EX-POST PAPER

PTSD, trauma, stress and the risk of (re)turning to violence

Summary

Both trauma awareness and recognition of trauma signals are important skills in the toolbox of a mental health worker, but they should also be present in a social worker's toolbox. With increasing numbers of returning foreign fighters (expected), and with them children who have grown up in conflict areas, either as children of parents active in Daesh-held territories or as refugees, but also as victims of terrorism, awareness-raising among practitioners will be crucial going forward.

In the same vein, local and national authorities will need to organise long-term follow-up of traumatised individuals and families, as experience from the conflicts in Northern Ireland and former Yugoslavia have shown. This requires equipped support structures and services, as well as cooperation between professionals in law enforcement, justice, prison and probation, social services, health and education. This is needed to enable adequate treatment and ensure long-term prevention strategies have a better chance of success.

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State of play: insights into PTSD, trauma and stress

A presentation from the European Society for Traumatic Stress Studies set the scene on trauma and post-traumatic stress disorder (PTSD). With the aim of boosting prevention, radicalisation research is attempting to explain how traumatisation can be linked to different forms of radicalisation. Traumatisation is a very complex phenomenon, and the terms 'trauma' and 'PTSD' are only two of many connected phenomena. Trauma is a dynamic process that becomes more complex over time.

Trauma means on the one hand being a victim to the events that have happened to a person. On the other hand, could the trauma also, as a result of trauma suffered, (re-)engage in violent behaviour. Some studies have shown that trauma exposure increases the risk of delinquency[1], while childhood abuse and mistreatment also increase the likelihood of the use of violence in adult life. Studies of disadvantaged children show that traumatised individuals do not feel safe and cannot find a space of safety.[2]

While there is a correlation or relationship between PTSD, delinquency and re-offending rates, this does not necessarily imply causality. It does however show that rehabilitation strategies need to be at the core of treatment in order to break the link between trauma and crime.

Often overlooked in discussions on trauma is the fact that it is not a static phenomenon fixed in time that only has a 'post' phase. Indeed, the concept of ongoing traumatic stress response (OTSR) should be recognised. A trauma is not just a happening from the past; it is certainly also related to the future. A trauma can reappear and the individual suffering from this can feel as if the original event is happening over and over again, thus developing chronic fear and a sense of helplessness.
The way trauma works is that the:

1. Amygdala[3] becomes physically bigger. It is overactivated and in a constant state of alarm;
2. Hippocampus[4] functions poorly;
3. Pre-frontal cortex is affected.

Another important concept is the 'window of tolerance'. The more exposed to trauma a person is, the less/smaller the 'window of tolerance'. This can lead to fast hyperarousal and engagement in risk behaviour to get arousal. So-called appetite aggression is typical of former combatants. A first step, is that the person might have become used to violence (numb) due to overexposure, and then starts to enjoy repetitive aggression over time. Former combatants might have difficulty keeping a calm state of mind.

[1] R. Vermeiren (2003), Psychopathology and delinquency in adolescents: a descriptive and developmental perspective
[2] Shown for example by Judith Herman in Trauma and Recovery (1994).
[3] The part of the brain dealing with emotions, emotional behaviour, and motivation.
[4] Highly involved with our memory and our emotions, it serves to consolidate information from the short-term memory to long-term memory,

State of play on challenges ahead: child returnees and foreign fighters

The key challenges going forward are mainly linked to the expected increase in child returnees and foreign fighters from former Daesh-held territories. The challenges are:

Immediate concerns
This includes: parents of child returnees being prosecuted, while children go into foster care or to a legal guardian; child returnees coming back on their own; practical and administrative concerns (judicial follow-up, access to documentation, school and education issues, re-integration and re-socialisation, etc.).
Medium- and long-term concerns
In particular: long-term effects of conflict on parents and children, separation from family members and loss of family members, and readjustment to society.

Dealing with these challenges presumes the setting-up of the right structures at national level to support victims, as well as foreign fighters themselves. This must be done and relatively quickly to ensure these people are not left on their own.

Challenges also exist at a more methodological level, including:

- Developing more detailed PTSD guidelines for relevant practitioners.
- Ensuring more emphasis is placed on interventions dealing with interpersonal and emotion regulation problems [5].
- Establishing holistic approaches. In Northern Ireland, sociocultural, transgenerational, and identity issues contribute to the expression and treatment of trauma. If a holistic approach is not taken, this could cause interventions to fail or clients to disengage [6].
- Ensuring a gradual approach. Direct trauma memory processing approaches are highly effective for PTSD, but may initially be too challenging for individuals with Complex PTSD. A more gradual phased approach, emphasising safety, coping strategies, relationship-building and stability, is likely to be required before trauma memory processing [7].

FTF returnees are a major security concern precisely because of their battlefield experience, training in the use of weapons and connections to international terrorist networks. FTFs often return to their previous radical milieus or criminal gangs, which has an adverse effect on social dynamics. There are many security challenges and possible scenarios for FTF returnees.

As the RAN Returnee manual highlighted, FTFs are also more likely than the average person to suffer from mental health problems.[8] If they didn't have problems before, spending prolonged periods in terrorist-

[5] Cloitre et al. (2010), Treatment for PTSD related to childhood abuse: a randomized controlled trial
[6] Dorahy et al., 2009, Anger, aggression, and self-harm in PTSD and complex PTSD
[7] Cloitre, M., Courtois, C.A., Ford, J.D., Green, B.L., Alexander, P., Briere, J., Herman, J.L., Lanius, R., Stolbach, B.C., Spinazzola, J., Van der Kolk, B.A., Van der Hart, O. (2012). The ISTSS Expert Consensus Treatment Guidelines for Complex PTSD in Adults.
[8] RAN Returnee Manual, p.63, see: https://ec.europa.eu/home-affairs/sites/homeaffairs/files/ran_br_a4_m10_en.pdf

claimed territory and conflict zones can leave significant psychological scars. Much of our knowledge about this comes from conflict-induced trauma suffered by regular armed forces.[9]

There is a risk of PTSD among persons returning from conflict zones — whether they have fought or not — which can leave them **traumatised, vulnerable to radicalisation, and potentially a danger to themselves or society**. While PTSD is at the far end of the spectrum, those returning from conflict zones can also be subject to a wide range of trauma-related problems.

Psychologists working with FTFs also report that some are **suffering from 'moral damage' rather than PTSD**: their belief systems have been altered by what they have seen in Syria, Iraq or other terrorist conflict zones, which might lead them to question their moral image of the world. They might also be left with a **sense of betrayal** after being exposed to the reality of the conflict, or disillusioned with the radical cause itself. These reactions could, in a sense, be described as positive in that they offer an opportunity for intervention. Left unsupported, however, these persons are also vulnerable.

Finally, as described by Magnus Ranstorp in the RAN Issue Paper The Root Causes of Violent Extremism, trauma and other mental health issues among refugees and asylum seekers are also potential root causes of radicalisation[10]. Of course, refugees and asylum seekers are not automatically at risk of radicalisation. However, given their past (traumatic) experiences and continuous exposure to difficult circumstances, including potential hostility to their arrival among the host society, refugees can be more vulnerable to radicalisation and recruitment. They are exposed to multiple short and long-term challenges that evolve throughout their journey, from a lack of money and disrupted education to detention and growing anti-immigration sentiment, which can make them vulnerable.

The way forward: lessons from Northern Ireland and former Yugoslavia

Northern Ireland

The Commission for Victims and Survivors for Northern Ireland reported that "with exposure to several decades of political violence, in excess of 3,500 deaths, over 35,000 injuries, 16,000 individuals charged with offences, 34,000 shootings and 14,000 bombings, it has been suggested that there are few individuals, families or communities in Northern Ireland who have not been directly or indirectly affected by the Conflict."[11] Significantly, more persons died through suicide or an indirect link to the conflict than were killed during The Troubles themselves; this is despite research findings from the University of Ulster on 'the trans-generational impact of the Troubles on Mental Health' [12] which suggest that the majority of those who experience traumatic events and violence are not adversely affected in the long run. Many people, both because of and in spite of their experience, re-evaluate and re-organise their lives, priorities and relationships in positive directions [13].

[9] See https://ec.europa.eu/home-affairs/sites/homeaffairs/files/ran_br_a4_m10_en.pdf p.63
[10] RAN Issue Paper *The Root Causes of Violent Extremism* by Magnus Ranstorp: https://ec.europa.eu/home-affairs/sites/homeaffairs/files/what-we-do/networks/radicalisation_awareness_network/ran-papers/docs/issue_paper_root-causes_jan2016_en.pdf
[11] See Commission for Victims and Survivors for Northern Ireland, 2010: 42, https://www.cvsni.org/media/1135/cvsni-annual-report-2009-2010.pdf
[12] See https://www.cvsni.org/media/1171/towards-a-better-future-march-2015.pdf
[13] See idem.

Certain people do go on to develop specific problems, including those that manifest themselves in serious mental disorders that impact their wellbeing and ability to function on a day-to-day basis. This can have a knock-on effect on their surroundings and indeed family life. The study estimates that this group represents around 14 % of the adult population in Northern Ireland[14]. Alcohol and other drugs are commonly used by this group (possibly as a coping mechanism for psychological stress) and suicide is more prevalent. Furthermore, economic deprivation constitutes an additional stressor which in turn impacts negatively on mental and general health.

Crucially, the political and social divisions in Northern Ireland have an impact on social integration and are associated with sectarianism and increasingly racism, homophobia and 'hate crime'. The transmission of narratives derived from memories of conflict and violence can also have a negative impact on the social sphere and convey or amplify perceptions of threat, fear and exclusion.

Relevant lessons and practices from Northern Ireland of potential relevance to dealing with refugees, returning foreign fighters and their families

- A Victims' and Survivors' Strategy can take years or even decades to get fully up and running. A Regional Trauma Network was started as late as 2017.
- A Regional Trauma Network helped to focus on creating a better evidence base via sharing good practice models and care pathways, working in partnership with community and voluntary sectors, training and workforce development, research, and achieving direct outcomes for victims.
- Support structures take a long time to set up, but also need to stay in place a long time: individual follow-up with survivors and victims might be needed for years or decades
- Victims came forward themselves or were actively sought. They were assigned a Case Worker, who could refer them to a therapist or eye movement desensitisation and reprocessing (EMDR) Counsellor and support them on their path to specific outcomes:
    - Health & wellbeing, social support and transgenerational support
    - Personal development plans
    - Financial & welfare support
    - Truth, justice and acknowledgement

Croatia

In Croatia, there are over half a million war veterans (11 % of the population), about 35,000 former combatants with PTSD, and 83,000 unemployed people. Suicide rates are high (over 3,000 since the end of the conflict).

There have been several cases of war veterans (from Croatia and other parts of the former Yugoslavia) feeling unsettled at home after their military service in combat zones, and consequently returning to similar combat zones in Ukraine as volunteers/mercenaries, or in Syria and Iraq to fight for or against Daesh. The Lisbon

[14] See idem, p. 10

meeting also looked into how PTSD diagnoses among veterans can influence such decisions to return to combat conditions and what can be done to prevent this.

Lessons can be drawn from the years and decades after the conflict in the former Yugoslavia. However, of those joining the conflict in Syria and Iraq, many were relatively young and born after the war in former Yugoslavia; they were from families who had suffered during the conflict. Relatively few within this group had been diagnosed with PTSD, and there were many women and children in the group - in some cases, three generations moved to Daesh-held territories.

Relevant lessons and practices from Croatia of potential relevance to dealing with refugees, returning foreign fighters and their families

- The country has a war veterans ministry, and a Law on Rights of Croatian War Veterans on veterans and their families.
- Response teams composed of social workers, psychologists and lawyers work with families.
- The country has a national hotline, and response teams can be sent in when needed.
- Some hospitals are specialised in follow-up for veterans, and former combatants have certain rights (such as an annual check-up); five regional centres for war veterans are being set up, alongside retirement homes for veterans.

Responses to challenges and recommendations

The meeting highlighted a number of possible responses and recommendations, such as those stemming from Croatia and Northern Ireland, as well as others from France and Denmark. Overall there is, in certain specific cases, a link between PTSD and re-engaging in combat/violence, although this can be very hard to establish. In certain cases, someone might have been functioning rather well for years or even decades before a specific trigger (divorce, unemployment) leads to events spiralling out of control. A number of such cases were highlighted during the meeting.

In dealing with PTSD and trauma affecting the various groups discussed in this paper, **government responses** can vary widely, and include **national policies and strategies**, specifically appointing a **national coordinator**, setting up relevant departments, and **organising mobile support teams,** a **specialised hospital** and **research centres**.

Fostering a culture of cooperation is paramount. The February 2018 strategy from **France** focuses on precisely that. The strategy of 'preventing to protect' promotes a pluralistic approach and finds a balance between the duty to protect and the duties of a professional (confidentiality). It also includes increased knowledge exchange, follow-up and assessment. Since 2014, a network of 101 local units have been set up and embody a multi-agency approach. Since March 2018, regional health agencies have been prompted to sign a framework agreement that includes mental health workers.

The focus is particularly on returnees as the country seeks to treat PTSD within this group. A National programme coordinator should support local teams all over the country. The government wants to support the selection of trainers, financing training courses, and the setting up of support teams. A large-scale meeting bringing together psychological and psychiatric research on radicalisation will be held in Paris in

September 2018. The goals are to map out practices in follow-up, build assessment tools, and develop a platform for exchange of good practices.

In **Denmark**, a 2013 study on refugee trauma showed that 30 – 50 % of refugees are traumatised or display symptoms of trauma. Some 70 % of professionals thought that trauma assessment could be carried out at their own discretion, or were unaware of existing tools at municipality level. Only a small share of municipalities (21 %) had a structured approach.

The country moved to a project for mobilising municipalities, which comprises five components:

1. Interdisciplinary model for collaboration.
2. Models for detection and identification.
3. Methods of treatment.
4. Feedback Informed Treatment (FIT).
5. Evaluation.

The FIT component considers whether the recipient of care appreciated the care received (Miller's tool). If after three to four sessions the care is not felt to be effective by the recipient, the approach or method is adjusted. The project model was chosen because the problems faced by traumatised refugee families often imply contact with a wide range of different local administrations and actors. Often interventions were scattered or too late, or there was a lack of knowledge about the special needs of the target group, and an unclear division of responsibilities. This led in particular to the establishment of a steering group within which management from every administration involved is represented, a fixed plan for regular meetings in the steering group, and the appointment of a coordinator for interdisciplinary interventions. An interdisciplinary team of professionals that all have clear responsibilities should be better able to provide support to individuals and families. It should also enable follow-up (every three months) and therefore ensure a degree of continuity. Municipalities are scored against an implementation barometer to see how well they are running this collaboration model.

In November 2016, RAN published an issue paper[15] on the various ways in which practitioners might respond to children returning to Europe after having travelled to Daesh-held territories in Syria/Iraq, having been born there to a European parent(s), or travelled from Daesh-held territory to Europe as non-European children as a result of forced displacement. Building on that issue paper and the findings from the Lisbon meeting, a number of recommendations can be put forward:

- As an intervention, trauma-informed Cognitive Behaviour Therapy (CBT) has been shown to be effective for both children and their families in overcoming trauma-related difficulties[16].
- Trauma awareness should be a key skill imparted to all individuals working with returnee children, but also to people working with refugees, veterans, FTFs etc. The ability to recognise the signs and symptoms of trauma is essential in correctly interpreting the behaviour of children.

[15] See https://ec.europa.eu/home-affairs/sites/homeaffairs/files/what-we-do/networks/radicalisation_awareness_network/ran-papers/docs/issue_paper_child_returnees_from_conflict_zones_112016_en.pdf
[16] Steel, M. &Malchiodi, C.A. (2010) Trauma Informed Practice with Children and Adolescence. Routledge, New York.

- There is a need for trauma-informed-care policy. This is based on the 4 'Rs' of Realise, Recognise, Respond, and Resist Re-traumatisation. Focus on strengths in the person. The Sanctuary Model by Sandra Bloom is a relevant approach in this regard[17].
- While a trauma-based approach is appropriate, what is missing from this framework is recognition of the fact that living with or being socialised into a society suffering armed conflict is not a one-off traumatic event with a distinct end point; living with violent conflict, particularly in unstable political contexts, often coincides with exposure to other traumatic events [18]. Scholars have used the term 'cumulative risk' to account for the likelihood that children exposed to armed conflict are highly likely to face multiple and ongoing trauma[19]. This repeat victimisation is primarily related to discrimination, instability, parental unemployment and the absence of peer networks of support.
- Trauma awareness training should occur at all levels of an organisation; from administration to practitioner, any individual who is likely to be in contact with the child or family affected needs to be aware that trauma generates extreme sensitivity to sensory overload, manifested in behavioural and emotional responses and disengagement[20].
- Assign an individual case worker or multidisciplinary teams to avoid the involvement of too many professionals and the risk of sub-par care.
- Given their past experience, child returnees and their families require a sense of empowerment if they are to succeed in managing their trauma. Physiological responses to trauma can create a sense of losing control. But given their engagement with security services, immigration services etc, their recent experiences are likely to have actually been controlled by others. In this respect, children and their families should be educated on trauma symptoms, preferably using strengths-based language. Individuals should feel they have a say in all decisions relating to their current circumstances.
- Practitioners should be aware of the fact that an inability to personally engage is a normal trauma response, and this is a slow gradual process that can take months to overcome. Trust and choice increase the likelihood of engagement, while children and those around them become at risk when they are isolated.
- Use relevant risk assessment tools (see the box below)

Risk assessment tools

RAN has created a risk investigative tool specifically for use with returnees. The RAN CoE Returnee 45 is a tool for use in relation to FTF returnees. It can help with organising reflection and operational planning for possible interventions, and with reducing the threat of violence. It is a framework for general investigation of the motivation, levels of commitment and other risk factors throughout the FTF process – from leaving to returning[21].

[17] See http://sanctuaryweb.com/TheSanctuaryModel.aspx
[18] Catani, Gewirtz, Weiling, Schauer, Elbert, and Neuner, 2010
[19] Ibid.
[20] Van Der Kolk, 2006.
[21] See https://ec.europa.eu/home-affairs/sites/homeaffairs/files/ran_br_a4_m10_en.pdf p.90

Annex 1

Figure 1: Victims and Survivors Services' Stepped Care Model for interventions

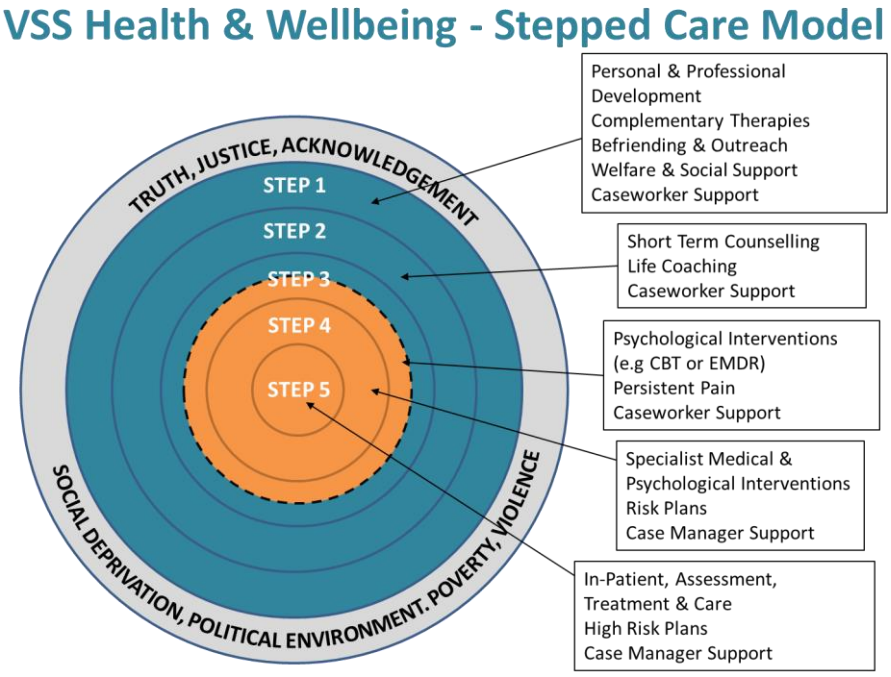

Figure 2: Danish questionnaire for identify trauma among asylum seekers and refugees

PROTECT Questionnaire (PQ)

PROTECT
Process of Recognition and Orientation of Torture Victims in European Countries to Facilitate Care and Treatment

Questionnaire and observations for early identification of asylum seekers having suffered traumatic experiences

Questions *"Often" means : more than usual and causing suffering*		Yes	No
1	Do you often have problem falling asleep ?		
2	Do you often have nightmares ?		
3	Do you often suffer from headaches ?		
4	Do you often suffer from other physical pains ?		
5	Do you easily get angry ?		
6	Do you often think about painful past events ?		
7	Do you often feel scared or frightened ?		
8	Do you often forget things in your daily life ?		
9	Do you find yourself losing interest in things ?		
10	Do you often have trouble concentrating ?		
Number of questions answered "Yes" →			

Rating : Please mark the proper category with an X to indicate the level of risk of traumatisation	0-3	4-7	8-10
	Low risk	**Medium risk**	**High risk**

In case of a "medium risk" or a "high risk" rating the asylum seeker should be referred for medical ans psychological examination !
A "low risk" doesn't exclude the possibility of the asylum seeker having suffered traumatic experiences. Symptoms may appear later. Another screening should be carried out.

Further observations (*For example : the person cries a lot, doesn't react, pays no attention... / difficulties to understand the questions / special circumstances for the interview...*) :

These observations must be shared with the person

Name of asylum seeker :

Date of birth :

Country of origin :

Date :

I agree that a copy of this document will be kept by the interviewer's organisation and can be used for statistical purpose (signature)	Organisation (stamp if possible)

After the review a copy of the Questionnaire should be given to the asylum seeker with the recommandation that he or she submits this paper whenever meeting with a Health Care System professional, a legal advisor or a reception official.