



Towards A Better Future: The Trans-generational Impact of the Troubles on Mental Health

Prepared for the **Commission for Victims and Survivors**
by Ulster University

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Foreword

'It should never happen again'. These words express the strongly held view of the Victims and Survivors Forum that current and future generations do not experience the tremendous hurt and loss they and their families have had to endure. Northern Ireland is a much safer and more peaceful place to live since the signing of the Belfast/Good Friday Agreement. However, we know from working closely with victims and survivors and wider society, conflict-legacy issues continue to threaten life opportunities and undermine the peaceful transition from our troubled past.

The Commission has a statutory duty to keep under review the adequacy and effectiveness of services provided for victims and survivors. As part of our strategic objective to empower and support victims and survivors to make a contribution to a better future the Commission has undertaken previous research examining the Troubles trans-generational impact on mental health. This work has informed the Commission's advice relating to the provision of appropriate services which can support the trans-generational needs of individuals and families affected by the legacy of the Troubles.

The genesis of this Towards a Better Future Research Project is located within previous research conducted by the Commission and close work with the Victims and Survivors Forum. The Comprehensive Needs Assessment (CNA) sought to develop our understanding of the trans-generational impact of exposure to conflict-related trauma. It highlighted how the effects of the Troubles on parents and in particular on their mental health, represented a potential serious risk to the wellbeing of younger generations. Meanwhile, Forum members' consideration of the conflict's trans-generational legacy recognised the imperative of examining the role of early years education in supporting parents and addressing sectarianism.

The Towards a Better Future Report continues the examination of the Troubles trans-generational legacy through understanding the impact of conflict-legacy issues on children and young people. It responds to the recommendations contained in the Young People's Trans-generational Issues in Northern Ireland Report produced by Queens University Belfast on behalf of the Commission in 2012. That Report concluded that 'trans-generational trauma is a real phenomenon affecting young people in Northern Ireland' and that there is a need to more rigorously examine the impact of psychological trauma transmission and other factors, including social deprivation and parenting styles likely to explain a trans-generational impact.

Ulster University were therefore commissioned in 2013 to further explore within this study the trans-generational impact across four key areas. These were parental mental health, the relationship between the Troubles' Legacy and suicide, the development of children in their early years and a review of existing service provision addressing the trans-generational impact on mental health and wellbeing.

The Report reveals that while the vast majority of the population who directly experienced decades of violence suffered no or minimal, long term mental ill-health, a significant number of individuals have gone on to develop serious mental health and substance disorders. Young people, in particular young men paid an especially heavy price throughout the

Troubles in terms of lost lives and high levels of exposure to traumatic events. In post-Agreement Northern Ireland young men living particularly in working class areas continue to remain a group exposed to conflict-legacy issues including interface violence and involvement in and threats from ongoing paramilitary activity. Further, children of victims and survivors, ex-combatants and serving and ex-security force personnel are especially vulnerable due to their exposure to the negative consequences of the Troubles.

Building on previous research, this Report further investigates how parents psychologically affected by the Troubles continue to affect the lives of children and young people today. It reveals that the transmission of poor mental health and prejudices within families in combination with economic deprivation is detrimental to the development of children in their early years. Furthermore, the Report also found that exposure to accumulated 'toxic stress' caused by continual experience of parental substance abuse and harsh parental practices can compromise a child's capacity to regulate their own emotions and behaviours which can increase the risk of poor general health in adulthood.

The Report highlights that the Troubles are linked to individuals dying by suicide in a number of ways. Exposure to traumatic conflict-related activity leading to the development of often chronic and enduring mental health disorders, coupled with drug and alcohol misuse and feelings of social isolation heighten the potential for suicide. Investigating the link between the lasting impact of the Troubles and suicide in Northern Ireland is itself complex and challenging. The report argues that new ways of targeting victims and survivors with conflict-related mental health conditions through screening for suicidal ideation and the systematic collection of data can assist understanding of prevalence and inform future service planning.

The Commission welcomes the series of wide-ranging recommendations contained within this Report. In recognising the complex and multidimensional nature of trauma transmission and wider societal conflict-legacy issues the Report recommends the adoption of a two-generation strategic approach. Such a coherent, integrated approach coordinating a range of interventions supporting investment in parents to promote the well being of children and young people, ensuring timely access to trauma aware mental health services while working together to address sectarianism, segregation and paramilitarism requires further examination.

The Commission acknowledges the ongoing commitment of practitioners based within the statutory and non-statutory sectors who work to address the Troubles' trans-generational impact on the health and wellbeing of victims and survivors. Services funded by the Victims and Survivors Service and through the Health and Social Care Trusts provide an invaluable source of support to individuals and families continuing to deal with the mental health legacy of our troubled past.

This Report highlights the ongoing and future challenges for our statutory and non-statutory service providers in an increasingly constrained economic climate. It equally asserts the need for moral and political leadership to ensure services are adequately resourced to effectively address high levels of unmet need. Commitments contained in the recently agreed Stormont House Agreement relating to the establishment of a comprehensive Mental Trauma Service and access to high quality services demonstrate the required leadership from our politicians in prioritizing the mental health needs of victims and survivors. The main findings

and recommendations emerging from this study reaffirm the imperative to deliver on these important commitments.

The Commission would like to commend the research team from Ulster University and the Initiative for Conflict-Related Trauma for their hard work and commitment in completing this significant research report over the past fifteen months. We would also like to express our thanks to all the service managers, clinicians and organizations that participated in the survey and engaged with the research team throughout the study. The Commission will make full use of the Report's comprehensive analysis and recommendations in shaping our approach and advice to help build a better future for victims and survivors and wider society in Northern Ireland.

Commission for Victims and Survivors Northern Ireland

March 2015

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EXECUTIVE SUMMARY & RECOMMENDATIONS

Executive Summary

Project Background

The aim of this research project was to contribute to the understanding of the impact of the Troubles on Northern Ireland society today. The Commission for Victims and Survivors appointed Ulster University to examine the nature and extent of the mental health impact of the Northern Ireland conflict's legacy on the lives of children and young people. The project aimed to examine the trans-generational impact of the Troubles in terms of mental health, suicide and the effects on early years' development. It also sought to identify the current services provided to meet the needs of those affected and to make recommendations for future service provision in this area.

In responding to this aim, the multidisciplinary team, led by Professor Siobhan O'Neill, designed a multi-faceted research methodology to address the project's objectives. This comprised a series of literature reviews, assessments of current services and population level analyses.

Report Summary

The findings from the research project established that the social, political and economic legacy of the conflict was complex, wide ranging and multidimensional. However, despite this, most people in Northern Ireland, including those who have directly witnessed the years of violence, suffered no, or minimal, long term mental health disorders. In fact, many of those exposed to traumatic experiences responded with notable levels of resilience and, with time, processed their experiences and went on to live fulfilling, meaningful lives. This research revealed that the group of people with few adverse mental health difficulties or adversities represents around 71.5% of the population. However, the mental health difficulties of at least half of the remaining 28.5% appear to be directly related to the Troubles. Based on an adult population figure of **1.5 million**, this equates to around **213,000 adults**. These figures are based on robust, internationally comparable data, adopting the same criteria for mental disorders as used by psychiatrists and point to the Troubles as a significant and distinctive stressor in the life of the community in Northern Ireland, over many years to circa 1968 to the present).

As noted, traumatic experiences and exposure to violence can lead to adverse mental health and other consequences not only for the person themselves, but also for their children and potentially, their grandchildren, resulting in a trans-generational cycle which impacts upon the well-being of subsequent generations. Specifically, the effects of violence, traumatic experiences and social segregation impact upon parenting practices which affect early attachment and the capacity of the child to self-regulate. Self-regulation difficulties increase the person's risk of mental disorders, behavioural problems and suicide. They also affect how that person engages with their own children when they become a parent. The accumulation of childhood toxic stress, resulting from negative parenting behaviours, exposure to violence and the use of harsh punishment, is associated with adverse mental

health outcomes. Social deprivation and poverty serve to exacerbate the mental health impact of the consequences of the conflict.

Opportunities for each of us to develop, amongst other things, effective and meaningful attachments, are very important matters for societies concerned with promoting the development of children and maximising their potential as adults. Failure to do so by the age of four years has been shown time and again to increase risks in adult life across a range of indicators such as development, educational attainment, average income, health (physical and mental) and adverse engagement with the criminal justice system. These studies suggest that investments in child development (which includes services for children, parents and other carers), for adolescents and young adults are for any society, an obvious priority.

Self-regulation difficulties which may arise as a result of poor attachments and toxic stress, increase the person's risk of mental disorders, behavioural problems and suicide. They also affect how that person engages with their own children when they become a parent. The accumulation of childhood toxic stress, resulting from negative parenting behaviours, exposure to violence and the use of harsh punishment, is associated with adverse mental health outcomes. Social deprivation and poverty serve to exacerbate the mental health impact of adverse events in the life of a family, including the consequences of the conflict.

Many of the services currently offered by the statutory and non-statutory sectors to address the mental health needs of those affected by the Troubles, match the recommended interventions for people with mild to moderate mental disorders. Statutory services (and some non-statutory services) also provide a range of treatments for people with moderate to severe mental health problems and functional impairment. There is significant concern however, about the level of unmet need and the potential for the trans-generational transmission of the impact of the conflict's legacy that results from this unmet need. The Northern Ireland Study of Health and Stress found that approximately 40% of those people with a mental disorder received treatment. Therefore, potentially 60% of the population (up to 127,800 adults) with mental health problems directly related to the Troubles have not received treatment.

Trans-generational transmission of trauma – A cyclical model

The literature review and research described in this report expose the risk factors and points in the life of the child-adult when the impact of trans-generational consequences of violence can take hold. This also reveals at what points appropriate interventions can be made. Figure 1 below demonstrates a model of the cyclical nature of the transmission of traumatic events and loss across generations. These impacts can include epigenetic risks (where the parents of the child transmit stress triggered and stress adapting genes to their children), developmental impairment, relationship and attachment problems, increased risk of mental health problems and the carrying forward of all or some of these problems in adulthood and then into parenthood. Several writers also comment upon the risks of these cycles contributing to new episodes of organised violence when for example there is a critical mass of people within the community who have unresolved loss and trauma related psychological difficulties.

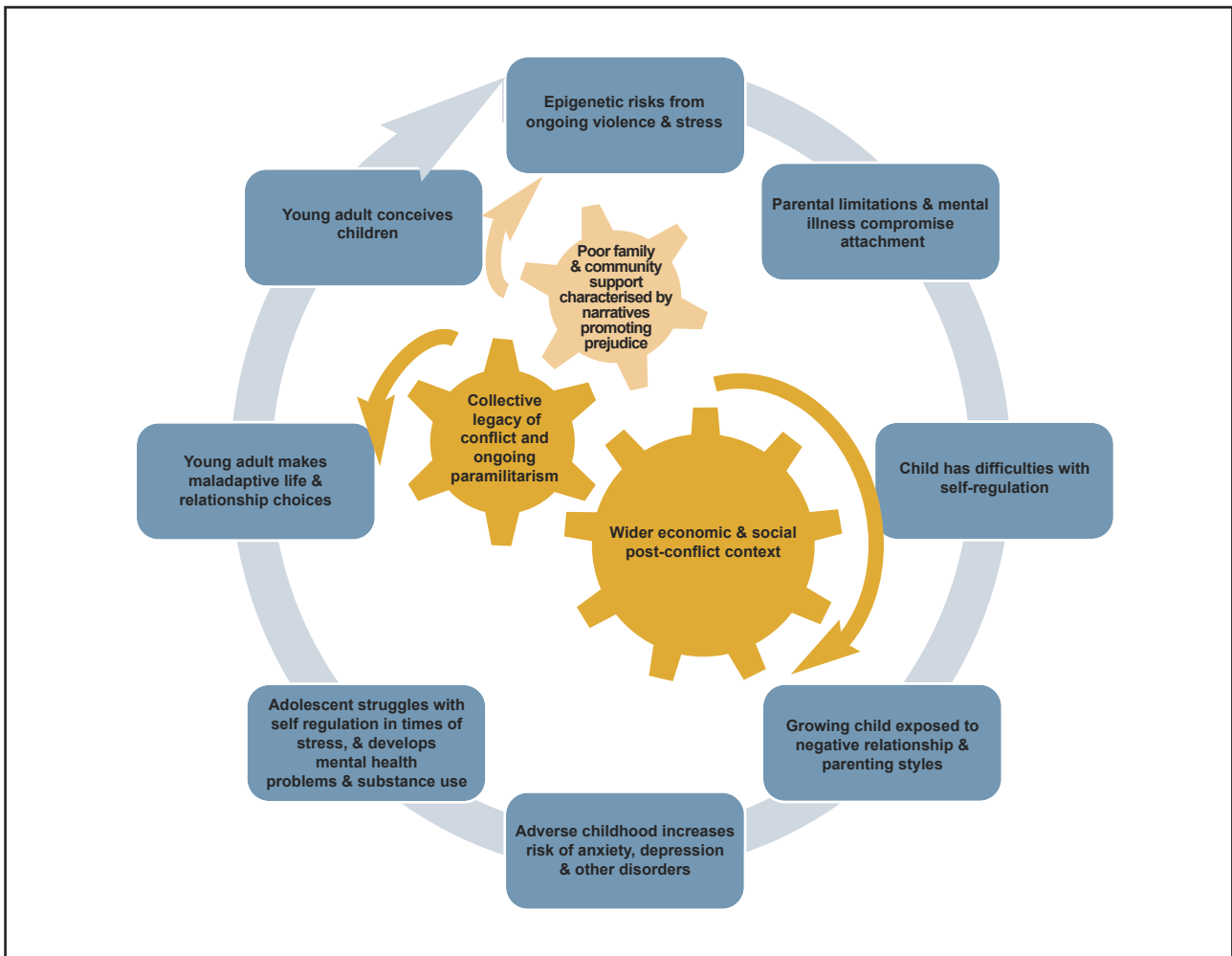


Figure 1: A developmental overview of the pathways through which the impact of the Northern Ireland Troubles are transmitted to subsequent generations

Area 1: The impact of the Troubles on mental health in Northern Ireland

The report commences with two reviews of the literature. Reviewing research from 2004-2014, the first part examines the effects of the years of violence linked to the Troubles on mental disorders among those under the age of 18 and the impact on the well-being of young people, generally. We then look at the effects of the legacy of the conflict on the early years' development of children. In doing this we provide an empirically based framework for understanding the mechanisms underlying the transmission of both poor psychological functioning and prejudice within families.

The research confirms that the majority of people who experience traumatic events (including sudden loss) and violence are not adversely affected in the long term. Many people, because of and in spite of terrible experiences, re-evaluate and re-organise their lives, priorities and relationships in very positive directions. However, a sub group develop problems, including those that manifest themselves as enduring and serious mental disorders which impact upon their functioning and in turn, that of their families and communities.

Many of those who have been adversely affected by traumatic events in Northern Ireland use alcohol and other drugs, leading to high rates of comorbid mental and substance use disorders. A disproportionate number of people who were exposed to the violence also

experience economic deprivation. This additional source of stress exacerbates the impact of traumatic events on mental and general health. The political and social divisions in Northern Ireland impact upon social integration and attitudes towards minority and segregated populations. This is demonstrated by high levels of sectarianism and an increasing prevalence of racism, homophobia and “hate crime”.

In an effort to profile the conflict-related mental health needs of the population, the research team analysed data from a series of studies undertaken as part of the World Health Organisation’s World Mental Health Survey Initiative, this work is presented in Chapter three. The first analysis revealed distinct profiles of adversity in Northern Ireland. The group of people who experienced economic adversities and a second group who had multiple additional adversities in childhood had increased risks of a range of mental disorders and suicidality in adulthood. Four distinct latent groups were identified in the data from the Northern Ireland study, based on the population’s experiences of the trans-generational impact of the conflict’s legacy (1) childhood adversities, (2) conflict-related traumatic experiences (3) mental disorders and (4) low risk group. The majority of people (71.5%) were in the low risk group; 9.6% had high levels of conflict-related traumatic experiences and mental disorders; a further 4.3% had high levels of childhood adversities and also multiple conflict-related traumatic events and mental disorders. The remaining 14.6% were a group of people who had mental disorders but few childhood or conflict-related traumas. This builds on evidence from international comparison studies, showing that the rates of economic adversity in Northern Ireland are significantly higher than in other countries.

At a societal level the research provided evidence that identified the following key findings:

- The majority of people who experienced traumatic events and violence are not adversely affected in the long term;
- However a group of people have developed problems including mental disorders which have impacted on their functioning at family and community levels. The most recent figures estimate that this group represents around 14% of the adult population;
- Alcohol and other drugs are commonly used among those adversely affected by the Troubles;
- Economic deprivation constitutes an additional stressor which in turn impacts negatively on mental and general health; and
- The political and social divisions in Northern Ireland impact upon social integration and are associated with sectarianism and increasingly racism, homophobia and “hate crime”.

Area 2: The impact of the conflict’s legacy on early years’ development

The research demonstrates that the human capacities to build compassionate and adaptive relationships with ourselves, with other people and with members of other ethnic groups are dynamically connected. The foundations for compassion, empathy and conflict resolution are determined during the earliest years of a child’s life. It is the nature of early caregiver-infant interactions that shapes the infant’s ability to feel compassion, to understand that others hold different opinions and beliefs to themselves and to transform or neutralise negative emotions such as anger or jealousy. These capacities are known collectively as self regulation. Self regulation is therefore synonymous with mental health. Research suggests that self regulation is the key mediator between genetic predisposition (inherited genetic

vulnerability to mental illness) and adult mental health outcomes. This is because they constitute the foundation of our humanity, the invisible thread that holds human relationships in place and human relationships are vital for mental wellbeing. Synchronous caregiver-infant interactions, such as reciprocal communication and mirroring of emotions, create a nurturing environment which promotes the development of compassion for the self and for others. This environment teaches the child how to identify their own and others emotions and how to express their needs which lays the foundation for later mental and social functioning.

Traumatic experiences, such as exposure to violence, in combination with economic deprivation, undermine parent and caregiver capacities for facilitating synchronous, interactions with their children. Parents affected by the conflict may exhibit emotionally hostile, indifferent or cold engagement with the child. This affects the child's capacity to self-regulate which increases the child's risks for developing behavioural and emotional problems. Trauma related psychopathology in parents is now recognised as being uniquely associated with aggressive parenting behaviours. The findings from Chapter five highlight that co-occurring exposures to interpersonal violence and parental psychopathology characterised the childhood phenomenology of the 'at risk' subgroups in Northern Ireland.

These traumatic events in the life of the developing child represent a new trauma, which plays itself out in the life of that child's own children. Direct exposures to violence during early childhood can have a devastating impact on the child's development and such exposures have been found to be associated with both the transmission of poor psychological functioning and poor general health. It is also associated with the transmission of prejudice.

The transmission of narratives derived from memories of conflict and violence can also impact adversely on identity in the social sphere and convey or amplify perceptions of threat, fear and exclusion. The children of those affected by the years of violence in Northern Ireland are at increased risk of experiencing co-occurring early childhood adversities which may result in the accumulation of toxic stress. The stress response triggers a series of biological adaptations that change brain, neuroendocrine and immune system functioning. Children who experience toxic stress are, therefore, at increased risk of adverse general health outcomes in adulthood. These include cardiovascular disorders, cancers, asthma and autoimmune diseases as well as mental disorders.

In Chapter four the data from the World Mental Health Survey Initiative was examined to establish the latent typologies of Childhood Toxic Stress in the Northern Ireland population. This analysis revealed three specific sub groups. The majority of the population were in the low risk group (91.3%). The other 8.7% experienced childhood toxic stress and aggressive parenting, and they were over four and a half times more likely to have conflict experience than the low risk class. The 4.4% in the "Harsh physical punishment" category were five times more likely to suffer from any mental disorder and three and a half times more likely to have suicidal thoughts. The 4.3% in the "childhood maltreatment" group were ten times more likely to have a mental disorder and four and a half times more likely to have suicidal thoughts.

The findings highlight the need to treat trauma related psychopathology in parents and to concurrently build their capacities so they can become co-regulators for their infants. This will reduce difficult behaviours and social skill deficits in their children and this should also

reduce the need for harsh behaviour management approaches. Parents also need to be supported to construct age and stage appropriate narratives for explaining their trauma related experiences to their children. Finally there is a need to embed evidence based social and emotional learning programmes within the Early Years' and School curricula.

The key findings to emerge from this area of the study are as follows:

- The interactions which happen in the first three years of any child's life are vital to their development and long term mental well being. Trauma related psychopathology in parents limits their ability to act as co-regulators for their children. This increases the likelihood of the child developing behavioural problems that in turn increases the risks of harsh or violent parenting practices;
- Traumatic experiences, such as direct exposure to harsh discipline and violence can have a devastating impact on the child's development;
- There is a sub group of the Northern Ireland population who have been affected by years of violence in Northern Ireland, whose children may be at increased risk of experiencing toxic stress;
- Children who experience toxic stress are at increased risk of developing poor health; and
- The effects of the years of violence had a specific impact upon particular groups of children. Children of victims and survivors, ex-paramilitaries and police officers have been impacted directly as a result of their parents' experiences.

Area 3: Associations between the legacy of the conflict and suicidal behaviour

Chapter five examines the rates of suicide in Northern Ireland and examines the associations between the Troubles and suicide. There has been a significant rise in the number of suicides in post-Agreement (1998) Northern Ireland. For example, in 2013, 303 suicides (and undetermined deaths) were registered in Northern Ireland compared to 144 a decade earlier (RGNI Report 2013: 26). Evidence from the Northern Ireland Study of Health and Stress, the database of deaths by suicide in Northern Ireland and other sources, is used to examine the associations between suicidal behaviour and the conflict. The Report illustrates how the Troubles may be connected to deaths by suicide through a number of pathways. The main findings from this part of the study are as follows:

- Individuals who die by suicide frequently experienced multiple, complex patterns of adverse traumatic events, endured social isolation and mental and/or substance disorders;
- The Troubles' legacy is associated with suicide on a number of levels and the intergenerational impact of the Troubles on the elevated suicide rates in Northern Ireland is, in itself complex and multidimensional;
- Major life experiences prior to suicide including relationship breakdowns, unemployment, financial difficulties and health diagnoses, may all be indirectly linked to conflict experiences;
- Conflict-related mental ill-health and substance disorders increase the risk of suicidal thoughts and behaviour;
- Heightened exposure to violence, death and pain (directly or indirectly) may contribute to an enhanced capability for suicide;
- Alcohol and drug misuse is evident within the toxicology profiles of individuals who have died by suicide. In many cases these substances will have been used as a means of coping with conflict-related psychological distress;

- Heightened levels of suicidal behaviour may be due to a sense of disconnectedness to community life and living with conflict-related mental disorders; and
- Suicide attempts followed by suicidal plans and ideation are the most notable predictors of death by suicide. Individuals who reported exposure to conflict-related events have an increased risk of suicidal ideation and plans.

Area 4: Service provision to address the needs of those affected by the trans-generational impact of the conflict's legacy

Chapters six and seven include an examination of practice. Chapter six presents the findings from a literature review examining the treatment of trans-generational trauma in terms of services. In Chapter seven the results of a Survey of service providers and others with an interest in the trans-generational impact of the Troubles is discussed. This provides an overview of services provided by statutory Health and Social Care Trusts and reference to key findings on the work of non-statutory providers working with victims and survivors.

This work was undertaken by researchers from the Initiative for Conflict-Related Trauma. The findings from the Survey of organisations and others concerned with the trans-generational consequences of the Troubles were examined in the context of the epidemiological data on exposure to the violence linked to the Troubles, what is known about deprivation and associated social and economic determinants of wellbeing and ill-health and the literature on effective service provision.

Findings from the earlier study of services, (Bolton and Devine, 2014) funded by the Victims and Survivors Service and carried out in 2013-14, drew attention to the distinctive role of non-statutory sector organisations and identified, amongst other things, how liaison within the sector and across and between it and statutory services could assist in improving access to a wider range of services at points relevant to the needs of individuals.

The main findings from the literature review in Chapter six are as follows:

- Given the duration and scale of the exposure to violence throughout the Troubles the long-term trans-generational impacts of the conflict are an important and understudied public health and societal concern;
- There is a need for both linear i.e. individual psychotherapy and related interventions that address the psychological distress and mental ill-health of individuals and family therapy approaches that address the wider relationship issues that impact on families;
- The International Society for Traumatic Stress Studies (ISTSS) guidelines for international training in mental health and psychosocial interventions for trauma-exposed populations in both clinical and community settings provide a common set of practice values and standards for all services working in this field in Northern Ireland; and
- The literature review of resilience concluded that building and maintaining resilience at individual and community level is an important but complex area of work and needs much more attention in the context of post- conflict Northern Ireland. As an example, the review noted the recently published Belfast Strategic Partnership Emotional Resilience Strategy, which recognises the psychological and wider trans-generational impact of the Troubles on the city.

Respondents and others consulted for the Survey drew attention to the need for a greater focus on the enduring and trans-generational impacts of the Troubles by public services. Likewise, senior managers and practitioners in the Health and Social Care Trusts who were consulted with regard to mental health and related services believe it would help very much if statutory services moved to be more explicit about the impact of the Troubles on individual and their families and communities - in their assessments of individuals' needs, in the design and delivery of services.

The main findings from the survey of service providers in Chapter seven are as follows:

- Out of the 41 survey respondents, 11 stated they currently provide services designed for trans-generational practice and development of resilience for young people. 10 were from the non-statutory sector; four providers also responded with examples of practice and programmes; and
- The needs reported by Survey respondents relate to 5 distinctive areas as follows, in descending order;
 - o Health and Wellbeing;
 - o Families, Parenting and Relationships;
 - o Poor Life Opportunities and Outcomes;
 - o 'Dealing with the Past', and
 - o Needs not included in the areas above.
- Findings revealed strong endorsement of the trans-generational impact of the Troubles on those who directly experienced violence linked to the Troubles, on their families, and more generally, on families in the wider community;
- Only one (out of eight) statutory respondents indicated they provided services specifically designed or funded to address trans-generational needs arising from the conflict;
- Whilst services to address identified trans-generational needs are provided in all of the 26 Council areas, the development and distribution of services is piecemeal. They have been developed largely through the initiative of individual providers who have secured the support of funders to address a need they have identified and/or to put in place a service, which they considered to be relevant to the needs of individuals, families and communities; and
- A small number of service providers funded by the Victims and Survivors Service provide youth-based services explicitly focussed on trans-generational needs, including the Ely Centre and the WAVE Trauma Centre.

Engagement with senior managers and practitioners in the statutory HSC Trusts (throughout the survey) highlighted the following:

- The trans-generational impacts of the Troubles are significant in comparison to other trends in mental health and other societal pressures;
- Their consequences on subsequent generations are a distinctive and significant factor associated with mental illness, substance dependency and other problems for young people and their families;

- The trans-generational impact of the conflict features as a significant theme in the mental ill-health patterns of need in the community and mainstream statutory services currently address needs relating to the secondary consequences of the years of violence;
- There are currently three identifiable services operating across the HSC Trusts in NI whose primary focus is the psychological and related impacts of the conflict. These are the Family Trauma Centre and the Trauma Resource Centre based in the Belfast HSC Trust and the Trauma Counselling Service operating across the Southern HSC Trust; and
- Each HSC Trust also provides a Child and Adolescent Mental Health Service (CAHMS) providing specialist care to children and young people with moderate to severe mental health difficulties.

The evidence from these studies and consultations indicate the impact of past and on-going organised violence on individuals, families and communities. Overall, the conclusions highlight the necessity of wider social, economic and environmental interventions that address those difficulties and risks that are linked to the trans-generational consequences of traumatic events. Also, working with individuals and families suggests the need for both linear, i.e. individual, treatments (such as trauma-focused cognitive behavioural therapy for adults and children affected by trauma related conditions, like PTSD) and systemic or family therapeutic approaches that address unhelpful dynamics in the relationships and context of family life.

Given the duration and scale of the exposure to violence linked to the Troubles and the evidence of trans-generational consequences, the long-term implications of the years of violence are an important but understudied public health concern. The findings from these Chapters support the need to identify those families at risk and those in which transmission is already at play and, adopting a strategic two-generation approach, provide evidence based interventions to address individual needs, restore cohesion and promote connectedness and resilience.

Key recommendations

The findings from this Report demonstrate that the consequences of the Troubles impact daily upon the lives of many people, their children and their children's children. The consequences of the legacy of the conflict on the mental health and wellbeing of the population need to be addressed. Yet mental health problems cannot be adequately addressed in isolation from other concerns. We have set out the recommendations from the research findings under three subheadings: policy and principles, services and further research.

Policy and Principles

1. Adoption of a strategic two generation approach

The findings of this research and the proposed model of trans-generational transmission, supports the adoption of a coherent strategy, which focuses such interventions on the wider task of rebuilding a post-conflict community. This strategy should have the adoption of a two-generation approach as its core principle (where the focus is not only on the needs of specific generations but also the relationships between them) and should aim to identify and address the trans-generational impacts of the years of violence on individuals, families and communities and the means by which problems are transmitted to future generations. This requires moral and political leadership and cross departmental and cross sector commitment. The required shift of focus and progress in this area will be reinforced by the use of public service aims and targets, which reflect the distinctive circumstances of Northern Ireland.

There is also a need to develop capability, across policy making, commissioning and service delivery, in understanding the trauma-related and consequential trans-generational impacts of the Troubles and in delivering relevant and effective interventions and practices. This includes addressing on-going violence and fear, which unaddressed, contribute directly to new experiences of loss and trauma and act against efforts to improve the mental health of individuals and communities.

2. Investment in parents and the promotion of positive parenting

Parental resources have a greater impact on child outcomes than preschool education. The research supports the need to improve the education, employability and income of vulnerable parents. In keeping with the two-generation approach and in view of the connection between physically abusive parenting styles, parental psychopathology, economic deprivation and conflict exposure, it is important that efforts are made to address the use of harsh parenting behaviours. Evidence based interventions should be used to address inappropriate parenting practices. This includes teaching parents alternative ways to set boundaries for their children to build their self regulatory capacities and consideration of parallel legislation to promote behavioural change.

3. Build on current best practice

It is imperative that we make optimal use of the current services and expertise, whilst at the same time moving to develop a capacity to address the public mental health consequences of the conflict more comprehensively. Progress can be made by ensuring that front-line services are 'trauma aware' in their engagements with service users, in particular in their assessments or needs and the early management of care and related services. Similarly, specialist services should become increasingly competent in delivering research supported trauma-focussed interventions for individuals and families. Both the statutory and voluntary sectors have much to offer, although considerable financial challenges are facing funding uncertainty and cutbacks.

4. Examine the mental health implications of policy decisions

Those at highest risk of having mental health difficulties and suicidal behaviour related to the conflict also endure multiple stressors, particularly economic deprivation. This exacerbates their risk of negative outcomes and consequently affects the health and well-being of their children and future generations. The association between economic adversity and psychopathology should be taken into account when deliberating social and economic policies in Northern Ireland. We recommend that policy decisions are reviewed to examine their impact on the sub-populations identified in this studies; the unemployed, with often poor levels of educational attainment, who live in areas of deprivation and who have been exposed to violence. If welfare reforms lead to a reduction in income for those with mental disorders it could exacerbate their problems, increase the likelihood of adverse outcomes and suicidal behaviour, hence contributing to the trans-generational transmission of the effects of the conflict. In addition, it is recognised that policies in relation to alcohol, drugs and other legislation will impact upon the mental well-being on those affected by the conflict so these merit particular scrutiny.

In summary we propose the following policy recommendations:

- Policy makers should adopt a strategic, two-generation approach to interventions addressing the conflict's trans-generational legacy on mental health and well being. There needs to be investment in parents in order to promote the well being of children and young people; and
- Governmental policies should be examined to determine their relevance to addressing mental health priorities and amending where necessary.

Services

5. Services: scoping, coordination and integration

Commissioners of services need to develop a framework for the delivery of services to address the trans-generational transmission of the effects of political violence. Partnership working and collaboration among all stakeholders needs be at the heart of the coordinated 'two generation' approach which provides individualised treatments and the full resources of government departments, public agenda and as well as civic society to resolve enduring conflict-legacy issues including segregation, sectarianism and paramilitarism. We recommend cooperation at both a strategic inter and intra-departmental level and also operation level (e.g. Secondary Care CAMHS Services across the Trusts) and between primary and secondary care providers.

To assist with this it is necessary to find out what capability is available within organisations working across different sectors, in order to better coordinate services and enable them to be more informed about trans-generational trauma related issues. There is potential to enhance levels of cooperation between service providers and the sharing of good practice between Victims and Survivors Service funded providers themselves and also with Health and Social Care Trusts.

It is recommended that this integrated approach emphasises the key role of the family in addressing the conflict's adverse trans-generational consequences. This involves working with whole families to promote healing, whilst also providing services and treatments to address individual needs. The systemic approach may also be relevant in working with groups and communities with trans-generational mental health needs. Research has shown a desire to work collaboratively by practitioners of both linear and family approaches, and that there are important benefits in doing so.

6. Meeting the mental health needs of individuals and families

Particular attention should be given to recognising, understanding and treating the psychological effects of exposure to violence across the generations. There is a need for both linear individual treatments (such as trauma-focused cognitive behavioural therapy for those affected by trauma related conditions) and systemic or family therapeutic approaches that address the family and Trans-Generational context of mental health. Wider actions are needed to address the social, economic and environmental determinants of mental disorders.

7. A focus on the impact of the conflict

The high rates of trauma exposure in Northern Ireland support the need for service providers to be “trauma aware” in their assessments of need and delivery of services. Where there is evidence to suggest certain groups could be at elevated risk, then there is a case for the introduction of efforts aimed at case finding, supporting earlier interventions, encouraging help seeking and facilitating case management. Relevant specialist services should become increasingly trauma-focussed in their intervention goals and practices.

8. Childcare and parenting interventions

The provision of high quality affordable childcare is central to any attempt to improve outcomes for ‘at risk’ children because it facilitates parental employment and provides early intervention. Vulnerable parents should also be supported in their parenting practice. Parenting programmes should draw from evidence based approaches to promote attachment and alternatives to physical punishment. Specific interventions could use coaching to improve memory, focus, attention, impulse control, organization and problem-solving. The interventions should be selected based on the available evidence. For example, mind body interventions may support quality parent child interactions and SEL (social and emotional learning) programmes teach social and emotional skills, which in turn facilitate executive functioning and self regulatory capacities. Some programmes based on commitment and rewards, the principles of behavioural economics, have shown promise in helping promote positive parenting.

9. Training

Early years' care and education has a key role in promoting the well-being of children and halting the trans-generational transmission of the effects of the conflict. These services should therefore be delivered by qualified practitioners who undertake Continuous Professional Development informed by the most up-to-date research. The defining feature of a competent early childcare and education system is the support it offers practitioners to develop their capacities. This support enables practitioners to realise their potential to develop practices that respond to the needs of children in complex societal contexts.

Children who have been repeatedly exposed to stress without having adequate nurturance from an adult carer (toxic stress) may exhibit behavioural problems. They are also at risk from physical health problems due to the repeated activation of the 'fight-or-flight' response. Early years practitioners who work with children in the high risk sub populations would therefore benefit from training in how to address the specific needs of these groups. Specifically we recommend training in the interpretation of behavioural signals and guidance on providing nurturance; and a predictable interpersonal environment.

In summary we propose the following Service recommendations:

- Services should be delivered within a “trauma aware” environment that has multidisciplinary and multi-agency working with trained staff at its core;
- Current services should be further developed to deliver evidence-based interventions for individuals with trauma related and other mental disorders, and to support screening in high-risk populations and groups;
- Evidence based parenting supporting programmes should be widely accessible with specific interventions for vulnerable and at risk families;
- Broader policies promoting education, employability and economic stability for high risk parents should be supported;
- Suicide prevention initiatives should take cognisance of the intergenerational impact of the Troubles on the mental health of individuals, families and communities exposed to conflict-related activity; and
- Providers of psychological therapies delivering services to Troubles impacted groups and communities should routinely screen for suicidal behaviour among their clients, not only to inform management and interventions, but also to enhance understanding of the prevalence and to assist future service planning.

Further research

10. Evaluation and the provision of an evidence base

Policies, programmes and services with the aim of addressing any of the issues linked to the mental health and well-being legacy of the conflict should be subject to ongoing evaluation. In particular, we need to examine the role that interventions play in the early stages of the childhood life cycle in supporting meaningful attachments, positive development, learning, life skills and the acquisition of self regulatory capabilities.

There is a dearth of quantitative research to help us establish the scale and breadth of the mental health impact of the Troubles across the generations. Whilst the evidence from the studies from Northern Ireland resonates with other sources of evidence, there is a clear case for further population based research that would aid our collective understanding, particularly of the health and developmental needs of children and young people and specifically to help quantify the need and prioritise the deployment of resources.

11. Understanding pathways of transmission

The evidence indicates that economic adversity still impacts profoundly on children in Northern Ireland. Further research which examines the long term impact of deprivation and the impact of economic policies on mental health outcomes would also be beneficial.

Research has highlighted that parents have a major influence in relation to the transmission of prejudice within families. Further research is required in order to understand the dynamics of prejudice transmission within families and how this may be addressed. Research on adults has reliably demonstrated that group attitudes can be learned in very specific ways. However, there is less evidence around the processes and mechanisms for learning prejudice during childhood and adolescence. It is therefore important to understand the effects of the interaction between child-rearing techniques and parenting style, genetic predisposition and physiological factors and exposure to social and structural conditions on children's intergroup attitudes.

There is a need to examine further the role that attachment to community and sectarian identities play in the transmission of trans-generational trauma. It is therefore important to study the effects of political and policy decisions on dealing with the past and how this impacts upon families across the generations. The role of segregated education in the transmission of prejudice should be examined and the effects of alternative education systems on the transmission of trans-generational trauma should be the subject of investigation.

Effective and appropriate communication between family members about the nature and impact of exposure to conflict-related violence is critical in terms of trans-generational transmission. Research into ways of supporting families in communicating about the Troubles to future generations is required. In particular we need to examine ways of communicating about conflict-related bereavement, mental illness and physical injury.

12. Using currently available data to inform future service

Consideration should be given to the kind of information that is required in order to better understand and represent events in the past and to identify gaps in our current knowledge. We need to collect and use statistical information and historical records, in a systematic manner in order to better inform government policy and to enhance the level of debate. Furthermore, the synthesised information and research reports should be publicly available.

The suicide database and self-harm register provides a unique and important opportunity to examine the impact of conflict on suicide and suicidal behaviour in a population emerging from a period of violence. The database of deaths from suicide should therefore be retained and kept up to date. There is however, a need for revised data collection procedures to

ensure that the circumstances surrounding each death are recorded appropriately in order to examine patterns and trends. This should include the routine systematic collection and analysis of data on conflict exposure and deprivation as well as the data required for the completion of psychological autopsy and international comparisons.

In summary we propose the following further research recommendations:

- Further research on treatments for mental disorders and service evaluations are central to inform the evidence base and ensure the effective use of resources;
- Further research should also be undertaken into the trans-generational effects of social policies, the pathways of trauma transmission and the impact of policies aimed to halt trans-generational transmission;
- As policies and services develop to address the traumatic and trans-generational impact of the years of violence, health and social care and other governmental targets should promote and reflect the shift in focus in commissioning and service delivery towards the aims of addressing the long term trans-generational risks to individuals, families and communities;
- Policy decisions should be reviewed to examine the impact on those affected by the trans-generational impact of the Troubles in the areas of unemployment, education, welfare and public health;
- There should be cooperation between service providers at both a strategic inter and intra-departmental level and also operation level (e.g. Secondary Care CAMHS Services across the Trusts) and between primary and secondary care providers; and
- Research into ways of supporting families in communicating about the Troubles to future generations is required. In particular we need to examine ways of communicating about conflict-related bereavement, mental illness and physical injury.

Glossary

Adversities: Negative events or situations which impact upon the person's risk of mental health problems. In this report we mainly refer to adversities in the context of the person's childhood.

Attachment: A psychological model describing the interactions and bonds between a young child and its primary caregiver. Attachment is believed to be an important determinant of the child's successful social and emotional development, and for their later risk of developing mental health problems. Positive attachment patterns teach the individual how to effectively regulate their feelings so that they can effectively manage stressful situations later in life.

Association: this is a statistical term used to draw attention to the presence of one variable (e.g. problem, feature) occurring alongside one or more other variables, but without there necessarily being a cause or effect link between the two.

CAMH Services or CAMHS: The term given to Child and Adolescent Mental Health Service offered by statutory Health and Social Care Trusts.

Chronic pain: usually refers to physical pain that is long term, persistent or recurring and which impacts on the daily life of the sufferer.

Cognitive Therapy: A range of therapeutic practices that try to produce change by directly influencing how we think about our problems and the impact they have on our lives.

Cognitive Behavioural Therapy (CBT): A range of techniques and therapies that try to produce change by directly influencing thinking, behaviour, or both.

Complementary therapies: a range of therapeutic and supportive therapies that people sometimes use alongside conventional medical treatments to help them feel better or cope better with physical, emotional or mental difficulties. They are broadly offered on the basis that the body or mind can heal, or can be helped to heal, themselves.

Conflict-related traumatic events: An individual was deemed to have experienced a conflict-related traumatic event if they reported experiencing any one of the following traumatic event types from 1968 onwards: participated in combat; served as peacekeeper or relief worker in a place of war or terror; was an unarmed civilian in a place of war; lived in a place of ongoing terror; was a refugee; was kidnapped or held captive; was in a man-made disaster; beaten by someone other than parents or partner; mugged or threatened with a weapon; witnessed someone being killed or seriously injured; purposely caused injury or death; saw atrocities.

Co-morbidity: The presence of more than one form of severe psychological distress in an individual at the same time.

Depression: A mood disorder characterised by the existence of one or more depressive episodes, in which the person experiences low mood or loss of interest, accompanied by such symptoms as low energy, changes in appetite, poor concentration, feelings of guilt or worthlessness, and suicidal ideation.

DHSSPS(NI): One of Northern Ireland's governmental departments – The Department of Health, Social Service and Public Safety.

Dose-response relationship: an association in which a change in risk of a particular outcome is affected by a change in the amount and intensity of exposure (e.g. to a drug or a stressor).

Epidemiology: Epidemiology is the study of the level/prevalence of a disorder within a population.

Epigenetics: The study of cellular and molecular changes that are passed from one generation to another and which whilst common and naturally occurring can also be influenced by external and lifestyle factors.

Evidence based: a programme, technique or therapy that has been found, following research studies, to produce change.

Eye Movement Desensitisation and Reprocessing (EMDR): A psychological treatment aimed to help clients overcome distress associated with traumatic experiences, in which clients are invited to focus on an external stimulus, such as a moving object in front of their eyes, while attending to emotionally disturbing material.

Latent Class Analysis: A statistical technique which identifies hidden sub populations (classes, or groups) which share particular characteristics.

Lifetime disorders: Lifetime disorders refer to disorders that were present at any point in an individual's life.

Logistic regression: Logistic regression analysis is a statistical method used to examine the statistical association of a range of characteristics with a given dichotomous outcome (an outcome with two possible options), such as having a conflict-related trauma or not.

Music Therapy: Music Therapy is an arts based psychological intervention which uses expressive elements of music as the primary means of interaction between therapist and client. Music therapy is an effective alternative to more standard forms of counselling and psychotherapy for clients who find it difficult to connect with, express or differentiate between their emotions.

Narrative: A story or a report of events using written or spoken words.

Odds ratio: An odds ratio is produced in the output of logistic regression analysis and indicates the risk of an outcome occurring compared to a base category. For example if we examined gender in relation to having a disorder and females had an odds ratio of 2, this would indicate that females were twice as likely to have a disorder as males (all else being equal).

Post traumatic stress: is the term often used to describe the stressful feelings, thoughts and behaviours a person might have following an traumatic experience but which do not meet the criteria for post traumatic stress disorder (see below).

Post-Traumatic Stress Disorder (PTSD): An anxiety disorder that follows from the experiencing of a traumatic or highly stressful event characterised by intrusive and distressing memories of the event, jumpiness, numbness, and attempts to avoid anything associated with memories of the event.

Qualitative research: Research, in which experiences, perceptions and observations, are interpreted and the characteristics (qualities) of the particular experience or event are identified.

Quantitative research: Research in which the phenomenon under investigation is measured and counted. Statistical analyses are used to determine patterns of cause and effect.

Prejudice: A pre-formed negative judgment, or opinion about an individual or group based on their personal characteristics, such as age, social class, religious denomination or sexual orientation.

Prevalence: The prevalence of a disorder indicates the percentage of the population who have or have had the disorder in a given period of time. For example, the lifetime prevalence of depression is the percentage of the population who have had depression at some point in their life.

Psychodynamic therapy: A family of psychological therapies which aim to help clients develop a greater awareness and understanding of the unconscious forces determining their thoughts, feelings and behaviours.

Psycho-education: A range of education strategies used to inform people about their problems and how to overcome them.

Psychopathology: Emotional or behavioural responses which are maladaptive or indicative of mental illness.

Resilience: The ability to recover quickly from illness, change, or misfortune and the capacity to adapt successfully in the face of threats or disaster.

Self Regulation: The ability to manage powerful emotions and adjust one's emotional state when faced with stressors to restore emotional stability functioning and promote appropriate social behaviour.

Societal Social Cognitive Motivational Theory: This theory suggests that components of the social environment such as parents, school environments and the media, influence the formation of intergroup attitudes and behaviours.

Statistically significant: in statistics, a result is called **statistically significant** if it is unlikely to have occurred by chance. The significance level (p-value) is the amount of evidence required to accept that an event is unlikely to have arisen by chance.

Systemic Family Therapy: A set of therapeutic practices to help people with psychological difficulties by helping the family rather than any one specific individual to mobilise the strengths of their relationships so as to make disturbing symptoms unnecessary or less problematic.

Toxic Stress: The strong and unrelieved activation of the body's stress management system (as a result of repeated exposure to stressful experiences in the absence of protective adult support).

Trans-generational Trauma: Shown impact of trauma experienced by one family member on another family member of a younger generation, regardless of whether the younger family member was directly exposed to the traumatic event.

Trauma Aware or Trauma Informed: adoption of practices, where practitioners, volunteers etc. focus on understanding or assessing a person's needs with reference to a loss or trauma the person might have had so as to better support them or refer them for other services.

Trauma focussed: where practitioners or volunteers have developed a level of specialist knowledge that enables them to offer interventions aimed at addressing the traumatic features of a person's problems, with a view to aiding their recovery or adjustment.

Trauma-focused Cognitive Behavioural Therapy (TF-CBT): Trauma-focused Cognitive Behavioural Therapy (TF-CBT) is a components-based model of psychotherapy that understands the traumatised person's experience and needs through a model of how trauma impacts on us and addresses the unique needs of individuals with PTSD symptoms, depression, behaviour problems, and other difficulties related to traumatic life experiences.

The Troubles: This term has been widely used to refer to the most recent (and a previous) period of violence in Northern Ireland and the border areas of the Republic of Ireland.

Two-generation approach: A principle, or underlying framework whereby the focus is not only on the needs of specific generations, but also the relationships between them.

Chapter One

THE IMPACT OF THE CONFLICT'S LEGACY ON CHILDREN IN NORTHERN IRELAND: A REVIEW OF THE RESEARCH

Margaret McLafferty

Introduction

Numerous studies have been conducted examining the mental health impact of the conflict's legacy on the Northern Ireland population. Early research suggested that the Troubles had little effect (Cairns & Wilson, 1984), however subsequent studies found evidence to the contrary, with those who grew up during the conflict in Northern Ireland displaying an array of mental health problems later in life (O'Reilly & Stevenson, 2003; Bunting et al., 2013). Muldoon and Trew (2000) suggest that the children's experience of the conflict was considerable and discuss the history of the debate relating to children's welfare and resilience during the earlier years of the Troubles. The variability of the impact was noted given that the experiences of children across the social and economic spectrum are also variable, and on whether children internalise their experiences or externalise them. Furthermore, Muldoon et al. (2000) reported that attachment and identification with national, religious, and political groups may be formed or framed by historic experiences that subsequently influence the life outcomes for individuals. In 2004, a number of key reports and studies were published examining the impact of the political conflict on children (Gallagher, 2004; Muldoon, 2004; Smyth et al., 2004). The current literature review builds on these reports and examines subsequent research, (2004-2014), focusing on those under the age of 18, in terms of the social, political and economic legacy of the Troubles.

The following databases were searched: Science Direct, PsychInfo, SAGE, PubMed, Web of Science, ARK – ORB children's database, CAIN archives, INCORE, Institute of Conflict Research, the Families Studies Centre and the Cochrane Library, using a combination of search terms: children/adolescents and conflict, troubles, mental health, social, political, economic, poverty, deprivation, well-being and victims. Data base driven searches however only captured some of the rich literature. In addition, the review explored the research of academics and other experts publishing work in this field, as well as examining grey (unpublished) literature. Government sources and records were used, along with reports from non-statutory organisations and community groups. Texts which were frequently referenced in the literature were also examined. Experts were invited to add to the list of articles identified. The quality of papers were examined to determine which to include in this review, in terms of the methods used, the validity of scales, the response rates and if they were representative of the population. Papers which did not reach the criteria or did not focus on those under the age of 18 were excluded.

In response to increasing suicide rates and mental health problems, the 2004 Young Life and Times survey examined aspects of mental health in Northern Ireland and found that 24% of 16 year olds were psychologically distressed (Cairns & Lloyd, 2005). This is supported by Gallagher et al. (2012) who also found that the Troubles impacted very negatively on young people in Northern Ireland. Bamford (2006) proposed that ongoing social and economic problems, along with poor parental mental health impacted profoundly on children. The legacy of the conflict is therefore complex. The Troubles impacted on the population both

directly and indirectly and the legacy being passed down to future generations has many social, political and economic aspects which are often intertwined. This literature review will consider research examining these social, economic and political effects of the legacy of the Troubles/conflict, looking at a range of mental health problems, whilst considering different groups of children, such as children of survivors, those of ex-combatants or of military personnel and children in care.

In a comprehensive report, Smyth et al. (2004) concluded that many young people in Northern Ireland had been impacted in a number of ways by the Troubles. Not only did the conflict damage them psychologically and emotionally but it also impacted on them socially and politically in terms of relationships with others, their education and therefore their future career, whilst also shaping their attitudes towards members of the other community and politics. Muldoon (2004) also reported that the Troubles impacted on children both socially and psychologically. The experience of continuous violence and growing up in a divided society shaped many lives, compounded by other factors such as poor education, housing and poverty (Burrows & Keenan, 2004). Gallagher and Hamber (2014) suggested that in order to address the legacy of the conflict in Northern Ireland it is important to address both psychological and social needs.

However, not all children experienced the Troubles equally and therefore the impact was also unequal. Children from areas of high deprivation or those living in border areas appear to have been affected the most (Gallagher et al., 2012), as these were areas which also experiencing elevated levels of violence and unrest. A recent report describes Northern Ireland as still being a highly segregated society (Knox, 2014), with those who lived in areas most impacted by the conflict still being the economic losers following the peace process. According to the 2014 Northern Ireland Peace Monitoring Report, child poverty stands at 35% in Derry-Londonderry and 34% in Belfast (Nolan, 2014), with limited opportunities for young people (McAlister et al., 2014). Welfare dependency has risen in these areas, the prevalence of mental health problems is higher and male life expectancy is lower.

Research shows that men experienced more conflict related events (Bunting et al., 2013), being more likely to be both victims and perpetrators. However, Bunting et al. (2013) also reported that the impact of the conflict varies between genders, with women reporting a higher prevalence of mood and anxiety disorders, while men display higher rates of substance disorders. Reporting on a case study examining the needs of young men in Northern Ireland, Gallagher and Hamber (2014) suggested that social exclusion, youth unemployment and limited prospects remain key issues for concern. These issues have led to low aspirations, low self-esteem and decreased self-worth in many young people, impacting on their mental health. Indeed, the authors propose that young men remain a priority group due to the growing rates of suicide and psychopathology in this cohort. Men however are reluctant to seek help with many resorting to risk taking behaviour such as drink or drug taking, self-medicating, sex or violence in order to cope. Others engage in anti-social behaviour which can subsequently lead to punishment attacks.

Social and political impact

The social and political legacy of the Troubles is immense, with a divided society still evident today. Merrilees et al. (2011) suggest that protracted intergroup conflict between communities in Northern Ireland placed an additional burden on mothers who had self-reported on the impact of the conflict on them and their children, but that social identity and identification with an in-group or social bonding processes played a moderating role on the impact. Research from the Centre for Social Justice 2010 also shows that across a range of social and economic indices such as health, education and occupational attainment etc. disadvantage linked to parental mental ill health is a distinctive factor.

Case studies, examining the impact of violence and social divisions on 3-11 year olds, found that attitudes and identities changed with age, with prejudices developing early in life (Connolly & Healy, 2004). From the age of 3, children identified with their own culture and from the age of 7 they were aware of political divisions. During the conflict many children were separated in their social life on religious grounds. Hanson (2005) found that teenagers, (14-17 year olds), who lived in interface areas had a negative outlook on life, shaped by continued violence and anti-social behaviour. This negative outlook can impact on future well-being. Gallagher (2004) emphasised the importance of integration from an early age. According to Kelly (2012) segregated education continues to have a negative impact on community relations in Northern Ireland.

In a community based project, participants (8-25 year olds) felt that segregation was a barrier and that both sectarian and non-sectarian violence were a normal part of life (McAlister et al., 2009) with marginalisation often resulting in anti-social behaviour (McAlister et al., 2014). Goeke-Morey et al. (2009) reported however that sectarian violence had a greater impact on children's adjustment problems, including conduct issues, their emotional security and ability to develop coping strategies, which can have a major influence on their future mental health. According to a recent report, over 500 children under the age of 17 were victims of paramilitary punishment shootings and beatings since 1990 and that these continued after the ceasefire (Kennedy, 2014). Additionally, many children were forced into exile with their families. Such experiences impacted not only on the population's mental health but also helped fuel the conflict.

Muldoon (2004) suggested that in response to the Troubles, young people became apathetic and indifferent towards politics. Smyth et al. (2004) found that many young people blamed politicians for the conflict and they had little trust in law and order. The authors recommended that young people should be permitted to take an active role in politics and their rights respected, to reduce political marginalisation. McAlister et al. (2009) also recommended the importance of consulting children and adolescents, giving them a sense of control and belonging. The 10 year strategy for children and young people in Northern Ireland, 2006-2016, made many pledges, including more involvement of children in decisions which impact on them (OFMDFM, 2006). However, in a recent survey, while 82% of respondents believed that young people could play a major role in uniting communities, only 14% felt they had any influence locally (ARK, 2013).

Muldoon (2013) proposed that children with a strong social identity are more resilient in times of conflict. Merrilees et al. (2011) reported that a mother's social identity moderated the impact of the Troubles on her mental health which was subsequently linked to her children's

psychological functioning. Merrilees et al. (2014) also found that group identity protected children from emotional difficulties in response to sectarian anti-social behaviour. However, Bull (2006) reminds us that it was Northern Ireland's polarised social identities that helped maintain the conflict.

A recent report, examining the impact of the Flag Dispute in 2012/2013, noted the significant deterioration in inter-community relations, with protests and violence erupting again on the streets of Northern Ireland (Nolan et al., 2014). Many young people became embroiled in rioting, stone-throwing and the burning of vehicles. This highlights the legacy of the conflict and the on-going tension that remains close to the surface in Northern Ireland. It also highlights that many young people remain vulnerable to becoming directly involved in legacy issues such as flag disputes, interface violence and anti-social behaviour and may also be drawn towards paramilitary activity. Such findings emphasise the need for continued reconciliation work to help young people move on from this legacy.

In recent years hate crimes have become increasingly common in Northern Ireland with many racist and homophobic crimes reported. Montague (2014) describes the upsurge in racist hate crimes as prejudices against out-groups or anyone who is different, a legacy of the Troubles in Northern Ireland and the deeply divided society that resulted. Sectarianism remains the most common hate crime, accounting for more than half of all hate crimes reported (Nolan, 2014), although it should be noted that the rate of sectarian related crimes has decreased slightly in recent years. The Together Building a United Community strategy (OFMDFM, 2013) aims to improve community relations. The shared aim for young people is to improve attitudes and build communities where young people are involved in building relations. The strategy has however been criticised for not consulting community groups working on the ground and for not addressing the role of integrated education (NICIE, 2013). In addition, it says very little about the need to address legacy issues that continue to affect the lives of children and young people in Northern Ireland.

Many inequalities continue to exist in Northern Ireland. According to the 2014 Peace Monitoring report, Catholics continue to experience more poverty and social disadvantages than Protestants (Nolan, 2014). However, despite these disadvantages Catholics have been found to out-perform Protestants at school and according to the 2012 Labour Force Survey the unemployment gap is decreasing (OFMDFM, 2014). Additionally more Catholics than Protestants over the age of 16 are in full time education. This would suggest that such inequalities may change in the near future.

Economic impact

The Troubles impacted very negatively on the economy in Northern Ireland. With the violence and unrest came poverty and deprivation, with money diverted away from essential services such as health, housing and education, towards security and rebuilding work following terrorist attacks. Tourism declined, many jobs were lost and industries diverted away from troubled areas. Investors and business have been encouraged to invest and set up in Northern Ireland following peace and stability, however, poverty remains a significant issue. According to Horgan and Monteith (2009, p.1) "Northern Ireland's most disadvantaged children and young people live in communities that face social exclusion and still experience violence that is the legacy of the conflict". The Troubles impacted on children not only in relation to the trauma their families experienced but also in terms of the poverty and deprivation that came with it.

Persistent child poverty in Northern Ireland is twice the rate of Great Britain and has a very detrimental effect on children's wellbeing (Monteith et al., 2008). The Poverty and Social Exclusion study found that when comparing living standards from 2002 to 2012, households in Northern Ireland were less able to cope financially, with many children impacted as a result (PSE, 2013). Further research by the PSE group reports that 26.6% of children live in poverty and that nearly a third of these children live with an adult who experienced moderate or high levels of political violence (Tomlinson, 2014). Examining the Young Life and Times Survey, Schubotz (2010) reported that nearly half the female participants from socially deprived areas experienced serious mental and emotional health problems in the previous year. Additionally, the 2013 survey reported that the majority of respondents have been affected by the recent financial crisis (ARK, 2013). Horgan (2011) warns that young people living in poverty often feel marginalised and have a negative outlook on life, with many dropping out of education and failing to gain employment, impacting on their future and the future of their families. It is important to break this cycle as it may also have a very negative impact on the future of Northern Ireland (Horgan, 2011).

Mental health problems

Harland (2013) proposed that the legacy of the Troubles and the social and economic problems that came with it should be considered together, when examining mental health in the Northern Ireland population, as they are interlinked. The Belfast Youth Development Study reported that 77% of adolescents (15-16 year olds) had experienced community violence and that exposure was associated with depression and substance misuse (McAloney et al., 2009). Sectarian violence has been strongly linked to higher rates of family conflict which can impact on a child's wellbeing in terms of adjustment problems and emotional security (Cummings et al., 2010). In a longitudinal study, Cummings et al. (2013) found that this was even more evident in areas with high crime rates. It has been suggested that emotional insecurity about the community a child lives in can augment internalising and externalising problems (Cummings et al., 2011). Muldoon (2004) suggested that the Troubles were related to more externalising than internalising problems in children. However, a recent epidemiological study, conducted as part of the World Mental Health Survey Initiative, found that many of those who grew up during the conflict have a high prevalence of internalising problems, such as mood, anxiety and substance disorders, later in life (Bunting et al., 2012).

Depression and anxiety

In a survey, Muldoon et al. (2005) reported that many adults attribute their mental health problems to the Troubles, with those directly impacted reporting higher prevalence rates of depression and anxiety disorders. Furthermore, 10% of participants reported symptoms of PTSD which was related to their experiences of the conflict (Muldoon et al., 2005). McDermott et al. (2013) also found that children directly exposed to the Omagh bomb had the highest levels of PTSD. Anxiety and sleep problems are also common in young people (Smyth et al., 2004). In addition to the direct effect of the conflict, the mental health of the population was impacted indirectly as a result of the social, political and economic issues that accompanied the conflict. Research would suggest that some groups of young people are particularly vulnerable to a range of psychological problems; including females, same-sex-attracted adolescents and children from socially deprived areas (Schubotz, 2010). However, there is little empirical research on prevalence rates in children which warrants

further research (Bamford, 2006). Of particular concern is that there are still barriers to accessing services due to stigma and a general lack of knowledge around services available and how to get support for mental health problems (McGrelis, 2011).

Post Traumatic Stress Disorder

Since the inclusion of post-traumatic stress disorder (PTSD) in the Third Edition of the American Psychological Association (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in 1980 (it was extended to children in the 1987 DSM-III-R), the availability of literature surrounding trauma related conditions has increased exponentially. Literature regarding the causes, pathology, diagnosis, and treatments for trauma related disorders is widely available. The literature on the psychological impacts of violence and other traumatic events on children is also extensive. Furthermore, Bunting et al. (2013) found that well over half of adults had had a first traumatic experience linked to conflict by the time they reached 20 years of age.

Drugs and alcohol

Research has found that people who grew up during the conflict often use alcohol or drugs to cope with their experiences (Muldoon et al., 2005). Goeke-Morey et al. (2009) reported that sectarian violence contributes to adjustment problems in adults as well as children, often resulting in the abuse of alcohol or drugs. This can impact greatly on family life in a number of ways, as it may lead to parental ill-health, loss of employment, marital breakdown etc. which subsequently impacts on children. In addition a recent study found that 1 in 5 of those with direct experience of the Troubles had used psychotropic medication within the previous year (Benson et al., 2014) and that the prevalence rate of usage in those with mental health problems and also in the general population was higher than rates reported in other countries.

Higgins et al. (2004) cautioned that many social problems which had been suppressed during the Troubles were likely to increase following the ceasefire. They reported that adolescent drug use was rising but there was a lack of services available to address the issue. Alcohol abuse was also increasing. Participants of the Childhood in Transition research project (8-25 year olds) reported that they drank because they were bored and wanted to forget about their problems (Haydon et al., 2010). Recent research would suggest that adolescent alcohol and drug use is decreasing (NISRA, 2012) but the rates reported are still worrying, with 46% of respondents (11-16 year olds) consuming alcohol, 15% taking illegal drugs and 19% smoking tobacco in the previous year, potentially impacting on their future physical and mental health. In addition, recent findings suggest that drug related offences are increasing in Northern Ireland (Nolan, 2014).

Suicide and self-harm

Northern Ireland has witnessed an upward trend in suicide rates, especially among young males, since the mid-1990s (Tomlinson, 2007), with Largey et al. (2008) finding that those aged 10-34 had a heightened risk. A recent study, using data from the Northern Ireland Study of Health and Stress, found a significant association between the experience of conflict related events and suicide ideation and suicide plans (O'Neill et al., 2014a) and suggest that those who experienced a conflict related event may be more likely to complete suicide on

their first attempt. Tomlinson (2012) also reported that children who grew up during the worst years of the Troubles have an increased risk of suicidal behaviour. In addition to the direct experience of conflict related traumas, bereavement and violence, the recent increase in suicides may be attributed to a number of indirect factors such as increasing social isolation since the ceasefire, with declining social integration and loss of purpose, as well as ongoing social, political and economic problems. Gallagher and Hamber (2014) reported that young men felt that there were limited accessible services or resources for them and that they often felt isolated in post-conflict Northern Ireland. Some young men reported that they struggled with a sense of identity. Since the end of the conflict men's roles have changed and many behaviours that were once deemed acceptable are no longer so. Of particular concern, while young men are reluctant to seek help from others for mental health problems, they are even less likely to seek help if they have suicidal ideation or behaviour due to stigma.

Tomlinson (2007) attributes higher rates of suicide to an increase in self harm among younger people. Of concern, a survey of 16 year olds found that 13% reported that they had self-harmed (ARK, 2013). A recent study of children, aged 15-16, found that self-harm was associated with Troubles/conflict related experiences (O'Connor et al., 2014), however, the rates of self-harm in Northern Ireland were lower than those reported in Ireland, England or Scotland. Other risk factors such as bullying, social media, alcohol and/or drug use and exposure to self-harm also appear to play a significant role (O'Connor et al., 2014) which may warrant future research in post-conflict Northern Ireland.

Specific groups of children: Children of survivors, ex-combatants and police officers

“Although many young people have never experienced the conflict directly, young people in Northern Ireland face a real life threat of inheriting the psychological vulnerability of their parents” (Gallagher & Hamber, 2014, p. 73).

Children of survivors of the conflict have been found to have poorer psychological functioning which may be a direct result of the trauma experienced but other indirect factors also play a role. For example, a parent, physically or mentally injured during the Troubles may be unable to care for their child. In addition, the child may become their carer. Injury also places a large burden on the family in terms of relationship and economic problems (Breen-Smith, 2012). Additionally, trauma may contribute to maladaptive parental behaviour, such as intra-family violence or neglect which subsequently impacts negatively on the child. Alternatively, parents may become over-protective as a consequence of the Troubles, giving the child little freedom.

Culture and the social environment also play an important role (Hanna et al., 2012). Not only can family life change, there may also be many changes in the community and other social situations which impact on a child's development and subsequent mental health (Cummings et al., 2009). According to Ghigliazza (2008) children were often overlooked as victims of the Troubles but it had a long term effect on them, with many failing to access adequate services due to fear and mistrust. Silence was also an issue, with many things not being discussed and this secrecy often led to strained intra-family relationships (Smyth et al., 2004). Examining the multigenerational legacy of the conflict, Downes et al. (2013) also found that how traumas were communicated and dealt with, impacted on future generations. Burrows and Keenan (2004) concluded that to recover from the Troubles an active process of remembering is required, recognising, acknowledging and addressing issues.

Children of ex-combatants faced a range of difficulties, with disruption to family life, witnessing their parents being arrested and visiting them in jail, all having a negative impact (Roulston, 2011). They encountered further difficulties when the parent was released (Hall, 2005), with many reporting that they still felt stigmatised by their parents actions during the conflict. Others may be afraid to talk about their parent's involvement for fear of recrimination. Black (2004) reported that children of police officers serving during the Troubles were impacted by fear, social isolation and their parent's mental ill health. Many still live in fear of violence and this fear continues to impact on family life (Black, 2004). While conducting this review it was noted that there is a lack of quality research examining the impact of the Troubles on children of military personnel, which may warrant further research.

Specific groups of children: Children in care

Due to problems within the family, some of which attributable to the legacy of the Troubles, such as parental physical or mental illness, a number of children in Northern Ireland spend time away from their family, living in state care. Looked-after children are a particularly vulnerable group. More than 60% of children in care, aged 4-10, were found to have a mental health problem, with the rate even higher for those aged 11-16 (Teggart & Menary, 2005). Cousins et al. (2010) also found that many looked-after children displayed emotional and behavioural problems, with 70.3% of 10-15 year olds at a high risk of meeting the criteria for mental health disorders. Of concern however, was that social workers greatly underestimated the risk. Children living in state care were also found to be at a heightened risk for self-harm and suicide (Cousins et al., 2008).

Current studies and priorities for research

While Northern Ireland is emerging from a protracted period of political violence, research suggests that ongoing social, political and economic issues are impacting on the lives of its children and young people. Current research suggests that many of the issues identified in earlier studies are still relevant today. A recent survey found that 28% of 16 year old respondents had serious mental health, emotional or personal problems in the past year, yet only a third received professional help (ARK, 2013). Hanna et al. (2012) reported that young people still appear to be reluctant to access mental health services due to stigma. Further campaigns to address this issue are required. It is important to promote mental health and well-being and educate young people, to help remove the barriers to help seeking behaviour. Promoting emotional resilience in young people is also a priority (Gallagher & Hamber, 2014).

A qualitative study of males (13-16 years) concluded that little has changed in young men's lives since the ceasefire (Harland, 2011). Violence, sectarianism and racism are still strong, with 75% reporting that they did not feel safe in their community, with divisions reinforced by ongoing issues such as contentious parades, bonfires and flag disputes. The 2013 Young Life and Times Survey found that 78% of young people felt that religion still made a big difference in community relations in Northern Ireland, however the authors concluded by saying that there are signs that the divide is improving (ARK, 2013), providing some hope for the future. Gallagher and Hamber (2014) suggested that it is important to educate young people about the Troubles in order to change attitudes and behaviour and also to deal with any outstanding conflict related issues. Additionally, it is imperative to improve personal and community relationships by enhancing interpersonal skills and communication proficiency.

McAloney et al. (2009) found that adolescents were very knowledgeable about the Troubles, with Haydon et al. (2010) reporting that negative attitudes are being passed on to future generations. Hanna et al. (2012) also reported that traumas experienced by parents had a detrimental impact on children but concluded that more work examining trans-generational trauma is required. According to recent reports, other priorities for research include examining resilience and protective factors following the Troubles, as well as identifying effective interventions and addressing the needs of specific groups, such as children with autism or those in the LGBT community (Macdonald et al., 2011). Further research examining the increasing rates of hate crimes, bullying and the impact of social media are also warranted.

While many studies focus on specific groups of young people in Northern Ireland, particularly those who are economically or socially disadvantaged, it would also be beneficial to further examine how the social and political impact of the conflict's legacy is contributing to or reinforcing marginalisation among some working class children and young people on both sides of the divide and other marginalised young people who do not feel integrated into post-Agreement Northern Ireland. More longitudinal studies would also provide a clearer picture on the long term impact of the Troubles. Bamford (2006) recommended that quality epidemiological research should be conducted into childhood mental health problems but this has yet to transpire.

Conclusions

Research suggests that many children and young people growing up in post-agreement Northern Ireland are still affected by the conflict. However, most agree that the impact of the conflict's legacy on children is complex, involving an interaction of many factors, including the trauma experienced by families and how this is transmitted to future generations, as well as parental mental health, poverty, culture, the social environment and ongoing sectarianism and community violence and maladaptive parenting that can accompany many of these issues. A key theme running through research is the dual impact of the Troubles and poverty on mental health in Northern Ireland. While the Troubles may have ceased, the negative impact is still being felt, with poverty and deprivation a growing concern in under-resourced communities struggling in the transition from political violence and unrest (McAlister et al., 2014). Connolly and Healy (2004) concluded that children living in areas of elevated unrest would benefit from targeted conflict resolution interventions and cross-community work. Interventions targeted at the whole family are recommended, to help address various adversities in childhood which can impact on future well-being. Current research would suggest that it is also important to give young people a say in political issues. Muldoon (2004) suggested that it may be the divisions in society that resulted from the Troubles, such as poverty, deprivation, racism and sectarianism that impacts negatively on a person. Recent research would suggest that while the conflict in Northern Ireland is over and things are improving for young people, many economic, political and social problems remain which warrant careful consideration.

Chapter Two

THE IMPACT OF THE CONFLICT'S LEGACY ON THE EARLY YEARS' DEVELOPMENT OF CHILDREN AND YOUNG PEOPLE

Áine McKenna

Introduction

This current review of the literature addresses three complementary agendas. The first is to synthesise current research evidence in relation to trauma transmission within families. The second is to synthesise current evidence in relation to the related construct of trans-generational prejudice. Finally the implications of these findings for developing appropriate intervention approaches will be discussed.

Trans-generational trauma

There is a growing awareness that trauma related psychopathology in parents is associated with poor psychological functioning in their offspring. Tomlinson (2012) revealed that over 40 per cent of children growing up in Northern Ireland are living with parents who have high or moderate experience of the conflict, while one in five are growing up with an adult who has high experience. The seminal work on trans-generational trauma in Northern Ireland was initiated by Hanna et al. (2012). They defined the phenomenon as the poor psychological functioning of children that seems to partially emanate from the 'consequences' of the trauma experienced by parents, resulting in detrimental effects on the interaction of parents and children. McNally (2014) extended this work and argued that trans-generational trauma was not a specifically identifiable and treatable pathology and argued for a broader and more general conceptualisation of trans-generational trauma that interrogates and acknowledges the enduring consequences that emanate from traumatic experiences. The focus of this current review is therefore to construct an integrated and evidence based understanding of these issues within the Northern Ireland context, based upon the contemporary research literature.

The biological transmission model

The biological perspective of trauma transmission suggests that physiological processes may be as important as psychological factors during the process of transmission. Recent evidence suggests that traumatic experiences of parents may indeed lead to a general disposition to develop PTSD in the offspring. Family and twin studies have found that more than 30% of the variance associated with PTSD is related to a heritable component (Skelton et al., 2014). Additionally, a recent meta-analysis revealed that the association between parents' PTSD severity and children's psychological distress did not differ significantly based on who experienced the traumatic event (Lambert et al., 2014). Kellerman (2014) highlights that genetic mechanisms alone cannot explain transmission and he argues in favour of a model that integrates environmental and hereditary factors. Kellerman (2014) argues that researchers need to focus on elucidating how children who themselves have not been traumatized tend to display inherited emotional problems. These investigations however, are complicated by the fact that parental PTSD has been found to be associated with increased trauma exposure in offspring (Roberts et al., 2012).

Maladaptive parenting practices

Parental symptoms of posttraumatic stress are uniquely related to an array of offspring outcomes, including internalizing-type problems, general behavioural problems, and altered hypothalamic-pituitary-adrenal axis functioning (Leen-Feldner et al., 2013). Roberts et al. (2012) revealed a dose–response relationship between parental PTSD symptoms and risk for PTSD symptoms in their children. The findings suggested that elevated exposure to traumatic events in children of mothers with PTSD was likely a major mechanism for this risk transmission. However, they found that mother’s PTSD symptoms predicted child’s PTSD even after extensive adjustment for child’s trauma exposure. Roberts et al. (2012) suggested that health care providers who treat mothers with PTSD should be aware of the higher risk for trauma exposure and PTSD in their children.

The findings of Roth et al. (2014) suggest that it is the child’s exposure to maternal family violence that accounts for the negative mental health outcomes in children of PTSD sufferers. Furthermore, their results revealed that it was not maternal PTSD-symptoms but mother’s exposure to family violence during her own childhood that was associated with the magnitude of adversities that a child experiences at home. Sailea et al. (2014) investigated if civil conflict contributes to family violence against children. Their findings revealed that the strongest predictors of self-reported aggressive parenting behaviours toward the child were: 1) guardians’ own experiences of childhood maltreatment; 2) female guardians’ victimization experiences in their intimate relationships; 3) male guardians’ PTSD symptoms and 4) alcohol-related problems.

It is further postulated that parental trauma exposures interfere with interaction patterns within families. A parent’s trauma exposure is postulated to lead to a less than optimal quality of attachment between parent and child (Katz 2003, Zeanah & Zeanah, 1989). Children of Holocaust survivors present a tendency to form “insecure-ambivalent” attachments with their parents. More recent evidence suggests that emotional numbing associated with PTSD interferes with a parent’s ability to bond and interact with their child (Ruscio et al., 2002). This difficulty with parenting has been shown to continue down the generations from the original survivor/victim to their children and to their children’s children. Recent international studies have focused on the impact of PTSD on bonding processes in early life (Enlow et al., 2014) and revealed how maternal PTSD undermines the quality of mother child interactions. This in turn negatively impacts on the child’s developing capacity to self regulate. These findings suggest that maternal PTSD is associated with offspring emotion regulation difficulties as early as infancy. Such difficulties may contribute to increased risk of mental health problems among children of mothers with PTSD.

In addition to this, there is evidence that a neglectful parenting style due to trauma, is associated with the children of the victim themselves becoming neglectful of their own children. This characterisation of how trauma may be transmitted down to the third generation and beyond has also been confirmed in trauma victims who were not diagnosed with PTSD. A recent qualitative study employing Interpretative Phenomenological Analysis (IPA) to investigate these issues was conducted in NI. This study examined the subjective experiences, beliefs and perceptions of four mothers from Northern Ireland, all of whom had endured troubles related trauma during their childhoods (Downes et al., 2013). All participants discussed how their own traumatic experiences impact on the ways in which they parent their own children. They all discussed bonding difficulties and they suggested

that they were overly strict with their children. Many of the mothers discussed how they as children, or their own children, took on the role of a parent during their childhood. This is in line with observations by Harkness (1993) who suggested that role reversals are common within families experiencing multigenerational trauma. Downes et al. (2013) also found evidence of over-protectiveness in the Northern Ireland sample. Among children of Holocaust survivors, over-protectiveness in parents led to an exaggerated sense of the dangerousness of the world later in life (Rowland-Klein & Dunlop, 1998).

The communication hypothesis of trauma transmission suggests that the continuous retelling of stories about past traumas or inversely the avoidance of storytelling about past events may be equally involved in trauma transmission. Evidence suggests that the telling of trauma stories when the context is not conducive to psychological integration of the trauma, may result in a transmission of the negative emotions to the listener (Lin et al., 2009). The continuing retelling of survivor stories (Mor, 1990) in extreme detail may be horrifying for children (Dekel & Goldblatt, 2008). Conversely Lin et al. (2009) suggest that lack of communication about the traumatic event may also result in a transmission of avoidance and discomfort surrounding their experiences to the next generation.

McNally's (2014) research conducted in Northern Ireland revealed that families affected by trauma develop unhealthy methods of communication. McNally's explored the extent to which the impact of conflict is passed on through families intentionally and unintentionally. McNally suggests that communication styles can vary from silence to intrusive attempts to discuss the events and imposing interpretations of those events on other family members, including children. Downes et al. (2012) also found that the mothers in their study managed their trauma by hiding the truth or through affective avoidance. McNally (2014) highlighted the existence of a culture of silence surrounding trauma in Northern Ireland and contends that this silence is an active transmitter of trauma.

PTSD and aggressive parenting

Leen-Feldner et al. (2011) focused on elucidating the relationship between parental PTSD, parental aggression and internalising patterns in children. The researchers found that offspring anxiety and depression was elevated among parents with PTSD, compared to those without the condition. They also found however that parents with PTSD were more likely to endorse the use of both moderate (e.g., pushing) and severe (e.g., hitting with a fist) physical aggression with their children. The researchers concluded that there is a unique relationship between PTSD and these aggressive parenting behaviours and that further research needs to further explore the relationship. These findings add to the findings of Roberts et al. (2012) whose findings also suggest that trauma exposures, in the form of interpersonal violence, may characterise one of the mediating pathways for transmission between parents and their children.

The impact of the conflict on mental health in Northern Ireland

Epidemiological studies show that 29% of lifetime PTSD in Northern Ireland is associated with having direct experience of traumatic events that were directly related to the civil conflict (Bunting et al., 2013). These findings revealed that respondents, who had direct experience of conflict related trauma, were more likely than those who had no such experiences, to suffer from PTSD, mood, anxiety, substance abuse, and impulse control disorders. The prevalence

of PTSD and mood and anxiety disorders among women who experienced conflict was generally higher than men, while men who had experienced conflict had a higher prevalence of substance use and impulse-control disorders. In addition to this, both men and women who had Troubles experience were more likely to have multiple lifetime disorders. This evidence clearly suggests that the children of the victims of the Northern Ireland civil conflict are more likely to be living with a parent who suffers from a mental disorder than those whose parents have no such experiences.

Merrilees et al. (2011) also found that mothers who had been affected by the Troubles had higher levels of mental health problems. Merrilees and colleagues found that poor maternal mental health impacted on children's adjustment. It is important to acknowledge that most parents with mental health problems do parent their children effectively (Parrott et al., 2008; Evans & Fowler 2008). Parental mental health problems do not always impact negatively on children's health, development and wellbeing and a range of factors (e.g. access to treatment and support, the type of mental health problems and the social and economic circumstance of the family) may influence the nature and extent of any impact. A recent synthesis of international research evidence however clearly highlighted that parental mental health problems do increase a child's risk of experiencing maltreatment (Hagemann-White et al., 2010). Evidence cited in this current review has highlighted that the mother's own experiences of maltreatment during childhood, and not maternal mental illness, predicted the association between parental mental health issues and child maltreatment. However, not all parents who were maltreated go on to maltreat their children. Research on intergenerational transmission has revealed three distinct patterns across generations: 1) cycle maintaining; 2) cycle breaking and 3) cycle initiation. Research has revealed that socio-demographic variables seem to account well for differences in cycle breaking and maintaining across generations.

Maltreatment typologies in the Northern Ireland population

Analyses conducted on the Northern Ireland Study of Health and Stress revealed three Maltreatment Typologies in Northern Ireland population (born between the years 1915 - 1990). These are described in detail later in this report. These findings highlight that within certain subpopulations in Northern Ireland, there is a dynamic association between parental psychopathology, harsh parenting practices, exposure to conflict related trauma and the subsequent development of psychopathology. These findings are important from a transmission perspective because research has highlighted that 47% of parents in Northern Ireland currently use physical discipline during childrearing (Bunting et al., 2008). In light of evidence that links parental psychopathology and the use of harsh parenting practices to both conflict related trauma and the development of psychopathology it is worrying that the use of physical discipline is a parenting norm in Northern Ireland. In addition to this, Allport (1954) suggested that harsh parenting practices are also involved in the transmission of prejudice against outgroups. International research evidence also suggests that harsh physical parenting acts as a dominant transmission mediator between generations (Harkness, 1993).

Toxic stress

A synthesis of the evidence outlined in this review thus far suggests that the impact of the conflict on the early development of the victim's children is a matter that requires urgent consideration. An integration of the evidence relating to trauma transmission strongly

suggests that the children of victims are at increased risk of experiencing toxic stress. Toxic stress has been defined as the extreme, frequent, or extended activation of the stress response, without the buffering influence of a supportive adult (Shonkoff et al., 2009). The empirically identified risk factors for experiencing early toxic stress include parental mental health problems, poverty, childhood neglect and abuse and family violence (Shonkoff et al., 2009). For example conflict experience has been found to be associated with both unemployment (Bunting et al., 2013) and deprivation (PSE, 2012). More specifically, deprivation rates for those with no conflict experience were found in a recent survey, to be below 20%, while the rates for those with conflict experience were 35%. Respondents who reported that they had lived in poverty in the past were 1.3 times more likely to have had conflict experience than those who had never lived in poverty.

The evidence elucidated a relationship between trauma related disorders in parents and insecure/disorganised attachment styles (Katz, 2003, Zeanah & Zeanah, 1989; Bar-On et al., 1998; Ruscio et al., 2002; Enlow et al., 2014) and both neglectful (Ruscio et al., 2002) and harsh parenting practices (Roberts et al., 2012; Leen-Feldner et al., 2011). Furthermore, Harkness (1993) found a relationship between family violence and PTSD. The findings of Sailea et al. (2014) suggest that in post-conflict societies an intergenerational cycle of violence persists, that is exacerbated by female guardians' experiences of domestic violence and male guardians' PTSD symptoms. Furthermore maternal PTSD has been found to be associated with harsh parenting practices. Harkness (1993) found that violence as a result of PTSD symptoms predicted greater distress in children than did the PTSD itself. In other words, the consequences of PTSD, increase the likelihood that the children of victims will experience early childhood adversity, in the form of interpersonal violence exposures.

These findings suggest that the children of the victims of the Troubles are at increased risk of experiencing co-occurring early childhood adversities which may result in the experiencing of toxic stress for the child. Experiencing of early toxic stress is known to trigger a series of biological adaptations that change the way the brain, neuroendocrine stress response, and immune system function, both individually and cooperatively (Johnson et al., 2013). Children who experience toxic stress are at increased risk for a multitude of health outcomes in adulthood including cardiovascular and obstructive pulmonary disease to cancers, asthma, autoimmune disease and mental health disorders (Anda et al., 2008; Björntorp & Rosmond, 2000; Carroll et al., 2011; Cohen et al., 2010; Felitti et al., 1998; Maughan et al., 2000).

Implications for early interventions

Extensive research on the biology of stress has revealed that healthy development can be derailed by excessive or prolonged activation of stress response systems in the body (especially the brain), with damaging effects on learning, behaviour, and both physical and mental health across the lifespan. The more adverse experiences that are endured during childhood, the greater the likelihood of developmental delays and later health problems.

Kalil (2014) argues that since parents are children's first caregivers and teachers the only way to balance the scales is for governments to invest in parents so that they can better invest in their children. Kalil further contends that gaps in children's emotional, social and behavioural skills could be narrowed if less-advantaged parents adopted the parenting practices of their more-advantaged peers. However others argue that poor executive functioning and mental health problems in vulnerable parents should be the target of

parenting courses and not simply information and advice about child development. Shonkoff and Fisher (2013) further argue that because parent characteristics typically explain a greater proportion of the variance in child outcomes than child centred early intervention programmes, there is a need for new intervention strategies that focus more explicitly on strengthening the capabilities of parents and other primary caregivers.

Growing evidence from neuroscience suggests that the longer it takes for interventions with children at high risk for problems to begin, the more difficult it will be to achieve positive outcomes later, particularly for children who experience the physiological disruptions of toxic stress during the earliest years (Knudsen et al., 2006; Shonkoff et al., 2009). Shonkoff and Fisher (2013) propose the concept two-generation approaches for children and families experiencing significant adversity and call for enhanced synchrony among the “silos” that separate child-focused and adult-focused services. It is therefore recommended that the needs of the children of parents presenting with trauma related mental health problems should also be considered during the initial treatment planning programme. Shonkoff and Fisher (2013) argue that early childhood policy and research need to turn the focus towards a family centred approach to intervention. They suggest that the focus of early childhood interventions should involve building the capacity of the caregivers. Their intervention approach diverges significantly from the traditional advice and information approach based on child development models. They argue that the best way to augment child outcomes is to enhance the caregiving environment by strengthening executive functioning skills and mental health in parents. This they argue will automatically enhance the parent’s employability which will strengthen the social and economic stability of the family. In addition to this they also suggests a focus on strengthening neighbourhood-level resources and capacities that can prevent, reduce, or mitigate the adverse impacts of toxic stress on families.

The development of resilience in children who experience high levels of toxic stress requires the availability of adults who can help them develop the coping skills they require to bring their overly activated stress response back to baseline. In order to do this caregivers require sound mental health and well developed executive function skills in problem solving, planning, monitoring and self regulation. So in addition to providing parents with access to evidence based mental health interventions other skill deficits in parents also need to be targeted in order to simultaneously develop their home management skills and employability. It is unlikely that providing parents with knowledge of child development is going to help them overcome their deficits in these areas. Indeed, although there is currently a paucity of experimental evidence, some promising programs for low-income parents are using coaching, multimedia, and computer games that have been specifically designed to create ways for adults to improve memory, focus, attention, impulse control, organization, problem-solving, and multitasking skills (Babcock, 2014). Mindfulness meditation training, mind–body exercises (e.g., relaxation breathing practice), and brain games are tools that may increase the quality of parent–child interactions, and likely better mental health and health outcomes (Davidson et al., 2003). These findings suggest that these types of capacity building interventions may address the current skill deficits that current parenting courses do not address.

This family-centred approach to early intervention suggests that in order to reduce intergenerational poverty governments need to invest in parents, rather than strictly focusing on providing education for parents in order to providing rich environments for their children. Interventions therefore should focus on building a core set of adult capabilities that are

essential prerequisites for success in the home and the workplace. Recent findings from the Republic of Ireland in relation to the effectiveness of the free preschool year indicated that the skills gap between the most advantaged and the most disadvantaged preschool children actually widened during the preschool year (McKeown, 2014). McKeown (2014) found that the best predictor of the children's skills following the preschool year was the children's skill level at baseline. In addition to this McKeown (2014) revealed that the best predictors of child outcomes were family and social characteristics obtained at baseline. McKeown argued that the free preschool year is not early in terms of intervening to promote brain development. McKeown (2014) concurred with Shonkoff and Fisher (2013) and argued that this evidence suggests the need for a family approach to early intervention that focuses on building parents capacities in order to augment outcomes for the most vulnerable children.

Trans-generational prejudice

According to figures contained in *Lost Lives*, there were 3,720 conflict-related deaths in Northern Ireland between 1966 and November 2006, and Morrissey and Smyth (2002) reported that well over 40,000 people were injured during the years of violence. The impact of the Troubles however, was not invariable, and certain relatively well-defined sub-regions of Belfast and Northern Ireland were particularly impacted upon. These sub-regions became known as high intensity zones. Smyth and Scott (2000) demonstrated that children living in high intensity zones in Northern Ireland exhibited more anger, suspicion, and sometimes hatred towards the other community (Catholic or Protestant) than children living in low intensity zones. Families in high intensity zones tend to have had more extreme experiences of a variety of forms of violence and tend to report that the troubles completely changed their lives (Fay et al., 2001). Tomlinson (2012) revealed that one third of children in Northern Ireland are growing up with parents who have no experience of the conflict. Over 40 per cent, however, live with parents who have 'high' or 'moderate' experience and one in five are growing up with an adult who has high experience of conflict.

It is currently unknown what parents with conflict experience teach their children about history, politics, sectarianism and attitudes to violence. It is clear however, that in certain regions of Northern Ireland, there has been little or no change in relation to sectarianism or attitudes towards violence more generally. For example in 2012 the Police Service of Northern Ireland (PSNI) recorded a total of 2,040 sectarian or racist incidents, and a total of 1,343 sectarian or racist crimes (PSNI, 2012). Northern Ireland remains a largely divided society, with Protestant and Catholic communities existing in parallel. The Peace Monitoring report (2012) pointed out that the number of "peace walls" separating Protestant and Catholic neighbourhoods had actually increased since the signing of the Good Friday Agreement (from 22 in 1998 to 48 as of 2012). Housing developments and schools in Northern Ireland remain mostly single identity communities. The depth of the sectarian divisions has been fully manifest in recent years during the annual summer "marching season," the street violence and riots during the 2013 season were some of the worst in recent memory. Tensions between the unionist and nationalist communities were also highlighted by a series of protests that erupted in late 2012-early 2013 following a decision to fly the union (UK) flag at Belfast City Hall only on designated days, rather than year-round.

The formation of prejudice in young children

Research from the former Yugoslavia found that parents intentionally taught their children hatred and a desire for revenge for opposing ethnic groups (Klain, 1998). It is now known

that attitudes towards ethnic groups are formed in early childhood and these early attitudes set the stage for future attitudes and behaviours. Prejudice is now known to begin in early childhood between 3 and 6 years of age (Raabe & Beelmann, 2011). The findings from Connolly et al. (2002) provided the first detailed insight into the levels of cultural and political awareness among young children in Northern Ireland. Connolly et al. (2002) found that three particular factors were influential in impacting on children's awareness and attitudes in relation to these matters. These were: 1) the family; 2) the local community and 3) the school.

Peace education initiatives in Northern Ireland

In response to these findings two innovative peace building education programmes were developed. The Media Initiative Respective Difference Programme achieved positive effects in relation to all three of the socio-emotional development outcomes specified, namely: 1) recognition of emotion in others; 2) recognition of instances of exclusion; 3) recognition of how being excluded may make someone feel. The programme was also found to have had positive effects in relation to each of the four outcomes relating to the recognition of cultural events and symbols associated with the Protestant and Catholic communities in Northern Ireland. However, the evaluation found no conclusive evidence that the Media Initiative Respecting Difference Programme had any effects on parental or practitioner outcomes. Most notably no discernible change was found in relation to their levels of prejudice. Findings from Connolly et al.'s (2002) initial study highlighted the need to work closely with parents. A recent meta-analysis offers very strong evidence that parent-child attitudes are related throughout childhood and adolescence and offers strong support for the impact of primary socialization processes on prejudice formation in both young children and adolescents (Degner & Dalege, 2013).

Overall research on the Sesame Tree intervention was associated with positive effects among the children. A positive association was found between the amount that children watched Sesame Tree and an increase in their willingness to be inclusive of others. The evaluation found no evidence that watching Sesame Tree was associated with changes in children's attitudes towards racial differences or the degree to which they see themselves as similar and different in relation to the Catholic/Protestant divide. No evidence, however, was found that children were any more willing to include someone from a different racial background.

The importance of early intervention

The findings from both of these trials suggest that exposing young children to anti-bias information about 'other' ethnic communities may equip them with the cognitive abilities to critically assess the validity or acceptability of stereotypical beliefs about the cultural practices of other communities. Devine (1989) proposed a theoretical model of prejudice formation in young children that suggests that children acquire stereotypes through common socialization processes. The acquisition of stereotypes is proposed to occur before children develop the cognitive ability or flexibility to critically assess the validity or acceptability of these beliefs. Findings from the Media Initiative Respecting Difference Programme found that children in the intervention group were more likely to express an interest in taking part in Orange parades and St Patrick's Day parades compared to those in the control group. Children who watched Sesame Tree also showed an increased interest in some of the cultural events associated with the other community. These findings suggest that both interventions may

have provided a context for young children to assess the validity or acceptability of attitudes towards the cultural practices of other communities. These findings are very important and clearly demonstrate the importance of undertaking such work with children in their earliest years.

It is worth noting that the results from the preschool pilot evaluation (Connolly et al., 2006) revealed that there was no pre-existing tendency for Protestant and Catholic pre-school children to be less willing to be inclusive of those wearing Celtic and Rangers shirts. These findings supported Connolly et al.'s (2002) initial survey results. The researchers observed that it was only once children began primary school that explicit evidence of sectarian beliefs became evident in some children (Connolly et al., 2006). Connolly et al. (2006) suggested that the educational segregation that begins once children begin attending primary school may partially account for this emerging prejudice. Indeed Cairns (1987) revealed that segregation fosters in-group vs. out-group distinctions by children.

Factors that lead young children to dislike, or even hate, outgroups

The effectiveness of both of these innovative interventions needs to be acknowledged and commended. The impact of the wider ecologies within which the children are reared also have an influence on the outcomes of these interventions. Nesdale's social identity development theory (SIDT; Nesdale, 1999, 2001, 2004; Nesdale et al., 2007) suggests that expressions of intergroup biases in early childhood are driven by mere ingroup preferences and do not imply negative out group evaluations. Therefore from a SIDT perspective the ingroup preferences of young children in Northern Ireland are based on self-categorization, ingroup identification, and biased social comparisons, just as in adults. Nesdale et al. (2007) argues that this is why they emerge in children as soon as they develop the social and cognitive abilities for social categorization, self-identification, and social comparison around the age of five or six years (Nesdale & Flesser, 2001).

SIDT however clearly distinguishes between the formation of prejudice in terms of outgroup negativity and rejection, from mere ingroup preference. Nesdale argues that negative outgroup prejudice only crystallizes at the age of 7 years but not for all children. Connolly et al. (2002) however, found that these negative outgroup prejudices begin to form as early as age 5 in a small percentage of Northern Ireland school children, with an exponential increase in this prejudice at age 6. According to SIDT dislike or even hatred for outgroups and their members only form if children adopt negative ethnic attitudes prevailing in their social ingroup. Connolly et al. (2002) found that only small numbers of three and four year old children demonstrated some identification with either the Protestant or Catholic communities (5% and 7% respectively), 13% of five year olds did, rising sharply to just over one in three six year olds (34%). From this perspective, ingroup identification is only problematic when children are aware that negative outgroup attitudes prevail within the ingroup. The adoption of prejudice is construed to be an active process and is facilitated if children: 1) highly identify with an ingroup holding a norm of negative outgroup attitudes; 2) perceive tensions and threat between social groups or their members, and/or 3) perceive open conflict between groups or their members. From this perspective the effectiveness of any intervention aimed to reduce prejudice in young children, and in particular sectarianism in Northern Ireland, is going to be hindered if the explicit or implicit messages they receive within their family homes and their broader community contexts are not congruent with the messages the children receive during the interventions.

It is clear that further research is needed to understand: 1) both the 'what' and the 'how' of prejudice transmission within families in Northern Ireland and 2) how broader societal factors interact with family factors in the crystallisation of prejudiced attitudes in young children. Recent findings strongly suggest that parental socialization processes impact on the formation of prejudiced attitudes in children (Degner & Dalege, 2013). In addition to this Societal–social–cognitive–motivational theory (SSCMT, Barrett, 2007) suggests that numerous sources such as parents, teachers or peer groups, school environments, school textbooks, contents of the media, television, books, and the internet influence the acquisition of intergroup attitudes in children. Parents are assigned a particularly influential role in prejudice transmission from this perspective because parents potentially influence their children not only directly based on their own discourse and practices in relation to social groups but also indirectly via their choices of the child's environment. According to SSCMT (*in Glossary*), parental socialization thus includes not only a direct but also an indirect transfer of intergroup attitudes.

Research on adults has reliably demonstrated that group attitudes can be learned in very specific ways (e.g., paired association learning, illusory correlations). However it is also possible that the process for learning prejudice during childhood and adolescence may diverge significantly from learning in adulthood. It is therefore important to understand the role that processes such as: 1) direct teaching; 2) indirect parental messages; 3) admonitions; 4) prohibitions; 5) concrete examples and modelling; 6) observational learning and imitation; 7) operant learning and social reinforcement; 8) child-rearing techniques and parenting styles; 9) inheritance and 10) selective exposure to social and structural conditions, play in children's acquisition of intergroup attitudes (Degner & Dalege, 2013). It is also important to elucidate how these socialization factors relate to active constructivist processes in children. Researchers also need to examine whether under circumstances where parents or teachers hold implicitly prejudiced attitudes, but do not express overt prejudice, do children also acquire implicitly prejudiced intergroup attitudes.

The role of early childhood care and education providers in addressing the impact of the conflict's legacy on early years' development

This review of the literature focused specifically on the needs of victims' children in Northern Ireland. It was highlighted that victims' children have increased risks for experiencing child poverty (Tomlinson, 2012; Bunting et al., 2013). Research suggests that income affects parental stress levels and thereby changes the consistency and harshness of the parent–child relationship, which in turn affects children's outcomes (McLoyd, 1990; McLoyd et al., 1994). More recent work by Evans and colleagues (Evans & English, 2002; Evans, et al., 2005) argues that poverty contributes to a context of chaos that impinges on children's physiology. Furthermore evidence suggests that policy induced increases to family income have a causal effect on the school achievement of preschool children (Duncan et al.2011). The provision of high quality affordable childcare is an important tool in any attempt to reduce child poverty because it facilitates parental employment and it provides early intervention to promote the healthy developmental needs of children. A successful early years system therefore is one which improves outcomes for all children while simultaneously narrowing the gap in outcomes between children. It is essential therefore that any evaluations of universal early years interventions in Northern Ireland make it a priority to investigate if the gaps between the most advantaged and most disadvantaged decrease as a result of the intervention.

Does ‘quality’ early childhood care and education significantly impact on social development, emotional well-being, executive functioning, and self-regulatory capacities?

This review also highlighted that the consequences of trauma related psychological disorders may hinder the development of buffering attachment relationships between the conflict’s victims and their children. The therapeutic implications of these early experiences cannot be overstated. Research clearly suggests that supportive, responsive relationships with caring adults as early in life as possible can prevent or reverse the damaging effects of toxic stress. It has been suggested that quality early years interventions (quality childcare and education programmes) offer the possibility of providing such buffering relationships for ‘at risk’ infants and children. However, research evidence from both the UK (Sylva et al., 2004) and the US (Keys et al., 2013) suggests that the impact of quality childcare programmes on children’s emotional and behavioural problems is not as strong or long lasting as might have been previously anticipated. For instance findings from the Effective Provision of Preschool Education (EPPE, Sylva et al., 2004) showed that children who begin to attend nursery before the age of two, exhibit higher levels of anti-social and worried behaviour when they begin attending school. This effect remained significant even when preschool centre quality was added to the model. A recent meta-analysis (Keys et al., 2013) conducted in the US, found that preschool centre quality was not reliably related to socio-emotional outcomes, although it was reliably associated with educational outcomes in the areas of both language and mathematics. The NICHD Study of Early Child Care and Youth Development (Vandell et al., 2010) found that higher quality was related to better cognitive, language, and pre-academic outcomes, although behaviour problems tended to increase for children who spent more time in childcare.

The need to embed evidence based social and emotional learning programmes within the early years’ curriculum

In order to address the issues highlighted by the aforementioned findings, intervention scientists have been exploring the value of paying greater attention to foundational skills of social development, emotional well-being, executive functioning, and self-regulatory capacities. These have been identified as key success factors for school readiness and subsequent academic achievement (Blair, 1999; Raver et al., 1999; Blair, 2002). Increasing support for this broader direction has been driven by the documentation of relative deficits in these domains among socioeconomically disadvantaged individuals (Raver, 2012) as well as growing evidence that these skills can be improved through targeted interventions. Importantly, evidence suggests that evidence based SEL (social and emotional learning) programmes offer the best method of achieving this goal (Durlak et al., 2011). It is therefore recommended that evidence based approaches to teaching social and emotional skills be embedded within the early years curriculum. Systematic evaluation of the effectiveness of these programmes within the Northern Ireland context needs to be ongoing. Family resources however have a far stronger impact on children’s social and emotional outcomes than the preschool year (McKeown, 2014) therefore it is imperative that a two generation approach to early intervention, for the most vulnerable families, is also introduced. It needs to be understood that improving children’s outcomes cannot be the sole responsibility of universal early years intervention programmes (universal preschool programmes).

Recent shift of focus onto the provision of earlier interventions in Northern Ireland

It is now known that the neural pathways for sensory and language function have already passed their peak stages of development before the child enters the free pre-school year (Nelson, 2000). Age three is not considered early in terms of brain development (Shonkoff & Fisher, 2013), especially for the most vulnerable children. Furthermore this evidence suggests that in order to augment outcomes for all children and reduce the gaps between children, interventions need to take place with infants and their parents between the ages of birth and three years. In response to this evidence there has been a shift of focus onto the provision of early years interventions for 2-3 year olds. In Northern Ireland this resulted in the launch of the 2-year old Sure Start programmes. Previously, both policy and research had focussed on 3-4 years in the pre-school year. In response to this The Early Years-the organisation for young children in Northern Ireland, developed a programme, Eager and Able to Learn (EAL), for 2-3 year-old children in early years settings. It was developed as a universal programme and it aimed to improve young children's eagerness and ability to learn through enhancing their physical, social, emotional, and linguistic development. A rigorous and independent evaluation of the Eager and Able to Learn programme was conducted by the Centre for Effective Education with the School of Psychology at Queen's. McGuinness et al. (2012) however recommended that in the light of the mixed findings on child outcomes, the content of the programme needed to be re-evaluated to ensure that the positive child outcomes can be maintained and the negative impact minimised. This research however was important because it highlighted some key issues that need to be addressed in relation to Early Years provision for the birth to threes.

The need for intensive interventions for the most vulnerable families

The baseline findings from the EAL evaluation highlighted that the skills gaps between the most advantaged and the most disadvantaged children in the sample were very wide on the majority of the developmental outcome scales. For example on the majority of the scales, scores ranged from 5 to 19 standardized points. Social-economic disadvantage had negative effects on developmental outcomes, particularly for children with the highest levels of disadvantage (i.e., those with Multiple Deprivation Scores in the top quartile of the sample). McGuinness et al. (2012) highlighted that these children need intensive intervention if a positive impact is to be realised, perhaps more intensive than is currently available in two-year-old Sure Start programmes. In addition to this McGuinness et al. (2012) highlighted the low levels of qualifications held by the staff in the majority of these settings. McGuinness et al. (2012) highlighted that initial qualifications for practitioners in early years settings as well as Continuous Professional Development (CPD) needs to be informed by the most up-to-date knowledge about research in child development and how it relates to early years practice. McGuinness et al. (2012) highlighted that the particular needs of the 0-3 age group needs greater attention in both initial training and Continuous Professional Development (CPD). McGuinness et al. (2012) further highlighted the importance of the quality of the settings for early years outcomes. McGuinness (2012) highlighted that the average rated quality of the early years settings in Northern Ireland, based on the findings from EAL pilot, deserved immediate attention.

The need for investment in the capacity building of early years' practitioners

Programmes that provide services for the most vulnerable families must have the expertise and capacity required to address the needs of vulnerable children if significant impacts on the development and well-being are to be achieved. There is a critical need for creative new interventions that strengthen the capacity of childcare practitioners to help build effective coping skills in children who experience high levels of stress. This scaffolding support is particularly critical for children who exhibit increased biological sensitivity to context, which renders them more vulnerable in the face of adversity and more able to benefit from positive experiences (Obradovic et al., 2010). Shonkoff and Fisher (2013) contend that governments need to invest in childcare practitioners so that they can better invest in children. They recommend similar investment in the capacity building of early years practitioners as they do for vulnerable parents. In addition to knowledge in relation to child development Shonkoff and Fisher (2013) recommend that childcare practitioners receive coaching to improve memory, focus, attention, impulse control, organization, problem-solving, and multitasking skills (Babcock, 2014). It has also been suggested that mindfulness meditation training, mind–body exercises (e.g., relaxation breathing practice), and brain games may increase the quality of practitioner–child interactions, and lead to better mental health and health outcomes for the children (Davidson et al., 2003).

The three critical needs of infants and young children who have had exposure to toxic stress

In addition to this, Dozier et al. (2002) suggest that early years practitioners who work with children who have been exposed to toxic stress require training so they can target three critical needs of infants and young children. Firstly, children who have been exposed to toxic stress tend to give behavioural signals that lead even nurturing caregivers to provide non-nurturing care. Practitioners therefore need training to help them to reinterpret children's behavioural signals. Second, some caregivers are not comfortable providing nurturance. At risk children need caregivers to provide nurturance or the children are at risk for a range of problematic outcomes. Some practitioners may therefore need training that helps them overcome their difficulties in providing nurturance. Thirdly, children who have been exposed to toxic stress are at risk for behavioural and bio-behavioural dysregulation as the result of disrupted relationships with caregivers. Childcare practitioners therefore need training to help them to provide children with a predictable interpersonal environment such that children develop better regulatory capabilities.

Conclusions: Two–generational approaches for family interventions in combination with the capacity building of early years' practitioners

In conclusion, early interventions to reduce the risks associated with trans-generational trauma in Northern Ireland need to adopt a family centred approach. It is therefore proposed that the government needs to invest in parents if parents are to develop the necessary capacities to invest in their children. This should involve the development and rigorous evaluation of new and innovative parenting programmes that target specific skill deficits in parents that are known to hinder their ability to manage a household and to secure employment. Cycles of intergenerational poverty that are strongly associated with the development of poor intrapersonal, interpersonal and intergroup functioning need to be addressed urgently. In particular these cycles are associated with maladaptive and in

particular harsh parenting practices that undermine children's mental health and which may also play a role in the socialization of prejudice. Clear messages about the detrimental impacts of the perpetration of violence against children need to be communicated to parents and parents need training to develop more adaptive approaches to teaching children the skills required to self regulate.

It is therefore suggested that quality early years interventions should include the provision of early parenting interventions, as well as, the provision of quality childcare and preschool programmes. It is noteworthy that concerns have been raised about the levels of quality and staff qualifications in childcare centres in Northern Ireland. These issues need to be addressed as a matter of urgency. According to Urban et al. (2012) the defining feature of a 'competent system' is the support it offers practitioners to develop their capacities. It is therefore the quality of this support that enables practitioners to realise their capabilities to develop responsible and responsive practices that respond to the needs of children and families in complex societal contexts. Urban et al. (2012) highlighted that in order to support competent practice practitioners need to be paid for engaging in these training activities. Furthermore, in light of evidence that 'quality' practice alone does not impact on children's social and emotional outcomes, it is recommended that evidence based SEL programmes be embedded within the early years curriculum in Northern Ireland.

Chapter Three

LATENT PROFILES OF CHILDHOOD ADVERSITY, EXPOSURE TO CONFLICT RELATED TRAUMA AND MENTAL HEALTH DISORDERS IN THE NORTHERN IRELAND POPULATION

Cherie Armour and Margaret McLafferty

Introduction

Studies have found that the Northern Ireland conflict impacted on the population's psychological health. However, it has been proposed that childhood adversities are also key etiological factors in the onset and persistence of mental health disorders. The current study utilized data obtained from the Northern Ireland Study of Health and Stress (NISHS), a collaborative epidemiological study, which used the WMH-CIDI to assess mental health disorders and associated risk factors in a nationally representative sample of 4,340 participants. The aims of this study were to examine the prevalence of childhood adversities in Northern Ireland, to assess co-occurrence across childhood adversities by using a person centred approach to uncover patterns of adversity, and to investigate the relationship between adversity profiles and subsequent psychological health. Three discrete childhood adversity profiles were uncovered, a low risk group, a poly-adversity group (i.e., multiple adversity experiences) and an economic adversity group. Statistical analyses demonstrated that individuals experiencing more prominent adversity profiles were more probable to report having mental health problems when compared to those with less prominent adversity profiles. For example, it was more probable that individuals in the economic adversity class would report having anxiety and substance disorders, while those in the poly-adversity class would report anxiety, mood, and substance disorders as well as suicidal ideation and behaviour. Subsequently, the study examined co-occurrence of childhood adversities, conflict related events and a range of mental health disorders using the same Northern Ireland population based data. Four profiles of trauma and mental health were revealed, a low risk class, a class which endorsed high levels of conflict related traumas and psychopathology, a multi-trauma class which endorsed high levels of childhood adversities, conflict related events and psychopathology, and finally a class which endorsed high levels of psychopathology with little childhood or conflict related traumas. Overall the study revealed that individuals who experienced a greater degree of adversity were those more probable to have negative mental health and suicidal outcomes. The findings highlight the need to consider the dual impact of the Troubles and childhood adversities when planning interventions and treatment.

Background

The Northern Ireland population endured over 30 years of political violence, colloquially known as the Troubles. As outlined in the literature review at the start of this report, research has found that the Northern Ireland conflict impacted greatly on the psychological health of the population (O'Reilly & Stevenson, 2003; Gallagher et al., 2012; Bunting et al., 2013). Muldoon et al. (2005) reported that many people attribute their mental health problems to the Northern Ireland conflict, with those directly impacted reporting higher prevalence rates of depression and anxiety disorders. A recent epidemiological study found that Northern Ireland has one of the highest rates of PTSD in the world and that this elevated rate was

associated with experiences of conflict related events (Bunting et al., 2013). Tomlinson (2012) reported that people who grew up during the worst years of the Northern Ireland Troubles have an increased risk of suicidal behaviour. Furthermore, O'Connor et al. (2014) found an association between experiences of the Troubles and self-harm in adolescents. These high rates of psychopathology may be due to the nature and longevity of the Troubles, however, levels of mental illness found in other conflict zones have been lower in comparison, suggesting that additional issues may be affecting the rates in Northern Ireland. Given the high prevalence and economic impact of mental health problems (Ferry et al., 2011), it is important to understand other factors and how they interact with conflict exposure to effect mental health. Doing so will help in the development of strategies to address these issues.

The associations between exposure to conflict related trauma and mental disorders are well recognised (de Jong et al., 2010). However, Miller and Rasmussen (2010) proposed that non-conflict related traumas add to the effect of conflict. For example, studies have found that military personnel with a history of childhood adversities have elevated levels of mental health problems (Cabrera et al., 2007; Sareen et al., 2012; Dohrenwend et al., 2013). A recent report examining psychopathology in civilians from war affected Northern Uganda found that childhood maltreatment had a greater detrimental impact on mental health than exposure to war (Olema et al., 2014). An examination of trajectories of internalising problems in youth from post-conflict Sierra Leone also found that continued psychological issues were associated with adversities such as parental loss, abuse and neglect within the family, as well as continued community stressors (Betancourt et al., 2013).

Epidemiological studies have reported that adversities during childhood can indeed have a detrimental impact on mental health. Findings from the WHO World Mental Health (WMH) Survey Initiative indicate that childhood adversities account for 29.8% of mental health problems globally (Kessler et al., 2010). Adversities related to maladaptive family functioning in particular, such as those involving parental maladjustment and maltreatment, are strongly associated with both the onset and persistence of many psychiatric disorders (Green et al., 2010; McLaughlin et al., 2010a). It has been suggested that the detrimental impact is due to the enduring nature of these types of adversities (McLaughlin et al., 2010b). Other studies also confirm that dysfunctional and abusive family relationships have a profound impact on mental health disorders, including depression, anxiety, and PTSD (Weich et al., 2009; DeVenter et al., 2013; Fryers & Bruga, 2013). In addition, externalising disorders, substance use disorders (Slopen et al., 2010), and suicidal behaviours (Bruffaerts et al., 2010) are all associated with adversity during childhood. A number of WMH Surveys which have been conducted corroborate that individuals who experienced childhood adversities, especially those involving dysfunction within the family, are more likely to report a range of mental health problems, (Pirkola et al., 2005; Benjet et al., 2010; Oladeji et al., 2010; Lee et al., 2011).

Some cross-national differences however have been found with regards to prevalence rates and the impact on various disorders, with some studies proposing that specific adversities can lead to the development of various types of psychopathology. For example, while examining the South Africa Stress and Health Study, Slopen et al. (2010) found that in comparison with Whites, Africans had higher prevalence rates of childhood adversities and that these adversities impacted on the development of anxiety disorders. A Japanese study reported that mood disorder was associated with physical abuse and mental health, yet they found no specific adversity associated with anxiety disorders (Fujiwara & Kawakami, 2011).

Oladeji et al. (2010) also found no specific adversity related to the onset of anxiety problems, however, they found that individuals who experienced three or more adversities were 12 times more likely to exhibit anxiety disorders later in life.

Childhood adversities may increase vulnerability to stress, impacting on the ability to cope with future stressors. The stress sensitisation hypothesis proposes that exposure to severe stress early in life can increase sensitivity to stress in adulthood (Breslau & Anthony, 2007). Indeed, McLaughlin et al. (2010b) found that stressful events in the previous year were related to an increased risk of 12-month psychological problems, with those who experienced adversity in childhood displaying elevated rates of psychopathology. A longitudinal study also found that emotional reactivity to stress was heightened in those who experienced childhood adversities and that this reactivity was in turn related to elevated levels of mood and anxiety disorders (McLaughlin et al., 2010c). Other studies have suggested that the impact of trauma can depend on both the nature of the traumatic event itself and the vulnerability of the person affected by that event (Chou & Su, 2012).

In the context of Northern Ireland, it has been proposed that it was not only the experience of the Troubles that impacted on the population's mental health, but also the associated poverty and deprivation (Muldoon, 2004), which in turn has been linked to maladaptive family functioning and subsequent psychopathology (Fryers & Brugha, 2013). Cummings et al. (2010) suggested that sectarian violence is strongly associated with increased rates of family conflict. Other studies have reported that conflict exacerbates daily stressors (Miller & Rasmussen, 2010), indirectly impacting on intra-family relationships and parenting quality, resulting in elevated rates of childhood adversities which can have long term consequences for the child and may also lead to the intergenerational transmission of trauma.

While early trauma studies focused on the impact of single adversities in childhood, research has found that many adversities co-occur, have a cumulative effect, and predict further adversity (Armour et al., 2014; Dong et al., 2004; Rosenman & Rogers, 2004; Copeland et al., 2007; Kessler et al., 2010). It is important therefore to account for co-occurrence as it is likely that different combinations of adversities may result in varying mental health outcomes. Additionally, it is difficult to separate out the impact of specific adversities. Shevlin and Elklit (2008) recommend that researchers should focus on individuals with comparable profiles of adversity. Recent studies have used a statistical technique called latent class analysis to identify adversity profiles (Hazen, et al., 2009; Ford et al., 2013; Armour et al., 2014) and subsequently explore associations between the profiles and psychopathology (Dunn et al., 2011). Poly-victimised subgroups reported higher rates of psychopathology and different profiles were related to specific mental health disorders (Dunn et al., 2011). Similarly, events related to the Troubles are unlikely to occur in isolation. As noted above, the impact of the Troubles on family life may result in elevated rates of childhood adversities which in turn could lead to the child becoming even more exposed to conflict related events. The direct and indirect impact of the Troubles is therefore complex and may result in the co-occurrence of both childhood and conflict related traumas. Northern Ireland, being a post conflict setting, provides a unique opportunity to research the dual impact of the Troubles/conflict and childhood adversities on psychopathology.

The aims of this analysis

- 1) To examine the prevalence of childhood adversities in the Northern Ireland population;
- 2) To assess co-occurrence across 12 childhood adversities and examine the association between the identified adversity classes and subsequent mental health disorders, including, DSM anxiety, mood and substance disorders and suicidal ideation and behavior;
- 3) To assess co-occurrence across 12 childhood adversities, 11 conflict related traumas, and DSM mood, anxiety and substance disorders.

Based on previous reports, it was predicted that a greater degree of adverse experiences would be associated with more negative outcomes with regards psychological health and suicidality.

Findings

Prevalence of childhood adversities in Northern Ireland

Questions related to childhood adversity are included in part 2 of the NISHS. The current study used 12 childhood adversities as identified in other WMH surveys (Green et al., 2010). The 12 retrospectively reported adversities experienced before the age of 18 were; parental death, parental divorce and other parental loss, parental mental illness, substance disorder, criminality and family violence and physical abuse, sexual abuse and neglect, along with economic adversity and serious physical illness during childhood. The type and frequency of childhood adversities were examined and prevalence estimates were then calculated to represent the percentage of all respondents who experienced any childhood adversities. Figure 3.1 presents the prevalence of childhood adversities in Northern Ireland and compares them with averages reported for other high income countries based on findings from WMH surveys (Kessler et al., 2010).

Other WMH studies have reported high prevalence rates of childhood adversities (Kessler et al., 2010). Rates in Northern Ireland ranged from 1.9% for parental criminal behaviour and neglect to 10.1% for parental death. Of particular note, economic adversity was very high in Northern Ireland when compared with averages from other high income countries. Even though Northern Ireland is classified as a high income country it has many disadvantaged areas, with high levels of poverty and deprivation reported, which may help account for the extent of economic adversity reported in the population. While most adversities associated with maladaptive family functioning, including parental maltreatment and maladjustment were much lower than those reported in other studies particularly neglect (Kessler et al., 2010), the prevalence of parental mental illness in Northern Ireland was higher.

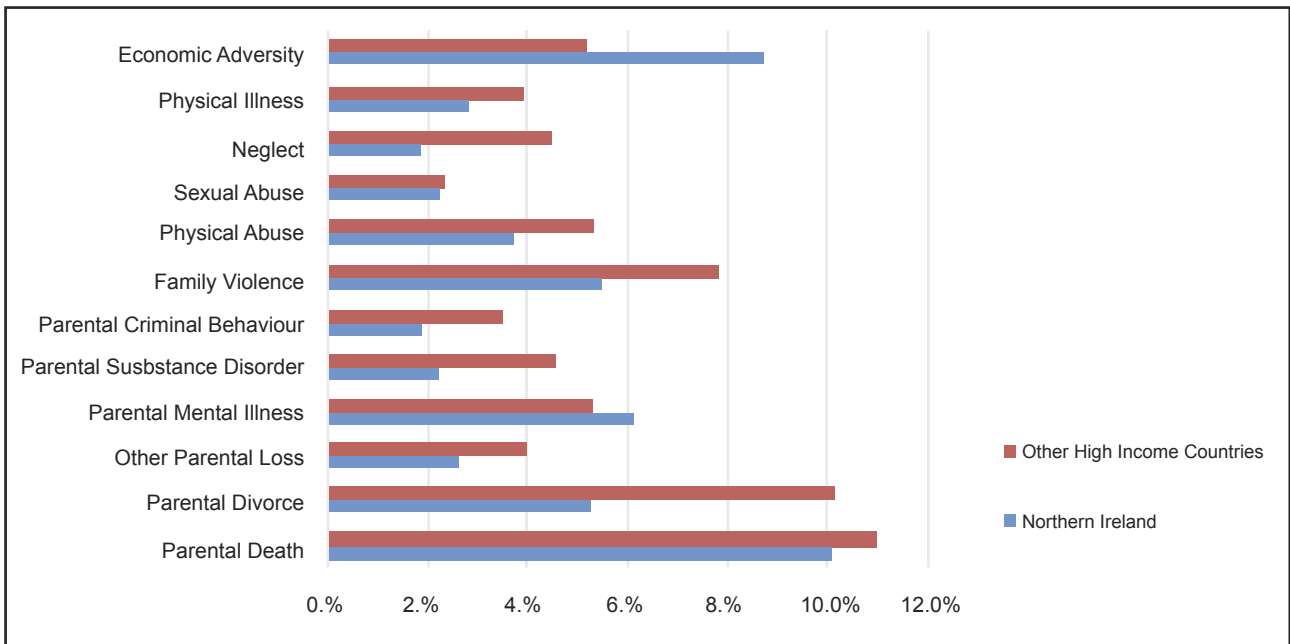


Figure 3.1 Prevalence rates of childhood adversities in Northern Ireland compared with average rates reported in WMH surveys (Kessler et al., 2010)

Overall 32% of participants reported childhood adversities in Northern Ireland, which is a cause for concern. While co-morbidity of adversities was found, of those who experienced adversity during childhood 62.5% experienced only one such adversity (Figure 3.2).

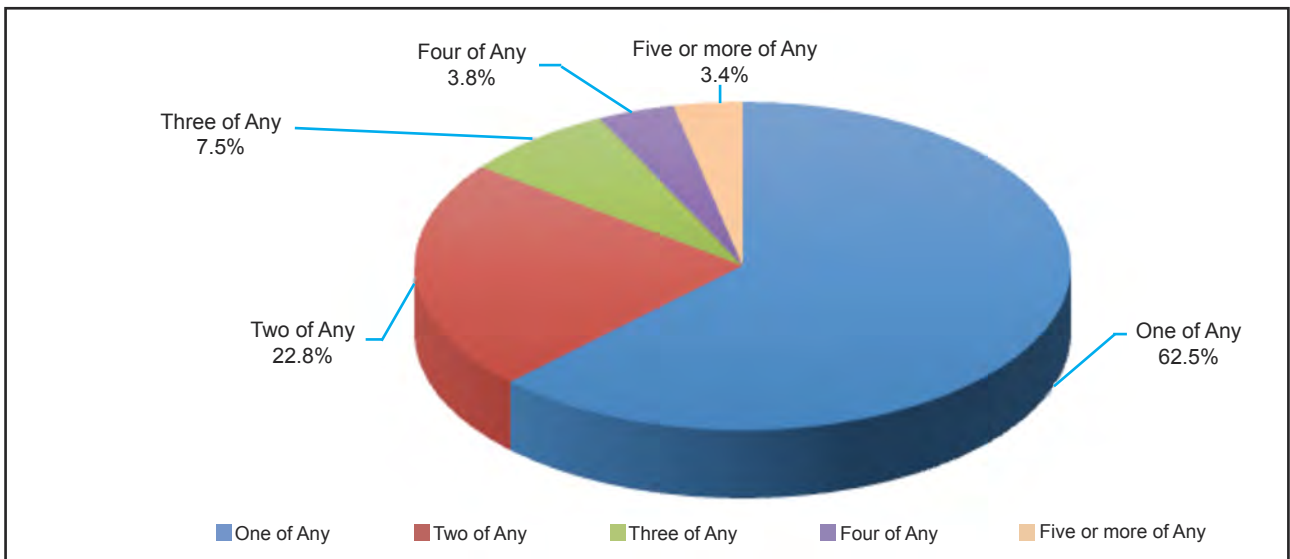


Figure 3.2 Prevalence estimates of childhood adversities

Profiles of childhood adversity

The study then used an exploratory process, Latent Class Analysis, to identify patterns of adversity in the population based on participant’s responses to 12 childhood adversities. Latent Class Analyses is essentially a technique which creates sub-groups from an overarching group. In order to determine the optimal number of groupings, a range of model fit indices (established guidelines used for selecting the number of groups that best represent

the data) were evaluated. After a thorough examination of these fit indices and the substantive meaning of the latent groups, the solution containing three groups was deemed the best representation of adversity groupings within the data.

- Group 1, representing 7.8% of the sample was characterised by a high probability of reporting **economic adversity** and was labelled the **economic adversity** group. This group also had a high probability of reporting parental death or divorce, suggesting that these are associated with economic adversity.
- Group 2 was characterised by the highest probability of reporting a range of childhood adversities particularly those concerning maladaptive family functioning, such as family violence and physical abuse and was labelled the poly-adversity group, accounting for 6.1% of the sample. This group was labelled the **poly-adversity** group.
- Group 3 accounted for 86% of the sample and was characterised by low probabilities of reporting childhood adversities. This group was considered the baseline or normative group and was labelled the **low risk** group.

In accordance with previous studies (Armour et al., 2014), the co-occurrence of childhood adversities appears to be common. In particular, adversities related to maladaptive family functioning are particularly likely to co-occur (Green et al., 2010; McLaughlin et al., 2010a). The identification of a group characterised by elevated levels of economic adversity however indicates the scale of the problem in Northern Ireland. The high rate of economic adversity reported may in part be related to the participants growing up during the Northern Ireland conflict (Gallagher et al., 2012). According to previous reports, areas most affected by the conflict in Northern Ireland also experienced high levels of poverty and deprivation (Muldoon, 2004) and continue to do so (Knox, 2014). Kelly et al. (2012) reported that in comparison to other areas in the UK, persistent child poverty remains high in Northern Ireland, suggesting that the Troubles, poverty, and associated social deprivation, may still be impacting on children today.

Childhood adversities and mental health

The statistical analysis revealed that individuals from groups characterised by a greater degree of adversity during childhood, were more likely to report poorer mental health outcomes compared with the low risk group. Indeed, individuals in the **economic adversity** group were almost twice as likely to suffer from an anxiety disorder or a substance disorder. McLaughlin et al. (2011) proposed that poverty leaves a person more vulnerable to mental health problems. Previous studies have also found a link between social deprivation and psychopathology in Northern Ireland (McConnell et al., 2002). Individuals from the **poly-adversity** group were five times more likely to have an anxiety disorder, three times more likely to have a mood disorder, more than four times more likely to have a substance disorder, and more than four times more likely to exhibit suicidal ideations or behaviour. These findings are in accordance with previous studies which found that adversities related to child abuse and family violence had the greatest detrimental impact on future psychopathology (Slopen et al., 2010; Fujiwara & Kawakami, 2011; DeVenter et al., 2013).

In accordance with previous studies (Eaton et al., 2012), males in Northern Ireland were more likely to have substance disorders but significantly less likely to have anxiety or mood

disorders. An additional finding in the current study was that long-term relationships are protective against adverse mental health outcome. Other studies have indeed reported that relationships and social support help to minimize the psychological impact of trauma (Smyth et al., 2013). In the current study, people who never married were significantly more likely to develop substance disorders. In comparison to those who were married or co-habiting, individuals who were previously married (therefore separated, divorced, or bereaved) reported significantly higher levels of mental health problems, including anxiety, mood and substance disorders as well as suicidality. In addition, individuals with a high income were significantly less to exhibit suicidality.

A number of age differences were revealed when examining mental health problems. When comparing groups with those over 65, all age groups were significantly more likely to have a range of mental health problems. Those aged 18-34 were more than eight times more likely to have a substance disorder as well as other mental health problems. People in the age group 35-49 were more than four times as likely to have a mood disorder and were also significantly more likely to report having an anxiety disorder, substance disorder, or suicidality. People in the age group 50-64 were over twice as likely to report anxiety disorders and suicidal ideation and behaviour. These individuals were also significantly more likely to have mood or substance disorders.

Due to the history of the Northern Ireland conflict, in the assessment of traumatic events, Bunting et al. (2013) distinguished between Troubles and Non-troubles related traumas. Troubles related events were assessed using questions identified in previous studies examining conflict and psychopathology (Karam et al., 2008), if the events were experienced after the beginning of the conflict in 1968. The 12 events included experiencing any of the following: refugee, kidnapped, relief worker in a war zone, combat experience, civilian in a war zone, experiencing combat, witnessing atrocities, manmade disasters, beaten by someone other than a partner or parent, mugged or threatened with a weapon, witnessing death of serious injury purposely causing death or serious injury and being a civilian in a place of ongoing terror. The trauma variables were created using each trauma question, the year the event was first experienced, the participant's current age and the year at interview. In the current study, after controlling for a range of socio-demographic factors such as gender, age, marital status, income and education and adversity classes, individuals reporting conflict related traumas were more likely to exhibit mental health problems. They were over three times more likely to report anxiety disorders, and over twice as likely to report mood disorders, substance disorders, and suicidality. These findings are in accordance with previous studies which found a strong association between conflict and negative mental health outcomes (Priebe et al., 2010), particularly anxiety disorders.

Childhood adversities, conflict and mental health

In the previous analyses above we assessed typologies of childhood adversity and how these were related to mental health outcomes, whilst controlling for a number of other factors such as gender and age. In this section we wanted to specifically assess whether any particular group of individuals have a high likelihood of reporting childhood adversities, conflict related traumas, and psychopathologies. In other words we wanted to see how these events co-occurred in the Northern Ireland population. To do this we again used latent class analysis to identify underlying latent classes. In this latent model, the indicators were the responses

to 12 childhood adversities, 11 conflict related traumas (the prevalence rate of purposely causing death or serious injury, n=7 was very low and therefore it was removed from the LCA), and a range of mental health diagnostic questions (any anxiety, any mood, any substance disorders). Models comprising of between 2 to 5 latent classes were estimated. Again to determine the optimal number of latent classes, we consulted a range of established model fit indices. Following a thorough examination of the fit indices and the substantive meaning of the latent classes the four class solution was deemed optimal.

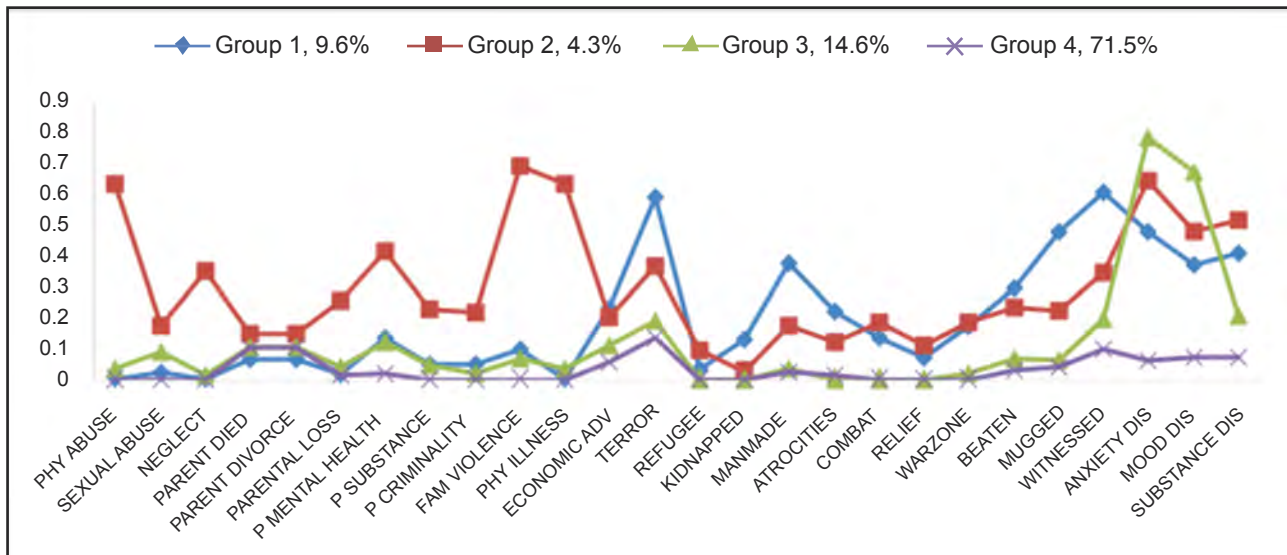


Figure 3.3 Latent profile plot of mental health disorders, childhood and conflict trauma indicators.

Note: Group 1 Conflict group, Group 2 Multi-trauma group, Group 3 Psychopathology group, Group 4 normative or baseline group.

Figure 3.3 depicts the latent class profile plot for the four class model.

- Group 1 was characterised by high levels of conflict related traumas along with some childhood adversities and moderate levels of mental health disorders. This group was labelled the **conflict** group, accounting for 9.6% of the sample.
- Group 2 accounted for 4.3% of the sample. This group was characterised by endorsing the highest probability of experiencing a wide range of adversities in childhood, particularly those termed maladaptive family functioning, with moderate levels of conflict related experiences and elevated levels of mental health disorders and was labelled the **multi-trauma** group.
- Group 3 accounted for 14.6% of the sample and was characterised by the highest levels of mental health problems, with little conflict related experiences but some adversities in childhood and was labelled the **psychopathology** group.
- Group 4, the largest group, comprised of 71.5% of the sample and was characterised by low probabilities of experiencing childhood adversities, conflict related traumas, and mental health disorders; this was considered the normative or baseline group and labelled the **low risk** group.

In summary, the current study revealed four groups of adversity and mental health in Northern Ireland; a **low risk** group, a group which endorsed high levels of conflict related traumas and mental health disorders (**conflict** group), a **multi-trauma** group which endorsed high levels of childhood adversities along with conflict related events and mental health disorders, and finally a group which endorsed high levels of mental health disorders with little childhood or conflict related traumas (**psychopathology** group). The study established that individuals with more prominent trauma profiles are also those who report co-occurring mental health problems. While the experience of the Troubles was found to impact on the development of anxiety, substance and mood disorders, individuals who endorsed high levels of childhood adversities along with conflict related traumas, the multi-trauma group, had more negative mental health outcomes, displaying higher levels of psychopathology. The group which endorsed high levels of mental health problems with low levels of trauma had the highest levels of anxiety and mood disorders but the prevalence of substance disorders were much lower than the groups which endorsed adverse life experiences. This would suggest that prior trauma involving childhood adversities and/or conflict related events severely impacts on the development of substance disorders in the Northern Ireland population. The elevated level of anxiety and mood disorders in this group warrants further investigation.

Limitations

While every effort was made to ensure the quality and reliability of the data collected, population based surveys can be problematic. A limitation of the study was that the sample may not be fully representative of the population as a number of people were excluded from participating in the survey, including people with learning disabilities, the homeless, immigrants, as well as those in hospitals, institutions, prisons, and military barracks. This may lead to an underestimation of mental health problems in the population as a number of these groups may display higher rates of psychopathology (WHO, 2012). In addition, some of these people may have experienced more conflict related events. However, all WMH surveys have the same sampling requirements and the NISHS followed the standardised design of the WMH-CIDI (Kessler & Ustun, 2004). A further limitation of the study could be the categorisation of traumas. Bunting et al. (2013), when examining conflict related events in the NISHS, acknowledged that the traumas were only presumed to be Troubles related. Furthermore, participants may have feared recrimination if they admitted involvement in a conflict related event. Finally those who had the most serious mental disorders and suicidal behaviour will not have been included in the study due to premature mortality.

Conclusions

This research may have some limitations however it provides valuable information on a range of childhood adversities and traumas and the detrimental impact they have on the mental health of the population in Northern Ireland, adding to previous literature. The study demonstrates that both childhood adversities and conflict related traumas play a major role in the development of psychopathology, highlighting the need to consider the dual impact of these risk factors when planning interventions and treatments in Northern Ireland. This research provides support for initiatives which attempt to address adversities associated with negative family environments and the trans-generational transmission of trauma. It also highlights the need to target interventions and services towards those at highest risk of poor mental health outcomes, i.e., children who have been exposed to multiple traumas and

childhood adversities, particularly poverty. Additionally the study informs policy makers and practice by emphasising the importance of targeting children at risk of multiple adversities. The association found between economic adversity and psychopathology in the current study should be taken into account when deliberating social and economic policies in Northern Ireland. Proposed changes in welfare benefits for those with mental health disorders may exacerbate their problems. Further research which examines the interaction of the Northern Ireland Troubles and childhood adversities on mental health would be beneficial, given the economic cost of addressing the associated problems, along with the increasing rates of mental health disorders and suicides in the population. The literature review conducted for this report found that economic adversity still impacts profoundly on children in Northern Ireland. Since elevated rates of economic adversity were found in the current study further, research which examines the long term impact of deprivation would be beneficial.

Chapter Four

TRANS-GENERATIONAL TRAUMA IN NORTHERN IRELAND: RESULTS FROM THE NORTHERN IRELAND STUDY OF HEALTH AND STRESS

Áine McKenna and Brendan Bunting

Introduction

The basic premise underlying the current research is that trauma exposures associated with the civil conflict/Troubles impacted negatively on the parenting practices and family functioning of the victims. Evidence suggests that these maladaptive parenting patterns persist in post conflict societies and that these patterns mediate poor psychological functioning from one generation to the next. Research from other post-conflict societies suggests that the psychological suffering associated with trauma exposure is transmitted intergenerationally (Kellerman 2014; Sailea et al., 2014). A well grounded concern for the psychological welfare of the victims and their children is now emerging in Northern Ireland. Tomlinson (2012) revealed that over 40 per cent of Northern Irish children live with parents who have 'high' or 'moderate' experience of the civil conflict. It has been previously established that those who had direct experience of conflict related trauma in Northern Ireland, were more likely than those who had no such experiences to suffer from PTSD, mood, anxiety, substance abuse, and impulse control disorders (Bunting et al., 2013). As far back as 1954, Allport suggested a connection between ethno-political violence and aggressive parenting practices. More recent research suggests that these aggressive parenting behaviours may be the consequence of psychopathology in parents that results from their own trauma exposures (Roberts et al., 2012; Roth et al., 2014; Sailea et al., 2014; Leen-Feldner et al., 2011; Harkness, 1993).

The current analysis aimed:

- 1) To elucidate typologies of Childhood Toxic Stress (CTS), engendering exposures to parental maladjustment and interpersonal violence;
- 2) To investigate if such exposures increased during the conflict years (1968-1994);
- 3) To investigate if patterns of childhood maltreatment, predominantly characterised by physically aggressive parenting, would significantly predict exposures to conflict trauma;
- 4) To examine if experiences of childhood maltreatment would be significantly and directly associated with mental health and suicide outcomes; and
- 5) To test whether the relationship between childhood maltreatment and mental health and suicide outcomes would be partially mediated through exposure to conflict trauma.

Identifying typologies of childhood toxic stress

Latent Class Analysis (LCA) was conducted to empirically elucidate subgroups within the population that had experienced exposures to toxic stress during their childhoods. The aim of this analysis was to uncover subgroups within the population who had experienced co-occurring patterns of parental maladjustment and aggressive parenting behaviours. The

purpose of LCA is to identify subgroups within a population within which there is no longer any association of one indicator with another, because the membership of this subgroup is considered to cause the association among the indicators. In this way different patterns of co-occurrence should be evident within the various identified subgroups. LCA is known as a person centred modelling approach because it groups individuals into subgroups based upon their response patterns to the indicators. The indicators included in the LCA can be viewed in Table 4.1 and the percentage of the population estimated to be members of each of the latent classes is illustrated in Figure 4.1

Table 4.1 Indicators used to estimate the latent classes

<p>Physical Abuse Were you ever kicked, bit or hit with a fist, beat up, choked, burned or scalded, threatened with a knife or gun?</p>
<p>Family Violence How often did (your parents/the people who raised you) do any of these things- pushed, grabbed or shoved, threw something, slapped or hit – to each other while you were growing up?</p>
<p>Harsh Physical Punishment How often were you pushed, grabbed or shoved, had something thrown at you, slapped or hit?</p>
<p>Sexual Abuse Sexual intercourse or penetrating their body with a finger or object when they did not want them to, either by threatening them or using force, or when they were so young that they didn't know what was happening OR inappropriate or unwanted touching.</p>
<p>Neglect Made to do chores that were too difficult or dangerous ; left alone or unsupervised; go without things you need like clothes, shoes, or school supplies because your parents spent the money on themselves; go hungry ; ignore or fail to get you medical treatment.</p>
<p>Parental Criminal Behaviour Parent engaged in criminal activities like burglary or selling stolen property or was arrested for criminal activity.</p>
<p>Parental Mental Health Disorder Major depression/ generalized anxiety disorder/ panic disorder/antisocial personality disorder.</p>
<p>Parental Substance Disorder Any substance or alcohol disorder.</p>

The LCA identified 3 subgroups within the Northern Ireland population:

- **Group 1 Harsh Physical Punishment** (4.1%);
- **Group 2 Maltreatment Group** (4.3%);
- **Group 3 Low Risk Group** (91.3%).

Figure 4.1 shows that the patterns of exposures to Childhood Toxic Stress were associated with subgroup membership. Members of the harsh and maltreatment subgroups were more likely than the low risk class to have experienced family violence, harsh physical punishment and to have had parents who suffered from mental illness or substance use disorders. The harsh class differed from the maltreatment class because they did not experience physical abuse or neglect. It is therefore suggested that membership of the maltreatment subgroup was characterised by more severe exposures to childhood stress than membership of the harsh subgroup and in addition to this, members of this class may have lacked the buffering support of caring adults. In order to examine the socio-demographic correlates of subgroup membership, logistic regression analyses were conducted. Age, childhood poverty and years in education were significantly associated with latent class membership.

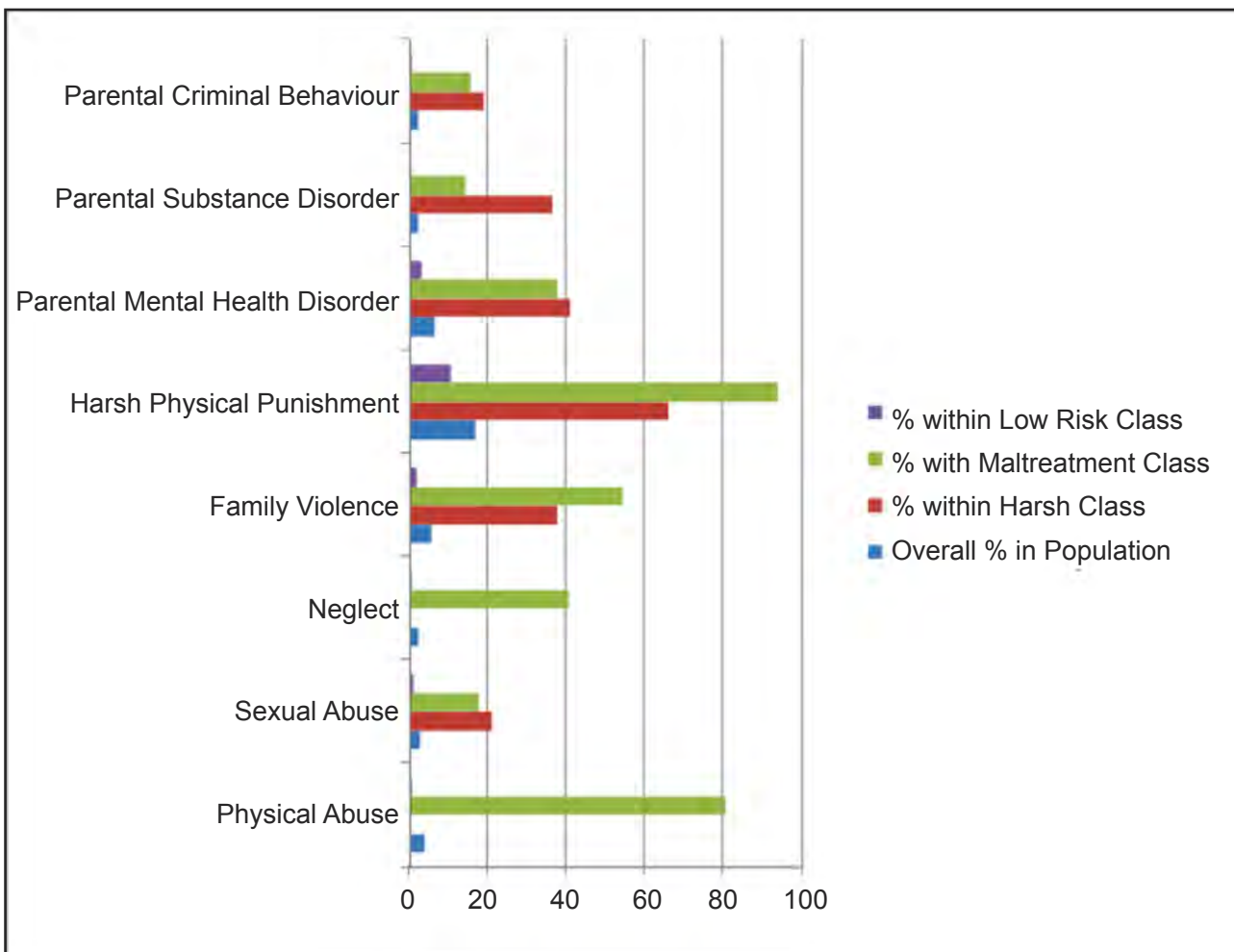


Figure 4.1 Percentages exposed to each toxic stress indicator in the overall population (blue) and within each latent class: Harsh (red); Maltreatment (green); Low Risk (purple).

Allport (1954) suggested that harsh parenting practices are associated with ethno-political violence. In addition to this, the findings of Harkness (1993) and Sailea et al. (2014) suggest that parental psychopathology resulting from trauma exposures leads to increasing prevalence of domestic violence and aggressive parenting practices. It was therefore hypothesised that membership of the Childhood Toxic Stress subgroups would have begun to increase around the time of the emergence of the civil conflict (1968) in Northern Ireland. This research confirms that this increase in subgroup membership became evident around the time of the emergence of the civil conflict, the mid to late 1960s. Those in the maltreatment and harsh subgroups were significantly more likely to be younger than those in the low risk class. The mean age for harsh subgroup membership suggests that the mean year of birth for this class was 1966 (1952 – 1980). The mean age for maltreatment subgroup membership suggests that the mean year of birth was 1963 (1949-1977). For the low risk group, the mean year of birth was 1960.

The Harsh Physical Punishment Group

The empirically identified risk factors for experiencing early toxic stress include parental mental health problems, poverty, childhood neglect, abuse and family violence (Shonkoff et al., 2009). Children who experience toxic stress are known to be at increased risk for mental health disorders (Felitti et al., 1998; Maughan et al., 2000). The percentage of respondents within the harsh class who experienced these indicators are illustrated in Figure 4.2.

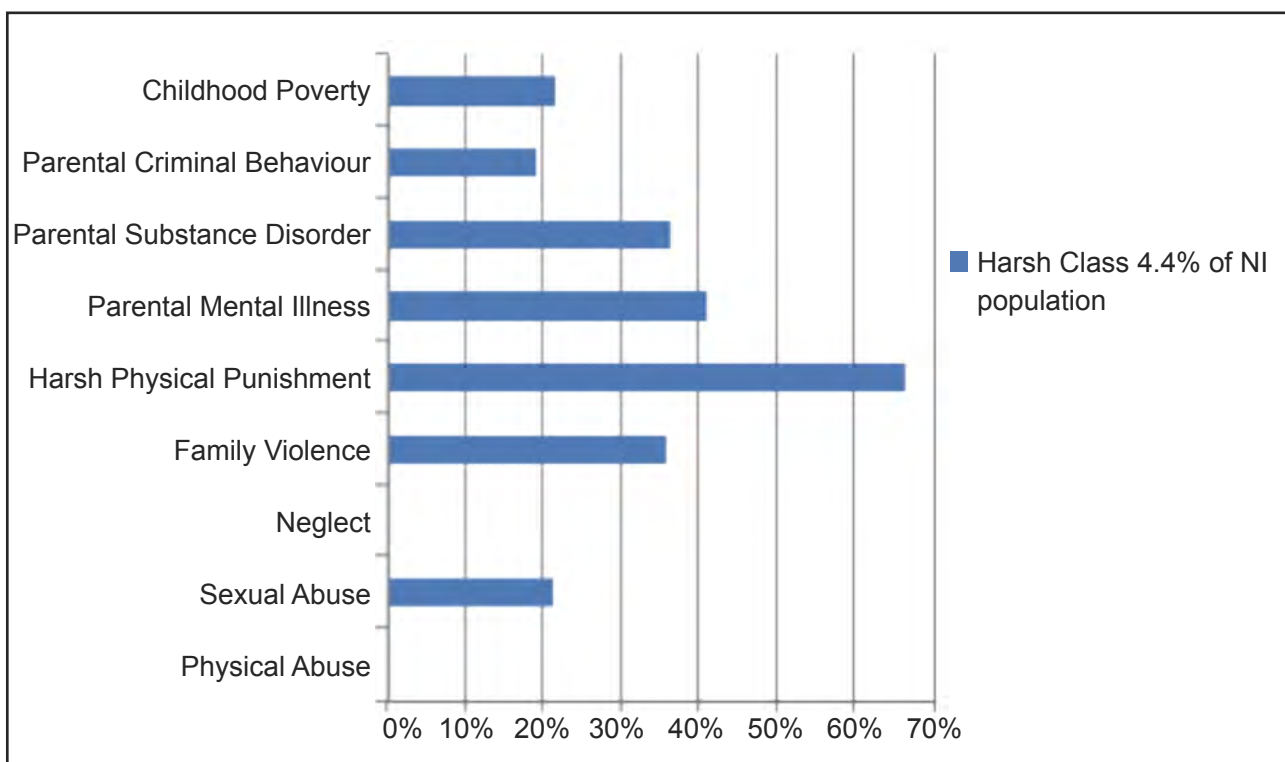


Figure 4.2 Prevalence of risks for toxic stress exposures within the Harsh Class

Figure 4.2 shows that 66% of the harsh class were exposed to harsh parenting practices and these practices co-occurred with family violence and parental maladjustment. This subgroup was also at risk of exposures to childhood poverty and sexual abuse. These findings suggest that this class were at increased risk of developing psychopathology and of exposures to conflict related trauma compared with the low risk class. Allport (1954) argued

that there is a dynamic connection between harsh parenting practices and participation in ethno-political violence. These are usually dealt with separately within the literature but an emerging body of evidence suggests that those who experience childhood toxic stress, characterised predominantly by aggressive parenting practices, are also more likely to be exposed to community violence (Overstreet and Braun, 2000; Cecil et al., 2014).

The Maltreatment Class

The percentage of respondents within the maltreatment class who experienced the toxic stress indicators are illustrated in Figure 4.3.

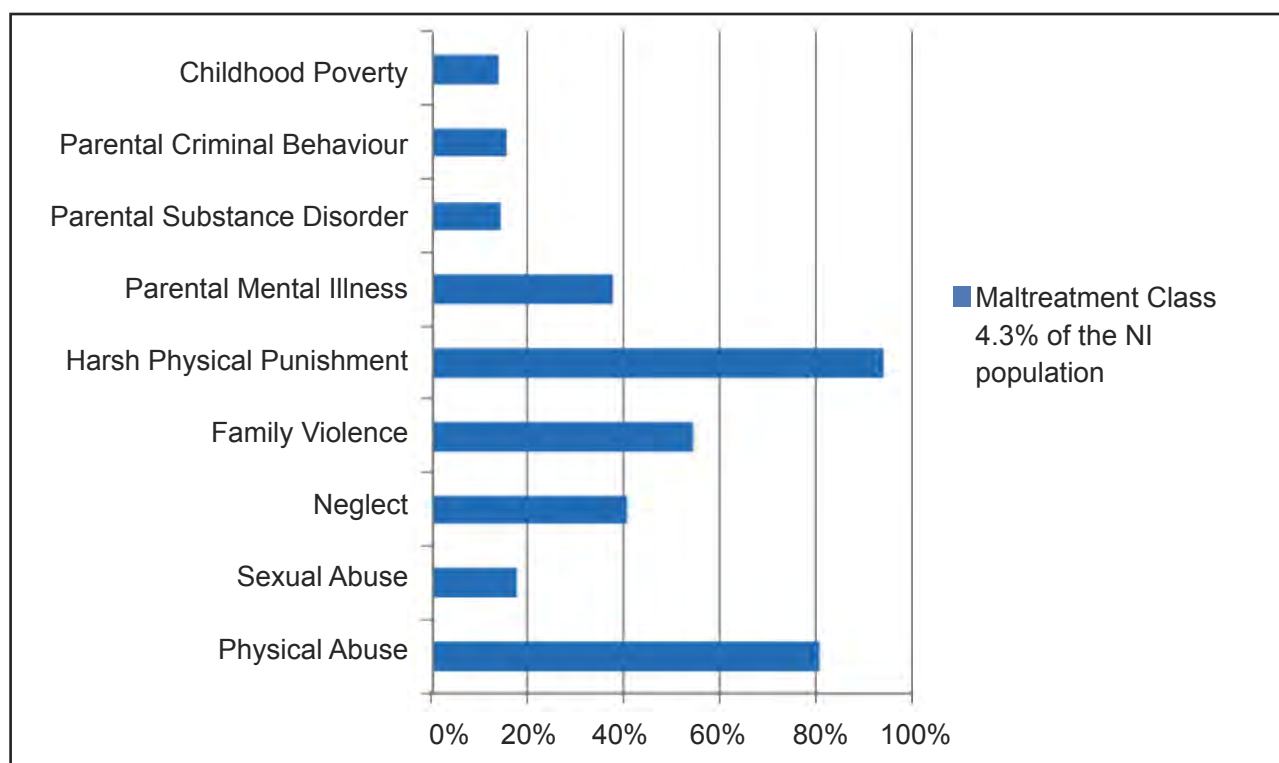


Figure 4.3. Prevalence of risks for toxic stress exposures within the Maltreatment Class

Figure 4.3 shows that 80.7% of the maltreatment class were exposed to physical abuse and 94.2% were exposed to harsh physical punishment. Similar to the harsh class these stressors co-occurred with family violence and parental maladjustment. This subgroup were also at risk of exposures to childhood poverty and sexual abuse. These findings suggest that this class were at increased risk of developing psychopathology and of exposures to conflict related trauma compared with the low risk class. A comparison of Figure 4.3 and Figure 4.2 reveals similar patterns of co-occurrence between both the harsh and maltreatment classes. It is evident however that the maltreatment class were exposed to more severe forms of violence during their childhoods. It is expected therefore that both classes will be more likely to develop psychopathology than the low risk class but that the maltreatment class will display higher risks than the harsh class. This is because previous research has revealed a dose response relationship between childhood physical abuse and the associated risks for developing psychopathology.

Testing associations between childhood toxic stress exposures, conflict trauma exposures and psychopathology

In order to test whether Chronic Toxic Stress (CTS) exposure patterns influenced exposures to conflict related trauma and increased risks for developing psychopathology, the following hypotheses were tested, using path analysis. First, it was predicted that the patterns of CTS, predominantly characterised by co-occurring parental psychopathology and physically aggressive parenting, would significantly predict exposures to conflict trauma. Secondly, it was predicted that experiences of CTS would be significantly and directly associated with mental health and suicide outcomes and that these relationships would be dose-response in nature. The final aim of the study was to test whether the relationship between childhood toxic stress and mental health and suicide outcomes would be partially mediated through exposure to conflict trauma. It was also predicted that the mediated relationship would hold stable after controlling for age and gender and a range of socio-demographic correlates which are known to pose a risk for mental illness. The paths for this model are illustrated in Figure 4.4.

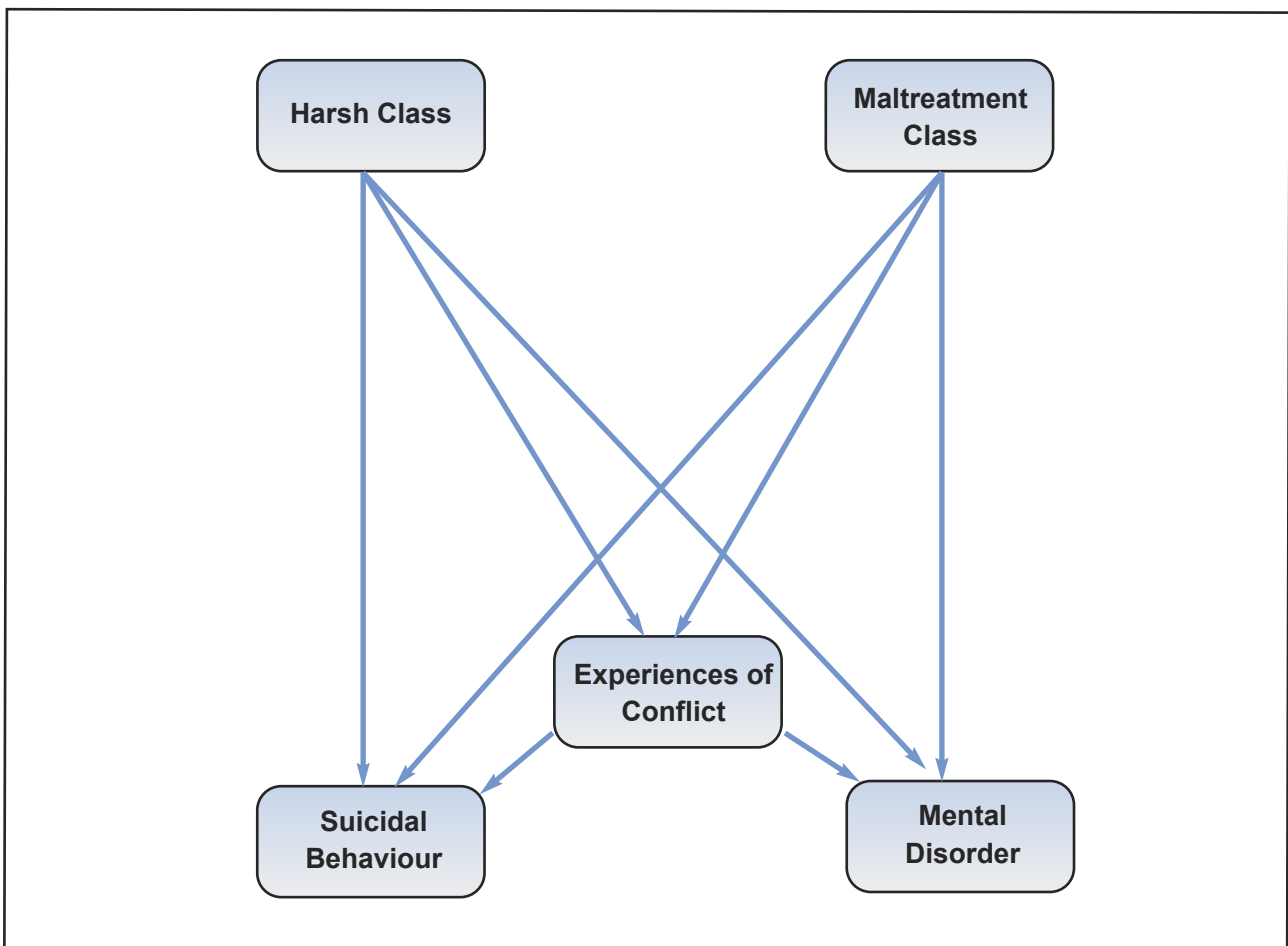


Figure 4.4 The bold lines represent c pathways demonstrating the direct effects of the maltreatment typologies on mental illness and suicidal behaviours. The black lines represent the indirect effects from the Chronic Toxic Stress typologies through the mediator (experiences of conflict related trauma) to the mental health and suicide outcomes.

As seen in Figure 4.4 membership of either the harsh or maltreatment classes was associated directly with both suicidal behaviour and having a mental disorder. Membership of either class was also indirectly associated with suicidal behaviour and having a mental disorder through their association with having experienced a conflict related trauma.

Membership of the harsh class and the maltreatment class were associated with conflict related trauma experiences. Both maltreatment classes were four and a half times more likely to have experienced conflict trauma by comparison to the low risk class. The odds ratios showing the direct effects of maltreatment patterns on mental health and suicidal outcomes were both positive and significant and they were dose-response in nature. Members of the harsh class were almost five and a half times more likely to suffer from any mental disorder compared with those in the low risk class and members of the maltreatment class were over nine and half time more likely to suffer from any disorder compared with those in the low risk class. Members of the harsh class were three and half times more likely, and members of the maltreatment class were over four and half times more likely to have engaged in suicidal behaviours compared with the low risk class.

Conclusions

As expected both of the “at risk” typologies, labelled the harsh and maltreatment classes, showed co-occurring exposures to parental maladjustment and physically aggressive parenting practices. Both harsh and maltreatment class membership significantly predicted mental health and suicide outcomes and these effects were dose-response in nature. Members of the harsh class were over five times more likely and members of the maltreatment class were almost ten times more likely to have a mental disorder compared with the low risk class. Members of the harsh class were over three and half times more likely and members of the maltreatment class were over four and half times more likely to have engaged in suicidal ideation or behaviours compared with the low risk class. These odds reflect the magnitude of the impact of childhood toxic stress exposures on mental health outcomes within these subgroups, while controlling for the mediated effects.

As predicted both of the childhood toxic stress typologies significantly predicted exposures to conflict related trauma. Conflict related trauma significantly predicted mental health and suicide outcomes. Both typologies showed similar levels of increased risk for conflict related trauma compared with the low risk class. Both ‘at risk’ classes were nearly four and half times more likely to have been exposed to conflict related trauma compared with the low risk class. These findings suggest that respondents whose parents suffered from mental illness and who engaged in physically aggressive parenting practices were more likely to have been exposed to conflict related trauma. Indeed, McNally (2014) found that within conflict victims’ families in Northern Ireland intrusive attempts can be made to discuss the traumatic events of the conflict and to impose interpretations of those events on other family members, including children. Empirically elucidating this association in the Northern Ireland population is important. This is because Allport (1954) suggested that harsh parenting in combination with a direct transmission of negative outgroup attitudes nurtures the disposition to develop problematic intergroup attitudes within the survivors’ children.

Conflict related trauma partially mediated the relationship between the childhood toxic stress typologies and both mental health and suicide outcomes. This suggests that in Northern Ireland there is a significant relationship between patterns of parental psychopathology, aggressive parenting behaviours and experiences of conflict related trauma. These findings suggest that these subgroups are at particularly high risk for developing psychopathology because they are doubly disadvantaged in terms of trauma exposures. It needs to be highlighted that the children of these subgroups may be particularly vulnerable in terms of trauma transmission. These findings concur with Cummings et al. (2011) who reported that sectarian violence in Northern Ireland was strongly associated with elevated rates of family conflict and that this in turn impacted on a child's adjustment and emotional security. They also extend upon these findings by highlighting the role that physically aggressive parenting practices, which co-occur with parental psychopathology within the 'at risk' subgroups, play within this dynamic. Individuals within these subgroups have suffered high levels of trauma exposures and so their offspring are vulnerable to same risks of CTS that they themselves were exposed to. These findings suggest that there should be an investment of resources for parents with trauma related mental disorders in order to help them overcome the consequences of both their childhood and conflict traumas. This is necessary so they avoid engaging in maladaptive parenting practices with their children. These interventions need to focus not only on improving mental health outcomes for these families but they also need to build the parents' capacities so that they acquire the skills that are necessary to manage a household and to secure employment. In this way the cycles of intergenerational poverty, trauma transmission and prejudice transmission may be greatly reduced in Northern Ireland.

Chapter Five

THE IMPACT OF THE LEGACY OF THE TROUBLES ON SUICIDAL BEHAVIOUR

Siobhan O'Neill

Introduction

As demonstrated in the previous Chapters, the legacy of the Troubles is multidimensional and complex. The conflict has resulted in death, injury, exposure to trauma, deprivation and social and economic adversity. In many ways everyone in the population has been affected. It has affected those who served in the armed forces, the police, those who were members of paramilitary organisations, individuals exposed to events associated with the conflict as well as their communities, families and friends. Theories of suicide and suicidal behaviour emphasise the role of the environmental context of the behaviour (Joiner, 2005; O'Connor, 2011) and in that sense every death by suicide in Northern Ireland may be considered in some way to be related to the conflict. This Chapter considers the recent evidence from the Northern Ireland Study of Health and Stress, the database of deaths by suicide in Northern Ireland and other sources, on the associations between suicidal behaviour and the conflict. The Chapter considers the specific mechanisms linking the conflict to death by suicide using a variety of pathways. We examine the environmental and contextual predictors of population suicide rates, the association between the Troubles and mental disorders and suicide, the association between exposure to trauma and suicide and the associations between medication and alcohol use and suicide. The events prior to death by suicide are examined with a view to determining the role of the conflict. Finally we discuss the evidence around prior suicidal behaviours, such as suicide plans and attempts and self harm, in terms of their associations with the conflict and as predictors of suicide.

The Northern Ireland suicide database

This Chapter provides an examination of the evidence relating to the associations between the legacy of the conflict and deaths by suicide in Northern Ireland. The primary source of data on this topic is derived from a database of deaths by suicide. This database was developed using the information within the coroner's files on suicides and undetermined deaths. This research involved the analysis of data of a very sensitive nature. Accordingly, the researchers obtained ethical approval from Ulster University Research Ethics Committee prior to commencement of the study. The electronic database was compiled by Dr Colette Corry. Following the required security checks and discussion with the Coroner's office, Dr Corry was granted permission to access the data files in the Coroner's office. Each case of undetermined death or 'suicide' was given a unique code. In each case Dr Corry elucidated the required data from the file and entered it onto a secure, encrypted data file on a password protected laptop stored in a locked cabinet at the Coroner's Office. Confidentiality and anonymity were of utmost importance; it was essential that the names and personal details of the deceased could not be identified from the data file. Names and other identifying features were not included in the database and each case was given an individual code. Address information was encrypted to numeric coding. Unusual cases were collapsed into the category 'other' to protect the anonymity of the deceased. Both the research team at Ulster University and the staff at the Coroner's office are bound by a strict code of

confidentiality. Data on location was transformed into an anonymised format suitable for Geographic Information Systems analysis by generating 'x/y' coordinates. Data was accessed through coronial files which contained cause of death, demographic information and personal history. Police reports and statements from the bereaved also provided important information on events surrounding death; levels of available information varied from case to case. Table 5.1 illustrates data items accessed at three levels: cause of death, demographic information and personal history.

Cause of Death	Demographic Information	Personal History
Coroners verdict, with or without an inquest	Gender	Prior adverse event Family and personal history Stressful or traumatic life events
Official cause of death	Date of birth	Prior physical health diagnoses with prescribing history
Toxicology results including prescribed or illicit drugs, and alcohol levels	Marital status Living arrangements Employment status	Contact with services (primary, secondary, tertiary) Treatment history
Method of suicide	X/Y geographical coordinates	Prior psychiatric health diagnoses with prescribing history
Presence of suicide communication (note, text etc)	Ethnicity/Nationality	Enquiry case notes (death in tertiary care/custody/services)

Table 5.1 Data accessed from coronial records

Medical details, including any known existing medical conditions and the names of medications that had been prescribed, were provided by the General Practitioners (GPs) or doctors of the individuals following their death. Prescription details were unavailable for 18% of the sample, therefore analysis was carried out on the remaining 1,371 cases. The majority of these cases was male (78.3%), while the mean age was 40 years. The prescription medications were then coded according to their typical licensed use using the British National Formulary (BNF). Unlicensed uses and specific combination uses were disregarded. If the medication was not contained within the BNF, such as those that have been discontinued, it was coded according to the most relevant category. Medications with different purposes or multiple BNF categories were coded in consultation with the person's medical notes.

Culture and connectedness - Suicide and the Troubles: continuing elevated rates among those who experienced the height of the conflict

A total of 1,682 deaths occurring between 2005 and 2011 were included in the database. Of these, 1,398 were classified as suicide, the remaining 284 as undetermined cause of death. Men were notably overrepresented among those who died by suicide (78%), with an overall average age of 40.3 years (SD=16.04). Men were also younger (mean=39.7, SD=15.9) than females (mean=42.1, SD=16.1) at time of death (p -values <0.01). There were higher proportions of males in the younger age groups while the inverse was seen for women. The highest incident rate in women occurred among those aged 35-44 years, while for men those aged 16-24 demonstrated higher proportions. The lowest overall rates were seen in those aged 65 years and over (Figure 5.1).

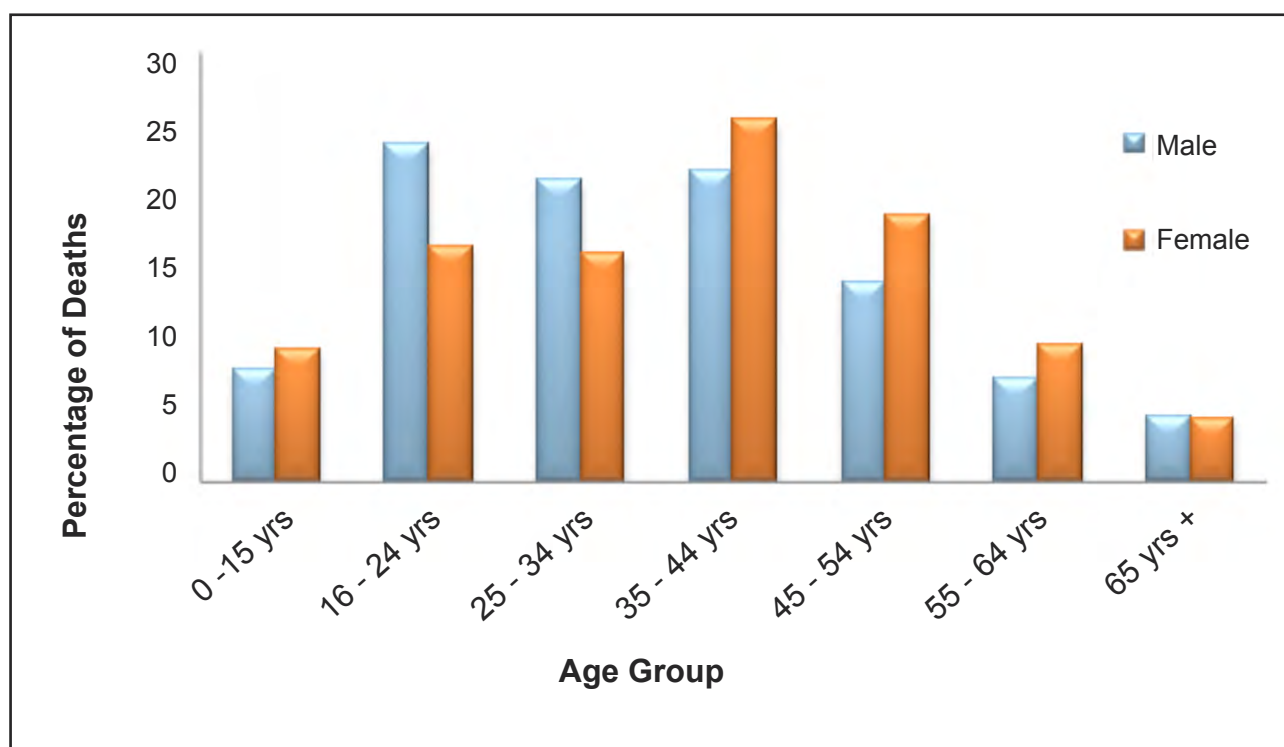


Figure 5.1 Age and gender distributions of completed suicides

The findings on age and gender indicates that whilst suicide continues to account for a high proportion of deaths in the young, the average age of the individuals in this population was 40 years and the rates of suicide were highest in those aged 20-50 years. The cohort of people who were most at risk of suicide several decades ago continue to remain at risk as they grow older. In Northern Ireland, this is the population who witnessed the years of the conflict when violence was at its peak. This is in keeping with Tomlinson's (2012) contention that the increased rates of suicide in Northern Ireland since the peace agreements are a consequence of the decline in social cohesion and social connectedness which was a characteristic of the conflict. Many of the leading suicidologists argue that social cohesion and connectedness prevents action to address suicidal ideation (Joiner, 2005). The breakdown in social connectedness, along with exposure to violence and high levels of mental disorders may have promoted the increase in suicide rates.

Violence, trauma and completed suicide

High proportions of the population have been exposed to trauma as a result of the Northern Ireland conflict. There are two main direct pathways linking an individual's experience of a traumatic event and death by suicide. The experience of trauma may directly increase the risk of suicide, or the experience of trauma may be associated with the development of one or more mental disorders, which are subsequently associated with suicide. Several suicide theorists have elucidated an association between exposure to violence and the enactment of suicidal ideation. It is suggested that trauma and violence can contribute to an acquired capability for suicide (Klonsky & May, 2014; Joiner 2005; O'Connor, 2011). In other words, witnessing death, violence and pain, increases acquired capability, which in turn increases the likelihood of an individual transitioning from suicidal thoughts and plans, to suicidal behaviour. This acquired capability may be achieved through exposure to pain and violence either directly or indirectly. Indeed this is one explanation for the higher burden of suicide amongst medical professions such as doctors, nursing staff, veterinarians as well as pharmacists and a range of other medical related occupations (Bartram & Baldwin, 2010; Meltzer et al., 2008; Platt et al, 2012). Likewise, police officers, members of the armed forces, as well as agriculture occupations (e.g. farmers and farm labourers) have been found to exhibit a higher rate of suicide compared to other occupational groups (Browning et al, 2008; Judd et al., 2006; Violanti, 2010).

Findings from the Northern Ireland Study of Health and Stress reveals that high proportions of the population have witnessed traumatic events related to the conflict. Bunting et al.(2013) estimates that 39% of the Northern Ireland population have been exposed to conflict related traumatic events with one in five people witnessing death or serious injury to another person. This, when combined with evidence of the media coverage of the violence, indicate high levels of exposure to trauma, pain and violence which could contribute to acquired capability, according to Joiner's (2005) model. The associations between exposure to conflict related trauma and death by suicide in Northern Ireland appear to be further evidenced by the analysis of the predictors of suicidal ideation, plans and attempts in the Northern Ireland study of health and stress. This research demonstrated that exposure to conflict related trauma further increased the risk of suicide ideation and plans, but not attempts, suggesting an increased likelihood of death at first suicide attempt in this group (O'Neill, 2014a).

Conflict as a predictor of mental disorders and subsequent suicide

The analysis of the coroner's data on suicides reveals that a third (31%) of the deceased had no recorded condition at time of death (n=510). This is however likely to be an overestimation due to the unreliability of the data. Mental disorders, (either alone, or in combination with general medical conditions) were recorded for 58% (n=964). These associations between mental disorders and suicide are also reflected in the data showing that high proportions of those who died by suicide were prescribed, or had taken psychotropic medications commonly used in the management and treatment of mental disorders. Mental disorders are a major risk factor for suicide and it is estimated that 15% of those diagnosed with depression eventually take their own lives. Recent evidence has shown that Northern Ireland has some of the highest rates of mental disorders in the world. The Northern Ireland Study of Health and Stress found that over 39% of the Northern Ireland

population met the criteria for diagnosis of a mental disorder at some point in their lifetime (Bunting et al., 2012a) and that over 23% of the population met the criteria for having a mental disorder in the past 12 months (Bunting et al., 2012). The current and lifetime rates of mental disorders in Northern Ireland were among the highest of the countries involved in the World Mental Health initiative and lower than only the US (47.4%) and New Zealand (39.3%) (Bunting et al., 2012). At 8.8%, rates of Post-traumatic Stress Disorder are the highest of all the WMH countries (Ferry et al., 2013) and rates of anxiety and mood disorders were the highest in Europe (Pinto-Meza et al., 2012). One in five men in Northern Ireland have had a substance disorder and again this rate is among the highest in Europe (Boyd et al., 2014).

The risk factors for mental disorders in Northern Ireland are similar to those of other western countries, women were significantly more likely to have lifetime anxiety and mood disorders, men had significantly greater odds of having impulse-control and substance disorders. Age at interview was also significantly associated with having a disorder and there was an overall trend of decreasing odds as age increased. Individuals who were separated or divorced were more than twice as likely as those who were married to have anxiety, mood and substance disorders. Having a low or low-average income was associated with significantly elevated odds of having anxiety, impulse-control and substance disorders. There is emerging evidence that the civil conflict may be associated with elevated levels of mental health problems in Northern Ireland. Individuals who stated that they had ever lived 'as a civilian in a place where there was ongoing terror of civilians for political, ethnic, religious or other reasons' were almost twice as likely to have mood disorders and more than twice as likely to have anxiety and impulse-control disorders as those who had not endured this trauma (Bunting et al., 2012a). 37.4% of the population have experienced a conflict related traumatic event and this figure rises to 40.8% among the over 45s.

Conflict related traumatic events were associated with a higher risk of mental disorders generally and a high risk of developing post-traumatic stress disorder specifically (Ferry et al., 2013). Ferry et al. (2013) estimates that around 27% of PTSD cases can be attributed to the conflict and that conflict related events represent 35.8% of the total burden of PTSD. Post-traumatic stress disorder was estimated to cost the Northern Ireland Economy £172 million in 2008 alone (Ferry et al., 2011). There is also evidence that people in Northern Ireland who have experienced conflict related traumatic events are more likely to have suicidal ideation and plans than those with other types of traumas, even when the effects of mental disorders are controlled for (O'Neill et al., 2014a). Given the evidence that the excess of mental disorders in Northern Ireland, particularly PTSD, may be attributable to exposure to traumatic events related to the conflict, it is reasonable to suggest that many of the suicides associated with those mental disorders are also therefore a consequence of those traumatic events. It is difficult to provide an accurate estimate of the proportions with the data currently available. Exposure to conflict related traumatic events is also associated with a higher risk of having any mental disorder and having more severe and enduring disorders (Bunting et al., 2013; Ferry et al., 2014). These more serious disorders are also associated with higher rates of suicidal behaviour so we may assume that disproportionate numbers of individuals with a mental disorder who died by suicide have experienced conflict-related traumas. Furthermore the literature review on the legacy of the Troubles demonstrates that the impact was not restricted to the direct impact of the traumatic events on individuals. The conflict was associated with economic and social disadvantage, childhood adversities generally and maladaptive parenting styles (as shown in the earlier Chapters of this report). These, even in the absence of exposure to conflict related traumatic events increase the risk of mental disorders, which in turn heighten the risk of suicide.

Conflict and general medical disorders contributing to suicide risk

In this research we differentiate mental disorders, which are regarded by many as being biological, psychological and social in origin, from other general medical disorders, which are more likely to have a biological basis. In addition to mental disorders, people with general medical disorders have an increased risk of self-harm and suicide (Singhal et al., 2014). Health service contact offers an opportunity for the delivery of suicide prevention interventions however, the inconsistencies in the recording of suicides have resulted in few studies of the patterns of general medical health service use prior to death by suicide. Retrospective research has reported that while visits to General Practitioners may increase prior to the final act, a high percentage of these visits are recorded as having a general medical basis rather than to address mental health issues specifically (Appleby, 1996). This is also the case for Northern Ireland, with evidence of clear gender differences in patterns of use of health services prior to death by suicide, with men reducing levels of contact and being more likely than women to consult for general medical or non-mental health related issues. Women on the other hand escalated their levels of contact with services prior to death and were more likely to report mental health problems (O'Neill, 2014b). The GP was the most frequently contacted health care professional for both genders. Finally, males were less likely to receive services beyond primary care.

There are a number of possible explanations for the gender differences. The presentation may have been genuinely related to a primarily physical health condition, and in a proportion of these cases, this may be a direct result of injury or illness associated with conflict related events. These patterns may also point to a reluctance among men to identify and report mental health problems. There is a wealth of evidence to indicate that men are reluctant to disclose mental health concerns with their General Practitioner and other health care providers (Snowcroft, 2013). Alternatively, men may not identify their symptoms or suicidal thoughts as being related to treatable mental disorders and thus do not seek help for these problems. Men were more likely than women to have a general medical health diagnosis only, however their physical conditions may in fact reflect the physical symptoms of an undiagnosed affective disorder. Contemporary theories of suicide view suicidal behaviour as goal directed, as a means of addressing pain and distress (Klonsky & May 2014; Joiner 2005; O'Connor, 2011) and somatic symptoms are a key feature of depression. The patterns revealed in this report suggest that some men attended to the physical or somatic, symptoms of mental disorders, rather than disclosing emotional distress or low mood. In NI, as with other world mental health countries, men are more likely than women to meet the criteria for externalising disorders, and women, internalising disorders. Externalising disorders, such as substance disorders are characterised by impulsivity and internalising disorders include mood and anxiety disorders. There may be less recognition of symptoms relating to externalising disorders as being indicative of a mental health problem, in Northern Ireland culture generally. One in five men in Northern Ireland meets the criteria for a lifetime substance disorder and much of this proportion have alcohol disorders which are again associated with impulsivity and suicidal behaviour (Boyd et al., 2014). Further research on men's experience of mental disorder and the role of physical symptoms in depression and suicidal ideation is necessary to obtain an understanding of the barriers to help seeking in this group.

Use of medication and suicide

There appear to be high rates of medication use among those who died by suicide and this is likely to be primarily associated with the presence of physical and mental disorders among the deceased. However, there are also links between the use of medication for mental disorders and experiencing traumatic events related to the Troubles which merit investigation. Turning firstly to the suicide figures, the analysis showed that almost two thirds (65.1%) of the sample had been prescribed any medication. Just over half of the sample (51.7%) had been prescribed medication relating to a mental health disorder, with one fifth (20.2%) taking a mental health medication exclusively. A smaller proportion of individuals (45.2%) had taken a medication for a physical condition, with 13.6% taking a physical health medication exclusively. Almost one third (31.6%) of the sample had been prescribed medications for both mental and physical health conditions.

Antidepressants were the most common medication used (37.3%), followed by hypnotics/anxiolytics (28.2%). Females (78.2%) were more likely than males (61.5%) to have been taking any medication. Females were also more likely to have been taking each of the most common types of medication as well as taking a greater number, with almost half (46.3%) prescribed more than three medications. There was also a significant association between age and prescribed medications. The majority of those aged 65 and over (91.2%) had been prescribed a medication prior to their suicide and were the group most likely to be prescribed a greater number of medications with 64% prescribed more than three. However, there were variations in the types of medication prescribed, with the 50-64 year old age group rather than the oldest group of individuals most likely to have been prescribed antidepressants, analgesics and antipsychotics.

The high rates of medication use among those who died by suicide mirror the high rates of medication use in Northern Ireland generally. The National Advisory Committee on Drugs (2012) reported that in 2010/2011, the twelve month prevalence rate was 11% for sedatives/tranquilisers and 12% for antidepressants. These figures were based on prescription data. The Northern Ireland study of Health and Stress 2005-2008 revealed higher rates, 15.5%, based on self-reported use of psychotropic medication. The same study showed that 38.5% of people who met the criteria for a 12 month disorder had taken any psychotropic medication. Both figures are higher in Northern Ireland than for other European countries (12.3%) the overall rate being surpassed only by France (19.2%). In Europe on average of 32.6% of those with mental disorders take medication (Alonso et al., 2004). Northern Ireland also has a high proportion of individuals with a current mood disorder (such as depression) who had taken any psychotropic medication (45.3%) however this is comparable to the European rate of 45.5% (Alonso et al., 2004).

The figures may simply be indicative of the high rates of mental disorders and a greater cultural acceptability of the use of psychotropic medications in their treatment. Indeed, mental disorders continue to be the main predictor of psychotropic medication use (Benson et al., 2014). However there is evidence that people who have experienced a traumatic event associated with the Troubles have an even higher likelihood of using psychotropic medications, particularly hypnotics and anxiolytics. One theory is that exposure to traumatic events is associated with chronic and more serious disorders (Ferry et al., 2014) with specific symptoms which increase the likelihood of medication use rather than alternative treatments.

For example, one feature of exposure to trauma and subsequent PTSD, is nightmares and flashbacks, another is numbing and avoidance. Both of these symptom clusters may be addressed by medication, particularly hypnotics and sedatives, in the absence of alternative treatments. Bunting et al. (2013) reported that under half (40%) of people who had a mental disorder in the past 12 months received treatment.

Alcohol and suicide in Northern Ireland

Alcohol was the most common substance found in those who had died by suicide, it was present in 41% of cases and was more common among males and young people. Males were more likely to have taken alcohol (46%) than females (33.9%). Those aged between 20 and 29 years were less likely to have a zero blood/urine alcohol reading (36.3%) than other age cohorts. The youngest age group (between 10 and 19 years) had the highest proportion of individuals with twice the legal limit (80mg of alcohol in 100 ml blood) of alcohol in their system (19.8%). In certain cases, for example death by drowning, it would not have been possible to assess alcohol levels post-mortem.

There are numerous explanations for this pattern. A proportion of the deceased would have had substance disorders including alcohol addiction. Many would have used alcohol to deal with stress or manage mental health problems, many of which would have been connected to experiences relating to the conflict. In certain cases the impulsivity associated with the effects of alcohol intoxication may have contributed to the suicide. Alternatively, individuals may have taken alcohol to reduce the fear or pain associated with the suicidal act. Alcohol use is common in Northern Ireland culture and the abuse of alcohol has widely been regarded as a way that the population has managed the stress and mental health effects of the conflict. In this sense, the evidence of alcohol in the systems of many of those who died by suicide can be said to be associated with the legacy of the conflict.

Adverse life events, death by suicide and associations with the conflict

Aetiological theories of suicide acknowledge the role of life stress in leading to the development of suicide and suicidal behaviour (Foster, 2011; O'Connor, 2011). In order to examine this in Northern Ireland information about events precipitating death was gathered from numerous sources within coronial files, such as family statements generated by attending police officers or doctors reports. Either singly or in combination, 61% of cases had experienced adverse events prior to suicide. Relationship difficulties were noted as the primary adverse event experienced by the deceased (34.1%). This category included those who were both married and co-habiting and also a small proportion that were known to be in a same sex relationship. Death/Illness included the loss of, among others, spouse, family members, romantic partner and in one case a family pet (10.7%). Fears for own health was of particular concern to those with chronic health conditions or a recent diagnosis (5.7%). Financial crisis included reports of recent job loss or bankruptcy, debt worries and business failure (5.3%), while employment worries related to issues such as fear of redundancy and pending disciplinary action (5.1%). The descriptions of events prior to death by suicide were scrutinised for evidence of events associated with the Troubles. Only a very small number of such events were reported, these were diverse in nature and included experiences of threat, experiences of violent events and people who had participated as members of the police or military or combatants.

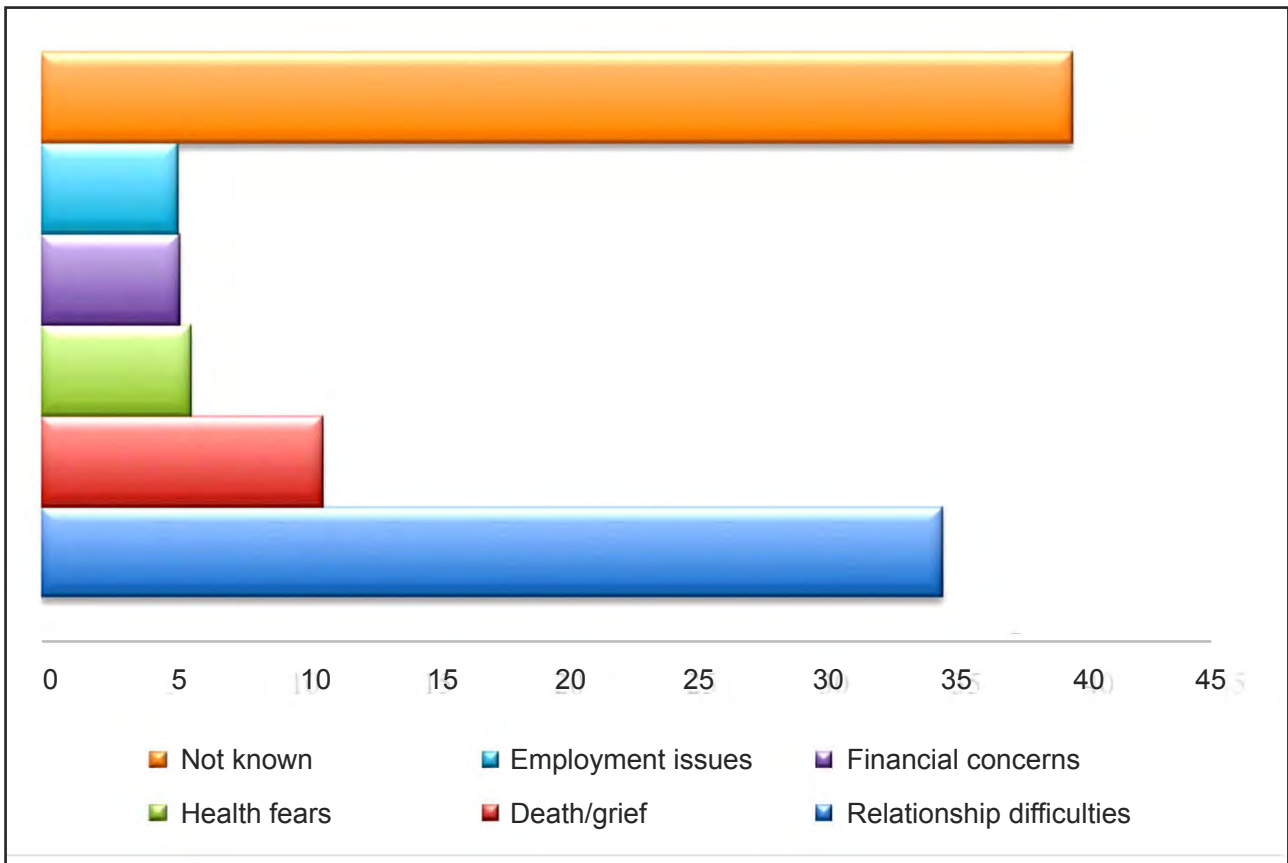


Figure 5.2 Percentages of the deceased who had experienced various categories of adverse events prior to death

The types of life events that are associated with suicide are also those which are, associated with the legacy of the conflict. Employment status is likely to represent one such factor since a litany of studies has demonstrated a link between unemployment (e.g. job loss or long term unemployment) and suicidality (Eliason & Storrie, 2009; Lundin & Hemmingsson, 2009; Schneider et al., 2011). This is particularly the case for males, and is reflected in the analysis of the data on deaths by suicide in Northern Ireland which show us that at least half of those who died by suicide were known to be unemployed and employment related problems were recorded prior to the death in at least 5.1% of cases. Financial concerns, which were recorded in 5.3% of cases, may also be related to employment issues, or associated with debts. Again, given that we know that economic adversity has been a feature of the legacy of the conflict, it is reasonable to assume that many of these cases are also connected in some way with the Troubles.

Access to means, notably firearms, could be said to be another factor linking employment variables and the Northern Ireland conflict and death by suicide. However firearms are responsible for only a small minority of suicide deaths in Northern Ireland (3.4%) and anecdotally, it appears that these were mostly using the person's own, legally held weapon. The majority of these cases were male and were employed in agriculture and police or armed forces. It is difficult to draw any other inferences from the data on means of suicide and the role of the conflict in the death. The most common means of death, used by more than half of those who died by suicide, was hanging (60.5%). The majority of cases (83.3%) of which were male.

The largest category of adverse event, experienced by a third of those who died by suicide, was that of relationship breakdown or discord. The associations between relationship status and suicide is also demonstrated in the fact that almost half of the deceased were single at time of death (47%), while 22.9% were married. A total of 17.5% had experienced a marriage breakdown, with 9% co-habiting in either a heterosexual or same sex relationship. More than twice as many men were single (67.7%) while the majority of women were married or in a marriage-like relationship (32.5%). Relationship status and living conditions are also associated with each other and the disproportionately high number of people who died by suicide who lived alone or who were separated or divorced reinforces the link between relationship difficulties, living conditions and suicide. Almost a third of those who died by suicide lived alone at time of death (31.4%), while 22.8% lived in the parental home. This included both younger individuals and those who returned to the family home in adulthood. More than two fifths lived with a spouse (21%), with 9% co-habiting in a marriage-like relationship. It is not possible to determine the proportion of these cases attributable to the conflict, however it is likely that events related to the conflict and circumstances caused by the legacy of the conflict are relevant in some of these cases. Finally, one in ten (10.7%) of those who died by suicide have recorded events relating to experiences of death and grief, a proportion of which will have been directly or indirectly attributable to the Troubles.

The conflict and self harm in Northern Ireland

Strong links between self-harm and death by suicide have been identified, as has an association with suicidal ideation (Hawton, 2012). Self-harm is associated with psychiatric and personality disorders and their co-morbidity (Haw, 2001), and analysis of patterns of self harm and suicidal intent suggest a continuum of behaviour which may culminate in death by suicide. An extension of this supposition is supported by research suggesting that suicidality may be considered a continuum of behaviour beginning with an endorsement of suicidal ideation and ending with a serious attempt to take one's own life (Scocco, 2008). It is also therefore relevant to examine self-harm in Northern Ireland and the associations between self-harm and exposure to the conflict. According to Joiner (2005), prior suicidal behaviour, including self-harm, even in the absence of suicidal intent may be associated with an increased likelihood of death by suicide. The theory posits that, by increasing the individual's pain threshold, exposure to pain contributes to an acquired capability for suicide.

Northern Ireland was one of the first regions in the world to develop a registry of self-harm admissions to Emergency Departments. The 2014 report from this registry, shows that the rates of self-harm were highest among young people (43% were in the 15-29 age group); and males and females were equally represented. The majority of attendances (around three quarters) resulted from drug overdoses followed by cutting. In one in 10 cases the methods used were hanging and/or drowning, suggesting high levels of suicidal intent (PHA, 2014). Earlier we noted possible associations between the use of alcohol and psychotropic medication and experience of trauma. In keeping with the suicide figures, alcohol was used in around half of the self harm admissions (PHA, 2014). A separate examination of the cases of intentional drug overdose revealed that the rates in Northern Ireland were twice that of the Republic Ireland. The most commonly used drugs were minor tranquilisers, although other psychotropic medications, illegal drugs and paracetamol were also commonly used (Griffin et al., 2015).

There is limited evidence on the associations between self-harm and exposure to the Northern Ireland Troubles. The fact that the rates are higher in Northern Ireland than Republic of Ireland is more likely to be related to the differing health care systems, rather than the conflict, because the Northern Ireland rates are more similar to those in other parts of the UK (Griffin et al., 2015). A recent UK wide study showed that rates of self-harm among adolescents in Northern Ireland were the lowest of all the UK regions (O'Connor et al., 2010). However, in addition to the established risk factors for self harm, school children in Northern Ireland who have reported having experienced the conflict have higher rates of self-harm. The authors recommend further research into the legacy of the conflict to establish the nature of this association (O'Connor et al., 2014).

Self-harm may also be conceptualised as on a continuum of suicidal behaviour and in certain cases it can be difficult to differentiate self-harm from suicide attempt. The Northern Ireland coroner's data was scrutinised to assess prior attempt. More than one third (37%) of the deceased had prior suicide attempts recorded either through medical or police records or in witness statements. Of these, almost one fifth (18%) were known to have made two or more suicide attempts prior to death. Statistically significant gender differences were identified with regard to number of previous suicide attempts. Males were more likely to have made only one previous attempt relative to females (17.3% and 15.4%); with females having increased proportions of non-fatal attempts prior to completed suicide generally. These findings prevailed among individuals who made 2-4 prior attempts and those who made five attempts or more. The results again demonstrate the risk associated with self-harm and suicide attempt and again demonstrate a pattern of males making one fatal attempt using highly lethal and violent means.

Conclusions

This Chapter used evidence from the first detailed study of the coroner's data on deaths by suicide and undetermined deaths, and a range of other sources to examine associations between the legacy of the troubles and the increasing rates of suicide in Northern Ireland. The evidence shows that the conflict is associated with suicide on a number of levels. On a societal basis, the post-peace agreement era may reduce the sense of connectedness experienced by those already vulnerable to suicide thus, removing a key barrier to the enactment of suicidal ideation. The characteristics of the conflict, exposure to traumatic events and living in fear, are risk factors for mental disorders, many of which suicidal ideation is a feature. These experiences are also associated with more chronic and complex mental disorders, which are associated with suicide. They also independently increase the risk of suicidal behaviour over and above that already conferred by virtue of having a mental disorder. Trauma and the subsequent mental health symptoms and disorders are reflected in the high proportions of people who die by suicide who have had a mental or general medical disorder and also among the proportions of people who take medications for mental health problems. Alcohol use, a feature of almost half of suicides may be indicative of a mental disorder, used to treat a mental disorder, or the effects of trauma exposure, or it may be used to relieve pain and increase capability.

The major adverse events experienced prior to death (relationship difficulties, economic adversity, employment difficulties, loss, and health diagnoses) may all be indirectly connected to the conflict and mental health problems generally. Finally, the heightened exposure to violence, death, pain, either directly or indirectly may lead to an enhanced capability for the

enaction of suicidal ideation generally, increasing the risk of death among those at risk. The analysis demonstrates that the troubles are inextricably linked to suicides in a variety of ways. Through mapping these connections on to the contemporary theories of suicide we gain an understanding of some of the mechanisms connecting our history of violence with the current elevated rates of suicide. It is vital that efforts continue to collect data on deaths by suicide in a more systematic way to increase the validity of the data and enhance our understanding of suicide in the Northern Ireland context.

The research findings demonstrate the need to consider suicide as a behaviour as well as a feature of mental disorder and exposure to trauma. Only one in five of those who died by suicide (18.2% and 23.9% for males and females respectively) presented to health services in the fortnight prior to death and males in particular had a tendency to disengage with services during this time (O'Neill et al., 2014). Suicide prevention initiatives should therefore target not only the identification and treatment of those with mental disorders, but also those whose social circumstances and experience of life events elevate their risk further. This invariably includes individuals and communities exposed to the conflict. We need to acknowledge the fact that individuals exposed to the conflict may not come forward for mental disorder treatments, particularly “talking therapies” because avoidance, denial and emotional numbing are characteristics of how people respond to trauma and are symptoms of PTSD. It is therefore essential that we explore new ways of targeting and meeting the needs of this vulnerable group of people, who may be described as victims of the conflict.

Chapter Six

TREATING TRANS-GENERATIONAL TRAUMA AND BUILDING RESILIENCE AMONG YOUNG PEOPLE IN NORTHERN IRELAND

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Introduction

This short review seeks to determine from the literature what evidence-based psychological practices, treatments and interventions are used to address trans-generational trauma in Northern Ireland and elsewhere and identify best practice in the treatment of trauma related disorders and the promotion of resilience among young people. A search of academic articles was conducted on five searchable databases: Wiley, PubMed, Google Scholar, Ulster University and University of Toronto Libraries. Search criteria included a combination of the following terms: trans-generational trauma, conflict, children, mental health, PTSD, resilience and Northern Ireland. Published and unpublished reports written by organisations based in Northern Ireland were also reviewed. The authors initially searched for trauma focused trans-generational practice and interventions for young people. However, as there was a lack of literature on interventions solely for children within a trans-generational context the search was reframed to include practices and interventions for adult parents (or grandparents) as such interventions, if successfully delivered within a trans-generational context, should have beneficial effects across the family system, including benefits for children or young people.

Since the inclusion of post-traumatic stress disorder (PTSD) in the Third Edition of the American Psychological Association (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in 1980, the availability of literature surrounding trauma related conditions has increased exponentially regarding the causes, pathology, diagnosis and treatments. Most of the literature on the effectiveness of therapeutic interventions for trauma related disorders have focused on PTSD as diagnosed in the DSM-III, yet only a proportion of those exposed to traumatic events develop PTSD (Kessler et al., 1995). Epidemiological studies in Northern Ireland however, show that 15% of adults who had been exposed to one or more traumatic events (including events linked to conflict) subsequently met the lifetime criteria for PTSD (Bunting et al., 2013). The recommended best practice for PTSD treatment in adults is for trauma focused cognitive behavioural therapy (TF-CBT) and Eye Movement and Desensitisation and Reprocessing (EMDR) in the National Institute for Health and Care Excellence (NICE) guidelines 2005 and 2012, and CREST-GAIN (DHSSPSNI 2003). Awareness of trauma and its impacts on individuals, families and communities is evolving. Given the range and complexity of post-traumatic stress responses in affected persons, and the developing field of trans-generational trauma the reviewers approached their search with a view that a broader approach to trauma should be taken, rather than the specific diagnostic category for PTSD in adults and children. This includes the recognition and inclusion of other trauma related conditions that may be ameliorated by emerging interventions and approaches, which in turn could create opportunities for collaborative working and evolving models for service development in Northern Ireland.

Current treatment approaches

There are differing theories on practice and on the historical development of trauma as a construct and diagnosis, particularly for PTSD. One view is that a focus on treatments for the individual can be characterised as a linear “medical model”, and that the current conceptualisation of PTSD does not take into account the group, or system within which a traumatic event occurs, and by extension the social context of the traumatic experience may be overlooked (Muldoon & Lowe 2012). On the other hand there is a view that interventions that support the individual are essential (Schauer & Schauer 2010). Approaches such as “Systems thinking” or family therapy consider individual, relational and family systems as interrelated elements and use a variety of clinical and other interventions to address traumas, and provide support. There is growing recognition of the psychosocial impact that wider societal and economic pressures have on the victim or survivor, and the role that attachment to, and identification with, these complex social and economic groups play in treatment (McNally 2014). Other approaches include storytelling as a mechanism through which a greater understanding can be developed of how trauma is transmitted and dealt with in individuals, families and between generations (Bar-On, 1995 & Irish Peace Centres, 2010).

Trans-generational trauma

Much has been written about the impact of the violence in Northern Ireland on children. Muldoon and Trew (2000) suggested that the children’s experience of the conflict was considerable. The variability of the impact was noted given that the experiences of children across the social and economic spectrum are also variable, and on whether children internalise their experiences or externalise them. Furthermore, Bunting et al. (2013) found that well over half of adults had had a first traumatic experience linked to conflict by the time they reached 20 years of age. Muldoon et al. (2000) explored how attachment and identification with national, religious, and political groups may be formed or framed by historic experiences that subsequently influence the life outcomes for individuals. Merrilees et al. (2011) suggested that protracted intergroup conflict between communities in Northern Ireland placed an additional burden on mothers who had self-reported on the impact of the conflict on them and their children, but that social identity and identification with an in-group or social bonding processes played a moderating role on the impact.

This review found three research papers on trans-generational trauma in Northern Ireland (Shevlin & McGuigan, 2003; CALMS, 2013; Irish Peace Centres 2010), none relating to evidence based practice or treatment of trans-generational trauma, and three literature reviews on trans-generational trauma in Northern Ireland (QUB, CVSNI, 2012; Irish Peace Centres, 2010, McNally, 2014). Research globally is mainly focused on family members across first and second generations (parent and child). Debate continues as to whether trauma impacts can be transmitted to a third generation. Epigenetic research on whether the Holocaust for example, could have changed how genes are expressed in the grandchildren of survivors showed that second-generation descendants had a different capacity for stress than non-descendants of survivors, which could have been the result of an adaptive change triggered by the highly stressful experiences of their parents (Yehuda,

2007). Schauer and Elbert in Martz (2010) notes the conclusions reached by Szyf et al. (2008) that if a pregnant mother is affected by chronic stress, epigenetic modifications in the child may act as a molecular or cellular memory that tune the offspring for one or several generations for survival in a hostile environment, making generations more vulnerable for mental illnesses, including suicide. Kaitz et al. (2009) defines the trans-generational transmission of trauma as the,

Shown impact of trauma experienced by one family member on another family member of a younger generation, regardless of whether the younger family member was directly exposed to the traumatic event. The underlying premise is that trauma related symptoms are passed on to children either directly, through talking about events, or as a consequence of living with a traumatised parent.

In recent years the conceptualisation of trans-generational trauma has provided a new avenue for research. The subjects include Holocaust survivors, Canadian First Nations, Australian Aboriginals, torture survivors, and other survivors of conflict and post-conflict traumas. In Canada and the United States the psychological effects of potentially traumatic events witnessed and endured in the Canadian First Nations residential school system, and the American Indian boarding schools respectively, have left a legacy of historical trauma which has been postulated to be passed down by survivors to their children and grandchildren (Bombay et al., 2014). The concept that historical (Heart, 2003) and collective (Krieg, 2009) trauma continues to impact today on current generations on cultural or ethnic communities is also cited in the literature on peoples such as First Nations in Canada and Aboriginals in Australia.

Trans-generational trauma has been linked to psychological and physiological transmission factors and although practice in trans-generational trauma treatment is an emerging field, there has been extensive research that shows association between parents' PTSD and children's psychological distress. This has included research on the implications of parents' trauma-related distress for the well-being of their children including psychological difficulties of children of Holocaust survivors, combat veterans and traumatised refugees (Weingarten, 2004). In this area the literature on the disadvantage risks for children of parents who suffer mental health and related problems is relevant (Lev-Wiesel, 2007; Weingarten, 2004; Lambert et al., 2014).

In a meta-analysis of 550 studies, Lambert (2014) concluded that parents' symptoms of post-traumatic stress disorder are associated with children's psychological difficulties and that parent PTSD symptoms positively correlate with children's anxiety, PTSD and behavioural problems. Shevlin and McGuigan (2003) showed that the immediate children of the victims of Bloody Sunday experienced significant psychological stress some thirty years after the event suggesting trans-generational psychological effects of loss and trauma on family members closest to the victims. Along with Kaitz (2009), Lambert concludes the importance of considering (1) the family context of trauma survivors as well as (2) the threat of interpersonal or community violence (of relevance to the context of Northern Ireland) each of which may have contributed to both family members' elevated trauma symptoms.

Increasingly research based on developmental or family systems theories (Coulter, 2013)

suggests that parents who experience trauma-related distress may not be capable of providing necessary support to help children cope with their own distress and to construct meaning around the traumatic event, or events. A qualitative study by CALMS (2013) into the trans-generational impact of parent's trauma on young adults in Northern Ireland suggests that young people's upbringing was impacted by living with a parent who experienced a traumatic event. The majority of participants described experiencing emotional problems, including anxiety, fear, hate and anger. The researchers suggest that trans-generational aspects of trauma were transmitted to the next generation by parents mainly through two communication mechanisms, namely silence and over-disclosure. Another qualitative study by the Irish Peace Centres (2010) also found that silence transmits trans-generational trauma to offspring.

Lev-Wiesel (2007) showed the trans-generational impact of trauma through the family narrative of traumatic events across three generations of three Israeli families, who respectively; survived the holocaust; experienced forced eviction and dislocation, and experienced living in a transit camp following emigration. The rise in terrorism across the world has also led to an increased interest in trans-generational trauma from terror and its impacts. Kaitz (2009) discusses the intergenerational transmission of trauma which he contends has "parents' trauma from terror as its precipitating pathogen".

Four trans-generational mechanisms of transmission of trauma linked to political violence were cited by Weingartan (2004) as being (1) biological, (2) psychological (including the attachment system), (3) familial and (4) societal and that each must be addressed in order to understand how traumatic experiences in one generation impact on the other,

...for what is passed is not the trauma itself but its impact and, how appreciating how these mechanisms operate on the individuals and families, offers opportunities for inquiry, reflection, understanding and change for those stuck in current struggles related to, or aggravated by, residues of political violence that insinuate themselves into the bodies, minds and spirits of those who were not exposed to the political violence itself.

The transmission of psychopathology through family frameworks or cycles is cited in the literature and describes how historical trauma and PTSD symptomatology adversely affect the family and the offspring of a survivor generation. First, whilst the approach stipulates that the transmission of psychopathology does not include the parental trauma itself, it is the psychological difficulties of the parents that negatively influence the "cognitive development, well-being, and emotional development" of the child (Downes, Harrison, Curran & Kavanagh, 2013), with implications for attachment and identity. Yet again, and within the home environment, the "conspiracy of silence" surrounding the history of the conflict, and factual information regarding related traumatic events - 'non-verbally and silently present' - can increase the susceptibility of offspring to the effects of intergenerational trauma. Early research into the impacts that combat veterans with PTSD had on their families (Scaturo & Hayman 1992) also suggested that the use of a family life cycle framework to discuss the consequences of combat trauma (originally developed by Haley to describe the growth and development of a family over time) provides a macroscopic view of the impact of the life-altering event upon the individual and significant others in that person's life.

Service provision in Northern Ireland

Despite research findings in the earlier years of the Troubles that indicated that children showed resilience in the face of communal violence, subsequent extensive research indicates that the legacy of the Troubles in Northern Ireland has had a negative impact on psychological wellbeing on both adults and children (Myers et al., 2009; Goeke-Morey et al., 2009, Merrilees & Cairns, 2011; Muldoon, 2004; Cairns & Wilson, 1984; Smyth et al., 1998; Bunting et al., 2012; McDermott et al., 2013). In examining the response of Social Services in Northern Ireland to the impact of trauma in children linked to the Troubles, Ghigliazza (2010) found that social service staff in particular found it difficult to carry out research, provide accurate assessments, or provide services due to fear and mistrust in the communities the statutory services sought to serve. She cites McDermott et al. (2004) in a paper on the impact of the Omagh Bombing on children:

Social Services were hindered by under reporting by parents, teachers or physicians of children's actual psychological stress; the children's inability to communicate their feelings, and level of distress; children trying to protect parents who have also been traumatised; parents inability to recognise signs of trauma in their children; parent denial of children's distress; the child's fear of being perceived as different, and the child's attempt to avoid memories of the trauma.

In the absence of statutory provision, services were developed largely by the community and voluntary sector (Dillenburger et al., 2007), many of whom are now currently funded through the Victims and Survivors Service Northern Ireland (Bolton & Devine., 2014). The Public Health Agency published a report (Macdonald et al., 2011) which noted that the impact of the Troubles on rates of suicide was unclear, but notwithstanding the problems associated with the official statistics, Northern Ireland appears to have higher-than-average rates of attempted and completed suicide amongst young people at least in certain areas. Socio-economic disadvantage places children at increased risk of exposure to poor parental health, including mental ill health, and that such children are themselves at increased risk of poor physical and mental health. The report concluded that more research is needed. However, groups who participated in the survey in Chapter seven reported trans-generational impacts on those directly affected by a range of consequences of the Troubles. There were strong indications that the trans-generational needs of these groups are not being adequately addressed.

Resilience

Resilience is a complex construct and research in the field is extensive, but consensus on definitions about what makes a person or community deemed at-risk or resilient have yet to be agreed. Luthar et al. (2000) defines resilience as a dynamic process encompassing positive adaptation within the context of significant adversity, and Kimhi and Yohanan (2009) cite Antonovsky (1979, 1987) to describe resilience within individuals as a personality tendency towards having a sense of coherence with three components: comprehensibility, manageability and meaningfulness. What is of interest is how some individuals react to the experience of events with the development of their own psychopathological problems, while others appear remarkably 'resilient' and are able to carry on with limited difficulty.

The topic of resilience, particularly in childhood, has been of considerable interest to researchers. Not only can it improve our general understanding of child development processes, but it may provide the basis for the design and implementation of interventions aimed at improving child development and growth, and in particular adaptation to stressful contexts. While it is difficult to identify a prevalence statistic for resilience in children, Tusaie (2004) has suggested that it could range from 15% to 50%, according to the population under investigation, and the definition of resilience used. Previously, resilience was regarded as an internal characteristic or trait, but it is now generally accepted that it is also, if not mainly, a dynamic process which is a result of various different interactions between the child and the environment. Vanderbilt (2008) highlighted three main areas in which such protective factors could be identified: Child Protective Factors (e.g. IQ, emotion regulation, temperament, coping strategies and genetic influences), Family Protective Factors (e.g. love, nurturance, safety, security, nutrition and shelter), and Community Level Protective Factors (e.g. neighbourhood quality and cohesion, youth community organisations, and the quality of the school environment). Riley (2008) suggests that resilience can be adequately enabled in children when they have supportive, responsive parenting, experience of positive activities and interactions, and exposure to positive adult models of problem solving.

It is important to distinguish resilience from simple survival. While survivors can still be absorbed by victimization, resilience involves unexpected or markedly successful adaptation to negative life events, trauma and stress. In a review of individual and political resilience within political violence Sousa et al. (2013) asserts that the concept of resilience, as applied to both individuals and communities, is still not fully comprehended nor is it easily defined. There is, however, general agreement that,

The concept of resilience signifies the successful recovery from or adaptation to, the adversity of stress through the use of individual or community characteristics, resources, strategies, and processes...and community resilience, like individual resilience, is a process supported by various traits, capacities, and emotional orientations towards hardship.

Compared with the field of individual resilience, there is limited knowledge regarding community resilience. Kimhi and Yohanan (2009) state that there seems to be an agreement among researchers that community resilience enhances individuals' coping during stress situations, and is instrumental in faster post stress recovery. There is a growing body of literature suggesting that within settings of political violence resilience may well be a normal course of adaptation to trauma for both individuals and communities, and represents a move away from an analysis of political violence that pathologises populations. Theories and practices of social identity and community development for example, that build confidence and capacity building within and between groups, may have a role to play. Many of the studies in Sousa's review (2013) emphasized cognitive processes whereby survivors of political violence make meaning of their suffering and that the importance of these processes for resilience should inform clinicians focused on mental health services. Building and maintaining resilience at both an individual and community level is an important but complex area of work and needs much more attention in the context of post conflict Northern Ireland. In Israel approaches have been developed to marry public health models that focus on strengthening the community and advancing health promoting behaviour, alongside clinical

models that focus on the detection and treatment of disorders. The Belfast Strategic Partnership for Health and Wellbeing has developed an emotional resilience strategy (2014) which recognises the psychological and trans-generational impact that the Troubles have had on the city,

Among individuals and families affected by the conflict, high levels of post-traumatic stress, clinical depression and substance abuse remain prevalent. There is no doubt the legacy of the conflict continues to be felt to this day, including the trans-generational impact on the emotional health and psychological wellbeing of many of our people who did not grow up during those years of conflict.

It is worth noting briefly the positive impacts of negative events. Tedeschi and Calhoun (1996) suggest that people exposed to even the most traumatic of events may perceive at least some good emerging from their struggle through a process of post traumatic growth. Along with resilience, this may further our understanding of the natural processes people use as they struggle with the aftermath of trauma to derive meaning and face uncertain futures with more confidence.

Addressing trans-generational trauma

Over the past two decades treatment for childhood trauma has evolved from individually focussed models imported from work with adults, to methods that recognise the familial context of children's trauma. According to Scott & Copping (2008) chronic or complex childhood trauma such as abuse, neglect, exposure to violence or parental criminality is strongly associated with the development of criminal behaviours later in life. Accordingly they developed an intergenerational trauma model to ameliorate the impact of chronic trauma on children's development as well as recognising any unresolved traumas in the childhoods of the parents. Attention is given to intergenerational patterns of trauma transmissions. A defining feature of the Scott and Copping (2008) practice model is that it actively engages caregivers in their child's treatment by training them to become "the mechanism of change for their child" by focusing on the trauma of the child as its core. It provides intergenerational psychoeducational group sessions for parents (for unresolved parental traumas), individual sessions to address parental trauma impact on the child, and a child and parent intervention to address trauma related behaviours and symptoms and promote stronger parent relations.

Yule et al. (2007) cites studies by Deblinger, McCleer and Henry (1990); Deblinger, Steer and Lippman (1999) and King et al. (2000) that suggest that TF – CBT is the best available treatment for PTSD, depression and anxiety arising from sexual abuse. In a treatment trial for children who developed PTSD following a single incident trauma Yule (2007) describes his treatment which, although it includes working with the child's parents, it is as a component of the wider treatment programme for the child's trauma only. In the U.S.A., where between 20% and 50% of children are touched by violence either as victims, or even more commonly as witnesses, larger scale interventions such as the Cognitive-Behavioural Intervention for Trauma in Schools (CBIT) programme has been shown to significantly reduce symptoms of post-traumatic stress and depression (Stein et al., 2003). Kaitz (2009) suggests a variety of interlocking interventions for families affected by trauma,

Families of victims are probably best served by multipronged efforts that include multidisciplinary assessments, individual treatment, dyadic interventions, parental guidance, parent education, and medication management. Effective treatment protocols could include various techniques for enhancing parent-child interactions, improving reflective thinking and altering mood states through the use of family CBT approaches, interactive guidance, touch and massage therapy and infant – parent’s psychotherapy.

Scaturro and Hayman (1992) described six stages of a family life cycle as a framework to discuss the impact and consequences of combat trauma on the families of returning war veterans and the role of family psychotherapists in addressing the trauma impact at each phase of family life. Meanwhile, Mendenhall and Berge (2010) state that family therapies represent a comparatively new discipline to join the larger field of traumatology as they bring with them a worldview that is comfortable with the biopsychosocial complexities of human and relationship systems. In post disaster and post conflict settings around the world family therapists are already bringing systems thinking into multidisciplinary trauma response teams working in the field. Mendenhall (2010) cites Bremner, (2002); de Zulueta, (2006); Engel, (1977); Doherty et al. (1987); Flakas, (2007); Mc Daniel et al. (1992) and Woodcock, (2001) to describe how family therapists in field-work readily conceptualise “systems” in accord with the biopsychosocial family systems model as they:

Consider multiple and interconnected systems, including patients anatomical and physiological make up (e.g. brain structure, somatic symptoms), psychological functioning (e.g. PTSD, depression, anger, sense of hope and / or hopelessness), relational and family systems (e.g. attachment, communication, boundaries, cohesion, adaptability) and larger social and ecosystemic structures (e.g. supportive peer and friendship networks, contemporary political milieux and neighbourhood wealth/poverty).

There is emerging evidence for the role that systemic family therapy might play in addressing trauma related conditions using a family therapeutic approach, and by extension a trans-generational intervention may be developed for family member(s) where one or more have been exposed to trauma. Literature reviewed on family therapy shows not only the role that the family plays in the transmission of trauma, but also indicated a growing recognition by practitioners that a trauma-focused capability is needed to therapeutically address the psychological distress of the individuals primarily affected, and that a family systems approach is also needed to address the impact on the wider family (Coulter, 2013; Figley, 2009). According to Figley (2009) treating trauma systemically is about managing the adverse consequences that the trauma impact has on the family unit by using the principles of family therapy to treat both the primary and secondary traumatic reactions. Family Systemic Theory encompasses a range of models developed inter alia by Adler, Bowen, Bowlby, Bandura, Rutter, Haley and Framo. What Figley (2009) calls ‘family empowerment therapy’ focuses on enabling systems to not only ‘process’ the traumatic event but also learn from, and make peace with, the past by developing a family healing theory. Coulter (2013) calls for Systemic Family Therapy to be considered in the treatment of the psychosocial needs of people suffering the impact of post-traumatic stress (not PTSD). The review

extends a rationale for the development of systemic psychotherapy services for survivors of traumatic events and their families. There is evidence for the effectiveness of Systemic Family Therapy with regard to disorders associated with (but not exclusive to) post-traumatic stress, including childhood bereavement, depression in adults, depression in children and young people, substance abuse, and eating disorders.

Examples of practice from Northern Ireland

The research reported in Chapter seven includes a survey of psychological and related services for children and young people and the trans-generational impact of the Troubles in Northern Ireland. Out of 41 agencies that returned questionnaires 11 indicated that they provided trans-generational services and the development of resilience for young people. Four organisations responded to a request for details.

WAVE Trauma Centre

WAVE is a voluntary, cross community group established in 1991 to support people bereaved of a spouse as a result of the Troubles. The group now provides services to address the needs of anyone affected by the conflict including those of children and young people. Its practice is informed through research. Its therapeutic approach to working with children and young people is based upon the principles of systemic family therapy within a broad psychosocial context. According to WAVE, 'this approach seeks to address people within the context of their family and social relationships and also relies upon important reference to Bowlby's attachment theory and Framo's object relations theory'. WAVE provides a Youth service for young people adversely affected by the Troubles. This is open to all young people between the ages of five and twenty five. From 2012 to 2014 WAVE's Youth service delivered a project to over 1200 young people entitled Breaking the Cycle of the Troubles: Legacy for Future generations which included a range of youth training courses to those aged 5-25 years with the opportunity to gain accreditation in specialist areas.

The Ely Centre

The Ely Centre describes itself as a victim support organisation whose aim is to offer care and support to victims and survivors of the Troubles throughout the Fermanagh and South Tyrone area. Formed in the aftermath of the Enniskillen Remembrance Sunday bombing of 1987, the Centre provides support for those families and individuals who have suffered and continue to live with the effects of terrorism, through the provision of therapeutic, financial, educational, social and psychological assistance to help rebuild victims lives and offer support to their families. The Centre explicitly states that it provides a youth and trans-generational service through a range of activities including a youth club, respite days, various mental health workshops, professional and personal development courses, youth counselling and peer-to-peer befriending. "Mothers and Daughters" and "Lads and Dads" trans-generational residential events have been held.

Save the Children (UK)

Save the Children (UK) describes its Families and Schools Together (FAST) as an early intervention programme bringing children, parents, schools and the wider community together

to make sure that children most in need get the academic and emotional support required to fulfil their potential at school and in life. FAST is based on research which shows that building supportive relationships within families and across communities makes it less likely children for children to fail at school, improves their engagement in positive activities and can have huge impact on their life chances and wellbeing. A respondent commented:

Poverty and multi-generation poverty is most associated with areas and communities that experienced the worst of the violence associated with the Troubles. We cannot deliver our programmes without acknowledging this and the range of issues that may arise for our beneficiaries.

Evaluation has shown that 33 schools and 694 families have already taken part with positive results in parental involvement in education, child behaviours at school (emotional, conduct, social) and family relationships (cohesion, expressiveness, conflict and parent child relationships).

CALMS

CALMS was established in Derry in 1994 to develop structured and effective support for individuals suffering from stress-related illnesses as well as mechanisms to prevent, reduce and manage stress. Its services and therapies are based on complementary therapies and approaches. They include: stress management, relaxation/meditation, Tai Chi, Yoga, counselling, listening ear and debt advice and money management. CALMS helps to progress service users into employment and mainstream social and economic activities, and are increasingly aware of trans-generational impacts on users. In 2013 the Centre was the focus of qualitative research (CALMS, 2013) on the impact of parents' trauma on young adults in Northern Ireland.

Conclusions and recommendations for policy, service development and practice

Literature has shown that following violent trauma adverse consequences are transmitted trans-generationally and that the impacts are felt by families, and that this has been observed in Northern Ireland and elsewhere. Research also indicated the extent and level of conflict-related trauma in Northern Ireland (notwithstanding other non-troubles related violence, abuse and deprivation) and by extension, trans-generational trauma. Given the duration and scale of the exposure to violence linked to the Troubles (Bunting et al., 2012) the long-term trans-generational impacts are an important and understudied public health and societal concern. Kaitz (2009) states that as a society we need to identify families at risk and those in which transmission is already at play, find effective means of helping family members cope with their own and each other's needs, restore cohesion and organization at the individual level and within the family, and reinforce and foster strengths of family members and the family as a whole.

Focussed actions are recommended to address the needs of those who suffer trauma-related disorders and experiences of trauma and loss, and their families. These include psychological, mental health and addiction related needs, and needs that drive the trans-generational consequences of traumatic experiences, with particular emphasis on parents, adolescents and young adults, grandparents and young children. Initiatives to establish

capabilities are recommended through trauma-aware and trauma-focussed services, and by systemically addressing trans generational problems and risks. Progress can be made by equipping existing services and/or by raising the trauma-aware capability of practitioners providing services within communities for people with adverse traumatic experiences, and through practitioners in services focusing on high-risk groups.

Practice integration

The International Society for Traumatic Stress Studies (ISTSS) guidelines (Weine 2002) for international training in mental health and psychosocial interventions for trauma-exposed populations in both clinical and community settings provide a basis for the development of a set of principles and values which can guide the development of integrated services and standards in Northern Ireland:

- 1) Respect the concerns, needs, strengths and human rights of individuals, their families and communities;
- 2) Be grounded in established scientific and clinical knowledge of trauma mental health and other related professional knowledge;
- 3) Recognise the legitimacy of multiple perspectives on trauma and related concerns;
- 4) Promote an open dialogue among different voices on trauma and related concerns;
- 5) Integrate different perspectives and positions on trauma in the quest for what is helpful in order to steer those who seek informed recommendations to generate focused debates on areas where there is as yet no broad consensus and to stimulate enquiry.

To these we add three other principles for practice on trans-generational effects of political violence in Northern Ireland.

- 6) Progress must be made using the evidence and practice base where it is clearest, and where it has demonstrated beneficial outcomes for individuals, families and communities;
- 7) Public mental health and wellbeing programmes, along with emotional resilience programmes, must have the trans-generational needs of families and communities at their core;
- 8) Interventions that have not been demonstrated as effective, or where practitioners are not willing to have them demonstrated as effective must not be used, as to do so is neither acceptable nor ethical.

Consideration of the literature suggests that family systems approaches for trans-generational trauma, accompanied by linear interventions such as trauma focused CBT for trauma related disorders and other mental health and psychological problems, be developed. Despite the lack of evidence in the literature for systemic family therapy in the treatment of PTSD or indeed trauma across generations, Figley (2009) and Coulter (2013) throw down a

challenge for more collaborative working that emphasises the role of the family as a key vehicle for addressing the adverse trans-generational consequences, whilst putting in place services that address individual need as long as they are compatible with understanding and respecting systems implications. Figley (2009) has drawn up a protocol for family therapy and other systems-informed practices designed to meet the standards of trauma-informed practice in line with treatment guidelines set out by the International Society of Traumatic Stress Studies (ISTSS).

Based on what we know about traumatic events, the secondary and cyclical consequences on subsequent generations and the specific concerns about on-going violence linked to the Troubles, a range of interventions that are capable of addressing the disabling psychological distress of the individual and the wider distress and consequences for the family, such as family therapy, are needed. Although they had never intended to address trauma or trans-generational needs, many organisations (other than those who participated in the survey) already provide psychosocial services for parents and children and whose contribution is highly relevant to the needs of traumatised individuals and families. Research by Barnardos (Nova) for example showed that its approach to trauma related needs helped individuals create and sustain positive changes in their lives in the context of ongoing violence. Other practice examples include arts therapies, youth programmes, addictions services, early years and child development programmes (Murphy, 2004).

One of the tasks of commissioning therefore is to develop a systematic framework for conceptualising the trans-generational transmission of the effects of political violence in Northern Ireland that is trauma-aware in assessments of need, and trauma-focused in the management of family and individual problems. Progress can be made by ensuring that evidence-based services for individuals and systemic multidisciplinary interventions that address the social and economic context of personal and family problems are developed. Using what already exists, where the evidence is strongest, will enable practitioners to be aware of other practices as part of a wider systematic framework of service delivery, and to operate effectively within their roles. Indeed, there may be an opportunity in the short to medium term for the Belfast Strategic Partnership for Health and Wellbeing to develop such a trauma-aware framework around its emotional resilience strategy for mental health and social and wellbeing approaches to support individuals, families and communities to build resilience and cope with the legacy of the past.

Research has shown a desire by practitioners to work collaboratively across both linear and family approaches, and that the strength and benefits in doing so far outweighs the effectiveness of any one working independently, particularly when the focus is on the trans-generational impact of trauma on families. An opportunity now exists to bring together these approaches using the values outlined by the ISTSS to develop practice in a Northern Ireland context. Advances should be made to improve access to systemic interventions for families and other groups and more needs to be known about the numbers and distribution of available practitioners in these methods working in statutory and non-statutory sectors. If systemic interventions are to be developed to address the trans generational impacts of the trauma and loss, improved referrals and liaison between trauma-focused therapy services on one hand, and family systemic therapy services on the other, would greatly assist. Similarly, improved knowledge of services and links within and between the statutory and non-statutory sectors is essential in building effective service connections. The range and

types of services offered will be determined largely by the availability of funding and the use of evidence based approaches (or a desire to move to evidence based approaches, or to test existing practices) that has multidisciplinary and multi-agency working with trained staff at its core. To achieve the ambition of the Stormont House Agreement (December, 2014) it is imperative that we make the best of what we have and develop the capacity to deal with the major public mental health impacts resulting from the years of violence on people who have experienced loss, injury and trauma, and address the trans-generational impact on subsequent generations.

Future research

Suggestions are made for future research to include a quantitative study on the trans-generational impact of the Troubles; an exploration of the transmission of pathology, and the effectiveness of interventions and treatments; the extent to which trans-generational trauma has impacted on the levels of suicide in Northern Ireland; an investigation of the mental health and related needs of children and young people using the World Mental Health Survey Initiative dataset at the UU, and the role that interventions play in the early stages of the childhood life cycle in supporting meaningful attachments (for parents and children), positive development, learning, life skills and resilience.

Chapter Seven

A SURVEY OF ORGANISATIONS IN NORTHERN IRELAND CONCERNED AND WORKING WITH THE TRANS-GENERATIONAL IMPACT OF THE TROUBLES ON CHILDREN AND YOUNG PEOPLE

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Introduction

This Chapter describes a survey undertaken in Northern Ireland in 2014, the chief aims of which were to obtain an understanding of those working in the field as to the trans-generational consequences of the Troubles on children and young people, and to find out what services were being provided to address identified needs. The Chapter also includes an overview of services provided by statutory Health and Social Care Trusts along with contributions from senior managers and practitioners, and observations on a previous study of the work of service providers delivering services for individuals and communities affected by the conflict.

The survey

The original aim of this Chapter was to consider the appropriateness of statutory and non-statutory psychological care provided to children and young people affected by the conflict-related experiences of their families. A preliminary literature review and investigation revealed that, besides services being offered by the statutory sector, there was a range of funders and non-statutory organisations involved in work that related to the psychological and other impacts of the violence. For example, the Victims and Survivors Service was, at the time this research study was initiated, funding 27 (later 28) service providers involved in delivering counselling, psycho-education and other related services for people and communities affected by the violence. It was observed that other Departments of the Northern Ireland Government were funding programmes (e.g. the Department for Social Development), which might also be relevant. Finally, it was noted that national Non-Governmental Organisations (NGOs) were funding programmes and others were relying upon funding from philanthropic sources. Early work also sought to distinguish between those services being provided for those who directly experienced and suffered the consequences of violence linked to the conflict on one hand, and on the other to find out more about those specifically designed to address identified trans-generational impacts and consequences for subsequent (and previous) generations.

Given this complexity and the evident lack of an overview of this area of work, it was agreed in consultation with the Commission for Victims and Survivors to undertake a survey aimed at better understanding the range of trans-generational concerns identified by those active in advocating for services or in delivering services. Further, the survey would seek information about those services in place. The Survey and associated work was informed by reports, published essays and research with particular relevance to Northern Ireland and the impact of the Troubles/conflict and to a wider body of international literature drawn chiefly from peer reviewed journals. Two such reports were particularly relevant. Hanna et al.'s report for the Commission for Victims and Survivors, which provided valuable background

information and whose observations and recommendations shaped the work undertaken in this (Hanna et al., 2012). The second report (McNally, 2014) likewise provided valuable contextual descriptions and observations, and offered an approach to addressing the trans-generational consequences of the violence. Discussions with senior managers and practitioners in the Health and Social Care Trusts also informed the approach, analysis and conclusions of this work, both at an early stage and later as it was being drawn to a conclusion. Finally, the authors had detailed conversations with service providers delivering health and well-being programmes for the Victims and Survivors Service. This took the form of meetings with 26 funded groups (and others) in late 2013-early 2014. The observations from this work were collated in a report for the Victims and Survivors Service (Bolton and Devine, 2014) and informed the approach to the survey, and to the discussion and conclusions that follow.

The Survey itself was developed in consultation with the Commission and representatives working in the victims and survivors field. It was launched primarily as an Internet based survey in June 2014 and closed in November 2014. Over this period information was widely communicated across a range of sectors, funders, umbrella organisations and other interests. Forty-one responses were received, of which 11 were involved in providing services aimed at addressing the trans-generational impacts of the years of violence. Responses came from a wide spectrum of organisations and interests including the victims and survivors sector (22%), community counselling and support organisations (17.1%), early years providers (7.3%) and major NGOs working in child care (4.9%). Addiction services provided 4.9% of the responses, as did the creative arts and the 'education, training and learning' sectors. One response came from an individual who had been directly bereaved as a consequence of the Troubles.

The following respondents contributed to the Survey:

Addiction Northern Ireland	The Aisling Centre
Anonymous	Ashton Community Trust
Belfast Health & Social Care Trust - Trauma Resource Centre	CALMS
Clan Mor Sure Start	Creative Change NI
Cruse Bereavement Care	The Dry Arch Children's Centres
The Ely Centre	FAIR
Families Moving On	Fírinne
HURT (Have Your Tomorrows)	Health & Social Care Mental Health Service
Individual	The Koram Centre
New Life Counselling Service	Northern Health & Social Care Trust
NI Music Therapy Trust	NOVA, Barnardos
Relatives for Justice	South Eastern Health & Social Care Trust
Save the Children	S.T.E.P
Surestart	SURVIVORS OF TRAUMA
Ulster University	WAVE
West Tyrone Voice	Western Health & Social Care Trust

All of the respondents indicated they had identified the trans-generational impacts of the conflict through direct contact with individuals. Some had undertaken or made use of local or wider needs assessments, or regional research. Apart from the facts and figures supplied by respondents, their comments have greatly enhanced the analysis, conclusions and recommendations.

Summary of key findings from the trans-generational survey

The findings reveal strong endorsement of the trans-generational impact of the Troubles on those who directly experienced violence, on their families, and more generally, on families in the wider community. The needs of those directly affected by the violence, including on-going violence also registered as a significant concern. At the time of writing this report we are still very much within living memory and experience of the conflict from 1969 to the present. Both those who are family members of those who were directly affected by that violence, and those who experienced violence directly themselves, were most often considered by respondents to have conflict-related needs. Reflecting the complex nature of the Troubles and its consequences, other groups are identified including prisoners/ex-prisoners and their families, and those who hold themselves responsible for violence and their families. Respondents also registered the needs of colleagues, former colleagues and peers of those caught up in violence. The needs of such specific groups may not be sufficiently understood (e.g. Shoulder to Shoulder, 2013; Jamieson and Grounds, 2003). One contributor who is an experienced trauma counsellor illustrated the impact and trans-generational consequences as follows:

“Patients who were involved in one way or another show high incidence of cutting ties with personal relationships, including children, in order to protect them from risk. Those children have lost contact with fathers and have often grown up in a lone parent situation within the benefits system. In addition they have limited or no access to family history from the paternal line e.g. medical history.” and,

“Those patients who were injured in so-called “punishment attacks”, show loss of contact with extended family, thereby eroding social support networks.” and,

“The children of these groups tend to achieve lower in education terms, due to moving house frequently and due to impact of having witnessed traumatic events, or at least have been told about them. The lower educational attainment of this group leads to few opportunities for employment. This in turn consigns a third generation to poverty.”

1. There was also strong endorsement of the trans-generational needs of these groups not being adequately addressed. (One sub-group ‘Young children 0-12 years’ scored at a notably higher level, indicating that this group in particular was, in the view of respondents, under provided for.)
2. The needs reported by respondents relate to 5 distinctive areas as follows, in descending order:
 - Health and well-being;
 - Families, parenting and relationships;
 - Poor life opportunities and outcomes;
 - “Dealing with the past”; and
 - Other needs not included in the other areas.

See Table 7.1, Figure 7.1 and Table 7.2 at the end of this summary, for detailed findings.

3. In the **Health and Well-being** category, '*Mental ill-health*' and '*Substance Abuse/Dependency*' were the most endorsed needs. Discussions with senior managers and practitioners in the Health and Social Care Trusts confirm the conclusion that the secondary or trans-generational impacts of the Troubles are significant in comparison to other trends in mental health and other societal pressures and that the conflict and its consequences on subsequent generations are a distinctive and significant factor associated with mental illness, substance dependency, and other problems for young people and their families.
4. Within the **Families, Parenting and Relationships** category '*Interpersonal-Family Conflict*' and '*Poor Family Functioning*' registered as the highest concerns;
5. In the **Poor Life Opportunities and Outcomes** category, all of the areas listed scored more or less equally with a slightly higher score for '*Social Isolation and Solidarity Needs*' and, '*Poor Participation in Education and Related Services*';
6. Within the **Dealing with the Past** category, the '*Desire or Search for Truth about Past Events*' was the most endorsed need;
7. Eleven respondents indicated they were delivering services aimed at addressing trans-generational needs. Ten were non-statutory services;
8. Whilst services are provided in all of the 26 Council areas, the development and distribution of services is piecemeal. They have been developed largely through the initiative of individual providers who have secured the support of funders to address a need they have identified and/or to put in place a service, which they considered to be relevant to the needs of individuals, families and communities;
9. Two-thirds of providers commenced their trans-generational services in or prior to 2010 i.e. few services have commenced in more recent years. Based on comments made by respondents this would seem in part to be linked to funding challenges and in part to the challenge of raising the trans-generational issue to a level where it can be supported by evidence-based commissioning of services;
10. Funders included the Victims and Survivors Service, the Department for Social Development, national NGOs and philanthropist sources;
11. The periods over which services are funded varied as follows:
 - 3+ years (3 providers);
 - 2 years (2 providers);
 - 1-2 years (4 providers);
 - Less than 12 months (1 provider);
 - Other (1 provider).
12. Services were being provided for those groups identified in (1) above, with a broadly similar priority to those considered to be most in need as a consequence of the trans-generational impact of the Troubles/conflict;

13. Only one (out of eight) statutory respondents indicated they provided services specifically designed or funded to address trans-generational needs arising from the conflict. Follow-up contact with the statutory sector confirms the trans-generational impact of the years of violence features as a significant theme in the mental ill-health patterns of need in the community and that mainstream statutory services currently addressing needs relating to the secondary consequences of the years of violence;
14. The principal aims of the eleven providers were, in descending order:
- To support personal development;
 - To better understand current needs;
 - To provide therapeutic services;
 - To support educational development;
 - To support community building.

Other less frequently endorsed purposes were, to promote solidarity or belonging, to enable acknowledgement, to support inter-community relationships, for justice reasons and for solidarity reasons;

15. The principal methods being used by service providers were, in descending order:
- Needs assessment or research into needs;
 - Personal development groups or programmes;
 - Counselling or psychological therapeutic services;
 - Complementary services;
 - Better understanding the origins, occasions and impacts of violence.

Nearly three quarters of the 11 respondents indicated they are undertaking '*Needs assessment(s) or research into needs*' and over half are using methods to '*Better understand the origins, occasions and impacts of violence*'. This emphasis on finding out about the trans-generational impact of the conflict reflects a theme in the survey of poorly understood (i.e. defined and differentiated) needs on one hand, and efforts to understand that need etc. on the other. Besides these two activities or methods, in the top five methods are '*personal development*', '*complementary therapy services*' and '*counselling or psychological therapeutic services*'. This echoes with the findings that the emphasis is on the health or developmental needs of individual and communities. Those activities or methods that more explicitly relate to the experiences of violence and come within the 'Dealing with the Past' frame, are used by comparatively fewer providers;

16. Of those organisations delivering psychotherapy or counselling services the chief approaches used were person-centred counselling and integrative or eclectic approaches. Whilst these interventions are likely to be most effective with Steps 1 and 2 needs (that is, on DHSSPSNI Stepped Care Framework, 2010), an earlier overview of the work of groups being funded by the Victims and Survivors Service (Bolton and Devine, 2014) identified other more specialist providers working to support individuals affected by the violence which have adopted trauma-aware and trauma-focussed interventions and other specialist approaches relevant to for example, bereavement, substance abuse and addiction. Also, some statutory services offer cognitive behavioural therapy for trauma-related disorders. In the wider voluntary sector (and the statutory health and social care system) there is a range of mental health, child care, youth, parent focused and other services which, whilst not focussed per se on the

impact of the conflict and their trans-generational consequences are part of a wider tapestry of services which to one degree or another can contribute to the response to the enduring impact of the years of violence;

17. A number of organisations use complementary therapies of which the most used modalities were reflexology, relaxation, aromatherapy, yoga and meditation;
18. From most of the service providers' responses there is clearly some awareness of international literature and writers in the fields of trauma, mental health, the trans-generational impact of violence, child development and parenting. There was comparatively less reference to local research suggesting either a scarcity or knowledge thereof. Accrediting bodies, regulatory bodies and the Victims and Survivors Service itself, were cited by a few respondents as important sources of information, guidance etc. A number of respondents made reference to internal arrangements for reflection and communication on research, and the use of practice or clinical audit;
19. Providers responding to the Survey use a range of methods to evaluate the impact of their services. The chief methods are, in descending order:
 - Monitoring the numbers attending and participating in programme activities;
 - Capturing the expressed experiences of service users or participants;
 - Assessing progress, changes, improvements or other outcomes through before and after assessments, or similar means.

The following Tables and Figures provide a more detailed overview of those areas, which the 41 respondents to the Survey and which are summarised in points 1-3 above. Table 7.1 lists the 5 broad categories, into which the 22 separate statements of need linked to the trans-generational consequences of the Troubles have been classified.

Broad category of concern	No. of endorsements by respondents
Health and well-being	125
Families, parenting and relationships	106
Poor life opportunities and outcomes	150
"Dealing with the past"	87
'Other'	24

Table 7.1 Number of responses from respondents for each broad category of trans-generational need.

Figure 7.1 shows in graph form the relative percentage responses to each of the 22 statements of need offered to respondents. The number of responses and percentages are shown in Table 7.2.

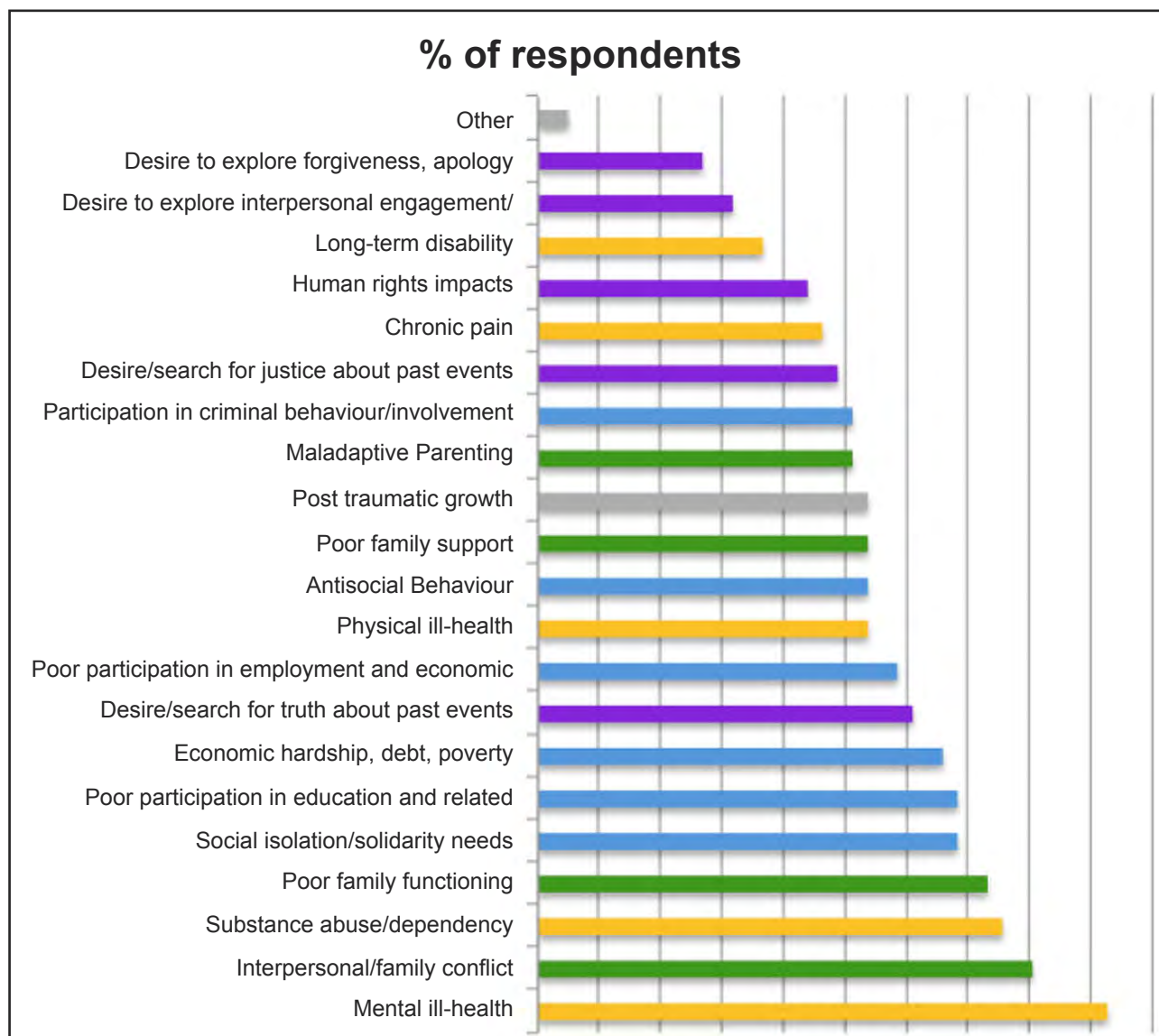


Figure 7.1 Illustration of the percentage of respondents indicating those concerns they have identified associated with the trans-generational impact of the Troubles

Areas of concern identified by respondents in order of tallies	No.	% (n=41)
Mental Ill-health	38	92.70%
Interpersonal/family conflict	33	80.50%
Substance abuse/dependency	31	75.60%
Poor family functioning	30	73.20%
Social Isolation/solidarity needs	28	68.30%
Poor participation in education and related services	28	68.30%
Economic hardship, debt, poverty	27	65.90%
Desire/search for truth about past events	25	61%

Areas of concern identified by respondents in order of tallies	No.	% (n=41)
Poor participation in employment and economic activity	24	58.50%
Physical Ill-health	22	53.70%
Antisocial Behaviour	22	53.70%
Poor family support	22	53.70%
Post traumatic growth	22	53.70%
Maladaptive Parenting	21	51.20%
Participation in criminal behaviour/involvement with the criminal justice system	21	51.20%
Desire/search for justice about past events	20	48.80%
Chronic pain	19	46.30%
Human rights impacts	18	43.90%
Long-term disability	15	36.60%
Desire to explore interpersonal engagement/ reconciliation/ forgiveness	13	31.70%
Desire to explore forgiveness, apology	11	26.80%
Other	2	4.90%

Table 7.2 Ranked tally and percentage of respondents indicating each concern they have identified associated with the trans-generational impact of the Troubles/conflict

The role of the wider voluntary and community sector in delivering counselling and related services

The focus of the Survey was on the trans-generational needs and services being delivered to address those needs. However, the findings do not capture the breadth of work being carried out within the non-statutory sector, particularly in relation to counselling and related services. In 2013-14 a study was undertaken as part of a Knowledge Transfer programme with the Victims and Survivors Service to find out more about the work of providers delivering psychological and related services for people affected by their experiences of the Troubles (Bolton & Devine, 2014). The programme was delivered by a partnership of the Initiative for Conflict-Related Trauma and Ulster University through a Knowledge Transfer programme of the Research and Development Office (DHSSPS). The study of services took the form of detailed discussions with 26 agencies and groups being funded by the Victims and Survivors Service under its Health and Well-being programme and which almost exclusively deliver services to adults. Whilst few of the programmes were explicitly directed at the trans-generational impacts of the conflict the great majority of the providers recognised that a proportion of the psychological and related needs they were addressing were second and

subsequent generational. (One provider gave an example of working with a family in relation to the Troubles, which was experiencing difficulties that could be traced back four generations '*although the original trauma is almost forgotten*'.) The discussions revealed that there was a spectrum of services being offered by the providers including generic stress-focused counselling or other therapies, person-centred (and related) counselling for more entrenched life problems, and, specific counselling or other interventions for specific problems and psychological or mental health disorders.

Across nearly all the providers, person-centred counselling was the most common intervention provided for victims and survivors. Within this, some counsellors had developed specialist practice, counselling approaches and other methodologies in relation to specific needs. Specific models of intervention, based on accumulated experience in service provision and practice were being used, for example in relation to addictions and bereavement.

Some providers had adopted a trauma-focused approach to their work. Others were taking a more generic approach, and a few did not favour a trauma-focused approach. Some individual counsellors or therapists were using trauma informed or trauma-focussed interventions with their clients. There was only a small number of examples of research-based or theoretical models of trauma being used that could (a) inform the understanding of trauma-related needs, (b) help identify the goals of counselling or therapy, (c) assist the counsellor or therapist with their client to navigate around the components of traumatic experiences and their consequences, and (d) provide the counsellor with a framework for addressing the trauma-related experiences and needs of clients.

These observations were amplified by the frustration expressed by a number of counselling organisations and by individual counsellors that they considered conventional counselling to be insufficient on its own, to address trauma-related needs (specifically the severe and chronic Troubles-related trauma needs being faced by those providers). These organisations made a strong case for assistance in trauma-focused training and development to enable them to further develop the capability and skills to better respond to the trauma needs of their clients – including trauma-related grief.

With reference to the Department of Health, Social Services and Public Safety's mental health stepped care framework from its Psychological Therapies Strategy the severity and levels of complexity of needs being addressed by the providers was considered. The aim was to establish where each provider considered its 'cut off' point to be i.e. the point at which the group considered its practitioners should refer clients on to other organisations or end their work with a client, or both. The framework goes from Level 1 (psycho-education and well-being support) to Level 4-5 (complex and supported practice). Some providers were very familiar with the framework and could relate their work to the Levels described in it. Others appeared not to be familiar with it or in some cases did not know about it.

Making decisions about levels of need requires systems and arrangements that support assessment and decision-making. Some providers had well thought through assessment arrangements in place, drawing in specialist inputs where they considered it necessary. This included the use of standardised or internally developed tools to assess clients' needs, to monitor their progress, to support decision-making and to assess the outcomes of the providers' interventions. Others said they were reluctant to use such tools.

There was a number of providers which recognised their intervention operates at Levels 1-2. Most of these have no ambition to work at Levels 3 or 4-5, although a few indicated they could envisage working at higher Levels if enabled to do so. Some work up to (and including) Level 3, and many of these providers seemed to have the staff, processes and linkages in place to support their work at this Level.

A small number indicated that they were working at Level 4 of which one or two providers probably were, mainly because they were managing complex cases and had developed specialist interventions which seemed to be particularly relevant for people with needs at Level 4 or even Level 5. They also seemed to have in place systems, linkages etc. to support their work.

As discussed earlier, the nature of the violence and its impact on help seeking and trust in services emerged as an important consideration in the work of the voluntary and community providers. Some stated that some users were only likely to access services through their organisation either because they were local and had established a local reputation and trust, or because it was thought that some victims and survivors were only going to access services through their organisation because of its identity with specific sections of the population affected by the Troubles. For these reasons some providers stretched themselves to work at higher Levels of the stepped care framework than they might have anticipated (or perhaps even wanted).

Another factor was the perceived poor response at times, and/or in some locations from the statutory sector. This included reluctance of the statutory sector to take referrals from providers, slow responses, poor follow up and feedback and for at least two providers, referrals being returned to the referring group on the basis that the statutory sector had nothing additional to offer the client. These problems tended to be less of an issue where there were good personal relationships with staff in the statutory sector, good inter-organisational arrangements, or an understanding by the statutory sector of the role of the voluntary body and where there are other service contracts between the statutory sector and the organisation. The discussions with providers revealed that new models of interagency cooperation, in Belfast for example, were creating agreed arrangements for cross referral and co-working amongst agencies in different sectors, which were overcoming some of these problems.

Links within the sector between providers were much less apparent with relatively few examples of referrals and work flowing to the more specialist providers as might have been expected, or to avail of interventions from other providers that were not otherwise available (e.g. family therapy). The general impression was of providers working in relative isolation (with some exceptions) when the capability, clinical governance and economies of scale of organisations could be improved with higher levels of cooperation.

Finally, most providers offered complementary or related services to support counselling or act as a pathway into counselling (or both). These were seen by the providers to be important in enabling people to seek help at their own pace and for the providers to support them in doing so.

Services provided by the Health and Social Care Trusts

Discussions with Senior Health and Social Care Trust managers and practitioners, and reference to information published by the Trusts, indicates there are currently three clearly identifiable services within Health and Social Care Trusts whose primary focus is the psychological and related impacts of the conflict. These are:

- The Trauma Resource Centre based in North Belfast - in the Belfast Trust - which provides multi-disciplinary treatment for adults who have been affected by the Troubles/conflict. It provides counselling delivered by a professionally trained trauma counsellor, occupational therapy and physiotherapy (Belfast H&SC Trust website; Jan 2015);
- The Family Trauma Centre in South Belfast – again in the Belfast Trust – which is a Trust and regional CAMH Service providing specialist treatment services (to step 3 and 4) for children, young people and their families following severe trauma (FamilySupportNI website; Jan 2015);
- The Trauma Counselling Service, based in three locations in the Southern Trust. This service is delivered by three part time trauma counsellors who take referrals from GPs and mental health services (discussion with senior manager Southern H&SC Trust, Jan 2015).

Findings from the Survey suggest Trusts do not have specific services or programmes to address the trans-generational impacts of the years of violence. However, each Trust provides a Child and Adolescent Mental Health Service (CAMH Services) including access to specialist CAMH Services. Access to these services is governed by a set of aims and criteria published by the Trusts (Health and Social Care Trusts (NI), 2012). Discussions with senior managers and practitioners indicate that it is most likely some of the children and young people being referred to CAMH Services have needs that could be linked to the trans-generational impacts of Troubles experiences. The specialist CAMH Services provision is part of a wider network of services to support children and young people who have emotional, behaviour and mental health difficulties. The guidance and criteria were developed to support the implementation of the Department of Health, Social Service and Public Safety (DHSSPS) CAMH Services Regional Service Model and to meet the standards outlined in the DHSSPS Mental Health Services Framework. The CAMH Services Regional Service Model had previously been developed in response to the recommendations of the RQIA (The Regulation and Quality Improvement Authority - Northern Ireland's independent health and social care regulator) CAMH Services Review to reduce service variation and develop a regional care pathway.

The specialist CAMH Services focus on children and young people who are regarded as having needs that fall into steps 3, 4 and 5 of the Mental Health Services Framework. That is the child or young person “is experiencing moderate to severe mental health and emotional difficulties, which is significantly impacting the young person’s daily psychological, social and/or educational functioning.” Typically CAMH Services provide care for children and young people with the following range of needs:

- Deliberate Self Harm and/or Suicidal;
- Depression (Moderate to Severe);

- Anxiety Disorders including panic/phobias;
- Post Traumatic Stress Disorders;
- Obsessive Compulsive Disorders;
- Attachment Disorders;
- Autism with co-occurring mental health problems;
- ADHD with co-occurring Mental Health Problem;
- Eating Disorders;
- Early onset psychosis;
- Substance misuse problems where there is a co-occurring mental health problem.

This range of services is likely to be highly relevant to mental health disorders experienced by young people and whose needs could be attributable to one degree or another to the trans-generational consequences of the Troubles and in particular for those with more serious disorders.

The five Trusts provide various profiles of local, Trust wide, specialist, and in some cases, sub-regional and regional services.

The CAMH Services rely upon referrals from and liaison with other services including GP services and Trust family, child-care and child protection services. Within these services and non-statutory (NGO) services are staff with qualifications and experience in delivering counselling and psychological therapies such as family therapy, which are an important resource and capability for children and their families. The CAMH Services play a key role in ensuring that young people transfer to adult services in a way that ensures their needs continue to be addressed.

Respondents and others consulted for this survey drew attention to the need for a greater focus on the enduring and trans-generational impacts of the Troubles by public services. Senior managers and practitioners in the Health and Social Care Trusts who were consulted with regard to mental health and related services believe it would help very much if statutory services moved to be more explicit about the impact of the Troubles on individual and their families and communities - in their assessments of individuals needs, the delivery of services etc. As one senior manager noted, *“It may highlight predisposing factors in relation to mental health. It may enable us to quantify the relationship between the Troubles and low educational attainment, consequent socio-economic issues and impact on mental health.”*

Moving to put in place universal trauma awareness in assessing and understanding needs, and trauma focussed capability in key therapeutic services, backed up by public service aims and targets, would contribute significantly to such a shift in emphasis. Where there is circumstantial evidence to suggest certain localities or groups could be at elevated risk, then there is a case for the introduction of screening and assessment arrangements aimed at case finding, supporting earlier interventions, encouraging help seeking and facilitating case management. Such measures could be substantially achieved by making the best use of current services in ways that are relevant to the needs of a post-conflict community, by policy and service development and training for practitioners. Developments such as this would assist greatly in achieving the ambitions of improving mental health services as desired by the signatories to the Stormont House Agreement (2014).

The cyclical nature of trans-generational consequences of conflict

Research confirms that most people who experience traumatic loss or other traumatic experiences will in the long term suffer no or minimal trauma-related disorders. Other writers, and common personal and clinical experience also confirm that many people will, because of and in spite of terrible experiences, re-evaluate and re-organise their lives, priorities, relationships in very positive directions, an outcome often referred to as post traumatic growth (Calhoun & Tedeschi, 2006). Similarly, following trauma and loss in the life of an individual, the transmission of adverse consequences to subsequent generations is not nor need not be inevitable, and as with primary traumatic experiences, many people do not succumb to the consequential risks for and impacts on families. However, some will experience and develop significant difficulties, including those that manifest themselves in enduring and interconnected social, economic, psychological, emotional and mental health problems.

The literature and the comments of respondents draw attention to this cyclical transmission of the consequences of traumatic events and loss down the generations. As just noted, the transmission of adverse impacts is not inevitable, yet as demonstrate elsewhere in this Report, the risks arising from negative life events can load the dice for future generations. This has two potential effects. The first is the impact on the children of those who have experienced the index loss or trauma, and in turn on their grandchildren and potentially further generations. These impacts can include epigenetic risks (where for example the parents of the child transmit stress-triggered and stress-adapting genes to their children), developmental impairment, relationship and attachment problems, increased risk of mental health problems and the carrying forward of all or some of these problems in adulthood and then into parenthood. Second, in the context of conflict several writers comment upon the risks of these cycles contributing to new episodes of organised violence when for example there is a critical mass of people within the community who have unresolved loss and trauma-related psychological difficulties (Maedl et al, in Martz, 2010). All of the above sources of evidence (the Survey, the review of the work of groups delivering services for victims and survivors, and the views of senior Health and Social Care staff) identify and demonstrate concerns about on-going organised violence such as the on-going activities of paramilitary groups - documented up until 2013 by Kennedy (2014).

The trans-generational consequences of primary loss and traumatic experiences manifest themselves in, amongst other things, missed opportunities in the life of the developing child and young person where for example they have insufficient opportunity to acquire satisfactory attachments, psychological and emotional competence, and to acquire life skills in behaviour and relationships, and in the management of their inner emotional world. In more extreme situations, the secondary consequences can lead to experiences of neglect and abuse - which can themselves become index traumatic experiences for subsequent generations of children. These traumatic events directly experienced by the developing child can then become the new original trauma or loss, which plays itself out, in time, in the life of that child's own children.

The transmission of narratives derived from memories of conflict and violence can impact adversely on identity in the social sphere, and convey or amplify perceptions of threat, fear, exclusion etc. A complex picture can develop.

Viewing these and other transmission processes as a cycle, opens up opportunities for identifying how and when interventions might be made to minimise adverse impacts and deliver ‘good enough’ parenting and other developmental and nurturing outcomes for the child, and, at times, for protecting the child from risk, neglect or harm.

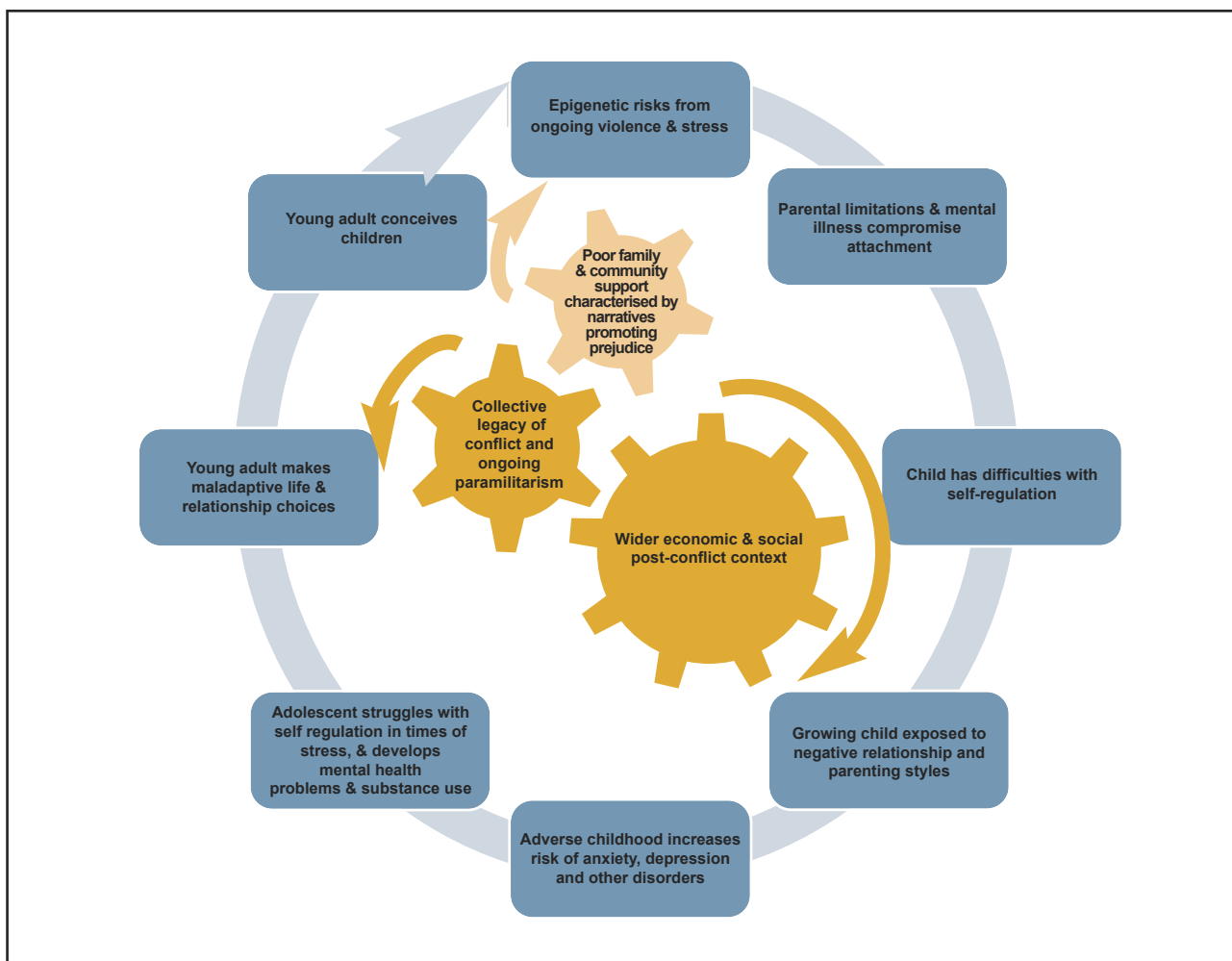


Figure 7.2 A developmental overview of the pathways through which the impact of the Northern Ireland Troubles are transmitted to subsequent generations.

Developing a strategic response to the trans-generational consequences of the Troubles

The findings of this Survey demonstrate that in the view of respondents the consequences of the years of violence are very much with us, impacting daily on the everyday lives of many people. Triangulation with international literature and the views of senior statutory Health and Social Care managers and practitioners suggests we should not at all be surprised at this. The implications are that rather than regarding the current period as being the end of the Troubles, there is a pressing need to view this period of time (after the Belfast/Good Friday Agreement of 1998) as a post-conflict period in which certain things need attention and certain things need to be done. Fundamentally, this is about the re-building a post-conflict community with the overarching aim of promoting the wellbeing and resilience, along with the social and economic life, of individuals and families. Drawing from the Survey

findings and other sources referred to earlier, wider and specific actions will be needed to impact on the personal and societal determinants of well-being. Actions are required to address the environmental, contextual and social determinants of disadvantage and poor mental health and wellbeing, alongside actions to deliver and develop counselling, psychologically therapeutic and other relevant personal and family services. In other words, the findings of this Chapter are placed in the context of a wider psychosocial understanding of needs and of the solutions to the problems faced by individuals, families and communities. Based upon the findings of the Survey and other sources of evidence referred to in this Chapter, a strategic response could include:

- Wider actions to improve the social, economic and environmental conditions for individuals, families and communities affected by primary experiences of trauma and their trans-generational consequences.
- Focussed actions to:
 - a. Address the needs of those who have had primary experiences of trauma and loss, and their families, including:-
 - I. Psychological, mental health and addiction related needs of people who suffer trauma-related disorders;
 - II. Chronic physical health needs linked to traumatic experiences and loss.
 - b. Address those cyclical risks and needs that arise as a consequence of the trans-generational consequences of traumatic experiences in the lives of individuals with particular emphasis on:-
 - I. Parents;
 - II. Adolescents and young adults;
 - III. Grandparents;
 - IV. Young children.

Wider actions

The evidence on the impact of the Troubles for individuals and families (e.g. Bunting et al., 2013), and now the evidence of the trans-generational consequences, establish the case for services that are capable of understanding, detecting and responding appropriately to adverse trauma and trans-generational needs. Action is needed from broad population initiatives to focussed personal services and interventions. In summary, wider actions are recommended to:

- Improve the social, economic and environmental conditions for individuals, families and communities affected by primary experiences of trauma and their trans-generational consequences – including reductions in organised and interpersonal violence;
- Improve the wellbeing and resilience of communities;
- Improve the self-esteem, self regard and confidence of communities;
- Address debt, and personal and family financial hardship;
- Reduce violence and improve conflict-resolution and management capabilities of communities;
- Put in place other relevant initiatives.

The following framework, drawn from the trans-generational cycle - Figure 7.2 above, illustrates programmes linked to key points in the trans-generational cycle where interventions are required to address the transmission of adverse consequences. Many government departmental programmes contain elements of these programmes, as does the work of statutory agencies, community and voluntary groups, and national NGOs working in Northern Ireland. It would greatly assist the task of creating a coherent joined-up approach if as many such programmes and areas of work were brought within a strategic trauma-trans-generational umbrella, where addressing the enduring personal and family impacts of the years of violence are agreed priorities. Much could be gained by developing capability across policy making, commissioning and service delivery in understanding the trans-generational impacts of the Troubles, and to develop capability in delivering relevant and effective interventions and practices. Early progress could be made in addressing the trans-generational impacts of the years of violence by coherently aligning the aims, policies and contributions of government departments and agencies, and maximising the contribution of the independent sectors. Current programmes should be audited to consider whether and to what degree they support the aims and work of addressing the trauma-related and the trans-generational needs of the population, and amended where necessary. Where new programmes that impinge on the trauma-trans-generational needs of the community are being developed, their aims, work and desired outcomes should address these priorities from the outset.

Overview of key points of intervention in the Trans-generational cycle after violence with example programmes

	Area of need; opportunity for intervention	Example programmes
1.	Epigenetic risks	<ul style="list-style-type: none"> • Reducing violence, fear and stresses for communities, families, women, children and young people; • Addressing the impact of the conditions for violence linked to deprivation, poor infrastructure and environments; • Trauma aware support and interventions for expectant mothers and fathers and young families;
2.	Parental support	<ul style="list-style-type: none"> • Supporting and equipping expectant and new parents; • Identifying and addressing parental skills deficits; • Promoting personal development, self-esteem, literacy; • Promoting regard for other groups and communities; • Addressing the transmission of fearful or aggressive anxieties regarding other groups and communities;
3.	Modelling positive gender roles, relationship and parenting styles	<ul style="list-style-type: none"> • Promoting respect, values and life skills from an early age; • Helping parents model positive roles, communication and values; • Civic/citizen education programmes ; • Enhancing communication and interpersonal skills; • Promoting knowledge of the past; • Promoting attitudinal change;

	Area of need; opportunity for intervention	Example programmes
4.	Promoting mental health and addressing risks	<ul style="list-style-type: none"> • Promoting wellbeing; • Promoting resilience; • Promoting positive coping strategies and skills; • Promoting help-seeking; • Promoting responsible sexual behaviour; • Promoting responsible use of alcohol and other addictive substances; • Progressing case finding of trauma originating health and related problems; • Addressing trauma-related disorders; • Addressing other mental health risks and disorders; • Addressing addiction and substance misuse; Addressing suicide risks;
5.	Supporting adolescents and young adults	<ul style="list-style-type: none"> • Promoting personal development, self-esteem, literacy; • Promoting wellbeing and resilience; • Promoting skills and know-how for a healthy emotional life; • Preparing for adult relationships, adulthood and parenthood; • Promoting help seeking; • Early detection of developing mental health disorders; • Addressing addictions and substance abuse; • Addressing suicide risks; • Addressing risks of becoming involved in organised violence.

Focussed actions

Focussed actions are recommended to:

- a. Address the needs of those who have had primary experiences of trauma and loss, and their families, including:-
 - i. Psychological, mental health and addiction related needs of people who suffer trauma-related disorders;
 - ii. Chronic physical health needs linked to traumatic experiences and loss.

- b. Address those cyclical risks and needs that drive the trans-generational consequences of traumatic experiences in the lives of individuals with particular emphasis on:-
 - i. Parents;
 - ii. Adolescents and young adults;
 - iii. Grandparents;
 - iv. Young children.

Some services are in place to address some of these areas, but the picture from a number of studies is piecemeal. To make progress initiatives to establish capability on four levels are recommended. These are:

- Trauma-informed care;
- Trauma-focussed therapeutic services;
- Systemically addressing trans-generational problems and risks;
- Case management for complex needs;

There is a difficulty in attempting to put in place responses and services based on the presumption of being able to isolate current needs linked to historic events associated with the conflict. Whilst many people will have had direct traumatic and loss experiences of the conflict (of whom some will have suffered serious psychological, mental health and other disorders) with the passing of time and over generations it will become increasingly difficult to attribute the presenting problems to the Troubles. (The association is clearest at population levels where patterns of cause, effect and association are more clearly visible). Also, many behavioural, psychological and mental health difficulties do not have their origins in loss or traumatic events. The implication is that practitioners will find it difficult to determine with certainty that a Troubles-related event is the origin of the presented life problem. This becomes a more significant difficulty if such determinations are required to support decisions as to whether the person should have access to services.

Therefore, given that the years of violence are one of a number of distinctive sources of traumatic stress in the lives of individuals, future service provision needs to be capable of identifying and addressing trauma-related needs, and their trans-generational consequences, regardless of the originating trauma or loss.

Trauma-informed care

Advances can be made by improving the detection of trauma-related life problems at the first point of contact (or as soon as possible thereafter), with improved outcomes for initial assessments, management and onward referral. For example, trauma informed family doctors, health visitors, mental health practitioners, youth workers, counsellors are better placed to assess the individual's experiences and difficulties in the context of a traumatic event that, at least, seems relevant to their current problems. Progress can be made by equipping existing services and/or by raising the trauma aware capability of practitioners in key roles, who are connecting with wider populations amongst whom are people with adverse traumatic experiences, or those who focus on high-risk groups. For example, a report for the Victims and Survivors Service (Simms et al., 2014) recommended that practitioners could be supported through a training programme to provide a trauma-informed response for victims and survivors. This can also be achieved through for example locating trauma specialists close to primary and community care services, such as in the pilot (Northern Area TAP, 2008) undertaken by the former Northern Board (now the Northern H&SC Trust) and the current Trauma Counselling Service (Southern TAP, 2006) in the Southern H&SC Trust. The report on the work of the providers delivering Health and Wellbeing services for the Victims and Survivors Service (Bolton & Devine, 2014) identified the need for improved linkages between non-statutory providers to maximise access for individuals to a wider range of services. The same report also

identified the need for improved statutory-non-statutory links and liaison. Together, these observations form core components of a systematic framework and reinforce the need for coordinated service pathways (managed clinical networks), especially in relation to those with complex and changing needs.

Trauma-focussed therapy and related services

From the published advice (CREST/GAIN, 2003; and NICE, 2005 & 2012) adults and children who have serious psychological disorders arising from traumatic experiences (specifically, post traumatic stress disorder) should have access to trauma-focussed interventions. At this stage these are trauma-focussed cognitive behavioural therapy and Eye Movement Desensitisation and Reprocessing (EMDR). These are currently the preferred interventions although research has demonstrated that there are not enough accessible services providing these interventions in Northern Ireland (Ferry et al., 2008; Bolton & Devine, 2014). Progress is needed to increase the availability of and routine access to specialist trauma-focussed services, building in the first instance on the evidence and practice base. In time, we might expect that evidence will be forthcoming to support the use of other trauma-focussed interventions, emphasising the need for on-going evaluation of services and practice, and for further research. In the meantime, with insufficient access to trauma-focussed services advances can be made by building the capability of existing services and practitioners. For example, a report prepared for the Victims and Survivors Service (Simms et al., 2014) has recommended that practitioners working with victims and survivors who do not have trauma-focussed interventions could be enabled to deliver trauma-focussed interventions by receiving additional training and supervision in a trauma model relevant to their practice modality. This reflects the innovation and commitment in the non-statutory sector in the context of significant trauma-related needs and where there is considered to be insufficient access to trauma-focussed services.

As noted before, people can experience and suffer other disorders and life problems linked to loss and trauma. So, for example, agencies delivering services for people with addictions or who are misusing substances have a key role to play in service provision and will benefit from support to extend services and capabilities in this field, especially as senior Health and Social Care managers and practitioners (and epidemiological research in Northern Ireland – Bunting et al., 2012) have highlighted this as a significant co-occurring disorder with many mental health problems.

This work will benefit from liaison across services especially those that can assist in better understanding the physical and mental health needs and problems of individuals and the impact on families. For example, arts based interventions have a role to play in assisting with the understanding and expression of need and the integration of change. Likewise, services aimed at addressing for example, chronic physical health conditions, chronic pain and disabilities will be for some service users central to their daily living problems, with clear benefits to be gained for liaison with therapeutic services.

As above, the importance of coordinated service pathways across all sectors is reinforced given on one hand the complex needs of many who have experienced violence and adversely suffered as a consequence, and the complex service architecture involving the statutory and non-statutory sectors.

Systemically addressing trans-generational problems and risks

When an individual presents with difficulties that have arisen within the context of historic loss or traumatic events in their family an assessment needs to be made as to whether their problems can be addressed by working with them alone (or possibly with a partner parent or child) or whether the person's needs are part of a wider systemic problem in the life of the family. Further, even if the needs are considered to be systemic in origins and resolution, there is the practical question as to whether the wider family system can be engaged. For example other people might not be willing to cooperate or key individuals might be dead or have removed themselves, or as in the case of immigrants or refugees the family system might not be accessible (by merit of location or language).

All the same there will be opportunities to work with a family to address the problems of the family and individuals. In such circumstances it is likely that individuals will require their own discreet services and interventions (e.g. the person who has post traumatic stress disorder will require access to a trauma-focused therapeutic intervention) whilst simultaneously (or perhaps before or afterwards) participating in a wider family systemic based intervention.

Case management for complex needs

When more than one service is identified as having a part to play in addressing the problems faced by an individual or a family, then the issue of coordination arises. This becomes more complex when different sectors (i.e. statutory and non-statutory) are involved – challenges that can be exacerbated by language, ideology, regulation, confidentiality, and differences over practice. To overcome these problems, conventionally case management has been used to ensure that the client or patient has an advocate who can assist them in navigating service structures and to ensure they get access to appropriate services. Provision is recommended for the case management of clients and families who have complex service requirements.

Making progress

Making progress needs moral and political leadership, and cross departmental and cross sector commitment. Addressing the mental health and psychological needs of the population is an important component of this ambition that requires attention, yet these problems cannot be adequately addressed in isolation from other concerns. There is a clear case for a post-Troubles 'Marshall Plan' that comprehensively and strategically sets about identifying and addressing the enduring and trans-generational impacts of the years of violence on individuals, families and communities, and the means and risks through which problems are transmitted to future generations.

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Professor Siobhan O'Neill is a Professor of Mental Health Sciences at Ulster University. Siobhan is also a Chartered Health Psychologist with expertise in qualitative and quantitative research into mental health and well-being. Siobhan has worked as a Public Health Researcher, conducting evaluations of health services and users' experience of care. Between 2005 and 2008 Siobhan, along with Professor Bunting and Dr Murphy, coordinated the largest ever study of mental health in Northern Ireland, the NI Research and Development Office funded, Northern Ireland Study of Health and Stress. Siobhan is also a coordinator of the NI suicide study, the first UK study of the characteristics of completed suicides and undetermined deaths. She is responsible for the dissemination of the research findings on trauma and suicide to policy makers and stakeholders in Northern Ireland. Siobhan is a member of the World Mental Health Survey Consortium, a Director of the Irish Association of Suicidology and sits on several national and international research committees. She has over 70 publications in peer-reviewed journals, including several ground breaking studies of mental health and suicidal behaviour in Northern Ireland. She also led the world mental health paper linking mental illness with the subsequent development of cancer.

Dr Cherie Armour

Dr Cherie Armour is a Lecturer in Psychology at Ulster University, and previously was a research associate at the National Centre of Psychotraumatology in Denmark. Cherie has both an MSc in Forensic Psychology and a PhD in trauma and Posttraumatic Stress Disorder (PTSD). She is on the editorial board of many well respected journals, including the European Journal of Psychotraumatology. Cherie has over 50 peer reviewed publications, some of which are in world leading Psychiatry journals, mainly focusing on trauma and psychological well-being. Cherie has conducted research with many traumatized groups (maltreated children, victims of sexual assault and rape, victims of intimate partner violence, refugees, the bereaved, and the military). Cherie supervises several PhD research students, who are investigating projects on domestic violence and mental health, the psychological consequences of experiencing childhood maltreatment, PTSD in the DSM-5, and the impact of military traumatising on families.

Mr David Bolton

Mr. David Bolton is a researcher with the Initiative for Conflict-Related Trauma. From 1999 until it closed in 2013, he was also a Director of the Northern Ireland Memorial Fund. For 30 years he has worked in the public sector health and social services to address the social and mental health impacts of the conflict related violence in Northern Ireland and elsewhere. His roles included as a social worker, and middle management and senior management. He was the founding director of the Northern Ireland Centre for Trauma and Transformation established as a comprehensive trauma treatment, research and training centre to build upon service developments after the Omagh bombing. This included an extensive research programme investigating the mental health impact of the Troubles in partnership with Ulster

University, producing a number of key reports and papers on the subject. He was directly involved in the immediate and long term responses to events linked to the Troubles/conflict including the Enniskillen bombing of November 1987 and the Omagh bombing of August 1998. He has contributed to conversations on peace and reconciliation, including contributions in 1995 and 1996 to the Forum of Peace and Reconciliation in Dublin. In 1998 he was a Commissioner with the Early Release Scheme.

Professor Brendan Bunting

Professor Brendan Bunting is a professor of Psychology and former Director of the “Bamford Centre for Mental Health and Well Being” at Ulster University’s Magee campus. His research team at the Centre are currently involved in over a dozen studies into mental health, including studies of suicide, trauma and the economics of mental health. Brendan specialises in measurement and statistical analysis and has a reputation internationally for producing high quality research into the measurement and classification of mental health disorders. In addition to formal qualifications in psychology Brendan has a range of certificates and related qualifications in statistics, psychometrics and sampling from the Universities of Ann Arbor (Michigan) and Essex (England). Brendan is the Principal Investigator of the Northern Ireland Study of Health and Stress and the NI Suicide Study. He also sits on several national and international research committees and is an evaluator for a number of prestigious grant awarding bodies.

Dr Colette Corry

Since completing her PhD in Suicidology in 2010, Dr Corry has worked on the NI Suicide Study. This study uses Coroners’ data to establish the characteristics of suicides and undetermined deaths in NI. Colette developed the database, the first of its kind in the UK, and has worked in the Coroner’s office as the Northern Ireland Suicide Study database manager. Colette is currently employed as a Researcher at the National Suicide Research Foundation, specialising in psychological autopsy following death by suicide.

Barney Devine

Barney Devine has 30 years’ experience of working in the Northern Ireland community and voluntary sectors, with a record of establishing strategic projects in a variety of fields including community relations, community development, further and higher education, social and economic regeneration and mental health. During this period he worked across all sections of the Northern Ireland community and developed an in-depth understanding and practical experiences of a range of peace building processes linked to the wider political changes in Northern Ireland society as it moved from conflict to political settlement, and eventual power sharing. He is a qualified teacher and has a Masters in Peace and Conflict studies. As a social entrepreneur he has been inter alia, the Director of a Peace & Reconciliation Centre in Derry-Londonderry for five years developing and delivering a range of cross-community programmes and initiatives; the Project Manager of a multi-agency programme that developed two significant signature buildings on the site of the 1987 Enniskillen bombing in County Fermanagh with associated economic, cultural and educational cross border

programmes. He then went on to help establish the Northern Ireland Centre for Trauma and Transformation in Omagh in 2002 where he was the Business, Training & Development Manager until 2011.

Dr Edel Ennis

Dr Edel Ennis completed her PhD at Ulster University. She has worked as a Lecturer in Psychology at the University of Portsmouth and is currently employed as a Lecturer in Psychology at Ulster University. Her research interests can be broadly defined under the domain of mental health, with a particular emphasis on adherence to medications, the psychological experiences of carers of those with either physical or mental health difficulties, and also the role of mental health in understanding suicidality.

Dr Finola Ferry

Finola Ferry is a Research Fellow at the in the Medical Research Council All Ireland Methodology Hub and Bamford Centre for Mental Health and Wellbeing, Ulster University. In 2012 Finola received her PhD in Health Economics based on her examination of the economic costs of mental health disorders in Northern Ireland. Since her appointment at the university in 2006, Finola has been the main researcher on numerous research projects which focus on the impact of the 'Troubles' on mental health and wellbeing in Northern Ireland (NI). She has produced several reports and peer-review papers on the mental health impact of the Troubles and has been centrally involved in the dissemination of findings from this research to inform policy and service provision. She has also been strongly involved in analyses of data from the Northern Ireland Study of Health and Stress (NISHS), a study of the WHO's World Mental Health Survey Initiative. She developed expertise in health economic evaluation and has received training from the Centre for Health Economics at the University of York and from the European Study of the Epidemiology of Mental Disorders (ESEMED) Group at the University of Leipzig and the University of Barcelona.

Dr. Áine McKenna

Dr. Áine McKenna is a Researcher in Ulster University. She was instrumentally involved in the development and validation of the BA in Applied Early Childhood Studies at Dundalk Institute of Technology. During this process she developed a module entitled 'Teaching Self-Regulation'. This module was designed to equip Early Childhood Professionals with the knowledge and evidence based skills, competencies and resources for developing self-regulatory capacities in young children. The module specifically focused on working closely with families. Áine's main research interests include investigating the mediating role of self-regulation in facilitating both social competence and resilience in children who have experienced toxic stress exposures. She has conducted research for children's arts organisations, Barnardo's, Louth County Childcare Committee and Ulster University.

Margaret McLafferty

Margaret McLafferty graduated from Ulster University in 2012 with a first class honours degree in Psychology. Prior to this she worked for a mental health charity for a number of years. In 2013 she completed a Masters in Research in Applied Psychology (with distinction). Her MRes dissertation was on the impact of childhood adversities on the development of PTSD in Northern Ireland. In September 2014 she commenced her PhD in Ulster University. Her doctoral research is examining the mental health impact of childhood adversities and predictors of resilience in Northern Ireland. Her research employs a multimodal approach to understanding risk and resilience factors for mental health disorders and suicidality. The aim of her work is to highlight factors that may mediate or moderate the impact of adversities in childhood, including individual factors, as well as the role of parents, peers and the wider community. Her current research interests include risk and protective factors and well-being in the student population. Margaret sits on various committees and volunteers for a number of local mental health related charities.

Dr Sam Murphy

Dr Sam Murphy completed his PhD at the University of Surrey with an epidemiological study looking at the Emotional and Physical risk factors for back pain amongst school children. He then worked at the University of Surrey as a research assistant and then a research Fellow before moving to Ulster University. He is a member of the World Mental Health Consortium and was one of the coordinators of the Northern Ireland Study of Health and Stress the largest study of mental health disorders ever completed in Northern Ireland. He has been a key member of the team from Ulster University that have published major prevalence papers on Mental Health and Suicide and PTSD as a result of the conflict in Northern Ireland. He is a member of the BPS and a Chartered member of the Institute of Ergonomics and Human Factors and has over 15 years' experience as a researcher.

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Nicoli, Apurva and Kerry are Masters' students at Munk School of Global Affairs, University of Toronto. They completed a work placement at the Initiative for Conflict Related Trauma and provided research support for the literature review and survey in Chapters six and seven.

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