

Pain from Torture, Organized Violence, and War

July 2005

Interim Committee

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Message from the Chair and Secretary

This is our first newsletter, and our first Congress as a full SIG. We were formed after a lively and well-attended workshop at the 10th World Congress in 2002, whose content is reflected in part in chapter 62 of the Proceedings¹. Our purposes are in the box below, and we are pleased to find new members joining us at a steady rate.

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.

IASP is the right home for an organisation concerned with addressing the problems of pain from torture, war and organised violence. As an international organisation which brings together basic scientists, clinicians, and varied health professionals and academics whose focus is on understanding and reducing pain and the burden of pain, IASP has authority and expertise. The recent global day against pain (the hard work of a partnership between IASP, the World Health Organisation and European Federation of IASP chapters) described treatment of pain as a human right.

There is a need for raising awareness, educating our fellow professionals and the public, and promoting research on pain from these experiences. Pain relief can be neglected in the search for treatable lesions; pain without evident structural causes may be attributed entirely to the psychological effects of trauma. Recognising and treating survivors' pain can make their everyday lives – and those of their significant others - more manageable, can substantiate their accounts of torture and hardship, and can establish their claim to adequate medical treatment. However, our human reaction at the horror of what survivors tell us, or what we suspect they endured, can impede our diagnostic and treatment skills, or make us feel overwhelmed by their unmet needs.

¹ Williams ACdeC, Amris K, Van der Merwe J (2003). Pain in survivors of torture and organised violence. In JO Dostrovsky, DB Carr, M Koltzenburg (eds.), *Proceedings of the 10th World Congress on Pain*. Seattle: IASP Press, pp. 791-802.

When we started to think about the Special Interest Group after the 2002 Congress, the focus of clinician members was on extending the highest quality pain services to refugee and survivor populations from developing countries or war zones. More recently, those of us who live in stable democracies such as the UK and the US, both signatories to the United Nations Convention Against Torture (1984), have been appalled that our governments are defaulting on their public commitment against torture. They have found ways both of using it directly or through other governments where it is a state weapon against political dissidents or minority populations (for further information, see www.amnesty.org, www.phrusa.org). This has extended our focus to our own governments and professional organisations, and, while the SIG is bound not to engage in political activity, the issue of torture, war, organized violence, and of the humane treatment of those who suffer under it, is a matter of human rights, not political persuasion.

Until we could hold a business meeting, members agreed to hold offices pro tem, and the interim committee is shown on the first page of this newsletter.

Meanwhile, since the IASP Council agreed our formation in early 2004, several members have been active on a variety of fronts:

Sierra Leone: pain work in the wake of war: This work is described below by Drs Phil Lacoux and Bill Macrae. It demonstrates the possibilities and worth of taking clinical expertise in pain into poorly resourced and unstable countries where there is often extensive unmet need.

“Nonlethal weapons” which cause pain. In early 2005, several of us were contacted by a journalist from New Scientist, a popular and reputable weekly science magazine, to comment on the development of supposed “nonlethal weapons” (“Active Denial Systems”) which cause extreme pain in targets. Such weapons are ostensibly for the control of crowds (e.g., rubber bullets) or of prisoners (e.g., electric prods), but in practice can cause more harm than their proponents admit, and could be used against civilians and in torture. The technology proposed uses microwaves to disable people, at a distance and

without direct contact, by causing intense pain. The development of this weapon draws on pain research. Professor John Wood, and Drs Andrew Rice and Amanda Williams all commented on the inhumanity and dangers of such a weapon (www.newscientist.com/article.ns?id=dn7077), and the article was widely read, according to website hits. We were glad to be given the opportunity to put a view from the pain community which we hope was representative.

Medical and other colleagues involved in inhumane treatment. There is, distressingly, increasing evidence of the involvement of medical and psychological personnel in “coercive interrogation”, for instance in Guantanamo Bay¹ and ethical guidelines from the US Department of Defense for their medical staff are even being changed to allow it (www.phrusa.org). In response, several members have made representations within their professional bodies to challenge those who are alleged to be involved. However, it is at the level of professions and institutions that we can probably have most effect and where some members are already active.

Research: Colleagues in Denmark have been building on research which will substantially aid documentation of those methods of torture which aim to leave no detectable signs but can cause lasting severe pain. Claims for asylum usually require substantiation of the survivor’s report.

Several members have research planned or underway, including into the outcomes of clinical care and psychological treatment of survivors, and some published work on pain treatment in Sierra Leone has already appeared in Pain.

Further activities, arising from discussion among the signatories and supporters of the SIG, are described below. We are keen to see these develop and expand through the varied activities of our membership. We welcome new members: it is not necessary to be involved already in work in this area to have a contribution to make, in education, research, clinical work or theoretical development.

Amanda C de C Williams, Johannes Van Der Merwe

¹Mayor S. Medical bodies urge investigation of alleged involvement in torture. *British Medical Journal* 2004; 329:473 (28 August)

SIG BUSINESS MEETING during the 11th World Congress on Pain

We will meet to discuss our work and to elect officers of our SIG

Wednesday August 24, 2005, 16.30 – 17.30,

Sydney Convention Centre, Promenade Meeting Room 3

All are welcome

Pain Treatment in the Wake of War

The West African country of Sierra Leone (population 4.5 million) suffered civil war for ten years from 1991. The complex struggle including coups, a revolutionary group and militias, developed into a conflict concerned with power and money, particularly diamonds. All sides used various methods of fear to terrorise and control the civilians. The burning of villages, torture and rape were commonplace, but also tragically common was the forced upper limb amputation of innocent people. There was no discrimination, with men, women and children suffering. This decade of conflict has inflicted extreme and long-lasting hardship on the civilian population, claiming thousands of lives and resulting in more than 400,000 refugees and over a million people estimated to have been displaced. Life expectancy, access to clean water, immunization rates, and access to essential drugs place Sierra Leone last in the world tables of human development.

Health services are virtually non-existent and this has led to many problems including basic pain management and rehabilitation. Medecins Sans Frontieres (MSF) have been involved in the surgical and ongoing medical care of the population. Murray Town War Wounded and Amputees Camp was set up by MSF as a place for internally displaced people and their families to live after hospital discharge. This camp is in Freetown, the capital of Sierra Leone, where some of the worst violence occurred. A Pain Clinic was established in early 2001 as part of the existing general medical clinic in the camp. It was not limited to particular pain problems and anyone with pain was able to attend. However, the clinic was established within the amputee camp so it was mostly upper limb amputees that attended. The aim was to establish the clinic, train a local community health officer, and leave it to run for a period, and then reassess. A useful outcome measure was whether such an activity could run for periods of time with minimal expert input. An assessment questionnaire was used, an explanation given and where appropriate medication (amitriptyline and/or carbamazepine) given.

The initial assessments showed that many of the amputees were still living with pain (1). When we asked people what they now wanted in life, pain relief was not on their list. They replied in terms such as finding their family members, if still alive, returning to their homes, finding their lost possessions, finding employment, obtaining a modicum of personal success or progress, stability in the country, and regaining respect. Revenge was rarely mentioned, and is still rarely an issue. These are important answers, but did not mean that we should not attempt to intervene with the pain problems identified. For MSF, the development of a protocol to treat neuropathic pain that could be used in other contexts was also useful.

At follow up, improvements were found in measures of mood, function (employment, prosthesis use, reaching physical goals, activities of daily living) and pain (measured by word scale and number scale) (2). Those on medication thought it had reduced their pain, and on examination there were fewer physical signs. These improvements cannot be attributed to medication alone, but probably also to the passing of time and the increasing stability in the country.

This work has suggested that a combination of explanation, interest and medication can help to improve the well-being of a vulnerable group in a setting of major social turmoil after nerve damaging injuries have led to neuropathic pain. The work had both humanitarian and medical aspects. The chance to tell one's story and to have acknowledgment of the pain appeared useful to people and – we hope - reduced fear. The main problems faced in undertaking this work were security, and language and cultural barriers.

1. Lacoux PA, Crombie IK, Macrae WA. Pain in traumatic upper limb amputees in Sierra Leone. *Pain* 2002.
2. Lacoux PA, Ford N. Treatment of neuropathic pain in Sierra Leone. *Lancet Neurology* 2002;1:190-5.

Proposed and Planned Activities

Newsletter. We would like this to be our public face, and particularly a way to recruit new members and to show what we are about. Two newsletters a year are the minimum. Suggestions and Contributions to the newsletter can be sent to :

SIG Secretary:

Dr. Johannes van der Merwe:

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Website. We are establishing a website which will be a further way to share information, link to the many professional and human rights organisations, and serve as a further statement of the importance of work with pain in this area. It could also publicize models of good care in different countries and settings, as the wealth of a country is no guide to the quality of its services in this area. University College London has kindly agreed to host the website.

Educational material. Those members of the SIG who are already involved in teaching in this area have kindly agreed to share their presentations on the website. This will provide a resource on which SIG members can draw when preparing sessions for colleagues and others about pain from torture, organized violence and war, and when invited to speak about pain and its treatment to organisations involved in treating survivors. We hope this will also encourage members to submit proposals to their national chapter conferences for sessions on this subject.

There was also the suggestion of sharing case material from survivors for use within continuing education in our professions, teams and workplaces, with due care for complete confidentiality. The aim would be to help colleagues to recognize survivors who at present go undetected, and to extend their skills and expertise to them.

Research. The survey of torture care organisations reported briefly in the chapter in the 2002 Proceedings was effectively a pilot, and needs extending and updating, particularly in Latin American countries. This would provide a snapshot of the services in members' own countries available for survivors, often nonstatutory organisations, and of the extent to which these services recognize and provide treatment for pain problems.

There is an urgent need for research, and for reporting of case work, despite the problems presented by the circumstances in which many survivors live, with language and cultural barriers, and by the inadequacy of some western concepts embedded in research methods and measures.

Members of the SIG on Torture, Organized Violence, and War, July 2005

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Ulrike Pilz de Ynga, MD (Anesth)

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Carlos L Nebreda, MD (Anesth)

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