The role of psychotherapy in rehabilitation and exit work

Authored by **Lotta Carlsson**, RAN Expert Pool Member

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Introduction

Recent years have seen a growing focus on the intersection between mental health and the field of preventing and countering violent extremism (P/CVE). In the past, researchers tended toward the view that it was people with mental health illnesses or psychopathic tendencies who committed extremist acts[1]. Scholars later eschewed these explanations in favour of the theory that radicalised individuals were rational actors in pursuit of specific objectives[2]. Now, overwhelmingly, the current literature recognises that the pathways to radicalisation are complex, multifaceted and interconnected, and that there is no 'single pathway' to radicalisation.

This recognition of the diverse ways of becoming radicalised has developed alongside a growing understanding that P/CVE calls for multi-agency, multidisciplinary, coordinated prevention strategies. In recent years, this has been reflected in the practice, research and work of several RAN working groups that have progressively explored the complex overlapping and interconnecting role of mental health in P/CVE[3].

In this context, mental health professionals have increasingly become involved in the design and implementation of deradicalisation programmes throughout Europe. Today, they are providing essential psychological support, risk assessments, and detection of early warning signals in the prevention process. It may therefore be useful to reconsider the role of psychotherapists and mental health professionals as running in parallel to deradicalisation, exit and rehabilitation work and to give them a more prominent role within a holistic rehabilitation approach.

Several EU Member States have indicated that the majority of currently detained extremist offenders will be released in the coming years[4], coinciding with the growing numbers of people returning from camps in Syria and Iraq. Recent RAN conclusion papers on incels [5] and on the increased diversification of right-wing extremists [6] highlight the growing prevalence of mental health problems in this field, as observed by practitioners. In light of the rising numbers of potentially mental health related cases, there is a clear and present need to further develop methodologies to rehabilitate and reintegrate released extremist offenders and returnees (as well as radicalised persons more broadly) in a more comprehensive manner than before. It is crucial that mental health approaches and methods of treatment are incorporated into disengagement, rehabilitation and reintegration programmes and approaches[7].

A positive trend in recent years has been the emergence of trauma-informed frameworks in P/CVE. Research exploring the link between trauma and radicalisation has helped shape and further our understanding of how issues like adverse childhood experiences and intergenerational and collective trauma may impact exit and rehabilitation work. Work in P/CVE can benefit significantly by learning from the trauma-informed care principles of safety, trust, peer support, collaboration and empowerment, and sensitivity to cultural, historical and gender issues[8].

Understanding and identifying the traumatic events that might have made an individual susceptible to radicalisation, as well as the trauma they may have experienced while in extremist groups, will be particularly important for future exit and rehabilitation work with camp returnees and their families. But other practitioners carrying out rehabilitation work will also benefit from the better inclusion of trauma-informed approaches into their fields.

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[1] Gill et al., Systematic review of mental health problems and violent extremism.
[2] Gill et al., Systematic review of mental health problems and violent extremism.
[3] De Marinis & Boyd-MacMillan, *A mental health approach to understanding violent extremism.* https://ec.europa.eu/home-affairs/system/files/2019-07/ran_hsc_prac_mental_health_03062019_en.pdf
[4] Radicalisation Awareness Network, *Rehabilitation and reintegration of extremist offenders from a mental health perspective.* https://ec.europa.eu/home-affairs/system/files/2021-04/ran_mh_rehabilitation_reintegration_of_extremist_offenders_10-11_032021_en.pdf
[5] Radicalisation Awareness Network, *Violent incels and challenges for P/CVE.* https://ec.europa.eu/home-affairs/system/files/2021-04/ran_small-scale_violent_incels_and_challenges_for_p-cve_25022021_en.pdf
[6] Radicalisation Awareness Network, *New offender types & appropriate measures of Exit work.* https://ec.europa.eu/home-affairs/system/files/2021-09/ran_small-scale_new-offenders_type_24032021_en.pdf
[7] Radicalisation Awareness Network, *Rehabilitation and reintegration of extremist offenders from a mental health perspective.* https://ec.europa.eu/home-affairs/system/files/2021-04/ran_mh_rehabilitation_reintegration_of_extremist_offenders_10-11_032021_en.pdf.
[8] Marsden & Lewis, *Trauma, adversity, and violent extremism.* https://crestresearch.ac.uk/resources/trauma-adversity-and-violent-extremism/

Focusing on trauma is not only about improving the well-being of the individual person; it also involves building trust with that person, a crucial step in the deradicalisation process[9]. If the underlying trauma is not addressed, there is a chance – even if the person has been deradicalised or has disengaged from violent extremist groups – of them turning back to previous coping mechanisms: this may present a risk factor for them to become radicalised again.

This trauma-informed approach will continue to grow in the next few years, as practitioners advance their understanding of the complex social and mental health challenges surrounding radicalisation. The COVID-19 pandemic placed additional stressors and burdens on existing mental health services around Europe; it is therefore critical that policymakers and practitioners design programmes and allocate resources for mental health in deradicalisation programmes.

The continuing integration of mental health and trauma-informed approaches in rehabilitation means that psychotherapy will also play a significant role, as its aim is to address the underlying mental health issues that might contribute to radicalisation. Ultimately, the outcome of deradicalisation should go hand-in-hand with the mental well-being of the individual.

The objectives of this paper are to:

a) assess the potential roles psychotherapy could play in relation to rehabilitation processes;

b) describe existing approaches;

c) investigate further potential in this area, including cooperation between these discrete, often unconnected professional groups.

This paper's core target audience is rehabilitation workers, exit workers, deradicalisation workers, psychotherapists and other mental health professionals, as well as practitioner organisation leaders responsible for programme design and development and implementing strategic cooperation with other actors.

The paper will begin by presenting an overview of how and when psychotherapy can be integrated into the holistic process of rehabilitation. The next section will examine existing approaches and lessons learned from rehabilitation programmes that integrate psychotherapy, and look at cooperation between mental health professionals and rehabilitation workers. Finally, the paper will identify gaps and needs for further research as well as make concise recommendations on next steps.

Integrating psychotherapy in exit and rehabilitation work

This section explores some of the current ways and modalities of integrating psychotherapy into rehabilitation work.

The term psychotherapy covers a range of approaches and methods. They all involve a psychological (as distinct from medical or pharmacological) treatment for a range of psychological, emotional and relationship difficulties and disorders [10]. Psychotherapy is a way to help people with a broad variety of mental illnesses and emotional difficulties. It can help eliminate or control troubling symptoms, allowing a person to function better, and can enhance well-being and healing.

Psychotherapy helps people with problems such as difficulties in coping with daily life; the impact of trauma, medical illness or loss (e.g. the death of a loved one); and specific mental disorders like depression or anxiety. There are several different types of psychotherapy; some types may work better with particular problems or issues. Psychotherapy may be used in combination with medication or other therapies[11].

Therapy sessions may be conducted in an individual, family, couple or group setting, and can help both children and adults. Sessions are typically held once a week, for about 30 to 50 minutes. Both patient and therapist must be actively involved in the psychotherapy. Trust and a respectful, good relationship between

[9] Sischka, *Female Returnees and their children: Psychotherapeutic perspectives on the rehabilitation of women and children from the former territories of the so-called Islamic State.* https://violence-prevention-network.de/wp-content/uploads/2020/11/Violence-Prevention-Network-Schriftenreihe-Heft-4_EN.pdf
[10] European Association for Psychotherapy.
[11] American Psychiatric Association.

a person and their therapist are essential if they are to work together effectively and benefit from psychotherapy.

Psychotherapy can be short-term (a few sessions) when dealing with immediate issues, or long-term (months or years) when dealing with longstanding and complex issues. The treatment goals and arrangements for how often and how long to meet are planned jointly by patient and therapist.

The literature and practice focused on mental health problems and their potential as risk factors for radicalisation have burgeoned in recent years. However, far less research exists on how psychotherapy and counselling could contribute to the deradicalisation process. A meta-analysis of outcome evaluations of psychosocial prevention programmes found only eight programmes that were systematically evaluated, to some degree. Notwithstanding this dearth of systematic evaluation, these programmes were found to have significantly reduced violent extremist behaviour, extremist attitudes and related psychological factors[12]. Importantly, it is usually considered best practice to begin treatment of mental health issues prior to exit work, although this must be planned on an individual basis[13].

Deradicalisation refers to 'behavioural disengagement from extremism-inspired activities and violence, plus cognitive distancing leading to rejection of extremist views'[14]. Disengagement from a violent group is the first step, but understood more broadly, deradicalisation means a wholesale cognitive shift away from extremist beliefs, and the adoption of new values and belief systems. The turn to extremist ideology can stem from a response to trauma or mental health problems experienced earlier in life. Many people are drawn to the stability and simplicity inherent in the structured lifestyle and coherent belief system typical of extremist ideologies. If the underlying trauma is not addressed, there is a risk – even if the person has been deradicalised or has disengaged from violent extremist groups – that they may turn back to previous coping mechanisms (drugs, alcohol, destructive or antisocial behaviour, etc.), and in turn, this may present a risk factor for becoming radicalised again.

Despite the relatively small evidence and practice base, a recent RAN HEALTH conclusion paper recognised that many P/CVE interventions 'involve some type of psychological intervention, ideological support and/or family therapy'[15].

Mental health professionals can play a role in the following three phases of the prevention process:

- first, in primary interventions, which focus on preventing radicalisation, with considerable emphasis on community-led approaches;
- second, in secondary interventions, which concentrate on identifying and treating vulnerable populations by targeting risk factors;
- third, in tertiary interventions, which work on addressing the underlying mental health problems of radicalised individuals[16].

Psychotherapy, and mental health treatment more broadly, should therefore play an active role in shaping holistic P/CVE programmes, as both practice and research have shown it has a positive impact. In terms of exit work and the rehabilitation process, psychotherapy can help radicalised individuals address underlying mental health problems.

In this regard, psychotherapy's role in rehabilitation differs according to the given circumstances, as explained below.

- For some individuals, severe mental health issues may limit the potential of rehabilitation efforts, or even block it entirely. In these instances, psychotherapy may be a prerequisite before P/CVE-focused rehabilitation work can begin. (Here, although both professional groups will work with an individual, the groups are separate from one another.)

[12] Jugl et al., Psychosocial prevention programs against radicalization and extremism: a meta-analysis of outcome evaluations.
[13] Radicalisation Awareness Network, *Setting up an exit intervention.* https://ec.europa.eu/home-affairs/system/files/2017-04/ran_exit_setting_up_exit_intervention_berlin_13-14_022017_en.pdf
[14] Radicalisation Awareness Network, *Rehabilitation Manual: Rehabilitation of radicalised and terrorist offenders for first-line practitioners.* https://ec.europa.eu/home-affairs/system/files/2020-06/ran_rehab_manual_en.pdf
[15] Radicalisation Awareness Network, *Mental health practices and interventions in P/CVE.* https://ec.europa.eu/home-affairs/system/files/2021-11/ran_mh_practices_and_interventions_in_p-cve_22-23_092021_en.pdf
[16] Ibid.

- In a holistic approach, psychotherapists and rehabilitation workers may be able to work jointly on the rehabilitation process of an individual, by designing complementary measures in a true cooperative setting.

Necessary conditions and environment

As has been noted in a RAN paper, mental health professionals should also be aware of the challenges in working with people who suffer from trauma. Direct trauma memory-processing approaches are highly effective for post-traumatic stress disorder (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[17].

It is important to note that for psychotherapy to be effective, the overall psychosocial conditions of the individual must be conducive to therapy. The person's environment (family, community, legal status, etc.) should provide the space to allow for the process of psychotherapy. Since the prison environment can be challenging for any prisoner's mental health, the provision of psychological services must factor in conditions such as isolation, violence, lack of purpose, and insecurity about the future, all of which can undermine prisoners' mental health, and in turn, impact rehabilitation efforts[18]. Practitioner views are mixed regarding the feasibility of offering psychotherapy in prison. What is clear, however, is that efforts must be made to ensure that the quality of the prison environment enhances prisoner outcomes. The Core Correctional Principles and Practices [19] provide an evidence-based approach to this issue, by focusing on increasing the effectiveness of treatment interventions as well as the therapeutic potential of relationships between inmates and prison staff[20].

Therefore, while prisons may not be the most optimal environments for engaging in psychotherapy, the emphasis should be on minimising risks as well as stabilising the person's mental health. As was recognised in a RAN meeting in 2020, mental health may not necessarily play a determining role in prison radicalisation. The feeling of being treated unjustly or as less than human in prison can be problematic and may create vulnerabilities for radicalisation. Inmates might express this through violence against other prisoners, the institution or prison staff, which can then form an effective breeding ground for radicalisation [21].

Existing approaches and lessons learned

This section will present some of the existing approaches to using psychotherapy in rehabilitation programmes. It will describe three different models and a tool, and then discuss specific psychotherapeutic treatment models that have proved successful in different contexts. The objective here is to highlight the diversity and range of interventions available to rehabilitation workers and the need to adopt these tools to the individual's local, cultural and specific context.

It is important also to stress the need to attend to the radicalised person's acute medical and psychological needs during first contact. This is especially relevant for traumatised returnees who may be in acute need of medical and therapeutical care when they first return. Practitioners should, as far as possible, try to establish a stress-free, stabilising and clarifying setting, to alleviate traumatic stress symptoms and begin to build trust[22]. There are good practice examples of returnees and their families benefiting from psychotherapy after their arrival in Kosovo, where mothers were offered acute and short-term therapy in the first few months of their arrival. This treatment helped families deal with unresolved family tensions and understand how to deal and cope with these specific stressful circumstances. It was shown to have a beneficial effect on the

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[17] Van der Velden & Krasenberg, *PTSD, trauma, stress and the risk of (re)turning to violence.*

[18] Radicalisation Awareness Network, *Rehabilitation Manual: Rehabilitation of radicalised and terrorist offenders for first-line practitioners.* https://ec.europa.eu/home-affairs/system/files/2020-06/ran_rehab_manual_en.pdf

[19] Hass & Cynthia, *The use of core correctional principles and practices in offenders.*

[20] Haas, S. M., & Spence, D. H. (2017). Use of core correctional practice and inmate preparedness for release. *International Journal of Offender Therapy and Comparative Criminology, 61*(13), 1455–1478.

[21] González, *Mental health in prisons.* https://ec.europa.eu/home-affairs/system/files/2020-12/ran_conclusion_paper_mh_in_prison_23-24_092020_en.pdf

[22] Sischka, *Female Returnees and their children: Psychotherapeutic perspectives on the rehabilitation of women and children from the former territories of the so-called Islamic State.* https://violence-prevention-network.de/wp-content/uploads/2020/11/Violence-Prevention-Network-Schriftenreihe-Heft-4_EN.pdf

relationship between mother and child, as well as their social environment, which is a crucial step in the deradicalisation process[23].

Rehabilitation and Reintegration Intervention Framework (RRIF)

Weine et al. (2020) developed the RRIF for child returnees from Daesh, drawing on 31 studies from fields where children's exposure to trauma and adversity overlapped significantly with that of child returnees from Daesh in Syria and Iraq[24]. The framework is based on five strands, with each strand focused on specific risk and protective factors empirically demonstrated to be related to violent extremism.

This framework is an excellent example of a holistic approach to rehabilitation that aims to address all relevant psychosocial factors relating to the individual. Psychotherapists and mental health professionals play a direct and key role in the strand for 'promoting individual mental health and wellbeing'. Although this framework was developed based on studies of children, it can be adopted and adapted to suit the needs of adolescents and adults, based on an individual assessment. The purpose of including this framework here is to demonstrate the need to take into consideration the psychosocial conditions of the individual and not to view radicalisation exclusively through one lens.

Table 1 The RRIF developed by Weine et al. (2020)

Strand	Risk factors treated	Protective factors supported
Promoting individual mental health and well-being Provide mental health and health services to help returnees recover from developmental, mental and physical injuries	• Trauma exposure • Displacement stressors • Alcohol or drug use • Health problems • Developmental delays • Violent behaviour	• Access to services • Family support • Belief systems • Hope and optimism • Social and emotional intelligence
Promoting family support Strengthen families and mitigate family conflict through family education, support and counselling	• Parental mental health/health • Family separation and conflict • Domestic violence	• Religious faith and support • Family acceptance, cohesion and adaptability • Family responsibilities
Promoting educational success Promote educational involvement and success with specialised educational programmes, integrated psychosocial care, and bullying prevention	• Learning problems • Bullying • Discrimination • Language barrier	• School attendance and engagement • Teacher support • Peer friendships and support • Recreational activities • School safety
Promoting community support	• Stigma, discrimination, humiliation and hostility • Social isolation/detachment	• Community well-being and awareness • Social support

[23] Ruf & Jansen, *Study visit: Returned women and children – Studying an ongoing experience on the ground.*
[24] Weine et al., *Rapid review to inform the rehabilitation and reintegration of child returnees from the Islamic State.*

Strengthen community resilience and support to mitigate stigma and discrimination	• Poverty and unemployment • Acculturation stressors	• Outside mentors
Improving structural conditions and enhancing public safety Improve living and working conditions for children and mothers; assess security threats and prevent future involvement in extremism and targeted violence	• Strenuous repatriation • Economic hardship • Lack of education and employment • Inequitable access to resources • Motivation to seek revenge • Exposure to violent extremism • Criminality	• Adequate housing • Parental employment • Job training and employment • Financial stability • Safe environment • Positive engagement with the state • Political activism • Civil engagement

The Entré programme (Sweden)

The Swedish Prison and Probation Service (SPPS)[25] has developed a counter-radicalisation strategy combining security efforts with intensive treatment. The strategy seeks to improve the transition to the community for identified violent extremist offenders who are at risk for future violent behaviour and association with persons and environments supporting violent extremism. It includes treating prisoners, parolees and probationers with dignity and respect, as well as providing directed services and programmes to prepare pathways leading away from violent extremism, where the radicalised person ideally distances themselves from their past radicalised lifestyle.

To overcome personal barriers to change and strengthen the skills needed to establish a meaningful lifestyle outside extremist environments, the SPPS uses a deradicalisation offender treatment programme called Entré. The name of the programme indicates that it is not only about leaving an old lifestyle, but primarily about beginning a new way of life, establishing a new network and circle, and in some cases, adopting a new identity. Entré is a one-to-one cognitive behavioural psychotherapeutic programme developed within the SPPS, originally designed to support clients leaving organised criminal groups or environments.

The client and therapist meet in person. Entré therapists have no specialist knowledge of the ideologies in question and do not challenge or discuss points of right or wrong in the views held by the client. The therapist meets the client in the framework of a professional relationship, where the client is the chief expert on their life and mental world. The role of the therapist is to show the client how their thoughts and behaviours have led them to a particular predicament and to supply the client with alternative perspectives and behaviours that increase their possibilities to lead a constructive life.

The Police, Social Services, and Psychiatry (PSP) model (Denmark)

The PSP model is a form of structured cooperation between the police, social services, and the psychiatric system in Denmark[26]. The aim of PSP is to ensure that relevant information is shared and supportive measures strengthened for citizens at risk. PSP representatives from each sector meet frequently.

Since 2009, so-called Info-Houses have been established in all 12 Danish police districts. They encompass a formal structure or network of local professionals from different sectors working in the field of P/CVE. All

[25] European Forum for Urban Security, *PREPARE: a look at how European countries prevent radicalisation through probation and release.* https://efus.eu/topics/radicalisation-polarisation-en/prepare-a-look-at-how-european-countries-prevent-radicalisation-through-probation-and-release/
[26] Sestoft et al., The police, social services, and psychiatry (PSP) cooperation as a platform for dealing with concerns of radicalization. https://doi.org/10.1080/09540261.2017.1343526

stakeholders participate in a formal forum where local challenges and concrete concerns related to radicalisation can be discussed. It also enables a clear distribution and allocation of duties and responsibilities that can be initiated from the outset, thus preventing cases from being lost or neglected in referrals from one authority to the other. When the Danish Security and Intelligence Agency (Politiets Efterretningstjeneste or PET) Prevention Centre receives a report of possible radicalisation, they conduct an intelligence-led assessment. If this assessment concludes that there is no threat to national security, but there is still a radicalisation risk, the case is referred back to the Info-House for rehabilitation measures. PET offers advice on which rehabilitation measures the local authorities should use, through the Info-House.

There were cases where mental illness was considered a major contributing cause to the threat that falls under PET's field of operation, whether radicalisation or threats to public individuals. Thanks to the PSP collaboration, it is possible to refer suitable cases of this type to mental health services. Here, the local PSP network can moderate the potential threat that the individual poses by focusing on the well-being of the individual through mental health treatment and support in their everyday life.

The Global Psychotrauma Screen (GPS)

The GPS[27] is a screening instrument designed to identify reactions to a severe stressor or potentially traumatic event (17 'yes/no' questions). It also assesses risk or protective factors known to influence the course of symptoms (five 'yes/no' questions). The GPS begins with questions about the given event or experience. It can be used in different settings: primary care, after a disaster, or in clinical practice. The app provides direct feedback on the scores. A positive score, above the cut-off point or in certain domains (e.g. PTSD, anxiety, or depression – see below) may require more detailed follow-up assessments, with structured interviews for specific disorders, for instance.

The GPS serves as an example of a practical tool that could be integrated into existing rehabilitation programmes. For instance, during the intake phase, the tool could be administered by a case worker, and if the score is high enough, then the person in question could be referred to a mental health professional as part of a structured process or system. This is an international tool, and therefore may be applicable in a range of contexts. It is available in 27 languages.

Specific treatment options

The following therapies are treatment options being used by different psychotherapists in exit programmes. It is crucial to stress that all of them have the potential to succeed, but they require ownership on the side of the psychotherapist as well as willingness from the patient.

In particular, eye movement desensitisation and reprocessing (EMDR), forensic offender rehabilitation narrative exposure therapy (FORNET) and narrative exposure therapy (NET) have been used extensively in work with radicalised individuals and particularly foreign terrorist fighters. Furthermore, practitioners need to be aware of the fact that trauma symptoms can manifest differently across age groups and depending on the developmental period in which the traumatic event occurred[28].

It is important for practitioner organisations in multi-stakeholder collaboration programmes seeking to include psychotherapeutic elements in an overarching approach to consider the options listed below.

- EMDR is a psychotherapy treatment that was originally designed to alleviate the distress associated with traumatic memories. The adaptive information processing model posits that EMDR therapy facilitates the accessing and processing of traumatic memories and other adverse life experiences, to bring these to an adaptive resolution.

[27] Global Psychotrauma Screen (GPS): https://www.global-psychotrauma.net/gps
[28] The Centre for Excellence on Social Welfare in the Helsinki Metropolitan Area, *National modelling for arranging long-term support measures for children returning from conflict zones and their family members.* http://www.socca.fi/files/9312/National_modelling_for_arranging_long-term_support_measures_for_children_returning_from_conflict_zones_and_their_family_members_Expert_report_(2).pdf

- Violent offenders and soldiers are at high risk of developing appetitive aggression and trauma-related disorders, which reduce successful integration into societies. Narrative exposure therapy (NET) [29] for forensic offender rehabilitation (FORNET) aims at reducing symptoms of traumatic stress (e.g. PTSD) and controlling readiness for aggressive behaviour. Research has shown that FORNET is a potentially effective intervention for reducing violent behaviour: children and youths undergoing the specific treatment showed significantly reduced involvement in different kinds of violent behaviour, compared with those who had not[30].
- Acceptance and commitment therapy (ACT)[31] helps a person understand and accept their inner emotions. ACT therapists help individuals use their deeper understanding of their emotional struggles to commit to moving forward in a positive way.
- Cognitive behaviour therapy (CBT)[32, 33] helps improve a person's moods, anxiety and behaviour by examining confused or distorted patterns of thinking. CBT therapists teach patients that thoughts cause feelings and moods which can influence behaviour. During CBT, a patient learns to identify harmful thought patterns. The therapist then helps the patient replace this thinking with thoughts that result in more appropriate feelings and behaviours. Research shows that CBT can be effective in treating a variety of conditions including depression and anxiety. Specialised forms of CBT have also been developed to help people coping with traumatic experiences.
- Dialectical behaviour therapy (DBT)[34] can be used to treat people who have chronic suicidal feelings/thoughts, engage in intentionally self-harmful behaviours, or have borderline personality disorders. DBT emphasises taking responsibility for one's problems and helps the person examine how they deal with conflict and intense negative emotions. This often involves a combination of group and individual sessions.
- Interpersonal therapy (IPT)[35] is a brief treatment specifically developed and tested for depression, but also used to treat a variety of other clinical conditions. IPT therapists focus on how interpersonal events affect an individual's emotional state. Individual difficulties are framed in interpersonal terms, and then problematic relationships are addressed.
- Mentalisation-based therapy (MBT)[36] involves working with individuals who struggle with who they are. For example, MBT is often used to help children grow and develop as healthy individuals.
- Play therapy [37] involves the use of toys, blocks, dolls, puppets, drawings and games to help a child recognise, identify and verbalise feelings. The psychotherapist observes how the child uses play materials and then identifies themes or patterns as a means of understanding the child's problems. Through a combination of talk and play, the child is given the opportunity to better understand and manage their conflicts, feelings and behaviour.
- Psychodynamic psychotherapy[38] is focused on understanding the issues that motivate and influence a person's behaviour, thoughts and feelings. It can help identify a patient's typical behaviour patterns, defences and responses to inner conflicts and struggles. Psychoanalysis is a specialised, more intensive form of psychodynamic psychotherapy, and usually requires several sessions per week. Psychodynamic psychotherapies are based on the assumption that a patient's behaviour and feelings will improve once the inner struggles are brought to light.

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[29] Lely et al., The effectiveness of narrative exposure therapy: a review, meta-analysis and meta-regression analysis, https://doi.org/10.1080/20008198.2018.1550344

[30] Crombach & Elbert, Controlling offensive behavior using narrative exposure therapy: A randomized controlled trial of former street children.

[31] Donahue et al., Acceptance and commitment therapy for anger dysregulation with military veterans: A pilot study.

[32] What is Cognitive Behavioral Therapy? https://www.apa.org/ptsd-guideline/patients-and-families/cognitive-behavioral.pdf

[33] Fornier, *Cognitive and behavioral analysis of two forms of violence: Jihadi and ethnic gang violence.*

[34] Chapman, Dialectical behavior therapy: Current indications and unique elements.

[35] Markowitz, J. C., & Weissman, M. M. (2004). Interpersonal psychotherapy: principles and applications. *World Psychiatry: Official Journal of the World Psychiatric Association (WPA)*, *3*(3), 136–139. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1414693/

[36] Mentalization-based therapy (MBT): https://tavistockandportman.nhs.uk/care-and-treatment/treatments/mentalisation-based-therapy/

[37] Theraplay UK: http://www.wp.theraplay.org/uk/

[38] European Association of Psychodynamic Psychotherapy: http://eapsyp.eu/

Lessons learned

- It is crucial to consider the individual's psychosocial conditions holistically. A person who is unemployed, living in poverty, struggling in their personal relations, or with an abusive family will have diminished chances of success for rehabilitation. It is critical to ensure that the psychosocial environment of the person is conducive for psychotherapy.
- A multi-agency approach is therefore crucial. If the person's environment is to be considered and addressed comprehensively, the effective involvement of all relevant stakeholders is critical. For example, psychotherapists, local municipalities, schools and social services could all be involved in the rehabilitation process of a given individual, if required.
- Screening tools are an effective way to ensure the early identification of trauma and mental health issues in individuals.
- Treatment options depend on the individual person as well as the psychotherapist. What works for a particular patient and therapist may not be appropriate for another patient and therapist.

Next steps

It is evident that the field of mental health and radicalisation is growing, but it is still at an early stage. As such, it is a field still in search of clearer guidelines as well as an overview of best practice. The evidence base is, at present, rather small, and resources should be dedicated to expanding it. For example, some research suggests that exposure therapies might not be suitable in cases of deradicalisation, while conversely, narrative exposure therapy has been shown to have positive results for child soldiers (among others).

There is therefore clearly a need for further academic research examining the interventions designed to address trauma and mental health in P/CVE policy. Likewise, efforts must be made to bring together practitioners to share best practice and learn from each other. One potentially beneficial avenue is to test the effectiveness of trauma-informed interventions (for example, those developed for traumatised refugees and asylum seekers) in programmes designed for radicalised individuals[39].

Furthermore, clarity around language and terminology is essential. Not only do different professions have different viewpoints within a multi-agency approach[40], but sometimes, even the same professions across different countries may have a very different understanding of treatment options.

More effort is also needed to include and engage communities, families, municipalities and local authorities. Engaging 'non-traditional' actors in the rehabilitation effort can be resource intensive, especially in terms of the time investment required to get them on board and aligned with the objectives of rehabilitation, and to advise and facilitate their actions. Nevertheless, without their cooperation (including the ability and willingness to welcome individuals), rehabilitation is almost impossible, so the return on this investment will be immeasurably high in the long run (civil society organisations with strong community links are an asset)[41]. It is also vital to reach out to communities, as there is still tremendous stigma around receiving therapy in many cultures.

Greater investment must be made in local community-based mental health programmes. The key benefit of these programmes is that they are rooted in the community, and therefore have greater legitimacy and thus a higher probability of success. One of the key dilemmas is that deradicalisation viewed one-dimensionally (i.e. exclusively through a security prism) will focus only on attaining a single cognitive outcome (i.e. deradicalisation). However, in the long term, if underlying trauma and mental health problems are not addressed, people may revert back to previous coping mechanisms (i.e. drugs, alcohol, violent or antisocial behaviour). Community-based programmes take a broader and more holistic view, working instead on improving the person's mental health, thereby securing better long-term success. As demonstrated by the

[39] Marsden & Lewis, *Trauma, adversity, and violent extremism.* https://crestresearch.ac.uk/resources/trauma-adversity-and-violent-extremism/

[40] Klein et al., Under-age children returning from jihadist group operation areas: How can we make a diagnosis and construct a narrative with a fragmentary anamnesis? https://doi.org/10.3389/fpsyt.2020.00149

[41] Radicalisation Awareness Network, *Rehabilitation Manual: Rehabilitation of radicalised and terrorist offenders for first-line practitioners.*

Swedish and Danish models described above, it is feasible to create multi-agency approaches like this that include law enforcement agencies.

One key area of further development will be to advance the understanding of trauma-informed care for all professionals dealing with exit work and rehabilitation. Trauma-informed care is an approach that assumes a radicalised individual is more likely than not to have a history of trauma. It recognises the presence of trauma symptoms, and acknowledges that trauma may play a significant role in that person's ability to engage and participate in everyday activities as well as in administrative and judicial procedures (such as in exit work). For example, a traumatised person may experience insomnia, which can cause them to miss appointments or struggle with irritability and angry outbursts, features which can be misinterpreted by untrained people. Likewise, other symptoms such as agitation, involuntary disassociation and difficulty concentrating can all be misconstrued as a lack of interest on the part of the radicalised person to engage in the exit work. This can potentially retraumatise the person, destroy trust, waste human resources and ultimately, lead to poor exit outcomes. Understanding trauma as well as identifying symptoms of trauma should therefore be a central skillset for mental health professionals. However, it is also critical for other professions to be trained in understanding how trauma impacts individuals and their ability to undergo a process, as well as to detect the signs and symptoms of trauma.

In the field of P/CVE, trauma-informed approaches recognise that the pathways to radicalisation are multifaceted and the result of varying and intersecting psychosocial factors. These approaches may therefore be particularly useful for P/CVE, as they locate the deradicalisation process within the psychosocial factors that cause vulnerabilities and contribute to engaging in violent extremism. However, it is clear that more research and sharing of experiences is needed if we are to examine the potential synergies here and explore how this approach can lead to better exit outcomes.

Recommendations

1. Carry out further research, especially analyses of practices.
2. Invest in community-led approaches.
3. Reach out to families to help them understand the potential impact of intergenerational or collective trauma.
4. Make greater efforts to understand culturally specific treatment options as well as the social and cultural risk factors in radicalisation.
5. Ensure all non-mental health professionals receive training on understanding the impact of trauma.
6. Establish supervision programmes with case studies, to allow practitioners to learn and share best practice.

Further reading

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About the author:

Lotta Carlsson is an exit-worker and independent expert for the RAN Mental Health Working Group. She is a counsellor educated in solution-focused psychotherapy and body-oriented psychotherapy with a focus on trauma.

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