

Pain from Torture, Organized Violence, and War

July 2006

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Message from the Chair and Outgoing Secretary

We apologise for the long wait for this newsletter. The first came out just before the 11th World Congress in Sydney, August 2005, and so was available to anyone from the IASP stand there and at our business meeting. There were many compliments to the SIG on starting to function, and on the newsletter. Of course, it's easier to consume a newsletter than to create it, and it has taken a while to collect material for this one. Many thanks to Gunilla Jansen at RCT for producing a very interesting piece, despite a high level of work demands. We have some promises for the next, planned for the end of 2006; but more contributions are needed both for that and for the first newsletter in 2007.

There were several posters at the Sydney meeting on the subject of pain from torture (Frank abstract 1457, Prip & Torp-Pedersen abs. 1308, Olsen et al. abs. 1307), organized violence (Lacoux abs. 1470), and their authors are to be congratulated on conducting research in this very difficult area. Also, a workshop on pain in children recognised particular issues related to traumatic injuries and war (van Lingen et al. abs. 1497). The SIG business meeting was well attended and useful in getting to know one another and to arrive at some consensus on priorities.

Now for more business: to put us on a more formal basis you will notice new officers listed to the left. These positions were all nominated and unopposed, so there is no need for an election. In the next newsletter there will be a brief statement from each about her or his experience and interests in this field, so that members can feel they have a better idea of who we are.

At last, the website is progressing, mainly thanks to help at my workplace, University College London, where it is to be hosted for the present. We shall alert members as soon as it is active, to get feedback and contributions. We already have some material for the archive of teaching material in which members have shown interest, from slides used at the British Pain Society (IASP chapter) meeting in April. I hope others will follow with theirs so that all find it easier to put talks together or to find the information they need

Amanda Williams and Jannie van der Merwe.

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.

Group Treatment for Pain at RCT in Copenhagen

Gunilla Brodda Jansen MD, Ph D. Rehabilitation and Research Center for Torture Victims (RCT) Copenhagen*

Since 1982, RCT has treated torture survivors mainly through individual therapy. From January 2006, however, RCT has partly changed its approach to the rehabilitation of torture survivors. We are now focusing on inter-disciplinary team rehabilitation with sessions of a minimum of two and a maximum of four professionals. The three teams consists of a medical doctor, a psychologist, a physiotherapist and a social worker, and our goal is to improve treatment results, to reduce the duration of the rehabilitation period at RCT and to improve the evaluation and monitoring of the outcomes. The main focus of the treatment are PTSD-symptoms, sleep disturbances, depression and long-standing nociceptive pain, as well as neuropathic pain disorder.

The treatment period starts with an inter-disciplinary assessment period of two weeks to establish whether the patient is suitable for, and could benefit from, group therapeutic sessions, individual sessions or family-oriented sessions.

Since January, RCT in Copenhagen also offers a “Pain School” to all patients treated at the rehabilitation unit, regardless of whether they are undergoing individual, family or group treatment.

The pain school consists of 10 sessions (see box) based on lectures and discussion of those pain mechanisms that are most common in torture survivors, musculoskeletal and neuropathic pains (i.e. from falanga , “Palestinian” hanging, etc.), as well as sensitisation and wind-up. A staff member representing each of the four disciplines is present at the first session to inform the participants about the basis for the coming sessions. Group discussions and individual sessions are offered in between the lectures. Each session lasts for two hours on a weekly basis. At the same time, the patients have either their individual, family-based, or group treatment. Beside basics about pain mechanisms and pain modulation, the lectures include information and discussion about pain treatments - pharmacological as well as non pharmacological. Also, the effects of depression, stress and anxiety on pain intensity and coping with pain are discussed in an interdisciplinary fashion. In most sessions, two professionals are present in a group of eight patients. After each session the patients are offered a written resumé, both in Danish and translated into their language. During 2006, we expect to conduct 3 “ Pain School” sessions of 10 weeks each, two in Arabic and one in Farsi.

Schedule for “Pain School” at RCT in Copenhagen		
1	Presentation of staff & participants Pain mechanisms	all professionals
2	Pain mechanisms	physiotherapist, CBT psychologist
3	Treatment of pain	PRM physician, physiotherapist, CBT psychologist
4	Treatment of pain	physiotherapist, CBT psychologist
5	Stress	physiotherapist, PRM physician CBT psychologist
6	Social consequences	social worker, CBT psychologist
7	Activity level	physiotherapist, CBT psychologist
8	Social activity/isolation	social counsellor, CBT psychologist
9	Pain, depression, crises, anxiety	PRM physician CBT psychologist
10	Discussion and evaluation	all professionals

What is our experience with the “Pain School” so far? For the treatment staff, the “Pain School” provides a possibility of giving a common basis for explanation of the mechanisms behind the development of chronic pain, such as sensitisation, wind-up, and endogenous pain inhibition, together with an explanation of the differences between acute and chronic pain. Both facilitatory and inhibitory mechanisms are discussed with easily understandable explanations that can be visualised by our patients. Many patients are very participatory and interactive in the sessions. They have plenty of time and possibility to discuss their “personal” pain problems. Often they interact with each other to share common experiences. After our first ten weeks of “Pain School” the patients are very positive about the experience. One patient reported upon evaluation that he had “become his own physician whenever his pain increased”.

With this common knowledge about pain mechanisms, we have found our work easier when discussing, for instance, coping strategies, physiotherapy, and pain medication. As far as possible, the theories in the “Pain School” are based

*See: www.rct.dk

on evidence-based medicine, and the same interpreter is used throughout all sessions. After three consecutive sessions of “Pain School” we are now about to write down the experiences learned and the results of the evaluation from the patients in order to work toward the development of guidelines for this very difficult patient group, regarding not only the treatment of pain.

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The Ticking Bomb Argument Used To Support Terror

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Concerns about terrorism are undermining the absolute moral prohibition against torture, using the often-revisited “ticking bomb” argument: that the moral harm of torture can be outweighed in certain circumstances by the harm averted by inflicting it to gain information. [The example used is that of torturing a terrorist who has planted a bomb in a crowded place to obtain information required to render it harmless – a common enough scenario in thrillers but not, as we shall see, in reality.] This utilitarian argument is used widely to justify the erosion of commitment to UN and other conventions and to ethical codes of conduct for professionals. Alan Dershowitz, a Harvard law professor, has recently proposed “warrants” for torture of terrorism suspects.

The arguments against the “ticking bomb” justification are several: moral, practical/clinical, and legal/institutional. The moral arguments will not be rehearsed here, other than to say that the UN Convention against Torture, to which most countries in IASP are signatories, allows no derogation, no exceptions. The practical and clinical arguments concern the dubious efficacy of using torture to obtain reliable information, and the legal/institutional ones describe the issues facing the state which permits torture under certain circumstances. Tellingly, the argument in favour of torture in the “ticking bomb” scenario is not supported by a single instance where torture has extracted information which has been used to save large numbers of people. It is a seductive and dangerous oversimplification of the real issues.

What evidence is there that torture is the most effective way to get reliable information? We know that much unreliable information comes from it: confessions to being witches and dealing with the devil were extracted from many people under torture in the UK and US, but are no longer regarded as true. Galileo, to avoid torture, agreed

that the sun went round the earth, while convinced that was false. In the 20th century, research on French resistance fighters under Gestapo torture, on Algerian nationalists under French torture, and accounts by American POWs under North Vietnamese torture, suggest that relatively few victims provided what their torturers sought. But the threat of torture or of rough treatment daily produces confessions from arrested people which are then withdrawn or discounted in court as unreliable or untrue. Any information given under extreme stress, even if the victim wishes to give a veridical account, is subject to serious problems of memory and of coherence.

What is more, there is an assumption that *only* those in possession of essential information would be subject to torture, but this is far from the case where it is used. Family members, neighbours, friends and colleagues are also rounded up for questioning. The key individuals are often unremarkable, and may not even be known to closest family, as is the case with (at least) one of the 7th July 2005 London bombers, whose family reported him as missing and a possible victim. Every political system which uses torture accepts that most of those tortured are bystanders with nothing to provide, but the accumulation of mountains of true and false data only drives the search for more.

On the legal side, one of the most persuasive papers I found (Arrigo, 2003) describes the state apparatus that needs to develop when torture is justified: training programmes for torturers and monitoring of standards; official links between torturers and police and judiciary; involvement of health care professionals and complete re-writing of their ethical codes to allow this; research on efficacy of methods and extent of suffering. These details, extraordinary as they are, underline how corrupting it is for the state to take to torture. As Morgan (2004) writes:

“What begins with clean and tidy utilitarian references to the public interest and the greater good ends with dirty, unregulated and personalized contests of will waged in secret by unaccountable police officials against demonized others whose assumed inhumanity means that they do not count in a calculus where almost anything goes.” (p.192)

The alternatives to official adoption of torture are either to redefine it by references to exceptional circumstances such as urgent threat – despite the no derogation condition of the UN convention – or to redefine torture as physical punishment short of torture. This was the resort of Israel, as recorded in the Landau report (1987), which called torture methods “moderate physical pressure”, applied by military staff who were described as believing that their “sacred mission” justified their methods – an argument familiar from terrorists. A reference to the websites of Amnesty International or Human Rights Watch reveals countries where state use of torture is widespread but denied. The furthest this is taken is to outsource it to other countries, and in the UK the acceptability of information obtained by these methods was only overturned when taken to the highest level, the Law Lords, one of whom commented that “by using torture or even by adopting the fruits of torture, a democratic state is weakening its case against terrorists, by adopting their methods, thereby losing the moral high ground an open democratic society enjoys”.

From the point of view of pain research and treatment, some of the most worrying areas are the increasing appeal to the amount of pain to define what is and isn't torture, as if that is completely predictable in the short or long term, or clear to those who inflict it. A memorandum from Bush in February 2002 concerning treatment of Al Qaeda suspects, states: “Physical pain amounting to torture must be equivalent in intensity to the pain accompanying serious physical injury, such as organ failure, impairment of bodily function, or even death.” How can pain researchers and clinicians not become part of such a system, inimical though it is to the purposes of IASP and professional ethics? The World Medical Association has recently re-emphasised its 1975 Tokyo Declaration: “Doctors shall not countenance, condone, or participate in torture or other forms of degrading procedures ... in all situations, including armed conflict and civil strife”. In some countries, such as Turkey, courageous doctors have provided documentation and treatment for torture survivors, thereby becoming targets themselves. On the other hand, where health care professionals accept the justification for tor-

ture, their actions (and inactions) can support and sustain it, as repeatedly criticised with reference to Guantanamo Bay in the *Journal of the American Medical Association* and the *Lancet* over the last few years. I hope this has outlined some of the main arguments against adoption of torture as state practice, even when levels of threat of terrorism are thought to be high. What torture achieves, directly, is intimidation of groups or whole populations; in doing so, it also alienates some of that population who are morally appalled by what is done in their name and radicalises some who are already alienated. Torture destroys people, intimidates many more, divides communities, and binds the perpetrators together in guilt and obedience. It does not, as some would have it, promote the wellbeing of the large majority at an acceptable cost to a few individuals whose actions put them beyond the protection of usual laws.

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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 March 31, 2006 the SIG account had a balance of: US\$1,312

For contributions, ideas and views please contact the SIG Newsletter editor:

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