

3 IMPACT OF THE NORTHERN IRELAND CONFLICT ON HEALTH AND WELL-BEING

INTRODUCTION

- 3.1 Research on the emotional and behavioural impact on people of the protracted violent and sectarian conflict in Northern Ireland over the last 35 years is difficult. This can be attributed not only to the complex nature of the issue, but also the resultant problems that are encountered when attempting to explore the impact of the conflict on the psychological health of people, particularly children and the young. Such research in a sensitive political climate is fraught with ethical, methodological and interpretational problems (McWhirter, 1992).
- 3.2 In addition to the meaning and impact on people of their experiences of violence, there is a need to take account of the characteristics of people's environment, including the levels of overt violence and conflict that vary over both location and time; individual, group and cohort differences in people's experience must be acknowledged (Cairns and Wilson, 1991; Wilson and Cairns, 1992; Muldoon and Trew, 1995; Muldoon *et al.*, 1998). Furthermore, account also must be taken of other psychosocial factors such as age, gender, social class, religious affiliation and minority group status that alter the nature of the risks people encounter (Cairns, 1996; Cairns and Cairns, 1995; Muldoon and Cairns, 1999; Muldoon *et al.*, 2000).
- 3.3 This chapter very briefly summarises the findings on children as this corpus of research has been comprehensively reviewed recently by Muldoon *et al.* (2000). A number of studies of adults conducted during the 1980s and 1990s are briefly reviewed but, given the paucity of recent studies on adults, the Chapter provides detailed data from some recent surveys related to self-reported perceptions and experience of the violence by different population sub-groups - as well as analyses that are more directly related to health - as it is likely that these perceptions may have a substantial impact on the general and mental health of individuals.

STUDIES ON CHILDREN

- 3.4 The review by Muldoon *et al.* (2000) charts the progress and current state of knowledge in relation to young people, and highlights the diverse social and psychological consequences of growing up in Northern Ireland that researchers have found since the early 1970s. Conclusions reached include the view that the consequences of the Troubles on young peoples' psychological wellbeing and social and school life are not clear, and that understanding of the long-term effects of such violence is very poor. The documented effects seem to represent a cluster of problems related to underachievement and behavioural adjustment. However, these behaviour problems also tend to be associated with gender, poverty and deprivation, which are factors that are also related to levels of experience of political violence.
- 3.5 A corpus of work that centers on the effects of the car bomb that exploded in the town centre of Omagh in August 1998 includes a school based survey to assess the extent and nature of psychiatric morbidity among children and adolescents aged between 8 and 18 years living in the Omagh area 15 months following the bomb (McDermott *et al.*, 2004). Around 14% of children and 16% of adolescents sampled had some direct experience of the bombing.
- 3.6 This study found that as the degree of exposure to the bomb increased, so did the levels of reported symptoms of Post Traumatic Stress Disorder (PTSD), depression and anxiety among children. Girls reported higher levels of depressive feelings than boys, with boy's depressive feelings appearing to decline with age. Girls were also more likely to experience higher levels of anxiety than boys. In addition, higher levels of overall anxiety were identified in younger children. Among adolescents, girls had a higher risk of suffering from a psychological disorder and reported higher PTSD scores.

STUDIES OF VICTIMS AND HPSS STAFF

- 3.7 There is relatively little reported research on direct victims of the violence in Northern Ireland. However, some studies have focussed on the psychological consequences of two of the most salient events, the

explosion on 8 November 1987 on Remembrance Day near the war memorial in the town of Enniskillen in which a total of 63 people were injured and 11 were killed, and the explosion in the town centre of Omagh on 15 August 1998 in which 29 people were killed and 220 injured.

- 3.8 An initial study of 26 survivors (13 males and 13 females aged at least 15 years) of the Enniskillen bomb who were referred for medico-legal assessments were appraised six months after the incident and assessed again 12 months later (Curran *et al*, 1990). Whilst the authors acknowledge that there are problems inherent in studying a litigant population, the results indicated that all victims had high scores on the General Health Questionnaire (GHQ) and that there was no relationship between psychological morbidity and physical injury. Following a psychiatric examination, half of the patients (9 women and 4 men) were diagnosed at six months, as suffering from PTSD. This group had less serious physical injuries than the non-PTSD group, and none of the five seriously injured victims had developed PTSD at six months. There was no significant correlation between GHQ scores and severity of physical injuries. A year after the incident only one of the patients suffering PTSD had recovered. Two further victims had developed PTSD, both of whom had suffered severe physical injuries that necessitated earlier hospital admission. Also, two patients who seemed to have recovered from PTSD at six months had symptoms again at the second assessment.
- 3.9 Some eight months after the bomb-blast a study into the mental health and coping processes of people in Enniskillen (Wilson and Cairns, 1992) compared to those in a nearby town that had experienced a lower level of violence, involved a quota sample of residents who responded anonymously. Denial of the violence was virtually absent among Enniskillen residents, who also used more of some other forms of coping than residents in the 'Low Violence' town: distancing from the violence, seeking of social support, and positive reappraisal of the violence. Church attendance and religiosity were also related to coping processes. No differences were found between the two towns in terms of psychological well being, as measured by the GHQ.
- 3.10 Eight years after the Enniskillen bomb explosion a study by Cairns and Lewis (1999) explored how salient the event was in Enniskillen and in a town approximately 20 miles away which had experienced lower levels of

violence. The study also explored how memories of the event were related to psychological wellbeing. Based on on-street interviews (using quota sampling) 282 people were asked to mention two Northern Irish events or changes that had taken place in the past 50 years that 'came to mind as important to you'. The vast majority of events cited could be classified as political violence in Northern Ireland and of these the cease-fire was mentioned most often (61%) followed by the Enniskillen bomb (25%) and the 'Troubles' in general. The finding that relatively few people mentioned the Enniskillen bomb may have been due to the timing of the study, which took place in June 1995 the period of the ceasefire. As expected, the majority of those who did mention the Enniskillen bomb were from Enniskillen and were Protestants. In addition, Protestants who mentioned the bomb and those respondents who lived in the 'Low Violence' town and mentioned the incident had poorer mental health, as measured by the GHQ.

- 3.11 A three-part study of health service staff at the Sperrin Lakeland Health and Social Care Trust was commissioned by the Trust to gauge the level of stress and PTSD encountered by staff following the Omagh bomb (Firth-Cozens *et al.*, 2000 and 2003). The first assessment took place four months after the event, the second occurred after 17 months with the third after 39 months. The initial study found that half of all respondents had been involved in the bombing in some way, and that of these 35% had above threshold PTSD symptom levels, while the overall level was 24%. Although PTSD and stress have continued to reduce over time, the third sweep showed that 20% of staff involved in the bombing still had above threshold levels of PTSD. Staff with high levels of PTSD were more likely to take sick leave, drink more alcohol and to have sought professional help.

COMMUNITY SURVEYS

- 3.12 The above findings are in line with previous research (reviewed by Cairns and Wilson 1993) that suggests that 'denial' of violence and a 'distancing' coping style moderate the psychological influence of the violence in areas affected by chronically high levels of violence but not where major violent incidents were concerned. A series of community based surveys of adults by Cairns and Wilson during the 1980s and the early 1990s, using the GHQ (reviewed in Cairns and Wilson, 1991; Wilson and Cairns, 1992) showed

that the mean GHQ scores found for the victims of the Enniskillen bomb (Curran *et al*, 1990) were in excess of what would be expected in a general population survey in Northern Ireland. More generally, the community surveys showed that variation in intensity of political violence between different areas of Northern Ireland was linked to area differences in the level of psychological disorder. However, the level of objective violence in different locations was found to account for only a small proportion of the observed psychological distress after other factors were controlled. Different coping processes were seen to be protective, dependent upon the nature and salience of violent events. A series of community based surveys of adults by Cairns and Wilson during the 1980s and the beginning of the 1990s, using the GHQ (reviewed in Cairns and Wilson, 1991; Wilson and Cairns, 1992) found that variation in intensity of political violence between different areas of Northern Ireland was linked to area differences in the level of psychological disorder. However, the level of objective violence in different locations was found to account for only a small proportion of the observed psychological distress after other factors were controlled. Different coping processes were seen to be protective dependent upon the nature and salience of violent events.

- 3.13 Other community-based research by Cairns and Wilson (1991) explored the possible relationship between self-reported physical health, reported use of family doctor or hospital services, and political violence. The survey revealed that, when other relevant factors were taken into account, women reported more physical symptoms than men, and people in high violence areas reported more symptoms than those living in low violence areas. Those who rated their own neighbourhood most highly in terms of perceived violence reported the greatest number of physical symptoms. However, no association was found between the uptake of services and political violence or perceived political violence.
- 3.14 A two phase study of the epidemiology of psychiatric disorders and needs for psychiatric treatment in a population aged 18 to 64 that was suffering social deprivation, social isolation and exposure to violence was undertaken in the early 1990s in the District of Derry (McConnell *et al*, 2002). The period of data collection – February 1993 to September 1994 – overlapped with the date of the first Peace Agreement in Northern Ireland. The sample was drawn at random, with over sampling in selected areas, and a range of well-established instruments were used. The GHQ 28 was

used in the first postal phase of the study, and participants in the second phase, all of whom scored above the threshold on the GHQ 28, were interviewed in their homes using a number of instruments. These included the Schedules for Clinical Assessment in Neuropsychiatry (SCAN Version 1.0; World Health Organization) that incorporates the 10th edition of the Present State Examination, and also the community version of the Medical Research Council Needs for Care Assessment (NFCAS – C). Judgements of needs for care were made by clinicians on the basis of a case presentation.

- 3.15 The study found a 1-month prevalence rate of psychiatric disorder of 7.5% and a 1-year prevalence rate of 12.2%; the equivalent prevalence rates for depressive disorders were 2.4% and 6.0% respectively; and those for anxiety states were 3.5% and 3.7%. There was an appreciable (but not statistically significant) gender difference in the total morbidity rates for 1-year prevalence (females 14.4%, males 9.1%), giving a ratio of 1.6 to 1. This difference was much less marked with the 1-month morbidity rates (7.8% females vs. 7.1% males). Depressive disorders were over three times as common in females than males, while anxiety disorders were almost twice as common. Only two additional anxiety disorder cases, both females, were identified when the previous year was assessed. This is interpreted as an indication that the anxiety disorders encountered were typically persistent, and much more so than depressive disorders. Only a quarter of needs for treatment were met, with the situation being better for depression than anxiety. There also seemed to be better provision for depression than anxiety.
- 3.16 The authors point out that prevalence rates of mental ill health that are established through clinical interviews tend to be lower than those derived from questionnaires completed by lay interviewers – which is the approach used in most of the other surveys cited in this chapter. They conclude, however, that the rates of psychiatric disorder observed in Derry were even higher than those reported by a similar study in inner London, and that this almost certainly reflects the very high levels of social deprivation in the District.

RECENT AND CURRENT STUDIES OF ADULTS

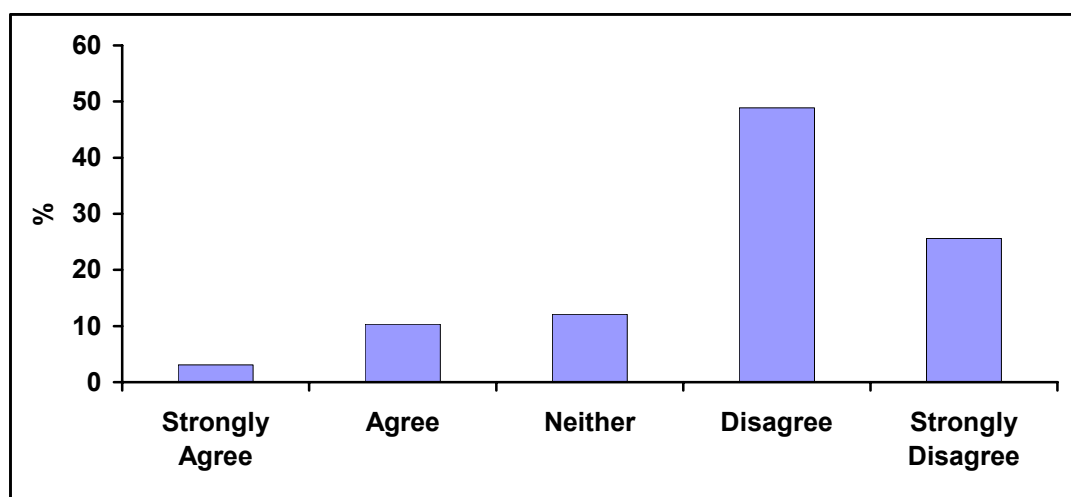
Caring Through The Troubles

- 3.17 This study used a number of different research methods, and used a range of data: deaths in the Troubles; survey data examining the impact on health; data on housing displacement; data on referrals to the Trauma Centre and Young People's Centre; and, data on Health and Social Services in North and West Belfast. Focus groups comprising social workers, district nurses, health visitors, residential workers, and in-depth interviews with N&W Belfast Trust management personnel were also conducted.
- 3.18 In the focus groups, one of the early comments recorded was "I feel we have an opportunity here to possibly get extra resources" (p53). This is a significant statement, because if participants believed that their comments might lead to much hoped-for extra resources, the discussion might be biased towards meeting this end.
- 3.19 The Cost of the Troubles survey was conducted in 1999. All wards in Northern Ireland were classified into 'high intensity', 'medium intensity' and 'low intensity' according to the number of people from those wards that had been killed in the Troubles. From each group, ten wards were randomly selected. Within each group of selected wards, 1000 addresses were selected. Of the 3,000 people contacted, 1,356 (45.2%) completed the questionnaire. The numbers of responses by each type of ward was: high 471; medium 464; and low 410. Due to the small numbers of returns from some wards, analysis could not be carried out at ward level, only by the groupings above.
- 3.20 The survey questionnaire was very lengthy (79 questions, several containing more than 10 sub-questions), and contained instruments such as the Short Form 12 (SF12), which measures general health and wellbeing, a section on medication, and an instrument that was designed to measure Post Traumatic Stress Disorder (PTSD). The approach used did not involve a reliable or valid measure of mental health and the assessment of PTSD fell well short of the normal diagnosis of PTSD, which requires a proper clinical interview. It is thus not surprising that this study found rates which are much higher than those found in other studies conducted in

Northern Ireland: 29% of the entire sample were reported to have PTSD, rising to 45% of respondents in 'high intensity' wards.

- 3.21 In terms of the prevalence of longstanding illness, it was found that 21% of Catholic respondents reported this condition, compared with 29% of Protestants. This is a curious finding because one would expect the results to be similar. The survey was unable to point to a reason for this differential, but it may well lie in the fact that the overall characteristics of the two populations were different (e.g. different age structures). This would pose questions over the representativeness of the sample: the religious split is a somewhat unrepresentative 70:30 in terms of Catholics to Protestants.
- 3.22 Just over 13% of people overall felt that the Troubles had affected their health while over 70% disagreed (Figure 3.1). Less than one in five agreed that the Troubles had damaged them or members of their families. However, 44% reported feelings of distress and emotional upset with 40% agreeing that the Troubles had left them feeling helpless. The majority of the sample reported little health impact of the Troubles, although a relatively high proportion admitted to feelings of emotional distress and rage.

Figure 3.1 Respondents' views when asked if their health had been affected by the Troubles



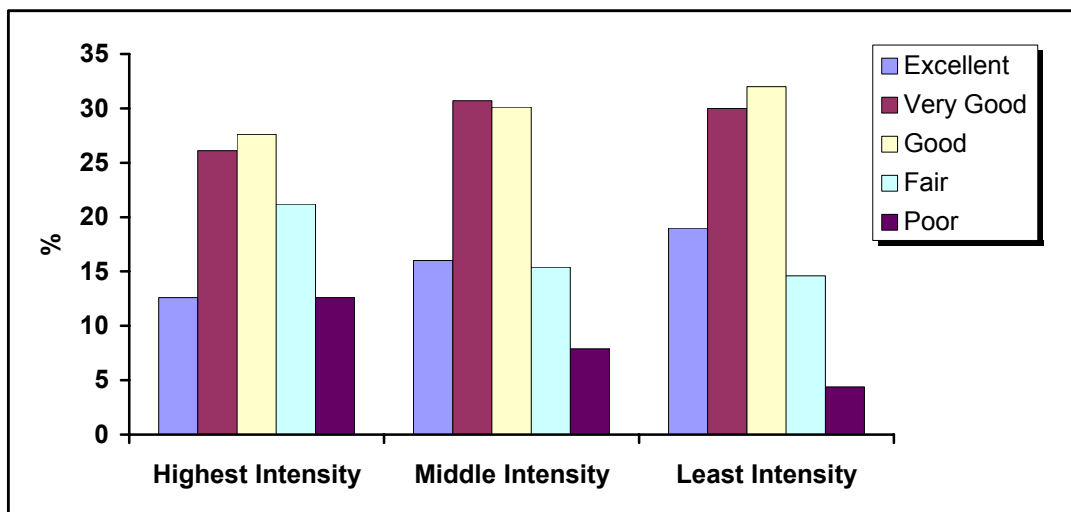
Source: Smyth *et al.*, 2001

- 3.23 There were significant variations in the way respondents reported on their health across the three different types of wards. As seen in Figure 3.2 there was a substantial significant difference between those reporting poor health in high intensity areas (13%) and those reporting poor health in low

intensity areas (4%). This was also the case when comparing poor health levels in high intensity areas with middle intensity areas. Those living in highest intensity areas also reported significantly lower levels of excellent health (Figure 3.2). However, on a number of indicators, the group in the high intensity wards exhibited a greater degree of deprivation than either of the other two. The variation in reported health status could thus be a reflection of deprivation, rather than the impact of the Troubles.

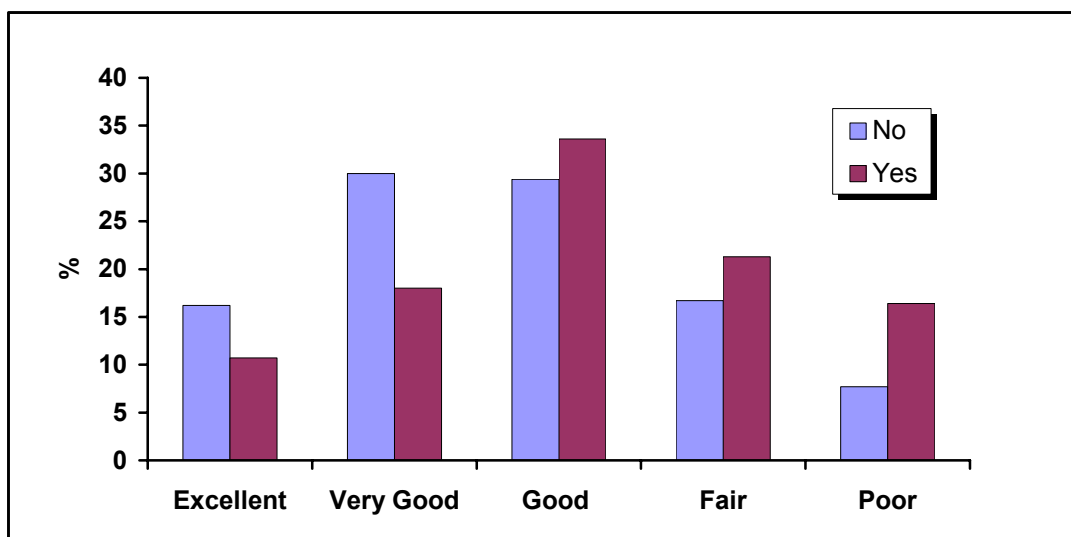
3.24 However, those living in high intensity areas did nominate Troubles related factors as causes of changes in their health over the previous decade. Almost a quarter agreed or strongly agreed that the Troubles had damaged their health compared to 8% and 6% in the other two ward groups. A third of people in high intensity areas cited Troubles related trauma as a factor influencing change in their health compared to 11% in medium and 6% in low intensity areas. Over 20% cited Troubles related bereavement compared to 7% in medium and 5% in low intensity areas. Of those living in high intensity areas, 22% strongly agreed that the Troubles had caused a great deal of distress and emotional upset compared to 10% in medium and 9% in low intensity areas.

Figure 3.2 Health status in different ward groups



Source: Smyth *et al.*, 2001

Figure 3.3 Self-reported health status by whether respondents had experienced severe experience of the Troubles



Source: Smyth *et al.*, 2001

3.25 The analysis was taken further by looking at the groups that had the most experience of Troubles related violence. Figure 3.3 shows how almost half of those without severe experiences reported that their health was excellent or very good, compared to less than 30% of those who had severe experiences. Over three quarters of those with severe experiences claimed distress and emotional upset compared to 40% of the rest of the sample. Of those with severe experiences, 36% claimed that the Troubles had damaged their health compared to 11% in the rest of the sample. Over a third of those who had very severe experience of the Troubles reported their health as fair or poor compared to less than a fifth of the main sample. However, due to the small number of persons experiencing severe and very severe experience of the Troubles, considerable caution needs to be exercised.

3.26 As part of the Short Form 12 (SF12) respondents are asked to answer a series of questions about their general health, their capacity to engage in a range of activities, their experience of pain and feelings of calm, energy and depression. On the basis of these questions eight scales are produced to generate two summary measures: physical health and mental health, and across these scales, higher scores reflect better health. As seen in Table 3.1, respondents living in high intensity wards had consistently the lowest scores on all eight scales, although in most cases the differences were marginal.

3.27 Significantly higher level of medication usage were also found among respondents in ‘high intensity’ areas – for example, respondents from these areas were three times more likely to be on permanent medication. The report, however, did not attribute this directly to experience of the Troubles, and it could be due to deprivation or other factors.

Table 3.1 Mean SF12 scores for each area

SF12 Scales	High Intensity Wards	Medium Intensity Wards	Low Intensity Wards
General Health	3.3	3.6	3.7
Physical Functioning	5.1	5.2	5.3
Role-Physical	3.4	3.6	3.6
Bodily Pain	4.8	5.1	5.4
Vitality	3.7	4.1	4.0
Mental Health	5.9	6.4	6.4
Social Functioning	3.9	4.3	4.4
Role Emotional	3.5	3.7	3.7

Source: Smyth *et al.*, 2001

3.28 One question, however, did link medication to the Troubles and the survey found that respondents from high intensity locations were high users of medication. The respondents claimed they used such medication for sleep disturbance, sedation, or anti-depressive purposes. Of note, 58 respondents from high intensity wards (out of a total of 471 respondents from these wards) claimed that they were taking Troubles related medication for the relief of physical pain.

Who are the Victims?

3.29 In a Northern Ireland Office commissioned investigation of self-assessed victimhood and the Northern Ireland conflict, a sample of randomly selected adults (18 years plus) were interviewed in their homes in the spring of 2001 (Cairns *et al*, 2003). The study used the GHQ12 to measure psychological well-being, and assessed victimhood both in terms of a simple self-classification and by more ‘objective’ impact criteria. The results indicated

that either being a victim of the Troubles, or thinking of one's self as a victim, is associated with poorer levels of mental health.

- 3.30 The authors note that political violence undoubtedly has impacted on mental health levels of some but perhaps not all individuals in Northern Ireland. They speculate that it may be that this impact largely has been confined to 'victims' or those more directly involved in the violence. Evidence to support this assertion, they suggest, comes from the fact that when the mean GHQ12 scores from the present study are compared with those from four other similar studies, two pre- and two post- ceasefires (Cairns, 1988; Wilson and Cairns 1992; Cairns and Lewis, 1999; Mallet, 2000), it appears that the ceasefires have not been associated with any notable change in overall levels of psychological well-being in the Northern Ireland population.
- 3.31 The authors offer various possible interpretations and suggest that the most likely explanation is that psychological health is influenced by a range of factors of which the Troubles are just one, and that until these other social factors also change, no appreciable improvement in the mental health of the Northern Ireland population will be achieved.

Enduring Values

- 3.32 The Nuffield Trust has commissioned research to investigate how professional values in the Health Service were sustained during the Troubles in Northern Ireland (Personal Communication).
- 3.33 The University of Ulster and the Queen's University of Belfast are involved in providing a work-base for and academic supervision of the research, which is being carried out by Dr Farhat Manzoor under the supervision of Dr James McKenna, who is the Trust's Rock Carling Fellow.
- 3.34 The fundamental question is: What impact did the Troubles have on professional and medical ethics? This involves examining records of medical provision, identifying key problems and difficulties, and looking at Government and other responses to these and also investigating issues from the point of view of non-medical staff such as administrative and ancillary staff as well as that of patients.

- 3.35 Some problems are relatively easily identified, others less so. The researchers hope, in the course of the research, to take the views and opinions from as wide a range as possible, about how they saw the major difficulties in the period.
- 3.36 The method of investigation includes examination of available records and seeking evidence from a variety of people: patients, relatives, professional and other staff, management, trade unions, staff associations and members of involved bodies such as universities. There are, in addition, people in public life who have knowledge and insights - anyone who can enlighten the investigation will be welcomed for their contribution.

1997 and 2001 Northern Ireland Health and Social Wellbeing Surveys

- 3.37 A report from the 1997 Northern Ireland Health and Social Wellbeing Survey (O'Reilly and Browne, 2001) describes the variation in self assessed health, use of health services and the demographic, social, socio-economic and area factors associated with these variations. The report indicates that people in poorer households were more likely to suffer significant health stresses and were also more likely to have borne the brunt of the Northern Ireland Troubles either in their areas or on their lives (Table 3.2).

Table 3.2 Significant stressors in lives (percentages)

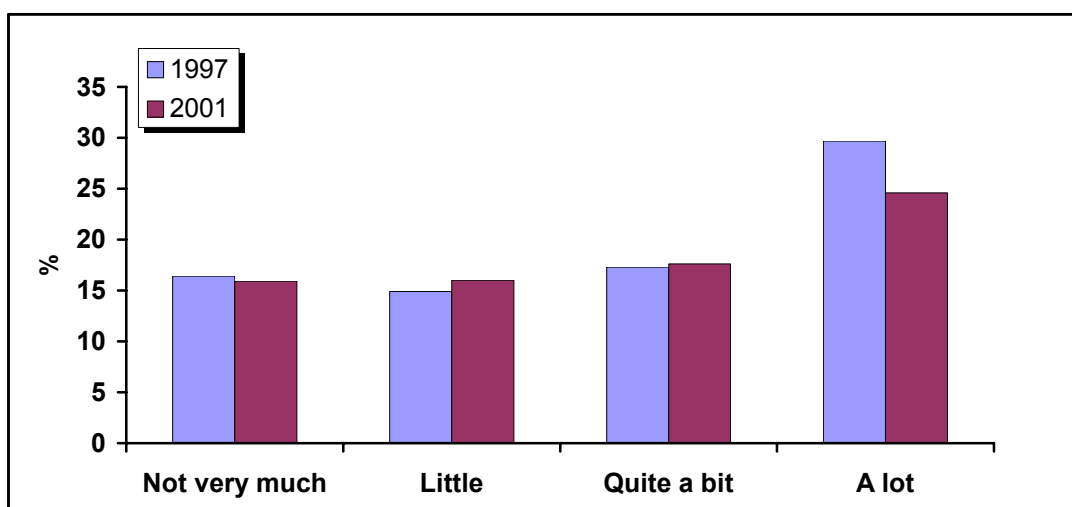
	Most Wealthy	Most Poor
Health stress in close others	37.2	42.4
Job stress	9.4	19.5
Family stress	11.7	18.1
Fear of assault	2.3	4.3
Major financial worries	1.9	6.2
Serious legal problems	1.4	2.1
'Troubles' affecting area	3.8	7.8
'Troubles' affecting life	4.5	7.6
Significant concerns about children	19.8	26.8

Source: Northern Ireland Health and Social Wellbeing Survey, 1997 (O'Reilly and Browne, 2001)

3.38 Analyses of both the 1997 and 2001 Northern Ireland Health and Social Wellbeing Surveys, (Miller *et al.*, 2004) provide support for this corpus of work on both physical and psychological health and explore the association with other factors.

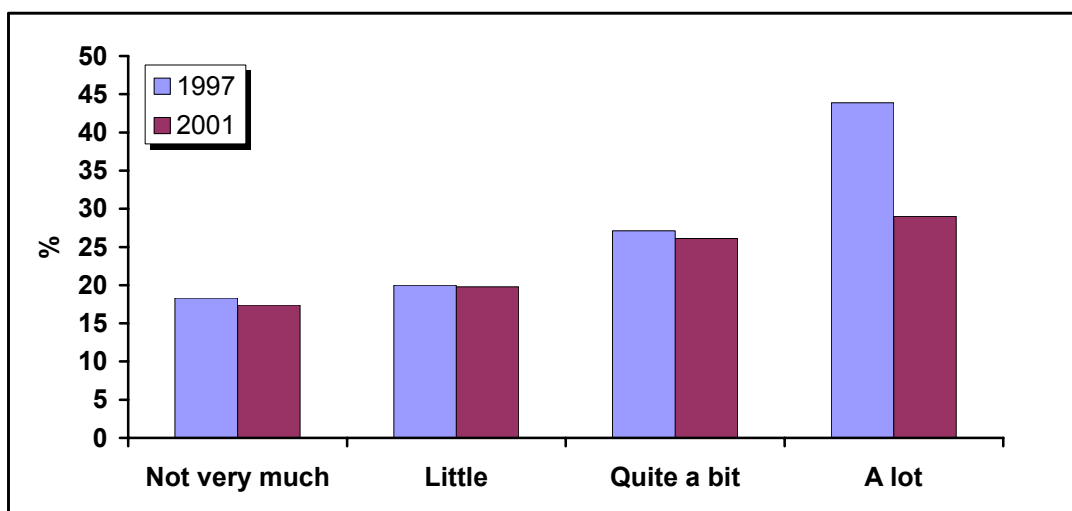
3.39 Respondents who said they experienced ‘not very much’ violence at all in their neighbourhood were much more likely to have a better GHQ12 score and to report good general health. This is true for both the 1997 and 2001 surveys (Figures 3.4, 3.5 and 3.6).

Figure 3.4 Amount of NI conflict-related violence experienced in neighbourhood since 1969 for respondents whose general health is ‘not good’ by year



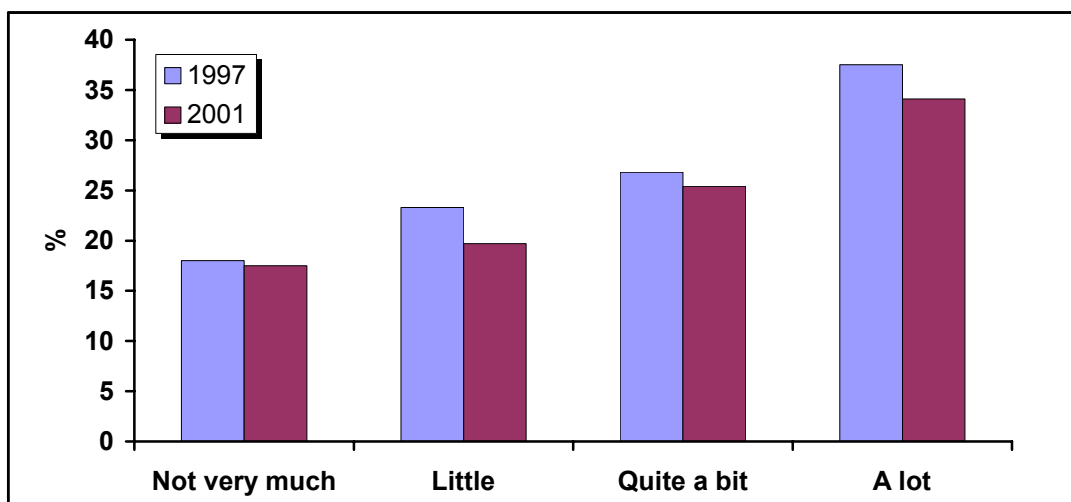
Source: Northern Ireland Health and Social Wellbeing Survey, 1997 and 2001

Figure 3.5 Respondents’ perception about the effect of the N I conflict on their immediate family and themselves by year



Source: Northern Ireland Health and Social Wellbeing Survey, 1997 and 2001

Figure 3.6 How much effect NI conflict-related violence has had on the respondents and their immediate family for respondents with poor mental health by year

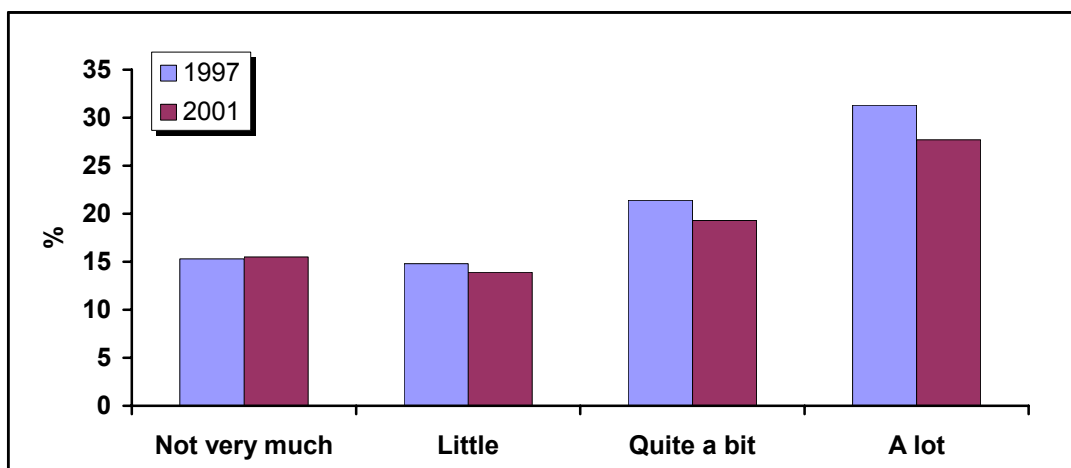


Source: Northern Ireland Health and Social Wellbeing Survey, 1997 and 2001

3.40 O'Reilly and Stevenson (2003) also analysed GHQ12 data from the 1997 Northern Ireland Health and Social Wellbeing Survey. They found that respondents whose life or area had been affected by the Troubles were more likely to experience psychological morbidity. They concluded that the Troubles had a significant impact on the mental health of the Northern Ireland population.

3.41 Respondents who said they themselves or their immediate families had been affected by NI conflict-related violence 'quite a bit' or 'a lot' were also much less likely to report good general health than respondents who were not affected or only a little affected (Figure 3.7).

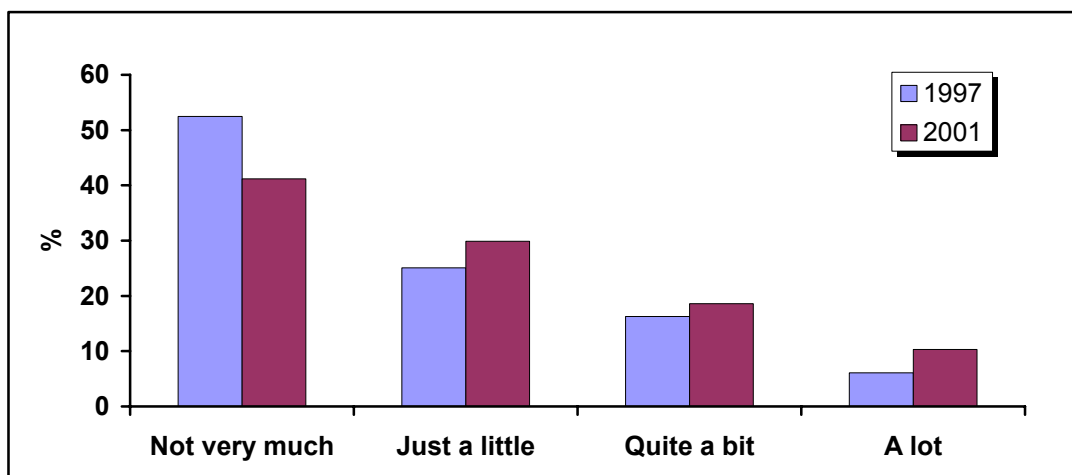
Figure 3.7 How much effect NI conflict-related violence has had on the respondents and their immediate family for respondents who have 'not good' general health by year



Source: Northern Ireland Health and Social Wellbeing Survey, 1997 and 2001

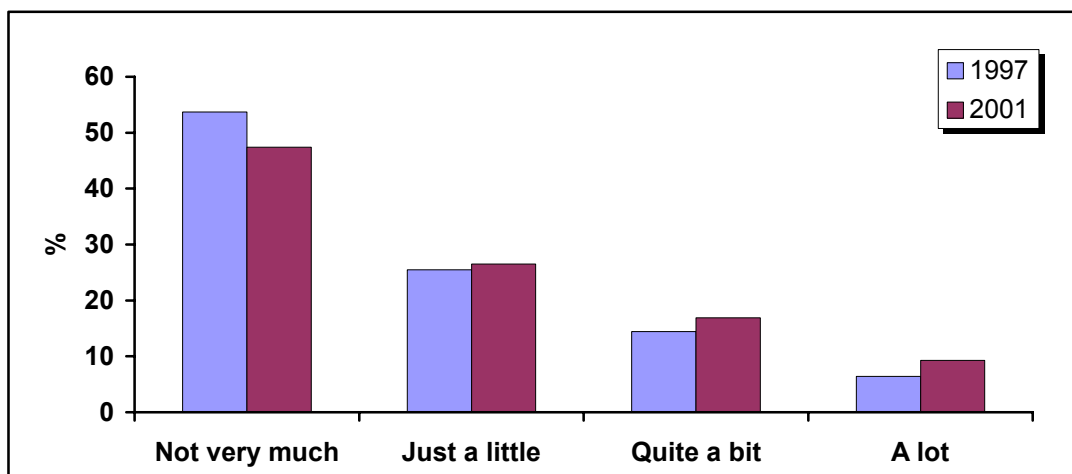
3.42 Overall, a smaller proportion of respondents worried about the political situation in Northern Ireland in 2001 than in 1997. Almost one-third of respondents (33%) said they did not really worry compared to just over one quarter (26%) saying the same in 1997. However, a higher percentage of respondents reported in 2001 that conflict-related violence affected either their neighbourhood or them personally (Figures 3.8 and 3.9).

Figure 3.8 Respondents' perception about the effects of the N I conflict on their neighbourhood by year



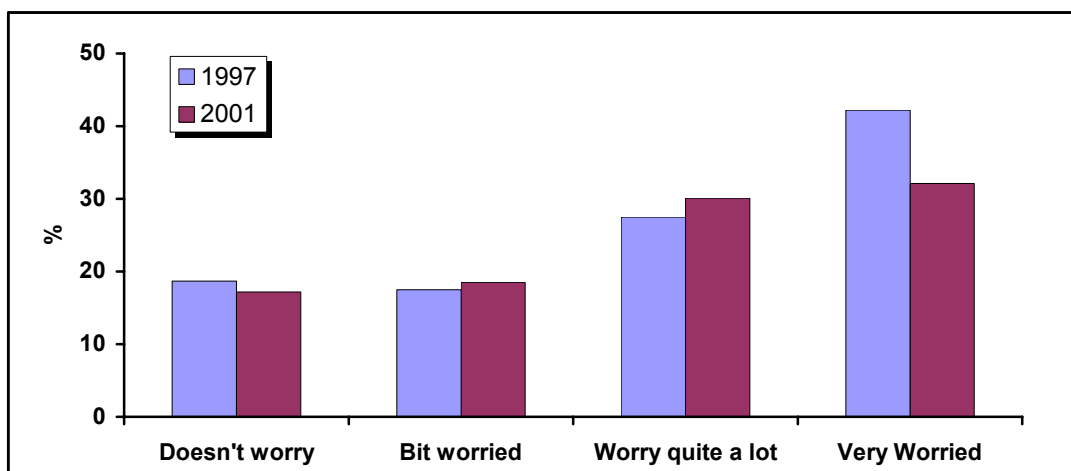
Source: Northern Ireland Health and Social Wellbeing Survey, 1997 and 2001

Figure 3.9 Perception about the effect of the N I conflict on their immediate family and themselves by year



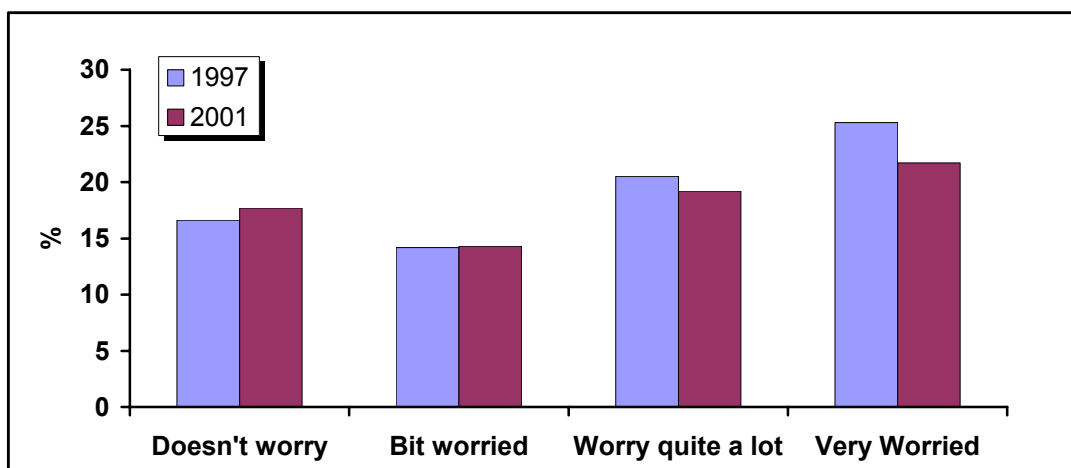
Source: Northern Ireland Health and Social Wellbeing Survey, 1997 and 2001

Figure 3.10 Feelings about the political situation in NI for respondents with poor mental health by year



Source: Northern Ireland Health and Social Wellbeing Survey, 1997 and 2001

Figure 3.11 Feelings about the political situation in NI for respondents who have a 'not good' general health by year

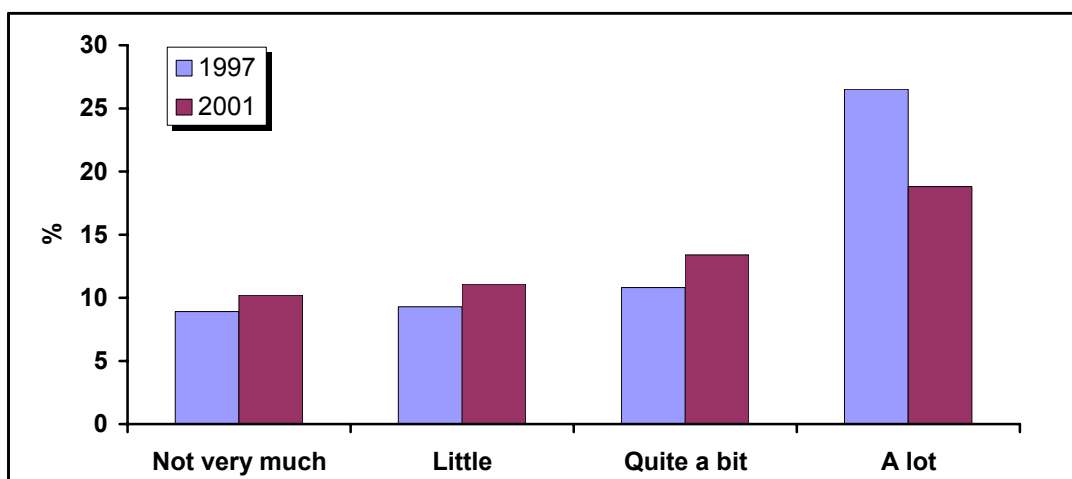


Source: Northern Ireland Health and Social Wellbeing Survey, 1997 and 2001

3.43 Over half of those who did not worry about the political situation in Northern Ireland reported good general health and had a low GHQ12 score, compared with only around a third of those who said they worried about the political situation in Northern Ireland (Figures 3.10 and 3.11).

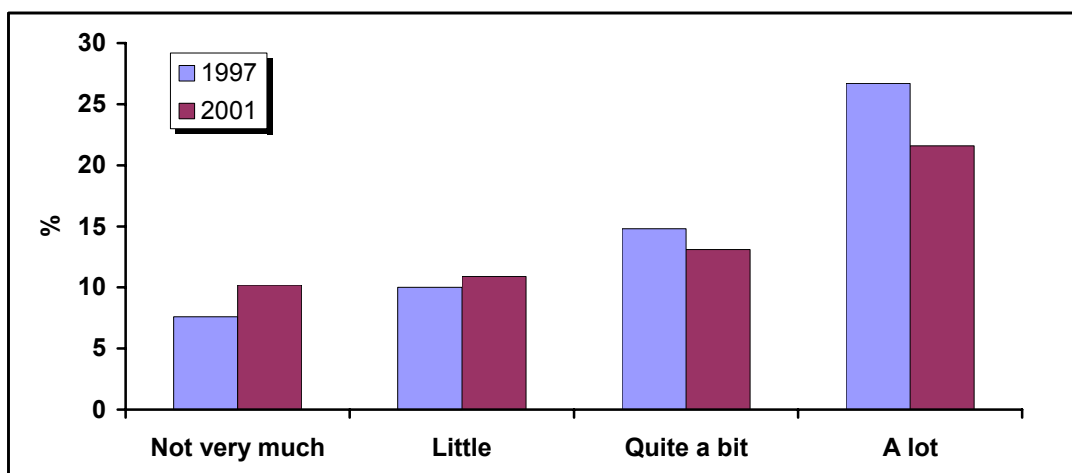
3.44 Miller *et al.* (2004) found that stress related factors are associated with poorer GHQ scores. In particular, when a range of other factors – including demographic factors and social contact - were controlled for, respondents in 2001 who said they were affected by the Troubles ‘a lot’ or ‘quite a bit’ were also significantly more likely to report poor mental health.

Figure 3.12 Amount of NI conflict-related violence experienced in neighbourhood since 1969 for respondents who have had a great deal of stress over the last 12 months by year



Source: Northern Ireland Health and Social Wellbeing Survey, 1997 and 2001

Figure 3.13 How much effect NI conflict-related violence has had on the respondents and their immediate family for respondents who have had a great deal of stress over the last 12 months by year

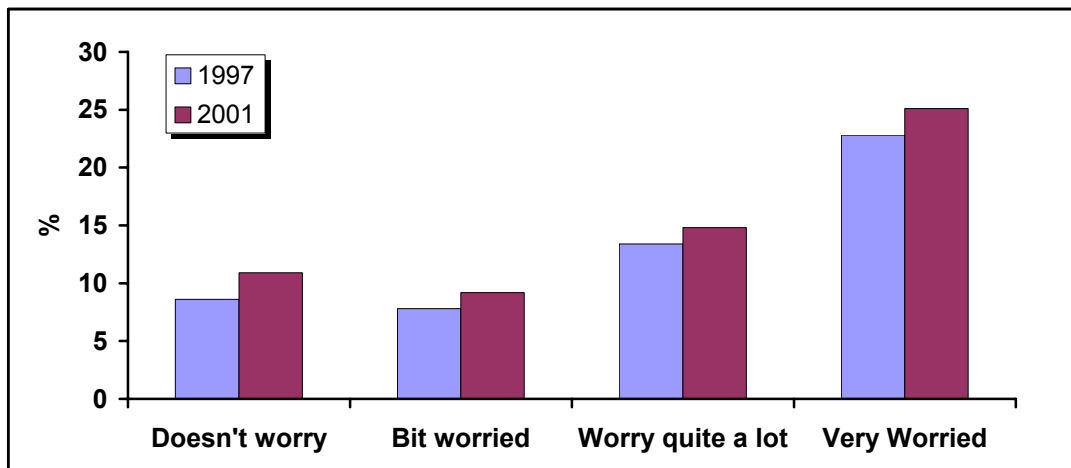


Source: Northern Ireland Health and Social Wellbeing Survey, 1997 and 2001

3.45 Respondents who said that they themselves, their immediate family or their neighbourhood had been ‘quite a bit’ or ‘a lot’ affected by Northern Ireland conflict-related violence were also significantly more likely to report high levels of stress over the last 12 months (Figures 3.12 and 3.13).

3.46 Worry about the political situation in Northern Ireland was also associated with significantly higher reports of stress (Figure 3.14).

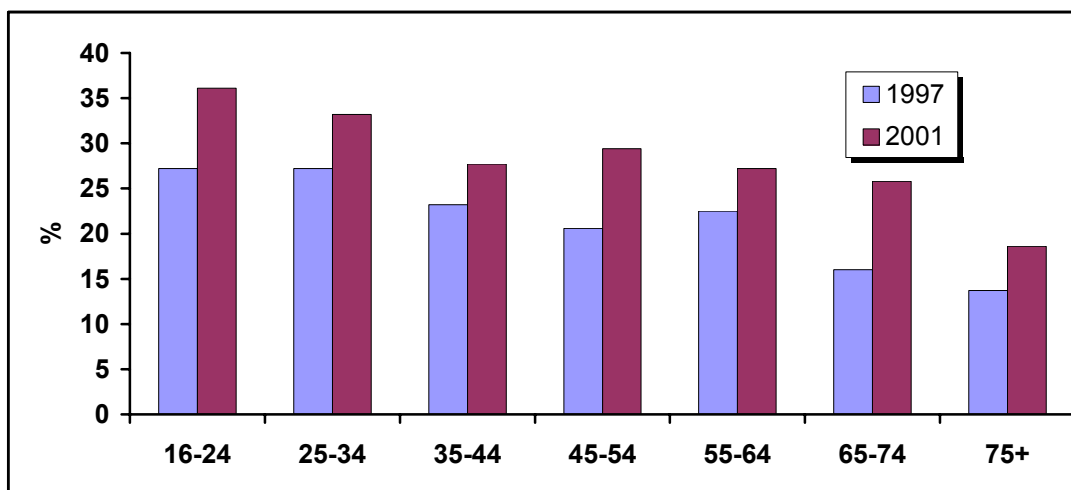
Figure 3.14 Extent of worrying about the political situation in NI by year



Source: Northern Ireland Health and Social Wellbeing Survey, 1997 and 2001

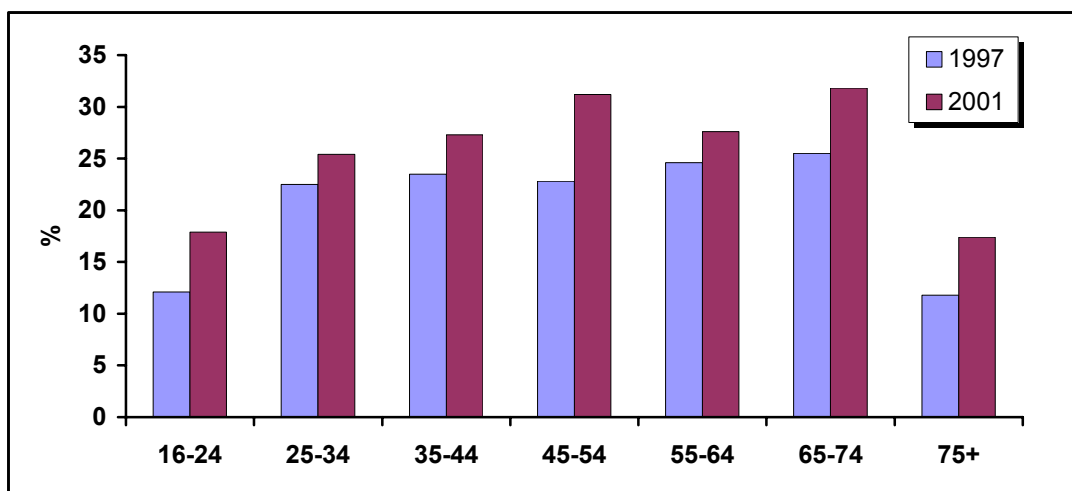
3.47 Experience of neighbourhood violence was negatively associated with age, with more younger people groups experiencing high levels (Figure 3.15). However, there was a curvilinear relationship with violence and both personal/family experience and worry, with the youngest and oldest ages groups being less affected (Figures 3.16 and 3.17).

Figure 3.15 Respondents who have experienced quite a bit or a lot of NI conflict-related violence in their neighbourhood since 1969 by age and year



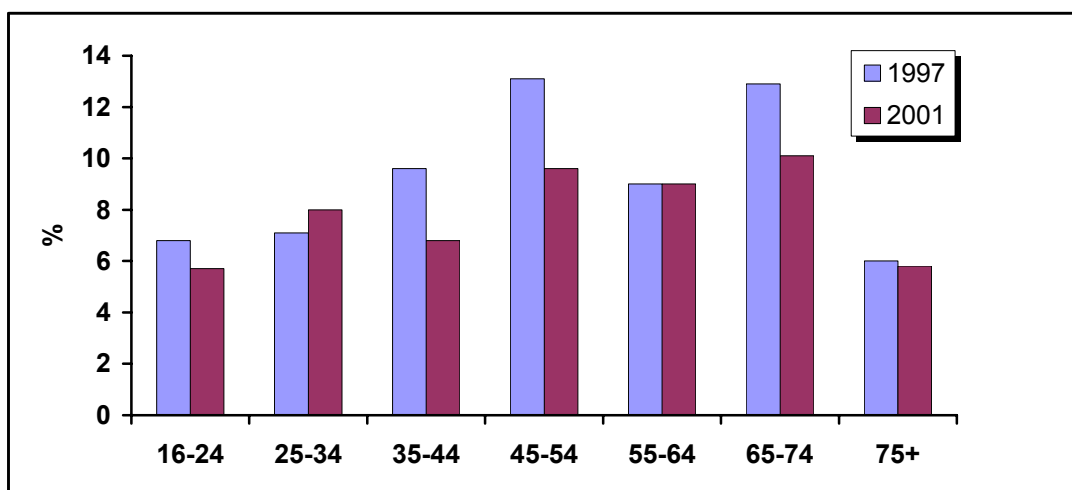
Source: Northern Ireland Health and Social Wellbeing Survey, 1997 and 2001

Figure 3.16 Respondents who felt they, or their family, have been affected quite a bit or a lot by NI conflict-related violence by age and year



Source: Northern Ireland Health and Social Wellbeing Survey, 1997 and 2001

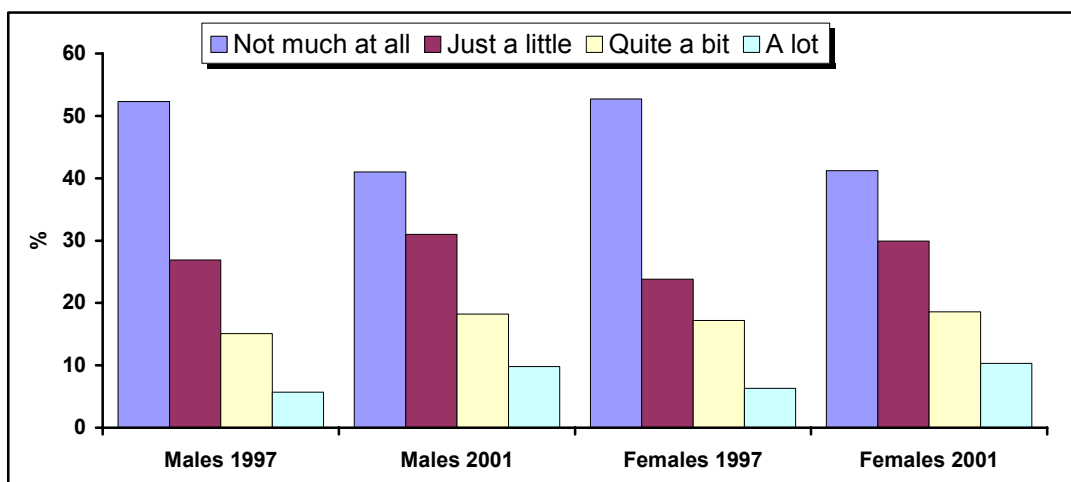
Figure 3.17 Respondents who were very worried about the NI conflict-related violence by age and year



Source: Northern Ireland Health and Social Wellbeing Survey, 1997 and 2001

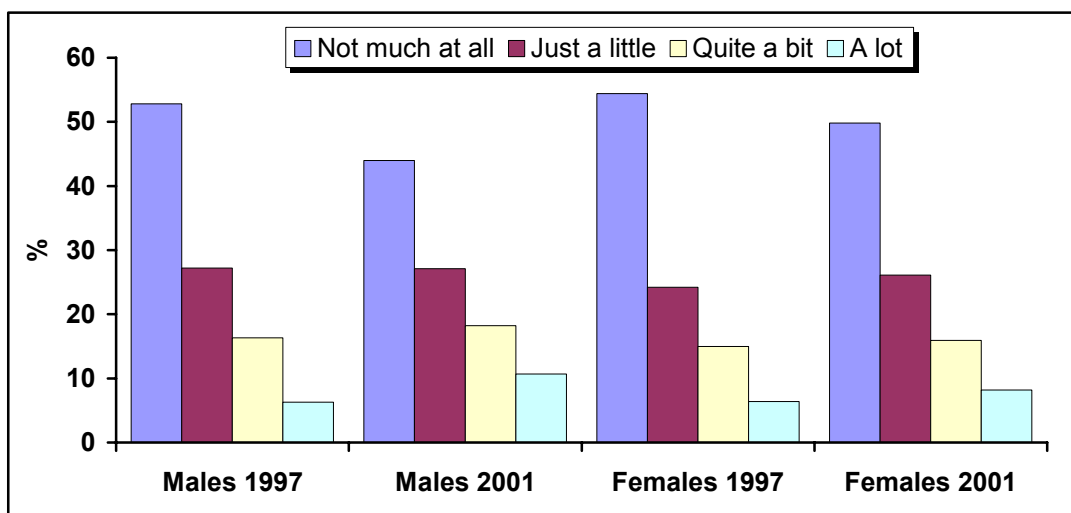
3.48 Male and female perceptions of levels of neighbourhood violence were similar (Figure 3.18). However, males were more likely than females to report that they or their immediate families were affected by Northern Ireland conflict-related violence (Figure 3.19). This difference was not statistically significant in 1997, but it was highly significant in 2001. There was also a small, but statistically significant, difference between the gender groups with regard to existing worries about the political situation in Northern Ireland (Figure 3.20) in both years.

Figure 3.18 Perception about amount of NI conflict-related violence in their neighbourhood by gender and year



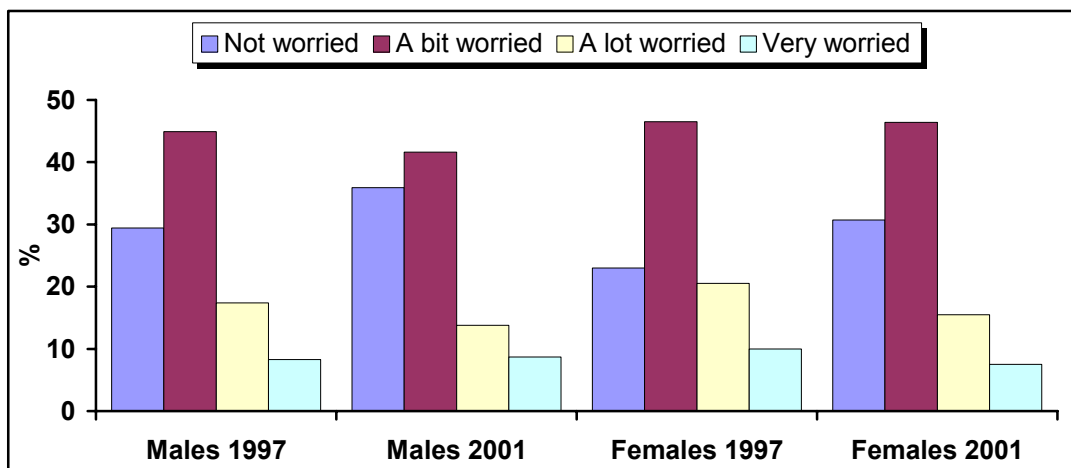
Source: Northern Ireland Health and Social Wellbeing Survey, 1997 and 2001

Figure 3.19 Perception about NI conflict-related effects on own lives and family by gender and year



Source: Northern Ireland Health and Social Wellbeing Survey, 1997 and 2001

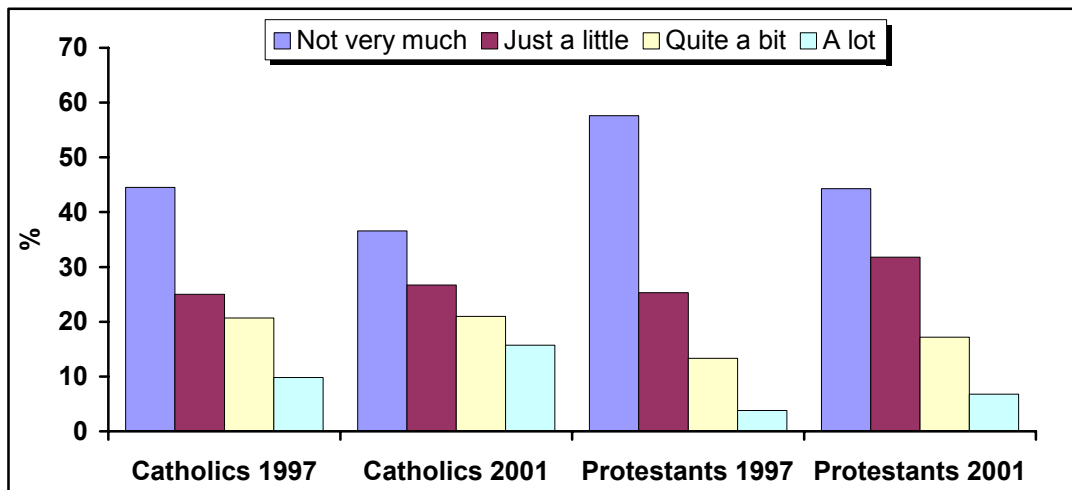
Figure 3.20 Respondents' extent of worrying about political situation in NI by gender and year



Source: Northern Ireland Health and Social Wellbeing Survey, 1997 and 2001

3.49 In 1997 Catholics were significantly more likely than Protestants to say that they experienced Northern Ireland conflict-related violence in their neighbourhood (Figure 3.21). This was still the case in 2001, but the difference between Catholics and Protestants had lessened.

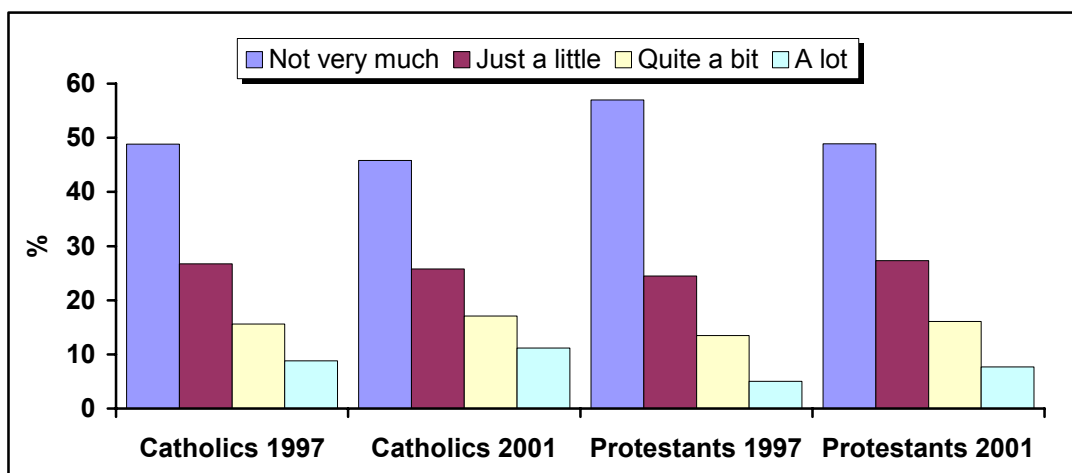
Figure 3.21 Perception about NI conflict-related violence in their neighbourhood by religion and year



Source: Northern Ireland Health and Social Wellbeing Survey, 1997 and 2001

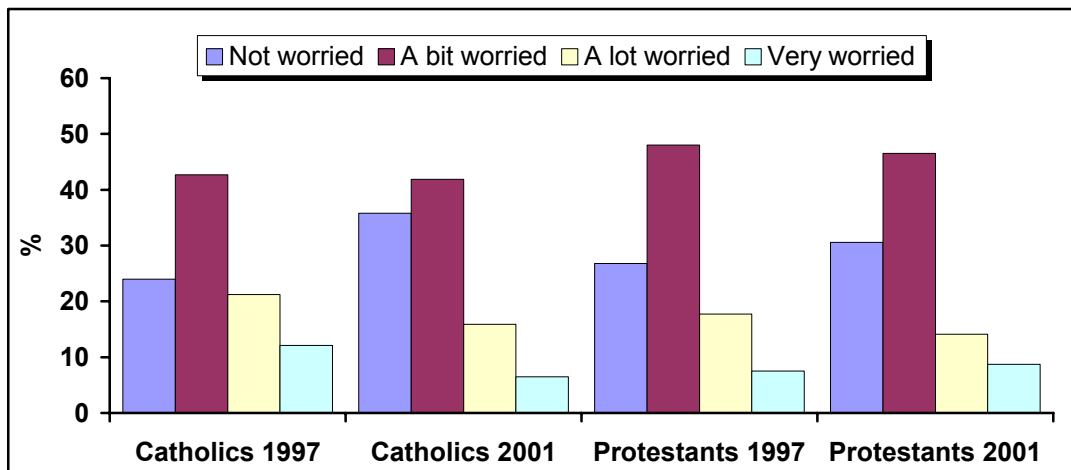
3.50 Protestants were also less likely than Catholics to report adverse effects of Northern Ireland conflict-related violence on their own lives and that of their families (Figure 3.22). Again the difference between the groups was smaller in 2001. Similar proportions of respondents from both community backgrounds worried about the political situation (Figure 3.23). However, whilst Catholics were likely to worry somewhat more in 1997 it was Protestants who were rather more concerned in 2001.

Figure 3.22 Perception about NI conflict-related affects on their own lives and family by religion and year



Source: Northern Ireland Health and Social Wellbeing Survey, 1997 and 2001

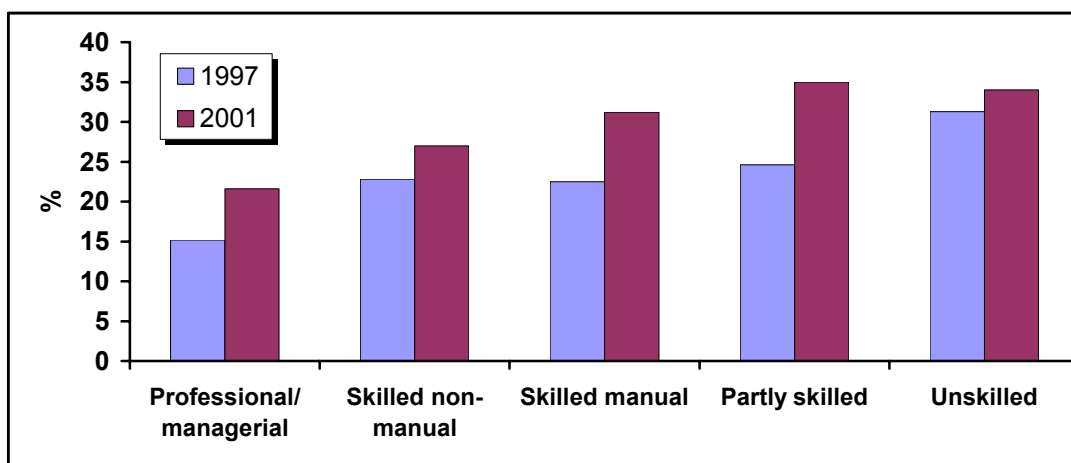
Figure 3.23 Extent of worrying about political situation in NI by religion and year



Source: Northern Ireland Health and Social Wellbeing Survey, 1997 and 2001

3.51 Professional and managerial workers were least likely to report conflict-related violence in their neighbourhood whereas unskilled and partly skilled workers reported the most (Figure 3.24). In fact, in 1997 professional and managerial workers were only half as likely to report the presence of violence in their neighbourhood as unskilled workers. In 2001, partly skilled workers reported most experiences of violence in their neighbourhood. The difference between the SEGs was smaller in 2001 than in 1997.

Figure 3.24 Respondents who had experienced quite a bit or a lot of NI conflict-related violence in their neighbourhood since 1969 by SEG and year

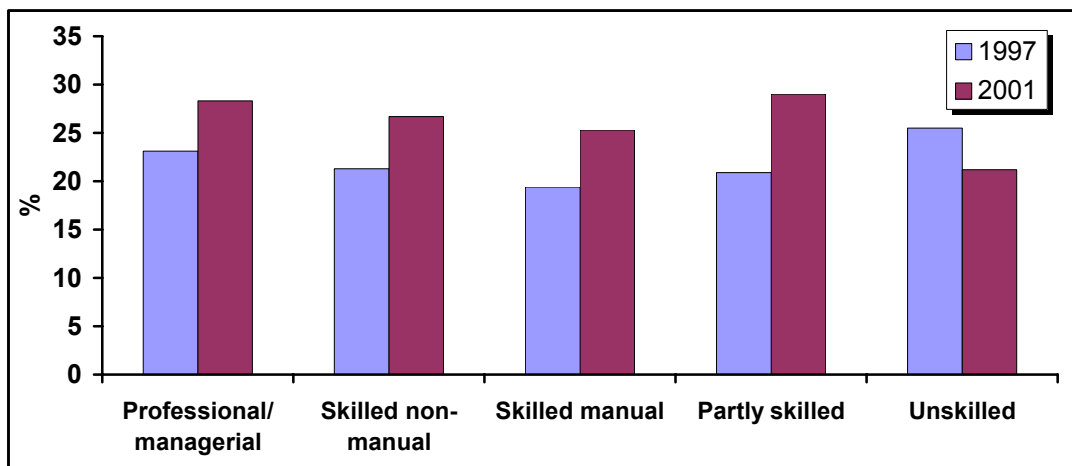


Source: Northern Ireland Health and Social Wellbeing Survey, 1997 and 2001

3.52 There was no clear association between SEG and the effects that the Northern Ireland conflict had on respondents' own lives and that of their families (Figure 3.25). It is noticeable that in 1997 unskilled workers were most likely to say that their own lives and that of their families were quite a bit or a lot affected by conflict-related violence, but in 2001 they were least

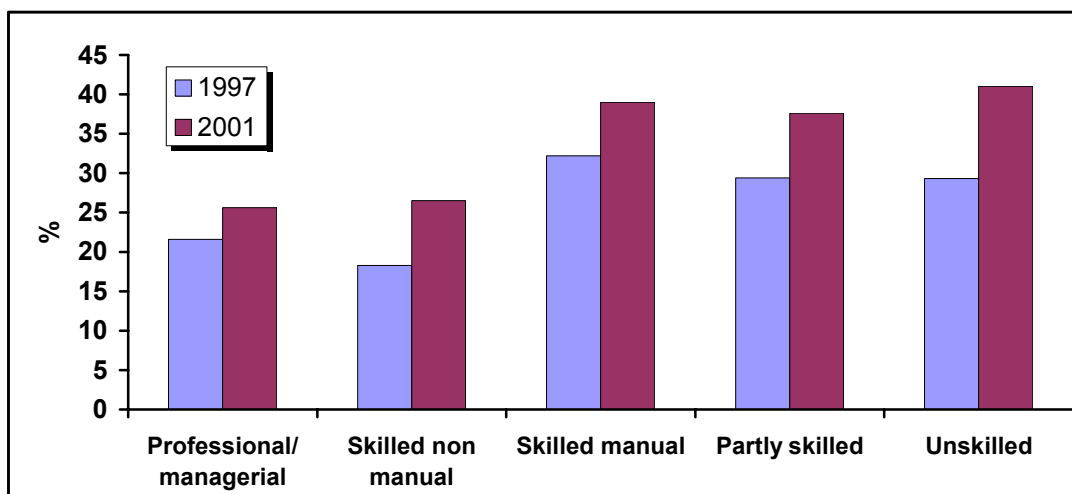
likely to say that. Also, professional and managerial workers were most likely not to worry (Figure 3.26).

Figure 3.25 Respondents who perceived that they or their family had been affected quite a bit or a lot by NI conflict-related violence by SEG and year



Source: Northern Ireland Health and Social Wellbeing Survey, 1997 and 2001

Figure 3.26 Respondents who were not really worried by NI conflict-related violence by SEG



Source: Northern Ireland Health and Social Wellbeing Survey, 1997 and 2001

CONCLUSION

3.53 The studies reviewed in the chapter and the new survey analyses presented provide valuable insights. However, much more evidence is required in order to fully understand the consequences, and particularly the long-term effects, of the Troubles on the general and mental health, or psychological wellbeing, of both children and adults overall in Northern Ireland and of the particular subgroups of interest to this report.