

## **The birth of a paper in the *British Journal of Psychiatry*: a complex voyage of development for Orla Muldoon and the editorial team**

Many members of the College and potential authors are curious to know more about the passage of papers through the Journal's editorial process. To accompany the publication of the paper by Muldoon & Downes in this issue (pp. 146–149) I thought an account of how it traversed the many obstacles we set up on the pathway to publication would be of some interest. The publication of all the comments have been approved by the referees and the author (but the reader should note that generally in the editorial process at least some of the referees choose not to disclose their names, particularly when the verdict is a negative one). I have interposed some general comments also that may help to guide reviewers.

### **General notes about submissions**

All authors follow the format described in 'Instructions to authors', easily accessed online (<http://bjp.rcpsych.org/misc/ifora.shtml>). The manuscript then joins the on-line queue to the Handling Editor (usually me but can be other senior editors from the International Editorial Board when I am unable to examine a manuscript or have a conflict of interest). The Handling Editor reads through the paper and decides whether or not it is worthy of review. If not, a letter is sent to the author explaining the reasons for this decision. The reason for this 'screen' is that 80% of papers are rejected and if all of those rejected had to be reviewed, it would create undue delay and also exhaust our reviewers. It is worth noting in this context that neither the Editor nor any of the reviewers, with the exception of our statistical advisors, receive any stipend for their work.

### **JANUARY 2006: FIRST SUBMISSION BY DR MULDOON AND ITS AFTERMATH**

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When Dr Muldoon first submitted her paper in January 2006 she added in her cover note 'We believe that the British Journal of Psychiatry is a suitable outlet for this research as

the journal has a wide readership amongst psychiatrists, clinical psychologists and mental health professionals. The data presented in this paper is based on new data, the study represents a valuable addition to the existing literature and as such will be of interest to your readership. ‘ I decided after looking at the paper that it did seem worthy of closer examination and one of my concerns was that we had not published a paper on the troubles in Northern Ireland for some time. This seemed to be a paper that covered the subject well and was a population based survey.

Here I have to declare an interest. My maternal grandfather was a farmer in County Monaghan and his livelihood, and that of my mother, was considerably affected by the conflict in Northern Ireland after partition, so I am fascinated by the subject area. Very few editors are completely neutral about a submission.

The reviewers I choose are ones who are likely to be informed and interested in the subject. I usually choose between four and five reviewers in the first set of reviews and expect two or three to be able to respond within two months, unless I am asking for a fast-track review. Sometimes none of the selected reviewers is able to review the paper and I am then compelled to undergo a second round of reviews. Authors at the time of original submission have the choice of recommending, or excluding, reviewers and this can be sometimes helpful to the Handling Editor. Very occasionally it is necessary to ask the authors if no reviewers are available after several attempts to nominate a set of potential referees.

On this occasion I only succeeded in getting a review from one of my four referees, Edgar Jones, a professor of the History of Medicine and Psychiatry. Here is his review.

## **REVIEW**

Reviewer: E Jones

Recommendation: Not suitable for publication in current form.

This is an interesting paper that attempts to explore an important question: the long-term psychiatric effects of terrorist violence in Northern Ireland. A telephone survey of a representative sample of 3000 adult was conducted to discover the incidence of PTSD. This was discovered to be 12% of those living in the North and 6% of those in the South, which are surprisingly high figures given earlier studies that have suggested that civilians in the Province had coped well with the Troubles: (see Curran, 1988). It is also higher than the rates recorded for British troops deployed to the Gulf in 1991 (1-3%) and British troops deployed to Iraq (7%). Soldiers, trained to cope with the stress of war, may record lower rates than civilians living in war zones, though they are, of course, exposed to greater risks.

The paper suffers from an obvious weakness, which the authors themselves have identified. They were only able to gain responses from 51% of those contacted – refusals running at 48% in Northern Ireland and 52% in the Republic. This suggests that their findings may not be representative as those who feel well probably have no desire to participate in the study. Furthermore, no attempt has been made to verify whether subjects who participated were actually exposed to life-threatening events. This is important as it is criteria A of the PTSD definition.

The Troubles, though terrifying to those directly involved, were in fact a low intensity war and mortality was mercifully low. Between 1969 and 2001, for example, 302 RUC officers and 2,263 civilians were killed as a direct result of the Troubles. To put this in context, 7,287 civilians were killed in road traffic accidents over the same period. We know that psychiatric casualties move in direct relationship to the killed and wounded rate, so the figure of 8.3% (or 1 in 12) seems high. We also know that most people exposed to a life-threatening event will not suffer from PTSD, and that of those that do exhibit the symptoms, 60% will recover with or without treatment within six months. One possible explanation is that some respondents do not fulfil criteria A of the PTSD definition. They may well have heard of frightening events or seen them on the news but not actually experienced them in person. Because the authors did not verify people's accounts (a major task admittedly), it may have elevated the incidence of possible PTSD.

Another possible explanation is that their sample included a disproportionate percentage of those with psychiatric symptoms.

The second clinical implication ('poverty appears to exacerbate the impact of chronic political violence' tells only part of the story. Historical studies of political violence tell us that the disadvantaged are more likely to riot than the wealthy or powerful; they have little to lose and may believe that they have something to gain.

## **Final Decision**

The Handling Editor is placed in a difficult position when only one review is available, particularly when the recommendation is 'not suitable for publication in current form', which is one notch above rejection. Should another review be requested, leading to delay, or can a decision be made on the basis of the recommendation received? On this occasion, despite some concerns, I was inclined to be generous and the first sentence of the review had perhaps the strongest influence on me.

*Decision letter: Send for revision*

Dear Dr Muldoon,

Thank you for sending us your paper. I am sorry it has taken longer than I would have liked to get reviewed and I have only one formal report. Rather than persist with other reviewers at this stage I thought I should make a decision about the fate of the paper. Because I feel the subject is an important one I am prepared to consider a revision at this point even though there are many aspects of the paper that are not satisfactory. It is too long and discursive, it deviates at times from its main purpose, it is too self-congratulatory, it does not cover the relevant literature from equivalent conflicts, it has a major deficiency in only having around 50% response rates, and it is a little parochial bearing in mind that we are an international journal. However, because it is topical and potentially important I am therefore offering you the opportunity of revising the paper in

shortened form (not more than 2500 words) and to let me have a revised version within the next three months of the date of this letter. I must stress that I will be determined to get a fuller set of reviews at that time and the chances of the paper being accepted will depend on their responses.

The Discussion section should have at least four subheadings.

Please explain in a separate letter the changes you have made and those that you have been asked to consider but feel are inappropriate. In making your revision please make every effort to ensure that the title is as short and as accurate as possible, that the abstract reflects the content of the main paper, and that your references conform to journal style. We are no longer putting a cap on the numbers of references but please include only those that are considered absolutely necessary.

Yours sincerely

Prof. Peter Tyrer

## **SECOND SUBMISSION**

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The authors accepted my suggestions and resubmitted their manuscript. On this occasion I was able to obtain the reports of three reviewers, Professor Jones again, a Dutch expert on post-traumatic stress disorder with a special interest in refugees, Dr Cornelius Laban, and Dr Murray Stein, a highly productive researcher on anxiety and post-traumatic stress disorders from the United States.

### **REVIEWS**

Reviewer: Edgar Jones

Recommendation: Not suitable for publication in its current form

I still think it is methodologically weak having a response rate of only 51%. This point is not acknowledged in the 'limitations' bullet points, which seems odd.

No attempt has been made to verify subjects' accounts of traumatic experiences. Some who have PTSD may have gained the disorder as a result of a RTA or family violence - ie nothing to do with the Troubles.

There are some weak statements about the relationship between poverty and political violence: 'poverty appears to exacerbate the impact of chronic political violence'. I think this is too simplistic. My understanding is that relative values are more important than absolutes and the speed of change in peoples' fortunes are also important. Some veterans rioted in 1918 not because they were worse off than others but because their incomes had dropped significantly from their pre-war wage.

Hence, I am not sure all the points I raised in my original assessment have been addressed.

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Reviewer: Cornelis Laban

Recommendation: Not suitable for publication

General remarks: The subject is very relevant. There are no epidemiological studies done so far in Northern Ireland on PTSD.

However, as known, trauma is not only a risk factor for PTSD but for all kinds of psychiatric disorders. (eg, the mentioned study of De Jong (2001) found that other anxiety disorders had high prevalence rates) A study on prevalence rates of a broad range of psychiatric disorders, using a solid and widely used instrument (like e.g. the CIDI), which also has been used in other countries , would have been more preferable. But, some knowledge is better than nothing.

The abstract is promising.

Introduction

The time frames and the instruments of the studies in Israel and Sri Lanka are not mentioned. In the discussion the authors compare their findings with these studies, but it is impossible to

the readers to really compare the results with these studies. Poverty and trauma are both riskfactors for psychiatric problems and it is interesting that the authors include both these factors in one study. On the whole the introduction needs some reframing.

#### Methods

Using telephone survey may limit the number of poor people, they either have no phone or they have cell phones only from which the numbers are not registered. Also the non-English speaking population is excluded, most immigrants belong to the poor classes.

I do not see how table 1 suggests that the sample was comparable with the census because there are no figures of the census shown. Was education and income of the group interviewed also comparable with the census? It would be helpful if the cut-off score for the PTSD instrument was mentioned.

The first question (did you encounter a distressing event as a result of the 'troubles'?) is crucial. 35 years is a long period to remember. I doubt if people were able to answer this question correctly. It would have been better if the list of 'experiences of political violence' was asked first (before the PTSD instrument). The researchers could have been able to decide if an experienced item fulfilled the A criteria of the PTSD criteria and then go on with the questions.

No information is given about the experiences which were investigated, not everybody (eg me) knows the study of Macksoud, 1992. The 2 added questions are coming out of the blue, they were not mentioned in the aims of the study, and coping was not mentioned as a research goal.

#### Results

Some more tables could be introduced, especially about the characteristics of PTSD cases; the present presentation is confusing. There is an inconsistency in presenting percentages: sometimes decimals: 6,1% 13,5 etc sometimes not eg 31% 20% etc.

Coping was not part of the research goals, but it gets a big place and even a table in the results. The authors should make a choice. My view is that this information does not bring any thing news, so it would be best to omit it.

We are not getting any insight in the type of experiences, what is direct, what indirect? I may be able to guess but in the aims of the study the authors tell us they assess the relationship between the trigger event and PTSD, but I do not see this in the results. Also it is a bit easy to talk about chronic traumatisation if somebody mentions a direct or indirect

experience. The reader is left with many questions; what experience, how often, how long, and what event is gives the highest risk?

Multivariate analyses are badly missing here. The authors are looking for the risks of trauma and poverty for PTSD. In a multiple logistic regression analyses they could have calculated Odds Risks for these items, corrected for age and sex eg and get more and better answers to their questions. Results of feeling a victim : this item was also not an aim of the study. The finding is not part of the discussion, it suggests that the authors have not kept to discussion of their main goals.

#### Discussion

This part is below standard. The significant difference between the two groups is interesting and should be mentioned here and discussed. I am not convinced why ‘the finding gives better support for the notion etc ‘Low income and low education is associated with higher PTSD rates. Maybe these determinants go together with more traumas (as the authors state by quoting Cairns) but because no multivariate analyses were done the authors can only guess which risk factor is more important.

I miss comparisons of prevalence rates with the non-conflict counties in Ireland.

#### Conclusion:

It is a pity but I think the article is not fit for publication

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Reviewer: Murray Stein

Recommendation: Accept with minor amendment

For the authors:

In this revised manuscript, the authors have polished the presentation and responded to a variety of reviewer critiques. The result is a succinct manuscript that clearly highlights the research questions and provides interesting data in response. Given the dearth of published data on PTSD in the Northern Ireland conflict, it is a valuable contribution to the literature.



Methodological limitations are noted. Most vexing is the response rate but there is nothing to be done about it at this point. The data are nonetheless of interest, with the appropriate caveats to their interpretation highlighted by the authors in the Discussion. Nonetheless, I would strongly recommend that the low response rate (high refusal rate) be further highlighted in point form in the concluding clinical implications section of the manuscript.

## **Final Decision**

In making a decision on this paper I was struck by the lukewarm response of Edgar Jones to the second submission and the many uncertainties still expressed about the study. I reluctantly decided, despite Murray Stein's positive report, that this paper was not quite up to standard, and so rejected the manuscript.

*Decision letter: Reject*

Dear Dr Muldoon,

I am sorry to say that I have not been advised to accept your revised paper for publication in the British Journal of Psychiatry. Although one of the referees was happy with this the real problem of the low response rate has been highlighted even more strongly and I fear we cannot go ahead. To view the reviewers comments please go to the 'Author Area' at <http://submit-bjp.rcpsych.org> and click on the 'Manuscripts with Decisions' queue. I hope this will be helpful to you should you decide to offer it for publication elsewhere.

There is extreme pressure on the Journal's capacity, and many papers which we would like to accept are not successful in the competition for space in it, so even consistent lukewarm support for a paper may not be sufficient for a positive outcome.

Thank you for letting us see your manuscript.

Yours sincerely,

Prof. Peter Tyrer  
British Journal of Psychiatry

## **APPEAL**

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<p>We offer our authors the possibility of an appeal against rejection of their papers, and Dr Muldoon, whom by this stage was getting more combative, felt a robust response was needed.</p>
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Dear Prof Tyrer

Many thanks for your response to our revised article (MS ID# BJP/2006/022038). Although, I realise it is unusual to query editorial decisions, I feel compelled to respond to your decision on this occasion.

Our paper has been rejected subsequent to revision. The main issue identified in your correspondence appears to be the response rate to the survey. If the stumbling block to publication is the response rate, I am unclear why we were invited to revise the paper. This issue had been raised by reviewer 1 on first review. If the response rate was deemed sufficient to invite a revision at that stage, it is unclear why it is so problematic on subsequent review, especially given that reviewer 1 and 2 consider the response rate acceptable at times 1 and 2 respectively. Reviewer 3 didn't even think the response rate warranted a mention. That aside, our sample remains representative of the population and the response rate and is similar to that obtained in previous surveys of this nature. In sum, given the response rate was known when the article was first submitted, a request for a revision should not have been made if it truly were a 'deal breaker'.

In relation to the other substantive points made by reviewer 1 (that some of those who

have PTSD may not have gained the disorder as a result of the Troubles); this criticism is unfair and disingenuous. We specifically asked respondents if they had symptoms as a result of troubles related experiences. This methodology has been used widely previously to establish the incidence of PTSD post conflict and these studies have been published in well established journals such as Journal of American Medical Association. Additionally the relationship between scores on the experience of the troubles scale and PTSD case-ness does provide verification. Overall, it would appear that reviewer 1 has some difficulty accepting the fact that civilian populations in Northern Ireland have been affected by the Troubles (see review 1), or perhaps even that they can be relied on to be truthful. Not only that, he/she is clearly unhappy with the contention that poverty may exacerbate PTSD (see both reviews 1 and 2). Whilst I acknowledge that the poor may be instrument of their own misfortune in situations of political violence (and have written on this topic) a full discussion of this issue really is beyond the scope of this 2000 word short paper.

My final concern is the rather long list of almost editorial queries made by reviewer 3 (I have attached short details of these response below). We would welcome the opportunity to respond to these comments, many of which are minor and merely require clarifications.

Clearly we are disappointed with the decision not to publish this study which is topical, important and valuable. To have the manuscript rejected because of the response rate seems akin to 'throwing the baby out with the bathwater'. Publishing this material in a US based publication will of course have to be our next course of action. This study is the only population level study of PTSD that has been undertaken in Northern Ireland over the 35 years of 'the Troubles'. I think this is a sad indictment of the UK system that a mainstream journal such as the British Journal of Psychiatry is unwilling to accept the work. As such I would urge you to reconsider your decision.

I trust that you will take our comments in good faith and thank you in advance for your consideration,

Yours truly,

Dr. Orla Muldoon

## **APPEAL REVIEW**

I thought there were some strong points in favour of a full reassessment of the paper. Many authors feel it is pointless appealing against a refusal as 'the editor has already made up his/her mind and will just get other referees to back it up'. This perhaps is too cynical. The life-blood of a good journal are the reviewers, and if an editor ignores their recommendations consistently there will be a fatal haemorrhage, I made an appeal to our extremely busy but sprightly editorial colleague, Professor Simon Wessely, to look at the substance of the paper again and examine the other reviewers' verdicts.

Reviewer: Simon Wessely

Recommendation: Accept with moderate amendment

Thanks for asking me to give a second opinion on this. As you know, usually I tend to agree that anything that requires a "second opinion" is probably not that interesting anyway, but on this occasion I am not of that opinion.

True, as so often is the case with any PTSD research, it takes a far too narrow psychiatric perspective, and also seems to take too little account of what is already published about mental health in Northern Ireland, and how that relates to the current findings.

For example, it does not mention anywhere what for years was the "conventional wisdom" to the effect that the "troubles" caused little in the way of psychological disorder in the population, other than acute/transient ones. The paper takes it for granted that adversity is *per se* a cause of psychiatric disorder. But this is not necessarily so. Durkheim argued that adversity can bring communities together, and increase resilience, as well as giving a sense of purpose to life. Jones and I have researched for example the

London Blitz. The civilians who stayed in London during the Blitz were a "community under stress" par excellence. Twice as many people died during each of the weeks of September 1940 than in the entire "Troubles". The purpose of strategic bombing, whether of London, Rotterdam or the German cities, was to break civilian morale. It was a weapon of terror, a weapon of mass destruction as we would style it today. And it was seen as such; every single pre war expert, planner, psychiatrist and politician assumed that the "bomber will always get through" and the consequence would indeed be mass panic, demoralisation and collapse of morale.

The bombers did get through, and the social order did not collapse. For the Blitz we confirmed that the popular stereotype of a citizenry that proved remarkably resilient to stress is indeed largely correct (Jones et al, 2005; 006). We concluded that it was the shared sense of purpose, and of risks shared equally, that was a principal reason.

The studies of Germany, under even heavier blows, likewise came to the same conclusion. Historian Catherine Merridale in her studies of death, mourning and trauma in Soviet Russia shows how the simplistic equation of adversity, trauma and psychiatric disorder can vary from culture to culture - the Russians for example simply had no concept of post traumatic stress disorder during the Second World War, viewing their immense suffering in political and nationalistic, rather than personal, terms - see Cathy Merridale's seminal studies on this point (Night of Stone).

There was no increase in psychiatric disorder in the Army in Northern Ireland - in the PTSD Judgement of Mr Justice Owen he cites a report by a British Army psychiatrist in 1970

"The incidence of psychiatric illness amongst troops in Northern Ireland remains low and it is noticeable that as tension heightened and operational activity increased in 1971, so the rate of psychiatric referral fell."

Research has already documented a fall in the suicide rate in the UK after Sept 11 (there is as yet no data from the USA, but we know that health care utilisation FELL after 9/11, see last weeks paper- only to rise about a year later, presumably as the mass counselling programme got underway - OK we don't know that was the reason, but that is my view!. Virtually every commentator has noted the increase in community feeling, interactions and sense of purpose that swept across America after the outrages.

I have to admit that my knowledge is coloured by our research on the police/RUC, but that is still relevant. For example, at the height of the Troubles, the "Health and Management of the Force" report of 1984 the authors report that "morale in some of the most difficult areas was in fact sound, and possibly better than in some of the less difficult ones". Durkheim would have understood that immediately. Likewise, in a brief commentary for the "Encyclopaedia of Stress" Paul Bell, an Northern Irish psychaitrist, noted beyond the RUC that for some the Troubles had led to an improvement in mental health, if they lived in "tightly knit ghettos with increased community spirit and support", invoking both the Blitz spirit and Emil Durkheim in support. Curran's oft cited paper that argued that the Troubles had not led to any increase in psychiatric morbidity made much the same point. Bell goes on to speculate that if "the troubles were to end, and Northern Ireland returned to more normal social functioning, then we might see an upsurge in psychological morbidity". Does the Muldoon/Downes paper suggest this has come to pass?

Also relevant is the Durkheimian literature on the RUC (Royal Ulster Constabulary). Mapstone(1992) for example argues that the antipathy that the RUC received from one side of the community divide increased, not decreased, RUC group solidarity - why should this not apply to other "sectarian" groups?. (Editor's note: readers not aware of the details of the Northern Irish troubles may not realise that the Royal Ulster Constabulary (RUC) was almost an exclusively Protestant organization and therefore regarded as biased by the Catholic population).

Jennifer Brown, an expert on police stress, comments on her findings of lower occupational stress in senior RUC officers compared to those in England and Wales with

the observation that "a credible external threat has the capacity to create a sense of coherence and solidarity among communities and increases their mutual interdependence". Again, whilst I accept without reservation that the RUC are not really civilians, and at least for some of the time were hardly above the sectarian divide, nevertheless, the point I am making, and the authors do not, is that it is simplistic to link "troubles" with "psychiatric disorder" let alone PTSD. The authors also make no mention of the contemporary studies, such as those by Curran, by Lyons after the Belfast riots, and so on, which at the time failed to document an increase in psych problems in the communities affected.

The general theme of the literature in the 1980s was to remark on the absence of any substantial increase in mental health problems as a result of the Troubles - the oft cited Curran paper of 1988 being a good example of this. Look at the 1999 paper that starts with the sentence "most studies which looked at the civil disturbances in Northern Ireland for the 25 years until the ceasefire declarations in late 1994 concluded that the impact on the psychological health of the population was insubstantial" (daly, Br J Psych). Or look at a recent study carried out on the mental effects of the Troubles begins by commenting on the relative lack of interest in the subject until recently, largely because of the general view that any effects were likely to be transient (see Morrisset and Smyth, Northern Ireland after the Good Friday agreement, 2002).

OK, so far so good, but how then can we explain the findings of Muldoon/Downes? Is it simply "PTSD" or is it in fact more complex? I would suggest that what they are missing is any consideration that the problems are more the result of peace than war.

How can this be? Well, Oscar Daly, whom the authors will I am sure know well, and is a Northern Irish psychiatrist, wrote that it was not until the end of the Troubles that people really started to come forward for treatment (see [http://www.dartcenter.org/europe/articles/news\\_events/n\\_i\\_transcript.html#\\_Toc78871602](http://www.dartcenter.org/europe/articles/news_events/n_i_transcript.html#_Toc78871602) . He also writes that

"Now the prevailing view until relatively recently was that the Troubles hadn't affected people psychologically. And that was probably the view until the Ceasefires. I feel that that's a mistaken view and there are a number of reasons as to why that might have been".

The conventional wisdom therefore during the period in question was that there was surprisingly little psychiatric impact to the Troubles, repeated in many publications.

It may be, as Daly believes, that the morbidity was always there, but only started to become obvious once the Troubles had ceased. The only way of knowing would be via a longitudinal study with repeated follow up measures on the same individuals over the period, which was never done or even as far as I can see suggested. It is telling that the 1997 epidemiological study from the District of Derry begins by saying "this is the first in depth study of psychiatric morbidity in Northern Ireland", and that was still only a cross sectional design . I note also that particular study concluded that

"it is striking that the 1-month and 1-year prevalences of psychiatric disorder in Derry were not appreciably different from a deprived inner-city area of London" [McConnell, 2002) - this study, like all the others I have cited, is not mentioned in Muldoon/Downes - they seem rather unaware of other population psychiatric morbidity surveys. For example, The 1997 Health and Wellbeing survey of Northern Ireland used the self report questionnaire the GHQ 12 as a marker for psychological disorder (OK, its not PTSD, but every study ever done shows it is tightly correlated to PTSD) and showed an overall caseness rate of 21%, which is rather low in population terms (we have reported higher rates in UK general practice and in the British Army). However, they did find some relationship to exposure to the "Troubles" - again, I am surprised however that this is not mentioned by the authors.

They were able to carry out some interesting cross sectional analyses of being a case - one relevant finding was that those living in disadvantaged circumstances were much more likely to rate an impact of the Troubles on their lives. This is in keeping with our understanding of the effects of adversity, which are moderated, or "buffered" in the



jargon, by factors such as social support and socio economic circumstances. This thus does support the current paper

Four years later the survey was repeated , and the rates of psychiatric disorder were unchanged. If the Troubles were indeed a substantial factor in psychiatric morbidity, one might predict that levels should have started to fall by then. (Northern Ireland Health and Social Wellbeing Survey 2001, Bulletin number 2; [www.nigra.gov.uk](http://www.nigra.gov.uk)). Overall people in Northern Ireland are however more likely to rate their own health as "poor" than those in the rest of the United Kingdom or the Republic of Ireland.

However, it is as plausible that for whatever reason these problems did not actually occur until after the Troubles, which would be the Durkheimian explanation. It is also difficult to reconcile this with other studies - for example in the study of the RUC by Wilson et al, published in 1997 only 2% of those who had been exposed to serious terrorist related life threatening violence exceeded the treatment cut off for PTSD, and only 5% achieved "caseness", and this was with a denominator of only those exposed to life threatening violence, not the entire RUC.

Reconciling these sources of data is not easy - if the total numbers involved in this litigation represents a major part of all those with occupational psychiatric injury, and the proportions in the Wilson paper are also correct, that gives us a figure of between 100,000 and 250,000 RUC officers exposed to life threatening violence. The total strength of the RUC during the period in question amounted to some 16,000 officers and a further 7600 full time reservists (data from Legal Services). Thus nearly 6,000 out of a total strength of some 24,000 are now claiming psychiatric injury, an implausible proportion if the sole reason for joining the litigation was acute psychiatric injury. Does this have relevance to the civilian population - it might?

What has happened to the RUC, and what might also have happened to civilians, is that the former, and possibly the latter have reassessed their own views of themselves in the light of the Patten process and the formal ending of the RUC. The crisis in morale in the

RUC came after the end of the IRA campaign, and was associated with the Patten report and the disbanding of the RUC and/or its metamorphosis into the PSNI. It was then that people began to wonder why they had withstood all the pressures of the Troubles, and what it was all about.

A sociological analysis of the RUC concludes that Patten challenged the collective memory of the RUC, which until then had been characterised by "sacrifice and commitment, community support and accountability" (Mulcahy). Chris Ryder, the unofficial historian of the RUC, describes it thus:

"For several years the peace process, with its associated and ever more rancorous talk of police reform and RUC downsizing, had been generating uncertainty and even anger within police ranks. There now smouldered a deep sense of hurt that their great sacrifice was being ignored and a growing sense of insecurity that come the peace they would be paid off and cast into an uncertain future, where there would find themselves unemployable, their reputations smeared and their personal safety compromised" .

The end of the Troubles has seen a general shift of interest into what sociologists call "victimhood" - now that the Troubles are over comes a reassessment of who did what to whom, who has suffered, and of course who is to blame . Morrissey and Smyth note how competing claims to victimhood are now political acts, with each side making claims and counter claims to be considered as the victims of the other.

Laying claim to victim status alongside other groups can be seen as a different strategy for gaining acknowledgement that all have suffered - the various communities, the RUC and so on. None of this would be possible when the war itself against the IRA was the pressing concern - to portray oneself then as a victim could seem to be a sign of weakness, and also giving propaganda to the "enemy", whichever enemy that might be. Only with the end of the conflict was there less necessity to continue with the stoicism and resilience necessary during the Troubles itself in the face of a common enemy.

I have just finished reading Arik Shalev's concerning the experiences of Israelis living under continuous terror - it is worth the authors taking a look.

"Possibly the most consequential lesson from years of terror in Israel is that despite leaving communities relatively untouched, more and more individuals come to pay the full price. When all this comes to solution, those affected survivors...will bear the full consequences of current follies. They will eventually become more and more alienated when societies reach solutions. Hence the need to remain vigilant and adamant about their rights and their destiny"

Israel and the Palestinian people have not had their Good Friday agreement or ceasefire, let alone Patten. But what Shalev is saying applies I believe to NI. When a "war" or civil emergency ends, although the rest of us can now get on with our lives, it is then that those who have been bereaved or damaged will start to experience bitterness, anger and alienation. Of course, as the authors show (and I found that to be the most compelling part of the paper), many of those in NI do not consider themselves "victims", much in the same way as Norwegian resistance workers, US GI's in World War 2 and so on and so forth, do not consider themselves victims or having any mental disorders (see Jones and my book on the subject) - but some do.

Anyway, this is an interesting paper. I liked it. It is population based. It had a lowish response rate, but who doesn't in this day and age? It doesn't seem to have been biased by that, since the associations were all predictable. I believe it is original, but I think it would benefit from a little more sociology, and a little less PTSD.

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## Appeal Decision

I responded to this review by writing to Dr Muldoon with a positive message. I clearly could not ignore such a powerful critique – but I still had many concerns.

*Decision letter: Send for Revision*

Dear Dr Muldoon,

Following your appeal I have a mixed message for you and your colleagues. Although the appeal is partly allowed as a consequence of the independent review I have received (see below), which incidentally is the longest review I have ever received as editor, I feel that its content indicates such a substantial rewrite of your paper that I have to still reject your paper and invite another resubmission. However, in view of the positive nature of the comments, and indeed my own reading of the paper when I first saw it, I am in 'accept mode' for your paper now and will do everything possible to get it over the line separating publication from rejection.

In making your revision I have looked carefully again at your resubmitted paper and feel that it can be reduced a little further to no more than 3,600 words as well as taking some of the important points raised by the referee. The message 'more sociology and less PTSD' is one which I generally endorse but need not be followed too slavishly. However, the criticism that you have not taken enough cognisance of the previous literature is apposite and I hope you can correct this.

If you accept these suggestions I look forward to receiving a revised version within the next two months if possible.

With best wishes,

Peter Tyrer

## **THIRD SUBMISSION**

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### **REVIEWS**

Reviewer: Simon Wessely

Recommendation: Accept with minor amendment

It is still not quite what I would have liked, but then again, its not my paper, its their's, so fair enough

I agree the title is a downer

How about "Psychological distress after the Troubles? Is peace worse than war?" or "Psychological distress and the Northern Ireland Troubles - the hidden costs of peace"

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Reviewer: Murray Stein

Recommendation: Accept with minor amendment

For the Editor:

Hi Peter. For a revised title, I like "Prevalence of post-traumatic symptoms following long-term conflict in Northern Ireland". I don't think the term "Troubles" is widely understood.

Parts of the paper are still difficult to follow. For example, the Abstract seems to contradict itself. It says that PTSD cases were more likely to rate national identity as relatively unimportant... but then goes on to say that group identity does NOT seem to protect against mental health symptoms in the post-conflict setting.

I have made a number of comments for the authors. Once they make the changes, it should be ready to go.

For the Authors:

The authors have made a number of changes to the manuscript as per the reviewer recommendations. The manuscript is improved, but there are still a few areas of inconsistency or lack of clarity.

Specifically:

1. The abstract seems to say that low rating of national identity was a risk factor for PTSD symptoms, but then goes on to say that group identity does NOT seem to protect against mental health symptoms in the post-conflict setting. This requires clarification.
2. The the term "Troubles" should be defined early in the manuscript. I do not believe that all readers will be familiar with this term.
3. In the methods section, the use of the PCL is described, and the authors refer to the utility of a cutoff score. But they don't tell the reader what the cutoff score was. This information should be provided.
4. The Discussion is not sufficiently critical about the relationship between the present findings and other studies that are referred to. For example, the authors claim that their rates of PTSD are similar to certain other studies... without noting how those other studies are radically different in terms of methodology (e.g., case definition, among other things). To say that their results are either similar to -- or higher than -- the other studies cited is meaningless without careful consideration (at minimum, mention) of methodological differences.
5. Also in the Discussion, the authors make the suggestion that social identity is protective against PTSD, but "may recede post-conflict." It is not clear how or why they make longitudinal claims based on cross-sectional data. This statement should be further supported, or deleted.
6. Toward the end of the Discussion, the authors refer to a "limitation" having to do with events viewed through the news media. It is unclear what they're saying. Are they saying they assessed this form of exposure and found no cases? Or that this type of exposure was not assessed? Either way, it is unclear why they feature this particular shortcoming here. Perhaps this could be clarified.

## **Final Decision**

*Decision letter: Send for Revision*

Dear Dr Muldoon,

Thank you for sending us your revised paper. I am glad to say that it is now getting close to being accepted. One referee is quite happy but the second has some concerns which may seem fairly trivial but I think need addressing. There is also concern about the title. Non-UK/Ireland readers do not fully understand the term 'The Troubles' and one of the referees has suggested the title 'Prevalence of post-traumatic symptoms following long-term conflict in Northern Ireland'. I think this type of title would be the most informative as the more lyrical alternatives (eg. A country no longer distressful, but some distress remains?) is quite unsuitable for a scientific journal. However, could you ensure that whatever title you choose is relatively short. Could you let me have your amendments as soon as possible as we both appreciate this paper has been too long in our system.

Please explain in a separate letter the changes you have made and those that you have been asked to consider but feel are inappropriate. In making your revision please make every effort to ensure that the title is as short and as accurate as possible, that the abstract reflects the content of the main paper, and that your references conform to journal style.

To view the referees' reports please go to the Author Area at [submit-bjp.rcpsych.org](http://submit-bjp.rcpsych.org) and click on Manuscripts with Decisions.

To submit your revised manuscript go to the Author Area at [submit-bjp.rcpsych.org](http://submit-bjp.rcpsych.org) and click on Submit a Revision.

Yours sincerely



Prof. Peter Tyrer

## **FOURTH SUBMISSION**

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*Decision letter: Accept*

Dear Dr Muldoon,

Thank you for sending your revised paper to the British Journal of Psychiatry. I am pleased to inform you that it has now been accepted for publication. Could I also request a favour. In the past we have occasionally published the text of correspondence relating to a paper as this can be helpful for readers and authors wanting to know about the process and systems for reviewing papers. Your paper had a somewhat byzantine passage through this maze but it was an interesting one. Would you be willing for the text of our correspondence to be published, together with the comments of our reviewers if they agree (not all of which you have seen), in an agreed and mildly edited form, probably at the same time as your paper is published? I emphasise that we would not go ahead until we had approval of the final text from all involved. Perhaps you could let the BJP office know about this separately from the on-line system for this paper. I do hope you will be happy to take part in this educational process.

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Peter Tyrer

(NB. In the future, if all journals become 'open access' ones, this last clause may become mandatory and all papers would then incur a publication fee).

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## Postscript

The reader will note that the period between first submission and publication of this paper (in this issue) was 19 months. This is a great deal longer than the average paper which, if accepted, is likely to appear in the Journal within a year of being first received and within 6 months of being accepted. Some authors of topical papers are invited to take part in a podcast with Professor Raj Persaud immediately after publication and after 6 months authors are asked if there have been any interesting or noteworthy developments following publication. The most important of these will be reported (Tyrer 2007). The journey along the publication trail can be a bit of a roller-coaster but its ending can be very gratifying.

**Tyrer, P. (2007)** Consequences of publication in the *British Journal of Psychiatry*. *British Journal of Psychiatry*, **190**, 188.