

NEWSLETTER of the IASP® Special Interest Group on
**Pain from Torture, Organized
Violence, and War**

March 2008

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Message from the Chair

There are several important items in this newsletter, but above all the call for nominations. Please think about how you would like to become more involved in the SIG, and to develop its work. All contributions are gratefully received!

The articles this time are an important outline of research needs in a field with considerable practical obstacles to such activity, and a sketch of the professional statements against involvement in torture by some of our national and international bodies. This may seem rather remote to most of us, but it obliges us to take up the issue if we suspect that professionals are assisting torture in any way, and recently doctors, psychologists, and others from the US, UK, and other western nations have crossed this line.

Amanda C de C Williams, SIG Chair

Call for Nominations

The next newsletter will be in July 2008, shortly before the IASP World Congress at which our SIG will have an AGM. So we need to elect new officers, as the present ones have run their term.

By July 2008, we need to have nominations for the following executive officer posts:

Chair Elect	becomes vacant
Secretary	currently Richard Payne, who will stand again
Treasurer	becomes vacant

Kirstine Amris, currently vice-chair, takes over as chair. Current Chair Amanda Williams and Treasurer Carlos Nebreda have served their terms of office and are not eligible for executive officer posts.

Nominees must be members of the SIG and must agree to stand. Nominations can then be e-mailed to Kathy Havers at IASP (kathyh@iasp-pain.org) by **May 10**. A ballot will be sent by e-mail in June, and the results will be announced in the July newsletter. Posts will be formally handed over at the AGM in August.

The remaining post, newsletter editor, has been held by Jannie Van Der Merwe, and his term will end at the same time. Further posts, such as research officer, can be established if we wish. Anyone can stand for these, or the new executive can appoint to these posts.

Relationship with IASP: website, discussion, liaison

IASP Council, responding to the majority opinion in a survey of SIGs, is going to host SIG websites, so the role of website master becomes one of coordinator. The content won't change, but the support of IASP will be welcome. IASP will also establish a discussion group for each SIG and clarify the role of liaison person on the Council.

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Publications by Members

Since the last newsletter, there have been two publications on pain and torture (see below) that we hope will prove useful for members in raising the issue among colleagues and contributing to training of health care professionals and others working with survivors of torture:

- Amris K, Williams ACdeC, Chronic pain in survivors of torture. *Pain: Clinical Updates*. Vol XV, Issue 7, October 2007. This is found on the IASP Web site www.iasp-pain.org under Publications and then Pain: Clinical Updates.
- Williams ACdeC, Amris K, Topical review: pain from torture. *PAIN* (2007) 133, 5-8.

World Congress & SIG AGM

August 20, 2008 at 16:30-17:30. The AGM of the TOVW SIG will be held at the 12th World Congress on Pain, Glasgow, UK at the Scottish Exhibition and Conference Centre. The room will be announced before the Congress. At the Congress, there will also be a workshop on pain from torture, and, we hope, some posters. We look forward to seeing you in Glasgow in August.

What do we need to progress research in chronic post-torture pain?

Kirstine Amris, MD

The issues around quality of health care and provision of health care services have become a subject of increasing public interest. Practitioners in the mainstream of modern health care are committed to the advancement of ‘scientific practice’ – a practice that is characterized by a theoretical framework that is rational and by the deployment, in such a framework, of knowledge derived from science, to ensure a continued quality development of the practice. Furthermore, it has been incumbent on health professionals to provide evidence of the effectiveness of the interventions they use.

Current status

In spite of a long history of rehabilitation of torture survivors, most of the published literature on the health-related consequences of torture and rehabilitation of torture survivors is based on observational cohort studies. Only a few clinical outcome studies exist, and these studies have limitations due to the lack of control groups, definition of diagnostic criteria, theoretical framework for problem identification and understanding, goal setting in therapy and provided interventions, and quality of assessment instruments applied in this particular population (Gurr & Quiroga, 2001).

The resulting gaps in evidence undermine efforts to improve the scientific basis of specific recommendations on the organization and functioning of specialized rehabilitation services and the interventions they offer in different socio-cultural contexts. The complexity of contributing factors and the lack of controlled studies mean that clinical decision making, selection for treatment, and design of therapeutic interventions have to be made based on simpler evaluation methods and professional judgement.

Chronic post-torture pain is one of the areas where research evidence adequate to establish evidence-based practice is missing (Amris & Williams, 2007). There are no systematic studies addressing:

1. the characteristics and severity of chronic pain in torture populations, including the natural history of pain
2. cross-cultural aspects and cultural beliefs about the meaning of pain
3. pain mechanisms underlying chronic pain conditions following torture, and the relationship to torture methods applied and specific torture-induced lesions

4. the relation between chronic pain and the effects of prolonged stress in survivors of torture
5. treatment and outcome of treatment in torture survivors with chronic pain

The lack of such research is unfortunate since it could significantly advance theory development, press forward consensus on how chronic pain is best addressed within the overall rehabilitation of torture survivors, and improve treatment efficacy.

Focus of research

Chronic pain has a serious impact on the functioning of individuals and is a barrier to overall rehabilitation. It is strongly associated with incapacity for normal employment, poor social participation, and progressive functional loss in persons disabled with pain. Poor coping may lead to chronic anxiety, depression, and problems interacting with health care, which are often associated with chronic pain conditions. Torture survivors are probably highly vulnerable to the secondary psychological disadvantages of chronic pain due to their prolonged history of violent trauma and stress.

Research suggests that exposure to severe stressors can permanently change neurobiological processes or structures, negatively affecting arousal thresholds and ability to cope with subsequent stress; cross-sectional studies support a positive relationship between history of traumatic or stressful life events and chronic pain. Clinically, a failure to appreciate the intricacies of the relation and co-occurrence of trauma-related problems and chronic pain carries a risk of reduced treatment efficacy and negative outcomes (Casey et al., 2008).

Research in chronic post-torture pain should therefore be clinically relevant, and systematic observation and data collection at baseline and on outcome following pain management in torture populations should be prioritized, with a focus on clinical, functional, behavioral, and psychosocial factors.

Assessment issues

Development in torture populations of assessment instruments across the various domains of pain and pain-related variables allowing for a continuous analysis, synthesis, and re-evaluation of the applied practice will be a prerequisite. Furthermore, the relevance of the various domains of pain and the extent of

change which constitutes treatment success, should be clarified within this particular population. In the light of the high prevalence of pain problems among torture survivors, the development of such assessment methods applicable in different socio-cultural groups and languages is a huge task, but an essential one.

Several guidelines have recommended core outcome domains and measures for chronic pain studies including measures of pain, emotional and physical functioning, and ratings of global improvement. However, these recommendations are primarily based on the perspectives of clinicians and researchers. Given the broad impact of chronic pain on health-related quality of life and ‘social health’ defined in terms of interpersonal interactions and social participation, it is important to obtain knowledge about the aspects of daily life that individuals experiencing chronic pain consider important in evaluating the consequences of their condition (Turk et al., 2007).

The impact of torture on ‘social health’ is described in terms of impairment of interpersonal interactions and of social participation leading to social isolation and stigmatization, family and marital problems, all of which factors may have a negative influence on pain, pain-related disability, and outcome of treatment. As opposed to the assessment of the individual’s abilities in relation to relevant aspects of his or her situation, restriction of participation is a consequence based on the circumstance of the disabled individual that place him or her at a disadvantage relative to others. It thus reflects the response of society to the disability and the opportunities and barriers presented by the environment. A context-specific assessment of

the domain of participation seems, therefore, a precondition for evaluating torture survivors suffering from chronic pain and a prerequisite for optimal planning of care and evaluation of outcome.

Analysis of the torture survivors’ perspective – expectations, experiences, and evaluations – should likewise be a component of research on chronic post-torture pain. Without it, we cannot be certain that we are providing the most effective help in the most accessible form, or that clinical research is providing sufficiently robust information regarding the effectiveness of alternative clinical interventions.

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Health care professionals, ethics, and the culture of abuse

Amanda C de C Williams

The film “Ghosts of Abu Ghraib” (2007, directed by Rory Kennedy:

www.hbo.com/docs/programs/ghostsofabughraib/index.html) is a telling account of how young military police, detailed to act as jailers at Abu Ghraib, became abusers as the pressure increased to get “results.” The main reason for the lack of information emerging from interrogations at Abu Ghraib was that Iraqi citizens had been picked up at random, or on a vague lead (one soldier gives an account of the instruction to arrest drivers of a black Dodge, a common enough car, because one had been behaving suspiciously), and had no information of the sort their interrogators wanted. When the photos of abuse were published, over 80% of detainees at Abu Ghraib were released without charge. The film rightly starts and ends with Milgram’s notorious experiment, in which naive subjects subjected other individuals (actor stooges, unknown to the naive subjects) to high levels of electric shock, despite (simulated) screams from their victims, under the stern instruction of an experimenter who took responsibility for whatever happened. The remainder of the film cuts between the junior military personnel describing naively how they became abusers; abused Iraqi ex-prisoners; and some Washington personnel who identify initiatives – like redefinitions of torture – from the top.

There were no health care professionals in the film, but the pressures and forces that acted on these soldiers act also on health care professionals. Decades of understanding this have

led to the formulation of policies within various professional bodies against any participation of their members in torture.

These policies make clear (or not so clear) the professional responsibilities and ethics that should guide the professional’s actions, whether employed by or under some sort of pressure from military or governmental bodies. Some also make clear what sanctions, such as professional deregistration, would follow infringement. The policies also help individuals resist coercive pressures, implicit or explicit, and to stand firm to professional guidelines, by referring to the sanctions that could be applied to themselves.

The World Medical Association (<http://www.wma.net/e/policy/t1.htm>) policy prohibits active or passive participation in or complicity in torture; it enjoins doctors to protest and denounce those responsible, saying that failing to do so is to tolerate it and to fail the victims who are themselves often unable to mount any protest. The World Psychiatric Association has a statement (<http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1525091#id2698339>) proscribing any involvement, even extending to legally authorized executions.

The International Council of Nurses also has a code (<http://www.icn.ch/pstorture.htm>) requiring active opposition to torture, and the World Confederation of Physiotherapists proscribes not only participation but presence at the procedure (<http://www.wcpt.org/common/docs/WCPTPolicies.pdf>), and

charges national physiotherapy associations with supporting physiotherapists who report torture.

Psychologists, regrettably, have produced weaker resolutions, both in the USA and in the UK. The Council of the American Psychological Association (APA), unlike doctors' and lawyers' organizations, decided that, while psychologists should not assist in torture and should report it, they could continue to work in Guantanamo and other sites where torture was reported and where psychologists contributed to the teams that designed, observed, and reported back on torture methods. See

<http://www.neverinournames.com/showDiary.do?diaryId=2033> for the resignation letter of a longstanding and active member, Marybeth Shinn; and

<http://physiciansforhumanrights.org/library/documents/letters/phr-letter-to-dr-brehm.pdf> for a letter to the APA President from the President of Physicians for Human Rights, outlining their concerns about the APA's weak position. The British Psychological Society (2005) issued a code of ethics that leaves the individual to interpret guidelines in such situations and to decide what is right, unlike in some other areas of ethical professional behavior where limits are very clearly specified (see Kwiatowski 2007, Patel 2007).

Some of the research on how people become torturers is described very clearly by Fiske and colleagues (2004); the social context at Abu Ghraib met all the known conditions to promote aggression and contempt toward an outgroup. It is easy in safe settings to believe that one would stand up for personal and professional principles against torture, but research tells us that it is not so easy to do so – far from home, perhaps isolated from all fellow professionals, subject to a

Meetings Calendar:

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August 17-22, 2008

12th World Congress on Pain to be held in Glasgow, Scotland, UK. Info: www.iasp-pain.org.
Early registration discount ends: May 1, 2008.

Start making plans to attend!

SIG Membership Information:

Currently the SIG has 58 members, in 20 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: US\$2,573.00.

Purposes of the SIG

- To promote the recognition and appropriate treatment of pain resulting from torture, organized violence, and war.
- To promote mutual education and training of health care workers who care for survivors of torture, organized violence, and war, and those who work in pain services.
- To promote liaison and exchange of information between pain treatment services and organizations working with survivors of torture, organized violence, and war.
- To foster research on all aspects of pain resulting from torture, organized 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, organized violence, and war.

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

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

cultural shift in values while working in the field of war, or in a large military or penal institution. Obedience to authority and conformity with the group – which can underpin heroism as well as cruelty – are very powerful influences on human behavior. Further, professionals in some settings have been led to believe that their involvement reduced suffering, or rendered the interrogation methods humane, not unlike the way in which abusers may see their behavior initially as upholding right by carrying out punishments on those whom they believe to deserve it. Fiske et al. also mention the few who resist these pressures and expose abuse, making it less likely to continue and undermining conformity among peers. Health care professionals tend to be low in aggressive and dominating characteristics compared to military personnel: it should be easier to encourage them to resist and expose abuse, and this encouragement can come from clear professional standards on the subject of torture.

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