

Traumatised by peace? A critique of five assumptions in the theory and practice of conflict-related trauma policy in Northern Ireland

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English

In recent years there has been a growing international recognition of the impact of violent conflict on mental health and a growth in interventions to deal with what have come to be referred to as the psychosocial dimensions of conflict. Mental health interventions are widely understood to be a crucial feature of contemporary peace building. This article critically examines the intersection of these two developments – peace building and psychosocial dimensions of conflict – as they have been articulated in relation to dealing with conflict-related trauma during the peace process in Northern Ireland.

Français

Depuis un certain temps, on reconnaît de plus en plus dans le monde entier l'impact qu'ont les conflits violents sur la santé mentale. Il y a aussi de plus en plus d'interventions pour faire face à ce que l'on appelle maintenant les dimensions psychosociales du conflit. Les interventions en santé mentale sont reconnues partout comme étant un élément crucial pour la consolidation de la paix. Cet article examine de façon critique l'intersection de ces deux développements – la consolidation de la paix et les dimensions psychosociales du conflit – comme ils ont été exprimés par rapport au traitement de traumatismes liés au conflit durant le processus de paix en Irlande du nord.

Español

En años recientes ha habido un creciente reconocimiento internacional del impacto del conflicto violento en la salud mental y también ha habido un crecimiento en intervenciones para ocuparse de lo que se ha llegado a referir como las dimensiones psicosociales del conflicto. Las intervenciones de la salud mental se entienden ampliamente como una característica crucial de la formación de paz contemporánea. Este artículo examina de manera crítica la intersección de estos dos desarrollos – formación de paz y dimensiones psicosociales de conflicto – como han sido articulados al ocuparse del trauma de conflicto-relacionado durante el proceso de paz en el Norte de Irlanda.

Key words: conflict-related trauma • counselling • peace building • Northern Ireland

Introduction

The end of the Cold War led to a significant reorganisation of the international framework for conflict management. The publication of the United Nations' (UN) policy document *An agenda for peace* in 1992 acknowledged the significance of peace processes when it added peace building to preventive diplomacy, peacemaking and peace-keeping as a central plank in the UN's approach to conflict management (Boutros-Ghali, 1992). The greater significance attached to peace building in contemporary international politics is reflected in a growing academic and policy focus on post-war reconstruction and peace building (see, for example, Miall et al, 1999: 185–21; Darby and MacGinty, 2003). The growing interest in peace building has been accompanied by both a growing recognition of the impact of violent conflict on mental health and interventions to deal with the psychosocial dimensions of conflict (see, for example, CERTI, 2000; Pedersen, 2002). This article critically examines the intersection of these two developments – peace building and psychosocial dimensions of conflict – as they have been articulated in relation to dealing with conflict-related trauma during the peace process in Northern Ireland.

In the 1990s a peace process developed and took root in Northern Ireland. The declaration of a ceasefire by the Irish Republican Army (IRA) in September 1994 marked a significant shift in ending what are colloquially referred to as the 'Troubles'. The Peace Agreement that was negotiated and signed in the first half of 1998 provided the institutional architecture for the peace process. One strand of these new institutional arrangements has been the development of what is locally referred to as the 'victim's agenda', the arrangements to deal with the legacy of those who were killed and injured as a consequence of the Troubles (see, for example, Bloomfield, 1998; Healing Through Remembering Project, 2002; Morrissey and Smyth, 2002; Bell, 2003). This article focuses on one aspect of the 'victim's agenda': the growth in the numbers of those diagnosed as suffering from conflict-related trauma. This growth in diagnoses is generally viewed in a positive light and is reflected in an increased interest in the issue of conflict-related trauma among academics, health professionals, voluntary and community organisations, church and faith workers, political actors and government officials (Social Services Inspectorate, 1998, 2002; Hayes and Campbell, 2000; Coulter, 2001; Manktelow, 2001; Muldoon and Wilson, 2001; Paterson et al, 2001; Peake, 2001; Luce et al, 2002; Victims Unit, 2002, 2004; CREST, 2003; Shevlin and McGuigan, 2003; Child Care in Practice, 2004).¹

The consensus view in the existing literature is that many people have been traumatised by the conflict, but that it is only with the development of a peace process that most people have been able to acknowledge their own personal traumatisation. As one report puts it: 'for many, the [IRA and Loyalist] cease-fire periods have offered an opportunity to begin to acknowledge trauma and hurt sustained in the past and this has been reflected in an increase in referral rates' (Social Services Inspectorate, 1998: 5). Manktelow (2002) provides a more sophisticated theoretical framework, which utilises Maslow's distinction between basic and higher needs, but provides essentially the same analysis: that the peace process provides the space for trauma to become manifested.

This article challenges this conventional view. I argue that those working in the

field of conflict-related trauma need to adopt a more sociologically and politically informed understanding of how people respond to conflict and peace building. Those working in the field should also resist the tendency to reduce trauma to a mental health issue, but rather acknowledge that people are moral agents who locate their experiences within a wider framework of meaning and consider quasi-legal and political approaches to dealing with the issues that often lie behind manifestations of trauma. Mental health professionals also need to reflect critically on their own role in the wider context of the politics of peace building. The article pursues these issues through a critique of five assumptions that are found in the conventional understanding of the relationship between peace, conflict and trauma in Northern Ireland. The conventional understanding, we argue, assumes:

- a dichotomous view of war and peace;
- a traumatic event is the cause of traumatic symptoms;
- the growth in referrals is primarily a response to 'patient'-led demand for mental health interventions;
- treatment of trauma is necessary and worthwhile;
- the growth in referrals is specific to the end of the conflict in Northern Ireland.

Dichotomous view of war and peace

The idea that trauma is *created* by conflict, but more likely to be *manifested* in a period of peace implicitly presents war as bad and peace as good. The assumption is that war creates trauma and peace provides the conditions in which trauma can be worked through and psychological health restored. This view of the conflict and peace process is too simplistic. It fails to acknowledge the ambiguities of the findings on the relationship between political violence and mental health, glosses over the positive aspects to the conflict that have helped people to deal with the realities of war, misses those aspects of the peace process that have negatively impacted on people and fails to capture the open-ended and politically contested nature of the peace process.

The political violence that has afflicted Northern Ireland since the late 1960s can be counted in terms of deaths (almost 4,000) and injuries (over 40,000) and in the emotional impact of having to deal with a range of consequences of political violence, such as loss and bereavement (Fay et al, 1999). The damage caused by political violence has, however, 'been distributed unevenly across space and time' (Fay et al, 1999: 133). The most intense period of violence was in the first half of the 1970s and the geographical 'hot spots' most affected during the course of the Troubles have been working-class residential areas in the two main urban centres of Belfast and Derry/Londonderry and the rural areas that border the Republic of Ireland. Members of the security forces and Catholics have been most likely to be victims of political violence (Fay et al, 1999: 133–79). There is some evidence that exposure to the Troubles has had a negative impact on mental health. An early study found evidence that the outbreak of street violence led to increased admissions to psychiatric hospitals and increased prescribing rates of tranquillisers by general practitioners (GPs) in Belfast (Fraser, 1973: 45–59); a more recent study has found

a positive correlation between 'the extent to which people and areas were affected by the Troubles ... and the likelihood of suffering from significant mental health problems' (O'Reilly and Stevenson, 2003: 491). The nature and significance of the psychological impact is, however, a matter of dispute. O'Reilly and Stevenson found a direct correlation between exposure and mental health outcomes; Fraser, however, found that serious psychiatric illnesses 'showed an increase only in areas *adjacent* to those affected by rioting' (1973: 59; emphasis in the original). Experts also disagree on the criteria for judging someone to be suffering mental health problems. Curran, for example, makes a distinction between mild psychological disturbance ('normal anxiety') and serious psychotic illness and he argues that the Troubles have led to a rise in the former, but not in the latter (Curran, 1988).

Mental health outcomes are influenced by a range of factors, not by exposure alone. In the literature on trauma and political violence there is, for example, widespread acknowledgement that informal social support networks provide protection from psychological distress (see, for example, Weisaeth, 1998). Social support networks appear to have been affected by the Troubles and the peace process. Early studies of the conflict noted that the social disruption caused by the outbreak of violent disorder and the collapse of state institutions did not lead to the collapse of social support networks, but that on the contrary the outbreak of political violence was accompanied by a growth in community action and a strengthening of community bonds in those areas, Protestant and Catholic, that were on the frontline of the conflict (Burton, 1978; Griffiths, 1978; Nelson, 1984). This invigoration of community helped to sustain the conflict, but also helped people to deal with the consequences of conflict. As Burton puts it, '[s]trong community bonds not only increase the likelihood of active resistance to external threat, they also simultaneously make it possible to absorb the consequences such confrontation results in' (Burton, 1978: 3). This community bond helped people to deal with exposure to violence, bereavement and social disruption. A recent study of social capital in Northern Ireland suggests that these protective community bonds have become frayed and the peace process has been accompanied by a growth of alienation and a powerful sense of community fragmentation (Cairns et al, 2003). This suggests that in respect to community bonds, a protective factor in mental health outcomes, the peace process has had a negative impact rather than a positive one.

There are also continuities between war and peace. The peace process has not, for example, brought an end to violence. The immediate post-ceasefire period was accompanied by the use of 'spoiler' violence by paramilitaries opposed to the peace process and a growth in violent clashes around the issue of Orange Order parades. The use of 'punishment beatings' by paramilitaries of all political hues and violent clashes at residential interfaces has continued to be a regular feature of life in the region (Jarman, 2004; Poole, 2004). There also appear to be continuities in terms of mental health. The regions that were most affected by the Troubles, and that some research suggests tended to display poorer mental health, also appear to be the regions where those 'affected individuals seeking help [to deal with trauma] are mainly located' (Social Services Inspectorate, 1998: 12).

The cases of community bonds and violence indicate that it is too simplistic to suggest that war is bad and peace is good; there were some positive aspects to war

in Northern Ireland and there have been some negative dimensions to the peace process. The IRA ceasefire in 1994 did fundamentally change Northern Irish society, but the region has experienced continuities as well as discontinuities with the Troubles. The decline of informal social networks marks a change, but the paucity of community bonds across the sectarian divide ('bridging social capital') has persisted as a feature of the region (Jarman, 2004: 425–6).² The locations of political violence also mark a continuity with the past (Shirlow, 2003), but the forms of political violence have altered (Jarman, 2004) and the overall intensity of violence has reduced in virtually all geographical areas of Northern Ireland (Poole, 2004). The idea that Northern Ireland has entered a period of peace is also misleading. In a sense the Peace Agreement is misnamed; it did not mark an historic agreement between the various signatories in the sense that they reached a consensus about the nature of the conflict and the best way forward. It is only an agreement in the more limited sense that it provides a framework in which the signatories have agreed to disagree. The Agreement does not bring peace either; rather, as Gilligan says of the peace process more broadly, it shifts 'the emphasis [from] an enlightened outcome, *peace* ... [to] the means to achieve that outcome, the *process*' (Gilligan, 1997: 20; emphasis in the original). This process is one in which different actors are engaged in an ongoing struggle to achieve an outcome that favours them. 'In this sense the peace process is war by other means' (Campbell, 2000: 148). Any analysis of the peace process needs to acknowledge that the region is in an ambiguous 'pre-post-conflict' situation (Wilson and Wilford, 2003).

The idea that 'war is bad and peace is good' makes sense in the abstract. Concrete reality, however, does not live up to this Manichean ideal. There were some positive aspects to war and there have been some downsides to peace. In some senses it may not even be accurate to characterise the current situation in Northern Ireland as one of peace. The region is undergoing an open-ended process of transition towards an, as yet, vaguely defined destination. As we shall go on and see, the growth in referrals for conflict-related trauma is intertwined with this process of transition.

Assumption that a traumatic event is the cause of traumatic symptoms

The diagnosis of post-traumatic stress disorder (PTSD) is based on the assumption that an event, or events, in the past *causes* the symptoms in the present. This 'architecture of traumatic time'³ is also evident in the assumption that the trauma that has been manifested during the peace process was created during the conflict. The development of the diagnostic category of PTSD in the American Psychiatric Association's *Diagnostic and statistical manual of mental disorders* (DSM-III) in 1980 'served to organize the field of traumatic stress' (Eth, 2001: xx) and it has acted as a reference point for therapeutic practice. In order to be diagnosed as suffering from PTSD an individual must have been exposed to a shocking event and display at least one of three clusters of symptoms: re-experiencing of the traumatic event (eg, recurrent nightmares of the event), numbing of responsiveness (eg, constricted affect), and arousal (eg, exaggerated startle reactions). These symptoms are not unique to PTSD. In order to be diagnosed as suffering from PTSD, rather than some other

mental health problem, the symptoms must not have been present prior to exposure to the traumatic event. In other words, a diagnosis of PTSD is based on an explicit assumption that it is exposure to a traumatic event that has *caused* the symptoms. The presenting symptoms are conceptualised as conscious or unconscious responses to the memory of the traumatic event.

The causality in the diagnostic category PTSD is clear. Young points out, however, that 'clinicians know that, in some cases, the relation of time to symptoms and events can be ambiguous' and that time can flow 'in two directions: from a significant event out to its symptoms ... and from a person's current psychological state back to the event' (Young, 1995: 135). The movement of traumatic time from the present *backwards* to an event in the past can be illustrated using a study of the psychological health of retired Royal Ulster Constabulary (RUC) officers carried out in 1998. The researchers interviewed 20 officers, nine of whom 'were in the clinical range for psychological distress' and had, in the previous two weeks, thought about a critical incident in which they had been involved during the conflict and found the memory 'moderately or extremely distressing' (Paterson et al, 2001: 17–18). Two of the former officers made explicit reference to the issue of the early release of convicted terrorists as part of the Peace Agreement in 1998 and assessed their past actions in relation to these events in the present. The two retirees 'were particularly dejected about their current psychological state, asking, 'What was it all for?' (18).

The example of the RUC retirees indicates that the recall of events from the past does not take place in isolation from events in the present. The importance of the present in the process of recall has been explored in detail by Prager who argues that remembering is not a mechanical act involving recall of stored data, but rather that 'memory is always mediated through an interpreting self engaged in a present-day, interpersonally embedded process of remembering' (1998: 92). Prager shifts our attention from the *content* of memory, the event, to the *process* of remembering. This shift highlights the role of individuals as active agents who are involved in assigning meaning to their experiences and locates this individual in a web of meaning through which they make sense of their experiences.

The conception of the individual as an active agent presents an important challenge to the causality found in the diagnostic category PTSD. The assumption that events in the past *cause* contemporary malaise assigns agency to the events and thus tends to present individuals as passive victims overwhelmed by their experiences in the past. The suggestion that individuals are active agents involved in giving meaning to their experiences does not involve a denial that people can feel overwhelmed by their experiences. A person may subjectively experience a memory of an event as overwhelming, but the problem lies in the difficulty he or she experiences in trying to integrate the memory into a framework of meaning, not in the power of the event (Prager, 1998: 171). The fact that the two former police officers made reference to early prisoner release in the peace process suggests that they experienced a difficulty because the meaning that they had assigned to their experiences had been undermined by events in the present. Their psychological difficulties were not *caused* by the early release of prisoners, any more than they were by the events in the past, rather they were caused by the difficulty the police officers experienced in trying to give meaning to the events they experienced in

the past in changed circumstances in the present. The difficulty they experienced in giving meaning to their experiences is neatly summed up in the phrase 'What was it all for?'

All individuals are active in giving meaning to their experiences, but we do so within the constraint of an 'interpersonally embedded' situation. In other words, the process of remembering involves drawing on tacit understandings and external cues, which are shaped by the geographical, cultural and social locations that the individual inhabits. The socially embedded nature of the process of remembering has been demonstrated in a Northern Ireland study, which showed that people were more likely to recall a particular violent event if it happened in their locality and if it was perceived to have affected their ethnic group (Cairns and Lewis, 1999). Two Belfast-based psychiatrists note that role expectations can also influence the response that an individual has to exposure to political violence. One of their patients explained that he had reacted differently to being wounded as a soldier during the Falklands War (he did not develop PTSD) and being shot while working as a postman in Northern Ireland (he developed PTSD), because being shot 'was not something that he expected to face as a postman' (Curran and Miller, 2001: 78). The significance of expectations was also indicated by one Northern Irish expert in the field of trauma when she noted that 'families often say that it is worse to experience such [violent] events now as 'we are supposed to be living in peace'' (Healey, 2004: 182).

Jones, in a study of the psychological impact of the war in Bosnia on children, challenges the causality of PTSD in a different direction. She notes that the children who were less well psychologically were 'more worried about the prospect of a future war' than those who enjoyed better mental health (Jones, 2004: 232). These children were more engaged in searching for a meaning for their experiences and were more politically sensitive to current events. There are two possible directions in which traumatic time is moving for these adolescents: *forward* from their present anxiety to a pessimistic vision of the future, or *backward* from a realistic assessment of a bleak future to anxiety in the present.

In this section we have questioned the causality involved in a diagnosis of PTSD. We have suggested that as well as moving forward from the event to a disturbed psychological state in the present, traumatic time can also move backward from the present to the past and can project into the future or backward from the future to the present. All of this is possible because the process of remembering involves individuals acting as active agents assigning meaning to their experiences; in assigning meaning people can draw on future expectations as well as past experiences and they always do so in a present-day, socially embedded, context. The range of initiatives aimed at dealing with the past in Northern Ireland involves a reappraisal of the past and this has consequences for how people view the past in the socially embedded position of the present.

The 'market' in counselling referrals

Health researchers around the world have noted that there is often wide 'variation in rates of hospitalisation and medical and surgical interventions' even within a

particular local region (Davis et al, 2000: 408). There can be various 'demand' factors – such as demography or environment – which account for this variation. The geographical concentration of those seeking help to those areas most affected by the Troubles appears to be an example of such a 'demand' factor influencing the regional variation in rates of mental health interventions. Demand-side factors, however, may not account for all of the variation. Davis et al identify two main analytical traditions, which have focused on the supply side of medical practice variation (MPV). The theory of supplier-induced demand (SID) suggests that practitioners 'take advantage of their role as patient's agent to influence the demand for their services' with an aim of personal financial gain (408). The other main school of thought focuses on the 'distinctive styles of practice which shape their [practitioners'] use of medical resources' as a way of dealing with situations of clinical ambiguity (408).

The expansion of government spending on trauma since the ceasefires, and particularly since the signing of the Peace Agreement in April 1998, is an obvious financial dimension to the supply side of the growth in referrals. The British government committed over £18 million to victims' issues between 1998 and 2001. Much of this money has gone towards helping deal with conflict-related trauma, including £700,000 for a Family Trauma Centre in Belfast, £1.5 million for the development of the Northern Ireland Centre for Trauma and Transformation, and £3 million core funding for victims'/survivors' groups, to promote models of community healing, among other things. Spending on trauma services is ongoing. In early 2002, for example, the Minister for Health announced an additional £104,000 for counselling and support for conflict-related trauma in North Belfast (Social Services Inspectorate, 2002). Money has also come from other sources. Over £3 million of the European Union (EU) Peace and Reconciliation Programme, for example, was allocated for victims of the conflict in the first wave of funding. Under the current 'Peace II' funding phase almost £5 million had been allocated for victims work by April 2003 and approximately half of this money went to counselling and trauma support groups (Victims Unit, 2003). The growth in funding has resulted in 'a rapid expansion of victim-related work' (Clio Evaluation Consortium, 2002: 43). A conservative estimate of the start date of the 55 groups funded for victims work under 'Peace II' suggested that only a third of the groups existed prior to the publication of the Victims Commissioner's Report (Bloomfield, 1998), only about a quarter existed prior to the ceasefires in 1994 'and some of these were not necessarily working with victims directly prior to the ceasefires anyway' (43). The fact that three groups did not even exist prior to the announcement of the EU Peace Funding in 1999 suggests that it was the opportunity for funding that brought them into existence. All of this, however, does not prove that personal aggrandisement was the motivating factor.

A number of authorities point out that in situations of political violence cultural and security factors act as a constraint on demand. A study of families of those killed by British soldiers on Bloody Sunday⁴ noted that family members would not have availed themselves of counselling services even if they had been available at the time because, in the words of one family member, 'anyone employed by the establishment equals government, equals army, equals police' (Hayes and Campbell, 2000: 717). It has also been suggested that former soldiers 'are reluctant to seek

help in the civilian community because of personal security concerns' (Social Services Inspectorate, 1998: 18). This suggests that the growth in referrals could be due to changes in service provision, which more effectively connects with the needs of client groups. The growth of groups in the voluntary and community sector satisfies a demand, articulated by some victims, for mental health services to be provided by 'local community groups headed by trained leaders from their cultural background' (Hayes and Campbell, 2000: 717). The creation of the Police Rehabilitation and Retraining Trust in 1998, with its Department of Psychological Therapies, is an example of new provision targeted at a particular client group (Black, 2004: 101). The growth in supply, however, cannot be solely attributed to the fulfilment of unmet need. Some groups, through education and awareness training, are involved in stimulating new needs. In the words of one parent asked to evaluate the work of a project that she had participated in: 'No one told us about trauma and its impact before. It's only now that we're able to see the impact on ourselves and our children. We were just surviving before. We hadn't thought about children picking up on everything' (Burrows and Keenan, 2004: 116). This community-based project was involved in educating people to reinterpret their responses to political violence through a discourse of trauma; it was not supplying a self-identified group of traumatised individuals. In this sense the supply of the service was creating the demand for the service.

Daly suggests a number of *clinical* factors that may have led to under-diagnosis of PTSD in Northern Ireland in the past. GPs, usually the first point of contact in the health service for those with mental health problems, often fail to diagnose PTSD because there is insufficient time 'in a short general practice consultation' to identify PTSD, and even if GPs are able to take some time with their patient the presenting symptoms may suggest an alternative diagnosis (1999: 202). The difficulty of making a diagnosis was a problem for GPs and those working in mental health services in the 1970s and 1980s because they were doing so at a time when 'the field of traumatology was in its infancy' (201). This suggests that greater awareness of PTSD on the part of GPs, and other service providers who come into contact with victims of the Troubles, may provide part of the explanation for the growth in referrals. Government may have contributed to raising awareness across different policy fields through the development of an administrative infrastructure for victims issues. A Victims Unit has been established within the devolved administration and a Victims Liaison Unit to deal with non-devolved victims matters established within the Northern Ireland Office. The Victims Unit oversees the implementation of a 'victims strategy' in Northern Ireland. This has involved liaison with civil servants in all departments and agencies to ensure victims groups and individuals are included in all relevant public consultation, develop awareness training on victims needs for civil service staff, and establish Trauma Advisory Panels in each Health Board area (Victims Unit, 2003: 2–6). An Interdepartmental Work Group – including members from the Department of Education and Learning, Department of the Environment, Department of Health, Social Services and Public Safety (DHSSPS), Northern Ireland Housing Executive, Social Services Agency, and the Victims Unit – has been established to coordinate activity across departments and to interact with victims. And guidelines on good practice have been established and promoted (CREST, 2003).

The evidence from Northern Ireland does not refute either personal financial gain or clinical ambiguity as factors in the growth of referrals, but it does suggest that we perhaps need to conceive of the 'market' in mental health interventions in terms broader than simply thinking of it as an aggregate of individual decisions with the GP or mental health professional as the key decision-making agent. The development of an infrastructure for victims issues points to a broader structuring of the field of trauma referrals. The development of the diagnostic category of PTSD has also acted as a mechanism that has structured the field of trauma referrals.

Assumption that the treatment of trauma is necessary and worthwhile

Casual readers of the literature on conflict-related trauma in Northern Ireland would be forgiven for assuming that the population of the region has been severely traumatised by the experience of the Troubles. Daly, however, points out that 'most individuals do adapt to traumatic incidents without experiencing clinically significant psychopathology' (Daly, 1999: 203). The majority of those who display PTSD symptoms recover within 18 months, and this is the case even within the context of ongoing low-intensity conflict and without therapeutic interventions (Bell et al, 1988). Daly warns that, in addition to the problem of under-diagnosis, there is the danger of over-diagnosis and that it is important not 'to unnecessarily medicalise' psychological reactions to stressful situations (1999: 203). In this section we point out that the field of mental health provision has not expanded dramatically because it has been conclusively proven to work and argue that medicalisation is a process that tends to relocate distress 'from the social arena to the clinical arena' (Summerfield, 2001: 98).

The research evidence indicates that some types of counselling interventions, particularly early debriefing-style interventions, at best make no difference to mental health outcomes and, at worst, actually retard recovery. Two other therapies, Cognitive Behavioural Therapy (CBT) and Eye Movement Desensitization and Reprocessing (EMDR), have received better report cards (CREST, 2003). The most comprehensive review of counselling for PTSD carried out to date examined the Anglo-American literature on critical incident debriefing interventions and suggested a number of possible reasons for the failure of this type of counselling. Counselling, the reviewers mooted, may actually interfere with adaptive defence mechanisms such as denial and dissociation; in addition the reimagining of the incident involved in debriefing may produce more anxiety rather than help with emotional processing; and, third, promoting awareness of psychological distress may help to consolidate stress reactions rather than alleviate them (Rose et al, 2002). This last point hints at a distinction between the individual and society more broadly. Mental health professionals appear to assume that awareness-raising activity leads to the 'capturing' of individuals with severe mental health problems and these individuals then benefit from professional help. The suggestions made by Rose and his colleagues indicate that even if CBT, EMDR or other therapies can be proven to accelerate the rate of recovery of *individuals* this is not, in itself, grounds for promoting these therapies or for extending them to those affected by

the Troubles. The benefits to those who receive professional help would need to be weighed against the cost of retarding the recovery of others who 'learn' that they require professional help. Furedi suggests a way in which therapeutic help for the individual might involve wider social costs when he argues that counselling interventions erode the sphere of informal relations through the 'professionalisation of everyday life' (Furedi, 2003: 98–102).⁵ Furedi's analysis suggests the possibility that the growth of conflict-related trauma counselling may be contributing towards community disaggregation and a sense of alienation in contemporary Northern Ireland. The awareness-raising activities of those working in the field of trauma encourage people to interpret symptoms that they had previously interpreted as normal responses to stressful situations as symptoms of psychological dysfunction. The diagnosis is intimately tied to the cure. If the symptoms are indicators of mental health problems then those who are affected require professional help, rather than informal support networks, to deal with the psychological legacy of the Troubles. The criticisms made by Rose et al and Furedi call into question the effectiveness of healing interventions; other critics question the very discourse of healing itself.

Healing is only one means of dealing with the legacy of violent conflict, and one that is not necessarily favoured by those who have been affected by the Troubles. The Report of the Victims Commissioner, for example, noted that groups representing those who had been killed directly by state forces, or killed in instances allegedly involving state collusion between the state and Loyalist paramilitaries, expressed a 'firm view that revelation of the full truth of [these] controversial events was far more important for the victims they represented than any other consideration' (Bloomfield, 1998: 36). Rolston (2002) reports that this statement was only included after considerable pressure from Relatives for Justice, one of the groups representing those killed by state forces. The relatives who are searching for 'truth' frame the issue of dealing with the past in terms of 'justice' rather than in terms of 'healing'. Healing, if it is considered at all, is viewed as a secondary issue and one that will be an outcome of achieving justice. The question of 'truth' and justice, however, has tended to be treated in a piecemeal fashion as it raises awkward questions about the responsibility of various actors – the British government, British Army, Republicans, Loyalists, Unionist politicians, the RUC – for events in the past (Bell, 2003). The promotion of trauma as a mental health issue medicalises distress through promoting therapy as the realm in which the past can be dealt with. In the conventional view of trauma and the peace process the emphasis is on helping people to manage their internal world; traumatic symptoms are not to be dealt with through attempting to manipulate the external world. In this respect the therapeutic approach individualises the issue of trauma and encourages a passive relationship to the external world.

There are parallels between the growth of the victims agenda as an element of government in Northern Ireland and the development of what Nolan (1998) has referred to as the 'therapeutic state' in the US. Nolan locates the stimulus to the development of the therapeutic state in what Habermas calls the legitimisation crisis. Nolan points out that for state power to be exercised effectively it must be viewed as legitimate in the eyes of those over whom it is exercised. American governments, he argues, have attempted to overcome the legitimisation crisis by justifying state

actions in therapeutic terms, a discourse that has a powerful resonance with the American people. The issue of state legitimacy is particularly pertinent in the context of a peace process in Northern Ireland. Previous justifications for the exercise of state power (eg, defence of Queen and country) were a central focus of political contest during the conflict. The peace process developed through promoting a more inclusive approach to governing, one which, in the words of the 1985 Anglo-Irish Agreement and subsequent Anglo-Irish intergovernmental accords, 'recognised the rights and identities of the two traditions' in Northern Ireland (see, for example, Gilligan, 2000). The peace process both necessitated and provided the opportunity for an overhaul of state institutions and the plight of victims has provided an important symbolic focus for the legitimation of the new institutions of governance. The preamble to the 1998 Peace Agreement, which provides justification for the institutional structures outlined in the document, proclaims that 'the agreement ... offers a truly historic opportunity for a new beginning' before going on to say that 'the tragedies of the past have left a deep and profoundly regrettable legacy of suffering. We must never forget those who have died or been injured, and their families. But we can best honour them through a fresh start' (The Agreement, Declaration of Support, paragraphs 1 and 2). The suffering of the victims provides a symbolic reference point in relation to which the new state structures have been legitimated; in doing so it also structures the terrain on which political contestation has been conducted.

Smyth acknowledges that politicians have taken an interest in victims, but suggests that this has been as part of an attempt to appropriate the function of victims as 'moral beacons' in order to 'bring unassailable moral authority to their [own] cause' (Smyth, 2000: 134). Victims can act as moral beacons because of a belief that great suffering confers 'deep moral knowledge'. The fact that such a wide range of institutions and groups as the RUC, the DHSSPS, Sinn Fein, anti-Agreement Unionists, the Office of the First Minister and Deputy First Minister and voluntary sector organisations have sought to associate themselves with victims testifies to the importance of the victim in the new political landscape (Gilligan, 2003).

The issue of victimhood has provided terrain on which different interests have been fought out. Mulcahy, for example, notes that a self-identification as victims is 'one of the most visible aspects of the RUC's official discourse ... [which] characterises the force as a long-suffering and heavily victimised organisation' ((Mulcahy, 2000: 75). He argues that this discourse of victimhood was employed as 'part of an effort to thwart proposals for radical change and to ensure that an 'evolutionary' perspective of police reform prevailed' (82). The fact that the force has been renamed as the Police Service of Northern Ireland indicates that this particular battle has been lost by the RUC, but the peace process proceeds through an ongoing process of battling to defend institutional domains and influence the evolving framework of governance. The Police Federation of Northern Ireland (PFNI) has reacted with hostility to suggestions that establishing a Truth and Reconciliation Commission (TRC) for Northern Ireland would be a useful way forward and argues that 'the only people who would benefit from such a Commission would be the terrorists and paramilitaries, who would use the Forum to justify their crimes' (PFNI, 2003). The PFNI's opposition to a TRC is diametrically opposed to the position of Relatives for Justice. The inherent tendency

towards conflict on the issue of victimhood is contained by the 'agreeing to disagree' nature of the Peace Agreement, which allows the main actors to take a relativist approach towards understanding of the past. Unionists, the British government and Nationalists have their own interpretations of the accountability and responsibility of various actors for actions carried out during the conflict (Rolston, 2000: 323). This relativism constrains conflicts between opposing views, but it also hampers attempts to create a 'new beginning' because unless there is an agreed narrative about the past it is difficult to generate an agreed narrative about the future. Groups working as advocates for those who are suffering from PTSD do not challenge the discourse of victimhood or suggest an agreed narrative about the future. Instead they confine themselves to making claims for recognition of their role in the framework that has been established by the Agreement.

Growth of referrals and the end of conflict

The fact that referrals have grown during the peace process suggests a causal link between the two. The link, however, may be largely coincidental. A number of authors have noted the development of a 'therapeutic turn' in Anglo-American societies during the 1990s. Furedi points to evidence for this new therapeutic sensibility in the increase in citations of the words 'stress', 'syndrome', 'counselling' and 'trauma' (the latter increased tenfold from less than 500 mentions to over 5,000) in British newspapers between 1994 and 2000 (Furedi, 2003: 4–7). The start date is significant as 1994 is the year of the ceasefires that marked the public phase of the peace process.

This therapeutic turn can be seen in the area of humanitarian assistance to war-torn societies, which increasingly emphasises the issue of war trauma (see, for example, Pedersen, 2002; Powell and Durakovic-Belko, 2002; Barenbaum et al, 2004). A number of authors suggest that the impetus for the growth of humanitarian psychosocial programmes to deal with war trauma comes from the West rather than from the societies affected by violent conflict. Jones comments that during six months (1996–97) of psychiatric practice in a Bosnian town 'there was no evidence here of the war-traumatised child so often portrayed in the [Western] media' (2004: 3). Pupavac indicates the more pervasive influence of a therapeutic sensibility in the West relative to Kosovo when she notes the research evidence that shows that Western 'international aid workers in the Kosovo crisis have been more vulnerable to stress than their relatively resilient recipients' (Pupavac, 2002: 293).⁶ She also indicates some of the perverse effects of the emphasis on psychosocial programmes when she recounts an aid worker telling her that international aid workers 'were tripping over each other demanding to do psychosocial work while refugees were without proper shelter' (499).

The therapeutic sensibility extends well beyond the realms of the management of violent conflict and can be seen in a range of government policy areas in the UK and the US. Giddens, for example, promotes lifelong education by stating that 'although training in specific skills may be necessary for many job transitions, more important is the development of cognitive and *emotional* competence' (Giddens, 1998: 125; emphasis added). Hoggett (2000) echoes this when he argues for a

greater role for the emotions in UK social policy. Nolan (1998) has documented the growth of a therapeutic sensibility in the education and criminal justice systems, in welfare policy and in political rhetoric in the US. The therapeutic turn can be seen in the growth of the counselling profession and of counselling interventions for a range of different issues in the UK. Northern Ireland has not been impervious to this broader trend. A review of counselling services in Northern Ireland notes that the growth in demand for counselling extends beyond the victims of the conflict to primary care patients and youth workers (Social Services Inspectorate, 2002: 13–14). The charity the National Society for the Prevention of Cruelty to Children, for example, has developed a counselling programme for school children in Northern Ireland. None of the three most common issues dealt with in individual counselling sessions since the programme was set up in 2000 – ‘family difficulties’, ‘bullying’ and ‘examination-related stress’ – are Troubles-specific issues (NSPCC, 2003). The growth in counselling referrals is not specific to conflict-related issues, or even to Northern Ireland, but part of a wider trend. This should caution against a simplistic reading of the growth of PTSD referrals as a post-ceasefire phenomenon. It also suggests the possibility that the growth in referrals may well have happened irrespective of a peace process.

Conclusion

In this article we have challenged the conventional wisdom on the growth of conflict-related trauma referrals. In concluding the article we want to suggest some reasons why it is important to challenge the conventional view. The first reason is that it is only through critical inquiry that flaws in policy and practice can be identified and new lines of inquiry initiated. The existing literature on the subject is almost exclusively written by those working in the field. Some of those writing on the subject, such as Cairns, Curran, Daly and Smyth, have provided some critical insights, but these insights often read as ‘in-house’ criticisms from within the disciplines of psychology, psychiatry and social work. This article has sought to widen the scope of criticism through placing the growth in referrals into a broader sociological and political analysis. We are not expecting those working in the area of conflict-related trauma to agree with all of the points made in our analysis, but it is incumbent on them to respond to the criticisms made here. In responding to our criticisms mental health professionals will have to reconsider some of the fundamental premises that have informed their practice to date. This critical reflection should benefit future activity in the area of psychosocial interventions in the context of the Northern Ireland peace process and some of the insights gained may be generalisable to psychosocial interventions and peace building internationally.

Although we argue for the need to place the growth in referrals into a broader sociological and political analysis, we also believe that this involves adopting a richer ontological conception of human psychology. The question ‘what was it all for?’ goes to the heart of the issue. The fact that this question is asked indicates that individuals reflect on the past from a socially situated location in the present (in the particular case cited in this article, a former police officer uncomfortable with

the reality of prisoner release). This question cannot be adequately answered in a therapeutic setting, however, as any attempt to do so reduces the question to one of how the individual *feels* about what happened in the past and about how he or she can learn to cope with present realities. The question reveals the limits of therapy as a dimension of peace building. Therapists cannot adequately answer the question 'what was it all for?' because it requires a political or moral answer. The relativist nature of the Agreement, however, makes the political domain one in which it is difficult to provide an answer to the question. The agreeing to disagree nature of the Agreement allows each faction to provide its own answer – it was a war of liberation, it was fought in defence of the Union, it was a war against terrorism – but does not provide a mechanism for adjudicating on these answers. The fact that a satisfactory answer to this question is precluded by the agreeing to disagree nature of the Agreement indicates that the relativist nature of the Agreement places limits on peace-building efforts. Peace building necessarily involves a vision of the future that can engage people in the process of building a better future. The relativist nature of the Agreement makes consensus on a vision of the future for the *whole* of Northern Irish society difficult to achieve; it even constrains the parties from putting forward this vision by encouraging them to think of the present and the future in relation to ethnonational blocs rather than society as a whole. The agreeing to disagree nature of the Agreement helped to ensure that the main parties were able to sign up to it. In this sense it enabled Northern Ireland to get to a 'pre-post conflict' situation. Now, however, this facet of the Agreement may be a fetter on peace-building efforts. We believe that this issue needs to be examined in more detail.

One of the core arguments advanced in this article is that people are active in giving meaning to their experiences of political violence. Research and mental health interventions that fail to recognise this treat people as passive recipients of their experiences. This is true of the conventional view of trauma and the peace process in Northern Ireland and of international psychosocial interventions in war zones more generally. These well-meaning interventions construct war-affected civilian populations as victims. Researchers such as Jones and Pupavac suggest that war-affected populations are more robust than is generally assumed by those Western governments and non-governmental organisations who promote, finance and provide the personnel for psychosocial interventions. The arguments advanced by Jones and Pupavac are in line with research from Northern Ireland, which found that 12% of those sampled self-reported as victims of the Troubles, while by 'more objective' criteria some 16% could be said to have been 'direct' victims of the troubles and some 30% 'indirect' victims' (Cairns et al, 2003: 1). The introspective, individualised and depoliticised approach to dealing with political violence is inherently self-limiting and may even serve to undermine peace-building efforts by promoting a view of the human subject as inherently vulnerable and in need of professional support. In order to rebuild a society torn by conflict a more ambitious and active vision is needed, one which looks to the future and what people can do to bring about this future. When we talk about healing war-torn societies we should recognise that healing is not a discrete process that only takes place in a therapeutic setting; it is tied up with wider questions of social justice and normative

concerns about what type of society we all want to inhabit. Ultimately, these wider issues can only be addressed in the political domain.

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Notes

¹ See also the information and links at the Victims Unit website (www.victimsni.gov.uk/usefulinfo.htm) and the CAIN website (<http://cain.ulst.ac.uk/issues/victims/>).

² For a critical appraisal of the concept of social capital applied to west Belfast see Leonard (2004).

³ The term 'architecture of traumatic time' was first employed by Allan Young (1995) in his pioneering study of the history and politics of PTSD.

⁴ In January 1972 British paratroopers opened fire on unarmed civil rights protestors in Northern Ireland's second city, Derry/Londonderry. Thirteen people died as a result of the shootings. The event has become known as Bloody Sunday.

⁵ A review of EU funding to victims groups notes a 'widespread ... anxiety of the voluntary groups ... that services which were important and helpful to victims would be replaced by the sorts of things in which it was possible to obtain credentials (for example, listening and socialising being replaced by aromatherapy or counselling)' (Clio Evaluation Consortium, 2002: 48). Ironically these groups appear to be oblivious to the parallels between this 'push to professionalise' and their own activity in relation to conflict-related trauma.

⁶ Elsewhere she notes that this is a 1990s phenomenon and that aid workers were generally viewed as resilient in the 1970s and 1980s (Pupavac, 2004: 497).

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