# HRFT
# Human Rights Foundation of Turkey

# Treatment and Rehabilitation Centers Report 1994

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# TREATMENT and REHABILITATION CENTERS REPORT

# 1994

**Ankara, November 1995**

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# INTRODUCTION

**Okan Akhan***

The Human Rights Foundation of Turkey (HRFT) has been giving therapeutic help to torture victims, since it was established. Treatment and Rehabilitation Centers were established in 1990 in Ankara, in 1991 in İzmir and İstanbul, and in 1995 in Adana, for this reason. Professional and volunteer teams work to solve physical, psychological and sociological problems of people referring to our foundation. 40 people have been referred to our centers in 1990, 238 in 1991, 393 in 1992 while 323 people have been referred to our centers in 1993.

This report, consisting of the 1994 study reports of the HRFT treatment projects, is prepared in Turkish and English, as in previous years, and has two parts. It's prepared and published within the framework of the means of the HRFT Documentation Center.

In the first article of the first part, HRFT President Yavuz Önen evaluates 1994 from the human rights aspect and displays the awful situation of human rights in Turkey. I know that desperate details of this picture will affect and move you deeply.

The second article in this part is a breakdown of Foundation's 1994 activities on health. This breakdown consists of information and comments about people applying to Ankara, İstanbul and İzmir HRFT centers with complaints due to torture. Totally 472 applications were made to our centers in the three provinces. All possible means of helping these people in physical, psychological and sociological aspects of their problems were exploited. We are now entering a period of intensifying our efforts to improve the quality of our services. We believe that such an endeavor has medical, humanitarian, political and social justification.

Second part of the report presents scientific studies conducted by Founda-tion personnel and volunteers, in 1994. Some of the experiences and observa-tions in treatment processes are converted to scientific data. One of our important aims is, producing more knowledge in the following period to augment interna-tional reservoir of knowledge.

The HRFT has more than 250 general practitioners, various specialists, psychiatrists, psychologists and social workers, participating professionally and voluntarily in health projects. Medical activities of the Foundation and this report are the accomplishments of this group living in various cities. We are grateful to all health personnel who have contributed to this process, Human Rights

* Assoc. Prof. Dr., Coordinator of the HRFT Treatment and Rehabilitation Centers

Associa-tion's Headquarters and centers, Turkish Medical Association and local medical chambers who have been supporting us from the beginning.

Ankara, November 1995.

**"The HRFT Treatment and Rehabilitation Centers Report-1994„ is available for US $ 10 or its equivalent from "HRFT Menekşe (2) Sokak No: 16/6 Kızılay-Ankara-Turkey„**

# AFTER 1994

**Yavuz Önen**[*]

The year 1994 was no different from previous years in essence. We did not observe any move towards protecting, promoting and improving human rights in any way, nor were investigations launched against those who abused human rights.

Systematic and widespread torture, extra-judicial executions, murders by unknown assailants, disappearances, prosecution of people for their writings and speeches especially under Article 8 of the "Law to Fight Terrorism", in which freedom of expression is equated with terrorism, abuses of civilians' rights -by security forces or armed groups- in the Emergency State Region, village burnings/evacuations, forced migrations, destruction of villagers' belongings, defilement of food, prevention of agriculture and stock-breeding, killing of animals, burning of forests, aerial or surface bombardment of villages and hamlets during operations continued.

One of the most important events of the last year was the lifting of the parliamentary immunities of DEP deputies, closure of the party by the Constitutional Court and acceptance of the argument of Prime Minister Çiller that "the deputies were PKK members" by the SSC and higher court (the Constitutional Court). After the verdict was disclosed, some of the deputies left

[*] HRFT President

the country, and others who received severe sentences were imprisoned. Thus, political discussions on the Kurdish problem were meant to be impeded and the message that “speaking about this problem would be identified with separatist armed movement” was conveyed.

According to the determinations by our Foundation in 1994, the number of people killed in the country as a result of all these abuses, armed clashes, armed attacks and bombings reached 4041. The majority of these people died in the Emergency State Region.

About a thousand villages and hamlets were evacuated or burnt down. Village evacuations and burnings in Tunceli were ascribed as “state terrorism” by Azimet Köylüoğlu, the State Minister responsible for human rights. As a result of these incidents, 2 or 3 million people were uprooted from their cultural environment and lands where they had lived for years. Urban centers were flooded by Kurdish immigrants. A large mass of people, in need of employment, health services, education, food, accommodation and security is currently undergoing a dramatic episode in those centers. Turkey even witnessed a mass emigration (20,000 people) across its borders (Northern Iraq).

One hundred and ninety-two people, including 37 children, were killed in armed attacks or bombings -of which more than half were attributable to PKK militants- against civilians and defenseless people. Attacks against defenseless people and civilian targets increased communal hatred and chauvinist-racist tendencies in the country.

In the attacks and assassinations most of which were carried out by PKK militants and some other by armed leftist groups, against teachers and other public officials, workers employed in governmental installations, party members, confessors, village guards and persons declared as “agents” or “state supporters”, 218 people died.

Twenty-four of the thirty-three teachers assigned to the Emergency State Region were killed by the PKK, and the remaining by unknown assailants. Besides thirty-three teachers, seven health officers working in the region were killed.

In murders by unknown assailants, 423 people were killed, mostly in the Emergency State Region. One hundred and twenty-nine people were killed in the “extra-judicial executions” by security forces.

Thirty-four people died in prisons and detention, under suspicious circumstances or because of torture. Neither deaths due to torture nor disappearances were eliminated. Throughout the year, 49 people, about whom there were serious evidence and witnesses that they had been detained or taken

away by security officers, disappeared. Cases of deaths due to torture and disappearances vastly increased when compared to previous years.

Freedom of thought, press and conscience were seriously suppressed. Strict judicial measures were taken and attacks were carried out against dissident publications. The main target of persecution was the newspaper Özgür Ülke. Its offices were bombed, and it was rendered unable to publish. Two of its staff members were killed.

A total of 172 people, of whom 45 were convicted and 102 arrested (columnist, writer, publisher), including 8 deputies and 17 party officials, were imprisoned. The total of prison terms given to journalists and writers reached 448 years 6 months 25 days, and fines totaled up TL 71 billion 614 million 945 thousand.

The figures in this grievous table are striking, and it is possible to give numerous other examples. In the report prepared by our Documentation Center concerning the year 1994, there are the details of the human rights balance sheet and sample cases.

As for developments in our Foundation's two main operating fields: We reported human rights abuses to our subscribers and authorities through our daily reports. We prepared written and oral answers to internal and international questions on related subjects. 1994 was a busy year in respect of our international relations. We had meetings with many officials and civilian groups and individuals. We released various publications in English and Turkish, prepared by our Documentation Center during the year. A report on torture (File of Torture-12 September 1980/1994), concerning torture cases and their manifold consequences between the Military Coup in 1980 and 1994, was published. Towards the year's end, a report (Education in the Emergency State Region/1984-1994) on attacks and assassinations against teachers in the Emergency State Region was released.

Throughout the year we tried to help 472 torture victims, in our Treatment and Rehabilitation Centers in Ankara, İstanbul and İzmir. These works of our Foundation is an effort against the most atrocious affronts to human dignity. This effort is realized by the support and contribution of a group of 250 people , consisting of physicians, psychologists, psychiatrists and social workers.

We took a significant step towards spreading and expanding our treatment services in the last months of 1994. The HRFT Representative Office in Adana was established in line with the "Five Cities Project" which was initiated at the beginning of 1994. The inauguration ceremony of the Representative Office on 4 February 1995 was attended by State Minister responsible for human rights Azimet Köylüoğlu, Adana Governor Naci Parmaksız, Vice representative of the Commission of the European Communities in Turkey Jörg Ketelsen, Vice

president of the IRCT Prof. Eric Holst, Dr. Zepp Grassmann from Germany, German Friedrich Naumann Foundation representative Wilhelm Hummen, British Embassy Press Consultant Owen Jenkins, representative of the Center for Tortured Refugees in Stockholm Per Stadig, Turkey Human Rights Support Committee representatives (Sweden) Lars Odefors and Albert Foneme, İHD Chairperson Akın Birdal, İHD İzmir Branch Chairperson Yeşim İşlegen and İHD Adana Branch Chairperson Öcal Ata, representatives from political parties, trade unions and democratic civil organizations.

Our studies had a significant effect on the local and international public. Some prizes were bestowed on the HRFT as a result. Those awards are: International Helsinki Federation for Human Rights Andrei Sakharov Prize, Lawyers Committee for Human Rights Roger Baldwin Medal of Liberty, International Human Rights Law Group Partners Prize, Progressive Journalists Association Board of Directors 1994 Honor Prize.

International organizations' support for our treatment and documentation work continued. Currently some future projects are under discussion with United Nations Volunteer Fund for Torture Victims, Commission of the European Communities, Swedish Red Cross Center for Tortured Refugees in Stockholm and The John Merck Fund.

Another response to our works came from the Ankara SSC Prosecution Office. The torture report concerning 1980-1994 period we published was the subject of an investigation. A trial, in which a prison sentence from 2 to 5 years and a fine of TL 100 million was demanded, was launched under Article 8 of the "Law to Fight Terrorism" against our Administrative Board member Fevzi Argun and me on charges of making separatist propaganda in our articles. Our hearings coincided with the hearings of İHD Chairperson Akın Birdal, Secretary General Hüsnü Öndül, former vice president Sedat Aslantaş and Administrative Board member Erol Anar, who were put on trial for a book they had published. Both trials ended with acquittal on the same day (11 January 1995). The acquittal decisions were upheld by the Supreme Court in May 1995.

The trial against us caused reactions both at home and abroad, and brought the support of many individuals and institutions. Hearings of the trials against the HRFT and the İHD administrators were followed by Ali Yurttagül on behalf of European Parliament Greens Group, German Greens Party Deputy Amke Dieter-Schener, on behalf of Center for Victims of Torture Douglas Johnson, Mark Williams and Michael Cline, Vice-representative of the Commission of the European Communities in Turkey Jörg Ketelsen, some diplomats, representatives of International Federation des Droits de l'Homme, Amnesty International, Centre for the Independence of Judges and Lawyers, and administrators and personnel of the HRFT, leaders and members of the İHD,

members of parliament, leaders of political parties and democratic civic organizations. At the final hearings of the HRFT and the İHD administrators, representatives of the member countries of the European Community were present (by common decision). Representatives of the US and Russian embassies were among the spectators as well.

We thank all international organizations and others who supported us and never left alone during the prosecution.

The reaction against our work was not restricted to that of the SSC Prosecutor. The international relations of the HRFT and the İHD were criticized by several groups. Some journalists and politicians writing/commenting for some newspapers and television channels collaborated with governmental spokesmen to accuse and disparage human rights defenders in their writings, speeches and comments.

The risk and threat of coming under the influence of developed country governments and their intelligence agencies, which has been frequently commented upon recently, is not only valid for the human rights field, but -especially- valid for political and unionist organizations, too. We shall remain in the established legal and institutional infrastructure of international human rights field. We shall preserve our independent status. It would be better for some political and unionist groups, who are criticizing us, to review and change their ideological and actual relations and dependencies.

Our struggle to defend, protect and promote human rights and to struggle against abuses, of course has a “political” context. Opposing abuses, criticizing various practices of the government and stressing responsibilities of the government, inviting it to take necessary measures, add an opposition mission on this “political” context, whether one likes it or not. The HRFT adds “politicization” and “opposition” to its mostly disliked mission of human rights defense in Turkey, by documenting human rights abuses, displaying torture, calling it a wide-spread and systematic practice, treating torture victims.

Our foundation informs the public and warns the officials, official bodies and the government through its activities. We even witnessed the Prime Minister’s words, “Find me an interrogation method having no torture in it, and remove torture equipment from police stations.” This was, in fact, an acknowledgment of torture, which had been denied until then. This proves that we are acquiring results in accordance with our essential objective of defending and promoting human rights. However, this is not enough. Our activities and studies have aimed at “removal of torture.”

Our extensive activities are quite annoying for the official circles in Turkey where almost every opposition is kept under pressure. They first

silenced social democrats by taking them into coalition; then they silenced Kurds by closing the DEP, and sending their deputies out of parliament, to other countries and to prison, accusing them of being “extension of the PKK”. Then it was the turn of human rights organizations, which were the sole opposing voice, in a public silenced thanks to the active propaganda of the official ideology and the contribution of the governments which were apparently civilian but in fact the leftover of the fourteen years old military regime. This is why trials and accusation campaigns are on the agenda. We of the HRFT will continue documenting human rights abuses and providing treatment for the torture victims in the country, and cooperating with our internal and international associates. These activities, contrary to the allegations, are beneficial for the public and the country. The principle of universality and integrity of human rights is correct; and non-governmental civil organizations have constructed an international infrastructure in human rights issue, as in the issues of women, children, ecology and other issues.

In Turkey, the atmosphere of criticism and suppression of human rights was created by the leadership of religious and nationalist movements. In this atmosphere, the reaction against us, which was voiced as “Down with human rights!” in funeral ceremonies of killed policemen and soldiers in 1992, turned into threatening chauvinism in the international arena in 1994. Even football matches have become the scenes of nationalistic paranoia recently. Festivities after the successes of the Turkish teams turned into street demonstrations and racist-chauvinist melees in which guns were fired. There were deaths and injuries because of the random firing.

In present-day Turkey, talking about human rights, democracy, peace and especially about the Kurdish problem and a peaceful political solution generally causes reactions. This is why democratization package of the coalition government could not be put into operation, despite all promises. A racist-chauvinist-religious alliance in the parliament, reminiscent of the “Nationalist Front” of 1970s, is one of the biggest obstacles to democratization. The most important factor strengthening the fascist ideology institutionalized in the country is the ongoing wars in various parts of the world. The inhuman practices of Serbs in Bosnia Herzegovina, just neighboring Europe, and the fact that no serious attempt to stop them is made, Armenian invasion of Azerbaijan and Karabagh, the Russian invasion of Chechnya, forceful and arm wielding solutions to problems, push democracy and democratization practices out of agenda in Turkey.

Under these conditions, the European Council’s and Parliament’s demands for an end to human rights abuses, changes in the Constitution, cancellation of Article 8 of the “Law to Fight Terrorism” and release of DEP deputies have put the status quo and its defenders explained above, into

hardship. It is not difficult to predict that the existing political powers will be facing an arduous test. Besides, we do not presume the European Union and the USA will be in a different position. Any internal and external support given to the government for maintaining the anti-democratic structure of Turkey will be equal to not defending universal human rights and democratic jurisprudence or destroying them. We wonder if human rights in Turkey will still be under violation, as in Bosnia Herzegovina.

The most prominent feature of 1994 was the government declaration that "1994 would be a year to end terrorism and separatist threats". The deadline given in the declaration made in New Year's Eve was May or June. In a statement made on 9 March it was, "September, at the latest", in summer months they said "It will end by the end of the year". At the end of the year it was "March or April 1995", but the clashes intensified, and gained permanency. Democratization was indexed to "removal of the PKK". So, civilization and democratization in Turkey remained dependent on Serbs in Bosnia Herzegovina and on the PKK in Turkey. Nevertheless, democratization promises were continuously given by the government and in the Parliament.

Steps to be taken in democratization, longed by the people gathered around human rights struggle, are definite. Our proposals for urgent democratization, addressed to the government and parliament and publicized on different occasions, are as follows:

**1.** Torture must be prevented. To attain this aim; CMUK must be revised thoroughly to include investigations of political nature, ensuring complete rights to detainees to contact their lawyers, families and relatives whenever they want. Detention periods must be in accordance with the Human Rights Convention standards (In practice, political suspects are kept in detention for 4 days if they are alone, 15 days if they are a group, and 30 days if they are in the Emergency State Region). Perpetrators must be investigated, prosecution must be allowed and the penalties must be given in a short time and must be deterrent. Penalties should be increased. Legal proceedings for this should begin as soon as possible. Concerned articles in the "Law to Fight Terrorism" and "Law on Prosecution Procedures of the Civil Servants", which has been in effect since 1913, should be removed or changed.

**2.** Freedom of thought and organization must be guaranteed. To attain this aim; Articles 6 and 8 of the "Law to Fight Terrorism" and Articles 155, 158, 159 and 312 of the Turkish Penal Code should be lifted or changed. The Law to Protect Atatürk, the Law on Press, the Law to Protect Children from Harmful Publications and similar laws should be included in this framework. All criminals of thought, beginning with the ones imprisoned under Articles 6 and 8 of the "Law to Fight Terrorism" and aforesaid articles of the Turkish Penal Code,

should immediately be released, and all pending trials should be dropped. The path to democratization should be opened. The amendments made to the Constitution are superficial and do not provide much freedom. Therefore, the issue of amendments to the Constitution should be dealt with again. Laws regulating democratic life should be redefined. Laws on associations, political parties, elections, the police force, labour unions, labour, meetings and demonstrations should immediately be discussed and changed. By these changes, the coalition government's promises in their program will be fulfilled and various problems beginning with the Kurdish problem will be open to discussion.

**3.** Emergency State legislation and the village guard system should be ended. Thus, promises given in 1991, 1992, 1993 and 1994 by the coalition government that came into power at the end of 1991, will be fulfilled.

**4.** The burnt down and demolished villages should be reconstructed, and turned into habitable areas again. The systematic and continuous policy of forcing people to migrate should be abolished.

**5.** Operations against civilians and killings of various kind in the Emergency State Region, should be stopped.

**6.** The right to life should be guaranteed. Extra-judicial executions, disappearances, murders by unknown assailants should end. The state should make effective investigations and find the assailants.

**7.** Civil servants should be provided with union rights including the right to collective bargaining and holding strikes.

**8.** Humane living conditions should be maintained in prisons.

Clearly these measures aim at urgent improvement. We are ready to accept a limited improvement. The society remains passive. The Kurdish problem, the Emergency State legislation, and the propaganda made and measures taken "to defend indivisible integrity of the state with its country and nation", loom above the peace and hopes of democracy just like Damocles' sword.

The instinct of protecting and defending values such as "integrity of the country" and "unity of the nation", which are already under the protection of national and international law, influences not only the National Security Council, President, Parliament, Government, SSC judges and prosecutors, security forces, but also the slum dwellers, factory and office workers, farmers, people in the streets, i.e., a large part of the society, and causes them to look upon with suspicion to our democratic, peaceful solutions and political proposals, and

induces everybody to maintain the status quo. Under these circumstances, military authority replaces “civilian” authority.

Unless the fear of separation and disintegration is eliminated, and civilian thoughts and approaches prevail, demands for democracy and human rights will remain on paper. In the last decade, the ever-present threat of division has begun to lose its credibility, and suspicions concerning its reality are increasing. Undoubtfully there is a logic and ground for the continuation of this armed conflict despite of all its negative aspects which has struck great blows to national economy, increased arms purchase, caused inflation, decreased standards of living, increased the number of the unemployed people, halted investments, caused enmity among people, and complicated our relations with Europe and rest of the world. However, the danger of separation and disintegration is the least persuasive among them.

Clearly the chauvinist nationalistic ideology and its organizations in the country, as a part of its seventy-year old program, have succeeded in obstructing democratic development. That is why the democratic part of the society which defends human rights, universal rights and freedoms, complains about the oppressive practices of the 12 September military regime. That is why it is important for certain forces capable of overcoming the conservative and fundamentalist barrier, to build up their identity, to express their opinions freely, and to organize around their opinions in a democratic environment.

The existing Constitutional system and its legal constructs are supported especially by the representatives of large capital, because they believe that “liberal democracy” will be harmful to Turkey; “a democratic social life” is dangerous. A tendency to modify the laws which regulate labour life and which are against the ILO agreements, oppressive and exploiting, and attempts to reach the European Union standards with respect to the social regulations such as union rights, minimum wage, retirement, social welfare, unemployment fee, attract harsh criticism of the representatives of large capital. Owners of these rejoinders, whom we try to expose on any occasion, are the most important supporters of the official ideology. Democratic expansions need “visas” and authorities of the visas are representatives of capital. The current balance of power in the society is against democratic forces and democratization, and that’s why the government, the Parliament and the political parties of this ambiance are continuously revitalizing the conjecture that the society is not ready for a “Western” type democracy.

Undoubtfully, each county, each society has its own social, political, cultural background and this background exists along with daily problems. Turkey’s more than two hundred years old connection with “Western” civilization, its relations with Western countries and rest of the world, the increased capacity and speed of economic relations due to recent scientific-technological advances,

are preparing the conditions for fast accomplishments in a short interval. Keeping Turkey as a democratically handicapped country within the European family and making the public pay for this defect places a heavy and historical burden on the people governing Turkey. Undoubtfully, social transformations essentially necessitate transformation of the ideas prevailing in society. We believe the ones who need to change their mentality are those in charge of today's Turkey. Contrary to the thesis of the official ideology, the society can be prepared for transformation in a short time, with less effort than spent by the racist-chauvinist-religious channeling against democratization.

Our efforts in the field of human rights aim at making Turkey an important, respected and influential part of the construction of a democratic, secular and modern world in the recent setting in Balkans, Middle East, Central Asia and Caucasus.

All our demands and proposals should be appraised in this context.

Imminence of a future in which concrete steps are taken for human rights and freedoms, all rights, particularly the right to life, written in human rights documents are respected, human beings do not kill other human beings, and peace is prevailing, is our biggest wish.

Ankara,10 September 1995

# *HRFT Treatment and Rehabilitation Centers Report*

**1994**

***Evaluation Results***

# HRFT TREATMENT and REHABILITATION CENTERS

# 1994 EVALUATION RESULTS

## INTRODUCTION

Torture, defined as one's tendency to deliberately inflict physical or psychological pain on another for specific purposes, is generally used to obtain information, force confession, punishment or intimidation.

Despite the international declarations and agreements against torture, the data indicates that torture is still a problem in most countries. In Turkey, torture is used as a systematic interrogation method on almost all suspects. The torturers and those who order them are protected and torture is institutionalized. The Human Rights Foundation of Turkey (HRFT) Documentation Center has found out due to its studies and the gathered information, that in 1994, 1,128 people, 24 of them children and 261 of them females, were tortured in detention or prisons[*].

The human rights abuses in Turkey are not limited to torture inflicted in detention and prisons. Atrocities committed while dispersing protesters, and during village and house raids, fire opened by security officers at a specific target or at random, torture inflicted outside detention places by security forces, intelligence organizations or by people reporting to have acted in the name of some secret organizations (counter guerrilla, Turkish Revenge Brigade [ TIT ], Hezbollah, etc.), constitute another dimension of these abuses.

Torture is a problem that affects the mother, the father, the spouse, the children and other relatives, along with the individual. In short, it affects the well being of the society directly or indirectly. So, the goal of struggling with the effects of torture on human beings should first be the abolition of torture. However, while struggling politically for the abolition of torture, the medical problems of torture survivors, which can sometimes last for a lifetime should be considered as well.

The HRFT tries to solve the medical problems, stemming from prison life and/or exposure to violence, of people either tortured in Turkey or with refugee status who were tortured in their native countries. The relatives of these people

[*] The chapter entitled “Torture Cases” of the Turkey Human Rights Report-1994 by the HRFT Documentation Center, was prepared through the compilation of information about the tortured people who publicized the torture they suffered, before courts or by means of press-publication organs, filed official complaints at the public prosecution offices and applied to the HRFT Treatment and Rehabilitation Centers. Therefore, the group of people, consisting mostly of ordinary judicial cases, who did not make public the torture inflicted on them, do not reflect the data.. When the difficulty in getting information from the Emergency State Region is taken into consideration, it appears that the numbers reported by the HRFT, reflects only a minority of the torture cases in Turkey.

are also considered within the treatment and rehabilitation works of the HRFT as torture affects the individual's relatives, as well.

These studies of the HRFT were carried out by the Treatment and Rehabilitation Centers in Ankara, İstanbul and İmir till the end of 1994. Upon the foundation of the Adana Representation Office, opened in 1995, the number of centers grew to four. In these centers, medical service is provided by practitioners, psychologists, psychiatrists and social workers. The physical examination and psychological evaluation of the applicants are made in these centers. People who need further examination and treatment are sent to specialists working outside the HRFT, and their examination and treatment are provided. All the expenses are paid by the HRFT, and the results are evaluated in the Centers. Within the context of these works, 243 people in 1990-1991, 393 in 1992, 323 in 1993 and 472 in 1994, a total of 1431 people received health services in the Treatment and Rehabilitation Centers of the HRFT.

## METHOD

This report is prepared retrospectively on 446 people, 126 of them female, 320 of them male, who applied to the HRFT Treatment and Rehabilitation Centers in Ankara, İstanbul and İzmir. 26 people are excluded due to lack of information. The data were obtained by using a 33-item questionnaire on the characteristics of applicants. The questionnaire was prepared to find out their sociodemographic characteristics, torture methods, and the psychological and physical complaints. The tables and graphics in the report are designed using the Microsoft Excel 5.0 computer program.

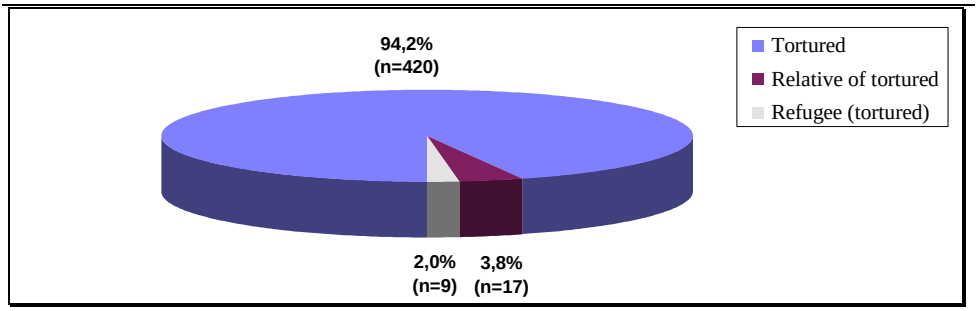
## RESULTS

### A-The sociodemographic characteristics of the applicants to the HRFT Treatment and Rehabilitation Centers

Out of the 446 applicants who applied to the HRFT Treatment and Rehabilitation Centers in 1994, 126 (28.3%) are female and 320 (71.7%) are male. 252 of these applicants reported that they had been tortured in 1994. 93 of these 252 applicants applied to the HRFT Ankara Treatment and Rehabilitation Center, 83 of them to the HRFT İzmir Treatment and Rehabilitation Center and 76 of them to the HRFT İstanbul Treatment and Rehabilitation Center.

94.2% of the applicants are those who were tortured, 3.8% are relatives of tortured people and 2.0% are tortured refugees. The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 1994 is shown in Graphic 1.

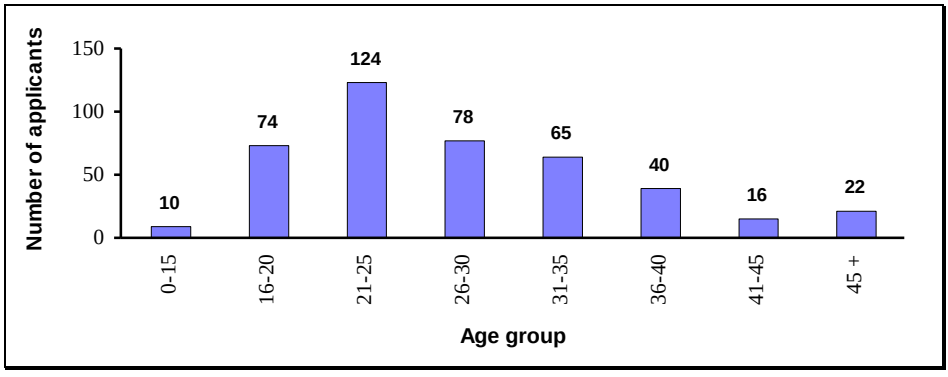
**Graphic 1. The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 1994 according to the reason of application**




The rest of the chapter entitled 1994 Evaluation Results in the HRFT Treatment and Rehabilitation Centers Report 1994, involves analysis that was carried out using the data about 429 tortured people, excluding the information about 17 relatives of torture survivors.

28.9% of the applicants are in the 21-25 age group. In the 1991 data, 31-35 age group was the largest with 38.2%. A likewise distribution can be seen in 1992. The reason why the young applicants' were numerous in 1994 is that the applicants in 1991 and 1992 are mostly those who were released on parole upon the amnesty law enacted in the summer of 1991. These people, who were imprisoned for long periods, had experienced torture under detention when they were 5-10 years younger. However, in 1994 most of the applicants are those who were exposed to torture recently. Taking this into account, it is obvious that the basic age group has not altered considerably. The distribution of the applicants according to their age group is shown in Graphic 2.

**Graphic 2. The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 1994 according to the age groups**

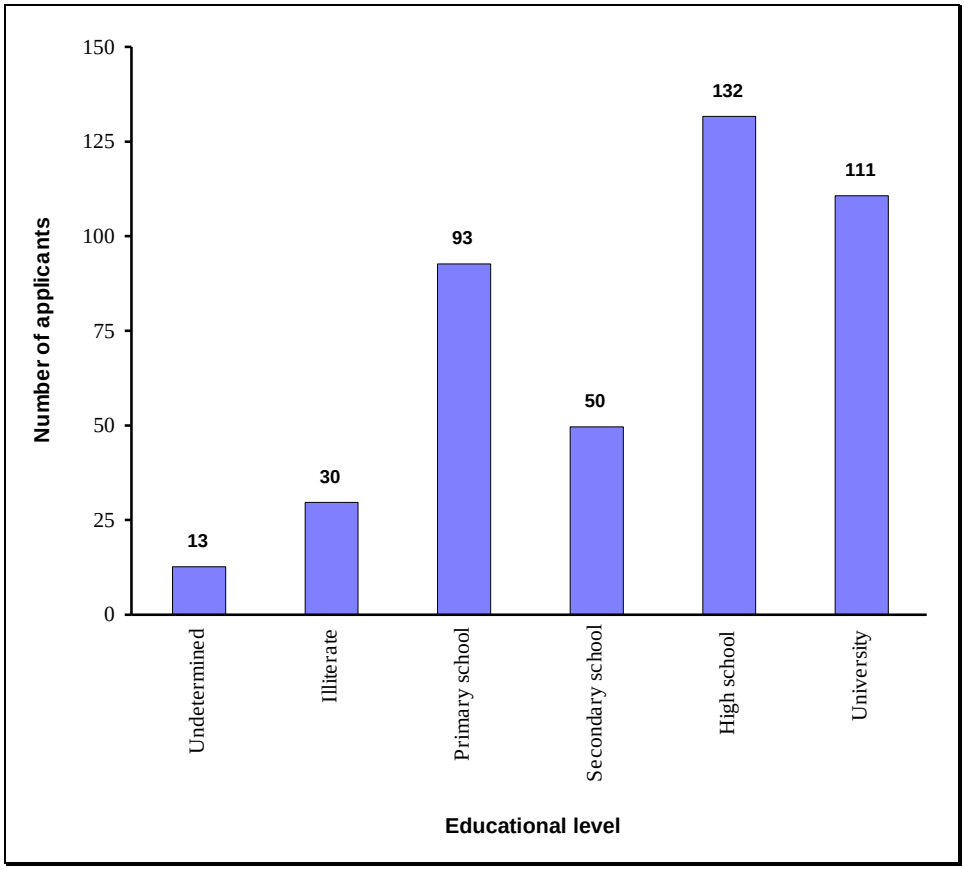



It is seen that out of the applicants in 1994, 245 (58.5%) of those 16 years old and older are single, 163 (38.9%) are married, 7 (1.7%) are widows and 4 (0.9%) are divorced.

When the educational level of the applicants is analyzed, it is found out that 7% of them are illiterate, and 21.7% are primary school, 11.7% are

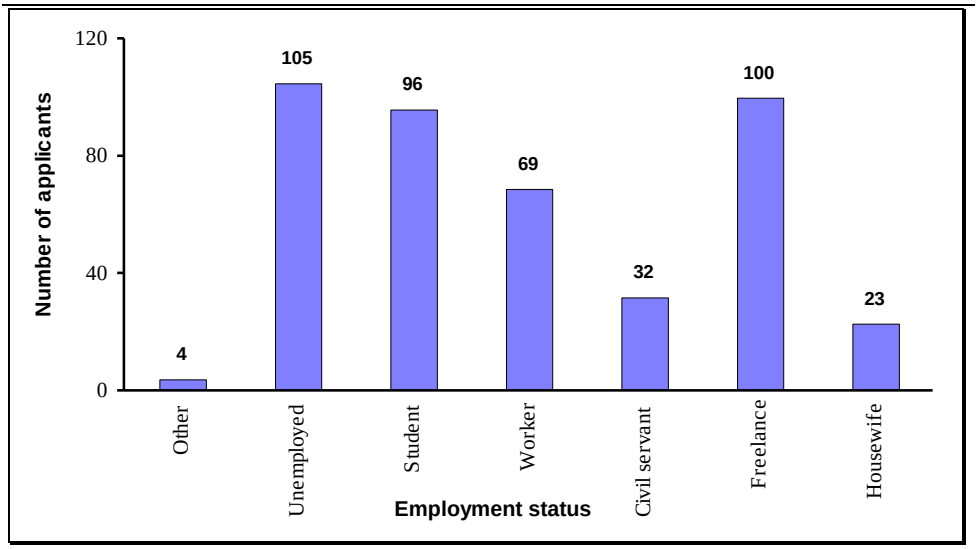
secondary school, 30.8% are high school and 25.9% are university graduates. The educational level of 13 people could not be determined. The educational level of the applicants is shown in Graphic 3.

**Graphic 3. The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 1994 according to the educational levels**



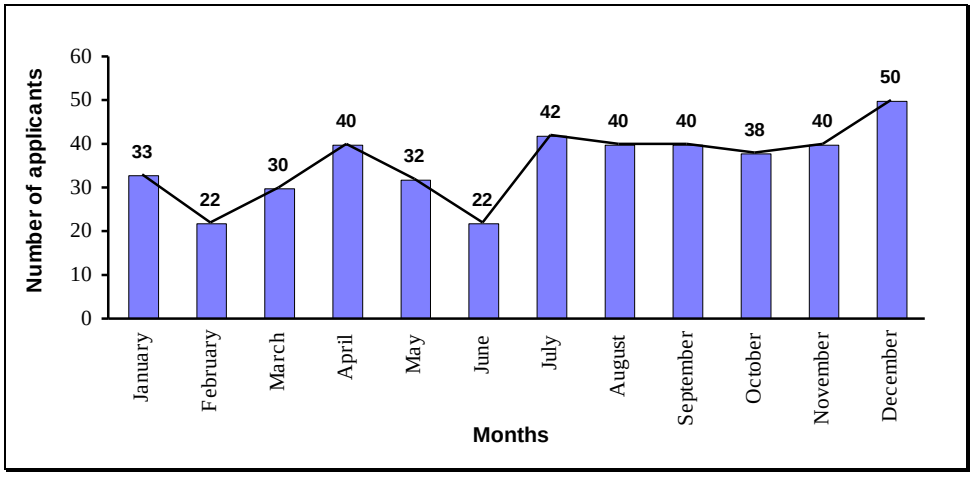

It is found out that 24.5% of the applicants were unemployed, 23.3% were working freelance and 22.4% were students. The smallest group is formed by the housewives and civil servants with 5.4% and 7.5%, respectively. The distribution of the applicants according to their employment status is shown in Graphic 4.

**Graphic 4. The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 1994 according to the employment status**




The number of applications reached the peak in December and July (11.7%) while February and June (5.1%) lay at the bottom. The mean number of applications per month is 35.7. The mean, being 29.8 in the first half of the year, climbed to 41.7 in the second half. The distribution of the applicants by months is shown in Graphic 5.

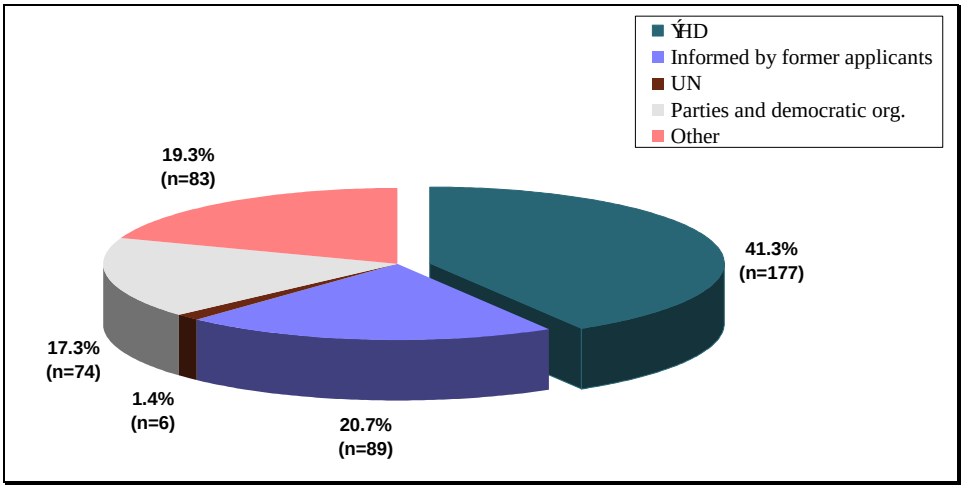
**Graphic 5. The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 1994 by months**




When the channels of contact with the HRFT Treatment and Rehabilitation Centers are investigated, it is found out that the applicants were mostly informed by the IHD Headquarters and branches (41.3%). Considering

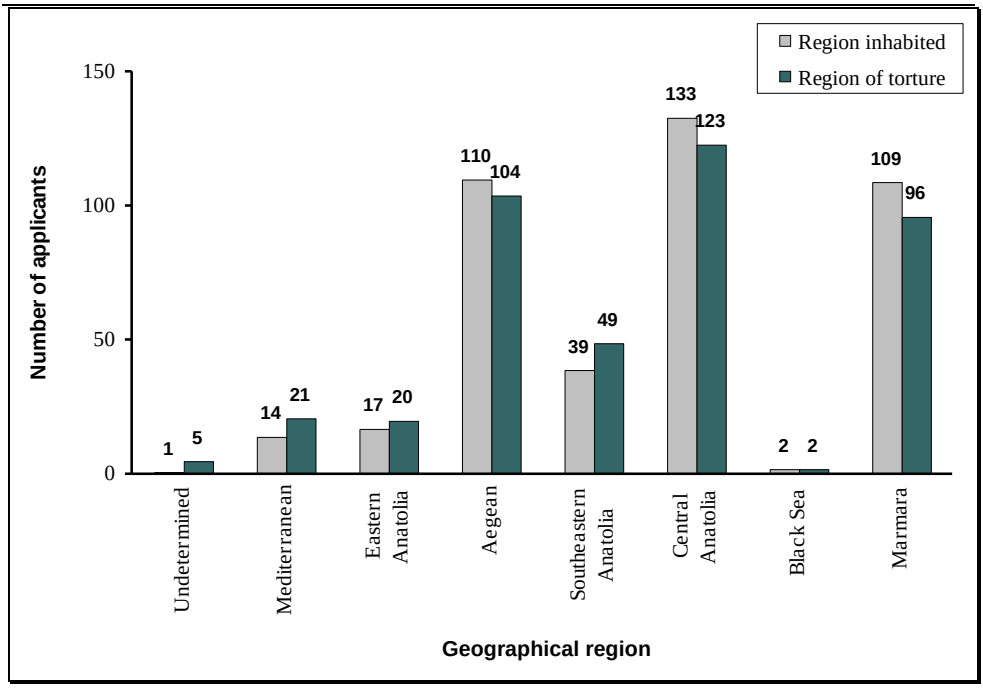
this rate was 11.5% within 1990-1991, it is concluded that the IHD refers more and more people every year. The distribution of the applicants in 1994 by channels of contact is shown in Graphic 6.

**Graphic 6. The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 1994 by channels of contact**




Out of the 429 people who applied to the HRFT Treatment and Rehabilitation Centers in 1994, 140 (32.6%) were living in the Central Anatolia, 110 (25.6%) in the Aegean Region and 109 (25.4%) in the Marmara Region. Among the 140 applicants who were living in Central Anatolia, are 9 refugees who applied to the Ankara Treatment and Rehabilitation Center, stating they had been tortured before coming to Turkey. Five of them stated that they had been exposed to torture in Iraq and four of them in Iran. As far the regions where the 420 applicants who stated to have been tortured in Turkey were tortured, Central Anatolia, with 123 cases takes the first place, followed by the Aegean Region with 104 applicants and the Marmara Region with 96 applicants. The region of application and of torture are shown in Graphic 7. When the relationship between the place of the application and of torture is examined, it is seen that the number of applicants from the Central Anatolia, Aegean and Marmara Regions where the HRFT Treatment and Rehabilitation Centers exist, exceeds the number of those who were tortured in these regions, and that the former number lags behind the latter in the other regions. This implies that the people tortured in the regions where there are no HRFT Treatment and Rehabilitation Centers can apply to the HRFT only after they move to the regions where ther Centers are located.

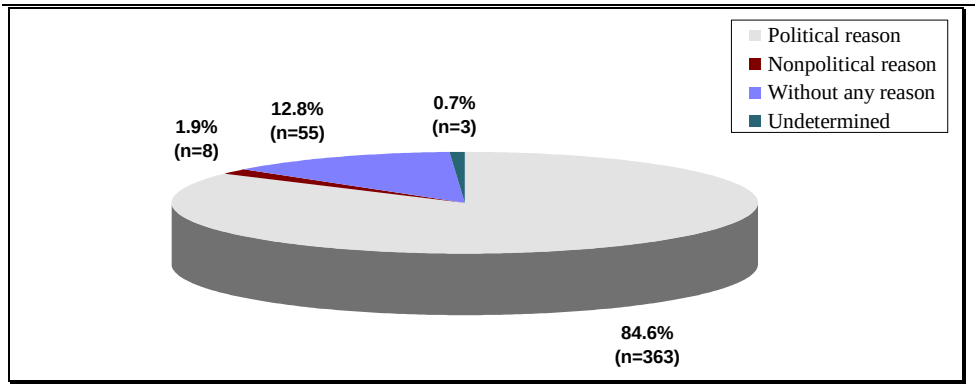
**Graphic 7. The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 1994 by the places they live in and the places they were tortured**




### B- Information Regarding the Period under Torture

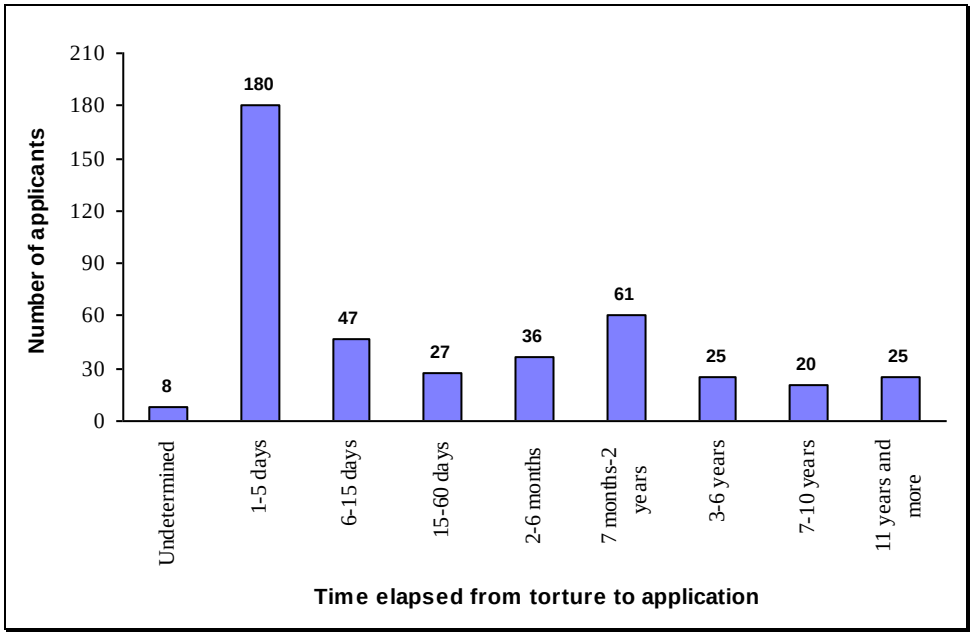
84.6% of the 429 applicants to the HRFT Treatment and Rehabilitation Centers were exposed to torture for political reasons. This considerably high ratio does not necessarily indicate that political suspects are rather more exposed to torture. In Turkey, torture has been inflicted, as a systematic interrogation method, on all suspects without any discrimination of political or judicial cases, whether the suspect is under detention or not. However, those exposed to torture for nonpolitical reasons, prefer to be silent rather than informing the public, filing official complaints at the prosecution offices, etc. For that reason, almost all the publicly reflected torture cases are related to those who were exposed to torture for political reasons. A likewise situation applies for applications to the HRFT, too. Most of the applicants, applying to the HRFT Treatment and Rehabilitation Centers, are those tortured for political reasons. It is a crucial fact that 12.8% of the applicants were exposed to torture without facing any charge (without any reason). The reasons for torture are shown in Graphic 8.

**Graphic 8. The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 1994 according to reasons of torture**




42.0% of the applicants to the HRFT Treatment and Rehabilitation Centers in 1994, indicated that they had been exposed to torture 1-5 days before their applications. The time elapsed from torture period to application is shown in Graphic 9.

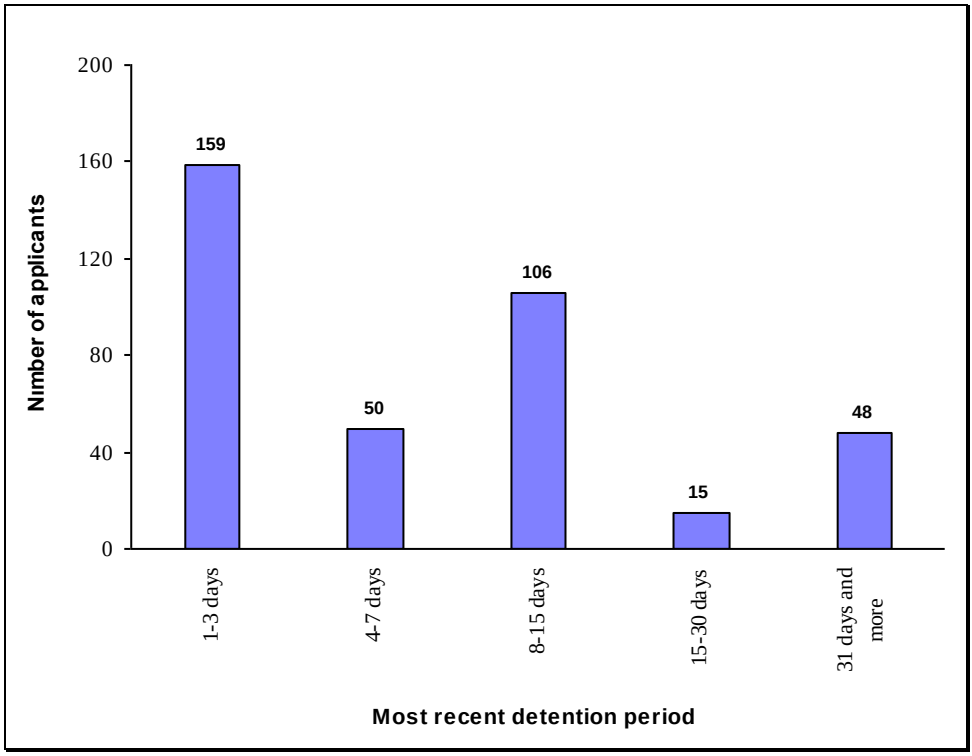
**Graphic 9. The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 1994 according to the time elapsed from torture to application.**




Out of the 429 applicants to the HRFT Treatment and Rehabilitation Centers, 378 have been detained. The other 51 people are those who were

exposed to violence during demonstrations, village and house raids, fire by security forces, and likewise incidents. Out of the 378 detained people, 224 were detained at least twice before applying to the HRFT. Among these 378 people, 42.1% were kept under custody for 1-3 days during the most recent detention. The recent detention periods are shown in Graphic 10.

**Graphic 10. The distribution of the detained applicants to the HRFT Treatment and Rehabilitation Centers in 1994 according to the recent detention periods**




The torture methods applied to the 378 detained people are shown in Table 1. Among the methods, beating with a percentage of 95.2 comes first, followed by blindfolding with 71.2% and insulting with 69.3%. In fact, restriction of food and water, blindfolding, beating, insulting, death threats are methods applied to all detainees, however, the torture survivors, since they were exposed to more violent methods, do not consider these methods as types of torture, and do not need to indicate them.

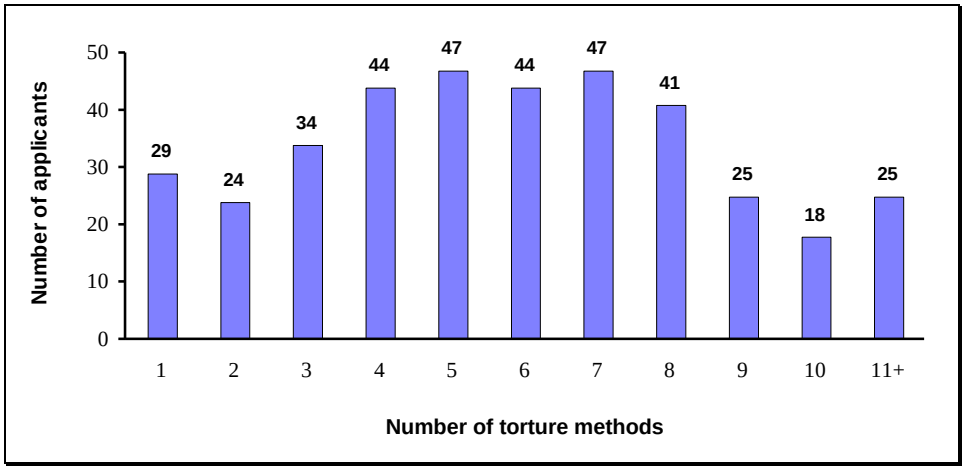
**Table 1. The methods of torture inflicted under detention on the applicants to the HRFT Treatment and Rehabilitation Centers in 1994**

| Torture method | n | % |
|---|---|---|
| **Blindfolding** | 269 | 71.2 |
| **Insulting** | 262 | 69.3 |
| **Beating** | 360 | 95.2 |
| **Applying electricity** | 158 | 41.8 |
| **Falanga** | 75 | 19.8 |
| **Pressurized water** | 109 | 28.8 |
| **Death threats** | 121 | 32.0 |
| **Suspension on a hanger** | 114 | 30.6 |
| **Sexual harrassment** | 95 | 25.1 |
| **Cell isolation** | 139 | 36.8 |
| **Restriction of food and water** | 113 | 29.9 |
| **Mock execution** | 32 | 8.5 |
| **Pulling out hairs, beards, etc.** | 46 | 12.2 |
| **Preventing urination and defecation** | 74 | 19.6 |
| **Exposure to cold floor** | 91 | 24.0 |
| **Other*** | 157 | 41.5 |

***Squeezing testicles, threats of torturing releatives, forcing to wait in a garbage like place, forcing to listen to torture of other, pulling out nails, beating in a tire, forcing to eat salt,etc.

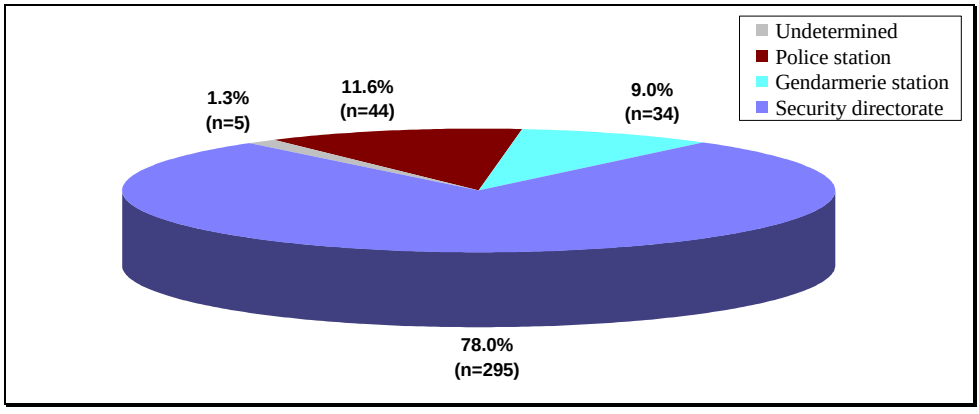
The data shows that all the 378 detained people were tortured, and 349 of them (92.3%) were exposed to at least two torture methods during their recent detention. Out of the 378 people, 11.6% were exposed to four, 12.4% to five, 11.6% to six and 12.4% to seven methods of torture, and 247 people (65.3%) were subjected to five or more methods of torture. The number of people who were exposed to 10 or more methods is 43 (11.4%). The number of torture methods inflicted on the applicants while in detention is shown in Graphic 11. While conducting this evaluation, the “other” item was inevitably counted as one method. In fact “other” item, as it is indicated in Table 1, covers more than one method of torture, most of them being too violent. As indicated above, people do not consider the “less serious” torture methods (blindfolding, restriction of food and water, etc.) to be noteworthy as they are exposed to more serious ones, and also they do not remember everything they experienced completely, due to the duration of the torture, its violence, the number of the methods and likewise conditions, and the time spent under detention. Taking account of all these, it is a fact that the actual numbers are much higher than stated. It is also worth to mention that 206 (92.0%) of the 224 people who were detained at least twice before applying to the HRFT Treatment and Rehabilitation Centers, had been tortured during their former detentions.

**Graphic 11. The distribution of the detained applicants to the HRFT Treatment and Rehabilitation Centers in 1994 according to the number of torture methods they were exposed to**




Among the detention places of torture, security directorates come first with 78.0%. The distribution of the detention places where torture is inflicted is shown in Graphic 12.

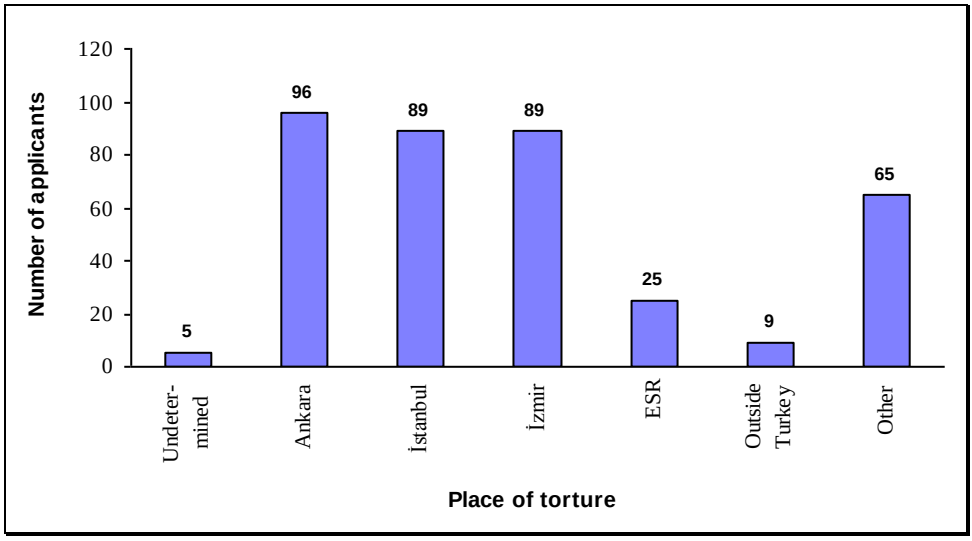
**Graphic 12. The distribution of the detained applicants to the HRFT Treatment and Rehabilitation Centers in 1994 according to detention places of torture**




Among the provinces where the 378 people, who applied to the HRFT Treatment and Rehabilitation Centers after detention, were tortured, Ankara (25.4%) holds the top followed by İstanbul and İzmir (24.0%). The ratio of people tortured in the Emergency State Region is 6.6%. Within the Emergency State Region (ESR), Diyarbakır is the province of most frequent torture cases with 14

cases and Van is the second with 6 cases. The fact that the majority of the applicants are those tortured in Ankara, İstanbul and İzmir, where there are the Centers, can best be explained by ease of access. The ones living in places where there are no Centers, have difficulties in contacting the Foundation. This difficulty becomes more serious when the Emergency State Region is of concern. For that reason, the number of tortured applicants from the Emergency State Region is considerably lower than the real number. The HRFT has aimed at acquiring access to the torture victims in this region by communicating with the Medical Chambers, IHD branches, some other professional institutions and likewise democratic mass organizations in Adana*, Diyarbakır, Gaziantep, Içel* and Malatya within the framework of the Five Cities Project that it formed with the aim of partially overcoming this difficulty at the least.

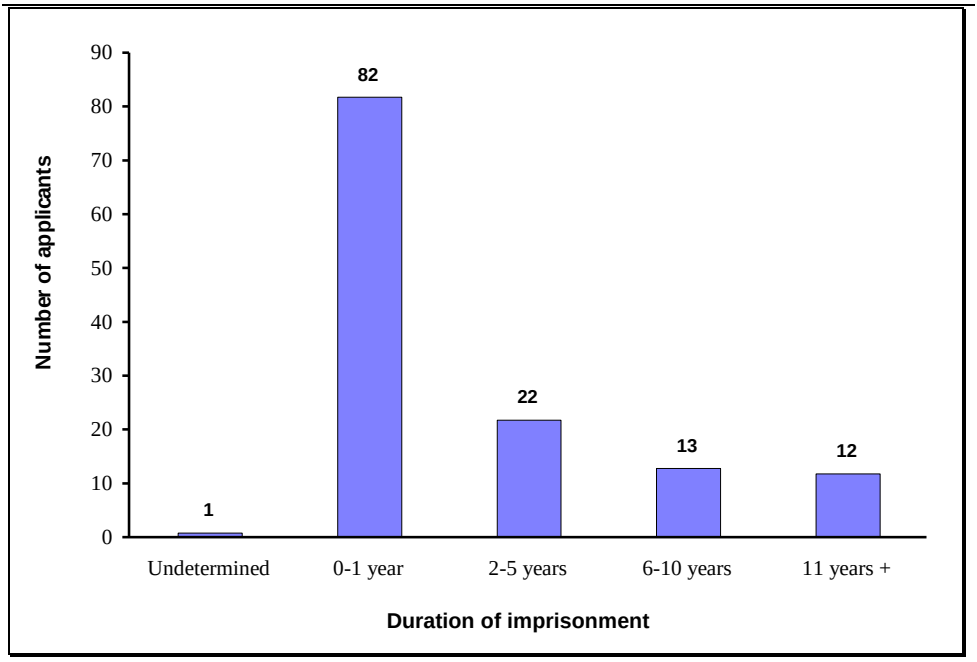
**Graphic 13. The distribution of the detained applicants to the HRFT Treatment and Rehabilitation Centers in 1994 according to place of torture**




130 (30.3%) applicants in 1994 had been in prison before. 63.1% of these spent less than one year in prison. The duration of imprisonment of the applicants is shown in Graphic 14.

**Graphic 14. The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 1994 according to the duration of imprisonment**

*Although Adana and Ýçel are not among the provinces under the Emergency State legislation, these two cities are included within the context of the Five Cities Project as there is a considerable migration from the Emergency State Region to these two cities. After the establishment of the HRFT Adana Representation Office in 1995, Van was included in the Five Cities Project, instead of Adana.




Out of the 130 people who stayed in prison before applying to the HRFT, 40.8% were exposed to beating, 29.2% to insulting and 26.2% to cell isolation. The information about the methods of torture in prisons is given in Table 2. However, the extremity of the torture and violence inflicted on prisoners is not reflected in the data. Restriction of basic needs such as food, drinks and clothes, bans and restrictions on paper, pencils, etc. and on printed material, overheated or cold wings, dearth of space and beds stemming from the number of prisoners exceeding the capacity of the prison, not allowing prisoners to get fresh air, restriction of medical aid to the unhealthy and wounded, even leaving them to die, plunder and seizure of personal properties on the pretext of searching wings, bans on visitors from outside and likewise implementations are not considered as torture methods, by people who stayed in prisons. These are summarized as “inhuman living conditions and pressure in prisons” and do not reflect to numbers. Prisoners usually go on hunger strikes to obtain improved conditions. Almost all the applicants in 1994, who stayed in prison, stated that they had gone on hunger strike in prison.

**Table 2. The methods of torture inflicted in prison on the applicants to the HRFT Treatment and Rehabilitation Centers in 1994**

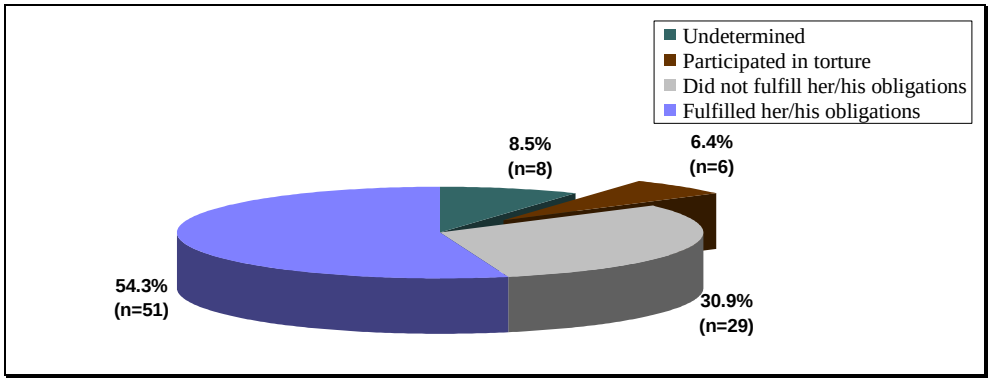
| Torture method | n | % |
|---|---|---|
| **Blindfolding** | 8 | 6.2 |
| **Insulting** | 38 | 29.2 |
| **Beating** | 53 | 40.8 |

| | | |
|---|---|---|
| **Applying electricity** | 3 | 2.3 |
| **Falanga** | 5 | 3.8 |
| **Pressurized water** | 5 | 3.8 |
| **Death threats** | 11 | 8.5 |
| **Suspension on a hanger** | 3 | 2.3 |
| **Sexual harrassment** | 6 | 4.6 |
| **Cell isolation** | 34 | 26.2 |
| **Restriction of food and water** | 14 | 10.8 |
| **Preventing urination and defecation** | 14 | 10.8 |
| **Exposure to cold floor** | 14 | 10.8 |
| **Other*** | 15 | 11.5 |

* Mock execution, pulling out hairs, beards, stripping naked, letting a dog bite the suspect, etc.

94 of the applicants in 1994, stated that they had seen a doctor during or after torture. 29 of them (30.8%) stated that the doctors had not examined and treated them, had not prepared a report, shortly, that they had not fulfilled their medical and/or administrative responsibilities. The active or passive participation of doctors in carrying out torture in 6 cases is a sheer awfulness to be stated.

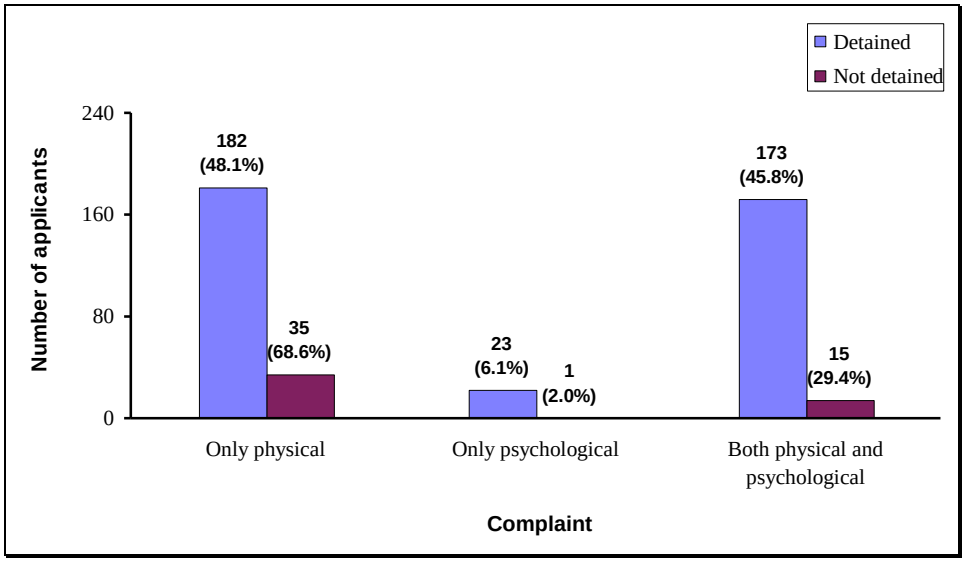
**Graphic 15. The treatment of doctors towards the applicants to the HRFT Treatment and Rehabilitation Centers in 1994**



### C- Physical and Psychological Complaints

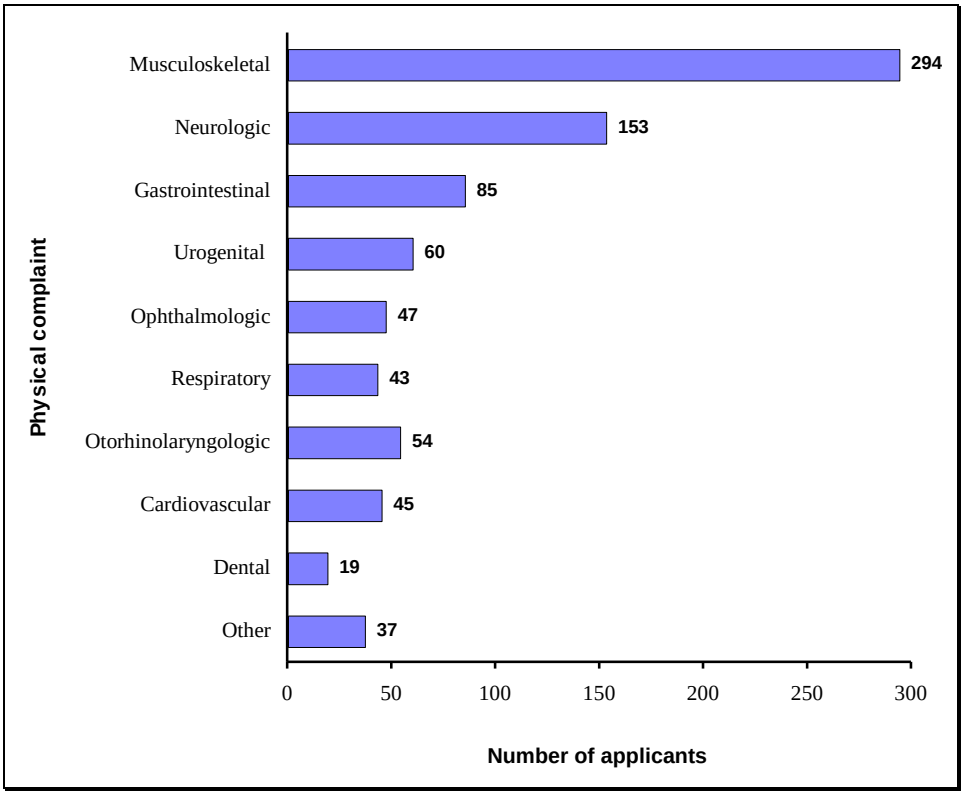
Out of the 429 tortured applicants to the HRFT Treatment and Rehabilitation Centers in 1994, 405 (94.4%) had physical and 212 (49.4%) had psychological complaints. 5.6% of them applied with merely psychological complaints. The percentage of those who applied only for having physical complaints is 49.6. 355 (93.9%) of the applicants who were detained before their applications and 50 (98.0%) of those who were not, had physical complaints. These figures diverse profoundly in the case of psychological complaints: 196 (51.9%) of those who were detained and 16 (31.4%) of those who were not, had psychological complaints. When the numbers are reckoned in a different manner, 87.6% of those with physical complaints and 92.5% of those with psychological complaints were detained before applying to the HRFT. The frequency of the psychological complaints being rather high among the detained applicants indicates that these people were exposed not only to physical torture, but to severe psychological trauma, as well. When the torture methods inflicted on these people are reexamined, it can be seen that physical torture methods come first. This shows that the methods used aim not only at giving pain but also at traumatizing the individual psychologically, and that they attained their goal. Apart from that, it should be emphasized once more that the applicants do not report (due to neglecting, forgetting, not remembering, developing psychological defense mechanisms, etc.) all the torture methods inflicted on them. The complaints of the applicants are shown in Graphic 16.

**Graphic 16. The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 1994 according to their complaints**



Beating comes first among the physical torture methods. It is followed by exposure to electricity and suspension on a hanger. As a consequence of the torture methods inflicted, as in 1990, 1991, 1992 and 1993, the applicants mostly had complaints about musculoskeletal system (68.5%) in 1994. This figure is followed by complaints related to the nervous system (35.7%) and gastrointestinal system (19.8%). When the physical complaints of the applicants in 1993 are examined, the same pattern can be seen (for the musculoskeletal system 66.7%, for the nervous system 38.9% and for the gastrointestinal system 36.9%) and the ratios are quite similar. The information about the physical complaints is given in Graphic 17.

**Graphic 17. The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 1994 according to their physical complaints**



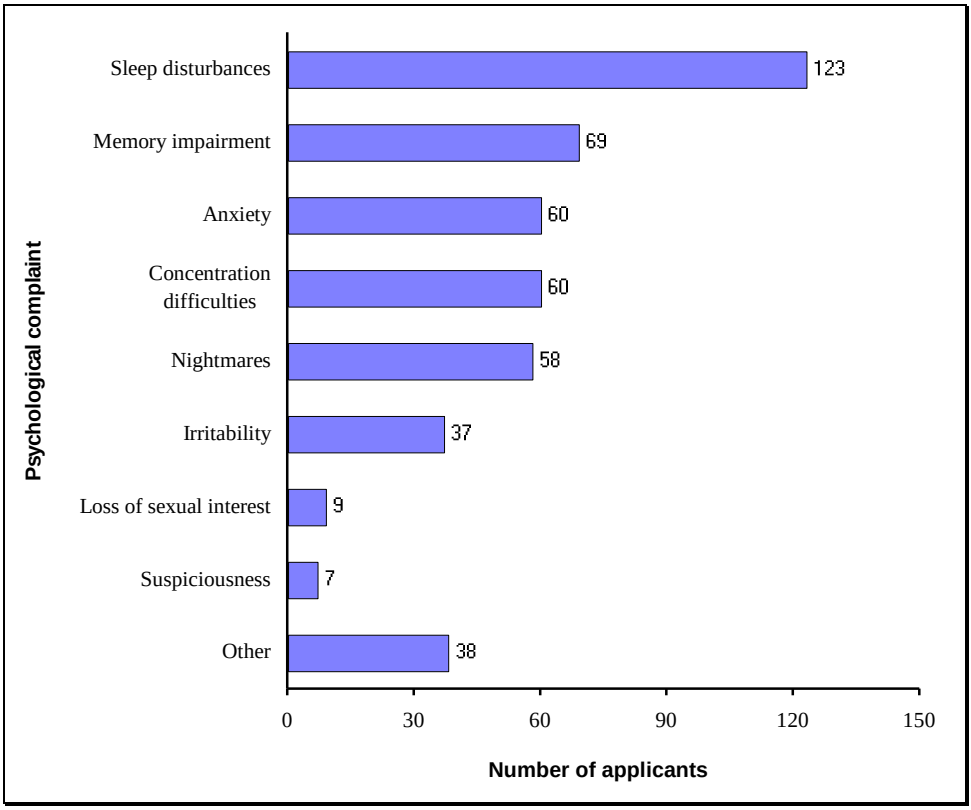

**Note:** Since an individual may have more than one complaint, the total number exceeds 429.

When the physical complaints of those who were detained are evaluated, the same order (musculoskeletal system 69.3%, nervous system 37.8%, gastrointestinal system 21.7%) is obtained. Comparing these figures with the figures of those who were not detained, it is concluded that the complaints about the musculoskeletal system (62.7%) are quite similar. The complaints about the

nervous system (19.6%) and gastrointestinal system (5.9%) are quite less and there were no complaints about urogenital system.

The frequencies of psychological complaints of the 429 tortured people are also similar to those of the previous years. 37.0% and 34.0% of the applicants in 1990-1991 and 1992 reported psychological complaints, respectively. The same ratio is 36.7% and 49.2% among the people tortured in 1993 and 1994, respectively. Among the psychological complaints of the 429 applicants in 1994, 28.7% of them complain about sleep disturbances, 16.1% about memory impairment, 14.0% about anxiety, 14.0% about concentration difficulties and 13.9% about nightmares. The psychological complaints of the applicants in 1994 are shown in Graphic 18.

**Graphic 18. The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 1994 according to their psychological complaints**

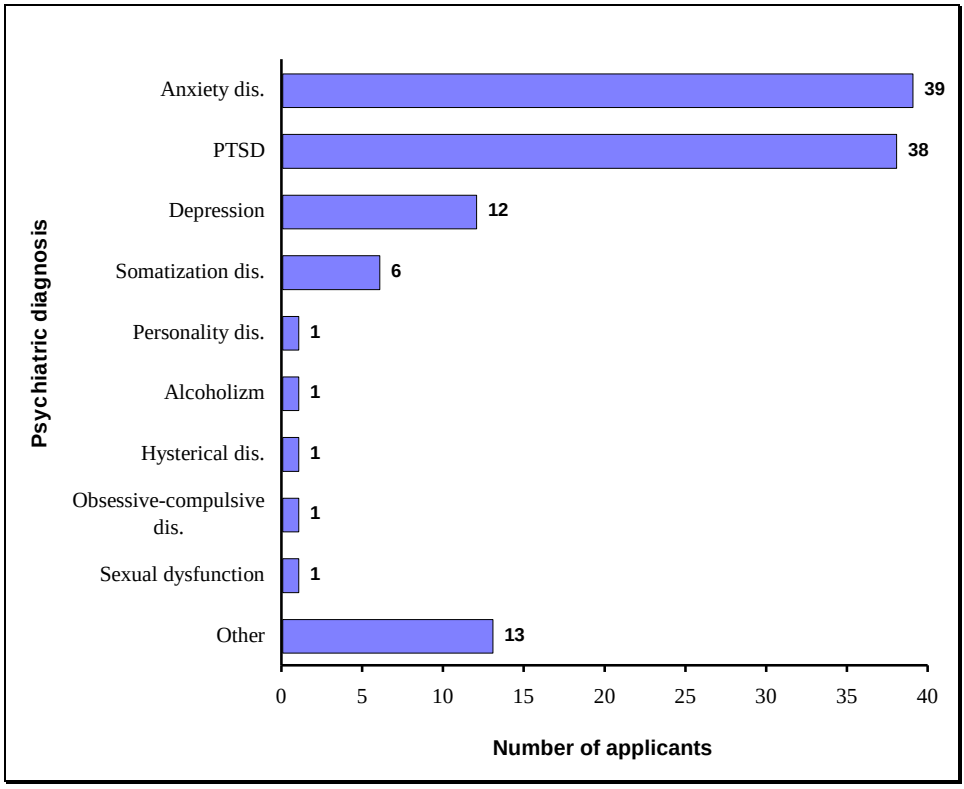



**Note:** Since an individual may have more than one complaint, the total number exceeds 429.

In a similar study carried out in 1993, it was concluded that 23.0% of the applicants complained about sleep disturbances, 19.4% about memory

impairment, 18.7% about anxiety, 13.8% about irritability, 10.3% about nightmares, 8.3% about concentration difficulties. Among the psychological complaints of the 378 detained people, sleep disturbances comes first with 31.0%. It is followed by 18.0% memory impairment, 15.9% concentration difficulties, 14.8% anxiety and 14.0% nightmares. On the other hand, problems like concentration difficulties, loss of sexual interest and complaints about irritability cases are not among the psychological complaints of the 51 applicants who were not detained. Out of the complaints of the latter, sleep disturbances with 11.8%, nightmares with 9.8%, anxiety with 7.8% and memory impairment with 2.0% are quite diverse from the other group.

**Graphic 19. The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 1994 according to their psychological diagnosis**

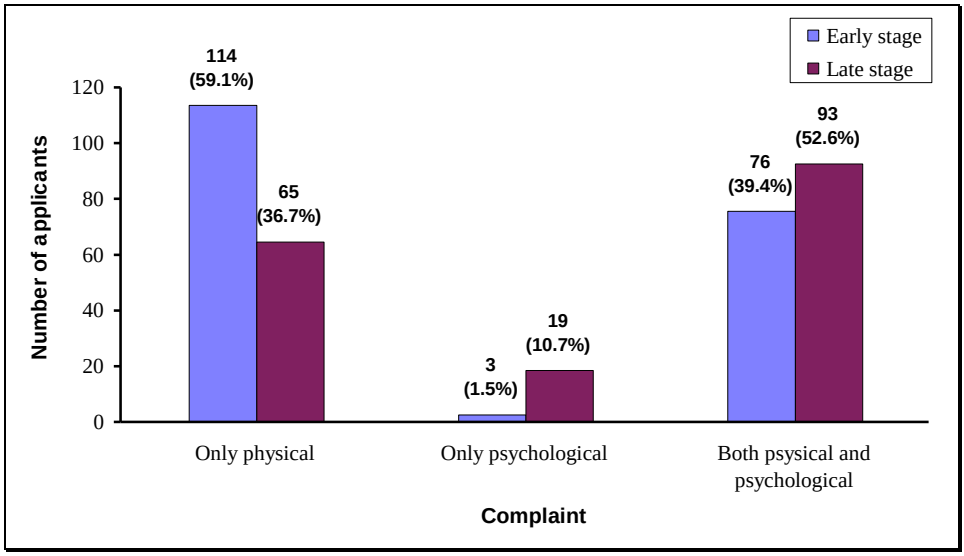



After psychological examination, 9.1% of the 429 applicants to the HRFT Treatment and Rehabilitation Centers in 1994 (212 of them had psychological problems) were diagnosed to have anxiety disorder, 8.9% post traumatic stress disorder (PTSD) and 2.8% depression. Among the 1993 applicants, the frequency of anxiety was 7.5%, PTSD 11.1% and of depression was 5.9%. In

1993, there were 18 (7.1%) people diagnosed as having sexual dysfunction, whereas in 1994 only 1 applicant was diagnosed as having sexual dysfunction.

Out of the 51 applicants who were not detained, one was diagnosed as having PTSD, one having somatization disorder and four were diagnosed as others. Also, among the group of detainees 39 people (10.3%) were diagnosed as having anxiety disorder, 37 (9.8%) PTSD and 12 (3.2%) people as having depression. The distribution of psychological diagnosis is seen in Graphic 19.

**Graphic 20. The distribution of the early and late applicants to the HRFT Treatment and Rehabilitation Centers in 1994 according to their physical and psychological complaints**



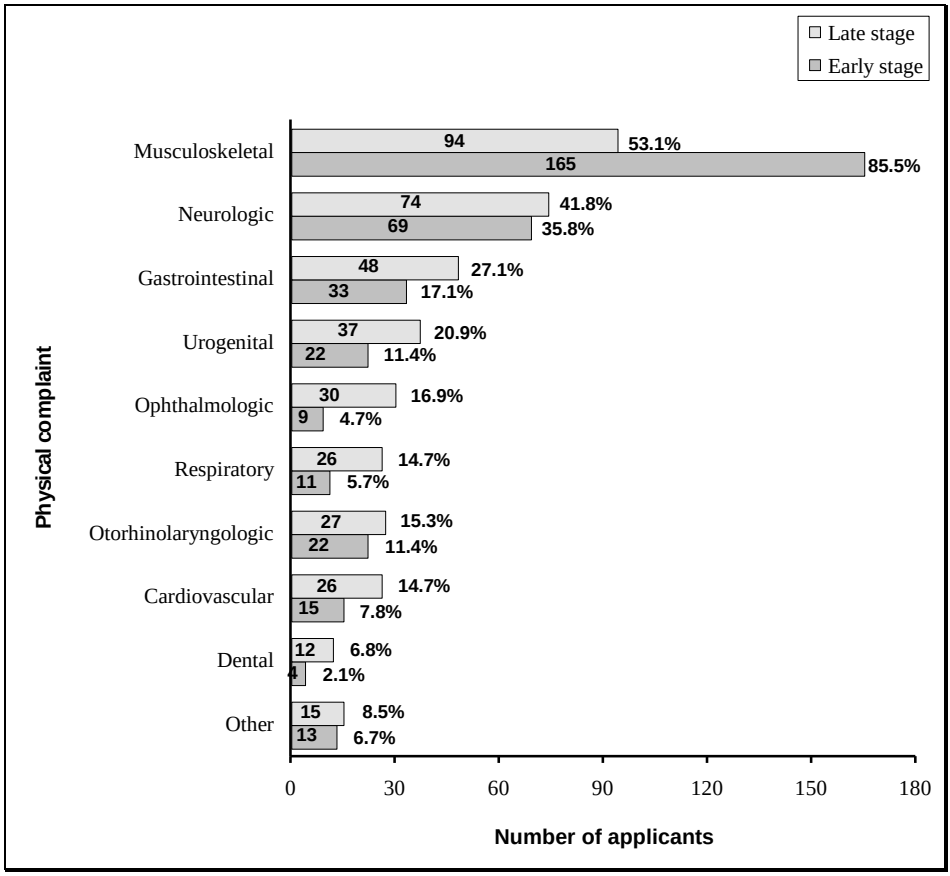

**Note:** No precise information was obtained about how long ago 8 of the applicants were taken under detention.

When the detained applicants are divided into two groups, according to the time elapsed between detention and application, as those who applied within the first 15 days (early stage) and those who applied later (late stage); two different pictures of complaints appear. Although the applicants in the early stage had a high rate of physical complaints, 98.4%, their psychological complaints remained at a level of 40.9%. However, 89% of the late stage applicants had physical and 63.3% had psychological complaints. It is observed that out of the applicants with only psychological complaints, 13.6% were in the early stage while 86.4% were in the late stage. The distribution of physical and psychological complaints in connection with the time elapsed from the detention and to the application is shown in Graphic 20.

The physical and psychological complaints of the detained applicants, are also studied in two groups, the early stage and late stage applicants.

When the physical complaints are compared, the musculoskeletal system complaints (85.5%) take the first place, followed by nervous system complaints (35.8%) and gastrointestinal system complaints (17.1%). It is found that the late stage applicants' musculoskeletal system complaints are 53.1%, nervous system complaints are 41.8%, gastrointestinal system complaints are 27.1% and urogenital system complaints are 20.9%.

**Graphic 21. The distribution of the early and late applicants to the HRFT Treatment and Rehabilitation Centers in 1994 according to their physical complaints**

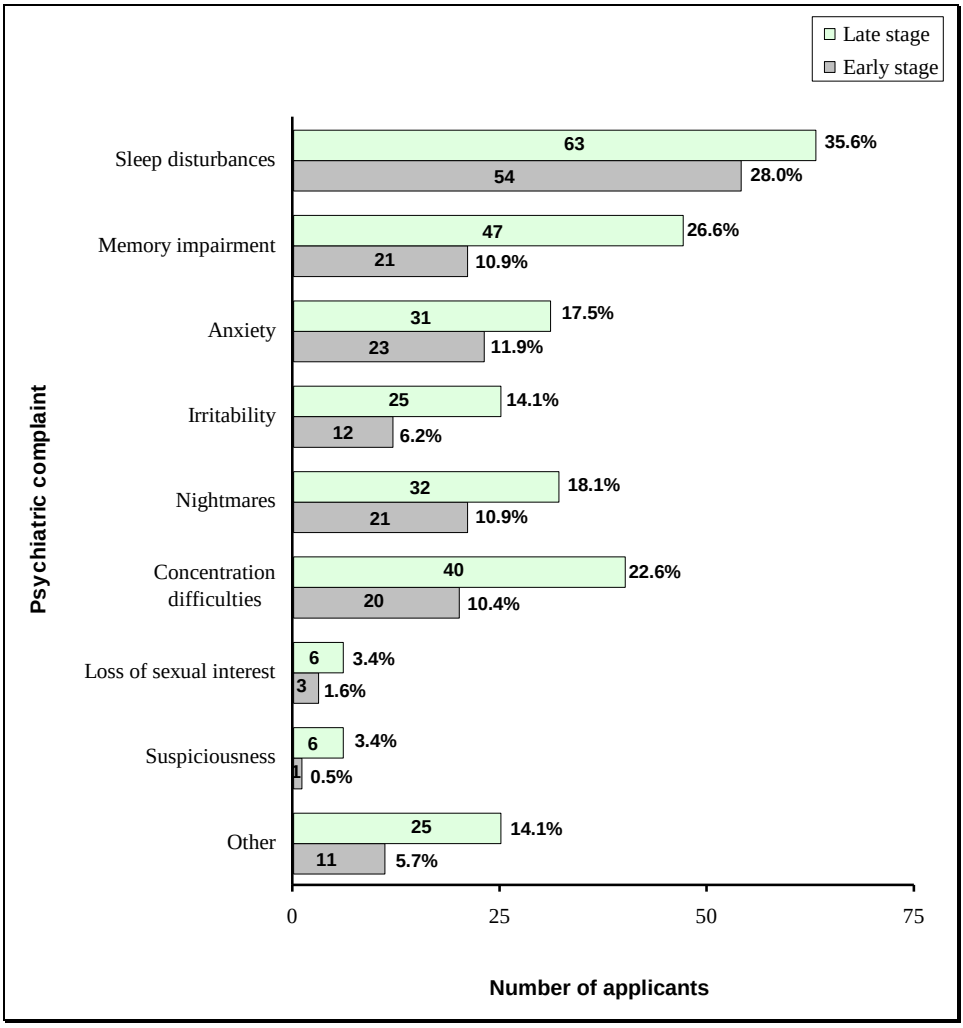



**Note:** Since an individual may have more than one complaint, the total number exceeds 429.

Respiratory, cardiovascular, ophthalmologic, otohinolaryngologic complaints and dental problems are seen more in the late stage applicants than the early ones. The high ratio of musculoskeletal system complaints observed in the early stage applicants, may stem from their application to the Treatment and Rehabilitation Centers short after the acute physical trauma. The distribution of

physical complaints in connection with the time elapsed from the detention and to the application is shown in Graphic 21.

**Graphic 22. The distribution of the early and late applicants to the HRFT Treatment and Rehabilitation Centers in 1994 according to their psychological complaints**



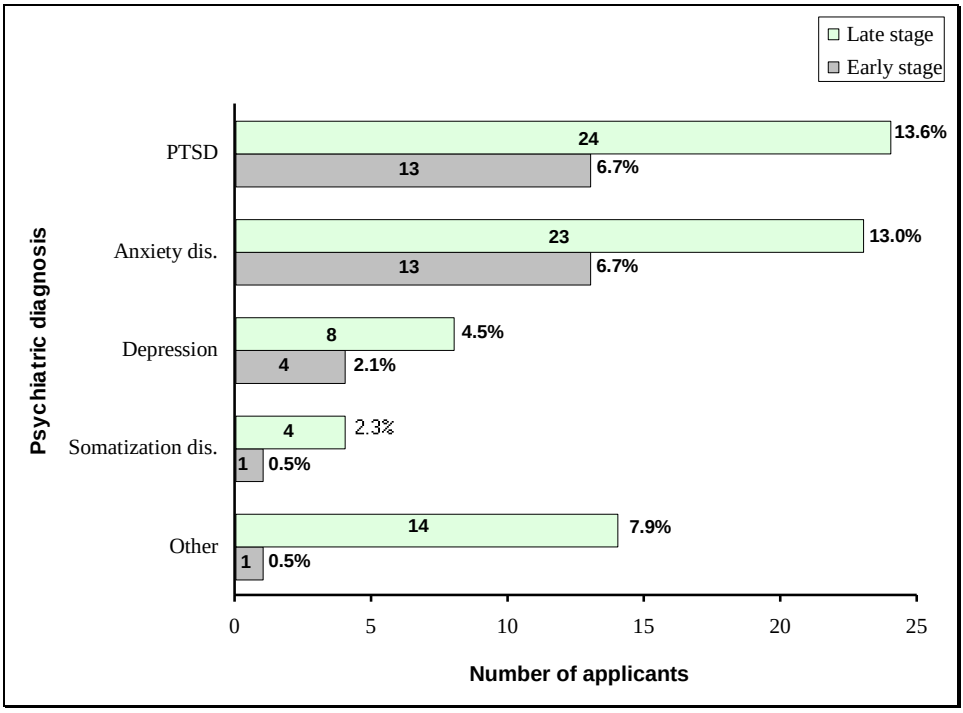

**Note:** Since an individual may have more than one complaint, the total number exceeds 429.

When the distribution of the psychological complaints (40.9%) of the early stage applicants is examined, it is seen that sleep disturbances (28.0%) is the most frequent. It is followed by anxiety (11.9%), memory impairment (10.9%) and having nightmares (10.9%). The psychological complaints of the late stage applicants are similar to them, but the ratios are higher. Among the late stage

applicants, the frequency of sleep disturbances is 35.6%, memory impairment 26.6%, concentration difficulties 22.6%, nightmares is 18.1% and anxiety is 17.5%. The distribution of psychological complaints in connection with the time elapsed from the detention and to the application is shown in Graphic 22.

When the distribution of psychological diagnosis is examined according to the early and late stages, it is seen that among the 193 early stage applicants, 32 of them (16.6%) and among the 177 late stage applicants, 73 of them (41.2%) were diagnosed as psychologically disordered.

**Graphic 23. The distribution of the early and late applicants to the HRFT Treatment and Rehabilitation Centers in 1994 according to their psychiatric diagnosis**




When the two groups are reexamined according to the diagnosis, it is found that 6.7% of the early stage applicants had post traumatic stress disorder and anxiety disorder, and 2.1% of them experienced depression. The same figures are 13.6%, 13.0% and 4.5% for post traumatic stress disorder, anxiety disorder and depression, respectively, among the late stage applicants. The psychological disorders mentioned here of the late stage applicants are almost twice of the figures related to the early stage applicants. The sexual dysfunction, obsessive-compulsive disorder, alcoholism, hysterical disorder and personality disorder are not observed in early stage applicants, therefore are classified as

"other" (Their graphical representation will otherwise correspond to a null value). The distribution of psychiatric diagnosis in connection with the time elapsed from the detention and to the application is shown in Graphic 23.

After the examinations and investigations, the illnesses of 380 (88.5%) applicants to the Treatment and Rehabilitation Centers in 1994, were revealed to be related to torture and prison life. The complaints of the four refugees out of 9, were discerned to be related to the refugee life.

**D- Treatment Period**

Among the applicants in 1993, the ratio of those who did not complete the examinations and consultations or who left their treatment unfinished was 38.9%. The same ratio in 1994 was 21.9%. Although the ratio of applicants who discontinued their treatment dwindled, it is important that almost one-fifth of the applicants have left with their treatments unfinished.

In 1994, pharmacological treatment was widely used. The ratio of those who received merely psychotherapy was 5.8.% and of those who received psychotherapy accompanied by pharmacological treatment was 10.0%, summing up to total psychotherapy cases of 15.8%. The ratio of those receiving physiotherapy accompanied by pharmacological treatment or not, was 6.1%. Apart from these, 4.5% of the applicants were diagnosed as having ailments requiring surgical intervention and their treatment was provided.

Among the 429 people who applied to the HRFT in 1994, 133 of them (26.3%) were diagnosed as psychologically disordered, but only 68 (15.8%) accepted the required treatment. When a similar evaluation is made on the detained applicants, it is seen that among 378 applicants, 106 (28.1%) were psychologically disordered and only 63 (16.7%) of them were treated. One reason for the exclusion of the applicants diagnosed to be psychologically disordered from the psychiatry treatment program may be that most of the applicants who applied to the HRFT in 1994 came on the first few days after being released from detention, mostly expected solutions to their physical complaints as they were suffering from musculoskeletal complaints and neglected their other complaints and as a result they were satisfied with the pharmacological treatment for their acute complaints. These may explain to some extent the reason for the widely used pharmacological treatment methods and the low ratio of the psychotherapy cases in 1994.

**CONCLUSION**

In 1994, 472 people who had health problems due to torture, applied to the HRFT Treatment and Rehabilitation Centers. The points indicated below are being reemphasized when the sociodemographic characteristics, the methods of

torture and the physical and psychological complaints stated by the applicants are taken into consideration.

- Almost all the applicants tortured in detention, had also been tortured under detention before. This indicates the systematization of torture in Turkey.
- Most of the applicants did not remember or express all the methods of torture inflicted on them. Out of the systematic torture applications, the “non-severe” ones are deemed so ordinary that even the tortured people do not need to emphasize them.
- A significant increase in the number of applicants from the Southeast (17 in 1993, 39 in 1994) and (11 in 1993, 17 in 1994) East Anatolian Regions has been realized. One of the main objectives of the HRFT is to get access to, particularly, the Emergency State Region, and the Southeast and East Anatolian Regions, where torture is widely practiced. In order to attain that objective, studies are conducted within the framework of the Five Cities Project.
- The data reveals that torture is used not only as a systematic interrogation method but also as a means of punishment and intimidation. The number of torture cases in prisons that reflects to the data of the Foundation also proves that.
- The early stage applicants apply with physical, especially musculoskeletal complaints. The psychological complaints do not appear in the short run. This indicates that the early applicants should be followed-up for a long period.
- It is steer awful that, contrary to the expected sensitivity from health care personnel, 30.9% of physicians did not fulfill their duties concerning the medical profession and that 6.4% participated in the practice of torture either actively or passively.

It should never be forgotten that the real solution to the medical problems evolving due to torture, can only be reached by the eradication of torture. Therefore, the struggle against the problems stemming from torture necessarily and primarily covers the struggle for the abolition of torture. Health care personnel also have responsibilities in that struggle.

# *Scientific Studies on Torture and Its Consequences*

# A STUDY ON SOME PSYCHOLOGICAL ASPECTS OF TORTURE

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## INTRODUCTION

Torture, intermittently seen in every country's history, is consciously causing physical and mental pain to a person, to acquire information, force confession or to punish[1]. Torture is one of the most important preventable causes of post traumatic physical and mental symptoms in an individual. It is a serious problem that affects not only the individual but the society as well. Amnesty International has reported in 1993 that, in 111 countries worldwide, torture is still extensively performed[2].

Some kinds of torture cause deeper psychological effects than physical. For example after torture by continuously threatening with death or disability, exhibiting torture on other people, mock execution, relentless exposure to disturbing noise, cutting social support to weaken resistance, causing helplessness by threats of never letting go, forcing to obey simple and irrational commands, many psychological symptoms accompany physical symptoms. Suicidal thoughts, de-pression, helplessness, anxiety, anger, fear, amnesia, concentration defects, insomnia, headaches, nightmares, loss of resistance, sexual disorders and aches due to a specific trauma are among them[3].

Peterson[4] emphasizes that individuals tortured and forced to emigrate in recent years have further problems in their adopted countries. These people are cut off from their previous life; refugee experiences have created social and cultural difficulties for them. They have lost their families, native languages, friends, cultures, social status and ideals. Cultural shock threatens their identities. Effects of torture are mixed with this sudden change, destroying their beliefs. These experiences cause apathy, depression, feelings of guilt, loss of self-confidence in them.

Researches have shown that psychological effects of torture persist for a long time. According to reports of Allodi and Cowgill, anxiety, nightmares of experienced torture, somatic symptoms and phobias caused by fear prevail in the individual for long periods. Studies on physical and mental health of torture victims

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have shown that although their psychological state improves in time, effects of torture never totally vanishes[5]. Gonsalves[6] have reported that though 32 Chilean political exiles living in the USA were deeply depressed when they arrived at the country, in two months' time of living in the camp they were experiencing totally positive feelings and the depression seen on their arrival was never observed again.

Studies on psychological symptoms of torture victims have reported that depression and anxiety were the most frequent findings. Studies conducted in other countries have reported 14% to 88% anxiety and 17% to 71% depression in torture victims. In the studies conducted in Turkey, these percentages were 17% to 48% and 4% to 57%, respectively. Although percentages vary in every study, they are relatively lower in those conducted in Turkey. Similarly, percentage of reporting at least one mental symptom is lower in the studies conducted in Turkey (33.5 %) than foreign studies (68 %)[7,8].

This study aims to determine whether depression, state and trait anxiety, and hopelessness seen in tortured individuals differ from other people and change due to situational facts, and to investigate differences in recovery periods of hopelessness, depression and state and trait anxiety between individuals who had left Turkey after being tortured and who are still living in Turkey.

Studies on torture, with their multidisciplinary properties, have recently begun to come into significance, and seem to have focused mainly on posttraumatic stress disorder (PTSD), sexual disorders, family interactions and therapies, and relations between torture, depression and anxiety. In our study, we evaluated general anxiety and depression levels in tortured individuals with mainly physical complaints, accounting for refugee status, as well.

## METHOD

### Subjects

This study was conducted in 1991-1992. Twenty-six individuals referred to the Human Rights Foundation of Turkey Ankara Treatment and Rehabilitation Center with physical complaints and agreed to participate, and 25 others who emigrated to Sweden as political refugees following torture experiences in Turkey, were included in the study. Those referred to the HRFT had been imprisoned for six to ten years and were released on parole, in 1991. As female referrals to the Center in 1991-1992 were not numerous, all subjects of this group were males. Consequently, the refugee group comprised of male subjects, too.

Control group used to evaluate and compare the mental symptoms of the above groups consisted of 40 individuals chosen from health personnel and students. Twenty of these were students and 20 were doctors. In selection of this group, besides comparability of gender and age, having no chronic physical or

mental disorders, and no referrals to a psychologist or psychiatrist with a mental illness in the previous two years, were considered to be the main criteria.

**Data collection tools**

Beck Depression Inventory, Beck Hopelessness Scale and State-Trait Anxiety Inventory were used in this study.

## RESULTS

Those who continued to live in Turkey after the torture experience, filled the questionnaires at least one, at the most six months after they were released from prison. Their mean age at that time was 32.00. One of them was a university graduate, 5 were high school graduates and 20 had abandoned high school. As they were just released from prison all of them were unemployed. All the partici-pants emphasized that they had remained in detention for 90 days and tortured both there and in prison.

Mean age of refugees abroad was 34.70 at the time they participated in the study. Six of them were university graduates, 4 had abandoned university, 8 were high school graduates, 1 had abandoned high school, 3 were secondary school graduates and 3 were primary school graduates. Two of the participants claimed to be journalists, 2 were teachers, 1 was technical expert, 3 were labor-ers and 17 reported that they had no profession. Their time spent abroad was 3 to 10 years. Detention period for this group was 15 to 90 days. They stated that they had been tortured in this period.

Control group consisted of doctors and students with no history of deten-tion or prison life. Mean age of doctors was 25.62. The group included 10 male physicians working at the Hacettepe University as research assistants and 10 others from the Batıkent Health Center. The second control group comprised 20 male students from various universities in Ankara. Their mean age was 22.07.

Torture methods used are shown in Table 1.

**Table 1. Torture methods used**

| Method | n | % |
|---|---|---|
| **Blindfolding** | 51 | 100.00 |
| **Beating** | 51 | 100.00 |
| **Threatening** | 51 | 100.00 |
| **Insulting** | 51 | 100.00 |
| **Forcing to listen or to watch torture of others** | 23 | 45.09 |
| **Hanging** | 45 | 88.23 |
| **Exposure to electricity** | 45 | 88.23 |

| | | |
|---|---|---|
| **Cell** | 30 | 58.82 |
| **Falanga** | 30 | 58.82 |
| **Restricting water and food** | 20 | 39.21 |
| **Pressurized water** | 22 | 43.13 |
| **Exposing to cold floor** | 11 | 21.56 |
| **Mock execution** | 7 | 13.72 |
| **Insertion of objects into anus** | 4 | 7.84 |
| **Prevention of sleeping** | 18 | 35.29 |
| **Sexual harassment** | 10 | 19.60 |
| **Cell isolation** | 15 | 29.41 |
| **Cramming in a tire** | 4 | 7.84 |
| **Forcing to watch a friend killed** | 3 | 5.88 |

Mean scores and standard deviations from the used scales, of tortured groups living in Turkey (group 1), living abroad (group 2), and control groups of doctors (group 3) and students (group 4) are given in Table 2.

One-way variance analysis was performed to observe the differences between the tortured groups living in Turkey, living abroad, and control groups of doctors and students. Table 3 shows a significant difference in Beck Depression Scale points of the tortured groups living in Turkey, living abroad and control groups of doctors and students according to the analysis of variance ($F=4.08$; $p<0.05$). Tukey-Kramer test was used to define significant differences. According to Tukey-Kramer test results, refugee group's and doctor group's mean scores of depression scale were significantly different from the other two groups (mean scores 14.72, 5.40, respectively; $q=4.93$, $p<0.05$).

**Table 2. Means and standard deviations from the used scales**

| **Scales** | **Group 1**<br>**n: 26** | **Group 2**<br>**n: 25** | **Group 3**<br>**n: 20** | **Group 4**<br>**n: 20** |
|---|---|---|---|---|
| **Beck Depression Inventory** | $\bar{x}_j$ = 9.23<br>$s_j$ = 7.29 | $\bar{x}_j$ = 14.72<br>$s_j$ = 12.90 | $\bar{x}_j$ = 9.80<br>$s_j$ = 6.80 | $\bar{x}_j$ = 5.40<br>$s_j$ = 4.40 |
| **Beck Hopelessness Scale** | $\bar{x}_j$= 4.50<br>$s_j$= 0.87 | $\bar{x}_j$ = 6.20<br>$s_j$ = 5.20 | $\bar{x}_j$ = 4.90<br>$s_j$ = 3.70 | $\bar{x}_j$ = 5.10<br>$s_j$ = 3.50 |
| **State Anxiety Inventory** | $\bar{x}_j$ = 60.96<br>$s_j$ = 8.06 | $\bar{x}_j$ = 60.60<br>$s_j$ = 7.39 | $\bar{x}_j$ = 59.10<br>$s_j$ = 5.12 | $\bar{x}_j$ = 60.55<br>$s_j$ = 7.24 |

| | | | | |
|---|---|---|---|---|
| **Trait Anxiety Inventory** | $\bar{x}_j$ = 45.73<br>$s_j$ = 6.70 | $\bar{x}_j$ = 46.44<br>$s_j$ = 8.58 | $\bar{x}_j$ = 43.80<br>$s_j$ = 7.90 | $\bar{x}_j$ = 40.25<br>$s_j$ = 3.22 |

**Table 3. ANOVA table of Beck Depression Scale scores**

| Source | Sum of squares | $s_j$ | Mean square | F | p |
|---|---|---|---|---|---|
| **Between groups** | 975.64 | 3 | 325.21 | 4.08 | 0.05 |
| **Error** | 6929.04 | 87 | 79.64 | | |
| **Total** | 7904.68 | 90 | | | |

$F_{0.05}$ (3-87) = 2.70

As seen in Table 4, no significant difference could be found in Beck Hope-lessness Scale scores of the tortured groups living in Turkey, living abroad, and control groups of doctors and students according to the analysis of variance.

**Table 4. ANOVA table of Beck Hopelessness Scale scores**

| Source | Sum of squares | $s_j$ | Mean square | F |
|---|---|---|---|---|
| **Between groups** | 32.46 | 3 | 10.82 | 0.63 |
| **Error** | 1483.29 | 87 | 17.04 | |
| **Total** | 1515.75 | 90 | | |

$F_{0.05}$ (3-87) = 2.70

One-way variance analysis displayed no significant difference in State Anxiety Inventory scores of the tortured groups living in Turkey, living abroad and control groups of doctors and students, as seen in Table 5.

**Table 5. ANOVA table of State Anxiety Inventory scores**

| Source | Sum of squares | $s_j$ | Mean square | F |
|---|---|---|---|---|
| **Between groups** | 84.75 | 3 | 28.25 | 2.50 |
| **Error** | 981.68 | 87 | 11.28 | |
| **Total** | 1066.44 | 90 | | |

$F_{0.05}$ (3-87) = 2.70

Table 6 shows significant differences in Trait Anxiety Scale scores of the tortured groups living in Turkey, living abroad and control groups of doctors and students according to the one way analysis of variance($F=3.39$, $p<0.05$). Tukey-Kramer test was used to define significant differences. According to Tukey-Kramer test results State Anxiety Inventory scores of tortured group living in Turkey and doctors group, and of the refugee group and doctors group were significantly different from the other group (46.44, 40.25, $q=3.95$, $p<0.05$).

**Table 6. ANOVA table of Trait Anxiety Inventory scores**

| Source | Sum of squares | $s_j$ | Mean square | F | p |
|---|---|---|---|---|---|
| **Between groups** | 500.76 | 3 | 166.92 | 3.39 | 0.05 |
| **Error** | 4272.22 | 87 | 49.10 | | |
| **Total** | 4772.98 | 90 | | | |

$F_{0.05}$ (3-87) = 2.70

## DISCUSSION

Torture is an important human rights violation on Turkey's agenda. Most of the current studies on torture victims, in Turkey and worldwide, focus on PTSD, sexual problems and treatment of the victims. This study, on the other hand, fo-cused on depression, state and trait anxiety, hopelessness of tortured individuals still living in Turkey and emigrated abroad.

### It was concluded that

**1.** There is a significant difference between Beck Depression Scale scores of refugees and doctors. Torture experiences, life abroad, cultural differences, language problem, unemployment and loss of family and relatives on refugees' side may play great role in that.

**2.** No significant differences were observed in Beck Hopelessness Scores of both groups of tortured subjects and controls. When the researches saying that hopelessness is the peak of depression are considered, it may be thought that the insignificant relationship between hopelessness scores of groups may be par-allel to depression scores. Although Beck claims that depressives have negative thoughts towards the future, in our study tortured subjects did not seem to have negative thoughts about the future. This brings into consideration that depressive behavior may be a way of defense for tortured subjects.

**3.** State anxiety due to threatening circumstances is a temporary anxiety type. On the other hand, trait anxiety is due to continuously stressful interpretation of circumstantial stimulants. There was no significant difference between the groups in state anxiety. This indicates that tortured subjects, including the refu-gees, do not act differently than the controls (doctors and students).

**4.** In trait anxiety inventory scores' analysis, there was a significant differ-ence between refugees and doctors. This finding may be explained as due to be-ing unable to return home, cultural differences, language problems, loss of friends and family, being unable to find employment. The fact that tortured sub-jects still living in Turkey does show a significant difference in trait anxiety, sup-ports our assumption. Employment anxieties of these individuals who had not been able to complete their education and consequently do not have a job be-cause of long prison terms, and their economic dependence to their families,

constant fear of being detained again, may explain this difference. We plan to investigate these facts minutely in a future study.

Although our study has moderately contributed to the subject in hand, we think that more detailed studies are necessary. We believe, for example, better scales for differentiating depression, state and trait anxiety are needed.

Apart from that, we believe another study on differences of depression and anxiety disorders between tortured individuals living abroad and those who have never been tortured, detained or imprisoned but left the country for occupational reasons, will contribute to the subject.

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# PSYCHOTHERAPEUTIC APPROACHES TO THE PSYCHOLOGICAL CONSEQUENCES OF TORTURE

**Evin Kantemir***

## INTRODUCTION

Despite the numerous international conventions against torture and efforts to control its occurrence, according to the 1994 Amnesty International Report, prisoners were subjected to torture or ill treatment in more than a hundred countries of the world during the previous year[1]. It appears that the above-mentioned measures have limited efficacy in preventing torture. Under these circumstances, the treatment of physical and psychological sequelae that occur as a result of organized violence attains utmost importance, both in relevance to the prevention of sustained injury in the victims, and the enhancement of public awareness and the interest of various professional groups regarding this issue.

During the last two decades, there has been an increased interest in the medical and psychological sequelae of torture among health professionals, that resulted in a relatively rapid accumulation of scientific information on the subject. This interest could have been prompted partly by the current debates surrounding human rights' issues, as well as the growing population of political refugees in Western countries which directed the attention of health care providers to the consequences of organized violence[2]. However, considering the prevalence of this human rights' violation and the size of the damage it causes, existing information on the effects of torture, as well as the number of people and organizations concerned with the care of survivors still remain inadequate.

Exposure to torture, affects the individual both physically and psychosocially. Initial studies that investigated the sequelae of torture, were mainly descriptive and carried out by the medical groups that have their origins in the activities of Amnesty International. These studies which have made an important contribution to the recognition of the subject in the medical community, have been published in various reports[3].

Psychological problems that arise as a result of torture are complex, and several stressors that are independent of the torture/captivity experience or are considered to be its secondary consequences, as well as factors that are directly related to the conditions surrounding the torture situation, may play a role in the

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long-term psychological outcome of the individual[4]. Some investigators attempted to define a "specific torture syndrome," but these formulations were criticized for lacking a theoretical framework[5]. Psychological problems that arise as a consequence of torture comprise a wide spectrum of symptoms that include memory defects, loss of concentration, emotional numbness, anxiety, depression, apathy, avoidance of social contact, headaches, sleep disorders, and sexual dysfunction.

Although the clinical picture shows considerable variation from one individual to another, the most commonly observed symptoms in survivors of torture are anxiety-related[5]. Therefore, posttorture psychological problems are often discussed in context of posttraumatic stress disorder (PTSD), a category included under anxiety disorders in Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III)[6]. Torture is only one of the various types of trauma that, according to the diagnostic criteria of this disorder, could be an etiologic factor in PTSD.

Although PTSD is frequently diagnosed in populations of torture survivors, both the diagnostic category and its relevance to this particular group of trauma victims have remained controversial. The discussions surrounding PTSD as a diagnostic category have focused on the lack of a universal standard to define "trauma leading to marked distress"; the rapid changes which the diagnostic criteria have been subjected to; and its taxonomic inadequacy as a subcategory of anxiety disorders which in turn are classified under mental disorders. The other aspect of the debate surrounding PTSD which involves its relevance to torture survivors, entails criticism pointing out that this diagnostic formulation is too limited to reflect the suffering of people subjected to prolonged trauma, which is usually the case with political survivors of torture. Another argument is that torture, because it is of human design, represents a unique trauma, with more severe and prolonged consequences, compared to those of other types of trauma[4]. Despite these arguments, PTSD has been validated as a diagnostic entity by various studies and biological investigations demonstrating its association with alterations in sympathetic nervous system arousal, the hypothalamic-pituitary-adrenocortical axis, the endogenous opioid system, and the sleep cycle[7].

It should be noted that both the formulation of posttorture problems and the treatment approaches used in such cases, rely to a great extent on studies concerning survivors of other types of trauma. An explanation for this situation could be that, to date, relatively little empirical information has accumulated concerning torture. This is due to a number of factors including the politically sensitive nature of the subject; the difficulty of distinguishing the direct consequences of torture from symptoms related to the refugee status in the majority of existing work which addresses refugee populations in the West; and

the reluctance of many investigators to approach this group of patients with a strictly scientific attitude[4]. Therefore, the treatment approaches utilized in cases of post-torture psychological problems, have been adopted mainly from studies on PTSD cases associated with etiologic factors other than torture. It seems that many of the results derived from populations exposed to combat trauma, can be applied to the study of torture victims, since certain important issues such as helplessness, terror, bodily injury, and feelings of guilt and responsibility over the experience, are shared by both forms of trauma[8]. Therefore, this article addresses investigations related to PTSD in general, as well as studies and hypotheses pertaining specifically to torture survivors.

A variety of treatments have been employed to assist in the resolution of psychological problems in traumatized individuals, but clearly these methods do not all provide the same therapeutic benefits[8]. It is difficult to judge the relative efficacy of any particular method of treatment with the currently available data, and the "natural history" of the effects of torture has not been described. Therefore, at present, the choice of a therapeutic method among the numerous approaches used in the psychological treatment of this group of patients depends mainly on the theoretical orientation of the mental health care professional. On the other hand, most writers suggest that the adoption of a flexible treatment approach, in which various perspectives can be considered according to the needs of the individual patient in question, is the best way to handle this group of patients[9]. This article provides a brief description of the current treatment approaches to posttorture psychological disorders.

When a person subjected to torture presents for psychological help, an initial interview and assessment are made, followed by a decision on therapeutic goals and the methods to be employed in the treatment process. Depending on the conditions of the individual case, a choice is made between stimulating long-term changes in certain aspects of the patient's personality which hinder the resolution of the trauma experience, or trying to achieve more adequate functioning as soon as possible[9]. Similar to the approach in victims of other forms of trauma, the currently employed methods of treatment in psychological disorders associated with torture are pharmacotherapy; individual psychotherapies with behavioral, cognitive or psychodynamic orientations; and various methods of group treatments, including family therapy.

Pharmacological treatment of torture survivors, is not addressed in this article. However we should note that biological approaches to the diagnosis and treatment of posttorture problems are receiving increasing attention from both clinicians and scientific investigators. According to the current understanding, psychotherapy continues to be the mainstay of treatment in posttorture psychological problems. Drug treatment, on the other hand, appears to be the most useful adjunct to psychotherapy, and it is suggested that that a biological

approach may complement psychological diagnostic and therapeutic techniques[7].

**PSYCHODYNAMIC APPROACH**

Psychodynamic psychotherapy, particularly in Latin American countries which have a strong psychoanalytic tradition, is among the most widely used approaches used in the treatment of this group of patients. The core of the psychodynamic approach is the intrapsychic processing of the trauma experience by obtaining insight into the past trauma. According to the psychodynamic assumption, individuals exposed to trauma have the need to integrate this experience into their understanding of the meaning of life, self-concept, and world image. The purpose of treatment is to allow the patients to work through the traumatic experience and resolve the discrepancy between internal and external information[10].

Several interpretations of PTSD and suggestions for its treatment have been developed within the context of psychodynamic theory. One of these approaches is based on Horowitz's[11] classification of different phases of PTSD according to the nature and degree of success of the predominant coping mechanisms used by the patient during that period. Horowitz suggests that during the phase of intrusive repetition, characterized by weakening of defenses, supportive techniques are needed to make the patient feel more in control, ameliorate his distress, and prevent regression. During the phase of denial, on the other hand, uncovering techniques, emphasizing the interpretation of defenses, should be utilized[11,12].

There have been two uncontrolled systematic studies addressing the efficacy of the psychodynamic approach in stress responses to trauma. In the study by Horowitz et al,[13] 54 cases, with only 14 fulfilling the criteria for PTSD, completed a short course of psychodynamic psychotherapy. The results of the meas-urements used in the study showed that at the end of the treatment period there was an improvement in occupational and interpersonal functioning as well as the capacity for intimate relations. However, a later meta-analysis[14] of psychotherapy outcomes, found that this improvement did not differ from that of untreated controls. The study by Lindy et al.,[15] reported that 10 of the 30 cases who received psychodynamic treatment showed an improvement in symptoms. These two studies represent an important initial step in the systematic evaluation of dynamic psychotherapy in syndromes associated with the stress response. Solomon et al,[10] in their review of literature on treatments for PTSD, found only one controlled study of psychodynamic therapy in this group of patients. In this study[16], patients receiving psychodynamic therapy, hypnotherapy, and systematic desensitization were compared with a waiting list control group. Patients in the three treatment groups, showed greater improvement of

symptoms than the control group. There appeared to be a greater improvement in avoidance symptoms, and less reduction in intrusion symptoms in the group receiving psychodynamic therapy.

The recent findings concerning torture trauma suggest that traditional psychodynamic treatment strategies should be revised before they are applied to torture survivors. It is recommended that the therapist using a psychodynamic technique in this group of patients, should adopt a more flexible approach, recognizing the needs of the patient at each stage of treatment and using appropriate interventions[17].

**BEHAVIORAL APPROACH**

According to behavioral theory, symptoms of fear and avoidance that develop in individuals exposed to trauma is regarded as a consequence of the pair-ing of a previously neutral stimulus with an innately frightening stimulus associated with the trauma. Behavioral interventions in such cases are designed to reduce anxiety by means of repeated or extended exposure to objectively harmless but feared stimuli. This exposure can be in vivo or imaginary[17]. Direct therapeutic exposure methods such as desensitization, flooding and implosive therapy have been used in traumatized individuals, and the results have been encouraging[7].

Systematic desensitization is based on the conditioning of competing responses. The patient is asked to employ a relaxation technique as he is presented a graduated series of increasingly anxiety-provoking cues. At the end of this process, he learns to associate the cues with feelings of relaxation rather than with anxiety. Thus, the anxiety response becomes deconditioned, being replaced with an alternative response[18].

Solomon et al,[10] in their review of PTSD treatments, found two controlled studies addressing the efficacy of systematic desensitization. The study by Peniston,[19] demonstrated that a program of relaxation and a 30-minute session of imaginary desensitization was superior to no treatment in terms of reducing nightmares, flashbacks, and muscle tension, with the treatment effect persisting through the 2-year follow-up period. The above-mentioned study by Brom et al.,[16] found that the systematic desensitization group, as well as the two other treatment groups, achieved more improvement in symptoms, compared to the control group.

In flooding and implosive therapy, the patient is directed to repeatedly and systematically imagine all aspects of the trauma, by presentation of anxiety-provoking cues in the context of a supportive relationship with the therapist. The patient is asked to vividly recall trauma stimuli, with the therapist promoting the re-experience of the event. This arousal is maintained as the patient becomes less aroused with the trauma memories within and across sessions, until the symptoms extinguish. The basic difference between flooding and implosive

therapy is that in flooding the patient is directed to imagine stimuli that are real or specific to the trauma situation, while implosive therapy involves imagination of all possible conditioned stimuli, including faulty beliefs and value systems[7].

Cases of severe complications have been recently reported in the use of flooding for PTSD, including exacerbation of depression, relapse of alcoholism, and precipitation of panic disorder[10]. Other authors, however, argue that it is appropriate and ethical to present conditioned stimulus cues which, although distressing to the patient are not themselves inherently harmful[18].

Initial studies involving flooding and implosive therapy in the treatment of posttraumatic disorders, were in the form of case reports. Studies on the flooding technique[20,21] or implosive therapy[22,23] reported an improvement in anxiety levels as well as intrusive symptoms associated with PTSD. More recently, randomized and controlled studies have been conducted to test the efficacy of these two methods. In the study by Keane et al.[24], 24 PTSD cases received 12-14 sessions of implosive therapy. At the end of the 6-month follow-up period, the treatment group showed a greater improvement than the control subjects with respect to depression, anxiety and flashback symptoms. Cooper and Clum,[25] in their study comparing a "standard" PTSD treatment program with the same standard treatment supplemented with flooding, found that the latter approach was superior in efficacy. In another study, Boudewyns and Hyer,[26] who compared implosive therapy with conventional counseling, observed a greater improvement, especially with respect to the arousal symptoms, in the implosive therapy group. In the study by Foe et al.,[27] prolonged exposure was compared with stress inoculation training, supportive counseling, and a control group. Evaluation of the patients immediately following treatment revealed that stress inoculation training had been the most effective among the three treatments; however in the follow-up evaluation 3.5 months later, prolonged exposure was shown to be superior to the other therapies.

Results of studies addressing these three techniques of behavior therapy suggest that therapeutic approaches based on exposure, produce a significant reduction in symptoms associated with trauma. However these treatments do not reduce all of the trauma-related symptoms to an equal extent. Exposure appears to have the greatest impact on the "positive", anxiety-based symptoms such as startle reaction, psychophysiological arousal, nightmares, irritability and feelings of anger, while "negative" symptoms such as numbing, and alienation remain relatively uneffected. In that case, additional treatments targeting negative symptoms may be necessary in order to achieve a better therapeutic outcome[7].

## COGNITIVE AND COGNITIVE-BEHAVIORAL APPROACHES

The cognitive approach in psychology, deals primarily with thought processes, acquisition and use of knowledge, and evaluation of experiences[28].

Despite its recognition as an effective treatment for depression, the role of cognitive therapy in anxiety disorders remains untested. However, the potential benefit of this approach in the treatment of PTSD which develops as a result of torture trauma, and the prevalence of depression that so often accompanies such cases, necessitate further investigations pertaining to the role of cognitive techniques in this therapeutic area[29].

According to cognitive theory, the psychological consequences of trauma are interpreted in terms of coping and attributional styles used by the patient in approaching his problems. The coping style adopted by the individual confronted with a trauma, determines the degree of damage he sustains. For example, it is suggested individuals who, when confronted with a trauma, attempt to change their responses by perceiving their experiences from a different perspective, have a better outcome than those who direct their energy to controlling their own emotional responses[28].

The trauma experience shatters the basic assumption that the world is meaningful and just and the illusion of personal invulnerability, that misfortune can be prevented by being cautious and behaving decently. Thus, the individual's perception of the world and self-image is altered; he feels powerless in a threatening world, interpreting formerly neutral phenomena as heralding danger. Accordingly, the patient has to go through a cognitive process in which he integrates his traumatic experiences with this new conception of the world and self[28].

Cognitive-behavioral therapy, which is based on a combination of cognitive and behavioral approaches, focuses on thoughts, convictions and cognitive strategies in solving problems as well as overt, observable action, contending that these patterns are susceptible to modification through instruction and education. With regard to trauma survivors, this approach involves training in alternative coping behaviors, cognitive restructuring, and elimination of conditioned responses associated with the trauma experience[28].

Although the efficacy of cognitive-behavioral therapy remains untested, it is reasonable to expect a greater benefit from the combination of these techniques. To date, several cognitive techniques have been developed to reduce anxiety by providing patients with skills to control fear. The best recognized of these cognitive strategies, "stress inoculation training" of Kilpatrick et al., is a treatment program consisting of a combination of several techniques including muscle relaxation, thought stopping, breathing control, communication skills, and guided self-dialogue. This last technique consists of cognitive restructuring by modifying the patient's thinking and underlying assumptions[10].

To date, there has been only one report with a case study design, evaluating the efficacy cognitive therapy[8] and the above-mentioned randomized,

controlled trial by Foe et al,[27] in which one of the treatment groups received stress inoculation training. Considering the potential benefit these methods may provide for trauma patients, research on their efficacy is clearly needed.

## OTHER TREATMENTS

### Testimony Method

This method was first developed by Cienfuegos and Monelli[30] as a consequence of their work with patients who had been subjected to torture in Chile during the military regime. The authors, claim that torture and other acts of violence which have a disrupting affect on cognitive and emotional functions lead to difficulties in the application of conventional psychotherapy techniques, and that the testimony method provides the self-esteem and trusting relationship with the therapist, which is necessary in dynamic psychotherapy. They also suggest that the therapeutic effect of this method is mainly linked to the relief of anxiety and depression resulting from the traumatic experience.

The testimony method involves the preparation of a document giving all the details about the torture experience, to be used in the future as evidence against the perpetrators. The therapist helps the patient in the preparation of the document and addresses the psychological reactions that occur during this process. Although there is, as yet, no evidence which supports the efficacy of this intervention, it is reasonable to expect a therapeutic benefit from this procedure which seems to alter the survivor's cognition of helplessness associated with the torture experience, and help him perceive the situation as an effective instrument of political struggle. Besides, the favourable outcome suggested by the authors is consistent with other experiences concerning former political prisoners, suggesting that those who had the opportunity to talk spontaneously to others about their pain and torture, had better outcomes in affective functions, compared to those who had a shorter term of imprisonment.

According to some authors, bearing of testimony is a cathartic healing process during which the torture experience is "reframed"; other authors, however, point out that this procedure shares the same therapeutic ingredient with cognitive restructuring[29].

### Skills training

Skills training interventions have been employed to address target symptoms in a variety of patient populations. It has been suggested that the trauma experience can lead to social avoidance through disruption of previously learned behavior patterns in the individual. Skills training involves promoting previously learned and new adaptive behavior patterns. Examples of target behaviors include social skills, assertiveness, stress management and anger control. Techniques such as role playing, cognitive restructuring, in vivo exposure

exercises, and relaxation training are utilized in skill acquisition. This approach may be especially useful in the treatment of negative symptoms of PTSD. On the other hand, positive symptoms of PTSD such as sleep disturbances, fear, and anxiety may be treated by relaxation training, guided imagery, stimulus control procedures, cognitive restructuring, and guided exposure[8].

**Group therapy**

Group therapy is believed to provide a mechanism for attaining therapeutic benefits separate from those derived through individual therapy. Yalom,[31] in his classical work on group therapy, summarized these benefits which include (1) instillation of hope, (2) universality, (3) imparting of information, (4) altruism, (5) the corrective recapitulation of the primary family group, (6) development of socializing techniques, (7) imitative behavior, (8) interpersonal learning, (9) group cohesiveness, (10) catharsis, and (11) existential factors. In survivors of torture, group environment may also facilitate exposure to trauma-related stimuli, through sharing with other members, experiences which reactivate painful memories associated with the trauma[8].

Group therapy has been successful in the treatment of a number of traumatized populations;[8] however, the only report on the efficacy of this method in torture survivors is the study by Fischman and Ross,[32] which describes a time-limited group treatment of exiled survivors of torture from Central and South America. Similar to other groups for trauma survivors, the group reported on in this study was a short-term, homogeneous one, whose members shared a common special condition. The core group consisted of 8 patients, who sustained typical posttraumatic somatic and psychological symptoms and the duration of treatment was 6 months, with one session per week. The main focus of the first sessions was to build trust and enhance group cohesiveness. Subsequent sessions addressed thematic conflicts common to torture survivors, such as fear of destroying others, fear of loss of control over feelings, shame and rage over the vulnerability and helplessness evoked by torture, guilt and shame over surviving, fear and rage at the unpredictability of and lack of control over events, and grief over the loss of significant others. Group members were made aware of the specific goals of torture, and events that triggered the symptoms that had developed as a consequence of torture. The identification of these triggers, coupled with the use of specific relaxation techniques, contributed to a decrease in the frequency of symptoms. The group members were also requested to write about their feelings concerning the torture event; this information was integrated in a collective testimony, which facilitated the perception of the traumatic experiences in their sociopolitical context. As treatment progressed, group members were encouraged to focus on difficulties concerning current life situations, with the aim of improving their functional state.

During the termination phase, each member's progress was evaluated and three follow-up sessions were scheduled for the following months to temper the impact of termination. The evaluation of the authors on this particular group experience, is based on subjective impression that some of the participants attained a new perspective on their torture experiences and developed a capacity to reassess their symptoms, which allowed them to feel less alone and less disturbed. Most of the patients reported relief of symptoms of anxiety, nightmares, and intrusive thoughts which they had experienced before treatment[32].

The positive treatment results reported in this study were based on subjective evaluations. Nevertheless, it is possible that group treatment can facilitate cure, by bringing together people with similar traumatic experiences which serves to validate what was previously considered a unique personal reality, and helps the participants to ascribe meaning to and integrate this experience into their lives. There is a need for further studies to identify the group of patients among trauma survivors who can benefit most from group therapy aimed to assess the relative effectiveness of this type of treatment compared to other modes of treatment[32].

**Acute interventions following trauma**

Timing of the therapeutic intervention is critical in the treatment of trauma survivors. In general, intervention during the period immediately after the trauma experience, when the disrupted cognitive, physiological, and behavioral patterns of the individual have not yet had time to become firmly established, appear to provide the greatest benefit. Evidence for this contention is provided in studies concerning persons exposed to battle trauma[8].

Immediately after the trauma exposure, the treatment of choice is to permit survivors to emotionally and cognitively process the experience with other survivors or trained professionals. The critical intervention in trauma debriefing is the education of survivors about the psychological effects of trauma, which will reduce their responses to the symptoms of stress, depression, guilt, sleep disturbance, and intrusive thoughts, that are frequently observed after the traumatic incident. When treatment is to be delivered immediately after traumatization, behavioral interventions can be modified to accommodate more acute manifestations of the disorder. During the acute-crisis period of treatment, anxiety or mood disturbances can be treated in the short term with anxiolitics or sedatives. Social support, which seems to be lacking in some traumatized populations, is essential at this stage, to enhance the traumatized individual's sense of "belongingness"[8].

**Family therapy**

It is essential to recognize the impact of the trauma on the survivor's family. In cases who are imprisoned after detention, the family's homeostasis is affected during the absence of the individual in question, and the family system has to be reorganized when he returns. Attempts to restore the original distribution of roles often lead to discord in the family. Therefore, it is recommended that family therapy be integrated into the rehabilitation program for survivors of torture[32].

Moreover, it has been reported that acute stress that is experienced during the trauma event, may recur during the period of readjustment to family and daily life. Family interactions, both affect and are affected by the psychological problems of the individual who has been exposed to trauma[8].

The therapist should also assess the impact of the trauma survivor's psychological disorder on family interactions, as well as the severity of the disorder, and direct his interventions to address both the stress disorder and the related dysfunctions within the family system. The results of a study evaluating family interaction in combat-related PTSD cases, suggested that family therapy had a positive effect on outcome[8].

Figley,[33] developed a five-phase family systems model to facilitate the individual's return to his previous level of functioning within the family. These phases include, (1) achieving commitment to therapeutic objectives; (2) framing the problem through testimonials; (3) reframing the problem to help the family in managing crises; (4) developing a "Healing Theory" which contains adaptive statements on the traumatic event, the responses of the family members, and a positive approach to possible future problems; and (5) reinforcement of the family's accomplishment. To date, this model has not been tested by controlled studies[8].

**COMMENTS**

The various psychotherapeutic approaches described in this article, all involve the expression by the patient of his feelings associated with the trauma, in a safe and therapeutic atmosphere where he has a chance to regain control over events and integrate the painful experience into his understanding of the meaning of life. This common ingredient is present in the process of "releasing unconscious material to integrate the traumatic event" during psychodynamic treatment; reexperience of the trauma in exposure-based behavioral techniques; and cognitive restructuring in cognitive psychotherapy. At present, however, the critical mechanism of effect in these various methods of treatment, remain unverified[29].

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# IMPACT OF SEXUAL TORTURE

**Şahika Yüksel***

## INTRODUCTION

The primary aim of torture is to break down an individual's personal and political identity through exertion of physical and/or psychological pain, rather than obtain a confession or information[1]. A great number of studies show that torture and organized violence have strong psychological after-effects on the survivors[2,3,4]. Although it is generally considered that being subjected to sexual torture affects a person's mental status in a way that is different from non-sexual torture, there are only a few studies on this subject[5,6].

There is no consensus on what comprises sexual torture; however, various authors have emphasized that, considering gender, age and cultural and religious background, different practices can be perceived under this category. One of the most widely accepted definitions of sexual torture was made by van Willigen[5] in 1984: "Sexual torture is a form of violence whereby the difference in power between the stronger and the weak is interpreted in a sexual way and a person's integrity is directly attacked." In the present article, the term "sexual torture" is based on the above definition by van Willigen, which places this form of abuse within a political context.

Although the effects of sexual torture on mental health are not well known, numerous studies exist on the effects of female sexual abuse[7,8,9]. If we define sexual torture as a specific type of sexual abuse, we may expect these cases to experience problems similar to those that appear as a consequence of sexual abuse in general. Accordingly, information on the subject of sexual abuse is useful in helping us identify the specific effects of sexual torture.

Sexual abuse is not only a sexual act; it is also a form of violence that uses a wide spectrum of means of enforcement and humiliation against women and men. A series of enforced sexual acts can be accepted as sexual abuse, regardless of whether or not there is penetration, and penetration is not a determinant of the severity of subsequent problems. Long or short-term psychological difficulties develop as a consequence of sexual abuse. It is suggested that these difficulties frequently take the form of symptoms included in posttraumatic stress disorder.

The treatment of sexual abuse is still in its early phase. A well-known feature is that the exposed person will show more resistance to treatment if the trauma is not disclosed. However, persons who have experienced sexual abuse

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cannot disclose this information readily. Most of the time they present various psychological and somatic symptoms while the history of sexual abuse remains covered[10,11].

Sexual abuse is mostly experienced by women and children. A woman, although she may never have experienced sexual abuse, grows up knowing that she is under risk for such an assault because of her gender and from a very early age, experiences this more or less as a threat. Therefore, sexual abuse is expected to carry different meanings among genders. It is quite obvious that similar differences will be experienced across different cultures[9,10].

The following questions are addressed in this study:

**1.** What is included under sexual torture?

**2.** Are women more often subjected to sexual torture than men?

**3.** Do people subjected to sexual torture experience different psychological problems than those subjected to non-sexual torture?

**4.** Are somatic and sexual dysfunctions or other difficulties in the relationship with the partner more frequent in survivors of sexual torture?

## MATERIAL AND METHODS

Fifty cases, tortured during detention/arrest, who referred to the Psychiatry Department of İstanbul University for various psychiatric problems were as-sessed. Among these, 39 patients who met the inclusion criteria, were included in this study. The inclusion criteria were (1) to be 18 years of age or elder, (2) to have been under detention for a period of at least 15 days, (3) released from de-tention/prison at least one month prior to the interview and (4) experienced ill treatment or torture. Twenty-eight cases who met these criteria and had been subjected to sexual torture were included in the first group (Group 1), and 11 cases meeting the same criteria but who had been subjected only to non-sexual torture comprised the comparison group (Group 2).

Sexual abuse is a method that is used in conjunction with other methods, and is generally applied as the torture gets more "intense". Therefore, we must note that it is quite difficult to discriminate the effects of sexual torture from those of torture in general.

Part of the problem of determining whether sexual torture had been experienced by the subjects is that certain practices that are generally conceived as sexual torture, such as applying electric shocks to the genitals or threatening to rape a female relative of the detainee, may not be defined as such by the subjects themselves. For the purpose of this study, a broad definition of sexual torture was adopted, based on the reports of the interviewees. Accordingly, we cate-gorized sexual torture in two groups: (1) Physical practices such as anal or

vagi-nal penetration and (2) Psychological practices such as threatening to rape. The groups were assessed and compared with respect to the type of torture that was applied. In addition, the group exposed to sexual torture was further subdivided according to gender, and the two subgroups were compared.

Psychiatric diagnoses were made according to the Diagnostic and Statistical Manual of Mental Disorders, Revised Third Edition (DSM-III-R)[12]. The subjects were asked to complete the Hamilton Anxiety Scale (HAS)[13], Hamilton Depression Scale(HAD)[14], Symptom Checklist (SCL-90)[15] and Impact of Event Scale (IES)[16]. The subjects were questioned about their history of genitourinary diseases and their sexual life and problems with partners during both pre and posttrauma periods.

## RESULTS

### Sociodemographic characteristics

Approximately 75% of both groups consisted of men. None of the women in the non-sexual torture group had experienced imprisonment and they had the shortest detention period among the study population. There were no significant differences between the groups, with respect to age and education level. The number of married subjects was relatively high in the sexual torture group and most of them had married before the trauma event (Table 1).

### Traumatic events

Except for three cases, all participants were political prisoners. The length of imprisonment varied between 10 days and 10 years. In both groups, all the patients had been subjected to beating, electrical torture, and psychological torture. The mean number (±SD) of types of torture that had been applied was 7.35 (±2.1) in the sexual torture group, and 6.14 (±2.1) in the non-sexual torture group. The difference between the two groups was not statistically significant ($p<1.4$).

**Table 1. Sample characteristics**

| Characteristics | | Group 1 | Group 2 |
|---|---|---|---|
| **Sex** | Female | 7 | 3 |
| | Male | 21 | 8 |
| **Civil Status** | Single | 17 | 4 |
| | Married | 9 | 6 |
| | Divorced | 2 | 1 |
| **Age** | Range | 18-44 | 18-42 |
| | Average (±SD) | 29.9 (± 7.8) | 28.0 (± 6.0) |
| | Primary school | 4 | 6 |

| | | | |
|---|---|---|---|
| **Education** | High school | 13 | 5 |
| | University | 11 | 3 |

SD: Standard deviation.

In addition to undergoing various types of torture, most subjects from both groups had traumatic experiences such as unemployment, imprisonment, migration and divorce, both before and after torture. These events had an impact on different aspects of their lives.

**Sexual torture**

Incidents of sexual torture were rarely disclosed during the early interviews. Some cases who had actually stated that there had been no sexual torture at the onset of treatment, later disclosed that they had experienced some form of sexual humiliation. The most frequently reported sexual tortures were application of electric shocks to the genital organs in men, and leaving naked and threats of rape in women. Below are some examples of what these patients had experienced:

-A woman: "When they were searching my house in the presence of my boyfriend, they tossed my underwear on the ground and humiliated me both orally and with their glances."

-A young woman: "I was lucky that they never undressed me, but they often threatened to do so."

-A woman: "They told me that my mother was in the other room and that they were going to rape her because of me."

-A young man: "They told me that they will rape me. Finally they inserted a stick into my anus. While I was suffering physical pain, they laughed and humili-ated me, saying 'You are no longer a man from now on.' While I was blindfolded, they raped a girl and afterwards said, now it is your turn."

**Table 2. Types of sexual torture**

| Torture methods | Female (7) | Male (21) | Total(28) |
|---|---|---|---|
| **Applying electricity to the genital organs** | 1 | 12 | 13 |
| **Threat of rape** | 5 | 2 | 7 |
| **Inserting an object into genitals/anus** | 2 | 2 | 4 |
| **Leaving naked** | 2 | - | 2 |
| **Threat of leaving naked** | 4 | - | 4 |
| **Threat of rape to spouse/relatives** | 1 | 3 | 4 |
| **Sexual humiliation*** | 6 | 12 | 18 |

* **For female:** “ugly”, “dirty”, "deprived of womanhood", “forced to urinate in front of the others”.
**For men:** "deprived of manhood", "threatening that he will become homosexual"

Although none of the persons who were interviewed reported a history of psychiatric disorders prior to the traumatic experience, they fulfilled the DSM-III-R criteria for at least one psychiatric disorder at the time of the interview. As shown in Table 3, there were no significant differences between the groups, anxiety disorders and PTSD being the most frequently diagnosed disorders in both groups. However, there was a tendency to have received multiple diagnoses among the sexual torture group.

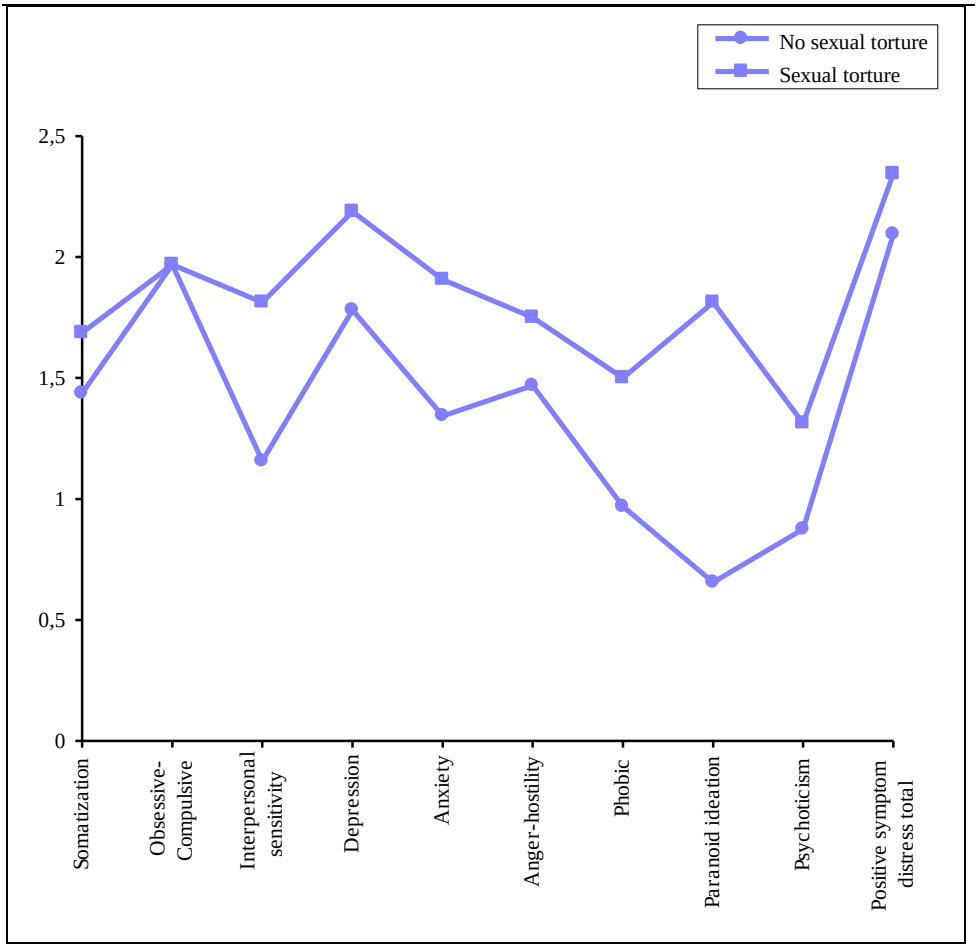
**Table 3. Distribution of diagnosis among the two groups**

| Diagnosis | Group 1 | Group 2 |
|---|---|---|
| **Anxiety disorders** | 24 | 9 |
| **-PTSD** | 11 | 2 |
| **-Complicated PTSD** | 8 | 5 |
| **-Unspecified anxiety disorder** | 5 | 2 |
| **Major depressive episode** | 9 | 4 |
| **Somatoform disorder** | 8 | 3 |
| **Psychotic disorder** | 5 | 2 |
| **-Atypical psychosis** | 1 | - |
| **-Brief psychotic episode** | 4 | 2 |
| **Paranoid personality disorder** | 2 | 1 |

**Note:** As each patient may have more than one diagnosis, the total number of diagnoses may exceed the total number of cases.

In both groups, the scores on IES, SCL-90, HAS, HDS were moderately high. The IES scores could not be compared statistically due to the small number of subjects in the groups; the scores, however, were moderately high in both groups. Among the SCL-90 subgroups, only the scores on paranoid and interpersonal sensitivity scales were significantly higher in the sexual torture group (Table 4)(Figure 1).

**Figure 1. The comparison of SCL-90 scores in cases exposed and not exposed to sexual torture**




### Genitourinary problems

Most of the cases had medical problems as a result of the various methods of torture they had been subjected to, as well as the long period of imprisonment under unsanitary conditions. In this article, only the genitourinary problems have been addressed. These problems were more common among the group who had been exposed to sexual torture, although the difference between the two groups did not attain statistical significance. In two of such cases, surgical removal of a kidney had been required because of chronic infection. Six of the seven women with a history of sexual torture, were currently suffering from physical problems (e.g. pelvic pain) as a consequence of torture. One man, with a history of insertion of a stick into his anus, had sphincter problems.

**Table 4. Results of measurements in the two groups**

| Scales | Group 1 | Group 2 |
|---|---|---|
| **Hamilton Anxiety Scale** | 26.0 (±10.0) | 22.5 (±9.3) |
| **Hamilton Depression Scale** | 23.0 (±4.5) | 23.0 (±8.5) |
| **Impact of Event Scale** | | |
| **-Total** | 36.9 (±11.6) | 31.0 (±16.0) |
| **-Intrusion** | 18.7 (±9.6) | 15.0 (±0.8) |
| **-Avoidance** | 17.9 (±6.5) | 14.7 (±6.0) |

### Sexual problems

Among the 28 subjects who had experienced sexual torture, four cases were not assessed because of insufficient information. In the group with a history of sexual torture, the rate of sexual problems was relatively high, the difference between men and women not being statistically significant. Sexual problems were in the form of low sexual desire and painful coitus in women, and erectile disor-ders in men.

### Partner relations

Approximately 70% of the subjects who had experienced sexual torture and 50% of those who had not, disclosed that their relations with their sexual partners were problematic or unsatisfactory.

Many subjects expressed fear of sexual intimacy. A man who had been raped and threatened with the rape of his girl friend, had flashbacks of this sexual trauma during intercourse. Some of the other subjects stated that the fear of injur-ing their partner during sexual intercourse affected their sexual lives.

## DISCUSSION

The rates reported for sexual torture are variable, but consistently higher among women,[17,18] and different causes may be considered regarding this vari-ability. First, the reported frequency of sexual torture is influenced by the context in which the information is collected. Second, the general taboo against talking about sexuality or sexual abuse in some cultures, such as in Turkey, can be an explanation for underreporting of such incidents. Third, there is still no established definition of sexual torture. Thus, there is no clear consensus on the various types of sexual torture practiced in different countries. In most cases, a history of sex-ual torture is not disclosed until the later stages of psychotherapy[1,11,18].

Little is known about the prevalence of sexual torture among detainees in Turkey. In studies using various definitions of sexual torture and in different populations, prevalence rates varied between 15% and 95%[19-21]. The result of the present study (76%) shows that sexual torture was frequently applied to

politi-cal detainees. Similar to the findings of the study by Paker,[22] the rate of exposure to sexual torture did not differ between genders.

The high rate of sexual torture in the two studies is probably due to the broader definition of torture that was adopted, which included threats of rape as well as actual rape.

It is well recognized that psychological problems are more frequent among patients who have experienced sexual abuse[9]. Accordingly, we expected to find more psychological problems among the sexual torture group. In fact, our results confirmed this expectation. It must be noted, however, that our study group con-sisted of patients who had referred for treatment because of psychological prob-lems. In addition, these cases were treated for long periods, which increased the probability of breaking down their resistance to disclosing this particular experi-ence. In his previous study on non-political prisoners, Paker[21] found a lower rate of sexual torture in his study group; his sample, however, did not include symp-tomatic individuals who were referred to a psychiatry clinic. In the light of our re-sults, the findings of this study suggest that the rate of sexual torture may be lower among non-political detainees and prisoners.

It is obvious that there is a difference in the meaning of sexual torture and ordinary sexual assault. This difference is reflected in the subjects' psychiatric problems and the indicated treatments. Sexual abuse is perceived in different ways, depending on the sexual, social and psychological characteristics of the individual in question. Similarly, political torture survivors with their various politi-cal, social and psychological backgrounds, constitute a heterogeneous group.

Sexual torture, because it is targeted against one of the most vulnerable aspects of the human being, is a very critical component of the torture process. Our study group consisted of individuals from the same cultural background in the sense of having grown up in the same country and coming from Islamic families; however, their attitudes on sex and their prior sexual experiences, as well as their levels of religious commitment, showed wide differences. It is obvious that the problems observed in this group of patients, can not be explained solely on the basis of their sexual torture experience. The cumulative experiences pertaining to sexual abuse and violence in general, should be taken into consideration in the evaluation of the current problems.

In accordance with the findings of Lunde and Ortmann,[18] who have stud-ied this subject extensively, patients with a history of sexual torture presented a higher rate of physical, sexual and relational problems. The distribution of medi-cal and sexual disorders was also similar to those reported by these investigators.

We must also note that it is appropriate to assess these disorders according to gender. Sexual torture in men, is a less studied subject. Van Tienhoven[23] points out that the severity of the trauma is not always proportional to the severity of consequent disorders. The physical (sphincter dysfunction), psychological (fear of being a homosexual), and sexual (erectile) problems that he reports, are simi-lar to our observations. The occurrence of these problems after sexual torture, which is also supported by other studies, suggests that sexual abuse can deeply affect the self-image pertaining to sexuality in men[24].

Torturers in Turkey are almost always men; therefore, sexual torture tends to have a different impact on male and female survivors. For example, a man who is forced to stand naked before the torturers will no doubt feel uneasy, but a woman will feel humiliated and sexually threatened more readily. The finding that three of the six female patients who had been subjected to sexual torture, had pelvic pains which could not be explained on a somatic basis, deserves to be underlined. Our observations suggest that in both genders, the sexual and mental problems that emerged as a result of sexual torture, did not correlate with the types of sexual abuse they had experienced. This is in accordance with previous findings which show that victims of attempted rape have psychological problems that are comparable with those of persons who have experienced actual rape[8].

## CONCLUSION

In this study, a small group of detainees who had survived multiple trauma, was described with respect to their experience of trauma and the meaning they attributed to it. Apparently, especially among political detainees, sexual violence is frequently applied as a means of repression, along with and overlapping other physical and psychological methods of torture, and it was not possible to discriminate the respective effects of sexual and non-sexual torture.

The role of sexual abuse, its prevalence and negative impact, especially in the lives of women, is well acknowledged. However, much less is known about the specific effects of sexual torture, which is a special type of sexual abuse that is applied along with other forms of organized violence. Contrary to other forms of sexual abuse, we can suggest that both genders are equally subjected to it during torture. Torture provides an appropriate setting for the sexual humiliation of a man, who has lost his attributes of dominance. The recognition of how sexual torture is experienced by the victims, will make an important contribution to the treatment of this group of torture-related disorders, which is still in a relatively early stage of development and not well known by the health care community.

On the other hand, violence and sexual torture, with their physical and psychological aspects, are not experiences that can be considered to be limited to the period of detention and imprisonment. In Turkey, especially in the south-

eastern regions, the prevailing extraordinary conditions affect all the inhabitants. The experience of such prevalent trauma, is expected to have a prolonged effect on the population in question. It is not possible to alleviate the adverse effects of such widespread trauma, which will persist for many years even if the traumatic situation is resolved, relying only on the activities of the Human Rights Foundation of Turkey. The physicians and mental health professionals in Turkey, have an obligation to share the responsibility of recognizing and treating these disorders, including those induced by torture and living under extraordinary conditions.

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# EMERGENCE OF PSYCHIATRIC DISORDERS AMONG PRISON INMATES:

## PRELIMINARY REPORT

**Pakize Geyran***

### INTRODUCTION

Despite the recognition of the prevailing adverse conditions in prisons, measures taken so far for the treatment and rehabilitation of psychologically disturbed prisoners in Turkey, as well as throughout the world, have been inadequate. The efforts of the relatively few mental health professionals concerned with this problem, has produced limited impact in the face of the continuously growing number of prisons. On the other hand, the question of whether psychiatric distur-bances are more prevalent among prisoners, compared to the general popula-tion, has always received considerable attention.

The incidence of mental disorders in prisons, has always been presumed to be higher than that in the general population[1,2]. Until recently, there has been relatively few studies on the psychological state of prison inmates. Earlier studies addressing this issue, have been criticized for their methodological limitations[3,4]. Some of these studies have used sample groups selected from people sentenced to prison, and others from those under arrest. The sample sizes in most of these studies have been relatively small and unrepresentative. Moreover, the methods used in the assessment of mental disorders have shown considerable variation.

During the last several years, a considerable number of studies have been published, with reliable results concerning the incidence of psychiatric disorders among prison inmates. These studies have used standardized instruments of measurement and representative samples. Overall, their results show that the most frequent diagnoses among prison inmates are alcohol and psychoactive drug abuse, that the risk of maintaining at least one mental disorder throughout life was higher than that in the general population, and that mental disorders such as schizophrenia, major depression and manic disorder were also frequently di-agnosed[4-7]. In contrast to the above-mentioned studies, one investigation[8] has yielded lower values of incidence. In this study, the incidence of psychiatric disor-ders in male convicts was 37%, the most frequently encountered diagnoses being alcohol abuse and personality disorder. The results obtained so far, indicate that prison inmates are in need of psychiatric

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help and that they are inclined to seek mental health services frequently (8%-16%)[9,10].

In the present study, sociodemographic data concerning people sentenced to prison or under arrest in prisons located in the northwestern region of Turkey between 1991 and 1993 and who were referred to the Forensic Psychiatry De-partment in the Bakırköy Hospital of Mental and Nervous Diseases, are investi-gated retrospectively. The objective of the study is not to initiate a discussion of the frequency and nature of the psychiatric disorders encountered in prison. The aim of this retrospective evaluation, designed as a preliminary investigation, is to outline the structure of a future prospective study. Both studies were designed to test the hypothesis that prison conditions could result in psychiatric disorders which persist for many years in some affected individuals.

## MATERIAL AND RESULTS

The Section for Arrested Prisoners at the Forensic Psychiatry Department of the Bakırköy Hospital for Mental and Nervous Diseases, covers the mental health services for referrals from Metris, Bayrampaşa and Paşakapısı prisons, located in the northwestern region of Turkey, with a total capacity of 4500 prisoners. During 1991-1993, 887 of the 988 referrals were transferred for treatment. Ninety-nine of these cases were hospitalized for treatment; among this group, 43 cases had a history of psychiatric diagnoses and hospitalization before imprisonment (Table 1). Of the remaining 56 cases, hospitalization for psychiatric treatment was indicated for the first time during the period of imprisonment, although 32 (Group 2) reported receiving a psychiatric diagnosis and outpatient treatment prior to imprisonment (Table 2). The cases which were the principal focus of attention in this study, were the 24 prisoners (Group 1) who initially developed over-the-threshold psychiatric symptoms in prison (Table 3). The diagnoses were made according to the Diagnostic and Statistical Manual of Mental Disorders, Revised Third Edition (DSM-III-R)[11].

**Table 1. DSM-III-R diagnoses of 43 cases with a history of psychiatric disorder and hospitalization for psychiatric treatment prior to imprisonment.**

| Diagnoses | Number of cases |
|---|---|
| **Schizophrenic spectrum disorders** | 15 |
| **Bipolar mood disorder** | 10 |
| **Organic mental disorder** | 3 |
| **Alcohol/psychoactive substance use disorders** | 10 |
| **Personality disorder** | 4 |
| **Factitious disorder** | 4 |

| | |
|---|---|
| **Adjustment disorder** | 2 |
| **Mental retardation** | 2 |
| **Total** | 50 |

**Table 2. DSM-III-R diagnoses of 32 cases (Group 2) with a history of psychiatric disorders and outpatient treatment prior to imprisonment.**

| Diagnoses | Number of cases |
|---|---|
| **Schizophrenic spectrum disorders** | 2 |
| **Bipolar mood disorder** | 2 |
| **Organic mental disorder** | 2 |
| **Alcohol/psychoactive substance use disorders** | 18 |
| **Factitious disorder** | 5 |
| **Mental retardation** | 3 |
| **Total** | 32 |

**Table 3. The 24 cases (Group 1) who initially developed over-the-threshold psychiatric symptoms in prison.**

| Diagnoses | Number of cases |
|---|---|
| **Major depression with psychotic features** | 8 |
| **Adjustment disorder with depression/anxiety** | 12 |
| **Brief reactive psychosis** | 1 |
| **Atypical psychosis** | 2 |
| **Schizophreniform psychotic disorder** | 1 |
| **Total** | 24 |

Group 1 and Group 2 were statistically compared, using the chi-square test (Yates adjustment). The two groups were similar with regard to age, sex, occupation, and history of medical disorders, as well as duration of imprisonment (Group 1, 11.8 months; Group 2, 7.4 months). There were only a total of 6 female prisoners in both groups. However, the ratio of arrested/sentenced prisoners was 50% in Group 1 (16 arrested vs. 8 sentenced), and 14% in Group 2 (28 arrested vs. 3 sentenced); the difference was statistically significant ($p=0.03$). The differ-ence between the two groups for history of prior imprisonment, was just below significance (Group 1, 0.4; Group 2, 1.2; $p=0.069$).

A total of 9 cases from both groups had a history of exposure to torture; none of these cases, however, sustained any physical signs or handicaps related

to the torture event. Statistically, the distribution of torture cases did not differ significantly among the groups (six cases in Group 1 vs. three cases in Group 2). Table 4 shows the diagnoses and Table 5 the alleged offenses of these 9 torture cases.

**Table 4. The diagnoses of the 9 torture cases.**

| Diagnoses | Number of cases |
|---|---|
| **Adjustment disorder with depression/anxiety** | 4 |
| **Depression with psychotic features** | 2 |
| **Bipolar mood disorder** | 2 |
| **Schizophreniform psychosis** | 1 |

**Table 5. The offenses of the 9 torture cases.**

| Offenses | Number of cases |
|---|---|
| **Theft, swindling, etc.** | 4 |
| **Homicide** | 5 |

There were a total of three political prisoners in both groups (Group 1, two cases; Group 2, one case). None of these three cases reported exposure to torture.

The difference between distribution of diagnoses among the two groups was highly significant ($p<0.00001$). The primary diagnoses in Group 1 were adjustment and depressive disorders (83%), whereas alcohol/psychoactive substance abuse (56%) was the most frequently diagnosed disorder in Group 2. The groups were similar with respect to the social support that was available during imprisonment and distribution of offenses (Table 6).

**Table 6. The distribution of offenses in Group 1 and Group 2.**

| Offense | Group 1 | Group 2 |
|---|---|---|
| **Theft, swindling, etc.** | 4 | 11 |
| **Carrying weapons** | 1 | 1 |
| **Sexual offenses** | 1 | 1 |
| **Homicide or attempted homicide** | 16 | 17 |
| **Political offenses** | 2 | 1 |
| **Total** | 24 | 32 |

## DISCUSSION

Many of the prison inmates are exposed to serious trauma and difficulties under prison conditions, and some of them develop significant psychiatric disorders. However, there are very few studies to verify these presumptions. Existing literature points out that psychiatric disorders occurring among prison inmates could result from the violence experienced in these institutions, from the exaggerated perception by the inmates of some physical problems they may have, and that somatic complaints associated with depression could be quite frequent[12]. The present study has determined that there is a significantly greater proportion of adjustment disorders and depressive disorders among the group with over-the-threshold symptoms developing initially in prison, and a higher ratio of persons sentenced to prison, but without a history of prior imprisonment. Similar to our observations in this study, other studies using standardized interviewing techniques, have failed to demonstrate a higher rate of psychotic disorders among prison inmates, compared to the general population[13-15].

In a study[16] that compared tortured and nontortured prisoners under arrest for political reasons in Turkey, the rate of anxiety-depression and posttraumatic symptoms was relatively low. The authors suggested that the political commit-ment and group support experienced by the study population could be one of the explanations for this finding. In the same study, the rate of current posttraumatic stress disorder was 18%, and the rate of ever having fulfilled the criteria for this diagnosis was 33%.

The only study[17] we found in literature, which evaluated the rate of posttraumatic stress disorder among prison inmates, was from Turkey. In this study, among 246 nonpolitical prisoners, 208 reported a history of torture and this group had a significantly greater rate of posttraumatic stress disorder. Moreover, the tortured cases in this population had higher scores on Symptom Checklist-90 (SCL-90)[18].

We believe that the issue of mental health among prison inmates requires investigation by further studies focusing on the incidence of psychiatric disorders that develop as a consequence of trauma as well as the association between trauma and symptoms. These studies should include a careful history of all possible traumatic experiences and a systematic search for psychiatric symptoms, especially those of posttraumatic stress disorder. Clarification of various types of stressful conditions and traumatic situations inherent in prison life would also be helpful in developing a better understanding of psychiatric syndromes that develop as its consequence.

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# BONE SCINTIGRAPHY AS AN EVIDENCE OF PREVIOUS TORTURE:

## EVIDENCES OF 62 PATIENTS

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### INTRODUCTION

Torture is a centuries old crime. Once openly practiced, in our century, it is being practiced secretly and denied consistently by numerous governments[1]. Al-though at least a hundred thousand people are estimated to have been tortured in Turkey during 1980's[2], very few of them could bring their cases in front of a court[3]. Objective clues of torture are scarce and hard to collect. We, as the İzmir Treatment and Rehabilitation Center of the Human Rights Foundation of Turkey, had previously reported 4 torture survivors examined by us, who had pathological signs of bone scintigraphy (scan) that persisted for 5-12 months[4]. This imaging technique is already accepted as a precise device in evaluating abused children[5], osteomyelitis[6], deeply invasive soft tissue injuries such as electrical burns[7], and especially stress fractures[8,9].

### MATERIAL AND METHODS

Since December 1989 till the end of 1992, we examined 221 people claiming to have been tortured in detention. Sixty-two cases could be sufficiently documented. There were 52 male (83.87%) and 10 female (16.33%) patients, with a mean age of 30.89 years (range: 9-64, standard deviation: 8.76). Their mean age at the time of torture was 24.76 (range: 9-64, standard deviation: 8.10). All of them declared that they had been beaten, 54 of them being severely (87.1%). Falanga torture, beating the soles of the feet with a stick was applied to 48 (77.42%) people. Other methods of torture such as suspending on a hanger, applying electric shocks, sexual abuse, and execution, etc. were also reported by diverse numbers of patients. For more detailed descriptions of terms "beating",

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"severe beating" (beating with an instrument, punching or kicking) and "falanga" the reader may refer to reference No. 15.

After obtaining a detailed medical anamnesis which included the types of torture and their duration, every applicant was examined (including the psychiatric evaluation of the patient) by specialists on various disciplines, and routine investi-gations were carried out: Direct radiographs of symptomatic areas; computerized axial tomographies (CAT scan) of feet (falanga cases only), of vertebral column (if symptomatic or with hyperactive vertebral findings of bone scintigraphy) and of brain (if severely beaten on the head) were taken, and every patient had at least one bone scintigraphy. 15-20 mCi of Technetium 99m pyrophosphate was given intravenously and complete bone scintigraphy was taken 2.5 hours later with a "Siemens scintiview gamma camera". Any hyperactivity on bones was accepted to be positive. Hyperactivity on mandible consistent with pre-existing dental pa-thology was excluded. If the initial bone scan was positive, consecutive bone scans were taken during the 1., 3., and the 6. months, and once in every 6 month, until the findings became normal. Those who had applied at least a year after torture and had positive bone scans were examined every 6 month. Urinalysis, biochemical blood analyses and electromyography were conducted if necessary.

## RESULTS

Twenty-six cases (41.94%) had applied 5-51 days after the torture incident (acute cases), the mean period from torture to examinations was 17.42 days (standard deviation: 14.86). Thirty-three cases (53.28%) were examined 1.5-15 years after the incident (chronic cases). The mean period from torture to exami-nation in this group was 10.46 years (standard deviation: 2.37). The people who stated to have been tortured both in the past and recently (There were 5 such cases.) were categorized according to their latest torture date. There were three other cases who came to us 3, 3 and 4 months after torture (undetermined or subacute). The demographic characteristics of these groups are summarized in Table 1.

**Table 1: Demographic characteristics of the study population**

| | Female (n-%) | | Male (n-%) | | Total (n-%) | |
|---|---|---|---|---|---|---|
| **Acute cases** | 18 | 69.23 | 8 | 30.77 | 26 | 100 |
| **Mean age-SD** | **25.00** | **12.49** | **29.63** | **8.50** | **26.42** | **11.61** |
| **Chronic cases** | 31 | 93.94 | 2 | 6.06 | 33 | 100 |
| **Mean age-SD** | **34.03** | **4.50** | **30.0** | **2.00** | **33.79** | **4.46** |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Subacute cases**<br>**Mean age-SD** | 3<br>**30.00** | 100.00<br>**7.48** | 0<br>**–** | 0.00<br>**–** | 3<br>**30.0** | 100<br>**7.48** |
| **Total**<br>**Mean age-SD** | 52<br>**30.89** | 83.87<br>**9.17** | 10<br>**30.6** | 16.13<br>**13.34** | 62<br>**30.89** | 100<br>**8.76** |

SD: Standard deviation.

Every patient was examined with bone scan at least once. There were 16 patients with positive scans (61.54%) among the “acute” cases, 17 patients among the “chronic” (51.52%) and all the 3 in the “subacute” group were positive, 36 positives in total (58.06%). The difference between the two major groups was not significant (p=0.613. Table. 2). Since the “chronic” cases had their first bone scans about 10.5 years after torture, positive scan findings in 17 (51.5%) of those 33 persons may be noteworthy.

**Table 2. Bone results of the two major groups**

| | **Bone scan + (n-%)** | | **Bone scan - (n-%)** | | **Total (n-%)** | |
|---|---|---|---|---|---|---|
| **Acute cases** | 16 | 27.12 | 10 | 16.95 | 26 | 44.07 |
| **Chronic cases** | 17 | 28.81 | 16 | 27.12 | 33 | 55.93 |
| **Total** | 33 | 55.93 | 26 | 44.07 | 59 | 100.00 |

Degrees of freedom = 1, $\chi 2$=0.256, p=0.613.

Falanga was reported by 32 of the 33 cases (96.37%) examined 10.5 years after torture, on the average, while its frequency fell down to 14 in 26 (53.85%) for the “acute” cases. The difference is highly significant ($\chi 2$=13.33 and p=0.0002). This indicates that this primitive and very painful method of torture has lost prevalence in Turkey.

### Follow-up Cases

Among the 62 survivors, we could follow-up 12 (19.36%) of them for a mean duration of 13.08 months (range: 1.5-31+, standard deviation: 8.99). Out of the follow-up cases, 8 were from the “acute”, 3 from the “chronic”, and 1 was from the “subacute” group. Bone scans of the two acute cases normalized in 1.5 and 15 months, whereas they were still persistently pathological for the other 10 patients at the end of a mean duration of 13.40+ months (range 4-31+, standard deviation: 9.80). At the end of the follow-up period, the mean duration of persistently positive scans for the 8 acute patients was 16.25+ months (range: 4-31+, standard deviation: 11.08).

### Tortured Children

There were 4 boys who applied to us 22-51 days (mean: 42.0, standard de-viation: 11.90) after torture. Their ages were 9,12, 13 and 13. All of them

reported severe beating, falanga was noted in 3 of them. Two of the children had positive bone scans consistent with falanga, on the 22. and 51. days. The child with positive bone scan on the 22. day had persistent pathological findings 4.5 months later.

## DISCUSSION

There were 552 cases of torture in Turkey in 1991 and tortures on 218 of them were confirmed by medical authorities[3].The number of applicants to our branch in İzmir until the end of 1992, summed up to 221. Torture survivors are kept in detention until visible signs disappear, and their demands for their legal rights were suppressed. Health care professionals do not know about torture, moreover, some of them are even in collaboration with torturers[10,11]. Sustained clues that can stand the erosion by time are the most important. As we focused our attention on the victims of recent torture, it soon became apparent that bone scan was a good candidate. Previous studies in the medical literature, which may come closest to ours, mostly deal with stress fractures and serious soft tissue injures. It is stated that any disorder that increases blood flow will cause a relative increase in bone uptake[12]. Scan becomes positive earlier than the conventional radiographs, and recovery starts in two weeks and turns into a normal image most probably within 4-6 months, at the least, and at the end of 2 years for most of the patients[13,14]. Exceptional cases may have positive scans persisting for about 30 years[12].

It is not surprising to find pathological bone scan findings among persons who were severely beaten. Falanga, accompanied by muscular damage, is locally more provocative. Many of our cases who stated to have been subjected to fa-langa torture and applied to us soon after the incident, had typical hyperactivity, which remained positive for a long time, at their metatarsal bones (11 of the 14 falanga victims -78.57%). Since falanga is a prevalent form of torture in the Mid-dle East[15], this strong relation and long-lasting objective clues may become le-gally acceptable. However; we must note that among our recently tortured “acute” patients, about 20% of falanga cases (40% on the whole) had normal bone scans. Searching for specific signs[16] or using more sophisticated devices such as triple phase 99m Technetium bone scan, or magnetic resonance imaging[17] may in-crease the sensitivity. Our first impression of CAT scan is also encouraging. Meanwhile, as the statistically significant difference between our two major groups implies, frequency of falanga torture has somehow declined in Turkey. Our group of “chronic” cases was composed of people interrogated and impris-oned at the time of the 1980 military coup. They spent about 11 years in prisons, where torture and ill-treatment were so prevalent, and they were released on pa-role between April and August 1991. All of our cases reported repeated and se-vere beating and various forms of torture. Falanga was experienced by all except one. In some cases, sum of the total time

under torture was even hard to conceive (194 days for one case, 450 days for another, etc.), and due to the enor-mous time gap, this parameter was not considered. The bone scans of 17 of these 33 chronic patients (51.52%) showed various combinations of hyperactive spots on costae, scapulae, vertebrae, knee joints and metatarsal bones. When three patients were re-examined 8-12 months later, the positive scans were still existent. Positive bone scan lasting for more than 3 years is very rare[12,14], therefore such a high ratio (more than 50%) of pathological results is noteworthy.

Persistence of bone scan abnormalities for a very long time is hard to explain. Muscular necrosis does cause hyperactive spots but does not persist for this much long[7]. Until recently, the investigators were more interested in its contribution to the diagnosis of occult fractures rather than their persistence as a clue. It has been proposed that "a continuing increase in metabolic activity, increased vascularity or other processes"[14] may give way to persistent positive scans.

Falanga torture and severe beating may cause -perhaps irreversible- periosteal reactions that could not be detected with conventional radiography. Radionuclide studies, on the other hand, may determine these metabolic and vascular pathological changes evolving locally.

There are various methods of torture[15]. Trying to prove its existence and determine its physical sequelae on every occasion would be a futile task. Even bone scan may draw negative results in about 40% of recently tortured individuals. Helping torture victims and struggling against its practice is one of the responsibilities of medical profession, but eradication of torture from society requires wide scale international efforts.

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# SIGNS OF ELECTRICAL TORTURE ON THE SKIN

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## INTRODUCTION

Torture is a much practiced crime against humanity, in many countries worldwide, as well as our country. Applying electricity to the flesh is a widely used method of torture[1,2]. Electricity is conducted via electrodes, placed on various places of the body. Electricity is considered to be an ideal way of torture by the torturers, as it causes pain and severe muscle contractions, having frightening effects such as breathlessness on the patient, and leaving almost no signs on the body.

Structural changes on the skin caused by electricity, have been expansively investigated on victims of electrical accidents and in experimental animal models[3]. In most of these studies, structural changes are considered to be due to heat amassed during the conduction of the current, rather than any specific changes caused by electricity itself. New diagnostic procedures are needed to clearly differentiate between signs of electrical torture, and superficial cutaneous damages due to heat and other causes. A branch of an interdisciplinary scientific group assembled in Denmark ("electrical group" of Anti Torture Research, ATR) have been conducting experimental studies on pigs, since 1976, to determine specific morphological changes due to electricity[1,4-13]. In these studies, some morphological differences were discerned between the skin changes caused by electricity and heat energies. They believe that at least two of many skin changes are rather specific for electrical destruction:

**1.** Vesicular nuclei seen in white necrosis areas (this term is used as cytoplasms of necrotic cells are not stained by hematoxylin and eosin) of epidermis, vascular walls and sweat gland cells.

**2.** Calcium deposition on collagen fibers of dermis.

The researchers claim that, the type and quantity of conveyed electrical energy have important quantitative effect on these morphological changes.

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This study was conducted on a group of people, applying to the Human Rights Foundation of Turkey (HRFT) İzmir Treatment and Rehabilitation Center with electrical torture claims, having visible skin lesions and accepting biopsy, to investigate specific signs for electrical torture.

## METHOD

Incision, punch or shave biopsies were performed on 12 people in 1991-1994 period. Skin specimens were first examined by dissection microscope. Mac-roscopic signs were defined in detail. 10% phosphate-buffered formaline was used for fixation. Cross-sections from paraffin embedded tissues were stained by hematoxylin-eosin, routinely. Light microscope examination was performed. In four cases, some of the preparations were tested for iron reaction and stained by alizarin red-S for calcium.

## RESULTS

Four of the cases were female, and 8 were male. Age range was 15 to 38, mean age was 25.9. The interval between electrical torture and biopsy was 4 to 20 days. Biopsies were performed from toes in 4 cases, ankles in 2 cases, dorsal side of hands in 2 cases and wrist, abdominal wall, chest wall and labial mucosa in 1 case. In 7 of the cases (63.3%), some definable morphological changes were demonstrated in epidermis and dermis.

### Macroscopic Changes

In 6 of the cases, a small, 1-2 mm diameter, slightly swollen, frequently red-brown spot was visible on the skin. In some of the cases it was circumscribed by a transparent looking circle, with a slightly more pale appearance. In one case, a 2 mm diameter ulcer was visible in the center.

### Microscopic Changes

In the case with ulcerous lesion, granulation tissue and dense inflammatory infiltration was seen in the dermis. In other cases no visible change was present in dermis. Conversely, epidermis generally had changes of regional nature. Macroscopically observed reddish spot was a keratotic or parakeratotic thickening, with hemolyzed blood and exudate in keratin layer. The epidermis below this lesion was frequently thinned, cells were compressed and cell boundaries were vague. Granular layer and retia were absent, basal layer cells were disarrayed and melanin-pigment carrying cells were scarce, in a zone larger than the area with thickened keratin layer. Minimal erythrocyte extravasation was seen in upper dermis and epidermis. Keratocytes with focal chromatin loss and obscured nuclei were observed in spinal cell layer. Their cytoplasms were more acidophillic, when compared with surrounding cells. In some areas, nuclei of spinal cells were densely basophillic and they were circumscribed by transparent

circles. In one case no reddish spot was seen on the skin. In dissection microscopy, many small brownish, slightly swollen, freckle-like spots were seen on the skin. In histological examination, these spots were observed to be parakeratotic thickenings, and they did not contain blood and exudate, as seen in other cases. This case differed from the others with scarce vesicular nucleated cells and giant-cell like structures, consisting of 3-4 densely chromatinized, pyknotic shaped nuclei, with no visible cytoplasm, in epidermis. Positive staining was not observed on superficial keratotic or parakeratotic thickenings, in iron reaction testing performed in 4 cases. When alizarin red-S staining was tried in those cases, calcium deposition was observed only in cells of sweat glands and small vessel walls, in one case. No deposition was found on collagen fibers.

## DISCUSSION

No gender discrimination is seen in the cases examined. Multiplicity of females in this study may be interpreted as a kind of courtesy for the women, as electrical torture may be regarded as a more refined way of torture than falanga or beating.

Mean age of our cases, as in other studies, shows that torture targets younger age groups more. As one of our cases was 15-years old, torturers seem not to spare even the children.

In our study, electric current was applied to almost every part of the body. Toes and especially between them are chosen most of the time.

Using a needle electrode to apply the current creates a reddish spot, 1-2 mm wide, on the skin, and these lesions are called “picana”[14]. This term may have originated from “peykan”, which means arrowhead in Persian. In all our cases of self-claimed electrical torture, skin lesions were “picana-peykan” type.

Thomsen[13], in his studies on pigs, observed that changes due to electrical energy are mostly in epidermis and principally dwelled upon epidermal morphology. Thomsen and colleagues[12], examined morphologies of direct current, acid and alkaline lesions and investigated the pathogenesis of changes due to electric current, as well. As we based our study on their findings, we think that it would be necessary to summarize their results:

*When electrical and thermal lesions were compared, electrical lesions were often segmental, thermal lesions were diffuse. In thermal lesions epidermis was detached from dermis, in electrical lesions it was not. 50 Hz and 8000 Hz alternative current lesions in stratum corium and an accumulated yellow material on anode lesions of direct current were observed. Light yellow accumulation as in electrical lesions was found in some high temperature lesions, as well. Granular and fibrinary cytoplasms were present in thermal and 100.000 Hz alternative current lesions. In all electrical lesions, except 100.000 Hz, “white necrosis” was ob-*

*served. In high temperature lesions, sometimes mild "white necrosis" was seen. "Vesicular nuclei" was seen only in cathode lesions and 50 Hz and 8000 Hz alternative current lesions.*

*When acid and alkaline lesions, and electrical lesions were compared; both in light and electron microscope, anode lesions and acid lesions, as well as, cathode lesions and alkaline lesions were similar.*

As described above, only "vesicular nuclei" are characteristic for electrical lesions. Detailed description of this sign is as follows:

*Cytoplasms of epidermal cells were pale and homogenous ("white necrosis"). Nuclei were disarrayed, having large "uni- or multilocular" clear nucleoplasm and sometimes consisting of large, irregular chromatin ("vesicular nuclei"). In the 48 hours after the damage, the lesions did not show any change, but after the third day "vesicular nuclei" were indistinct and most of the lesions disappeared on the fifth day.*

In our cases, the interval between electricity application and biopsy was 4 to 20 days. It is known that efforts are spent to disrupt time orientation of detainees. For this reason, reported intervals are far from reliability. We observed "vesicular nuclei" like structures only in one case, who was released after 4 days and an immediate biopsy was performed. No "white necrosis" was found in that case. In other cases, biopsy may have been performed more than 5 days after the electrical damage. In the fifth day a mending tissue replaces necrotic, discarded tissue. In one of our cases, an ulcerous lesion and in 5 of them, renewed epidermis signs were present. We believe that in electrical torture victims, it is almost improbable to find "vesicular nuclei" which disappear after the third day.

We observed yellowish keratin accumulation defined in stratum corneum, in our cases. Iron reaction was reported to be positive in those alternative current and anode area lesions[11]. We elicited negative results of iron reaction, in 4 cases. Thomsen[13], suggests that iron may be due to electrolysis from the electrode they have used. In our cases, iron-free electrodes, for example copper wire may have been used.

In some of our cases, segmental pyknotic-nucleated cells with transparent haloes and empty looking nucleated cells with chromatin loss were seen in epidermis. Similar changes are reported in thermal damage, alternative current and anode lesions in epidermis, though they are not considered a specific sign[13].

It is clear that specific but durable morphological evidence is needed to prove electrical torture. Karlsmark and colleagues of ATR (Anti Torture Research) from Denmark "electrical group", have studied the changes caused by heat and electrical damage in dermis, in pigs[1,6]. The authors have reported calcium deposition on skin annexes and vascular cell structures caused by heat energy, in contrast to a characteristic calcification on collagen fibers of dermis, at

the places where alternative current or cathode of direct current was applied. These changes appeared two to seven days after electrical current was applied and still existed even after two months. The authors suggest alizarin red-S staining, which is highly sensitive and specific, to demonstrate calcium deposition.

We determined calcium deposition in sweat glands and vessels, in one of the four cases (the case with ulcerous lesion) this staining was performed. We did not observe collagen calcification, deemed characteristic for electrical damage.

Karlsmark and colleagues have reported that, characteristic collagen calcification appeared only in cathode placement lesions of direct current, not in alternative current lesions, in their first article[6]. Thinking that specific calcification might necessitate higher energy levels with alternative current than direct current, the authors used 0.5 milimeter wide needle-point electrodes instead of previously used metal electrodes having dimensions 3x3 cm or 2x4 cm, applying same amount of energy (35-160 joules) to increase energy input per area unit, and observed characteristic calcium deposition on collagen fibers in six of eleven subjects, after the seventh day, in their following study. They concluded that a high and definite energy range (95-160 joules) is needed, to cause collagen calcification with alternative current[1].

Findings in our cases suggest that, alternative current was applied by a needle-point electrode for torture. The reason for non-appearance of characteristic collagen calcification may be insufficiency of given amount of electrical energy.

Danielsen and colleagues have observed characteristic collagen calcification in a 5 years old child with ulcerous skin lesions, and attributed the skin lesions to electrical damage[15]. We could not find any other article on humans, except this, in the literature.

**CONCLUSION**

It is impossible to determine type, voltage and amount of electrical energy used in torture, precisely. As time orientation of torture victims is muddled, the time interval between application of electricity and biopsy cannot be estimated accurately, as well. For these reasons, it is not plausible to expect all the findings of experimental studies, to exist in human victims of torture, having to endure unfathomable conditions. Although some signs may be present, interpreting them accurately and reliably might be a hard task.

This study was conducted on a group of people, who do not know each other and who have claimed to suffer torture on diverse occasions. We could not demonstrate histopathological signs characteristic to electrical torture clearly, on them. But two thirds of the cases had similar lesions on their skins. “Picana-

peykan" like appearance of the lesions suggested application of alternative current by needle-point electrodes, for torture. Though it is hard to claim that electrical energy is definitely the etiologic agent, it is concluded that those people have had a physical energy trauma.

We believe that skin biopsy must be performed on people claiming to suffer electrical torture and specific signs for electrical energy must be searched extensively.

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# MEDICAL CERTIFICATION IN TORTURE

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Torture is as old as humanity itself. Diminishing torture gradually and attaining abolition is the ultimate goal of every society. Physicians have a great role in this process. Presenting scientific proofs of torture to the judiciary is the physicians' duty, but lack of medical knowledge on the subject constitutes a problem. Studies on gathering clinical and laboratory data, and medical certification techniques are necessary. Recently torture has become a subject of research and education in medical schools, in other countries. Distressingly, in our medical schools torture is not even mentioned. Due to the Hippocratic Oath, dealing with torture should be the principal aim of medicine and it is a prerequisite for a physician for accurate medical certification. First of all, a physician should know the definition of torture by heart. Only by this way, she or he can weigh what he is facing and then can phrase medical certification properly.

World Medical Association have defined torture, on 10 October 1975 as follows: Torture is the intentional and systematic degrading, inhuman practice, causing great physical or mental pain or damage, performed by one or more individuals, on their own or under other authority, to force, frighten or punish another individual to disclose information, enforce a confession or talk for other purposes.

The definition of the United Nations, made in 1984 is a similar but somewhat more elaborate statement. Underlined points are: there is intent, and specialized methods-tools in the practice.

The judgment on torture should be made by judiciary. The court should decide whether torture is practised or not. Physician's duty is to present reliable, persuasive proofs to court. An irrefutable fact is the importance of scientific value of medical certificate and its undeniable power. The physician's educational background and adequacy on the subject have great importance. She or he should have acquired some knowledge.

The Turkish Republic has undertaken obligations in 1953, by undersigning the "European Human Rights and Basic Privileges Convention". Inhabitants of our country have the right to appeal to the "International Human Rights Court" on proclaimed points, and the Turkish Republic has to comply with its decisions. Torture is amongst them; that is the reason for the existence of an international definition. Therefore the contents and preparation technique of the medical cer-

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tificate must conform to international standards. Otherwise, the deficient certificate would be unacceptable for the International Human Rights Court.

Collaboration between medicine and law is necessary for proper medical certification. Words have great importance in law. Certificate language should be compatible with the terminology of law. Law requires clear comments and decisions, but in certification of torture, clear comments and decisions are not always possible. Enumeration of certain technical nomenclature in collaboration, while determining the judicially acceptable wording, would enhance this possibility.

The physician who would issue the medical certificate must be free of prejudice. Medical certification by a physician who is too sensitive to torture or to the allegation the victim is accused of, insofar as she or he cannot control herself or himself, is not befitting. For example a previously tortured physician, or someone with a tortured relative, or another carrying a deep hatred towards people who have been involved in acts of violence, may not be totally impartial and objective in the evaluation, in spite of good will. Some findings may be exaggerated, others may be invented. One of the principal duties of a physician is protecting scientific neutrality. In such cases the physician should refuse to issue the certificate, and another physician should undertake the duty.

The physician who would prepare the medical certificate, should recommendably be independent and free of any kind of pressure. That's why certificates by physicians working in their own names are more trustworthy, in other countries. Contrarily, judges in our country are much more ready to trust certificates by official physicians. There may be some points favoring this preference. Medical Chambers, that might well be considered as public organizations, might be a suitable solution to this problem. They have the potential to assemble independent physician teams and provide necessary laboratory facilities. Therefore, it should be the next step, on the part of judiciary, to assign the Chambers this duty, recognizing their potential, and on the part of Chambers, to prove their scientific approach, objectivity and impartiality.

The physician should be trained and adequate in approach to torture, as will be emphasized in technical qualifications' part. The context and format of the certificate must be consistent with international norms, as it may be necessary to submit it to an international court. Profound progress has been achieved on this subject in the last 2 or 3 decades. Examination, symptomatology, treatment and certification of torture have reached a high point by the establishment of the Rehabilitation and Research Centre for Torture Victims (RCT) in Denmark, in 1982. Training programs have been put into operation by this international institute, which is recognized by the United Nations as well. The previously negligible amount of literature on the subject has begun to multiply quickly, proving to be a new dimension in research. Our physicians should be well informed on these studies, for adequate certification.

For example one of the widely accepted RCT regulations is that a torture certificate should be prepared after a team examination. This team should include at least one orthopedist-traumatologist, one neurologist, one psychiatrist, one internal medicine specialist preferably with rheumatology training and one dentist. Other specialists are invited to participate, if necessary. Wording of the certificate should be performed by a reporter assigned within the team, preferably the spe-cialist of the branch with foremost findings. Certification is prepared after a dis-cussion over the draft prepared by the reporter.

It should be noted that having adequate laboratory facilities is a prerequisite. Laboratory examination has a great role in determination of torture, and reaching a positive or negative decision. If the physician has inadequate laboratory facilities, referring the patient to the nearest center with documentation is the best course.

**TECHNICAL INFORMATION**

The certificate should basically be free of unnecessary information, but ample enough to clarify every point adequately. Generally speaking, omission of necessary information is more inconvenient than including unnecessary details.

The certificate should be prepared as follows:

**Anamnesis:**

- Date and place of the (alleged) torture should be clearly stated. In evaluation of findings, elapsed time and physical conditions of the location is important.
- Type and duration of the torture are among the most significant data.
- Complaints and symptoms just after the torture should be noted.
- Treatments given just after the torture, and in the following period must be recorded. If there has been hospitalization, it must be stated. If necessary, the mentioned hospital may be inquired.
- Any diseases and accidents after the torture must be noted.

**Past medical history:**

- Health condition before the torture, previous diseases, accidents are important in differential diagnosis.
- Any previous hospitalizations, treatments applied should be noted.

**Current complaints associated with torture:**

- They are important for interpretation. If the patient can not explain clearly, clarifying questions should be asked.

**Examination:**

- General Condition: Her/his age, weight, height, general health condition should be recorded.
- Conducted physically and mentally.

- Patient must be totally or adequately naked; examination must be done while walking, standing and lying down.
- Head, neck and trunk, upper and lower limbs are examined one by one. All findings, associated with torture or not, are recorded.
- Injury scars and deformities are precisely recorded. They are measured accurately.
- Lengths and circumferences of extremities, active and passive movements of the joints are determined.
- Muscle tests are performed.
- All findings are recorded, whether associated with torture claim or not.
- In some cases, patient is taken under observation. In the case of torture, simulation should never be overlooked. In suspicious cases single or group/family observation may be needed for decision.

**Laboratory examination:**

- Ample tests are made according to type of torture and findings. Laboratory examinations should be restricted, but must not be underdone.
- Blood analysis and urinalysis, EMG, EEG, X-ray, CT, MRI, scintigraphy and needle biopsy may be performed, if needed. In some cases photographic records are taken, as well.

**Interpretation:**

- This is the most important part of the certificate with scientific emphasis. All findings must be stated as associated with the implied type of torture or not; clinical and laboratory findings associated with torture, their relations to type of torture, elapsed time, previous treatments, age and general physical condition must be clearly and scientifically determined.
- Definite diagnosis will ease interpretation.
- Interpretations must denote objectivity and neutrality.
- Statements must be as conclusive as possible.
- Negative and positive associations between findings of different disciplines and torture must be clarified.

**Conclusion:**

- It is often difficult to state a definite conclusion in a torture certificate. Reaching to a definite conclusion is more probable in acute cases.
- As it is mostly hard to end up with a conclusion in chronic cases, judicially acceptable statements should be used. Usually expressions such as probably, most probably are used.

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