Letters to the Editor

Psychiatry and the Prevention of Torture

Dear Editor:
We welcome the Canadian Psychiatric Association (CPA) Position Statement on *The Involvement of Psychiatrists in Coercive Interrogation and Torture*.[1] The statement is short and to the point. Dr Chaimowitz states it came about as "geopolitical events suggest a need for a position statement on this matter." Unfortunately, the statement diplomatically eschews describing the events that prompted its release. As such, we feel it is necessary to describe the context and consider the broader significance of the prevalence of torture in psychiatric practice.

It has been reported that a small number of physicians, psychiatrists, and psychologists were involved in torture in Afghanistan, Guantanamo Bay, and Abu Ghraib in Iraq. They were present while torture was practiced, directed its intensity, and guided the torturers. Some psychologists have been employed to make interrogations more productive through developing and executing interrogation strategies. They have prepared psychological profiles of detainees and participated in interrogations.[2,3] The American Psychiatric Association was concerned by these reports and published a clear position statement prohibiting psychiatrists from participation in interrogation of detainees in settings where torture and human rights violations take place.[4] After some debate, the American Psychological Association followed suit.[5]

It is morally right for psychiatry as an institution to respond robustly to reject torture and coercive interrogation.[6] The position statement is a positive step toward eradication of psychiatrists' involvement in any forms of torture or cruel, inhuman, or degrading treatment or punishment, as indicated by United Nations conventions (1989). However, more needs to be done in terms of training and capacity-building. Canada receives more than 25 000 people seeking refugee status annually[7]; many may be victims of torture. Psychiatrists and other mental health professionals must provide appropriate rehabilitation for torture victims and their families.

Providing training for psychiatrists to perform appropriate psychological evaluation and documentation of torture victims should be part of the core training curriculum. Psychiatrists must be equipped with skills, knowledge, and procedures to avoid the risk of re-traumatizing these victims. Training in interview techniques is important to learn to determine when and how to explore a history of torture experience. Cognitive-behavioural techniques can ameliorate some of the posttraumatic sequelae of torture.[8] Information to assist clinicians is available from the International Rehabilitation Council for Torture Victims (IRCT), a global health-based organization advocating and developing rehabilitation services for torture survivors and their families. More than 142 rehabilitation centres around the world have joined the IRCT movement, providing rehabilitation and prevention of torture.

Beyond this important statement of professional ethics, we hope the CPA considers the importance of providing psychiatrists with opportunities to develop skills to support appropriate and effective rehabilitation for torture victims, their families, and communities.

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REPLY

Re: Psychiatry and the Prevention of Torture

Dear Editor:
The letter from Dr Afana and Dr Kirmayer is a welcome response to the Canadian Psychiatric Association's position statement on *The Involvement of Psychiatrists in Coercive Interrogation and Torture*.[1] As Dr Afana and Dr Kirmayer point out, there is much that stands behind and prompts the release of such a document. Unfortunately, psychiatry and physicians in general are not able to take any moral high ground regarding their involvement in torture or other crimes against civilian populations. Although the events post-9/11 have brought into focus the potential for physician involvement in torture, there is a long history of physician involvement in such events and activities.

Although we have remained relatively insulated in Canada over the last few decades, the recent years have brought into sharper focus the relevance that a position statement

on this subject has for the psychiatric community. September 11 and the subsequent involvement of Canadian Forces in Afghanistan has pricked our cocoon. We are increasingly a multicultural nation, populated by people from around the globe who may have witnessed and experienced torture and other crimes against humanity. Among our physician groups are people who have witnessed and documented such torture and coercive interrogation. Mental health professionals are called on regularly to assess and treat people experiencing posttraumatic stress disorder as a result of direct exposure to the effects of war and torture

We remain creatures of circumstance and are fortunate to live in a peaceful country relatively far from a war zone. Nonetheless, it is prudent to focus on what is morally right when confronted by the conflicts and fog associated with war. It is important that psychiatry looks beyond our hospitals and offices and take positions of professional ethics that have both local and global impact. There are many among us who are active in providing treatment and support for victims of torture. We are a country that accepts refugees, often scarred by torture and in need of psychiatric help. It is important to build awareness and capacity to treat and assist this population. I am appreciative of the request that we encourage psychiatrists to develop skills to support appropriate and effective rehabilitation for torture victims, their families, and communities. Hopefully awareness can be raised and hopefully we as a group of physicians with a fiduciary duty to our patients can add to the voices decrying torture and coercive interrogation. Not only will this build capacity to deal with current needs, but it may sensitize Canadian psychiatrists to the moral and ethical issues that will continue to arise, given the increasingly prevalent nature of global conflict, and when the situation is not as comfortable and clear as it seems today.

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Hamilton, Ontario

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Controlling for Known Risk Factors for Suicide in Multivariate Models

Dear Editor:

This letter is in response to the article by Lemstra et al[1] published in the September 2009 issue. We would like to commend the authors for tackling such an important issue using the Canadian Community Health Survey: Mental Health and Well-Being (CCHS 1.2) and a social determinants of health perspective; however, we have significant concerns about the manner in which the analysis was conducted which cast doubt on the authors' interpretation of their findings.

It is well known that previous history of suicide attempt, psychiatric disorders, substance abuse, and access to lethal means, in addition to the risk factors noted by the authors (physical and social environment, cultural factors, childhood adversity, alcohol abuse, and poverty) are important risk factors for suicide in Aboriginal people in Canada.[2–5] However, none of these key variables were controlled for in the analysis, despite the fact that CCHS 1.2 (2002) investigated Canadians' mental health and well-being and collected information on prevalence of mental disorders and substance use, both for the preceding 12 months as well as for the lifetime. Because of their strong, previously documented relation to suicide, it is possible that these factors could explain the variability found by the authors. By not controlling for these risk factors, the authors may have erroneously reached the conclusion reported.

Further, this study used suicidal ideation as the outcome of interest; however, we assume that the purpose of the study was to promote better understanding of the issue of suicide, not just suicidal ideation. It is well appreciated in the literature that most people reporting suicidal ideation do not die by suicide. The history of suicide research is bedevilled by the use of proxy measures such as suicidal ideation, which do not and cannot accurately reflect the complex interplay amongst the different variables associated with suicide death. Therefore, policies and programs such as the ones suggested by the authors in this study on suicidal ideation may be advanced or applied at substantial direct and opportunity costs as suicide prevention strategies but lead to little or no substantive change in the primary outcome, suicide.

It is our contention that suicide researchers must address these important methodological and conceptual issues. Indeed, we would go so far as to suggest that research that neglects these issues should not be reported, as publications arising from such work, rather than improving our understanding of suicide, may actually hinder it.

Stan Kutcher, MD
Magdalena Szumilas, MSc
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REPLY

Re: Controlling for Known Risk Factors for Suicide in Multivariate Models

Dear Editor:

Dr Kutcher and Ms Szumilas give their opinion on the risk factors of suicide and cite 4 references to support their position.

The article by Boothroyd et al[1] is a retrospective chart review of 71 suicides without psychological autopsy or information on important variables such as income. This study found that contact with health care services was the only covariate independently associated with suicide. The study also found that lifetime psychiatric diagnosis, substance abuse, and access to lethal means were not independently associated with suicide. Regardless, contact with physicians, contact with mental health practitioners, and alcohol abuse were included as covariates in our study.

The article from Laliberte and Tousignant[2] includes interviews with relatives of 30 people (out of 62) who committed suicide up to 10 years before the interview. The authors tried to create a control group but quit. The study presents baseline information without tables or even cross-tabulations, let alone multivariate analysis.

Within the article, relatives believed that 23 out of 30 people were intoxicated prior to their suicide, but the authors were only able to verify 7 cases. However, the authors state that 21 out of these 23 people who died by suicide had a significant life event 12 hours prior to suicide and suggest alcohol abuse is a coping mechanism for personal trauma and not a true risk factor. Only 6 cases out of 30 had any type of previous psychiatric illness. Most importantly, the authors concluded that poverty, social assistance, unemployment, and overcrowded housing were main vulnerability factors.

The opinion article from Katz et al[3] briefly discusses that suicidal behaviour is associated with mental disorders and substance use but qualify that these findings from non-Aboriginal populations may not be generalizable to Aboriginal populations. The discussion paper from MacNeil[4] does not address any of the points raised by Dr Kutcher and Ms Szumilas. Both papers conclude that poverty is a very important predictor.

Dr Kutcher and Ms Szumilas suggest we should focus our efforts on identifying and treating underlying mental health conditions. A literature review on effective suicide prevention strategies concludes that mass screening programs for suicide prevention do not work.[5] A meta-analysis and a review found that antidepressants were no more effective than placebos in treating depression.[6–8] Between 1981 and 2000, the number of prescriptions for antidepressants increased from 3.2 million to 14.5 million per year in Canada, with a corresponding increase in annual costs from $31.4 million to $543.4 million.[9] During the rapid advancement in use and costs of antidepressants, the annual prevalence of major depression remained unchanged.[10]

None of the references provided by Dr Kutcher and Ms Szumilas found that suicide rates in Aboriginal populations are reducing. Our research suggests that targeted strategies to improve the social conditions for Aboriginal people would provide helpful adjuncts to individual treatment strategies. It seems futile to try to prevent suicide without actually addressing the cause of the problem.

That said, it would be wrong to completely dismiss the points raised by Dr Kutcher and Ms Szumilas. It would be equally wrong to dismiss our findings.

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