NEWSLETTER of the IASP® Special Interest Group on

Pain from Torture, Organized Violence, and War

January 2007

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Message from the Chair

This is the third newsletter, and the SIG is slowly growing in membership. We are now on a proper footing after our first election, although because all nominations were uncontested there was no need for a vote. In this newsletter we introduce your officers to you in short biographies.

The website will at last be live by the end of January, on www.ucl.ac.uk/clinical-health-psychology/Research-Groups/PainSIG. We are keen to build on the website, so please email anything you want to put on it to me and to Jannie Van Der Merwe (amanda.williams@ucl.ac.uk or jannie.vandermerwe@realhealth.org.uk) who will act as editors for the time being. In particular, we would like to include:

- Bibliography of writing on pain from torture. We already have a substantial list of references obtained for a review of the subject, and all these will go into the bibliography, but there are doubtless others, so please send references which you think might be helpful to others, and, if possible, DOI numbers.
- This is the ideal place to list, or even better to have in their entirety, chapters and papers written by members, but remember that you need permission from publishers to do so, unless you hold the copyright yourself.
- Presentations (preferably in powerpoint, but also as a .pdf file) on the website can be used by other members to add to their own material when they are teaching on issues of pain from torture, organized violence and war, so please use this if you are happy to share.
- Notices of meetings, conferences, expressions of interest to share workshops or develop presentations for them.
- Suggestions for joint audit or research projects using the expertise and contacts of SIG members.

It would also be good to have any relevant news or information which members would like to share. Please have a look at the website and send material which will contribute to attracting new members and publicising our work.

We are also very grateful to Professor Michael Nutkiewicz for his very interesting account of his long experience in working with survivors of torture and the pain and other problems they bring. We are already thinking about the content of the next newsletter, in the summer of 2007, so if you are inspired by Michael's piece, please send us your ideas.

Amanda Williams, Chair, SIG on TOVW.

For contributions, ideas and views please contact the SIG Newsletter editor:
Dr. Jannie van der Merwe, Email: jannie.vandermerwe@realhealth.org.uk

Introducing your SIG Board

Chair: Amanda C de C Williams

Amanda Williams qualified as a clinical psychologist in 1985 and soon after started work in chronic pain rehabilitation at St Thomas' Hospital London. In 1996 she completed her PhD on outcome of pain management, and subsequently divided her time between an academic post in the medical school and her clinical work at St Thomas'. In 2004 she moved to University College London where she is a Reader in clinical health psychology; she also does some clinical work in the pain service at the National Hospital Queen Square. For several years she did volunteer clinical work at the Medical Foundation for Victims of Torture, London, and supervised work by the physiotherapist there. Dr. Williams also became involved in the audit work of the Medical Foundation, and on the development of evaluation techniques for the clinical treatment services there. She now works regularly on this at the MF. After a well-attended workshop on pain from torture, run with Dr. Amris, at the IASP 10th World Congress in 2002, she worked with others to establish the Special Interest Group in IASP. Dr. Williams has written many papers and chapters on aspects of pain and psychology, including several chapters on pain from torture, in which she is now developing research projects at UCL and at the MF.

Vice Chair: Dr Kirstine Amris

Kirstine Amris qualified in medicine from the University of Copenhagen in 1987, subsequently gaining specialist qualifications in Internal Medicine and Rheumatology. She is currently Consultant at the Clinic of Rehabilitation, Department of Rheumatology, Frederiksberg Hospital where she is consultant in charge of patients with Chronic Muscular Pain Syndromes; she is also Senior Researcher at the Parker Institute, Frederiksberg Hospital. From 1992-2002 Dr. Amris held a post at the Rehabilitation and Research Centre for Torture Victims (RCT) in Copenhagen, overseeing diagnosis and treatment for all clients referred to physiotherapy. There she also carried out research on the sequelae of torture, with particular interest in chronic pain and the musculoskeletal system, and from 2002-2003 she headed the Research and Education Unit at the International Rehabilitation Council for Torture Victims (IRCT), Copenhagen, managing the health professional staff and researching outcome assessment in rehabilitation of survivors of torture. She has published papers and book chapters on the clinical assessment and rehabilitation of torture survivors, on chronic pain in torture survivors, diagnostic imaging after specific torture methods, and quality and outcome markers across sociocultural differences for multidisciplinary rehabilitation.

Secretary: Professor Richard Payne MD

Dr. Payne's current activities encompass treatment, research, training and community outreach in the areas of pain management and palliative care. Dr. Payne has developed innovative educational and training programs to address the well-documented knowledge deficits of many healthcare providers. For this work, he has received grants from the National Institutes of Health, Health Services Resource Administration (HRSA), The Robert Wood John Foundation, The Nathan Cummings Foundation, the United Hospital Fund of New York, the Aetna Foundation, the US Cancer Pain Relief Committee and the Soros Open Society Institute Project on Death in America. He has been a leader of both national and international projects addressing health care access disparities in medically underserved populations, especially as they relate to cancer and HIV/AIDS patients requiring palliative and end of life care. Recently, Dr. Payne received the John Bonica Award of the Eastern Pain Association for his work in pain management, and emphasized the need for the pain community to return to ethical principles of compassionate interdisciplinary care in its application to all persons suffering with acute and chronic pain. Currently, Dr. Payne serves as the chair of the board of FHSSA (Foundation for Hospices in Sub-Saharan Africa) of The National Hospice and Palliative Care Organization, which advocates for just health policies and access to appropriate care to relieve pain and suffering throughout Africa.

Treasurer: Carlos L. Nebreda MD, MSc

Carlos L. Nebreda MD, MSc, is Director of La Floresta and Atias Pain Clinic and Staff Anesthesiologist at Clinica Atias, both in Caracas, Venezuela. Dr. Nebreda received his medical degree from the Universidad Central de Venezuela, Caracas and his MSc in anesthesiology from Hospital Universitario de Caracas, Department of Anesthesiology. He completed his chronic pain training as an associate at the Pain Clinic of Duke University Medical Center, North Carolina, USA. and as a visiting program in few important Pain Clinics in USA.

Dr Nebreda is member of several professional societies and has co-authored journal articles and the first book on medications to treat chronic pain published in Spanish for the IASP. His special interest is in depression associated with pain from the use of violent methods to control peaceful demonstrations. He produced a statement for the Inter-American Commission on Human Rights of the Organization of American States on the use of tear gas as a chemical weapon; he also reported to the Commission

that the Venezuelan government keeps a list of opposition members. He has also published on the UNESCO website a paper (Tortura por Omision) on the treatment of pain in children without analgesia.

Newsletter Editor: Dr Johannes D. van der Merwe

Johannes Van Der Merwe attained his qualification in Clinical Psychology from the University of Stellenbosch, close to Cape Town, South Africa, where he has also completed a Doctor's Degree in black urbanisation, violence and the youth. He came to England in 1996 and furthered his theoretical and clinical skills with study at the University College London.

His fields of interest and specialisation are cognitive-behavioural therapy, chronic pain management, post-traumatic stress disorder and organisational consultancy. He was the Clinical Head of the INPUT Pain Management Unit at St Thomas' Hospital London for five years prior to joining The RealHealth Institute. Apart from leading the clinical team and his role as unit manager, he also supervises psychologists and other clinicians working with people experiencing persistent pain.

He is a member of the British Psychological Society; The International Association for the Study of Pain and The British Pain Society. His research interests include post-traumatic stress disorder and persistent pain. He also acts as a referee for papers regarding trauma and pain submitted to the British Journal of General Practice.

Chronic Pain Patients and Torture Survivors: Intersecting Lines and Lines of Demarcation

Michael Nutkiewicz, Ph.D
Program for Torture Victims, UCLA Interdisciplinary Group for the Study of Pain

Those of us who work in chronic pain and with survivors of political torture work with invisible populations. Their invisibility is self-imposed. The torture survivor feels deep shame, guilt, and anguish, and cannot find the language to convey an experience that is so beyond the normal human experience. Transformed into an object to be manipulated, his or her shame emerges out of powerlessness and unwilling passivity, and guilt comes from the self-doubts about whether something could have been done to avoid arrest, detention, and torture. Finally, personal anguish is born out of the fear of having inadvertently betrayed loved ones or colleagues.

Torture survivors also initially have uneasy relationships with their health care providers. In the United States and Europe, a large proportion of survivors arrive at torture treatment centers because they are petitioning for political asylum and require forensic evaluations that are submitted as evidence in court. Sent by their attorneys, in many cases the survivor is not clear about the nature of the clinic: Is it part of the government? Do the doctors and therapists work for the court system? Further, some survivors never encountered Western-style healing, especially psychotherapy. It takes time for practitioners to convey what it is they do.

Health care providers who have not worked with refugees may be unaware of cultural-specific ways in which survivors cope with trauma. Clinicians will typically observe and note in their reports psychological and physical responses such as Post Traumatic Stress Disorder (PTSD), depressive disorders, generalized anxiety disorder, somatic complaints, phobias, and so forth. Asylum judges understand and are drawn to this "scientific" jargon. But these symptoms are only part of the picture, and they reflect a common mental health bias that neglects familial, communal, and other collective aspects of the experience.

During torture, pain is utilized to destroy relationships and ultimately deny the very idea of relationships altogether. If the torturers are successful they will invert and reorient relationships by turning the victims into informer, an unwilling ally of the state. In some way torturers always succeed because they plant the seed of doubt in those waiting on the outside: did he or she speak? The torturer sets out to make victims believe that each is alone, that there will be no help, no comfort, and no compassion from the outside. Survivors emerge from the torture experience hyper-vigilant, fearful, and mistrustful.

Torture compromises another sacred relationship, namely, between doctors and patients. In his recent book, *Oath Betrayed: Torture, Medical Complicity and the War on Terror,* Dr. Steven Miles describes how doctors and psychologists were integral to torture in Iraq and Afghanistan. Torture requires medical expertise.

Another problem area is the reliance on a narrow biomedical approach taken by inexperienced health care providers who work with torture survivors. The dependence on clinical diagnosis – so important to the asylum process – has the unintended consequence of medicalizing or pathologizing the survivor. Clinicians who have not

worked with victims of political violence regard PTSD in a narrow medical framework rather than the socio-political framework that points to the cause of trauma. They focus on the triggering event when torture is merely one of a series of stressful life events for the survivor, including loss of family, job, educational opportunities, and displacement through expulsions, exile, and flight. And they treat PTSD as a conditioned response when it should be linked to the survivor's existential dilemmas, including shame, guilt, trust, and so forth. Some clinicians who work with torture survivors have suggested that the term PTSD be replaced with "torture syndrome."

This reliance on diagnosis is found in the pain management field as well. Even children with chronic or recurrent pain are troubled by a narrow biomedical approach. Oral testimonies conducted by the Interdisciplinary Group for the Study and Treatment of Pain at the UCLA Pediatric Pain Clinic reveal that for children the search for a diagnosis appears to preclude any interest in the experience of pain, and consequently, an acknowledgement and empathetic approach to suffering: "I've seen enough doctors that somebody should have been able to help me. It kind of makes me wonder why I'm not better already. I mean, it's been six months. That's a long time to be lonely and frightened." Loneliness and fear describe the patient's broader experience with his or her chronic pain, but they also allude to a common byproduct of illness that physicians sometimes do not address, namely, the individual's lived experience of pain.

Finally, to cure or heal is often an impossible treatment goal for both torture survivors and pain patients. Torture survivors have an unmasterable past, and healing entails the opportunity to achieve justice or bear witness. These are generally not given to the survivor, and clinicians may be unequipped to deal with these core existential issues. Chronic pain is not well-defined or clearly understood even in existing biomedical paradigms, and is especially resistant to diagnosis. As noted, physicians may not feel equipped to deal with the lived experience of pain. Clinicians should understand that for both populations, the greatest practical concern revolves around how they function during daily activities. The greatest service that clinicians can provide their clients or patients is to alleviate their anxiety and hyper-focus on pain (or torture) and increase their ability to function in everyday activities.

The profile of torture survivors and chronic pain patients intersect in important ways, some clinical and others existential. For torture victims, however, the lines of demarcation are political and social: torture is used to betray the trust citizens place in their government and to obliterate relationships. How we address this dramatic difference will remain a topic of interest to all health care professionals who link health and human rights.

Michael Nutkiewicz, Ph.D. is Executive Director of the Program for Torture Victims (PTV) in Los Angeles and a member of the UCLA Interdisciplinary Group for the Study of Pain. He is the oral testimony consultant for a multidisciplinary study at the UCLA Pediatric Pain Clinic. Michael lectures and writes on trauma narratives and social justice education. He can be reached at nutkiewicz@ptvla.org or darcheinoam@yahoo.com.

SIG Membership Information:
Currently the SIG has 52 members, in 13 countries, representing 16 disciplines.

To continue to receive the SIG newsletter and SIG membership please remember to pay the US$20.00 SIG dues in addition to your IASP membership dues.

Treasurer's report: As of December 31, 2006 the SIG account had a balance of: US$1724.00

Purposes of the SIG

- To promote the recognition and appropriate treatment of pain resulting from torture, organised violence and war.
- To promote mutual education and training of health care workers who care for survivors of torture, organised violence and war, and those who work in pain services.
- To promote liaison and exchange of information between pain treatment services and organisations working with survivors of torture, organised violence and war.
- To foster research on all aspects of pain resulting from torture, organised violence and war.
- To establish an international forum within the pain field for discussion and action, using knowledge about pain to mitigate the health effects of torture, organised violence and war.

New **SIG Web Site** online by the end of January, on www.ucl.ac.uk/clinical-health-psychology/Research-Groups/PainSIG. Please email anything you want to put on it to Amanda Williams and to Jannie Van Der Merwe: amanda.williams@ucl.ac.uk or jannie.vandermerwe@realhealth.org.uk