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.

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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.



https://doi.org/10.1192/bjp.176.3.296 Published online by Cambridge University Press