

worthlessness and had active suicidal tendencies, rather than death worries. Furthermore, in both of our studies, diurnal mood variations were motivated (i.e. linked to situations stressing handicaps and disabilities) in patients with major PSD, but unmotivated (with a prevalence of depression in the early morning) in patients with endogenous depression.

In conclusion, even if we share with Dr Ramasubbu some doubts about the validity of dichotomous endogenous/reactive classifications, we would stress two points: (a) our criticism was addressed to an influential model based on such dichotomy; and (b) our tentative hypothesis that psychological factors play an important role in PSD seems, at least in part, justified.

**Gainotti, G., Azzoni, A., Razzano, C., et al (1997)**

The Post-Stroke Depression Rating Scale: a test specifically devised to investigate affective disorders of stroke patients. *Journal of Clinical and Experimental Neuropsychology*, **19**, 340–356.

**Herrmann, M. & Wallesch, C. W. (1993)** Depressive changes in stroke patients. *Disability Rehabilitation*, **15**, 55–66.

**Starkstein, S. E. & Robinson, R. G. (1989)** Affective disorders and cerebral vascular disease. *British Journal of Psychiatry*, **154**, 170–182.

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## Psychiatry and civil unrest in Northern Ireland

In his editorial, Daly (1999) is critical of the research that has been done on the psychological impact of the civil unrest in Northern Ireland, both in terms of its quality and quantity. He states that opportunities for valuable research have probably been missed, and those studies that have been carried out, he weighs in the balance and finds wanting. I consider his article a potentially misleading reflection on psychiatry in Northern Ireland over the past 30 years.

Much of the research he reviews emerges as speculative and inconclusive. He is critical of Lyons' (1971) concept of "normal anxiety". The work of Cairns & Wilson (1984) is, Daly believes, of limited usefulness as the populations studied were rural, whereas violence is largely an urban phenomenon. Curran (1988) is exposed as mistaken in his view that individuals habituate to trauma. These authors published their findings 29, 16 and 12 years ago, respectively. It is all too easy to find fault today.

Daly concludes that lack of trust in the authorities and a fear of breaches of

confidentiality have resulted in treatment avoidance and exacerbation of symptoms. He gives no evidence for these conclusions. Psychiatrists in Northern Ireland have striven to avoid opportunism and prejudice, and to maintain impartiality. It would be a matter of concern if this was not the public perception.

Daly widens the concept of victim to include "terrorists incarcerated for paramilitary crimes". If offenders are to be viewed thus, there is a risk of widening the concept of victim to the point where it becomes meaningless. The research to which he refers in his next sentence (Lyons & Harbinson, 1986) related to one crime only, that of murder. Political murderers were found to be a more stable group than non-political murderers. That paper had no comment to make on the victim status of prisoners or on political crimes in general, contrary to the impression conveyed by Daly. His subsequent reference to a report in a local newspaper (*Belfast Telegraph*, 26 September 1998), in the context of psychological problems consequent on imprisonment, is speculative.

Finally, Daly has overlooked a crucial consideration in his editorial. It is no exaggeration to say that the political situation in Northern Ireland has made it difficult, if not at times hazardous, to carry out research on offenders and victims. On occasions where research has been done, it has not been feasible to publish it. Psychiatrists practising in Northern Ireland over the past 30 years have laboured under difficulties not experienced by colleagues elsewhere in the UK. Daly should not victimise them.

**Cairns, E. & Wilson, R. (1984)** The impact of political violence on mild psychiatric morbidity in Northern Ireland. *British Journal of Psychiatry*, **145**, 331–635.

**Curran, P. S. (1988)** Psychiatric aspects of terrorist violence: Northern Ireland 1969–1987. *British Journal of Psychiatry*, **153**, 470–475.

**Daly, O. E. (1999)** Northern Ireland. The victims. *British Journal of Psychiatry*, **175**, 201–204.

**Lyons, H. A. (1971)** Psychiatric sequelae of the Belfast riots. *British Journal of Psychiatry*, **118**, 265–273.

— & **Harbinson, H. J. (1986)** A comparison of political and non-political murderers in Northern Ireland, 1974–1984. *Medicine, Science and the Law*, **26**, 193–197.

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**Author's reply:** Dr Harbinson criticises my recent editorial in a rather defensive manner but does not provide any evidence to refute my opinion that opportunities for

valuable research have been missed over the past 30 years or so.

He/she seems unhappy with my review of some of the research carried out, commenting that "it is all too easy to find fault today". In my editorial I commented that "at the time Lyons (1971) was carrying out his research the field of traumatology was in its infancy" and, in relation to Curran (1988), that "more recent research in the field suggests" a different view to that of Curran regarding habituation to trauma. The whole purpose of a literature review is to examine previous research critically in the light of further developments.

In the Social Services Inspectorate document referred to in my paper (Department of Health and Social Services, 1998), the issue of confidentiality was addressed; for example, "Another G.P. noted that 'the individuals that are most affected in our area are of a predominantly nationalist viewpoint. There is a fundamental distrust of Government agencies [and] distrust and fear of leakage of sensitive information' ". Information received from the project leader in the Social Services Inspectorate has confirmed a minority, but consistent, viewpoint, mainly from those of a nationalist background, that the authorities, including those working in health and social services, are not to be trusted (J. Park, personal communication, 1999). As Dr Harbinson writes, this indeed should be a matter of concern.

Dr Harbinson is critical of me for commenting that "some people would consider terrorists incarcerated for paramilitary crimes to be victims". It has been reported that a number of people who subsequently become involved in terrorist crime have themselves previously been victimised (Smyth, 1998). A study looking at 80 perpetrators of homicide found that 52% met criteria for current post-traumatic stress disorder (Pollock, 1999). It would seem unethical to exclude anyone from being considered a victim, and therefore a potential candidate for treatment, on the basis of having been involved in criminal activity. Dr Harbinson has commented that on occasions it has not been feasible to publish research carried out. I find it difficult to understand why properly structured and anonymised research could not have been published. In order to ensure that psychiatrists maintain impartiality, it is important that such research should be published whatever the results, provided the findings are clinically relevant.

Dr Harbinson's final comment about my victimising other psychiatrists is rather emotive. He/she is correct regarding the speculative nature of some aspects of my paper. This has been necessary because of the relative lack of research. However, I am certainly not intending that criticism be directed at colleagues, a number of whom have carried out valuable research while also carrying heavy clinical workloads. It remains my view that there is a need for a detailed epidemiological community study which specifically addresses the issue of trauma.

**Curran, P. S. (1988)** Psychiatric aspects of terrorist violence; Northern Ireland 1969–1987. *British Journal of Psychiatry*, **153**, 470–475.

**Department of Health and Social Services (1998)** *Living with the Trauma of the Troubles*. Belfast: Social Services Inspectorate, DHSS (NI).

**Lyons, H. A. (1971)** Psychiatric sequelae of the Belfast riots. *British Journal of Psychiatry*, **118**, 265–273.

**Pollock, P. H. (1999)** When the killer suffers: post-traumatic stress reactions following homicide. *Legal and Criminological Psychology*, **4**, 185–202.

**Smyth, M. (1998)** *Half the Battle: Understanding the Effects of the 'Troubles' on Children and Younger People in Northern Ireland*. Belfast: INCORE.

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### Studying grief in adults with learning disabilities

I read with interest the article by Bonell-Pascual *et al* (1999) and would agree that recognition of, and service provision for, the bereaved adult learning disability population is markedly deficient. However, their conclusion that learning disability is a significant predictor of future mental health problems following bereavement is not substantiated and should be interpreted with caution in view of the flawed research methodology.

The original cohort reported short-term psychopathological and behavioural outcomes following bereavement (Hollins & Esterhuyzen, 1997). This case-controlled study found an increase in aberrant behaviours and psychopathology in those bereaved compared with controls. Bonell-Pascual *et al* aimed to investigate whether the same outcomes had changed over a longer term (six to eight years). Unfortunately, the control cohort was not followed up, thereby making meaningful inferences impossible, as confounding life events are not controlled for. Also, more than half the study population had additional medical

disorders of likely prognostic significance. The authors recognise the limitations of their small sample size, but this is further compounded by incomplete follow-up of the original cohort, with greater than 15% of the original cohort excluded. Furthermore, follow-up data are missing from the analysis of psychopathology and aberrant behaviour.

In the classification of psychopathology, each sub-scale shows varied changes with no interpretable trends over time. Psychopathology identified in the original 1997 study had resolved in over 70%, although a few new cases were identified, especially in the adjustment and anxiety disorder sub-categories. However, we cannot attribute these new cases to underlying learning disability as confounding medical and life events may have played a significant role. Aberrant behaviour patterns were reported as showing a mean increase in each sub-scale over time. The individual change in aberrant behaviour patterns was, however, in both directions in all sub-scales (i.e. an improvement and deterioration in behaviour). The mean change quoted by the authors in such a small study sample with wide ranges of behaviour is, therefore, unreliable. Similarly, the one statistically 'significant' result, showing inappropriate speech to be more common, should also be treated with caution and taken in isolation is unlikely to be of clinical significance. Furthermore, the authors allude to problems with validation of the behavioural and psychopathological measures used in the significant proportion of the study population who were taking antipsychotic and antidepressant medication.

It is now recognised that people with learning disability do understand the permanence of death and consequently grieve (Harper & Wadsworth, 1993; Read, 1996). Bonell-Pascual *et al* highlight the need to better understand the general and specific needs of this vulnerable group of people and provide some useful insight into effective interventions. Future studies should be aimed at addressing these issues, be carried out prospectively and have adequate control groups to allow safe and meaningful conclusions to be drawn.

**Bonell-Pascual, E., Huline-Dickens, S., Hollins, S., et al (1999)** Bereavement and grief in adults with learning disabilities. A follow-up study. *British Journal of Psychiatry*, **175**, 348–350.

**Harper, D. C. & Wadsworth, J. S. (1993)** Grief in adults with mental retardation: preliminary findings. *Research in Developmental Disabilities*, **14**, 313–330.

**Hollins, S. & Esterhuyzen, A. (1997)** Bereavement and grief in adults with learning disabilities. *British Journal of Psychiatry*, **170**, 497–501.

**Read, S. (1996)** Helping people with learning disabilities to grieve. *British Journal of Nursing*, **5**, 91–95.

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**Author's reply:** We have read Dr Lyons' letter with interest, and considered his/her comments with great care. It is encouraging that the letter also highlights the need for further research in this area, and we are happy to say that we have new research in progress.

We acknowledge that the methodology of the published report has limitations, but that does not mean that it is flawed. Dr Lyons does little more than amplify the limitations spelled out in what was, after all, only a short research report. It is perfectly acceptable to use data from the first study as longitudinal data in the follow-up study. Furthermore, although follow-up of the original control group might have yielded some useful material, it is more probable that it would have been unreliable, because of the likelihood that these individuals would have experienced bereavements themselves in the intervening time between the first and second study.

Dr Lyons suggests that new 'cases' at follow up cannot be attributed to the underlying learning disability as confounding medical and life events may have played a part. One of the key points made in both 1997 and 1999 papers is that the effects of bereavement are compounded by the increase in life events experienced by the client group at such a time.

With regard to the size of the second sample, the shortfall is not excessive: as stated in the paper, three of the missing individuals were dead, and three untraceable, possibly also dead. The true follow-up rate could thus be more accurately described as 41 out of 44, or 93%. Furthermore, two of the remaining three carers refused to help with the follow-up interviews because bereavement was too sensitive an issue for either the relative or the person with learning disability.

Dr Lyons suggests that the results of the study are not 'meaningful'. The original manuscript, which was cut in length at the request of the Editor, included qualitative material collected from carers at the same time as the quantitative data. This material supports the results of the quantitative data,