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Children, Trauma, and the Troubles: Northern Ireland's Social Service Response

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CHILDREN, TRAUMA, AND THE TROUBLES: NORTHERN IRELAND'S SOCIAL SERVICE RESPONSE

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ABSTRACT

Society in Northern Ireland has been wrought by sectarian conflict for decades. The conflict, punctuated by random acts of bloodshed and violence from paramilitary groups, police, and the British military, had been the predominant model for conflict resolution in Northern Ireland until the signing of the Good Friday Agreement in 1998. Neighbors and friends had become enemies because of religious and political ideologies which lead to death, injury, and a deeply divided society. There was also an unseen cost of the conflict known as the Troubles; the immeasurable toll the conflict had taken on the mental and emotional health of children who had lived their whole lives in turmoil. Northern Ireland's most vulnerable members of society are children and many have suffered from life-long psychological trauma of the violence. Children, however, have been the most underserved population in terms of psychological and social needs. The purpose of this study was to understand the body of research which has been produced on the response from the social service sector to children traumatized by the violence of the Troubles and to evaluate the effectiveness of those responses.

INTRODUCTION

Social work's core values include service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence (NASW, 1999). The first of these values, service, is guided by the ethics of helping people in need (NASW, 1999). Social workers respond to the needs of people in crisis and provide therapy for victims of war, conflict, and violence. Responding to people's psychosocial needs and providing services are key components to help victims who seek help. Psychosocial needs refer to the individual's psychologi-

cal wellbeing and their social interactions (psychosocial, (n.d.)). Social workers serve vulnerable populations at risk, of which children are the most vulnerable. Children are often unable to or ill-equipped to deal with circumstances beyond their control, such as war, ethnic conflict, or sectarian violence. When children are subjected to the violence of armed conflict, they either internalize or externalize the stress of the trauma they suffer. The social service sector must be prepared to respond to these children with appropriate, adequate, and timely therapeutic treatment programs. This study seeks to understand the body of literature produced thus far on children in Northern Ireland including the psychosocial effects of trauma caused by armed conflict, the complexity of studying this population, and the response from the social service sector to children traumatized during the Troubles.

METHOD OF DISCOVERY

This study was a preliminary inquiry using a qualitative design which employed the following research methods: participant observation; interviews; analysis of cross-national archival, scholarly works and data; and Qualrus® qualitative data analysis software. Based on Dudley's (2005) model in, Research Methods for Social Work, a combination of structured and unstructured observation methods were used in this study. Culture and physical environments in Belfast and Portstewart, Northern Ireland were observed. Interviews with faculty members of Queen's University Belfast were conducted in Belfast and Portstewart. Articles of international research on children, trauma, armed conflict, and the psychological effects of armed conflict on children were located using Eastern Michigan University databases, Queen's University Belfast databases, the United Nations databases, as well as other online databases. Books on children and trauma, The Troubles in Northern Ireland, and social work were reviewed. Documents were analyzed, compared, and entered into Qualrus® data analysis software for coding, linkage, and analysis.

HISTORICAL CONTENT

Northern Ireland was plagued by violent sectarian conflict, known as the Troubles, from 1969 until the signing of the Good Friday Agreement in 1998. Ramon, et al. (2006) described the complex nature of the conflict in terms of socio-economic inequalities, a failure by the state to ensure adequate standards of justice, and the role of external states in the possible causes and resolution of the violence. These

socio-economic disparities, political ideologies, and religious alliances all played integral roles in the dissension of society in Northern Ireland. The Youthquest 2000 Survey identified segregation as a common feature in all aspects of everyday life in Northern Ireland (Joint Society for a Common Cause & Community Conflict Impact on Children [JSCC & CCIC], 2000). The Survey found children and young people experienced segregation, conflict, and violence in the wider social context of assets, education, resources, residential, and occupational terms (JSCC & CCIC, 2000). Areas with the highest concentrations of sectarian violence were also the areas of greatest deprivation in Northern Ireland. Fear, suspicion, and mistrust of the "other community" created a universal sense of victimhood as well as a culture of silence in the highly segregated communities (JSCC & CCIC, 2000). Together, these dynamics produced difficulties for researchers to assess the population of children at risk of developing psychological illnesses and the ability of social service agencies to provide appropriate and adequate care for children and young people traumatized by the violence of the conflict.

NATURE OF CHILDREN AND TRAUMA

One of the unseen tolls of the conflict in Northern Ireland was on the psychological health of its children. For years it was widely believed that children were highly resilient and, therefore, did not suffer from the psychological impact of war and conflict. However, in 1989 Dawes, Tredoux, and Feinstein (as cited in Binks and Ferguson, 2007, p. 241) warn the expectation of resiliency in children exposed to violent societies may have led to the psychological impact of this population being underestimated. Likewise, in 2004 Barenbaum, Ruchkin, and Schwab-Stone (as cited in Binks and Ferguson, 2007, p.228) also dispute the claim of resiliency and insist children are highly vulnerable to trauma during war. From these studies I concluded that children who are exposed to the violence of war, become a victim of armed conflict or participate in violent acts, often develop a variety of psychological illnesses. The impact of this violence may have detrimental consequences on the child developmentally, emotionally, and socially. Psychological illnesses are not only produced by witnessing violence, but may also be caused by participation in the violence.

Children in Northern Ireland were not only witnesses to riots, bombings, and murders but they also participated in these brutal acts. Fraser (1973, p. 8) asserted when children and their parents are themselves the combatants, psychological stress takes on new and horrifying

meanings. He also maintained children between eight years and adolescence were the worst affected by political violence (Fraser, 1973, as cited in Binks and Ferguson, 2007, p.231). McDermott, Duffy, and McGuinness (2004) concur with Fraser(1973) that young people have always been among those at greatest psychological risk from armed conflict. McDermott, et al. (2004) found the mental impact of living through and experiencing the violence of the conflict in Northern Ireland did manifest as Post Traumatic Stress Disorder (PTSD), depression, anxiety, and phobias in children. In a 2004 Northern Ireland Department of Health, Social Services, and Public Safety [DHSSPS] Report McDermott and Fitzgerald reported that as the degree of exposure to a bomb increased, so did the levels of reported symptoms of PTSD, depression and anxiety among children (Department of Health, Social Services, and Public Safety, 2004). Degrees of exposure include the child's proximity to the bomb, whether they were first-hand witnesses to or related to someone whom had been injured or killed by a bomb, or whether they had only been exposed to a bombing event by viewing a television broadcast of the event.

Additional research supports the theory that children are adversely affected by the violence of armed conflict. Black (2004) emphasized that terrorist-related trauma was distinctly different from other traumatic stressors because the act of terrorism is carried out by one human being and targets an individual or group, with the aim of causing death, injury, or evoking terror. Dillenburger, Fargas, and Akhonzada's (2007) reported pre- and post-ceasefire violence had adversely affected the lives of many children and young adults in Northern Ireland. Many researchers agree there are many factors which determine how a child responds to the stress of violent conflict.

Children display varying degrees of psychological stress depending upon the degree of violence to which they are exposed. Cairns (1996) and Muldoon, Trew, and Kilpatrick (2000) noted children across Northern Ireland were exposed to varying amounts of violence depending on the year, location, age, gender, social class, and religious affiliation of the child (as cited in Binks and Ferguson, 2007, p.230). Machel (2000) concurs children react differently to armed conflict depending on their age, gender, personality type, family history, cultural background, and experience. A Northern Ireland DHSSPS (2004) report found the consequences of the Troubles on the psychological wellbeing of young people was not clear and the issue lacked understanding of the long-term effects on children. The DHSSPS indicated more research needed to

be conducted to better understand how children were affected by living with the prolonged, violent conflict.

However, the social service sector in Northern Ireland, which includes social workers, has been hindered in its ability to conduct research with children living through the conflict and in its ability to provide necessary therapeutic services to these children. According to Ramon, et al. (2006) the role social workers have played in the conflict has been, until recently, under-researched. Sectarian prejudice and violence have also had an impact on researchers' ability to conduct accurate assessments of the population. Dr. Karola Dillenburger, professor of social work at Queen's University in Belfast (personal communication, May 14, 2008) acknowledged these limitations were due to the social division and the danger researchers and service providers faced. Dillenburger described other difficulties which included finding acceptable terminology for describing events and identities, suspicion or fear of reprisal from paramilitaries in both communities for talking about the Troubles, and people's mistrust of government intentions (personal communication, May 14, 2008).

In addition to these factors, McDermott, et al. (2004) cite the following issues which have also hindered social service providers: under-reporting by parents, teachers or physicians of children's actual psychological stress; the children's inability to communicate their feelings and level of distress; children trying to protect parents who have also been traumatized; a traumatized parent's inability to recognize signs of trauma in their children; parent denial of a child's distress; the child's fear of being perceived as different; and the child's attempt at avoiding memories of the trauma. In addition, children often worried about reprisal from paramilitaries for talking about the violence they experienced.

INTERNATIONAL EVIDENCE

Internationally, research has, however, been conducted on the impact armed conflict has on children and young people's mental health. In 1994 Grac'a Machel was appointed by the Secretary General of the United Nations to conduct the first extensive study on the impact of armed conflict on children. In this study, Machel conducted six regional consultations which involved governments, military authorities, legal experts, human rights organizations, the media, religious organizations, eminent leaders from civil society and women and children directly involved in armed conflicts (Machel, 1996). The consultations were held in: the Horn, Eastern, Central and Southern Africa; the Arab Region;

West and Central Africa; Asia and the Pacific; Latin America and the Caribbean; and in Europe (Machel, 1996). Machel also conducted field visits to areas affected by armed conflict, including Angola, Cambodia, Colombia, Northern Ireland, Lebanon, Rwanda (and refugee camps in Zaire and the United Republic of Tanzania), Sierra Leone and various places in the former Yugoslavia (Machel, 1996). The Machel Report (1996) presented to the Secretary General at the 51st session of United Nations General Assembly called for State Parties to adhere to article 39 of the Convention of the Rights of the Child, which required them to take all appropriate measures to promote children's physical and psychological recovery and social reintegration during and following armed conflict. Machel (1996) suggested this was best accomplished by ensuring assistance programs addressed the psychosocial needs of a child's growth and development. Acknowledging the need for psychosocial intervention on behalf of children suffering from stress due to violent, armed conflict is the first step social service providers must take.

SOCIAL SERVICE RESPONSE

According to Dr. Karen Trew, professor of psychology at Queen's University Belfast, psychological trauma in children affected by the violence of the conflict, was not addressed for many years (personal communication, May 12, 2008). It was thought children were highly resilient, even when witnessing direct violence such as murder, therefore children were not given psychiatric counseling (K. Trew, personal communication, May 12, 2008). In fact, according to the Northern Ireland Department of Health and Social Services (1996), there were individuals who had been bereaved or seriously affected by the civil unrest in Northern Ireland and had not yet been identified as victims (DHSS, 1996, as cited in Coulter, 2004). Further, in its 2003 report the Northern Ireland DHSSPS found services to assist victims were usually developed as a result of a response to a specific tragedy, often with service developments taking place in an ad-hoc manner (Department of Health, Social Services and Public Safety [DHSSPS], 2003). However, as the conflict continued, researchers began to look at the implications of growing up in a violent society on a child's psychosocial wellbeing. From this body of research several factors surfaced which clarified the reasons for the sometimes slow response from the social service sector in addressing this most vulnerable population – children. Fear for personal safety and mistrust of the government, the shortage or availability of specialized services for children, insufficient funding for services, and inadequate

training of service providers were the most common obstacles service providers faced.

FEAR AND MISTRUST

Both Dillenburger (personal communication, May 14, 2008) and Trew (personal communication, May 12, 2008) confirmed the greatest impediment to rendering services had been sectarian division and mistrust of cross-ethnic communities. Dillenburger stated, "you had to look under your car for a bomb and service providers from cross-ethnic communities could not go into the other community, even if they were right next door" (personal communication, May 14, 2008). The DHSSPS (2003) substantiated the view that there was still an element of 'distrust' between the statutory and voluntary/community sector. Even the Police Rehabilitation and Retraining Trust's Child and Adolescent Therapy Service found in the majority of its cases, officers were reluctant to allow their own children to be referred to statutory (government operated) child and adolescent mental health services due to a concern for their personal security (Black, 2004). Police and security forces and their families were often the targets of violent reprisals from both sides' paramilitary groups. Not only did this fear and mistrust hinder the officers' own recovery from traumatic stress-related illnesses, it also prevented their children from receiving necessary therapies and skewed figures in reports of child trauma-related stress. The lower figures may have also had an impact on the opinion about the need for specialized services for children which may have contributed to the lack of service providers for children.

AVAILABILITY OF SERVICES

In the PAVE report, Dillenburger, et al. (2007) note a common definition of the kind of services offered by the voluntary sector for victims of the Troubles was, "a service is provided if it meets the relevant and appropriate minimum standards of practice for this service." In studies conducted by Northern Ireland's Commissioner for Children and Young People (2004) and by the Social Services Inspectorate (2005) serious shortages of mental health services, both community and hospital based, for children and young people in Northern Ireland were noted (as cited in Horgan, 2005). The DHSSPS (2003) reported the main specialist service provider to children in Northern Ireland was the Family Trauma Centre located in Belfast. However, the Family Trauma Centre was not readily accessible for a large percentage of the Northern Ire-

land's population (Department of Health, Social Services, and Public Safety, 2003). In addition, there were only a relatively small number of dedicated services for victims across the general DHSS (Department of Health, Social Services and Public Safety, 2003).

While availability of service was a problem, so too was the wait for access to the services which were available to victims. The DHSSPS (2003) found with some particular specialties, which victims accessed more frequently (i.e. pain management, physiotherapy, mental health, social services etc.), users were subject to long waiting lists. Inadequate funding was cited as one reason for the long wait lists.

FUNDING

Funding for victims services received modest attention in the early years of the conflict. Not until 1998, was major funding allocated to a variety of organizations whose mission was to provide support services to victims of the conflict (McDougall, 2006, as cited in Dillenburger, et al., 2007). McDougall, et al. (2006) reported £44 million from the central British government and European funding had been sent to agencies in Northern Ireland servicing victims of the Troubles (as cited in Dillenburger et al., 2007). In spite of this allocation, representatives of the voluntary and community sector as well as other groups expressed the opinion there was 'competition for scarce funding' between statutory (government operated) and non-statutory organizations (Department of Health, Social Services and Public Safety, 2003). Additionally, these funds were largely sent to service providers for adult victims. Funding was not the only barrier to delivering therapeutic services to children, however, it did affect the availability of workers specifically trained to deal with trauma-related psychosis in children.

TRAINING

Because services were at times developed in the aftermath of a traumatic event, social service workers in Northern Ireland were often not qualified to deal with the specific needs of trauma-related stress in children. Even though Ramon, et al. (2006) found in a sample of social workers questioned in Northern Ireland, nearly one-fifth possessed a Masters degree in Social Work (MSW) and 43 percent of the respondents had spent more than sixteen years in the profession, inadequate training in addressing the impact of sectarianism, crisis debriefing work, and use of psychodynamic counseling techniques with clients added to the scarcity of the response from the social service sector to children in need.

The Family Trauma Centre expressed that current services provided to victims of the conflict were not holistic and in many cases mainstream service providers did not have the awareness or skills to treat victims of the conflict (Department of Health, Social Services and Public Safety, 2003).

SUMMARY OF FINDINGS

For approximately the first 25 years of the conflict in Northern Ireland, insufficient research was conducted due to mixed opinions on the effects of violence-related trauma on children. In addition, sectarian violence and segregation prevented researchers and service providers from rendering necessary psychosocial treatment programs to children suffering from trauma-related psychosis. For many years, social service workers were ill-equipped to provide appropriate therapeutic programs of recovery for children with stress-related trauma. More recent research and data confirms the adverse effect armed conflict and terrorism has on children's psychological wellbeing. Recent efforts have been made in Northern Ireland to address the needs of children suffering from sectarian violence.

PRACTICE IMPLICATIONS

Research on children and trauma in Northern Ireland has confirmed children and adolescents are affected by violent, armed conflict. Stress can manifest in children as PTSD, depression, anxiety, phobias, behavioral problems, as well as affect a child's growth and development. It is vital for social workers and other social and mental health care providers to fully understand the effects of trauma on children's growth, development, and psychological wellbeing. To this end, continued research should be done with this population.

Social service providers need to be specifically trained on how to identify and respond to children traumatized by armed conflict and terrorism. Specially trained workers will be better equipped to develop and implement therapeutic programs designed to meet the unique needs of children in distress. Programs need to be developed in advance of incidences in order for services to be rendered in a timely and effective manner. Therapeutic programs and treatments need to be culturally sensitive to the child's customs and experiences.

Consistent and adequate funding needs to be allocated through legislation designed to insure the continuity and stability of child treatment and recovery programs. Both statutory and non-statutory services

should be considered in all funding proposals.

Education of the public to include parents, teachers, public servants, and social service providers should be a component of all recovery and therapeutic programs. Specific funds should be budgeted for these educational components. Education should include the signs and symptomology of stress-related trauma in children.

Information on best practices in child recovery and reintegration programs should be disseminated across communities and networks of social service providers. This will promote understanding, cooperation, and increase child recovery outcomes.

In terms of policy practice implications, existing laws and protocols designed to protect and rehabilitate children during and after armed conflict must be adopted and adhered to by all state governments. Consistency throughout the globe will increase awareness of the specific needs and vulnerabilities of children and may prevent undue stress, trauma, and abuse of children during and following armed conflict.

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