New Bridge

Findings from a Community Survey

In Lawrencetown

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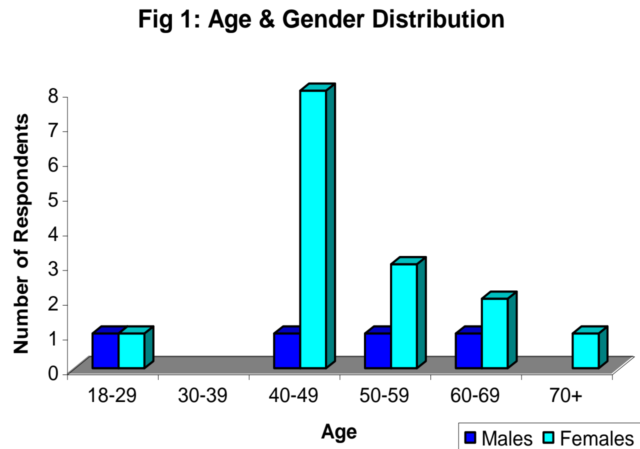
DEMOGRAPHICS[1]

19 individuals from the Lawrencetown area completed the survey questionnaire. 79% were female (n=15). 21% (n=4) were male. Their ages ranged from 23 to 80, with an average age of 51 years.

Figure 1 displays respondent age by gender. The majority of females fell within the 40-49 years age category (n=8).



Data on marital status was available for 17 individuals. 88% (n=15) of respondents were married/living with a partner. 1 individual was single, never married and 1 was widowed.

The majority of respondents identified their religion as 'Roman Catholic' (56%; n=10). 39% (n=7) reported their religion as 'Protestant'. 1 individual was unwilling to provide this information and 1 did not respond.

AREA & HEALTH

Respondents were asked a number of questions about the area they lived in. This included how individuals viewed the area in which they lived and what they considered to be the main social and/or economic issues affecting their community.

Resident Stability

The majority of respondents had lived in the Lawrencetown area for more than 10 years (79%; n=15). 2 respondents had lived in the area between 1 and 5 years and a further 2 had lived in the area between 6 and 10 years.

Various reasons were given for living in the area, the most common being because they were born in the area (42%; n=8) and/or they moved to be close to either their own or their partner's work (42%; n=8). 16% (n=3) moved to the area to be near to family/friends.

[1] Due to rounding up or down, some percentages may be less than or exceed 100 when totalled.

Views on the Area

58% (n=11) of respondents indicated that the area they lived in was *' a good area, it is a good place to live'*. The remaining 42% (n=8) reported that they *'don't mind the area, it's as good a place as any other'*. None of the respondents indicated that the area was *'not a good area'*.

A variety of statements were presented and respondents were asked to indicate how much they agree or disagree with each statement when thinking about the area that they live in. As indicated in Table 1, Lawrencetown respondents were generally positive about their area. All respondents described people in the area as friendly. The majority also felt that the area was safe, with good community spirit and the people were willing to help each other. Many indicated that the area was a good place to bring up children, although facilities for teenagers were generally viewed as inadequate. Lack of jobs was viewed as a problem by 44% (n=7) of respondents.

Many respondents reported that alcohol abuse was rising in the area and drug abuse was viewed as a problem by just over half of those respondents who answered this question (6 respondents failed to answer). Only 39% (n=7) of respondents felt that their area was *'changing for the better'*, although 83% (n=14) described the area as having a lot of potential.

Table 1: Views on the Area

	Strongly Agree	Agree	Disagree	Strongly Disagree	D/K or No Answer
People here are friendly	42% (n=8)	58% (n=11)			
Alcohol abuse is rising in this area	40% (n=6)	40% (n=6)	13% (n=2)	7% (n=1)	N=4
I feel safe here	44% (n=7)	44% (n=7)	13% (n=2)		N=3
There are not enough facilities for teenagers around here	44% (n=7)	44% (n=7)	13% (n=2)		N=3
This area is changing for the better	6% (n=1)	33% (n=6)	56% (n=10)	6% (n-1)	N=1
There is conflict between old and young		35% (n=6)	47% (n=8)	18% (n=3)	N=2
This is a good place to bring up children	16% (n=3)	68% (n=13)	11% (n=2)	5% (n=1)	N=3
Drug abuse is a problem here	22% (n=3)	31% (n=4)	46% (n=6)		N=6
There are too many people moving in and out of the area	6% (n=1)	29% (n=5)	59% (n=10)	6% (n=1)	N=2
There is a good community spirit here	11% (n=2)	74% (n=14)	16% (n=3)		
Lack of jobs is a big problem here	13% (n=2)	31% (n=5)	44% (n=7)	13% (n=2)	N=3
This area has a lot of potential	12% (n=2)	71% (n=12)	18% (n=3)		N=2
There is a lot of noise at night here	17% (n=3)	6% (n=1)	61% (n=11)	17% (n=3)	N=1
People around here are willing to help each other	11% (n=2)	84% (n=16)	5% (n=1)		N=1

Social Problems

Respondents were asked to indicate whether various social issues were problems in their area by rating them as either *'a serious problem', 'a problem but not serious'* or *'not at all problem'*. Responses are summarised in Table 2.

Respondents viewed litter and rubbish in the street as the main social problem affecting their area. Approximately 1 in every 2 respondents indicated that vandalism/hooliganism and theft/burglary were either *'serious problems'* or *'problems but not serious'*. Joy riding and threat of sectarian violence were least likely to be viewed as problems by Lawrencetown respondents.

None of the respondents indicated that any of these social problems affected their health (1 respondent indicated that s/he did not know whether these problems had affected his/her health).

Table 2: Social Issues

	A Serious Problem	A Problem but not Serious	Not a Problem
Vandalism and hooliganism	16% (n=3)	37% (n=7)	47% (n=9)
Graffiti	5% (n=1)	42% (n=8)	53% (n=10)
Theft or burglary	16% (n=3)	32% (n=6)	53% (n=10
Litter and rubbish in the street	21% (n=4)	68% (n=13)	11% (n=2)
Threat of sectarian violence		11% (n=2)	90% (n=17)
Joy riding	11% (n=2)	5% (n=1)	84% (n=16)

LOCAL SERVICES & FACILITIES

Respondents were asked to rate on a 4-point scale, ranging from *'very easy'* to '*very difficult'*, the accessibility of a range of services/facilities. This included access to medical facilities, leisure/social facilities and general community facilities.

As indicated in Table 3, almost two thirds of respondents indicated that it was either *'very'* or *'fairly easy'* to access the chemist and Doctor's surgery – although over one third of respondents found it difficult to access these services or indicated that these services were not available in their area. Over half of respondents reported that a hospital casualty was not available in their area, with a further 16% (n=3) indicating that, where available, this service was difficult to access.

Respondents generally found it easy to access the post office, bus stop and supermarket. Many also indicated that some leisure-type facilities such as the community centre and pensioners' drop-in were

easy to access, although the leisure centre, children's playground and youth club were viewed by many as either difficult to access or not available. Over half of respondents also indicated that a job centre was either not available to them or difficult to access.

Table 3: Local Services & Facilities

	Very Easy	Fairly Easy	Fairly Difficult	Very Difficult	Service not Available	D/K or No Answer
Bus Stop	47% (n=9)	32% (n=6)	11% (n=2)	11% (n=2)		
Chemist	32% (n=6)	32% (n=6)	21% (n=4)	5% (n=1)	11% (n=2)	
Community Centre	33% (n=6)	39% (n=7)	17% (n=3)		11% (n=2)	N=1
Doctor's Surgery	21% (n=4)	42% (n=8)	16% (n=3)	16% (n=3)	5% (n=1)	
Hospital Casualty	11% (n=2)	21% (n=4)		16% (n=3)	53% (n=10)	
Job Centre	16% (n=3)	26% (n=5)	5% (n=1)	11% (n=2)	42% (n=8)	
Leisure Centre	11% (n=2)	32% (n=6)	5% (n=1)	16% (n=3)	37% (n=7)	
Children's Playground	17% (n=3)	39% (n=7)	22% (n=4)		22% (n=4)	N=1
Pensioners' Drop-in	31% (n=5)	38% (n=6)	6% (n=1)		25% (n=4)	N=3
Post Office	42% (n=8)	37% (n=7)	11% (n=2)	5% (n=1)	5% (n=1)	
Supermarket	42% (n=8)	26% (n=5)	11% (n=2)	5% (n=1)	16% (n=3)	
Youth Club	38% (n=6)	19% (n=3)	13% (n=2)		31% (n=5)	N=3

Transport

63% (n=12) of Lawrencetown respondents indicated that they had regular use of their own transport - 25% (n=1) of males and 73% (n=11) of females.

21% (n=4) used public transport at least once a week, with 5% (n=1) using it almost daily. 1 respondent used public transport 2-3 times per month. 73% (n=14) of respondents either never or rarely used public transport.

Of the 26% (n=5) of respondents who used public transport, all indicated that they used the bus. No respondents used the train or any other types of public transport. The most common reason given by respondents for using their own transport was that they preferred to use their own transport (79%; n=11).

HOUSING

The relationship between housing and health has been well documented. Indeed, the government white paper 'Saving Lives: Our Healthier Nation' (1999) recognises housing as a key health determinant. Much research has examined the complex relationship between poor housing and risk to health. For

example, Evans and Bennett (1998)[2] summarised studies linking poor housing to increased levels of limiting long-term illness, respiratory and infectious diseases, accidents, psychological problems, perceived poor health and even increased mortality. It was therefore considered important to examine housing issues within the New Bridge study. Individuals were asked about their current housing situation, the number of household occupants, household overcrowding, household complaints and the impact of such housing conditions on their physical and mental health.

Housing Type

47% (n=9) of respondents lived in detached housing. 26% (n=5) lived in semi-detached housing, with a further 26% (n=5) living in terraced housing.

Housing Tenure

68% (n=13) of respondents had bought or were buying their home. 26% (n=5) rented their property from the Housing Executive. 1 individual co-owned his/her home.

Household Occupancy

A total of 64 individuals lived in 19 households, an average of 3.4 individuals per household.

No respondents lived alone. 37% (n=7) lived with 1 other person. 53% (n=10) of households had between 3 and 5 people living within. 1 household accommodated 6 people and 1 accommodated 7 people. Only 3 individuals did not live full-time in the home.

Housing Problems

Respondents were asked to rate, on a 4-point scale, the extent to which they experienced a number of housing problems. 18 respondents provided this information. Their responses are summarised in Table 4.

Respondents were generally satisfied with their housing, with very few problems identified. Outside noise was viewed as a *'very serious'* problem by 2 respondents. Other serious problems identified by respondents were a leaking roof, draughty windows and lack of space.

Table 4: Housing Problems

	Very serious problem	Quite serious problem	Minor problem	Not a problem
Damp/condensation		6% (n=1)	17% (n=3)	78% (n=14)
Outside noise	11% (n=2)		6% (n=1)	83% (n=15)
Leaking roof	6% (n=1)			94% (n=17)
Draughty windows/doors	6% (n=1)	6% (n=1)	33% (n=6)	56% (n=10)

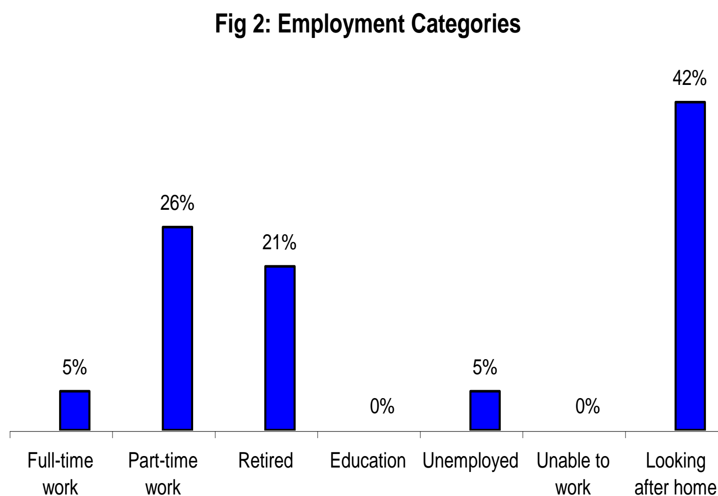
[2] Evans, M, & Bennett, A. Healthy Environments. Health Evidence Bulletins. Wales. http://hebw.cf.ac.uk/healthyenvirnments/chpater10.html

Faulty electrical wiring			6% (n=1)	94% (n=17)
Inadequate hot water			6% (n=1)	94% (n=17)
Poor heating			6% (n=1)	94% (n=17)
General disrepair		6% (n=1)	6% (n=1)	89% (n=16)
Steps into the house			6% (n=1)	94% (n=17)
Lack of space	6% (n=1)		6% (n=1)	89% (n=16)

Individuals who indicated that they experienced housing problems (n=4) were asked whether these problems affected either their mental or physical health. However, no respondents provided an answer to this question.

EMPLOYMENT

The relationship between employment and health has been well-documented. For example, Faragher, Cass and Cooper (2005)[3] reported job satisfaction to be associated with a number of psychological problems such as burnout, self esteem, depression and anxiety. Therefore individuals were asked about their current employment situation and the impact of this on their physical and mental well-being.



As indicated in Fig 2, 32% (n=6) of respondents were in employment. Only 1 individual was in full-time employment (30 or more hours per week) and 5 were in part-time employment (less than 30 hours per week).

1 respondent was registered unemployed. 42% (n=8) indicated that they were looking after the home/family. 21% (n=4) of respondents were retired. 3 had been retired between 2 and 5 years. 1 respondent had been retired for 10 or more years.

No respondents were unable to work due to long-term sickness or disability and no individuals were in education.

[3] Faragher, E.B., Cass, M. & Cooper, C.L. (2005). The relationship between job satisfaction and health: a meta-analysis. *Occupational & Environmental Medicine, 62, pp105-112.*

Economically Active

As indicated above, 32% (n=6) of respondents were employed. The individual in full-time employment was male. 4 of the 5 individuals in part-time employment were female. Respondents cited a variety of jobs: a classroom assistant; a caretaker's assistant; a housekeeper; a ramp supervisor; a school supervisor; and a youth worker.

The majority of respondents worked within the local area (83%; n=5). 1 individual worked elsewhere in Northern Ireland.

The majority of respondents had been in their job between 1 and 5 years (67%; n=4). 2 respondents had been in their current job for more than 10 years.

83% (n=5) respondents were *'very'* satisfied in their current job. 1 respondent was *'quite dissatisfied'*- however s/he indicated that this dissatisfaction did not adversely affect his/her health. 60% (n=3) indicated that they thought their job was either *'very'* (n=1) or *'fairly'* (n=2) secure. 2 felt that their job was *'insecure'* and 1 didn't know how secure his/her job was. The 2 individuals who indicated that their jobs were insecure did not feel that this had an adverse affect on their health.

Economically Inactive

47% (n=9) of respondents were economically inactive[4] - all were female. 71% (n=5) had never had a paid job. 1respondent had last been in a job 2-5 years ago and 1 had not been in a paid job for 6 years or more. 1 respondent indicated that she didn't know how long it was since she was last in a paid job. All 3 respondents left their last paid job to look after children/home.

75% (n=6) of economically inactive respondents indicated that they would not like a job at present. The other 2 indicated that they did not know whether they would like to be in a job. Only 1 respondent reported that being out of work had a negative effect on her health – her mental health. She also reported that being out of work caused some arguments/tension with family/friends. This person was economically inactive due to looking after children/home.

Voluntary Activity

39% (n=7) of respondents were involved in voluntary work – 1 male and 6 females. All voluntary work was connected to an organisation. Hours per week involved in voluntary activity varied.

[4] 'Economically inactive' incorporates individuals who were either registered unemployed, looking after the home/family or long-term sick. The 3 retired respondents are not included here.

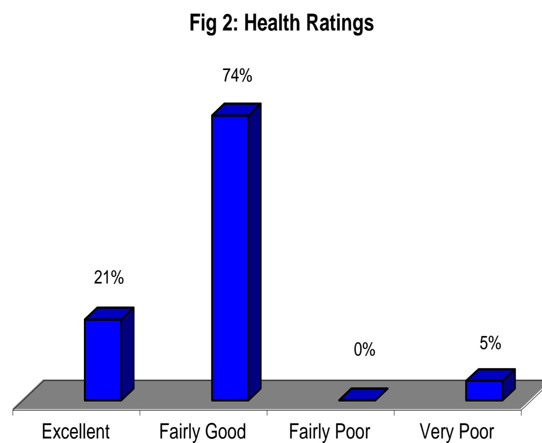
Of those respondents who did not volunteer, only 2 indicated that they would be interested in volunteering.

PERSONAL HEALTH

Personal ratings of health are commonly assessed in population and community-based surveys. They have the advantage of capturing multiple dimensions of health, being easily answered and are viewed as a reliable predictor of future morbidity and mortality (Grau et al, 1998)[5]. Therefore, respondents were asked to rate their general health, compared to people of their own age, on a 4-point scale ranging from *'excellent'* to '*very poor*'.

As indicated in Fig 2, the majority of respondents (95%; n=18) reported that they had either *'excellent'* or '*fairly good'* health compared to other people their age. 1 respondent rated his/her health as *'very'* poor.

Fig 2: Health Ratings



The majority of respondents (74%; n=14) reported that their health was *'about the same'* as a year ago. 2 indicated that their health was *'somewhat better'* than a year ago and 3 felt that their health was *'somewhat worse'* than a year ago.

Factors Affecting Health

Respondents were presented with a list of attributes associated with good health and asked to rate how important each of them were to having overall good health. These responses are presented in Table 6. The 2 factors most rated as being *'very important'* were getting enough exercise (74%; n=14) and having a healthy diet (68%; n=13). Respondents generally viewed being in a paid job and having adequate income to be less important to good health.

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[5] Grau, L., West, B. & Gregory, P. (1998). 'How Do you Feel?: Self-reported health as an indicator of current physical and mental health status.' *Journal of Psychosocial Nursing, Vol 36, 6, pp25-30.*

Table 6: Factors Affecting Health

	Very Important	Quite Important	Not Very Important	Not at all Important	D/K or no answer
Getting enough exercise	74% (n=14)	26% (n=5)			
Having access to good health services	58% (n=11)	37% (n=7)	5% (n=1)		
Having a healthy diet	68% (n=13)	32% (n=6)			
Being in a paid job	6% (n=1)	22% (n=4)	56% (n=10)	17% (n=3)	N=1
Feeling good about yourself	58% (n=11)	37% (n=7)	5% (n=1)		
Living in decent housing	42% (n=8)	47% (n=9)	11% (n=2)		
Having support from family/friends	58% (n=11)	32% (n=6)	11% (n=2)		
Having adequate income	32% (n=6)	42% (n=8)	21% (n=4)	5% (n=1)	
Having time to yourself	47% (n=9)	42% (n=8)	11% (n=2)		

Ill Health/Disability

22% (n=4) of respondents indicated that they had a long-term illness or disability that affected their day-to-day life. 2 respondents suffered from arthritis and 2 from osteoporosis.

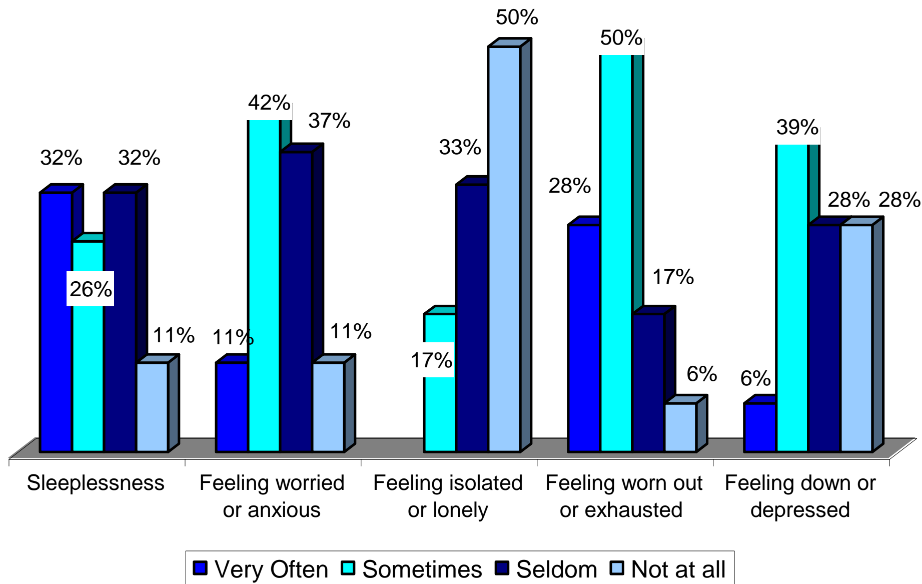
2 of these individuals indicated that they received support. 1 received help with personal care, household chores, paperwork/financial matters and emotional/mental health needs. The other respondent received help with household chores only and indicated that s/he did not wish to receive help in any other area. Both respondents received this support from a family member.

Emotional Stress

To obtain an overall indication of emotional stress levels within the community, respondents were asked how often, over the previous few weeks, they had experienced:

- Sleeplessness
- Feeling worried / anxious
- Feeling lonely / isolated
- Feeling worn out / exhausted
- Feeling down / depressed.

As indicated in Fig 4, over three quarters (78%; n=14) of respondents reported feelings of exhaustion either *'very often'* or *'sometimes'* over the last few weeks. Over half of respondents indicated that they had experienced sleeplessness (58%; n=11) and/or felt worried or anxious (53%; n=10) either *'very often'* or *'sometimes'* over the previous few weeks. 45% (n=8) reported feeling down or depressed. Respondents were least likely to report feeling isolated or lonely, with only 17% (n=3) indicating that they had felt this way over the last few weeks.



Respondents who expressed feeling any of the above feelings/problems were asked how they would normally deal or cope with these feelings. 17 individuals responded to this question. The most frequent ways were:

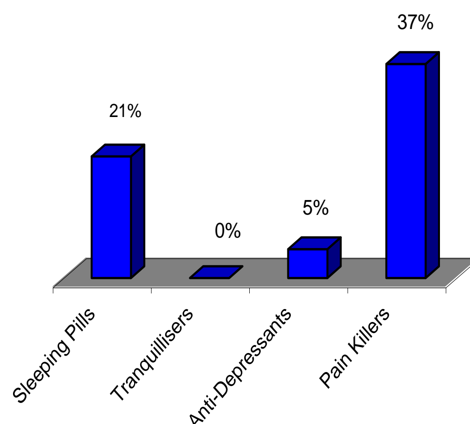
- Talk to a family member or friend (35%; n=6)
- Deal with the feelings alone (29%; n=5)
- Try to get out to take their mind off their problems (24%; n=4)
- Don't deal with them/ignore them (24%; n=4)

Social Support

74% (n=14) of respondents indicated that they had someone to confide in if they had a problem, indicating a high level of support within the community. 37% (n=7)) had *'a lot'* of people they could rely on. 42% (n=8) had *'a few'* people they could rely on and 21% (n=4) had *'very few'* people they could rely on. No respondents had '*no one'* they could rely on.

Prescribed Medication

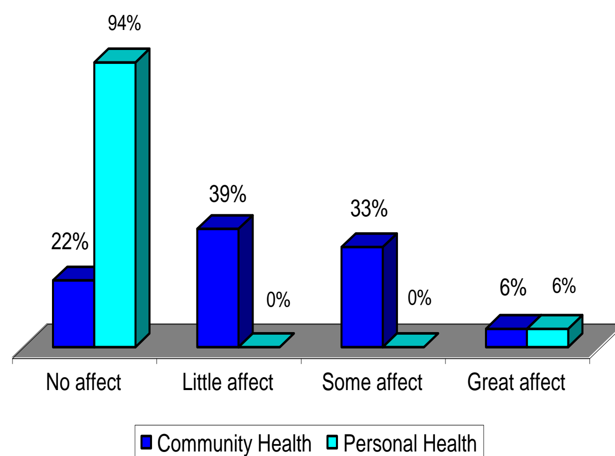
Respondents were asked whether they had been prescribed any of four types of medication over the past year. As indicated in Fig 5, 37% (n=7) had been prescribed painkillers over the past 12



months. 21% (n=4) of respondents had been prescribed sleeping pills. 1 individual had taken anti-depressants. No respondents had taken prescribed tranquillisers.

IMPACT OF 'THE TROUBLES'

It is widely acknowledged that 'the Troubles' have had a negative affect on the mental and physical health of individuals and communities across Northern Ireland. For example, Smyth, Morrissey and Hamilton (2001)[6] reported that a higher proportion of people living in areas of high intensity violence reported having poorer health than those living in areas of low violence. To determine the impact of 'the Troubles' within the Gilford area, respondents were asked to rate the effect 'the Troubles' had on the health of their community and on their own personal health. 18 individuals responded to this question.



As indicated in Fig 5, 39% (n=7) of respondents felt that 'the Troubles' have had either *'some'* or a *'great affect'* on the health of their community. However, 61% (n=11) indicated that the 'the Troubles' have had either *'little'* or *'no affect'* on the health of their community.

A greater number of respondents (94%; n=17) indicated that 'the Troubles' had *'no affect'* on their own personal health. Only one respondent felt that 'the Troubles' have had a *'great affect'* on his/her own health.

CARERS

53% (n=10) of Lawrencetown respondents were caring for a person on a regular basis. 8 carers were female and 2 were male. All were caring for 1 individual. 4 respondents were caring for an individual with a physical disability only; 1 for an individual with a physical illness only; and 1 for an elderly person.

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[6] Smyth, M., Morrissey, M. & Hamilton, J. (2001). Caring Through the Troubles: Health and Social Services in North and West Belfast. Derry/Londonderry: Institute for Conflict Research.

The other 4 carers were caring for an individual with more than 1 ‘need’: an elderly person with a physical illness; an elderly person with both a physical illness and physical disability; an individual with a physical illness and disability; and an individual with a physical illness and learning disability.

40% (n=4) of carers were caring for a son or daughter and 40% (n=4) were caring for a wife/husband or partner. 1 carer was caring for a parent and 1 for a neighbour. All but 1 carer (90%; n=9) lived in the same household as the person they were caring for. 33% (n=3) of respondents had been caring for over 10 years. 55% (n=5)) had been caring for between 4 and 10 years and 1 carer had been caring between 2 and 3 years.

9 respondents provided information on the type of activities they assisted the person they cared for with. All assisted with personal care, supervision with medication, household chores, and emotional or mental health needs. 33% (n=3) also helped with paper work or financial matters. All cared 7 days a week. Hours per week spent caring varied:

- 5 (56%) cared 11+ hours per day
- 2 (22%) cared 24 hours per day
- 2 (22%) cared 6-8 hours per day

Support

Carers were asked whether they were receiving any support in their caring role. 9 provided this information and all were receiving support. 4 received support from a support group; 2 received practical support, a sitting service and support from a support group; 2 received respite and support from a support group; and 1 received respite alone.

3 carers received their support from a voluntary group and 3 from both a voluntary group and social services. 1 received support from social services only. 1 received support from a voluntary group and a family member and 1 received support from a family member only.
8 carers provided information on whether they received enough support in their role as carer. 7 (88%) indicated that they received enough support. 1 carer did not receive enough support.

5 (56%) carers reported that it was either fairly difficult or impossible to get a break from caring. 4 (44%) indicated that it was easy to find someone to help.

Caring and Health

9 carers provided information on the impact caring had on their health. 33% (n=3) reported that caring had a negative impact on their physical health and 1 felt that caring had a negative impact on his/her

mental health. 4 carers (44%) indicated that caring had a negative affect on both their mental and physical health. 1 carer indicated that caring had no noticeable affect on his/her health.

5 carers indicated that being a carer placed additional stress on their relationships with family and friends, with 4 indicating some arguments/tension and one reporting a complete breakdown of relationships. 4 carers reported that being a carer did not affect their relationships. 1 carer did not answer this question.

GENERAL HEALTH QUESTIONNAIRE

The General Health Questionnaire is a self-administered screening test aimed at detecting psychiatric disorders among respondents in community settings (Goldberg & Williams, 1988[7]). It is a widely used questionnaire having been employed in a range of clinical studies (for example, individuals with diabetes, individuals recovering from a stroke). It has been used across a range of occupational groups (for example, teachers, pharmacists, and nurses) and also within special interest groups (for example, teenagers, lone parents, and disabled individuals).

The GHQ-28 involves asking individuals whether they have experienced a particular symptom in the previous 2-week period. Responses are rated on a 4-point scale. There are two main ways in which to score the scale:

- One is the 'Likert method' where the 4-point scale is scored from 0 to 3 (0,1,2,3). This scoring method allows for an average GHQ-28 score to be calculated.

- An alternative scoring method is the 'GHQ scoring method' which involves scoring the scale as either 0 or 1, with the first 2 responses on the 4-point scale producing a rating of 0 and the last two responses obtaining a rating of 1(0,0,1,1). This method of scoring enables the identification of 'potential cases of psychiatric disorder'.

As each of the scoring methods serve different purposes, both were used to score the questionnaires. GHQ data was available for 16 respondents.

Likert Scoring Method: When the GHQ-28 is scored on a scale from 0 to 3, the lowest possible score is 0 and the highest possible score is 84.

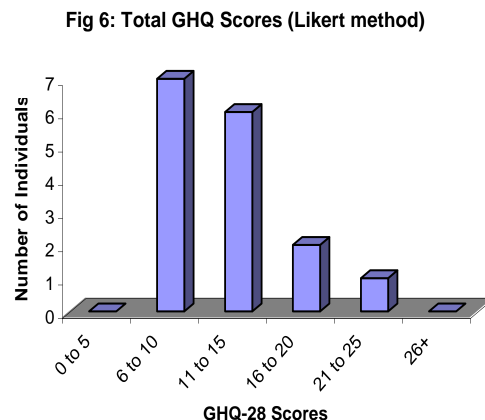
- The average score from individuals who completed the questionnaire was 11.88

[7] Goldberg, D. & Williams, P. (1988). A User's Guide to the General Health Questionnaire. NFER-NELSON.

- The lowest score was 6.
- The highest reported score was 23.

As indicated in Fig 6, no respondents reported GHQ-28 scores between 0 and 5. The majority of respondents scored between 6 and 15 on the scale (81%; n=13). A further 2 scored between 21 and 25, and 1 scored between 21 and 25. No respondents scored 26 or above on the GHQ-28.

A study carried out by Cairns and Wilson (1984)[8] obtained GHQ-30 scores from a community sample of 797 Northern Irish adults. Individuals lived in 1 of 2 towns that experienced contrasting levels of violence. These were labelled Hightown (which experienced a high level of sectarian violence) and Lowtown (which experienced a low level of sectarian violence). The study found that:



- Individuals who lived in Hightown reported an average GHQ-30 score of 23.50
- Individuals who lived in Lowtown reported a lower average GHQ-30 score of 20.87
- The average GHQ-28 scores from individuals living in the Lawrencetown area (11.88) is considerably lower than either of these 2 scores.

GHQ Scoring Method:

When the GHQ method of scoring is used, the lowest possible score is 0 and the highest possible score is 28. A cut-off score between 4 and 5 is used to calculate the number of 'cases' in a given population. A 'case' is a term attached to those individuals who have a higher score than the cut-off point and could therefore be considered 'potential cases of psychiatric disorder' (Felicia et al., 1988). Individuals with total scores below the cut-off point are considered to be 'non-cases'.

When the cut-off point between 4 and 5 (scores of 4.5 and over) is used with the Lawrencetown sample, only 13% (n=2) of individuals can be considered to be 'cases'. This is a lower percentage of 'cases' than that found by Cairns and Wilson, where 32% of individuals in Hightown were considered to be 'cases' and 21% of individuals in Lowtown were considered 'cases'.

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[8] Cairns, E. & Wilson, R. (1984). 'The Impact of Political Violence on Mild Psychiatric Morbidity in Northern Ireland.' *British Journal of Psychiatry, 145, pp 631-635.*