HRFT
Human Rights Foundation of Turkey

Treatment and Rehabilitation Centers Report

1997

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INTRODUCTION

Metin Bakkalcı*

The Project for the Treatment and Rehabilitation of Torture Survivors has been one of the most important projects the Human Rights Foundation of Turkey (HRFT) conducts with success since its inception. The project is implemented by the Treatment and Rehabilitation Centers of the HRFT in Adana, Ankara, İstanbul and İzmir. The project started in 1990 and 2767 persons applied to our centers till the beginning of 1997. In 1997, 537 persons applied to our centers increasing the total number of applicants to 3304. Hundreds of health professionals either working professionally or voluntarily contribute to the solution of physical, psychological and social problems of the applicants to the HRFT. In the regions where human rights violations are intense but where the HRFT does not have centers, the Five-Cities Project (including Diyarbakır, Van, Malatya, Gaziantep and Mersin) has been implemented in 1997, too.

Concerning the Treatment and Rehabilitation Project, we have tried to render the Treatment and Rehabilitation Centers more efficient in 1997. There have been developments in relations with various elements of the scientific field; an Ethical Board was formed; the preparations for the establishment of Medical Boards reached the last stage; discussions on cases have been intensified; the ratio of psychological assessment increased to 57%; the ratio of applicants abandoning treatment has decreased to 14.6% (27.3% in 1995 and 23.5% in 1996).

In 1997, attempts were intensified regarding the establishment of a center in Diyarbakır which has long been on the agenda of the HRFT. Concrete steps are taken in 1998.

The Adana trial reached an end on 2 May 1997. Lawyer Mustafa Çinkılıç, the Adana Representative of the HRFT, was acquitted of “operating an unlicenced health center” while Dr. Tufan Köse, physician at the HRFT Adana Treatment and Rehabilitation Center, was fined (TL. 18.787.000) for "failure in notifying the authorities of our tortured applicants " (Turkish Penal Code Article 530). At this point, we would like to express that the rightness of our opinions and values have been revealed clearly. Disclosing of no information without consent of the person, a universal principle of medical ethics, holds vital importance from many aspects in a specific issue such as torture. What has indisputable priority in this specific issue is that the torture survivor should psychologically, sociologically and physically be restored to and enjoy good health. Therefore the physicians working for the HRFT have declared that they would carry out their duties as they did before, regardless of the verdict.

However, the verdict opposes to this point of view. It is without doubt that the values accumulated throughout centuries cannot be destroyed with a verdict. For this reason, we will intensify our efforts at all levels where we have the right to do so (the Supreme Court, international/supranational judicial processes). The case is currently pending before the Supreme Court.

We are grateful to everyone who have been attentive and contributed to the issue and created an atmosphere of solidarity in this period.

The Treatment and Rehabilitation Project includes not only treatment and rehabilitation services but also training, scientific researches and activities for the improvement of the quality of these services.

This report, which covers the results of the activities of the HRFT Treatment and Rehabilitation Project 1997 is published in Turkish and English as in previous years.

Publication and presentation dates are obviously important for the functionality of annual reports. Therefore, publication of the 1997 report in June 1998 would have suited that functionality. Certainly, greater care will be taken concerning publication dates in the coming years.

The Treatment and Rehabilitation Centers Report 1997 comprises two parts following the foreword by President Yavuz Önen on behalf of the Governing Board, who makes an assessment of the year 1997 from human rights point of view.

The first part of the report furnishes an account of the medical activities of the Foundation during 1997. It contains information and comments on those who applied to the HRFT Treatment and Rehabilitation Centers in Adana, Ankara, İstanbul and İzmir with complaints consequent to torture.

In the second part of the report there are articles related to certain themes that the Treatment and Rehabilitation Centers of the HRFT were involved in 1997.

The first article in this part is the article by Dr. Cem Kaptanoğlu entitled "Secondary Traumatic Stress." It is argued that traumatic events affect the person experiencing it and it has a ripple effect on the family, close friends and society of the traumatized person. Dr. Kaptanoğlu's attempt to relate Secondary Traumatic Stress with the act of "One Minute Darkness for Continuos Enlightenment" constitutes an interesting and meaningful subject of debate. Dr. Kaptanoğlu describes this act as the "first session of the group therapy that we are all in need of" and adds that "there are many sessions for us to attend all together in order to heal ourselves."

The second article of the same part is related to hunger strike - death fast: an issue, which has deeply affected the public conscience and for which we feel compelled although we are not. It is related to the clinical assessment of the hunger strike - death fast participants whose cases were medically intervened by İstanbul University Neurology Department with great success appreciated as a proud achievement in all medical circles and in society on the whole, during the period of hunger strikes - death fasts in May 1996 that resulted in 12 deaths.

Activities of the HRFT are the fruits of hundreds of sensitive people, including health professionals and human rights defenders, who work towards a common objective in different parts of the country. We thank all our friends who have contributed to these efforts and stood by us, and to the Human Rights Association (İHD) and Turkish Medical Association (TTB) which supported our work from the very beginning.

Ankara, May 1998

FOREWORD

Yavuz Önen*

Location, Gazi Quarter, İstanbul, year 1995, March 12. Some plainclothes among policemen on İsmetpaşa Street are aiming and firing at demonstrators with rifles. The result is 19 deaths and some 300 wounded people, most of them by bullets. The trial launched in İstanbul against the security forces is being transferred to Trabzon for security reasons. Families and lawyers who go to Trabzon to attend the trial are being attacked by some "civilian" people. The defendants are being released. The evidences cannot be gathered, and the testimonies cannot be received. The judicial process is not working.

Location Manisa Security Directorate, year 1995, month December. Sixteen students below the age of 18 are being tortured. In the trial launched thereupon the 10 police officers are acquitted

Location Eyüp District, İstanbul. Journalist Metin Göktepe is being killed under beating at the sports hall he is detained. The police officers on trial are passed on a sentence at the lower limit to be given to for "ill-treatment." Five years imprisonment.

Location Grand National Assembly (Parliament), year 1996, February 29. A total of 96 years' imprisonment to six students because they opened placard in the Grand National Assembly (quashed by the Supreme Court).

Hunger strikes, death fasts in many prisons of Turkey. May, 1996. Resulting in 12 deaths.

Location Diyarbakır Prison, year 1996, September 24. A group of 60 people including policemen, soldiers and wards are beating the prisoners with iron sticks and killing 10 of them by smashing their heads. The trial is continuing.

Susurluk, a lorry is crashing into a Mercedes. Inside are Abdullah Çatlı, whose name is mentioned in relation to many political murders, wanted by the police for years as a suspect of murder, Hüseyin Kocadağ, Commander of Special Teams and Security Director, Sedat Bucak, Head of village guards and an MP of the True Path Party (DYP) from Urfa, a woman, and arms used in murders, silencers are all together. No defendant is under arrest, and the trial is still continuing.

Above I made an outline of certain important events that have been reflected on TV, carried to newspaper columns, and thus have been publicized. Now, I want to draw attention to certain issues that have not occupied our minds, and that have not been revealed.

In the last five months of the year 1997, 43 persons were given the death penalty and many trials on the demand of death penalty are continuing.

From 12 March 1997, when the legal arrangements related to the reduction in detention periods were put into force, to 30 November 1997, 94 people applied to the HRFT Treatment and Rehabilitation Centers claiming to have been tortured in that period.

Urfa, year 1997, month June. Chairman of the İHD Urfa Branch Aziz Durmaz was detained. He was subjected to such torture methods as "beating, keeping in the refrigerator, hanging, falanga, and giving electricity," His ribs were broken.

Torture methods such as "hosing pressurized water, hanging, giving electricity and beating" were applied to Murat Coşkun, the Chairperson of the Genel-İş Trade Union Ankara Branch, while in detention.

In Sefaköy, İstanbul, on 27 October, two youngsters at the age of 16 were detained because they were looking suspicious and were tortured at İstanbul Public Order Directorate where they were taken to.

İzmir, 3 November 1997. University student Bülent Taşkın was taken to a remote place by three policemen while he was on his way to his house at around 23:00. Bülent Taşkın claimed that when he had not accepted the offer of becoming an agent for the police he had been kept under cold water, beaten and released at around 03.00 without any legal transactions.

Adana, year 1997, November 15, Çukurova University Fevzi Çakmak Students' Dormitory. A student named Mustafa Özdemir stated that after being detained by some plainclothes police officers he had been taken to a remote area and threatened with death unless he became an agent.

İzmir Provincial Administration Board decided that the police officers, who broke the arm of a young man named İbrahim Tekbudak under beating at Konak Square during the May Day Meeting in 1996, should not be put on trial.

The prison terms given to police officers named Nezih Karakuş and Ahmet Seçkin because they tortured Songül Yıldız, a member of the Executive Board of the Democracy and Peace Party Seyhan District Organization, who was detained in Adana on 14 December 1996, were reprieved.

All these indicate that;

- Security forces use excessive violence, torture is systematic and widespread throughout the whole country, people are interrogated and tortured also in houses and at unknown places, officials fire without any necessity and with the intention of killing;

- As a general rule, no investigation or trial is launched against those who are responsible for all these, and when launched the trials continue for very long times, the sentences given are very insignificant compared to the offense and usually reprieved, the assailants are acquitted, and tactics like intentionally delaying, letting be forgotten, and finally covering up the events are used as in the case of Susurluk;

- A judicial system that is not fair and independent, which is very slow and not fitting to the rule of law cannot be preventive, cannot satisfy the public conscience, and cannot carry out the function of protecting victims. Thus, the conditions that led to the conviction that there is no life security in the country and the right to life is under threat remain, and assailants and gangs are still active within the country.

In the recent years, subsequent governments have started to develop strategies for democratization and protection of human rights and talk about various action packs. However, the facts prove that there is not a decrease but an increase in human rights violations despite all promises.

Secondly, while taking steps regarding torture, freedom of expression and thought, Kurdish problem, etc., Turkish governments always take into account the relations with the USA and the Western Europe. Democracy and human rights agenda in Turkey is always driven from an international source. Thus, on the one hand Turkish governments receive support from foreign politicians and diplomats, and on the other hand violations continue.

There are pressures on the freedom of thought and expression, and freedom of organization and assembly. There have been many violations concerning these freedoms. Human rights defenders have one after the other been convicted. The branches of the Human Rights Association (İHD) and of the trade unions that are members of the Confederation of Public Laborers' Unions (KESK) have been closed. Peaceful meetings and demonstrations have been barred or dispersed with force. The gravity of living conditions in prisons prevails and pressures have intensified. Torture in prisons is a component of daily life. It is officially proclaimed that fatal and epidemic diseases such as tuberculosis and Hepatitis-B are widespread among prisoners, but no measure is taken against them.

People who put forward opinions and demands opposite to the policies of state authorities are brought before court as criminals of "terror".

The Kurdish problem, which is a political problem, is still within the authority of the National Security Council (MGK). The abolition of the Emergency State has been postponed. In regions where Kurdish citizens live all kinds of human rights violations persist. Our people who forcibly left their villages cannot find the means to provide themselves with fundamental needs such as nutrition, accommodation, health and education services, and they are totally uncertain and hopeless about their future.

In the 28 February 1997 dated National Security Council meeting, amendments were made to the document of National Military Strategy Concept and the Sharia threat was considered to be equivalent to the PKK threat. The subsequent course of events led to the closure of the Welfare Party (RP), prevention of RP Chairperson Necmettin Erbakan and five of his friends from politics for five years, and to investigations against some deputies

and mayors, and punishment of some of them. REFAHYOL Government was made resign in such an atmosphere and ANASOL-D Government was brought to power with support from "civilian" forces. But the debate between Prime Minister Mesut Yılmaz and Head of General Staff İsmail Hakkı Karadayı and four commanders of forces on the implementation of the 18-item demands of the MGK led to the issuance of a memorandum by the commanders against the new government. Cross border operations and operations in the State of Emergency Region further increased the tension that prevailed since 28 February 197. It is clear that democracy and human rights issues cannot come to the forefront in such a context. (In a meeting of the Human Rights Supreme Board of the Parliament, to which the HRFT was also invited, it was mentioned that the democratization report prepared by the Ministry of Foreign Affairs stated that the military did not consent fundamental changes.)

The HRFT is determined to utter the demands for peace, democracy and human rights, and to work for the eradication of all kinds of human rights violations, especially torture, whatever the conditions are. This report will serve its duty if it helps us to keep our memories alive, directs us to create solidarity with victims of violations and arouses the feelings of conscience and justice. We wish our attempts contribute to a democratic, civilian will to come to power in the country.

Ankara, May 1998

HRFT Treatment and Rehabilitation Centers Report

1997
Evaluation Results

HUMAN RIGHTS FOUNDATION OF TURKEY
TREATMENT AND REHABILITATION CENTERS
1997 EVALUATION RESULTS

INTRODUCTION

The Human Rights Foundation of Turkey (HRFT) is an independent non-governmental organization established in 1990 in accordance with the Turkish Civil Law, as an outcome of the related studies conducted by the Human Rights Association (İHD) and the Turkish Medical Association with the participation of a group of intellectuals. Along with the headquarters located in Ankara, the HRFT has representation offices in İstanbul, İzmir and Adana.

The HRFT carries out its activities in accordance with all international conventions, whether undersigned by Turkey or not.

The HRFT works on the basis of projects. The projects prepared are communicated to non-governmental international human rights organizations and as soon as the required support is secured, are put into practice. As a principle, the HRFT strictly refrains from accepting support or donations from governments as well as institutions or individuals involved in practices violating human rights.

At present, the HRFT conducts its studies within the framework of two main projects: The Treatment and Rehabilitation Centers Project and the Documentation Center Project.

The Documentation Center Project aims to monitor and document human rights violations.

The Treatment and Rehabilitation Centers Project provides treatment and rehabilitation to people who suffer from health disorders due to the torture and ill-treatment they have been subjected to during official or unofficial detention periods and in prisons, taking into account the physical, psychological and social integrity of people. In the Tokyo Declaration by the World Medical Association, torture is defined as; "The deliberate, systematic, wanton infliction of physical or mental suffering by one or more persons acting alone or on the authority or any authority to force another person to yield information, to make a confession, or for any other reason." In Turkey, torture not only takes place during detention or in prisons but is also frequently applied during village and house raids, while searching and quartering in houses, and in cases of kidnapping by plainclothes officials or by people reporting to have acted in the name of some secret organizations of the state. As torture is very likely to influece the relatives of the tortured person, providing solutions to the psychological problems of relatives of torture survivors related to traumatic periods has also been considered within our field of work. Within this framework, relatives of torture survivors are also provided with the required service.

The HRFT carries out its work by means of its representation offices located in Ankara, İstanbul, İzmir and Adana. At these centers, professional teams formed of general practitioners, psychiatrists, social workers, psychologists and medical secretaries, arrange the treatment and rehabilitation work in cooperation with specialists from all medical disciplines. The preliminary evaluation of applicants is carried out at the centers, and then a treatment and rehabilitation plan is constructed. In line with the plan constructed, the required medical examination, laboratory examination and treatment are carried out by specialized people and institutions either on a contractual or voluntary basis. Excluding the contributions of volunteer physicians, all expenses are covered by the HRFT. The period of treatment is coordinated by the teams in charge at the centers. The results and evaluations of the work are publicized in the form of regular reports.

Establishing a treatment center in Diyarbakır has always been on the agenda of the HRFT from the very beginning since Diyarbakır is a city with a relatively developed medical environment in the State of Emergency Region that can be reached from any point in the region. However, in Diyarbakır where a center could not be opened for seven years due to some "special" reasons, the conditions to open the Diyarbakır Representation Office attained maturity in 1998. Upon this development, the "5 Cities Project" that included Mersin, Gaziantep, Malatya, Diyarbakır and Van will be implemented with the addition of Adıyaman, Urfa and Hatay. "5 Cities Project" aims to provide social and financial support for the travel and accommodation expenses of those who have suffered from torture in the regions that are included in the project and where there is no treatment center. The project is realized through the active support of the branches of the Human Rights Association (İHD) and the medical chambers in those cities attache to the Turkish Medical Association (TTB). In the cities where the project is in effect, a network of individuals and institutions who voluntarily referee is formed to admit the applicants and maintain the necessary contacts with the centers where they are to be treated. Regular communication with the referees is secured by the Project Coordinator at the Headquarters. Whenever there is an application, the referees contact the Project Coordinator and get an appointment. The HRFT also covers all the expenses for the applicants' transportation to the city where they receive medical treatment their accommodation and nourishment. This project is primarily carried out in Ankara. However, centers in other cities also accept applicants within the framework of the 5 Cities Project when necessary.

Infliction of torture sometimes causes losses of organs or extremities, or dysfunctioning. “Special projects” are developed to provide solutions to the health problems of such cases that cannot be efforted within the budget allocated to the Treatment and Rehabilitation Project. The special projects are submitted to the relevant organizations and when the necessary support is secured the projects are implemented.

The HRFT has developed a humane-medical institutionalization that organizes the multi-disciplinary studies of health care workers from various branches and professions, who perceive to be involved in the treatment of torture survivors as a requirement of being human and as an ethical responsibility of health workers.

METHOD

This report is prepared retrospectively on 537 applicants to the Treatment and Rehabilitation Centers of the HRFT in Ankara, İstanbul, İzmir and Adana in 1997.

The data were obtained using a questionnaire of 49 items on the characteristics of the applicants. The questionnaire was prepared to find out the sociodemographic characteristics of the applicants, information on detention and prison periods, torture methods, and the consequent physical and psychological complaints.

The tables and graphics in the report are designed using the Microsoft Excel 5.0 computer program.

There is no information regarding torture or detention periods of 19 applicants since they are relatives of torture survivors. Therefore, evaluation was made taking into consideration the available data on 518 applicants.

As for the hardships encountered during the conduct of the study, the lack of standardization in connection with the fact that the data are gathered at four centers, and the applicants' difficulty in remembering certain details were singled out.

STUDIES OF TREATMENT AND REHABILITATION CENTERS

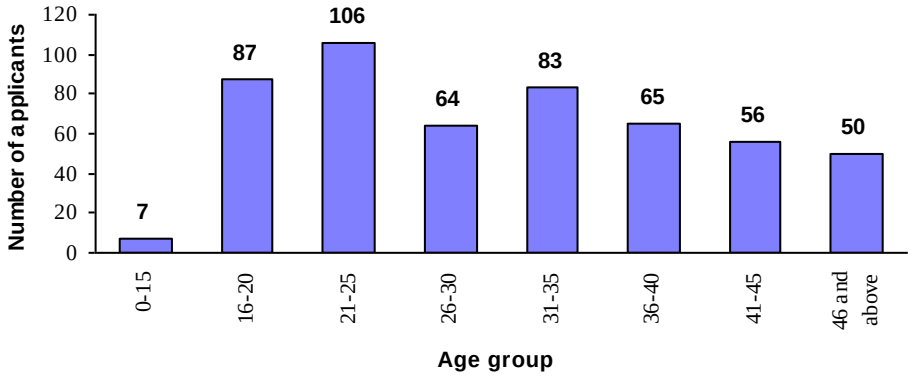
A. The Sociodemographic Characteristics

In 1997, the HRFT provided medical care to 537 applicants within the framework of the “Treatment and Rehabilitation Project.” The data belonging to 19 applicants who are relatives of torture survivors were not taken into consideration during the evaluation process. The evaluation was made on the data belonging to the remaining 518 persons. The term “applicant” used in evaluation refers to this group of 518 persons.

Of the 518 applicants, 151 are female, and 367 are male.

The age of our applicants varied between 4 and 70. The mean age was 31 (Graphic 1). 43 persons in the 0-18 age group applied stating that they had been tortured. Torture practices directed at children and youth, while giving an idea about the extent of torture practices, need special emphasis considering the destruction it caused / may cause on people at their childhood.

Graphic 1. The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 1997 according to the age groups



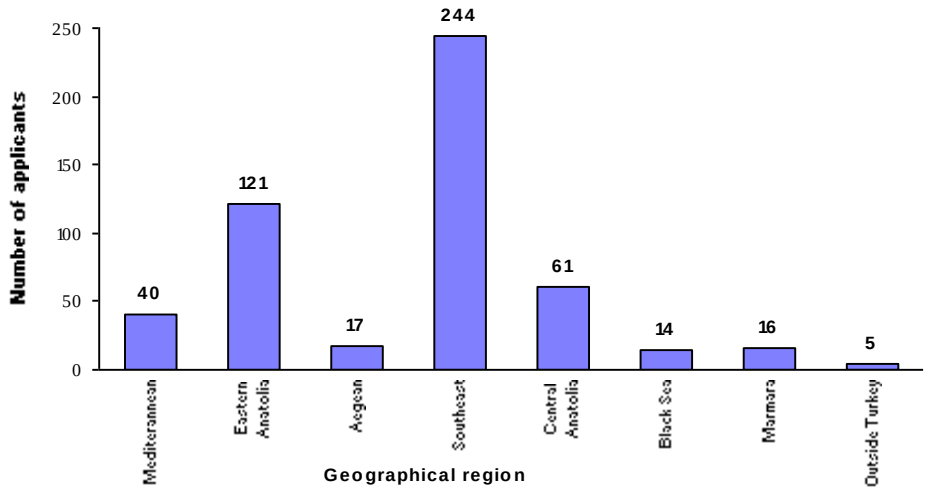
Regarding the distribution of the applicants according to the place of birth, the Southeast Anatolian Region ranked first, followed by the East Anatolian Region as in previous years (Graphic 2). This fact can be considered as a finding supporting claims of intensity of torture practices, or torture and pressures against the ethnic identities in these regions.

When the educational levels of the applicants are analyzed, it is seen that the number of primary school graduates exceeded the number of high-school graduates who ranked first in this regard in 1996 (Graphic 3).

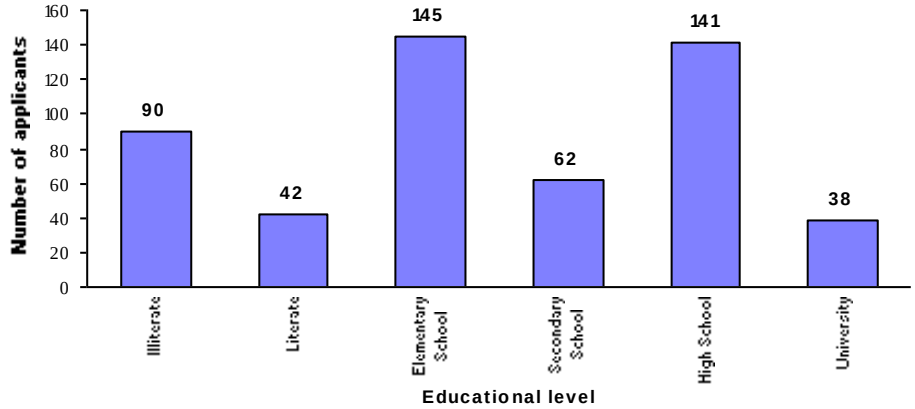
Regarding the employment status of the applicants, the high rate of unemployment is determined to prevail as in previous years (Graphic 4).

Considering the total number of applicants, the HRFT Istanbul Treatment and Rehabilitation Center received 160 applicants, whereas 149 applications were filed at İzmir, 140 at Adana, and 69 applications were filed at the HRFT Ankara Treatment and Rehabilitation Center.

Graphic 2. The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 1997 according to place of birth

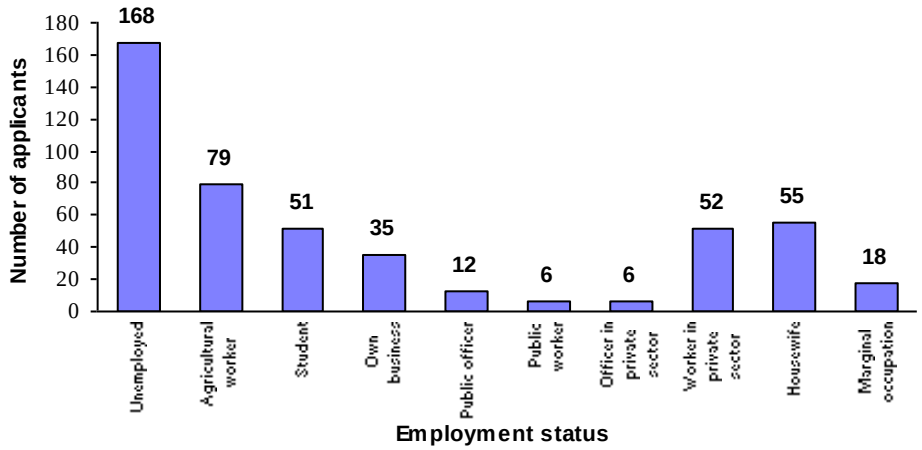


Graphic 3. The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 1997 according to educational level

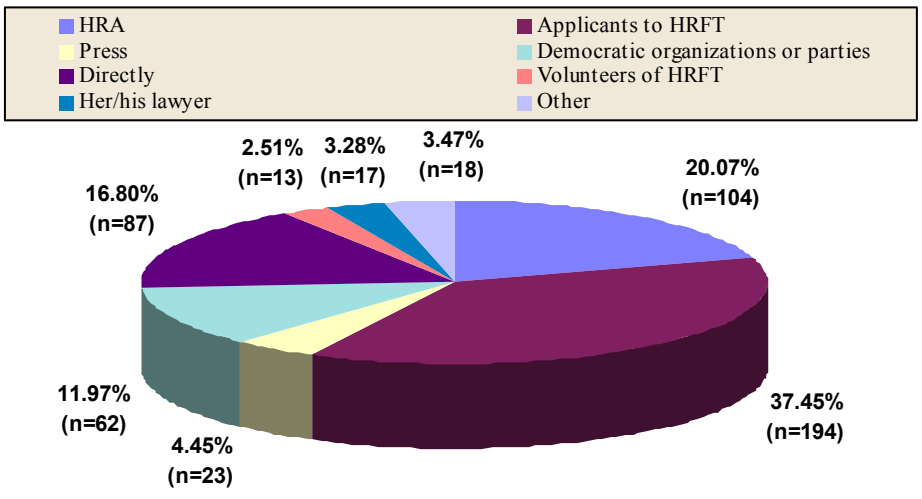


Concerning the channels of contact and reference, it is seen that the ratio of referrals by former applicants is higher than the ratio of referrals by the Human Rights Association, which, in this regard, ranked first in previous years. (Graphic 5) This can be considered as an indication that the HRFT meets an important demand efficiently and also that the applicants act in solidarity with each other.

Graphic 4. The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 1997 according to employment status



Graphic 5. The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 1997 according to channel of contact



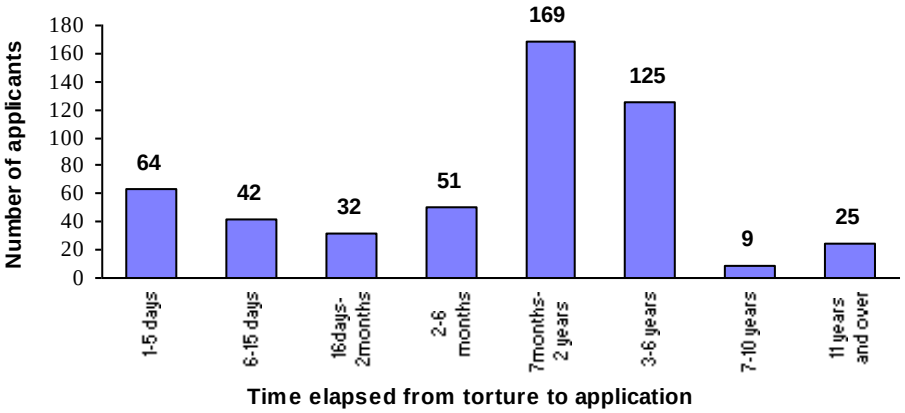
B. Information Regarding the Period under Torture

The data on torture survivors, who stated they had been exposed to torture more than once, are evaluated on the basis of their recent detention period.

32.81% of the applicants (170 people) stated that they had last been subjected to torture in 1997 while 26.25% of the applicants (136 people) stated they had last been tortured in 1996.

How long ago the applicants were tortured is informative in approaching the problem of continuity of torture. The figures reveal that torture is still applied systematically despite all the promises and claims of improvement by political powers. (Graphic 6).

Graphic 6. The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 1997 according to the time elapsed from the latest torture practice to their application

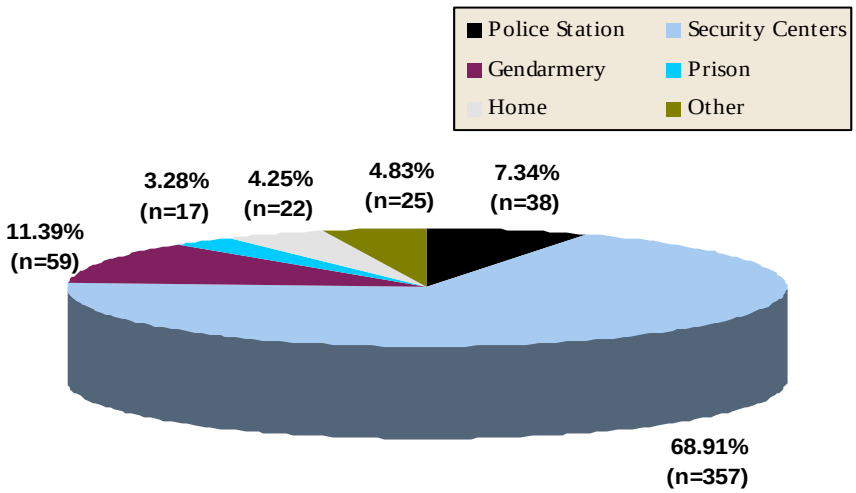


24.52% of the applicants (127 people) indicated that they have recently been tortured within the borders of the Emergency State Region. 33 applicants were last subjected to torture in Diyarbakır and 51 in Mardin. The considerable number of applications despite the lack of a treatment center of the HRFT in that region is a sign of the urgent need for a treatment center in that region.

94.40% (489 people) stated to have been tortured on political grounds and 5.60% (29 people) on non-political grounds. The low ratio of applicants who were tortured on non-political grounds is not because the detention conditions for this group is better but mainly because they are hesitant to seek for their rights and they do not know much about the HRFT.

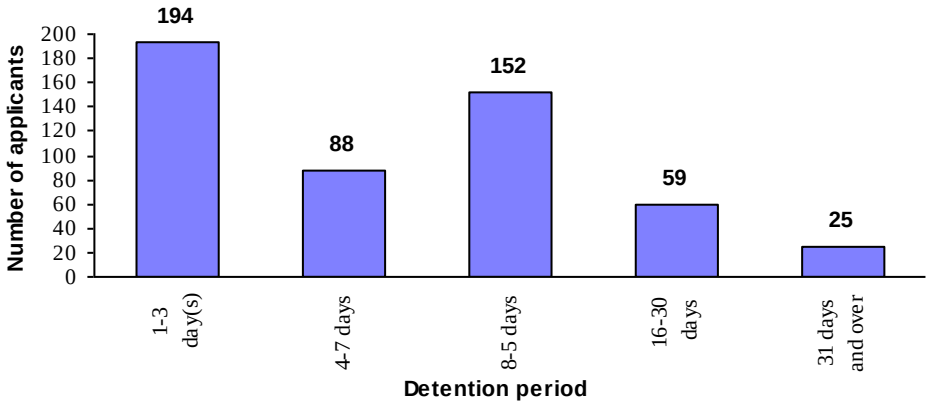
Security Directorates occupied the first rank with 68.91% (357 people) in the list of places where torture has been practiced recently (Graphic 7).

Graphic 7. The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 1997 according to the places of recent torture practice



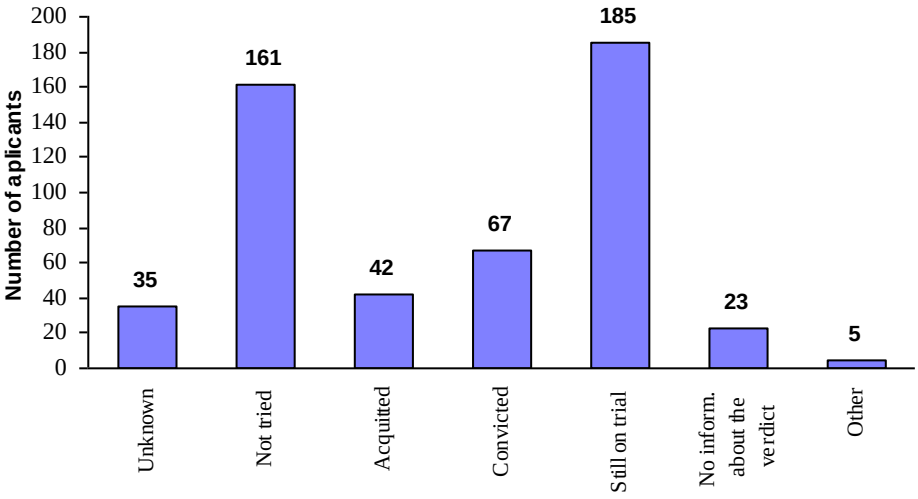
Considering the period of detention and its consequences, 45.56% of the applicants (236 people) stated that they had been kept in detention for eight or more days when they had last been detained (Graphic 8).

Graphic 8. The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 1997 according to the duration of their recent detention period



46.52% of the applicants (241 people) stated that they had been arrested following their recent detention period, 23.36% (121 people) that they had been released either by the prosecution office or by the court and 30.12% (156 people) that they had been released without being taken to a prosecution office. The legal results of the detention period of applicants yield meaningful results (Graphic 9).

Graphic 9. The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 1997 according to the legal process that followed their recent detention period



Methods of torture inflicted on the 518 applicants to the HRFT Treatment and Rehabilitation Centers are shown in Table 1.

The torture methods inflicted on the 282 applicants who were kept in detention for 1-7 days are presented in Table 2.

Considering the numerical assessment of torture methods inflicted during the recent detention period of applicants, it is seen that more than one torture method were inflicted at the same time (Graphic 10).

Of the 518 torture survivors who applied to the HRFT, 43.63% (226 people) acknowledged that they had been detained once, 17.95% (93 people) twice, and 38.42% (199 people) three times or even more.

Graphic 11 shows the period of applicants' stay in prison either as arrestee or convict in any time in their life.

Table 1. Torture methods inflicted on the applicants to the HRFT Treatment and Rehabilitation Centers in 1997.

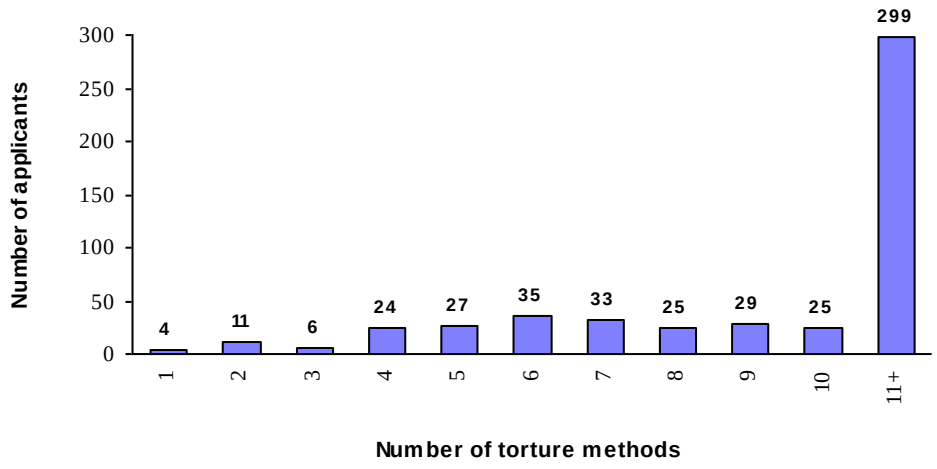
Torture Method	n	%
Insulting	500	96.5
Beating	484	89.6
Threats (other than death threats) against the person	471	90.9
Blindfolding	425	82.1
Death threats	418	80.7
Threats related to relatives	301	58.1
Stripping	273	52.7
Pressurized/cold water	258	49.8
Restricting food and water	256	49.4
Restricting defecation and urination	244	47.1
Sexual harassment	230	44.4
Forcing to wait on cold floor	229	44.2
Cell isolation	227	43.8
Electricity	224	43.2
Suspension on a hanger	218	42.1
Pulling out hairs/mustaches/beards	186	35.9
Witnessing torture	166	32.0
Squeezing testicles	141	27.2
Restricting sleep	139	26.8
Forcing to listen to marches or high volume music	116	22.4
Falanga	113	21.8
Forcing to extensive physical activity	100	19.3
Asking for serving as an informer	83	16.0
Forcing to obey nonsense orders	82	15.8
Mock execution	77	14.9
Creating a sense that torture will begin at any time	65	12.5
Torturing close relatives	44	8.5
Strangling	25	4.8
Rape	19	3.7
Burning	18	3.5
Other	182	35.1

Table 2. Torture methods inflicted on applicants to the HRFT Treatment and Rehabilitation Centers in 1997 who stayed in detention for 1-7 days (282 people).

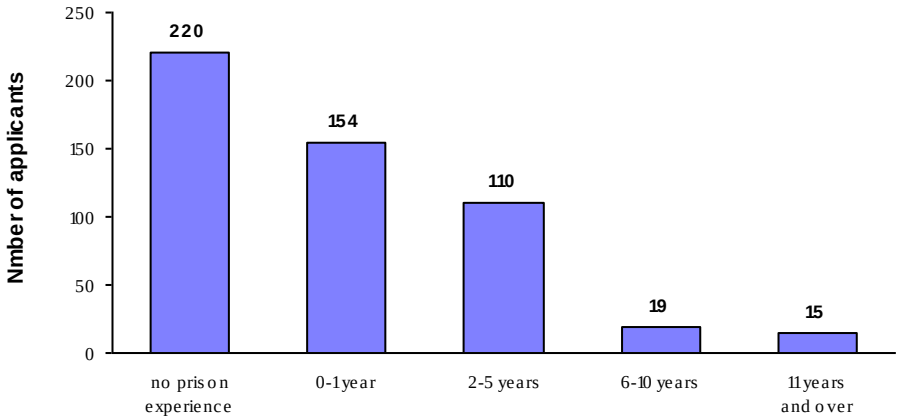
Torture Method	n	%
Insulting	267	94.7
Threats (other than death threats) against the person	247	87.6
Beating	240	85.1
Death threats	198	70.2
Blindfolding	194	68.8
Threats related to relatives	143	50.7
Restricting food and water	113	40.1
Restricting defecation and urination	110	39.0

Sexual harassment	106	37.6
Stripping	102	36.2
Forcing to wait on cold floor	90	31.9
Pressurized/cold water	88	31.2
Cell isolation	83	29.4
Pulling out hairs/mustaches/beards	74	26.2
Electricity	64	22.7
Witnessing torture	59	20.9
Suspension on a hanger	53	18.8
Restricting sleep	47	16.7
Squeezing testicles	44	15.6
Asking for serving as an informer	42	14.9
Forcing to extensive physical activity	38	13.5
Falanga	36	12.8
Creating a sense that torture will begin at any time	32	11.4
Forcing to obey nonsense orders	29	10.3
Mock execution	23	8.2
Forcing to listen to marches or high volume music	22	7.8
Torturing close relatives	20	7.1
Rape	9	3.2
Strangling	6	2.1
Burning	6	2.1
Other	60	21.3

Graphic 10. The distribution of the number of torture methods inflicted on the applicants to the HRFT Treatment and Rehabilitation Centers in 1997.



Graphic 11. The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 1997 according to the period spent in prison.



298 of the applicants stated that they had been to prison. Table 3 shows the torture methods inflicted on those applicants who have prison experience, in prison.

Table 3. Torture methods inflicted in prison on applicants to the HRFT Treatment and Rehabilitation Centers in 1997 who have a prison experience

Torture Method	n	%
Insulting	199	66.8
Beating	127	42.6
Forcing to obey nonsense orders	94	31.5
Threats (other than death threats) against the person	71	23.8
Death threats	40	13.4
Cell isolation	34	11.4
Forcing to wait on cold floor	30	10.1
Restricting food and water	18	6.0
Falanga	17	5.7
Forcing to listen to marches or high volume music	16	5.4
Pulling out hairs/mustaches/beards	15	5.0
Witnessing torture	14	4.7
Threats related to relatives	13	4.4
Stripping	10	3.4
Restricting sleep	10	3.4
Continuous blows to a definite point on body	10	3.4
Strangling	10	3.4
Forcing to extensive physical activity	9	3.0
Restricting defecation and urination	8	2.7
Pressurized/cold water	6	2.0
Squeezing testicles	6	2.0
Mock execution	5	1.7
Blindfolding	4	1.3
Sexual harassment	4	1.3
Asking for serving as an informer	4	1.3
Suspension on a hanger	3	1.0
Torturing close relatives	3	1.0

Electricity	2	0.7
Rape	0	0.0
Burning	0	0.0
Other	42	14.1

During the interviews with the 298 applicants who stayed in prison, they were asked about their opinions about the prisons. Some of the common points raised are presented below:

72.49% of the applicants (222 people) in this group stated that they thought negative about or found bad the nutrition conditions, 73.48 % (219 people) the accommodation, 84.90% (253 people) the hygienic state, 69.12% (206 people) the communication facilities, 81.54% (243 people) health services, 54.69% (163 people) access to open air and sportive activities, 64.76% (193 people) facilities of using printed and visual material, and 87.58% (261 people) the conditions of transfer from one prison to another.

Of the 518 applicants 272 stated that they had been taken before a forensic physician after their recent torture experience with the initiative of officials. Among those applicants who have undergone forensic examination 67.28% (183 people) stated that security forces had not been made leave the examination room, 73.1% (199 people) that the medical examination had not been carried out properly, and 61.40% (167 people) that the medical reports issued following the forensic examination had not been in competence with the findings. Meanwhile, 14.48% (41 people) were determined to have received medical reports on their own initiative after the infliction of torture.

C. The Treatment Process

Of the 518 applicants to the HRFT Treatment and Rehabilitation Centers in 1997, 29.92% (155 people) had only physical complaints and 4.83% (25 people) had only psychological complaints, while 65.25% (338 people) sought medical assistance for both physical and psychological complaints.

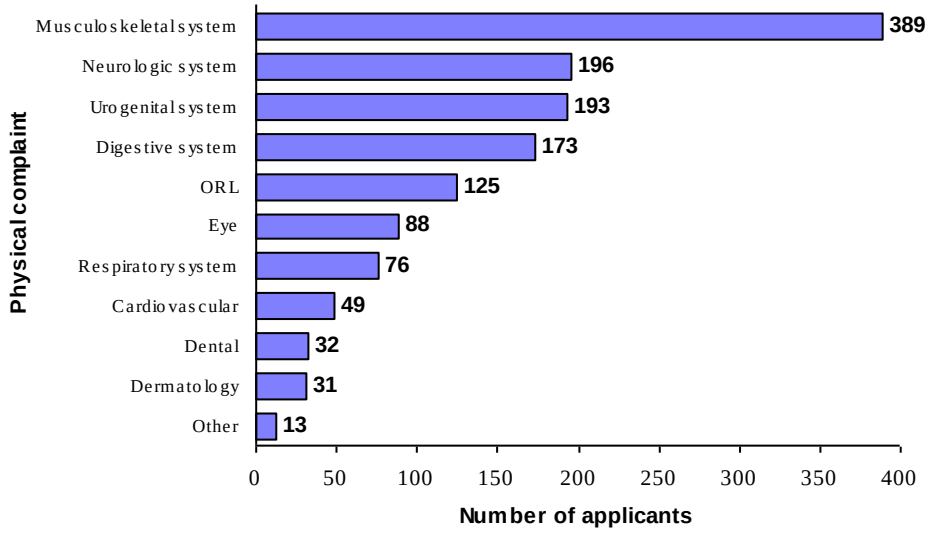
When the physical complaints of the applicants are evaluated on the basis of frequency, complaints related to the musculoskeletal system ranked first as in previous years (Graphic 12).

When the frequencies of the diagnoses that the 518 applicants received are evaluated, the diagnosis related to musculoskeletal system occupied the first rank (Graphic 13).

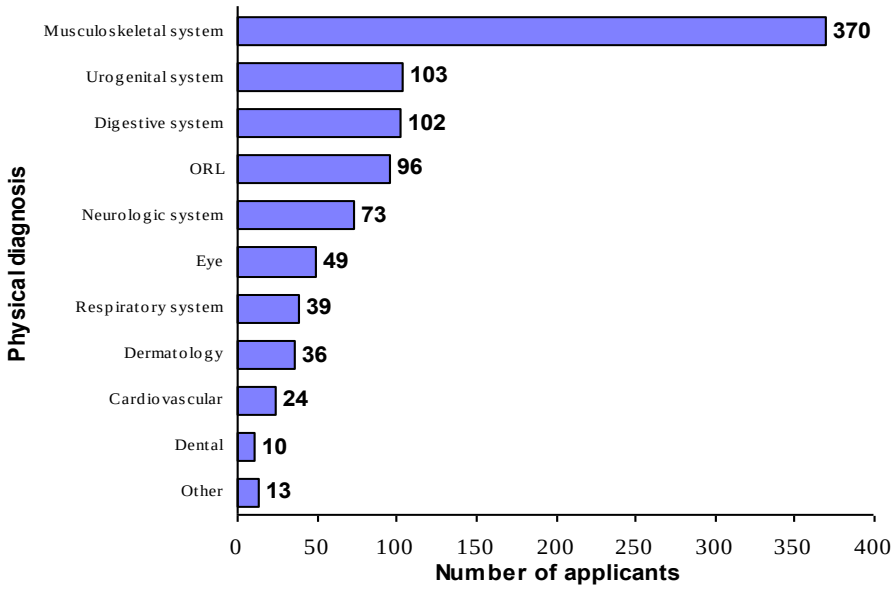
The relation between the torture inflicted on the applicant and the diagnosis obtained as a result of the medical and laboratory examinations, is studied within the framework of 5 options: “Not related to torture or prison experience, ” “Torture or prison experience is one of the etiologic factors,” “Torture or prison experience worsened the existing pathology or caused the emergence of the pathology,” “Torture or prison experience is the only etiologic factor," and “Relation could not be determined." The distribution of the physical diagnosis’ relation with torture is presented in Graphic 14.

Of the 518 applicants, 14.48% (75 people) had permanent traces or some kind of physical disability due to the torture.

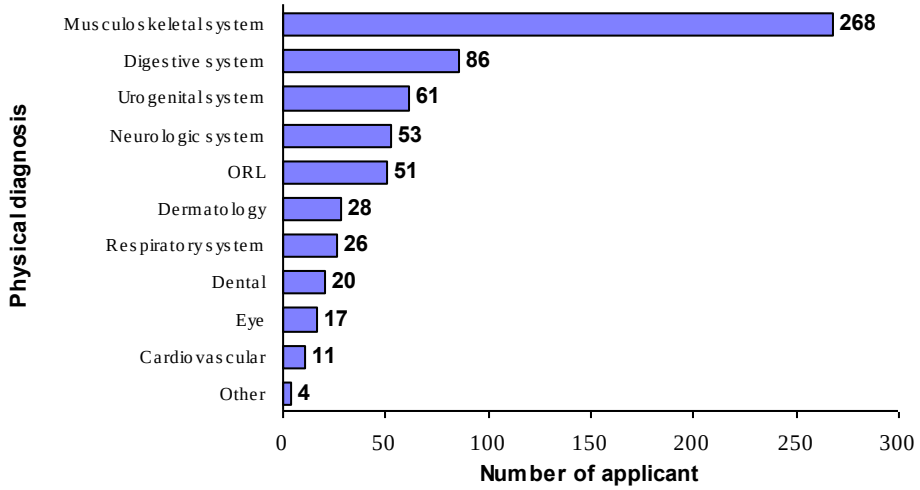
Graphic 12. The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 1997 according to their physical complaints.



Graphic 13. The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 1997, according to their physical diagnosis.



Graphic 14. The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 1997, according to their physical diagnosis related to torture.



The applicants to the HRFT are advised to have sessions with psychiatrists working for or having relations with our centers. However, the ones who object to these sessions for various reasons are not compelled to do so. In 1997, 283 applicants had sessions with a psychiatrist whereas 235 did not either because there was no need or they did not want to have sessions.

Looking at the psychological complaints of the applicants on the basis of frequency, it is seen that sleep disturbances were leading (Table 4).

Considering the psychological diagnosis related with torture on the basis of frequency, Post-Traumatic Stress Disorder (PTSD) ranked first (Table 5).

In 1997, out of the 518 applicants, physical treatment of 223 was completed, and while the data for this report were being processed, physical treatment of 146 was continuing 76 applicants abandoned the physical treatment period and the files of 38 applicants were shelved as no diagnosis related with torture or prison experience could be obtained.

The psychological treatment of 137 applicants was completed, and while the report was being prepared, the psychological treatment of 86 applicants was continuing and the psychological treatment of 81 applicants was abandoned.

The evaluation of treatment and rehabilitation methods applied to the applicants reveals that 428 applicants received pharmacological treatment, and 140 received psychotherapy. Physiotherapy was applied to 74 applicants, various surgery operations to 29, orthopedic operations to 13 and dental treatment to 16 either single or in combination.

Table 4. The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 1997 according to their psychological complaints.

Psychological complaints and symptoms	n	%
Difficulty in falling or staying asleep	251	48.5
Anxiety	228	44.0
Memory impairment	224	43.2
Weakness, fatigue	210	40.5
Concentration difficulties	209	40.4
Acting or feeling as if the traumatic event recurring	206	39.8
Recurrent and intrusive distressing recollections of the event	187	36.1
Intense psychological distress at exposure to internal or external cues that symbolize resemble an aspect of the traumatic event	176	34.0
Irritability or outburst of anger	174	33.6
Recurrent distressing dreams of the event	167	32.2
Increase or decrease in the duration of sleep	158	30.5
Feeling of detachment or estrangement from others	141	27.2
Efforts to avoid activities, places or people that arouse recollections of the trauma	113	21.8
Hypervigilance	112	21.6
Markedly diminished interest or participation in significant activities	111	21.4
Depressive mood	108	20.9

Physiological reactivity on exposure to internal or external cues that symbolize resemble an aspect of the traumatic event	104	20.1
Sense of a foreshortened future	95	18.3
Change in appetite/weight (an increase or decrease)	93	17.9
Response involved intense fear, helplessness or horror to the traumatic events that are experienced, witnessed or confronted by person	89	17.2
Agitation (irritability)	83	16.0
Efforts to avoid thoughts, feelings, or conversations associated with the trauma	65	12.6
Exaggerated startle response	65	12.6
Blunted affect	59	11.4
Dysphoric mood	57	11.0
Loss of sexual interest	49	9.5
Diminished psychomotor activity	30	5.8
Suicidal thoughts or attempt	26	5.0
Obsession	17	3.3
Inability to recall an important aspect of the trauma	13	2.5
Hallucination (visual, auditory, tactile)	13	2.5
Compulsion	10	1.9
Delusion	7	1.4
Use of alcohol or substance(s)	2	0.4
No symptoms or signs	156	30.1

Table 5. The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 1997 according to their psychiatric diagnosis.

Psychiatric diagnosis	n	%
None	275	53.0
PTSD	109	21.0
Major depressive disorder	60	11.6
Acute stress disorder	21	4.1
Generalized anxiety disorder	17	3.3
Other anxiety disorders	17	3.3
Adjustment disorders	15	2.9
Dysthymic disorder	7	1.4
Schizophrenia	5	1.0
Panic disorder	4	0.8
Somatization disorder	4	0.8
Obsessive-compulsive disorder	3	0.6
Other mood disorders	3	0.6
Conversion disorder	3	0.6
Other organic mental disorders	3	0.6
Sexual dysfunctions or paraphilias or gender identity disorders	3	0.6
Pain disorder	2	0.4
Sleep disorders	2	0.4
Delusional disorder	1	0.2
Alcohol abuse	1	0.2
Dissociative disorders	1	0.2
Eating disorders	1	0.2
Personality disorders	1	0.2
Other	4	0.8

CONCLUSION

In a country where human rights are violated systematically, the HRFT aims to present a brief account of generous efforts of hundreds of medical staff from various occupations through its annual HRFT Treatment and Rehabilitation Centers Report.

The fact that 32.81% of the 518 people who applied to the HRFT in 1997 (170 people) were tortured in 1997 supports the assertion that torture is continuing and systematically applied in Turkey.

Unemployment, a major factor that negatively affects the treatment and rehabilitation, was again at a significant level this year. Projects have been developed concerning supplying work and occupation and social support.

Long detention periods facilitate infliction of torture. Nevertheless, torture cannot be prevented solely with the shortening of the detention period. Accordingly, an evaluation of the torture methods inflicted on the applicants who stayed in detention for 1-7 days reveals that they were intensely tortured. The prevention of torture primarily requires the political powers to give an end to their attitudes that encourage and protect torturers.

The statements of the applicants made it clear that psychological torture methods are more common but such torture methods as electric shocks or hanging are also applied systematically. This should be taken into consideration during discussions on the prevention of torture and determination of torture findings by medical reports.

That many symptoms of torture were not mentioned in forensic reports though they were observed, should be evaluated within the content of the forensic report procedures and the responsibility of the physician in prevention of torture.

Although the proportion of those who abandoned treatment decreased in comparison to the previous year, it still constitutes an important problem.

With the hope of a world where torture is thrown into the dark pages of history.

Studies and Assessments
On Torture and
Its Consequences

SECONDARY TRAUMATIC STRESS

Cem Kaptanoğlu*

The psychological effects of traumatic experiences have until recently been discussed considering only the people directly subjected to a traumatic event. However, traumatic events affect not only the person directly subjected to trauma, but also her/his close affiliates and even society at large. These effects known as **secondary traumatic stress** may lead to a clinical picture similar to post-traumatic stress disorder (PTSD) which is observed in people who have directly experienced trauma. Figley indicates that the psychological reactions related to secondary traumatic stress (secondary traumatic stress disorder) are shockingly similar to PTSD[1]. In the DSM-IV, the content of traumatic experiences has been widened and it has been accepted that secondary traumatic stress may lead to PTSD[2]. In other words, persons who are indirectly affected by a traumatic event can be diagnosed as having PTSD in line with the diagnostic criteria of the DSM-IV.

According to the diagnostic criteria of the DSM-III-R, directly experiencing a traumatic event was the necessary condition for diagnosing PTSD as mentioned in the quotation below. "The person has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone."[3]. In the DSM-IV the same part has been altered and redefined as follows: "The person experienced, **witnessed**, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self **or others**" Within the context of this definition, DSM-IV emphasizes that the following experiences may lead to PTSD:

a) **Witnessing** injury or unnatural death of a person.

b) **Hearing** all at once the death of a family member or a close friend.

c) **Hearing** that a family member or a close friend was attacked seriously, had an accident or was wounded.

d) **Hearing** all at once that her/his child has caught a fatal disease.

e) Coming across unexpectedly with a dead body or pieces of a dead body.

It is the result of research and discussions that have taken place in the last two decades that witnessing or hearing a traumatic event, i.e., secondary traumatic stress, has been directly related to PTSD. Several terms were used to describe the indirect effects of trauma before the generally accepted term "secondary traumatic stress disorder" used by Figley in 1991. Danieli (1982) used the terms “ripple effect” and “trauma infection”, Miller (1988), “emotional contagion”; Verbosky (1988), “proximity effects”, Remer (1988), “secondary survivor”; Mc Cann (1990), “vicarious traumatization”; and Dixon (1991), “peripheral victims” to describe the same issue[1].

Trauma, as Danieli states, has a *ripple effect*. It affects the person who directly experienced the trauma, and the family, close friends and society of the person, in gradually expanding ripples (proximity effects). The study conducted by Solomon and his friends on the Israeli soldiers who participated in the war in Lebanon, and the study of Davidson and his friends on the US soldiers who participated in Vietnam War point out to the fact that the families of the soldiers who had PTSD had more internal conflicts and functional disorders than the families of the soldiers who did not have PTSD. The wives of soldiers having PTSD were more hopeless and had more adaptability problems[4,5]. The indirect effects of trauma on children were analyzed taking into consideration the children whose parents saved their lives from the Nazi massacre and who were born after the war. It was found out that the parents who survived the Nazi massacre had a dependent and an extremely protective relationship with their children which prevents individualization of the children[6]. The psychological support sought by traumatized

parents may reverse the parent-child roles and the child may take upon the roles of parent (parentification)[7]. The follow-up studies conducted on these children showed that they were more depressive and aggressive compared to the children in the control group[8]. The children of Cambodian refugees were reported to carry the effects of the trauma experienced by their parents for two generations[9]. Although there are millions of people who were tortured, killed or exiled, or who disappeared, or whose professional and educational lives were cut in our country, yet, no one institution has dealt with the secondary traumatic stress reactions observed in the families of those people, and yet no one has apologized from them.

While accepting that hearing about torture, death or disappearance of a "family member" or a "close friend" may lead to PTSD, it would be wrong to say that when it is not "a family member" or a "close friend" who experienced the same traumas, the witnesses will not be affected, as stated in the DSM-IV. Giving a secondary traumatic stress reaction does not depend on one's closeness to or being a relative of the primary victim of trauma, but on the level of identification one establishes with the victim. If a person hears the traumatic event on TV and has no personal relation with the victims, s/he may still present symptoms of PTSD if s/he forms a strong identification with them. This possibility is quite high if the person has experienced or witnessed a similar traumatic event before. From a psychodynamic point of view the psychological effects of secondary traumatic stress are not much different from the symptoms pertained to post-traumatic stress disorder. The person feels her/himself helpless, weak and indequate due to what s/he experienced, saw or witnessed. Her/his feeling of security is shaken; her/his positive opinions about her/himself, others and the world are broken down. After the trauma nothing is the same as it was before[10].

At present, the main reference point for understanding secondary traumatic stress is the autodidactic perceptions of the therapists involved in the treatment of traumatized persons about their own secondary traumatic stress reactions. Psychotherapists or care givers to traumatized people are the groups that run a high risk of developing secondary traumatic stress symptoms. During the psychotherapy process the victim is generally asked to relate in detail the traumatic event. The therapist imaginatively experiences the traumatic event as s/he tries to create it in the mind. It is almost inevitable that the therapist, in empathy with the victim, while trying to see the event from the victim's point of view and trying to understand her/him, and hence experiencing the trauma at an imaginative level, asks the fundamental questions, to which the victim is seeking for answers, to her/himself also. 1) What happened? 2) Why did it happen? 3) Why did I feel or behave in that way? 4) Why do I now feel and behave like tis? 5) What should I do if I encounter a similar event? If the therapist starts to ask her/himself these questions, it means the therapist has started accounting for the trauma s/he experienced. This process of accounting for the trauma is not different from the process that is experienced by the primary victim and that forms the cognitive symptoms of PTSD. The symptoms that are observed with the therapist at this stage are the following: 1) For the traumas caused intentionally by human beings there is always the shadow and the threat of the creator of the trauma between the victim and therapist. The therapist can easily be seized by the feelings of helplessness and fear felt by the victim. 2) The therapist's belief in her/his own power, authority and that s/he is safe is destructed by what s/he has witnessed. 3) Her/his confidence in people in general and his hopes related to humanity is upset. 4) S/he feels indignation for her/his colleagues, people around and society at large because they are not sensitive enough. 5) S/he may form identification with the indignation of the victim or may become frightened by the victim seeing how deep her/his indignation is. 6) The therapist may be caught up in the conflict between the assailant and the victim. The therapist assumes the role of witnessing. In such a situation when it is almost impossible to remain impartial as a witness, identification with the victim is not the only possibility. The therapist may identify her/himself with the assailant as well. 7) The therapist may join the victim in her/his mourning. 8) The emotional reactions of the therapist are not only the results of her/his relationship with the assailant or the victim. The therapist may react similar o the witnesses, onlookers of the trauma "who remain as mere spectators." The therapist questioning the role of the helpless witness may experience witness guilt[11].

The secondary traumatic stress reactions of the therapist do not allow us to understand the secondary traumatic stress in its entirety; however it is clear that the experiences of the therapist make important contributions to our comprehension of the case. What is mentioned above may also be considered as transference and counter-transference that take place or may take place in any therapy process. But the central role the trauma assumes in this specific therapy process does not allow us to explain the indirect effects of the trauma on the therapist only with the concepts of transference and counter-transference.

In the countries where human made traumas are intense, continuous, and widespread secondary traumatic stress is a concept that can be utilized in the analysis of "social emotional state." In Turkey we, as members of society, continuously experience fierce traumas either directly or indirectly. We frequently witness traumatic incidents by way of the media. Every day we come across with torn apart dead bodies, severely beaten people,

people shot dead with a single bullet to the back of the neck and children tortured, on TV. I think that even that much is enough for us as members of society to have symptoms of primary or secondary traumatic stress. The head-line of a popular newspaper was as follows on 29 January 1998: “Susurluk Report of Kutlu Savaş revealed how helpless we are. Who will protect us?"[12] We are helpless against what we witness. We are concerned because the institutions that are in charge of protecting us from the "bad" are awaiting to kill us in cooperation with the bad. Susurluk Accident was beyond all our cognitive schemes because what we (at least most of us) are accustomed to see was a scene where a black Mercedes was trying to escape from a white police car pursuing it courageously. We could not believe what we saw in Susurluk. The black and the white, the good and the bad were intermingled, and there was no pursuance as we have been expecting but instead, there was complicity that is not "individual" but systematic assigned by the system. Who is really going to protect the Snow White (us) in this surrealist world where the seven dwarfs formed a gang with the witch and the handsome prince is indeed a coward dwarf? Or what is left to Snow White is to say, in the words of the President of the Turkish Republic, "We have to wait for long"?

"Don't keep quiet or next time it will be your turn" is a slogan known since the Nazi Germany but it became a very popular political slogan in Turkey in the past few years particularly with the publicizing of the information about state terror. Especially the middle and upper classes and some right wing politicians and writers seem to have broken the general opinion that bad things happen to only "bad persons" and to "whom deserves." This is not a result of a sudden jump up of political, ethical or social awareness but their acknowledgement that the state terror can also "put them in order." There is an important result to be derived: There is a security crisis in Turkey that affects not a certain political, ethnic or class group, but the whole society at various degrees. Our belief that the world is secure and just has been broken, and this is one of the fundamental symptoms of secondary traumatic stress. The slogan "Don't keep quiet or next time it will be your turn" is being shouted by the ones at the forfront who stand by the victims, to invite others to be more sensitive and to do something. The people for whom it is the next time, who had been traumatized or are expecting to be traumatized at any time remind those who think they are not in the list, not to feel so comfortable since they can also become victims. This slogan involves reproach, resentment, accusation, criticism and anger just like the reactions of the therapist who feels empathy with the victim.

What we witness, for example, watching the students being beaten harshly with truncheons and kicks on TV or out of our window, we stand somewhere between the victims and assailants. Some of us identify themselves with the victim, with her/his pain and anger. But, it is not a rule to identify oneself with the victim; some of us identify with the assailant. Who cheer for the assailant and shout "hit, hit" are the latter ones. It is highly probable that these people who join the use of violence by identifying themselves with the "legitimate" forces and by "being proud of" violence machine like murderers; can easily use violence in their daily lives. A most striking example has been experienced in the USA. As stated by Archer and Gartner, there has been an increase in crimes of violence committed by male and female civilians after the Vietnam War during which violence was rewarded in the USA. Violence among males increased by 101% and among females by 59% between 1963-1973[13]. Another study by Archer and Gartner shows that after World War I, World War II, Vietnam War and 11 other wars there has been a considerable increase in the percentage of murders in the countries where war occurred in comparison to the countries where it did not[13]. The increase in crimes of violence in Turkey cannot also be explained without reference to the effects of war going on in the Southeast region and of systematic human rights violations on ordinary people.

The reason why some of us identify ourselves with the victim while some with the assailant is a matter broad enough not to be discussed in this article. But what we said for the therapist is valid here also. It is also possible that one may not identify her/himself with either the victim or assailant but remains as a witness. But being a witness does not keep away the feeling of anger, helplessness, insecurity, hopelessness and powerlessness. Furthermore, the whole society feels guilty about being witnesses but knowing that witnessing will not change anything (witness guilt).

Millions of people in Turkey put on and off their lights during the act of "One minute darkening for continuous enlightenment" securing themselves at their homes. This was a demand from the State and the others to acknowledge their witnessing. The method of the act, symbolizing the traumatic experiences by darkness and then reaching all together the light, was quite similar to compulsive re-experiencing of trauma, which is a symptom of the PTSD. We reproduced the trauma, i.e. darkness, for a couple of minutes but different from the trauma created by state terror, the control was in our hands for the first time, and we ended the symbolic trauma we created. Nevertheless, what the victims frequently do after a traumatic experience is to re-experience the trauma unintentionally during sleeping or while awake. The difference in the act was to re-experience the trauma -

darkness- under control. We had the power during the act. This act was in a sense was the first session of a group therapy that we were in need of.The doing-undoing ritual relieved us a bit. But we need to attend many more sessions in order to heal ourselves.

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THE CLINICAL ASSESSMENT OF THE PARTICIPANTS IN THE HUNGER STRIKE - DEATH FAST OF MAY 1996

Emel Gökmen, Hakan Gürvit, Demet Kınay, Nermin Demirci, Hüseyin Şahin, Rezzan Tuncay, Emre Öge, Gencay Gürsoy*

INTRODUCTION

On 20 May 1996, 1500 prisoners initiated hunger strikes (HS) in 41 prisons in 38 provinces of Turkey. On the 45th day of the hunger strike, 159 prisoners decided to turn it into a death fast (DF) and 61 prisoners -with a political differentiation- to continue it as an indefinite hunger strike. Another group decided to end the hunger strike on the 55th day. On the 55th and 65th days, 111 prisoners formed the second and third death fast teams. The other participants decided to re-start the hunger strike from the 55th day onwards. As a result, this period of 69 days during which 220 persons (death fast + indefinite hunger strike teams) remained hungry, ended on 27 July 1996. 12 people, one female and eleven males, lost their lives.

All the participants consumed water with sugar, salt, tea and tea of linden tree during the hunger strike. Those who turned into a death fast limited the liquid consumption to 4 glasses of water with sugar and salt in a day.

A group of participants in the death fast and indefinite hunger strike (18 patients) were treated as inpatients at İstanbul University Medical Faculty Neurology Clinic for one-and-a-half month following the death fast and indefinite hunger strike period; after they were subjected to further examination they were discharged and followed up once a month at least. The team who managed the treatment of this group also assessed the medical state of all the participants in the hunger strike at Bayrampaşa Prison, İstanbul, which was decided to be the area of a pilot study, and other participants in the death fasts and indefinite hunger strikes from other prisons whom they had the chance of examining medically. In short, 40% of the 220 people who remained hungry for 69 days were medically assessed by this team. (These people include participants from Gebze, Ümraniye, Sakarya, Bursa Prisons as well as a few number of prisoners from Konya, Eskişehir, Çanakkale, Ankara and Malatya Prisons who applied to the HRFT for medical treatment.)

This article is about the clinical, neuropsychologic, electrophysiologic (EEG, EMG, EP) and neuroradiologic assessment of the 18 patients and the clinical assessment of the study that contains the clinical follow-up of the participants from Bayrampaşa Prison, the pilot study area.

Clinical Assessment:

Patients: The 18 patients (3 females and 15 males) who ended the hunger strike and death fast were given medical treatment at İstanbul University Medical Faculty Neurology Clinic within the first 4 weeks. Sixteen of them were either from the first death fast team or participants in the indefinite hunger strike, one was from the second death fast team, and one of them had ended the hunger strike on the 39th day. The last patient mentioned had had to end the hunger strike on the 39th day because his general state had deteriorated, and he had been given IV (through the vessel) glucose treatment and, he remained in a comatose state for a few days, and then it was found out that he had a permanent amnesic state.

Table 1. The characteristics of the patients

Characteristics	Values
Age	23-50 (29.9)
Height (cm)	158-186 (171.5)
Weight before the HS-DF (kg)	50-105 (69.6)

Weight after the HS-DF (kg)	36-74 (47.7)
Lost weight (kg)	11-31 (21.8)
BMI after the HS-DF ended (kg/m²)	11.8-18.4 (16.5)**

* Body Mass Index = weight (kg) / height x height; the minimum acceptable BMI value is 20.

** One patient with a 23.8 BMI was excluded from the average.

The symptoms that appear during long-term hunger are: the feeling of weakness, fatigue, dependency on bed in the long run, clouding of consciousness, continuous vomiting and hiccup, feeling of fainting and dizziness while on stand (orthostatic hypotension), truncal ataxia, paresthesia, loss of senses, numbness, pains and cramps, extreme sensitivity to light, smell and sound, impairment of vision, night blindness, tinnitus and humming in the ears, impairment of hearing, and headache similar to occipital neuralgia.

Six of the eight patients who were taken to the Emergency Service of İstanbul Medical Faculty just after the HS-DF had disorders of consciousness at various levels (somnolence-stupor). The general state of all was so bad to the extent that they were all dependent on bed. Four had pneumonia. The consultation made by Pediatrics Department, Nutrition and Metabolism Department showed that all had severe protein energy malnutrition.

On the following days, the patients, whose number increased to 18, were urgently subjected to thiamine replacement (8 patients, who were taken to the Emergency Service in the hours following the end of the hunger strike, had intravenous catheter and the 20% dextrose perfusion was continuing; it was revealed that the patients who had subsequently been taken to hospital had been given dextrose before administration of thiamine). In order to maintain a positive nitrogen balance and stop the catabolism, parenteral nutrition, semielementary nutrition or polimetric diet was applied to the patients. In addition, folic acid, A, E, K and B complex vitamin replacement was applied.

The table below presents the findings of the first examination and the examination at the end of the first year of the 18 patients.

Symptoms and Findings	**First Examination (n=18)**	**Examination at the end of the first year (n=18)**
Disorders of consciousness (slight confusion-somnolence-stupor)	12	0
Korsakoff amnesia	10	10
Apathy Euphoria, childish behavior Depression and schizophreniform psychosis Generalized anxiety disorder	5 3 2 1	6 0 2 0
Nutritional amblyopia Impairment of vision, edema and paleness on optic disc Retinal hemorrhage *Xerophthalmia* Night blindness Conjunctivitis	 9 2 3 2	 0 0 0 0
Extreme sensitivity to sounds Tinnitus, impairment of hearing Positional vertigo	16 3 2	0 2 1
Horizontal nystagmus Vertical nystagmus	18 8	18 2
Ophtalmoparesis	12	0
Truncal ataxia Extremital ataxia	18 4	10 5
Muscular atrophy Muscular weakness	10 5	0 0
Diminished reaction in tendon reflexes	5	0
Impairment of vibration sense Impairment of position (posture) sense	6 1	0 0

As can be seen from the table, the patients had various symptoms and findings that were in compliance with their complaints. Among the neurologic symptoms, the findings belonging to Wernicke-Korsakoff Syndrome (WK) which can be considered as a sequel were important and still observed at the end of the first year.

WK presents a two-stage state that develops due to deficiency of thiamine (Vitamin B1). B1 is a coenzyme used in carbohydrate metabolism. As it is generally consumed at adequate levels owing to the consumption of grains - especially bread- B1 deficiency is normally not observed, but during long-term hunger B1 deficiency emerges, and it can be argued that after the hunger ends, when the liquids which contain carbohydrates are given intravenously without providing adequate amount of thiamine, Vitamin B1 stock is consumed for the metabolism of the carbohydrate given, and this may lead to WK disease. The second state was experienced at the end of the previous HSs, and partially in 1996.

Wernicke Encephalopathy (WE) is normally tetrad.

- Changes in consciousness (from the state of tendency to sleeping to more severe clouding of consciousness)
- Ophtalmoparesis (diplopia)
- Nystagmus
- Ataxia (usually truncal ataxia but can sometimes be accompanied by extremital ataxia)

In the subsequent period, Korsakoff Syndrome can be seen. Korsakoff Syndrome is characterized by amnesia. Amnesia has a retrograde component (involving a few years before the sickness) and an anterograde component (inability to take into memory the new pieces of experiences). Some psychiatric pictures can also be seen due to the emotional state and disorders in thinking that accompany amnesia. The Korsakoff Syndrome cannot be considered as demantia. It is a specific state limited only to amnesia. The main component of demantia is forgetfulness but other components of cognitive functions (such as linguistic capacity, complicated visual perception, planning, abstraction, judgment) may accompany the loss of memory. However, the patients suffering from the Korsakoff Syndrome only have amnesia, and furthermore the tests we applied to our patients revealed that they had kept all the other functions at a level significantly higher than the average. Korsakoff Syndrome is a limbic system disease. Limbic system is bot the entrance to the memory, and a region organizing emotions. A widespread damage on this region leads to psychiatric states accompanied by disorders in emotions and thought. That is why Korsakoff Syndrome is also called Korsakoff Psychosis.

Thirty-nine patients had WK and WE. 69% of the hunger strikers who survived got ill.

For 40% of the patients WE symptoms appeared around the 60th day of the hunger strike.

Mortality and morbidity assessments of the participants from Bayrampaşa Prison, the area of the pilot study:

Deaths	4 (6.25 %)
Wernicke Korsakoff Syndrome	6 (9.37 %)
Wernicke Encephalopathy	33 (51.56 %)
No symptoms of WK	21 (32.81 %)
Total	64 (100 %)

These results belong to the sample population from Bayrampaşa Prison and are specific to the conditions of the hunger strike in 1996. They may change in different conditions. For example, the first death incident occurred on the 61st day during the hunger strike in May 1996 whereas four prisoners on hunger strike died on the 45th, 50th, 53rd and 55th days in Diyarbakır Prison in 1982, and in the death fast in 1984 two prisoners lost their lives on the 49th and 52nd days in the same prison.

At this point, it became clear that the hunger striker should consume Vitamin B1 together with sugar, salt and water. But it seems difficult to maintain the consumption of Vitamin B1 during hunger strikes in Turkey while some people and institutions who are parties to the incident make speculations by saying, "They feed themselves, they are not on hunger strike" despite all the death incidents.

Visual Materials

The drawings of Abidin Dino are taken from a publication of the Human Rights Foundation of Turkey.

The works of Maaria Wirkkala and Hale Tenger are taken from the catalog of the Fourth International İstanbul Biennial.

The photograph by Zeynel Yeşilay is taken from “Güzel Bolu ve Yedi Mevsimi” (Beautiful Bolu and Its Four Seasons” published by the Foundation for the Development and Promotion of Bolu.

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