

The physical and psychological effects of torture in Kurds seeking asylum in the United Kingdom

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Abstract

There were over 2000 applications for asylum from Turkish nationals to the UK in 2003. A large proportion of these were persons of Kurdish origin, many of whom claimed to have suffered torture. We sought to evaluate the physical and psychological effects of torture in those with physical injuries.

A total of 97 Kurdish asylum seekers requiring medical evaluation for evidence of torture were examined and interviewed in the presence of an interpreter. Physical injuries, pain, disability and psychopathology were documented for each.

A wide variety of injuries and psychological disorders were documented. Posttraumatic stress disorder, major depression and organic brain damage were present in a substantial proportion of those surveyed. Methods of torture not previously documented were revealed.

There are long term healthcare needs of this population, which are complex and require a multidisciplinary approach. Survivors of torture may be disadvantaged in the asylum process because of organic brain damage or major psychological disturbance.

Keywords: torture, posttraumatic stress disorder, pain

Introduction

The institutionalised use of torture by the Turkish state to suppress political dissent has been well documented. The state's suppression of its many ethnic minorities, particularly its large Kurdish population has led to widespread claims of human rights abuses and a steady exodus of political refugees claiming to have suffered torture. There were over 2000 applications for asylum from Turkey in 2003 (Home Office statistics).

Turkey's wish to join the EU has acted as a catalyst for the creation of legislation to prevent the use of torture while at the same time releasing information about many of the methods used by its practitioners. For example although there has been a decline in reported cases in detention there has been a corresponding rise in complaints of torture outside of formal detention centres¹. The vast majority of individuals presenting to the legal practice from which this sample was drawn, are Kurds originally from

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the southeast of Turkey. Without exception they allege that they have suffered beatings at the hands of Turkish security forces for expressing their Kurdish ethnicity or political affiliation. Clients who live in a village invariably report being lined up in the village square and beaten, sometimes with rifle butts or truncheons. These beatings are often accompanied by attempts to humiliate the victim in front of the group, for example victims will be forced to strip naked in front of the village, crawl in the snow or beat one another. This survey represents an attempt to systematically document the physical and psychological effects of torture on Kurds seeking asylum in the United Kingdom.

Methods

A retrospective analysis was performed with the records of 97 Kurdish asylum seekers from Turkey who were referred for medical evaluation of allegations of torture through a legal practice in North London, The United Kingdom. At the time of interview a full physical examination and psychological assessment were performed on each patient in accordance with established guidelines as proposed by the Medical Foundation for the Victims of Torture (UK)². In order to allow patients to feel comfortable and recall as much detail as possible about their experiences, interviews were unstructured, although the specific symptoms of depression and posttraumatic stress disorder (PTSD) were evaluated in terms of the DSM (IV) criteria³ for the diagnosis of these disorders, by explicitly asking about the presence or absence of the symptoms that define these disorders in this diagnostic framework. Chronic pain and disability were not asked about directly, although these problems were recorded where they had been raised by patients during the assessment.

An initial examination of any injuries

volunteered by the patient was followed by a general physical examination. In none of the cases was any incidental injuries seen ascribed to previously forgotten torture.

The nature of the alleged torture employed was recorded in each case, and compared for consistency with physical injuries, which were present. Incidental physical injuries from unrelated causes were not recorded. In all cases, the patient was accompanied by a translator.

Results

The mean age of individuals undergoing evaluation was 30 with a range of 16 to 64 years. There were 14 women (14%) in the sample. The patients were all ethnic Kurds from Eastern Turkey. They had all had one or more episode of detention by the police or military authorities, during which time the torture was carried out. The mean time from the episodes of torture to presentation was two years with a range of one month to eight years.

Physical injuries

Only one patient had no physical injuries. The others had a range of burns, lacerations, grazes, gunshot wounds, blast wounds and stab wounds.

A total of 18 individuals (18%) had scars from deliberately inflicted burns. Eight of these were from one or more cigarette burn.

The majority of the patients (65%) had sustained facial or dental injuries as a result of torture. These ranged from missing or broken front teeth, to loss of an eye resulting from blunt trauma. The average number of facial injuries sustained was 1.8 per individual.

Scars on the limbs and torso were less common, with around half (49%) of the patients seen having no scars in these areas. The nature of these lesions varied between

cuts to the hands as a result of attempting to protect the face and head when being beaten with a blunt instrument, to multiple lacerations. One individual had over 30 linear scars to his torso, resulting from being cut multiple times with a bayonet. Another individual had 16 scars, sustained in a similar manner. The mean number of scars to the torso and limbs, where present, was 3.3.

29% of patients had fractures. Two of these had multiple fractures (wrist and shoulder, wrist and fingers). The relative proportions of fracture types sustained are shown (Figure 1). The fractures were all sustained as the result of trauma from blunt instruments during detention.

16% of patients had multiple shearing scars across the front of the lower legs, reportedly the result of traumatic impact from heavy boots.

In 14% of cases penetrating stab wounds were present. These were usually to the legs or torso. Multiple stab wounds were present in four cases. The injuries were all sustained from fixed bayonets. None were of sufficient depth to warrant major surgical intervention at the time that the injuries were sustained.

5% of patients had localised burns resulting from electric shock torture. Two of

these cases involved application of the electrodes to the genitals, two had electrodes applied to the lower limbs and one to the upper limb, leading to a unilateral brachial plexopathy (this is a recognised complication of electrical injury to the upper limbs)⁴.

30% of the women in the sample were sexually assaulted in detention. Only two men reported sexual assault. One was anally raped with a glass bottle, while the other suffered genital mutilation with a knife.

5% of patients suffered complete hearing loss in one ear as a result of blunt trauma to the side of the head.

Three patients were shot in the legs; one was shot in the chest. In no case did their injuries receive urgent medical attention or follow-up. In all cases the bullet produced an exit and entry wound, and did not lead to longer term medical complications.

Two patients had stretch marks clearly visible across the anterior surface of both shoulders. These individuals had been bound with their arms behind them in forced internal rotation and extension for approximately an hour.

12% of the patients interviewed are disabled by their physical injuries in terms of being unable to work or carry out their activities of daily living unassisted.

22% of patients had chronic pain of sufficient severity to interfere with their sleep or activities of daily living. Of these around half were back pain and half were headache. There was no correlation between head trauma and the development of chronic headache ($\chi^2=0.687$). None of the patients with chronic pain had other neurological signs or symptoms. There was no correlation between sex and the development of chronic pain ($\chi^2=0.167$).

There were two unusual injuries from novel forms of torture, which have not been previously documented (case 1 and 2).

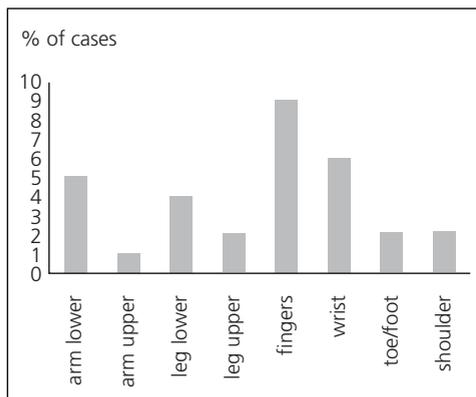


Figure 1. The percentage of individuals in the case series with fractures by location of injury.

Psychological effects

14% of patients had symptoms, which fulfilled the DSM criteria³ for posttraumatic stress disorder. A number of others had nightmares and flashbacks of their experiences, but these were not associated with the other features of PTSD.

7% fulfilled the diagnostic criteria³ for a major depressive episode. Again almost all of the patients interviewed reported low mood and fatigue, but did not fulfil the other criteria for a diagnosis of major depression to be made.

7% fulfilled the diagnostic criteria for generalised anxiety disorder³ (without posttraumatic stress disorder). Almost all of the patients reported some physical symptoms of anxiety or other psychological difficulties, which do not fulfil DSM diagnostic criteria.

There was no association between the development of chronic pain and psychological problems ($\chi^2=0.653$). There was no correlation between sex and the development of psychological problems ($\chi^2=0.541$), although psychological problems occurred with greater frequency in women who had been sexually abused, this did not reach significance ($\chi^2=0.071$).

6% of patients who had suffered closed head injury with subsequent disturbance of consciousness demonstrated the features of organic brain damage, with memory problems, emotional lability and impaired concentration and attention. None of the patients who had not suffered head injuries reported these problems.

One patient developed a disabling stutter following his experiences in detention, which led to difficulties in communication when he was attempting to claim asylum.

Case 1

In early 2001, SK, a 43 year-old man, was awoken in the night by the local police

banging on his door. He was accused of collaboration with a local guerrilla group, arrested and taken to a nearby police station. Upon arrival in the police cells, he was hit across the face with a baton, leaving a 4 cm linear scar on his mandible. He was tied to a chair, and a metal clamp was applied to his tongue. This was tightened, and traction was applied for between five and ten minutes, before being removed. The tongue has subsequently become chronically painful with altered taste sensation and obvious scarification on the superior aspect. Unable to offer the police any information on the activities of which he had been accused, he was thrown to the floor of the cell, and kicked repeatedly about the head and body. This has left him with scars over both legs and chronic low back pain. Although there are no neurological deficits, local spinal tenderness or limitation of movement, the pain is sufficiently severe to produce difficulties in walking over long distances. He suffers with generalised anxiety and difficulty sleeping. After two days in a cell, alone without food or water, he was released. No charges were ever formally brought.

Case 2

In early 2003, AK, 39, was arrested with a group of eight other men from the village where he lived. They were taken to a police station. They were not informed of any charges or accusations against them. The men were all beaten with batons and kicked, before being locked in a small cell for a day. The men were taken out of the cell individually. AK was one of the last to be called. He was taken into a brightly lit room and bound to a table. Two policemen held his eyes open while a third directed a high pressure jet of water into his face from close range. This lasted for around five minutes. The water was turned off, and a bright desk lamp was

placed a few inches from his face. His eyes were, again, forcibly held open, and he was made to look into the light for around ten minutes. By this point he had lost sight in both eyes. He was taken from the police station in a truck, and dumped on a hillside near his village. His visual acuity gradually returned over the following weeks, although it is still limited to 20/30 bilaterally. He has periorbital oedema and corneal scarring. Fundoscopy is normal. He experiences daily discomfort and “grittiness” in both eyes, although he reports no psychological problems.

Interpretation

There are a many different forms of torture alleged by Kurdish refugees from Turkey. These results are similar to previous data on torture survivors from Turkey⁵.

This survey did not include those individuals without visible injuries, as would be the case with victims of falaka (suspension by the ankles and beating the soles of the feet) or forced submersion in water. Patients regularly report being forced to walk around immediately after receiving falaka, sometimes in salty water, in order to prevent swelling and disguise evidence of torture having taken place. Although bone scintigraphy has been used to evaluate such injuries⁶, this diagnostic modality was not available to the authors. Many clients allege the use of electric shock, normally administered to genitalia or fingertips. In some cases a method known as Palestinian Hanging is used. This involves tying the victim's wrists together behind his back and then inserting a stick or pole between the victim's arms and back. He is then suspended from the stick so that all of the victim's body weight is borne by the chest and shoulders. Therefore, this survey is likely to underestimate the total burden of psychopathology on the survivors

of torture from this population, given that the sample group was referred for evaluation of physical injuries in the first instance.

Sexual assault is commonly reported in female patients and there is a strong association with the subsequent development of psychological problems. The possibility of sexual assault having occurred should be considered in the assessment of torture survivors as this may assist in the assessment of individuals at high risk for the development of mental illness. Although only two men in this sample reported sexual assault, this may relate to a reluctance to discuss such issues as has been described in other populations⁷.

PTSD and depression occur in all demographic groups without a clear association with the type of torture inflicted. This is consistent with data on torture survivors from other populations⁸. Obviously the susceptibility of individuals to the development of problems like this will depend on more than the nature of the physical abuse, itself⁹. It is clear that there is a need for the deployment of psychological and psychiatric services for torture survivors, but these needs are not always being met¹⁰. The high level of occurrence of psychological symptoms not covered in DSM criteria is also noted¹¹.

Chronic pain has previously been documented in torture survivors as a specific neuropathic sequel of certain types of torture¹². None of the individuals with chronic pain in this sample had the features of classical neuropathic pain. There was also no correlation between psychopathology and the manifestation of the symptoms. The proportions of sufferers of headache and low back pain are in keeping with previously published data⁵.

Although bayonet wounds and evidence of gunshot injuries may also be seen in the context of armed conflict, these injuries in this series were ascribed to the process of

torture. It may be the case where the torture is not “planned” as such, that those perpetrating such actions use whatever instruments are available.

Navigation of the asylum process requires a number of interviews and appeals. None of the individuals in this sample spoke English, and over a quarter show evidence of major psychopathology or organic brain damage, thus limiting their capacity for concentration and comprehension further. The particular difficulties with recall that occur with depression¹³ and traumatic brain injury¹⁴ may present particular challenges where claimants’ accounts are repeatedly sought and scrutinised for inconsistencies. Neuropsychological assessment of torture survivors claiming asylum may be appropriate in this context to prevent those with cognitive dysfunction being disadvantaged.

There remains a question of how the roles of medical and legal specialists are defined within the context of attempting to prove that torture has taken place. Obviously, the presence or absence of a particular scar does not prove that torture has taken place. Nor, indeed, does the absence of physical injuries or psychological trauma mean that torture has not taken place. Unfortunately, the harmonisation of asylum law across Europe means that the onus is placed upon the claimant to convince a legal authority that there is a danger present in their country of origin. Evidence of torture having taken place would clearly support such a proposition, but it should not be a requirement. Many of the individuals examined in this group had coincidental injuries that were not the result of physical abuse. In every case, the individual concerned did not attempt to ascribe such wounds to torture having taken place. While this does not and cannot prove the veracity of the accounts, it does suggest that there is substance in the

accounts given by the claimants. Further work is required to define the process of “proving” the existence of torture in asylum claimants in different countries.

The variable combinations of chronic pain, disability, psychological disturbance and unusual physical injuries mean that the healthcare needs of this population of torture survivors are complex and require a multidisciplinary approach in their evaluation and management¹⁵. The appropriate collection and analysis of data on torture survivors seeking asylum can assist in the organisation of provision of such services. Such data would also allow the patterns of development of novel torture techniques (case 1 and 2) to be monitored.

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