likely to have an awareness of respondent's needs are the General Practitioners. They were the front line of support for respondents. Two respondents mentioned that an occupational therapist gave valuable assistance, but in one case there was no follow-up when that person changed job. One respondent sees a Psychiatrist four times a year. Another said that with hindsight his siblings and mother could have done with counselling, even though they experienced good community support. Two respondents asked if one of their relatives could also participate in this study, since lack of counselling at the time of trauma led to them having unresolved grief. One respondent had received helpful counselling support from the local Trauma Counselling Service.

Self-help in the form of doing voluntary work brought benefits to some; it made people feel valued and helped self-esteem.

It brought a dilemma with it, according to one respondent, who said he feared people would say why not go back to work. Another respondent said it was time to give something back, to “help people now by doing things for them.”

Respondents reflected on their current personal health issues. They said that they had:

- ❖ *developed chronic conditions*: “I got psoriasis and arthritis 14 years ago after the trauma. I never had a pain or an ache before then”, and, “I have high blood pressure, insomnia, night sweats and am tired in the morning. It was a gradual build-up. I had no history of these things.”
- ❖ *a need for medication*: for “constant pain, with kidney, bowel and leg problems. Terrible pain”, “I need anti-depressants and medication for joint pain.” One person had been on “lots” of different anti-depressants.
- ❖ *disturbed sleeping patterns*: “I had sleeping problems and was eating nothing.” “I had sleep problems; I was on 100 tablets a week for a year”, “I wasn’t able to eat or sleep. I lost four stone in weight. I was put on medication for insomnia. I was really struggling.”
- ❖ *physical and emotional scars*: “hurt to my lower back, injuries round the head and cut my face”. This includes unresolved grief, flashbacks, crying.

Medication was needed but all expressed fear of becoming drug dependent.

The most persistent symptoms headaches, flashbacks, pain and insomnia were debilitating. One respondent took anti-depressants for six months but, with a supportive GP and family, succeeded in going off the tablets. Satisfaction was evident when people could report that they were on a lower dose of painkillers or anti-depressants or had dispensed with them completely.

Hospital attendance continues to be accessed for damage that occurred during bomb blasts or shootings. Hearing problems, paralysis, surgery were specifically mentioned and these all arose out of experiences during the Troubles.

More than half of respondents experienced aromatherapy, reflexology or other complementary therapy treatments at some time. While these therapies have become more regulated in the last decade, there seemed to be insufficient awareness of their potential as a viable option for emotional support, relaxation and pain relief. These therapies offer patients valuable contact time that the medical profession cannot afford to offer.

“Complementary therapies keep the amount of medication down: the chat, the release, the grief.”

Self-help: going to the gym and swimming are forms of self-help, but one respondent with mobility problems said that insufficient attention was paid to personal needs by the pool staff and she stopped going.

Services Availed Of

Statutory Services

Respondents were not asked nor could they remember specific details regarding the number of appointments or services they had received. The interview focused on their experience of what worked best for them. The statutory services most utilised were: GP, Physiotherapist, Occupational therapist, Counsellor and Psychiatrist. Other services accessed included hospital accident and emergency departments, outpatient clinics, social worker, community psychiatric nurse and health visitor. These specified services were not all being accessed at the time of the interview, but were initiated at the time of injury or stress.

The majority of respondents said they were satisfied that they had received as much physical treatment from statutory services as was needed at the time of the injury. Pain relief was of particular relevance to three respondents and they knew exactly what they wanted: “The physiotherapist told me I shouldn’t have to suffer and referred me on for injections”. “I wasn’t offered relaxation techniques. I got reflexology through the Pain Clinic at the local hospital”.

And there were those who had a struggle for treatments or aids. “There’s an NHS waiting list of one - two years. That is too long and doesn’t guarantee the type of equipment I need.”

Private Services

Complementary therapies were both paid for privately and offered at a reduced rate via victims groups. These were described as being very helpful for stress. One person received two reflexology treatments at the victims group office. Another had Indian head massage once and reflexology as a treat through the group. A third got ten subsidised aromatherapy sessions via the group and the respondent reported that she would really need it every week.

Respondents said they could not afford to pay for complementary therapy treatment on their low income. One person had acupuncture for “only five sessions and I would have more if I could afford it.” Another tried head massage for six months but found it too expensive.

Complementary therapies were described as helpful both in terms of the relaxation and as regards the time given to focussing on the client. To quote one respondent, “I have been using them for the last two - three years. They keep the amount of medication I take down. I find it as good as counselling.” Another reported that “aromatherapy is an amazing help, absolutely brilliant. Receiving treatments led me to train myself.”

One respondent said that self-help books were another route to self-understanding.

Voluntary Services

15 of the 19 people interviewed belong to or are connected actively with a victim/survivors group. 13 said their connection had lasted anything from 19 years to just a few months. Reasons for joining victim/survivor groups varied.

People were disappointed that they couldn't get relevant help at their time of greatest need. They had to find ways of managing emotional and psychological stress themselves. The typical response of employers early in the Troubles was described by one person; "my employer gave me a week off which was unheard of in those days. Counselling wasn't available until near the end of the Troubles. It wasn't available to everyone. I started up a support group."

"Through the group we've heard other stories; I know I am not alone."

Victim/survivor groups were said to make a significant contribution to their sense of wellbeing, especially helping people affected by the Troubles to:

- ❖ manage their lives better: "what I do for the centre is my way of helping me and it's good for me to feel I have been of assistance."
- ❖ inspire others and motivate them to take action: "the support group I work with inspires people. I like the way this work influences things to benefit people."

- ❖ undertake skills training: training at introductory and advanced levels, makes it possible for members with mixed interests to attend classes. Trainings mentioned include computer skills, poetry writing, personal development, counselling, the Training for Transformation course, and reflexology. One respondent said; “I did the personal development programme and self-awareness training which made me feel self worth”.
- ❖ feel supported and acknowledged: “the group gives help for the whole person”. “The group is positive, provides confidentiality and safety” and “takes me out of the house”.
- ❖ give something back to the community: “my group helps people from a wide area. It helps us put into the community not only take out. I wouldn’t miss a meeting. I’m working on getting funds for a project and I’m engaged in youth activities. We go on day trips too.” One respondent who was supported by the group developed the confidence to become involved in a local community association.

Other respondents who did not belong to a victim/survivor group told how they made efforts to connect with the wider community with negative results. One person went to a fitness club where staff had to remove piles of linen to provide access to the disabled changing room making it difficult to attend.

“People think they don’t deserve to be a member of a group.”

Outcomes

Respondents were asked if efforts to access services had a satisfactory outcome.

The important role of General practitioners was repeated; they were variously described as being “accessible, very supportive” and “would see me for 10 minutes when needed”. Others were not. They did not ask about a persons life experience (in respect of how they were affected by the Troubles); “s/he made me feel I’ve wasted their time.” Some GPs took a proactive stance and signposted patients towards appropriate other services.

One person said they “didn’t know what services were available but accessed what they were offered.” Two people did get positive results when they asked for help and were able to access a Counsellor straight away.

Benefits

One respondent did not apply for financial assistance from grants or benefits early on during the Troubles, and only accessed it when prompted by the GP. Receiving incapacity benefit plus DLA was a great help. There were those who didn’t get to know they would be eligible “until I met a neighbour who told me about DLA, eight - nine years ago. We went 16 years without it. At one time I had £2 left over every week after I spent my pension on bills.”

For some people the assistance they are eligible for is neither easy to get information on, nor to access: “benefits are a struggle to maintain. As for incapacity benefit, I have to fill in a form every year: they send you to see a medical doctor who may or may not be supportive: I have been through appeals several times. I wasn’t told about industrial injuries by my work. I should have been registered as a Carer because I looked after my mother, but no-one told me about it.”

Positive Feedback

The respondents reflected on positive experiences regarding services they had accessed, who had helped them access these and the financial aspects. Ten people said that the services they required were accessible and available locally. One respondent’s experience was that waiting lists were long: “ten months wait for one thing and four months wait for a scan”.

Access to affordable treatments made a big difference psychologically - some people bypassed the NHS in order to get treatment; one paid to see a psychiatrist. Not all services were free or affordable: “I have to pay for eye tests/glasses and the dentist” and “acupuncture was too dear”.

For others the search for successful treatments goes on; “I need alternatives, something for the pain. I would like to be able to have some reflexology to see would that help”.

Two respondents said that particular statutory services such as physiotherapy were successful, “got me back to normal”, and appropriate: “the GP arranged for “polyclinic and traction”. One person expressed disappointment about statutory treatment options: “I was sometimes offered what I felt was the wrong thing. There was no understanding of my individual needs.” There was praise for the professionalism of health and social services personnel who were deemed “competent and capable”.

When asked if services to which they had access were of sufficient duration, respondents verified the need for input into planning their treatments for painkillers and physiotherapy. They knew what felt right for them. “I’d need physiotherapy once a fortnight.” “I only needed physio for a week.” Another judged their treatment to be too short: “I had only four – six weeks on a PTSD management course at the hospital” without follow-up.

Respondents found that they were required to return to work too soon. For some this proved impossible. For them the negative experiences of being checked up on made them worried that they would not be believed to be ill or unwell enough to work brought extra pressure: “I had to be on the sick and go before the Board. They made me feel dreadful. I broke down in front of them. I felt they felt I should go back, but I subsequently changed jobs.”

The Trauma Advisory Panel helped to access services for some respondents interviewed.

Respondents reported that accessing services via a victim/survivor group community worker helped. But for one person who needed an important piece of equipment time was running out because no-one could help him finance it “before it’s too late.”

FUTURE NEEDS FOR HEALTH AND WELLBEING

Asked what health needs they expected to have in the future, the comments demonstrate that these respondents' concerns are for physical and emotional wellbeing. Two respondents summed up their overall attitude: "I am hopeful for a healthy future" or "to be strong as before – I think I could be."

They require suitable housing, sheltered accommodation, central heating and, home improvements. Help in the house was a high priority "support for me with my conditions. Practical items were important too: "Hearing aids would give me back a bit of life I have lost." Simple personal pleasures would give comfort: "Listen to music, be with animals, take breaks."

For some medical treatments or physiotherapy were ongoing needs that will feature for the rest of their lives. Hopes were high for flexibility and new developments in medicine; "I would like hydrotherapy to ease the pain or an implant for pain relief."

In the absence of physical injuries respondents thoughts were on continued general good health: "hoping to be as good as I am now." "I want everything to be okay for my children." even if it is necessary for me to have to continue on medications."

A carer's concern was for the person they cared for: "we need to be sure we get what they need." There were those who defined health as being able to stay useful by keeping busy doing odd jobs.

Wider Context

An important condition for staying healthy was peace of mind arising from resolution of the political situation, coupled with respite from physical and emotional pain. “I hope things get no worse! Peace in the Province would go a long way to help me”. One respondent spoke clearly: “the following conditions apply to me in terms of my wellbeing. When I can say that I’ve done everything in my power to find out the facts about what happened. When there is acknowledgement by the State of their role – when it is agreed that we all had a role to play and that this can never happen again. These are conditions for my healing. I am here and this is where I want society to be. Recognition of what happened is important.”

“People are now only beginning to speak of what happened.”

Fears for the future did not revolve around specific physical health issues. Concerns and worry varied considerably, and included fear of the unknown, of not being able to get help when it is needed. Isolation was another worry: “afraid that if anything happens I’ll have nowhere to visit, to go out to, or be unable to go shopping.”

Little wonder that respondents said family support would definitely be needed, as well as the continued support of the victim/survivor groups. Respondents expressed the fear of the withdrawal of support in the future and that “pains would get worse.”

One respondent said he feared “falling back into depression.”

Finally, in the context of ageing and experiencing health issues in the later stages of life respondents expressed the hope that their faith would support them. This would underlie their physical and psychological challenges “if I can keep the peace I have now in what I have achieved and then rest in peace.” They believed that they would be supported by faith in “the Man Above” “family and friends” “continued prayers” “miraculous medals and the angels.”

ISSUES ARISING FROM THE INTERVIEWS

Several additional points for discussion came up during the interviews. They are relevant in the broader context of management of health issues and personal wellbeing. An indicator of the overall success of this particular interview experience lies in the words of the person who said; “it was a fine experience talking to you today”.

What Concerns People Most

People with different histories were united in their concerns about physical, emotional and mental health issues. Management of physical and emotional pain divided those who perceived themselves to be coping from those who did not. Faced with the challenges of impaired memory, reduced mobility, years of medication possibly with side effects, respondents reflected that their choices for management of health issues became limited with the passage of time i.e. they wondered if they will ever get better.

People still wonder what life would have been like if a relative had not been killed, if they had been offered professional counselling at the time instead of being put on anti-depressants, if they had not had to take enforced retirement. Ex-service staff expressed regrets at the limit to which they were supported through stress and injury. Their sense of identity with their purpose and their colleagues which gave meaning to very stressful jobs was lost.

It was said several times that families were bereaved again through accelerated natural deaths of family members subsequent to exposure to trauma.

“They never asked me my story.”

Living with disablement and disfigurement continues to be painful emotionally and physically. Cumulative stress was the invisible injury of the Troubles that is being allowed to surface now in time of peace. The people who talked about the stressors that played a part in changing their health status are still suffering from emotionally unresolved issues. The desire for peace, justice and healing were also recurrent themes.

Despite huge disparity in their experiences of loss, injury and trauma respondents exhibited similarities in their suffering, their concerns and their health needs regardless of the facts associated with how they were injured or how they experienced cumulative stress during the Troubles. Where health is the divider, pain is the equaliser.

Appropriateness of Help Offered

Meaning given by the individual to what happened or is happening to them becomes part of their identity and validates their present predicament. They want to be taken seriously.

People who were emotionally affected by their experiences during the Troubles found that some personnel who dealt with them tuned in to their personal history and some did not. Respondents were easily hurt by the attitude of professionals to their plight noticing especially as time goes by that younger staff members are less aware of the suffering experienced and the reasons why.

“I’m not fully able to trust the world.”

The interface between these respondents and the statutory health services was the GP surgery. It was from there that hospital outpatient clinics and appointments and operations were arranged, and where referrals to psychiatric/psychological/counselling support were made.

In answer to the question whether victim/survivors were getting the help they needed to address health issues it would appear that some needs are catered for. In the absence of a proactive system that examines people’s health needs from a holistic perspective (simultaneous focus on physical, emotional and mental levels) it is only the acute physical stress or crisis that attracts considerable and adequate resources.

It is understandable that feelings of helplessness pervade people with intractable illness or injuries. This is exacerbated for people with low disposable income; their personal power is limited and they live with low expectations of recovery or improvement.

Additional Options for Treatment and Support

While there was a lack of knowledge amongst these respondents about complementary therapies some of the respondents mentioned that the few private/subsidised treatments they received afforded relaxation, time out and personal attention, and were of considerable value. In their experience, the results of regular treatment brought comfort and nurtured the emotionally drained and physically exhausted individual. They expressed curiosity as to which of the therapies available could still be helpful if all medical solutions had been exhausted e.g. where medication is stopped because of unpleasant side effects.

Carers Needs

The continuous demands placed upon a carer are particularly stressful as there are no clearly defined boundaries between 'on duty' and 'off duty'. These are unpaid 'homeworkers' for whom employment outside the home and substitution by a stranger is not an option. They have experienced the secondary impact of trauma.

Memorial Fund

Memorial Fund payments have both advantages and disadvantages. The benefits are considerable when they fill immediate gaps in the ability to finance capital expenditures of an exceptional nature.

There are disadvantages when people know what they need but cannot convince the Fund to be flexible in meeting those needs. The greatest regret expressed by respondents related to their not being aware of what was available – that they got “too little, too late”.

While some respondents experienced anomalies in the system, others alluded to the fact that equality in distribution of support to people affected by the Troubles is better now than in early years. This added to the hopes placed by members in their groups to lobby for and support them. Transparency in provision and distribution of resources is the key to good services.

“We need equal compensation with everyone else.”

The Next Generation

The needs of children in families where trauma or cumulative stress occurred was not acknowledged in the early days of the Troubles. This can be attributed to a lack of awareness in society generally as to the long term effects of trauma. A ripple effect was noted from respondents who said that they still have issues of an emotional nature that remain unresolved for them, their parents and siblings. Children as young as ten years old are asking questions that cannot be answered. This ripple effect compounds the grief, loss and sense of injustice. This is the living legacy of the Troubles even though the violence has for the most part ceased. Civil society is peaceful but under the surface there is turmoil.

In their own words, people affected by the Troubles work hard to prevent their children and grandchildren from allowing hate and hurt to carry on to new generations.

“I was preoccupied with how to rear the kids not to show bitterness so that they wouldn’t have revenge or seek hatred.”

Continuous Assessment of Needs in an Ageing Population

A number of people affected by the Troubles continue to be housebound for a variety of reasons, including advancing age brought about by injuries, side effects of medications or panic attacks. It was noted by one respondent that although an occupational therapist visited once, they had never returned over the years to visit them at home to assess their changing needs for walking aids, installation of a shower, handrails or other aids and equipment.

The fact of being prescribed anti-depressants for up to 30 years caused dismay and hopelessness. While particular circumstances may necessitate long term medication, some respondents requested more balanced information on the pros and cons of long term antidepressant use.

Role of the Family and Wider Community

This study shows that the family carried the brunt of the legacy of the Troubles by caring for injured and grieving relatives.

For the housebound person isolation from society and even their local community is a constant concern. Respondents were often dependent on family/friends to provide transport to hospital appointments which were in some instances very tiring as waiting times were long.

Healing

Healing at all levels, body, mind and emotions, is probably the goal most desired by all respondents to this study and for each person the solution is unique. Every one of them had experienced some healing at one or other level, in their own way and at their own pace. Emphasis differed from one to another depending on the meaning they attributed to their suffering or to being incapacitated. Careful listening made it possible to hear the yearnings, acknowledge their stories and discover the gaps in resources. The interview experience added in part to their healing, to their ownership of their struggle and recovery of personal power. Respondents wondered how they could be more useful; they wanted to take an active role in putting something back into the community.

Coping Mechanisms

It became apparent in this study that what women do to cope is “just get on with it”. Men say they have to get on with it but find themselves emotional, sad and easily overwhelmed with grief, years after the events of trauma or cumulative stress. A later study might usefully explore and compare the gender difference as regards use of drugs, social networking and support therapies.

Meanwhile special attention might usefully be focussed on men who, burdened by social expectation to be strong, might now welcome professional caring support and understanding as they grow older.

It became apparent that of the respondents who live with constant, physical pain some tended to rationalise the experience of pain by wondering if they deserve to live without it. This is an indication that people sometimes cope by giving meaning to their experience even if the meaning is not apparent to an outsider, albeit a GP or other health professional. Hence the importance of listening to understand fully what needs actually exist.

Being part of a victims group constitutes service to the community; it implies a shared understanding of history, hopes and frustrations and a desire to help people get better. All seek the progression from victim to survivor to personal power. They feel empowered by engagement in useful activities such as doing training, and participating as volunteers in the wider community.

Reaction to the Interview

The Trauma Advisory Panel expressed gratitude for the time respondents contributed to the study and their willingness to share information about the health challenges they face. The reason some individuals gave for participating in this study varied: those who agreed did so in the hope this study would benefit others. Some said they would find it too painful at this time which is in itself a powerful indicator of the sensitivity of this work.

As was foreseen some respondents became emotional and the interview was halted temporarily or re-scheduled. This wasn't a probing interview: in fact some respondents perceived it as more of a therapeutic conversation.

Respondents did find themselves talking about events of 30 years ago with emotional intensity and commented on that fact. They reported that they felt safe and reported positive feelings of release and relief at the end of the interview. Feedback from respondents indicated that therapeutic conversation like this gives an opportunity to reflect on the positive side of things, like personal progress and achievements through adversity.

Many respondents expressed gratitude to the TAP and the interviewer for the experience saying they found it useful, interesting and even enjoyable. Several respondents asked if someone else they knew could participate in the study, e.g. a mother, a son, a brother, in the belief that they could benefit from a conversation of this nature.

The need for a follow-up interview with each respondent – offering some practical information and relaxation techniques - had not been anticipated. In the event four respondents did express an interest in a follow-up session with the researcher to 'finish' matters arising during the interview.

CONCLUSIONS

Healing

Some of the people interviewed appeared to be coping better than others mainly due to support from their families coupled with inner resilience. This does not necessarily mean that their pain has been healed.

It is concluded that even though traumatic events happened a long time ago people still have a need for ongoing support. The need for emotional freedom from guilt, and shame and loss overrides everything. Emotional pain lingers under the surface. The search for justice is a form of self-healing and is in itself a route towards inner peace and wellbeing.

Cumulative Stress

The impact of cumulative stress on individuals and its association with ill-health must be acknowledged. Many people had multiple experiences that were stressful during the Troubles and their needs went unrecognised. Given the chance to talk about what happened and its impact on their health they had regrets that counselling was not available at the time. They said they had family members who could still benefit from talking about their experiences of how the Troubles affected them.

Life changed irrevocably as the experience of sudden bereavement or injury through violence impacted on family life. Emerging health issues and financial hardship were totally overwhelming as was evidenced by respondent's accounts of lost opportunities for employment, career and marriage. These affected their self-esteem, confidence and ability to trust.

Coping Mechanisms

Some men interviewed demonstrated that they had unresolved emotional pain and needed help to alleviate troublesome memories. There was a sense of regret that they had an in-built reluctance to seek professional help and fewer channels of social support than women.

Even though families and communities supported each other, a respondent told how it had only recently become apparent that other family members had, separately, been wrapped in their own grief for years for fear of causing more upset. Such protectiveness is not surprising but it masks the need to share information and seek help. Very few people said they actively sought help – they were more likely to be referred and expressed gratitude for the services they received.

Self Esteem and Confidence

The words of one respondent refer to the power of reflection. "It's good to talk about my own experiences, to realise how much I've moved on. I have moved forward and am able to get through. By talking I realise how much I have achieved and gained. By doing the

counselling skills course and knowing I would now like to do a diploma is a goal for me.”

Some victim/survivors who have regained their self esteem and confidence need help with funding for training that will enable them to give back something to society and get them out of the poverty trap.

Statutory Services

The statutory services most frequently mentioned were acute hospital services, GP surgery and primary care teams, occupational therapy, physiotherapy and psychiatric services. Not all respondents could recollect in detail all the services they received over the years except in general terms, hence the lack of quantitative data here about statutory services used. They accessed services without identifying themselves as having been affected by the Troubles. This makes it difficult for services to quantify their specific needs.

Some people affected by the Troubles are invisible to the statutory services because they appear to be coping. But they are coping with problems which need to be transformed into management of health issues.

There is a need for ongoing long term follow-up and support in the community. Mainstream medical care is easy to access and respondents are generally satisfied with the service they get.

People were not aware of the increasing variety of therapies available and some fall through the net.

Those who asked the Trauma Advisory Panel for help in signposting them to services, facilities and support benefited most.

It may be concluded that competence and confidence to work with people who suffer Post Traumatic Stress Disorder is required. New and younger staff members throughout the health services need to be offered training to recognise trauma and know where to refer on for support.

Gaps in Services

While the health services met physical acute need they were not proactive in meeting chronic need. The needs are evident at physical levels but when there are deeper psychological issues that remain uncovered and untreated, personal problems persist.

The statutory health services do not routinely gather information on the provision of services for Troubles related issues. They operate in a vacuum. Counselling and pain management were not widely accessible. People were not asked what their needs were, never knew they could be helped and fell through the net.

Gaps in provision were evident. Some respondents specifically stated that medication was not the only answer. They suggested that hydrotherapy/physiotherapy, repeat visits by the occupational therapist every few years for re-assessment, and pain management would be useful.

Respondents' experience of chronic pain was still met with the medical or drugs response and they concluded, with hope, that there must be more options for treatment.

People in need reported a lack of holistic, integrated treatments to deal with physical, mental and emotional issues. They concluded that they could be empowered through accessing a range of information and services currently beyond the traditional statutory medical care package.

There are regrets that people did not get help years ago, that nobody from the statutory services approached them offering support – or visited their home to ask if they needed anything. Trauma was affecting people and before they recovered something else happened. When help was needed it wasn't offered. There is still time for statutory services to make a difference with information, services and signposting to help meet the needs now.

Silence is damaging because the people who need help do not get it – this has potentially adverse consequences for mental and emotional wellbeing. People need to be encouraged to make the step towards accessing relevant therapeutic support via a credible source such as a victim/survivor group or the Trauma Advisory Panel Information Directory which lists qualified providers of relevant therapies.

Hidden Victims

The study revealed hidden victims of the Troubles: more died than were killed. It may be concluded that more people suffered injuries, sickness and premature death directly related to loss and trauma experienced than are officially recorded.

Medication and Drug Dependency

Although not investigated in depth it may be concluded that prescribed drugs and alcohol play a part in soothing emotions, handling pain and tackling the boredom of isolation. While there was no suggestion of major drug or alcohol problems among those interviewed, people who have experienced trauma do sometimes develop these behaviours and coping mechanisms as a form of self medication. This is often a cry for help.

Role of Victim/Survivor Groups

It was suggested that some of the work victim/survivor and self-help groups do needs to be mainstreamed so as to free up statutory services to address more specialist needs. For example, it was suggested that victims groups could “listen and visit and understand because they will always take into consideration the meaning that is attached to events. Things happen that are meaningful to each person. The role of victim/survivor groups is helping people take control of emotions, feelings, thoughts, behaviours.

The respondents who were active members of victim/survivor groups also emphasised the importance of continuation; “we got an office and had a long and hard fight and struggle to get funds to help with that. I’d love to see the project finished.” “I started a cross community group in my area. It’s going well. We got things sorted out.”

From a health perspective victim/survivor groups provide their members with a cushion of safety and a wall of protection, making an important contribution at times of vulnerability. Their function is as a focal point and network for people whose mental, physical and emotional worlds have been turned upside down. The groups both connect members and protect them from perceived risk of being hurt again. These groups are in a position to successfully provide a progression route from social isolation to reconnection with the world.

Victim/survivor group staff members have the ability to maintain an overview of health issues. They can be in a position to express opinions on typical health needs through time. They could be instrumental in transforming hurt and anger into service and support and healing. Trauma resolution is a major role for victims/survivors groups whatever form it takes. Individuals who did not belong to a victim/survivor group felt that their views had not been heard; that only groups are consulted or represented.

Complementary Therapies

It appeared that services not belonging within the category of statutory or voluntary health services such as GP, hospital, community care and counselling were little understood. Health professionals were reluctant to recommend therapies if they did not know they were scientifically proven to alleviate disease or promote health.

Complementary therapies were recommended by individual GPs and some victim/survivor groups who recognise the contribution they make as an option for pain relief, emotional support, giving release from flashbacks or insomnia. Some groups provided members with the opportunity to test various complementary therapies. Subsequent employment of on-site therapists validated the very important contribution they made to members' wellbeing at all levels. Subsidy of these services made them accessible and affordable. This brought benefit to members in the short term- relaxation and long term- potential employment.

The cost of private treatments is a big concern for those on low incomes: one respondent summed it up: "if only there was some sort of assistance towards treatment and complementary therapies. They want somewhere to go, someone to talk to, to advise on life and on general mental health". It is important to differentiate between the therapeutic effects of counselling and the positive affect of relaxation and quiet time away from the pressures of daily living.

NI Memorial Fund

There are those who have been disappointed and frustrated by eligibility criteria held by some of the services they apply for, saying they have had to fight for what they need e.g. the Memorial Fund have not granted some requests even though applications are supported by medical evidence and appear to meet the criteria.

There were criticisms on the limitations of discretion regarding payments from the Memorial Fund: and respondents felt the fund should be operated with the help of people who are victims who understand health issues faced by victim/survivors.

One respondent suggested that the Northern Ireland Memorial Fund could facilitate provision of taxi transport to hospital appointments, expenses for food and a companion if journeys are long.

The Poverty Trap

It may be concluded that reduced lifestyle due to loss of income lowered expectations of returning to the workforce. Dependence on benefits created more expectation of being trapped in poverty.

The Trauma Advisory Panel

The Southern Health and Social Services Trauma Advisory Panel has made a positive impact in terms of its accessibility and fulfilment in a signposting role.

The Trauma Advisory Panel helped to access services for a number of respondents interviewed.

The role of signposting services, and providing information and resources has positively affected respondents. Identifying the need for and commissioning this report is an indicator of the level of understanding and respect for health needs which exists within the Southern Trauma Advisory Panel.

The panel has also responded to identified need by commissioning Troubles related awareness raising training for frontline health and social services staff in an effort to address some of the issues identified in this report.

Review of the Study Method

The study set out to explore the health and wellbeing needs of people affected by the Troubles using a specially designed data-gathering model.

Interviews were conducted with a cross section of people who had personally experienced trauma. Those interviewed came from a variety of backgrounds and reflected a geographic, gender and religious mix.

The health status and needs of those interviewed for this study is broadly similar to the profile of clients attending the Trauma Counselling Service (see Appendix 4). It can therefore be concluded that this study has wider applicability on a regional basis.

In the planning, piloting, revising and implementation of this study the needs of the interviewee were central. This emphasis ensured that no unnecessary questions were asked and information was collected in a sensitive, therapeutic and safe manner. The interviewer ensured personal self care through use of supervision to safeguard against vicarious traumatisation.

It may be concluded from what has been reported here that the opportunity to talk briefly and purposefully while being acknowledged for hurt experienced was of enormous value to the respondents. People with complex and varied needs appreciated the opportunity to talk about their health issues. Their commitment to the task combined with speaking to an experienced researcher with therapeutic skills made resolution of emotion possible, leaving people better off for the experience.

In the event a key conclusion was that this carefully thought out process proved to be safe and positive for respondents and ensured they were not re-traumatised. People said that these interviews were timely. A view was expressed that some people were only now beginning to be able to speak about what happened to them. The Trauma Advisory Panel rightly estimated that it was appropriate and timely to conduct this study.

RECOMMENDATIONS

- ❖ The Trauma Advisory Panel should ensure that up-to-date information on a range of services and holistic support mechanisms is available to people affected by the Troubles. This includes information on statutory and voluntary service provision, community facilities and complementary therapies.
- ❖ Respondents have identified the GP practice as the gate keeper to services. Primary care teams must have access to up-to-date information in order to provide support and assistance to those accessing their services.
- ❖ Widespread dissemination of the updated TAP directory and website and access to the Troubles related awareness raising training should be made available to GPs, practice nurses and other key support services.
- ❖ Those interviewed indicated a need for psychological and emotional support to help them deal with their hurt and loss. The Trauma Counselling Service is helping meet this need. The emotional needs of people affected by the Troubles are also met by counsellors who are community based. Information about these valuable services needs to be made more widely available to victims/survivors.
- ❖ Experiencing continuous physical pain is a major disability for sufferers and needs to be addressed as a priority.

Easy access to pain clinics and to non-medical interventions which are proven to alleviate pain is required.

- ❖ When accessing mainstream health and social services, people affected by the Troubles need to feel understood and acknowledged. Health and social services staff need ongoing training to meet the needs of victims/survivors with sensitivity and empathy. As no record is kept of the general healthcare needs of people affected by the Troubles, no specific resources are allocated to meet these needs.
- ❖ Many respondents questioned the value and impact of long term use of antidepressants. They saw prolonged use of medication as a personal failure. They request better information on the role, side effects and value of long term medication and need to be assured that they are receiving the best care available. GPs and medical practitioners should be mindful of this.
- ❖ Physical demands on carers brought about in part by heavy lifting and constantly being on duty affects their state of health. Visits by an Occupational Therapist to victim/survivors who are ageing would provide patients and carers with information, education and resources to make daily living easier and safer.
- ❖ Respondents to the study who had physical injuries identified a need for up-to-date information on practical aids and adaptations that would improve their quality of life.

Visits from Occupational Therapists to review and manage their changing needs are required.

- ❖ It was acknowledged that the health services dealt with the acute needs relating to peoples injuries but did not adequately meet the ongoing chronic, complex, needs of people with long term illness. Any plans for addressing the needs of people with disabilities needs to take on board the particular sensitivities of Troubles related injuries.
- ❖ Difficulties in accessing outpatient clinics and hospital appointments for both the patient and carer were identified. Funding to assist in provision of drivers could help alleviate this problem.
- ❖ Respondents valued the positive benefits of complementary therapies which helped them deal with physical, mental and emotional pain. The cost of recurring treatment was prohibitive to people on low incomes. Creative approaches are needed to subsidise costs either through the Memorial Fund or through the victim/survivor groups.
- ❖ The role of complementary therapies has been little explored. The anecdotal evidence gathered here could well be researched further in respect of aromatherapy, reflexology, hypnotherapy that have already been proven to work for specific ailments and are quickly becoming standardised and regulated. The NI Complementary Therapies Network comprises a valuable resource of professional therapists and research based information that could be drawn upon directly by groups and individuals alike.

- ❖ People who experience ongoing health problems described behaviours and coping mechanisms they have used, i.e. self medication, alcohol and drug use. These issues need to be addressed and alternative positive coping mechanisms encouraged.
- ❖ Social isolation can be lessened through membership of a group. Since victim/survivor groups have a pivotal role to play in monitoring health management issues they could be encouraged to become more actively engaged in provision of services on their premises and networking with professionals who can provide relevant skills to address member's health management issues.
- ❖ The valuable role of support and service provided by victim/survivor groups must be recognised. Those interviewed who were members of groups paid tribute to their work. Groups providing this support need ongoing funding to maintain their services.
- ❖ A major issue emerged in this study identifying the adverse effects of loss of income, dependence on benefits and loss of career on overall health. The difficulties experienced when claiming benefits and having frequent reviews of benefit need to be addressed.
- ❖ Some people interviewed expressed their need for truth and information about what happened to their family during the Troubles. These issues are an important part of the journey towards healing and resolution.

- ❖ Because trauma impacts on the whole person, there is a need for a holistic programme to address need. The Capacitar programme which offers mind, body, spirit practices and gives people skills to heal and transform stress should continue to be made available with sponsorship from the Trauma Advisory Panel.
- ❖ Respondents interviewed who were not members of any group reported that they had felt isolated. They acknowledged the benefit of being involved in the study and of the support derived from the Trauma Advisory Panel. Ways must be found to offer isolated and hidden victims information so that they have the choice to access support made easier.
- ❖ Despite their suffering, some respondents indicated their willingness to help and reconcile with others and contribute to building a better society. This evidence of resilience in some should be acknowledged while not forgetting the ongoing pain of others. The Trauma Advisory Panel should be in a position to direct people to a confidential, impartial, reconciliation service.
- ❖ The SHSSB Trauma Advisory Panel should bring the needs and issues identified in this report to the attention of policy makers in order to bring about positive change.
- ❖ This study demonstrates that important information can be collected in a safe therapeutic manner. This should inform future studies and ethical guidelines.

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- ❖ Men and women appear to respond to, and cope with traumatic exposure in different ways. This should be the subject of future research in order to develop appropriate service responses.
 - ❖ Specific attention should be focussed on the emotional needs of men who do not access professional support services. An innovative approach to providing support should be initiated.

AFTERWORD

Much work still needs to be done to bring specific health resources to victims and survivors of the Troubles. With a careful approach and with safety considerations in place, progress could be made in conducting needs assessments in order to keep policy makers informed of their ongoing health needs. Hence they could make informed decisions for management of health issues and address need effectively. Of particular relevance are people who are in chronic pain, who experience unresolved emotions and who are suffering from Troubles-related incapacity exaggerated by ageing.

This report raises the question as to how the statutory, voluntary and private health services can connect with isolated people affected by the Troubles who need help with managing their health issues. The victim/survivor groups could be assisted in creating a bridge between members who need to build trust with mainstream society and the necessary health services at all levels.

More exploration of the efficacy of complementary therapies in the SHSSB victim/survivor sector is needed if anecdotal evidence of their apparently beneficial impact elsewhere in the Province is to be consolidated in hard facts.

The Trauma Advisory Panel has a central role to play in disseminating information, coordination of service delivery and influencing policy developments in the interest of victims/survivors.

It is hoped that the lessons learned from this study are sufficient to inform readers as to the health issues people affected by the Troubles experience from day to day. In the hands of trained people the model designed for this study would appear to be helpful in gathering useful information. It is hoped that more people might accept an invitation to participate in a similar study of this nature in the future.

While these interviews were taking place, elsewhere, the reverberations of loss and grief were being felt:

(In this) “crumbling world, hold on to faith.
Things make no sense but life has to go on,
with no explanation and no apologies.
When rain falls let it flow and when
the storm passes you are not alone.
We honour memory by sharing with those around us.
We ask others to honour us, that they not forget
to seek truth and justice for those who were lost.”

**Air Canada crash 20 year memorial ceremony,
6 July 2005**

“People think I should have healed by now.”
**Girl on TV documentary about Omagh,
Summer 2005**

APPENDIX 1

METHODOLOGY

Pre-planning and Preparation

A steering group was set up comprising four members of the Trauma Advisory Panel and the Co-ordinator. Exploratory discussions between Panel Coordinator and the researcher, who was also a professional therapist, resulted in agreement to follow the Trauma Advisory Panel guidelines on working within an ethical framework. It was agreed that quality data could be collected, while preserving the integrity and privacy of a wide range of respondents without re-traumatising them.

The next step was to decide upon the scope of the study. People affected by the Troubles would be asked what health issues they face on a day-to-day basis. Physical, mental and emotional aspects would be explored. The respondents would be asked about the effects of trauma and/or cumulative stress on themselves and their families during the Troubles. They would be asked what health services they use or have used with a view to finding out if there are gaps in provision of statutory, voluntary or private services such as complementary therapies. The role of victim/survivor groups would be a focal point, as also the family and other support in the community. Lastly respondents would be asked about their hopes in terms of health and wellbeing.

It was agreed that a small number of in-depth, semi-structured interviews would provide insight into the daily lives of people injured/suffering on account of the Troubles. The approach to this audit of need was developed within sound ethical principles according to guidelines already utilised by the Trauma Advisory Panel. Confidentiality, safety and avoiding negative impact and re-traumatisation were paramount.

Thorough preparation was required since this type of study had not been done before. A questionnaire was drawn up to be used at every interview. These semi-structured interviews would enable the researcher to take note of broadly comparable data while giving respondents plenty of freedom to relate their (very different) stories.

Then the questionnaire was piloted by three victim/survivors who were members of the Trauma Advisory Panel steering group for this study. Modifications to the questionnaire were so slight that the data collected was usable and is included in the study.

The researcher then conducted a semi-structured interview with the counsellor for the Trauma Counselling Service with a view to gaining more general background information on the needs of victims/survivors in the area. (See Appendix 4).

Criteria for Selection of the Researcher

As foreseen by the Trauma Advisory Panel Coordinator and Steering Group, there were many advantages in having an experienced professional therapist conduct the study in the belief that to be heard truly and deeply would allow respondents to feel acknowledged as well as safe. It was useful at certain times e.g. to pace and lead respondents away from details that were too upsetting for them.

The task of the interviewer was to listen without judgement to as much detail as the respondent wished to share in confidence. It was also foreseen that interviews might need to be structured to include therapeutic input and this did occur twice, briefly, before successfully concluding the sessions.

Selection of Respondents

The Trauma Advisory Panel was fully aware that this study could be neither scientific nor random given its nature. It was agreed that what would be sacrificed in terms of quantitative statistical analysis could be more than compensated for by the quality insights gained.

Respondents were identified with the help of staff members of victim/survivor groups and a community group. The Trauma Advisory Panel also identified a number of individuals to whom they offered support. Finding respondents who would represent the population served by the SHSSB was a challenge.

For the validity of the study, those interviewed needed to represent a wide range of personal histories, political and religious backgrounds, type of injuries, and geographical spread. It was agreed that the TAP coordinator would be best placed to make contact personally with representatives of victim/survivor groups and other community support groups, and with a number of individuals known to TAP staff who do not belong to any group. While the cooperation of these intermediaries was crucial to the selection process, the Trauma Advisory Panel maintained emphasis on factors that would make the interview experience a positive one for the respondents. The chances of accessing the hidden victim/survivors was increased by interviewing individuals who were not members of groups.

The victim/survivor group representatives requested a number of their members to participate in the study. The selection of proposed respondents was based on specific criteria to ensure wide representation, postal code, gender, age, context in which the person (or their relative) was injured, and type of injury sustained. Potential respondents were told that the interview would last approximately an hour and a half. The respondents were assured of privacy and confidentiality; they could have someone with them at the interview. Keeping in mind that not all respondents were undergoing counselling or therapy at the time of the interview, they were invited to request a follow-up visit by the researcher, should the need arise. This was solely with the purpose of addressing any issues that came up during the interview. In the event, three such requests were made.

Respondents were encouraged to say whether they wanted the interview to take place in their home, at the group offices or another venue of their choice. Of paramount importance was taking care of their needs.

As names of people committed to participate in the study were put forward, the Trauma Advisory Panel Coordinator together with the researcher monitored representation of its general target group based on the criteria established earlier. Selection of respondents was made in such a way as to achieve representation of as wide a variety of people resident throughout the geographical area covered by the Southern Health and Social Services Board as possible. Unfortunately, it was not possible to find potential respondents in every postal code area nor to collect data regarding all kinds of loss and injury. Many victim/survivors have no contact with TAP directly nor do they belong to a support group. These are the invisible victims who, it is hoped may find their experiences represented in the stories contained here.

With these safeguards in place all respondents entered into the interview experience without reservation and expressed satisfaction with the outcome.

Respondents were individually known to TAP, or were drawn from a number of victim/survivor groups including HURT, MAST, RAFT, SAOL, SAVER/NAVER, WAVE, The Sub-Committee for Victims/ Survivors on behalf of South Tyrone Area Partnership.

Their cooperation and support was essential to the success of this study and the interviewer and the Trauma Advisory Panel are indebted to them for their cooperation. It is hoped that these groups can use this report as a reflection of the overall health needs of their members.

APPENDIX 2

THE SEMI-STRUCTURED INTERVIEW MODEL

Factual information was gathered so as to ensure a variety of personal histories and representation of a wide spread of respondents. Everyone was asked to give their postal code, gender, age group, marital status, children living within 20 miles of the respondent, religious affiliation, occupation, benefits, (and whether they were on benefit), or if they or a member of their family had ever received assistance from the Memorial Fund.

The researcher then guided respondents through speaking about their experiences from a health perspective. This enabled them to restrict their input specifically a) to what details they wished to share and b) to consider traumatic events or experience of cumulative stress in respect of its consequences on their health. This gave each person the opportunity to experience the interview as a reflective process. It also acknowledged to those who did not suffer physical injuries the difficulties of living with cumulative stress which might not have been validated or treated by the health services.

Respondents were asked about the effects of health challenges on their quality of life, both historically and also at the time of interview. Finally, they were asked to express hopes for their future health.

They spoke about injuries sustained during the Troubles. They assessed what impact the Troubles had on their family. This accentuated two things, firstly in what way one's own injuries had an impact on the immediate family circle, and secondly that it was important to acknowledge the pain of death or injury of a sibling/spouse/child during the Troubles. It became apparent that this was of particular relevance to respondents who lived with unresolved grief that this be recorded.

As the interview progressed it became possible to build a picture of health issues that people affected by the Troubles live with and have to manage. Talking about their experiences, whether it was one, two or almost three decades since they were impacted by traumatic events made no difference. Everyone was emotional. Everyone was in pain. The interview was a way of measuring personal and family progress health-wise and what this meant for each person.

It was possible to reflect how health issues have changed over time. Any person living with pain, whether chronic physical pain or emotional and mental strain gets to know in great detail – and so do their carers – about the ongoing daily pressures of managing health. It is hoped that something of this detail will serve to educate those who read this document by bringing to them, in the words of those who suffer day in and day out, a sense of what life is really like for them. It is hoped that it will also be an indicator of the role GPs and other health professionals play in helping people manage their health issues.

Respondents were encouraged to relate their personal experience of services they had used/or were using, i.e. statutory services, voluntary or private. This indicated the extent to which respondents were in need of ongoing care and management of physical injuries and mental / emotional stress. It also referred to what support groups were being availed of: since victims groups exist to support people affected by the Troubles, it seemed useful to ask what people's experiences were as regards support they received for health issues. Reference was made to any and all social or community groups that addressed health needs. The facts obtained would point to gaps that existed in statutory, voluntary or private sectors.

Respondents were asked about perceived needs in the future for management of their personal health since it is they themselves who know their needs and how these are likely to change over time. This was with a view to assessing the extent to which those needs could be met by mainstream health services.

Another purpose in asking this question was to find out whether respondents were engaged in thinking ahead. It was estimated that the data would point to what type of residual work remains to be done on unresolved trauma, grief, anger and loss which might lead to recommendations regarding ways to fill gaps in services.

Each interview ended with an invitation to respondents to give their comments, requests, and feedback to TAP a) on issues that were not covered during the interview

and b) to mention what they felt about the experience as a whole. This gave the researcher an opportunity to make a final assessment as to the emotional state of each respondent on completion of the interview. This was to ensure that the respondent was left at least as well, if not better off, than when the interview began.

It is important to repeat that the questionnaire was a tool for the researcher: it helped keep the conversation within the scope of the study. The highest priority was to attend to the comfort and wellbeing of respondents, not to answer questions per se. While the number of questions formulated was high (see Appendix 3), it was not expected that all respondents would answer all of them.

Some interviews took a bit longer than others, and the generous time allowance meant no-one was under pressure to finish. The average length of interview was 1 hour and 40 minutes. It was necessary to terminate one interview halfway through due to respondent fatigue; a second visit was scheduled for one week later and the interview was successfully concluded.

In the event, all respondents related their personal story in a new way. They said what their health issues were. They assessed how they were supported by statutory, voluntary and private services, and expressed their desires for future health and wellbeing.

APPENDIX 3

SEMI - STRUCTURED INTERVIEW QUESTIONNAIRE

- Q1 Respondent number
- Q2 Date
- Q3 Location
- Q4 Postal code
- Q5 Gender
- Q6 Age group
- Q7 Marital status
- Q8 Children if any, gender/age living within 20 miles
- Q9 Religious affiliation
- Q10a Occupation
- Q10b If employed, state how
- Q11 Are you on benefit? If so, which?
- Q12 Are you registered?
- Q13 Have you ever received a bursary/award?
If yes, specify
- Q14 Was/is a member of your family ever in receipt
of bursary/award?
- Q15 What has happened to you?
Describe as briefly as possible
- Q16 Origin of injury/ies
- Q17 Type of injury/ies
- Q18 How did life change?
- Q19 How did the events of the Troubles affect your
immediate family?
- Q19a Social contact
- Q19b Economically
- Q19c Educationally

THIS PART IS ABOUT YOUR HEALTH. IT GIVES YOU THE OPPORTUNITY TO THINK ABOUT YOUR TOTAL HEALTH SITUATION AND NEEDS.

- Q20 How would you describe your state of health at this time?
- Q20a Physically, Q20b Mentally, Q20c Emotionally, Q20d Spiritually
- Q21. How are your physical, mental, emotional, spiritual needs being met?
- Q22. What health needs do you have that arise out of being affected by the Troubles: i.e. that you wouldn't otherwise have called upon had you your relative(s) not been injured, or suffered loss in the way that you did?
- Q 23 What services have met your needs adequately?
- Hospital Acute/Emergency
 - G.P
 - Outpatient Clinics
 - Social Worker
 - CPN
 - Psychiatrist
 - Physiotherapist
 - Health Visitor
 - Counsellor
- Q23a Complementary Therapy/ies
- specify which ones and for how long
- Q24 Which support Groups have helped you/or hindered you?
- Q25 When did connection with the group/s start?
If finished, when did it end?
- Q26 Were efforts to access services successful/satisfactory in outcome?

-
- Q27 Were the services offered to you by the various agencies/family/friends- Accessible, Affordable, Appropriate, Professional, of sufficient duration?
- Q28 Would you perceive the experience of arranging for the services to be provided a positive or negative one for you?
- Q29 What do you think your needs will be in the future: Physical, Mental, Emotional, Spiritual
- Q30 Additional comments/requests/feedback to TAP as regards your health needs, and how you experienced this interview.

APPENDIX 4

TRAUMA COUNSELLING SERVICE

One of the outcomes of this work was to demonstrate that the people who participated in the study were representative of all those affected by the Troubles. Established in 2000 to address the psychological needs of people affected by the Troubles, it is part of the SHSSB response to meet the ongoing needs of victims and survivors. The Trauma Counselling Service which covers the Newry and Mourne area is the front line organisation for serving the needs of people affected by the Troubles. It is of interest to note that the health status of those using the service is similar to that of those covered by this study.

More men than women come to see the counsellor. Clients range in age from 18 – 63 years. Most are 46 – 50 years old. More than half the clients are married.

Equal numbers of clients are unemployed, work full-time, work part-time and a few are homeworkers, students or retired. Nearly half of a client's weekly income is derived from benefits, while a small number get carers allowance. Some have applied over the years to the Memorial Fund for financial help, with varied success.

Referrals are made by Psychiatrists, GPs, family members, the voluntary organisations and other health services and quite a few people refer themselves. How long ago the events happened about which a person decides to come for counselling varies.

The majority make their first visit to the counsellor between one and five years after the event. However, some people wait until 21-25 years later.

The day to day focus and aim of the service is to provide a safe therapeutic environment to those affected by the Troubles. Those who attend may have suffered shock or trauma 20-25 years ago related to an incident they witnessed or experienced directly. For example, people are presenting now who may have had a family member murdered and it is only when family life is not so busy that they can reflect on and feel the pain of their loss. Ex-prisoners may present with a delayed psychological reaction to their imprisonment. Those in high risk occupations, who may have retired on medical (psychological and physical) grounds begin to acknowledge the sheer enormity of the daily risk they lived through.

The type of events that lead to traumatic reaction and cumulative stress about which clients seek counselling include assault on the person, intimidation or death threats, a serious incident (bombing/shooting), witnessing of an event or events, imprisonment and sudden bereavement. 66% present with more than one of these experiences.

Witnesses to these events who got on with their lives at the time find at a later stage, for example when they have had children, that something impinges on their emotional responses and they realise that they are still carrying the strain.

Life changes most often referred to are loss of employment, loss of educational opportunities and relationship and marriage breakdown.

In terms of how clients and their families coped during the Troubles, it is often reported that no-one helped. Success in working through stress was less likely if the family didn't talk, or they went back to work too soon. It was not unusual at the time for the police/army/customs to give their staff a week off following a traumatic event. That policy has now been changed.

Being affected by the Troubles has brought about a change in career for many people, in particular a drop in income. This brings them into the poverty trap where they depend on benefits, incapacity benefit or Disability Living Allowance and that would seem unfortunately to prevent them from getting back to work. Some clients have reported leaving their place of learning e.g. university, and never going back because they felt they had to return home to support their family. This adds to the shortage of income.

With regards to physical health, those attending the service present with a wide range and often complex list of physical problems. Some clients have been deafened as a result of the Troubles, others suffer from chronic pain disorders such as neuropathy, fibromyalgia and arthritic conditions. Others report that they went on to develop alcohol, illegal drugs/or prescriptive drug addictions as a direct result of a troubles-related incident in their lives.

Many of those physically injured continue to experience ongoing pain as a result of their injuries even up to 20+ years later.

Some clients want to tell their story – even if it is only a once-off event. Others say they are afraid to express feelings of injustice, their feelings of anger whether towards individuals or the system. Many say they are irritable and aroused by the present political situation. Some still experience anxiety in the form of nightmares and intrusive images. The range of emotions varies from helpless to hopeless; people feel that they are stuck with an identity as a victim/survivor of things that happened 10-25 years ago, and fear that it will never leave them.

Some clients are supported by attending victim/survivor groups and/or going to church. They have complaints about the benefit system, the number of appeals, benefits being stopped and having to fill in forms. Clients access AA groups, victim/survivor groups and attend adult education courses.

The type of services offered by statutory health services are counselling and community mental health services. A welfare rights office in the area provides an invaluable service. The Counselling service feedback questionnaires are positive and people continue to attend and recommend the service which has been positively evaluated by external research.

Clients can be seen at the office or at Daisy Hill Hospital. They can also ask to be seen at a victim/survivors group office.

Hopes for the future are mainly that the service remains funded and can be expanded according to need.

The interview with the Trauma Counsellor from Newry and Mourne Health and Social Services Trust demonstrated that the respondents to this Health study have a similar demographic profile to those attending the Trauma Counselling Service. Many issues relating to exposure to traumatic experience, coexisting physical conditions and problems with benefits are common to both.

APPENDIX 5

A SYNOPSIS OF THE DATA ON RESPONDENTS

Ten Protestant and nine Catholic people participated in the interviews. Although they were not asked if they were active church-goers as this was not considered relevant to health issues per se, several respondents referred to their faith as having kept them going through painful times over the years.

Each respondent was asked where and when would suit them to be interviewed. Seven respondents were seen at their home, six at the office of a victims group, and five at the TAP office in Newry. One person was interviewed at another mutually agreed venue. Five respondents lived in BT63, four in BT60, 3 in BT34, two in BT61/BT71 and one each in BT35, BT64 and BT70. This was their postal code at the time of interview, and not the place where they were interviewed or experienced events during the Troubles.

Gender balance was approximately equal. More victims were male while those left bereaved and are now carers were female. 12 respondents were married, two widowed, three separated and two single.

Respondents were asked what close family was living at home or lived within 20 miles. The total number of children living within 20 miles of these 19 respondents was 60. 13 respondents had either two, three or four children living with them or within 20 miles. Of these a number were teenagers or younger. Respondents

spontaneously talked about grandchildren. Although it wasn't intended as such to assess the number of grandchildren the total referred to was 38 with four respondents enjoying great-grandchildren. Those who had children nearby were in touch by phone or visit regularly.

Seven respondents were homemakers and five retired (includes early compulsory retirement). Respondents who described themselves as being in retirement include some who were forced to leave their work due to illness or injury caused by Troubles related events. One person who was 'unemployed' felt hopeful of returning to work again at some time in the future.

Only four respondents were in paid employment. Not all of these worked full-time. For people affected by the Troubles capacity to earn a living is severely restricted, due to emotional and psychological as well as physical factors which will be referred to below. It is not unusual for people who have suffered injury or trauma to experience a strong urge to move towards giving something back to their community. They want to 'be there' for others and in so doing acknowledge what others have gone through.

The data shows that a total of 13 separate sources of financial support were being accessed by the respondents at the time of interview. Strictly speaking not all these were benefits, but included work related or retirement pensions. Some respondents were in receipt of up to three separate benefits linked to their health status.

Eight, that is nearly half the respondents, were receiving incapacity benefit. Five were in receipt of retirement pension and four were on Income Support. Three were on DLA, two each on a work-related pension or industrial injuries benefit. Family Tax Credit, Widows Benefit, War Pension, Service Pension, Sickness Benefit and Child Benefit were benefits accessed.

It was considered to be too intrusive to ask about people's financial status in any detail. The data was intended only to give a broad indication as to what extent people affected by the Troubles are forced to survive on low income and whether they can or cannot take on paid employment. According to one person "holding down a full-time job was too stressful."

Generally speaking, those on benefit are managing day-to-day expenses by careful budgeting and, as is common in such circumstances, any unusual outlay for new equipment such as a fridge or a washing machine or transport is difficult to come by. Memorial Fund helps with one-off payments and Victims Groups subsidise therapeutic treatments and trainings.

One registered carer of a victim/survivor was interviewed with a view to finding out the indirect impact of the Troubles on carer's health needs.

Just over half those interviewed had ever requested and received a payment from the NI Memorial Fund. Eight respondents received one or more payments over the space of a few years while the remainder had never been in receipt of any assistance.

Information was not requested as regards exact amounts. Assistance was needed for practical things e.g. furniture, washing machines and tumble dryers, holidays and respite breaks. One respondent who was housebound got help towards acquiring a pet for companionship. While there is no doubt that people on low income benefited from acquiring household equipment and aids they could otherwise not have afforded, it was the holiday and respite that were described as “excellent; a nice break” and were remembered as having made a difference. No questions were asked about compensation.

Five respondents replied that their mother, brother, sister or children received assistance for the purchase of capital items such as furniture, uniforms and help towards the cost of driving lessons, which they otherwise could never have afforded. Disappointment in being turned down was a factor that people live with as when a relative “didn’t qualify because s/he wasn’t perceived as a victim”.

APPENDIX 6

RESPONDENT CAMEOS IN THEIR OWN WORDS

Respondents gave their whole-hearted consent to participate in this study and spoke about their experiences at considerable length. They did so in return for a guarantee of privacy. To protect their identity and afford them confidentiality certain details have been left out.



Dad was killed in a bar when I was seven. At the time, my brother was six and my sister two days old. Dad was coming from work and decided to go for a drink with his friends: he never got that drink.



Both my job and that of my husband were extremely stressful. There were threats to my own and his life. I believe he died prematurely, from a heart attack. I don't think my employer even realised how much stress I was under given all that I witnessed. I lived on my adrenalin.



I cared for my father and mother, then my spouse had an accident and my sister was shot. They were in hospital at the same time, when my youngest was seven years old. The parents are gone, the children are gone. It's just the three of us now. I would do anything for my sister: she has never fully recovered.



I worked in the Civil Service when a colleague was shot; the trauma of it plus caring for my mother brought on stress that only got worse. The GP said take two weeks off. The pressure built up and things came to a head a few years ago; I found myself shaking all over. I never went back to work and retired shortly after.



My son was in the UDR reserve for a few years then joined the RUC. He was killed in a bomb – we heard it first on the radio. He left a young family.



I was always fairly healthy until I took a bout of depression in the late 1970s. After a bit of medication I went back to work but left work with depression. Went back to work for ten years and it hit me again. Soon as I felt well I went back to work. I battled for two-three years, let it go too long and now I'm not even in a position to think of getting work again.



I was in the Security Services going out for lunch one day when I was injured in an ambush. I lost everything but my life. I'm dependent, immobile and isolated.



My older brother and my dad were interned when I was three and eight respectively. My husband was imprisoned. The police and army never left our house looking for my brother sometimes at 4.00am. I witnessed my brother being shot at by the army and my

mother being dragged out by the police. The house was trashed and destroyed. That kind of thing went on for six years.



My brother was a policeman – killed in a bomb. For the way he came home the coffin was closed I couldn't accept it. I was a young parent and I had to get on with it. The usual family gatherings were affected over the years as there was always one of us missing.



Me and my spouse were finishing supper – a gunman outside fired through the living room window. Bullets went through me and shrapnel stuck in my body. The children were witnesses. It was a case of mistaken identity. I was unconscious for months and they thought I'd have to go into a home. I proved the doctors wrong and learned to walk again.



I felt the impact of fourteen UDR people being killed in the seventies; it left a mark of mistrust in an area where there had been nothing happening. I came upon the Shankill bombing in 1974 on my way from a football match and was terribly affected by what I saw. I've also suffered from my work. I've seen people whose needs are not being dealt with when spouses have been killed.



My father was interned at the beginning of it. I was about 13. We didn't know for five/six days where he was. We were a big family and some of us needed constant

care. And my mother had to bring us up on her own. I left school at 15 to bring a wage into the house. Two brothers left the country due to harassment. Dad came back a year and a half later. We carried on with our lives and then he was shot dead on the way to the dole. The Security Forces admitted responsibility. Then, eight years later, my brother was shot dead too.



My brother, a policeman, was quite young when he was killed in a bomb. He wasn't meant to be in the car that day. He was a great family man. He left young children behind. We were very close.



I was having a drink in a bar when a bomb went off, killing the young boy beside me. All I saw was a flash of lighting; I got injured. I often think I was the last one who talked to him.



Masked men running a checkpoint stopped me suddenly one dark morning at 7.30am when I was a student: I panicked about it later. I got a job, and where I worked they left bombs, and there were break-ins too. At the height of the Troubles the phone was going three/four times a night: some of the calls were hoaxes. Once the Army called me to say there was a massive bomb; I was to go and open the building. Then they diffused it. The stress built up and it affected us all.



My family moved here from Belfast when I was six. It wasn't easy and my father took us to England but we came back some years later. Then he disappeared (was interned) and was gone for a year and a half. People fired stones at us, we had bricks through the window, abuse on our way to school, and there were threats. My brother was picked up and interned for a year, then jailed for ten. He died three years later, before he turned forty. He nearly died as a child; my mother always worried about him. Still now his children are very affected by the trauma of it.



My husband was shot dead. We lived in a lonely rural place. I felt the hail of bullets but nothing touched me. I was left with a son who was a year old and my daughter three and a half. They were in bed. Yes, I think she and he were affected psychologically. She changed and it affected her learning. They were raised with only one parent who sometimes couldn't cope.



You could say I got to this state of health in the line of duty. My job was extremely stressful. Not only that, there was a threat on my life. They shot at me on my way home from work once. For a time I needed close protection. I had to leave my home one day and never returned to that house. Away from the family I missed them terribly; it still hurts that I couldn't be with them and they couldn't support me.



My brother was killed going into a pub; he just happened to be there. I was severely traumatised; we all were. I never felt safe because it was a time of random killings in our area. It took a long time for me to get over it, but without counselling or support at the time there is unresolved grief. I have some trust in people now.

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On her return to Northern Ireland in 1993 she established the ALANNA Consultancy and works by invitation within the victim/survivor sector to heal the past. ALANNA is a registered training provider with the Northern Ireland Open College Network creating a forum to meet the personal development needs of victim/survivors of the Troubles. She runs a successful private practice, “Time4ChangeTherapies”.

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