INTRODUCTION
Northern Ireland was beset by civil disturbances for the 25 years until the ceasefire declarations in late 1994. During that time well over 3,000 people were killed and many times that number seriously injured. A number of studies have been carried out during the period of the civil disturbances to examine the effects that they have had on the mental health of the population. Lyons, who examined the number of referrals, hospitalization rates and suicide rates when the civil disorder first broke out in 1969, found no increase in more serious, i.e. psychotic types of psychiatric illness. He felt that there was, however, some effect on the population, and called this an increase in “normal anxiety”. There would appear to be some evidence especially in urban areas where civil violence occurs, of increases in tranquilizer consumption with the risks of dependence. A community based study found that there was some negative relationship between the violence and an individual’s psychological well-being.

In a review Curran concluded that the violence has not resulted in any obvious increase in psychiatric morbidity. He suggested a number of reasons as to why this might be: non reporting of illness, migration of the ill, denial of or habituation to the disturbances, a latency period, catharsis, improvement of those already ill and improved community cohesion. Overall Curran felt that there was a balance of effects with, on the one hand, a certain number of people experiencing psychological distress and, on the other, some gaining protection against psychiatric morbidity. Curran’s own group, in a series of papers, reported on over 700 litigants. They found that over 25% suffered from an anxiety state, 15% from a depressive neurosis and, using Diagnostic Statistical Manual (DSM-III-R) criteria, 23% from P.T.S.D. Just over 11% of the group were referred to psychiatric out-patients and a further 4.5% required in-patient psychiatric treatment.

Comparison of the percentage of individuals diagnosed as ill with the number referred for specialist treatment would suggest that either the general practitioners felt confident enough to treat their patients themselves or that the illnesses were not sufficiently recognized, the latter a point suggested by Curran’s own group.

It is quite possible that, as postulated by Curran, much post traumatic psychiatric morbidity has not been reported and that there has, indeed, been a significant increase in psychological disturbance secondary to the Northern Ireland troubles. Many victims, in a state of post traumatic helplessness, may feel that nothing can be done. In addition, clinical experience has suggested that doctors on occasions have not referred individuals because they feel that their post traumatic reactions are...
understandable and not pathological and/or that treatment is either not indicated or ineffective. This paper examines the understanding doctors have of post traumatic neurosis.

METHOD
All general practitioners and Occupational Health Physicians within Northern Ireland were sent a questionnaire which included items with regard to demography and experience in post registration psychiatry, and checklists relating to knowledge of post traumatic neurosis. Additional comments were also welcomed. These results were analysed using The Statistical Package for the Social Sciences (SPSS).

RESULTS
Of 1005 questionnaires sent, 552 were returned (54.9%); 528 of 968 general practitioners replied (54.5%) as did 24 of 37 Occupational Health Physicians (64.8%). Not all respondents completed every section of the questionnaire although most sections were completed by over 99%. With regard to the efficacy of the different treatments and the features of P.T.S.D., there was a higher rate of non-completion, perhaps reflecting the absence of a “don’t know” option, left out in order to increase the likelihood that a positive decision would be made. The rate of non-completion was highest for the proposed treatments (critical incident debriefing 14.1%, lithium 13.9%) and next highest for the different symptoms (elated mood 8%, diminished interest 3.3%). There were no significant differences between the two groups of doctors in terms of content of replies and the results presented are for those doctors, general practitioners and Occupational Health Physicians, who responded to each particular section of the questionnaire.

FREQUENCIES
Almost 25% of responses came from doctors working in Belfast, the major urban conurbation in Northern Ireland. Seventy five per cent were male. Eighty per cent were aged 31 to 50. Sixty per cent had no experience of psychiatry, 25% had six months’ experience and the remainder had more extensive psychiatric experience. Sixty per cent had never attended a lecture on post traumatic neurosis. Ninety nine per cent felt the majority of psychological reactions to traumatic events were understandable. Ninety five per cent felt that such individuals required treatment usually/sometimes. Eighty eight per cent felt there were effective treatments for such individuals. The perceived effectiveness of different treatments as presented in the questionnaire is detailed in Table I.

Seventeen per cent of respondents said they were very aware of P.T.S.D., 60% quite aware and 23% only vaguely aware of the condition. In DSM-III-R, P.T.S.D. is diagnosed according to four criteria being fulfilled: a person is exposed to a threatening traumatic event which induces a severe emotional response (Criterion A); the event is persistently re-experienced e.g. nightmares, distressing intrusive memories (Criterion B); persistent avoidance of associated stimuli and numbing of general responsiveness e.g. loss of interest, feeling of detachment from others (Criterion C); hyperarousal e.g. sleep disturbance.

Table I

|                              | very useful | quite useful | not very useful | not at all useful |
|------------------------------|-------------|--------------|----------------|------------------|
| Supportive psychotherapy     | 53.9        | 43.3         | 2.4            | 0.4              |
| Critical incident debriefing | 37.3        | 50.6         | 8.9            | 3.3              |
| Cognitive-behavioural treatment | 27.5        | 54.9         | 14.7           | 2.9              |
| Anti-depressants             | 9.2         | 61.6         | 27.6           | 1.6              |
| Phenothiazines               | 0.9         | 16.5         | 60.6           | 22.1             |
| Lithium                      | 0.0         | 3.1          | 30.0           | 66.9             |
| E.C.T.                       | 0.0         | 1.7          | 23.8           | 74.5             |

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irritability, poor concentration (Criterion D). Respondents tended to recognize the features of P.T.S.D. as defined in DSM-III-R in the questionnaire, scoring highest for features associated with criterion D (sleep disturbance 99.8%), next highest for criterion B features (intrusive memories 99.2%) and then for criterion C features (emotional constriction 81%). Regarding other symptoms, 84% felt appetite disturbance was a feature of P.T.S.D., 38% disorientation, 37% delusions, 12% elated mood and 10% morbid jealousy. Fourteen per cent of respondents made further comments. The two most common types of comment were those about an individual doctor’s own experience of the frequency, cause and treatment of P.T.S.D. and those that were critical with respect to the interface with the legal profession.

SIGNIFICANCE TESTING

The possible associations between the different variables were analysed by chi-squared testing. Female respondents (X 8.47: p < .005) and younger respondents (X^2 37.41: p < .00001) were more likely to have post-graduate experience in psychiatry. Females (X^2 5.96: p < .05) and younger respondents, particularly those under 40 years of age (X^2 14.66: p < .005), were more likely to believe that effective treatments were available. Females were significantly (X^2 5.14-7.91: p < .05) more likely to believe psychotherapy, cognitive therapy, critical incident debriefing and antidepressants were effective and significantly (X^2 4.64: p < .05) less likely to believe phenothiazines to be effective. Females (X^2 7.12: p < .01) and those with experience in psychiatry (X^2 4.13: p < .01) were more likely to be interested in further education. Those who attended lectures on post traumatic neurosis were much more likely to be aware of P.T.S.D. (X^2 29.28: p < .00001). Examining other variables, e.g. younger respondents and recognition of features of P.T.S.D., did not reveal any significant differences. There were some isolated statistically significant results e.g. females were more likely (X^2 4.79: p < .05) to recognize anger as a feature of P.T.S.D. but these were not felt to contribute to the results overall.

FACTOR ANALYSIS

Factor analysis was carried out to examine the relationship, if any, between the different possible features of P.T.S.D. and other variables such as the respondents’ acknowledged level of awareness of the condition or his/her experience of psychiatry among others. Using rotating factors, three underlying constructs were identified with regard to the possible features of P.T.S.D. (Table II). The items in factor 1 are features associated with criteria B and D of P.T.S.D. while the items in factor 3 are symptoms associated with criterion C. The items in factor 2 are not features of P.T.S.D. Level of awareness was indicated by multiple regression as being the best predictor of factor 1 (Beta = .248820). Level of awareness was also indicated by multiple regression as being the best predictor of factor 2 (Beta = - .185393) i.e. those who believed themselves to be aware of P.T.S.D. would have been less likely to incorrectly identify the items in factor 2 as being features of P.T.S.D. Experience in psychiatry, as against no experience, was indicated as being the best predictor of factor 3 (Beta = .226744). Multiple regression further indicated that the best predictor of a high awareness of P.T.S.D. was previous attendance at lectures on the subject (Beta = .301165).

DISCUSSION

A response rate of 55% for a postal survey can be considered a satisfactory response. Information received from the Central Services Agency, the overseer of general practitioners within the region, would indicate that the non responders do not differ in terms of sex or age. As an individual would be perhaps more inclined to complete a questionnaire if knowledgeable about the relevant subject, it is quite possible that the non responders have a lower level of knowledge with regard to post traumatic neurosis.

Table II

| Factor Analysis |
|-----------------|
| Factor 1        | Factor 2      | Factor 3      |
| Intrusive recollections | Delusions     | Diminished interest |
| Distressing dreams | Morbid jealousy | Emotional constriction |
| Sleep disturbance | Appetite disturbance |
| Irritability     | Elated mood   |
| Exaggerated startle | Disorientation |
The doctors who returned the questionnaire scored highly in recognizing the features of P.T.S.D. A sizeable number of respondents incorrectly felt that some of the other features were important manifestations of P.T.S.D. That 84% felt appetite disturbance was part of the condition is probably a reflection of respondents' awareness that appetite disturbance, like sleep disturbance, is a very common feature in many psychiatric illnesses. It is perhaps more surprising that over one third of respondents felt disorientation and delusions of persecution or reference were features of the condition. Again this might reflect a general awareness that such features occur in psychiatric illness. If this is the case then it may be that the high recognition level for the features of P.T.S.D. was to some extent a reflection of the fact that these were simply recognized as features of psychiatric illness in general rather than post traumatic neurosis in particular. However, the factor analysis demonstrated that those respondents who believed themselves to be more aware of P.T.S.D., or who were more experienced in psychiatry, were also more skilled at identifying the relevant symptoms.

The vast majority of respondents felt that, while most reactions to traumatic events were understandable, most of these individuals, nonetheless, required treatment. Responders in general, and female responders in particular, were also quite optimistic about the efficacy of certain treatments, and the manner in which they ranked the treatments by usefulness would probably be shared by most workers in the field,9 with one important exception: Critical Incident Debriefing is a technique developed as a prophylactic intervention and is not particularly useful in the treatment of an established post traumatic neurosis. It is heartening to see so few respondents felt phenothiazines, lithium or ECT to be of much use. Was the particularly optimistic outlook female doctors had a reflection of the greater likelihood that they had post graduate experience in psychiatry and the greater interest in the field as suggested by their declared interest in further education? It is possible that some of the associations found in the statistical analysis were chance findings due to multiple testing.

Factor analysis revealed that awareness of P.T.S.D. was the main variable associated with an ability to distinguish between those features of P.T.S.D. which form criteria B and D of the syndrome and the other features of psychiatric illness. Almost one quarter of the respondents said they were only vaguely aware of the condition. This is not surprising given the fact that 60% had never attended a lecture on post traumatic neurosis and multiple regression indicated that attendance at lectures is the best predictor of awareness of P.T.S.D. What is perhaps surprising is how relatively few of the respondents have attended such lectures, given the recent interest worldwide in post traumatic neuroses, the civil disturbances in Northern Ireland and the amount of research done on the psychological sequela to these disturbances.

Individual reactions to traumatic incidents can vary considerably. Some victims of trauma seem to cope very well without any psychological decompensation. Some individuals develop acute stress reactions which can cause considerable subjective distress but usually settle within days. Others experience adjustment reactions which can be similar in form to the acute stress reactions or, alternatively, predominantly composed of symptoms of anxiety or depression; these reactions can last for several weeks or a few months. A further group of trauma victims go on to develop phobic states, generalized anxiety states, depressive disorders or, more rarely, hysterical illnesses. A number of individuals subjected to trauma develop the condition known as P.T.S.D., of which the diagnostic criteria are listed earlier in this paper. The frequency of P.T.S.D. depends upon the nature of the trauma but it is usually not the most common post traumatic psychological reaction.

There is considerable literature worldwide which would suggest that the various types of post traumatic psychiatric morbidity are often not detected. Various reasons for this poor rate of detection have been postulated including the presence of avoidant symptoms,10, 11, 12 symptoms being viewed as understandable13 or attributed to other conditions,14 the time of presentation and the manner in which the individual presents e.g. with somatic complaints,15 and inability by doctors to diagnose post traumatic conditions.16 Twenty of the first 64 attenders at the Stress Disorders Clinic, Lagan Valley Hospital, Lisburn had first been seen for the purposes of producing a medico-legal report (Daly, O. The Development of a Stress Disorders Clinic. Paper presented at the third ECOTS, Bergen, Norway, 1993). This figure corresponds closely with the experiences at the stress disorders clinic in Edinburgh where one
third of attenders were seen initially for medico-legal purposes (C. Freeman, personal communication). This view, that one of the best ways, into specialist services for individuals with post traumatic neurosis is via the medico-legal system, is supported by others (J. Gunn, personal communication). This would suggest that individuals seen by psychiatrists for non-treatment purposes were considered sufficiently unwell to be offered specialist treatment, an opinion that did not appear to be shared by the general practitioner. It is interesting to note in the present study, that of the two most common types of comment made by respondents, one was of a critical nature with respect to the interface with the legal profession. A doctor and a solicitor can clearly be involved with the same individual who has experienced psychological difficulties following trauma for very different reasons. While clear cut diagnoses are much favoured by the legal profession, clinical psychiatry is frequently much less exact and tensions can perhaps arise when medical practitioners resist pressures brought to bear upon them to try to fit the symptoms an individual has into a diagnostic rubric when this is inappropriate.17

While the doctors in the current study performed quite well in identifying features of P.T.S.D. on a questionnaire, identification of those same features in a short consultation during a busy surgery is perhaps a different matter. Other authors have previously shown the wide variation in the abilities of general practitioners and other health professionals to diagnose mental illness.18, 19 Goldberg has described how a fairly brief programme of instruction can help doctors to recognize psychiatric illness with increased accuracy.20 The present study has shown that attendance at lectures on post traumatic neuroses may lead to a higher level of awareness of P.T.S.D. among doctors, this awareness possibly being an important factor in helping to differentiate between signs and symptoms which are features of P.T.S.D. and those which are not. It is, of course, also possible that these links are not causal and that individuals with a good knowledge of P.T.S.D. attend lectures on the subject because of their prior interest.

In conclusion, while a survey of doctors has demonstrated that they are as a group quite accurate in identifying the features of P.T.S.D. on a questionnaire, there is evidence to suggest that, as has happened worldwide, post traumatic neuroses have been under-recognized clinically and, therefore, under-treated in Northern Ireland with many individuals experiencing the considerable distress these conditions can cause, perhaps avoidably. Training doctors to recognize psychiatric illness with increased accuracy may also help in the detection of post traumatic neuroses. In addition, it may well be that attendance at post graduate lectures on post traumatic neuroses or, indeed, other forms of education in this field will lead to better awareness of the conditions, better recognition of the features and, therefore, better opportunities to diagnose the conditions and, thereby, provide the individuals with the necessary treatment.

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Copies of the questionnaire can be obtained from the author on request.

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