

Pain from Torture, Organized Violence, and War

August 2007

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Dr. Kirstine Amris, Denmark

SIG Mailing Address

Sub-Dept of Clinical Health Psychology,
University College London,
Gower St, London WC1E 6BT,
United Kingdom.
Email: amanda.williams@ucl.ac.uk

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Message from the Chair

This month the main newsletter article is – we hope – for discussion. Some of you may have read in the BMJ (16th December 2006) an editorial by Metin Başoğlu, a psychiatrist experienced in work with torture survivors, recommending that brief behavioural (or perhaps cognitive-behavioural) therapy is not only sufficient but the treatment of choice for post-torture traumatic stress. It generated ferocious discussion, much by people working in the field. We have summarized this in the article, and are keen to have your responses and comments for the next newsletter.

The dates for poster submission for the IASP 12th World Congress on Pain, August 17-22nd 2008 in Glasgow, Scotland, is starts provisionally October 1, 2007 until February 1. It would be great to have several posters on issues of pain from torture: they could be case examples of treatment; or they could be surveys, audits, or research. In previous congresses, posters have been an excellent place for discussion and raising issues around the topics. There will also be a workshop ‘Using pain expertise in work with survivors of torture and war’ covering work with both adults and children which you may want to make a note of to attend. And there will be a SIG meeting and AGM at which we are very keen to see (and hear) all of you.

The website (www.ucl.ac.uk/clinical-health-psychology/Research-Groups/PainSIG/pain_sig-home.htm) is developing, slowly, but comes up on the third page if you Google ‘pain torture’, so obviously people are looking at it. Contributions would be welcome, but particularly for the bibliography, which is in progress, and a library of slides and teaching materials, yet to be started. Please e-mail to jannie.vandermerwe@realhealth.org.uk.

For those within easy reach, there is a day long meeting on 12th March 2008 in London, at the Royal Society of Medicine, on *Pain from torture, organised violence and war*. We have managed to get speakers from torture survivor projects and from the pain field to speak, and hope to be able to put slides on the website after the event.

Amanda C de C Williams, UK

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

Post-traumatic stress disorder What is it and how should it be treated?

Summary of an editorial by Metin Başoğlu that was published in the BMJ, 16th December 2006

The study of the effect of trauma on humans remains controversial, especially when it comes to the diagnostic criteria and the various treatment options. This was again clearly illustrated in the British Medical Journal at the end of 2006. Başoğlu, a psychiatrist researching traumatic stress and treatment trials (<http://www.iop.kcl.ac.uk/staff/profile/?go=10277>) wrote an editorial arguing that torture causes post-traumatic stress disorder (PTSD), that PTSD can be treated effectively by cognitive and behavioural methods (CBT), and that it is regrettable that these bodies of evidence are not the basis of practice in much treatment of torture survivors. He emphasised the association between torture and PTSD and the ‘pathogenic mechanisms that underlie the illness.’ This led to ferocious correspondence (as rapid responses, and therefore not online indefinitely) about the adequacy of the bodies of evidence for each of these, and what room there is for diversity in treatment methods.

Başoğlu is critical of the use of non-CBT psychotherapies, and of the lack of routine outcome measurement by projects treating torture survivors; the Rehabilitation Centre for Torture Victims (RCT) in Denmark in particular came under fire for a recent report which showed that 55 survivors did not improve after psychotherapeutic treatment on the distress and quality of life measures used.

In an early response, clinical staff from the Medical Foundation for Victims of Torture (MF) in London pointed out that their work is routinely audited, and that they place the task of rehabilitation within a wider human rights framework. They contested Başoğlu’s insistence that brief effective interventions were available and adequately demonstrated to be effective in relieving the distress of torture survivors. First, the MF clinicians found PTSD limited as a diagnosis. It was adopted within the context of the post-Vietnam war, a particular type of trauma which then informed the instruments developed to measure

it. Some commentators (Watters, 2001; Bracken et al., 1995; Johnson & Thompson, 2007) emphasise the political context in which the construct was developed, and are highly critical of unquestioning application across large cultural differences, since PTSD-type symptoms may have different value or meaning in different cultures and some symptoms may not be perceived as distressing.

Second, they questioned the applicability of the PTSD diagnosis to the particular prolonged and multiple struggles of refugees and torture survivors. They referred to the complexity that survivors of torture often present: multiple losses, struggles with the asylum process, hostility on the streets, poverty, and isolation in exile: all in themselves sources of distress with no quick fixes. Several other responses emphasised the broader context and the complexity of torture survivors’ needs: from a Canadian professor of rehabilitation psychiatry, a GP from a UK city with a substantial refugee population, and a UK academic rheumatologist. A review by Campbell (2007) describes the consensus that complex PTSD symptoms often result from prolonged exposure to trauma, for example, sexual or physical abuse and torture, as opposed to short-term, single exposures to trauma such as natural disasters. Generalising from earthquake survivors or war veterans to torture survivors poses difficulties.

Başoğlu responded that the complexity of torture survivors’ problems is “simply another myth. Family separation, bereavement, loss of social status, poverty, uncertainty about the future, and cognitive effects (and much more) apply equally to natural disaster survivors.” Because he does not differentiate between various traumatic events, he finds the same treatment equally applicable to torture and to earthquake survivors. Although he cites the National Institute for Clinical Excellence (NICE) in the UK (<http://guidance.nice.org.uk/CG26>), its guidelines on trauma review the evidence for effective treatments, but conclude that there are still grounds for providing

diverse treatments, selected on clinical – not ideological - grounds.

Much of the evaluation of interventions is carried out in centres for treatment of trauma in developed countries. The traumatic events affecting their clientele are more likely to be non-torture related, and often single-event trauma such as assault or accident. In contrast, survivors of torture have been subjected to deliberate cruelty over a prolonged period of time, followed by the traumatic asylum seeking process. Torture survivors do not always find their way to specialised health services and often have more pressing problems to resolve than their psychological or even their physical health. The consequences of torture are complex and rarely fall only within the confines of PTSD symptoms, so that a wide range of health care disciplines may be involved in offering help.

The crux of behavioural PTSD treatment is brief exposure to cues which continue, after danger is over, to elicit a powerful stress response and to cause distress and efforts to avoid those cues. Başoğlu's treatment was delivered in two steps. The first step involved explanation of the treatment rationale, treatment target setting, and self-exposure instructions. Participants were asked to confront their fear until they felt in control. No systematic cognitive restructuring was undertaken. The second step involved exposure to simulated earthquake tremors. The participants controlled the tremors and were instructed to focus on specific problem areas. The session was terminated when the survivors felt in complete control of their distress or fear.

Dissenting from Başoğlu's presentation of the quality of the evidence for brief exposure therapy for survivors of torture, a UK forensic doctor and GP also proposes that supportive counselling is more suitable and accessible for people with their lives in chaos than the rather demanding processes of CBT. In response, Başoğlu again emphasises the parity of suffering in earthquake survivors and in torture survivors, and refers to the behaviour therapy he tested, insisting that he knows of no evidence that torture survivors have worse or different symptoms from survivors of other disasters. Undoubtedly these are his findings, but they are not consistent with

studies in refugees in Australia (Silove et al. 2002) and in Nepal (van Ommeren et al. 2001).

A French public health doctor who treats survivors of torture joined the debate, asserting that it is disrespectful of the particular horror of torture to equate survivors with those of natural disasters because of the “intentional and man-made trauma”. Bengt Sjolund, a rehabilitation professor and director of the RCT, argues for broader measurement than of mood and trauma symptoms on which Başoğlu relies in his evaluations, and for recognition of chronic pain as an almost universal problem in the survivor population, requiring treatment designed to reduce the associated disability. To this, Başoğlu not only criticises the RCT for failing to take up his offers of joint work in the 1990s, but refers to pain, in passing, as a “psychosomatic problem”.

Jaranson and colleagues, all working in California in the treatment of torture survivors, and conducting research, eloquently put the case for recognising the multiplicity and complexity of survivors health and social problems, and while supporting good evidence in practice, point out the importance of clinical skills and engagement with the patient. They remind readers that the evidence for CBT-based treatment is strong partly because CBT lends itself to treatment trials in a way which other psychological therapies do not, but that is not evidence that the latter are not effective. They point out the difference between collectively experienced time-limited events, such as an earthquake, and the sadistic violence of torture which generates deep distrust of others and in some, existential despair.

A last comment from the director of a Swiss treatment agency for torture survivors reflects on the “ferocity” of the debate, and temptation in this field to avert therapeutic hopelessness by faith in a quick and easy remedy. Başoğlu does not answer this one, although if it does underlie some of his urgings on the efficacy of BT, there are many who believe in remedies less well based in theory and practice – magnets, dance therapy, or ever more detailed narrative of the torture.

There is some agreement! Experienced professionals in Copenhagen, at the RCT and elsewhere, including

Stine Amris (vice chair of this SIG), agree with Başoğlu on the regrettable lack of outcome research and propose a three point plan to remedy it: national funding for research awarded by peer review of competitive bids; collaboration of the research team with experienced torture survivor treatment teams as at the RCT; and global networking of those working in the field, in the academic or clinical settings, and in nonstatutory agencies.

Further research remains important despite numerous challenges. Torture survivors are often excluded from PTSD treatment trials and the question remains concerning applicability of treatment trials to their needs. Particular attention should be paid to clients' indigenous expressions of disorder and distress and to the value and meaning which they ascribe to post-traumatic symptoms and experiences rather than focusing on the application of diagnostic categories (Johnson et al, 2007). Much further research is necessary in this field to clarify the affects of war trauma and torture. Cultural differences also need to be investigated.

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Meetings Calendar

12th March 2008, London, UK on *Pain from torture, organized violence and war*. Info: Royal Society of Medicine, 1 Wimpole Street, London W1G 0AE, UK
Tel: +44 (0) 20 7290 2900; Fax: +44 (0) 20 7290 2989

August 17-22, 2008 12th World Congress on Pain to be held in Glasgow, Scotland, UK.

Info: www.iasp-pain.org

Abstract/poster submissions:

October 1, 2007 –February 1

Financial Aid applications (including a poster):

Deadline: January 15

Start making plans to attend!

SIG Membership Information:

Currently the SIG has 45 members, in 15 countries, representing 14 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 August 1, 2007 the SIG account had a balance of: US\$2272.

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

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