QUEEN'S UNIVERSITY BELFAST

50 YEARS OF EDUCATIONAL PSYCHOLOGY TRAINING AT QUEEN'S UNIVERSITY BELFAST

THE TRANSGENERATIONAL IMPACT OF '**THE TROUBLES**' IN **NORTHERN IRELAND**

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Foreword

This group-based exercise is a summary of the work completed by Year 2 trainees (2016-2017). Each trainee researched one aspect of the topic.

Maighread Gough's introductory chapter focuses on international literature on the psychological impact of armed conflict before exploring the conflict in Northern Ireland.

Chloe Miskelly's focus in Chapter Two looks at the impact of "the Troubles" on the family system. This is followed by Victoria McIlwaine's chapter, which examines issues surrounding young people's mental health.

In Chapter Four, Linzi Kelso explores suicide rates amongst children and young people today in Northern Ireland. In Chapter 5, Mark Given explores the role of Education in Conflict Resolution in Northern Ireland, whilst in the final chapter Emily Fitzgerald continues the focus on Education in Northern Ireland with specific reference to trauma in the classroom and other issues in post-conflict Northern Ireland.

Thanks are due to Dr Karen Trew who assisted with this Research Project and subsequent publication.

Bridgeen O'Neill

1

The Psychological Impact of "The Troubles" in Northern Ireland on Today's Children: A Post-Conflict, Transgenerational Perspective

Maighread Gough

Many studies have revealed that children exposed to armed conflict are at risk of a range of negative outcomes, including heightened aggression, anxiety, depression and post-traumatic stress disorders (Qouta, Punamäki & Sarraj, 2008). Considering the prevalence of violent conflicts worldwide, a deeper understanding of the impact of armed conflict on children is vital, and has been identified as a strategic goal for The Society for Research in Child Development (Masten, 2014). Children may be affected directly or indirectly by violence, and in recent years, research has focused on the transgenerational impact of conflict. This chapter, in a bid to determine the transgenerational impact of "the Troubles" on people living in Northern Ireland, investigates international literature on the psychological impact of armed conflict on children, and ways that trauma may be transmitted across generations.

1.1. International Literature on the Psychological Impact of Armed Conflict

Worldwide, millions of children are affected by armed conflict and the inevitable traumatic societal changes that accompany it. The short-term consequences include death and serious injury, loss of a family member, displacement, witnessing traumatic events, risk of exploitation and other adversities. Longer term, the psychological impact pervades, and for some leaves an enduring scar. Since the end of the Second World War, the number of armed conflicts has not abated. These conflicts reportedly deleteriously affect the social determinants of mental wellbeing, including family and community networks, access to essential services such as health and education, and morality and spirituality (Tol et al., 2010).

Children in particular are routinely considered a vulnerable group in relation to war. The 2001 UN report entitled 'We the Children' describes how war affects every aspect of children's development. The psychological impact of armed conflict on children has typically focused on mental health outcomes, both at a clinical and sub-clinical level. In their review of the literature on the prevalence of mental disorders among children exposed to war, Attanayake et al. (2009) report post-traumatic stress disorder as a primary outcome. Other focuses in the literature included diagnoses of depression, generalised anxiety disorders and adjustment problems.

In the international literature, a dominant theme regarding the psychological impact of armed conflict is that of the posttraumatic impact. In Miller and Rasmussen's (2010) research into factors that may influence mental health in conflict and post-conflict areas, the focus is on two possible categories of stressors: direct exposure to conflict/violence and daily stressors, which reflect the stressful societal and economic conditions that often are influenced by armed conflict. This, they claim, reflects the contentious divide between researchers who are trauma-focused in their approach to psychopathology in war-affected populations and those who advocate understanding from a psychosocial perspective. They suggest that much of the psychological distress seen in conflict-affected populations originates largely from the stressful conditions of everyday life, within the context of the violence, and offer conditions such as poverty, displacement, loss of livelihoods and destruction of social networks as examples of these stressors. Miller and Rasmussen promote the idea that daily stressors are a continuous form of proximal threat to mental health, and advocate aiming to reduce daily stressors before any specialist clinical trauma focused treatment may begin. They argue that daily stressors may in part mediate the relationship between war exposure and mental health, and that a narrow focus on addressing post-traumatic stress disorder (PTSD) may increase the risk of failing to notice ongoing traumas or adversities that occur daily.

Neurer (2010) challenges Miller and Rasmussen's (2010) belief by suggesting that poor mental health may lead people to experience high levels of daily stressors. Neurer (2010) also questions the benefit of distinguishing between war trauma and other types of stressors. It would appear that both categories of stressor – direct exposure to conflict and daily stressors influenced by the conflict – contribute to psychological distress in these populations (DeJong, Komproe & Van Ommeren, 2003; Miller & Rasmussen, 2010). This discussion has led researchers and practitioners to argue for concurrent and multi-level interventions that use the provision of clinical treatments alongside psychosocial activities (DeJong, Komproe & Van Ommeren 2003; Miller & Rasmussen, 2010).

1.1.1. Children of parents with PTSD

Leen-Feldner et al.'s (2013) review on the psychological and biological correlates of children with parents suffering from post-traumatic stress disorder (PTSD) or post-traumatic stress syndrome (PTSS) reveals an association between elevated parental PTSD/PTSS and offspring outcomes, even when the child has not been exposed to the trauma. Leen-Feldner et al. (2013) propose that parents with elevated PTSD/PTSS may confer psychological vulnerability to their children, and highlight evidence that indicates that elevated maternal PTSD/PTSS is an even more reliable predictor of child symptomology than parental PTSD/PTSS. It is thought that parents with PTSD/PTSS may expose their offspring to dysregulated mood, thoughts and behaviours, leading to affective distress in the child during key times of development, and possibly has a role in the transmission of psychopathology (Goodman & Gotlib, 1999). Parent dysregulation may impact parenting behaviours in more generalised negative ways, such as lack of engagement, employing hostile or harsh parenting styles (Leen-Feldner et al., 2011) or displays of anger or violence. Another pattern emerging from the review is that of a 'dose effect', whereby elevated PTSD/PTSS in both parents is more strongly associated with their children experiencing problems.

1.1.2. Conflict in the Middle East

The Middle East, in particular Palestine and Israel, has been an area of conflict for many decades, with the ongoing violence as yet unresolved. The area is also considered to have a

high proportion of children in the population, and has been the focus of much research. Dimitry's (2012) systematic review of the mental health of children and young people living in areas of armed conflict in the region examines the factors that mediate between exposure to conflict and mental, behavioural and emotional difficulties. Dimitry (2012) found that children and young people living in these conflict areas were likely to have been exposed to traumatic experiences, and that the number of conflict-related traumatic experiences showed a positive correlation with prevalence of mental health and adjustment problems. Dimitry (2012) argued the case for determining factors such as level and type of traumatic exposure, age, gender, social support and socio-economic adversity. The study found that older children were more likely to have experienced higher levels of exposure to trauma and had more post-traumatic stress syndrome than younger children. These findings indicate that girls have a higher prevalence of internalising difficulties such as post-traumatic stress syndrome, depression, anxiety and psychological symptoms than boys, while males have more externalising problems such as behavioural issues, aggression and hyperactivity. Although Cummings and Davies (1996) conclude that child gender offers little in terms of explaining the variability in outcomes for children exposed to conflict, it is worth being mindful of the gender and cultural stereotypes within specific research contexts and in general when evaluating the literature.

1.1.3. The war in former Yugoslavia

The war that occurred when the former Yugoslavia fragmented lasted from 1991 until 1999, and is known as the Balkans War. Hundreds of thousands of people died in the ethnic conflict, and many more were internally displaced, with the number of people forced from their homes estimated to exceed one million. Significant numbers of refugees and internally displaced persons (IDPs) were supported by host families, yet as the conflict continued and resources became increasingly limited, declining living standards were inevitable (Danopoulos, Kapor-Stanulovic & Skandalis, 2012). Even children who were not forced to flee their homes report similar problems to those who were displaced. Many families experienced breakdowns, especially where parents were of different ethnicities. Another feature of this conflict was wartime sexual violence, with some researchers estimating that between 10,000 to 60,000 females were raped during the war (Ashford & Huet-Vaughn, 1997). So-called 'rape camps' were run by Bosnian Serbs, where Muslim and Croat women were held and raped, with impregnation the aim of a systematic ethnic cleansing programme (Bastick, Grimm & Kunz, 2007). Children born as a result of these rapes faced issues surrounding acceptance, identity and group membership, among other things (Denov, 2015). Research from the region has demonstrated that parents in the former Yugoslavia intentionally instilled in their children a hatred for opposing ethnic groups and a desire for retribution (Klain, 1998). The legacy of the conflict is such that even today sectarianism remains a significant issue, with some researchers suggesting that the levels of sectarian and provincial views among the current generation are higher than those of their parents (French, Kovacevic & Nikolic-Novakovic, 2013). The Rose-Roth (2009) report highlights that post-conflict, schools in Bosnia and Serbia are increasingly becoming segregated, and attempts to document the history of the conflict in less nationalistic ways have been met with opposition from the separate countries (Rose-Roth, 2009).

1.1.4. Limitations to generalising from specific conflicts

It is important to note that it is difficult to generalise the findings from studies of conflict and post-conflict areas proves difficult. Each conflict occurs within its own societal context, and conclusions drawn from one such culture may not apply to others. It is important to be mindful

that conflicts occur within certain contexts, and often will not involve universal exposure or response. These types of events will differ across countries and communities, therefore the impact of exposure will vary greatly also, making generalisation problematic. Many researchers (Attanayake et al., 2009; Bronfenbrenner, 1992; Cummings et al., 2009) warn about these difficulties and emphasise the need for governments and aid agencies to ensure assessments and treatments for war-affected populations are culturally valid. This is imperative to maximise the potential impact and effectiveness of interventions.

1.2. The Conflict in Northern Ireland

The sectarian nature of the conflict and violence in Northern Ireland, often referred to as "the Troubles", is underpinned by complex historical, religious, economic and psychosocial factors. The period of conflict was prolonged, from 1968 until 1994, and although several attempts were made at brokering political and peaceful solutions, it is only since the 1998 Good Friday Agreement, which received widespread support among the population, that "peace" has been possible. Although deadly forms of sectarian violence have decreased, in post-Agreement Northern Ireland the threat and perpetuation of violence, sectarianism and political disagreements remain ongoing (Cummings, Goeke-Morey, Schermerhorn, Merrilees & Cairns, 2009).

Early research into the conflict in Northern Ireland suggested that the Troubles had little effect on children (Cairns & Wilson, 1984), however subsequent studies have indicated that those who grew up during the Troubles tended to present with a number of mental health problems in later life (O'Reilly & Stevenson, 2003). It would appear that a higher number of people who experienced violence during the Troubles also experienced economic deprivation. It is argued that this additional financial stress intensifies the impact of the trauma on mental health and general wellbeing (O'Neill et al., 2015). This in some way reflects Miller and Rasmussen's (2010) theory that exposure to trauma and daily stressors both are factors in mental ill health. A recent Mental Health Survey Initiative by the World Health Organisation revealed that rates of economic adversity in Northern Ireland are significantly higher compared to other countries (WHO, 2012). Certainly, the violence and armed conflict in Northern Ireland had a negative impact on the economy of the region. Government spending focused on security and rebuilding work and funding was withdrawn from what would be considered essential spending in a typical society, such as healthcare, education and promotion of the economy. Tourism was greatly affected and jobs were lost when companies decided to relocate to other countries. Even with the benefits of the peace dividends, poverty remains a significant concern for some areas in post-accord Northern Ireland, with estimations that child poverty in Northern Ireland is twice the rate of Great Britain (Monteith, Lloyd & McKee 2008).

1.2.1 The transgenerational transmission of trauma

It is well recognised in the literature that direct exposure to armed conflict is associated with psychopathology, in particular post-traumatic stress disorder, anxiety and depression (Attanayake et al., 2008). The idea that the 'psychological reverberations' of trauma may continue into subsequent generations has increasingly been considered. In recent years, focus has shifted to the potential for traumatisation in the children of traumatised individuals, and this shift has been supported by numerous studies on the offspring of Holocaust survivors (DeGraaf, 1975; Yehuda, Schmeidler, Wainberg, Binder-Brynes & Duvdevani, 1998) and

survivors of the Rwandan genocide (Danieli, 1998). In recent decades, extensive research has been conducted on what is meant by the transgenerational transmission of trauma. Transgenerational trauma may be defined as '[t]he poor psychological functioning of children that seems to partially emanate from the consequences of the trauma experienced by parents, resulting in detrimental effects on the interaction of parents and children' (Hanna, Dempster, Dyer, Lyons & Devaney, 2012).

McNally (2014) argues that this definition should be extended to include a broader and more general conceptualisation that recognises the enduring outcomes that often originate in traumatic experiences. It has been argued that parental trauma exposure disrupts the patterns of interaction within families, leading to a less than ideal quality of attachment between parents and children. There is also evidence to suggest that early bonding processes may be impacted if the parent has been exposed to trauma (Enlow et al., 2014). A study on the transgenerational impact of the Troubles in Northern Ireland indicates that trauma related psychopathology in parents can compromise their ability to facilitate synchronous interactions with their children. This impacts the ability of the parent to assist the child with self-regulation, and may increase the propensity of the child to develop emotional and behavioural problems (O'Neill et al., 2015).

The transgenerational impact of the Troubles in Northern Ireland is increasingly an area of concern for many researchers and clinicians, with some estimating that potentially 60% of the adult population with mental health problems directly linked to the Troubles, have not received support (O'Neill et al., 2015). In order to assist individuals and families affected by the transmission of trauma, an understanding of the ways in which the trauma is transmitted is imperative. A model describing the cyclical nature of the transmission of trauma and loss across generations (O'Neill et al., 2015) provides a developmental overview of the ways through which the impact of the Troubles can be transmitted to the next generation. This is examined in more detail in a later chapter. The impacts associated with this model of trauma transmission include epigenetic risks (where the parents of the child transmit stress-triggered and stress-adapting genetic material to their offspring), developmental impairment, parenting relationship and attachment problems, increased risk of mental health problems and the propagation of all or some of these issues into adulthood, then parenthood, where the cycle may typically begin again.

1.3. Theories of Transmission of Trauma

Several theories have been proposed to explain the transgenerational transmission of trauma including:

- The stress vulnerability model
- The transmission of psychopathology model
- The transmission of genetic/physiological material model
- The psychodynamic model
- The family systems model
- Social psychological models

Each model will be discussed in brief, and several of these models will be examined in greater detail in the next chapter.

1.3.1. The stress vulnerability model

This model of the transmission of trauma proposes that an increased vulnerability to the development of psychopathology is passed onto subsequent generations only when they themselves are exposed to traumatic events (van IJzendoorn, Bakermans-Kranenburg & Sagi-Schwartz, 2003). Studies with Holocaust survivor offspring support this hypothesis by demonstrating that the indirect stress of the Holocaust affects those who are already part of a clinical population that is stressed by other factors. However, there is evidence to suggest that children of Holocaust survivors report higher levels of subjective distress in stressful situations; they tend to have higher rates of childhood adversity than other populations, and this may be the factor that accounts for the increased rates of psychopathology found in this group (Yehuda, Halligan & Bierer, 2001). With particular regard to elevated levels of PTSD in parents whose children were not exposed to the initial trauma, parental PTSD predicts offspring psychiatric difficulties, including PTSD and reports of childhood traumatisation such as emotional abuse and neglect (Yehuda, Blair, Labinsky & Bierer, 2007). This correlational evidence implies that parents with elevated PTSD may confer psychological vulnerability on their children (Leen-Feldner et al., 2013).

1.3.2. The transmission of psychopathology model

Transmission of trauma and the area of offspring vulnerability may be conceptualised as a conferring of both psychological and biological vulnerability. This perspective proposes that parental psychopathology is the key factor that influences the next generation. Numerous studies highlight the deleterious effects of maternal psychological difficulties on child development (Cummings & Kouros, 2009; Goodman et al., 2011). Existing literature in the area of transmission of trauma suggests that PTSD in parents is associated with a higher occurrence of PTSD in their offspring (Downes, Harrison, Curran & Kavanagh, 2012).

1.3.3. The transmission of genetic/physiological material model

The offspring biological vulnerability model of trauma transmission suggests that something of the traumatic experience and ensuing stress response is transmitted physiologically to successive generations born following the traumatic event. Research into cortisol levels and hypothalamic pituitary axis (HPA) functioning (an area implicated in stress reactivity) suggests further work in this area would be beneficial. Researchers have found changes in HPA axis responsiveness, even when the individual does not have PTSD, with effects more salient for offspring of mothers with PTSD, and have gone as far as to suggest a chrono-biological risk profile among Holocaust survivor offspring (Yehuada et al., 2007).

1.3.4. The psychodynamic model

Psychodynamic proponents suggest a number of ways that trauma may be transmitted across generations. Kestenburg (1989) argued for a transposition mechanism, whereby children of Holocaust survivors simultaneously inhabit a dual world of the present day and their parents' Holocaust past. This involves the child identifying with the parent in their attempts to deal with the traumas of their past. According to DeGraaf (1998), the transmission of trauma occurs when parents project the 'bad child' element of their identity onto their offspring. It is argued the parent externalises their negative emotions and behaviours towards the child, which may manifest itself later in the child's adult life as psychopathology. Transposition and projective

identification theories of trauma transmission prove difficult to measure empirically; however, when considering the attachment relationship and its impact on child development, these approaches become more plausible. This model is considered in more depth in the next chapter.

1.3.5. The family systems model

By way of explaining the transmission of trauma, the family systems model highlights the specific interpersonal patterns that exist in family structures in which a member has been exposed to trauma. Danielli (1998) in particular noted the conspiracy of silence found within families of Holocaust survivors, whereby the trauma is not mentioned and factual information is not shared between parents and children. However, the impact of the trauma remains silently present and is expressed non-verbally (Downes, Harrison, Curran & Kavanagh, 2013). A number of studies involving children of parents who have been exposed to traumatic events indicate that silencing the trauma within families may be associated with higher vulnerability to second generation effects (Ancharoff, Munroe & Fisher, 1998; Felsen, 1998; Nagata, 1998). The silence approach to trauma has been documented in Northern Ireland by family therapists (Healey, 2004) and certainly evidence suggests that this silence is detrimental to family relationships (Smyth, Fay, Brough & Hamilton, 2004). McNally (2014) argued that far from preventing the transmission of trauma, in fact silence is an active transmitter of trauma.

The communication hypothesis of trauma transmission suggests that continually retelling accounts of past traumas and the avoidance of storytelling about past traumatic events may be equally involved in the transmission of trauma (Lin, Suyemoto & Nien-chu Kiang, 2009; Mor, 1990). McNally's (2014) study of transgenerational trauma transmission in Northern Ireland concluded that families affected by trauma can develop harmful ways of communication. The range of communication styles varied from silence to intrusive attempts to talk about the event. The family systems model, and theories of communication and silence, are considered further in the next chapter.

1.3.6. Social psychological models

As early as the 1950s a link between ethno-political violence and aggressive parenting styles was suggested (Allport, 1954), and contemporary research indicates that these aggressive parenting styles may be due to psychopathology in parents as a consequence of their traumatic exposure (Sailea, Ertl, Neuner & Catania, 2014). Understanding the non-genetic transmission of trauma involves examining the social psychological approaches that focus on social learning and its effects on parenting. The fundamental premise supporting current research on transgenerational trauma in Northern Ireland is that the armed conflict impacted negatively on the parenting practices and family functioning of victims, and that these problems continue in the post-conflict setting. It has been suggested that 40% of children in Northern Ireland live with parents whose exposure rating to the conflict is considered moderate or high (Tomlinson, 2012). This model also is discussed in more detail in the next chapter.

It would appear that not all children in Northern Ireland experienced the Troubles equally. Children who live in areas that have high levels of deprivation appear to have been impacted the most (Gallagher, Hamber & Joy, 2012). There are a number of risks for children and young people growing up in interface areas in Belfast. Interface areas describe places of high religious segregation. Often life for young people growing up close to these interface areas is related to an almost homogenous religious segregation, poverty, low educational attainments,

paramilitary influences and potential higher risks of substance misuse. In communities close to interface areas, which often have suffered high levels of conflict-related violence, symptoms of post-traumatic stress disorder may be more widespread (Shirlow & Murtagh, 2006).

1.4. Coping with Conflict

Resilience is a complex construct, and definitions about what makes an individual or community resilient remain the subject of debate. Luther, Ciccetti and Becker (2000) define resilience not as a trait but rather as a dynamic process involving positive adaptations in the face of adversity. Vanderbilt-Adriance and Shaw (2008) propose three types of protective factor: child protective factors (such as IQ, self-regulating ability and genetic influences), family protective factors (such as love and nurturance) and community-level protective factors (such as neighbourhood quality and cohesion). Youth participation in conflict may be a factor that relates to resilience among youth exposed to violence. In their systematic review of resilience and armed conflict, Tol et al. (2013) determined that resilience is a complex process whose outcomes are determined by dynamic interactions of societal factors and other intra-personal variables. Dimitry (2012), for example, found that Middle Eastern children and young people cope with the ongoing conflict by relying on routine and focusing on education, get support from their families, friends and communities and rarely use alcohol. Like other researchers, Tol et al. (2013) emphasise the importance of considering the conflict contextually and culturally in a bid to determine effective interventions.

1.4.1. Positive outcomes from exposure to traumatic events

Much of the literature to date has focused on the potential for negative developmental outcomes for adults, children and communities exposed to political violence. However, research also points to the opportunity for positive outcomes and processes to develop, such as prosocial behaviours (Macksoud & Aber, 1996) and activism (Barber & Olsen, 2009). Cummings, Merrilees, Taylor and Mondi (2017) suggest other areas of civic engagement may occur as a result of young people's experiences of political violence. Theories of post-traumatic growth may explain why positive outcomes may occur in these contexts. Tedeschi and Calhoun (1996), for example, propose that the struggle involved in dealing with a trauma can result in cognitive restructuring, changing schemas and a new life narrative. Similarly, Vollhardt's (2009) theory of altruism formed in suffering asserts that negative life experiences may act as a motivating factor in helping others enduring adversity. Another theory suggests that ingroup relationships are strengthened by the experience of intergroup conflict, enabling positive community goals to be met (Merrilees et al., 2014).

1.5. Mediating Role of Childhood Adversities

While it is without doubt that the conflict in Northern Ireland has had an impact on the psychological health of some of the population, there are many who argue that childhood adversities are also key etiological features of the onset and persistence of psychopathology. The World Health Organisations' World Mental Health Survey Initiative (WHO, 2012) suggests that childhood adversities account for approximately 30% of mental health problems worldwide. It appears that adversities relating to maladaptive family functioning are strongly associated with the onset and continuation of psychiatric disorders (Green et al., 2010; McLaughlin et al., 2010a). One such argument proposes that childhood adversities may

increase vulnerability to stress, affecting an individual's ability to cope with future stressors. This stress sensitisation hypothesis suggests that exposure to severe stress in childhood can increase and adult's sensitivity to stress (Breslau & Anthony, 2007). Armour et al.'s (2015) research into childhood adversities, exposure to conflict and mental health profiles in Northern Ireland indicates that both childhood adversities and trauma relating to the conflict have a major role in the development of psychopathology. The authors use this evidence to suggest a dual impact of risk factors of childhood adversities (including poverty, maladaptive parenting and family conflict) and exposure to trauma related to the conflict, and urge policy makers and clinicians to considering the findings carefully.

When considering exposure to traumatic events in the context of political violence, it could be argued that higher levels of exposure to traumatic experiences may result in increased levels of distress, yet this has not been endorsed by researchers. Despite the trauma and damaging effects that accompany political violence, maladaptive functioning and psychopathology are not inevitable. Other factors must be considered when examining how children are affected by exposure to such violence. Bronfenbrenner's (1992) ecological model of child development stresses the importance of reflecting on the context of the experienced events when considering the impact these events have on the individual. This is a stance taken also by Cummings, Goeke-Morey, Merrilees, Taylor and Shirlow (2014), who advocate taking a socio-ecological process oriented perspective on child development and political violence. Cummings et al. (2014) argue that while many studies document risks for maladjustment associated with exposure to political violence, some children fare better than others and the diversity in outcomes requires a more sophisticated understanding of the relationship between political violence and child development.

1.6. Children and their Communities in Northern Ireland

The literature examining the impact of the legacy of the conflict on children in Northern Ireland reveals the variety of the experiences of the children involved and their socio-economic and family backgrounds. Muldoon (2004) concluded that legacy issues impacted on children socially and psychologically, with those children living in areas of high deprivation affected the most (Gallagher, Hamber & Joy, 2012). Bamford (2006) argued that ongoing social and economic difficulties coupled with poor parental mental health had a profound impact on children. The complex nature of the conflict and its legacy and its impact on the population should not be underestimated.

It has been suggested that the social and economic difficulties that accompanied the Troubles and the legacy of the conflict should be considered together with relation to the mental health of the population. Many adults in Northern Ireland attribute their mental health issues to the conflict, and report depression, anxiety and sleep disorders and PTSD (Muldoon, Schmid, Downes, Kremer & Trew, 2005). Muldoon et al. (2005) also reported that the use of alcohol or drugs is a common coping mechanism for those who grew up during the conflict. These outcomes are examined in greater detail in subsequent chapters. There has been an upward trend in suicide rates, particularly among young men, since the mid-1990s (Tomlinson, 2007). However, to get a better understanding of the increase in suicides, the impact of direct exposure of conflict-related trauma such as violence and bereavement must be considered in

tandem with the indirect factors, such as social isolation and loss of a sense of identity (Hamber & Gallagher, 2014). This area also is considered in greater detail in later chapters.

Some researchers argue that the real impact of political violence can be viewed as a function of the changes initiated in the communities, families and wider social ecologies where these children live and are raised (Cummings, Goeke-Morey, Schermerhorn, Merrilees & Cairns, 2009). Cummings et al. (2009) propose examining the effects at multiple levels of societal functioning and the associated psychological processes. With regards to Northern Ireland, the impact of the role of the community has had a far-reaching effect, which has only recently been investigated and understood.

1.7. The importance of Social Identity

Social identity may be considered as a factor in the impact of the conflict. Social identity is often understood to refer to an individual's self-categorisation as a member of a certain group, and the associated evaluation of group membership (Tajfel & Turner, 1979). Certainly, social identity theory has been identified as a significant factor in relation to the Serb/Croat conflict (Ajdukovic & Biruski, 2008). In Northern Ireland, it has been claimed that children as young as 5 develop an awareness of their social identity, which may impact their thoughts, attributions and behaviours towards other groups (Cairns, 1987). Muldoon (2013) proposed that children with a strong social identity are more resilient in conflict situations, and Merrilees et al. (2011) reported maternal social identity moderated how the Troubles impacted on the mother's mental health. Yet the polarised nature of social identities in Northern Ireland is often used to partially explain the enduring nature of the conflict (Bull, 2006). At this point it becomes important to note that many children in Northern Ireland attend schools segregated along religious lines. This daily reinforcement of the segregation may impact children's perspectives, and is explored in later chapters.

Identification with certain sides during an armed conflict may be a factor influencing subsequent levels of distress following exposure to politically violent events (Shechner, Slone & Bialik, 2007). Studies conducted in Northern Ireland demonstrate the relevance of social identity to young people's adjustment, with both positive and negative outcomes noted (Cummings, Taylor & Merrilees, 2012; Merrilees et al., 2011; Merrilees et al., 2014). Community involvement may allow populations to lend meaning to traumatic events, which may facilitate coping. This is evident in Palestine, where the community attaches meaning to their suffering by honouring victims for their stoicism and depicting the opposition as deplorable (Peteet, 1994).

1.8. Transmission of Prejudice

Connolly, Smith and Kelly's (2002) research on the political and cultural awareness of young children in Northern Ireland, highlighted several influential factors relating to these issues, namely the family, the local community and school. The parental role in the transmission of prejudice is significant, as parents not only influence their children directly by their own behaviours and conversations on particular social groups, but also indirectly by making decisions about their children's socialisation and what type of environment their children will

be exposed to (Degner & Dalege, 2013). Further research into the transmission of prejudice is required.

1.9. The Role of Emotional Security

Emotional security traditionally focuses on security relating to the parent/caregiver-child relationships (i.e. attachment; Bowlby, 1969) and this concept has been extended recently to include other family relationships, including family spanning processes and the marital relationship. Emotional security theory (EST) (Davies & Cummings, 1994) argues that children's protection, safety and security are central concerns with regard to their regulatory functioning. Cummings et al. (2011) advocate that a child's emotional insecurity about the community they live in can increase internalising and externalising difficulties. They view emotional security, and the psychological processes underpinning this security, as regulatory systems with significance for social and community explanations for relations between political conflict and child adjustment.

1.10. Does Sectarian Violence Have a Specific Impact on Children's Development?

The ways in which political strife and sectarian violence affect children's wellbeing and development remain little understood. Calls for research to elevate our understanding of the processes that account for the associations between political violence and child development led Cummings et al. (2014) to adopt a social-ecological, process-oriented perspective on the relation between political violence and child development. When considering children within the ecological contexts of political violence, the types of violence children are exposed to may become significant. Sectarian community violence is defined as political tension expressed at a community level (Cummings et al., 2009). It consists of antisocial behaviour, conflict and violence that manifests itself between religious, ethnic or cultural groups. Non-sectarian violence is often considered to be 'ordinary crime' common in any community and is not specifically expressed between groups (Cummings et al., 2009). Sectarian conflict and violence appears linked to increased levels of family conflict, and Cummings et al. (2010) proposes this impacts on a child's wellbeing in the form of adjustment problems and emotional security.

Cummings et al.'s (2011) study on children's emotional security with regards to community violence revealed that politically motivated sectarian violence had a distinctive effect on children's adjustment problems, and proposed that this was due to the children's increasing emotional insecurity about the community. This longitudinal research also suggested that the emotional security construct expanded beyond the family to include extra-familial constructs such as the community. Cummings et al. (2014) argued that this evidence strengthens the idea that psychological processes of security are potential explanatory processes for child outcomes in areas of political violence. That is not to say that non-sectarian violence does not impact youth adjustment. There is evidence to suggest that non-sectarian violence influences children's adjustment by means of different process-oriented pathways (Cummings et al., 2010), and both sectarian and non-sectarian community violence has been implicated in children's adjustment longitudinally (Cummings et al., 2013).

1.11. Post-Accord Northern Ireland

Studies of post-accord cultures internationally indicate that these periods may be characterised by continuing sectarian issues, whereby the re-escalation of violence is a real concern (Darby, 2006). The potential for this resumption of hostilities, particularly at a community level, may reflect what MacGinty (2006) identified as ‘no war no peace’. Some researchers would argue that for many in Northern Ireland, little has changed post-accord, and that violence, sectarianism and racism remain a concern (Harland, 2011). The propagation of negative attitudes is in some instances being passed onto subsequent generations (Haydon, McAlister & Scraton, 2010), and the transmission of prejudice continues in certain areas (Smyth & Scott, 2000). In some ways, it may be considered that the history of the Troubles is almost ‘kept alive’ by events such as marches, commemorations and the daily living alongside murals that depict historic events (Cummings et al., 2009). Also in Northern Ireland, there are ongoing controversies about historical violence, and these events continue to impact perceptions and attitudes, especially in relation to inter-community relations (Cumming et al., 2009).

1.12. Conclusion

Internationally, Northern Ireland and its people are often perceived to have emerged successfully from decades of political violence, yet the impact of the conflict remains and affects communities and generations. Examination of the complex and multidimensional nature of how trauma can be transferred will help inform policy and practice. Transmission of poor mental health and prejudices within families, the role of the community, social identity, emotional security, types of ongoing violence and the impact of other adversities all appear to have an impact on child development and adjustment, and in some way, may reflect the cyclical nature of trauma transmission. Researchers, policy makers and clinicians need to be ‘trauma aware’ and conscious of this pattern to understand and support individuals and communities affected.

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2

The Transgenerational Impact of "The Troubles" in Northern Ireland on the Family System

Chloe Miskelly

2.1. Introduction

The social and political conflict[1] in Northern Ireland (NI), due to dispute between primarily Protestant/Unionists[2] and Catholic/Nationalists[3] over the country's legal status, led to outbreaks of violent conflict known as "the Troubles". This violence took the lives of approximately 3,600 people and more than 40,000 were injured (McKittrick, Kelters, Feeney, Thornton & McVea, 2007). The Troubles commenced in the late 1960s and intensified in 1969 when the British army were deployed. Ceasefires in 1994 and 1995 led to the peace process known as the 'Good Friday Agreement' in 1998, and the hope that violence would end.

The extent of a family's exposure to the Troubles depended on a number of factors. In some locations. families experienced multiple bereavements or witnessed numerous violent incidents, however in other areas there was less exposure to these incidents. Exposure to this conflict caused many victims to experience trauma, negatively impacting on their mental health and potentially affecting their wider family circle, resulting in poor psychological functioning. For example, clinical levels of Post-Traumatic Stress symptoms were found in the immediate and second generation of families who had directly witnessed the Bloody Sunday shooting of 13 civilians in 1972 (McGuigan & Shevlin, 2010), indicating secondary trauma.

Research in this area has used the terms 'transgenerational', 'intergenerational' and 'multigenerational' trauma interchangeably. For simplicity, the term 'transgenerational trauma' will be used throughout. Hanna, Dempster, Dyer, Lyons, & Devaney (2012) suggest that in order to define transgenerational trauma, 'trauma' as a term should be defined primarily. The Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM-5) (American Psychiatric Association, 2013) defines trauma as:

> 'Exposure to actual or threatened death or serious injury, or sexual violence through:
> - Direct exposure
> - Witnessing the trauma in person

[1] Political violence refers to violence perpetrated by one group of people on another, who were often strangers before the violence occurred. (Cairns, 1996)
[2] Those who wish to see NI remain part of the United Kingdom.
[3] Those who wish for a united Ireland.

- Learning that a relative or close friend was exposed to a violent or accidental traumatic event
- Indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g. first responders, medics).'

Trauma can involve the victim being in a state of 'helplessness', which can negatively impact upon their self-efficacy and ability to cope with stressful events, and increase the risk of developing certain types of psychopathology (Doucet & Rovers, 2010). The effects of trauma are a combination of the individuals' 'perception and appraisal' of the event and its consequences (Ehlers & Clark, 2000).

Hanna et al. (2012, p. 20) define transgenerational trauma as 'the poor psychological health of children that appears to result (partially) from the consequences of the trauma experienced by parents, resulting in detrimental effects on the interactions between parents and children'. Buchanan, Anderson, Uhlemann and Horwitz (2006) refer to this as secondary traumatic stress, whereby the individual hasn't experienced the trauma themselves, but experience symptoms in reaction to the experience of a traumatised individual, often affecting those closest to the traumatised individual. As has been noted in the previous chapter, much of the research on the impact of transgenerational trauma has focused on Holocaust survivors and their children, with less research available in the Northern Ireland context of the Troubles.

2.2. Theoretical Underpinnings of Transgenerational Trauma

Theoretical concepts have been used to describe the transgenerational transmission of trauma. This chapter will briefly introduce four theoretical approaches to trauma transmission.

2.2.1. Sociocultural model

The sociocultural model proposes that social norms and cultural values are passed from one generation to the next. Children form their beliefs based on what has been conveyed from their parents, influencing how they perceive a conflict situation (Muldoon, Trew & McWhirter, 1998). Subsequently, a transgenerational cycle can result from the traumatic experiences of one generation being passed down to the next. This can negatively impact parenting practices, affecting early attachment and the ability of the child to self-regulate, increasing the probability of the child developing mental health and behavioural problems. Schwartz, Dohrenwend and Levav (1994) have identified two different avenues of transmission: (a) direct, specific transmission and (b) indirect, general transmission. Specific transmission can create distorted thought patterns in children through a parent's behaviour communicating that the world is a frightening place, eliciting anxiety within the child. General transmission refers to problematic caregiving interactions between the parent and child. These exchanges may be abusive, hostile or anxiety provoking, due to the parents' trauma-related symptoms, impacting on the child's behaviour and distorted thought patterns.

2.2.2. Parenting styles and attachment

Parenting styles can mediate a child's psychological outcomes when exposed to violence. A supportive parenting style has been linked to better outcomes, whereas an intrusive, controlling parenting style has been associated with an increased likelihood to develop psychological problems (Cummings, Merrilees, Taylor & Mondi, 2017). Baumrind (1973) describes three classic parenting styles:

1. Authoritative[4]
2. Authoritarian[5]
3. Permissive[6]

The parenting style adopted can impact on the quality of attachment that will form between parent and child. Attachment theory refers to the bond between a child and their caregiver, which contributes to their social and emotional development. Infants have a universal need to seek close proximity to their primary caregiver when feeling stressed or threatened, particularly when separated (Ainsworth, 1969; Bowlby, 1958). Bowlby postulated that the attachment figure (AF) should ideally act as a secure base, by consistently communicating a sense of safety, security and availability. When unfulfilled, this can result in a disorganised,[7] avoidant[8] or insecure-ambivalent[9] attachment between the parent and child.

Children who have experienced disruption during their early years of development have less of an opportunity to build a secure emotional bond with their primary caregiver. Hanna et al. (2012) propose that a secure attachment will be less likely if a parent is trying to cope with traumatic symptoms resulting from the Troubles. Various factors can interfere with the bonding process, including lack of physical/emotional care, neglect, lack of stability in the home environment, prolonged periods of time spent away from the primary caregiver and bereavement. Downes, Harrison, Curran and Kavanagh (2013), for example, uncovered evidence of attachment difficulties from a mother who described how she struggled to bond with her daughter who was born weeks after her husband was killed, as she feared that her daughter would also be taken away from her.

A disorganised style of attachment could be more probable in cases were the parent is 'inconsistent' in how they share their traumatic experiences with their children (Bar-On, Eland, Kleber, Krell, Moore & Sagi, 1998). Parental mental health concerns such as PTSD can interfere with a parent's ability to care for and bond with their children, due to symptoms of trauma. This pattern is likely to repeat down through the generations (Ruscio, Weathers, King & King, 2002).

Baumrind, Larzelere and Owens (2010) found that an authoritarian parenting approach with children aged 3-5 was a predictor of internalising problems at the age of 14, when compared

[4] This is widely recognised as the most effective parenting style. It consists of discipline balanced with nurturance, good communication and firm control when necessary.
[5] This parenting style over-disciplines, with severe physical and verbal correction, and less physical affection and warmth.
[6] This style is characterised by a lack of discipline and more of an emphasis on nurturance and the child's independence.
[7] Caregivers of children with this attachment style tend to be abusive (Carlson et al., 1989), frightened or frightening (Main and Hesse, 1990). Often the AF is a source of danger and so the child is unable to find an effective attachment strategy.
[8] Caregivers of children with this attachment style tend to be emotionally unavailable and hesitant to provide physical/emotional contact. They tend to promote premature independence and discourage dependency.
[9] Children with this type of attachment style are overly seeking of proximity, even before separation occurs. When separation occurs, they become very distressed and they are difficult to comfort when the AF returns. They are often preoccupied with the caregivers' availability, but will frequently reject closeness when it is offered. This may be due to the caregiver's inconsistent response to the infant's signals and to the unpredictability of their emotional availability.

with permissive or authoritative parenting. They suggest this may be due to verbal hostility and high levels of psychological control. Schwerdtfeger, Larzelere, Werner, Peters and Oliver (2013) suggest that parenting styles and parental behaviour is key in understanding the transmission of transgenerational trauma, particularly through mothers with traumatic histories. They found that children of trauma survivors were adversely affected by their parents' trauma, making them more vulnerable to stress and increasing the likelihood of them developing DSM-related symptoms. Maternal parenting styles were assessed using the Parenting Styles and Dimensions Questionnaire (PSDQ)[10] (Robinson, Mandleco, Olsen, & Hart, 2001) and DSM symptoms in children were assessed using DSM-oriented scales of the Child Behaviour Checklist (CBCL)[11] (Achenbach & Rescorla, 2000). Maternal trauma experiences were assessed through the 'Stressful life events screening questionnaire' (SLESQ)[12] (Goodman, Corcoran, Turner, Yuan, & Green, 1998). Results indicated that both authoritarian and permissive parenting styles were correlated with DSM-orientated symptoms, however authoritative parenting did not correlate with any DSM symptoms. The strongest intergenerational effects were associated with interpersonal trauma and an authoritarian parenting style. In particular, the verbal hostility component increased the risk for the development of DSM characteristics in the next generation.

This is consistent with previous findings (Baumrind et al., 2010) that verbal hostility is the most harmful type of authoritarian power assertion. Therefore, future interventions should target the reduction of verbal hostility to decrease the transgenerational impact of interpersonal trauma. Walker (1999) suggests that parents who have been traumatised may be less functionally and emotionally available for their children. Findings from Kaitz et al. (2009) expand on this further, suggesting that authoritarian parenting occurs as a result of a decreased capacity for maternal sensitivity, emotional regulation and enjoyment of the parenting role. Due to PTSD symptoms, the parent may interpret a child's behaviour as a personal threat rather than an age-appropriate response to a situation, and therefore respond more harshly in discipline.

2.2.3. Psychodynamic theory

The psychodynamic approach focuses on unconscious influences, and postulates that the child unconsciously absorbs the repressed experiences of the parent who has experienced the trauma. Unresolved or insufficiently dealt with emotions are passed from the trauma victim to the next generation through 'unconscious absorption' (Kellerman, 2001). Rowland-Klein and Dunlop (1998) define this as 'projective identification' whereby the parent projects trauma-related anxieties onto their child and attempts to self-heal by 'splitting-off' the unwanted part of themselves and 'projecting' it onto their child to contain it. The authors noticed the themes of 'over-identification and re-enactment' emerging within their research, whereby the child tried to find meaning by placing themselves in a similar situation, in order to 'share in their parents' suffering'. Downes et al. (2013) discovered patterns of unconscious repetition of trauma from

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[10] A 32-item questionnaire using a 5-point Likert scale indicating the extent to which parents exhibit authoritative, authoritarian and permissive parenting styles including warmth/support, reasoning/induction, autonomy granting, physical coercion for discipline, verbal hostility and non-reasoning punishment.

[11] The five scales measured affective, anxiety, pervasive developmental disorder (PDD), attention deficit/hyperactivity disorder (ADHD) and oppositional defiant disorder (ODD) symptoms (Schwerdtfeger, Larzelere, Werner, Peters & Oliver, 2013).

[12] The SLESQ explores experiences of 13 traumatic events which may be indicative of PTSD symptoms and cumulative trauma. Mothers were divided into four categories: sexual interpersonal, non-sexual interpersonal, non-interpersonal and no trauma.

one generation to the next, exemplified by a son who was a victim of sectarian attack just like his grandfather had been when he was killed. The authors suggest that this event of re-enactment symbolised to the mother how her father's choices to become involved with paramilitaries had been unconsciously transmitted to her son.

DeGraaf (1998) theorised that trauma was transmitted from parent to child by parents who project the 'bad child' identity of themselves onto their children as a result of experiencing extreme helplessness. This can lead parents to externalise their anger, rage, disappointment and grief onto their child, increasing the risk of the child developing poor mental health. This was evidenced in an interview with a mother who described how she demonstrated anger towards her daughter for simple things, such as not practising her violin, thereby revealing her own unconscious dissatisfaction at the life that she never experienced because of her traumatic experience (Downes et al., 2013).

2.2.4. Biological/genetic approach

Biological approaches argue that trauma is purely transmitted through genetics. Children of trauma victims may possess a genetic/biochemical predisposition to stress or other trauma symptoms because they are innately less able to metabolise stress, increasing the risk of developing symptoms of PTSD. This perspective postulates that the stress response is transmitted physiologically to the next generation, who have not experienced the initial traumatic event; this has been illustrated in a study conducted by Yehuda et al. (2014), which examined cortisol levels of infants whose mothers were exposed whilst pregnant to the attacks on the World Trade Centre on 11 September 2001. Lower cortisol levels were found in the infants of mothers who developed PTSD compared with mothers who did not develop PTSD, although the authors appreciate that this could also result from being parented by a mother with PTSD. Johnston et al. (2001) agree with this theory, suggesting that psychological disorders may be more likely to develop in the children of trauma victims due to maladaptive parental behaviour. Neurobiological brain pathways are thought to transmit trauma unconsciously (Herman, 1997).

2.2.5. Family systems/communication model

The Communication Model refers to a family's style of interaction, whether parents speak openly about their trauma, or it is not discussed.

McNally (2014) proposes that families who have experienced trauma can develop unhealthy means of communication, either through silence/avoiding the topic (expressed non-verbally, remaining 'silently present') or imposing their interpretations of events onto their children. Hanna et al. (2012) propose that the degree to which traumatic events are shared, the level of content and the timing/context within which the events are shared can impact on the extent of psychological consequences for the next generation. For example, if experiences of the Troubles are shared during a time when other stressful events are occurring within the family, this can result in the next generation associating strong negative emotions (from the current stressful situation) with their parents' experience of trauma (Lin, Suyemoto & Nien-chu Kiang, 2009).

An over-communication of traumatic events, whereby survivors frequently retell their story in extreme detail, could lead to the transmission of trauma (Dekel & Goldblatt, 2008). Danieli (1998) proposed that some survivors did this in order to teach the next generation a 'life lesson'

in how to survive if the traumatic incident were to recur, which may transmit parental anxiety and dread to the child. Whilst the parents may have felt that this could aid their child's survival, they were potentially unintentionally transmitting their own trauma. Equally, a lack of communication regarding the trauma, known as 'a culture of silence', can negatively impact the next generation. Danieli (1998) suggests that this could be even more harmful than over-exposure.

2.3 Culture of Silence

Sometimes parents choose not to share their memories about a trauma so as not to expose their children to it. Therefore, to avoid the parent having to relive the trauma, the child does not ask, thereby creating a 'double wall'. Consequently 'sensitive topics are avoided to prevent the intensification of stress' (Dekel & Goldblatt, 2008, p. 285). Nevertheless, the child is aware that something traumatic has happened, as they overhear conversations or notice emotional reactions to the trauma from their parents. Thus symptoms are noticed but never explained, perhaps causing the child to imagine what happened; they create their own narratives of the story, but with no confirmation of the context and cause of the trauma. Baron et al. (1998) highlight the concern that such children may obtain partial facts, leading them to imagine a narrative that could be worse than the factual story.

Goldsmith et al. (2004) caution that an unawareness of the trauma and lack of a coherent narrative can lead to poor psychological functioning within the child. Downes et al. (2013) describe this as 'cognitive and affective avoidance', leading children to come to their own explanations. The authors found evidence of this in the case of a participant whose father was killed in the Troubles and who described how, in the absence of information, she invented her own explanations for her father's death. Fargas-Malet and Dillenburger (2016) suggest that silence can transmit trauma as powerfully as words. They found that children of parents who did not talk about the Troubles experienced more behavioural and emotional symptoms on the SDQ than those whose parents did.

Brown (1998) introduces two common types of silence: conscious and unconscious silence. Conscious silence is motivated by three fears (Brown, 1998):

1. Fear of being retraumatised by memories
2. Fear of traumatising their children/future generations
3. Fear of not being understood by those who were hearing the story.

Unconscious silence is a coping mechanism of cognitive and affective avoidance. This type of avoidance involves not talking about the trauma and parents purposefully hiding the truth from their children. Downes et al. (2013) uncovered the theme of 'hiding of the truth' amongst a sample of mothers who had direct exposure to conflict during the Troubles. Mothers in the sample used silence as a way of coping with their trauma, being keen not to burden the next generation with their traumatic experiences. One participant was quoted as saying, 'They're not old enough to understand. I don't want them knowing, they don't need to know' (Downes et al., 2013, p. 9). When this was explored further, there was a general consensus amongst participants that they want to stop the cycle of trauma and sectarianism and are trying to end the trauma cycle by not discussing it.

Hanna et al. (2012) found an example of how anxiety was passed to the next generation through silence. The daughter of a victim of the Troubles described focusing on helping her father to manage his anxiety by keeping an emotional distance between herself and him whilst suppressing her own symptoms of anxiety. The researchers suggest that anxiety symptoms develop in children due to feeling fearful and uncertain about what actually happened to their parents. Receiving counselling from an individual who had experienced the Troubles was helpful, as 'filling in the blanks' would help them to better understand the situation that their parent encountered. The culture of silence can be particularly problematic when engaging in family therapy sessions (Goldsmith et al., 2004). Healey (2004) observed the silent approach in her work with families in Northern Ireland. She learnt that this silence infiltrated the wider community and statutory agencies, hindering treatment opportunities such as psychotherapy. She describes how she wasn't taught how to deal with issues of the Troubles in her social work training. The same was found for teachers, GPs and others who encountered children on a daily basis professionally.

2.4. Transmission of Trauma in the Northern Ireland Context

Fargas-Malet and Dillenburger (2016) explored the extent that parents transmitted their traumatic experiences of the Troubles to their children by analysing children's drawings and examining the role of the child's school, socioeconomic context, age and gender in shaping a child's knowledge of the violent past. They investigated children's behavioural responses through use of functional contingency analysis, suggesting that trauma-related memories are transmitted through stories. The verbal behaviour of the 'speaker' (parent) affects the behaviour of the 'listener' (child).

The 73 child participants, aged 9-11, were all born after the 1998 Good Friday Agreement, and were drawn from a range of school backgrounds (maintained, integrated and state-controlled). Children were asked to draw two pictures on a blank piece of paper with two headings: 'Living in Northern Ireland Now' and 'Living in Northern Ireland Before I was Born'. Digital tape recordings were used to record children's verbal descriptions of what they had drawn. Parents completed a questionnaire, which contained questions about their national and political identity, their experience of the Troubles and whether they or a close family member or friend had been injured, bereaved or attacked. To assess the process of transmission, parents were asked to indicate the extent to which they had spoken about their experiences with their children.

Over half of the sample had spoken to their child openly about The Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997). Scores for these children indicated lower levels of behaviour problems and better peer relationships. Numerous factors influenced parent-child communication. One was the age of the child; the older the child was, the more likely, and easier, it was for the parent to talk about the Troubles. Equally, the older the child was, the more likely they were to depict violence in their drawings (67% were Primary 7, 33% were Primary 6). Those who hadn't spoken about the Troubles stated that this was because they didn't feel it was necessary for their children to know, they felt their children were too young or because the child hadn't asked. Difficulty discussing the Troubles correlated with the personal experience of the parents. Discussion was significantly more difficult in circumstances where the parents had experienced loss or direct exposure to violence, or where the child had witnessed sectarian incidents. SDQ scores for children whose parents

found talking about the Troubles difficult indicated higher levels of emotional symptoms, and 70% depicted violence in their drawings.

Parents completed the General Health Questionnaire (GHQ-12)[13] (Goldberg & Williams, 1988) and the SDQ[14] (Goodman, 1997). Results indicated that poor parental mental health correlated positively with emotional and behavioural difficulties for the child. GHQ scores were highest amongst parents who had directly experienced the Troubles, and SDQ emotional scores were highest for children who had witnessed sectarian incidents. Those who depicted scenes of violence in their drawings were more likely to present with conduct problems and low levels of prosocial behaviour in their SDQs.

Children who attended (Catholic) maintained schools had the highest levels of depictions of violence, whilst those who attended integrated schools (where Catholic and Protestant children are educated together), particularly in rural areas, were less likely to depict violence in their drawings. Overall the findings suggested that children of parents who had higher levels of mental health difficulties were more likely to demonstrate emotional and behavioural difficulties themselves. However, as these findings were based on self-reports from parents, they should be treated with caution, as correlation does not necessarily equate to causality. Violence depicted in drawings could be influenced by other factors, such as the child's learning history (the school History curriculum often includes World War 2). The authors suggest that gender, age, peers and socioeconomic area had a strong influence on the extent of violence depicted in pictures.

2.5. Associations between Mothers' and Children's Psychological Functioning: the Role of Social Identity

Merilees et al. (2011) examined associations between the mental health of mothers who have grown up experiencing violent political conflict in Belfast, Northern Ireland, and the psychological adjustment of their children.

They looked closely at participants' social identity[15] and how it impacted psychological outcomes, as it has been linked to an increased risk for developing mental health difficulties. Within the context of Northern Ireland, social identity theory refers to whether an individual affiliates himself or herself with being a Protestant/Unionist[16] or a Catholic/Nationalist.[17] This influences the 'development of children's perceptions, behavioural roles and rules of social interactions'. The authors found that social identity created bias in children towards their own group by the age of nine (Muldoon et al., 1998, p. 37).

[13] This questionnaire identifies short-term changes in adult mental-health.
[14] The SDQ is a screening and assessment tool completed by parents regarding their children's behaviour, emotions and relationships. It seeks data about emotional symptoms: conduct problems, hyperactivity and inattention, peer relationships and pro-social behaviour (Goodman, 1997).
[15] 'An individual's identification with any number of in-groups as well as the value and emotional valence of those memberships' (Tajfel, 1972).
[16] Those who wish to see Northern Ireland remain part of the United Kingdom.
[17] Those who wish for a united Ireland.

The study examined the correlation between a mother's self-report of the impact of the Troubles and her current mental health outcomes. This was then compared to the mental health outcomes of her child. Results demonstrated an association between the mother's mental health and her child's, despite the decrease in political violence experienced by the second generation. Negative child-outcomes included poor cognitive and emotional development and general wellbeing (Downes et al., 2013).

They found that strong social identity amongst Catholic mothers acted as a protective factor against poor mental health, whereas increased social identity amongst Protestant mothers was associated with poorer mental health outcomes. The researchers attributed this to the relative social, political and economic gains and losses resulting from the Belfast Agreement (Shirlow & Murtagh, 2006). For the Catholic community, these gains have included a growth in Irish language and greater economic access to the labour market. By contrast, within the Protestant community, the researchers suggested a loss in territory, as the city has shifted from being predominantly Protestant, and the loss of status in the labour market, as well as greater control measures surrounding Orange parades. However, this study recognises the limitations of the cross-sectional nature of the data and emphasises that it is important to consider that other factors may also impact upon mental health outcomes. Mental health outcomes resulting from the trauma of the Troubles will be discussed in greater depth in an upcoming chapter.

2.6. Parenting Roles within the Family

A disruption to normal family interactions can occur for a number of reasons, for example a parental bereavement, or a change to the parenting style due to the victim finding it difficult to cope, affecting their ability to function effectively as a parent. This can result in the child being required to take on the parenting/caregiver role. However, children in this role report feeling an absence of emotional support (Baron et al., 1998) as well as pressure to suppress their personal aspirations in order to fulfil their parents' hopes for the family (Ermann, Pflichthofer & Kamm, 2009).

A parent's ability to maintain the caregiving role can be compromised when trying to deal with a traumatic past. Without good support, some parents turn to alcohol or misuse of medication to cope with their loss/trauma (Smyth, 1998). This can cause a reversal of the parent-child role, as the child becomes concerned for the wellbeing of their parent, and the parent is temporarily unable to care for their child.

Downes et al. (2013) found evidence of this in their research when a participant described how her eldest son (aged 6 at the time) took on the role of his father after he died. Another participant shared how, when growing up, she felt responsible for looking after her mother, and how she sees the same pattern of overprotectiveness with her son, who is now caring for her.

2.7. Factors Impacting on the Experience of Conflict

2.7.1. Impact of deprivation and socio-economic factors

McAlister, Scraton and Haydon (2009) found that children who grew up in areas with physical reminders of sectarianism and segregation, such as murals and flags, were more likely to

become involved in violent acts. Muldoon et al. (1998) found that it was the most socially disadvantaged areas of Northern Ireland (NI) which experienced the most violence during the conflict.

2.7.2. Age as a factor in the experience of the Troubles

Young children (0-5) are particularly vulnerable to the outcomes of instability within a family unit, due to their high level of dependence. Behavioural responses to separation or imprisonment of a parent can result in bedwetting, clingy behaviour, fearfulness and disruptive behaviour (Smyth, 1998, p. 124). It is also important to consider that this is a critical period for brain development. Perry (1994) explored how brain development and function can be impacted by exposure to violence, increasing the likelihood of aggressive behaviour later in life, due to an increase in the reactivity of the brain stem. He found that violence could hinder empathy and attachment in young children due to atypical patterns of neural activity in the brain at a critical stage of development.

Children aged 6-11 showed more awareness of threats, however not at an abstract level, and not enough to be able to maximise safety and lessen their fears (Smyth, 1998). At the stage of adolescence (12-18), young people are more able to comprehend threat at an abstract and conceptual level. They are often fearful of threats to their physical and emotional wellbeing, and at this stage are less dependent on family.

2.7.3. Bereavement

A family bereavement can affect the parent-child relationship, changing family dynamics, particularly when the person who has died is the other parent. Children who experience such separation and loss are amongst the most severely affected (Smyth, 1998). Dealing with bereavement can be particularly difficult if there is avoidance from the parent to talk about the loss, forcing the child to deal with their grief in isolation, and a reluctance of the child to bring it up in conversation in order to protect the surviving parent from distress.

Families bereaved during the Troubles found that the death often negatively impacted upon their communication with each other. It can also disrupt family roles, causing the surviving parent to feel 'disabled by grief and shock', often resulting in a child taking on the role of the deceased parent. This sometimes led to the child concealing their underlying grief and need for support (Smyth et al., 2004). Bereaved families reported feeling stigmatised by others in the community, who implied that their family member had been targeted due to paramilitary associations.

2.8. The Psychological Impact of Bloody Sunday on the Victims' Families

Bloody Sunday refers to a traumatic event which took place in Derry/Londonderry, Northern Ireland, on 30 January 1972 where 13 civil rights marchers were shot dead and 14 were injured. McGuigan and Shevlin (2010) designed a long-term study to examine the levels of psychological distress across four groups with differing levels of exposure to the Bloody Sunday incident. The first group was the 'wounded group' consisting of 5 participants who were wounded by gunshots. The second group (n=29) comprised immediate family members who were directly related to an individual killed on Bloody Sunday, five of whom either directly witnessed the event or were present at the event. The third group consisted of 'the second-

generation group' (n=14), the children of the immediate family (group 2). Group 4 consisted of a comparison group who didn't know the victims but had grown up in a similar geographical area, and were close in age to those in all three groups.

The Impact of Events Scale-Revised (IES-R) (Weiss & Marmar, 1997) was used to measure levels of intrusion, hyper-arousal and avoidance in relation to the events of Bloody Sunday, and can also indicate symptoms of Post-Traumatic Stress Disorder (PTSD). Results indicated clinically significant levels of psychological distress amongst those in the first and second groups ('wounded' and 'immediate family'). However, the majority of those in the immediate family group had not been directly exposed to the event, which supports findings from Zimering et al. (2006) that direct exposure is not necessary for psychological distress to occur. Those in the second-generation group also reflected high levels of psychological distress, although lower in comparison to the first two groups. McGuigan and Shevlin (2010) propose that this could be due to events surrounding the Saville Inquiry at the time of the study, or an outcome of living with a parent experiencing post-traumatic stress. This study nevertheless demonstrates empirical evidence of transgenerational trauma amongst a generation who has not been directly exposed to the conflict in NI.

2.9. Children of Those Serving in the Security Forces and Children of Prisoners

Three hundred and two police officers were killed and 9,333 were physically injured during the Troubles (Royal Ulster Constabulary [RUC], 2000). Families in the security forces had to live under constant vigilance, due to being targeted and vulnerable to attack at any time, even when off-duty, meaning home did not always feel like a safe place. They often had to live in secrecy, being unable to speak openly about what they did. Paterson, Poole, Trew and Harkin (2001) found that 16% of those who were medically retired and 6% normally retired demonstrated symptoms of PTSD due to their service. This appeared to have an impact on their wider families, including children. Families had to move frequently, resulting in upheaval from their home, school and community. Family dynamics were disrupted, as the serving parent's presence at home was often inconsistent, increasing the burden on the non-serving parent.

It is more likely that this group of children will have witnessed violent attacks or attempts. Black (2004) suggests that this is worse than other traumatic stressors, as their parent is the direct target of intentional harm.

Children can witness their parents' reaction to traumatic experiences and internalise their own feelings, not wanting to become an additional burden. This could potentially lead to feelings of isolation, as they are unable to speak to their parents or peers due to the need for secrecy. This could lead to problematic symptoms occurring in the school environment. Black (2004) attributes this to the high number of referrals for internalised symptoms, such as Obsessive-Compulsive Disorder (OCD) or eating disorders.

Parent-child relationships can be impacted as a result of the parents' job role. Black (2004) refers to this as 'parental distancing', whereby the child may be an antecedent for intrusive symptoms if the child has been part of a traumatic event. He also refers to 'parent overvaluation' whereby the parent says that 'the child is the only thing that keeps them going',

leading the child to feel an excessive amount of responsibility for their parents' wellbeing. Often families were forced to move home due to intimidation; this was highly disruptive, often leading to feelings of loss and insecurity (Smyth et al., 2004).

2.10. Support Services for Families Involved in the Troubles

Many individuals are still negatively impacted by the Troubles, manifested through poor psychological health, anxiety, flashbacks and depression (Dillenburger, Fargas & Akhonzada, 2008). Hanna et al. (2012) found that adults exposed to the Troubles were more likely to seek professional support if they felt the professional had a similar experience, believing that only someone with a similar experience could successfully help them to cope due to better understanding of what was experienced. Therapeutic support for transgenerational trauma can take the form of individual psychoanalytical therapy for both the first and second generation exposed to trauma.

Alternatively, 'systemic family therapy' provides the opportunity to reflect on family interactions and family dynamics, which could be facilitating the trauma transmission process. Downes et al. (2013) found a general consensus amongst participants interviewed that they wanted the cycle of trauma and sectarianism to end, so as not to affect future generations. Therapists should support this desire.

Hanna et al. (2012) reviewed support services in Northern Ireland which targeted individuals impacted by the Troubles. They found that the majority of services targeted the individual directly exposed to the trauma. However, many also supported others in the family system who had been indirectly affected. Few specifically mentioned 'transgenerational trauma' in their documentation, however most addressed issues of transgenerational trauma, providing the opportunity for young people to share their experiences in order to address the issue of the culture of silence.

2.10.1 The Police Rehabilitation and Retraining Trust (PRRT)

This service specifically supports children and adolescents of current and retired police officers who have psychological problems due to service-related incidents or indirectly via parental psychopathology therapy. This is not specific to, but includes those who served during the Troubles. Black (2004) found that there was reluctance amongst those who served in the Police Service to allow their children to access statutory services for child and adolescent mental health in order to protect their security. This presented as a difficulty when the child was demonstrating symptoms in relation to a traumatic event, but the antecedent could not be disclosed, due to the family's security concerns. The majority of children and young people who avail of this service have either been directly exposed to a traumatic incident or have been negatively affected by parental psychopathology related to their parents' service.

2.10.2. Family Trauma Centre

Based on findings about the adverse consequences of 'silence', it may be beneficial for support services to focus on assisting first generation victims of the Troubles to effectively communicate their experiences to their families through family therapy, helping the child to recognise their parents' experience and to comprehend their trauma symptoms, removing the

uncertainty and reducing anxiety. The Family Trauma Centre[18] was developed to specifically target young people and their families who have had exposure to traumatic events, including the Troubles. Centre staff directly address transgenerational trauma through psychotherapy with the initial victim and their family, exploring the changes to family life. They utilise systemic models to address family interactions and communications which may contribute to transgenerational trauma. The intervention used is tailored to the needs of the child and their family. Therapies available include:

- Cognitive Behaviour Therapy
- Eye Movement Desensitisation and Reprocessing
- Psychoanalytic Psychotherapy
- Supportive Therapy
- Family Therapy

Healey (2004) worked as a therapist within the Family Trauma Centre, where she advocated ‘systemic family therapy’ (SFT) and the use of psycho-education materials to support families to develop a sense of meaning in relation to the situation, and acquire coping mechanisms. Feltham (2000, p. 10) asserts that psycho-education can ‘enhance cognitive, behavioural and interpersonal functioning’ by teaching skills such as ‘parent-effectiveness, relapse prevention, and stress inoculation’.

Healey (2004) used SFT to support parents to ‘break the silence’ to aid communication within the family, and ‘therapeutic witnessing’ to recognise the clients’ experience, how their life has changed because of it and how they feel about themselves. Blackwell (1997, p. 87) advocated this approach. stating that ‘recognition’ helps family members to ‘integrate the past with the present’ and the possibility of the future, and realise ‘how violence can disorganise and fragment communities, cultures and belief systems’. Eagle and Kaminer (2013) suggested that conventional treatment models would be ineffective until the ongoing threat of violence was removed.

2.10.3. Wave Trauma Centre

This service was originally established to support individuals who had been bereaved of their spouse through the Troubles. Later, services expanded to include anyone who experienced trauma through the Troubles, even indirectly. ‘Whilst 3,600 people died, the number of family members also affected reached multiple times this number’ (McNally, 2014). They use a psychodynamic approach to address the impact of the trauma, and cognitive approaches to increase the self-efficacy of clients. The sharing of experiences is facilitated with others who have had a similar experience, addressing the silence within families. By breaking this silence, the aim is for the child to better comprehend their parents’ experience of the Troubles.

Whilst the above services target the family in different ways, they all share the same ambition: to reduce the psychological distress associated with trauma as a result of the Troubles. As mentioned earlier in this report, parents who have experienced trauma from the Troubles can transmit this trauma to the next generation, through maladaptive parenting styles and parent-child interactions and through finding it difficult to coping with their trauma. These services aim to target the manifestations of psychological difficulties, which could reduce the likelihood of

[18] The Centre is a statutory psychotherapy service, which focuses on working with and treating trauma in children and young people and their families.

the transmission of trauma. Hanna et al. (2012) highlight the importance of family members supporting the victim through therapy with emotional support. However, this process can sometimes be difficult for families when they are recovering from their own experiences of trauma or are not equipped to support the victim.

2.11. Conclusions and Reflections

Hanna et al. (2012, p. 71) concludes that 'transgenerational trauma' can be defined as 'the poor psychological health of children that appears to result from the consequences of the trauma experienced by parents, resulting in detrimental effects on the interactions between parents and children'.

The main focus of this chapter was to explore the transmission of trauma within the family system. Previous research discussed suggests that parents who have experienced trauma due to the Troubles can act in maladaptive ways, potentially instigating the transgenerational transmission of trauma through different means of communication, or lack thereof, with their children. However much of this research is quite speculative in nature, raising the need for further research to explicitly examine the association between the experience of trauma as a result of the Troubles in one generation and observable adverse psychological consequences in subsequent generations. This research could help distinguish whether poor psychological functioning from young people is as a consequence of Troubles-related trauma, or if it is associated with social deprivation, parenting styles or maladaptive family dynamics.

It is important to consider the development of poor psychological outcomes within the context of a multi-nested model, such as the ecological systems approach (family, school, the community and broader culture; Bronfenbrenner, 1979), to enable a more comprehensive understanding of the effects of violence. While the family makes up part of the microsystem, it is important to look further, to other systems, which interact with the child. Macro-systemic factors such as the impact of economic downturn can create tension within the family microsystem. Cairns and Dawes (1996) found that political violence had a more damaging effect on those from lower socioeconomic families. Further research could look at macro-system factors in more detail, such as the impact of the Troubles in different geographical and societal contexts, to gather a more comprehensive representation of the impact of exposure to violence in multiple contexts.

In conclusion, evidence has shown that trauma has a bio-psycho-social basis, which should not be assessed through a purely medical model of diagnosis. It is important to consider wider systemic factors. Later chapters will look at the child in the context of the school environment, and will explore the specific mental health outcomes for children who are experiencing transgenerational trauma.

Gaining a better understanding of the factors, which increase the risk of a child developing poor outcomes could help services to identify, support and intervene sooner on behalf of children who are at an increased risk. Therefore, future research should aim to transform findings into evidence-based interventions in order to promote healthy child development and reduce the impact of transgenerational effects.

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3

The Transgenerational Impact of "the Troubles" on Children and Young People's Mental Health

Victoria McIlwaine

This chapter will explore the transgenerational impact of "the Troubles" on children's mental health. It will examine the risk factors and subsequent disorders that children may experience due to the transmission of trauma from their family. It will then look at the support services and policies available to help children with mental health issues and conclude with recommendations for the future.

3.1. Mental Health and Northern Ireland

The Troubles (1968-1998) in Northern Ireland (NI) impacted on the population both directly and indirectly, and legacy issues have had psychological, social, political and economic consequences which are 'complex, wide ranging and intertwined' (O'Neill et al., 2015). One of the outcomes of the Troubles was poor mental health.[19] The elevated prevalence of mental health problems and the need for a strategic national framework for the development and improvement of mental health services in Northern Ireland was notably endorsed in the Bamford Review of Mental Health and Learning Disability (Bamford, 2007). The report highlighted the high levels of mental health issues in Northern Ireland, where over one in five individuals have a diagnosable mental health disorder in any given year.

Harland (2008) stated that children and young people (CYP) in Northern Ireland have a higher risk of developing mental health disorders due to the social, political and economic changes since the Troubles. Evidence from research shows that 20% of children in Northern Ireland will develop a significant mental health problem before their eighteenth birthday (NICCY, 2015); however, this may be higher, with 28% of 752 children stating that they are concerned about their mental health (NICCY, 2015). Recent research has found that of those in Northern Ireland suffering poor mental health, 15% of these are as a direct result of the Troubles (NICCY, 2015). It is estimated that one in six people in Northern Ireland will experience a diagnosable mental health condition (DHSSPS, 2008), with people from Northern Ireland 20-

[19] The World Health Organisation defines poor mental health as 'a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community' (WHO, 2016).

25% more likely to have mental health problems compared to the rest of the United Kingdom (AYPH, 2015). Could this higher rate be explained due to the legacy of the Troubles and transgenerational trauma?

O'Reilly and Stevenson (2003) examined the effects of the Troubles on the Northern Ireland population by conducting a secondary analysis of data collected on 1694 respondents (aged 16-64) as part of the 1997 Northern Ireland Health and Wellbeing Survey. Overall, 21.3% of respondents said that the Troubles had either 'quite a bit' or 'a lot' of impact on their lives or the lives of their family. The corresponding figure for impact on their community was 25.1%. Analyses of General Health Questionnaire-12 (GHQ-12) data revealed that respondents whose lives or community had been affected by the Troubles were more likely to experience psychological problems. O'Reilly and Stevenson (2003) concluded that the Troubles represented a significant and additional impact on the mental health of the Northern Ireland population. To further support these findings, a recent government survey (Mental Health Foundation, 2016) focusing on the mental wellbeing of the Northern Ireland population examined the mental health statistics of Northern Ireland resulting directly from the trauma of the Troubles. It found that the levels of poor mental health are in the upper end of the international scale, perhaps due to the population's experience of conflict. The findings showed that 19.5% of respondents claimed to have trauma related to experiences of the conflict, with 16.9% witnessing a death or serious injury. This resulted in 32% of the sample having a mental health disorder as a direct consequence of this conflict. Furthermore, 8.8% of the population met the criteria for Post-Traumatic Stress Disorder (PTSD), with 5.1% meeting the criteria in the last 12 months, showing that although the Troubles ended in 1998, the effects are still present today.

What is key to note, however, is that despite these statistics most people in Northern Ireland, including those who were victims or witnesses of the violence, suffered no or minimal long-term mental health disorders. Research would suggest that many of those exposed to traumatic experiences responded with notable levels of resilience[20] and with time processed the events and have led fulfilling lives (O'Neill et al., 2015). The *Towards a Better Future: The Trans-Generational Impact of the Troubles on Mental Health* (O'Neill et al., 2015) report found that those in Northern Ireland with few adverse mental health difficulties represent approximately 71.5% of the population. However, of the remaining 28.5% of the population with mental health difficulties, half of this sample's mental health problems appear to be directly linked to the Troubles. Based on Northern Ireland having a population figure of approximately 1.5 million, this equates to approximately 213,000 adults suffering from a mental health condition as a result of the Troubles. This report adopted the same criteria for mental disorders used internationally and based its questionnaire on robust stress criteria utilised by psychiatrists. One factor that this report did not examine was the prevalence rates of children's mental health difficulties resulting from the Troubles. Perhaps this is due to the complex interactions of genetics, family factors and community support making it impossible to establish cause and effect. What is clear from the literature, however, is that certain trends have appeared due to the Troubles, and with these associated risk factors.

[20] "Psychological resilience" refers to effective coping and adaption although faced with loss, hardship or adversity (Tugade & Fredrickson, 2010).

3.2. Trends in Mental Health in Northern Ireland

Early research studies (Cairns & Wilson, 1984) suggested that there were few mental health difficulties passed on to the next generation due to the Troubles. However, a vast amount of recent research (Bunting et al., 2013; Muldoon & Trew, 2000; O'Neill et al., 2015) found that those families who grew up with the Troubles and their future generations experience significant mental health difficulties. The Young Life and Times (YLT) survey has monitored the mental wellbeing of 16-year-olds in Northern Ireland since 2004. Research from this survey suggests that 24% of 16-year-olds are were psychologically distressed. This research is supported by Gallagher et al. (2012), who also found that the Troubles impacted negatively on young people in Northern Ireland. In a comprehensive report, Smyth et al. (2004) concluded that many young people in NI had been impacted in a number of ways (employment prospects, physical and mental health) due to the legacy of the Troubles. They stated that the conflict had affected them not only psychologically but also socially and politically due to them growing up in a divided society. These studies only show a relationship between the Troubles and children's mental health, and factors such as exposure to the Troubles, deprivation and gender can explain the variance in children's mental health problems.

3.2.1. Experience of the Troubles

Exposure to the violence during the Troubles was not evenly distributed across the Northern Ireland population. The violence varied along the 'dimensions of intensity, location and nature' (Campbell, Cairns & Mallett, 2004). Analysis of Troubles-related deaths revealed that the violence was mainly concentrated in the inner Belfast area, with over 40% of Troubles-related deaths occurring here and with 75% of these deaths occurring in North and West Belfast (Smyth, Morrissey & Hamilton, 2001). Rural areas such as Armagh, Fermanagh and Derry also experienced violence or threats of violence, with Gardiner (2008) reporting the 'fear and isolation' felt by the community of Clogher. While a significant number of communities were exposed to the Troubles, a markedly smaller proportion of individuals regarded themselves as victims of the Troubles. Cairns, Mallet, Lewis and Wilson (2003) examined the issue of victimhood in a randomly selected sample of 1,000 Northern Ireland adults aged 18 years and over. They found that only 12% of the sample would label themselves as a victim; this research was further supported by Muldoon et al. (2005), who found that 8% of their respondents considered themselves a victim. This is important to note as the discrepancy between exposure and victimhood raises questions regarding the respondents' coping mechanisms, and thus caution is advised when generalising Troubles-related outcomes due to multiple confounding factors. It is clear that exposure alone does not mean that someone is necessarily a victim and as such does not always result in trauma.

3.2.2. Deprivation after the Troubles

An important confounding factor to note is that although the experience of the Troubles impacted upon the population's mental health, the subsequent poverty and deprivation also acted as key risk factors for developing mental health problems (Muldoon, 2004). Gallagher et al. (2012) reported that children living in areas with high levels of deprivation or border areas appear to be the most affected by mental health issues. Knox (2014) confirms this, stating that those living in those areas are still the 'economic losers' following the peace process. Not surprisingly, the areas with continuing high levels of poverty were also the communities exposed to the most violence. Gallagher et al. (2012) stated that in inner city areas such as Newry, Belfast and Derry, some families continue to live in severe poverty compared to their

rural counterparts. Around 33% of the population of Northern Ireland live in rural areas (Mental Health Foundation, 2016) and as such their rates of trauma-related mental health issues are lower, perhaps due to less direct or indirect exposure to the Troubles.

The rate of persistent child poverty in Northern Ireland is twice that of England and has a detrimental effect on children's wellbeing (Monteith et al., 2008). Further findings from the YLT survey stated that a large majority of female children in socially deprived areas experienced serious emotional health problems. Nolan (2014) stated that, according to the Northern Ireland Peace Monitoring Report, child poverty stands at 35% in Derry and 34% in Belfast, with limited opportunities for young people resulting in increased mental health problems, especially for men.

3.2.3. Gender differences and mental health

Bunting et al. (2013) also reported that the impact of the Troubles varies between genders, with females reporting higher prevalence of mood/anxiety disorders while males report higher rates of substance disorders. Northern Ireland has a unique culture for children and young people (CYP), particularly males, to grow up in due to the changes in male roles. Previously males were seen as 'defenders' or 'protectors' of their community and aggression was seen as a desirable attribute. However, in today's post-conflict society, that level of aggression is no longer tolerated and young men are now criticised if aggressive. Harland and McCready (2012) suggested that although young males are aware of the transition from conflict to peace they 'may not have been equipped with the skills to manage this change'. Gallagher et al. (2012) suggested that indirect consequences of the Troubles such as social exclusion (in-groups and out-groups) and unemployment may have led to low aspirations and a sense of decreased self-worth and impacted upon the mental health of the male population.

3.3 Transgenerational Trauma

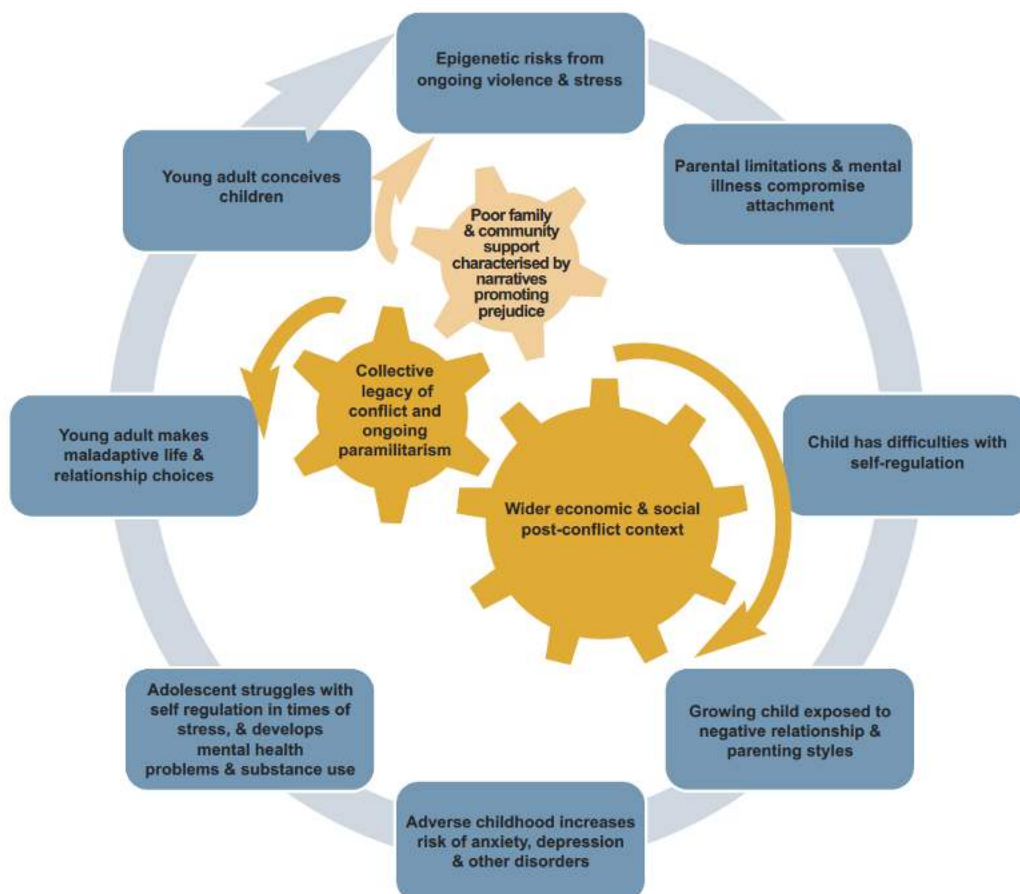
Regardless of the differing trends of mental health in CYP, what is clear is that research shows that there are biological and psychological consequences from living in a post-conflict society (Hanna et al., 2012; Lev-Weisel, 2007). Research would suggest that the trauma experienced by parents can be associated with later poor psychological functioning in CYP (O'Neill et al., 2015). Tomlinson (2012) revealed that over 40% of CYP live with a parent who experienced a high level of trauma from the conflict. Therefore, their coping and mental health patterns could have been passed down through the family.

Hanna et al. (2012), one of the first teams of researchers to work on the theory of transgenerational trauma in NI, defined the phenomenon as 'the poor psychological functioning in CYP that seems to partially emanate from the consequences of the trauma experienced by their parents, resulting in detrimental effects on the interaction of parents and children'. McNally (2014) expanded on this definition by stating that transgenerational trauma is not only passed on through the interaction of parents and children, it could also be biologically passed on or consciously or unconsciously transmitted through exposure to their societal environment. Children therefore are a vulnerable group in NI society, who, 'although [they] may have never experienced the conflict directly, face a real-life threat of inheriting the psychological vulnerability of their parents' (Gallagher & Hamber, 2014, p. 73).

Although previous models to represent the transmission of trauma have been discussed, Figure 3.1 (below) shows the model that will be used in this chapter in relation to mental health. This model encompasses psychological, sociocultural and biological theory and describes the transmission of trauma as a cyclical model. This model shows that there is a biological risk (transmission of stress genes/mutation of genes in the child) and environmental risk (developmental issues, culture and society), increasing CYP's risk of developing mental health problems which they in turn may pass on to future generations.

Each of the sectors outlined in the model is linked to a risk factor for CYP or adults developing mental health difficulties. Naturally all children are at risk from transgenerational trauma due to the Troubles as a vast proportion of the NI population had both direct and indirect experience of the conflict (doctors, journalists, police etc.). There are particular children, however, who may be more at risk of transgenerational trauma due to their parents' or family's direct involvement with the Troubles.

Figure 3.1: A developmental overview of the pathways through which the impact of the Northern Ireland Troubles is transmitted to subsequent generations (O'Neill et al., 2015).



3.4. Children of Survivors, Ex-Combatants and Police Officers

According to Ghigliazza (2008), children were often overlooked as victims of the Troubles, but recent research into the transmission of trauma shows that the conflict had long-term mental health consequences for CYP. Children of survivors of the conflict have been found to suffer from mental health issues which may be a result of the trauma faced by their parents. Their parents may have been physically or mentally affected by the Troubles and as such unable to look after their child, with perhaps the child becoming the carer. Additionally, trauma may have led to maladaptive parental behaviour such as neglect or over-protective parenting styles which impact negatively on the child. Therefore, as discussed in the previous chapter, the trauma experienced in the family system can impact upon the child's later mental health.

Children of ex-combatants may also face a range of mental health issues due to the disruption of family life, e.g. if the parent went to prison, witnessing their parent being arrested or visiting prison (Roulston, 2011). The child may also feel stigmatised by their parent's involvement and therefore suffer from anxiety due to the fear of other people finding out about their parent's role during the conflict (Roulston, 2011).

Children of military personnel are also prone to suffer from anxiety, in particular Obsessive-Compulsive Disorder, due to the ongoing fear of attack (Black, 2004). Due to the ongoing threat to military personnel in Northern Ireland such as police officers or those working for the prison services, children live in social isolation, afraid of disclosing their parent's role, and this has an impact on their family's mental health. It is important to note that other children were also affected, such as the children of doctors or journalists, but the most commonly cited mental health issue that their family members experienced was PTSD (Roulston, 2011). The following section will explore PTSD in Northern Ireland and the subsequent disorders that CYP may experience as a result of parental PTSD.

3.5. Post-Traumatic Stress Disorder

Post-traumatic stress disorder (PTSD) is the most frequently reported and extensively studied outcome of traumatic events (Somer, Ruvio, Soref & Sever, 2005). The National Institute for Health and Clinical Excellence (NICE, 2005) state that PTSD is the name given to 'the psychological problems that may follow particular threatening or distressing events'. Epidemiological studies show that 29% of lifetime PTSD in Northern Ireland is associated with the Troubles (Bunting et al., 2013). The Northern Ireland Study of Health and Stress (NISHS) (Ferry et al., 2008) provided the first nationally representative estimates of PTSD using a validated survey instrument based on the DSM-IV diagnostic criteria. Preliminary data suggested that two thirds of the Northern Ireland population have experienced a traumatic event at some point in their life and it is estimated that 50% of all traumatic events were related to the Troubles. Furthermore, Bunting et al. (2013) found that over half of the adults' traumatic experience of the Troubles happened before they had reached 20 years old. McDermott et al. (2013) found that children directly exposed to the Omagh bomb had the highest levels of PTSD later in their adult life. The estimates from this epidemiological study fall in the upper end of other comparable epidemiological studies, e.g. those from the USA (Ferry et al., 2010). While men were significantly more likely to have experienced a Troubles-related traumatic event, women were more likely to meet the criteria for PTSD (Ferry et al., 2008). These findings

showed that those who had a direct experience of the Troubles were more likely to develop PTSD, anxiety/depression or substance misuse disorders than those with no such experience.

3.5.1 Impact of parental PTSD on the child

Leen-Feldner et al. (2013) found that PTSD in parents is correlated to internalising and externalising behavioural disorders in their children, perhaps due to an altered hypothalamic-pituitary-adrenal axis functioning. They also found that parental PTSD can interfere with the interaction patterns within the family and therefore lead to a less than optimal attachment. Family and twin studies have also found that more than 30% of the variance associated with PTSD has a heritable component (Skelton et al., 2011). The trauma may also be passed on through family communication styles such as the culture of silence or over-disclosure (as discussed in the previous chapter). Additionally, a recent meta-analysis of 550 studies found that the association between parents' PTSD and their children's mental health problems did not differ significantly based on who experienced the trauma (Lambert et al., 2014). They also found that parental PTSD correlated highly with their children experiencing anxiety. These findings suggest that maternal PTSD is associated with offspring emotional regulation difficulties as early as infancy and as such lead to future mental health difficulties. It is important to note that most parents with PTSD do parent their children effectively (O'Neill et al., 2015), however transgenerational trauma can have a negative impact on the child, leading to future mental health problems.

3.6. Transgenerational Trauma and Childhood Toxic Stress

Evidence from research studies into PTSD (Lambert et al., 2014; Skelton et al., 2011) and transgenerational trauma studies (Muldoon et al., 2005) suggest that the transmission of trauma to children of victims of the Troubles make them more prone to developing toxic stress in childhood. Toxic stress has been defined as 'extreme, frequent or extended activation of the stress response, without the buffering influence of a supportive adult' (Shonkoff et al., 2009). The empirically identified risk factors for experiencing childhood toxic stress include parental mental health problems, poverty, childhood neglect and abuse/family violence (Shonkoff et al., 2009). As previously discussed, the aftermath of the Troubles resulted in high levels of deprivation and subsequent poverty, therefore children post-conflict may experience a multitude of risk factors and be more vulnerable to developing toxic stress.

Research studies examining the transmission of toxic stress suggest that there is a relationship between PTSD in parents and children having insecure attachment styles (Katz, 2003); both neglectful and authoritarian parenting styles lead to toxic stress (Leen Feldner et al., 2013). Sailea et al. (2014) also reported in their study that violence within the family still exists post-conflict due to females experiencing domestic violence and males potentially having PTSD symptoms, which can lead to toxic stress in children and later adolescent delinquency.

The findings from these studies suggest that the children of the victims of the Troubles are at increased risk of experiencing co-occurring early childhood adversities which may result in experiencing toxic stress. Experiencing toxic stress can trigger a series of biological adaptations that change the way the brain's neuroendocrine stress response and immune system function both individually and cooperatively (Johnson et al., 2013). O'Neill et al. (2015) report that therefore children who experience toxic stress are at risk of health problems (e.g.

cardiovascular disease) and mental health problems (e.g. substance misuse). Findings from the World Mental Health (WMH) Survey Initiative indicated that toxic stress can lead to childhood adversities which in turn account for 29.8% of mental health problems globally (Kessler et al., 2010). Childhood adversities may increase vulnerability to stress, impacting on ability to cope with future stressors (O'Neill et al., 2015). The stress sensitisation hypothesis proposes that exposure to severe stress in early life can increase sensitivity to stress in adulthood (McLaughlin et al., 2010).

3.7. Outcomes of Toxic Stress on General Psychological Wellbeing

One of the mental health difficulties which children may face is emotional vulnerability due to toxic stress. McLaughlin et al. (2010) found in their longitudinal study that emotional reactivity to stress was heightened in those who experienced childhood toxic stress and that this reactivity was in turn related to elevated levels of mood and anxiety disorders. The Belfast Youth Development Study reported that 77% of 15-16 year olds had experienced community violence which impacted on their psychological wellbeing resulting in depression and substance misuse (McAloney et al. 2009). Cumming et al. (2010) in a longitudinal study also found that sectarian violence was linked to higher rates of family conflict which in turn affected the child's psychological wellbeing. They suggested that 'emotional insecurity about the community the child lives in can lead to internalising and externalising problems'. Although Muldoon (2004) suggested that children would display more externalising problems, the Worth Mental Health Survey found that as a result of the Troubles, children developed internalising problems such as mood, anxiety and substance disorders (Bunting et al., 2012).

3.7.1. Anxiety and depression

In a survey, Muldoon et al. (2005) reported that those who were directly impacted by the Troubles reported higher prevalence rates of depression and anxiety disorders. Furthermore, 10% of the participants reported symptoms of PTSD. A number of mood, anxiety or substance use disorders may develop in connection with exposure to a traumatic event. From analysis of the National Health and Stress study, Ferry et al. (2008) found that individuals who met the criteria for PTSD were twice as likely as those who did not to have at least one other co-morbid mood, anxiety or substance use disorder. Smyth et al. (2004) found that the children in their sample experienced high levels of anxiety and sleep problems. Smyth et al. (2004) suggest that perhaps this was a learned behaviour from children living in a family with experience of the Troubles. They could have developed these anxieties through stories from their parents or perhaps from still living in a high crime rate area. Due to potential attachment difficulties from maternal PTSD, children may display separation anxiety when presented with novel situations (NICCY, 2015). Population-based surveys also showed that those who live in an area with a high rate of crime/violence have significantly higher rates of depression compared to those with little or no such experience (NICCY, 2015). This in turn affects their school attainment and employment opportunities.

3.7.2. Substance misuse

Muldoon et al. (2005) found that people who grew up during the Troubles often use
drugs or alcohol to cope with their experiences. This substance misuse has been reported to lead to an increase in sectarian violence which can impact greatly on the family (O'Neill, 2015). Substance misuse may lead to parental ill-health, subsequent loss of employment, martial breakdown, domestic violence etc., which subsequently affects the children. The subsequent

social deprivation and economic uncertainty that followed the Troubles has led to an increase in alcohol and drug abuse in CYP (O'Neill, 2015). Nolan (2014) reported that drug-related offences in CYP are steadily increasing. Participants of the Childhood in Transition research project (8-25 year olds) reported that they drank because they were bored or else to forget about their problems (Nolan, 2014). NISRA (2012) research found that of their respondents (11-16 year olds), 46% consumed alcohol, 15% took illegal drugs and 19% had smoked tobacco in the previous year, potentially impacting on their future physical and mental health.

3.7.3. Self-harm and suicide

The ARK (2013) survey found that 13% of children (15-16 years old) self-harmed due to secondary experiences of the Troubles. Research also indicates that 10% of children aged 15 and 16 years have self-harmed (NICCY, 2015.) The rates of self-harm in Northern Ireland are not significantly greater than those in Ireland or England and therefore could be due to a multitude of difficulties such as bullying rather than due to the Troubles. Tomlinson (2014) suggests that an increase in self-harm among CYP may explain why there has been an increase in suicides in Northern Ireland.

Recent statistics suggest that Northern Ireland has witnessed an upward trend in suicide rates, especially within the male population and those aged 10-34 years old (Tomlinson, 2014). Tomlinson (2014) found a significant association between experience of the Troubles and suicide ideation and plans, suggesting that those who had experience of the conflict may be more likely to complete suicide in their first attempt. This topic will be discussed in more detail in the next chapter.

3.8. Coping

This complex range of mental health disorders associated with the Troubles poses the interesting question of what coping mechanisms have been used by those who effectively dealt with their trauma. Campbell, Cairns and Mallett (2004) stated that most of the population coped partly by habituation, distancing and/or denial. Ferry et al. (2008) investigated the impact of the Troubles through a series of in-depth interviews and found that those living with the unrest 'normalised' the experience and as such didn't experience a constant strain on their emotional wellbeing. Ferry et al. (2010) reported that dissociation may be a better explanation of how people coped. They found that dissociation was significantly higher for those who had been directly exposed to violence and that it linked to the perceived impact of the trauma rather than the experience itself.

Resilience factors may also explain how many have coped with the trauma. Previously resilience was regarded as an internal trait but it is now generally accepted that it is a 'dynamic process which is the result of the interaction between the person and their environment' (Vanderbilt-Adriance & Shaw, 2008). Vanderbilt-Adriance and Shaw (2008) highlighted three main areas in which child resilience could grow: child protective factors (IQ, emotional regulation), family protective factors (nurturance, safety) and community-level protective factors (cohesion, neighbourhood quality). Although research has examined child and family factors in detail there has been limited research into community resilience (Vanderbilt-Adriance & Shaw, 2008). Community resilience enhances the individual's coping during stressful times and is instrumental in expediting post-stress recovery, and this is an area that needs more work on post-conflict Northern Ireland (O'Neill et al., 2015). The 2011 Commission

for Victims and Survivors' report highlighted that during the Troubles there was little practical or emotional support for individuals affected by trauma and this report claims that victims and survivors continue to be unaware of the support available.

3.9. Support Service Provision in Northern Ireland

As a result of the findings of the Commission for Victims and Survivors' report (2011), statutory and community services in recent years have promoted their services in local schools and communities in order to highlight their assessment and treatment options. Perhaps one reason why services were unknown to victims' families was that at the statutory level, Social Services staff found it particularly difficult to carry out research to provide adequate support services due to a culture of mistrust and fear (Ghigliazza, 2008). McDermott et al. (2013), in their paper on the impact of the Omagh Bombing on children, reported on the difficulties faced by the statutory sector in providing help:

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

Other barriers stated by the CYP quoted in this report included the stigma[21] associated with poor mental health, especially for males. Although CYP stated that this is less now than in the past, this barrier still exists for many. They also stated lack of awareness of the services available as a key barrier. They were not sure how to access the services and would prefer to access them without a referral from their GP (Appendix 4). Lastly, they stated that there was a deficit of knowledge among the general population of what a mental health disorder is or how to keep themselves mentally healthy, and as such communities and families are failing to spot the signs sooner (McDermott et al., 2013). These barriers expressed by the participants in this study could be used by policy makers to introduce innovative ways to help promote an emotionally healthy life style and as such will be reflected upon later when discussing future recommendations.

Although at a statutory level the government experienced barriers to establishing trauma specific services, they do utilise a "Stepped Care Model" (Figure 3.2) for adult mental health services and Child and Adolescent Mental Health (CAMHS) services (Figure 3.3) to support transgenerational trauma as well as other mental health problems (Bets & Thompson, 2017).

[21] According to WHO (2016), 'Stigma can be defined as experiencing feelings of shame, disgrace or disapproval which results in them being shunned or rejected'.

Figure 3.2: Stepped Care Model for adult mental health

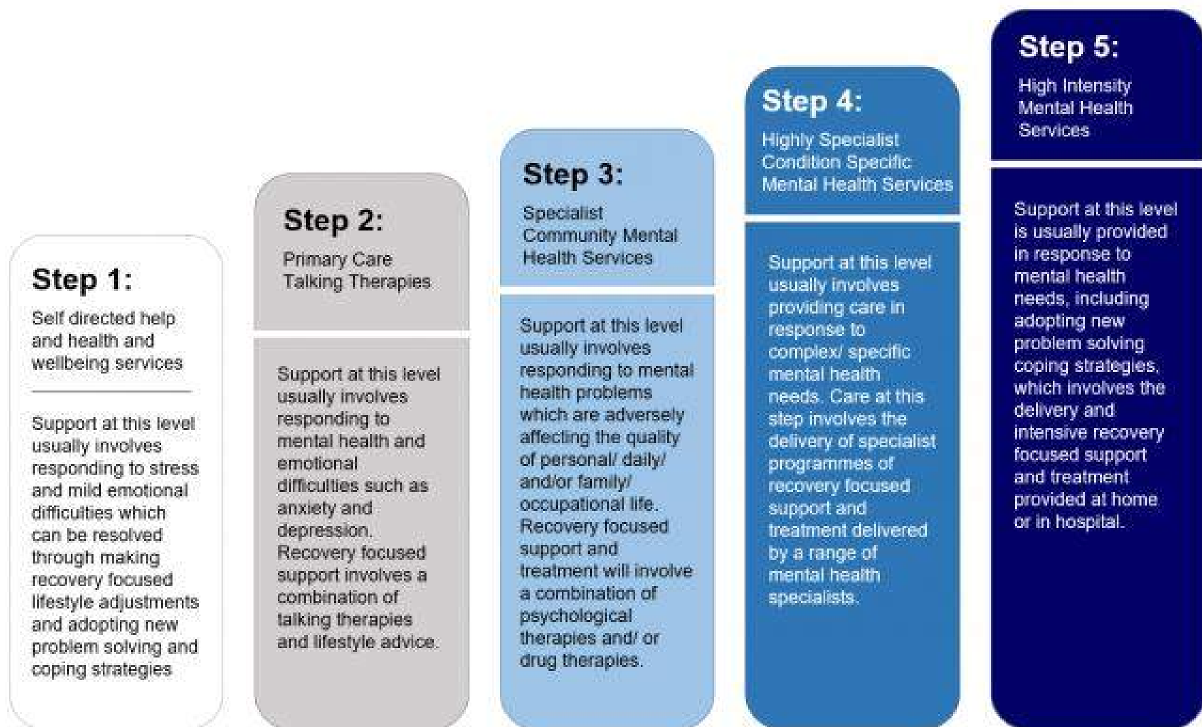
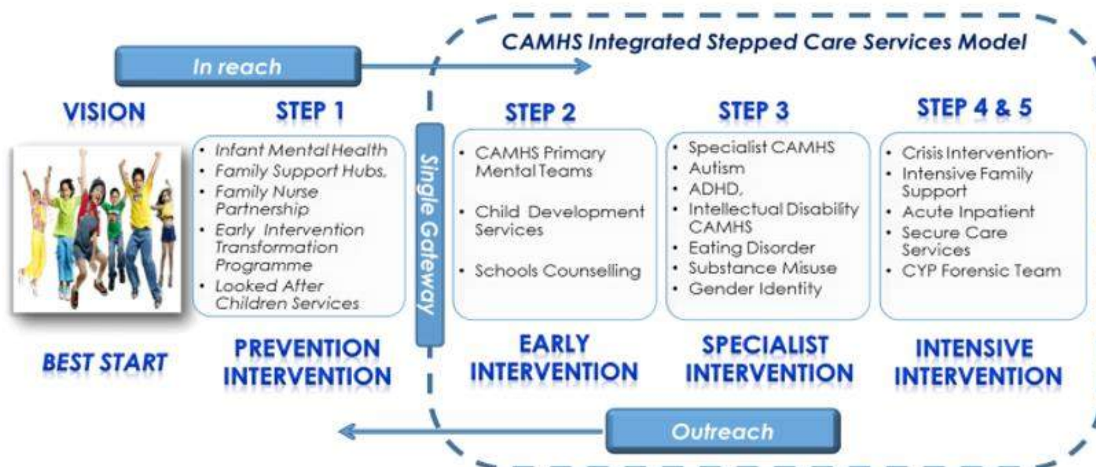


Figure 3.3: CAHMS Pathways



Source: Department of Health (NI)[102]

The government has also responded by conducting reviews into the effects of transgenerational trauma such as the Bamford Review (Bamford, 2007) and with the *Promoting Mental Health Strategy and Action Plan 2003-2008* (PHA, 2003), which focused on the transgenerational trauma aspect of children's emotional vulnerability and suggested that a systemic approach was needed when treating the child. It appears that for the most part progress in implementing the recommendations from the Bamford Review has been slow and resource allocation throughout the geographical area limited (NICCY, 2015). The Northern Ireland Executive in 2016 approved an action plan which included a £175,000 NI mental trauma service. This trauma service would include a range of psychological assessments and treatments including Cognitive Behavioural Therapy (CBT) and Eye Movement Desensitisation and Reprocessing (EDMR). This 'Improving Mental Health Strategy' aims to create a service model in co-partnership with patients, service users and staff. It will focus on prevention and tackling the aforementioned barriers to accessing services (Figure 3.4).

Figure 3.4: 'Improving Mental Health' Government trauma service

Source: *Health and Wellbeing 2026, Delivering Together*

The 'Recovery' focus is about building a meaningful and satisfying life, whether or not there are recurring or ongoing mental health problems. The key themes are[57]:

Agency – a patient gaining a sense of control over their life and illness. Finding an identity which incorporates illness, but retains a positive sense of self.

Opportunity - building a life beyond illness. Using non-mental health agencies, informal supports and natural social networks to achieve integration and social inclusion.

Hope – A patient believing that they can still pursue their hopes and dreams, even with the continuing presence of illness and not settling for the reduced expectations of others.

Recovery Colleges provide education as a route to recovery, not as a form of therapy. The colleges stem from the ImROC Project (implementing recovery through organisational change) (see section 4.5.2 for further details) delivered by the Mental Health Network and the Centre for Mental Health (supported by the Department of Health, England).[58]

Alongside the statutory services, the voluntary sector established a wide range of therapeutic services to support the victims of the Troubles. These organisations were mainly funded by the Victims and Survivors Service Northern Ireland (O'Neill et al., 2015) with the aim of reducing the impact of transgenerational trauma. Below are some examples of the organisations set up to help CYP who are suffering due to the legacy of the Troubles.

3.9.1. WAVE Trauma Centre

WAVE is a voluntary cross-community group which helps anyone affected by the Troubles. It adopts a therapeutic approach to intervention, working on the principles of systemic family therapy. WAVE also provides a youth service for children aged five to twenty-five delivered to over 1200 young people called 'Breaking the Cycle of the Troubles: Legacy for our Future Generations'.

3.9.2. The Ely Centre

This service supports victims of the Troubles and those who are still under terrorist threat. It provides therapeutic, financial, educational, social and psychological assistance to families and provides a transgenerational service. Its transgenerational services include youth activities, respite days, mental health workshops, counselling and 'Mothers and Daughters' and 'Dads and Lads' bonding days.

3.9.3. Save the Children

Save the Children provides a programme entitled 'Families and Schools Together' (FAST), which is an early intervention programme bringing children, parents, schools and the wider community together to support children to achieve emotionally and academically. An evaluation of this programme showed that 33 schools and 694 families had taken part, resulting in parental involvement within education, improved child behaviour and improved family relationships (O'Neill et al., 2015).

Although the above is not an exhaustive list, it appears that most services are intervening at both the parental and child level. This family approach to therapy is supported by empirical research and therefore shows that these organisations are using evidence-based practice. What is key to note, however, is that because these organisations are not government-regulated, it is crucial that their interventions are evidence-based and evaluated to ensure that their clients are availing of the best treatment options.

It is important therefore to now examine what the research literature states is the most effective way to treat transgenerational trauma. Growing evidence from neuroscience suggests that the longer it takes to intervene with children at high risk for mental health problems the more difficult it will be to achieve positive outcomes later, especially for children who have experienced toxic stress (Shonkoff et al., 2009). Shonkoff and Fisher (2013) propose that services should intervene with a two-generation approach for families experiencing trauma. They recommend that the needs of the children should be considered when adults present with mental health difficulties. They suggest that family intervention programmes should focus on building the capacity of the caregivers to strengthen their skills set. They argue that upskilling the parents will strengthen the social and economic aspect of the family system and indirectly benefit the child.

Providing parents with the skills to gain employment or improve their social skills in turn strengthens their executive function skills in problem solving, thus improving overall mental

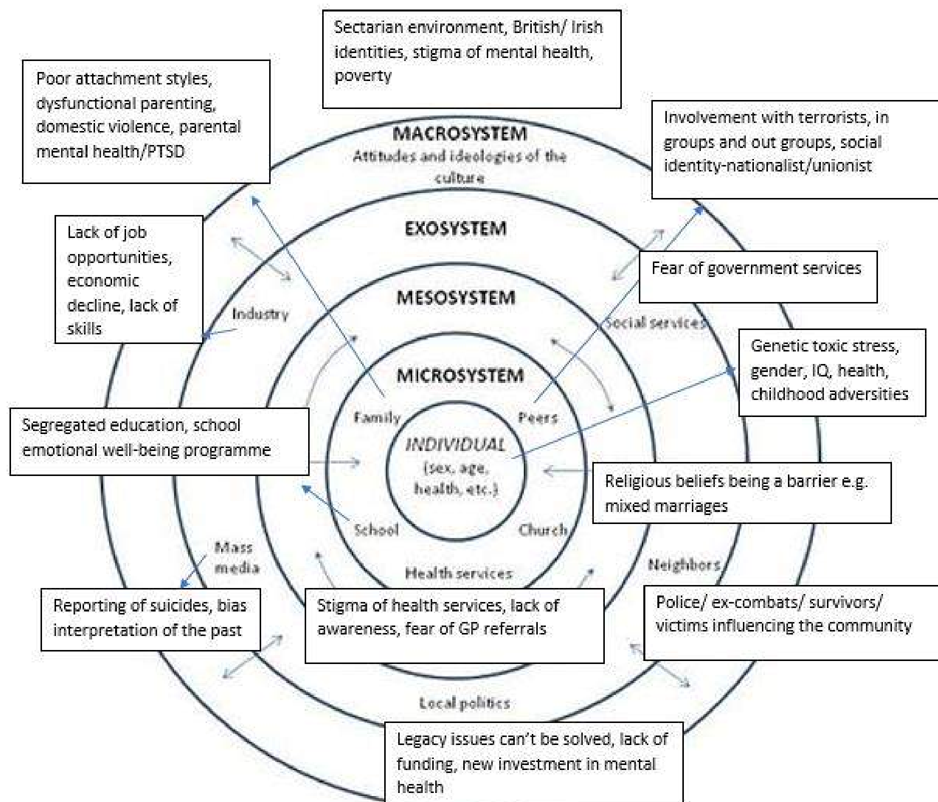
health. Mentally healthy parents therefore can help their children develop resilience skills to overcome their toxic stress by being emotionally available to help their child cope with stress (O'Neill et al., 2015). Dozier et al. (2002) also suggest that early years' practitioners need to be upskilled on how to deal with a child who is experiencing toxic stress. Firstly, children who are experiencing toxic stress tend to give harsh, non-conforming behavioural signs that could make it hard on the parent/ teacher to provide nurturing care. Therefore, the early years' practitioners need to train parents/teachers to reinterpret these signs. Secondly, children who experience toxic stress are at risk of bio-behavioural dysregulation and therefore children need training to help them regulate their emotions. Children can build emotional resilience through the use of CBT, and specifically trauma-focused CBT has been widely cited as the main form of treatment for PTSD or trauma symptoms in children (O'Connor & O'Neill, 2015; O'Neill et al., 2015). The WHO published a meta-analysis of empirically supported treatment for childhood stress and specifically PTSD and concluded that trauma-focused CBT and EMDR are recommended for CYP and adults (Tol, Barbui & van Ommeren, 2013). From examining the current service provision and what the literature states, it is clear that early intervention within the family appears to be best practice.

3.10. Conclusions and Recommendations

To summarise the key findings of the effects of transgenerational trauma on the child's mental wellbeing, Bronfenbrenner's Ecological Systems Theory (Bronfenbrenner & Vasta, 1992) will be used. Bronfenbrenner's theory (Appendix 5) states that children do not exist in isolation; instead, they are being impacted upon at many different levels. Figure 3.5 is a pictorial representation of the variables that impact upon the child from the legacy of the Troubles and subsequently affect their mental health.

This representation shows the vast and varied factors that are impacting upon CYP today due to legacy issues of the Troubles. It is clear that to reduce the impact of transgenerational trauma, CYP should not be treated in isolation as that will not change their current environment. Instead the government should look at all the subsystems and develop preventative strategies at each stage.

Figure 3.5: Adaption of Bronfenbrenner's ecological system theory to relate to transmission of trauma



The following are recommendations to help reduce the impact of transgenerational trauma on CYP mental health:

Children and young people:

- Early intervention if a child is in a high-risk family (e.g. parental PTSD)
- Intervention for early years' practitioners to teach resilience strategies to young vulnerable children
- CYP to avail of CBT/ EDMR
- Peer education projects to help discuss issues
- Child voice-led therapy
- Early access to screening and assessment

Family:

- Family therapy to assist all members to deal with the trauma of the Troubles
- Capacity building for parents to create nurturing attachments
- If paternal PTSD, children to be involved to stop transmission of trauma

Community:

- School and youth projects to help foster family relationships
- Space for CYP to express their trauma safely e.g. art therapy/play therapy

- Integration of communities
- Building on the success of voluntary sector organisations

Northern Ireland Assembly:

- Programmes to reduce the stigma of mental health
- CYP to be taught signs of poor mental health
- Training of early years' practitioners to spot childhood toxic stress
- Mental wellbeing programmes/media campaigns
- Preventative programmes in key trend areas e.g. deprivation/male suicide
- Easy access to mental health services

To conclude, it is clear that although the conflict has ended in NI, the effects of the Troubles are still impacting upon future generations. Due to a multitude of intertwined factors such as parental mental health and social and economic deprivation, CYP in NI are at a high risk of developing a trauma-related mental health problem. The cyclical nature of transgenerational trauma suggests that early intervention in the cycle could stop the transmission of trauma to younger generations. The recent investment in mental health by the NI Executive projects a hopeful future for trauma-related mental health in NI. Although an array of mental health problems from alcohol abuse to depression may present in CYP, the increase in suicides paints a worrying picture. More research is needed into why the rates of CYP completing suicide are increasing in NI.

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4

Exploring the Transgenerational Impact of the Northern Irish "Troubles" on Suicide Rates amongst Children and Young People Today

Linzi Kelso

4.1. Introduction

> '*High levels of deprivation, the legacy of conflict and high levels of mental ill-health create a very challenging set of circumstances for many people in the north of Ireland'* (O'Neill, 2016; as cited in Torney, 2016).

The legacy of the conflict in Northern Ireland known as "the Troubles" continues to permeate the lives of today's population. Exposure to violence and traumatic experiences are directly linked to mental health difficulties for those involved but are also known to impact subsequent generations, resulting in a transgenerational cycle (O'Neill et al., 2015). The current high rates of mental health disorders and suicide statistics indicate an ongoing and transgenerational impact of the Troubles in today's society. This chapter aims to identify the changing trends in suicide rates over the past fifty years within Northern Ireland in order to attempt to explain and better understand the potential links between growing up in a conflict zone and the risk of suicide for today's children and young people.

4.1.1 Definitions of suicide in Northern Ireland

Almost nineteen years after the Northern Ireland Peace Agreement, the impact on mental health, and in particular suicide rates, remains concerning for today's young population despite being born and raised in a time of 'relative peace and stability'. Within Northern Ireland, it is important to note that the definition used for suicide deaths is that of the UK, which refers to deaths both from 'self-inflicted injury' and those from 'events of undetermined intent' (WHO, 2011). Death as a result of 'self-inflicted injury' refers to instances whereby it is clear that the individual's intention was suicide or alternatively where the evidence clearly establishes that the person has died as a result of self-harm or self-injury, even when it is not clear that the intention was death. 'Events of undetermined intent' refer to cases where it is unclear if the death was a result of intentional injury, an accident or assault (Samaritans, 2016). The definition also refers to deaths that have been registered in a particular year; however, the death may not have necessarily occurred in this given year due to the potential for delays in determining the cause of death.

In contrast to the rest of the UK, suicide rates within Northern Ireland are significantly higher than they were thirty years ago (Samaritans, 2016). It is therefore necessary to first examine the current rates of suicide within Northern Ireland before attempting to examine the relationship between the past conflict and its impact on the suicide rates of today's generation.

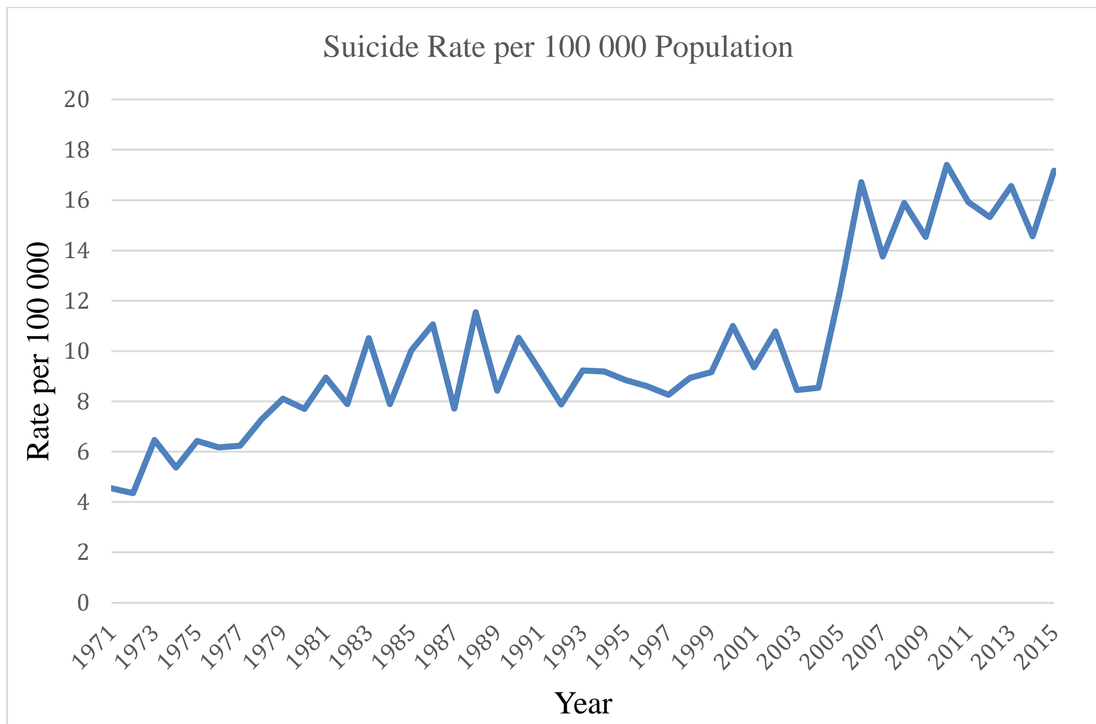
4.2. Suicide Trends

4.2.1. Suicide trends since the beginnings of "The Troubles" in 1968

Since the beginnings of "the Troubles" in the late 1960s and during the 1970s and 1980s, the suicide rates within Northern Ireland rose steadily to a rate of 10 per 100,000, a figure which was deemed 'low' based on international standards, before falling slightly over the subsequent ten-year period (Collingwood, 2016). However, since the signing of the Good Friday Agreement in 1998, an event deemed to represent the beginning of a movement from conflict to "peace" within Northern Ireland, the rates of suicide have dramatically increased and currently remain the highest throughout the whole of the UK. Suicide rates during 2015 in Northern Ireland represented the highest rate since records began in 1970, with 318 suicides registered – an increase from 268 in 2014 (NISRA, 2016). The current rate of suicide, at 16 per 100,000 per population for the period between 2013-2015 (Figure 4.1), remains significantly higher than the target set for an average annual suicide rate of 10.7 per 100,000 for 2010–2012 by the Programme for Government (PfG) (Torney, 2016).

Historical data indicates a total of 7,697 suicides registered in Northern Ireland from the beginning of 1970 until the end of 2015, with approximately 74% (5,666) of these being male deaths (NISRA, 2015). A decade after the Good Friday Agreement, suicide rates for both men and women had doubled. An examination of suicide trends over a 40-year period beginning in 1966 also indicated that the highest suicide rates in Northern Ireland are amongst men aged between 35-44 years, followed by the 25-34 age group and then the 45-54 age group. Overall this suggests that children growing up during the most violent periods of the Troubles, between 1969 and 1978, are those who exhibited the highest suicide rate and the most rapidly increasing incidence of suicide (Tomlinson, 2012).

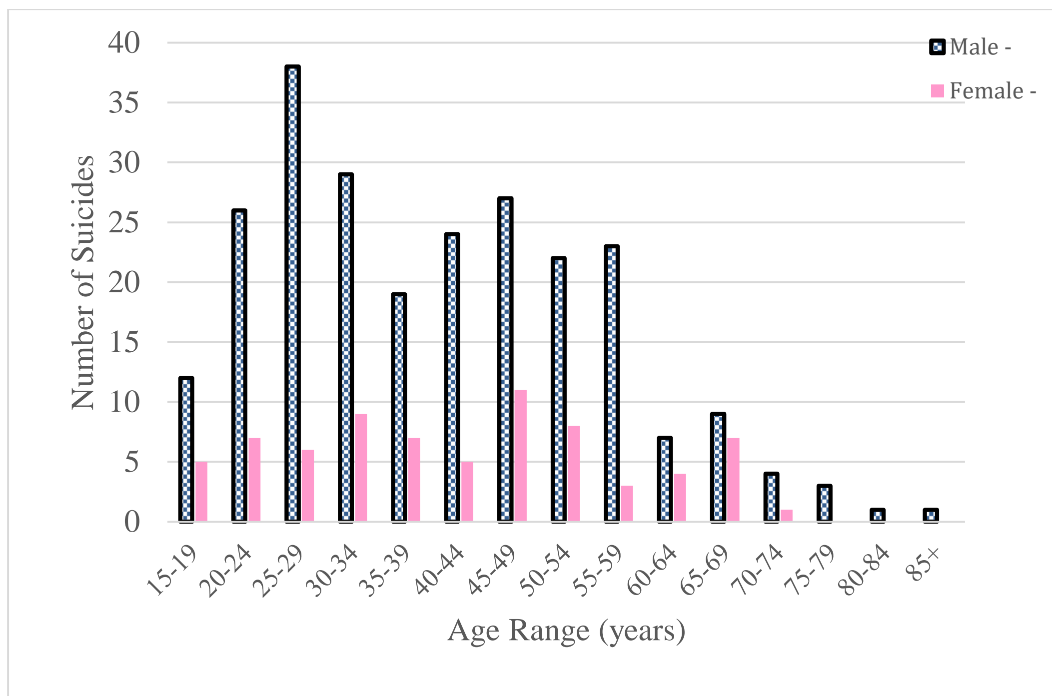
Figure 4.1: Suicide rate per 100,000 population from 1971 to 2015 (NISRA, 2015)



4.2.2. Current rates of suicide in Northern Ireland

Closer examination of the 2015 rates of suicide in Northern Ireland highlights a 19% increase in the number of suicides recorded from the previous year. During 2015, approximately six people each week committed suicide. Of the 318 suicides, 77% (245) were male, with the highest rate observed amongst men aged 25-29 years (n=38; 12%) (Figure 4.1). Despite the highest rates in this age group, individuals below the age of 25 also showed high suicide rates, equating to 16% of all suicides in this year (n=50) (NISRA, 2016). Overall 132 individuals aged 15-34 committed suicide in 2015, equating to 42% of all suicides.

Figure 4.2: Number of suicides by gender and age in 2015 in NI (NISRA, 2016)



4.2.3. Suicide by geographical area in Northern Ireland

Examination of the rates of suicide in 2015 across Northern Ireland also shows variability according to the demographic region. Across the seven district councils in Northern Ireland, suicides within the Belfast region accounted for 31% of all suicides, equating to 88 of the 318 recorded suicide deaths in 2015 (Figure 4.3). Closer examination of the parliamentary constituencies in Northern Ireland for 2015 indicates that 69% of these suicides occurred in North and West Belfast, reflecting some of the most economically deprived areas within Northern Ireland (Figure 4.4) (NISRA, 2016).

Figure 4. 3: Percentage suicide rates in Northern Ireland by district council (2015)

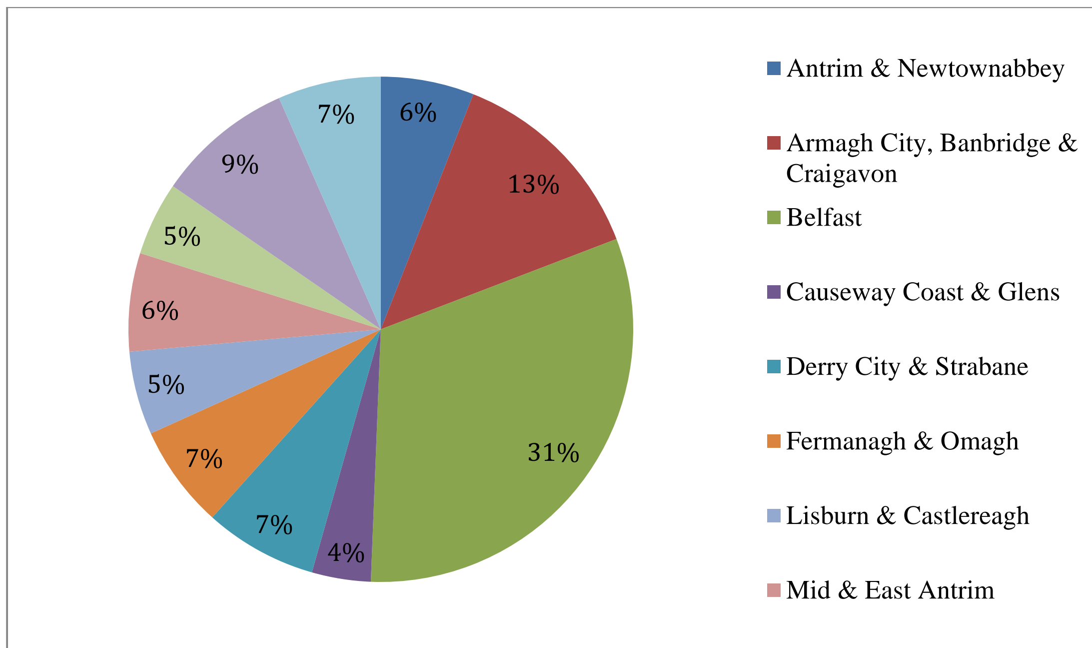
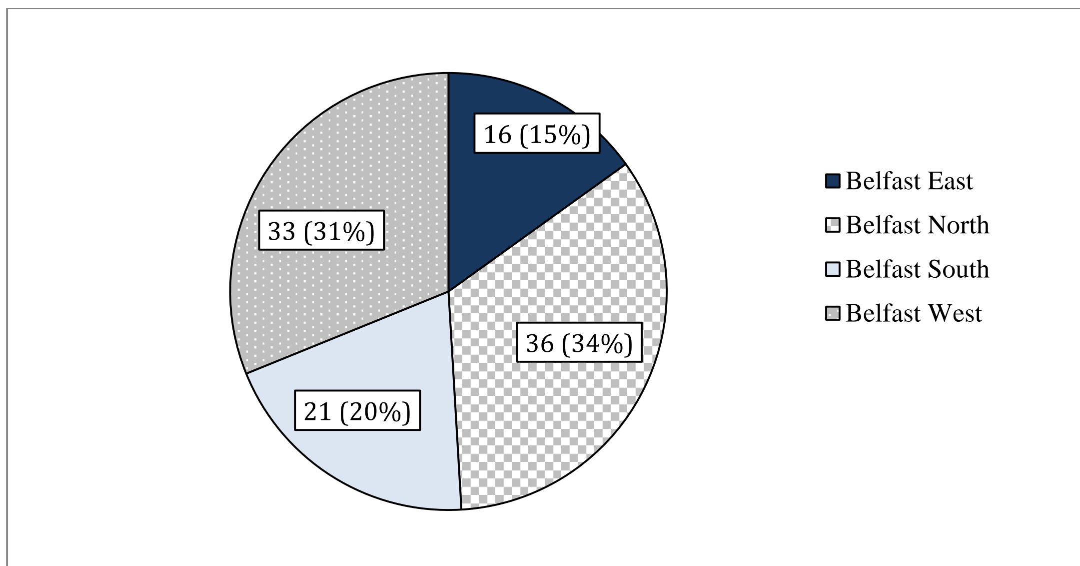


Figure 4.4: Number of deaths by suicide across parliamentary constituencies in Belfast (2015)



4.2.4 Comparisons with UK rates of suicide

In order to grasp the severity of the high rates of suicide in Northern Ireland, it is necessary to make comparisons with those across the UK. In 2015, the UK rate of suicide rose to 10.9 deaths per 100,000 deaths. This appears considerably lower than that of Northern Ireland in 2015, which was the highest in the UK at 19.3 deaths per 100,000. This also ranks higher than suicide rates in Scotland and Wales for 2015, which were 13.9 and 13.0 deaths per 100,000 respectively. Importantly within Northern Ireland, the rate of suicide for males was approximately 1.5-2 times higher than in any other country in the UK. From 2014 to 2015, the

suicide rate within Northern Ireland increased compared to the second year-on-year decrease observed in England. In relation to females, Northern Ireland also had the highest rate of female suicides in 2015 at 8.8 deaths per 100,000 population in comparison to 7.9 for Scotland, 5.0 for England and 5.5 for Wales per 100,000 population (ONS, 2016). One commonality noted within the data relating to 2005–2011 was that the most common method of suicide within Northern Ireland was hanging followed by overdose, similar to the patterns observed across the UK for this time period (ONS, 2013).

This chapter will now critically examine the literature pertaining to the high rates of suicide amongst populations of young people today and how these patterns can be linked to the 'transgenerational transmission of trauma' – i.e. the transmission of traumatic events and loss across generations.

4.3. Transgenerational Models of Trauma in Relation to Suicide

This section aims to contribute to the understanding of the impact of the Troubles on suicide rates amongst today's youth. As highlighted above, those at the highest risk of suicide are individuals who grew up in the midst of the conflict, reflecting not only the older age groups but also those now aged 25-29 years, who are potentially representative of the children and grandchildren of those who grew up during the worst of the Troubles. Research on the Troubles has demonstrated that there are various after-effects of the trauma including biological, sociological and psychological effects whereby coping patterns and maladaptive adjustments are inherited by future generations (Lev-Weisel, 2007). Firstly, a prominent sociological perspective pertaining to deaths by suicide will be considered, before an in-depth examination of a Biopsychosocial Model of the transgenerational transmission of trauma.

4.3.1. A sociological perspective of suicide related to the Northern Ireland conflict

In an attempt to explain the dramatic increase in the rates of suicide in Northern Ireland following the signing of the Good Friday Agreement in 1998, it is first necessary to highlight the sustained levels of sectarianism and hate crime that have continued, adding to the notion that the peace process has in fact lead to lower levels of social cohesion between both communities. One theory in the field of suicide discusses the high levels of social connectedness and cohesion amongst communities during periods of war as a protective factor against suicide, as people unite to defend their collective interests (Durkheim, 2002). This theory postulates that following periods of war, levels of social connectedness are broken and as such this protective factor dissipates. Durkheim (2002) argued that wars in fact cause a stronger integration of society as well as allowing for externalised violence to be deemed acceptable, whereas following conflict, levels of suicide increase as the protective effects of war subside and violence becomes internalised (Durkheim, 2002, p. 166). Following the peace process in Northern Ireland, this theory would postulate that higher rates of suicide amongst today's young people may be a result of them experiencing lower levels of social integration, leading them to internalise the violence, resulting in higher rates of mental health and suicide.

Despite this theory providing a potentially valid explanation as to why suicide rates remain high amongst today's younger populations, this theory cannot account for the fact that those who are most at risk of suicide today are also those who grew up in the midst of the conflict even though suicide rates should have been low in this group due to the proposed high levels

of social cohesion. Subsequently, Tomlinson (2012) conducted a case study of suicide trends by age, gender and cause of death over a forty-year period and found that the recent rises in suicide involve a range of social and psychological factors, a notion that was discounted by Durkheim whose sole focus remained on social factors and the negative impact of the dramatic change in the social context within Northern Ireland from 1990 onwards (Tomlinson, 2012). The latter perspective is in agreement with that taken by the authors of this report, who attempt to explain the impact of the legacy of the conflict on today's youth using a transgenerational model incorporating a range of biological, psychological and sociological risk factors.

4.3.2. A biopsychosocial perspective of suicide related to the Northern Ireland conflict

Earlier chapters and the literature cited above have sought to acknowledge various schools of thought in relation to the transgenerational impact of trauma; however, when considering the multidimensional and complex nature of suicide, this chapter will adopt a biopsychosocial model which allows for the interplay between a range of biological, psychological and sociological factors to be considered. Rather than postulating that one model can account for the patterns observed today, this model considers the multidimensional impact of the Troubles to include:

- Biological explanations focus on epigenetic risks, postulating that the negative consequences faced by today's young people stem from the transmission of stress-adapting genes from their parents who in turn have experienced potential exposure to conflict and ongoing violence causing mental health difficulties. Such explanations are based on 'the assumption that there may be a genetic predisposition to the etiology of a person's illness' whereby some mental illnesses have a clear hereditary etiology resulting in a biological vulnerability to the child (Kellerman, 2001, p. 12). Yehuda et al. (2000) examined cortisol levels in the offspring of Holocaust survivors and found that low cortisol levels were significantly associated with post-traumatic stress disorder (PTSD)[22] in parents and lifetime PTSD in offspring. Results indicated that low cortisol levels in adults with PTSD may constitute a genetic vulnerability marker related to parental PTSD and symptoms within their offspring (Yehuda et al., 2000). Furthermore, recent family and twin studies have indicated that more than 30% of the variance associated with PTSD is related to a heritable component (Skelton, Ressler, Norrholm, Jovanovic, & Bradley-Davino, 2012). Biological risk factors in relation to suicide amongst today's young people as a result of the conflict will be explored further in the next section, which examines a range of biopsychosocial risk factors.
- Psychological explanations focus on the poor psychological functioning of children of parents who grew up in the conflict as a direct result of their parents' experiences. It is estimated that over 40% of children growing up in Northern Ireland are living with parents who experienced high to moderate levels of conflict (Tomlinson, 2012). Parental trauma exposure is a known cause of maladaptive family functioning, which is directly linked to the evidence stating that childhood adversities can increase vulnerability to stress and the inability to cope with future stressors, thus impacting the

[22] Post-Traumatic Stress Disorder (PTSD) is described as '[a]n anxiety disorder that follows from the experiencing of a traumatic or highly stressful event characterised by intrusive and distressing memories of the event, jumpiness, numbness, and attempts to avoid anything associated with memories of the event' (O'Neill et al., 2015, p. 25).

psychological outcomes of offspring and increasing the risk of suicide (McKenna, 2015).

- Sociological explanations linked to the transgenerational impact of trauma following conflict specifically relate to societal impacts such as economic deprivation caused by conflict and the negative impact that this has on young people. Within Northern Ireland, it is claimed that a disproportionate number of people who were exposed to violence also experience economic deprivation, whilst political and social divisions continue to impact upon social integration and attitudes. Children growing up under these conditions are known to be more at risk of suicide, represented in the statistics demonstrating that areas of the highest levels of economic deprivation are those with the highest rates of suicide amongst young people (O'Neill et al., 2015).

It is important to note that whilst the integrative transgenerational model provides various single types of explanations, it is the complex interplay between biological, psychological and social factors that is responsible for some of the poor mental health outcomes and elevated levels of suicide within Northern Ireland. Evidence from the Northern Ireland Study of Health and Stress (NISHS),[23] relating to the database of deaths by suicide in Northern Ireland, concluded that the impact of the Troubles may be linked to suicide through a range of complex pathways which lead to an increased risk of suicide in some individuals (O'Neill et al., 2015). The upcoming section will examine some of the post-conflict transgenerational risk factors in an attempt to account for the high rates of suicide in today's younger populations.

4.4. Bio-Psycho-Social Risk Factors of Suicide in Relation to The Troubles

Potential risk factors will be examined closely in relation to their link with suicide rates among Northern Ireland younger generations, whilst reference to suicide in the older generations will also be acknowledged in order to allow for transgenerational explanations.

4.4.1. Exposure to trauma and conflict: Transgenerational pathways

The first risk factor to be explored is that of parental exposure to the conflict. High proportions of the population in Northern Ireland have been exposed to conflict-related trauma, which in turn can be linked to suicide via two main pathways. First of all, the experience of trauma or violence may contribute to an acquired capability for suicide and secondly, the experience of trauma related to the conflict may be associated with the development of one or more mental health disorders that can subsequently be linked to suicide (Bunting et al., 2013; Klonsky & May, 2014).

4.4.1.1. Parental exposure to conflict and increased risk of suicidal ideation

Exposure to the conflict in Northern Ireland is now known to be a significant risk factor amongst older populations, whereby those who grew up in the heart of the conflict continue to remain at high risk of suicide (O'Neill et al., 2014b). It is therefore important to explore how direct

[23] The NISHS was the largest epidemiological study of mental health in NI. It aimed to gauge the state of emotional and physical health within family units in NI. The study was conducted by the University of Ulster with support from the Research & Development Office. It was one of nearly 30 national and international World Mental Health Survey Initiative studies, all using the same methodology and research instruments, being undertaken under the auspices of the World Health Organisation (O'Neill et al., 2015).

exposure to the traumatic events of the conflict may be indirectly impacting the risk of suicide for the younger generations. Exposure to trauma-related conflict is estimated to impact approximately 39% of the Northern Ireland population (Bunting et al., 2013). This exposure is directly linked to death by suicide in Northern Ireland, since exposure to conflict-related trauma has been shown to lead to an increased risk of suicide ideation and plans but not attempts. Consequently, this evidence suggests that such exposure leads to an increased likelihood of death and first suicide attempt for this population (O'Neill et al., 2014b). With 40% of children in Northern Ireland estimated to be growing up in a household with a parent who experienced the trauma, these children may also face an increased risk of suicide as a result of the indirect consequences of exposure to the trauma having grown up in a family system whereby a parent, aunt, uncle or grandparent may have either committed suicide and/or shown increased suicidal ideations. This may subsequently impact the upbringing of the younger generations and their emotional wellbeing as they may face higher levels of maladaptive parenting practices or poor upbringings. Such unfortunate experiences and/or poor mental health following the suicide of a relative may consequently increase the child's risk of developing suicidal behaviours (O'Neill et al., 2015).

4.4.1.2. Exposure to conflict and the development of mental health disorders

In line with the second potential pathway that direct exposure to conflict leads to the development of mental health disorders and subsequent death by suicide, analysis of the coroner's data on suicide within Northern Ireland, taken from the NISHS, indicates that approximately 58% of recorded deaths by suicide occurred among people who had a mental health disorder. Some of the highest rates of mental health disorders in the world are recorded within Northern Ireland, with 8.8% of the population known to suffer from PTSD, of which 27% of cases were estimated to be attributed to conflict (Ferry et al., 2013). Having a parent with a mental health disorder, specifically PTSD, as a result of their exposure to the conflict also places younger generations at risk of developing a mental health disorder. This can be linked to a combination of biological pathways and childhood adversities including general maladaptive parenting styles. Again, it is estimated that 40% of children growing up in Northern Ireland today are living with parents who have experienced moderate to high levels of conflict, whilst 61% of individuals aged 16-34 showed signs of a mental health disorder in 2014/2015 (Bell & Scarlett, 2015; Tomlinson, 2012). Hence, even in the absence of direct exposure to conflict, some of the high suicide rates amongst today's youth may be attributable to the direct exposure experienced by caregivers and the subsequent mental health difficulties faced by those individuals and their children (O'Neill et al., 2015).

4.4.2. Economic deprivation, substance misuse and lack of opportunities

A further risk factor relating to high suicide rates within Northern Ireland is that of economic deprivation which again can lead to high rates of suicide via multiple pathways. Poverty and deprivation following the conflict of Northern Ireland was widespread but remained particularly pertinent in areas within Belfast and Derry/Londonderry which were described as areas 'within the heart of the Troubles'. McLafferty et al. (2016) conducted a study examining the link between childhood adversities and psychological wellbeing in Northern Ireland. The results of this study indicated that economic adversity (as well as parental death) was one of the highest risk factors for heightened risk of anxiety and substance abuse. In turn, the *Towards a Better Future* research, which examined the transgenerational legacy of the Troubles using data from the NISHS, showed that there were high rates of medication and substance use amongst those who had died by suicide between 2005-2011. Such usage is claimed to be associated

with the presence of mental health disorders whereby 51.7% had been prescribed medication and 41% of cases were associated with alcohol use (O'Neill et al., 2015). Growing up in an economically deprived area with direct or indirect exposure to trauma may lead to a higher risk of substance misuse and risk of developing mental health disorders, both of which are known risk factors for suicide. Therefore, the interplay between economic deprivation as a result of the conflict and the subsequent presence of mental health disorders and substance misuse offers a potential yet complex pathway between the conflict and suicide rates today.

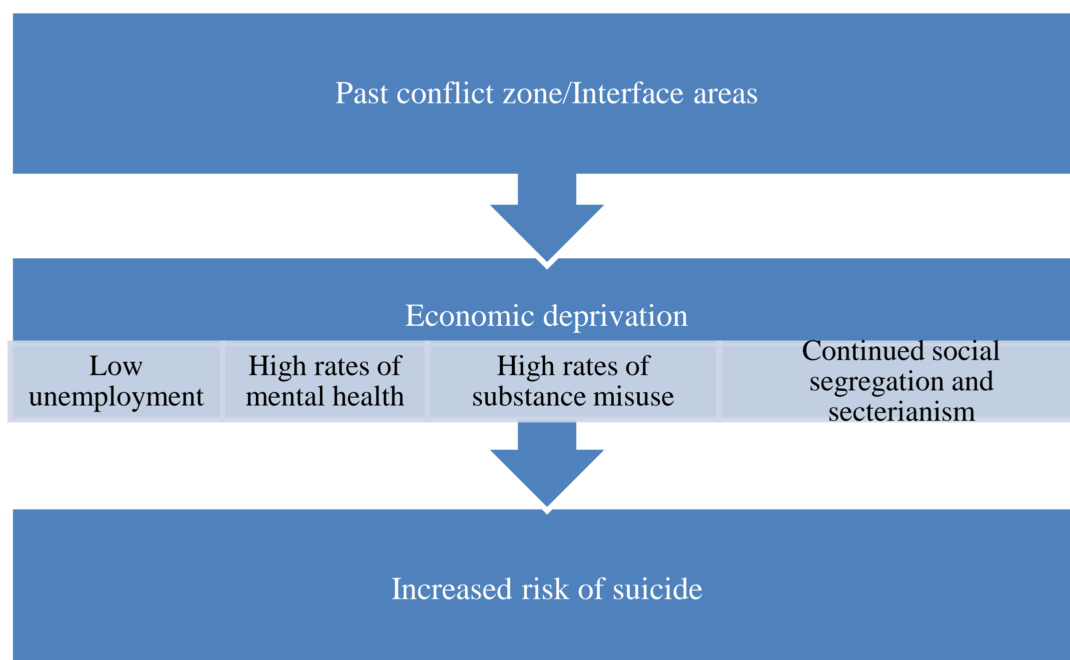
An alternative pathway relating to that of economic deprivation is the detrimental impact of economically deprived areas on opportunities for employment amongst today's generation. This in turn is likely to impact self-esteem, resilience and stress levels. The NISHS data also indicated that this is particularly relevant for male cases of suicide, where at least half of those who died by suicide were known to be unemployed. Given the above possible pathways (Figure 4.5), it is reasonable to conclude that economic adversity is a pertinent legacy of the conflict which is likely continuing to impact on suicide rates amongst today's younger generations (O'Neill et al., 2015).

4.4.3. Ongoing sectarianism, social isolation and political divisions

Linked with economic deprivation, young people growing up in certain interface areas within Northern Ireland face continued social segregation based on religious grounds; for many these areas constitute divided societies. Within these often economically deprived areas, levels of social isolation have reportedly increased since the ceasefire, leading to decreased levels of social integration and increased loss of purpose for today's young generations (Mc Lafferty, 2015). Reports from young men have indicated that in post-conflict areas many feel isolated and this subsequently impacts on their sense of identity. One specific report which aimed to give insight into the lives of 18 young people from Northern Ireland between 1990 and 2010 found that for those young people growing up in working-class, segregated areas, early experiences of sectarianism and segregated community life influenced their future transitions, education and employment pathways, as they felt less able to explore "outside" areas and opportunities for work and personal development (McGrellis, 2011). Coupled with other indirect factors, such as a lack of resources and opportunities, and stigma around seeking help for mental health difficulties, the risk of suicide increases (Figure 4.5).

Exposure to sectarian violence also continues to permeate the lives of young people within these societies. Exposure to violent traumatic events is also known to negatively impact the mental health of young children. For example, Kennedy (2014) conducted a report into paramilitary child abuse within Northern Ireland and found that between 1990 and 2013, 344 children below the age of 17 were subject to paramilitary beatings whilst a further 167 were shot by paramilitary groups (Kennedy, 2014). Exposure to sectarian violence and traumatic events has been linked to poor psychological adjustment in children, including conduct issues and reduced ability to develop effective coping strategies, which all negatively impact mental health (O'Neill et al., 2014b). Given that mental health poses a significant risk factor for suicide, the above statistics are concerning and provide a potential pathway linking ongoing political violence to the high suicide rates noted today.

Figure 4.5: Pathway representing the transgenerational impact of economic deprivation and social segregation on suicide rates



4.5. The Role of Gender

As previously illustrated in Figure 4.2, 77% (245) of all recorded suicides in 2014/2015 were male, with the highest rate observed amongst men aged between 25 and 29 years (n=38; 12%). In total, 132 suicides registered in 2015 were males aged between 15 and 34 years. Within Northern Ireland, males in these younger age groups remain at the highest risk of death by suicide, the most common cause of death of young males in Northern Ireland (DHSSPS, 2006; NISRA, 2016). In the context of the conflict, one plausible explanation of the high rates of suicide amongst today's young males relates to a complex phenomenon, which specifically relates to being young, male and growing up in a society that continues to undergo a transition from conflict to peace. It has been suggested that today's young males may not be equipped with the skills to manage this change, since previous generations grew up in a society where the male gender role granted a sense of significance in society as protectors and/or defenders of their local communities. Now, in a "conflict-free" society, it is no longer socially acceptable to show such aggressive behaviours and instead both communities and the media have condemned these types of behaviours. As such, this has been postulated to impact the sense of "self" in young men causing 'masculine contradictions' whereby, although it may be socially unacceptable to display openly violent acts, young men may, through the legacy of the conflict, believe that it is through macho behaviour and engaging in risk-taking behaviours that they can gain status; however, they do not have the resources to do so and subsequently experience a sense of powerlessness (Connell, 1995). As a result, young men may internalise their difficulties and experience mental health challenges. They are also less likely than females to seek support as they fear being stigmatised by public perceptions of what it means to be a male and the belief that part of their identity requires them to dismiss their emotional pain, resulting in them growing up in such a way that forces them to keep their emotions private

(Harland, 2008). Consequently, despite the fact that females in general are more likely to suffer from a mental health disorder, males continue to account for higher rates of suicide that can be explained via a range of complex pathways, some of which may relate to the gender roles developed in part by the past conflict in Northern Ireland.

There are also clear gender differences in relation to health service use prior to death by suicide, with evidence showing that males exhibit reduced levels of contact. Additionally, men are more likely than women to seek support for general, non-mental health-related issues, resulting in males being less likely to receive services beyond primary care (O'Neill, Corry, Murphy, Brady & Bunting, 2014a). In addition to having a mental health disorder, individuals known to have general medical disorders are also at an increased risk of self-harm and suicide. One possible explanation is that for a proportion of these cases, male presentation to GPs may be a result of a primary physical health condition as a direct result of injury or illness associated with conflict-related events. Moreover, these physical symptoms may in fact reflect the somatic symptoms of an undiagnosed affective disorder such as depression. It is also known that within the Northern Ireland context, one in five men meet the criteria for a substance disorder, yet substance disorders are characterised as an externalising disorder, which may discount the recognition or diagnosis of a mental health difficulty. This may also impact the younger male generations growing up in Northern Ireland where male mental health is not as well recognised and/or discussed within families due to misconceptions, and/or men presenting to health services with more physical symptoms which are actually related to mental health difficulties. Subsequently, without open discussions around mental health, young men may struggle further to recognise their own mental health needs and subsequently be at a higher risk of substance misuse, all of which are related to increased risk of suicide (Boyd et al., 2015; O'Neill et al., 2014a). Additionally, McNally (2014) highlighted that within Northern Ireland specifically, a culture of silence surrounding the trauma related to the conflict acts an active transmitter of trauma and so parents who have been exposed to the conflict may not recognise their own mental health difficulties and choose not to discuss this with their children, each of which adds to the increased risk of transferring trauma onto younger generations who do not seek support (McNally, 2014).

4.6. Self-Harm and Suicide

One final potential risk factor to be explored is that of self-harm. As death by suicide and suicidal ideation are known to have strong links with self-harm,[24] it is important to consider whether self-harm has any links with the high rates of suicide in Northern Ireland in relation to the past conflict (Hawton, Saunders & O'Connor, 2012; Owens, Harrocks & House, 2002). Joiner (2005) states that self-harm may be categorised as 'prior suicidal behaviour' even in the absence of suicidal intent and thus self-harm may be in turn linked to increased risk of death by suicide as self-harm can increase an individual's pain threshold and exposure to pain contributes to an acquired capability for suicide (Joiner, 2005; O'Neill et al., 2015). Within the 2014 Northern Ireland registry of self-harm admission to emergency departments, 43% of

[24] NICE (2013) defines self-harm as 'any act of self-poisoning or self-injury carried out by a person, irrespective of their motivation. This commonly involves self-poisoning with medication or self-injury by cutting. Self-harm is not used to refer to harm arising from overeating, body piercing, body tattooing, excessive consumption of alcohol or recreational drugs, starvation arising from anorexia nervosa or accidental harm to oneself'.

admissions were amongst individuals aged 15-29 years, with the majority of attendances resulting from drug overdoses followed by cutting (PHA, 2014). The associations between substance misuse and the Northern Ireland conflict have been noted above; given that the majority of individuals with self-harm hospital admissions were also shown to be substance abusers, it is plausible that self-harm may be higher in individuals who have indirect experiences of the conflict and who become substance abusers as a result of the pathways discussed earlier. To date, there appears to be limited evidence on the relationship between rates of self-harm in today's younger generations and exposure to the Northern Ireland conflict; however, one study conducted by O'Connor, Rasmussen, and Hawton (2014) explored this relationship to determine the prevalence of self-harm in Northern Ireland adolescents and the factors associated with it, including exposure to the conflict. Results of this study, which involved 3,596 secondary school pupils, indicated that exposure to conflict was associated with self-harm in combination with other established risk factors (gender, bullying, family factors, mental health). Data indicated that those who had experienced the conflict had higher rates of self-harm (O'Connor et al., 2014). Despite these findings, the authors of this study comment that there is a need for further research into the legacy of the conflict and rates of self-harm whilst acknowledging that they did not directly explore the impact of recent exposure to violence or intimidation on self-harm, which may or may not be related to the legacy of the conflict. In the context of this report, it is hypothesised that current rates of self-harm may be linked to the conflict via a number of indirect pathways including a range of social and economic risk factors which have been discussed and each of which has potential links to the conflict. For example, an increased risk of self-harm and suicide can result from the lack of opportunities as a result of ongoing economic deprivation or family relations as a result of poor mental health in parents who have past exposure to the conflict. As mentioned, further research is required to examine such pathways.

For the purpose of this research, the above risk factors attempt to specifically relate and identify the high rates of suicide amongst today's youth in Northern Ireland in relation to Northern Ireland conflict factors; however, it is worth noting that these risk factors cannot account for all of the possible individual differences in relation to suicide. Many alternative non-conflict-related explanations may also be plausible and must not be discounted when considering why suicide rates remain high within Northern Ireland.

4.7. Discussion

4.7.1. Overview of findings

This chapter explores the range of potential pathways between the legacy of the Troubles and the high rates of suicide in Northern Ireland. A range of biopsychosocial risk factors associated with suicide are identified and related either directly or indirectly to the conflict. Social and economic factors include the reduced sense of social integration within some parts of Northern Ireland as a direct result of the peace process as well as ongoing exposure to political violence, sectarianism and conflict-related traumatic events. Further experience of adverse events including economic adversity and employment difficulties also adds to the potential risk of suicide. Psychological transgenerational risk factors include those that put the younger generations at risk as a result of being raised by parents who experienced the conflict and are at an increased risk of suffering from mental health disorders. Substance misuse is also shown to be a significant feature in almost half of the deaths by suicide reported in 2014 and may be

traced back to indirect exposure to conflict-related events. Finally, biological risk factors also influence today's younger generation's susceptibility to mental health disorders as a consequence of parental involvement or exposure to the conflict. Whilst this chapter aims to explore the direct and indirect pathways of the conflict to suicide amongst today's younger populations, it is generally accepted that the connections to suicide susceptibility result from the interplay of multiple risk factors, once again highlighting the importance of considering each risk factor in light of a multi-dimensional, complex transgenerational model.

4.7.2. Implications

The evidence linking current rates of suicide to the past conflict in Northern Ireland highlight the need for interventions that target multiple generations. Professionals must become aware of the need to consider any presenting difficulties in relation to a wider, multi-generational approach which focuses support on not only the generation which is presenting with the difficulty but also the relationship between multiple generations and the interacting effects. For example, given that it is known that children of mothers who present with PTSD are at increased risk of mental health difficulties, wider systemic approaches should be applied in order to treat not only the "presenting victim" but also those impacted indirectly such as their children. Furthermore, it is known that high rates of mental health disorders were recorded by the NISHS for those who died by suicide. It is therefore important when working with young people, who may or may not have or be at risk of mental health disorders, to take a full developmental history in order to identify any potential risk factors in relation to the conflict and subsequent trauma. It is through clear identification and knowledge that interventions can be individualised and take into consideration any indirect effects. At a community level, it may be important to target the mental health of those children growing up in economically deprived areas. Furthermore, given that a significant proportion of children are growing up in households with parents who had direct experience of the conflict, coupled with the evidence showing the transgenerational impact on younger generations, future interventions should specifically target children and families who are known to have past involvement in the conflict. Working with and investing in parents in high-risk areas to educate and support them with resources may also help to reduce transgenerational stress. Screening of the younger generations for mental health disorders and suicidal ideation may also be useful to specifically identify those at high risk of suicide. Targeting young men who are known to be at increased risk may also prove beneficial in equipping them with higher levels of resilience or general life skills and supporting them in their awareness and recognition of mental health difficulties to reduce the stigma that they appear to face.

When planning interventions to target those "at risk" of suicide, it is imperative that professionals aim to identify and address the transgenerational impact of the conflict in order to identify the multiple generations who may be at risk and the means by which future generations can continue to be impacted (O'Neill et al., 2015). The current chapter highlights that those at risk of suicide face multiple stressors, some of which can be linked back to the Troubles. It is through improved understanding that future interventions can take into account the relationships between these risk factors to reduce the impacts on children and future generations.

4.7.3. Addressing suicide within Northern Ireland

Within Northern Ireland, there are a number of strategies in place to attempt to reduce the impact of the legacy of the Troubles on the psychological and emotional wellbeing of the population. To avoid overlap with the previous chapter, one strategy whose sole focus relates

to suicide will be discussed. In 2006, *Protect Life – A Shared Vision: The Northern Ireland Suicide Prevention Strategy and Action Plan 2006-2013* (Protect Life Strategy) was developed in response to the strong representations made by families bereaved by suicide, especially in socially-deprived areas. This action plan contained over 60 actions, including community-led suicide prevention and bereavement support services, local research into suicide, GP Depression Awareness, Lifeline 24/7 Crisis Referral Helpline, establishment of the Deliberate Self-Harm Registry and the development of local suicide cluster emergency response plans. In 2012, this action plan was evaluated and it was found that despite having links with other strategies in place, there remained a need for a separate strategy for suicide prevention within Northern Ireland. Additionally, whilst families valued the support that they had received, others highlighted barriers to accessing support, including long waiting lists, lack of understanding on the part of service providers and travel issues. The report also concluded that the issue of suicide had not diminished and highlighted a need for both crisis response and preventative intervention (DHSSPS, 2012). In response to the evaluation, consultation on an updated policy, *Protect Life 2*, was conducted in 2016 and it is believed that the new strategy will involve widening of the scope of the scheme. This updated policy will provide direction on emotional wellbeing in order to build resilience and provide positive protective factors as well as a focus on tackling repeat self-harm. The *Protect Life 2* policy currently remains in draft format; however, the main aims of the draft strategy are as follows:

- Gain a better understanding of suicidal behaviour in Northern Ireland
- Improve the identification of and response to suicidal behaviour
- Support recovery from suicidal behaviour and repeat self-harming
- Support those bereaved by suicide.

Whilst suicide prevention remains one of the key focuses for government in Northern Ireland, further implications from the findings of this chapter highlight the need for long-term suicide prevention initiatives that place a focus on early intervention in order to develop emotional wellbeing and resilience among both young people and families at the individual and community level, particularly for those who have experienced the Troubles.

4.8. Final Remark

This chapter highlights that the Troubles in Northern Ireland can be linked to suicide rates of today's youth through a number of pathways. Examining such pathways is both complex and challenging due to the need to consider such associations using a systemic approach that allows for the transgenerational impact of the conflict to be considered in light of various interconnected risk factors. This report recommends the continued use of integrated and systemic approaches when conducting future research and the planning of future interventions with a key focus on promoting emotional wellbeing in the early years. One potential mode of delivery of such interventions is that of schools. The education system of Northern Ireland will now be considered in relation to its ongoing role in reducing the transgenerational impacts of the Troubles along with an examination of what schools are and can be doing to reduce any potential negative impacts of the past conflict on today's children of Northern Ireland.

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5

The Role of Education in Conflict and Reconciliation in Northern Ireland

Mark Given

5.1. Introduction

Education is a basic human right and therefore integral to the development of children and society alike. However, the importance of education within areas of conflict may have even greater relevance, moving beyond academia to include the responsibility of sheltering children from harm, providing security and socialisation, developing skills and fostering values and attitudes (Smith, 2010). This implies that education has the potential either to play a negative role in fuelling conflict by exacerbating grievances or to have a positive influence through schemes to encourage reconciliation.

The current chapter aims to consider the role of education in relation to the conflict in Northern Ireland, more commonly known as “the Troubles”, taking into consideration the transgenerational impact education may have. In order to do this, the responsibilities of education will be addressed both during the Troubles and post conflict with a focus on the current and future role of education in the process of reconciliation. Given that education is a fundamental part of society, its influence in the past and present is considered, along with how education can assist successive generations in understanding the historical context for difference in the community and help establish long-term peace.

5.2. Conflict and Education in Northern Ireland

> *Education is a fundamental right that should be maintained at all times, even in the most difficult circumstances. This is not simply an ideological statement. Where education is maintained in the midst of conflict it may provide an important mechanism for the protection of children against abuse* (Smith & Vaux, 2003).

It is difficult to perceive conflict in any society in a positive light as, invariably, the negative outcomes of violence will manifest in the disruption of basic human needs and provisions for many. The impact on services can be wide-reaching, from healthcare to housing, policing to

sanitation. However, interruption to educational provision in conflict-affected areas may have the most considerable impact given the number of vulnerable children and young people affected (Bush & Saltarelli, 2000). During the Troubles in Northern Ireland, education was not immune from the effects of conflict, despite condemnation from political leaders and the majority of the population. Perhaps the most notable disturbances related to schools took place post-conflict in 2001 when children and parents at Holy Cross, an all-girls Catholic primary school, were physically and verbally abused by loyalist protesters aggrieved that the school was situated on a predominately Protestant area. Images of protesters throwing bricks, fireworks and urine-filled balloons at girls aged between 4 and 11 years made global news and was perceived, by some, as child abuse (Campbell, Guardian, 2003). While events at Holy Cross Primary School have remained memorable, it may be argued that the reason this incident gained notoriety was due to the fact that the Troubles were over and attitudes towards peace throughout Northern Ireland lay in contradiction to the actions of the few at the school gates. Kilpatrick and Leitch (2004) highlight the ways in which schools were affected during the period of conflict, specifically through attacks on school buildings and staff. Most serious of these incidents was the shooting of a school principal on his way to school, an attack from which he never fully recovered and after which he could not return to his post (Kilpatrick & Leitch, 2004). Other examples of the impact on school property during the conflict include arson attacks, vandalism and the destruction of school equipment; however, within the greater context of violence, these acts often received little attention.

The impact of conflict on education during the Troubles, therefore, may be described in terms of its longitudinal effect rather than isolated incidents, such as the blockade at Holy Cross. Smith (2010) highlights that it is important to consider education and its role both during and after the conflict. For instance, education in a time of conflict may have the responsibility to play a protective role by offering consistency and routine to children. Immediately post-conflict, education has a role to play in social transformation by helping children and young people to understand the new dynamics involved in reform. Additionally, in order to help maintain long-term peace, education has a preventative role, for example, by considering changes to the structure of education itself to develop understanding between groups. Therefore, the influence of education on the Troubles reaches beyond specific conflict-related events to include successive generations of children and young people by shaping their understanding of the violent past experienced by their parents and grandparents, and therefore may impact the views and attitudes of children in a transgenerational manner (Cole, 2007).

Despite the potential capacity of education to shape Northern Irish society positively, Davies (2010) warns that education systems may unwittingly contribute to continued conflict through their curriculum, religious belief and at times their political alignment, even though these aspects of education also contribute to peace. This suggests that the role of education, while well-meaning, can often be very complex. As the next chapter indicates, the vital importance of classroom-based interventions to peace building cannot be underestimated. However, examining the education system in Northern Ireland and the structures within it may provide a more holistic perspective by considering the role of education at a macro level and consolidating the positive impact of classroom-based interventions towards reconciliation. For example, Gallagher (2016) indicates that governance of the education system in Northern Ireland is crucial to facilitating equity, inclusion and social cohesion. However, the nature of the devolved power-sharing government in Northern Ireland means that educational polices are vulnerable to change with the views of opposing parties, potentially leading to inconsistencies. Similarly, the structure of the school system in Northern Ireland raises issues

with regards to the identity of pupils in different "types" of schools based on religious background and how this may foster the segregation of groups and in turn promote inequalities and, consequently, conflict.

5.3. Structure of Education in Northern Ireland

In Northern Ireland, the most notable feature of the education system is segregation along religious lines with the structure of schooling here differing from other parts of the UK. Enrolment statistics indicate that over 90% of children in Northern Ireland attend either a predominantly Protestant or Catholic school for both primary and post-primary education (Department of Education, 2017). Therefore, it is pertinent to understand the 'types' of school in operation in Northern Ireland. Controlled Schools (de facto Protestant) are under the authority of the Education Authority of Northern Ireland, which is also the employer of teaching and non-teaching staff. These schools are managed by their Board of Governors and recurrent costs are met by school budgets. Voluntary Maintained Schools are managed by a Board of Governors (mostly Catholic) and the Catholic Church. The employing authority here is the statutory body, the Council for Catholic Maintained Schools (CCMS). Voluntary Non-Maintained Schools are mainly grammar schools managed by a Board of Governors which is constituted in line with the school's management scheme and includes representatives of the Education Authority and Department of Education. Integrated Schools include pupils from both Protestant and Catholic communities and are managed by a Board of Governors which also holds the responsibility of an employing authority. These schools are supported by the Northern Ireland Council for Integrated Education (NICIE) and are funded directly by the Department of Education. Irish Medium Schools are owned and managed by a Board of Governors, supported by Comhairle na Gaelscolaiochta (CnaG) and generally funded by the Department of Education. It is also important to note that, while the formal 11-Plus test was scrapped in Northern Ireland in 2008 (BBC News, 2008), there remains a strong tradition of selective grammar education, with these schools setting entrance exams which are attended by over 14,000 primary school pupils each year prior to transition to post-primary (Department of Education, 2017). Even in this assessment there is a divide as a result of the controlled and maintained sectors failing to agree on a single exam, effectively resulting in what are commonly known as Protestant and Catholic tests (Borooah & Knox, 2013).

Previous research in Northern Ireland has suggested that segregation by denomination in schools can perpetuate negative attitudes between groups and, therefore, potentially breed conflict (Abbott, Dunn & Morgan, 1998). This may be particularly apparent from the fact that children wearing a school uniform can easily be identified as either Protestant or Catholic and can often feel threatened that this can make them a target for sectarian abuse (Magill, Smith & Hamber, 2009). More recent studies, however, indicate that segregation may not be the cause of intergroup conflict; however, it is likely to be a factor in maintaining conflict between the two communities (Gallagher, 2016). Nonetheless, disagreement remains regarding the educational separateness in Northern Ireland and whether this is the cause or the consequence of wider sectarian conflict (Hughes, 2011). However, with such a stark divide between educational settings for both Catholic and Protestant children it is difficult to conceive how schools can remain entirely neutral in their understanding of past violence and its association with religious beliefs. It has also been argued that separate schooling in Northern

Ireland is merely a reflection of the political, social and cultural divisions in society (Smith, 2010), suggesting that education is neither a cause nor a consequence of conflict but rather a symptom of division.

Regardless of whether or not the structure of education in Northern Ireland is a cause, consequence or symptom of political violence, the nature of the system is inextricably linked to the concept of identity. On the whole, identity in Northern Ireland is generally split by religion and political beliefs into two main strands: Protestant/Unionist/Loyalist communities identifying as British and Catholic/Nationalist/Republican communities identifying as Irish (Hughes & Donnelly, 2003). With recent electoral poll statistics suggesting that only 4% of voters will cross the religious divide to vote for parties of generally opposing faith (Electoral Office for Northern Ireland, 2016), it is clear that a tradition of voting for particular parties transcends generations in families and in communities. Given that the vast majority of children are educated in predominantly Catholic or Protestant settings and given the strong association between religion and political allegiance that exists in Northern Ireland, it is fair to assume that many school-age children will have little understanding of opposing political views (Hayes & McAllister, 2009). Additionally, separate schooling may serve to exaggerate and strengthen identity within groups by highlighting an awareness of difference in concrete terms at a young age, therefore creating an "us and them" perspective (Baylock & Hughes, 2013). This indicates that separate schooling may support the principal underpinnings of Social Identity Theory proposed by Tajfel and Turner (1979). Social Identity Theory posits that people gain a great sense of pride and self-esteem from the groups that they belong to, and that people within one group (the in-group) will often discriminate people against those in another group (the out-group). A central hypothesis of Social Identity Theory is that members of an in-group will actively seek to find out negative aspects of the out-group, which can result in stereotyping and ultimately prejudice. It may be no surprise that previous research on separate schools in Northern Ireland suggests that problems associated with the school structure include long-term effects on social attitudes (Hughes, 2011). Therefore, while schools may not intend to foster division based on religion, they may have little power to facilitate change under the shadow of wider political stances in society, which have been long-held and transgenerational.

Physical settings in which children are educated are not the only divides between Catholic and Protestant pupils in Northern Ireland. While there have been some changes to the curriculum in each sector aimed at promoting understanding and respect on both sides of the community, for example by ensuring that all schools follow a programme of 'Education for Mutual Understanding' (EMU), the curriculum that children from each religion will generally experience also highlights marked differences in their overall education. Disparities between predominantly Protestant and Catholic schools include topics and perspectives in History, Religious Education, Citizenship, Languages and Physical Education (Richardson & Gallagher, 2011). Unsurprisingly, the variance in the curricula for these subjects is often related to cultural differences, identifications and traditions between both religions. With such strong traditional views held by each side of the community, the challenge for education rests in the design of a system that promotes equality through experience of opposing views to endorse long-term peace.

5.4. School-Based Responses to Conflict

How school-aged children responded to the Troubles varied greatly depending on the level at which they were directly affected, whether their wider family and community were affected and on individual differences (Magill, Smith & Hamber, 2009). Examples of violence and its impacts experienced by children and young people included sectarian attacks on their homes in the form of smashed windows, petrol bombs and death threats; family members injured or killed as a result of conflict between and within terrorist groups; police violence towards members of the public; bombings and bomb threats displacing people from houses and public buildings; parents being arrested, leading to a sense of loss in children; and children of police and service men and women experiencing abuse, threats and regularly moving home. While these traumatic incidents had an effect on children, in general the day-to-day running of schools remained largely unchanged (Magill, Smith & Hamber, 2009). Nonetheless, while schools may not have experienced regular disruption to service, schools had and continue to have a responsibility for conflict-affected pupils within their care (Kilpatrick & Leitch, 2004). As a result, analysing how schools responded to conflict during and after the Troubles may provide insight into the importance of the role of education.

Many of the studies investigating the responses of schools to conflict and the impact of conflict on school-age children relied on qualitative data surrounding individual experiences of the Troubles (Kilpatrick & Leitch, 2004; Magill, Smith & Hamber, 2009). Themes from this research indicated that during the conflict schools were perceived by children as a safe haven which provided a "business as usual" approach to service delivery (Kilpatrick & Leitch, 2004). This suggests that violence was a backdrop to the daily school experience, with schools ignoring conflict by keeping it outside the school gates. However, in order to offer this provision, schools were often required to respond to the violence in the societies they served by erecting barriers and fencing to protect school property and considering carefully the safety of pupils and staff in school planning (Hayes & McAlister, 2009). While attacks on schools, personnel and pupils will have an immediate impact on teaching and learning, the long-term influence of these incidents will have detrimental effects on children and staff in the form of physical injuries, stress and other mental health issues, as discussed in greater detail in earlier chapters. Previous research has indicated that schools too often failed to address these difficulties experienced by children, with criticism suggesting that the lack of response from schools may have contributed to the significant numbers of individuals experiencing mental health issues later in life and even more critically to rates of suicide (McGlynn, Niens, Cairns & Hewstone, 2004).

Conversely, other studies indicate that this perceived unresponsiveness on the part of schools may in fact have provided a protective barrier between the security and stability of education and the unpredictable nature of violence in society (Smith, 2010). To this extent it may be reasoned that schools, and the education system overall, were not unaware of the political violence in society; rather, they made a concerted effort to distance themselves from the conflict and concentrated on shielding children by maintaining the status quo. It may also be asserted that schools faced a greater challenge by adopting this stance of continuing normal operation and enabled many children to focus on more positive aspirations through education.

Although historically some authors have perceived schools as lacking the drive to improve cohesion in communities by facilitating contact between Protestant and Catholic schools and

pupils (Dunn, Darby & Mullan, 1984), others have reported promising outcomes from a number of cross-community and inter-school initiatives (O'Connor, Hartop & McCully, 2002). Hayes and McAllister (2009) found that these cross-community interventions were most valuable in promoting mutual understanding when they were focused around the curriculum and were sustained themes of work rather than one-off extra-curricular activities. However, it is estimated that fewer than 5% of children have accessed these schemes, which suggests that barriers persist in the form of funding for these programmes and potentially reluctance to participate from schools (Borooah & Knox, 2015). Despite the fact that the majority of schools in Northern Ireland are denominational with analogous curricula, researchers maintain that schools have a greater capacity to promote reconciliation than they have previously employed or are currently employing (Gallagher, 2016); this can have a transgenerational impact on attitudes and understanding which remains deep-rooted (Hayes & McAllister, 2009).

5.5. Education and Reconciliation

Since the Good Friday Agreement in 1998 and the efforts that were made by political, community and even paramilitary leaders to make that contract possible, Northern Ireland overall has embraced peace and is committed to the peace process. However, society and key services within it have remained deeply divided (Borooah & Knox, 2015). Nonetheless, a number of educational interventions have attempted to ameliorate the potential negative effects of segregated schooling and its influence across generations. Such interventions have included projects of pedagogy (Malone, 1973), the teaching of Citizenship (Arlow, 2004) and History (Smith, 2005) and Early Years programmes (Connolly, Fitzpatrick, Gallagher & Harris, 2006) and were based on theoretical underpinnings. Potentially the most influential of these theories in the context of schooling in Northern Ireland is Contact Theory, originally proposed by Allport (1954). Contact Theory states that under appropriate circumstances, interpersonal and intergroup contact is an effective way of reducing prejudice between opposing groups by focusing on an appreciation of group differences. From a psychological perspective, it is hypothesised that Contact Theory facilitates learning between groups which can enable knowledge and understanding to reduce stereotyping and prejudice. Additionally, intergroup contact is believed to reduce feelings of fear and anxiety individuals may have regarding the "other" group (Stephan & Stephan, 1985).

Based on these assumptions, schools were encouraged to run contact programmes aimed at bringing Protestant and Catholic pupils together for joint projects. However, many of these interventions have been criticised as often the projects were not designed to address issues related to conflict or cultural differences, which were often ignored in an attempt to build relations based on similarities instead (Gallagher, 2016), suggesting that the design of these interventions lacked ambition to achieve change (O'Connor, Hartop & McCully, 2002) and failed to adhere to the fundamental principles of Contact Theory. In their meta-analysis of research on Contact Theory, Pettigrew and Tropp (2006) found that much of the literature perceives the potential for conflict only in cognitive terms, failing to address the affective, situational and institutional aspects of the issue. These researchers also indicate that the effects of intergroup contact on the reduction of prejudice are significantly stronger when the contact work is conducted in organisational settings rather than recreational settings. This implies that there may be a tendency for participating groups to dilute the importance of the

contact work in relation to the perceived importance and gravity of the setting. Therefore, if Contact Theory is viewed in overly simplistic terms, bringing groups together to carry out activities but failing to design programmes appropriately, it is unlikely that the benefits of intergroup contact will be maximised.

The power of education to contribute to the process of reconciliation was highlighted fastidiously in the Bain Report (Bain, 2006). This review maintained that the segregated schooling system was obstructing the course of reconciliation and indicated the benefits of integrated schooling. The report suggested that integration of Protestant and Catholic children would promote tolerance, mutual understanding and intergroup relationships through engagement in the whole curriculum. Bain (2006) also states that pupils would have a wider curriculum with greater choice and access to more facilities, with the added benefit of providing a much more cost-effective provision of education throughout Northern Ireland. While this proposed reformation of the school system may be idealistic, the realities of funding cuts to education departments suggest that creative measures may, in time, require consideration to ensure quality of service (Borooah & Knox, 2013). Hayes and McAllister (2009) also highlight the importance of the education system in ameliorating social and political divisions, maintaining that education should be the core component in reconciliation. These researchers state that educational reconstruction is crucial to the economic stability of post-conflict societies as this underpins successful reconciliation. Nonetheless, the practicalities of restructuring education entirely appear improbable in the short term, regardless of the potential this may have for reconciliation.

In an attempt to investigate the role of education in segregated societies, Gallagher (2005) carried out a comparative analysis, concluding that no single systemic change mitigated the challenges of diversity. However, Gallagher (2005) suggested that enabling participative dialogue through school collaboration may provide an opportunity to promote school cohesion. Similarly, it has also previously been suggested that establishing Collegiates in Northern Ireland containing diverse schools may support collaboration and interdependence between schools as opposed to competition for school enrolment (Burns, 2001). Exploring the views on school collaboration in communities in Northern Ireland, O'Sullivan, Flynn and Russell (2008) found that parents and schools were inclined to endorse collaborative projects as long as schools maintained their own ethos and identity. Research on attitudes towards school collaboration also indicates that parents are willing for their children to take classes in other schools and are generally not concerned with the type of school this would be but are more conscious of the quality of teaching and learning their children experience (Fishkin et al., 2007).

The body of research on school collaboration suggests that this approach may be valuable in promoting social cohesion in Northern Ireland because it allows for differences within schools while acknowledging these differences through planned periods of contact (Gallagher, 2016). Hewstone, Tausch, Hughes and Cairns (2008) supported the value of consistent, regular contact, highlighting the potential for indirect contact and indicating the benefits of developing meaningful, personal contacts between groups and individuals rather than superficial meetings for the sake of making contact. These researchers recommend that contact mediations should initially address anxieties within groups surrounding contact before attempting to build trust and subsequently relationships between groups. This research also supports the hypotheses of Contact Theory, while paying close attention to the details within the theory intended to ensure it is most effective. Hughes (2014) also contends that school

collaboration in Northern Ireland can be a method of advocating reconciliation at a systemic level without restructuring the school system.

While establishing initiatives to facilitate contact between groups has been shown to have positive outcomes, it is pertinent to note that the quality of education related to maintaining peace can also play a decisive role in reconciliation. Danesh (2006) maintains that education and peaceful civilisations are inseparable, insisting that peace must permeate all levels of society and civilisations should consciously perpetuate peace by educating their children appropriately. However, Danesh (2006) suggests that societies generally ignore this fundamental fact and train each new generation in accordance with conflict-based perspectives. He proposes an Integrative Theory of Peace which holds that all human states of being are shaped by our worldview, and in order to achieve peace individuals should adopt a unity-worldview in which differences are cast aside to realise peace as a common goal. In an educational setting, this may include building knowledge of the destructive nature of conflicts in the past and establishing an understanding that peace offers more opportunities for a shared future. Considering the pervasive divisions within Northern Ireland at the societal level and in education, this philosophical view of peace may appear naïve and unachievable without significant changes at every level of society. However, at present, peace remains in Northern Ireland largely as a result of the overwhelming will of people to maintain that peace. This implies that reconciliation, albeit in a segregated society, is also preferred by the majority in Northern Ireland.

5.6. Integrated and Shared Education

Based on the assumptions of Contact Theory, a significant body of research suggests that contact between children from both Catholic and Protestant backgrounds offers the potential to promote reconciliation. However, as highlighted above, this contact must be carefully considered and designed to exploit this potential (Gallagher, 2016). Accounting for this empirical base from which to build positive change, there have been large systemic initiatives introduced in Northern Ireland in an attempt to encourage social cohesion. Indeed, the catalyst for this change was initially driven when parents lobbied for the establishment of Integrated schools, leading to the first integrated educational setting being established in 1981 (Moffat, 1993). The aim of these schools was to educate approximately equal numbers of Catholic and Protestant children in the same school, giving equal recognition to each tradition to promote equality (NICIE, 2004). An initial period of growth in Integrated Education was supported by governmental reform in which parents were given the power to vote to transform existing Protestant or Catholic schools to Integrated settings (Gallagher, Smith & Montgomery, 2003). Integrated schools now exist throughout Northern Ireland and are intended to enrol, at minimum, a split of 70:30 in proportion of either Protestant and Catholic children at both primary and secondary level. However, ensuring this generally equal ratio has been challenging for some Integrated schools given the fact that societies themselves can be segregated and the location of the school may naturally attract one side of the community over the other. Despite the demographic Integrated schools serve in certain localities, statistics suggest that enrolment is genuinely mixed (Department of Education, 2017), indicating that regardless of the segregated nature of housing across Northern Ireland, parents (and to an

extent, children themselves) are choosing Integrated Education to provide their children with an understanding of other cultures and an appreciation for equality.

While Integrated Education in Northern Ireland is relatively new when compared to the largely segregated school structure, Hayes and McAllister (2009) found that individuals who attended Integrated schools were significantly more likely than those attending segregated schools to have more moderate political views and more favourable views of the opposing community. Additionally, these researchers indicate that individuals who have attended Integrated schools are also significantly more likely to have friends from the opposing side of the community and that this leads to a more optimistic view of future community relations. This suggests that the impact of Integrated Education is transgenerational, insomuch that experiencing contact with the other side of the community through education may shape an individual's view of society with an understanding that polarised political stances may do little to promote cohesion for the next generation of pupils. Hayes and McAllister's (2009) research also implies that Integrated schools are achieving their aim of promoting equality and an understanding between children from each tradition. While critics of Integrated Education posit that these schools offer an alternative for parents and children with weaker religious views and traditions, evidence suggests this is not the case, with Catholic children attending Integrated schools having equally strong religious beliefs as their counterparts in Catholic maintained schools (Gallagher & Coombs, 2007).

Irrespective of the emergent body of empirical support for Integrated Education and the influence it may have on reconciliation, challenges persist for this sector. After an initial period of growth, the establishment of Integrated Education settings had largely stalled by the mid-2000s, meaning that currently only 7% of pupils in Northern Ireland attend Integrated schools. Moreover, within this minority sector issues associated with a balanced religious enrolment create further barriers to true integration, with over half of all Integrated schools failing to meet the minimum ratio split of 70:30 of each religion (Gallagher, 2016). Compounding the challenges facing Integrated Education and its drive to attract equal proportions of Catholic and Protestant pupils, religious authorities in Northern Ireland strongly support segregated schooling. In particular, the Catholic Church maintained that religiously segregated schools are equally well placed to promote reconciliation when compared to Integrated schools (Catholic Bishops of Ireland, 2001). However, the government initiative, *A Shared Future* (OFMDFM, 2005), refutes this view, arguing that denominational schools should do more to engage across institutional boundaries to provide opportunities for inter-cultural education at all levels. This document also encouraged Integrated Education as well as greater integration in education; however, the publication of this document coincided with the decline in growth of Integrated schooling.

Accounting for the challenges facing Integrated Education, its growth and lack of support from certain authorities, an alternative approach towards reconciliation may be required within education. Given the existing evidence-base promoting the principles of Contact Theory for the process of reconciliation and social cohesion, researchers have suggested that greater collaboration between schools may offer that alternative through Shared Education. Shared Education is an initiative proposed to encourage sustained and meaningful contact between pupils from different backgrounds by promoting collaboration between separate schools in which teachers and pupils move between schools to take regular classes (Connolly, Purvis & O'Grady, 2013). This enables schools to maintain their own ethos, religious position and identity while allowing for interaction with pupils, teachers and schools with differing views.

The rationale behind Shared Education suggests that effective collaboration between schools has the potential to provide educational, economic and social benefits (Connolly, Purvis & O'Grady, 2013). The Shared Education Programme was rolled out in 2007 with a simple four-stage delivery model: i) establish a school partnership; ii) establish collaborative links between schools; iii) run shared classes; and iv) promote economic, educational and reconciliation outcomes.

Overall, outcomes from Shared Education initiatives have indicated several positive and promising results, including the opportunity for sharing good practice between staff, the ability to offer a wider curriculum to pupils from each school and more positive attitudes among pupils towards people from a different religious background (Hughes, 2014). However, these initial Shared Education project also have some shortcomings, indicating that no one model of collaboration applies to school partnerships and that it is important to acknowledge the local complexities when designing a bespoke model for any school pairing. Moreover, the logistical challenges of organising transport between settings, the difficulty in creating timetables and the additional planning and preparation expected from teachers have created barriers to realising the potential advantages of Shared Education (Duffy & Gallagher, 2014). Nonetheless, at present, the overwhelming corpus of research on Shared Education has been positive in terms of providing a greater academic and social learning experience for children (Booroah & Knox, 2013). Most relevant within the context of the present article is the potential influence Shared Education may have on reconciliation and social cohesion, which offers optimism for the future within Northern Ireland's divided society (Blaylock & Hughes, 2013; Duffy & Gallagher, 2014; Gallagher, 2013).

5.7 Implications for Educational Psychology Practice

Given the history of violence in Northern Ireland and the persistent divide that remains throughout society, it is fair to say that the education system has both been influenced by and influential in the conflict and the process of reconciliation (Smith, 2016). While initiatives aimed at addressing the segregated structure of education have had varying levels of success on a small scale, most have failed to make meaningful large-scale systemic change in education. Considering the challenges of attempting a seismic shift in the education system away from segregation and towards integration, it is unlikely that the religious denominational institutions will relinquish their power, traditions and identity to promote reconciliation. Therefore, a responsibility lies with committed teaching staff and educational support organisations to address the need for active reconciliation systems to encourage educational and social cohesion to ensure long-term peace (Gallagher, 2016). In this regard, Educational Psychologists may find themselves suitably placed to play a role at both systemic and individual levels. While the impact of the Troubles will undoubtedly manifest in the psychological wellbeing of individuals either at the time or years after the event, there is a clear onus on educational settings to respond to these needs. Considering this in a transgenerational context, children who are currently of school age may be affected by the mental health issues experienced by their parents or grandparents, as discussed in greater detail in earlier chapters.

The influence on Educational Psychology at a systemic level may not be as explicit as dealing with transgenerational impacts of violence, however. In a consultative role, Educational

Psychologists may advise schools on key aspects of school planning, policies and the curriculum. Considering Educational Psychologists may carry out this role with several schools they are responsible of supporting, they may be best positioned to support collaborative initiatives such as Shared Education. The unique position in which Educational Psychologists operate between local schools, external support agencies and the Education Authority means that these practitioners have a systemic understanding of the interactive factors associated with successful Shared Education schemes and are likely to recognise suitable partnerships between various schools.

Educational psychology may also have an important contribution to make in the promotion of social cohesion through education. Here, too, at a systemic level Educational Psychologists function as scientist-practitioners, which implies an evidence base for professional practice. While schools may not be aware of this responsibility, it could be argued that Educational Psychologists have a professional duty to provide schools with relevant empirical support in the academic, social and personal interests of pupils. The present article has indicated the potential benefits associated with the principles of Contact Theory, through interventions aimed at encouraging intergroup contact between pupils and schools of differing backgrounds; Educational Psychologists may provide a bridge between educational research and educational practice related to reconciliation by consulting with schools on how contact initiatives can promote equality through understanding of diversity.

5.8. Conclusion and Recommendations

Northern Ireland is a deeply divided society where Protestants and Catholics are educated separately, are often residentially segregated, vote for religiously opposing political parties and display low levels of intermarriage (Hughes & Donnelly, 2003). However, Northern Ireland has experienced a prolonged period of peace over the last two decades and there is overwhelming public support to maintain that peace. Given that no children currently in primary or secondary education have had direct experience of the Troubles, it is surprising that a dichotomy persists within the education system, with the majority of Protestant and Catholic children having little or no experience of children from across the divide. While historically schools offered a sanctuary for children and young people, sheltering them from the violence and disturbance during the active years of conflict, a greater responsibility now rests with schools and the education system as a whole in relation to the process of reconciliation. Perhaps as a result of the Troubles, the education system in Northern Ireland has operated in a risk-averse manner by avoiding addressing difficult, controversial issues related to religion for fear that this could incite further conflict. However, research suggests that a greater understanding of other beliefs and traditions can support cohesion by acknowledging diversity. Therefore, schools in Northern Ireland have a responsibility to challenge prejudice by exposing children to alternative views with the intention of developing personal and social attributes to enable children and young people to become part of a cohesive society. In order to assist schools with the challenge of promoting social cohesion and reconciliation, the following recommendations may be considered:

- Education should recognise the Troubles by providing children with a balanced view of the nature and impact of the conflict. This should be carried out taking consideration of the age of the children and the location of the school in relation to major violent events.
- Education should encourage transgenerational discussion, for example, by inviting appropriate individuals to speak to pupils about their differing experience of the Troubles. This may allow for a more balanced understanding in children as some may only have a narrow view of the conflict from home.
- Education has a duty to consult with children on matters affecting their development and wellbeing. Therefore, schools have a responsibility to address difficult issues related to the Troubles, even though the impact of the conflict may have been indirect. Additionally, schools should consult pupils on their views of potential reconciliation programmes and how they view the most effective method of promoting social cohesion.
- Education should increase funding, awareness and support for initiatives which encourage contact between pupils from religiously segregated schools. Given the evidence-base for the ability of such schemes to promote reconciliation through addressing differences and increase understanding of opposing cultures, the Department of Education should increase funding, awareness and support for initiatives which encourage contact between pupils from religiously segregated schools.

Research has indicated that the transgenerational impact of intergroup contact through educational initiatives has a positive long-term benefit in promoting a less isolationist stance towards cross-community relations and a more optimistic perspective on community cohesion (Hayes & McAllister, 2009). Therefore, in order to build a peaceful, united society for successive generations, more should be done at the systemic level to ensure schools are committed to the responsibility of providing children with the optimism to embrace social change. Accountability should also be acknowledged by the government given the scale of reform required within the education system to address segregation in schools. Over 90% of children continue to be educated in religious denominational schools in Northern Ireland, despite overwhelming empirical support suggesting that Integrated Education and Shared Education foster better community relations. While education alone cannot solve the issues of prejudice and social division, it can be a crucial component in the process challenging community divisions and promoting reconciliation post-conflict in Northern Ireland.

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6

Looking Towards the Future: The Role of Northern Ireland's Schools. Trauma in the Classroom and Other Issues in Education in Post-Conflict Northern Ireland

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6.1. Introduction

This chapter will continue the focus on education in Northern Ireland. The previous chapter took a 'macro' view of education, looking at the impact of "the Troubles" on the education system as a whole. This chapter will look at schools from a microsystem perspective (Bronfenbrenner, 1979) and discuss how schools can directly impact the lives of their students, their staff and those parents/families who may be dealing with ongoing legacies from Northern Ireland's Troubles. In line with Ecological Systems Theory (Bronfenbrenner, 1979), schools cannot and should not be looked at in isolation and therefore the family systems and communities surrounding children will also be acknowledged and referred to as appropriate.

As of 2017, every student attending primary and post-primary schools in Northern Ireland has grown up following the signing of the Good Friday Agreement (1998). However, each of the previous chapters has noted the impact transgenerational trauma can have and has examined this specifically in the Northern Ireland context. Therefore, it is crucial to note that today's students are being raised by parents and grandparents and being taught by teachers who lived through the Troubles, meaning that they may have indirectly experienced the impact of the Troubles via their caregivers (Enright, Gassin & Knutson, 2003; Fargas-Malet & Dillenburger, 2016; McElearney, Roosmale-Cocq, Scott & Stephenson, 2008; Muldoon, Trew & Kilpatrick, 2000). In addition to this transgenerational impact, students may be exposed to the legacy of the Troubles in the wider society via, for example, the segregated school system (see Chapter 5). This interaction means that some children and young people may struggle to cope with the legacy of the Troubles despite many being resilient (Enright et al., 2003; Muldoon et al., 2000) and schools need to be aware of and understand how best to support them. Some schools will encounter these difficulties more than others as not all areas in Northern Ireland were affected the same way by the violence during the Troubles and/or ongoing tensions between divided communities following the Good Friday Agreement (1998). Risk factors for children and young people experiencing Troubles-related difficulties include geographical location, gender, religious affiliation and level of social deprivation (Muldoon et al., 2000; Muldoon, 2003). Schools in Northern Ireland have been referred to as "safe havens" from the Troubles and as being a protective factor for students who are at risk of developing difficulties (Enright et al., 2003; Kilpatrick & Leitch, 2004). This, combined with research on

the role of schools in post-conflict reconciliation discussed in the previous chapter, indicates that schools in Northern Ireland can be an invaluable resource in supporting not only students but staff and families if utilised effectively.

This chapter aims to explore how schools and teachers can be effective 'agents of change' (Duffy & Gallagher, 2015; McCully & Clarke, 2016) in a post-conflict Northern Ireland. It is divided into two sections. First, school-based interventions for students experiencing Troubles-related difficulties as identified in previous chapters are explored. Then, some wider issues for education are discussed. The chapter will conclude with specific recommendations for how Educational Psychologists (EPs) can support schools.

6.2. Trauma in the Classroom: Working with Specific Difficulties

The previous chapters on family systems and mental health in Northern Ireland identified a number of Troubles-related difficulties that children and young people in Northern Ireland are at risk of encountering either due to direct experiences or transgenerational trauma:

- attachment difficulties
- anxiety
- depression
- PTSD
- self-harm/suicide
- substance misuse

This section will explore strategies for managing each of these difficulties and their impact in the classroom. As mentioned previously, it is important to keep in mind that each school will experience differing prevalence of these difficulties and that not all students in at-risk schools will experience Troubles-related difficulties (Muldoon et al., 2000). Groups that are particularly at risk include children of parents with multiple/recent traumas, mental health difficulties and/or substance misuse (Fargas-Malet & Dillenburger, 2016; Muldoon et al., 2000). It follows that groups such as children of police/soldiers, children of prisoners and children bereaved through suicide may be particularly vulnerable, as discussed in previous chapters.

While the aim of this section is to focus on school-based interventions, it is not the intention that schools should act alone in developing and carrying out the suggestions. Ubha and Cahill (2014) note that few teachers have sufficient training in psychological theories to carry out therapeutic work with children with clinically significant symptoms (e.g. attachment disorder or depression), and schools should ensure that such children are referred to appropriate services, e.g. the Behaviour Support Team (BST), the Child & Adolescent Mental Health Service (CAMHS) and the Educational Psychology Service (EPS). However, even after referral and during specialist intervention, schools can play a critical role in supporting students (Lonsinski, Katsiyannis, White & Wiseman, 2016) e.g. by accessing advice/training from external services such as the EPS. It is not possible within the scope of this essay to provide recommendations of specific intervention programmes as each young person's case will be different. Therefore, the aim is to provide some starting points and ideas for supporting all students.

6.2.1. Attachment in the school setting

Attachment Theory (Bowlby, 1969) was discussed previously in relation to the family system and the Troubles (see Chapter 2 for more information). Children with attachment difficulties can have problems with emotional regulation, forming and managing relationships and self-confidence (Moullin et al., 2014), therefore difficulties are not limited to the home setting and are also likely to present in school e.g. as social problems, externalising behavioural problems (aggression, hyperactivity) and internalising behavioural problems (withdrawal, anxiety) (Belsky & Fearon, 2002; Fearon, Bakermans-Kranenburg, Van Ijzendoorn, Lapsley & Roisman, 2010; Kok et al., 2013). The school context provides key opportunities to form strong relationships with adults which can in turn have a powerful impact on children's social and emotional behaviours (Ubha & Cahill, 2014). Research suggests that attachment difficulties can be mediated in the school environment via a 'key adult' figure who builds a secure relationship with the child (Bomber, 2007).

Effectively managing a diagnosed attachment disorder in the school setting requires specific training and understanding that may go against more 'traditional' school techniques such as 'time out' (Bomber, 2007). A recent case study based in a primary school in England identified the following six components of an attachment approach (Webber, 2017, p. 13):

- Whole-school approach of a therapeutic PACE (Playfulness, Acceptance, Curiosity, Empathy) (Hughes, 2009) attitude
- Communication between staff including support for transitions
- Physical contact – touch, regulating emotions
- Bespoke provision for each child
- Not shaming children
- Working with families and multi-agencies

While suspected attachment difficulties should be assessed on a case-by-case basis, the following intervention strategies may prove useful and can be tried both in primary and post-primary settings: providing a consistent, predictable environment; providing a safe place for the student to retreat to if needed; carrying out functional behaviour assessments to establish the causes of the behaviour and enable the writing of a behaviour plan; responding to need not diagnosis/label; and engaging a multi-system approach e.g. open communication with family/other key individuals to ensure a consistent approach across settings (Lonsinski et al., 2016). Books such as Louise Bomber's *Inside I'm Hurting* (2007) and *What About Me?* (2011) offer straightforward, practical strategies for school-based attachment intervention.

Schools could also run small groups aimed at increasing children's capacity to build relationships. Ubha and Cahill (2014) describe such an intervention which was carried out in a primary school by a trained Learning Support Assistant with children identified by teachers as being passive and withdrawn. The intervention was carried out in weekly, one-and-a-half-hour blocks for 10 weeks and activities included discussion of stories selected for emotional content and drawing. A positive impact on both children's behaviour and their relationships was noted at the end of the intervention. This is an example of a sustainable intervention as once a staff member has received training e.g. from the local Behaviour Support Team, they can work within the school as needed.

Children in some areas and schools in Northern Ireland may have the opportunity to join a Nurture Group (Boxall, 2002). A Nurture Group is a small group setting that children attend for four and a half days per week and involves curriculum-based tasks, social learning and emotional literacy tasks, play and interactions with an adult as well as the other children e.g. having breakfast together. The aim is to provide a secure context for children to develop relationships. A review by Hughes and Schlosser (2014) found that while more longitudinal research is needed, there is evidence that Nurture Groups improve children's emotional wellbeing. These results are supported by a recent review into the primary school Nurture Groups funded by the Department of Education in Northern Ireland (Sloan, Winter, Lynn, Gildea & Connolly, 2016), which found that Nurture Groups were a cost-effective method of significantly impacting children's social, emotional and behavioural outcomes.

A key message from this section is that while much can be done within schools to support students with attachment difficulties, they should not feel that they need to do so in isolation. Services such as the BST and EPS can provide information, training and support to schools as they implement an attachment-based approach. Schools may also need to have discussions regarding their child safeguarding policies, e.g. regarding the use of touch, to develop an agreed approach.

6.2.2. Anxiety and depression

Anxiety and depression are grouped together in this section as they are often researched together (e.g. Werner-Seidler, Perry, Calear, Newby & Christensen, 2017). Recent research has described the school environment as an ideal context for delivering both anxiety and depression prevention programmes (Waters, Groth, Sanders, O'Brien & Zimmer-Gembeck, 2015; Werner-Seidler et al., 2017). School-based interventions for anxiety and depression can either be universal (delivered to the whole population) or targeted (focused on an at-risk or symptomatic individual/group) (Werner-Seidler et al., 2017). Both types of intervention have benefits and drawbacks. Universal interventions remove the need for screening, remove the stigma of being singled out and may act as a preventative measure for students not currently at risk, while targeted interventions can be more focused in their approach (Werner-Seidler et al., 2017). As before, schools can access advice from their EP on how best to support individual children about whom they are concerned. A key issue for schools when choosing to implement an intervention programme is cost effectiveness. For example, Waters et al. (2015) noted that lack of investment in resources such as continued training and supervision for teachers or the recruitment of outside professionals was a barrier to the sustainability of otherwise successful anxiety interventions.

School staff may be ideally placed to implement interventions, particularly with younger students who feel more comfortable with familiar faces (Werner-Seidler et al., 2017), although there is controversy within the research in this area. In a systematic review of school-based depression and anxiety prevention programmes, Werner-Seidler et al. (2017) compared externally delivered programmes and those delivered by school staff. They found that while externally delivered programmes led to larger reductions in depressive symptoms, no such difference was observed between the two delivery methods for anxiety symptoms. As well as this, they found that universal and targeted anxiety prevention programmes had similar effects, whereas universal depression prevention programmes were not as effective as targeted interventions. A further review of the area by Das, Salam, Lassi et al. (2016) found that

targeted, group-based interventions were effective in reducing both depression and anxiety symptoms. In terms of age of onset of symptoms, it is also important to note that prevention programmes for anxiety may work best in childhood, while childhood or early adolescence may be best for depression programmes (Kessler et al., 2005).

In terms of what types of interventions can be successful, 84% of reviewed studies in Werner-Seidler et al. (2017) had a Cognitive Behavioural Therapy (CBT) basis, with a further 6% combining CBT with other methods, making it by far the most popular method. Waters et al. (2015) carried out universal Cognitive Behavioural Intervention for anxiety with 9-11 year olds over 8 sessions within class time, resulting in significant improvements not only in self-reported anxiety, but also children's perceptions of their social skills and coping ability. However, a key limitation of this intervention was that despite acknowledging the unsustainability of external practitioners it was delivered via a partnership with members of the local university's Clinical Psychology department. While effective partnerships such as this should be developed and encouraged, most schools in Northern Ireland cannot currently benefit from such an arrangement. O'Callaghan and Cunningham (2015) found that a 10-session, group-based CBT programme resulted in significant improvements in anxiety and depression symptoms in 9-11 year olds in Northern Ireland. A teacher, education welfare officer and two classroom assistants facilitated this intervention, with support from the school's educational psychologist, making it a more viable, sustainable option for schools.

Overall, the literature notes a need for further refinement and development of effective school-based prevention programmes, particularly those which can be delivered by existing school staff within school hours. Effective collaboration and partnerships between schools and youth mental health services may help to reduce the resource pressures (Waters et al., 2015). Werner-Seidler et al. (2017) and Musiat and Tarrier (2014) note that computerised programmes may be useful in this regard, either as a manualised approach to carry out interventions or as booster modules to ensure maintenance of preventative strategies.

6.2.3. PTSD

As with anxiety and depression, schools can also play a role in supporting children who are experiencing Post-Traumatic Stress Disorder (PTSD) even if they are also attending specialist services. Schools can provide a familiar, safe and supportive environment for children whether the intervention is classroom-based or simply takes place within the school (Rolfsnes & Idsoe, 2011). Indeed, research has highlighted the role that schools had during the Troubles in providing children with a sense of security (Enright et al. 2003; Kilpatrick & Leitch, 2004). Morina, Koerssen and Pollet (2016) note that classroom-based interventions have only small effect sizes for reducing PTSD symptoms compared to a waitlist control, perhaps because these interventions cannot be as tailored as individual treatment. However, Rolfsnes and Idsoe (2011) take a different viewpoint, suggesting that school staff can be successfully utilised in providing interventions and that such an approach can lead to more students both accessing and completing treatment than if the intervention took place in a clinical setting.

As with anxiety and depression prevention interventions, Rolfsnes and Idsoe (2011) found that 84% of the studies included in their review used CBT as the main treatment approach with good effect sizes. While Rolfsnes and Idose's (2011) review included traumatic events such as natural disasters, community violence, terrorism and war, three studies focused on political

conflict, two of which centred on Israel, which is probably the closest available comparison to the Troubles in this study. The techniques used in the school-based universal interventions from these two studies (Berger, Pat-Horenczyk & Gelkopf, 2007; Gelkopf & Berger, 2009) included:

- parent psycho-education and teaching of coping skills e.g. breathing techniques
- classroom-based activities (e.g. the stress continuum, strengthening coping skills, being in your body, knowing your feelings, controlling your emotions with your mind, dealing with anger and rage, dealing with fears, coping with grief and loss, reframing negative experiences, boosting your self-esteem, building your support system)
- body-oriented strategies
- narrative work
- meditative exercises

Training and supervision of school staff is central to successful interventions and it is also important to adapt programmes as much as possible to the type of trauma exposure and needs students have (Rolfsnes & Idsoe, 2011). With this in mind, schools may decide to only seek support for and run a PTSD-based intervention if a portion of their student population is particularly at risk due to school location and/or family history (see Chapter 3).

6.2.4. Self-harm and suicide

Teachers can be considered gatekeepers (individuals who have day-to-day contact with a large number of people in their community as part of their usual routine) in the world of suicide prevention (Hatton et al., 2017). Participating teachers in Hatton et al. (2017) overwhelmingly agreed that teachers are frontline participants in school-based suicide prevention efforts but also noted that those roles and the necessary training are not clearly defined. Further barriers to intervention noted by participants included a fear of making the situation worse and fears of legal repercussions; this likely comes from fears of the "contagion effect" – the idea of "putting ideas into their heads" by mentioning self-harm or suicide. This fear has been noted in other research in the area (Evans & Hurrell, 2016; Rae, 2016). Any training therefore needs to consider teachers' perception and address their concerns in order to enable them to create teacher-student interactions that may lead students to seek help. Hatton et al. (2017) noted that teachers with suicide prevention training were twice as likely to have had a suicidal student/peer of a suicidal student approach them to talk about suicide.

The idea that self-harming and/or suicidal students may approach their peers before a familiar adult has been noted in the research. Hawton (2015) argues for the need to develop and deliver school-based interventions which educate and inform all young people about the causes and triggers to self-harm and suicide. Rae and Walshe's (2016; as cited in Rae, 2016) educational and preventative support intervention for suicide and self-harm is based around this principle. Development and evaluation of this programme is currently ongoing in the UK but in its current form it is run as part of the personal, social, health and economic PSHE curriculum and in partnership with the school's EP. It consists of two parts:

- Whole school
    - policy development, education and awareness raising amongst staff e.g. "contagion effect", information leaflets for parents, staff and pupils regarding self-harm

- Group level
    - 8-session programme to groups in the school setting aiming to cover the main issues of self-harm and suicide and to provide a safe space to develop preventative strategies and techniques:
        - What is self-harm? (myths, realities, stigma)
        - Understanding stress and anxiety
        - Triggers and traumas (including social media and the internet)
        - Stopping the cycle of self-harm – tools and strategies
        - Supporting friends who self-harm – issues and sources of support
        - Tools from CBT to practice and use
        - Tools from positive psychology to create positive mind-set
        - Breaking the cycle and moving forwards

Rae (2016) notes that these are incredibly sensitive topics and time should be spent at the training/policy-making/awareness-raising stage, undertaking appropriate risk assessments and ensuring ground rules are established. She also recommends that groups should be facilitated in pairs and facilitators should have access to supervision.

In terms of the school factors that may influence rates of self-harm and suicide, Evans and Hurrell (2016) note that while school factors may influence students' self-harm, their impact on suicide is limited. Their systematic review identified the following five themes as potential reasons for this influence:

- Self-harm is often invisible within educational settings and is not prioritised in the curriculum
- Self-harm may be treated as "bad behaviour", therefore limiting adequate support
- Referring self-harm to external experts may contribute to non-help seeking behaviour amongst students who desire confidential support from their teachers
- Anxiety and stress regarding school performance may escalate self-harm and suicide
- The effect of peers: Bullying in school can contribute to self-harm, whilst other students may engage in it as initiation into a social group

Das, Salam, Lassi et al. (2016) caution that further research is needed on interventions for suicide prevention, particularly regarding how they affect suicide-related attitudes and behaviours rather than simply knowledge. However, the *Northern Ireland Suicide Prevention Strategy* (DHSSPSNI, 2012) emphasises the beneficial outcomes of interventions such as including coping and life skills in the curriculum, ensuring protection from bullying, suicide awareness and positive mental health training for teachers and the promotion of a help-seeking culture throughout the school. They also recommend that all schools should have a critical incident response plan, which can be developed by working alongside the area's Critical Incident Response Teams and EP. Self-harm and suicide are key issues in Northern Ireland (see Chapters 3 and 4) and a multi-systemic, collaborative approach should be taken in supporting schools and students.

6.2.5. Substance abuse

Similar to the aforementioned interventions, interventions for alcohol and other substance abuse can be universal, selective (for at-risk populations) or indicated (for those already

abusing substances) (Healey, Rahman, Faizal & Kinderman, 2014). Healey et al. (2014) note that indicated interventions are often carried out at crisis point e.g. in hospital emergency departments, and while this in itself is not relevant to schools, they point out that healthcare locations can be a barrier to adolescent engagement with interventions. Therefore, as noted in previous sections, schools could have a role in facilitating such interventions in safe, secure and familiar locations. However, in general, schools will be more likely to engage in universal or targeted interventions. The rest of this section is split into alcohol, smoking and drug abuse.

6.2.5.1. Alcohol

Foxcroft and Tsertsvadze (2011) conclude that universal school-based preventative interventions show some evidence of effectiveness compared to the standard curriculum. McKay, Sumnall, McBride and Harvey (2014) note that while schools in Northern Ireland typically have written drug and alcohol policies, these can vary both in quality and delivery. In their study, the School Health and Alcohol Harm Reduction Project (SHAHRP) (McBride, Farringdon, Midford, Meuleners & Phillips, 2004) was implemented with 13-16 year olds in 29 schools in the Greater Belfast area. This intervention is classroom-based, consisting of ten 40-minute sessions carried out over two academic years, and has the benefit of targeting both adolescents who already drink and those who do not. The intervention was carried out either by trained teachers or external professionals and included alcohol education, skills training (e.g. how to say no) and activities designed to encourage behavioural change. McKay et al. (2014) found significant changes in knowledge and attitudes across all categories and significant positive behavioural changes in unsupervised drinkers – the group at greatest risk. Most interestingly, these results were strongly and consistently observed for those in the teacher-led group. The researchers conclude that the intervention is a viable health promotion tool in the UK. In keeping with discussions earlier regarding cost-effectiveness, the fact that this intervention can be successfully delivered by trained teachers may increase its sustainability in the school context.

6.2.5.2. Smoking

A review by Das, Salam, Ashard et al. (2016) concluded that school-based prevention programmes are typically effective at reducing smoking. Thomas, McLellan and Perera (2013) reached a similar conclusion, but they cautioned that the form the intervention takes is a crucial factor for success and identified five intervention types:

- Information only: Provide information on actual rates of smoking and correct inaccurate beliefs regarding the social acceptability of smoking.
- Social competence curricula: Help adolescents refuse offers to smoke by increasing their social competencies i.e. increasing their self-control and self-esteem and teaching cognitive skills for resisting interpersonal or media influences.
- Social influence curricula: Increasing adolescents' awareness of the social influences that support substance use and teaching them skills for handling peer pressure and high-risk situations.
- Combined social competence and social influence curricula.
- Multimodal approaches: Combine the adolescent focus with the systems around them e.g. programmes for parents, school/government smoking policies.

Thomas et al. (2013) concluded that social influence curricula, multimodal and information-only approaches were ineffective at reducing smoking initiation. Combined social competence

and social influence curricula were found to have significant effects up to a year after the intervention was administered. A rather more novel approach to intervention is the 'smoke-free class competition', which is designed to reduce the number of students who are already smoking. This takes the form of a class committing not to smoke for 6 months. The commitment is monitored by both the teacher and the students and prizes are awarded (Hoeflmayr & Hanewinkel, 2008). While there are some questions surrounding the long-term impact of this intervention (Wiehe, Garrison, Christakis, Ebel & Rivara, 2005), Hoeflmayr and Hanewinkel (2008) conclude that overall it is a cost-effective intervention. While more research is needed to identify the specific components of effective smoking prevention interventions and how to maximise their long-term impact, the research overall is pointing towards their effectiveness.

6.2.5.3. Drug abuse

Similar to the smoking prevention intervention results above, research has found that school-based drug prevention programmes based on a combination of social competence and social influence approaches or more comprehensive programmes combining anti-drug information, refusal skills, self-management skills and social skill training have protective effects against drug use (Faggiano, Minozzi, Versino & Buscemi, 2014; Lemstra et al., 2008). A system-wide approach such as promoting a positive school ethos and reducing student disaffection with authority may effectively complement drug prevention programmes (Fletcher, Bonell & Hargreaves, 2003).

6.2.6. Section conclusion

The above research shows that schools can and should play a role in supporting students, even if they are attending specialist services. Rae (2016) argues that any intervention aiming to protect and improve young people's mental health should build both knowledge and skills and actively involve parents/carers and wider systems; this may be particularly true in the context of Troubles-related trauma in Northern Ireland as parents themselves may be struggling, e.g. with PTSD, which is in turn impacting their children. As mentioned throughout this section, schools should not feel that they need to work in isolation in implementing any of the ideas presented in this section and should access support and advice from their area's EPS, BST and Critical Incident Response Teams as appropriate. Agencies such as Barnardo's offer services such as support for children affected by parental imprisonment/substance misuse, support for children who have been bereaved (including through suicide), Incredible Years Parent and Teacher training, trauma support and a range of other programmes aimed at children and families deemed to be at risk of poor mental health.

While more evaluation and research is needed regarding which specific intervention components are effective, schools can support their students and the wider community by creating supportive environments, paying attention to their students' needs and responding with evidence-based interventions and ensuring that adequate policies regarding mental, social and emotional health are in place and followed to promote mental wellbeing. Rae (2016) and O'Mara and Lind (2013) suggest that focusing on mental health promotion is more effective than focusing on mental illness prevention, particularly when it is ingrained in school life as opposed to being a stand-alone module and when parents and the wider community are supportive. The following section aims to move beyond the specific difficulties discussed in this section to explore wider issues regarding education in post-conflict Northern Ireland.

6.3. Wider Issues for Education in Post-Conflict Northern Ireland

The previous chapter described educational interventions such as the Sharing Education Project (SEP) and the changes that occurred within the primary and secondary school curriculums in Northern Ireland in response to the Troubles; it also discussed the potential for future changes e.g. in the subjects of Religion and History. This section will briefly explore the practical challenges of such changes such as addressing difficult topics in the classroom. Suggestions for supporting teachers and working with familial or community uncertainty are also given.

6.3.1. Addressing difficult topics

Gallagher (2004) described a 'culture of silence' in Northern Ireland i.e. the avoidance of discussion of controversial issues that has developed since the Troubles as a coping mechanism. This was discussed in the family context in Chapter 2. Further research has supported the idea of a 'culture of avoidance' (Donnelly, 2008) or taboo subjects also existing in Northern Irish schools e.g. paramilitary involvement (Kilpatrick & Leitch, 2004) and an avoidance of political/social issues compared to religious/cultural issues which are seen as less controversial (Hughes, 2014; Loader, 2015). The following quote from a research participant illustrates the impact such avoidance can have on students and school staff:

> *Pastoral Co-ordinator: An odd time a concerned parent would tell us…but more often we would become aware when pupils would be giving other cause for concern such as attendance, poor works, etc. and we would then discover…"Oh, my mother was in England visiting my brother who's in prison"* (Kilpatrick & Leitch, 2004, p. 575).

Teachers and pupils may be anxious not to be perceived as sectarian, leading to an over-emphasis of similarities between groups despite the existence of divisive issues (Loader, 2015). Furthermore, evidence has been found which suggests a view that engaging with different political perspectives in the classroom can be framed as sectarian or controversial (Donnelly, 2008; McEvoy, McEvoy & McConnachie, 2006). In practice, views such as these have led to History teachers deliberately choosing to exclude the Northern Ireland peace process from their classes to avoid conflict both with students and the wider community (Donnelly, 2008, p. 11). Integrated schools are not immune to such issues and may also avoid directly discussing difficult topics (Ben-Nun, 2013; Smith & Neill, 2005).

6.3.2. Identity development and conflict

One example of a taboo, yet important, subject in Northern Ireland's schools is identity (see Chapter 1 for a discussion on social identity theory including in-groups and out-groups). Identity exploration should be considered important within schools because questions of religious and national identities are central to the Troubles (Muldoon, Trew, Todd, Rougier & McLaughlin, 2007). The literature notes that children begin to develop their identities from a very young age and are heavily influenced by the adults around them (Donnelly et al., 2016 Montgomery & McGlynn, 2009). However, a key aspect of social identity is that it is considered to be salient i.e. identity is not fixed, rather it is possible to hold multiple social identities and to develop new identities in response to circumstances (Deaux, 1996). Therefore, it follows

that schools can encourage salience by encouraging students to look at situations in new ways and formulate new possibilities (Donnelly et al., 2016; Furey et al., 2017; McCully & Clarke, 2016).

Recent research has suggested that religious identity (e.g. Catholic/Protestant) may be seen as less controversial and more open to discussion particularly in integrated schools when compared to political or social identity such as Irish/British (Donnelly et al., 2016). One integrated school principal quoted in Donnelly et al. (2016) described the steps that she taken to make national identity salient, such as displaying both flags outside the school and arranging visits from representative of various political parties. A key issue for this school was that while the head teacher was committed to this approach she did not account for the discomfort and reluctance many parents felt towards it, so much so that some removed their children from some events. Teachers may also find this identity work challenging, particularly if they have not had appropriate training or opportunities to reflect on their own identities (Kilpatrick & Leitch, 2004; Montgomery & McGlynn, 2009). One of the criteria for the Intergroup Contact Theory (Allport, 1954; see Chapter 5 for further details) to be a success is 'institutional support'. If teachers appear unsure and parents' voices are not sought or their concerns are overlooked, then children may perceive that important parts of their system are uncomfortable with the formation of intergroup relations. This lack of institutional support (perceived or otherwise) is then likely to reduce the effectiveness of any intervention.

Another challenge to effective identity work is the aforementioned anxiety regarding being perceived as sectarian, which can lead to an over-emphasis of group similarities at the expense of explicit discussion of differences and divisive issues (Loader, 2015). However, genuine engagement with difference is vital to change attitudes towards other groups, therefore it is vital to explore difference sensitively to develop true acceptance and tolerance (Hughes & Loader, 2015). This was noted by Ben-Nun (2013), who found that teachers in an integrated school in Northern Ireland avoided highlighting students' identities and differences even when these were clearly portrayed in the children's drawings. In an equivalent activity in an integrated school in Israel, the teacher introduced the drawing task using her own life as an example and had resulting success in encouraging the students to think about their roots, to reflect on the complexities of their own and others' identities and to have a class discussion on national identity. Such a direct approach would require adequate teacher reflection, training and open communication with parents regarding the rationale and aims of the activities. A conclusion drawn by Ben-Nun (2013) is as follows:

> *An integrated classroom has the potential to demonstrate to students that different, often conflicting views of the past and the present can coexist and be equally tolerated, through negotiation and acceptance. If this opportunity is overlooked students may walk away from their experience with integration with only shallow appreciation of difference and diversity and without understanding the implications of identity and the conflicts that can rage over its mishandling* (Ben-Nun, 2013, p. 15).

A potential concern regarding this identity work could be bullying between students e.g. upon discovering each other's identities. Indeed, Collins, McAleavy and Adamson (2004) found that a small number of pupils described sectarian bullying experiences, which referred either to their religion or to forming friendships with peers from a different religion. However, Gallagher

(2016) notes that despite initial fears, sectarian incidents were rare among students participating in the SEP. In fact, he found that such collaboration actually worked to remove the culture of silence regarding handling sectarian issues. Whereas in the past, the response to a sectarian incident between pupils would have been to 'hush things up and suspend activity until things quietened down' (Gallagher, 2016, p. 370), the public nature of the SEP framework provided a context for dealing with issues openly.

6.4. Supporting Teachers

The above section highlighted the need for appropriate teacher support to enable them to handle difficult topics in the classroom. This section describes how training can be implemented right from the beginning of teachers' careers. McCully and Clarke (2016) note that the teaching profession in Northern Ireland is known for its conservativeness and that religious affiliation is a key factor in decisions regarding teaching posts. This has led them to argue for the importance of integrated teacher training as well as integrated schools. This is view is shared by Montgomery and McGlynn (2009), who note the segregated nature of undergraduate teacher training in Northern Ireland. This, along with the segregated nature of Northern Ireland's primary and post-primary schools as discussed in the previous chapter, means that many teachers may never have experienced the "other" setting either as children or as adults. As well as this, current student teachers (just like their future students) may be impacted by transgenerational trauma from the Troubles. In order to facilitate teaching and discussions on the difficult topics outlined above and to be agents of change (Duffy & Gallagher, 2015; McCully & Clarke, 2016), it is necessary that student teachers have the opportunity to clarify and reflect upon their own thinking on sensitive issues through discourse (McCully & Clarke, 2016).

The General Teaching Council of Northern Ireland's (GTCNI, 2011) competence framework and Code of Values emphasise the creation of reflective, activist teachers who 'commit the profession to enabling our young people not just to develop as rounded individuals able to prosper in the world but, as importantly, to live together in a culture characterised by tolerance and respect for diversity' (p. 8). In order for this to be achieved, this aim should be a priority across Initial Teacher Education (ITE), Induction, Early Professional Development and Continuing Professional Development (CPD). Ideas for supporting this aim in ITE include "mixed" (Catholic-Protestant) training, encouragement to complete placements in schools within the "other" religious tradition, lectures introducing key concepts of community relations, and elective modules in Local and Global Citizenship that could generate the teaching profession's 'change agents' (McCully & Clarke, 2016). Beyond ITE, the importance of self-care and training (e.g. in transgenerational trauma, teaching difficult topics) for existing teachers through CPD is noted in the literature (McGlynn, Niens, Cairns & Hewstone, 2004; Muldoon, Trew & Kilpatrick, 2000).

6.5. Working with Parents/Family

As mentioned throughout this and previous chapters, students' parents and families may also be dealing with their own traumas from the Troubles and each will have their own perspectives and viewpoints. In order for any of the interventions or curriculum adaptations described in this chapter to be successful, it is vital to have parental, and at a wider level, community support. O'Callaghan and Cunningham (2015) acknowledged that anxious children may have anxious parents and that it was important to work with their concerns in order for intervention to be successful. Hughes (2014) notes that young people from communities with ongoing tension find it harder to make and maintain friendships with the "other" group as there can be a conflict between their school ideals (e.g. mutual respect, tolerance and reconciliation) and the realities of their community (e.g. fear, suspicion, hostility). Gaining more institutional support (Allport, 1954) could involve parents meeting with the school to discuss a programme of identity development (Donnelly et al., 2016) or events such as Grandparent Days which aim to dispel uncertainties, e.g. regarding integrated education, and increase understanding of the importance of topics such as identity development (Ben-Nun, 2013).

The quote from a participant in Kilpatrick and Leitch (2004; p. 575) presented earlier highlights the importance of information sharing between school and home. The development of supportive, pro-active schools may allow parents to feel comfortable sharing previously taboo information, thereby having benefits for the child in the classroom. For example, if a child is presenting with challenging behaviour in the classroom and the parent feels comfortable enough to share background information, e.g. that a parent is in prison, then this information (with the parent's permission) could be shared with staff on a need-to-know basis. Consultation techniques for challenging behaviour such as the approach described by Farouk (2004) rely on participants developing theories for why the behaviour is occurring in order to create effective strategies to manage it. Missing information could lead to a delay in identifying an appropriate behaviour plan and therefore potentially negatively impact the child, the teacher and other pupils in the classroom.

6.6. Overall Conclusions and the Role of the Educational Psychologist

This chapter has explored how schools in post-conflict Northern Ireland can best meet the needs of their students as well as the wider family and community. A key theme throughout this chapter is that schools should not need to work in isolation, but should access support from the range of services available in their area. Schools can be supported in this from a governmental level, such as through policies solidifying the role of teachers and schools in reconciliation by making targets core-curricular, not extra-curricular (Montgomery & McGlynn, 2009) and making 'the Troubles part of the core history curriculum, thus removing the necessity for teacher choice (Smith & Neill, 2005).

6.6.1. The role of the Educational Psychologist

Educational psychologists (EPs) should have an awareness of the transgenerational impact of trauma that has been discussed throughout this and previous chapters. This awareness should ensure that a detailed case history is taken, and that when deemed necessary the difficult questions are asked in a sensitive manner, e.g. regarding previous parental trauma. In this way, EPs can also play a role in removing the "culture of silence". Ubha and Cahill

(2014) point out the EPs are well placed to support identification, to help schools to plan and implement appropriate interventions and to facilitate consultation techniques such as Farouk's (2004), as described earlier. O'Callaghan and Cunningham (2015) highlight the need to develop the EPS model in Northern Ireland in order to allow EPs to use their skills to develop specialisms, interventions and training for their schools. They conclude that '[g]roup-based, multi-agency, systemic, early prevention interventions…can support almost double the number of children that would normally have received help had the school chosen to use their time allocation for individual assessments instead' (O'Callaghan & Cunningham, 2015, p. 324).

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