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The Pave Project
Report

An exploration of the effectiveness of services for victims of the troubles in Northern Ireland

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Preface

The idea for the PAVE (**P**eople **A**ffected by **V**iolenc**E**) project was born over 20 years ago, when I conducted the first study of violently bereaved widows in Northern Ireland in the mid-1980s. These women had lost their husbands in horrendous circumstances as a direct result of the Troubles. While the study showed the magnitude and longevity of the suffering of these women, there was little in the line of support for them and reports of their torment seemed to fall on deaf ears (Dillenburger, 1992). It was not until the Good Friday Agreement in 1998, that victims' issues were more openly addressed and services became more widely available. I conducted a replication of the original study, only to find that the pain for many of the widows had not eased, even 30 years after the loss of their husband (Dillenburger, 2002). Why were these widows not feeling better after such a long time? In 2003, the new Victims Minister, Ms Angela Smyth, asked for views regarding the needs of victims. I wrote to her outlining the urgent need to collect evidence of the effectiveness of services offered to the victims and the development of effective treatment methods. Her positive response led to the research reported here.

The two main research questions addressed in this report relate to a detailed description and categorisation of core-funded voluntary sector services presently available to victims of the Troubles and to an exploration of the effectiveness of these services in relation to improvements in the general psychological health of service users.

This research would not have been possible without the help of many. First, I would like to thank explicitly the individuals and groups who took part in the research. They allowed us to ask repeated questions about their experiences, their life, and their personal circumstances. This process was painful at times. However, without questions we will not find answers, and therefore a very special thanks to them for bearing with us throughout the process. Great appreciation also goes to the Victims Unit (OFMDFM), in particular John Clarke, William Redpath, and Edward Godfrey, as well as Ronnie Long (DHSSPS) who encouraged and supported this work actively. The support of the Trauma Advisory Panels and others who are working in the area of trauma recovery in Northern Ireland was invaluable. I would like to personally thank the research staff on the project, Ms Montserrat Fargas, Mrs Rym Akhonzada, and also Mrs Grace Kelly, for their tireless efforts, dedication, and enthusiasm in data collection, analysis, and reporting throughout the past 2 years. It was not always easy and this report would not be available without them. My appreciation also goes to the staff in the School of Sociology, Social Policy, and Social Work at Queen's University of Belfast, who allowed us to conduct this project in an atmosphere of support and encouragement. Finally, I want to thank our external scientific advisor, Dr Mickey Keenan (University of Ulster), for his guidance and advice throughout this project and beyond. His academic rigour and personal commitment make for the potent mix of enthusiasm, expertise, and integrity that has stimulated and shaped this research.

Dr Karola Dillenburger
Principal Investigator

1. The PAVE Project: Background and objectives

1.1. INTRODUCTION

Although the conflict in Northern Ireland, locally known as the *Troubles*, has affected the lives of many individuals, families, and communities, it was not until recently that its long term psychological effects have been fully recognised and more extensively researched. Recent years have witnessed a dramatic increase in the number of community victims groups who offer a wide range of services to help their members cope with the Trauma of the Troubles. The research project presented here establishes an overview and categorisation of the services offered to people affected by the Troubles and explores the effectiveness of the current range of services. This chapter provides a background to the project in which the concept of victimhood is discussed and the human cost of the Troubles is outlined. Furthermore, it explores the impact of the Troubles on people's psychological health and describes the current situation of service provision for people affected by the Troubles. In this introductory chapter, the aims and objectives of this research project are also presented.

1.2. LITERATURE REVIEW

THE CONCEPT OF VICTIMHOOD IN NORTHERN IRELAND

There are a range of definitions of victimhood that depend on the context and the agenda of the person speaking (Kulle, 2001). The idea of victimhood is central to politics in Northern Ireland, in the sense that "[b]oth Loyalist and Republican paramilitaries make reference to their status as victims as a context that justifies their respective recourse to armed conflict" (Morrissey & Smith, 2002, p. 5). At the same time, many people affected by the Troubles do not like to be identified as victim, since the concept "traps them in a specific moment when they experienced loss and it reduces their identification to that experience" (Hamber & Kulle, 2001, p.10). The term "survivor" has been introduced as a more politically correct term, since it contains a more active dimension and is a more far-reaching and self-empowering term.

The concept of victim invokes mainly situations of loss, pain and vulnerability and "most people in everyday life would not willingly court any of these circumstances or eagerly build an identity upon them" (Rock, 2002, p. 14). Being labelled as victim conjures up stereotypes of vulnerability, passivity, weakness, of needing protection, and of belonging to a social group that may be considered particularly vulnerable. Moreover, those regarded as victims have been used as objects of political and media campaigns to serve particular interests and motivations (Rock, 2002). Arguably, there

may be some benefits of victimisation such as sympathy, attention, validation and credit, assistance, support, or financial compensation, yet these seemingly beneficial aspects of the victim label can cause additional difficulties in relation to disempowering those who experienced violence, leading to learned helplessness (Seligman, 1991) and thus preventing healing. In societies that are deeply divided such as Northern Ireland, the whole issue becomes particularly convoluted.

Undoubtedly, the question of whether people who experienced violence are victims or survivors is a complex one. Ultimately, societies and communities, based on their own vision of the world, determine who deserves to claim the status of victim and who does not; sometimes labelling people as victims, who do not see themselves as victim or who do not want to be identified as such. The term victim clearly represents a certain pre-conceived idea of what happened to a person, how much of this they brought onto themselves, and how a person is coping in adverse circumstances. However, there are many more implications. In Northern Ireland, unless someone is regarded as legitimate or innocent victim they cannot ask for financial help or compensation. To-date, there are no survivor benefits. Therefore, definitions are vigorously contested by individuals, groups, and Northern Irish society as a whole, each constructing their own meaning. Moreover, definitions are contingent upon the political landscape and thus change constantly, making the whole picture much more complex.

While the categorisation as victim or survivor is still very much subject of political debate and personal opinions, those severely affected by violence in Northern Ireland

must be identified in order to meet their needs and help them move on from their suffering. Thus, the issue of victim or survivor or, more precisely, the issue of meeting the needs of those affected by the Troubles remains at the heart of any effort to bring peace to Northern Ireland.

THE HUMAN COSTS OF THE TROUBLES

It is generally agreed that since 1969, over 3,600 people have been killed, more than 40,000 have been injured, thousands have witnessed violent events, and many more have been intimidated out of their own homes (Bloomfield, 1998; Social Services Inspectorate, 1998; Fay, Morrissey, & Smyth, 1999; Smyth, 2000).

It is difficult to assess the extent of the impact of the conflict on people living in Northern Ireland, since there is a lack of systematic information (Hillyard, Rolston, &Tomlinson, 2005). However, various regional sample surveys suggest that the scale of the conflict has been considerable. For instance, in the Poverty and Social Exclusion Survey (PSENI; Hillyard, Kelly, McLaughlin, Patsios, & Tomlison, 2003), half of the respondents reported knowing someone who had been killed due to the Troubles, and 30% stated to have lost close friends or relatives. Muldoon, Schmid, Downes, Kremer, and Trew (2005) reported that 42% of their sample of 3000 people living in Northern Ireland and the Border Counties had experienced a Troubles-related event that they found particularly distressing.

In terms of geographical distribution, Belfast has seen the greatest relative as well as absolute number of violent deaths. The statistics also illustrate that violence, in particular with regard to conflict-related deaths, has been concentrated in certain geographical areas, which means that, "the 'reality' of the Troubles is different for people in different locations and in different occupations" (Fay, Morrissey, & Smyth, 1999, p. 136). While people in urban centres such as Belfast and Derry have experienced most of the deaths and injuries, rural populations have suffered more sporadic but no less intense periods of violence.

THE IMPACT OF THE TROUBLES

During the early years of the conflict, researchers and psychiatrists contended that people were reacting with astonishing resilience (Fraser, 1973; McCreary, 1976; Cairns and Wilson, 1984). On the whole, "data collected during this period showed a relatively low impact of violence on psychological health" (Dillenburger & Keenan, 2001, p. 189). For instance, in 1971 the Belfast psychiatrist Morris Fraser reported that there "was no increase in the number of patients being referred to psychiatrists or admitted to psychiatric wards from areas directly involved in rioting" (McCreary, 1976, p. 249). During this time, people affected by the Troubles who had problems coping, were mainly treated by general practitioners and therefore, it was suggested that the only real indicator for measuring the psychological well-being of people in Northern Ireland was the official drug expenditure for tranquillizers, anti-depressants and sedatives (McCreary, 1976).

Early studies that showed the psychological impact of the Troubles were largely ignored and at times their accuracy even questioned. For example, the study of survivors of the Remembrance Day bomb in Enniskillen in 1987 (Curran, Bell, Murray, Loughrey, Roddy, & Rocke, 1990) showed that, 6 months after the incident, nearly 50% of people who had witnessed the bomb showed symptoms of post-traumatic stress disorder (PTSD). Dillenburger (1992), in her study of long-term traumatic bereavement, showed that by 1985 over two thirds of the widows in her sample who had lost their husbands due to the Troubles suffered significant psychological health problems, even 10 years after their loss. Regardless of this kind of evidence being available, nothing much was done to help those who were most severely affected by the trauma of the Troubles or to support the small number of existing voluntary victims groups (Darby & Williamson, 1978)

However, with the beginning of the Peace Process in the mid-1990s, further research confirmed significant long-term psychological suffering. For instance, the Cost of the Troubles Study (COTTS; Fay, Morrissey, Smyth, & Wong, 1999) found that about half of the sample reported that the Troubles had a significant impact on their lives and presented symptoms of emotional distress, such as sleep disturbance (Smyth, 1997). In a study of relatives of those who died on Bloody Sunday in 1972, Hayes and Campbell (2000) suggested that, even 25 years after the incident, there was a relationship "between the general emotional health of this group and PTSD resulting from the Bloody Sunday trauma" (p. 718). More recently, O'Reilly and Stevenson (2003) pointed out that there is "a positive and graded relation between the extent to

which people and areas were affected by the Troubles in Northern Ireland and the likelihood of suffering from significant mental health problems" (p. 491). Thus, time is not necessarily always a good healer, at least not for everybody; "for many, the hurt of thirty years ago is just as strong as it was then and remains undiminished by the passage of time" (Potter, 2004, p. 4).

Obviously, over thirty years of community violence in Northern Ireland have not constituted a homogeneous experience. Each person has had different and unique experiences of the Troubles that, in turn, produced different impacts and effects on their lives and health. Consequently, it has been recognised that there are a great number of different realities of the conflict in Northern Ireland. At the same time, not everybody responds in the same way to the same traumatic experience; that is to say, similar experiences do not cause identical effects to different people. How people cope with bereavement and other Trouble related traumata depends on the context in which people find themselves. While some people are well supported and enabled to re-group, go on, or even experience adversarial growth (Joseph & Linley, 2004), others find it difficult to put their lives back together, especially if they experience additional life stresses such as poverty, unemployment, or lack of social support.

CURRENT SERVICE PROVISION

With the beginning of the Peace Process in the mid-1990s, the Government began to pay considerable attention to those who had been bereaved and injured through the Troubles. Reports (e.g., Bloomfield, 1998) were commissioned, a Victims Unit was set up as part of the Office of the First Minister and Deputy First

Minister, and a Victims Strategy (Reshape, Rebuild, Achieve, RRS, 2002) was developed. The Good Friday Agreement in April 1998 stated that 'it is essential to acknowledge and address the suffering of the victims of violence as a necessary element of reconciliation' (Northern Ireland Office, 1998), and committed government to take steps to address their needs.

Since 1998, £44 million of central government and European funding has been allocated to a variety of organizations, with the aim to support victims and survivors of the conflict (McDougall, 2006). As a result, the number of victims' organisations has increased dramatically (Dillenburger, Akhonzada, & Fargas, 2005; Kulle, 2001; Morrissey & Smyth, 2002). These groups provide a range of interventions and services aimed to improve the quality of life of those most acutely affected by the Troubles and/or have an advocacy role.

However, there is a lack of information regarding these groups and the interventions they provide. Smyth (2001) is probably right when she contented that there is not one specific service that fits all, however, irrespective of the service chosen, there should be a focus on efficacy and evidence of effectiveness (Dillenburger, 2001). Despite acknowledged disagreements with regard to methods, content, or politics in the evaluation of the work of victims groups (Lavoie, 1990), the Victims Unit (2005) confirmed that "relatively little is known as to the effectiveness of these services at a level which would inform future service development and investment" (p.19), and commissioned the study reported here, with the aim to place the work of victims'

groups on a "sounder basis and increase confidence in the approaches being adopted"

(p.19).

1.3. AIMS OF THE **PAVE** PROJECT

With the ultimate realization that recovery from trauma is not merely a medical problem, but an interactive process that has to happen in multiple contexts (Dillenburger & Keenan, 2005), individuals turn to community services and victims groups. Thus, traumatised individuals are actively coping by taking concrete actions to improve their circumstance (LeDoux, & Gorman, 2001). This process has many advantages, not least because it ensures that support can be sustained over the long-term, is less costly, and often offered by people with similar experiences. The importance of this kind of help has been recognised, especially for individuals who feel socially isolated and helpless (HPRT, 2005).

However, little detail is known about the services offered by community groups and therefore, the aims of this research were, first, to learn how these services are delivered and utilized and, second, to explore the effectiveness with which they are helping users to overcome their traumatic experiences and achieve improved psychological health.

The core objectives of the PAVE project were:

1. The establishment of an overview and categorisation of the services offered to people affected by violence in Northern Ireland;

2. To explore the effectiveness of some of the most commonly used services in regard to achieving their set aims/goals;

3. To encourage collaboration through sharing and dissemination of outcomes of this research.

The project comprised two main phases. Phase 1 involved conducting a survey of core funded services and generating a detailed categorisation of these services. Phase 2 involved a time-series design to explore the effectiveness of some of the services.

2. Methodology

2.1. THE SERVICES SURVEY

ETHICAL APPROVAL

Ethical approval was granted by the Office of Research Ethics Committees Northern Ireland (OREC, NI). The research was conducted under research governance of Queen's University of Belfast (QUB) and in adherence to OFMDFM published ethical principles (Connelly, 2003).

PARTICIPANTS

The target population for Phase 1 were services provided by voluntary groups that were core funded through the Strategic Implementation Fund by the Victims Unit (VU) in Northern Ireland. Of a population of 48 core-funded voluntary groups identified by the Victims Unit, 4 referred to one group in multiple locations and 6 either no longer existed or no longer served as a victims group. Of the remaining 38 groups, 26 took part in the study, a return rate of 68%. The groups were located across all of Northern Ireland; 4 in County Armagh, 3 in County Fermanagh, 4 in County Tyrone, 3 in County Derry/Londonderry, 5 in County Down and 7 in County Antrim.

The groups' membership ranged from 20 to 2,000. Some of the larger groups worked with other populations in addition to those affected by the conflict, for example, with people affected by other bereavement or other kinds of violence (n=10), however, most of the groups worked with people affected by the Troubles only (n=16). Some groups worked with specific populations, for example, members of a particular organisation (n=2), victims/survivors from a particular geographical area (n=2), or people affected because of a particular incident (n=1). The vast majority of the groups were established in 1995 onwards (n=19), many of them in 1998/1999 (n=11). The majority of the groups were single identity, while some others were cross-community groups.

RESEARCH INSTRUMENT

The *Community Services Questionnaire* (CSQ) (Appendix 1) was designed specifically for the first phase of this study. The first part of the questionnaire requested general information about the groups, such as name, year they were founded, etc.

The second part requested information about the number, demographics, and needs of service users, and how they had been affected by the Troubles, and referral source. Questions in the first and second parts were similar to those posed by Coll (2006),

Deloitte and Touche (2001), Dillenburger (1992b), Manktelow (in press), and Kelly and Smyth (1999).

In the third part, the range of services generally offered by voluntary groups in Northern Ireland (see Magowan & Patterson, 2001) were listed and respondents were asked if their group offered each of these services. Detailed questions about staffing, uptake, staff training and supervision, and length of service provision were included in order to obtain information about each of the services offered. In addition, questions about the reasons for offering these services, about selection and eligibility criteria for service users, and rationale for allocation of service were posed. Finally, respondents were encouraged to supply previously completed evaluation reports and asked about their willingness to participate in the next stage of the project.

PROCEDURE

A pilot study was carried out with five groups (approx. 10% of the total population) that were located across Northern Ireland. The contact persons of these groups were contacted by telephone and asked to take part in the pilot. Subsequently, the participant information letter and questionnaire were sent by surface mail. Respondents were encouraged to make suggestions for modifications of the questionnaire. Follow-up telephone contact was made with groups who had not returned the questionnaire after two weeks. One group supplied the necessary information on the telephone. Only minor modifications were required for the final

questionnaire, e.g., the order in which the services were addressed was changed and the term respite care was changed to respite care/time out.

The participant information letter and the revised CSQ were sent to the remaining groups. Follow-up telephone calls were made to groups who had not returned the questionnaire after 2 weeks and another call was made to groups who had not responded after 4 weeks; a final scoop was undertaken 6-8 months later. Repeat questionnaires were sent by e-mail or by post when requested; a total of 26 groups participated.

DATA ANALYSIS

Descriptive statistics were utilized to create a categorization of services and the establishment of minimum standards of service delivery. In the main, frequencies and percentages were recorded for each of the relevant variables in relation to each of the service under investigation.

2.2. THE EFFECTIVENESS EXPLORATION

PARTICIPANTS

A total of 75 men and women took part in the exploration of effectiveness of services. All participants had been affected by the Troubles in a variety of ways and at the time of the study were using one or more of the services offered by the groups.

RESEARCH INSTRUMENT

The research instrument consisted of the following 5 parts:

1. For the initial assessment, the *Personal Experience and Impact of the Troubles Questionnaire* (PEIT-Q) (Dillenburger, Fargas, & Akhonzada, 2005) was designed to gather data regarding age, gender, socio-demographic background, details of traumatic experience(s), and details of services received (adapted from Dillenburger, 1992). The PEIT-Q included a 7-point Likert scale to assess social validity of services (i.e., social significance of goals, social appropriateness of procedures, and social importance of intervention) (Appendix 3). A short version PEIT-Q was used for subsequent assessments, requesting information about the services received since the previous assessment (Appendix 4).

2. The *General Health Questionnaire* (GHQ-30) has been used widely in Northern Ireland and internationally as indicator of psychiatric disturbance (Goldberg, McDowell, & Newell, 1996). GHQ-30 is scored on the standard binary scale, and has a threshold score of 5, at which respondents are classified as *cases* or *non-cases*. Scoring over 5, and thus being classified as *case*, means that the respondent is likely suffering levels of tension, anxiety, and depression that have an adverse effect on their physical and mental well-being. There is a 95% probability that respondents who score 10 or more are suffering severe psychological distress or even emotional illness (Tennant, 1977).

3. The *Beck Depression Inventory – Second Edition* (BDI-II; Beck, Steer, & Garbin, 1988) is a 21-item self-report rating inventory. Each question is scored between 0-3 and total scores are rated *normal* ups and downs (scores of 5-9), *mild to moderate depression* (scores of 10-18), *moderate to severe depression* (scores of 19-29), or *severe depression* (scores of 30-63). Scores below 4 are unusual and are thought to possibly indicate denial of depression. Scores over 40 are significantly higher than those of most severely depressed persons, and thus may mean that depression is exaggerated and other personality disorders are present (Groth-Marnat, 1990).

4. The *Posttraumatic Stress Diagnostic Scale* (PDS; Foa, Cashman, Jaycox, & Perry, 1997) is a self-administered inventory that indicates symptoms and

severity of posttraumatic stress disorder (PTSD) according to the Diagnostic Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994). The shortened, self-administered version of the PDS was used in this study. Responses are rated as *mild PTSD symptoms* (scores of 1-10), *moderate symptoms* (scores of 11-20), *moderate to severe PTSD symptoms* (scores of 21-35), and *severe PTSD symptoms* (scores of 36-50) (Gillespie, Duffy, Hackmann, & Clark, 2002).

5. The *Stressful Life Events Scale* (or *Social Readjustment Rating Scale*) (SLES; Holmes & Rahe, 1967) is a list of 41 ranked, stressful life events that assesses overall stress levels that are due to specific life events. Life events are ranked in order from the most stressful (death of spouse) to the least stressful (minor violations of the law). A modified and shortened version of SLES was used in this study (Appendix 4).

The three standardised psychological questionnaires, GHQ-30, BDI-II, and PDS, have undergone extensive validation and reliability tests across age, gender, and culture and have shown to be useful tools in the assessment of general mental health, depression, and PTSD symptoms severity.

PROCEDURE

A gate-keeper approach was used to access participants (Erickson, 1982). This means that chairpersons of victims groups were contacted and asked to approach service users to participate in the research. Times and places for administration of the research instrument were arranged to suit services users. In the main, meetings were arranged in the groups' drop-in centres. The research instrument was handed to each participant by one of the researchers, completed in the presence of the researcher, and returned immediately after completion. In most cases, this was done in a group setting, although where individual participants required assistance with completion of the instrument this was done in a one-to-one setting (n=5). Postal questionnaires were issued where this was preferred.

Those who agreed to participate were given a participant information and consent sheet (Appendix 2). Only those who signed the consent sheet took part in the study. At the initial assessment point (A1), participants completed the PEIT-Q, GHQ-30, BDI-II, and PDS. After approximately 3-4 monthly, they were asked to complete a shortened version of the PEIT-Q (i.e., identify the services they had received since the last application of inventory), the adapted SLES (i.e., identify life events that happened since the last application of inventory), as well as the three other psychometric inventories (A2). This procedure was repeated twice (A3 and A4), giving a total of 4 completed inventory scores (i.e., GHQ-30, BDI-II, and PDS) per participant, over a period of nine to twelve months.

Seventy-five service users participated in the baseline assessment (A1), 25 service users participated in the first exploring effectiveness assessment after approximately 3 months (A2), 20 service users participated in the second exploring effectiveness assessment after a further 3-4 months (A3), and 13 service users participated in the third assessment after a further 3-4 months (A4).

DATA ANALYSIS

SPSS for Mac OSX (Version 11) software was used to store, code, and analyse the data. Basic statistics included frequencies, means, standard deviations, and cross tabulations. Independent-samples t-tests were used to examine if the differences between means of two groups (e.g. males and females) were significant ($p < .05$) or not, while one-way analysis of variance (ANOVA) were used to explore differences between three or more groups (e.g. between different ages groups) ($p < .05$). Paired-samples t-tests were used to explore statistically significant changes ($p < .05$) between the means of a same group at two different times (e.g. GHQ-30 means in A1 and A2). In addition, Pearson correlation coefficients (*r*) (where $p < .01$; or $p < .05$) were calculated in order to explore relationships between continuous variables. The correlation coefficient measures the strength of a linear relationship between two variables and it can take on the values from -1 to +1. Where -1 is a perfect negative (inverse) correlation, 0 is no correlation, and 1 is a perfect positive correlation. The closer the correlation is to +/-1, the closer to a perfect linear relationship.

Where significance scores are not otherwise reported, this means $p < .05$.

2.3. SEMI-STRUCTURED INTERVIEWS

PARTICIPANTS

T wenty service users participated in semi-structured interviews. Interviewees came from the same population as participants in exploration of effectiveness study (see 2.2), but had not necessarily taken part in the exploration of effectiveness study.

RESEARCH INSTRUMENT

T he research instrument consisted open questions related to four thematic areas: coping, experience with the group, identity (victim/survivor), and the future. Questions were open and researchers asked additional explorative questions or gave explanations where this deemed appropriate (Appendix 5).

PROCEDURE

T he semi-structured interviews were carried out in the groups' drop-in-centres to provide a safe and comfortable environment for participant. Before starting the interview, participants were asked to read the participant information sheet and sign the consent sheet (Appendix 2). Interviews lasted an average of 30 minutes

(range 15 to 45 minutes) and were tape-recorded. Participants were given the option to stop the interview at any time. Once the transcripts were completed, they were sent to the interviewee for verification. Subsequent changes (omissions, but no additions) were included in the transcript.

DATA ANALYSIS

Qualitative analysis was carried out using NVivo software. This meant that the transcripts were read repeatedly to identify common codes and sub-codes. The text was then coded and relationships between codes, sub-codes, and different attributes of the interviewees were analysed. This meant that specific interview quotes could be retrieved based on particular search criteria.

3. The victims groups: Formation, aims, service users, and services

3.1. OVERVIEW

T he rapid growth of the voluntary sector since the beginning of the Peace Process has led to a situation where voluntary victims organizations and groups are now considered to be the main service providers for those affected by the Troubles (Smyth, 1997). However, Kelly and Smyth (1999) found that service provision was limited and patchy. While 22% of the groups they surveyed offered a wide range of services to bereaved and injured of the Troubles, only 16% offered structured counselling, therapeutic services, or emotional support; 24% of the groups offered services only to particular sets of people, e.g., women, young people.

In fact, only scant detail is known about the services that victims groups and organisations offer, how they are staffed, how their staff are trained and supervised, how referrals are received and allocated, how long services are used, and most importantly, how effective these services are in helping services users to cope with their traumatic experiences. The importance of detailed understanding of what community services and voluntary groups do cannot be underestimated. Due to the virtual absence of support from statutory services during the first three decades of the Troubles (Darby & Williamson, 1978), the situation now is far from straightforward.

In fact, 3/4 of service users interviewed in this research mentioned the lack of structured support in the early days and the incapacity of professionals (e.g. doctors, teachers, police, etc.) in dealing with the depth of psychological trauma they had experienced, for example, they described how prescriptions of anti-depressant drugs and tranquilizers were the only help available.

> *"The night that (my brother) died, the doctor, I knew the GP, and he wrote a prescription for sixty Diazipan and I can't remember what the other thing was, and he says, 'Yous will need to take this and I looked at him and thought 'What?!!' You know, to mummy and she was really… you know. We are not really into that type of lifestyle. So, we were quite annoyed with that."* (Interviewee P)

> *"And… of course, go… the local doctor, you know, both me and my daughter, and heavy medications, taking tablets, taking tablets for years 'til we eventually put ourselves off (pause) So, that's the way it all was, you know."* (Interviewee C)

Other interviewees talked about how there was nowhere to go for help and professional support:

> *"All those years… I mean, and just went from bad to worse (pause) so, there was never any help there at all, and I think that there's a lot of people and this that they didn't, that I knew that lost their husbands and sons, and we had just each other to speak to."* (Interviewee B)

> *"There was no therapies about, then. And the impact of what happened to people, not even as a result of the Troubles, in any sort of traumatic situation, I don't think it was understood how much of an impact it did have on people."* (Interviewee E)

Due to this lack of structured help in the early days, Hamber (2003) found that today there is a considerable lack of trust and communication between victims groups and the statutory sector. "Crudely put, voluntary groups remain suspicious of official motivation for getting involved in assisting victims, after years of neglect, and feel their work is not appreciated" (Hamber, 2003, p. 20).

In addition, Caserta and Lund (1993) suggested that, while many of these groups may help improve coping and social functioning of their members, there is the potential for serious negative side effects, such as pressure to conform to group norms, stress related to group obligations, interdisciplinary tensions, feelings of being overwhelmed or inadequate, or even dissemination of ineffective or inappropriate social or coping skills. In addition, Galinsky and Schopler (1994) considered the dangers for staff, especially per voluntary workers or those on short-term contracts, of suffering from burnout and power struggles between committee members, that oftentimes result in tension and additional stress for staff and service users.

In this and the next chapter, the results of the Services Survey (Phase 1) are described and analysed. First, findings regarding the formation of the groups, their aims, their members and services users, and their services are reported, and then a detailed

categorization, including details on the services provided by the groups, is presented in the next chapter.

3.2. DESCRIPTION OF THE GROUPS

FORMATION OF THE GROUPS AND STAFFING

In total, 26 groups took part in the study. These groups were formed between the years 1971 and 2002. Most of the groups were formed in 1998 onwards (Figure 1). Many of these groups were founded by people who themselves had been bereaved or injured through the Troubles and who had experienced the lack of available support first hand. These people took it upon themselves to set up victims support for others with similar experiences. For instance, interviewee S, who lost his brother in the late 1970s and worked in the group since its formation, talked about his experience:

> "I was probably fairly well self-resolved, by the time I started work here [name of a group], but my work here opened up a lot of hurt and a lot of pain and triggered trauma that I had had in the past. … people understood if you're having a bad day, there was understanding there, which was important, sort of reaffirming."

Some members of the groups had been involved setting up the group. Interviewee C, a widow, explained how her group began:

> *"Well, there was a lot of er… victims like myself in this area. And I was working with [name of leader of the group] here. And we seen… he knew about me, you know. The victims need help. And we sat down and we talked about it, you know… and trying to do something for victims, because he noted there was no help out there. So, it started from there, the two of us talking about it, and then we gathered up…well, different victims like myself. And formed the group."*

Interviewee A, a woman affected by a paramilitary feud, also became a member of a group during its formation, as she explained:

> *"The women, most of the women that was put out, they said to get together and they had a meeting, in one of the clubs on the road. And I says, 'Well, I'll go up and listen, see what's happening'. And there was hundreds at it. And I was talking to a couple of the girls. And one of the girls says, 'We are going to start up a group. Would you like to come?' And I says, 'Well, I'll go and see what it's like and give it a try'. And there was a… [organisation] up the road and they let us use their office. And then… we decided to put in for funding. So… we got the premises next door. And started it up from there."*

Figure 1: Year of formation of the groups
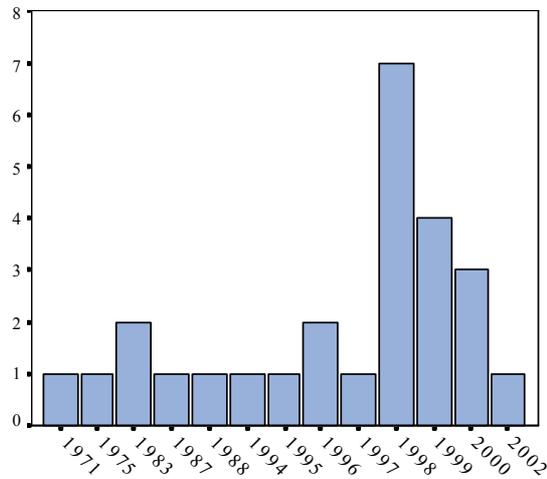
The majority of the groups were working only with people affected by the Troubles (n=16), but some of the groups were helping other people as well (n=10).

The groups employed between 1 and 37 staff, although most of them had between 3 and 6 (n=14), while some did not employ any paid staff and were staffed by voluntary workers (n=3) (Figure 3).

AIMS OF THE GROUPS

Most of the groups had both support (service provision) and advocacy aims, confirming Hamber's (2003) observations that, while victim or survivor support groups "offer direct support and services to their members (e.g., counselling and befriending), most have broader goals of continuing the fight for recognition, acknowledgment and justice in the post-conflict phase" (p.85).

The importance of both, support and advocacy, was reflected in the statements of service users, that frequently touched on themes such as the need for empathy and friendship, of being with people with similar experiences, the feelings of trust and safety, as well as the necessity for lobbying for justice and recognition:

> "I feel people do still need to be heard, and, unless they are heard, then, no one can help or even understand what is like to go through those things. I wouldn't dismiss anybody as being a victim at all. Because I feel that, in a sense, everyone is a victim. But it's learning how… to give them survival techniques in order to help them to move on."   (Interviewee L)

> "Well, they're helping me in that the people who come here are all on the same boat, and if you excuse the expression, and I feel there's a common denominator there. And we are all sort of focused on the one element on it in that we are all there to heal your mind"   (Interviewee O)

"Once victims support centres have been established, yes, that's somewhere you can go to, that's somewhere where you can er… have a safe haven. It's somewhere where you can speak to other people. It's somewhere where you can go and take part in activities and knowing that nobody is going to be laughing and sneering at you, because you are er… affected by the Troubles." (Interviewee M)

"… in the group there's trust. You know everybody and you know the person beside you, behind you and in front of you, and everyone of the victims are the same, they'd tell you, that's the reason why they enjoy the group, because they know everybody is the same, where everybody is a victim, so… It means… a lot." (Interviewee C)

Figure 2 shows the reasons for providing specific services. Common responses related to a demand for services that were not otherwise available, specifically targeted towards personal development and psychological wellbeing, as well as safety and trust.

Figure 2: Reasons for offering services

1	As a means to bring people from a traumatised state into one in which they are competent to interact socially at an acceptable level.
2	As a victims support group, we need to offer the previous mentioned services as in [town] we have no other statutory or voluntary organisation offering them. To get to [town] is too difficult for most of our members which shows how isolated we are.
3	Because there is a demand for these therapies, because they work and because those who avail off them could not afford to access them through a private therapy practice.
4	Because they have been put forward and at the wish of group members as being what they are interested in participating in.
5	Educational and recreational purposes and to keep in contact with families on our database.
6	Need was identified in an independent analysis carried out in [date].
7	No-one else in town does it.
8	Our Listening Ear/Counselling and Programmes are viewed as a community response to the needs of victims and survivors in the district. Our work is underpinned by an ethos of assisting people to help themselves through empowerment methods.
9	Programmes are designed and developed to assist in the recovery process for victims/survivors. They create a safe place where victims/survivors can discuss, reflect and understand their past hurts and traumatic experiences.
10	Therapies are a good way of getting people involved again without expecting sth from them
11	There is certain amount of trust simply not there for our members when dealing with DHSS, etc. …, they still feel unsafe about asking for help or releasing their details.
12	They address a range of needs of a particular group, particularly with a view to entering the labour market, with a mix of psychotherapies, physiotherapy and careers and training.
13	It relieves stress and helps members feel better.
14	By bringing people together and interacting, they are being supportive and helping people.
15	To enable victims of the Troubles and their families to recover- not to forget but to move forward in a better (healed) frame of mind ready to accept diversity.
16	To meet the unique needs of … victims. The program of activities has been designed following years of grass-roots work to identify key needs and concerns of … victims of …. It addresses the trauma and social exclusion.
17	To promote the recovery of traumatised victims and their families.
18	We actually began as a victim only group, then, as public demand and need drove the agenda, we faced each one. We see ourselves as a service provider who won't take on a client unless we meet their entire mental health needs.
19	We feel that with these services, we are making a marked positive impact on the proposed beneficiaries of the group.
20	We have piloted many services in response to needs presenting from clients. These current services offer a holistic approach to enhancing personal development and well-being, and enable and encourage users to take responsibility for their own health.

SERVICE USERS

In total, an estimated 6,000 or 7,000 people used the services of the groups in this study. Most groups served between 100 and 1,000 people (n=15), although some served fewer than 100 (n=9), and one group served as many as 2000+. In all, over the years an estimated over 15,000 people had been served by these groups. Staffing stood in direct relation to the number of services users, i.e., larger groups generally employed more staff than the smaller groups (Figure 3).

Figure 3: Number of staff * Number of service users

Number of staff members	Number of service users					
	fewer than 35	35-65	66-99	100-1,000	more than 1,000	Total
N/A			1	1		2
None paid	2			1		3
1-3		2		6		8
1-2 paid & 8-11 volunteers	1			1		2
1 paid & 10 manag.committee		1				1
4-6		1	1	6	1	9
37					1	1
Total	3	4	2	15	2	26

The majority of service users were female, although the vast majority of the groups worked with men as well as women (n=23). Most groups worked with adults aged between 18 and 64, although some worked also with children or young people.

Figure 4: Characteristics of service users

Group	Age	Gender	Widowed	Bereaved relatives	Bereaved parents	Injured	Carers	Intimidated	Witnesses
1	All ages	Both	-	100	20	15	10	-	-
2	All ages	Both	-	-	-	-	-	-	-
3	18+	Both	-	-	2	800	-	-	-
4	18+	Both	-	70	10	-	-	-	-
5	18-64	Women	-	50	15	10	20	-	-
6	45+	Both	-	-	-	-	-	-	-
7	18+	Both	-	-	-	-	-	-	-
8	All ages	Both	-	20	-	-	-	-	-
9	45+	Both	-	10	10	50	5	-	-
10	-	-	-	-	-	-	-	-	-
11	0-64	Both	-	60	9	12	4	majority	-
12	All ages	Both	Not sure	Not	-	Not	-	86	Not sure
13	All ages	Both	98	About	80	30	30	-	-
14	All ages	Both	15	235	10	1	1	-	-
15	All ages	Both	80%	60%	50%	25%	10%	30%	100%
16	All ages	Both	180	940	270	410	160	790	550
17	All ages	Both	80	120	20-25	30	40	40	-
18	All ages	Both	75%	90%	75%	75%	50%	100%	100%
19	18+	Both	3	-	-	-	-	-	-
20	0-64	Both	6	40	40	20+	20	25	60
21	All ages	Both	60%	80%	30%	25%	75%	80%	91%
22	18+	Both	5	23	12	3	239	287	158
23	All ages	Both	11	233	27	43	11	-	63
24	18+	Women	-	-	-	-	-	-	-
25	18+	Both	2	100+	26	5	5	all	all
26	All ages	Both	2	24	2	7	8	5	9

-    no data supplied

The majority of services users were bereaved relatives, while some were physically injured or intimidated (Figure 4). In the majority of groups, services users were referred by personal referral through a relative or friend (n=15), while a few groups also received referral from professionals, such as GP or community nurse (n=11).

THE SERVICES

The groups offered a wide range of services (Figure 5). Most frequently used services were advice and information (n=22), indirect services (e.g. courses, advocacy, funds, training) (n=18), complementary therapies (n=18), support and self-help groups (n=17), and befriending (n=17). Although a substantial number of groups also offered counselling (n=16) and respite care (n=15), fewer groups offered structured therapeutic services such as group therapy (n=7) or psychotherapy (n=3). A detailed explanation and categorisation of these services is provided in the next chapter.

Figure 5: Services offered by the groups
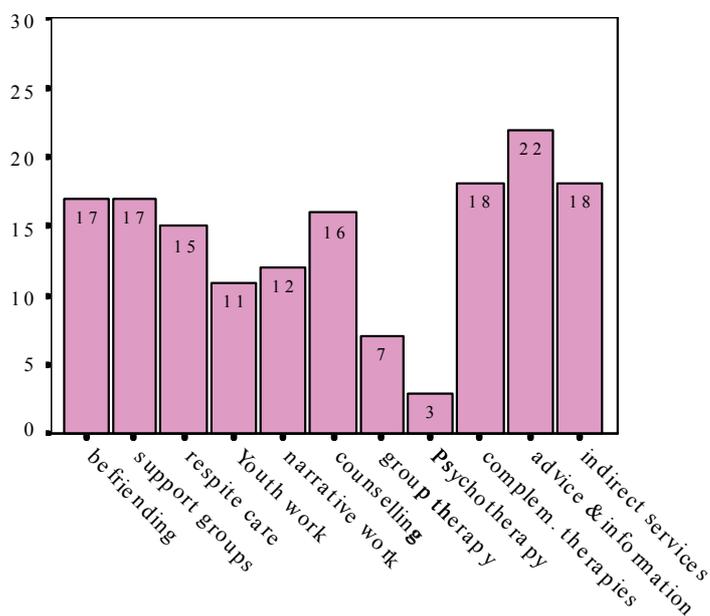
Groups that were formed after the ceasefires (from 1995 onward) were often larger than those created earlier. These groups had greater numbers of service users and provided a wider range of services (Figure 6 and 7).

Figure 6: Number of groups * Date of formation * Number of service users
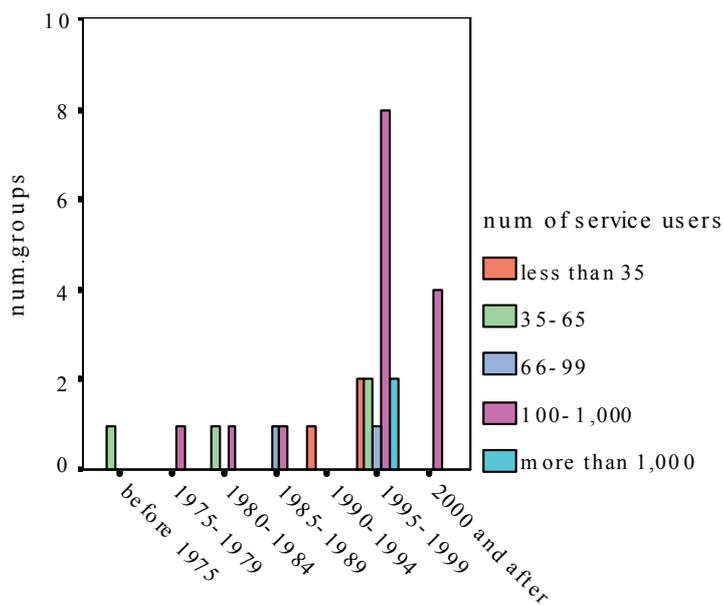
Figure 7: Number of groups * Date of formation * Number of services
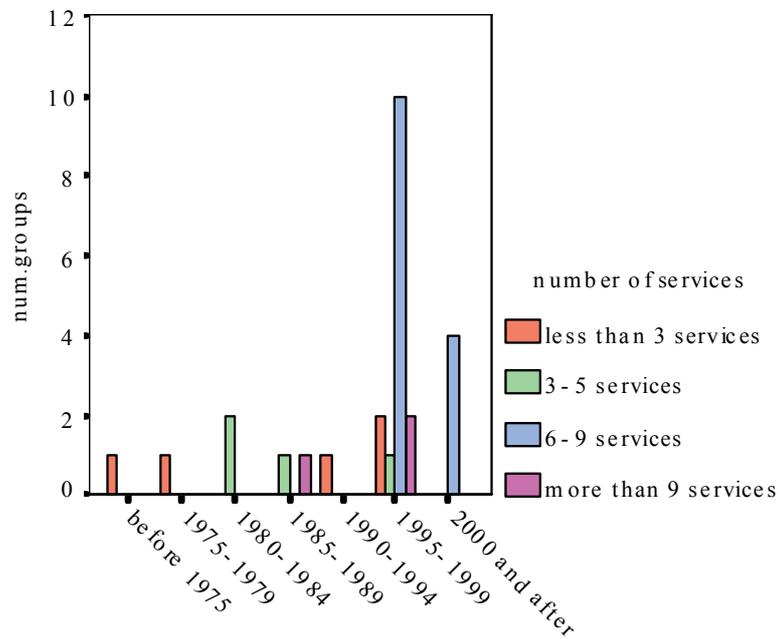
SELECTION OF SERVICE USERS/MEMBERS

Most of the groups (n=19) had selection or eligibility criteria for service users, such as being part of a certain organisation, being from a certain geographical

area, or having been affected by a particular traumatic incident. Eleven of the groups had assessment criteria for the allocation of services. Eleven of the groups wanted to widen their appeal to include other areas/groups of people that were not presently involved, such as young people (n=3), people from rural isolated areas (n=1), the travelling community (n=1), ethnic minorities (n=1), or cross-community members (n=1).

Most of the groups (n=21) stated that they evaluated their services, either by informal feedback (n=17) or by formal feedback, such as interviews or questionnaires (n=17) or both, however, only 8 of the groups had written up their evaluation in a formal report. Despite requests for copies of these reports, only one such report was provided to inform the present research.

3.3. DISCUSSION

Services provided by victims groups have experienced vast increases since the mid-1990 ceasefires, and above all, the Good Friday Agreement in 1998. This increase

of voluntary sector services provision was clearly related to an increase in funding (McDougall, 2006). By and large, victims groups offer specific services aimed at dealing with the effects of traumatic experiences in a safe environment, and/or advocate on behalf of their members and help them in their search for justice, acknowledgement, and truth and reduce social isolation.

Findings reported here indicate that, while in the past there was a lack of structured support for victims, today much more support is available, however, there is a lack of provision within some aspects of the voluntary victims' group sector. For example,

the lack of service uptake by men and the lack of provision for young people remain to be addressed.

Overall however, it is intriguing that victims of the Troubles still seem in need of such large-scale support, some 10 years after the ceasefire, and 8 years after the Good Friday Agreement. This state of affairs calls for a thorough and detailed exploration of service provision.

4. The services: Description, categorisation, and recommendations

4.1. OVERVIEW

Victims/survivors groups in Northern Ireland provide a wide range of services, however there is scant information on details of how these services are delivered. In this chapter, services provided by the groups are described and classified, and, on the basis of the findings of the services survey, specific recommendations for minimal standards are made for each service.

4.2. CATEGORISATION OF SERVICES

On the basis of the services survey, the services delivered within the voluntary sector in Northern Ireland were grouped into four main categories:

1) *Community-based services* included self-help projects, befriending, respite, group holidays. These services were often initiated by people who had themselves experienced bereavement and Troubles related trauma;

2) *Philosophy-based services* were interventions that were carried out from a certain philosophical stance, such as complementary therapies based on Eastern Philosophy (meditation, yoga, aroma therapy, reflexology, shiatsu);

3) *Education-based services* were services that were primarily concerned with education, such as advice and information, or indirect services, such as specific skills courses, e.g., information technology or cookery classes;

4) *Psychology-based services* were interventions that were carried out by professionally trained and accredited therapists who worked from a clear psychological, theoretical, and methodological basis. In the main, these interventions were either psycho-analytic, humanist, or behaviourally oriented.

Most of the groups used education-based approaches (n=17) and community-based services (n=16), while psychology-based services (n=12), particularly counselling (n=9) and group therapy (n=6), and philosophy-based approaches (n=12) were also very popular (Figure 8).

Figure 8: Services offered by groups

Group	Community-based					Psychology-based			Philosophy-based	Education-based	
	Befrie nding	Support groups	Respite/ time-out	Youth work	narrativ work	Counsel.	Group therapy	Psychot herapy	Comple- mentary th.	Advice -info.	Indirect services
1	√	√	√		√	√			√	√	√
2			√								
3								√		√	
4	√										
5	√	√	√		√	√	√		√	√	√
6											√
7									√	√	
8	√		√							√	√
9	√	√								√	√
10	√	√	√		√	√	√			√	√
11		√		√	√				√	√	√
12	√	√	√	√		√			√	√	
13	√	√	√	√	√	√	√	√	√	√	√
14	√	√	√	√	√		√		√	√	√
15	√	√	√	√	√	√			√	√	√
16	√	√	√	√	√	√			√	√	√
17	√	√	√	√		√			√	√	√
18	√	√	√	√	√		√		√	√	
19		√	√		√	√	√		√	√	√
20	√	√		√		√			√	√	√
21	√	√	√	√		√	√	√	√	√	√
22	√					√					√
23		√			√	√			√	√	√
24						√			√	√	
25	√		√		√	√			√	√	√
26		√		√		√			√	√	√
N.	17	17	15	11	12	16	7	3	18	22	18

COMMUNITY-BASED SERVICES

Evidence suggests that appropriate social support is crucial when coping with traumatic experiences and that most individuals who experience adequate social support do not require professional interventions. At the same time, for those who do require some support, community-based services are less stigmatising and more empowering when compared with statutory services (Smyth, 2001). Nevertheless, community-based service providers should be well trained, in particular in attentive listening skills, relationship skills, empathy, personal coping strategies, and observational skills (Osterweis, Solomon, & Green, 1984). Appropriate referrals and staff supervision are important key elements for community-based services.

In the Services Survey, community-based services were offered in the following five sub-categories:

1. Befriending

2. Support/self-help groups

3. Respite care / time-out

4. Youth work, and

5. Narrative work (story telling).

Befriending

To-date, there are no clear definitions of befriending. However, some research has found that befriending by volunteers, especially, if well trained and supervised, can be an effective way of combating problems of loneliness and isolation (Bradshaw & Haddock, 1998; Harris, Brown, & Robinson, 1999; Taggart, Short, & Barclay, 2000; Heslop, 2005).

Befriending was offered by 17 of the groups, to 10 - 500 service users per group. Each group had between 1 and 12 befrienders, who offered this service between 1 and 32 hours per week. In many groups the number of hours depended on the needs of the service users (n=7). Most of the befrienders had some sort of qualifications (n=13) and some level of supervision (n=12). Befriending usually consisted of home visits or group meetings/activities in drop-in centres. Often, befrienders helped members with filling in forms or with other practicalities.

Interviewees regarded befriending as a crucial service. It was described mostly as home visits, offered by people who listened, helped with small tasks, and offered company to the service users, as interviewee J, a man who lost his brother, explained:

> *"… we have K (name of a man), who is our outreach worker and he was out visiting families. And what they tried to do is getting him to visit my sister-in-law and her family when they have problems, or when they feel under pressure, and that's been very good. So, it means they've always… I live forty miles from here. So, it's not easy for me, you know, to help my sister-in-law. So, if there is anything…, if she rings me about something, I can ring K to visit her, if I'm working. So, that's been very good."*

Interviewee E, who lost her mother when she was a child, talked about befriending as the service that helped her most. She understood befriending as being able to call in to the drop-in-centre and be able to talk to somebody, one of the workers who had a similar experience and who will listen to her:

> *"… it's probably not a service that you would see so much, because it wasn't a class,… I suppose you could call it befriending, the fact that somebody took the time to sit and talk to me. … the therapies… and the classes… and that, great! you know, because they stretch you and you are out socialising with other people and all the rest. But the fact that somebody took the time to listen to you and it wasn't a…, wait until you hear what happened to me, it is let you have your time to speak and get it off your chest."*

Recommendations:

Based on our findings, services could be categorised as **befriending** if they include the following:

1. A selection process to identify befrienders;

2. some level of training for befrienders, either appropriate professional training or in-service training;

3. regular supervision of befrienders, including accountability to service provider (group);

4. meetings between befriender and service user that are planned and scheduled;

5. availability of befrienders to meet with service users usually on a regular basis (weekly/monthly); although occasionally once off meetings can be considered befriending;

6. availability of befrienders to visit service users in their homes;

7. availability of befrienders to help service users with practical things, e.g., form filling;

8. befriender's ability of referring service users to other agencies or services if required;

9. befriender's ability to set certain boundaries with the individual in order to avoid creating dependency;

10. user feedback.

Support and self-help groups

Self-help groups offer a rich source of social support, information, and general sharing of common problems and concerns. Burnell and Burnell (1986) argued that while relatives and friends can offer temporary emotional support, mutual support groups provide a longer-lasting resource. Osterweis' et al. (1984) thought that mutual support/self-help groups can offer person-to-person based identification and reciprocity, access to a body of specialised information, an opportunity to share coping techniques, based on realistic expectations for optimal functioning, and an increased sense of personal worth, obtained by focusing on how similar members are to others confronting the same situation.

In total, 17 of the groups surveyed offered self-help groups. The number of users of this service in each victims group ranged from 6 to 700 people. The number of people in each support group varied greatly (between 3 and 35), although they were mostly small groups of 4 to 12 people, and the vast majority were groups for individuals in similar circumstances (n=14). The frequency with which they met fluctuated between twice a week and once a month, although most of them met at least once a week (n=9). Skilled and trained workers facilitated most of the self-help groups (n=11), either working alone (n=8) or in pairs (n=3).

The exact function of self-help groups remained somewhat unclear. For the most part, self-help groups seemed to meet in a rather unstructured way. Interviewee N, a woman who lost her father in the 70s, recounted:

> "Well, really, at the start, it was more friendship, it was… you know, meeting other… widows and victims of the Troubles and… … we used to meet like, you know, like in a living room in somebody's house and just have wee chats. And er… that's how we all met at the start, and get to know one another really."

Interviewee M, a man who was injured nearly 30 years ago, understands the self-help groups as a place where people with similar backgrounds meet:

> "… the services that I have… er… taken up in here is coming in, attending meetings, meeting people, meeting people … other traumatised people, getting a sort of a bond between them, er… getting a feeling that er… we are united group, we get together. Er… (coughs) we might have different outlooks but we can share outlooks and it's certainly getting me a lot more settled outlook on life."

Recommendations:

Based on our findings, services could be categorised as **support and self-help groups** if they include the following:

1. Small groups of 4 to 20 people, with similar previous life experiences/stresses;

2. facilitated by one or two identified, skilled staff;

3. meeting in a regular basis at a pre-arranged venue for a pre-arranged length of time;

4. usually, have a formal or informal agenda for the meeting.

Respite care/time-out

Respite care/time-out was offered by 15 of the groups in this study. Between 20 and 300 people availed of this service in each group. The main respite care activities were day trips, holidays, or short breaks away, although in one case, time-out consisted of residential work and personal development courses. The groups considered respite care/time-out a good way of bringing people together and offer a safe environment for their members.

Throughout the interviews, respite care/time-out proved to be a very popular service, whether it consisted on one-day trips or on holidays abroad:

"… the thing about the trips is that you are with people you know, and maybe between 10 and 20 people, and where you are in the… you can go and stay individually, you don't have to be with the group during the day. We kind of break up into small groups and then we meet up for tea or we meet up for dinner or we meet up… And you're always meeting people who you know, and I find that very good." (Interviewee J)

"… decided that we would like to go for maybe wee weekends and things. And it was a great, great success. And I mean, a great success. Everybody enjoyed it. And the only thing they didn't enjoy was coming back home and like myself, going in, looking at four bare walls again. And I think that this was great to get away together, talk about it, and chatting and doing things like that. So, it grew from there on, then, the… pantomimes and shopping trips, weekends away. And everyone in the group really, really, really enjoyed it. And still does." (Interviewee C)

Recommendations:

Based on our findings, services could be categorised as **respite care/time-out** if they include the following:

1. Day trips, short breaks, or holidays for service users;

2. facilitated by staff members with a qualification in the caring professions;

3. a selection process to identify facilitators and service users;

4. activities that are pre-planned and have a definitive time span and location.

Youth work

Pre- and post-ceasefire violence has adversely affected the lives of many children and young adults. Some of the victims groups were trying to involve young people in their activities and services. Adult members of some groups participate actively in the organisation and development of youth work activities, and they found that their own participation in these activities helped them to feel better.

Youth work was organised by 11 of the groups. Between 15 and 150 people were using this service. It was facilitated by between 2 and 20 facilitators, although some of the facilitators were brought in from other service providers. Most of the facilitators were trained (n=7). They offered a great variety of group activities such as sport training events, trips away, summer schemes, drama, music, computer courses, and social events such as parties.

In many groups, adult members and service-users participated in youth work activities, organising them or helping with the children and young people on the trips or activities.

"… we did one year with the group, we went… we took young ones to a… football match across the water. And we had a very, very good group of young lads. And that it stuck out in my mind to see those children's faces at that football match, they were never at this before. … . And you would have thought in their child's faces that their father walked in through the door again or their parent or whoever they lost. … it was just like the world had changed for them. If the funding was out there, I'm not joking you, I would have them children away once a month, to a football match or activity, the way they enjoyed that." (Interviewee C)

"… the children were badly affected during the feud, and everybody knows that, kids had to change schools, change houses, move away from their friends and… So, what we done was… we started to take them on trips. We've had ten trips in one year. And camping, go karting, skating… tones and tones of different things, big parties for them, to get them out and take their mind of things, because… they were badly affected, … Anybody that comes to this group will volunteer to work with the children and would volunteer to go and accompany them." (Interviewee 4)

Recommendations:

Based on our findings, services could be categorised as **youth work** if they include the following:

1. Organised group activities, such as sport, music, art, special events etc.

2. facilitated by trained and experienced facilitators;

3. specifically aimed at young people;

4. pre-arranged activity, time and location;

5. a selection process to identify facilitators and service users;

6. supervision of facilitators.

Narrative work

Narrative work entails different formats, such as oral, auditory, visual, or written (Chaitin, 2003), for example, the creation of a book, a digital archive, a journal, or poetry. Bolton (2004) argued, that when the certainties of life are stripped away by death, dying, and bereavement, writing can enable the bereaved to question and begin to find some sort of a route to answering their questions. Freedman and Combs (1996) agreed and described the work of narrative therapists as "working with people to bring forth and thicken stories that do not support or sustain problems. As people begin to inhabit and live out the alternative stories, the results are beyond solving problems. Within the new stories, people live out new self images, new possibilities for relationships and new futures." (p.16).

Twelve groups reported offering narrative work, i.e., allowing service users to tell their stories. Narrative work or storytelling was carried out in group meetings (n=4), in individual meetings (n=3), or both (n=3). The frequency of the meetings was not consistent. In one of the groups, it was done during six months, in another, during one year. In others, it was said to depend on each individual or was offered as and when needed. In another group, it meant the creation of a book and in another, the creation of a digital archive. In most of the groups, narrative work was facilitated by trained staff (n=8) and the number of service users ranged from 5 to 400.

Recommendations:

Based on our findings, services could be categorised as **narrative work** if they include the following:

1. The opportunity to talk about traumatic incidents, stressful life events, etc.

2. meetings in a 'safe' environment;

3. a pre-arranged setting, time, and location;

4. to have story recorded on one form or anther (written, oral, audio, visual, etc)

5. a selection process and supervision of trained, experienced facilitators;

6. individual or group meetings;

7. meetings held once off or more often, usually not exceeding a period of 6 months.

PSYCHOLOGY-BASED SERVICES

There is a great variety of theoretical and professional approaches to psychological interventions for individuals affected by traumatic experiences or bereavement. However, the evidence of effectiveness of these services differs considerably. For example, as regards psychoanalytic or psychodynamic therapies (Fonagy, 2000; Milrod et al., 1997; Shapiro et al., 1995; Zimbardo, 2005), a comprehensive review of outcome studies conducted by Research Committee of the International Psychoanalytical Association showed that there is no clear evidence that psychoanalysis is effective when compared to either alternative treatments or placebos (Fonagy, 2000, p.622). Likewise, while there are some qualitative reports and

preliminary evaluations regarding systemic therapies (Boss, Beaulieu, Wieling, Turner, & LaCruz, 2003), there is no reliable quantitative research evidence of its effectiveness. Client-centred bereavement counselling is very popular with a large number of agencies and is probably one of the most widely used approaches for the treatment of the bereaved (Zimbardo, 2005). However, ultimately, there is not much rigorous research evidence of its effectiveness either (Cutcliffe, 2004; Doermann, 2002).

The best evidence of effectiveness comes from behaviour therapy. Some research findings suggest that a number of different behavioural protocols (e.g. Rational Emotive Behaviour Therapy (REBT), Dialectic Behaviour Therapy (DBT), Eye Movement Desensitization and Reprocessing (EMDR), or Solution Focussed Therapy) can be effective in bereavement and trauma related treatment (AABT, 1991; Gillespie, Duffy, Hackmann, & Clark, 2002; Gray & Litz, 2005), however availability of these services varies widely across the sector.

Psychology-based interventions were not as popular among the victims groups as community-based service, probably because of the potential stigma involved, and many service users remained sceptical regarding their effectiveness. In fact, some feared that psychologically-based services could actually make people worse. For instance, in the summary report of 'Living with the Trauma of the 'Troubles'' (SSI, 1998), it was argued that 'there is little evidence that generic counselling, provided by itself, is particularly effective. More attention needs to be given to the content and

effectiveness of specific forms of counselling and the skills of counsellors before this approach is extended too widely" (p.12).

Actually, some of the interviewees in this research found that counselling made them worse, although most had availed of it outside the group:

> "My house was attacked, it was shot up one night by the IRA, you know. They sent me afterwards, you know, … , they sent me for counselling, away to doctor in [name of hospital], a nice enough man, but after three or four visits, I took my wife and me. And I said to my wife, I think it was the third or fourth visit, I asked her 'do you think this is helping us?' and she said, 'no', and I said, 'Thank God, me and you agree in something, because I don't think it's helping me.' And because, for a start, it was too early. This was just right after my house was attacked and there was a rage in me, you know, that somebody would come and shoot up my house and could have. It should have come later, you know." (Interviewee I)

> [Going to the psychiatrist] made us worse. Because… you know, he brings the daughter and you get out everyday and, as I did said to the doctor, I says, 'Look, I take her up here and she's coming back worse, she's coming out crying', and I was coming out crying. It just made things worse. It does not help whatsoever.
> (Interviewee C)

> And, in the end, my doctor put me on anti-depressants. I'm still on them. And I can't do without them. I went and got counselling, one-to-one counselling. It didn't help. … I've done the counselling for about… five months, once a week. … The last time I had counselling and that was enough (laughs), the last time I had counselling was last year. (Interviewee A)

Psychology- based services were offered in the following three sub-categories:

1. Psychotherapy

2. Counselling

3. Group therapy.

Psychotherapy

Psychotherapy was offered by only 3 of the 26 groups. In one of these groups, 4 people used the service on a referral basis (using a therapist from outside the group). Another group had 3 trained psychotherapists, who were helping 130 people. The other group did not state how many psychotherapists were employed, but they were all trained. The approach used in one of the groups was cognitive-behavioural therapy (CBT; Harvey, Bryant, & Tarr, 2003), including Eye Movement Desensitisation Reprocessing (EMDR; Shapiro, 2001). The other two groups used a combination of different approaches. For the most part, the service did not involve a specified number of sessions, rather number of sessions depended on the needs of each individual. The longest period of therapy for one person had been 18-24 sessions, and in another group, one year, while the shortest period of intervention had been 2-3 sessions.

Recommendations:

Based on our findings, services could be categorised as **psychotherapy** if they include the following:

1. A selection process of fully trained and accredited psychotherapists;

2. use of a certain therapeutic approach (eg., CBT; EMDR) or a mixture of different approaches;

3. meetings at pre-arranged times and location as often as deemed necessary;

4. evaluation and follow-up of each service user's case in order to determine the duration, frequency and effectiveness of the service.

Counselling

Counselling was used by 16 of the groups. Some groups brought in trained and accredited counsellors for one-to-one sessions or referred their service users to counsellors outside the group (n=4). Between 2 and 150 people availed of this service in each group and it was offered by 1 to 4 trained counsellors in most of the groups, although one of the groups had 8 and another up to 12 counsellors. The number of sessions usually depended on the needs of each individual (n=15). The longest period of counselling in one of the groups was 2 years and in another group it was 30 sessions, and the shortest time was a single counselling session. The most popular approaches were client-centered Rogerian (n=8), cognitive-behavioural (n=8), problem-solving (n=7), humanistic (n=4), and eclectic (n=3). Two of the groups were

using a psychodynamic approach. Other approaches used were EMDR, Human Givens, and transactional.

Recommendations:

Based on our findings, services could be categorised as **counselling** if they include the following:

1. A selection process of trained and accredited counsellors including counsellors brought in from other service providers;

2. use of a specific counselling approach (Rogerian, cognitive-behavioural);

3. meetings at pre-arranged times and location as often as deemed necessary;

4. evaluation and follow-up of each service user's case in order to determine the duration, frequency and effectiveness of the service.

Group therapy

Seven groups reported offering group therapy, although, in some cases it was not clear what exactly was meant by this. In most cases, the activities that were labelled group therapy resembled those of support groups rather than specific therapeutic interventions. Between 12 and 250 people were using this service. Each group consisted of between 2 and 18 people and had between 1 and 3 facilitators, who were trained in 5 of the groups. They met in different frequencies, from 6 times per year to

as frequently as more than once a week. Five organisations based their groups around themes, such as conflict, anger, dealing with trauma, or personal empowerment.

Recommendations:

Based on our findings, services could be categorised as **group therapy** if they include the following:

1. Group meetings of no more than 20 people,

2. meetings at pre-arranged times and location as often as deemed necessary;

3. groups meeting that can be based around themes,

4. facilitated by one or two selected, trained, and experienced professionals.

5. Use of specific group therapy or group work approach;

6. Selection of membership.

PHILOSOPHY-BASED SERVICES

There is a very wide range of complementary treatments based on Eastern philosophy, such as acupressure, acupuncture, aromatherapy, autogenic training, biorhythms, massage, meditation, neuro-linguistic programming, reflexology, reiki healing, shiatsu, yoga (Chris-UK, 2005). While subjective reports of wellbeing abound, there is very little quantitative evidence of effectiveness (Ernst, 2000).

Philosophy based services offered by the groups in this study included complementary therapies, which were particularly popular among their members and in high demand, but relied heavily on funding cycles.

<div style="text-align:center">

Complementary therapies

</div>

Eighteen groups offered a range of **complementary therapy** services, including reflexology (n=18), massage (n=13), aromatherapy (n=12), reiki (n=10), art therapy (n=8), music therapy (n=5), drama therapy (n=4), Indian head massage (n=3), yoga (n=3), and acupuncture (n=2). Other therapies offered were the Bowen technique and homeopathy. The number of complementary therapy service users per group ranged from 7 to more than 100, and the number of trained therapists ranged from 1 to 19. Therapists were usually brought in rather than in permanent employ of the groups. The number of sessions offered varied greatly among the groups, and in the vast majority of cases, as stated above, this depended on the funding cycle.

Many interviewees were particularly fond of complementary therapies, although not everybody enjoyed the same ones, and many lamented the fact of not being able to have them for longer periods of time due to funding restraints:

"I have had complementary therapies, and I actually did train in them as well. I have used reflexology, Indian head massage, and I have to say I think it was one of the best things that I ever tried. … Every time that you have a therapy, it's maybe half an hour, an hour, that you don't have to think"   (Interviewee E)

"there's a girl in here, G, and she does like… reiki, and aromatherapy and all this stuff, and she does this other thing, sounds or something. I don't know what it is, but of course I went to it, just to see, … but like I found maybe six weeks I did it for, the difference was unbelievable. … . All I did was smile the whole day after I came out of it. And I don't know why or what or… But er… I've loved it like… and it's great because she knows exactly what you need or what you don't need or… you know." (Interviewee K)

"…yeah, head massage, we went along to head massage in [a town]. And it was absolutely brilliant, very, very relaxing. Everybody enjoyed." (Interviewee C)

Recommendations:

Based on our findings, services could be categorised as **complementary therapies** if they include the following:

1. facilitated by a specifically trained, experienced, and accredited therapist;

2. offer recognised treatment approach, such as reflexology, massage, aromatherapy, reiki, yoga, acupuncture, or Indian head massage, etc.;

3. offer sessions at pre-arranged times and location as often as deemed necessary and on a regular basis.

EDUCATION-BASED SERVICES

Education-based interventions are used to disseminate information about the traumatic event, explaining the usual response to trauma, suggesting coping strategies, offering practical, and financial help. Oftentimes, these interventions are very welcomed by victims, who do not know how to respond in a traumatic situation, what to do next, and require practical help, or need help to realise that their response is normal and expected, given the experience they are going through (Dillenburger, 1992).

These interventions were very welcome, especially if they involve courses (e.g. computer courses, digital photography, basic skills) that helped service users develop new skills or re-build self-esteem and confidence, or offered information on funding, welfare, or advocacy.

Education-based interventions were offered by most of voluntary groups in the following two sub-categories:

1. Advice and information
2. Indirect services.

Advice and information

In total, 22 groups provided advice and information, being the most frequently offered service. The vast majority of service users used this service, and the number varied from 2 to more than 1,000 people. The kinds of advice/information given most frequently were financial assistance (n=19), advice regarding practical needs (n=17), and legal matters (n=10). Other advice or information was related to benefits, grants and welfare advice (n=10), housing (n=3), careers guidance (n=2), and health and dietary issues (n=2). Advice/information was usually provided in a drop-in facility (n=18), as written information in leaflets or newsletters (n=15), by appointment (n=13), or through a telephone helpline (n=9).

Recommendations:

Based on our findings, services could be categorised as **advice and information** if they include the following:

1. Facilitated by all workers, although some may have specialist information;

2. offered at all times to all service users on request;

3. offered in a variety of media, flyers, leaflets, newsletters, telephone, face to face;

4. offered in relatively unstructured way.

Indirect services

Indirect services were provided by most of groups (n=18). The number of users ranged from 4 to more than 400. The indirect services most frequently offered were small grants for members (n=14), training and supervision for staff members (n=14), research (n=13), working with new or developing groups (n=11), lobbying (n=9), advocacy (n=8), and giving advice to community development and capacity building (n=8). Many groups also provided computer courses and other kind of courses (e.g., music, drama) and workshops (such as picture framing) (n=13). These latter services were very popular, for example, one of the groups was exclusively dedicated to help families seek financial help for evacuation from their homes and farms after intimidation.

Interviewees had attended all kinds of courses (e.g., computer, digital photography, essential skills), which helped them to build up confidence and increase self-esteem:

"…the thing that really helped me was the classes, our own program that we run for… for the women, that really brought everybody, I think, out of themselves. It's the one thing that helped the most. … it was giving you self-confidence and self-esteem, and… you know, it actually made me do things that you wouldn't have done, like getting up and talking, and doing presentations and… just bringing women out of themselves, you know… And it really did work."   (Interviewee N)

> *"We've done erm… we call it '(name of a course)' and '(name of a course)', it's learning you to be positive, to be strong as a woman. … We've done erm… digital photography. Our photos is on the wall. We have done art. We do ceramics every Friday. We love it to bits. We do… English every Thursday. And… at the minute, we are putting in for swimming lessons for the ones that can't swim. Now, the courses we've done has really helped us. It helped us to be stronger."* (Interviewee A)

> *"The tutor will come from [further education college] and erm… she will facilitate then the class and it's usually for two hours. It's on every morning. We have maybe three, four, classes on a week. And erm… that will… probably be a fifteen or thirty week course, depending on what the course is. Erm… but they are really, really good courses…"* (Interviewee D)

Recommendations:

Based on our findings, services could be categorised as **indirect services** if they include the following:

1. Facilitated by all workers, although some may have specialist skills;

2. offered to service users on request;

3. offer in a variety of formats, such as courses, one-to-one meetings, training sessions, workshops;

4. usually offered in structured but flexible way.

Figure 9 offers an overview of the number of service users in each of the service categories.

Figure 9: Estimated number of individuals using each service
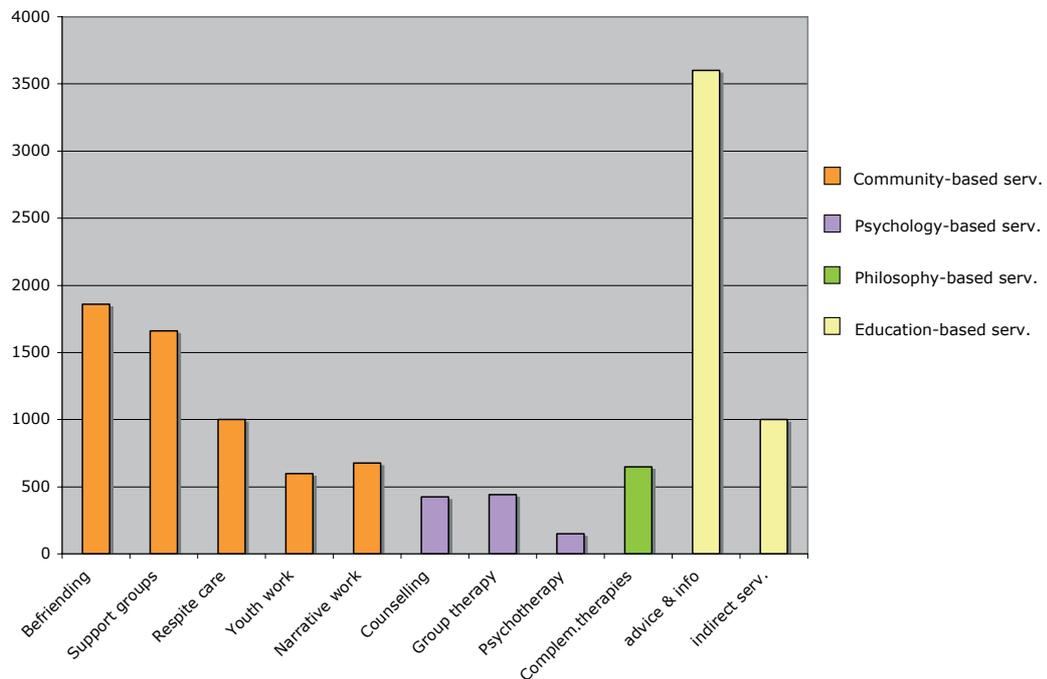
4.3. DISCUSSION

A detailed Services Survey was conducted with 26 core-funded voluntary sector victims organisations. This sample offered sufficient and representative data of the main services offered by these kinds of groups (Kelly & Smyth, 1999).

The Services Survey allowed the delineation of a categorization of core-funded voluntary sector services for victims of the Troubles and the establishment of a minimum good practice guide. In this sense, it is now possible to come to a common definition of the kind of services offered by the voluntary sector for victims of the

Troubles in that a 'service is provided if it meets the relevant and appropriate minimum standards of practice for this service'. This definition can be used for future reference and research.

We found that services were offered in four different main categories. While services varied vastly in terms of availability, by and large staff were trained and supervised and services were allocated according to a system of assessment. While some services were distinct, others were more defuse and even group representatives were not very clear about some of the differences between the services, e.g., the difference between group therapy, support groups, or befriending. Some of the more popular services (e.g, complementary therapies) were particularly vulnerable to funding cycles.

However, overall the majority of services provided by the groups received favourable feedback from interviewees. On an anecdotal level, they found most of the services helpful and their use of these services was considerable. Figure 10 offers an overview of the categorization and minimum good practice guidelines that resulted from the Services Survey.

Figure 10: Categorisation of Services and minimum good practice guidelines

Community-based:		
These are interventions based on initiatives from an individual or a community group, such as befriending, group holidays, narrative work and are often initiated by people who experienced trauma themselves.	**Befriending**	o Trained and supervised befrienders. o Planned, scheduled, and regular meetings (weekly, monthly) o Ability to refer service users to other agencies or organisations o Ability to help service users with practical things (e.g form filling) o User feedback
	Support groups	o Small groups of 4-20 people with similar previous life experiences/stresses. o Pre arranged regular meetings for pre-arranged length of time o Formal/informal agenda for the meeting o One or two identified facilitators
	Respite care	o Activities, trips, short breaks/holidays o Facilitated by staff members with a qualification in the caring professions o A selection process to identify facilitators and service users o Pre-planned activities with a definite time span and location
	Youth Work	o Organised group activities such as sport, music, art etc. o Trained and experienced facilitators o Pre-arranged activities, time and location o A selection process to identify facilitators and service users o Supervision of facilitators
	Narrative work	o A selection process and supervision of trained facilitators o Pre-arranged time and location in a safe environment o Story recording in different forms (written, audio, visual) o The opportunity to talk about traumatic incidents.

Cont.

Figure 10 cont.

Psychology-based: Interventions carried out by professionally trained and accredited therapists that work from a clear psychological, theoretical, and methodological basis.	Counselling	o A selection process of trained and accredited counsellors o Use of specific counselling approach o Pre-arranged meetings o Evaluation & follow-up of each case
	Group Therapy	o Group meetings of no more than 20 p o Pre-arranged meetings as often as necessary o Trained and experienced professional facilitators o Use of specific group therapy or group work approach
	Psychotherapy	o A selection process of fully trained and accredited psychotherapists o Use of certain therapeutic approach (CBT, EMDR) or a mixture of different approaches o Pre-arranged meetings as often as deemed necessary
Philosophy-based: Interventions carried out from a certain philosophical stance, such as Eastern Philosophy (yoga, aroma therapy, reflexology).	Complementary therapies	o Use of trained, experienced, and accredited therapist o Offer recognised treatment approach (Reflexology, aromatherapy etc) o Pre-arranged sessions offered on a regular basis and as often as deemed necessary
Education-based: Interventions that are primarily concerned with education such as advice and information giving.	Advice and Information	o Facilitated by all workers, although some may have specialist information o Offered at all times to all service users on request o Offered in a variety of formats: flyers, leaflets, newsletters, telephone or face to face o Offered in a relatively structured way
	Indirect services	o Facilitated by all workers, although some may have specialist information o Offered at all times to all service users on request o Offered in a variety of formats: courses, meetings, training sessions, workshops. o Offered in a structured but flexible way.

5. Psychological health assessment

5.1. PARTICIPANTS

A total of 75 service users took part in baseline assessment. A total of 20 services users took part in semi-structured interviews. Since most of the interviewees did not take part in the base line assessment, their details will be discussed separately (see 5.3).

Of the 75 participants who took part in the formal baseline assessment, 46 were women and 29 were men, most were aged over 50, and between 30 and 50 (Figure 11), and living in inner city, the country or a small town (Figure 12).

Figure 11: Age of participants

under 30
9.3%

over 50
49.3%

30-50
41.3%

Figure 12: Location

country
29.7%

inner city
37.8%

small town
29.7%

outskirts
2.7%
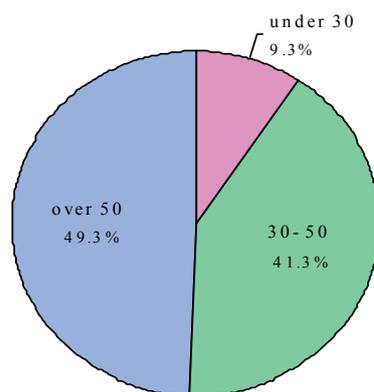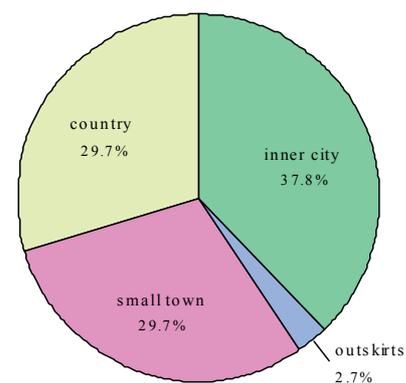
Many of the respondents stated not holding any type of qualifications (n=17), although some had GCSE's (n=11) and/or other second level educational qualifications (n=9). Few had third level education (n=5) (Figure 13).

Figure 13: Educational and professional qualifications
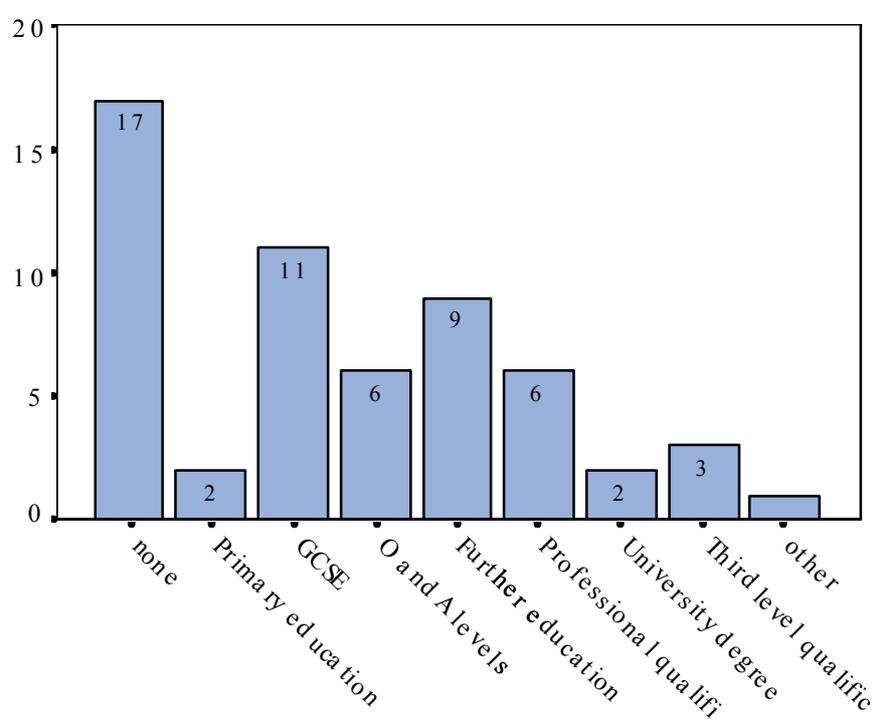
Most of the participants were not in paid employment (n=47) and for most of them, their main financial resource was their pension or/and benefits (Figure 14). Forty-three participants reported having worries about money and referred mainly to not being able to make ends meet or being in debt (e.g., mortgage or other loans).

Forty-five percent of the respondents (n=34) claimed to have a fair state of health and 28% claimed to have good health, although 68% had seen their doctor at least twice in the last six months and 71% reported taking some kind of tablets.

Figure 14: Financial support
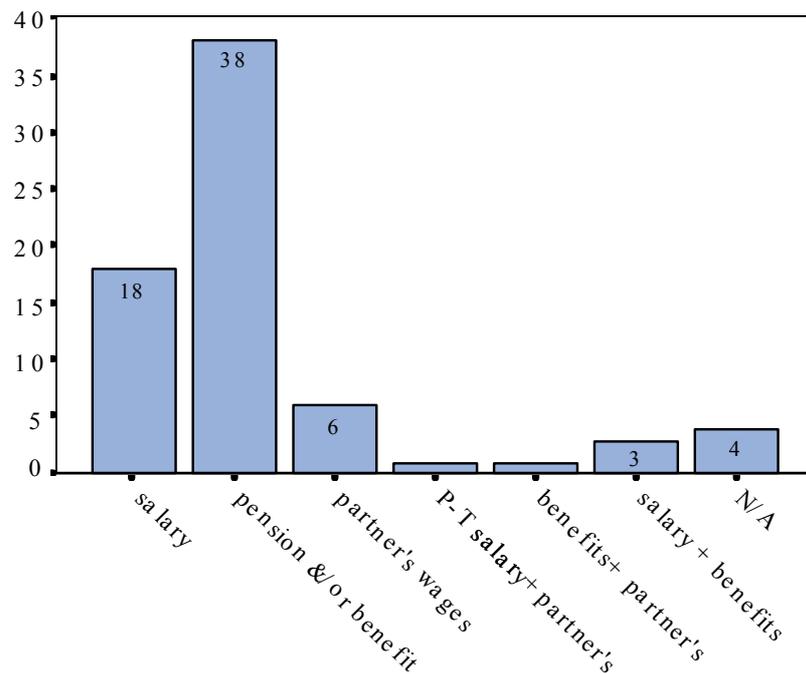
More than half of the participants had lost a member of their immediate family (n=41), while 47% (n=35) had witnessed a violent event (shooting, bomb explosion). Many had lost a close friend or distant relative as a direct result of the violence of the Troubles (n=35), and/or had been intimidated (n=24). Some had been injured or disabled (n=16) (Figure 15). Sixty-four per cent (n=48) of the participants had been affected by more than one traumatic Troubles related event.

Figure 15: Experience of traumatic events
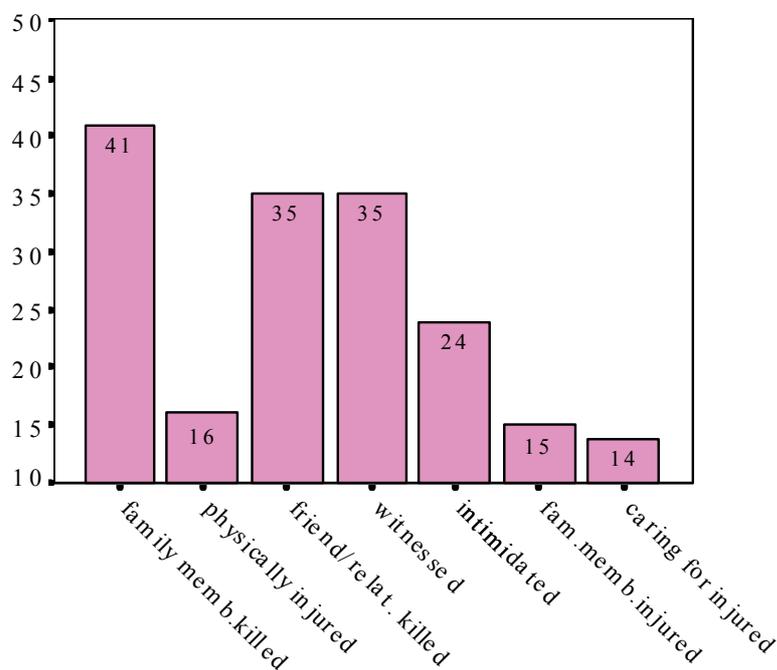
Figure 16: Time since traumatic event/s

	N	%
More than 25 years ago	7	9.3
Between 25 & 20 years ago	5	6.7
Between 19 & 15 years ago	4	5.3
Between 14 & 10 years ago	7	9.3
Between 9 & 5 years ago	21	28
Dif times-less than 11 years ago	2	2.7
Dif times- between 38 & 5 years ago	10	13.4
Missing	19	25.3
Total	75	100

While the study included individuals that had experienced trauma during the entire duration of the Troubles, the majority of participants had experienced more than one traumatic event and therefore it was difficult to discern the exact period of time since traumatisation. Having said this, 35 participants reported pre-ceasefire experiences

and 21 participants reported post-ceasefire traumatisation. For some of the participants, violent experiences were ongoing (Figure 16).

The great majority of participants had worried that traumatic events could happen to them prior to the event (n=48). Many had never shared these worries with anyone, while some participants (n=20) had talked about their worries, mainly with family members (n=11) (Figure 17).

Figure 17: Communication about worries

	N	%
Nobody	18	24
Family/relatives	11	14.7
Support/community group	3	4
Doctor	2	2.7
Army/police colleagues	2	2.7
Carer	1	1.3
Friends	1	1.3
Missing	37	49.3
Total	75	100

Many of the participants were told about the death of a relative or friend by a relative, while others were present during the traumatic event (Figure 18). One person heard about her son's death on the television news. Most of the participants stated that their first reaction was shock (Figure 19).

Figure 18: Information received
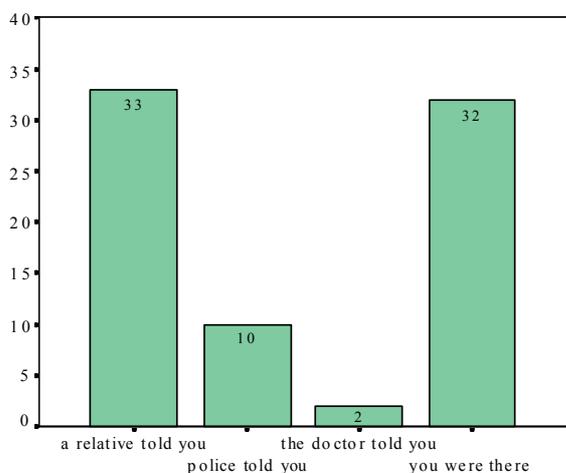
Figure 19: First reaction
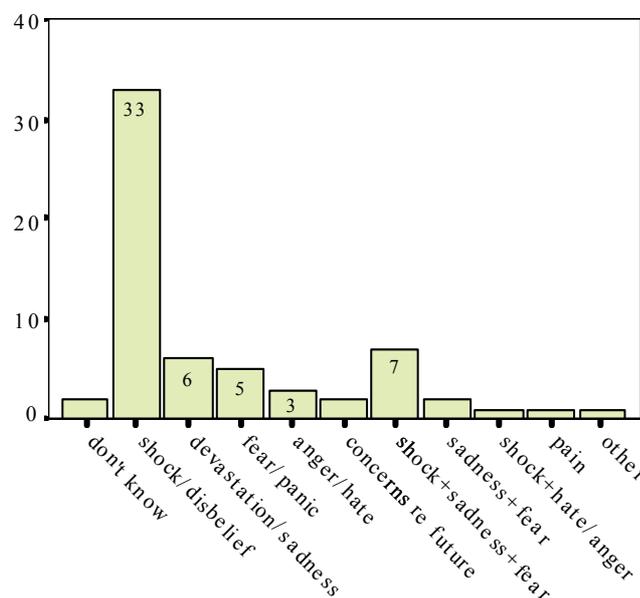
More than half of the participants thought that they coped fairly well (n=44) (Figure 20), although most of the respondents (n=48) claimed that somebody help them to cope, mostly support groups (n=24) and family (n=15) (Figure 21). Many respondents blamed a paramilitary organisation or society in general for what happen, while some blamed the Government (Figure 22).

Figure 20: Perception of coping
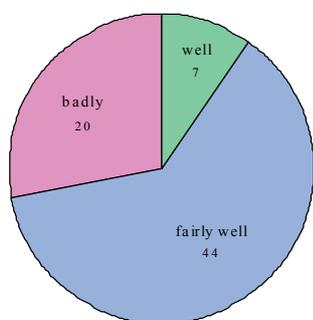
Figure 21: Help received
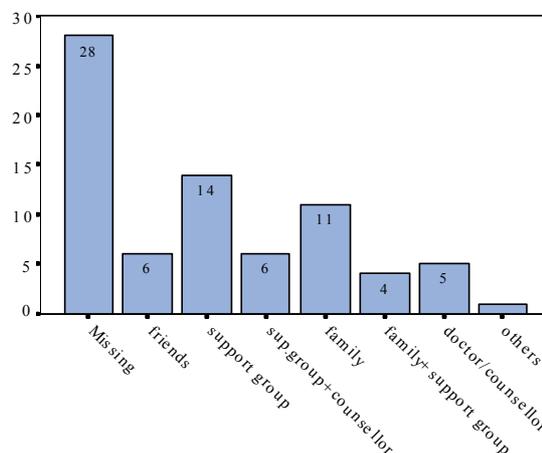
Figure 22: Blame attribution
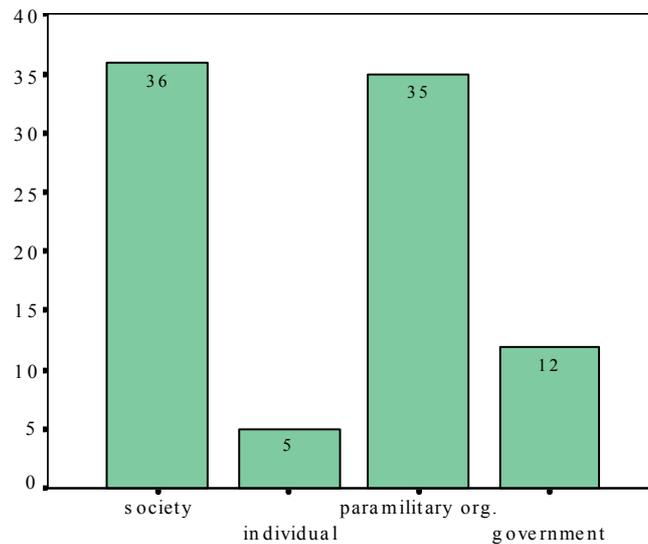
Most of the respondents had availed of services provided by victims groups for a relative long period of time, i.e., at least three years (Figure 23). Services most frequently availed of were: support/self-help groups (n=51); complementary therapies, above all, reflexology (n=42), massage (n=27) and aromatherapy (n=26); advice and information; and befriending. Indirect services such as courses and workshops were also quite popular (Figure 24). Sixty-seven participants (89% of the sample) availed of more than one service.

Figure 23: Length of time with the group

	N	%
Less than 1 year	6	8
1-2 years	14	18.7
3-5 years	31	41.3
6 years and over	22	29.3
Missing	2	2.7
Total	75	100

Figure 24: Services availed of
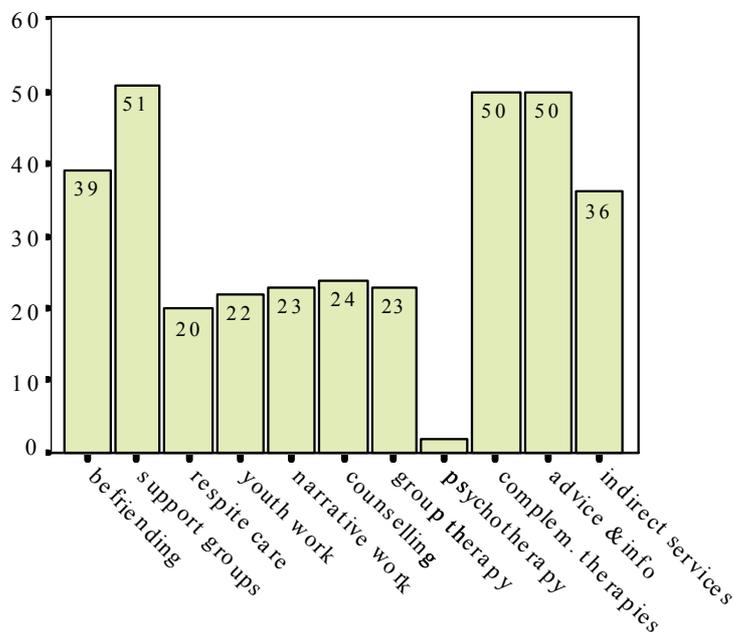
With regard to social validity, the great majority of the respondents felt that the services they received were socially valid. Social validity was measured on a Likert Scale, with 1 indicating *strongly agree* and 7 indicating *strongly disagree*, across all three of the social validity domains of perceived significance, appropriateness, and effectiveness of intervention. Figure 25 shows frequency of response and mean scores (standard deviation) on all three social validity domains, while Figure 26-28 show percentage scores of responses on the Likert Scale in relation to each of the domains separately.

Figure 25: Social validity

	I feel that the service/services I receive are significant to me	I feel that the service/services I receive are appropriate to my case	I feel that the services I receive are helping me cope with what happened
N Valid	73	73	73
Missing	2	2	2
Mean	1.78	2.05	2.18
Std. Deviation	1.373	1.545	1.711

Figure 26: Perceived significance
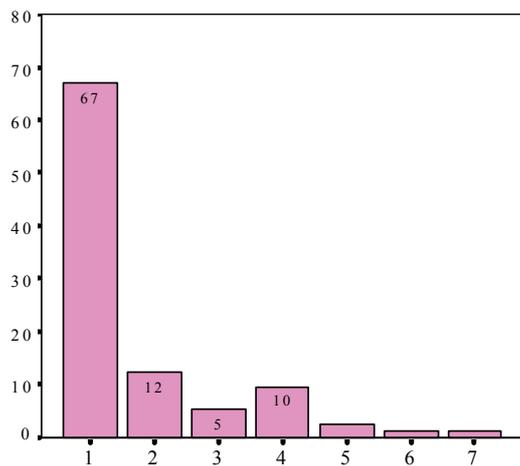
Figure 27: Perceived appropriateness
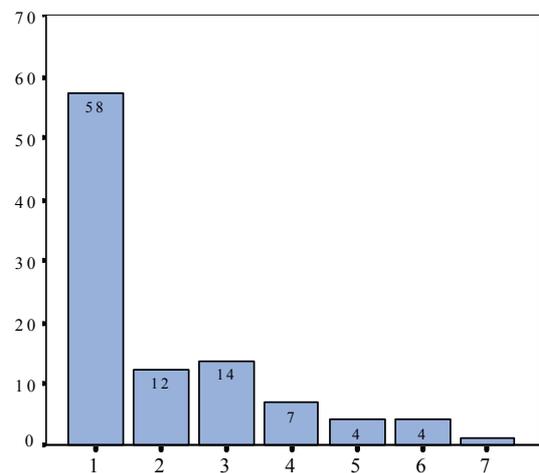
Figure 28: Perceived effectiveness
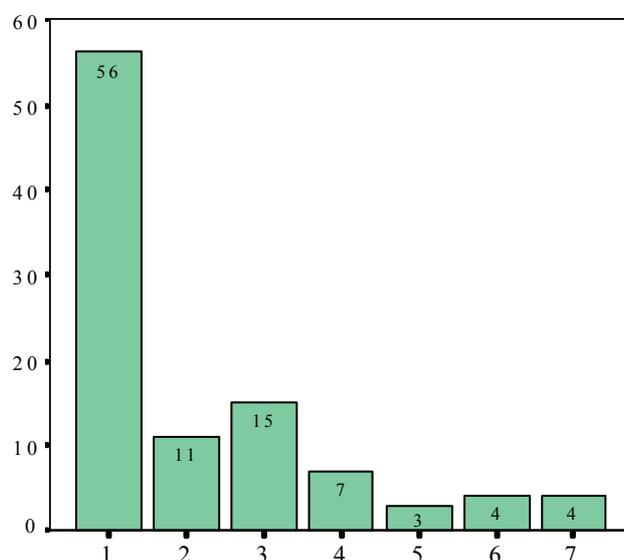
5.2. PSYCHOLOGICAL HEALTH (BASELINE ASSESSMENT)

The general psychological health of respondents at baseline was very poor (Figure 29), as indicated by extremely high GHQ-30 (mean 10.26; SD 9.66). Sixty per cent of the respondents scored over 5 and therefore would be considered *cases* in need of full psychological assessment (Goldberg et al., 1996).

In terms of depression, as measured by the BDI-II, the mean score was also very high (mean score 19.32; SD 13.78), in fact, 45 % of the respondents scored above 19 and therefore would be considered moderately to severely depressed (Beck et al., 1988).

The overall PTSD severity, as measured by the PDS, was particularly high, with a mean score of 25.44 (SD 15.09). The scores of 60% of the respondents were over 21, indicating moderate to severe PTSD symptoms, and 29% of participants scored over 36, indicating severe PTSD symptoms (Foa, et al., 1997). Figures 30, 31, and 32 show these scores in more detail.

Figure 29: Mean scores and standard deviations for GHQ-30, BDI-II, and PDS

	N	Minimum	Maximum	Mean	Std. Deviation
GHQ-30	74	0	30	10.26	9.66
BDI - II	73	0	56	19.32	13.78
PDS	73	0	51	25.44	15.09

Figure 30: GHQ-30 scores
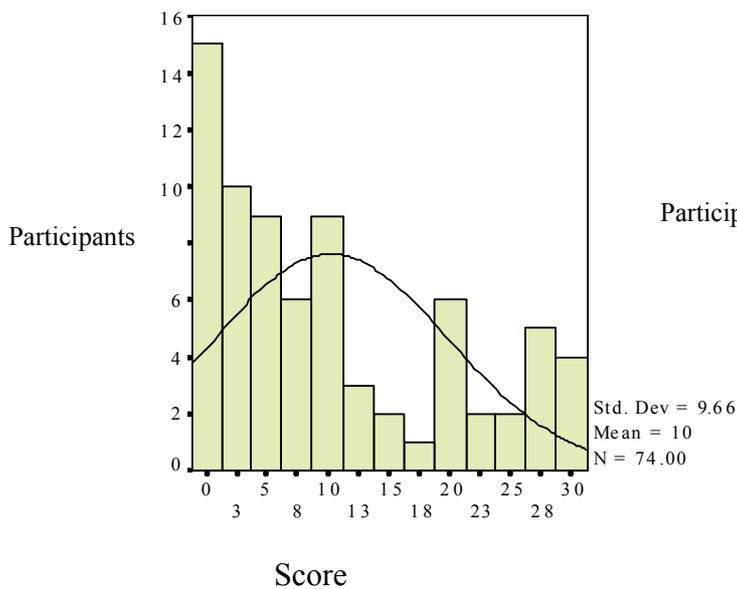
Figure 31: BDI-II scores
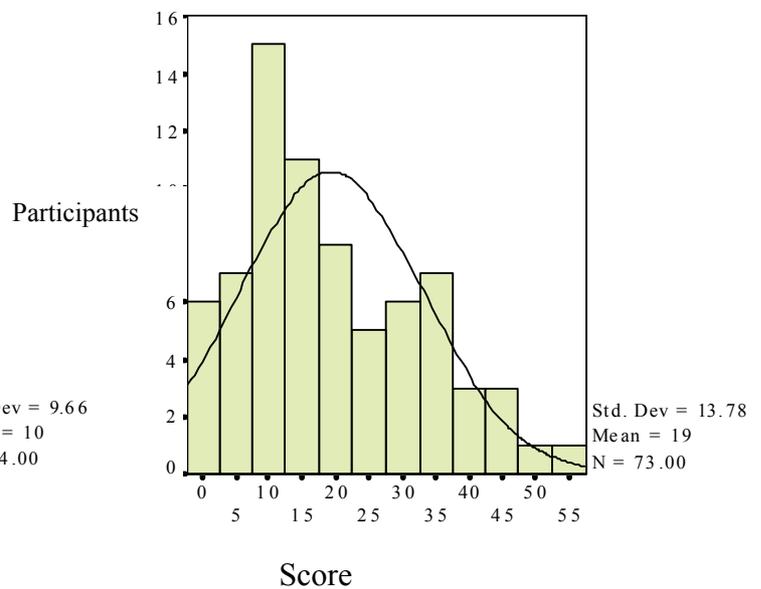
Figure 32: PDS scores
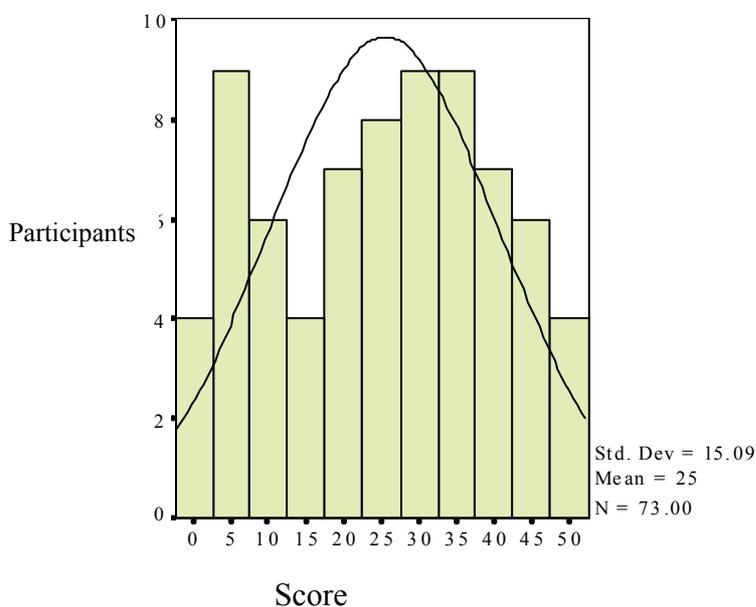
There was a strong statistically significant correlation between the three psychological measures ($r \geq 0.715$; $p < .01$) (Figure 33).

Figure 33: Correlations GHQ-30, BDI-II, PDS

Correlations		GHQ-30	BDI - II	PDS
GHQ-30	Pearson Correlation	1	.715**	.764**
	Sig. (2-tailed)		.000	.000
	N	74	72	73
BDI - II	Pearson Correlation	.715**	1	.750**
	Sig. (2-tailed)	.000		.000
	N	72	73	72
PDS	Pearson Correlation	.764**	.750**	1
	Sig. (2-tailed)	.000	.000	
	N	73	72	73

** Correlation is significant at the 0.01 level (2-tailed).

5.3. PSYCHOLOGICAL HEALTH OF INTERVIEWEES

In total, 20 participants were interviewed: 12 women and 8 men, aged between 30 and 80 years. Twelve of the interviewees had experienced the violent death of a close relative that was directly related to the Troubles, 2 of the interviewees had lost their husbands, 6 of them had lost a brother, and 3 had lost one of their parents when they were children. Four of the 20 interviewees had been injured due to the Troubles, and 2 of them had been affected by intra-paramilitary feuding and another 2 had suffered post-ceasefire violence and intimidation.

The interviewees were generally long-term traumatized. Seven of them had been traumatized approximately 30 years ago, 4 of them experienced the traumatic event around 20 years ago, 4 of the interviewees had been traumatised about 10 years ago, and 2 of them had been traumatised within the past 5 years. Most of the interviewees instantly recalled the date and time of the incident:

> *"This happened in nineteen seventy-five. It will be thirty-one years this August."* (Interviewee B)

> *"…our [brother' name] was dead … , the [exact date], that was 1974."* (Interviewee R)

> *"That was 25 years now on the [exact date]."* (Interviewee H)

> *"It will be 23 years in May."* (Interviewee K)

Seven of the interviewees were foundation members of a victims group, while others had become members of a group later. Eight of the interviewees had been involved in a group for 7-9 years, 2 had been members of the group for 5-6 years, 4 had joined the groups 2-4 years ago, and 6 of the interviewees had become services users 1-2 years ago. Most of them were self-referrals, having heard about the group by word of mouth.

Two of the interviewees worked for the group on a full-time basis, 4 were committee members of a group, others worked for the group as volunteers, while some availed of the services without further involvement.

Traumatic event/s affected the interviewees psychologically, financially, socially, and educationally. Psychological effects frequently mentioned were nightmares, depression, anxiety, fear, flashbacks, and suicidal thoughts. For instance, interviewee C, who lost her husband 17 years ago, still has nightmares:

> "… til this very day, it has left me with terrible, terrible nightmares. Now, erm… whenever daddy and mummy, they would have stayed with me, … I would start in the middle of the night and I would be screaming and yelling… And they'd come in and woke me, you know, and I always said, 'Please if you hear me, wake me' because you have no idea how sore and severe it is in your chest, … And those nightmares are still continuing… to this very day. Now, not at… then, it would be every, every night, but now, it would be erm… maybe a couple of nights a week, or the least wee thing, you know, would annoy me, … The least wee thing, it triggers er…. I would go to bed and have a nightmare."

Other psychological effects, such as insomnia, weight fluctuation, hopelessness, tension, and depression, were also illustrated in the interviews:

> "I had, I never slept, I was scared to sleep. Then, if I did finally get asleep, the least wee noise, and I was up. Because you didn't know what the noise was, who it was, where it was coming from. And, in the end, my doctor put me on anti-depressants." (Interviewee A)

> "Nightmares. Er… Feelings of hopelessness, er… deep tension, er… not very willing to go out into crowds of people that I don't know. You are looking always over your shoulder. You wish you had been born with wing mirrors on each shoulder that you wouldn't have to turn round." (Interviewee M)

> "I put on an awful lot of weight and I got very depressed, which I didn't see. I, you know, the whole time I says, 'No, I'm fine, no, no, I'm fine, I'll just get over that'." (Interviewee P)

Interviewees explained how the impact of violence changed lives, truncated education, and altered career paths. Interviewee N's father was shot when she was just entering secondary education, affecting her psychologically as well as educationally. She decided to attend adult education courses offered by the victims group to catch up:

> "I'm doing 'Essential Skills' course at the minute. … . A lad came in and asked us if we were interested in, and of course I would because my education was, you know, affected or whatever… by the Troubles. I'm starting to get…, hopefully, to get brainier (laughs)."

As one of the widows (Interviewee C) illustrated, traumatic events had serious financial repercussions:

> "… he was a businessman and those er… him and I ran a business together. So, whenever that happened, I had to close the business… I had a thirteen-year old daughter … and I had to cope with bringing that kid up on my own. … I did not want to go on. I thought the world came down round me, my business, I lost my business, I lost my husband, and… I just didn't want to go on".

For some, the traumatic event meant the break-up of family relationships. Interviewee B recounts how losing contact with her son after the death of her husband 30 years ago, meant also losing contact with her grandchildren:

> "I had one son that time. He was nine years of age. He's forty now and I haven't saw him for seven years. … we never got together again so… I'm also a grandmother, which I don't see the child either so… all these wee things that I have lost out of, you know, for the loss of my husband".

For interviewee R, the loss of her brother had a lasting impact on the relationship with her mother. She committed her life to her mother's wellbeing and she took care of her until she died:

"[my mother] went like a recluse, you know, and she only died last year and I just realised that I'm 61 and the last 32 years of my life have just passed. I don't remember my children growing up, you were concerned about my ma, you know. Like, me and her were always fighting, you know, but I mean, that's just the way it has affected me, and she was the same, she was like in a time warp, she just never moved on really and I was looking after her, but I don't know… she just never accepted or even came to terms with his murder."

Social segregation caused by intimidation, rioting, feuding, and displacement is widespread in Northern Ireland (Hillyard, Rolston & Tomlison, 2005). Some of the interviewees illustrated how they were affected by rioting:

"It split the community in two. And this is my community. This is where I'm from. And it devastated me when I see what was happening to my area." (Interviewee D)

"And it was very difficult… situation to be in, … you were afraid to say anything around other people, … it was very, very, very intense, so it was too, because it just totally, I feel, actually destroyed this community. And the atmosphere was… you could have cut it with a knife. Really, really awful." (Interviewee L)

5.4. PSYCHOLOGICAL HEALTH CORRELATES: D.I.S.C ANALYSIS

I t is now recognized that the way in which people cope with trauma, violence, and bereavement does not follow a universal linear pattern of progression, but that instead, responses vary depending on a range of different factors (Hamber, 2003; Spates, 2002; Orsillo, Batten, & Hammond, 2001). Dillenburger and Keenan's (2005) D.I.S.C. analysis demonstrates how trauma and bereavement responses depend on at least four intertwined contexts: the mode of **D**eath (or Trauma), **I**ndividual factors, **S**ocial context, and **C**ultural/Political milieu. In this section, the D.I.S.C. analysis is utilised to illustrate psychological health of participants, as measured by GHQ-30, BDI-II, and PDS. It focuses on: (1) the traumatic event, including mode of death or type of trauma, duration, and intensity; (2) individual variables, such as age, gender, health, and personal trauma history; (3) social circumstances, such as family relationships, social support networks, and stressful life events; and (4) cultural and political context, such as cultural norms, rites, and changing political milieu.

TRAUMATIC EVENT RELATED VARIABLES

The relationship between specific traumatic experiences and general psychological health, level of depression, and PTSD symptom severity of participants was statistically significant. Figures 34, 35, and 36 show mean scores for the three standardized measures respectively, for participants who experienced particular traumatic events and those who did not experience these events.

Figure 34: GHQ-30 mean scores by traumatic event
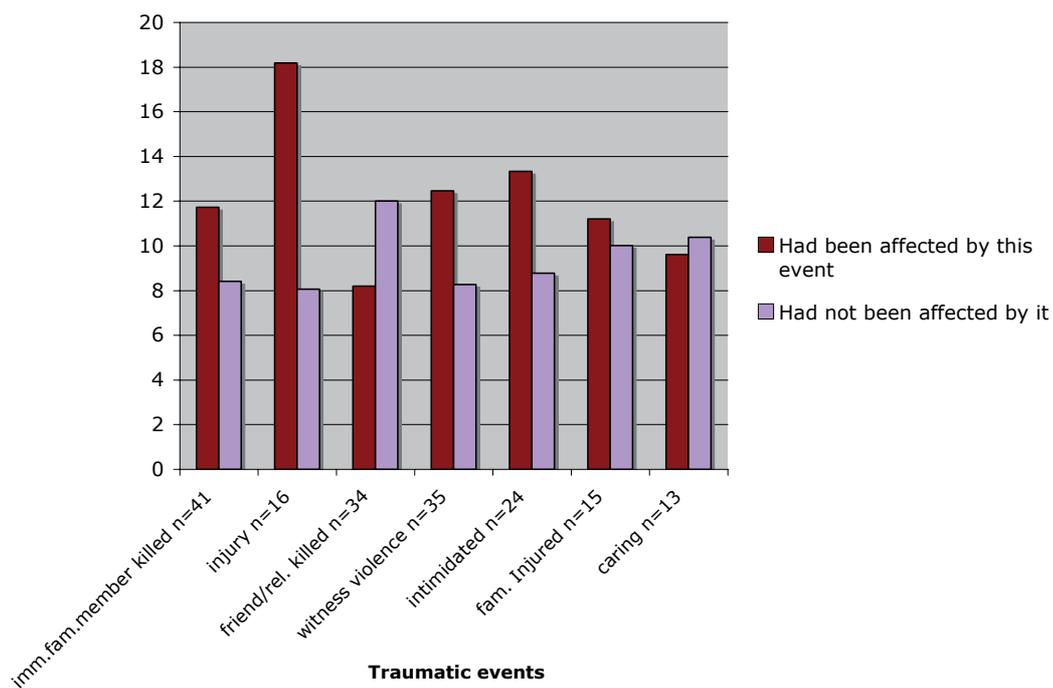
Figure 35: BDI-II mean scores by traumatic event
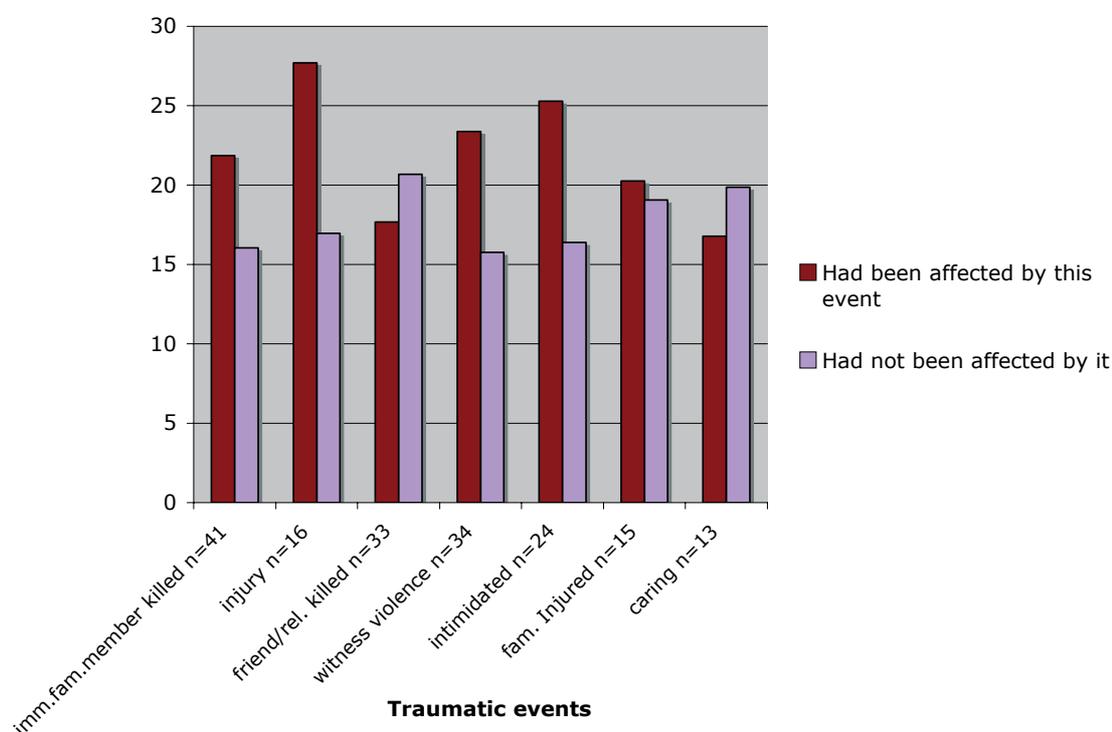
Independent t-tests yielded statistically significant differences between mean scores of participants who had experienced a certain traumatic event and those who had not ($p<0.05$), i.e., GHQ-30, BDI-II, and PDS mean scores for those who had been physically injured or disabled were significantly higher than for those who had not. The BDI-II and PDS mean scores were found to be significantly higher for those who had witnessed a violent incident than for those who had not. Those who had been intimidated had a significantly higher BDI-II mean score than those who had not. In addition, those who had been affected by the violence of the Troubles in more than one way presented higher GHQ-30, BDI-II and PDS mean scores than those who had been affected in one way (Figure 37).

Figure 36: PDS mean scores by traumatic event
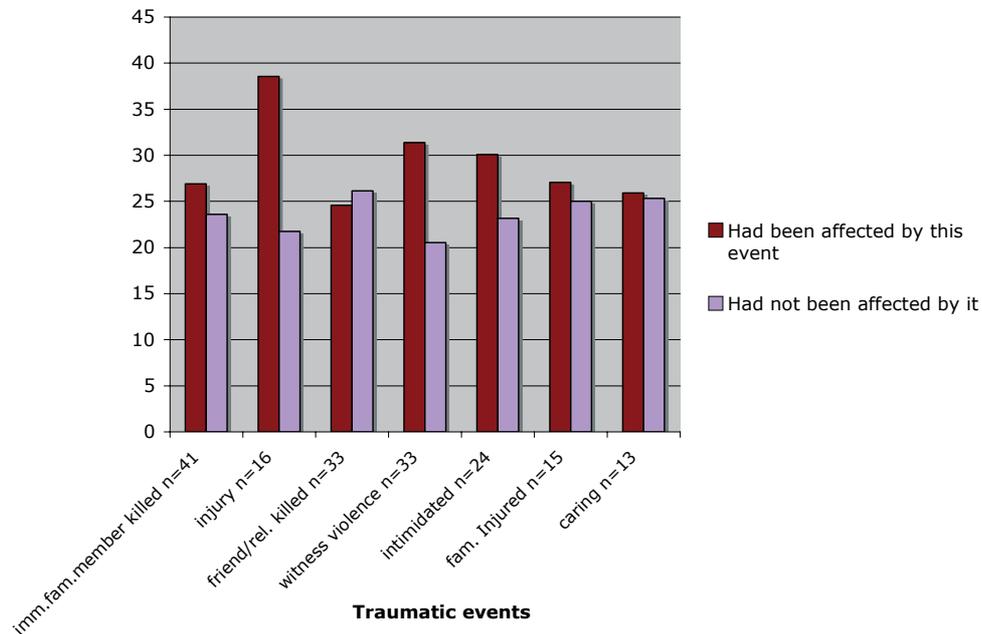
T-tests showed that those who were there when the traumatic event happened scored significantly higher in all three measures than those who heard about the traumatic event from other means (e.g. a relative, the doctor, or the police). In addition, those who stated that their day-to-day life changed because of the event scored significantly higher than those whose daily life had not changed. Moreover, those who felt the event changed the way they felt about themselves also scored significantly higher than those who did not feel in this way. Those who claimed they coped badly scored significantly higher than those who claimed to cope well/fairly well (Figure 38).

Figure 37: Significant mean score differences (t-tests) between those who had experienced a certain event & those who had not

		N	GHQ mean (SD)	BDI mean (SD)	PDS mean (SD)
Injured	Had been	16	18.19 (9.72)	27.69 (13.00)	38.56 (9.62)
	Had not been	58	8.07 (8.49)	16.96 (13.16)	21.75 (14.32)
	Difference		**10.12**	**10.72**	**16.81**
Witnessed	Had	35	12.46 (10.93)	23.38 (14.68)	31.36 (14.99)
	Had not	39	8.28 (7.99)	15.77 (12.04)	20.55 (13.48)
	Difference		Not sig.	**7.61**	**10.81**
Intimidated	Had been	24	13.33 (9.77)	25.29 (13.97)	30.08 (13.97)
	Had not been	50	8.78 (9.34)	16.39 (12.83)	23.16 (15.23)
	Difference		Not sig.	**8.9**	Not sig.
Been affected	In 2+ ways	47	12.15 (10.37)	22.50 (14.12)	29.72 (14.73)
	In 1 way only	27	6.96 (7.35)	13.89 (11.5)	18.15 (12.95)
	Difference		**5.19**	**8.61**	**11.57**

Figure 38: Significant mean score differences (t-tests) between different groups (traumatic event measures)

		N	GHQ mean (SD)	BDI mean (SD)	PDS mean (SD)
Been there at the time	Yes	32	13.38 (10.65)	24.61 (14.30)	32.77 (14.06)
	No	35	7.06 (7.4)	14.83 (11.04)	18.66 (12.86)
	Difference		**6.32**	**9.78**	**14.12**
Felt they life had changed	Yes	57	11.91 (9.64)	21.89 (13.97)	28.12 (14.15)
	No	13	5.54 (8.55)	11 (8.80)	16.15 (14.77)
	Difference		**6.37**	**10.89**	**11.97**
Felt they changed due to event	Yes	47	12.94 (10.06)	23.19 (14.32)	29.65 (14.49)
	No	25	5.88 (7.05)	12.92 (9.6)	17.17 (12.59)
	Difference		**7.06**	**10.27**	**12.47**
How coped?	Well/Fairly well	50	7.66 (7.74)	15.18 (10.77)	21.84 (14.51)
	Badly	20	17.35 (10.42)	31.75 (13.31)	35.35 (10.72)
	Difference		**-9.69**	**-16.57**	**-13.51**

INDIVIDUAL VARIABLES

Psychological mean scores for women and men, and for different ages did not differ significantly from one another (t-test and a one-way ANOVA) (Figures 39 and 40).

Figure 39: GHQ-30, BDI-II and PDS mean scores and standard deviations by gender

Sex		GHQ-30	BDI - II	PDS
Women	Mean	**10.43**	**19.91**	**25.83**
	N	46	46	46
	Std. Deviation	9.5	12.51	15.24
Men	Mean	**9.96**	**18.3**	**24.78**
	N	28	27	27
	Std. Deviation	10.08	15.91	15.10
Total	Mean	**10.26**	**19.32**	**25.44**
	N	74	73	73
	Std. Deviation	9.66	13.78	15.09

Figure 40: GHQ-30, BDI-II and PDS mean scores by age
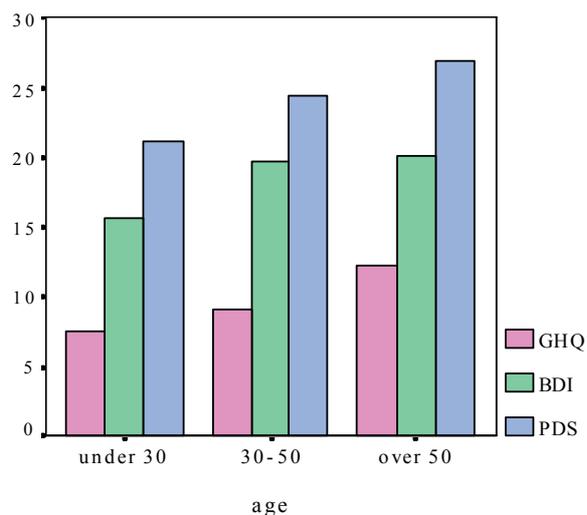
Participants who stated that they had problems with physical health scored significantly higher on psychological health measures than those who stated that their physical health was good or fair (Figure 41) (t-test).

Figure 41: GHQ-30, BDI-II, & PDS mean scores by perceived state of health.
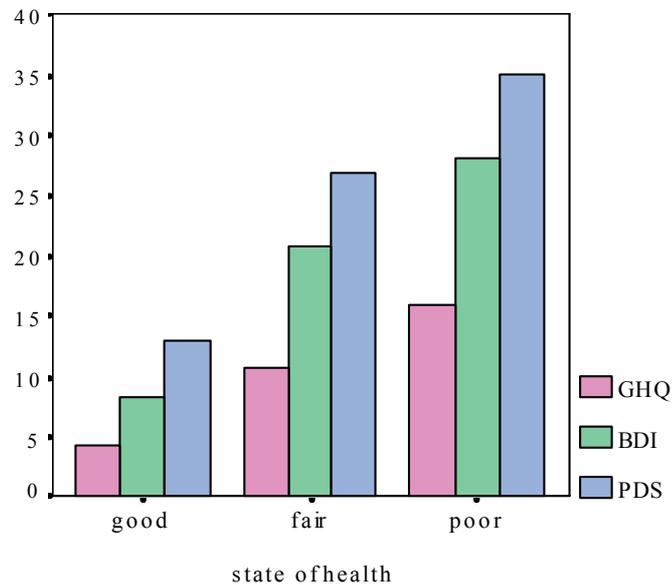
In addition, participants who were not on medication at the time of the study had significantly better general psychological health and presented fewer symptoms of depression and lower PTSD symptom severity than those who were taking tablets (t-test) (Figure 42).

Figure 42: GHQ-30, BDI-II & PDS mean scores by use of medication

Taking tablets		N	Mean	SD
GHQ	**No**	22	**6.55**	8.33
	Yes	52	**11.83**	9.82
BDI	**No**	21	**12.9**	11.44
	Yes	52	**21.9**	13.89
PDS	**No**	21	**17.43**	15.71
	Yes	52	**28.67**	13.69

SOCIAL SUPPORT VARIABLES

There were statistically significant differences in relation to social support measures (t-tests). For instance, participants who were not able to talk freely to their families (n=22) showed poorer general psychological health than those who were able to talk freely with family members (n=49) (GHQ-30 mean scores: 14.91 v. 8.20). They also showed higher levels of depression (BDI-II mean scores: 26.14 v. 16.75) and higher PTSD severity (PDS mean scores: 32.68 v. 22.04), and these mean differences were significant. However, the demographic variables (e.g., rural vs. urban living) made no significant difference to the GHQ-30, BDI-II, and PDS scores.

Financial situation was related to general psychological health of participants, i.e., those who had worries about money (n=42) scored significantly higher in the GHQ-30 (11.93 v. 6.38), BDI-II (26.14 v. 16.75), and PDS (32.68 v. 22.04) than those who did not have such worries (n=29). In addition, those who had a paid job (n=28) scored significantly lower in the GHQ-30 (6.11 v. 12.78) and the PDS (19 v. 29.22), than those who were not in paid employment (n=46). Those who felt they had no spare time (n=39) scored significantly higher in terms of depression symptoms (BDI-II mean score 22.67 v. 15.72) than those who felt they had enough time (n=30).

Length of service use and the number of services used were not significantly related to psychological health, depression, or PTSD severity. Statistically significant differences were found only between those who had availed of indirect services and reflexology, and the small number of yoga and psychotherapy users, and those who

had not availed of these services (t-tests). The following showed significant differences:

1. Indirect services: 38 participants who had availed of indirect services (GHQ-30 mean score 7.67; SD 8.31) scored higher than 36 participants who had not availed of indirect services (GHQ-30 mean score (12.71; SD 10.29);

2. Reflexology: 41 participants who had availed of reflexology (PDS mean score 28.51; SD 14.31) scored higher than 32 participants who had not availed of reflexology (PDS mean score 21.50; SD 15.36);

3. Yoga: 5 participants who had availed of yoga (GHQ-30 mean score 1.4; SD 1.67) scored lower than 69 participants who had not availed of yoga (GHQ-30 mean score 10.9; SD 9.68);

4. Yoga: 5 participants who had availed of yoga (BDI-II mean score 6.4; 5.08) scored lower than 69 participants who had not availed of yoga (BDI-II mean score 20.26; 13.75);

5. Yoga: 5 participants who had availed of yoga (PDS mean score 5.8; SD 6.61) scored lower than 69 participants who had not availed of yoga (PDS mean score 26.88; SD 14.53);

6. Psychotherapy: 2 participants who had availed of psychotherapy (GHQ-30 mean score 29; SD 1.41) scored higher than 72 participants who had not availed of psychotherapy (GHQ-30 mean score 9.74; SD 9.26); and

7. Psychotherapy: 2 participants who had availed of psychotherapy (PDS mean score 48; SD 1.41) scored higher than 72 participants who had not availed of psychotherapy (PDS mean score 24.8; SD 14.81).

Thus, while indirect service users showed better general psychological health than non-users and reflexology users showed higher PTSD symptom severity than non-users, the number in the other categories were too small to draw conclusions. Most importantly however, there were no significant differences between users and non-users of any of the other services, thus indicating that by-and-large for the vast majority of services, users and non-users had similar levels of mental health, depression, or PTSD symptom severity at baseline. Consequently, any subsequent differences would be related to the intervention rather than baseline differences. Figures 43, 44, and 45 illustrate GHQ-30, BDI-II, and PDS mean scores for all participants according to services received at baseline.

Figure 43: GHQ-30 mean scores by service
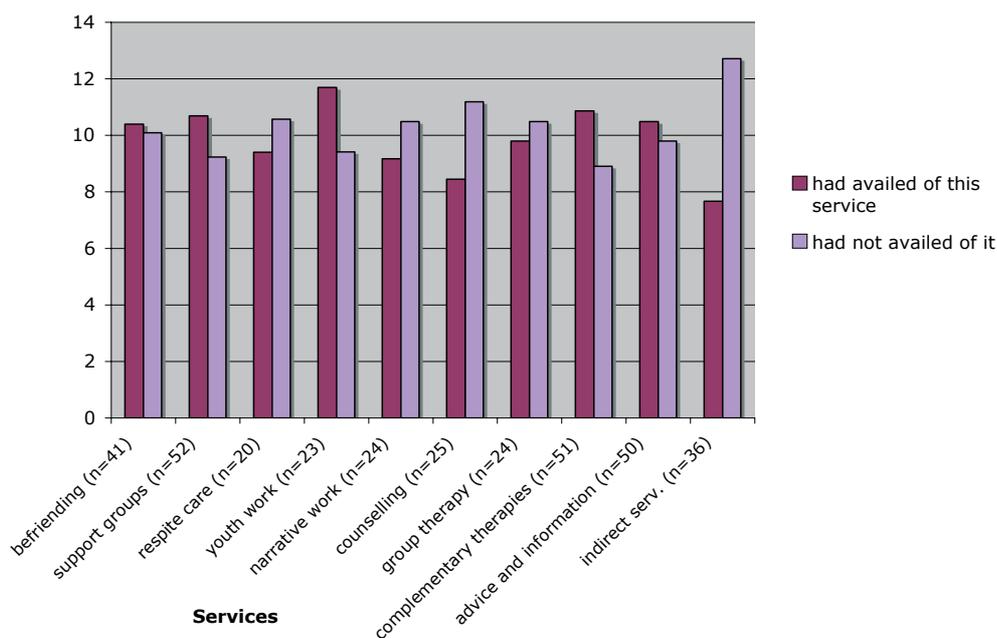
Figure 44: BDI-II mean scores by service

Legend:
- had availed of this service
- had not availed of it

Services: befriending (n=41), support groups (n=52), respite care (n=20), youth work (n=22), narrative work (n=24), counselling (n=25), group therapy (n=24), complementary therapies (n=50), advice and information (n=49), indirect serv. (n=36)
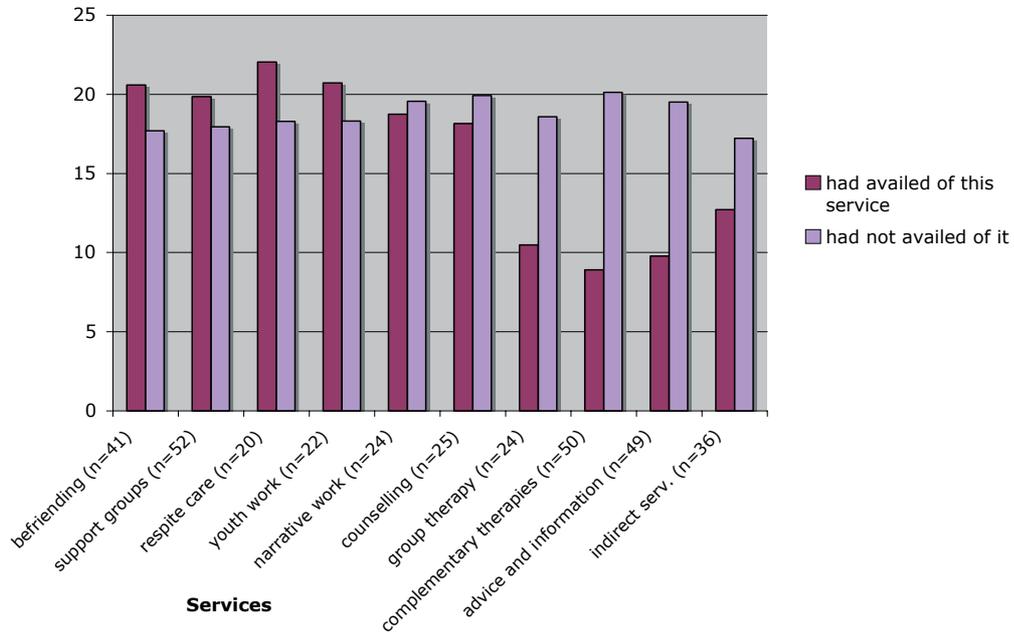
Figure 45: PDS mean scores by service

Legend:
- had availed of this service
- had not availed of it

Services: befriending (n=40), support groups (n=51), respite care (n=21), youth work (n=22), narrative work (n=23), counselling (n=25), group therapy (n=24), complementary therapies (n=50), advice and information (n=49), indirect serv. (n=36)
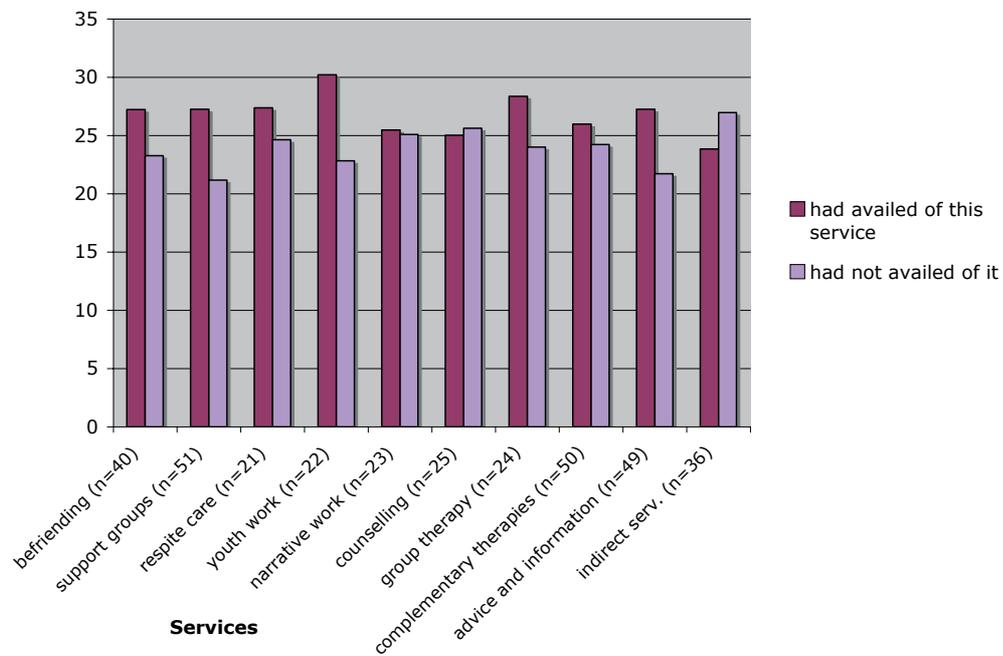
CULTURAL MEASURES

When results from the baseline assessment were compared with findings from general population studies in Northern Ireland, England, and Scotland using similar methodologies substantial differences were found (nb. to aide comparison with studies in which GHQ-12 had been used, GHQ-12 scores were extracted from baseline data; note that threshold for *caseness* in GHQ-12 is 4, not 5 as in GHQ-30; see 2.2).

Figure 46 shows GHQ-12 scores in the general population as reported in the Health and Lifestyle Study for NI (2002) and Figure 47 shows GHQ-12 scores for participants in the present research (PAVE project). People in the present study, who had been affected by trauma, scored much higher on the GHQ-12 (mean score 4.65 SD 4.19) than the general population in Northern Ireland. 26% of women in the Health and Lifestyle Survey scored above the threshold of 4, compared to over 52% of the women in the present research, and 23% of men scored 4 or more in the Health and Lifestyle Survey, compared to over 46% of the men in the present research.

Figure 46: Percent of GHQ-12 scores by gender Health and Lifestyle Survey for NI (2002).
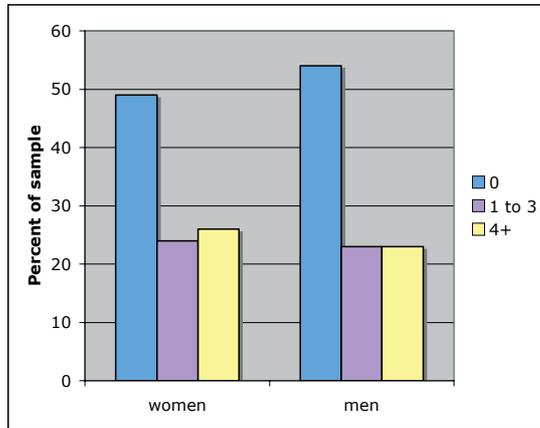
Figure 47: Percent of GHQ-12 scores by gender PAVE project.
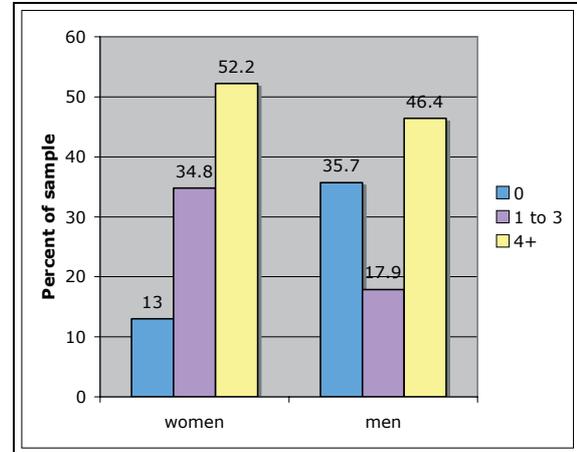
When compared with other cultural contexts such as England (Health Survey for England, 1995), Scotland (Health Survey for Scotland, 1995) or Northern Ireland before and after the Good Friday Agreement in 1998 (Northern Ireland Health and Social Wellbeing Survey, 1997; 2001), people affected by violence in the present study (PAVE) scored much higher on the GHQ-12 (Figure 48).

Figure 48: Percentage of women and men scoring 4 or more on GHQ-12.
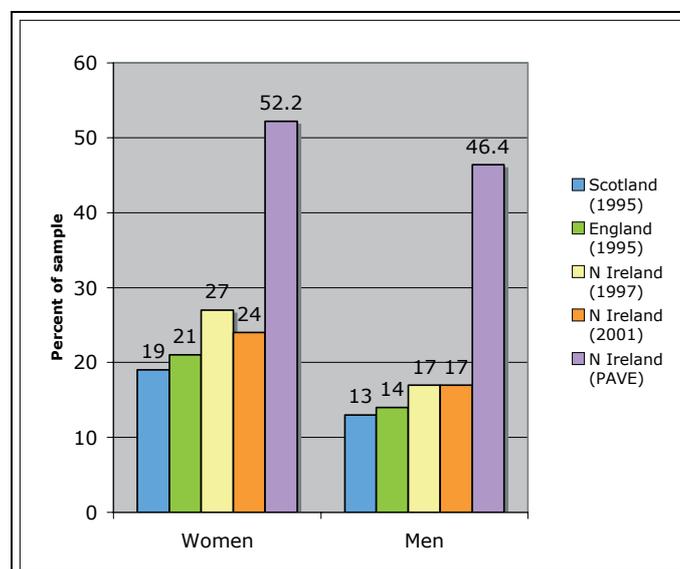
Adapted from O'Reilly & Brown (2001) and McWhirter (2002).

Although a certain level of cultural differences was found in GHQ-12 scores of the general population across the nations, the differences were marginal. However, participants in the present study, thus people who were affected by trauma and who were services users of voluntary sector victims groups in 2005-06, scored much higher than the general population.

Within this population, a comparison between pre- and post-ceasefires shows not much difference. In the mid-1980s, and thus at the height of the Troubles and over 10 years pre-ceasefires, the GHQ-30 mean score for violently bereaved widows (service users of victims groups) was 9.8(SD 8.2) and 67% of the widows were classified as *cases* (Dillenburger, 1992). Shortly after the Good Friday Agreement, the GHQ-30 mean score in this population was 8.1 (SD 10.06) and 43% were classified as *cases*

(Dillenburger, 2002). In the present study, 10 years post-ceasefires and 7-8 years post Good Friday Agreement, the GHQ-30 mean score was 10.26 (SD 9.66) and 60% of the participants were classified as *cases,* scoring 5 or more.

With regarding religion, there were statistically significant differences (t-test) in terms of depression and PTSD severity between of those who felt that their religious faith had helped them cope (n= 45) and those who thought religion had not helped (n=23) (BDI-II mean score: 16.44 v. 25.82; and PDS mean score: 21.82 v. 31.65).

On a more general level, the perception of whether justice had been done was important to participants. Many interviewees felt that justice for their loved ones or themselves had not been done:

> *"And they were never caught the ones that murdered my husband. They knew it was a [….] because he was a […], but they were never caught. No-one was ever brought to justice. … No, I don't think it would feel any better no matter what happened but I'd just loved them to be caught. Just the thought of maybe them walking about and enjoying life better than I'm enjoying it. And… that there really gets to me, you know…"*   (Interviewee B)

"…the ones who actually did it, and this is hard to believe what happened to them. They wrecked the police car, the police car came, they smashed it to bits, beat up the police, when the other police came, one policeman said he drew his gun that was going to fire on the crowd. People were covered in my brother's blood. They were arrested and they were let out because there was no evidence. Nobody was ever charged. … it was more or less forgotten about. An uncle of mine, who was… he's over forensics in [country], he lifted the files and said 'it's impossible that nobody was ever charged with murder, never charged with assault, never mind nothing'." (Interviewee P)

"It was… every time you went to a graveyard to bury one of your mates or one of your relations, there's a small part of you that goes into that grave, you are never the same person after that. I think that's where we've had chunks taken out of us. We still haven't got justice. My brother was shot in [name of town]. Nobody was prosecuted for it." (Interviewee I)

"There is one thing that… would be a big burden off my shoulders. It is to see the ones that murdered my husband in a courthouse, and be punished for what they did. … They chose to go out and murder my husband, and they should be made pay for their crime. It's not fair on me that they can walk about ten foot high, laughing, and I have suffered over them. … They chose to murder him and they should be made… I don't… I'd probably never see them before, I'd love to see them before a court. It would be a big, big help to me. In fact, I would be in the court to face them." (Interviewee C)

"I still hold the same core convictions that I had thirty years ago, and am still pursuing justice for [name]'s murder. I don't see that stopping. Erm…whether it comes or not." (Interviewee S)

5.5. Discussion

Long-term recovery from trauma is difficult to assess and even more difficult to achieve. Results indicate that most participants scored significantly higher on measures of general psychological health, depression, and PTSD severity than people in other parts of the UK and overall levels of general psychological health, depression, and PTSD severity were significantly correlated. Most participants were affected by more than one traumatic event. These events occurred pre- as well as post-ceasefire and 2/3 of the participants were there when the traumatic event happened. In other words, many of the participants had witnessed the violent death or injury of a loved one.

Nearly half of the participants felt that they had coped fairly well with their trauma, although results from the standardized measures of psychological health, depression, and PTSD severity told a different story. While some *protective factors* were identified that seem related to better psychological health (e.g. being able to talk with family), *risk factors* were identified that seem related to poorer psychological health (e.g. been affected by violence in more than one way or having money worries).

The baseline assessment revealed that services offered by victims groups were used frequently and in the long-term. Generally speaking, allocation to specific services was not related to levels of mental health, depression, or PTSD symptom severity, and most participants availed of more than one service at a time. Yet, little is known about

the effectiveness of services delivered by voluntary sector organisations (Dillenburger, Akhonzada, & Fargas, 2006).

The next chapter of this report is devoted to an exploration of effectiveness of services delivered by voluntary sector victims groups. The assessment tool (see 2.2) was applied repeatedly, approximately every 3-4 months. After the baseline assessment reported above, 3 further assessments were carried out, thus allowing for an exploration of effectiveness of services over a 9-12 months period.

6. Exploration of effectiveness of services

F ollowing the baseline assessment described in Chapter 5, effectiveness assessments took place throughout a 9-12 month period. These assessments were carried out in 3-4 month intervals, using the following 5-part assessment inventory. In order to establish which services participants had used in the interval between assessments, the short version PEIT-Q was applied. In order to establish if other important life events took place between assessments, a shortened version of the *Stressful Life Events Scale* (or *Social Readjustment Rating Scale*) (SLES; Holmes & Rahe, 1967) was included, and finally, the three standardized baseline measures (GHQ-30, BDI-II, and PDS) were used. For full details of the procedure see 2.2.

Of the 75 participants who took part in the baseline assessment (A1; see 5.1), 25 took part in the second assessment (A2), 20 service users took part in the third assessment (A3), and 13 participated in the fourth assessment (A4). Given the voluntary nature of the research, some of the participants did not complete all 4 assessments in sequence. Figure 49 shows details of the actual process. Overall, 11 service users took part in all

4 assessments, 16 participants completed 3 assessments, and 31 service users took part in 2 assessments.

Figure 49: Assessment process
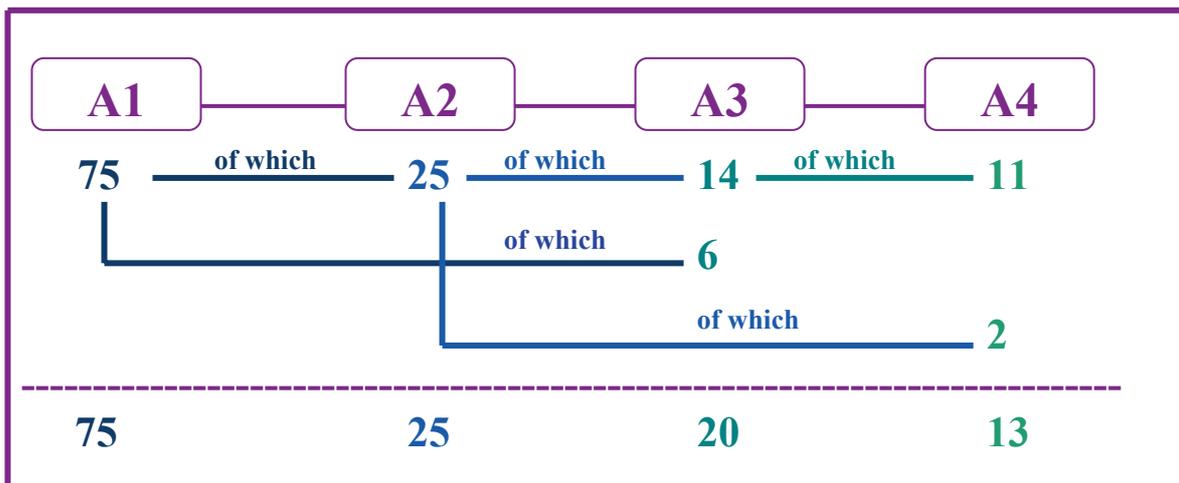
Figures 50, 51, and 52 present socio-demographic and services use data of participants who took part in the effectiveness assessments. A2 participants were those who took part in the assessment that took place 3-4 months after the baseline assessment, A3 participants were those who took part in the assessment that took place 6-7 months after the baseline assessment, and A4 participants were those who took part in the assessment 9-12 months after the baseline assessment.

Figure 50: Participant characteristics (A2)

		n	%
Gender of respondent	Female	18	72
	Male	7	28
Age	Under 30	1	4
	30-50 years	11	44
	Over 50	13	52
State of health	Good	4	16
	Fair	14	56
	Poor	7	28
Experience of the Troubles	Fam.member killed	9	36
	Friend/rel. killed	11	44
	Injured	5	20
	Witnessed events	14	56
	Intimidated	12	48
	Fam.member injured	5	20
	More than 1 event	19	76
Period of time in the group	1-3 years	5	20
	3-5 years	10	40
	6+ years	9	36
Services availed of in A2	Befriending	17	68
	Support groups	19	76
	Respite care	4	16
	Narrative work	12	48
	Youth work	7	28
	Counselling	13	52
	Group therapy	13	52
	Reflexology	12	48
	Massage	8	32
	Aromatherapy	9	36
	Advice & info	13	52
	Indirect services	3	12

Figure 51: Participants characteristics (A3)

		n	%
Gender of respondent	Female	16	80
	Male	4	20
Age	Under 30	1	5
	30-50 years	12	60
	Over 50	7	35
State of health	Good	3	15
	Fair	10	50
	Poor	7	35
Experience of the Troubles	Fam.member killed	5	25
	Friend/rel. killed	7	35
	Injured	6	30
	Witnessed events	12	60
	Intimidated	12	60
	Fam.member injured	4	20
	More than 1 event	14	70
Period of time in the group	1-3 years	5	25
	3-5 years	14	70
	6+ years	1	5
Services availed of in A3	Befriending	12	60
	Support groups	7	35
	Youth work	6	30
	Group therapy	3	15
	Art therapy	6	30
	Advice & info	10	50

Figure 52: Participants characteristics (A4)

		n	%
Gender of respondent	Female	12	92.3
	Male	1	7.7
Age	Under 30	1	7.7
	30-50 years	7	53.8
	Over 50	5	38.5
State of health	Good	1	7.7
	Fair	8	61.5
	Poor	4	30.8
Experience of the Troubles	Fam.member killed	2	15.4
	Friend/rel. killed	4	30.8
	Injured	3	23.1
	Witnessed events	8	61.5
	Intimidated	8	61.5
	Fam.member injured	1	7.7
	More than 1 event	10	76.9
Period of time in the group	1-3 years	5	38.5
	3-5 years	7	53.8
	6+ years	1	7.7
Services availed of in A4	Befriending	10	76.9
	Support groups	13	100
	Respite care	5	38.5
	Narrative work	3	30.8
	Youth work	4	23.1
	Group therapy	5	38.5
	Reflexology	9	69.2
	Massage	5	38.5
	Aromatherapy	3	23.1

6.2. PSYCHOLOGICAL HEALTH IN A2, A3 AND A4

P sychological health, level of depression, and PTSD severity as measured by GHQ-30, BDI-II, and PDS was better in A2 than in baseline assessment (A1) for most of the respondents (Figure 53). Differences in GHQ-30 and BDI-II mean scores were statistically significant (paired-samples t-test; p<0.05).

Figure 53: GHQ-30, BDI-II, and PDS mean scores and standard deviations (A1 & A2)

	N	Minimum	Maximum	Mean	Std. Deviation
GHQ-30 – A1	25	0	29	**10.68**	9.52
GHQ-30 – A2	25	0	26	**5.88**	7.35
BDI-II – A1	25	0	56	**19.08**	12.75
BDI-II – A2	25	0	36	**11.76**	10.24
PDS – A1	24	0	51	**24.67**	17.33
PDS – A2	24	0	51	**21.63**	13.31

The correlations between the three psychological measures remained statistically significant in A2. Figure 54 shows correlations between the three measures in A1 and A2.

Figure 54: Correlations GHQ-30, BDI-II, and PDS (A1 & A2)

		GHQ- **A1**.	BDI – **A1**	PDS – **A1**	GHQ- **A2**	BDI- **A2**	PDS – **A2**
GHQ-30- **A1**	Pearson Correlation N	1 25	.743** 25	.792** 24	- 25	.512** 25	- 24
BDI-II– **A1**	Pearson Correlation N	.743** 25	1 25	.752** 24	- 25	.657** 25	.548** 24
PDS – **A1**	Pearson Correlation N	.792** 24	.752** 24	1 24	- 24	.435* 24	.481* 24
GHQ-30- **A2**	Pearson Correlation N	- 25	- 25	- 24	1 25	.432* 25	.630** 24
BDI-II– **A2**	Pearson Correlation N	.512** 25	.657** 25	.435* 24	.432** 25	1 25	.529** 24
PDS – **A2**	Pearson Correlation N	- 24	.548** 24	.481* 24	.630** 24	.529** 24	1 24

- No significant correlation
** Correlation is significant at the 0.01 level (2-tailed).
* Correlation is significant at the 0.05 level (2-tailed).

Participants in the third assessment (A3) tended to score lower than in the baseline assessment (A1) on all three measures (Figure 55), although only differences in BDI-II mean scores were statistically significant (paired-samples t-test; $p<0.05$).

Figure 55: GHQ-30, BDI-II, and PDS mean scores and standard deviations (A1 & A3)

	N	Minimum	Maximum	Mean	Std. Deviation
GHQ-30 – A1	20	0	29	**10.15**	10.62
GHQ-30 – A3	20	0	25	**7.55**	8.88
BDI-II – A1	20	0	56	**21**	14.6
BDI-II – A3	20	0	34	**12.25**	11.47
PDS – A1	20	4	47	**25.60**	15.64
PDS – A3	20	0	40	**16.65**	13.99

Correlations between the three psychological measures at A3 were statistically significant ($p < 0.01$), but there were no significant correlations between assessment measures at A1 and A3 (Figure 56).

Figure 56: Correlations GHQ-30, BDI-II, and PDS (A1 & A3)

		GHQ- **A1**.	BDI – **A1**	PDS – **A1**	GHQ- **A3**	BDI- **A3**	PDS – **A3**
GHQ-30- **A1**	Pearson Correlation N	1 20	.746** 20	.891** 20	- 20	- 20	- 20
BDI-II– **A1**	Pearson Correlation N	.746** 20	1 20	.761** 20	- 20	- 20	- 20
PDS – **A1**	Pearson Correlation N	.891** 20	.761** 20	1 20	- 20	- 20	- 20
GHQ-30- **A3**	Pearson Correlation N	- 20	- 20	- 20	1 20	.903** 20	.825** 20
BDI-II– **A3**	Pearson Correlation N	- 20	- 20	- 20	.903** 20	1 20	.868** 20
PDS – **A3**	Pearson Correlation N	- 20	- 20	- 20	.845** 20	.868** 20	1 20

- No significant correlation
** Correlation is significant at the 0.01 level (2-tailed).

Participants in assessment four (A4) also seemed to improve regarding all three psychological measures when compared to baseline assessment (A1), although none of the differences were statistically significant (paired-samples t-test) (Figure 57).

Figure 57: GHQ-30, BDI-II, and PDS mean scores and standard deviations (A1 & A4)

	N	Minimum	Maximum	Mean	Std. Deviation
GHQ-30 – A1	13	0	29	**13.62**	10
GHQ-30 – A4	13	0	30	**6**	10.01
BDI-II – A1	13	8	56	**22.15**	12.63
BDI-II – A4	13	0	36	**13.77**	11.33
PDS – A1	13	3	47	**27.23**	16.68
PDS – A4	13	0	34	**16.38**	11.2

Correlations between standardized questionnaires were not calculated in A4 due to small numbers. Figures 58, 59, and 60 give a more detailed view of means scores in each assessment. The first bar represents A1 mean score for all participants of each of the subsequent assessment, while the second bar represents the mean score for the respective effectiveness assessment (see x-axis). Variations in A1 mean scores are due

to the fact that they were calculated for respondents who took part in each of the subsequent assessments.

Figure 58: GHQ-30 mean scores for 4 assessments
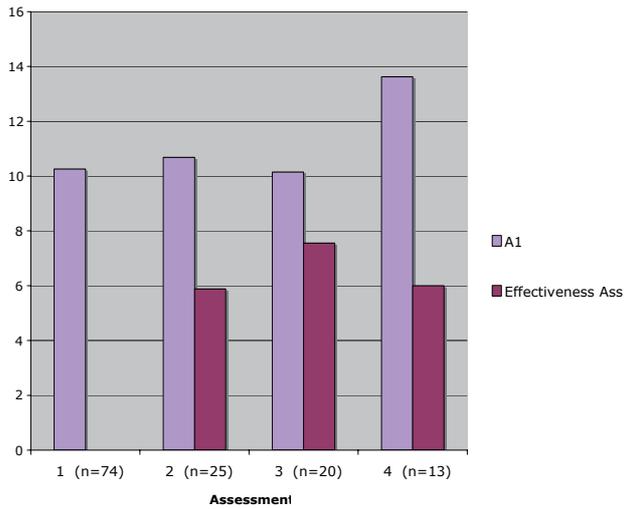
**Figure 59: BDI-II mean scores for 4 assessments**
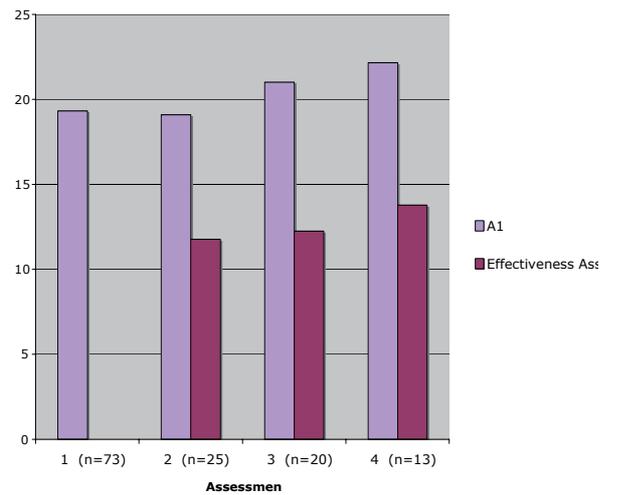
Figure 60: PDS mean scores for 4 assessments
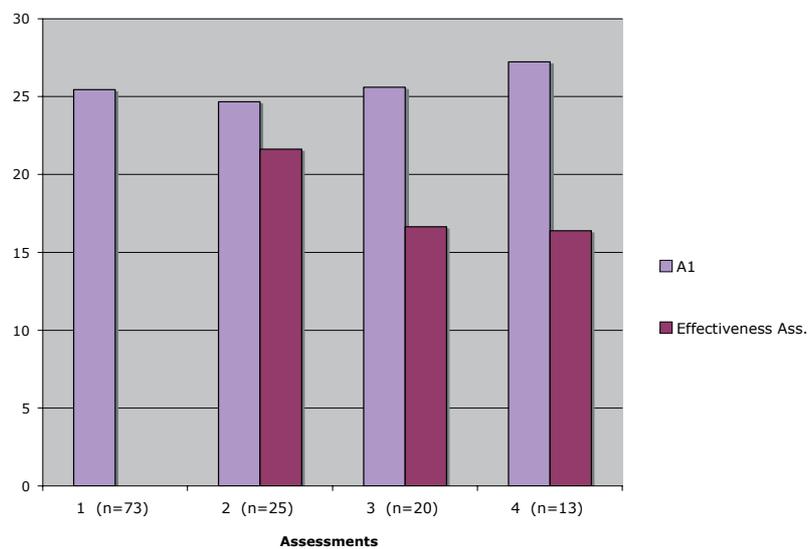
6.3. CONTEXTS INFLUENCING THE PSYCHOLOGICAL HEALTH OF THE PARTICIPANTS IN A2, A3 & A4

TRAUMATIC EVENT RELATED VARIABLES

In order to establish if an intervention was effective or not, the possibility that other exogenous events had an effect on psychological health needed to be excluded. In the context traumatic event related measures, the only statistically significant difference (independent-sample t-tests; $p<0.05$) of mean scores for psychological health, depression, or PTSD symptom severity were A2 PDS mean scores (26.85 v. 15.45) between those who had witnessed a violent incident and those who had not witnessed such an event. In addition, detailed paired-samples t-tests were carried out to establish significant differences between A1 and A2 measures with regard to specific traumatic events (Figures 61, 62, and 63).

Figure 61: GHQ-30 mean scores by traumatic event (A1 & A2)

	Been affected		Not been affected	
	A1	A2	A1	A2
imm.fam.member killed n=9 •	8.11	8.89	12.13	4.19
injury n=5	15.4	7	9.5	5.6
friend/rel. killed n=11*	12.64	3.5	8.18	8.91
witness violence n=14	10.79	6.21	10.55	5.45
intimidated n=12	13.58	6.5	8	5.31
fam. Injured n=5 •	8.2	8.2	11.3	5.3
more than 1 way n=19	11.32	6.79	8.67	3

* significant differences among the A1 and A2 means for those who had been affected in that way.
• significant differences among the A1 and A2 means for those who had not.

Regarding specific traumatic events, the only statistically significant difference between mean scores in A1 and in A2 in general psychological health was found for those who had experienced violent bereavement of a friend or distant relative. In addition, statistically significant differences in general psychological health were found for those how had not experienced violent death or injury of a family member. As such, it seemed that for the most part, the nature of the traumatic event did not significantly influence general psychological health in A2 in comparison with A1.

Figure 62: BDI-II mean scores by traumatic event (A1 & A2)

	Been affected		Not been affected	
	A1	A2	A1	A2
imm.fam.member killed n=9 •	14.33	11.44	21.75	11.94
injury n=5*•	24.4	6.2	17.75	13.15
friend/rel. killed n=11*	21.14	9.29	16.45	14.91
witness violence n=14*	21.64	13.07	15.82	10.09
intimidated n=12*	25.75	15.33	12.92	8.46
fam. Injured n=5 •	16.4	14	19.75	11.2
more than 1 way n=19*	20.63	13.74	14.17	5.5

* significant differences among the A1 and A2 means for those who had been affected in that way.
• significant differences among the A1 and A2 means for those who had not.

For those who had been affected by a specific traumatic event, statistically significant differences in depression were found for respondents who had experienced injury, witnessed violence, or had suffered intimidation themselves, participants who had lost a friend or distant relative and/or had been affected in more than one way. On the other hand, statistically significant differences in depression were found for those how had not experienced violent death or injury of a family member. As such, it seems that to some degree, the nature of the traumatic event may have been related to depression levels in A2 when compared with those in A1.

Figure 63: PDS mean scores by traumatic event (A1 & A2)

	Been affected		Not been affected	
	A1	A2	A1	A2
imm.fam.member killed n=9	16.78	20.89	29.4	22.07
injury n=5	40.2	24.8	20.58	20.79
friend/rel. killed n=11	28.07	21.64	19.9	21.6
witness violence n=14	29.92	26.85	18.45	15.45
intimidated n=12	30.58	25.5	18.75	17.75
fam. Injured n=5	22.6	22.8	25.21	21.32
more than 1 way n=19	27.06	24.11	17.5	14.17

As regards PTSD symptom severity, there were no statistically significant differences with regard to the kind of traumatic event experienced, indicating that the nature of the traumatic event was not related to PTSD symptom severity differences between assessment 1 and 2.

However, PDS mean scores at A2 for those who were present when the incident took place (n=12) were significantly higher than for respondents who had found out about the event by other means (27.5 v. 14.64) (independent-samples t-tests). GHQ-30 mean scores at A2 were also significantly higher for those who thought that their daily life had changed (n=20), when compared with participants who did not think their life had changed (7.25 v. 0.4); and for those who stated that the event changed the way they felt about themselves (n=9) compared to those who did not think they felt differently about themselves after the event (8.06 v. 2).

Paired-samples t-tests showed statistically significant differences in BDI-II mean scores between A1 and A2 for those who were there when the event took place (25.83 v. 14.58); those who claimed that their daily life changed (22.25 v. 12.75); those who

thought the event changed them (22.25 v. 12.75); and those who thought they coped badly (31.25 v. 13.00).

INDIVIDUAL VARIABLES

There were no statistically significant gender differences (paired-samples t-tests) in regard to general psychological health, depression, or PTSD symptom severity between A1 and A2 (Figure 64), and A1 and A3 (Figure 65).

Figure 64: GHQ-30, BDI-II, and PDS mean scores by gender (A1 & A2)

	GHQ-30		BDI-II		PDS	
	A1	A2	A1	A2	A1	A2
Women	11.39	3.67	19.67	11.22	25.39	20.39
Men (n=7)	8.86	11.57	17.57	13.14	22.50	25.33

Figure 65: GHQ-30, BDI-II, and PDS mean scores by gender (A1 & A3)

	GHQ-30		BDI-II		PDS	
	A1	A3	A1	A3	A1	A3
Women	9.81	8	19	12.5	25.31	15.38
Men (n=4)	11.5	5.75	29	11.25	26.75	21.75

There were no statistically significant age differences (paired-samples t-tests or independent-samples t-test) in regards to general psychological health, depression, or PTSD symptom severity between A1 and A2 (Figure 66), A1 and A3 (Figure 67), and

A1 and A4 (Figure 68), except for 30- to 50-year olds, whose BDI-II mean score in A4 was significantly lower than their scores in A1.

Figure 66: GHQ-30, BDI-II, and PDS mean scores by age (A1 & A2)

	GHQ-30		BDI-II		PDS	
	A1	**A2**	**A1**	**A2**	**A1**	**A2**
30-50 (n=11)	4.36	10.27	6.73	20.73	20.64	24.73
Over 50	7.62	9.62	14.15	14.85	22	22.75

Figure 67: GHQ-30, BDI-II, and PDS mean scores by age (A1 & A3)

	GHQ-30		BDI-II		PDS	
	A1	**A3**	**A1**	**A3**	**A1**	**A3**
30-50 (n=12)	6.67	8.83	17	12.08	22.58	18.75
Over 50 (n=7)	13.43	6.43	22.86	14.14	27.71	15.43

Figure 68: GHQ-30, BDI-II, and PDS mean scores by age (A1 & A4)

	GHQ-30		BDI-II		PDS	
	A1	**A4**	**A1**	**A4**	**A1**	**A4**
30-50 (n=7)	12.71	5.14	22.29	12.14	27.71	16.14
Over 50 (n=5)	11.8	8.4	15.2	18.8	22.6	16.8

With regard to perceived state of health, there were no statistically significant differences (paired-samples t-tests or independent-samples t-test) regarding general psychological health, depression, or PTSD severity between A1 and A2 (Figure 69), A1 and A3 (Figure 70), and A1 and A4 (Figure 71), except for respondents who perceived their health as fair in A2; their GHQ and BDI-II mean scores were significantly lower than in A1.

Figure 69: GHQ-30, BDI-II, and PDS mean scores by state of health (A1 & A2)

	GHQ-30		BDI-II		PDS	
	A1	A2	A1	A2	A1	A2
Good (n=4)	3.50	4.25	5.75	6.25	2.33	4.33
Fair (n=14)	12.21	7.29	22.14	13.14	26.79	25.21
Poor (n=7)	11.71	4	20.57	12.14	30.00	21.86

Figure 70: GHQ-30, BDI-II, and PDS mean scores by state of health (A1& A3)

	GHQ-30		BDI-II		PDS	
	A1	A3	A1	A3	A1	A3
Good (n=3)	1.67	1.67	6.33	3.33	4.33	8.33
Fair (n=10)	9.6	10	20.7	14.9	25.8	17.9
Poor (n=7)	14.57	6.57	27.71	12.29	34.43	18.43

Figure 71: GHQ-30, BDI-II, and PDS mean scores by state of health (A1 & A4)

	GHQ-30		BDI-II		PDS	
	A1	A4	A1	A4	A1	A4
Fair (n=8)	13.75	4.88	24.75	9.88	26.62	15.75
Poor (n=4)	14	7.5	19.75	22.5	34.5	20.5

Omitted n=1 (good)

SOCIAL SUPPORT VARIABLES

There were no statistically significant differences with regard to being able to talk freely to family and friends (paired-samples t-tests) in regards to general psychological health, depression, or PTSD severity between A1 and A2 (Figure 72). However in A3, those who could not talk freely to their families showed significantly lower BDI-II mean scores than those who stated that they could speak freely with their families (Figure 73).

Figure 72: Mean scores by being able to talk freely to one's family (A1 & A2)

	GHQ-30		BDI-II		PDS	
	A1	A2	A1	A2	A1	A2
Able to talk freely to family (n=20)	8.25	6.45	16.7	10.95	21.16	21.95
Not able to talk freely (n=4)	19.25	4.5	30.5	13.5	37.25	21.25

Figure 73: Mean scores by being able to talk freely to one's family (A1 & A3)

	GHQ-30		BDI-II		PDS	
	A1	A3	A1	A3	A1	A3
Able to talk freely to family (n=13)	5.77	9	15.58	14.08	19.62	18.23
Not able to talk freely (n=6)	17.17	5.67	33.17	9.67	36	15.83

A4 data were omitted, because of small numbers (i.e., only two participants stated that they were not able to talk freely to their families).

The experience of additional stressful life events was a significant factor with regard to poor outcomes for participants. Thirteen participants had experienced one or more stressful life events over the past 3-4 months prior to A3. The type of stressful events experienced included major change in health or behaviour of a family member (n=7), Christmas (n=7), family issues (e.g. son or daughter leaving home, more arguments with the partner, etc.) (n=5), gaining a new family member (n=4), moving home (n=3), taking on a significant mortgage (n=3), death of a close family member (n=2) or a close friend (n=2), personal injury or illness (n=2), marriage (n=2), change in employment situation (n=2) and pregnancy (n=1).

Participants who had experienced these kinds of life events scored significantly higher in A3 than they had scored prior to experiencing these events (GHQ-30 mean scores 3.67 v. 12.67 and BDI-II mean scores 10.22 v. 19). They also suffered significantly higher levels of psychological health problems, depression, and PTSD severity than those (n=7) who had not experienced stressful life events during this period (independent-samples t-test) (GHQ-30 mean scores 11.62 v. 0; BDI-II mean scores 17.69 v. 2.14; PDS mean scores 24.38 v. 2.29). For those who had not experienced stressful life events between A1 and A3 scores reduced significantly (GHQ-30 mean scores 14.14 v. 0, BDI-II mean scores 22.71 v. 2.14 and PDS mean scores 26.86 v. 2.29) (paired-samples t-tests).

Eight participants had experienced one or more stressful life events in the past 3-4 month prior to A4. The type of stressful events were family issues (n=4), major change in health or behaviour of a family member (n=4), gaining a new family

member (n=3), stressful political news (n=2); death of a close friend (n=1), taking on a significant mortgage (n=1) and moving home (n=1). These participants scored significantly higher on the BDI-II (20.88 v. 2.4) and the PDS (21.38 v. 8.4) than those who had not experienced stressful life events (n=5) during this period.

In conclusion, it can be said that while trauma related, individual, social, and cultural variables made little difference in general psychological health, depression, and PTSD severity, the experience of additional stressful social life events increased the likelihood of poorer general psychological health and higher levels of depression and PTSD symptom severity.

Therefore, improvements in scores across assessments were more likely to be a function of services or interventions than exogenous events, especially for those participants who experienced additional life stresses.

6.4. EFFECTIVENESS OF SERVICES

COMMUNITY-BASED SERVICES

Community- based services included befriending, self-help/support groups, respite care, youth work, and narrative work (see 4.2). Comments in the interviews reflected the importance of community-based services:

> "it's more like a group of friends, where everybody is welcomed to come in. Anybody that wants to come in, can come in. They are made welcome. Erm… what way can I put it? (pause) If it closed down tomorrow, I'd be devastated. (laughs) Because of the closeness really that we all have. And we can say anything to each other and nobody takes offence." (Interviewee A)

> "Because I'm in and I know people…, like there's women… like you can sit down and talk to them, maybe somebody is in the same position and even if you don't talk about that, you know, they know what your… You can just come in some days and say, 'Really bad day'. People know. I don't mean all goes back to…my daddy,…and people sort of go, 'Can I get you a cup of coffee?…You can rub all on together in here." (Interviewee K)

Figures 74-76 show GHQ-30, BDI-II, and PDS scores for 25 participants who had used community-based services in each of the 4 assessments. Each bar indicates actual test score for one participant. Grey squares indicate non-response, while coloured squares indicate non-use of service.

Figure 74: GHQ-30 mean scores for community-based service users
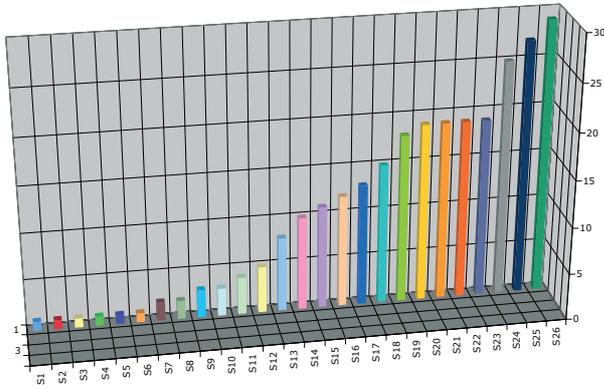
A1 (baseline assessment)
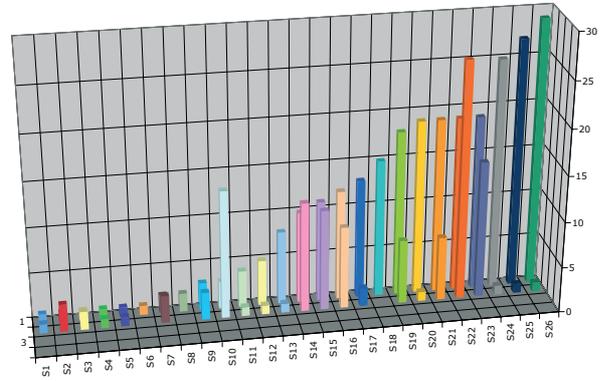
A1 and A2 (taken 3 months later)
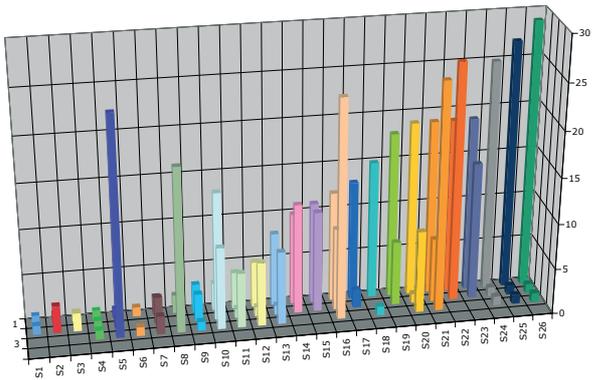
A1, A2 and A3 (3 months later)
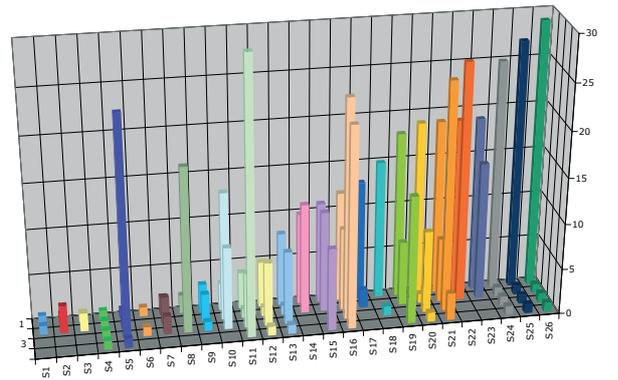
A1, A2, A3 and A4 (3 months later)

Figure 75: BDI-II scores for community-based service users
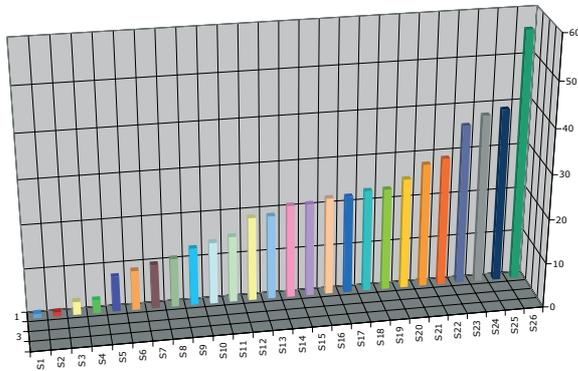
A1 (baseline assessment)
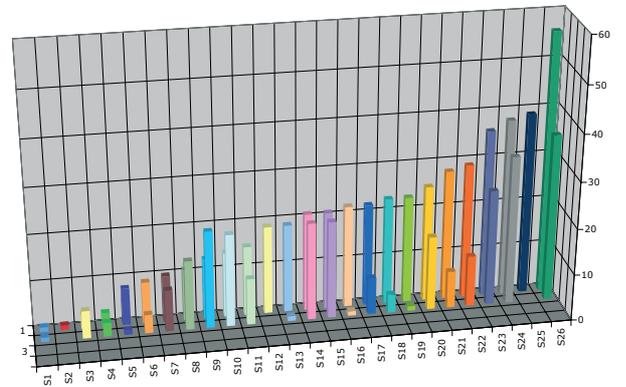
A1 and A2 (taken 3 months later)
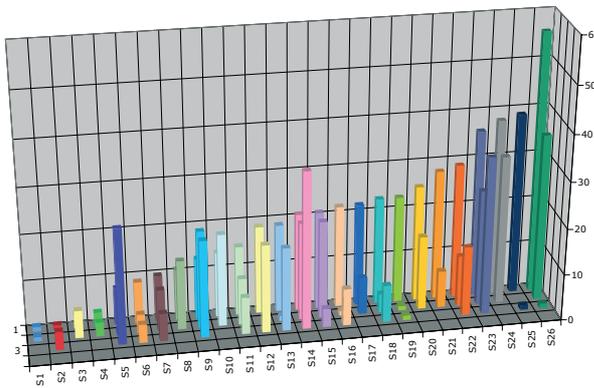
A1, A2 and A3 (3 months later)
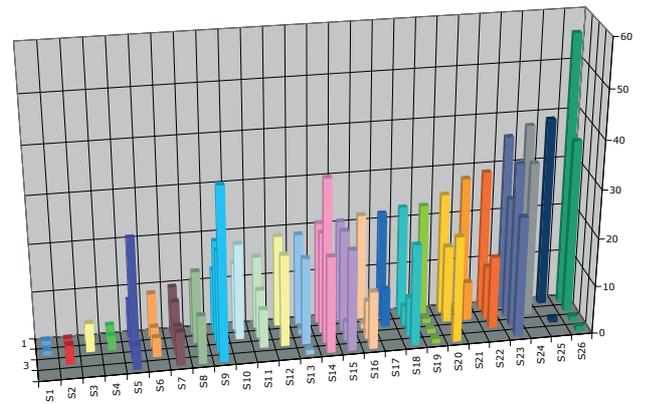
A1, A2, A3 and A4 (3 months later)

Figure 76: PDS scores for community-based service users
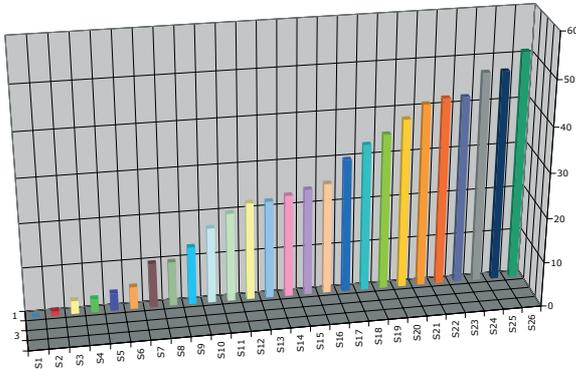
A1 (baseline assessment)
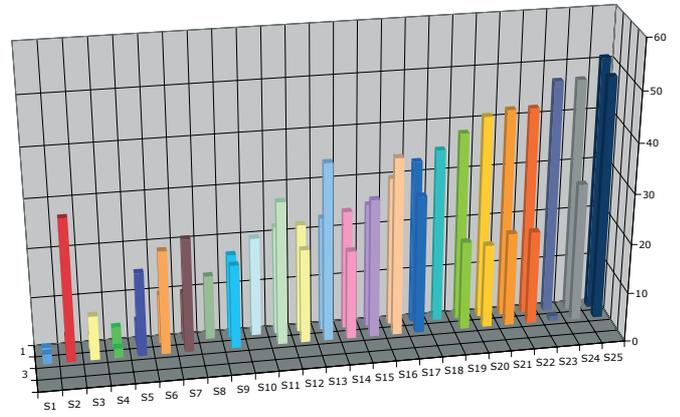
A1 and A2 (taken 3 months later)
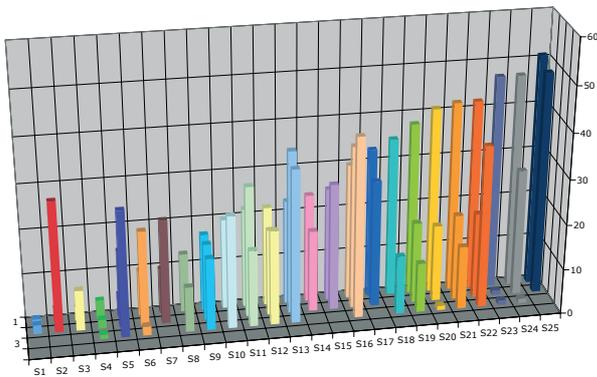
A1, A2 and A3 (3 months later)
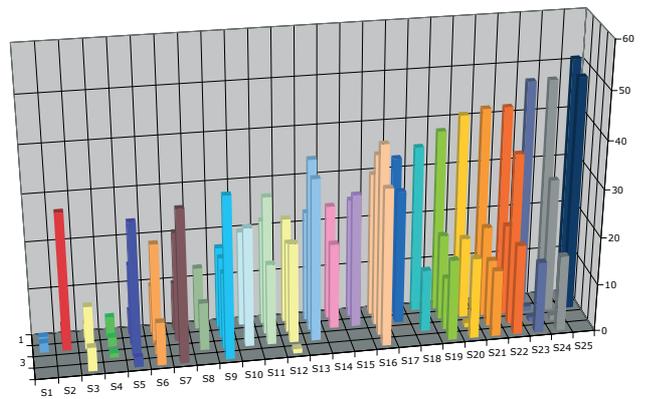
A1, A2, A3 and A4 (3 months later)

Befriending

Befriending was one of the most popular services of participants in this study. Fifty-five percent (n=41) of all participants had used befriending before Assessment 1 (A1). Sixty percent (n=17) of the 25 individuals who participated in Assessment 2 (A2) had used befriending in the past 3-4 months. Sixty percent (n=12) of the 20 participants who took part in Assessment 3 (A3) had used befriending since their last assessment, and 70% (n=10) of the 13 individuals who took part in Assessment 4 (A4) had availed of befriending since their last assessment.

Figures 77, 78, and 79 show GHQ-30, BDI-II, and PDS mean scores for participants who used befriending during the 3 months prior to each assessment and for those who did not use this service. There were no statistically significant results, except for statistically significant improvements with regard to PTSD symptom severity at A3 for befriending users (paired-samples t-test) (Figure 79). N equals the number of those who availed of that particular service at that particular assessment.

Four bars at each assessment point represent data as follows:

1. First bar: A1 mean scores for those who used the service;

2. Second bar: A2 (A3 or A4) mean score for those who used the service;

3. Third bar: A1 mean score for those who did not used the service; and

4. Fourth bar: A2 (A3 or A4) mean score for those who did not used the service.

Figure 77: GHQ-30 mean scores for befriending users (4 assessments)
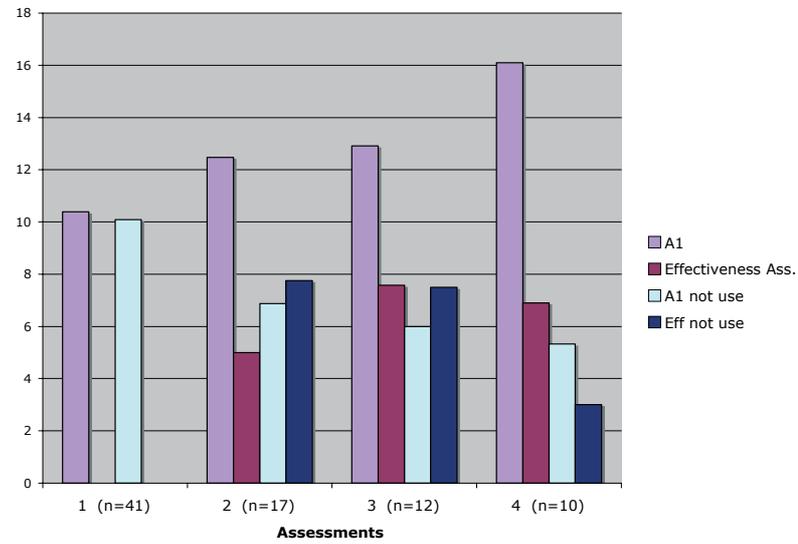
**Figure 78: BDI-II mean scores for befriending users (4 assessments)**
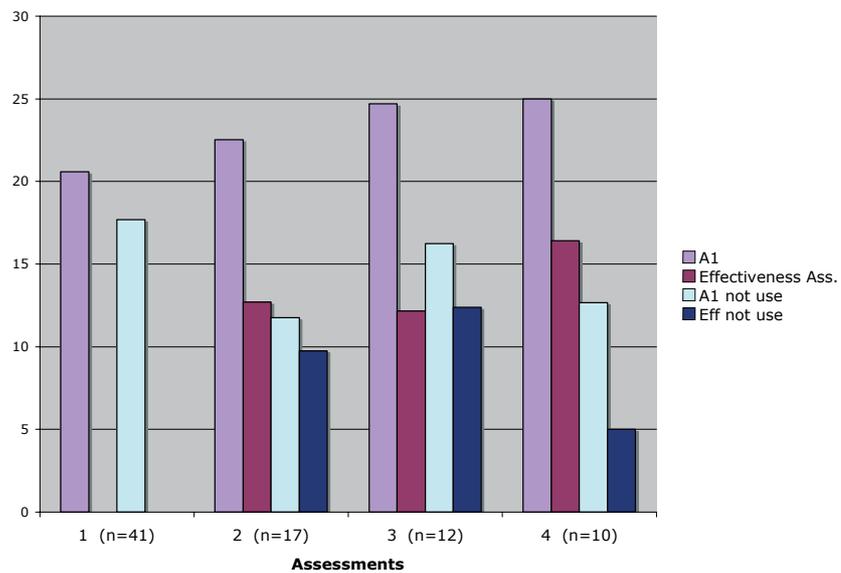
Figure 79: PDS mean scores for befriending users (4 assessments)
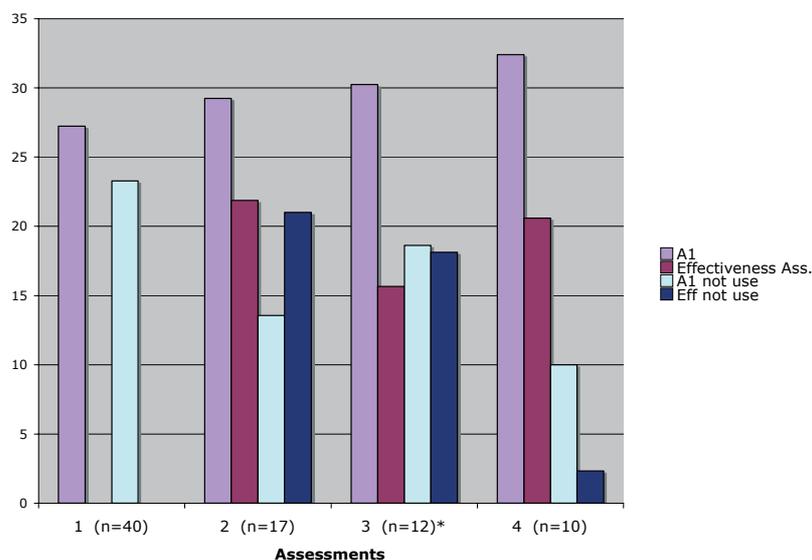
* statistically significant differences between A1 and A3 scores for services users

Figures 80-82 show GHQ-30, BDI-II, and PDS scores for participants who had used befriending services in each of the 4 assessments. Each bar indicates actual test score for one participant. Grey squares indicate non-response, while coloured squares indicate non-use of service.

Figure 80: GHQ-30 scores for individual befriending users
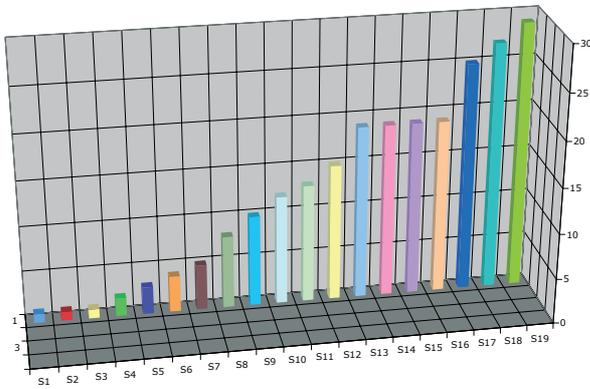
A1 (baseline assessment)
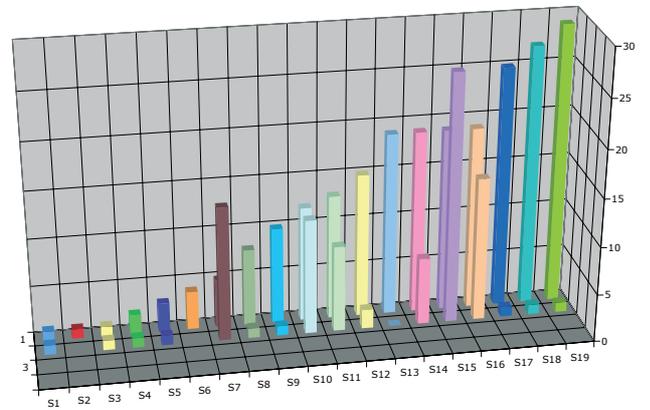
A1 and A2 (taken 3 months later)
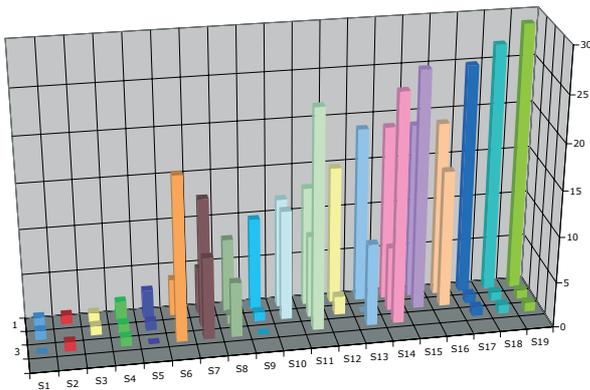
A1, A2 and A3 (taken 3 months later)
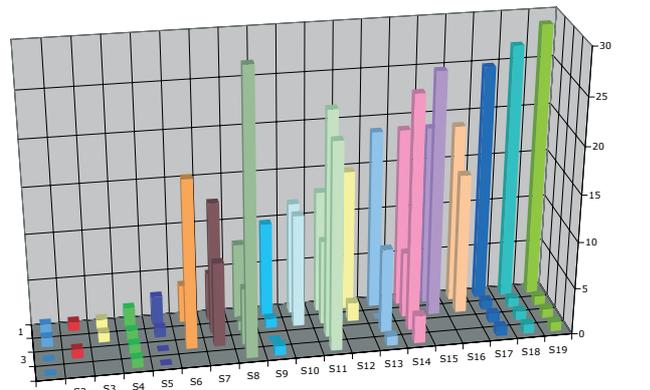
A1, A2, A3, and A4 (taken 3 months later)

**Figure 81: BDI-II scores for individual befriending users**
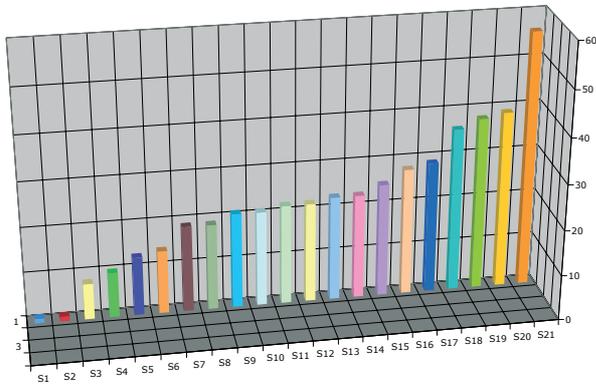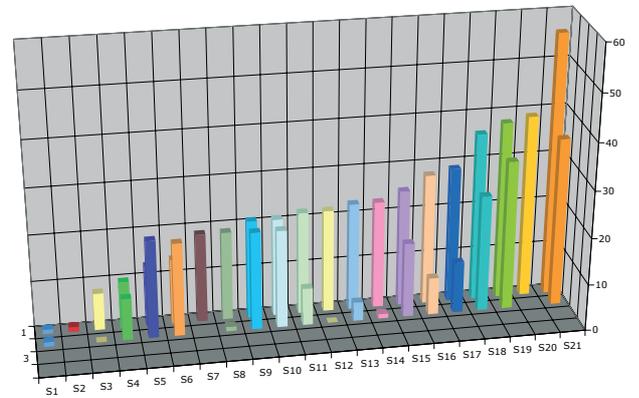
A1 (baseline assessment)


A1 and A2 (taken 3 months later)
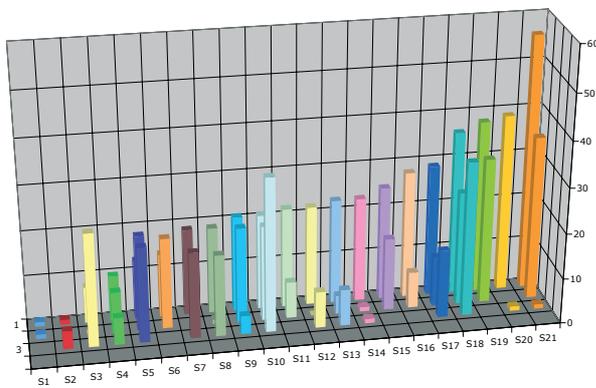
A1, A2 and A3 (taken 3 months later)
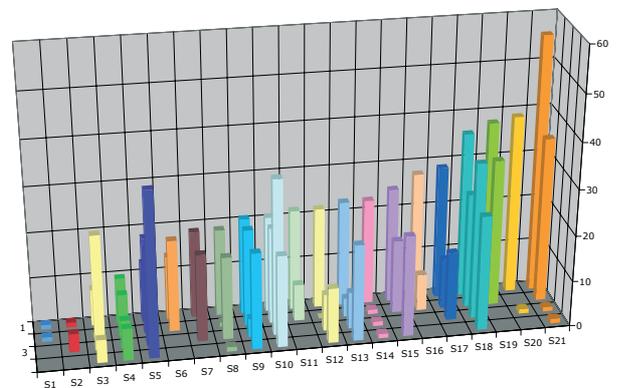
A1, A2, A3 and A4 (3 months later)

Figure 82: PDS scores for individual befriending users
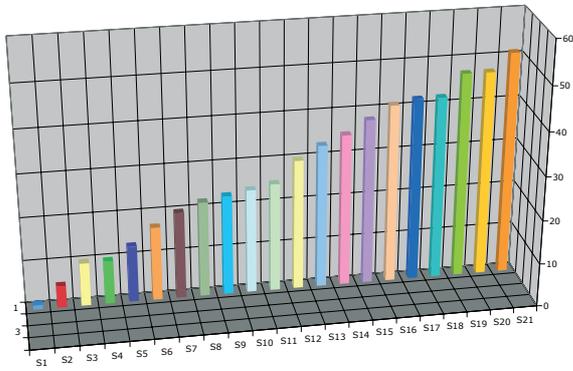
A1 (baseline assessment)
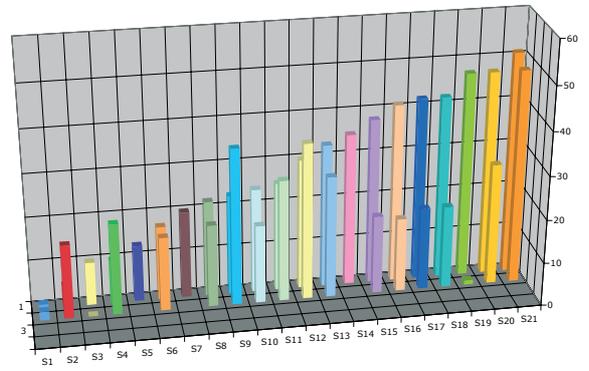
A1 and A2 (taken 3 months later)
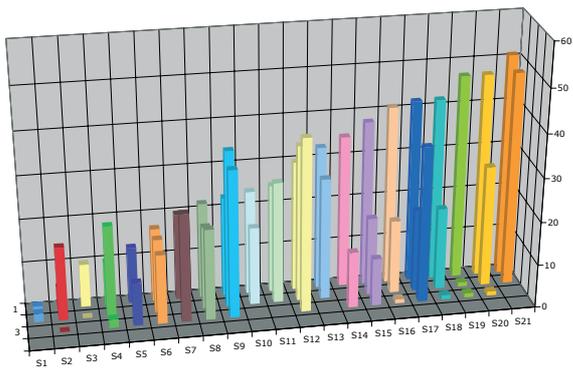
A1, A2 and A3 (3 months later)
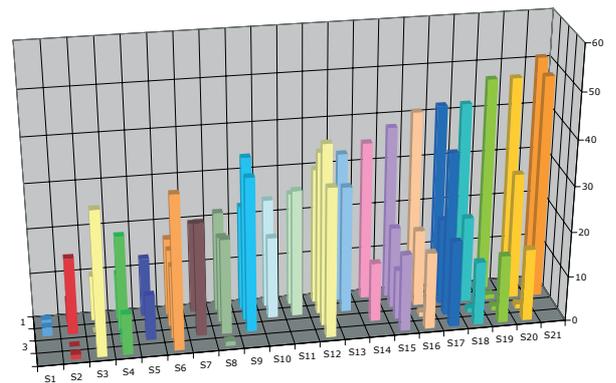
A1, A2, A3 and A4 (3 months later)

Support/Self-Help Groups

Support and self-help groups were a very popular service. At baseline (A1), 69% of participants (n=52) availed of self-help groups, this figure remained similar at A2 when 76% of participants (n=19) took part in self-help groups, at A3 when 35% of respondents (n=7) used self-help groups, and increased at A4 when 100% of participants (n=13) availed of this service.

Figures 83-85 show GHQ-30, BDI-II, and PDS mean scores for participants who used self-help and support groups during the 3 months prior to each assessment and for those who did not use this service. There were statistically significant improvements with regard to general psychological health and depression between A1 and A2 for those who availed of self-help groups (paired-samples t-test) (Figure 83). Four bars at each assessment point represent data as previously in Figure 77.

**Figure 83: GHQ-30 mean scores for support group users (4 assessments)**
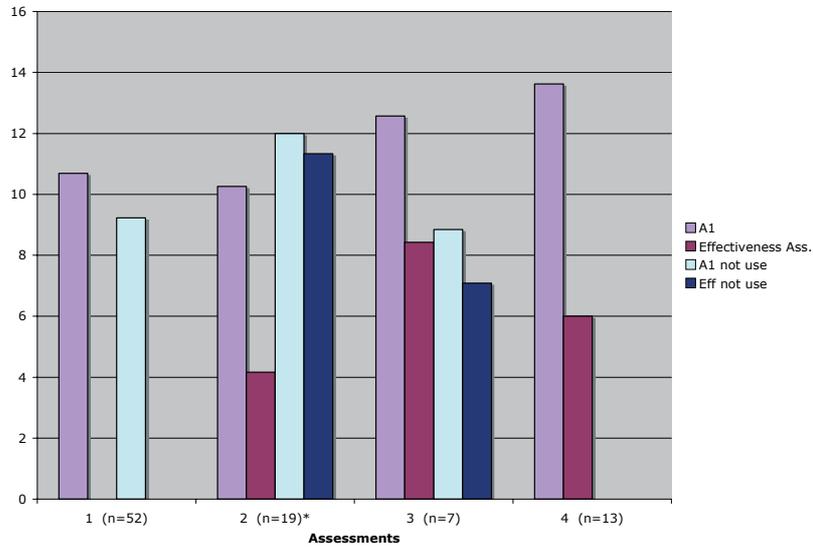
* significant differences between A1 and A2 for those who had availed of self-help groups.

Figure 84: BDI-II mean scores for support group users (4 assessments)
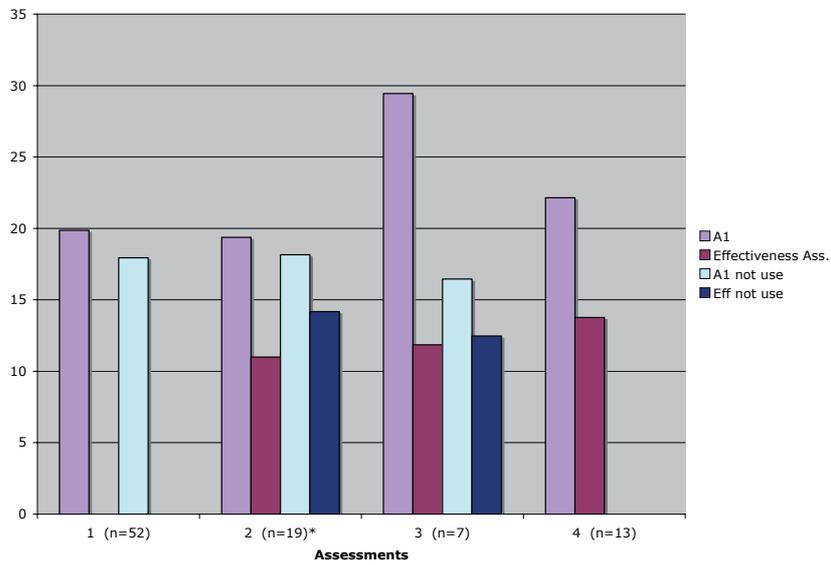
* significant differences between A1 and A2 for those who had availed of service.

Figure 85: PDS mean scores for support group users (4 assessments)
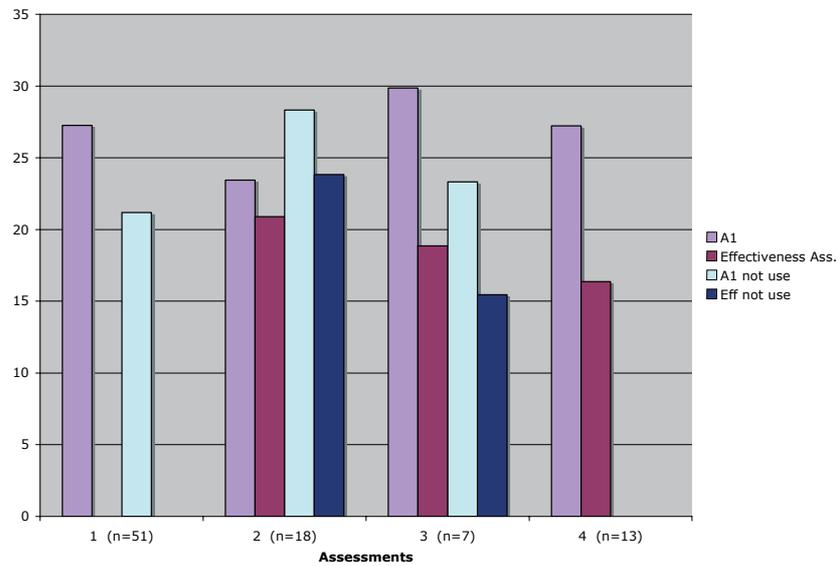
For a visual analysis, Figures 86-88 show GHQ-30, BDI-II, and PDS scores for participants who used self-help and support group services in each of the 4 assessments. Each bar indicates actual test score for one participant. Grey squares indicate non-response, while coloured squares indicate non-use of service.

Figure 86: GHQ-30 scores for individual support group users
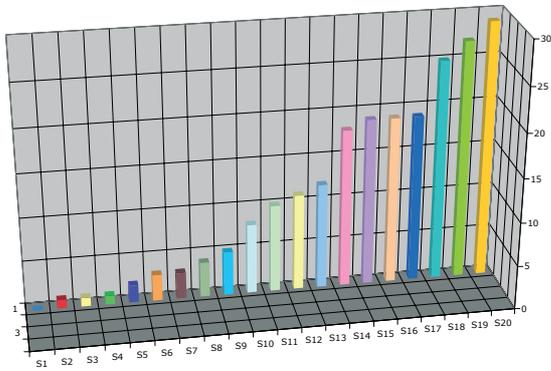
A1 (baseline assessment)
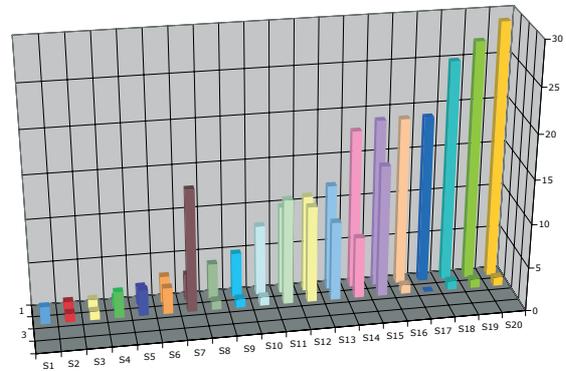
A1 and A2 (taken 3 months later)
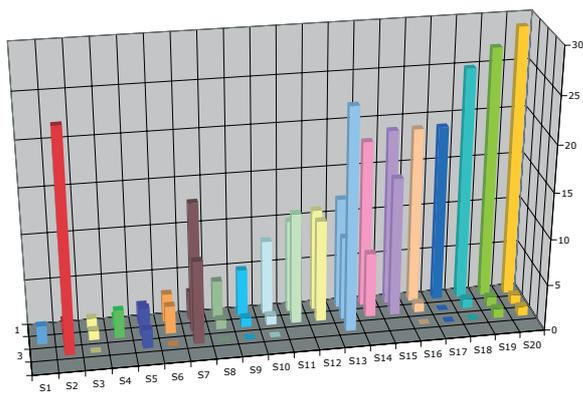
A1, A2 and A3 (3 months later)
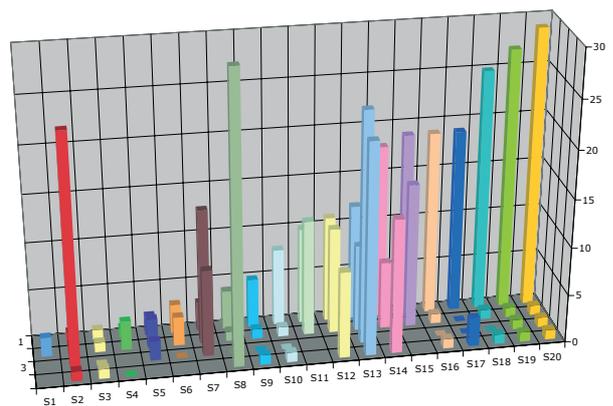
A1, A2, A3 and A4 (3 months later)

Figure 87: BDI-II scores for individual support group users
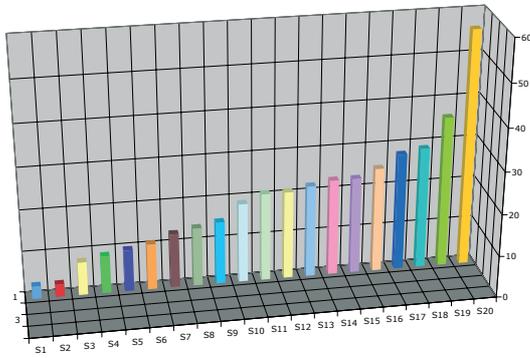
A1 (baseline assessment)
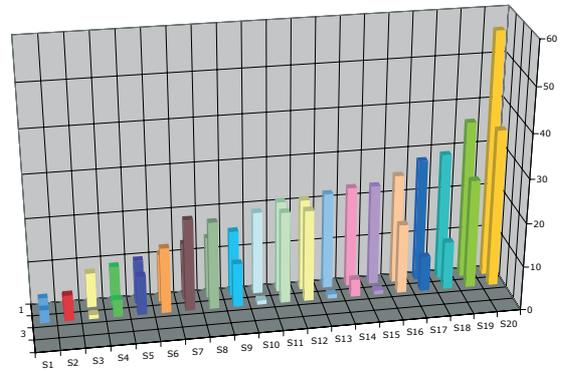
A1 and A2 (taken 3 months later)
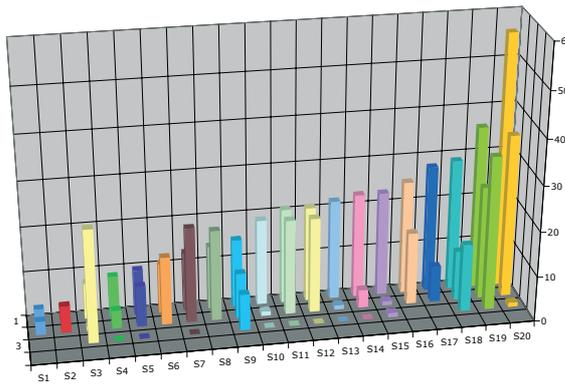
A1, A2 and A3 (3 months later)
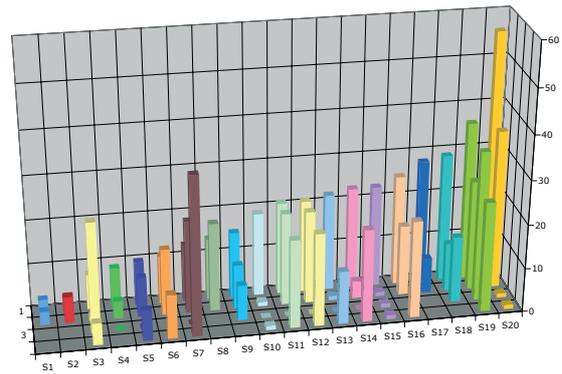
A1, A2, A3 and A4 (3 months later)

Figure 88: PDS scores for individual support group users
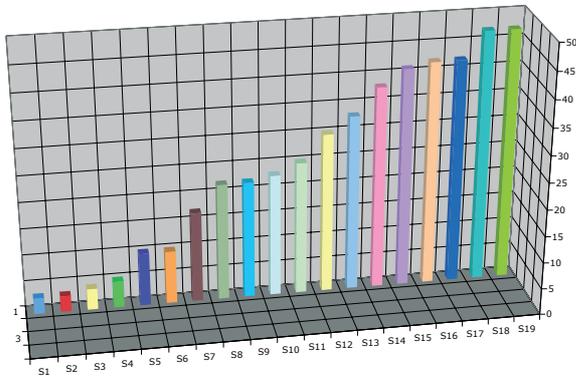
A1 (baseline assessment)
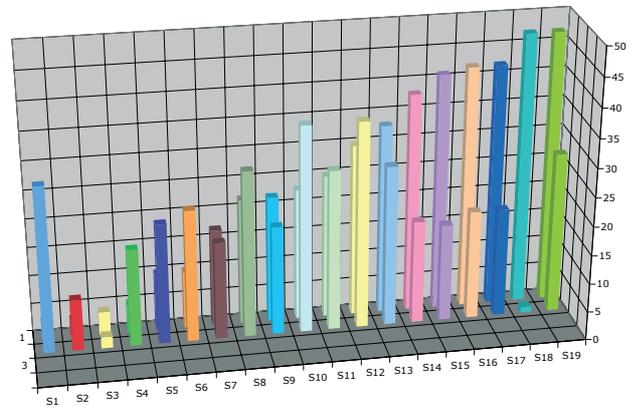
A1 and A2 (taken 3 months later)
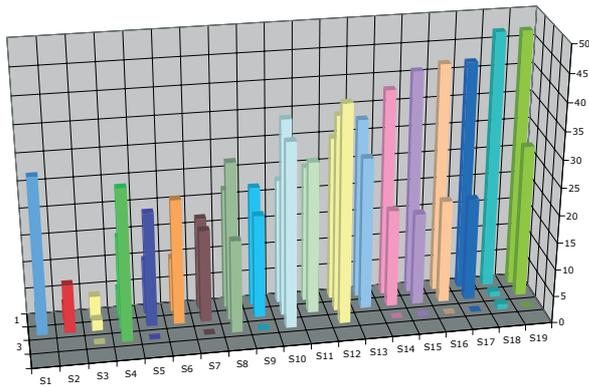
A1, A2 and A3 (3 months later)
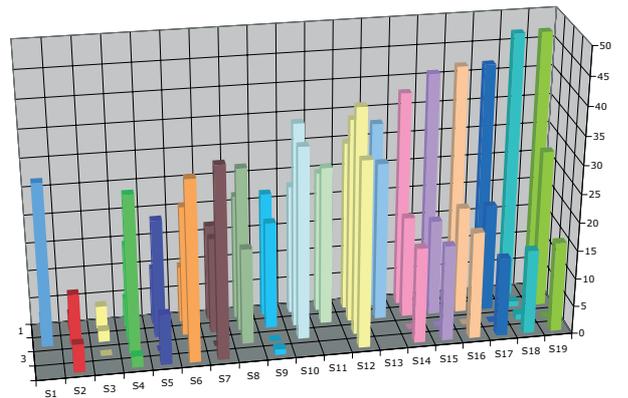
A1, A2, A3 and A4 (3 months later)

Respite care / time out

Respite care and time-out were used by 27% of participants (n=20) at baseline, 16% of respondents (n=4) availed of these services at A2, only 2 participants availed of respite care/time out at A3, while 38% of respondents (n=5) availed of this service in A4.

Figures 89-91 show GHQ-30, BDI-II, and PDS mean scores for participants who used respite care/time out during the 3-4 months prior to each assessment and for those who did not use this service. There were statistically significant improvements with regard to general psychological health and depression between A1 and A2 for those who did not avail of respite care/time out (paired-samples t-test). Four bars at each assessment point represent data as previously in Figure 77.

Figure 89: GHQ-30 mean scores for respite care users (4 assessments)
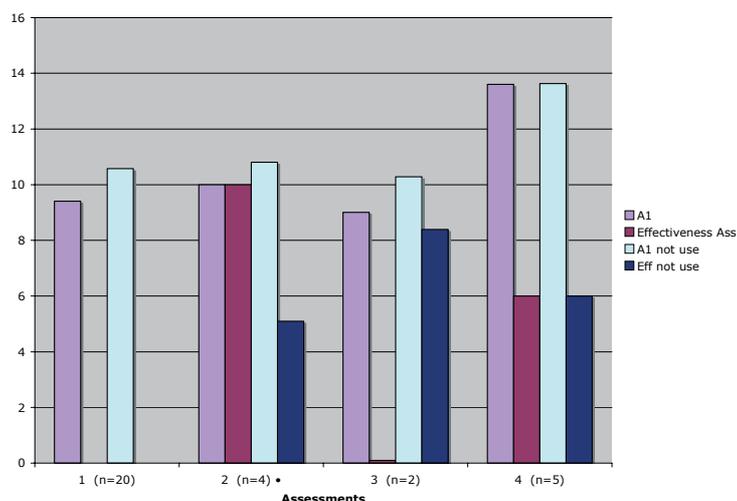
• significant differences between A1 and A2 for those who had not availed of service.

Figure 90: BDI-II mean scores for respite care users (4 assessments)
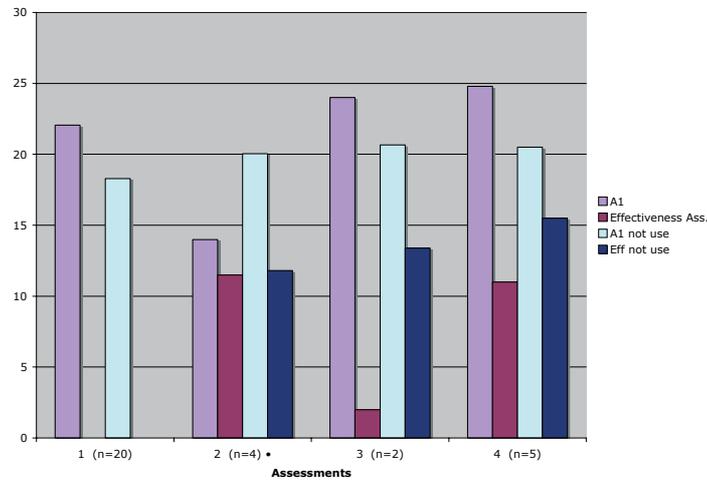
• significant differences between A1 and A2 for those who had not availed of service.

Figure 91: PDS mean scores for respite care users (4 assessments)
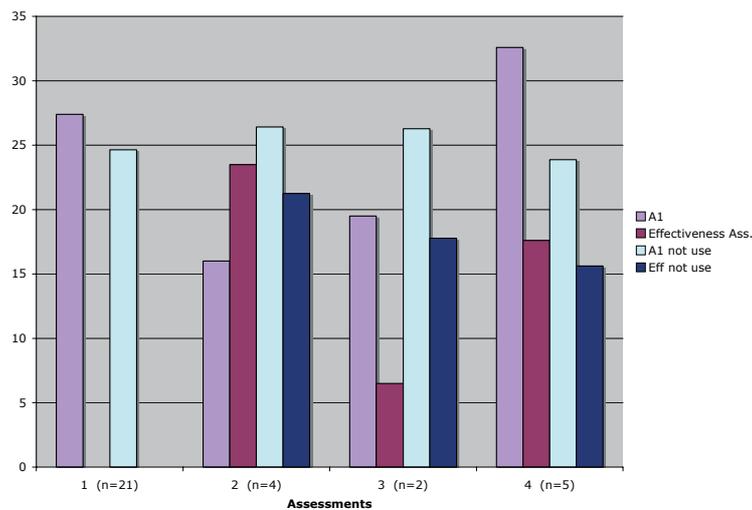
Figures 92-94 show GHQ-30, BDI-II, and PDS scores for participants who used respite care/time out in each of the 4 assessments. Each bar indicates actual test score for one participant. Grey squares indicate non-response, while coloured squares indicate non-use of service.

Figure 92: GHQ-30 scores for individual respite care users
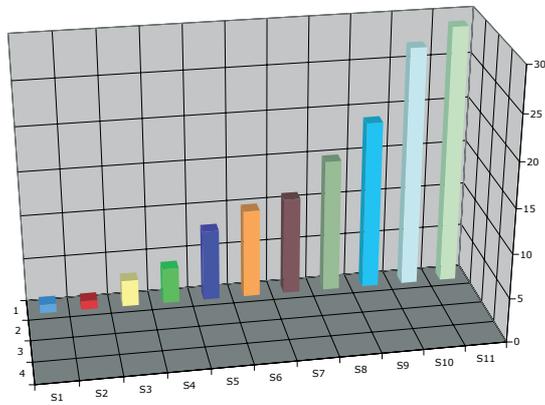
A1 (baseline assessment)
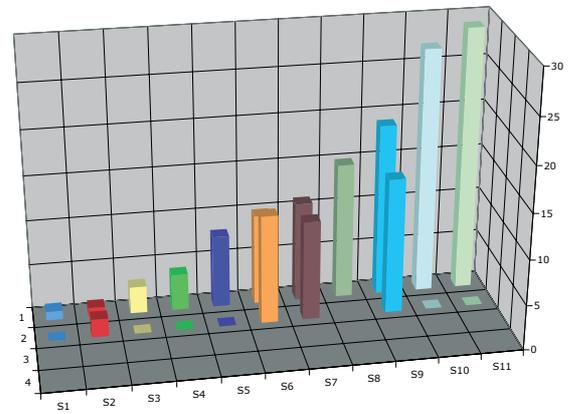
A1 and A2 (taken 3 months later)
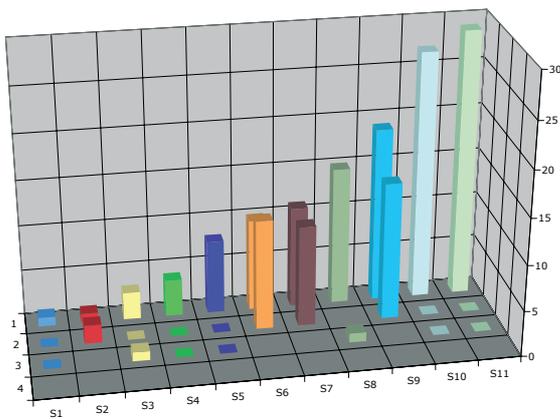
A1, A2 and A3 (3 months later)
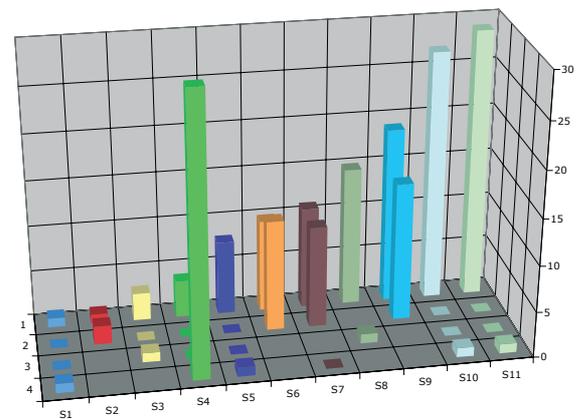
A1, A2, A3 and A4 (3 months later)

Figure 93: BDI-II scores for individual respite care users
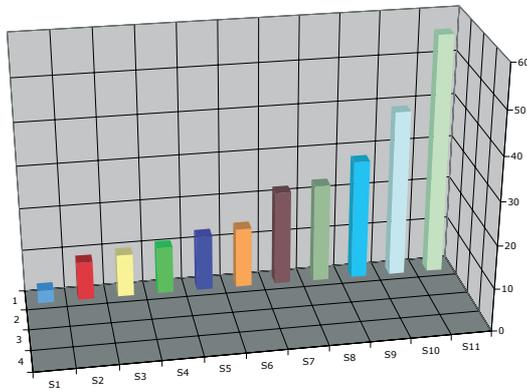
A1 (baseline assessment)
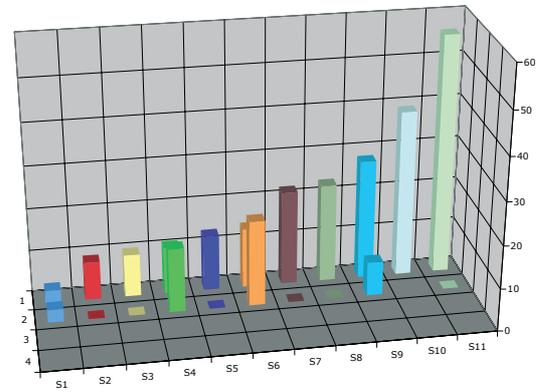
A1 and A2 (taken 3 months later)
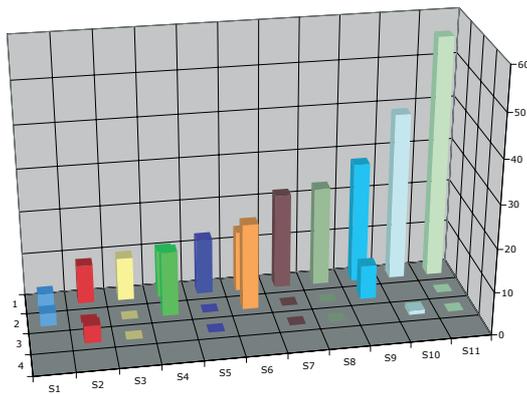
A1, A2 and A3 (3 months later)
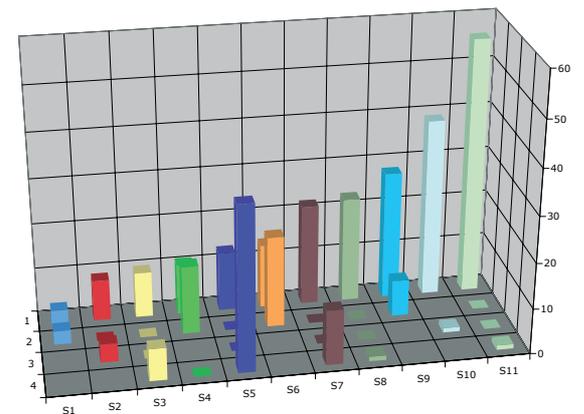
A1, A2, A3 and A4 (3 months later)

Figure 94: PDS scores for individual respite care users
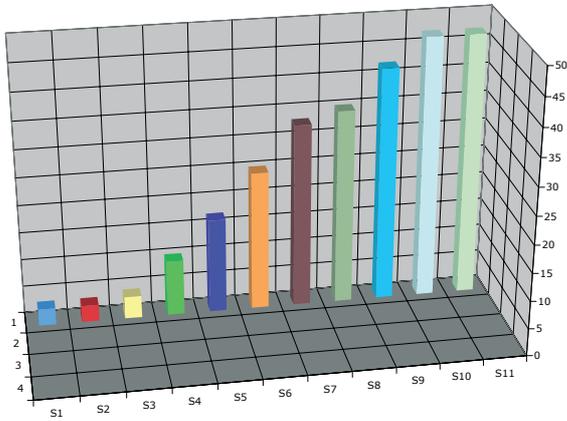
A1 (baseline assessment)
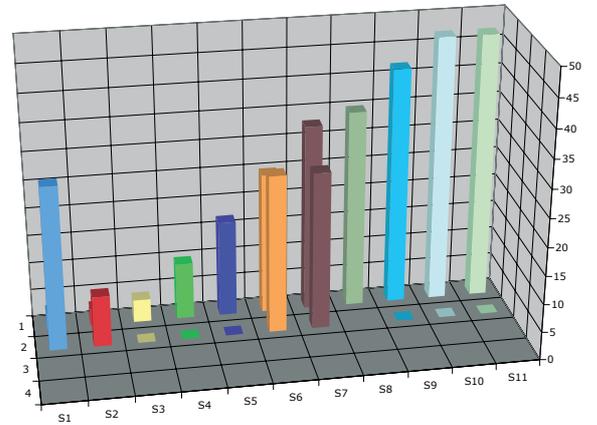
A1 and A2 (taken 3 months later)
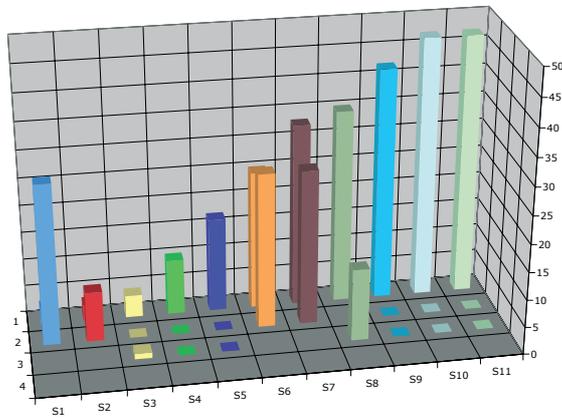
A1, A2 and A3 (3 months later)
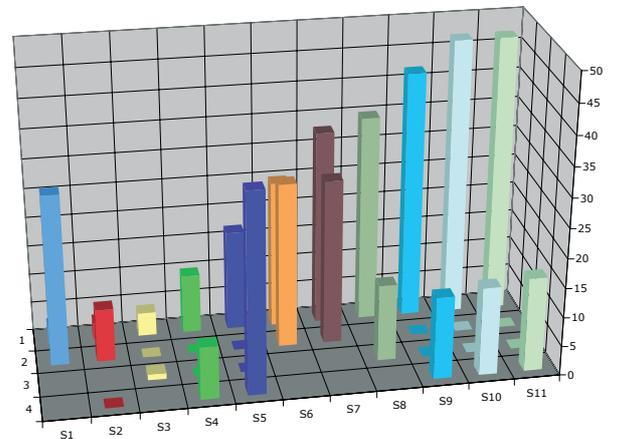
A1, A2, A3 and A4 (3 months later)

Youth work

Thirty-one percent the participants (n=23) had taken part in youth work prior to A1, in A2, 28% of the participants (n=7) used that service, while in A3, 30% of participants (n=6) availed of it, and in A4 only 4 participants were involved with it.

Figures 95-97 show GHQ-30, BDI-II, and PDS mean scores for participants who took part in youth work during the 3 months prior to each assessment and for those who did not take part. Four bars at each assessment point represent data as previously in Figure 77.

Figure 95: GHQ-30 mean scores for youth work (4 assessments)
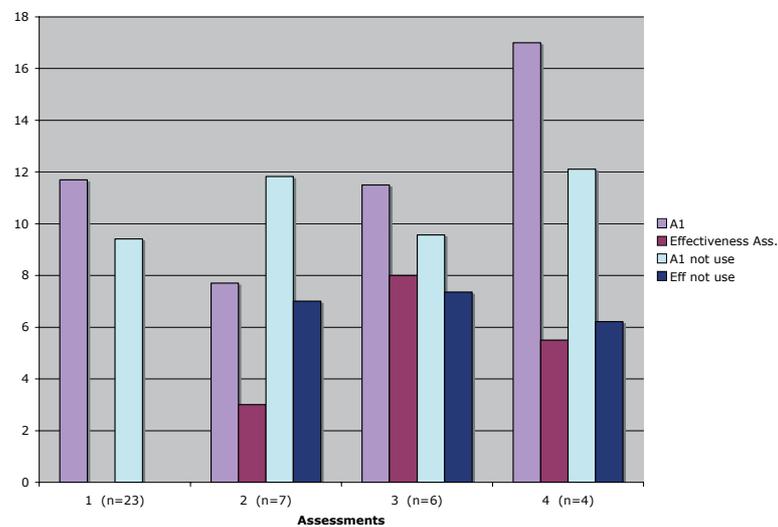
There were statistically significant improvements regarding general depression between A1 and A2, and between A1 and A3 for those who took part in youth work. However, there also were statistically significant improvements with regard to general

depression between A1 and A2 for those who did not take part in youth work (paired-

samples t-test).

Figure 96: BDI-II mean scores for youth work (4 assessments)
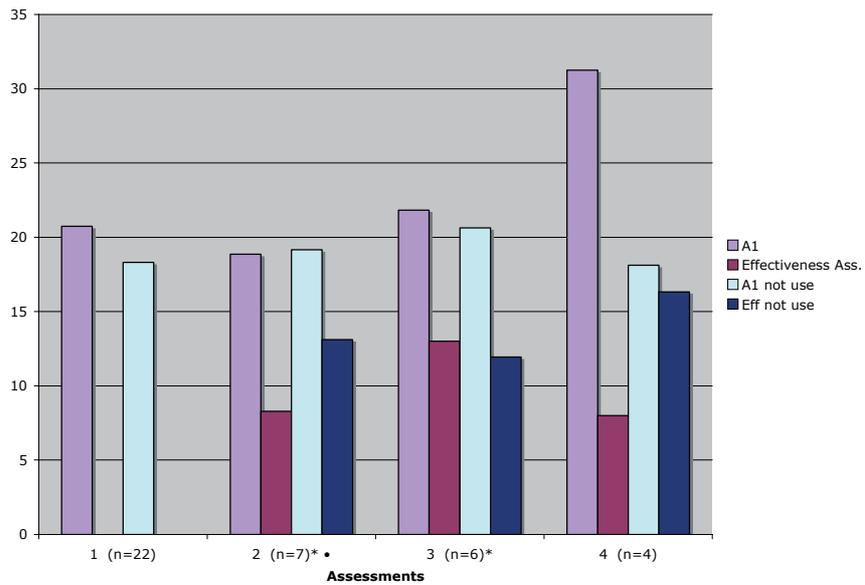
* significant differences between A1 and A2 and A3 for those who had taken part in service.
• significant differences between A1 and A2 for those who had not taken part in service.

**Figure 97: PDS mean scores for youth work users (4 assessments)**
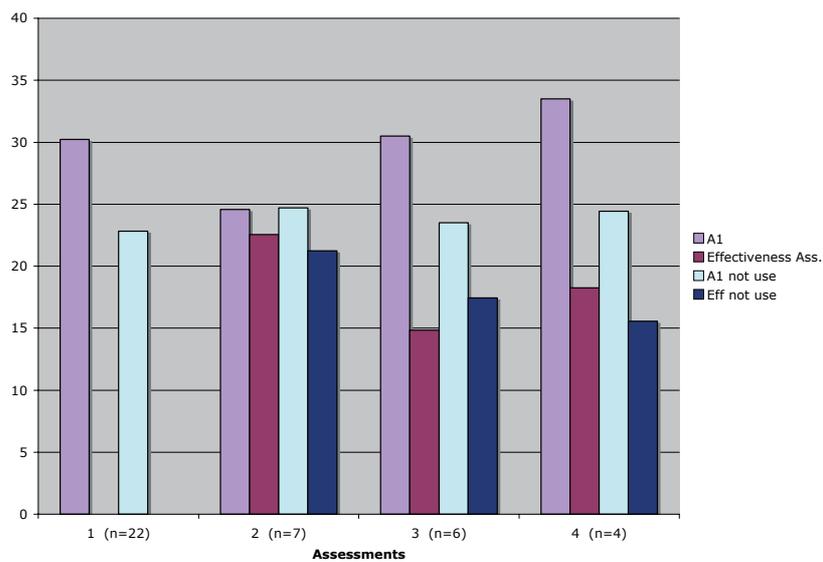
Figures 98-100 show GHQ-30, BDI-II, and PDS scores for participants who took part in youth work in each of the 4 assessments. Each bar indicates actual test score for one participant. Grey squares indicate non-response, while coloured squares indicate non-use of service.

Figure 98: GHQ-30 scores for individual youth work
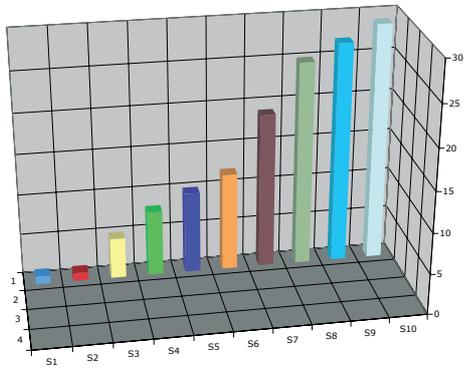
A1 (baseline assessment)
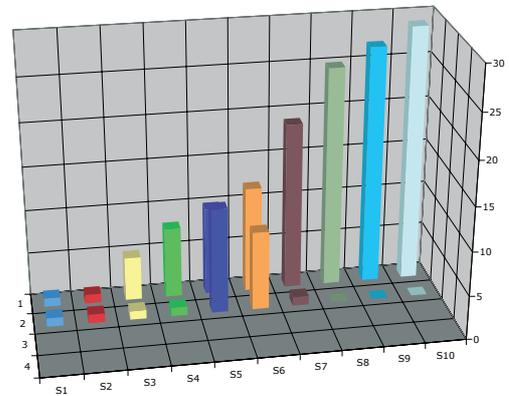
A1 and A2 (taken 3 months later)
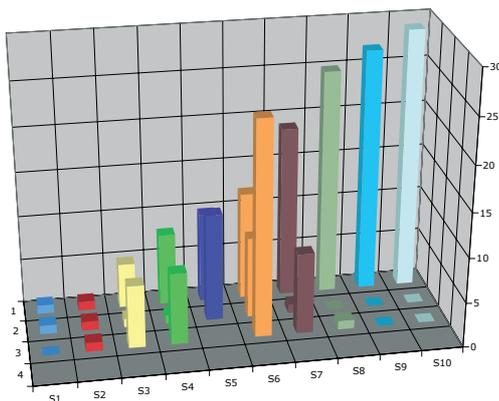
A1, A2 and A3 (3 months later)
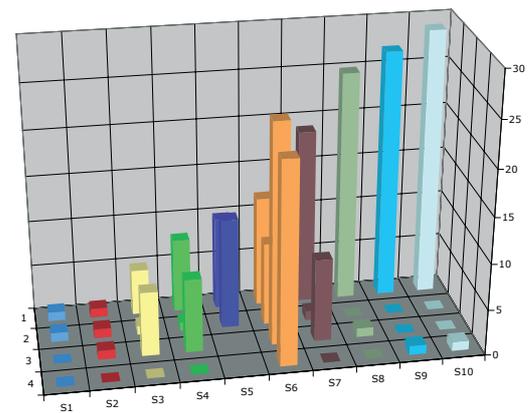
A1, A2, A3 and A4 (3 months later)

Figure 99: BDI-II scores for individual youth work
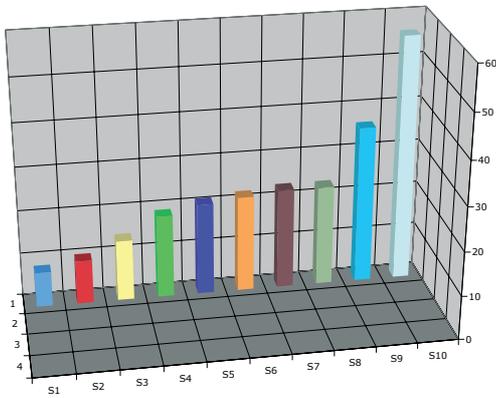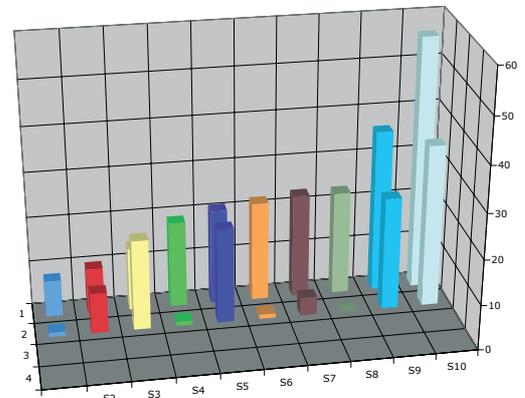
A1 (baseline assessment)

A1 and A2 (taken 3 months later)
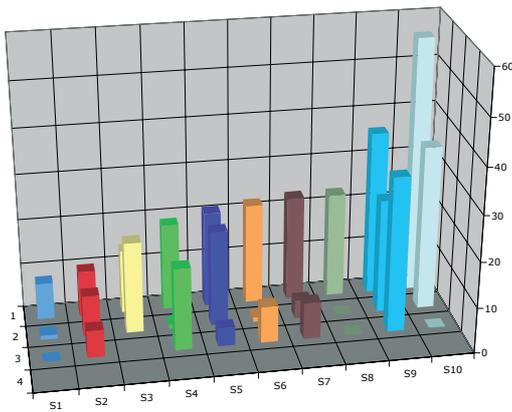
A1, A2 and A3 (3 months later)
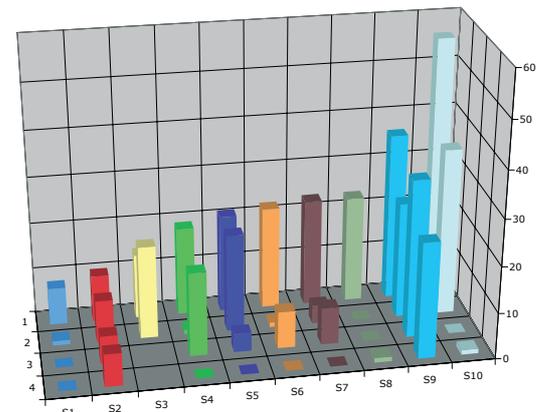
A1, A2, A3 and A4 (3 months later)

Figure 100: PDS scores for individual youth work
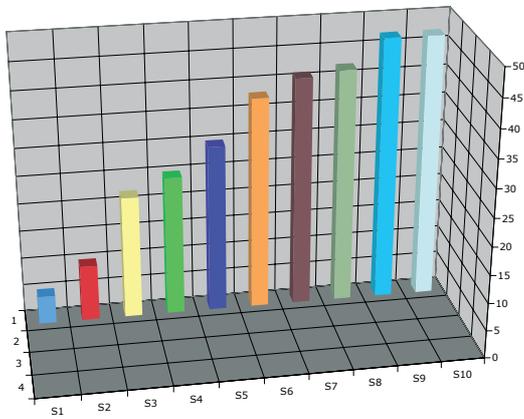
A1 (baseline assessment)
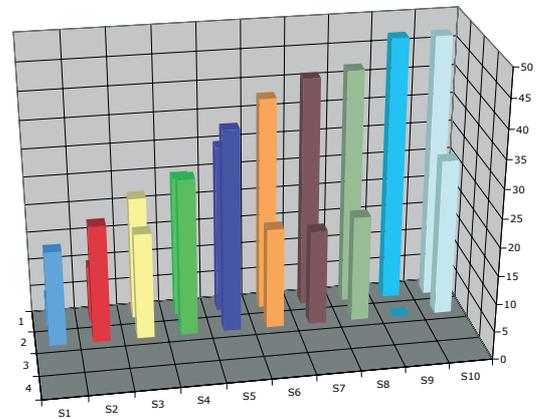
A1 and A2 (taken 3 months later)
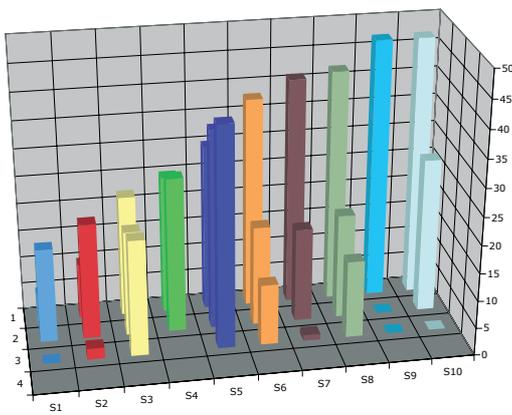
A1, A2 and A3 (3 months later)
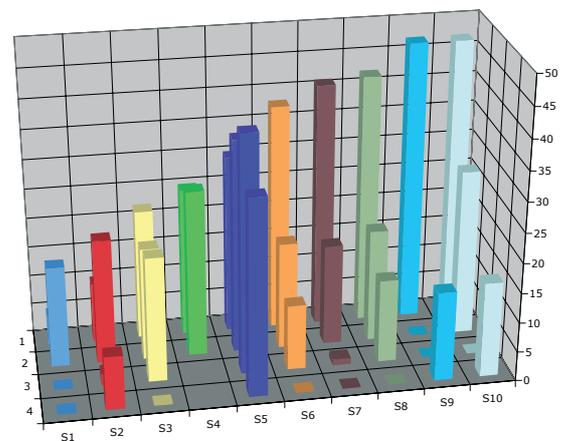
A1, A2, A3 and A4 (3 months later)

Narrative work

At baseline assessment, 32% of the participants (n=24) availed of narrative work. In A2, 48% of the participants (n=12) used this service, while at A3, none of the participants availed of narrative work, and at A4, 3 respondents used it.

Figures 101-103 show GHQ-30, BDI-II, and PDS mean scores for participants who used narrative work during the 3 months prior to each assessment and for those who did not use this service. There were statistically significant improvements with regard to general psychological health between A1 and A2 for those who availed of narrative work (paired-samples t-test), however, there also were significant improvements between A1 and A4 for those who did not used narrative work. Four bars at each assessment point represent data as previously in Figure 77.

Figure 101: GHQ-30 mean scores for narrative work users (4 assessments)
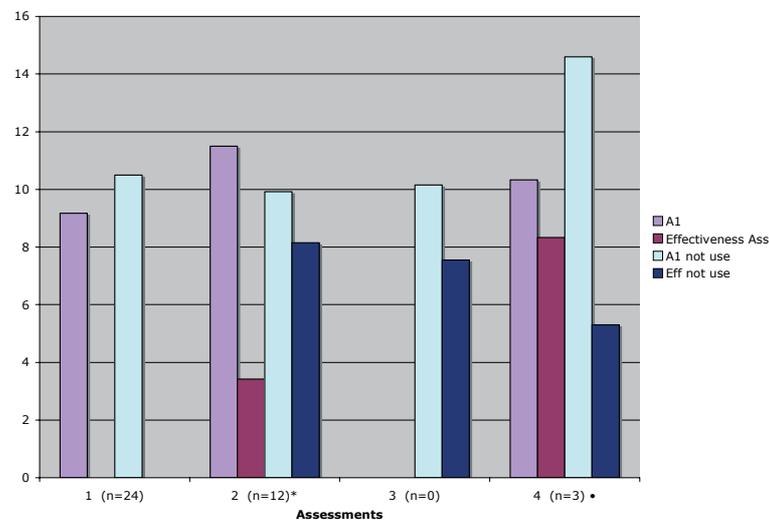
* significant differences between A1 and A2 for those who had availed of service.
• significant differences between A1 and A3 for those who had not availed of service.

Figure 102: BDI-II mean scores for narrative work users (4 assessments)
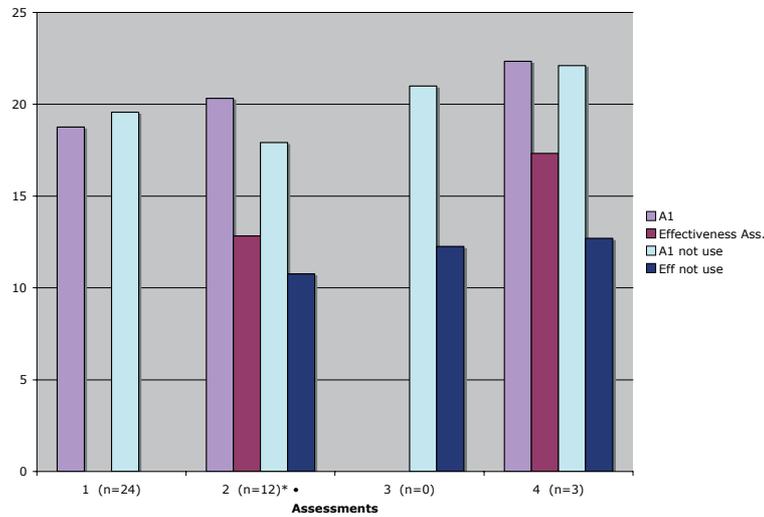
* significant differences between A1 and A2 for those who had availed of service.
• significant differences between A1 and A2 for those who had not availed of service.

There were statistically significant improvements with regard to depression between A1 and A2 for both those who availed of narrative work and those who did not use narrative work (paired-samples t-test).

Figure 103: PDS mean scores for narrative work users (4 assessments)
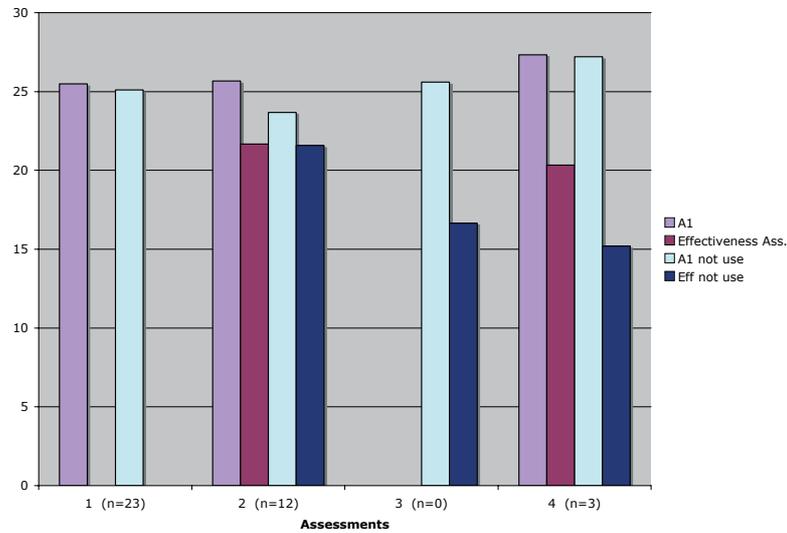
Figures 104-106 show GHQ-30, BDI-II, and PDS scores for participants who used narrative work prior to each of the 4 assessments. Each bar indicates actual test score for one participant. Grey squares indicate non-response, while coloured squares indicate non-use of service.

Figure 104: GHQ scores for individual narrative work users
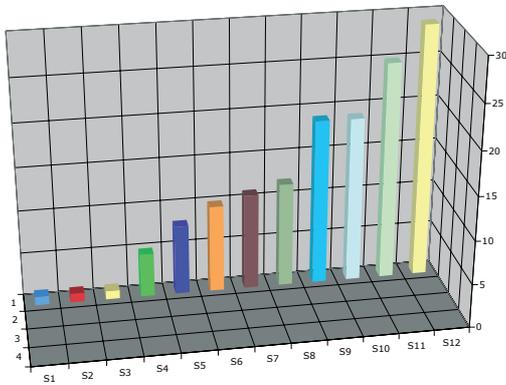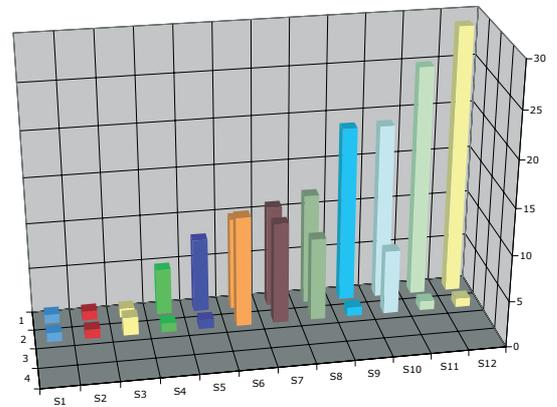
A1 (baseline assessment)

A1 and A2 (taken 3 months later)
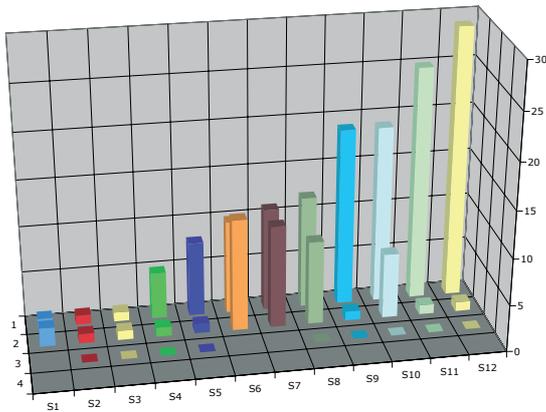
A1, A2 and A3 (3 months later)
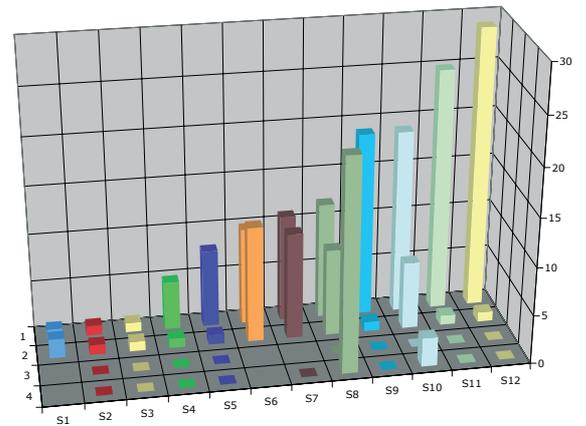
A1, A2, A3 and A4 (3 months later)

Figure 105: BDI-II scores for individual narrative work users
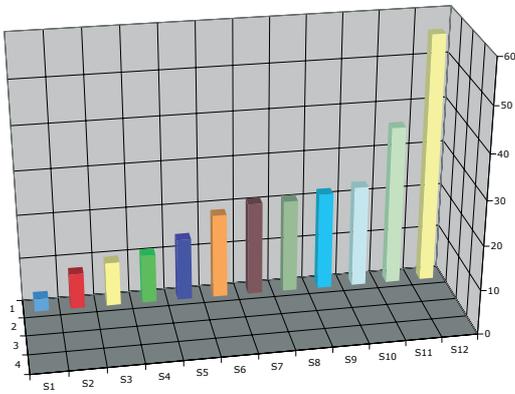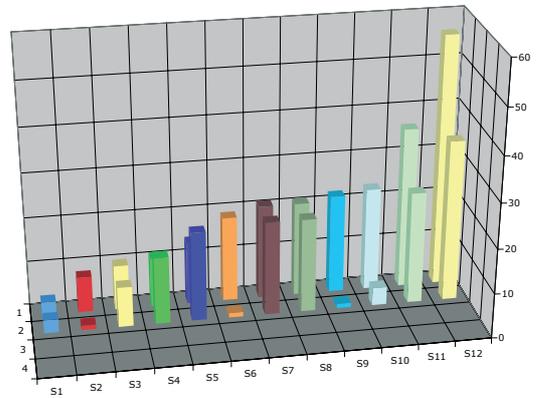
A1 (baseline assessment)

A1 and A2 (taken 3 months later)
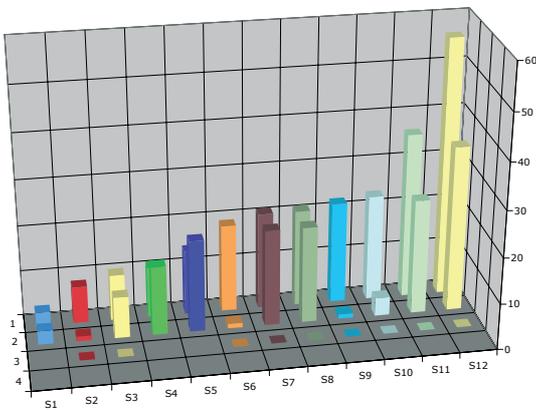
A1, A2 and A3 (3 months later)
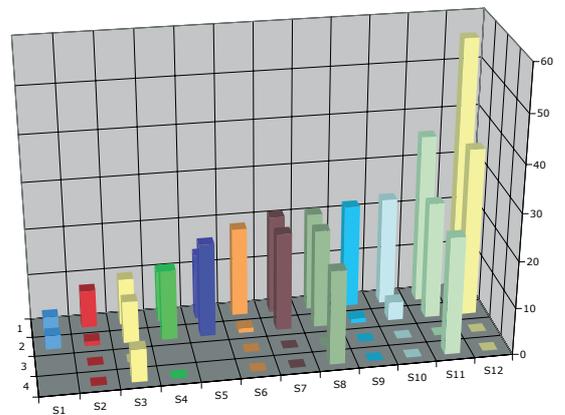
A1, A2, A3 and A4 (3 months later)

Figure 106: PDS scores for individual narrative work users
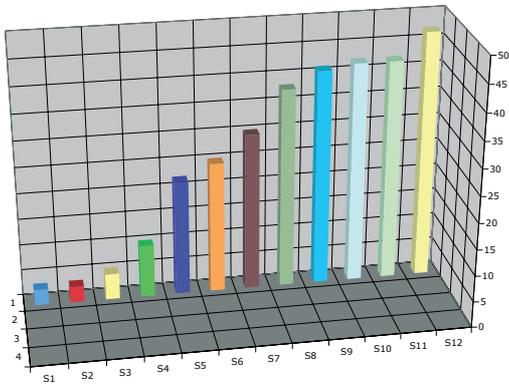
A1 (baseline assessment)
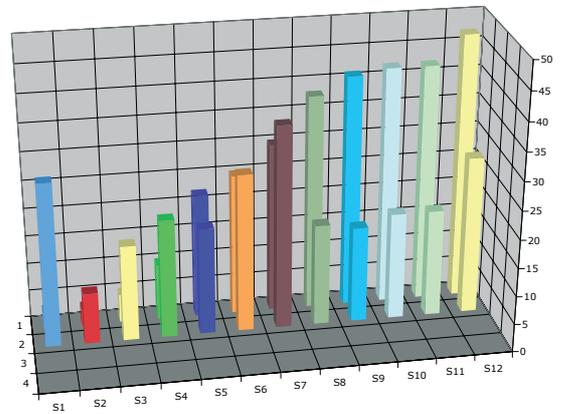
A1 and A2 (taken 3 months later)
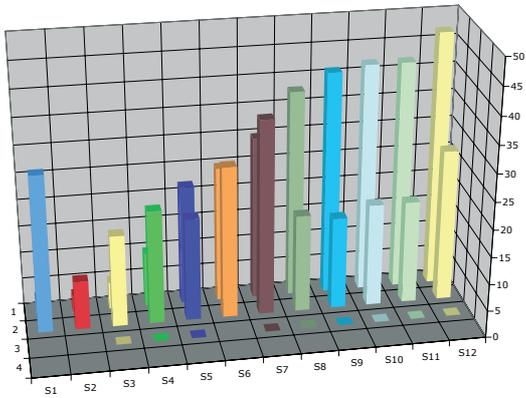
A1, A2 and A3 (3 months later)
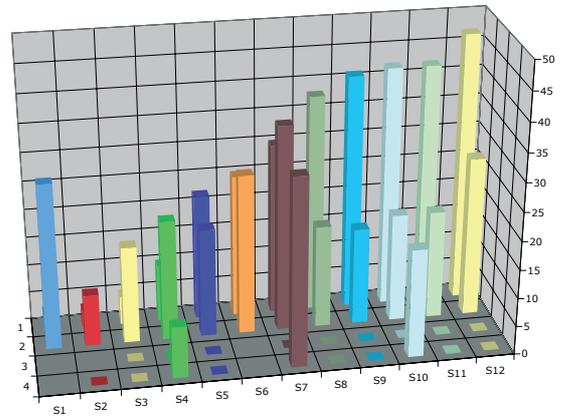
A1, A2, A3 and A4 (3 months later)

PSYCHOLOGY-BASED SERVICES

Psychology-based services include counselling, group therapy, and psychotherapy. Twenty-five participants used counselling in A1 and 24 participants used group therapy, however, the numbers dropped in subsequent assessments. Interviewees did not regard psychology-based services as helpful.

Counselling

At baseline, 33% of participants (n=25) had availed of counselling, at A2, 52% of participants (n=13) used counselling, however, at A3 and in A4, numbers dropped to only 2 respondents in each assessment.

Figures 107-109 show GHQ-30, BDI-II, and PDS mean scores for participants who used counselling during the 3-4 months prior to each assessment and for those who did not use this service. There were statistically significant improvements with regard to depression between A1 and A2 for those who availed of counselling, however, there also were statistically significant improvements with regard to depression between A1 and A2, and between A1 and A3 for those who did not avail of counselling (paired-samples t-test). Four bars at each assessment point represent data as previously in Figure 77.

Figure 107: GHQ-30 mean scores for counselling users (4 assessments)
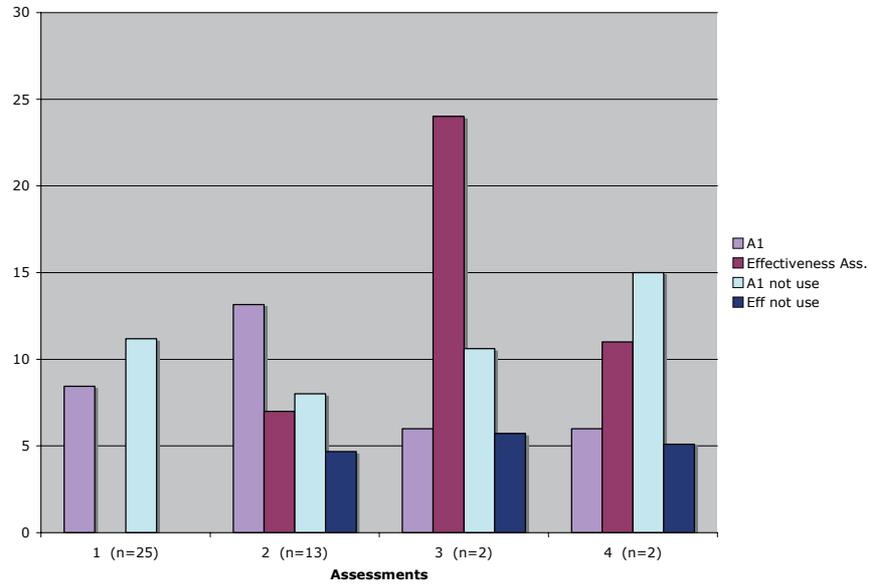
Figure 108: BDI-II mean scores for counselling users (4 assessments)
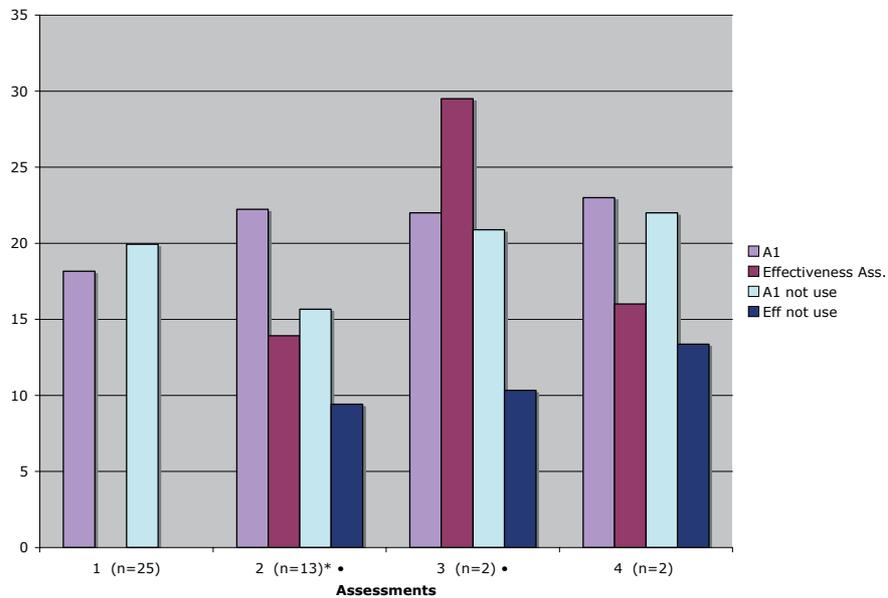
* significant differences between A1 and A2 for those who had availed of service.
• significant differences between A1 and A2 and A3 for those who had not availed of counselling.

Figure 109: PDS mean scores for counselling users (4 assessments)
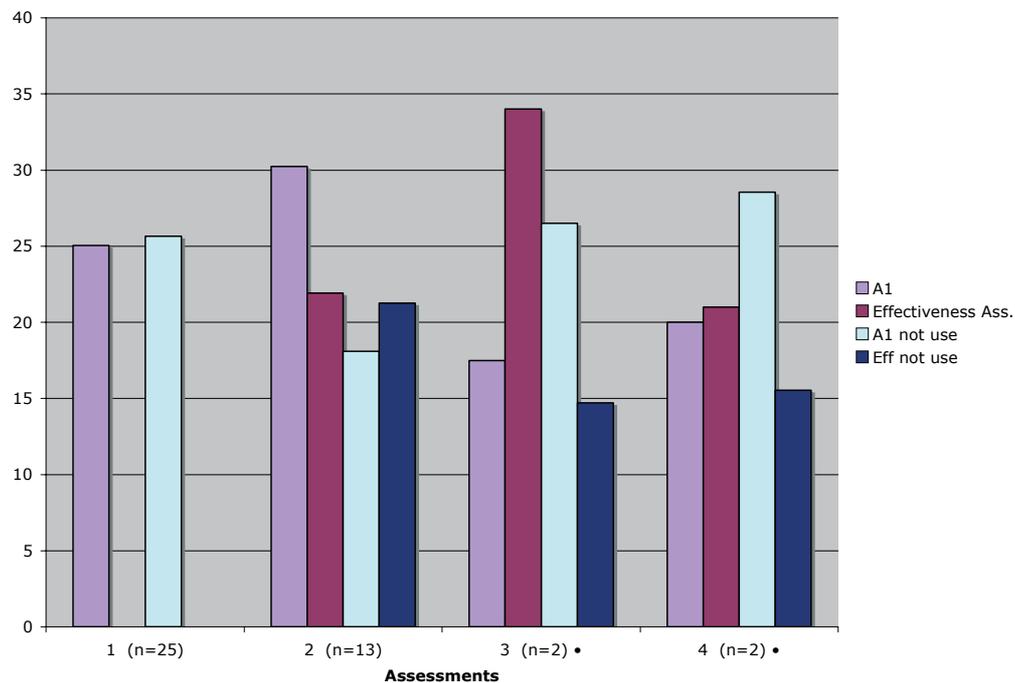
• significant differences between A1 and A3 and A4 for those who had not availed of counselling.

There were statistically significant improvements with regard to PTSD symptom severity between A1 and A3 and A4 for those who did not availed of counselling (paired-samples t-test).

Figures 110-112 show GHQ-30, BDI-II, and PDS scores for participants who used counselling in each of the 4 assessments. Each bar indicates actual test score for one participant. Grey squares indicate non-response, while coloured squares indicate non-use of service.

Figure 110: GHQ-30 scores for individual counselling users
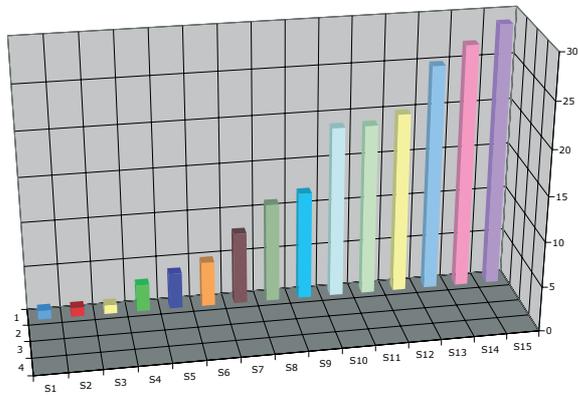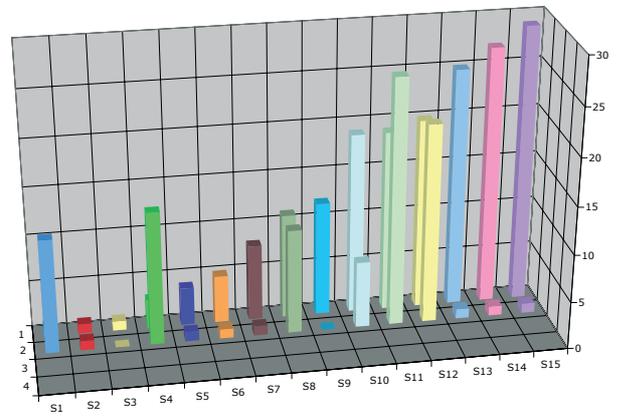
A1 (baseline assessment)

A1 and A2 (taken 3 months later)
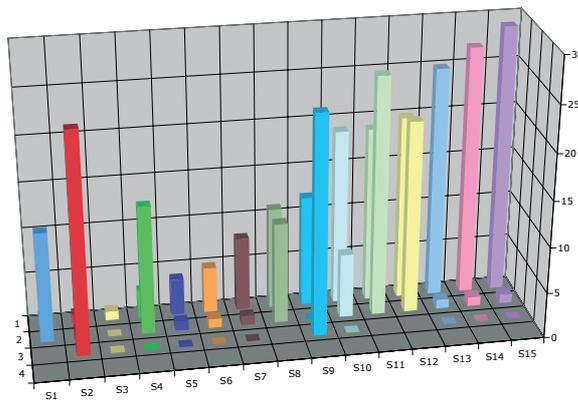
A1, A2 and A3 (3 months later)
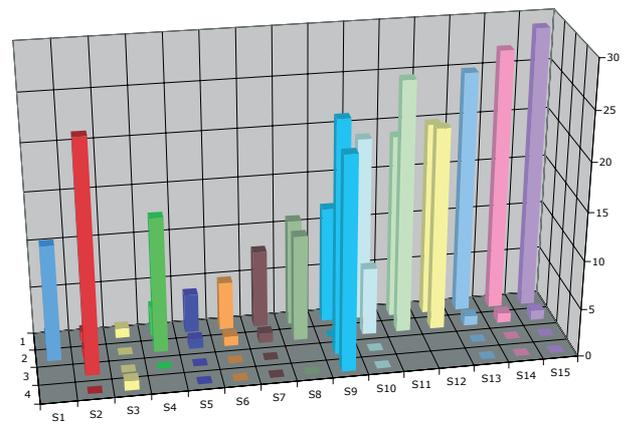
A1, A2, A3 and A4 (3 months later)

Figure 111: BDI-II scores for individual counselling users
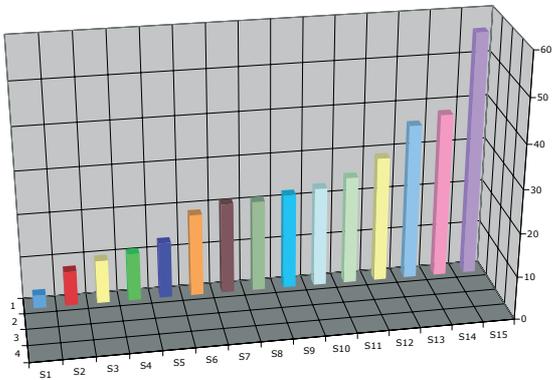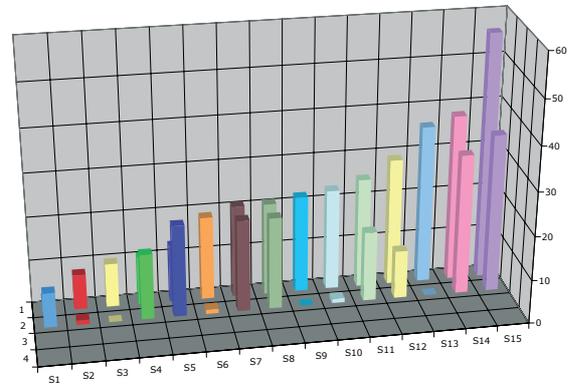
A1 (baseline assessment)

A1 and A2 (taken 3 months later)
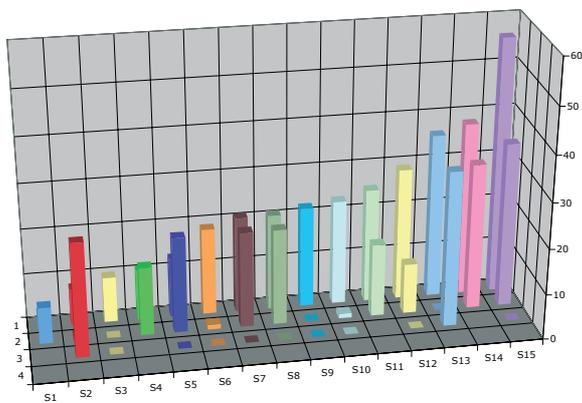
A1, A2 and A3 (3 months later)
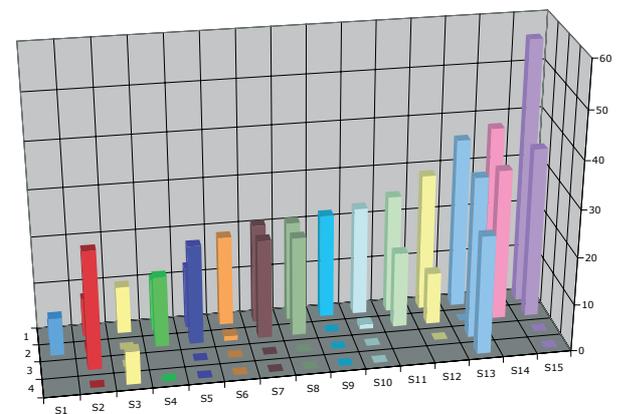
A1, A2, A3 and A4 (3 months later)

Figure 112: PDS scores for individual counselling users
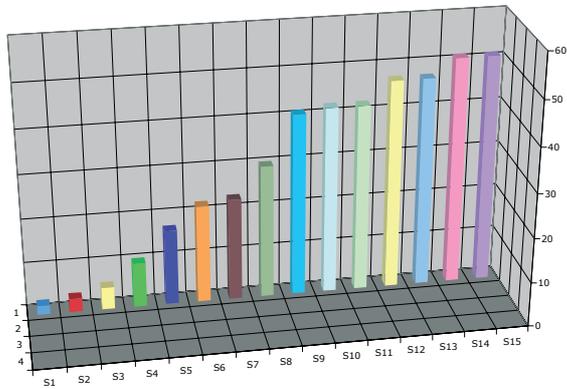
A1 (baseline assessment)
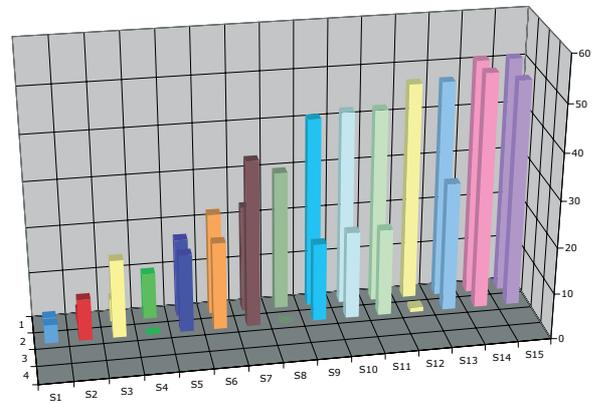
A1 and A2 (taken 3 months later)
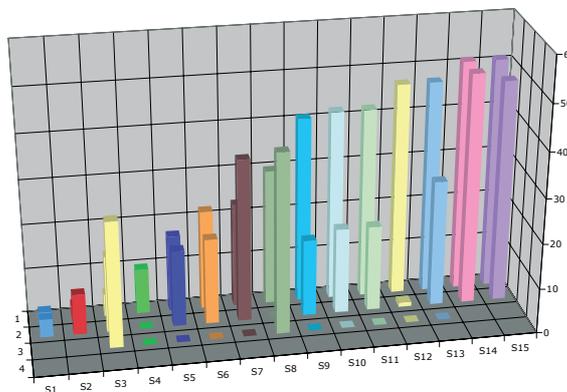
A1, A2 and A3 (3 months later)
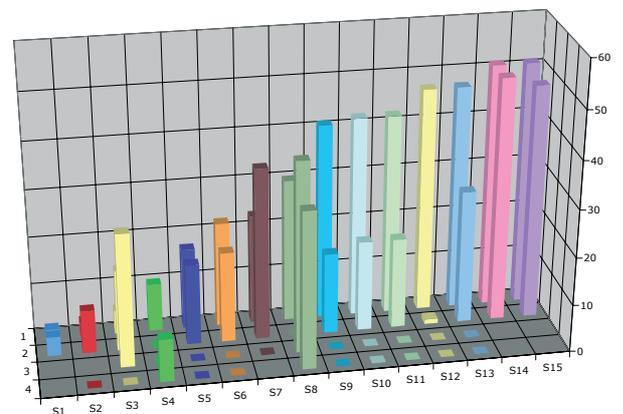
A1, A2, A3 and A4 (3 months later)

Group therapy

There were 24 group therapy users at baseline assessment (32%). At A2, 52% of the participants (n=13) used group therapy, at A3, only 3 participants used this service and at A4, 38% of participants (n= 5) used it.

Figures 113-115 show GHQ-30, BDI-II, and PDS mean scores for participants who used group therapy during the 3-4 months prior to each assessment and for those who did not use this service. Four bars at each assessment point represent data as previously in Figure 77.

Figure 113: GHQ-30 mean scores for group therapy users (4 assessments)
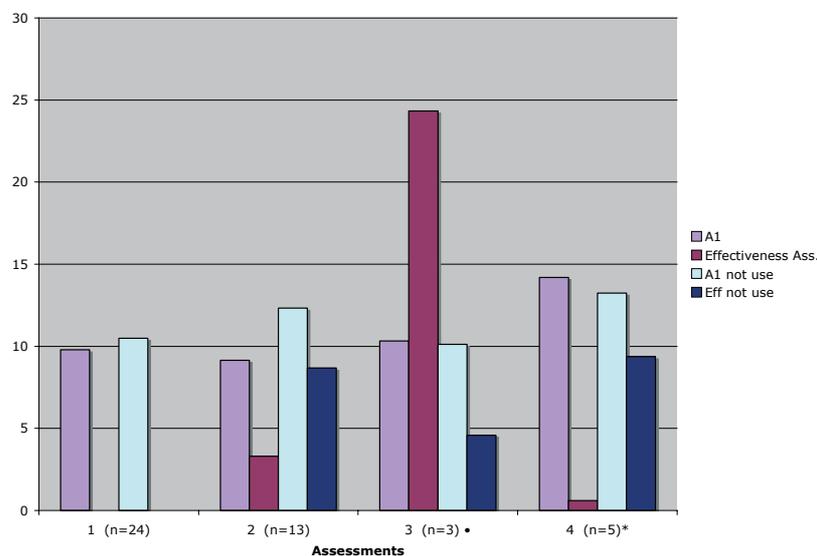
* significant differences between A1 and A4 for those who had availed of service.
• significant differences between A1 and A3 for those who had not availed of service.

There were statistically significant improvements with regard to general psychological health between A1 and A4 for those who availed of group therapy, however, there also were statistically significant improvements with regard to general psychological health between A1 and A3 for those who did not avail of the service (paired-samples t-test).

Figure 114: BDI-II mean scores for group therapy users (4 assessments)
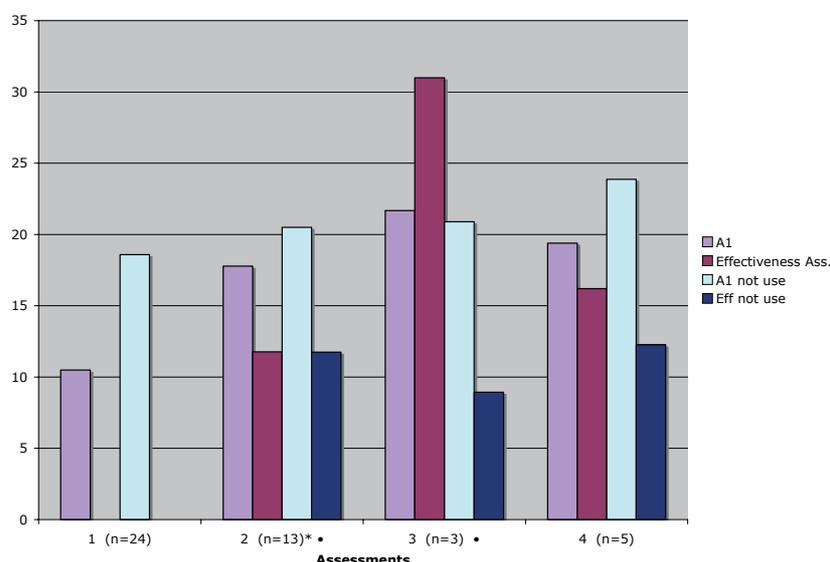
* significant differences between A1 and A2 for those who had availed of service.
• significant differences between A1 and A2 and A3 for those who had not availed of service.

There were statistically significant improvements with regard to depression between A1 and A2 for those who availed of group therapy, however, there also were statistically significant improvements with regard to general psychological health between A1 and A2, and between A1 and A3 for those who did not availed of group therapy (paired-samples t-test).

There were statistically significant improvements between A1 and 2, and between A1 and A4 with regard to PTSD symptom severity for those who used the group therapy between these assessments.

Figure 115: PDS mean scores for group therapy users (4 assessments)
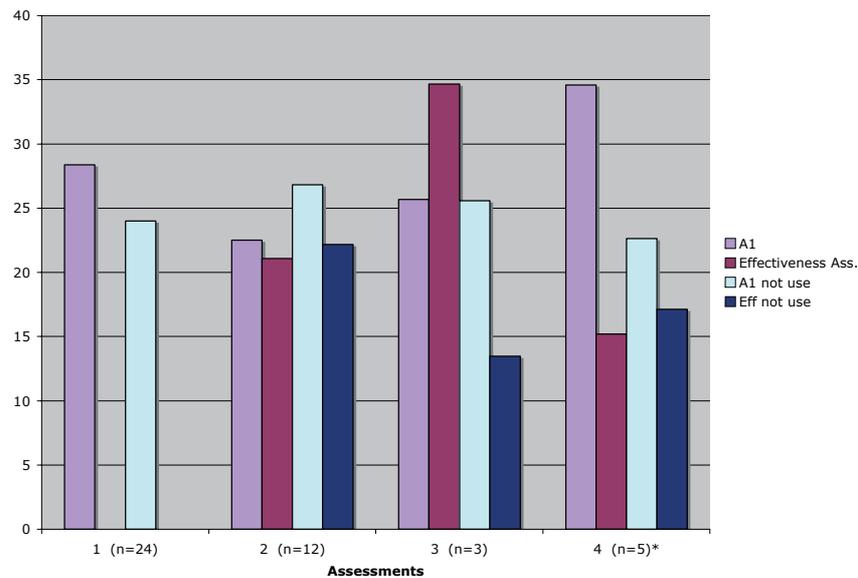
* significant differences between A1 and A4 for those who had availed of service.

Figures 116-118 show GHQ-30, BDI-II, and PDS scores for participants who used group therapy in each of the 4 assessments. Each bar indicates actual test score for one participant. Grey squares indicate non-response, while coloured squares indicate non-use of service.

Figure 116: GHQ-30 scores for individual group therapy users
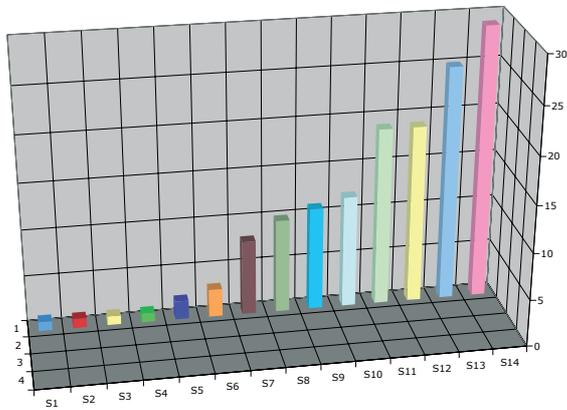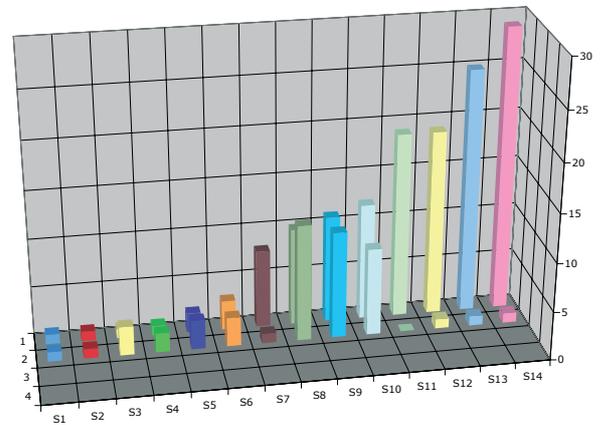
A1 (baseline assessment)

A1 and A2 (taken 3 months later)
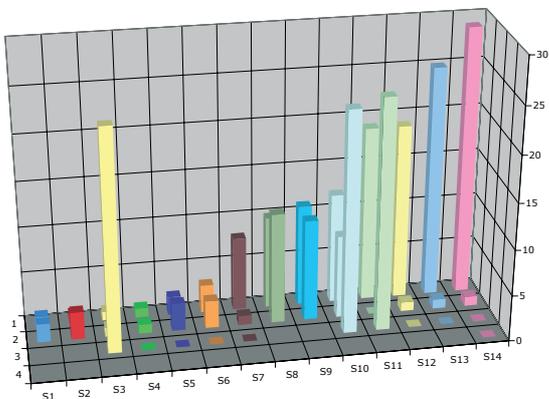
A1, A2 and A3 (3 months later)
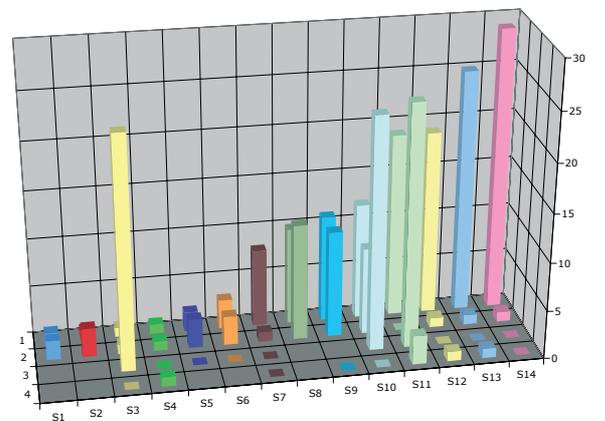
A1, A2, A3 and A4 (3 months later)

Figure 117: BDI-II scores for individual group therapy users
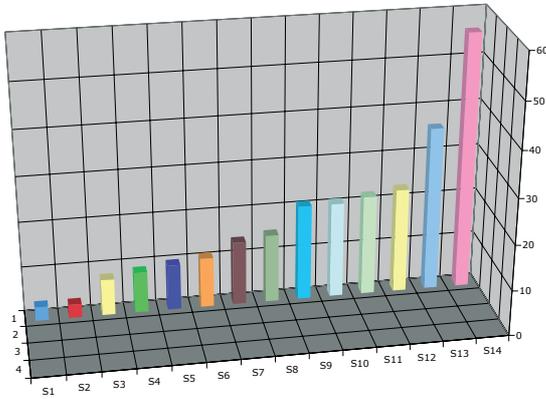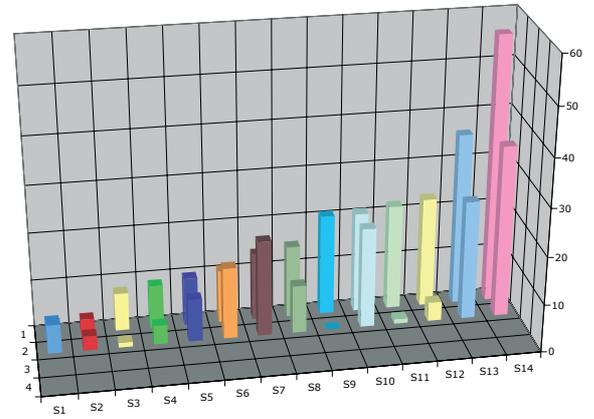
A1 (baseline assessment)

A1 and A2 (taken 3 months later)
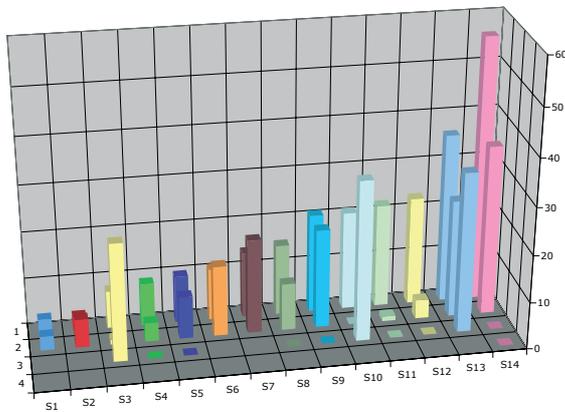
A1, A2 and A3 (3 months later)
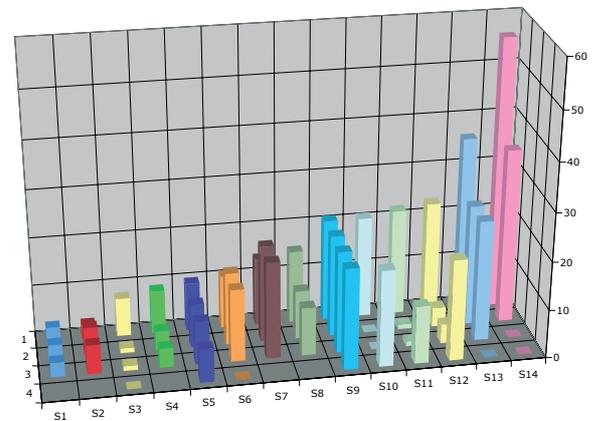
A1, A2, A3 and A4 (3 months later)

Figure 118: PDS scores for individual group therapy users
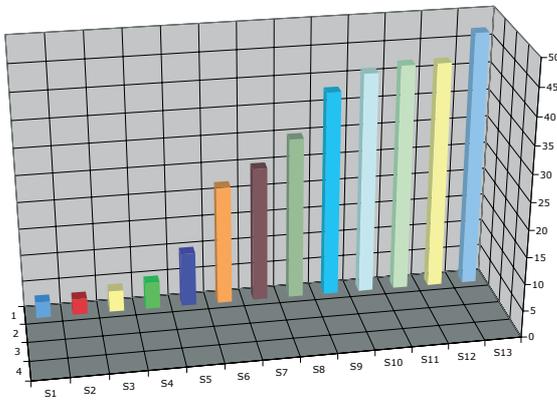
A1 (baseline assessment)
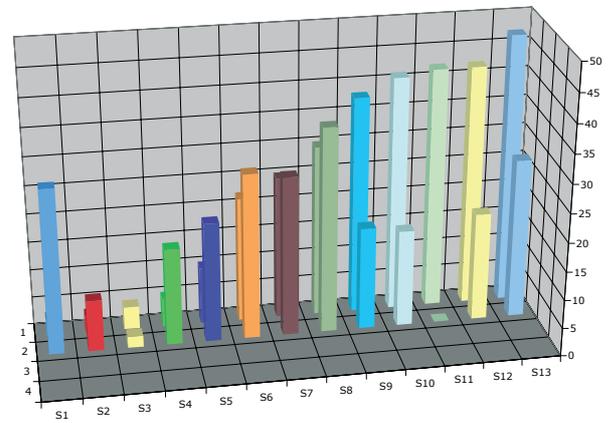
A1 and A2 (taken 3 months later)
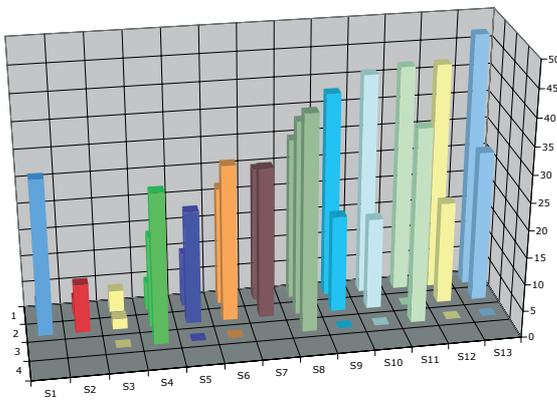
A1, A2 and A3 (3 months later)
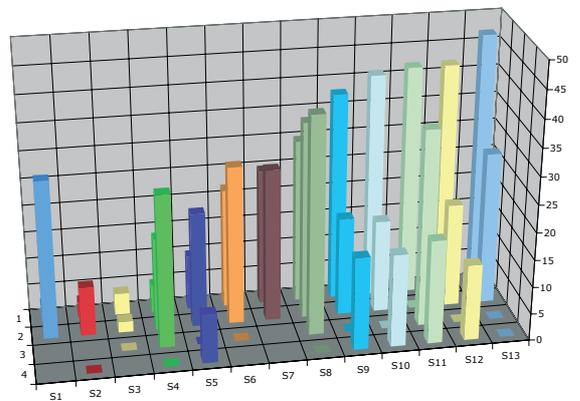
A1, A2, A3 and A4 (3 months later)

PHILOSOPHY-BASED SERVICES

Philosophy-based services included mainly complementary therapies based on Eastern philosophies, such as reflexology, aromatherapy, yoga, massage, or reiki. While these services seemed to be very popular among services users, due to funding cycles, they often were offered on a short-term and temporary basis. In total, 20 participants used complementary therapies throughout the study. Figure 119 shows number of complementary service users at each assessment point.

Figure 119: Complementary therapy service users (4 assessments)

	A1	A2	A3	A4
Reflexology	42	12	1	9
Massage	27	8	2	5
Aromatherapy	26	9	0	3
Reiki	16	2	0	0
Art therapy	18	2	0	0
Music therapy	10	0	0	0
Yoga	5	0	1	0

Figures 120-122 show GHQ-30, BDI-II, and PDS scores for participants who used complementary therapies at each of the 4 assessments points. Each bar indicates actual test score for one participant. Grey squares indicate non-response, while coloured squares indicate non-use of service.

Figure 120: GHQ-30 scores for individual complementary therapies users
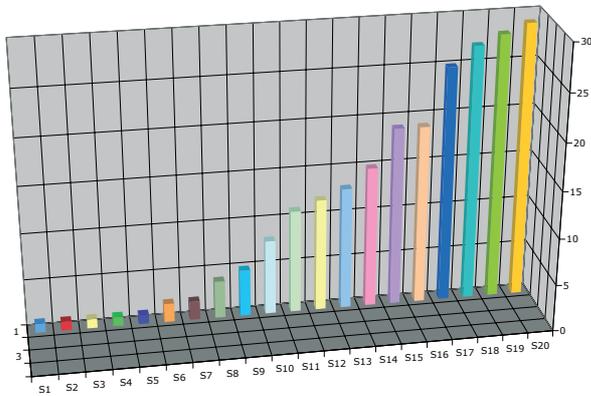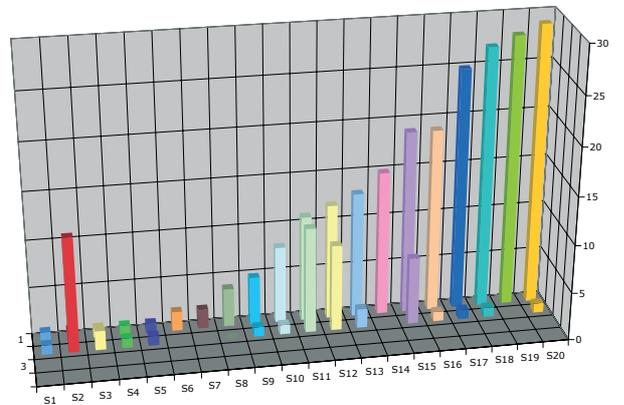
A1 (baseline assessment)

A1 and A2 (taken 3 months later)
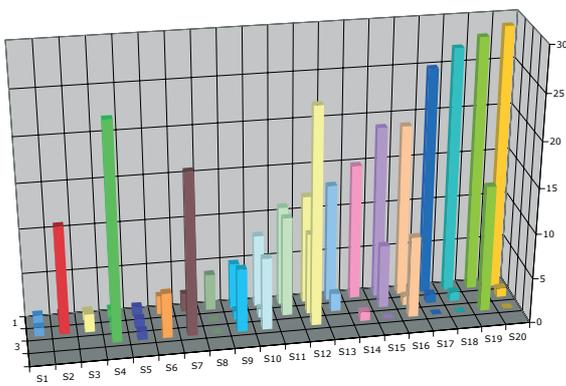
A1, A2 and A3 (3 months later)
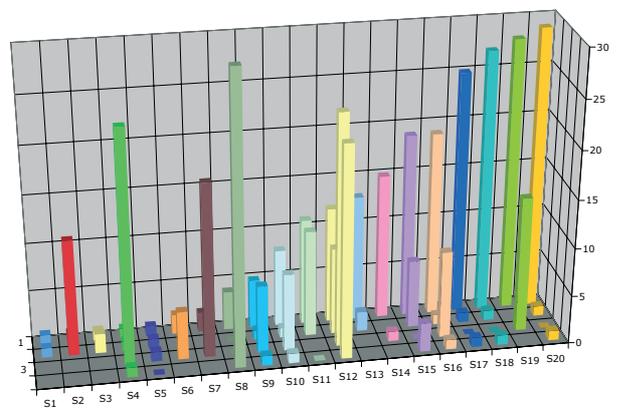
A1, A2, A3 and A4 (3 months later)

Figure 121: BDI-II scores for individual complementary therapies users
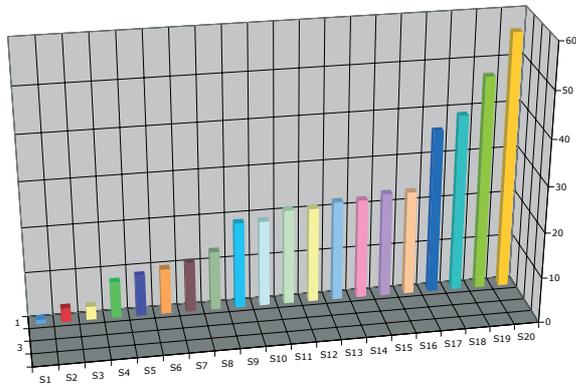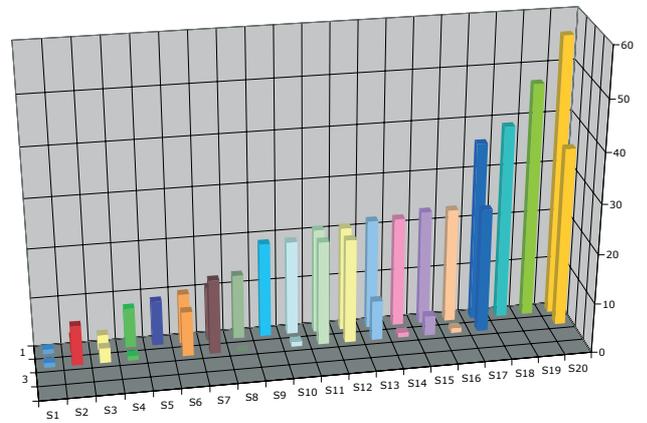
A1 (baseline assessment)

A1 and A2 (taken 3 months later)
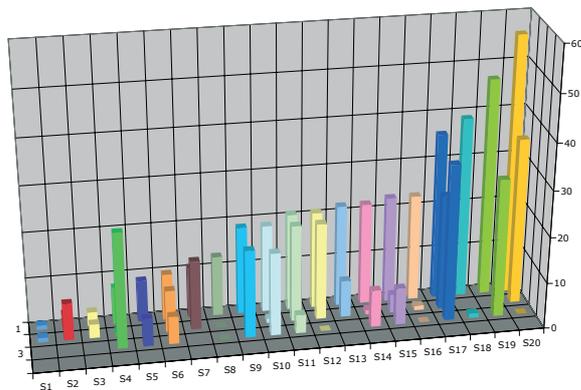
A1, A2 and A3 (3 months later)
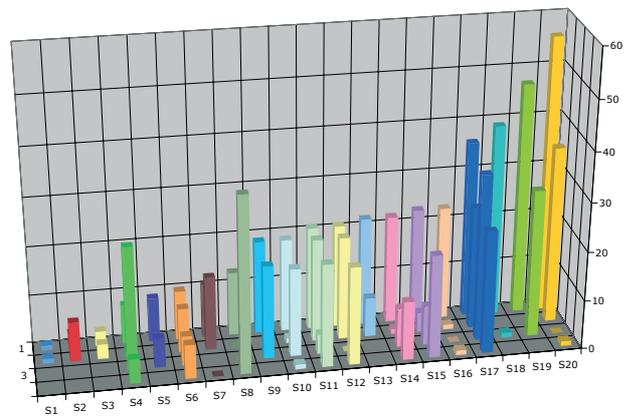
A1, A2, A3 and A4 (3 months later)

Figure 122: PDS scores for individual complementary therapies users
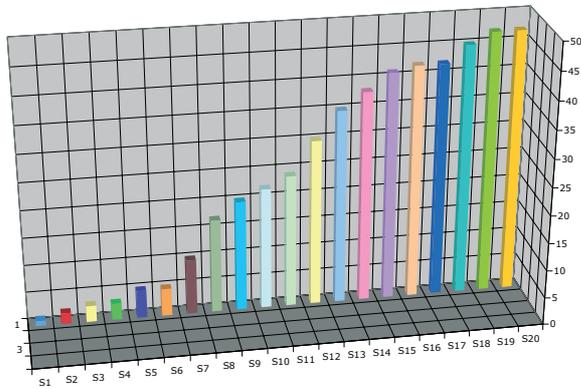
A1 (baseline assessment)
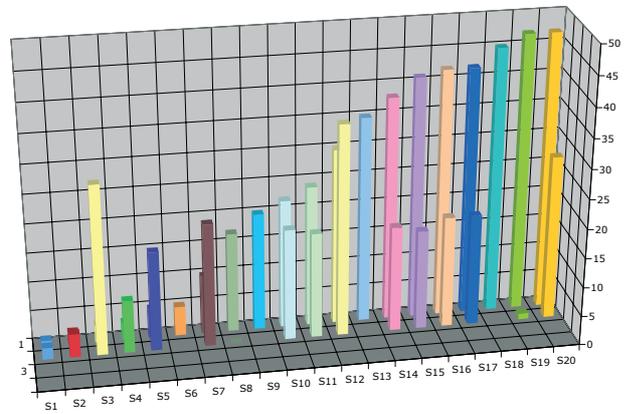
A1 and A2 (taken 3 months later)
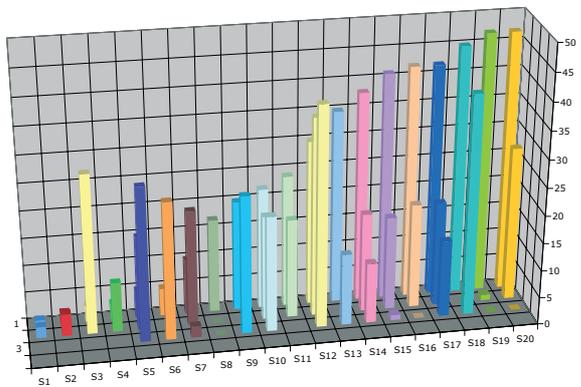
A1, A2 and A3 (3 months later)
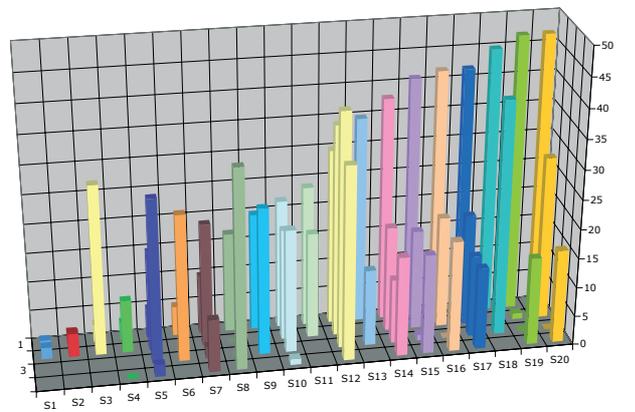
A1, A2, A3 and A4 (3 months later)

Reflexology

Reflexology was probably the most commonly used complementary therapy among the participants. Figures 123-125 show GHQ-30, BDI-II, and PDS mean scores for participants who used reflexology during the 3-4 months prior to each assessment and for those who did not use this service. There were statistically significant improvements with regard to general psychological health and depression between A1 and A2 for those who availed of reflexology (paired-samples t-test). Four bars at each assessment point represent data as previously in Figure 77.

Figure 123: GHQ mean scores for reflexology users (4 assessments)
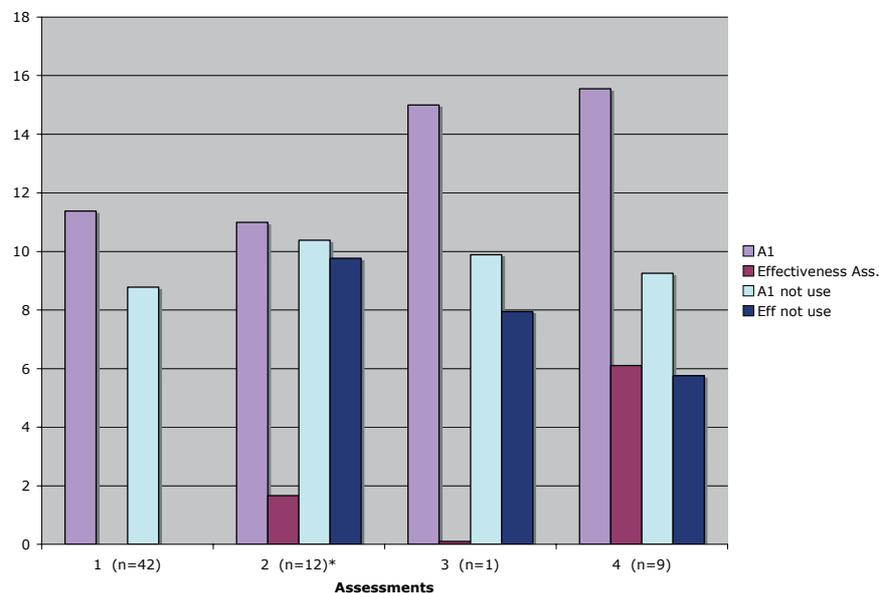
* significant differences between A1 and A2 for those who had availed of service.

Figure 124: BDI-II mean scores for reflexology users (4 assessments)
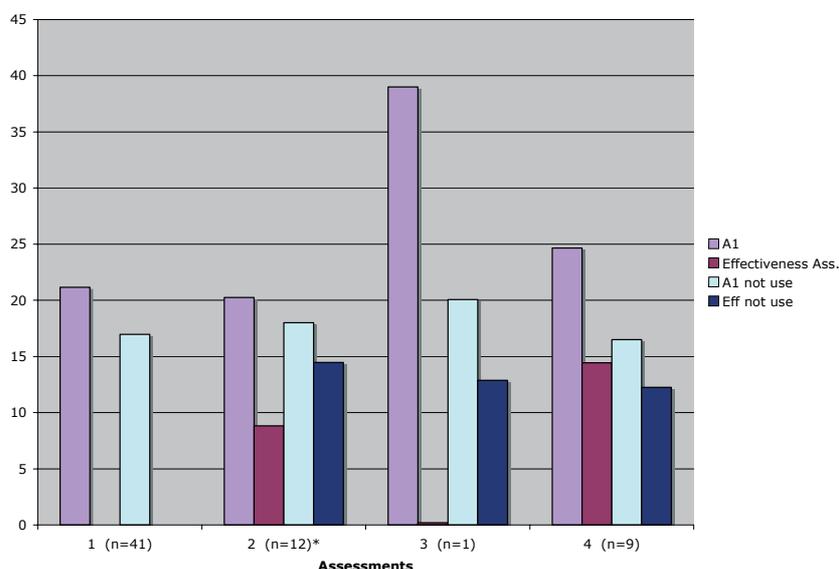
* significant differences between A1 and A2 for those who had availed of service.

Figure 125: PDS mean scores for reflexology users (4 assessments)
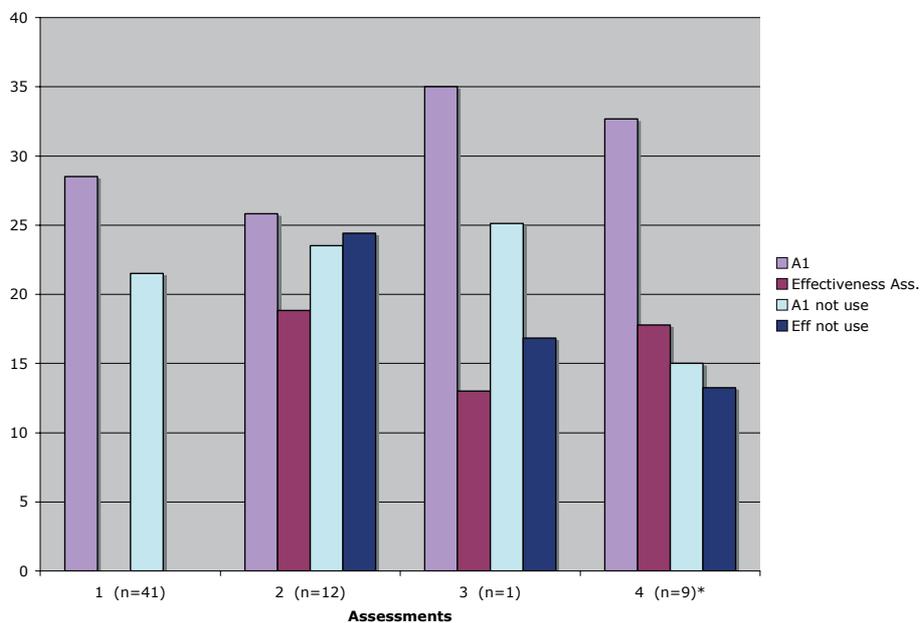
* significant differences between A1 and A4 for those who had availed of service.

There were statistically significant improvements in PTSD symptom severity between A1 and A4 for respondents who used reflexology.

Massage

Thirty-six percent of participants (n=27) in the baseline assessment used massage. Figures 126-128 show GHQ-30, BDI-II, and PDS mean scores for participants who used massage during the 3-4 months prior to each assessment and for those who did not use this service. Four bars at each assessment point represent data as previously in Figure 77.

Figure 126: GHQ-30 mean scores for massage users (4 assessments)
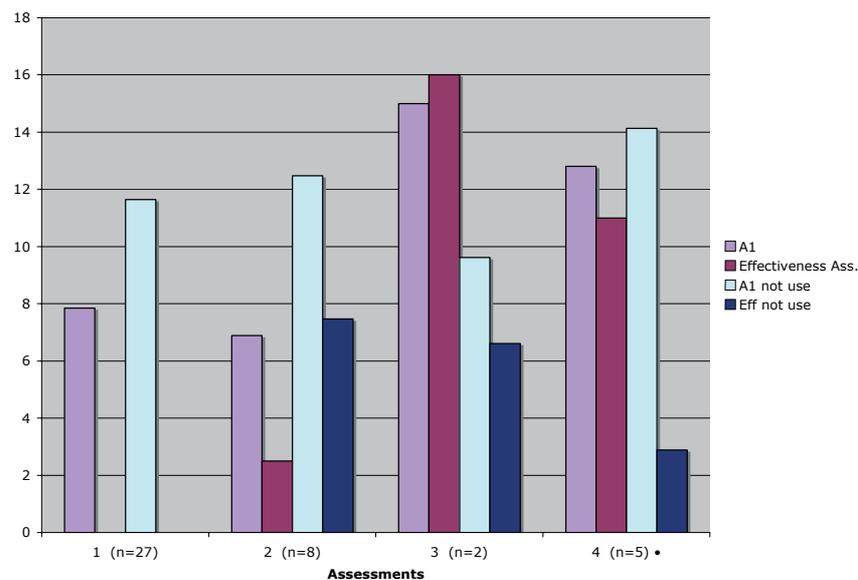
• significant differences between A1 and A4 for those who had not availed of massage.

There were statistically significant improvements with regard to depression between A1 and A2 for those who availed of massage, however, there also were statistically significant improvements with regard to depression between A1 and A2, and between

A1 and A4 for those who did not avail of massage. In addition, there were significant improvements regarding general psychological health between A1 and A4 for those who did not avail of massage (paired-samples t-test).

Figure 127: BDI-II mean scores for massage users (4 assessments)
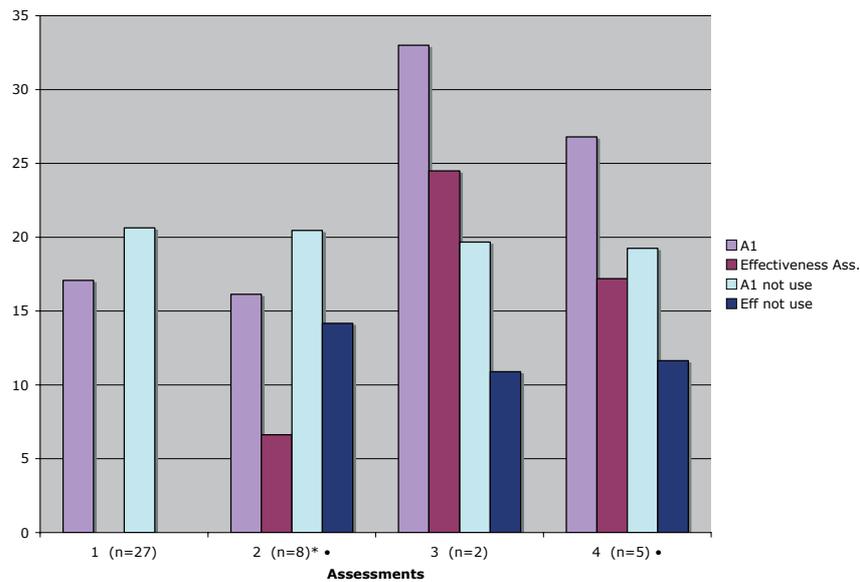
* significant differences between A1 and A2 for those who had availed of service.
• significant differences between A1 and A2, and A1 and A4 for those who had not availed of massage.

Figure 128: PDS mean scores for massage users (4 assessments)
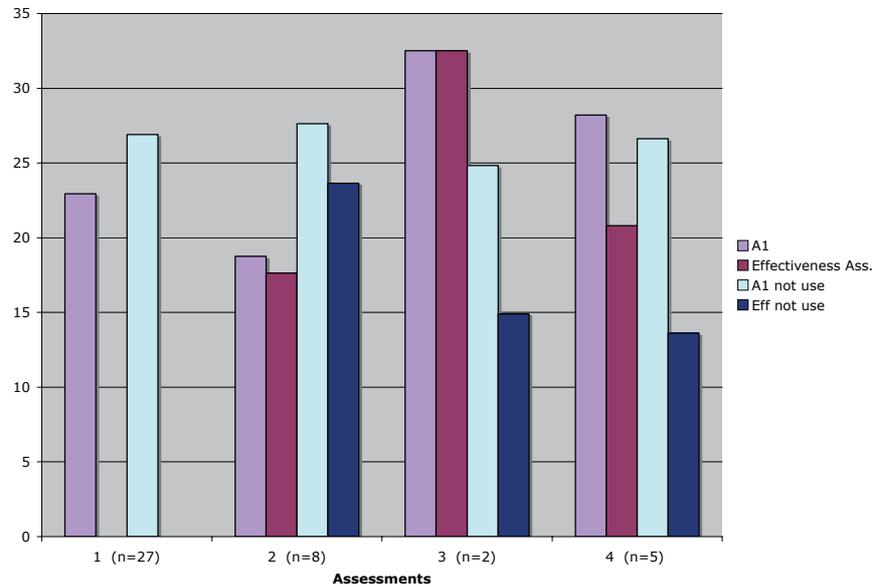
Aromatherapy

While aromatherapy was used by 35% of participants (n=26) at A1, only 11 of the respondents used it throughout the remainder of the study.

Figures 129-131 show GHQ-30, BDI-II, and PDS mean scores for participants who used aromatherapy during the 3-4 months prior to each assessment and for those who did not use this service. There were statistically significant improvements with regard to general psychological health and depression between A1 and A2 for those who availed of aromatherapy, however, there were also significant differences in depression between A1 and A2 for those who did not use aromatherapy (paired-samples t-test). Four bars at each assessment point represent data as previously in Figure 77.

Figure 129: GHQ-30 mean scores for aromatherapy users (4 assessments)
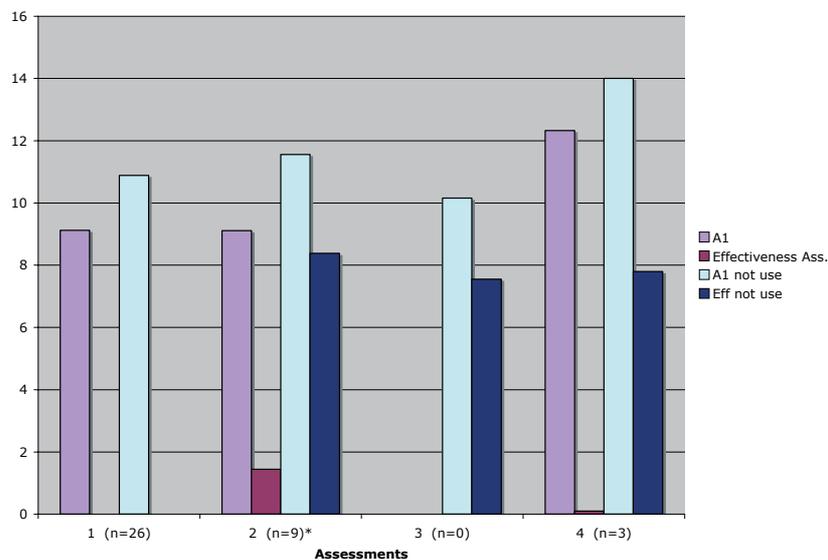
* significant differences between A1 and A2 for those who had availed of service.

Figure 130: BDI-II mean scores for aromatherapy users (4 assessments)
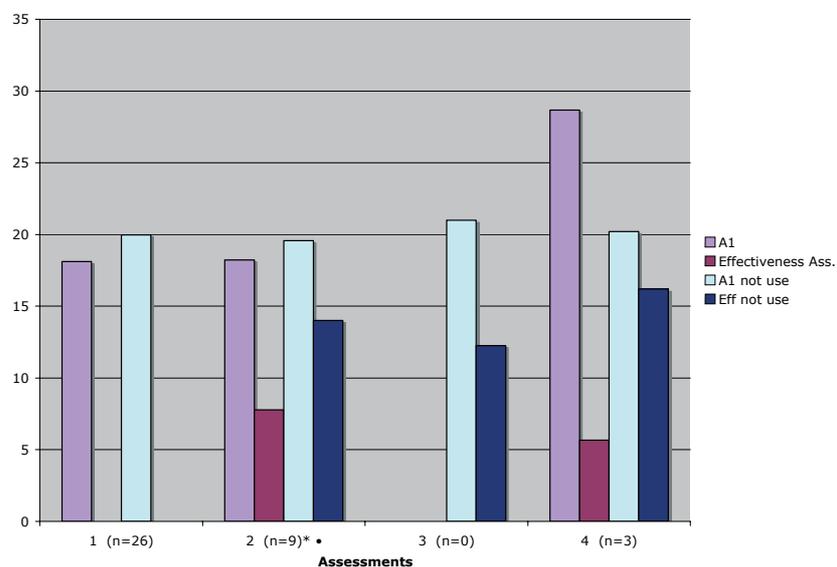
* significant differences between A1 and A2 for those who had availed of service.
• significant differences between A1 and A2 for those who had not availed of aromatherapy.

Figure 131: PDS mean scores for aromatherapy users (4 assessments)
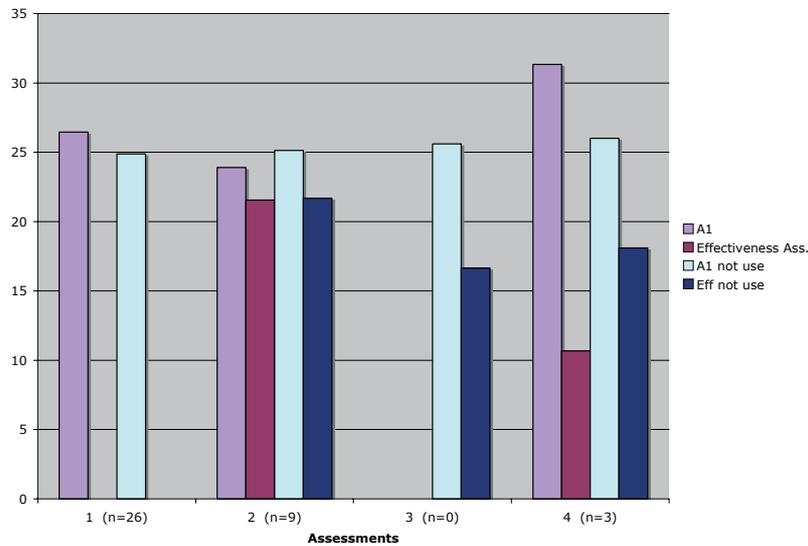
Art therapy

While 24% of participants (n=18) used art therapy at A1, only 7 used it throughout the research. Figures 132-134 show GHQ-30, BDI-II, and PDS mean scores for participants who used art therapy during the 3-4 months prior to each assessment and for those who did not use this service. There were statistically significant improvements with regard to depression between A1 and A3 for those who availed of art therapy (paired-samples t-test). Four bars at each assessment point represent data as previously in Figure 77.

**Figure 132: GHQ-30 mean scores for art therapy users (4 assessments)**
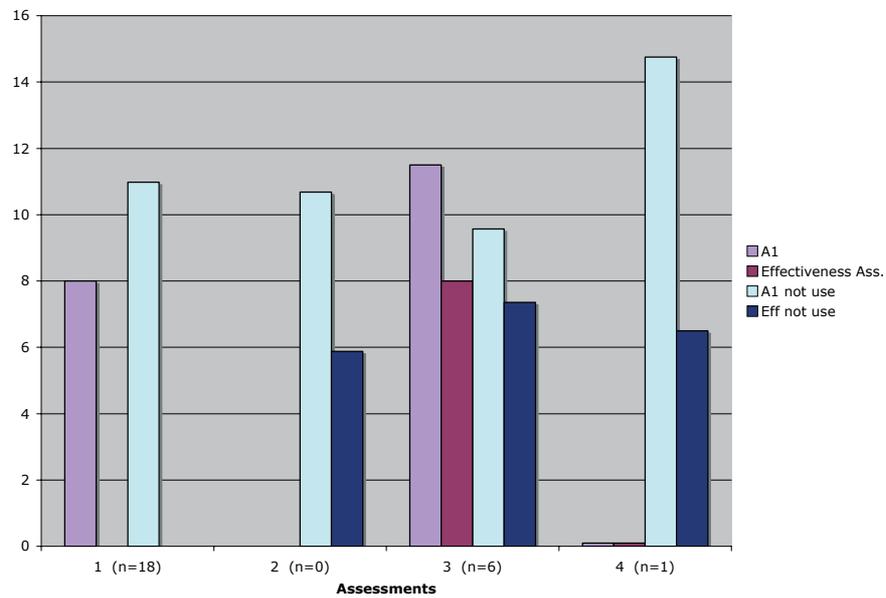
Figure 133: BDI-II mean scores for art therapy users (4 assessments)
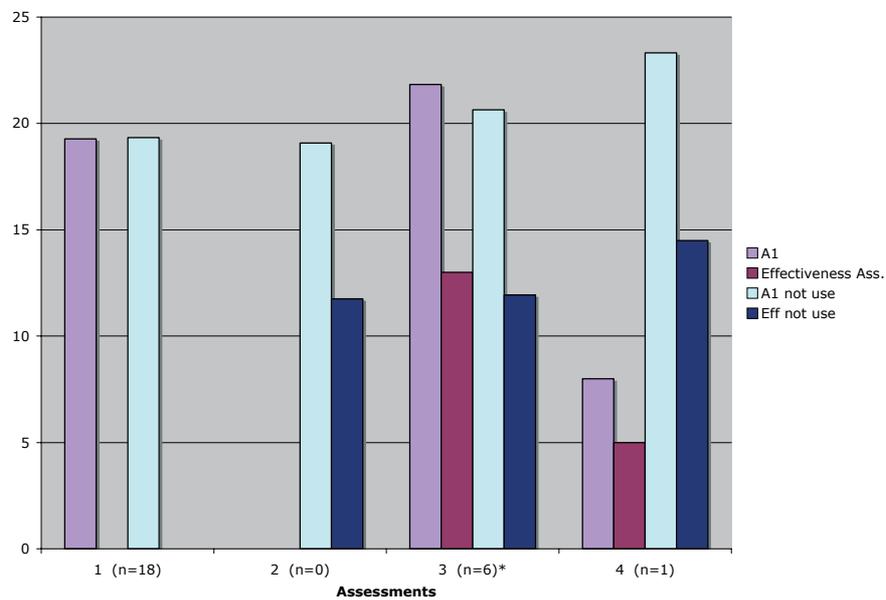
* significant differences between A1 and A3 for those who had availed of service.

Figure 134: PDS mean scores for art therapy users (4 assessments)

.
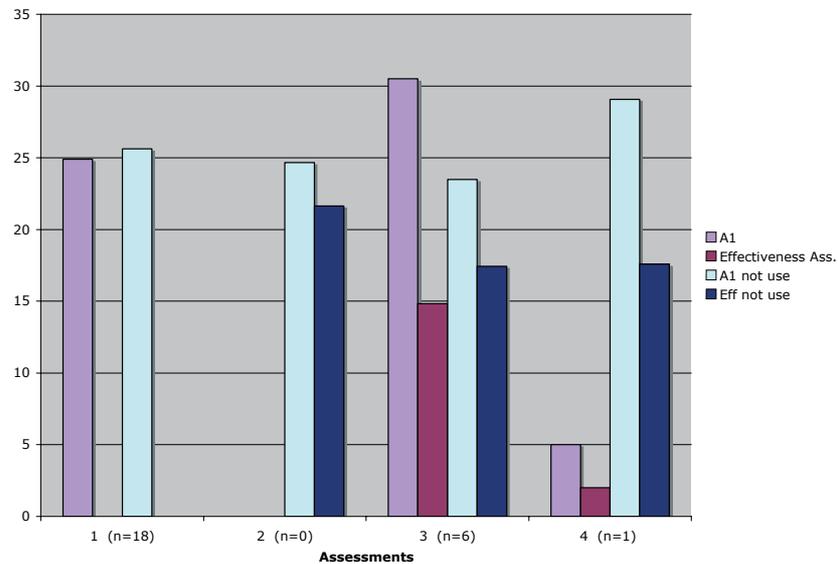
EDUCATION-BASED SERVICES

Education-based services, including advice and information as well as indirect services (e.g. courses or advocacy), were used by virtually all participants at one time or another throughout the study, with 67% of participants (n=50) using information and advice services and 48% of respondents (n=36) using indirect services at baseline assessment.

Figures 135-137 show GHQ-30, BDI-II, and PDS scores for participants who used education based services in each of the 4 assessments. Each bar indicates actual test score for one participant. Grey squares indicate non-response, while coloured squares indicate non-use of service.

Figure 135: GHQ-30 scores for education-based service users
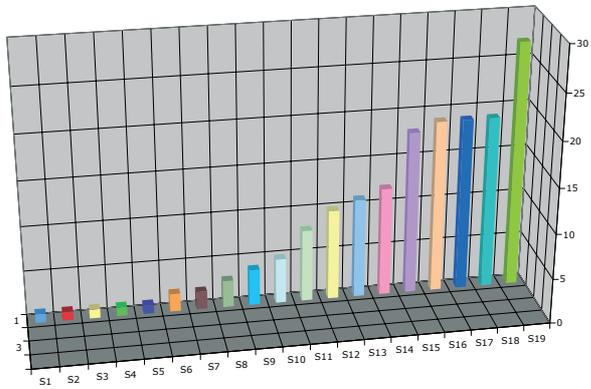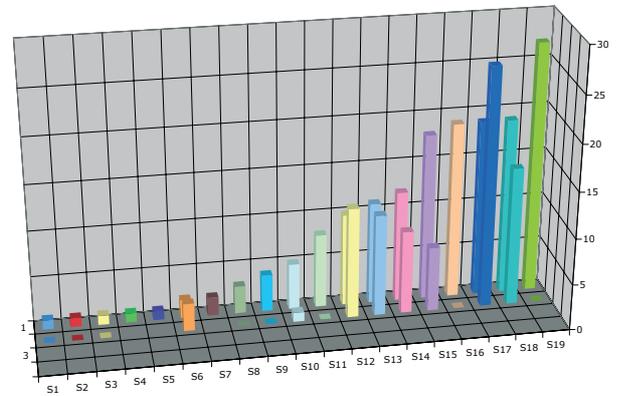
A1 (baseline assessment)

A1 and A2 (taken 3 months later)
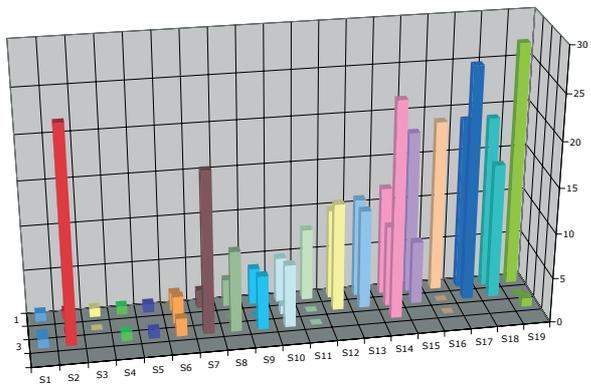
A1, A2 and A3 (3 months later)
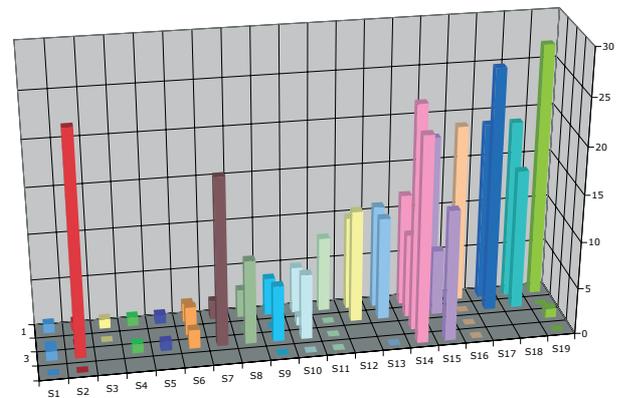
A1, A2, A3 and A4 (3 months later)

Figure 136: BDI-II scores for education-based service users
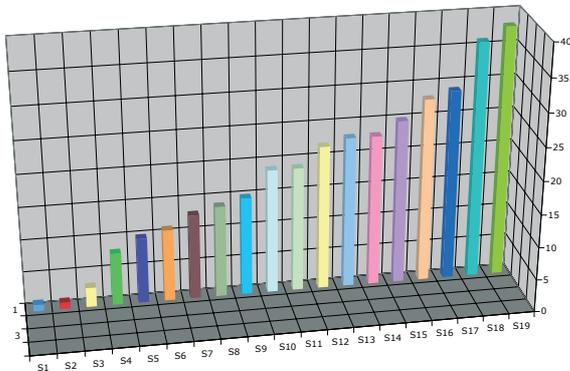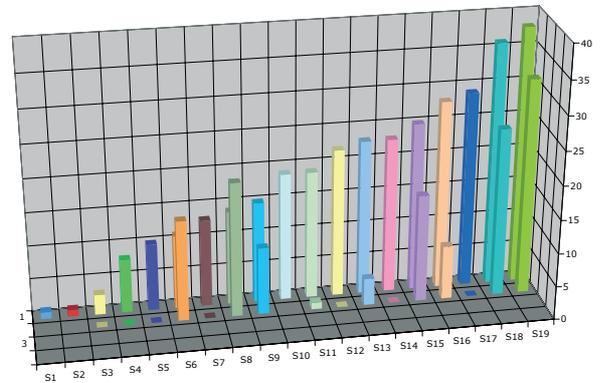
A1 (baseline assessment)

A1 and A2 (taken 3 months later)
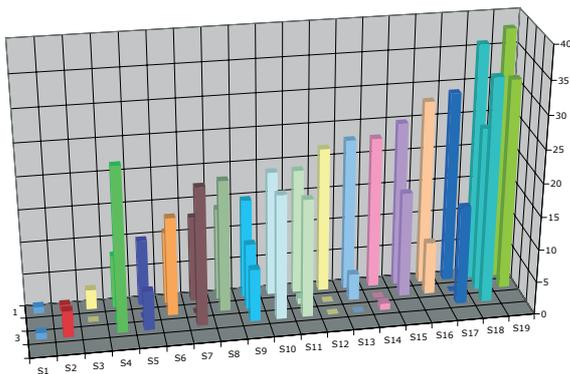
A1, A2 and A3 (3 months later)
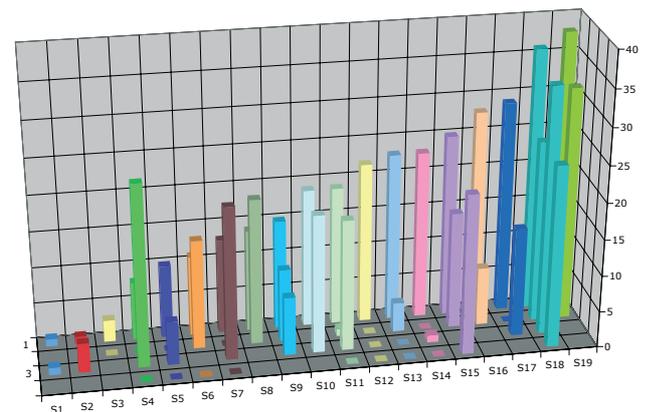
A1, A2, A3 and A4 (3 months later)

Figure 137: PDS scores for education-based service users
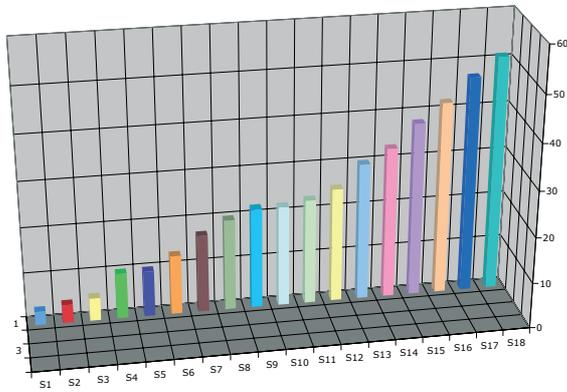
A1 (baseline assessment)
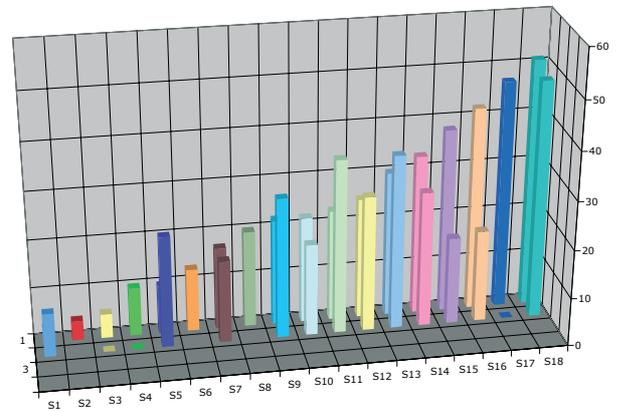
A1 and A2 (taken 3 months later)
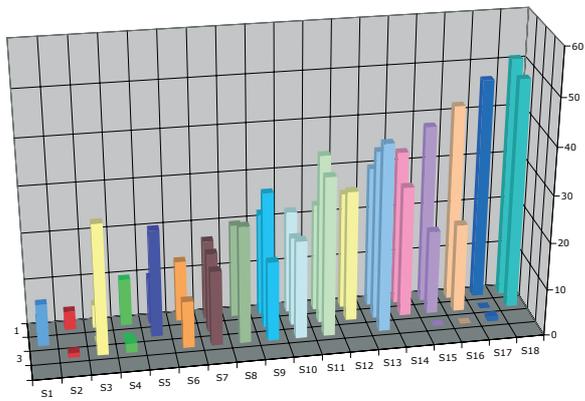
A1, A2 and A3 (3 months later)
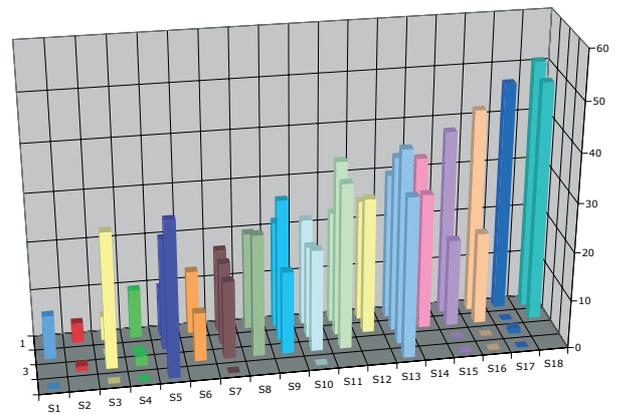
A1, A2, A3 and A4 (3 months later)

Advice and Information

Advice and information were offered by most of the groups. At baseline assessment, 67% of participants (n=50) had availed of advice and information services, at A2, 52% of participants (n=13) availed of this service, while at A3, 50% of the participants (n=10) availed of it, and only 1 person availed of advice and information services at A4.

Figures 138-140 show GHQ-30, BDI-II, and PDS mean scores for participants who used advice and information services during the 3-4 months prior to each assessment and for those who did not use this service. There were statistically significant improvements with regard to depression between A1 and A2 for those who availed of advice and information services. However, there also were statistically significant improvements with regard to PTSD symptom severity between A1 and A3 for those who did not avail of advice and information services (paired-samples t-test). Four bars at each assessment point represent data as previously in Figure 77.

Figure 138: GHQ-30 mean scores for advice and information service users (4 assessments)
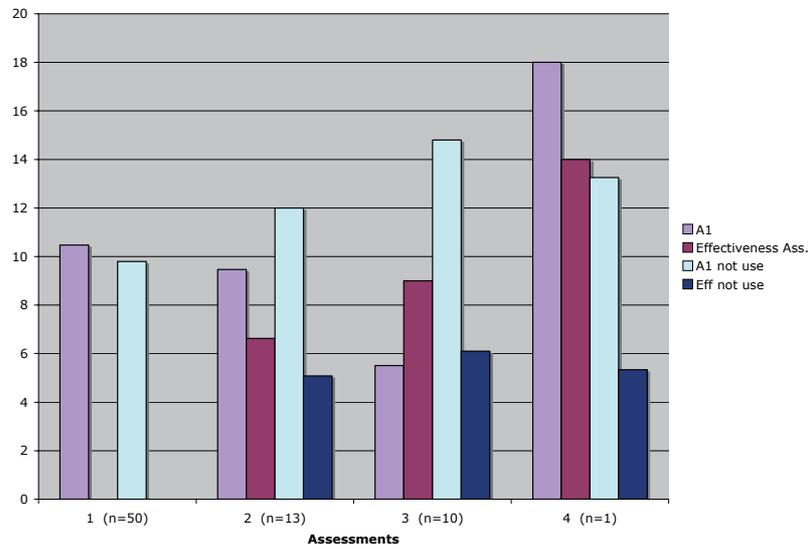
Figure 139: BDI-II mean scores for advice and information service users (4 assessments)
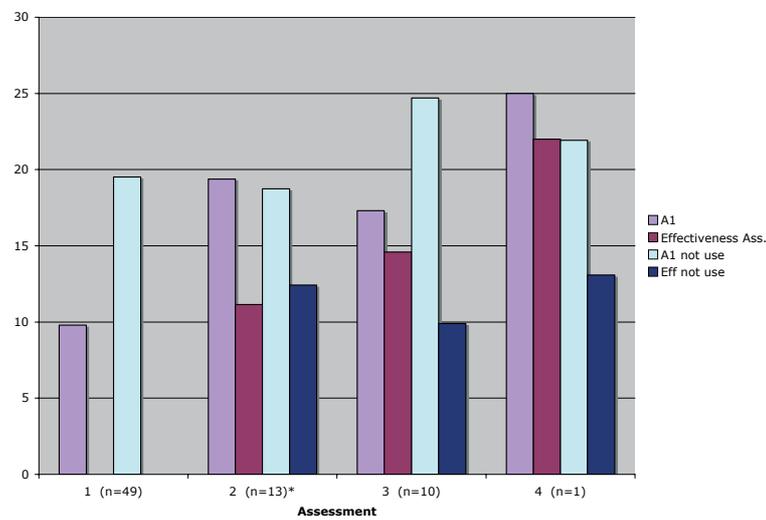
* significant differences between A1 and A2 for those who had availed of service.

Figure 140: PDS mean scores for advice and information service users (4 assessments)
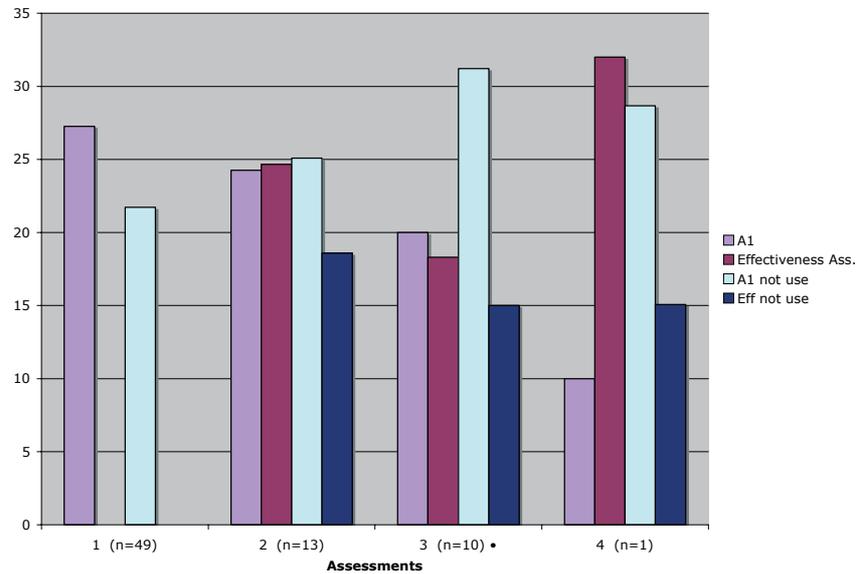
• significant differences between A1 and A3 for those who had not availed of it.

Indirect services

While indirect services, especially courses and craft classes, were regarded positively in the interviews and used by 48% of the respondents (n=36) at baseline assessment, only 3 participants used indirect services in A2, 2 respondents used indirect services in A3, and 1 participant used them in A4. However, in the baseline assessment, 36 participants reported to had used them.

Figures 141-143 show GHQ-30, BDI-II, and PDS mean scores for participants who used indirect services during the 3-4 months prior to each assessment and for those who did not use this service. There were statistically significant improvements with regard to general psychological health between A1 and A2 and with regard to

depression between A1 and A2, and A1 and A3 for those who did not avail of indirect

services (paired-samples t-test). Four bars at each assessment point represent data as

previously in Figure 77.

Figure 141: GHQ-30 mean scores for indirect services users (4 assessments)
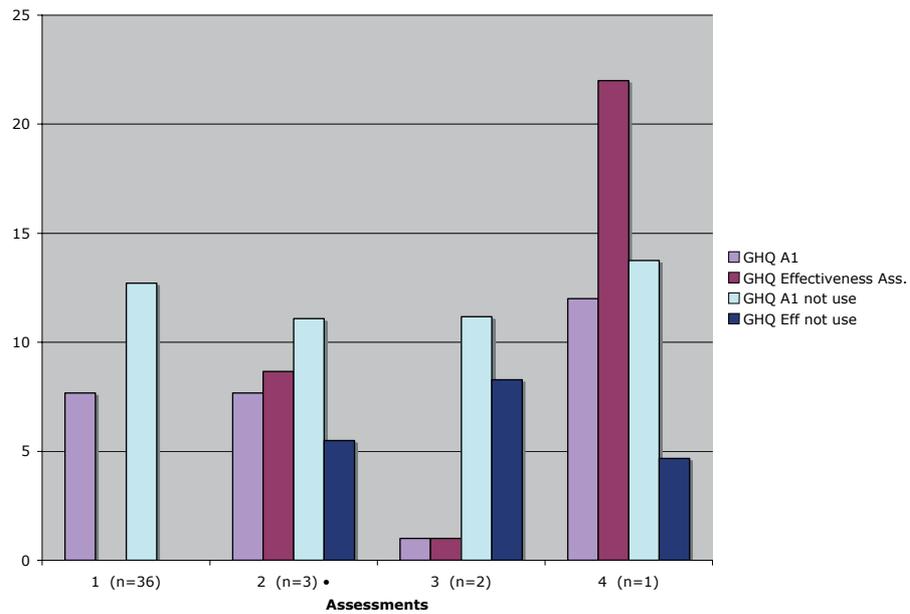
• significant differences between A1 and A2 for those who had not availed of it.

Figure 142: BDI-II mean scores for indirect services users (4 assessments)
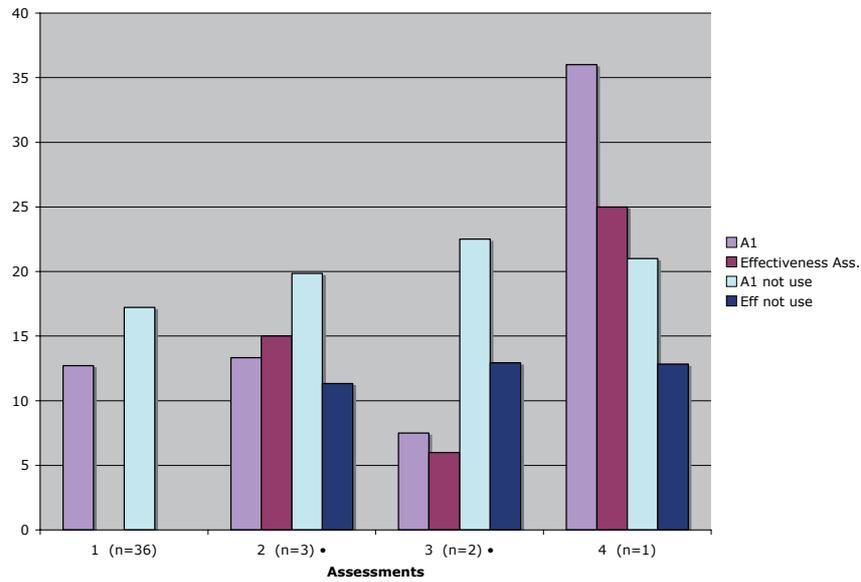
• significant differences between A1 and A2 and A3 for those who had not availed of it.

Figure 143: PDS mean scores for indirect services users (4 assessments)
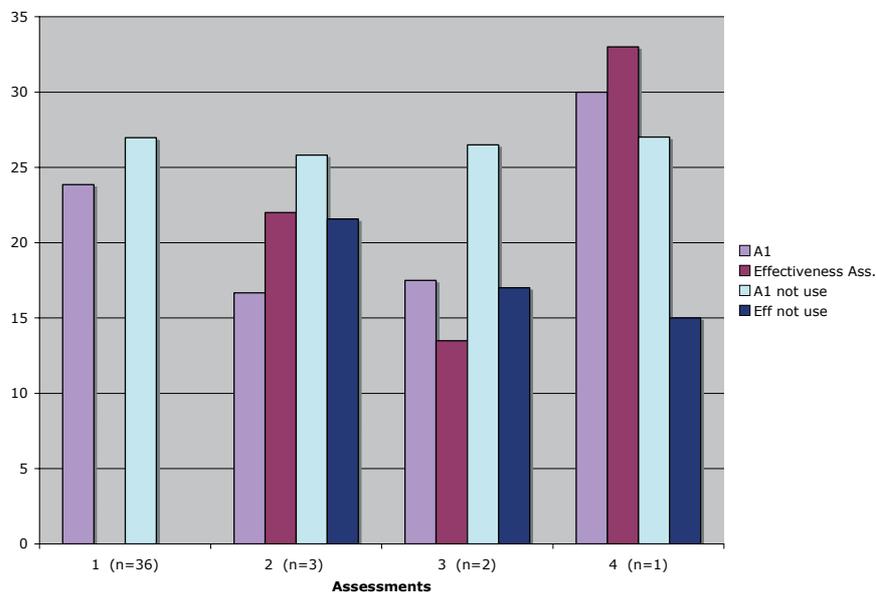
6.5. DISCUSSION

The effectiveness of voluntary sector services was explored using a time-series design in which participants were asked to complete the research inventory on up to 4 occasions with intervals of 3-4 months between assessments. The inventory was designed to assess general psychological health, levels of depression, and PTSD symptom severity. In addition, we sought to establish which services had been received and which significant life events had been experienced in the interval between each of the assessments. In total, 75 participants took part in the baseline assessment (A1), 25 took part in the second assessment (A2), 20 took part in the third assessment (A3), and 13 participants responded to the fourth assessment (A4). Twenty individuals responded to lengthy semi-structured interviews. This means that in total 133 assessments and 20 interviews were carried out.

This was the first multi-method, quantitative and qualitative, study that explored the effectiveness of voluntary sector services for victims of the Troubles in Northern Ireland. The amount of data collected allowed for a detailed analysis of how services delivered by the voluntary sector affect individuals who remain traumatized up to nearly 40 years after they had experienced traumatic events, i.e., events that took place anytime between the beginning of the Troubles in 1969 and the date of data collection for this research (2005-06).

We found that overall during the assessment period (9-12 months), psychological health and levels of depression improved significantly for participants. The same was

not true for PTSD symptom severity. Before concluding that these effects were due to services received, we excluded other extraneous causal factors. We did this by utilizing the D.I.S.C. framework proposed by Dillenburger and Keenan (2005). We found that death or trauma-related events, individual variables, social factors, and cultural variables only had marginal effects on psychological health, levels of depression, and PTSD symptom severity during the assessment period. However, we found that the experience of additional stressful life events affected psychological health as well as levels of depression and PTSD severity adversely. Therefore, we were able to conclude that, overall, voluntary sector services seem to be achieving their stated aims of helping services users who experienced Troubles-related trauma, especially for those who experienced additional life stresses.

The identification of exactly which services were most effective was more difficult, as most of the participants used more than one services at a time. However, statistical analysis showed that there were clear indications that some services, specifically **befriending**, **self-help/support groups** as well as **reflexology** were related to significant improvements in general psychological health and levels of depression. The results for some of the other services, such as advice and information, massage, aromatherapy, group therapy, respite care/time-out, youth work, narrative work and counselling were not as clear, i.e., while some people improved significantly using these services, others who did not avail of these services also improved significantly. However, all of these services were highly valued by interviewees. In sum, we found that community-based and some complementary services were significantly related to improvements in generally psychological wellbeing and lowering levels of

depression. These findings were corroborated by the interviews, which confirmed the helpfulness and philanthropic utility of these services.

However, with regard to trauma recovery the evidence was not convincing as the majority of services did not seem to be effective in lowering levels of PTSD symptom severity. A number of reasons can be responsible for this finding. First, in the psychological literature, the concept of PTSD is not without contention (Kutchins, & Kirk, 1999). Therefore, it is entirely possible that PTSD is not the appropriate classification for individuals who were traumatized by events that happened many years ago. On the other hand, it is possible that due to the lack of appropriate support at the time of the trauma, these people have become chronically traumatized and need much more professional input in order to 'recover'.

7. Conclusion

T his study achieved three major aims. First, it established an overview and categorisation of the services offered to people affected by violence in Northern Ireland. Second, it explored the effectiveness of some of the most commonly used services as regards achieving their set aims/goals. Third, it encouraged collaboration through sharing and dissemination of research outcomes.

1. For the first time, a detailed outline and categorisation of voluntary sector services is now available. The suggested categorisation allows for expansion and addition if and when new services become available. In the meantime, available services can now be assessed according to minimal service standards. A bottom-up approach was used to establish these basic service standards, i.e., they were drawn up from data that were provided by voluntary service organizations about the services they presently provide. With time and further information, it should be possible to raise these standards to increasingly proficient and effective levels of service delivery.

2. Through the exploration of effectiveness of voluntary sector services provided by this research, it has become clear that this sector provides a much valued and important service to victims of trauma in Northern Ireland. Findings show the synergetic effectiveness of voluntary sector services and evidence that overall these services achieve their aims of helping people gain improved mental health and to cope with trauma. However, individually, some of these

services seem to be more effective than others. More specifically, community-based services such as befriending, self-help groups, and some complementary therapies, seem to be the most effective aspects of service provision. These are the kind of services not provided elsewhere in the service hierarchy, that spans across social support provided by family, to community/voluntary sector services, and finally, statutory service provision, such as clinical psychology, psychiatry, nursing, or social work. As such, findings reported here show the need and the efficacy of community-based voluntary sector services, while at the same time identifying some important gaps in service provision.

3. Dissemination and collaboration were an important part of the project. We found that locally as well as internationally this project received intense interest. The importance of sharing knowledge gained at a local level, with the community from which data emanated, as well as with the international community cannot be underestimated. Future discussions and collaborations in the area of evidence-based practice should be encouraged as part and parcel of the sector's policy and practice.

Finally, research reported here concentrated on the exploration of effectiveness of voluntary sector services with specific regard to general psychological health, levels of depression, and PTSD symptom severity. Obviously, there are other potential benefits that emanate from voluntary sector support services, such as social inclusion, social capital, and/or social cohesion, and these may have economic, health, and/or

educational consequences, as well as trans-generational effects. Future studies would do well to consider these issues.

References

A

American Psychiatric Association (Ed.) (1994). *Diagnostic and statistical manual of mental disorders. Fourth edition (DSM-IV)*. Washington, D.C.: American Psychiatric Association.

Association for Advancement of Behavior Therapy (AABT; 1991). *What is behavior therapy?* Retrieved from the Web on 3/20/2005.

http://www.utulsa.edu/cpsc/bereavement.htm

B

Beck, A. T., Steer, R..A., Garbin, M.. G., (1988) Psychometric properties of the Beck Depression Inventory: Twenty-five years of evaluation. *Clinical Psychology Review,* 8, 77-100.

Bloomfield, K. (1998). *'We will remember them': Report of the Northern Ireland Victims Commissioner*. Belfast: The Stationery Office Northern Ireland (April).

Bolton, G. (2004) Opening the word hoard. Editorial: Death, dying, and bereavement, *Journal of Medical Ethics, Medical Humanities,* 30, 49–52

Boss, P., Beaulieu, L., Wieling, E., Turner, W., & LaCruz, S. (2003). Healing loss, ambiguity, and trauma: A community-based intervention with families of union workers missing after the 9/11 attack in New York City. *Journal of Marital and Family Therapy*. 29, 455-468.

Bradshaw, T. & Haddock, G. (1998). Is befriending by trained volunteers of value to people suffering from long-term mental illness? *Journal of Advanced Nursing*, 27, 713-720.

Burnell, G.M., & Burnell, A. L. (1986). The Compassionate Friends: A support group for bereaved parents. *The Journal of Family Practice,* 22, 295-296.

C

Cairns, E. & Wilson, R. (1984). The impact of political violence on mild psychiatric morbidity in Northern Ireland. *The British Journal of Psychiatry*, 145, 631-635.

Caserta, M.S. & Lund, D.A. (1993). Intrapersonal resources and the effectiveness of self-help groups for bereaved older adults. *The Gerontologist*, 33, 619-629.

Chaitin, J. (2003). Narratives and storytelling. In G. Burgess & H. Burgess (Eds). *Beyond intractability.* Boulder, Colorado, USA, University of Colorado: Conflict Research Consortium.

Chris-UK (2005). *Complementary healthcare information service – UK*. Retrieved from the Web on 3/23/2005. http://www.chisuk.org.uk/index.php

Coll, S. (2006). *Contributing to well-being. Addressing the human and community consequences of civil violence. Standards for counselling, listening ear & befriending services.* Enniskillen Community Victims & Survivors Initiative in Partnership with the Sperrin Lakeland Health and Social Care Trust (February).

Connelly, P. (2003). *Ethical principles for researching vulnerable groups*. Belfast: Office of First Minister and Deputy First Minister (OFMDFM).

Curran, P.S., Bell, P., Murray, A., Loughrey, G., Roddy, R. &Rocke, L. G. (1990). Psychological Consequences of the Enniskillen Bombing. *The British Journal of Psychiatry*, 156, 479-482.

Cutcliffe, J.R. (2004). *The inspiration of hope in bereavement counselling*. London: Jessica Kingsley Publishers.

D

Darby, J. & Williamson, A. (1978). *Violence and social services in Northern Ireland*. London: Heinemann.

Deloitte & Touche (2001). *Evaluation of services to victims and survivors of the Troubles.* Belfast: Victims Unit, OFMDFM.

Department of Health (DH) (1997). *Health Survey for England 1995*. London: The Stationery Office.

Dillenburger, K. (1992). *Violent Bereavement: Widows in Northern Ireland.* Aldershot: Avebury.

Dillenburger, K. (2001). 'Discovery' and treatment of trauma. Response. In B. Hamber, D. Kulle, & R. Wilson. *Future policies for the past* (pp. 65-72). Belfast: Democratic Dialogue.

Dillenburger, K. (2002). *Psychological perspectives on the Trouble*s*: Violent bereavement.* Belfast: British Psychological Society, Northern Irish Branch (September, 27)

Dillenburger, K. & Keenan, M. (2001). Islands of pain in a sea of change: Behaviour analysis and bereavement. *European Journal of Behaviour Analysis*, 2, 187-207.

Dillenburger, K. & Keenan, M. (2005). Bereavement: A D.I.S.C. analysis. *Behavior and Social Issues*, 14, 92-112.

Dillenburger, K., Akhonzada, R., & Fargas, M. (2006). Post-trauma: Is evidence-based practice a fantasy? *International Journal of Behavioral and Consultation Therapy*, 2, 95-107.

Dillenburger, K., Fargas, M. & Akhonzada, R. (2005). Victims or survivors? Debate about victimhood in Northern Ireland. *International Journal of Humanities*, 3, 222-231.

Doermann, D.J. (2002). *Gestalt therapy. Gale Encyclopaedia of medicine*, Farmington Hills, MI: Gale Group.

E

Erickson, F. (1982). *The counselor as gatekeeper: Social interaction in interview*s. New York: Academic Press.

Ernst, E. (2000). The role of complementary and alternative medicine. *British Medical Journal, 321*,1133-1135.

F

Fay, M-T., Morrissey, M. & Smyth, M. (1999). *Northern Ireland's Troubles. The human costs*. London: Pluto Press

Fay, M. T., Morrissey, M., Smyth, M. & Wong, T. (1999). *The Cost of the Troubles Study. Report on the Northern Ireland Survey: The experience and impact of the Troubles.* Belfast: INCORE.

Foa, E. B., Cashman, L., Jaycox, L., & Perry, K. (1997). The validation of a self-report measure of posttraumatic stress disorder: The Posttraumatic Diagnostic Scale. *Psychological Assessment*, 9, 445–451.

Fonnagy, P. (2000). The outcome of psychoanalysis. The hope of a future. *The Psychologist, 13*, 620-623.

Fraser, M. (1973), *Children in conflict,* Norwich: Norfolk Pelican Book.

Freedman, J. & Combs, G. (1996). Shifting paradigms: From systems to stories. In J. Freedman & G. Combs. *Narrative therapy: The social construction of preferred realities*. New York: Norton.

G

Galinsky, M.J., & Schopler, J.H. (1994). Negative experiences in support groups. *Social Work in Health Care,* 20, 77-95.

Gillespie, K., Duffy, M., Hackmann, A., & Clark, D. M., (2002). Community based cognitive therapy in the treatment of posttraumatic stress disorder following the Omagh bomb. *Behaviour Research and Therapy*, 40, 345-357.

Gilligan, C. (2006). Traumatised by peace? A critique of five assumptions in the theory and practice of conflict-related trauma policy in Northern Ireland. *Policy & Politics*, 34, 325-345.

Goldberg, D., McDowell, I., & Newell, C. (1996). *Measuring health: A guide to rating scales and questionnaires* (2nd ed.). New York: Oxford University Press.

Gray, M. & Litz, B. (2005). Behavioral interventions for recent trauma: Empirically informed practice guidelines. *Behavior Modification*, 29, 189-215.

Groth-Marnat G. (1990). *The handbook of psychological assessment* (2nd ed.). New York: John Wiley & Sons.

H

Hamber, B. (2003). Healing. In D. Bloomfield, P.B. Hayner, B. Hamber, L. Huyse, & T. Barnes. *Reconciliation after violent conflict: A Handbook*. Stockholm: International Institute for Democracy and Electoral Assistance.

Hamber, B. & Kulle, D. (2001). Introduction. In Hamber, B., Kulle, D. & Wilson, R. (Eds), *Future Policies for the Past, (Report No 13)* (pp. 9-14). Belfast: Democratic Dialogue.

Harris, T., Brown, G.W., Robinson, R. (1999). Befriending as an intervention for chronic depression among women in an inner city. *British Journal of Psychiatry,* 174, 219-224.

Harvard Program in Refugee Trauma (HPRT; 2005). *Psychopharmacology.* Retrieved from the Web 11/10/2005. http://www.hprt-cambridge.org/Layer3.asp?page_id=14

Harvey, A.G., Bryant, R.A., & Tarr, N. (2003). Cognitive behaviour therapy for posttraumatic stress disorder. *Clinical Psychology Review*, 23, 501-522.

Hayes, P. & Campbell, J. (2000). Dealing with Post-Traumatic Stress Disorder: The psychological sequelae of Bloody Sunday and the response of State services. *Research on Social Work Practice,* 10, 705-721.

Health Promotion Agency (2002). *Health and Lifestyle Survey for Northern Ireland 2002*. Belfast: Health Promotion Agency.

Heslop, P. (2005). Good practice in befriending services for people with learning difficulties. *British Journal of Learning Disabilities*, 33, 27-33.

Hillyard, P., Kelly, G., McLaughlin, E., Patsios, D., & Tomlinson, M. (2003). *Bare necessities: Poverty and social exclusion in Northern Ireland*. Belfast: Democratic Dialogue.

Hillyard, P., Rolston, B., & Tomlinson, M. (2005). *Poverty and conflict in Ireland: An international perspective,* Dublin: Institute of Public Administration/Combat Poverty Agency.

Holmes, T.H. & Rahe, R.H. (1967), The social readjustment rating scale. *Journal of Psychosomatic Research*, 11, 213-218.

J

Joseph, S., & Linley, P. A. (2004). Adversarial growth and positive change following trauma: Theory, research, and practice. *Ricerche di Psicologia*, 27, 177-190.

K

Kelly, G. & Smyth, M. (1999). Report on a survey of voluntary groups serving the needs of those bereaved and injured in the Troubles. Belfast: The Victims Liaison Unit.

Kutchins, H. & Kirk, S.A. (1999). *Making us crazy: DSM-The psychiatric bible and the creation of mental disorders.* London: Constable.

Kulle, D. (2001). Victims and survivors: A study of the dynamics of the victims debate in Northern Ireland. In J. Magowan & N. Patterson (Eds), *Hear and Now… and Then… Developments in victims and survivors work* (pp. 79-87). Belfast: The Northern Ireland Voluntary Trust.

L

Lavoie, F. (1990). Evaluating self-help groups. In J.M. Romeder (Ed). *The self-help way: Mutual aid and health* (pp. 41-54). Otawa: Canadian Council on Social Development.

LeDoux, L.E. & Gorman, J.M. (2001) A call to action: Overcoming anxiety through active coping. *American Journal of Psychiatry*, 158, 1953-1955.

M

Magowan, J. & Patterson, N. (Eds) (2001). *Hear and now… and then… Developments in victims and survivors work*. Belfast: The Northern Ireland Voluntary Trust.

Manktelow, R. (in press). The needs of victims of the Troubles in Northern Ireland: The social work contribution. *Journal of Social Work*.

McCreary, A. (1976). *Survivors*. Century Books: Belfast.

McDougall, B. (2006). *First interim report*. Belfast: Northern Ireland Victims Commissioner Office (June).

McWhirter, L. (2002). *Health and social care in Northern Ireland: A statistical profile*. Belfast: Northern Ireland Statistics & Research Agency.

Milrod, B., Busch, F., Cooper, A., & Shapiro, T. (1997). *Manual for panic-focused psychodynamic psychotherapy*. Washington, DC: American Psychiatric Press.

Morrissey, M. & Smyth, M. (2002). Northern Ireland after the Good Friday Agreement. Victims, grievance and blame. London: Pluto Press.

Muldoon, O., Schmid, K., Downes, C., Kremer, J., & Trew, K. (2005). *The Legacy of the Troubles: Experience of the Troubles, mental health and social attitudes*. Belfast: Queen's University Belfast.

N

Northern Ireland Statistics and Research Agency (1997, 2001). *Northern Ireland Health and Social Wellbeing Survey.* Belfast: Northern Ireland Statistics and Research Agency.

Northern Ireland Office (1998). *The Agreement.* Belfast: Northern Ireland Office (April, 10).

O

O'Reilly, D. & Brown, S. (2001). Health and health service use in Northern Ireland: Social variations. A report from the Health and Social Wellbeing Survey 1997. Belfast: Department of Health, Social Services and Public Safety.

O'Reilly, D. & Stevenson, M. (2003). Mental health in Northern Ireland: Have "the Troubles" made it worse?. *Journal of Epidemiology and Community Health*, 57, 488-492.

Orsillo, S.M., Batten, S.V., & Hammond, C. (2001). Acute Stress Disorder and Posttraumatic Stress Disorder: A brief overview and guide to assessment. In M.M. Anthony, S.M. Orsillo, & L.Roemer (Eds). *Practitioner's guide to empirically based*

measures of anxiety. Association for Advancement of Behavior Therapy. Clinical Assessment Series. New York: Kluwer Academic/Plenum Publishing.

Osterweis, M., Solomon, E., & Green, M. (Eds). (1984). *Bereavement: Reactions, consequences and care* (Report by the Committee for the Study of Health Consequences of the Stress of Bereavement, Institute of Medicine, National Academy of Sciences). Washington, DC: National Academy Press.

P

Potter, M. (2004). *In their own words: A research report into the victims sector in Northern Ireland*. Belfast: Training for Women Network.

R

Reshape, rebuild, achieve (RRA, 2002). The Victims Unit. Office of the First Minister and Deputy First Minister. Retrieved from the Web 12/30/2002. www.victimsni.gov.uk

Rock, P. (2002). On becoming a victim. In C. Hoyle & R.Young (Eds.), *New visions of crime victims.* Oxford: Hart Publishing.

S

Seligman, M.E.P. (1991). *Helplessness: On depression, development, and death.* (2nd Ed). New York: W.H. Freeman.

Shapiro, F. (2001). *Eye movement desensitization and reprocessing: Basic principles, protocols and procedures* (2nd Ed). New York: Guilford Press.

Shapiro, D.A., Rees, A., Barkham, M., Hardy, G., Reynolds, S., & Startup, M. (1995). Effects of treatment duration and severity of depression on the maintenance of gains after cognitive-behavioral and psychodynamic-interpersonal psychotherapy. *Journal of Consulting and Clinical Psychology, 63*, 378-387.

Smyth, M. (1997). *Submission to the Northern Ireland Commission on Victims.* (December). Retrieved from the Web 11/2/05.

http://www.cain.ulst.ac.uk/cts/smyth97a.htm

Smyth, M. (2000). The human consequences of armed conflict: Constructing 'victimhood' in the context of Northern Ireland's Troubles. In M. Cox, A. Guelke, & F.Stephen (Eds), *A farewell to arms? From 'long war' to long peace in Northern Ireland* (pp. 118-135). Manchester: Manchester University Press

Smyth, M. (2001). The 'discovery' and treatment of trauma. In B. Hamber, D. Kulle, & R.Wilson (Eds), *Future policies for the past, (Report No. 13)* (pp. 57-65). Belfast: Democratic Dialogue.

Social Services Inspectorate Report (1998). *Living with the trauma of the Troubles*. Belfast: Department of Social Services and Public Safety.

Spates, C.R. (2002). *Posttraumatic Stress Disorder: A behavior analytic interpretation of the disorder and its treatment.* Paper presentation to the Annual Convention of The Japan Association for Behavior Analysis (August, 25).

T

Taggart, A.V., Short, S.D., & Barclay, L. (2000). 'She has made me feel human again': An evaluation of a volunteer home-based visiting project for mothers. *Health and Social Care in the Community*, 8, 1-8.

Tennant, C. (1977). The General Health Questionnaire: A valid index of psychological impairment in Australian populations. *Medical Journal of Australia* 2, 392-394.

V

Victims Unit (2005). *Services for victims and survivors. Consultation on next phase of policy in relation to services for victims and survivors of the Troubles in Northern Ireland and on the establishment of a Commissioner for Victims and Survivors.* Belfast: The Victims Unit, OFMDFM. (March)

Z

Zimbardo, P.G. (2005) *Discovering psychology*. Retrieved from the Web on 3/18/2005.

http://www.learner.org/discoveringpsychology/therapeutic/psychological.html

PAVE project publications

Journal articles and book chapters

Dillenburger, K., Fargas, M. & Akhonzada, R. (2005). The PAVE Project. *Victims and Survivors Newsletter*. Belfast: Victims Unit, OFMDFM.

Dillenburger, K & Keenan, M (2005) Bereavement: A D.I.S.C. analysis. *Behavior and Social Issues*, 14, 92-112.

Dillenburger, K., Fargas, M. & Akhonzada, R. (2005). Victims or survivors? Debate about victimhood in Northern Ireland. *International Journal of Humanities*, 3, 222-231.

Dillenburger, K., Akhonzada, R., & Fargas, M. (2006). Post-trauma: Is evidence-based practice a fantasy? *International Journal of Behavioral and Consultation Therapy*, 2, 95-107.

Translated into German by Christoph Bördlein (2006). Evidenzbasierte Behandlung der Posttraumatischen Belastungsreaktion: Dünne Forschungslage, *Der Skeptiker*, 2, 67-68.

Dillenburger, K., Fargas, M. Kelly, G.P., & Akhonzada, R. (2006) Traumatic bereavement and coping: Implications for a contextual approach. In K. Woodthorpe. *Making sense of dying and death.* Oxford, UK: Inter-Disciplinary Press. ISBN 1-904710-39-5

Dillenburger, K., Fargas, M., Kelly, G.P., & Akhonzada, R. (2006). *Long-term effects of trauma in Northern Ireland: Personal accounts on coping with violence over a twenty-year period*. Trauma Research Net (International Network for Interdisciplinary Research about the Impact of Traumatic Experience on the Life of Individuals and

Society).   Retrieved   from   the   Web   on   01/01/2006   from
http://www.traumaresearch.net/

Dillenburger, K. & Fargas, M. (in press). Doing sensitive research: Reflection as
development. In P. Maiti *(Ed.) Development Studies (Vol 3)*. New Delhi, India:
Atlantic Publishers & Distributor.

Dillenburger, K., Fargas, M. & Akhonzada, R. (in press). Psychological impact of
long-term political violence. An exploration of community service users.
Traumatology.

Dillenburger, K., Akhonzada, R., & Fargas, M. (in press). Community services for
people affected by violence: An exploration and categorisation. *Journal of Social
Work.*

Dillenburger, K., Fargas, M., & Akhonzada, R. (under review). The individual as unit
of analysis of coping with post-ceasefire violence. *The Journal of Behavior Analysis
of Offender and Victim Treatment and Prevention*.

Conference presentations

Dillenburger, K (2005*). Bereavement and people affected by violence: A D.I.S.C. analysis* Invited Keynote. Victims and Survivors Conference. Templepatrick, NI, Community Relations Council (7-8 March).

Dillenburger, K. & Keenan, M. (2005). *Basic behavioural processes in bereavement: A D.I.S.C. analysis*. Poster. British Association for Behavioural and Cognitive Psychotherapies. Annual Conference. University of Kent. Canterbury (July 20-23).

Dillenburger, K., Fargas, M., & Akhonzada, R. (2005). *Victims or Survivors? The debate on victimhood in Northern Ireland.* The Third International Conference on New Directions in the Humanities. University of Cambridge, Cambridge (August 2-5).

Dillenburger, K., Akhonzada, R., & Fargas, M., (2005). *Community violence in Northern Ireland: Categorisation of services and therapies for people affected by violence.* Poster. 4th European Congress on Violence in Clinical Psychiatry. Vienna, Austria. (Oct 20-21).

Dillenburger, K., Fargas, M., & Akhonzada, R. (2005). *Violence and mental health in Northern Ireland: Exploring effectiveness of therapeutic services*. Abstract. 4th European Congress on Violence in Clinical Psychiatry. Vienna, Austria. (Oct 20-21).

Dillenburger, K., Fargas, M., & Akhonzada, R. (2005).*The PAVE project: Exploring effectiveness of services for people affected by violence*. Staff/student Seminar, QUB, Belfast, (Dec 9).

Dillenburger, K., Fargas, M., & Akhonzada, R. (2006). *People affected by violence: Can community services promote equality and social inclusion?* Equality and Social Inclusion in the 21st Century: Developing Alternatives. An international multi-disciplinary conference, Belfast (Feb 1-3).

Dillenburger, K., Fargas, M., & Akhonzada, R. (2006). *Community violence and psychological trauma: Exploring effectiveness of services*. Fourth International Conference On New Directions In The Humanities, University of Carthage, Tunisia, (July, 3-6).

Dillenburger, K., Fargas, M., & Akhonzada, R. (2006). *Traumatic bereavement and coping: Implications for a contextual approach*. 4th Global Conference. Making Sense Of: Dying and Death, Mansfield College, Oxford (July, 12-14)

Dillenburger, K. & Keenan, M. (2006). *D.I.S.C. analysis of bereavement and loss*. 3rd Conference of the European Association for Behaviour Analysis. Milan, Italy (July 18-21).

Dillenburger, K., Fargas, M., Kelly, G.P., & Akhonzada, R. (2006). *Long-term effects of trauma in Northern Ireland: Personal accounts on coping with violence over a*

twenty-year period. 3rd International Trauma Research Net Conference Trauma – Stigma and Distinction. Social Ambivalences in the Face of Extreme Suffering. St. Moritz, Switzerland (Sep. 14-17).

Dillenburger, K., Fargas, M., & Akhonzada, R. (2006). *People affected by violence: Psychological health and services offered by voluntary self-help groups in Northern Ireland.* Staff/student Seminar. QUB (Nov, 15)

Dillenburger, K., Fargas, M., & Akhonzada, R. , & Kelly, G.P. (2006). *Evidence-based practice for victims of political violence in Northern Ireland.* Enhancing Social Work Practice Conference. Knockbracken Healthcare Park, Belfast (Nov 29).

Dillenburger, K., Fargas, M., & Akhonzada, R. (2006). *Mental health of people affected by violence in Northern Ireland: Exploring the services offered by voluntary victims group*s. 5th International Conference on Social Work in Health and Mental Health, The University of Hong Kong, Hong Kong (Dec 10-14).

Award

Outstanding Service/Project Award (Professional) (2006). Mental health of people affected by violence in Northern Ireland: Exploring the services offered by voluntary victims groups (P0075). Hong Kong: Social Work in Health and Mental Health.

Appendices

APPENDIX 1: THE COMMUNITY SERVICES QUESTIONNAIRE (CSQ)

About the group:

1. Name of organisation _____

2. Address _____

_____

_____

3. Telephone number _____

4. Contact person _____

5. Which year was your organisation formed? _____

6. Who do you mainly work with? *(Please tick appropriate box)*

    . Only people affected by the Troubles ☐
    . People affected by the Troubles and others ☐

    If appropriate, please state specific population that you work with

    _____

7. How many staff members does your organisation have? _____

About "the people affected by the Troubles" who seek your services:

8. How many people are using your services at the present? _____

9. How many people affected by the Troubles did the group help over the years? ___

    _____

10. Please indicate the gender and age of your service users by ticking appropriate boxes.

    Male ☐   Female ☐

    Under 18 ☐   18-44 ☐   45-64 ☐   65+☐

11. How many members or users of your organisation are:
    ❑ Widowed   _____
    ❑ Bereaved relatives *(please specify)*   _____
    ❑ Bereaved parents   _____
    ❑ Physically injured or disabled   _____
    ❑ Carers of someone injured by the Troubles _____

❑ Intimidated people as result of the Troubles _____
❑ Witnesses of direct violence of the Troubles _____
❑ Others. Please specify _____

12. Referral: who suggested the members or users of your organisation to come to seek your services? *(Please tick the appropriate box / boxes)*

. Personal referral (relative / friend)   ☐
. Professional referral (GP/ nurse)   ☐
. Others. Please specify _____ ☐

<u>About the services</u>

13. Does your organisation offer:

13.1. –Befriending?   **Yes** ☐   **No** ☐

If yes,
    How many of your members are presently using this service? _____
    How many have used this service over the past 12 months? _____
                    24 months?_____
    How many befrienders does your group have? _____
    How many hours does each befriender usually offer his/her service?_____
    Are the befrienders trained?
        Yes ☐   No ☐
        If yes, please state qualifications / accreditation: _____
        _____

    Does the group provide supervision for befrienders?
        Yes   ☐   No   ☐

    If yes, how is that supervision provided? _____
    What kind of activities do befrienders carry out? _____
    _____

    Do these persons avail off other services offered by your group at the moment?
        Yes   ☐   No   ☐
        If yes, please list other services used _____
    _____

13.2. – Support groups/ self-help groups? **Yes** ☐   **No** ☐

If yes,
    How many of your members are presently using this service?_____
    How many have used this service over the past 12 months? _____
                    24 months?_____

How many people are there in each group? _____

How often do they meet? *(Tick appropriate box)*
          More than once a week   ☐
          Once a week   ☐
          Once every two weeks   ☐
          Once a month   ☐
          Others (specify)_____   ☐

Is the group facilitated by skilled experienced group workers?
          Yes   ☐   No   ☐
       If yes, how many workers facilitate each group session?_____
          Are they trained?   Yes   ☐   No   ☐
              If yes, please state qualification / accreditation:

_____

_____

Is it a group of people in similar circumstances aiming to support each other?
          Yes   ☐   No   ☐

Do these persons avail off other services offered by your group at the moment?
          Yes   ☐   No   ☐
       If yes, please list other services used _____

_____

13.3. - Respite care / time out?   **Yes** ☐   **No** ☐

If yes,
    How many of your members are presently using this service? _____
    How many have used this service over the past 12 months? _____
                                    24 months?_____

Please describe briefly activities involved in respite care

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Do these persons avail off other services offered by your group at the moment?
          Yes   ☐   No   ☐

If yes, please list other services used _____

_____

13.4.- Youth work? **Yes** ☐ **No** ☐

If yes,
How many of your members are presently using this service? _____
How many have used this service over the past 12 months? _____
24 months? _____

How many facilitators are involved? _____

Are they trained? Yes ☐ No ☐
If yes, please state qualifications / accreditation: _____

_____

Does it consist of one-to-one activities? Yes ☐ No ☐
If yes, what kind of activities does your organisation carry out?

_____

Does it consist of group activities? Yes ☐ No ☐
If yes, what kind of activities does your organisation carry out?

_____

Do these persons avail off other services offered by your group at the moment?
Yes ☐ No ☐
If yes, please list other services used _____

_____

13.5.- Narrative work (for example, giving accounts of traumatic events or recording stories)? **Yes** ☐ **No** ☐

If yes,
How many of your members are presently using this service? _____
How many have used this service over the past 12 months? _____
24 months? _____

How is this facilitated? _____
Number of meetings _____

Tick appropriate Individual meeting ☐
Group meetings ☐
Other, please specify _____ ☐

Are the facilitators trained?   Yes ☐   No ☐
      If yes, please state qualifications / accreditation: _____

_____

How long is this offered for? _____

Do these persons avail off other services offered by your group at the moment?
      Yes ☐   No ☐
      If yes, please list other services used _____

_____

13.6.- Counselling?   **Yes** ☐   **No** ☐

If yes,
    How many of your members are presently using this service? _____
    How many have used this service over the past 12 months? _____
                                   24 months? _____
    How many counsellors does your group have? _____

    Are the counsellors trained?   Yes ☐   No ☐
      If yes, please state qualifications / accreditation: _____

_____

Does the counselling involve a certain number of sessions?
    Yes ☐   No ☐
    If yes, how many sessions? _____

Does it depend on the needs of the person who is being counselled?
    Yes ☐   No ☐
    If yes, what has been the longest period of counselling? _____
      What has been the shortest? _____

What kind of counselling methods does your group use? *(Tick appropriate box)*

-Rogerian-person-centred approach   ☐
-Humanistic approach (i.e. Gestalt)   ☐
-Transactional analysis   ☐
-Problem solving approaches (i.e. solution-focused techniques)   ☐
-Cognitive behavioural techniques   ☐
-Others. Please specify _____ ☐

Do these persons avail off other services offered by your group at the moment?
    Yes ☐   No ☐

If yes, please list other services used _____

_____

13.7.- Group therapy?   **Yes** ☐   **No** ☐

If yes,
    How many of your members are presently using this service? _____
    How many have used this service over the past 12 months? _____
                               24 months?_____

    How many people are in each group?_____
    How many therapists / facilitators work with each group? _____

    Are they trained?   Yes ☐   No ☐
          If yes, please state qualifications / accreditation: _____
    _____

    How often do the groups meet? *(Tick appropriate box)*
               More than once a week   ☐
               Once a week   ☐
               Once every two weeks   ☐
               Once a month   ☐
               Others (specify)…._____   ☐

    Is the group based around themes/issues?   Yes ☐   No ☐
          If yes, what themes and issues are addressed?
          _____
          _____

    Do these persons avail off other services offered by your group at the moment?
          Yes ☐   No ☐
          If yes, please list other services used _____
          _____

13.8. - Psychotherapeutic services?   **Yes** ☐   **No** ☐

If yes,
    How many of your members are presently using this service? _____
    How many have used this service over the past 12 months? _____
                               24 months?_____
    How many psychotherapists does the group have? _____

    Are they trained?   Yes ☐   No ☐

If yes, please state qualifications / accreditation: _____

_____

Does it involve a certain number of sessions for each person?
       Yes ☐   No ☐
       If yes, how many?   _____

Does it depend on the needs of each individual?
       Yes ☐   No ☐

       If yes, what has been the longest period of therapy for one person?
       _____

       What has been the shortest period?   _____

What kind of therapeutic approaches do your group's therapists use?
(Tick appropriate box / boxes)
      -Cognitive-behavioural   ☐
      -Humanistic   ☐
      -Systemic family therapy   ☐
      -Psychoanalytic/psychodynamic psychotherapy   ☐
      -Others. Please specify   _____ ☐

Do these persons avail off other services offered by your group at the moment?
       Yes ☐   No ☐
       If yes, please list other services used _____
       _____

13.9.- Complementary therapies?   **Yes** ☐   **No** ☐

If yes,
     How many of your members are presently using this service? _____
     How many have used this service over the past 12 months? _____
                                24 months?_____
     How many complementary therapists does your organisation have?

     _____

     Are they trained?   Yes ☐   No ☐
        If yes, please state qualifications / accreditation: _____

     _____

     What kind of complementary therapy does your organisation provide?
     (Tick appropriate box / boxes)

-Reflexology ☐
-Massage ☐
-Aromatherapy ☐
-Art therapy ☐
-Music therapy ☐
-Drama therapy ☐
-Reiki ☐
-Play ☐
-Others. Please specify _____ ☐

How many sessions do you offer?
    Minimum   _____
    Maximum   _____
Do these persons avail off other services offered by your group at the moment?
    Yes   ☐   No   ☐
    If yes, please list other services used _____

_____

13.10. -Advice and information?   **Yes** ☐   **No** ☐

If yes,
    How many of your members are presently using this service? _____
    How many have used this service over the past 12 months? _____
                                    24 months?_____

Please specify the kind of advice/information given *(Tick appropriate box/boxes)*

-Legal matters ☐
-Financial assistance ☐
-Practical needs (aids and appliances) ☐
-Others. Please specify _____ ☐

How is the information/advice provided? *(Please tick appropriate box / boxes)*

-Written information in leaflets or explanatory notes ☐
-Telephone helpline ☐
-Drop-in facility ☐
-By appointment system ☐
-Other means. Please specify _____ ☐

Do these persons avail off other services offered by your group at the moment?
    Yes   ☐   No   ☐
    If yes, please list other services used _____

_____

13.11. - Indirect services?   **Yes** ☐   **No** ☐

If yes,
    How many of your members are presently using this service? _____
    How many have used this service over the past 12 months? _____
                                 24 months? _____

    Tick the services that your group provides:
    -Advocacy   *(Please describe briefly)*   ☐
    _____

    -Funding:
            Small grants for members   ☐
            Funding for groups   ☐
            Other, please specify _____   ☐

    -Community Development and Capacity building:
            Giving advice to community development   ☐
            Working with new or developing groups   ☐
            Other, please specify _____   ☐

    -Lobbying (please specify)   _____   ☐
    -Public Education   ☐
    -Training and Supervision for staff members   ☐
    -Research (please specify) _____   ☐
    -Other indirect services (please specify) _____   ☐

    Do these persons avail off other services offered by your group at the moment?
        Yes   ☐   No   ☐
        If yes, please list other services used _____
        _____

13.12. - Other services?   **Yes** ☐   **No** ☐

Please specify _____

How many of your members are presently using this service? _____

How many have used this service over the past 12 months? _____
                                 24 months? _____

Do these persons avail off other services offered by your group at the moment?
        Yes   ☐   No   ☐

If yes, please list other services used _____

_____

14. Why does your organisation offer these particular services / therapies?

15. Do you have selection / eligibility criteria for service users who want to join your group?   Yes   ☐   No   ☐

If yes, please specify

16. Do you have selection / eligibility criteria for allocation of service that you provide in each case?   Yes   ☐   No   ☐
If yes, please specify

17. Are there any areas / groups of people that you are not presently involved with but you would like to include?   Yes   ☐   No   ☐

If yes, please specify

18. Do you evaluate your services?   Yes   ☐   No   ☐

If yes, please specify:
    Informal feedback   ☐
    Formal feedback (interviews/questionnaire)   ☐
    Others, (Please specify)   _____   ☐

Have you written a report about your evaluation?   Yes   ☐   No   ☐

(If yes, we would greatly appreciate a copy of this report in order to be able to include it into our review)

The next stage of our research includes a more detailed exploration of the effectiveness of services delivered to people affected by the Troubles.

Would you like to take part in the next stage of our project?

                    Yes   No

If yes, we will contact you regarding your continued involvement in the near future.

Thank you for your time and co-operation in completing the questionnaire. Please return the completed questionnaire within one week of receipt. If we have not heard from you within one week we will be in touch.

APPENDIX 2: PARTICIPANT INFORMATION & CONSENT SHEET

Dr Karola Dillenburger
School of Social
7 Lennoxvale
Belfast BT9 5BY
Northern Ireland
Tel. +028 9033 5426/7

October 2004

An exploration of services for people affected by the Troubles

Participant information sheet & consent form

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.'

Over many years now, efforts have been made to develop standards for working with those affected by the Troubles but there has not been a detailed study of such services in Northern Ireland. The purpose of this study therefore is to establish an overview of services offered to people affected by the Troubles and to explore different service approaches in more detail.

You are invited to take part in this study because you are presently in receipt of such services.

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive.

If you decide to take part you will be asked to complete a set of questionnaires, which should not take more than 30 minutes, at the beginning of the study, about 2-3 month later, and at the conclusion of the study (after about 6 month) and to describe how you are getting on. This gives us an indication of how things are progressing for you.

You will not have to do any extra travelling or do anything else to take part in this study. The researcher will travel to the agency that delivers your services.

All information that is collected about you during the course of the study will be kept strictly confidential. Any information about you will have your name and address removed so that you cannot be recognised from it. Others in the helping professions (such as your GP for example) will only be informed of your participation if you explicitly agree for this to happen.

The research is organised by Queen's University Belfast, funded by the Strategic Implementation Fund (OFMDFM Victims Unit), and has been reviewed by the Office of Research Ethics Committees for Northern Ireland. Results are likely to be published in a relevant journal and presented at relevant meetings or conferences.

For further information, please do not hesitate to contact me at the above address. Thank you for taking time to read this information sheet.

Centre Number::   QUB/SIF
Study Number:
Participant Identification Number:

CONSENT FORM

An exploration of services for people affected by the Troubles

Name of Researcher: Dr Karola Dillenburger
                           School of Social Work
                           7 Lennoxvale
                           Belfast BT9 5BY
                           Northern Ireland
                           Tel. +028 9033 5426/7

Please initial box

1. I confirm that I have read and understand the information sheet dated October 2004   ☐
    (version 1) for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time,   ☐
    without giving any reason, without my medical care or legal rights being affected.

3. I agree to take part in the above study.   ☐

_____   _____   _____
First name of Participant   Date   Signature

_____   _____   _____
Name of Person taking consent   Date   Signature
(if different from researcher)

_____   _____   _____
Researcher   Date   Signature

1 for participant; 1 for researcher.

APPENDIX 3: THE PERSONAL EXPERIENCE AND IMPACT OF THE TROUBLES QUESTIONNAIRE (PEIT-Q)

Service users questionnaire

Section 1 About yourself

1. What age are you?   under 30 years ☐
                                    30-50 years   ☐
                                    over 50 years   ☐

2. Female ☐   Male ☐
3. Is the area you live in: inner city.   ☐
                                    outskirts   ☐
                                    small town.   ☐
                                    country.   ☐

4. Are you in paid employment?   yes.   ☐
                                     no   ☐

5. What educational or professional qualifications do you have? ----------------------------

6. Have you any worries
about money?   yes.   ☐
                                    no   ☐

        If yes, what are your worries? --

7. What are your main sources of financial support at the moment? -------------------------

8. Do you feel you get enough time
for yourself?   yes.   ☐
                                    no   ☐

9. How do you generally spend your free time --

10. What is your state of health?   good.   ☐
                                    fair.   ☐
                                    poor.   ☐

11. How often have you seen your
doctor in the past 6 months?   once.   ☐
                                    2-6 times.   ☐
                                    more than 6 times. ☐

12. Are you taking any tablets?   yes   ☐
                                    no.   ☐
        If yes, what kind?..

13. How have you been affected by the Troubles? (Please tick all relevant boxes)

a.   An immediate member of the family has been killed   ☐
b.   Physical injury or disability   ☐
c.   A close friend or relative has been killed   ☐
d.   Witnessed a violent event (shooting, bomb explosion)   ☐
e.   Intimidation   ☐
f.   Caring for someone injured by the troubles   ☐
g.   A member of the family has been injured   ☐
h.   Others *(Please specify)* ------------------------------------- ☐

14. How long ago did this/these traumatic experience/s happen? ……………………………………

15. Did you ever worry that
this might happen ?   yes.   ☐
                                                         no.   ☐
        If yes, who did you talk to about your worries? --

16.How did you hear about it?   a relative told you   ☐
                                                         police told you.   ☐
                                                         the doctor told you   ☐
                                                         you were there   ☐
                                                         other, say how   ☐

17.What was your immediate reaction? ---

18.Has anyone helped you to cope?   yes   ☐
                                                         no.   ☐
        If yes, who helped and how did they help?...

19.Has your day to day life changed?   yes.   ☐
                                                         no.   ☐
  If yes, how...

20.How do you think you have
coped with the loss/injury?   well.   ☐
                                                         fairly well.   ☐
                                                         badly.   ☐

21.Who do you blame for what
happened?   society.   ☐
                                                         Individual   ☐
                                                         doctor.   ☐
                                                         family.   ☐
                                                         yourself.   ☐
                                                         other, say who   ☐

22.Can you talk freely to your
family?   yes   ☐
                                                         no   ☐

23.What kind of things do you or your family find difficult to talk
about?..

24.Has the event changed
the way you feel about yourself?   yes.   ☐
                                                         no.   ☐
        If yes, how?...

25. What religious denomination are you?   Protestant   ☐
                                                         Catholic   ☐
                                                         other   ☐
                                                         none   ☐

26. Have your religious views helped
you to cope ?   yes.   ☐
                                                         no   ☐

Section 2 About the services you receive

1. How long have you been with this group? --

2. What services do you avail of in this group? (*Please tick)*

	Services	√	Period of time used
1	Befriending		
2	Support groups/ self-help groups		
3	Respite care/ time out		
4	Youth work		
5	Narrative work (e.g.giving accounts of traumatic events/recording stories)		
6	Counselling		
7	Group therapy		
8	Psychotherapeutic services		
9	Complementary therapies		
	• Reflexology		
	• Massage		
	• Aromatherapy		
	• Reiki		
	• Art therapy		
	• Music therapy		
	• Yoga		
	• Others. Specify ………………………………		
10	Advice and information		
11	Indirect services		
12	Other services *Please specify*		

3. Circle the answer (1-7) that best describes how much you agree/disagree with the following statements:

    a. I feel that the service/services I receive are significant to me.

        Strongly agree   1 - 2 - 3 - 4 - 5 - 6 - 7 -   Disagree

    b. I feel that the services I receive are appropriate to my case.

        Strongly agree   1 - 2 - 3 - 4 - 5 - 6 - 7 -   Disagree

    c. I feel that the services I receive are helping me cope with what happened.

        Strongly agree   1 - 2 - 3 - 4 - 5 - 6 - 7 -   Disagree

4. Do you have any other requirements or needs that are not covered by these services?
    Yes ☐   No ☐
    Please comment: ………………………………………………………………………

5. Are you a carer for someone affected by the troubles? Yes ☐   No ☐
    If yes, please give
        details.………………………………………………………………………………..

APPENDIX 4: SHORTENED PEIT-Q AND SHORTENED STRESSFUL LIFE EVENTS SCALE (SLES)

Second/Third assessment questionnaire

1. **In the last 3 months**, has any significant stressful life event like the ones listed below happened to you?

    Yes ☐   No ☐

    If yes, which of the ones listed below? (tick appropriate box/boxes)

    Death of spouse or child   ☐

    Divorce/separation   ☐

    Death of a close family member (e.g. parent or sibling)   ☐

    Major personal injury or illness   ☐

    Marriage   ☐

    Change in your employment situation (being fired, change to a different type of work or in responsibility, retirement, troubles with the boss…)   ☐

    Major change in health or behaviour of family member   ☐

    Pregnancy   ☐

    Gaining a new family member (e.g. through birth, adoption etc)   ☐

    Death of a close friend   ☐

    Taking on a significant (to you) mortgage   ☐

    Family issues (e.g. son or daughter leaving home (marriage, college etc), more arguments with the partner, etc.)   ☐

    Moving home   ☐

    Christmas   ☐

    Stressful political news, which?...   ☐

    Other ……………………………………………………………..   ☐

2. Which services have you been availing of since our last visit? (Tick appropriate box/boxes)

	Services	√
1	Befriending	
2	Support groups/ self-help groups	
3	Respite care/ time out	
4	Youth work	
5	Narrative work (e.g.giving accounts of traumatic events/recording stories)	
6	Counselling	
7	Group therapy	
8	Psychotherapeutic services	
9	Complementary therapies	
	• Reflexology	
	• Massage	
	• Aromatherapy	
	• Reiki	
	• Art therapy	
	• Music therapy	
	• Yoga	
	• Others. Specify ………………………………	
10	Advice and information	
11	Indirect services	
12	Other services *Please specify*	

APPENDIX 5: SEMI-STRUCTURED INTERVIEWS

<u>Question/Topics List:</u>

1. **Experience in the voluntary co-funded group:**

   - How did you hear about this group? For how long have you been a member?

   - What services have you been availing of during this time?
     a. What do they consist of? How do they work? (brief description of each one)
     b. How regularly have you been using them?
     c. Why are you using these specific services?

   - Do you think these activities or services have helped/are helping you in any way? In what ways?

   - Is there anything that you would single out as being of particular importance or relevance in helping you to move on?

   - Would you like to use a particular service or do a certain activity that is not available at the moment, or would you like a certain service/activity to be offered in a different way?

   - What does this group mean in your life? Why are you availing of these services here and not anywhere else? Have the reasons why you joined the group in the first place changed over the years? And have you changed over the years? If so, how?

2. **How have you been affected by the Troubles?** (Explain briefly)

3. **Coping**

   - How have you coped with these traumatic experiences over the years (in the short and in the long term)? How did this affect you immediately after and as the years passed by? (nightmares, being jumpy, not able to concentrate, etc.)

   - Do you still suffer from any of these effects?

- Have you talked about it? (Why not? Or with whom did you talk?)

- Did you get any help of any kind immediately after and later on? From who (family, institutions, organisations, doctor, etc.)? (Do you feel you get enough help?)

- How have those events affect the rest of the family (children, etc)? and also the relationship between family members?

- How do you think those event/s changed you?

4. **Identity**

   - Do you consider yourself a victim or a survivor, or both of them or neither of them? Why?

   - Has your perception changed over the years? How?

5. **The future**

   - How do you think the group is going to evolve in the future? Do you see yourself being part of the group for many more years to come?

   - What do you think would make you feel significantly better in the future?