

# Trauma and trauma care in Europe

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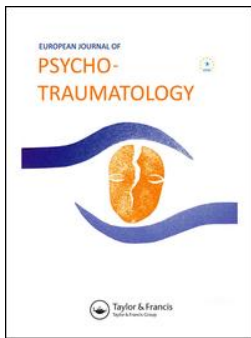
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REVIEW ARTICLE



## Trauma and trauma care in Europe

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### ABSTRACT

The European countries have a long history of exposure to large-scale trauma. In the early 1990s the increasing awareness of the consequences of trauma within the mental health community led to the foundation of local societies for psychotraumatology across Europe and the European Society of Traumatic Stress Studies (ESTSS), which celebrated its 25th anniversary in 2018. The focus of this article is to describe the current state of care for survivors of trauma in the 15 European countries where ESTSS member societies have been established. Brief descriptions on the historical burden of trauma in each country are followed by an overview of the care system for trauma survivors in the countries, the state-of-the-art of interventions, current challenges in caring for survivors and the topics that need to be most urgently addressed in the future. The reports from the different countries demonstrate how important steps towards a better provision of care for survivors of trauma have been made in Europe. Given the cultural and economic diversity of the continent, there are also differences between the European countries, for instance with regard to the use of evidence-based treatments. Strategies to overcome these differences, like the new ESTSS training curricula for care-providers across Europe, are briefly discussed.

### Trauma y Atenciones de Trauma en Europa

Los países Europeos tienen una larga historia de exposición a traumas de larga escala. A principios de la década de 1990, la creciente conciencia de las consecuencias del trauma dentro de la comunidad de salud mental condujo a la fundación de las sociedades locales para la psicotraumatología en Europa y la Sociedad Europea de Estudios de Estrés Traumático (ESTSS), la cual celebra en el 2018 su 25° aniversario. El enfoque de este artículo es describir el estado actual de la atención de los sobrevivientes de traumas en los 15 países Europeos, donde las sociedades miembros de la ESTSS se han establecido. Las descripciones breves sobre la carga histórica de trauma en cada país son seguidas por una descripción general del sistema de atención para sobrevivientes de trauma en el país, el estado de la técnica de las intervenciones, los desafíos actuales en el cuidado de sobrevivientes y los temas que necesitan ser abordados con mayor urgencia en el futuro. Los reportes de los diferentes países demuestran los pasos importantes que se han dado en Europa en la entrega de atención para los sobrevivientes de trauma. Dada la diversidad cultural y económica del continente, hay también diferencias entre los países Europeos, por ejemplo en relación al uso de tratamientos basados en la evidencia. Las estrategias para

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### 关键词

心理创伤学; 历史; ESTSS;  
欧洲; 创伤; 治疗; 护理; 心理治疗

### HIGHLIGHTS

- Important steps towards a better provision of care for victims of trauma were made in the European countries.
- In 2018, ESTSS celebrates its 25th anniversary.
- Strategies to promote a better practice include new ESTSS curricula for professionals across Europe.

resolver estas diferencias, como el nuevo curriculum de entrenamiento de la ESTSS para los proveedores de atención a lo largo de Europa son discutidas brevemente.

## 欧洲的创伤和创伤护理

欧洲国家有遭受大规模创伤的久远历史。在20世纪90年代早期，精神卫生界内越来越意识到创伤的后果，导致了在欧洲各个地区性创伤心理学会和欧洲创伤应激研究学会（European Society of Traumatic Stress Studies; ESTSS）的成立，该学会将于2018年庆祝其成立25周年。本文旨在描述在已建立ESTSS子协会的15个欧洲国家中创伤幸存者护理的当前状况。首先是对每个国家创伤的历史负担的简要描述，之后概述了各国创伤幸存者的护理系统的概述，干预措施的最新技术，护理幸存者面临的当前挑战以及将来最迫切需要解决的问题。来自不同国家的报告展示了，在欧洲是如何实现为创伤幸存者提供更好的护理。鉴于大陆的文化和经济多样性，欧洲国家之间也存在差异，例如在循证治疗的使用上。我们简要讨论了克服这些差异的策略，例如为跨欧洲的护理服务提供者新的ESTSS培训课程。

## 1. Introduction

Exposure to trauma is common (Kessler et al., 2017) and its consequences on the individuals and communities affected can hardly be overestimated. In Europe, as in other regions of the world, a high burden of trauma is related to human-made events. In the twentieth century, military conflict took place during every single year in the European region and many of them affected numerous countries (see Table 1). Mass traumatization was also related to military conflicts associated with European colonialism, or conflicts in other continents where European military forces were involved in conflicts (see Table 2). Another massive burden of trauma across Europe resulted from the Holocaust and, throughout most of the twentieth century, from the political oppression by the Soviet communism. Trauma has occurred and still occurs in many societal contexts. For example, these include the familial and institutional abuse of children, different forms of gender-based violence in the European societies, various forms of institutional violence (i.e. in detention facilities of some countries) and also large-scale disasters and terror attacks that struck individual countries. Finally, over the last decades, an increasing number of migrants have reached the European countries, due to

war and violence in their homeland (Hall & Olff, 2016; Kartal & Kiroopoulos, 2016; Knaevelsrud, Stammel, & Olff, 2017; Munz & Melcop, 2018).

In the last two decades of the twentieth century, the increasing awareness of the consequences of trauma in the mental health community led to the foundation of local working groups and societies for psychotraumatology in several European countries. The European Society of Traumatic Stress Studies (ESTSS), which celebrated its 25th anniversary this year, was founded in 1993. Over two decades, ESTSS was an organization that included both member societies and individual members, which in the first years mainly came from western European countries. Recently, ESTSS has developed into an umbrella organization of the European societies for traumatic stress. This change is the result of a strategic plan that has been pursued over a longer period of time (Gersons, 2013). The ESTSS board consists of representatives from all member societies, which facilitates the work towards common strategic aims, such as promoting a standard curriculum for training in psychotrauma across Europe. In 2018, ESTSS com-

**Table 1.** Examples of military conflicts in Europe.

Year	Military conflict	Countries affected
1914–1918	First World War	Pan-European
1917–1922	Soviet revolution	Former Soviet countries
1936–1939	Spanish civil war	Spain
1939–1945	Second World War	Pan-European
1944–1953	Lithuanian partisan war against Soviet occupation	Lithuania
1968–1998	The Northern Ireland Troubles	UK, Republic of Ireland
1991–2000	Wars following the dissolution of former Yugoslavia	Slovenia, Croatia, Bosnia and Herzegovina, Serbia, Montenegro, Kosovo
Since 1990	Military conflicts/wars in the South and North Caucasus	Georgia, Armenia, Azerbaijan and Russia (including North Caucasian region of Russia)
2008	Russian-Georgian war	Georgia, Russia
Since 2014	Conflict in East Ukraine	Ukraine, Russia

The list of military conflicts and countries involved is not all inclusive.

**Table 2.** Examples of military conflicts outside of Europe.

Year	Military conflict	European countries affected
1945–1949	War in the former Dutch East Indies	The Netherlands
1946–1954	Vietnam war	France
1954–1962	Algeria war	France
1950–1953	Korean war	Belgium, France, Greece, Luxembourg, Netherlands, UK
1961–1974	Portuguese Colonial War in Africa	Portugal
1979–1987	Afghanistan war	Former Soviet countries, UK
1990–1991	Gulf war	Belgium, Denmark, France, Germany, Greece, Hungary, Italy, Netherlands, Norway, Poland, Portugal, Romania, Spain, Sweden, UK
2001–2014	Afghanistan war	Albania, Belgium, Croatia, Czech Republic, Denmark, France, Georgia, Germany, Italy, Lithuania, Norway, Poland, Portugal, Romania, Russia, Spain, Sweden, UK, etc.

The list of military conflicts and countries involved is not all inclusive.

prised of 13 member societies that included 15 European countries and regions. These included Austria, Belgium, Croatia, Georgia, Germany, Lithuania, Italy, The Netherlands, Poland, Portugal, Sweden, the German-speaking and the French-speaking part of Switzerland, Ukraine and the UK ([www.estss.org](http://www.estss.org)). Moreover, ESTSS had 12 additional affiliated societies and institutions in 2018. The society is constantly working towards the inclusion of further European societies and actively supports the formation of new societies in countries where they do not exist yet, as currently happened in Finland where the Finish Society for Psychotraumatology was launched in 2018.

While a series of articles at the occasion of ESTSS' twentieth anniversary focused on the inspiring and often also entertaining recollections of former presidents on the development of ESTSS (Lueger-Schuster, 2013b), the focus of this article is on the current member societies of ESTSS and on the development of trauma care in the respective countries. After some reflections on the historical burden of trauma in each country, representatives from all the national societies describe the structure of care organizations for trauma survivors, the state-of-the-art of interventions, current challenges in caring for survivors and the topics that need to be most urgently addressed in their countries in the future.

## 2. Psychotraumatology in Belgium

Five to eight million deaths, perhaps even 10: this was the devastating toll of the conquest and colonial exploitation of the Belgian Congo with King Leopold II, between the 1880s and the First World War (Hochschild, 1998). All traces of this Genocide remained secret until the early 1980s. Concerning the historical burden of the two World Wars (Manfred, 2015), it is the First World War more than the Second World War which, in the collective memory, constitutes a great trauma because of the looting of the country and the massacre of more than six thousand civilians. Recent events that stay more broadly in the mind of the Belgian people include the Heysel Drama in 1985 and the Dutroux affair with the sexual abuse, sequestration and death of young children and adolescents in 1996. In March 2016, the terrorist attacks at the national airport and in the metro of Brussels caused the death of 35 persons (Deschepper et al., 2018). Psychosocial structures vary across the country and have little or no coordination between them. One of the reasons is a difference between the functioning of French- and Flemish-speaking communities. Some structures can be found in both the French- and the Flemish-speaking communities. For instance, Public Welfare Centres and police victim services can be found in both of them. The integration of a psychosocial dimension into emergency and intervention plans was formalized in 2006. For the last 20 years, psychotherapists and

other clinicians working in private practices started to specialize in trauma care for survivors. More and more specifically trained psychologists are working in hospitals and mental health centres. Recently, the development of outpatient trauma treatment centres linked to hospitals is evident. Some centres for the provision of trauma care for refugees were established in Brussels and cover the Dutch- as well as the French-speaking part of the country. In 2017, the High Council on Health received a Ministerial request for an opinion on the psychological care and support of persons following terrorist incidents or related disasters.

Until recently, there were no trauma-focused intervention methods in use in Belgium. The main therapeutic currents, for instance cognitive behavioural therapy (CBT) and psychodynamic therapies, were putting their own accents on working with trauma. In 2006, the BIP (Belgian Institute for Psychotraumatology) started the first psychotraumatology course. More trauma centres were created in the following years in principle cities, mainly Antwerp and Brussels. The course is organized in collaboration with two Universities. BIP organizes conferences in collaboration with other institutes or centres in Belgium. An independent Belgian trauma society needs to be created in the near future.

Current challenges in caring for trauma survivors concern the coordination of different support services. The political system in Belgium involves varying responsibilities at several levels, which makes decision-making complex. More visibility through studies on the positive impact and benefits of qualified trauma-focused care will be important. Finally, a well-structured national accreditation system should be put in place in order to continue provision of quality care for trauma survivors.

Among the topics to be most urgently addressed in the future is accessibility of services which is limited due to long waiting lists before survivors get access to psychological care in the Belgium mental health care system. Moreover, new ways of thinking about specialized trauma-care structures are needed.

## 3. Psychotraumatology in Croatia

The still living burden of the Second World War psychotrauma in Croatia has merged with the trauma of the Homeland War (1991–1995). Throughout the whole post-World War period there was no awareness of the consequences of trauma exposure, the issue was present neither in the health nor in public discourse. Consequently, no specific care was developed and provided. In contrast, the war in the 1990s brought about a high level of awareness of trauma and posttraumatic stress disorder (PTSD). Decades later the war-affected population reports 18% prevalence of PTSD (Priebe et al., 2010). This may be



partly due to lack of effective early trauma interventions and a number of hindering social factors, such as the prolonged economic crisis that affected more the vulnerable populations. The spin-off effect of massive trauma at the social level is a new understanding of the impact of traumatic events on physical and psychological health, as well as on communities (Corkalo Biruski, Ajdukovic, & Löw Stanic, 2014; Lončar & Henigsberg, 2007), which in turn facilitates access to specialized services by people exposed to trauma in everyday life.

Trauma survivors have access to psychiatric services in major hospitals, while veterans receive help within the three specialized regional centres and the National Centre for Psychotrauma. The cost of services are covered by universal national health insurance. Several non-governmental organizations with qualified staff provide supportive therapy to survivors of sexual assault, traffic accidents and other life threatening incidents, as well as domestic violence. The Polyclinic for the Protection of Children based in Zagreb specializes in working with traumatized children. Other facilities focus on prevention and support in the immediate aftermath of traumatic incidents, such as the Crisis Response Network maintained by the Society for Psychological Assistance (SPA).

The psychiatrists' first treatment choice is psychopharmacology. The prevalent therapeutic approach in psychiatric services for veterans is group therapy. Some veterans have been attending such groups for over 25 years. Low use of evidence-based trauma-focused therapies reflects (Schnyder et al., 2015) the prevailing traditional approach in Croatian psychiatry. Hence, traumatized populations still have poor access to effective, evidence-based trauma treatments. Training in trauma-focused CBT and EMDR is offered to practitioners, but this is not fully integrated into the helping system. With the existing high level of competencies in dynamic psychotherapy and psychopharmacology (Britvić et al., 2012), the challenge remains to develop a more stepwise approach to trauma-informed services, increase public awareness of risk and resilience factors, and to expand treatment choices to include evidence-based trauma-focused therapies and make them more available to the general populations in need. The Croatian Society for Traumatic Stress (CSTS) has been working on this challenge since it was founded in 2011 by organizing training workshops. It is currently promoting the ESTSS certified training in psychotrauma for mental health providers. One of the ambitions is to further integrate such training into university curricula so that future generations of mental health professionals are able to provide state-of-the-art care to traumatized people. Similarly, basic and intermediate levels of trauma-related knowledge and skills will be made more available to first responders and other health professionals.

#### 4. Psychotraumatology in France

According to the World Mental Health survey, 72.7% of the French population has been exposed to traumatic events in their lifetime (Husky, Lépine, Gasquet, & Kovess-Masfety, 2015). Intimate partner violence, serious illness of a child and rape were the events associated with highest risk of PTSD. While rape is underreported in France, each year nearly 100,000 individuals claim to be survivors of rape or attempted rape and 500,000 claim to be survivors of intimate partner violence. A fifth of the French population was exposed to war-related events (mainly the Second World War). The twenty-first century was scarred by numerous Islamism extremist attacks, of which the November 2015 Paris attacks have been the bloodiest to date, resulting in more than 264 dead and 914 injured individuals. Traffic fatalities decreased in the past decades, reaching 5.1 per 100,000 inhabitants per year.

Since 1995, medico-psychological emergency units (CUMP for 'Cellules d'Urgence Médico-Psychologiques') are deployed in the case of mass casualty situations and provide immediate psychological support and care. These units were very effective after terror attacks in Paris and Nice, supporting thousands of survivors over many weeks (Hirsch et al., 2015). Psychological assistance aims at providing survivors with an entry point to psychological health care and giving them a first sense of relief, even though they do not provide psychological follow-up care (Vandentorren et al., 2018). In order to ensure long-term high-quality trauma care to all survivors in need across the country, President Emmanuel Macron in November 2017 announced the creation of about 10 ambulatory services specialized in trauma care. These services are aimed at providing medical and psychological care to survivors (minors or adults) that have experienced violence or any traumatic event during their lifetime.

The traditional psychodynamic approach is gradually but slowly replaced by structured trauma-focused psychotherapies, such as CBT or EMDR, and also new technologies (e-PTSD) are being introduced (Bourla, Mouchabac, El Hage, & Ferreri, 2018). However, the provision and access to treatment remain limited by the fact that there is a limited number of experienced trained trauma therapists and that care centres are not always clearly identified or equitably distributed across the country.

The challenges in caring for survivors are to achieve universal access to prevention, improve access to trauma-focused psychotherapies and ensure coordination of specialized care and support. One major challenge is to expand public funding of structured psychotherapies by trained psychologists. It is advisable to ease access to structured trauma-focused

therapies as part of mental health care programmes in compliance with international guidelines. In the end, patients should benefit from personalized treatment strategies for their trauma-related disorders, based on objective information.

The future ambulatory care services specialized in trauma will have to structure the organization of care, to establish a single French umbrella society (involving the national trauma centre and psychotrauma societies such as AFORCUMP-SFP, ALFEST and ABC des Psychotraumas), to be involved in qualifying training curricula, and to set up a French certification committee connected to the ESTSS accreditation committee, in order to meet modern European and international standards.

## 5. Psychotraumatology in Georgia

Georgia is a post-Soviet country, with a population of approximately 3.3 million. Since becoming independent in the early 1990s, it went through a prolonged series of civil war and ethnic-political conflicts followed by a war with Russia in 2008 and loss of control over more than 20% of the country's territory. Ongoing social, political and economic crises create pressure on the population, 20.6% of whom live under the poverty level and 7.3% of whom are internally displaced. Among the conflict-affected population, 23.3% suffer from PTSD symptoms, 14.0% from depression, 10.4% from anxiety and 12.4% have more than one mental health condition (Makhashvili et al., 2014). In addition, the population still suffers from the inter-generational effects of trauma related to the Soviet invasion and totalitarian past (Javakhishvili, 2014, 2018).

The large proportion of conflict-affected population led to the build-up of trauma care capacities and corresponding institutional developments, i.e. trauma-focused torture victim rehabilitation centres (GCRT), functional since 2000, with the head office in the capital city Tbilisi and branches in eastern and western Georgia. The multidisciplinary teams provide free of charge care for their clients that include forced migrants, ex-prisoners and others. There are a number of non-governmental organizations providing trauma-informed psychosocial services to socially disadvantaged groups, including forced migrants, domestic violence survivors and other target groups.

The Georgian Society of Psychotrauma (GSP) was founded in 2007 with the support of ESTSS. GSP builds capacity within the local professional community and has introduced such evidence-based treatment methods as Trauma-Focused CBT, Brief Eclectic Psychotherapy for PTSD (BEPP) and EMDR, as well as other relevant psychosocial interventions. Since 2008, GSP regularly conducts an annual international multidisciplinary conference

'Trauma and Society'. To assure capacity building and good quality care, an innovative Master Program in Mental Health was founded in 2012 at Ilia State University in Tbilisi, under the lead and with a main perspective on psychotraumatology.

The mental health treatment gap is about 90% in the country. There is a predominant focus on hospital care; community-based services are under-developed. Common mental disorders are under-recognized and under-treated by the state services. There is a need to develop a trauma-informed primary health care system, enlarge the trauma care infrastructure and establish corresponding referral pathways. Another challenge is low awareness of one's own mental health condition. According to a recent study, of those who suffered from mental health symptoms, only 24.8% sought care, 19.6% acknowledge mental health problems but did not seek care, and 54% did not acknowledge mental health problems (Chikovani et al., 2015).

Since most trauma survivors belong to socially disadvantaged groups who are often exposed to multiple traumatization as well as a series of everyday life stressors, we rarely find among these patients simple PTSD. The most widespread trauma-related condition are complex posttraumatic disorders. Therefore, the most urgent need is to evaluate effective methods of addressing complex trauma conditions. From 2016 to 2018, within the framework of an Erasmus Plus cooperation, the Trauma-Focused Cognitive-Behavioural Therapy Train of Trainers (ToT) module was developed, piloted and adapted to the Georgian cultural context in cooperation with Cardiff University. It has proved its effectiveness in the treatment of not only simple but also complex trauma-related disorders. There is a need to collect strong evidence to further prove the effectiveness of these approaches.

## 6. Psychotraumatology in the German-speaking countries

As in many European countries, the largest historical burden of trauma in Austria, Germany and Switzerland comes from the two twentieth century World Wars and the Holocaust. Over the decades, the different roles of the three countries in these catastrophic events had an influence on the perception of their traumatic impact. In contrast to Switzerland, discourses in Germany and Austria had been more focused on their role as perpetrators and their responsibility for these events. In general, Switzerland has been much less concerned by the two twentieth century World Wars than Germany and Austria. It took a longer time before the trans-generational consequences of war and displacement on parts of the German and Austrian population were also discussed (e.g. Glück, Tran, & Lueger-Schuster, 2012,

Kuwert, Brähler, Glaesmer, Freyberger, & Decker, 2009). Another population that requires expertise on psychotraumatology in the three countries is that of the refugees (e.g. Knaevelsrud et al., 2017; Spiller et al., 2017).

Services for trauma survivors are organized in a similar way in the three German-speaking countries. Non-governmental organizations play an important role in the psychosocial response to disaster and other mass incidents. Some of them also provide care for survivors of individual trauma in the form of local 'crisis intervention units' that closely collaborate with other emergency services. Specialized counselling agencies, usually funded by the local municipal authorities, offer low-threshold services for survivors of childhood abuse, sexual assault and domestic violence. In all three countries, there are also growing networks of clinical outpatient services for survivors of interpersonal violence that are frequently located at psychiatric hospitals. Psychotherapists in private practice play an important role for the treatment of posttraumatic disorders in both children and adults. Moreover, in each of the three German-speaking countries, a larger number of hospitals offer specialized inpatient care for patients with posttraumatic disorders.

The German-speaking Society for Psychotraumatology (DeGPT), the common trauma society of the three German-speaking countries (Germany, Austria and Switzerland), has developed curricula for the training of professionals in different settings (e.g. staff in counselling services, psychotherapists for children and adults) in trauma-related practices. The curricula for psychotherapists have been recognized by important national bodies, like the national chambers of physicians and psychotherapists in Germany. At present, about 50 training institutes in Germany, Austria and Switzerland offer the curricula. The society also coordinates the national German guideline for the treatment of PTSD. Such activities have contributed to the dissemination of evidence-based practices in different settings. However, as in other European countries (Kazlauskas et al., 2016), many psychotherapists still do not feel competent to deal with traumatized populations. As a result, patients can face substantial problems to find adequate help, for instance in the form of trauma-focussed interventions for individuals with PTSD.

The prevention of trauma in different settings remains a challenge. Recently, initiatives in all three German-speaking countries addressed the problem of institutional violence, e.g. in foster care settings, but more efforts are needed to sustainably implement preventive efforts and bodies like the independent commissioner into childhood sexual abuse in Germany (Bergmann, 2011). The dissemination of

trauma-informed practices in all parts of the health care system and the social sector is another urgent issue. Finally, the provision of adequate care for the considerable number of migrants from contexts of war and persecution in the German-speaking countries is a challenge for the years to come.

## 7. Psychotraumatology in Italy

Trauma permeates the history of Italy: war, terrorism, major mass disasters, abuse and maltreatment deeply affected the Italian society across time and generations. During the Second World War, many Italians experienced the effects of torture and deportation leaving a scattered society (Favaro, Rodella, Colombo, & Santonastaso, 1999). In the 1970s, the Italian society faced the 'dark period' of *Brigate Rosse*, a terroristic group who caused many deaths and created a deep sense of fear in the population. Domestic violence is the most common crime against children; indeed, child abuse and maltreatment is a major public health problem. A recent report (Autorità Garante per l'Infanzia, CISMAI and Terre des Hommes, 2016) revealed that each year 950 children are exposed to sexual abuse. In the past year, the percentage of maltreatment and abuse increased by 6%. Italy has also experienced a significant number of natural disasters, like floods and earthquakes, that potentially increased the prevalence of post-traumatic syndromes in the communities. There are no robust data about the actual burden of such traumatic experiences and their effects on the society today.

Italian health and social care systems have not yet fully embraced a trauma-informed approach. This led to fragmented responses to the needs of survivors, especially in terms of preventive initiatives. There is some resistance to implement routine screening and assessment tools for the early detection and prevention of post-traumatic syndromes. For this reason, the system responds late and mainly to traumatization that became complex as a result of missed accurate diagnoses. It is a challenge to acquire a systemic vision of care for traumatized populations, with shared policies and protocols.

Exposure-based therapies are rarely used; EMDR is the only widely implemented intervention in the social care system at all levels. Other trauma-focused therapies (Ehring et al., 2014) – such as trauma-focused CBT or Narrative Exposure Therapy (NET; Schauer, Neuner, & Elbert, 2011) – struggle to be disseminated. Clinicians are asked to integrate different treatment approaches with a good understanding of assessment and psychoeducation techniques. Training of health and social care professionals is a key issue. In Italy, trauma is still seen as a 'psychologist/psychotherapist business', undermining the importance of multidisciplinary. Furthermore, a synergy between clinical work and research should be



promoted to investigate the outcomes of treatment and to adapt service models accordingly.

There are a few important strategic points the Italian Society of Traumatic Stress Studies (SISST) should consider for the future. Highly traumatized migrants and refugees are one of the priorities requiring a long-term preventive plan to fight longer-term consequences for the society. The second point is the promotion of a more articulated reasoning about the implementation of evidence-based therapies. Furthermore, epidemiological studies are warranted to determine the actual prevalence and incidence of traumatic events in Italian society. Finally, another crucial issue is a comprehensive training in psychotraumatology. The new ESTSS certification represents a good opportunity for trauma-informed capacity building initiatives in the near future.

## 8. Psychotraumatology in Lithuania

The burden of trauma in Lithuania was largely influenced by the political situation in Europe in the twentieth century. Large-scale traumas associated with the two World Wars, the Holocaust and the prolonged Soviet occupation had a significant impact on the Lithuanian population, marked with suffering and oppression for several generations. Interest in trauma and trauma research in Lithuania was started soon after the collapse of the Soviet Union in the 1990s and several studies explored posttraumatic effects of political violence in the country (Kazlauskas & Zelviene, 2016).

Survivors of traumatic events can seek treatment for mental disorders in the public mental health care system, which includes about 100 primary mental health centres spread across the country, and in more severe cases in psychiatric hospitals. Several non-governmental organizations and crisis centres in the biggest cities in Lithuania are providing help for survivors of interpersonal violence, including psychosocial support and psychotherapy. Additionally, psychotherapists in private practice are also available for trauma survivors. Despite these positive developments, care organizations for trauma survivors are not developed in Lithuania and evidence-based trauma-focused treatments for trauma survivors are not available in the public mental health care system.

Mental health professionals are increasingly aware of the negative effects of trauma on individuals and are interested in learning new ways to help trauma survivors. There is significant progress regarding the implementation of evidence-based trauma-focused treatments, such as EMDR and BEPP, in Lithuania recently. The numbers of therapists trained in trauma-focused treatments are growing, but these treatments are not offered in the public health care system and are available predominantly in private

practice which is expensive and not covered by national health care insurance.

Despite the high prevalence of traumatic experiences in Lithuania (Kazlauskas & Zelviene, 2016), it was reported that PTSD is not identified in the Lithuanian national health care system (Kazlauskas, Zelviene, & Eimontas, 2017). The lack of acknowledgment of trauma and PTSD in Lithuania is a major barrier for the development of treatments for trauma survivors in the country.

Future directions of the trauma field in Lithuania include ensuring access to evidence-based treatments for trauma survivors. There is a need of trainings for practitioners to update their knowledge about the impact of trauma, with a particular focus on how to diagnose stress-related disorders and how to provide trauma-focused treatments. Finally, health care and social policy changes on the national level are needed to acknowledge trauma survivors and include evidence-based treatments in the health care of survivors exposed to various traumas, particularly children and adolescents. The Lithuanian trauma society is taking an active role in raising awareness about the effects of trauma to facilitate the further development of care for trauma survivors.

## 9. Psychotraumatology in the Netherlands

The Second World War marks the largest historical burden and the starting point for psychotrauma care in the Netherlands. Occupation by German and Japanese (in the former Dutch East Indies) armed forces and subsequent post-colonial wars led to over 250,000 military and civilian lives lost. Public awareness for the psychological effects of wartime and other traumatic experiences started around 1975, with the awareness of the Holocaust. In response, Foundation Center '45 was funded, first focusing on Second World War concentration camp survivors, but soon extending their services to other traumatized populations. The focus on post-war reconstruction, tensions between interest groups and an emphasis on heroics and the resistance, together with a poorly developed mental health care, contributed to this late societal response (Vermetten & Olff, 2013). Subsequent national and international disasters, such as the 1992 Bijlmermeer airplane disaster and the 2000 Enschede fire explosion, further increased professional and public awareness of psychotrauma, and fuelled the establishment of the Dutch Society of Psychotraumatology in 2006.

Mental health care for trauma-related disorders is covered by health insurance at little or no additional personal costs. Facilities for trauma care have been integrated at many levels of health care. Routinely, the first step for individuals with trauma-related symptoms is to consult their general practitioner for referral to secondary health care organizations.

A national standard of care for trauma- and stressor-related disorders is currently underway (Kwaliteitsontwikkeling GGZ, 2018).

Trauma-focused treatment is increasingly offered next to interventions directed at emotion regulation, day-night structure and social support (Vermetten & Olff, 2013). Examples are EMDR, CBT, NET, BEPP and Imagery Rescripting. There is a growing role for E-health interventions (e.g. Olff, 2015). Some institutions use treatment intensification (EMDR or CBT), with preliminary positive effects (Van Woudenberg et al., 2018; Zepeda Méndez, Nijdam, Ter Heide, van der Aa, & Olff, 2018). Although not yet implemented, other treatment innovations include hormonal enhancers (D-cycloserin, cortisol, oxytocin; e.g. Thomaes et al., 2016).

Effective treatment for PTSD due to events in adulthood in fairly well functioning patients seems available, as well as special services and care for the military and the police. One of the greatest practical challenges are the long waiting lists in secondary mental health care, limiting accessibility to care for vulnerable patient groups, such as individuals with multiple (childhood) traumatization, patients with severe physical, neurocognitive and/or psychiatric comorbidities or severe psychosocial problems, and (asylum seeking) refugees. The latter in particular experience difficulties accessing evidence-based care due to stigma, requirement of referral by general practitioners, and language and cultural barriers. Moreover, research on the (cost-)effectiveness of treatments for these target groups is relatively lacking (e.g. Sijbrandij et al., 2017), as well as on improving symptom recovery and treatment adherence of current PTSD treatments.

Topics which should be urgently addressed in the future include improving treatment outcome for specific target groups, i.e. patients with childhood trauma; implementing treatment for target groups that are currently excluded from regular PTSD treatments; family- or system-oriented interventions to prevent inter-generational consequences of trauma and enhance opportunities for social support; evaluation of e-mental health interventions for PTSD and comorbid disorders, including blended treatment options administered within routine clinical practice; increased use of transdiagnostic treatment options for trauma-exposed patients targeting a variety of psychopathology limiting psychosocial functioning; and the use of low-intensity interventions, carried out by non-professional helpers to increase coverage of mental health interventions.

## 10. Psychotraumatology in Poland

The recognition of the socio-psychological consequences of the Second World War in Poland is an extremely important issue. Poland belongs to the part of Europe

which Snyder (2010) called the 'Bloodlands'. The number of ethnic Poles and Polish Jews who died or were murdered in connection to the Second World War amounted to about six million. Poland lost about 17% of its pre-war population (Materski & Szarota, 2009). Moreover, the Soviet invasion and the subsequent imposition of a communist regime led to large groups of people being persecuted. Many survivors of the war (e.g. resistance movement members, people deported to Siberia) were not even recognized as survivors, and speaking about many aspects of war experiences could lead to prosecution. Very little attention has been paid to Second World War issues in medicine and psychology, in comparison to the volume of analogous research in western countries (Lis-Turlejska, Szumiał, & Drapała, 2018). Psychological help for survivors of the war was practically absent, and the need is still not recognized today. Since the collapse of communism, neither war nor other traumas have been recognized on a broader scale. Research has been conducted on the consequences of the great flood of 1997 (Strelau & Zawadzki, 2005), however, other traumatic events, including the death of the president and other governmental officials in the Smolensk plane crash in 2010, have not yet been the subject of psychological research.

There is no coherent care system in Poland for survivors of various traumatic events. A number of crisis intervention centres provide help for 'families in crisis' – mainly for survivors of domestic violence ([www.spoleczenstwoobywatelskie.gov.pl](http://www.spoleczenstwoobywatelskie.gov.pl)). There are non-governmental organizations working with survivors of trauma (e.g. battered women, abused children, survivors of crime). However, they are all underfunded and their capacity is limited. Access to psychotherapy under national health insurance is also limited. Despite the fact that there are many psychotherapists working privately, mainly in larger cities, there are still very few professionals who are specialized in psychotraumatology.

Crisis intervention is probably the most widely offered help to trauma survivors. Practitioners have the opportunity to be trained in different approaches in psychotherapy, including CBT, prolonged exposure therapy and EMDR. However, there is no clear emphasis on evidence-based treatments and they are not widely used in practice. There is also a lack of research on the effectiveness of trauma therapy. The issue of prevention is neglected in general, except training for professional groups (e.g. flight crews, emergency services).

Currently, the most important challenge is to increase access to professional care, specifically increasing access to therapists who offer evidence-based interventions. However, education of the general population about the importance of help seeking and potential benefits out of it is also crucial. It is necessary to further develop research on the

psychosocial consequences of both the Second World War and other large-scale traumatic events. It is also important to encourage the teaching of contemporary curricula on abnormal psychology, including content specific to trauma. This seems to be the most urgent task, alongside further development of the trauma care system and promotion of good practices in psychological care and psychotherapies for trauma survivors.

## 11. Psychotraumatology in Portugal

A colonial war of 13 years has left to Portugal an individual and collective traumatic heritage (Maia, McIntyre, Pereira, & Ribeiro, 2011). The consequences remain to this day through the intergenerational transmission of trauma (Dias, Sales, Cardoso, & Kleber, 2014). Throughout the years, clinicians, academics and other professionals discussed the psychosocial consequences and reactions to this trauma. Later, the coordinated response to two major accidents promoted a national approach to survivors of crisis and disaster. In 2009, the Centre for Social Studies of the University of Coimbra created the Centre of Trauma (CT), a society that brings together the country's leading organizations who directly deal with potentially traumatic events. Since 2010, CT is a full member of ESTSS.

In Portugal, the National Authority for Civil Protection provides central technical guidance to the organizations who deliver services to survivors of disasters or catastrophes. It is a governmental entity which coordinates the interventions developed and implemented by the different professional groups and organizations (fire fighters, medical emergency services, etc.). Clinical care to trauma survivors is provided by the National Health Service in the first place, but in cooperation with organizations (both non-governmental and governmental) who are specialized in trauma therapies and relevant psychosocial interventions. There is a core team of trained and certificated psychotherapists within CT whose service is accessible to people in need.

The most widespread therapy methods in Portugal are CBT, EMDR, Psychodrama and brief supportive psychotherapeutic strategies. Psychopharmacotherapy is also frequently used alone or in combination with psychological interventions. Treatment takes place in public and private health institutions. A number of governmental and non-governmental organizations currently invests in building the capacity of their staff in trauma care and designing and implementation of preventive interventions. CT is responsible for regular organization of conferences, seminars and the delivery of a biannual psychotrauma course. The course equips professionals from different fields with relevant knowledge and skills.

Professional and organizational preparation and knowledge to treat trauma consequences at the individual, family and social level needs to be optimized and updated. Minorities and refugees at risk may benefit from more integrated assistance. The ability to effectively respond to disasters and catastrophes through the provision of acute trauma care and coordination among the different organizations that are involved in disaster management has to be improved. There is room for improvement regarding the identification of populations at risk, screening for trauma related disorders and responding to the needs of the health care system. Family doctors and nurses, firemen and other professional groups have to be trained to assure their trauma-informed professional performance.

The topics to be addressed in the near future include creating a national plan for PTSD prevention and psychosocial interventions in case of crisis and disaster, as well as founding a network for specific treatment responses to trauma-related disorders, namely PTSD. Good practices have to be disseminated and young researchers and clinicians need to be motivated to work in the field of psychotraumatology. Finally, more effective and organized strategies to address potentially traumatic contexts such as unemployment, marital violence, cyber bullying and road accidents need to be developed, and the cooperative and coordinated work with national and European entities needs to be further increased.

## 12. Psychotraumatology in Sweden

The Swedish population has enjoyed peace for over 200 years. For a long time, the country did not experience the same increase in attention to psychotraumatology as other European countries with afflicted veteran soldiers from the nineteenth century wars. The impetus for trauma-informed services has instead come from disasters, large accidents and the increased attention to interpersonal abuse. A harrowing bus crash involving 12-year-olds on a school trip in 1988 (Arnberg et al., 2011) became the initiating event for the public organization of crisis support after large-scale events. Events such as the 1994 Estonia ferry disaster in the Baltic sea (e.g. Arnberg, Hultman, Michel, & Lundin, 2013) and the 2004 Southeast Asia tsunami (e.g. Michélsen, Therup-Svedenlöf, Backheden, & Schulman, 2017), both leading to hundreds of Swedish casualties, as well as the recent deployment of Swedish peacekeeping forces around the world, have highlighted the psychosocial consequences of trauma. More recently, the refugee crisis has set off many activities related to culturally informed trauma services.

In Sweden, every municipality has a psychosocial crisis team and there are psychosocial disaster contingency teams at the larger hospitals. A major step forward was the legislation passed in 2000 that

mandates employers to ensure that they have adequate knowledge of and plans for crisis support for their employees. Beyond the acute crisis support, however, access to qualified treatment of chronic traumatization varies across the country. In some regions there are dedicated trauma clinics; in others, there are trauma teams within the psychiatric services. Some regions lack both dedicated trauma clinics and teams.

The acute crisis interventions that are available in Sweden include Psychological First Aid, various forms of unstructured crisis support and a variety of debriefing methods including psychological debriefing (Witteveen et al., 2012). As for the treatment of PTSD, the Swedish National Board of Health and Welfare issues guidelines for public health care. In their latest guidelines from 2017 (The Swedish National Board of Health and Welfare, 2017), trauma-focused psychological treatments were given the highest priority; selective serotonin reuptake inhibitors (SSRIs) were prioritized as a potential but not necessary option for adults with PTSD, although they probably are the most widely used treatment in the country.

Several challenges lie ahead. The use of ineffective preventative interventions remains and the provision of psychosocial support beyond the acute phase is very limited, partly due to compartmentalized organizations. Further development of acute interventions in health care would benefit from robust evidence for early interventions. Trauma-related problems in patients too often go undetected in health care assessments (Al-Saffar, Borgå, & Hällström, 2002). In addition, access to prioritized treatments is underdeveloped in many parts of Sweden: the concentration of relevant competence in metropolitan areas is a salient issue in this country due to its large rural areas.

Another challenge related to the treatment of PTSD is that a large proportion of therapists are due for retirement in the next five years. It will become important for the field to continue to attract younger professionals. It is hoped that a stronger professional community, aided by the Swedish Society for Psychotrauma, can prevent fragmentation of the many regional initiatives, particularly in light of the many refugees across the country, and serve as a force for increasing the quality of and access to trauma treatments.

### 13. Psychotraumatology in Ukraine

The historical burden of trauma in Ukraine mainly consists of man-made catastrophes. They include the famines in the years 1933 and 1947, the Second World War, the explosion of the Chernobyl nuclear power station, and the current military conflict with Russia, which is officially called 'Anti Terrorist

Operation (ATO)'. All events that happened during the Soviet times were hushed up and psychological support has never been provided to the people in need. It was not until the Maidan revolution and the beginning of the current war that psychological services in Ukraine were organized for victims of mass violence.

In Ukraine, care organizations for trauma survivors are currently under development. It presupposes an effective coordination of governmental and non-governmental organizations and professional institutions. The non-governmental organization Ukrainian Society for Overcoming the Consequences of Traumatic Events (USOCTE) was created to reach that aim. This professional organization aims at the development of crisis intervention services as well as capacity for provision of trauma-focused psychological therapies in Ukraine, in accordance with the international standards. Currently, USOCTE provides psychological help to wounded ATO soldiers and veterans, as well as other people who suffer from consequences of the ATO: those living in the ATO zone, internally displaced persons, families of killed soldiers and participants of the Maidan revolution. USOCTE is also engaged in developing training programmes for psychologists and psychoeducational materials for the general population. The methods used in trauma care are EMDR, CBT and the SEE FAR CBT treatment protocol of the Israeli coalition of trauma.

These treatments are offered in a strictly structured way. All clients sign an agreement, which determines the focus of the therapy. According to that agreement, a client has a right to attend 12 free-of-charge sessions. The first sessions are devoted to a detailed diagnostic interview, psycho-education on the signs and nature of posttraumatic disorders and providing information on therapeutic approaches. The following stabilization phase is intended to create a sense of safety by means of different techniques. It is followed by the trauma-focused interventions mentioned above. The final phase of treatment has the aim to integrate the experiences into daily life, assess the results and adapt to the achieved changes.

Challenges in this work are the very high level of psychological disturbance among the people living close to the conflict zone, and their reluctance to acknowledge this and to ask for psychological support (Roberts et al., 2017). It should also be mentioned that women are especially vulnerable on the front-line territory, and suffer multiple problems including high levels of psychological violence. These problems are often not recognized and the population has a tendency to believe that the end of military activities will solve all problems.



To overcome the consequences of the current military conflict in Ukraine, USOCTE is confronted with a number of tasks. They include building up a multilevel system of psychological assistance with the support of governmental and non-governmental organizations as well as monitoring and evaluating the activities of specialists in the psychological field on a regular basis. Moreover, the local communities need to be involved in supporting the aggrieved. Finally, there is a need for a more intensive cooperation and sharing of experiences with international organizations.

#### 14. Psychotraumatology in the UK and Northern Ireland

The 2014 Adult Psychiatric Morbidity Study (APMS) provides the most comprehensive estimates of PTSD within the UK, although the sample is of English residents only (Fear, Bridges, Hatch, Hawkins, & Wessely, 2014). APMS found a PTSD prevalence of 4.4%, with similar rates observed between men and women. PTSD rates in women declined with increasing age; 12.5% of 16–24-year-old women had PTSD. In contrast, in men PTSD remained roughly consistent until declining from age 65. Northern Ireland (NI) has historically experienced a sustained period of political conflict known as the Troubles. The NI Study of Health and Stress identified that NI has one of the highest global rates of PTSD with lifetime and 12 month prevalence rates of 8.8 and 5.1%, respectively (Bunting et al. 2013). Lifetime prevalence in NI females (11%) was substantially higher than the rates in NI men (6.4%). Although there is no specific information on prevalence rates in Scotland and Wales, it is anticipated they are similar to English rates.

The UK's mental health services are provided by the National Health Service (NHS). Although regional variations exist, the first point of access is via family doctors. Community services, often available via self-referral, typically treat survivors of single incident traumas where a diagnosis of PTSD is present without co-morbid problems (e.g. substance misuse). Treatment of more complex cases (e.g. survivors of child abuse, refugees, etc.) is via specialist mental health teams. NHS treatment complies with best practice guidelines compiled by the National Institute for Health Care and Excellence. A range of other non-governmental organizations exist that are staffed by qualified health professionals and offer support to sub-populations of trauma survivors (e.g. survivors of domestic abuse, veterans, etc.). In NI, a Regional Trauma Service is under development to address the mental health legacy of the Troubles.

Interventions to treat PTSD in the UK are typically trauma-focused psychological therapies such as, but

not limited to, trauma-focused CBT, EMDR and prolonged exposure (NICE, 2005). In addition, psychopharmacology support is given to manage co-morbid mental health presentations. Increasingly, e-technologies are being developed to help provide cost-effective support that also promote accessibility. For example, an online guided self-help tool for PTSD has been developed and internet-based video technologies have been successfully used to deliver PTSD treatments with much reduced therapist time required. Some providers also utilize compressed therapy where 16–20 hours of TF-CBT are delivered over a week.

Currently, whilst there is often some delay in accessing specialist mental health assessment services, the biggest bottleneck is in the provision of specialist services for more complex cases of PTSD. Also, whilst APMS has shown that help-seeking for PTSD is improving, the majority of people with PTSD in the UK still do not seek any help.

Whilst, the UK has made considerable efforts to improve the public understanding of mental health, more needs to be done. Additionally, organizations which routinely expose staff to trauma (such as the emergency services, military and child social workers) need to address the issue of PTSD as a result of chronic trauma exposure as there has been limited work done on this topic.

#### 15. Conclusion

The perspectives above show that important steps towards a better provision of care for survivors of trauma have been taken in the European countries. Given the cultural and economic diversity of the continent, there are still some differences between the countries, for instance with regard to the use of evidence-based treatments. Effective treatments have many elements in common (Schnyder et al., 2015) and the treatment of choice is often based on culture and history. The dissemination of evidence-based knowledge and skills has always been a priority of ESTSS (Ajdukovic, 2013, Bisson, 2013, Olff, 2013) and further strategic steps towards this aim have been made recently. In 2018, the first of a series of new ESTSS curricula, the 'Advanced Training in Treating Posttraumatic Disorders in Adults', was approved by the board. The curriculum comprises 120 hours of training and 20 hours of case supervision. It has a strong focus on evidence-based approaches and provides knowledge and skills for the treatment of acute stress disorder, non-complex PTSD and complex posttraumatic disorders (for more detail see [www.estss.org](http://www.estss.org)). The curriculum has already been adopted by several member societies who are building up local structures to offer the trainings or adopt their national curricula to meet the requirements of the ESTSS curriculum. Other

curricula, for instance for the treatment of trauma-related disorders in children and adolescents, and more basic curricula to promote the idea of trauma-informed care among different groups of professionals, are currently being developed.

The country reports presented in this paper show that many countries share similar challenges and have topics in common that need to be addressed. These topics include, among others, the prevention of trauma, the promotion of trauma-informed practices in the whole health care system and standards of care for groups with special needs, including refugees and internally displaced people. Of increasing importance in the field of mental health is the involvement of trauma survivors in mental health care teams (Van der Schrieck-De Loos, 2013). It was beyond the scope of this paper to describe the large amount of research in the field of psychotraumatology in the European countries, which represents a significant proportion of the global research activities in this field (Olf, 2018). However, similar to the differences with regard to the use of evidence-based treatments, these activities are not evenly distributed between the different European countries. It is part of ESTSS's mission to stimulate and promote research Europe wide.

The current structure of ESTSS allows for a more direct exchange between the member societies and thereby provides the opportunity to effectively address such common issues. It has always been the aim of the society to provide a platform for all professionals in Europe in the field of psychotraumatology to connect, to develop together training and research, guidelines and actions where needed. ESTSS is constantly working towards this aim, for instance by identifying successful models in individual countries or regions and disseminating these experiences among all others. A recent example of this exchange is a series of movies providing information on the consequences of trauma and effective treatments tailored to the needs of the public, professionals from the health care system and trauma survivors that can be downloaded from the ESTSS website. They were developed by a national society (DeGPT) and translated into 10 European languages with the help of other member societies.

ESTSS can look back on 25 years of advocacy for the field of psychotraumatology in Europe. The first European Conference on Traumatic Stress, which can be considered one of the roots of ESTSS, was held three decades ago (Ørner, 2013). During these years, ESTSS has developed a unique profile as a truly international professional society that integrates the diversity of the European countries and greatly benefits from their cultural richness (Lueger-Schuster, 2013a; Olf, 2013). An important part of the society's success story are the ESTSS conferences that attract delegates from all parts of the world. Other important activities included

projects like the European Network of Traumatic Stress (TENTS; Bisson, 2013) and the *European Journal of Psychotraumatology* (EJPT). EJPT has become an important platform for the dissemination of knowledge related to psychological trauma and, thanks to the relentless efforts of its founding editor Miranda Olf, has become one of the journals with the highest impact in the field (Olf, 2018).

Over the years, ESTSS had fruitful collaborations with large societies from other regions of the world. There is also a strong involvement of ESTSS in the global collaboration of trauma societies, an initiative that had initially been proposed by the International Society for Traumatic Stress Studies (ISTSS; Schnyder et al., 2017) and developed to a collaboration of all large trauma societies on an equal basis. It already has the function of a global umbrella for defined projects and holds promise to become a more formal global structure.

Only about half of the more than 40 countries on the European continent have established local trauma societies so far, most of which are members of ESTSS. In the coming decades, it will remain one of the most important aims of ESTSS to support the formation of new societies in countries where they do not exist yet, and to provide a common platform and a professional home for trauma specialists from the whole European region.

In their articles at the occasion of the twentieth anniversary of ESTSS, several former presidents described what some of them called the 'infancy and adolescence' of the society (Schnyder, 2013; Turner, 2013). At the age of 25 years, ESTSS has become a young adult. The society has 'grown up' and, with the latest change of its structure, has completed a developmental process that made it stronger and prepared it for the tasks ahead. This would not have been possible without the enthusiasm of a large number of dedicated colleagues from all over Europe. They invested their time and energy over the last 25 years to make the society what it is today. We congratulate ESTSS on its 25th birthday and strongly believe that it will successfully continue its 'adult life' for the good of psychotraumatology in Europe.








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