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Commentary

Management of Chronic Pain in Torture Survivors

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2019 is the year named by the International Association for the Study of Pain (IASP) as the year against pain in vulnerable populations, and that is why it is very important to know the management of pain in patients surviving torture.

Torture is understood by international law as the intentional infliction of severe mental or physical pain or suffering by or with the consent of the state authorities for a specific purpose (United Nations). Despite many countries being signatories to the United Nations Convention, torture remains a widespread practice which is maintained by widespread impunity for perpetrators. Challenging torture entails not only asylum and access to healthcare and welfare, which some developed countries provide, albeit with restrictions, but also rehabilitation and reparation for the individual. The right to reparation is part of international legal standards states that "each State party shall ensure redress and adequate compensation, including rehabilitation". The aim is to restore, as far as possible, torture survivors' independence; their physical, mental, social and vocational ability [1,2].

The first medical group within Amnesty International was formed in Denmark in 1974. The primary assignments were to document torture allegations, to give descriptions of torture methods and to carry out research about torture sequelae. These investigations uncovered an enormous need for rehabilitation of torture victims and their families and led in 1984 in Copenhagen to the establishment of the first Rehabilitation and Research Centre for Torture Victims (RCT). Starting with no experience in the field, great efforts have been invested to find reliable instruments for measuring torture and its consequences. However, there is still a need for valid instruments that are simple, culturally sensitive, and capable of improving the clinical management of torture survivors [3].

Torture consequences

Torture is associated with a wide range of health related consequences, among which persistent pain and pain related disability are defining features. When treating torture survivors, pain and its consequences need to be addressed. However, the research literature on the rehabilitation of torture survivors predominantly targets mental health problems without reference to pain in its own right or as a significant cause of distress and disability. Reviews of rehabilitation literature note a lack of scientifically rigorous studies of multicomponent interventions for torture survivors. Treatment recommendations are that good clinical practice is applied sensitively to patients who may be seriously traumatized. It is important that best practice from pain management in general is extended to torture survivors, and that pain is not mistakenly assumed to be a symptom of post-traumatic stress, neglecting pain treatment. It should be recognized that torture survivors may have considerable psychological and social problems in addition to pain and other health concerns, complicating presentation, assessment, and treatment: uncertainty about civil status; unstable accommodation; isolation from family, friends, culture; and usual means of support and access to work [4].

Types of torture

Torture aims to destroy a human by the systematic infliction of severe pain, brutalization and psychological cruelty. Torture methods are often somewhat illogically classified as physical or psychological methods. In addition, imprisonment often includes inadequate food

and water, exhaustion and debility through sleep deprivation, isolation from communication with any but the captors and monopolization of perception [1,4].

Most studies of torture survivors are set in specialized documentation and/or treatment centers, and indicate high prevalence of persistent pain, with overall estimates as high as 78 - 83%. Although multiple pains and widespread pain are common, particularly headache and musculoskeletal pain, the best studied pain problems associated with specific methods of torture are foot pain from falanga and shoulder and upper limb pain from hanging by the arms [1,4,5].

In the torture survivor, pain originating in peripheral nociceptors may be caused by: 1. Permanent injury in the musculoskeletal system, such as lesion of the shoulder joint after suspension by the upper extremities, lesion of the knees caused by direct blows or forced prolonged knee-loading positions or lesion of plantar structures after falanga; and/or 2. Strain in the musculoskeletal system secondary to overload and disuse due, for instance, to joint dysfunction and compensatory altered posture [5].

Falanga, beating of the soles, is commonly reported by torture survivors. It leaves no gross signs long term, the immediate effect of falanga is bleeding and oedema in the soft tissues and severe pain. swelling of the feet, haematomas in the soles and various degrees of skin lesions are typical and diagnostic findings in the acute phase. Falanga is characterized by a neuropathic burning and stinging pain in the sole; sensory and autonomic changes; a dull deep pain in the feet on weight bearing, spreading up the lower leg with walking and eased by rest; increased pain on rest after activity; and distorted gait and avoidance of weight bearing. Scars and/or pigmentations in the soles may be evident, and reduced elasticity in the foot pads on palpation, loosening of the skin, soreness and coating of the plantar fascia and sensory disturbances. MRI and Doppler examination identified thickening of the plantar aponeurosis. Quantitative sensory testing suggests some small fiber neuropathy [1-5].

Suspension by the arms, especially with the arms tied behind the back, the shoulder joint maximally extended and inwardly. A typical presentation is of pain in the shoulder, upper arm and neck; weakness and fatigue in the arm; sensory changes; restricted movement and a sensation of looseness and instability in the shoulder joint. Neuropathic pain has also been described in the suspension by the arms resulting in burning pain, secondary to partial injury to the brachial plexus [1-5].

There are rather less well developed associations of pelvic pain in women with sexual assault and sexual torture, and of anal pain and urological problems in men after sexual torture. these pains are located in soft tissue with little or no findings on examination or scanning, but they are entirely consistent with phenomenology of pelvic pain in the general population [2,5].

Central sensitization and dysfunction of descending pain modulating systems are implicated in several chronic muscular pain syndromes from torture: regional or widespread pain often associated with poor sleep, fatigue, cognitive impairment, headache and visceral symptoms. Better sense of this type of pain is made using understanding of changes in pain signaling in the central nervous system in the context of prolonged high levels of pain and distress [1-6].

Chronic pain management in torture survivors

Biopsychosocial models, integrating physical, psychological and social contextual factors in the total experience of pain, have been instrumental in the development of multidisciplinary and multimodal treatment regimes for chronic pain. Knowledge of common methods of torture and of the likely mechanisms by which they produce pain is required for a systematic and effective examination [1].

Interdisciplinary pain management generally integrates education, psychological interventions targeting cognitive and behavioral aspects of adaptation to pain, physical therapy with the principal goal of enhancing overall physical functioning and reducing musculoskeletal impairment caused by the torture, and pharmacological treatment of pain and other [1,3].

Since the systematic review and other recent narrative reviews offer no guidance on treatment, nor have any randomized studies been found for pharmacotherapy or other mainstream treatments for chronic pain from torture, there is no reliable evidence to guide treatment. The clinician should therefore proceed as with any other patient, assessing the pain, trying to identify treatment mechanisms, and applying treatment for which there is good evidence [2,4,7,8].

Where are we going?

When viewing the near future, continuing military disagreements and the unstable political landscape will cause the number of refugees to increase. These global developments place a focus on developing treatments that will help this vulnerable population psychosomatically. The need for treating refugees and torture survivors with chronic pain and post traumatic stress disorder will continue to prove necessary; thus further specialized treatment options must be developed and evaluated. Also of interest, next to psychosocial care and psychotherapeutic support, is the use of pharmacotherapy to provide multidisciplinary attention [9].

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