HRFT
Human Rights Foundation of Turkey

Treatment and Rehabilitation Centers Report 1998

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TREATMENT and REHABILITATION CENTERS REPORT

1998

Ankara, June 1999

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Turkish version of
Treatment and Rehabilitation Centers Report-1998
is available at the HRFT.

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PREFACE

Metin Bakkalcı*

The Human Rights Foundation of Turkey (HRFT) has, since its establishment, been carrying out the Project for the Treatment and Rehabilitation of Torture Survivors as one of its main projects.

The project started in 1990 and by the beginning of 1998, 3304 people had applied to the treatment and rehabilitation centers of the HRFT. With 706 people applying to the centers in 1998, the number of applicants reached 4010. Multidisciplinary teams of hundreds of health professionals work, either on a professional or voluntary basis, for the solution of the physical, psychological and social problems of the applicants to the centers.

In 1998, we have caught up, to a great extent, with the program that we have developed in previous years and set for ourselves for the year with regards to the treatment and rehabilitation project. Our teams have attempted to turn the treatment and rehabilitation centers into more effective institutions.

The project was carried out by the treatment and rehabilitation centers of the HRFT in Adana, Ankara, İstanbul and İzmir until June 1998. The opening of the Diyarbakır Treatment and Rehabilitation Center in June was a very important step regarding the project. The Human Rights Foundation of Turkey took the decision to establish a center in Diyarbakır as early as 1992 but for several reasons it was not possible until 1998. With the efforts of the relevant people and organizations in Diyarbakır, the preparations for opening a center, which started in 1997, were concluded in June 1998 and the HRFT's fifth center started functioning. In addition to the daily work, the Diyarbakır Treatment and Rehabilitation Center has organized a series of activities. Despite the opening of the Diyarbakır Center and despite the fact that the Adana Center started to work in cooperation with İçel, the 5 Cities project continued in 1998 in the provinces of Malatya, Gaziantep, Hatay, Adıyaman and Şanlıurfa as human rights violations were persistent in this region.

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

Another important field of activity in 1998 within the context of the Treatment and Rehabilitation Centers Project was the preparations regarding the "Second International Meeting for the Development of a Manual on the Effective Documentation of Torture – Istanbul Protocol." It is a great honor for the HRFT to have had an important function in the realization of this study. After a 3-year preparatory period, the İstanbul Protocol meeting was held on 11-13 March 1999 in İstanbul with the participation of the relevant people and organizations from all over the world and from Turkey. Attempts are under way to turn the İstanbul Protocol into a UN Protocol in this field.

The Treatment and Rehabilitation Centers Project, besides providing medical treatment and rehabilitation for torture survivors, also supports training, scientific research and scientific activities for increasing the quality of services.

Both Turkish and English versions of this report, including the results derived from the Treatment and Rehabilitation Centers Project carried out in 1998, have been published as in previous years.

Concerning the effectiveness of annual reports, the date of publication is important. Therefore, the publication of the 1998 report in May 1999 might have achieved this effectiveness. In the coming years, the HRFT will pay more attention to this point.

The 1998 Treatment and Rehabilitation Centers Report includes an introduction by President Yavuz Önen on behalf of the Governing Board, followed by two sections.

The first section includes an outline of the health services provided by the HRFT in 1998. The outline includes information and evaluations regarding the applicants to the HRFT Treatment and Rehabilitation Centers in Adana, Ankara, İstanbul, İzmir and Diyarbakır for torture related problems.

The second section consists of articles on certain issues that the treatment centers of the HRFT have worked on in 1998.

This part starts with an article by Dr. Cem Kaptanoğlu, which is entitled "Complex Posttraumatic Stress Disorder (C PTSD)." Dr. Kaptanoğlu indicates in his article that the discussions on the clinic of PTSD will concentrate on a complex versus simple PTSD conception in the future and argues that complex PTSD appears to be very different from simple PTSD. He stresses that we need a diagnostic category to facilitate our understanding of torture survivors who face prolonged, repetitive trauma. He ends his article with the following sentence: "This is a country where for more than 20 years instead of fairy tales there have been stories of warfare, people being killed in the streets and in their homes, torture, kidnapping and disappearances as well as gangs. Perhaps the diagnosis of complex PTSD would help us to understand the present and future behavior, the responses, thoughts and emotions of children growing up in Turkey, many of whom have reached 20 years of age."

The second article in this section is Dr. Ümit Şahin's article on complaints and disorders related with the musculoskeletal system, which are widespread

among torture survivors. Dr. Şahin points out that a distinguishing characteristic of musculoskeletal disorders related with torture is that the pain can become chronic in time and it can appear in the late period, in the years following the infliction of torture. He argues for the necessity of interdisciplinary cooperation among the physical, psychological and social disciplines. Dr. Şahin makes an assessment of the physical disorders, especially chronic or late-term disorders of the applicants to the HRFT İstanbul Representation Treatment and Rehabilitation Center who had musculoskeletal system complaints and who had received physical treatment and rehabilitation consultations. He makes an analysis of the complaints of these applicants, the diagnosis they received and the treatment applied.

Prof. Dr. Gül Şener and Asst. Prof. Dr. Mintaze Kerem from the Hacettepe University Physical Treatment and Rehabilitation Faculty in their article show the importance of the rehabilitation approach in eliminating or minimizing the problems following torture. The authors present a study on musculoskeletal and neurological problems related with torture and on the physical treatment methods selected in line with the needs of the patient. They stress the need for a good rehabilitation team, a reasonable treatment method and social approaches for minimizing the physical and psychological problems.

The next article is entitled “Forensic and Psychiatric Aspects of Trauma and Some Suggestions,” and is by four authors: Dr. Ü. Biçer and Dr. B. Çolak from the Kocaeli University Medical Faculty Forensic Medicine Department, Dr. M. Bilgili from the Ministry of Justice Forensic Medicine Institute, and Dr. Y. Ergezer. The authors emphasize that while the physical consequences of trauma have been analyzed in depth with regard to forensic medicine, the psychiatric consequences of trauma had not been dealt with until recently. They draw attention to the forensic, medical and legal regulations that are required concerning the psychological aspect of trauma. The article is an important contribution to the debate on the recognition of forensic and psychiatric aspects of psychological trauma and its evaluation from forensic, medical and legal points of view with regard to some objective criteria.

The last article in this part is about a sample case in which N. Betül Vangölü and Selçuk Kozanoğlu were the attorneys. The case involves the discussion of various aspects of the practice of forensic medicine.

The activities of the HRFT are realized through the efforts of hundreds of health professionals and human rights defenders from many cities in Turkey. We would like to thank all our friends who contribute to our work and who have stood by us, and to thank the Human Rights Association and Turkish Medical Association who have been lending their support from the very beginning.

Ankara, May 1999

FOREWORD

Yavuz Önen[*]

In 1998, Turkey was ruled by the ANASOL-D coalition government [formed by the Motherland Party (ANAP), Democratic Left Party (DSP) and Democratic Turkey Party (DTP), and supported by the Republican People's Party (CHP)], the 55th government of Turkey, headed by Mesut Yılmaz. This government was established when the former government led by the Welfare Party (RP), which represents political Islam, under the leadership of Necmettin Erbakan was dissolved following the decision of the National Security Council on 28 February 1997 against Islamic fundamentalism.

With the implementation of 8-year primary education, which was one of the most important articles of the 28 February decisions, we experienced a year of intense protests organized by graduates and students of Imam Hatip schools (schools giving religious education), and their families. Especially on Fridays after the Friday prayer, the crowds coming out of mosques held widespread protests against 8-year continuous education and against the ban on headscarves in state institutions. The political atmosphere of 1998 was marked by the Secularism move and commitment by the State and Government.

Another important issue on Turkey's political agenda was the gangs. The government created the impression that it was determined to combat the gangs, defined as criminal organizations. A report prepared by Prime Ministry Chief Inspector Vural Savaş was issued. The report revealed that the gangs had connections to the State and had been directing the economic life through acts such as affecting the decisions in privatization adjudications, or providing credit from public banks for certain businessmen.

[*] President of the HRFT

Corruption was among the issues that were debated at length in 1998. Many files of corruption including the ones related with the leaders of ANAP and the True Path Party (DYP) were handled by the Turkish Grand National Assembly.

In 1998, the Parliamentary Migration Commission invited certain non-government organizations, including the Human Rights Foundation of Turkey (HRFT) and the Human Rights Association (IHD) to a meeting to listen to their views on the issue. The Parliamentary Human Rights Inspection Commission dealt in particular with the use of torture. The Commission gave reliable information to the public. The Chair of the Commission, Sema Pişkinsüt, has left positive impressions on the public through the inspections she carried out in police stations and the State of Emergency Region. The Minister of State Responsible for Human Rights, Hikmet Sami Türk, did not extend any invitation to human rights organizations for the meetings of the Parliamentary Human Rights Coordination Supreme Board in 1998, which he did in 1997 in order to start a dialog with human rights defenders. Minister of Foreign Affairs İsmail Cem had a relatively more realistic attitude concerning human rights violations. He abandoned the policy of denial. He espoused a relatively more reasonable discourse at the national and international level.

However, the "good intention" observed in parliament and the government did not bring about positive developments with regard to the protection and improvement of rights and freedoms. Torture continued in a systematic manner. The freedom to express one's opinion has always been kept under surveillance and pressure. There were incidents in prisons and no improvement in prison conditions. Extra-judicial executions and murders by unknown assailants, and evacuation of villages continued though in decreasing numbers. The freedom to free assembly and demonstration was harshly restricted. Police resorted to extreme violence during the acts organized by the Confederation of Unions of Public Workers (KESK). The police continuously intervened in the sit down protests by the mothers and families of disappeared people, in other words the Saturday Mothers, in front of the Galatasaray High School in İstanbul. They detained the people participating in the sit down protests and, many times, did not give permission for these protests. The legitimate and peaceful acts by university students were confronted by the extreme violence of the police and ultranationalist militants. The demands for free and democratic universities, and the economic demands of the students became the target of the State Security Courts (SSC) as well as the police. The students who displayed placards and made peaceful demonstrations in Parliament in pursuance of these demands were sentenced to prison terms approaching 100 years in total.

The press was also made to pay a high price for doing their job in 1998. The reporters and cameramen shooting or reporting social incidents and protests were beaten by the police, and their cameras were broken. Dissident newspapers Özgür Gündem and Emek were closed down.

The dissident political parties were kept under intense scrutiny. Some activities organized by the Freedom and Solidarity Party (ÖDP), Labor's Party (EMEP) and other socialist parties were prevented, investigations were launched against these parties, and their executive members were detained or arrested. The People's Democracy Party (HADEP) was particularly the target of such oppressive practices. HADEP leader Murat Bozlak was detained twice (he was not allowed into Diyarbakır after the general elections in 1995). The HADEP Headquarters was raided three times. A very important incident in the political arena was the Constitutional Court's closure of the Welfare Party (RP), which received the highest number of votes in Turkey. Some high-ranking executive members of the RP were sentenced to a five-year ban from politics and were deprived of their public rights for 5 years.

Recep Tayyip Erdoğan, the mayor of İstanbul, Turkey's largest city, and a member of the Welfare Party (RP), was suspended from duty and sentenced due to a speech he had delivered; he was deprived of his political rights and the sentence became definite.

Şemdin Sakık Incident, Attack against Akın Birdal

In 1998, Turkey went through some important developments regarding the Kurdish problem. The first incident was the surrender of a leading executive of the PKK, Şemdin Sakık, to the security forces. The accusations that Şemdin Sakık allegedly made in his statements were leaked to the press. In the accusations, which can be summarized as some people and organizations having relations with or aiding the PKK, the name of Human Rights Association (IHD) Chairperson Akın Birdal was brought to the forefront. Akın Birdal was turned into a target due to the efforts of media monopolies and some columnists. It was seen that the aim of publishing of these fake statements was to constitute an "atmosphere of provocation" against the İHD and other opposition groups. What followed was Akın Birdal's being the target of a hail of bullets fired by two men who came to the Headquarters of the İHD on 12 May 1998. Five of the bullets hit the body of Birdal who miraculously survived. In the year which coincided with the 50th anniversary of the Universal Declaration of Human Rights, in which the UN Declaration on Human Rights Defenders was adopted, an International Criminal Court was established and Pinochet was arrested in England being held responsible for the crimes he committed against humanity, we experienced in our country this shameful attack against a human rights defender.

Abdullah Öcalan and the Rome Process

The Moscow-Rome adventure, which started with PKK leader Abdullah Öcalan's departure from Syria, was the most important topic on the agenda of Turkey towards the end of 1998. The course of events created diplomatic activity in the international arena and attracted public attention at every level within the country.

Protests that took place at the HADEP buildings during the Rome process led to intervention by the security forces. In the process, around 3000 executives and members of HADEP were detained. Some were remanded in custody and trials were launched against them. Counterreactions organized as a part of an official program and under the leadership of the Nationalist Movement Party (MHP) took place in front of embassies. Ultranationalists turned these acts into violence. Two people of Kurdish origin were killed in the attacks. The funerals of soldiers who died in clashes with the PKK were manipulated to create a wave of chauvanism and nationalism in the country. During that period, even the columnists of certain newspapers that are virtually cartels, had a critical attitude to this atmosphere.

Early general and local elections

In such a context of political instability, early general and local elections became inevitable. The Parliament took the decision to hold early elections. Hence, the ANASOL-D government worked in an early election atmosphere. However, it was not able to hold onto power; it collapsed after a parliamentary investigation. When some other political initiatives also failed, a general conciliation was achieved for a government model in which only deputies of the DSP would serve under the leadership of DSP leader Bülent Ecevit. The main function of this government would be to take the country to the elections on 18 April 1999. In addition, the government would fight “criminal organizations” and “money laundering.” In contrast, members from the DYP, ANAP and DSP of relevant parliamentary commissions acted jointly to drop the corruption investigations against ANAP leader Mesut Yılmaz and DYP leader Tansu Çiller towards the end of 1998. Consequently, Bülent Ecevit became Prime Minister in the first half of January 1999 in an atmosphere of conciliation.

With the initiatives of Ministers from the DSP and Minister of Justice Hasan Denizkurdu, steps for democratization were placed on the agenda. However, the death penalty was not abolished, nor were the State Security Courts (SSC) restructured in line with the criticisms of the European Court of Human Rights. Only lip service was paid to regulations such as a “General Political Amnesty” which might ease the route to peace or a Repentance Law. The move towards democratization has been postponed once again. In 1998, the necessary amendments were not made in existing laws which would adopt these laws with the Constitutional amendments made prior to the adoption of the Customs Union.

Examples from judicial proceedings on human rights violations

In the trial launched against some police officers for torturing a number of youths in Manisa, the officers were acquitted by the local court. One reason given by the Prosecution Office for the acquittal demand was that the medical reports, constituting the evidence of torture, had not been issued by official bodies. The Supreme Court of Appeals overturned the original ruling and the trial was reheld by the local court. When the Court insisted on its original decision of acquittal, the file was referred to the Supreme Court General Penal Board. The conclusion of

the Board was that the reports were valid, that torture had been inflicted, and that the police officers were guilty and should be punished.

Five of the police officers who were defendants in the trial of the murder of journalist Metin Göktepe were first given 18-year's imprisonment each, but for "good behavior before the Court" and "the impossibility of establishing the real assailant" the sentence was reduced to 7 years in prison, each. Five other police officers were acquitted.

There were few developments regarding the trial launched against 20 police officers in connection with the incidents in the Gazi district of İstanbul in 1995 during which 19 people were killed. The demand to transfer the trial from Trabzon to İstanbul was rejected; furthermore, the evidence related to the incident could not be gathered.

The police officers who tortured Baki Erdoğan to death in 1993 were sentenced to 5 years 6 months in prison. The Supreme Court overturned the decision on the grounds that the information that Baki Erdoğan might have been suffering from "epilepsy" had not been taken into account.

Captain Musa Çitil who had been put on trial for allegedly torturing and raping Şükran Aydın, was acquitted due to insufficient evidence (The European Court of Human Rights decided that Şükran Aydın had been tortured).

In March 1998, the Supreme Court of Appeals overturned the heavy prison sentences given by Ankara SSC, on 6 December 1996, to 8 students who had been put on trial for displaying a placard in Parliament. In November, Ankara SSC again sentenced the students, but decreased the sentences by half, i.e. from a total of 96 years given in the original decision to 46 years in the retrial.

The trial launched against 11 police officers in connection with the death of Mehmet Yavuz (18) at Adana Security Directorate on 13 March 1998 was concluded on 23 November 1998. Adana Heavy Penal Court No.3 decided to acquit 10 of the police officers, and sentenced one, Murat Güldaş, to 10 years in prison. The sentence given to Güldaş was later reduced to 1 year 8 months on the pretext that he had "defended" himself, and he was released.

50th Anniversary of the Universal Declaration of Human Rights

On the 50th Anniversary of the Universal Declaration of Human Rights, the Human Rights Foundation of Turkey (HRFT) and the Human Rights Association (İHD) organized a conference entitled, "The Human Rights Movement in Turkey on the 50th Anniversary of the Universal Declaration of Human Rights: Accumulations and Perspectives," on 28 and 29 November. People who had been involved in the human rights movement in Turkey from different backgrounds and different periods participated in the conference.

The main objective of the conference was to discuss the Universal Declaration of Human Rights and the developments that had taken place in the fields of human rights and arrive at some conclusions for the future in the light of the expe-

riences of the human rights struggle in Turkey and worldwide. The conference achieved this objective and a "Concluding Report" and a "Final Declaration" consisting of 36 articles were published.

The HRFT also participated in certain activities of international organizations on the 50th Anniversary of the Universal Declaration of Human Rights. The HRFT took part in the Steering Committee of the Human Rights Defenders Summit organized jointly by Amnesty International (AI), the International Federation of Human Rights (FIDH), ATD Quart Monde and France Liberte. Following the studies of the Steering Committee, which took more than a year, a conference was held on 3-11 December, at Chaillot Palace where the Universal Declaration of Human Rights had been adopted, in which more than 500 human rights defenders from all over the world participated. At the end of the conference, "the Paris Declaration" of human rights defenders was made and an "Action Plan" for the future was adopted. New regional representatives were selected for the Steering Committee who organized the Human Rights Defenders Summit. In 1998, the HRFT also participated in the conferences organized by the OMCT in Geneva, the Council of Europe in Strasbourg and Amnesty International in İstanbul.

Another important development on the 50th Anniversary was the adoption by the United Nations General Assembly of the "Declaration on Human Rights Defenders" and the constitution of an International Penal Court at a UN Conference held in Rome in June and July 1998.

Committee for Prevention of Torture (CPT)

The Council of Europe Committee for the Prevention of Torture (CPT) paid an official visit to Turkey on 5-17 December 1998. The Turkish Government, for the first time, gave permission to the Committee to publicize its report on Turkey (on 23 July 1998). The Committee could not carry out inspections in the State of Emergency Region and the surrounding provinces. (The Turkish Grand National Assembly Human Rights Inspection Commission carried out inspections in prisons and other centers in that region. The Commission's Chairperson Dr. Sema Pişkinsüt stated that torture was widespread in the detention centers and prisons in the region.)

Immediately prior to the CPT's visit, on 3 December, the Prime Minister issued a circular entitled, "Respect for Human Rights: Prevention of Torture and Ill-treatment." The Committee made the observation that the other circulars that had been issued previously had not been respected, and that the new circular "could not yet be understood." The Committee particularly emphasized the arbitrary practices and bad conditions at the Foreigners Department in İstanbul. They demanded that the cell-type constructions be demolished. The Committee observed improvements in the psychiatry organizations that they inspected, but pointed out their concerns regarding the application of electroshocks. In the interim report that the government submitted to the Committee on 3 February 1999, the Ministry of Justice replied to the criticisms that the Committee raised against "special" practices in E type prisons as follows: "In these prisons, it is not the prisoners who are

at risk of inhuman treatment, but the personnel. The personnel are continuously subjected to harassment, threats and physical attacks." (Unfortunately, the "defensive" position of the Ministry makes us pessimistic concerning the establishment of an environment based on human rights in prisons.)

HRFT Awarded the European Human Rights Prize

In 1998, the HRFT was awarded the "European Human Rights Prize" by the Council of Europe. The HRFT shared the prize with Ms. Chiara Lubich and the Committee on the Administration of Justice.

Prosecution Against Pinochet

One other important incident in the world in 1998 was the arrest of the Chilian dictator General Pinochet in London for crimes against humanity. The House of Lords, with its decision, did not allow Pinochet to return to Chile and paved the way for his prosecution in Spain. This was a very important blow against the immunity of those who have committed crimes against humanity and a threat to those who have been involved in similar crimes. This international incident showed that crimes against humanity would not be left unpunished, and it has pleased not only the mothers and families of the disappeared and killed people in Chile, but all human rights defenders.

Longing for a world where torture is condemned.

HRFT Treatment and Rehabilitation Centers Report

1998
Evaluation Results

HUMAN RIGHTS FOUNDATION OF TURKEY
TREATMENT AND REHABILITATION CENTERS
1998 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 joint studies conducted by the Human Rights Association (HRA), Turkish Medical Association (TMA) with the participation of a group of intellectuals. The headquarters of the HRFT is in Ankara and it has representation offices in İstanbul, İzmir, Adana and Diyarbakır.

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

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

At present, the HRFT is working on 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 in daily and annual reports.

The Treatment and Rehabilitation Centers Project aims to provide medical treatment and rehabilitation to people who suffer from health disorders due to the torture or ill-treatment they have been subjected to during official or unofficial detention periods and in prison, taking into account the physical, psychological and social integrity of the people.

In the Tokyo Declaration by the World Medical Association, torture is defined as "the deliberate, systematic, or wanton infliction of physical or mental suffering by one or more people acting alone or on the orders of any authority to force another person to yield information, to make a confession, or for any other reason." The stories of the applicants to the HRFT reveal that torture is not inflicted only in detention places or prisons, but is also frequently applied during village and house raids, during searches in houses or when police turn the suspect's house into a police station, detaining and interrogating all visitors, and in cases of kidnapping by plainclothes police officers or by people claiming to have acted in the name of some secret organizations of the state.

As torture is very likely to influence the relatives of torture survivors, the HRFT's work also covers seeking solutions to the psychological problems of relatives of torture survivors that are related with the traumatic experience. Within this framework, relatives of torture survivors are also provided with treatment.

The HRFT provides treatment and rehabilitation services by means of its representation offices in Ankara, İstanbul, İzmir, Adana and Diyarbakır. At these centers, professional teams of general practitioners and family physicians, psychiatrists, social workers, psychologists and medical secretaries conduct the treatment and rehabilitation of torture survivors in cooperation with specialists from all medical disciplines. The preliminary evaluation of the applicants is carried out at the centers as well as the planning of the treatment and rehabilitation to be provided to each applicant, and in line with the plan, the necessary medical examinations, laboratory examinations and treatment are provided by specialists and institutions either on a contractual or voluntary basis. Except for the contributions of volunteer physicians, all other expenses are covered by the HRFT. The teams in charge at the centers coordinate the treatment process at each stage. The results and assessment of the treatment and rehabilitation work are publicized in the form of annual reports.

The HRFT implements the "5 Cities Project" in the provinces of Gaziantep, Şanlıurfa, Hatay, Malatya and Adıyaman, in order to reach those torture survivors who live in provinces where the HRFT does not have a representation office. The project aims to provide social and financial support for the travel and accommodation expenses of those who have been subjected to torture in regions where there is no treatment center, and to inform them of the services that the HRFT provides.

The project is carried out with the active support of the branches of the HRA and the medical chambers attached to the TMA. In the cities where the project is in effect, a network of voluntary organizations and individuals processes applications and maintain contact with the centers. The Project Coordinator at the headquarters maintains regular contact with the relevant people in the five cities. When there is an application, the contact volunteers get in touch with the Project Coordinator to get an appointment. The HRFT covers all the expenses for the applicants' transportation to the city where they receive medical treatment, for their accommodation and for daily living. Most of the applicants are referred to the Ankara Treatment Center, but if necessary the other centers also accept applicants within the framework of the 5 Cities Project.

Infliction of torture sometimes causes losses of organs or extremities, or dysfunction. In such cases, if the budget allocated to the Treatment and Rehabilitation Project is not sufficient to cover the expenses of medical treatment, then "Special projects" are developed. The special projects are submitted to those organizations that can provide financial support, and they are implemented when the necessary support is secured.

The HRFT has developed a humane medical institution which coordinates the multidisciplinary efforts of professionals from various branches of medicine who regard offering medical services to torture survivors as a requirement of humanity and an ethical responsibility of health professionals.

METHOD

This report has been prepared retrospectively based on the information provided by 706 torture survivors who applied to the Treatment and Rehabilitation Centers of the HRFT in Ankara, İstanbul, İzmir, Adana and Diyarbakır in 1998.

As 23 of the applicants were relatives of torture survivors, there is no data pertaining to the torture or detention stories of these people. Nine other applicants were excluded from the evaluation because of insufficient information.

A special project was designed for one applicant in 1998 and the necessary support was secured. The information on that applicant is not included in the evaluation report.

Therefore, the evaluations have been made on the data of 673 applicants. The term "applicant" refers to these 673 people.

The data were obtained using a questionnaire of 47 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 stories, which torture methods were inflicted and on which parts of the body, the con-

sequent physical and psychological complaints, the diagnoses and treatment processes.

The tables and graphics in the report were designed using the Microsoft Excel 97 computer program.

The difficulties encountered during the study were mainly connected with the low level of standardization in the collection of information in the five different centers and the difficulty of the applicants in remembering some of the details.

The variability of data gathered under certain headings has led to abundance of cells in some of the graphics and to the accumulation of data under the "other" cell in some of the graphics.

STUDIES OF TREATMENT AND REHABILITATION CENTERS

A. The Social and Demographic Characteristics

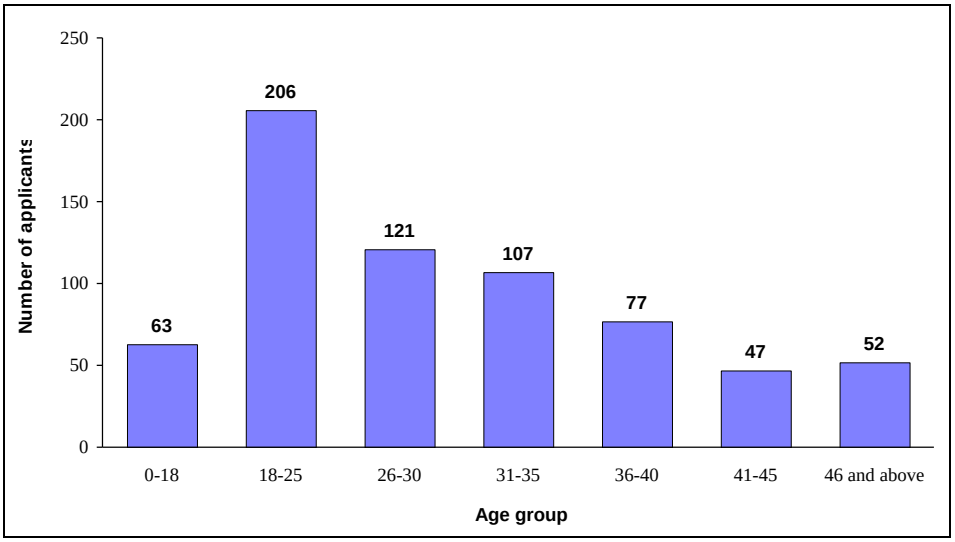
Out of the 673 applicants to the HRFT Treatment and Rehabilitation Centers, the highest number, 260, applied to the İstanbul Representation Office. The İzmir Center had 160 applicants, Adana 157, Ankara 66 and Diyarbakır 30 in 1998. The Diyarbakır Treatment and Rehabilitation Center admitted applicants from 30 July 1998 onwards.

Of the 673 applicants, 196 were women and 477 men.

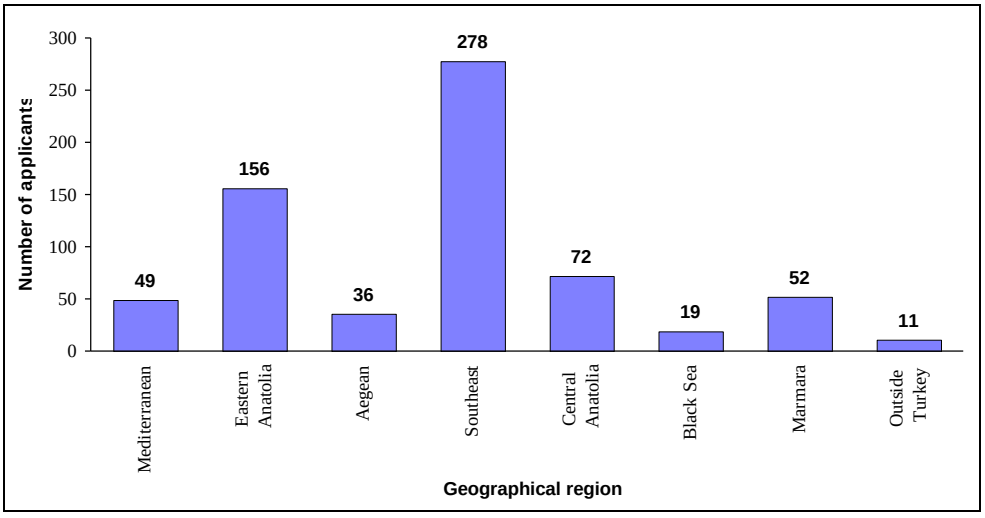
The age of our applicants varied between 3 and 90 and the average age was determined to be 30 $\pm$ 10.53 (Graphic 1). Sixty-three people in the 0-18 age group applied stating that they had been tortured. The application of torture to children and youths, who are the future of the society, continued in 1998; this gives an idea about the extent of torture and needs special consideration with regards to the damage it causes or may cause to people during childhood.

The classification of applicants according to place of birth shows that the highest ratio belongs to the Southeast Anatolian Region, followed by the East Anatolian Region as in previous years (Graphic 2). This fact can be considered to support claims about the intensity of torture in these regions and claims that torture of and pressures against the ethnic groups who live mostly in these regions also continue in the regions where they migrate to.

Graphic 1. The classification of the applicants to the HRFT Treatment and Rehabilitation Centers in 1998 according to age group

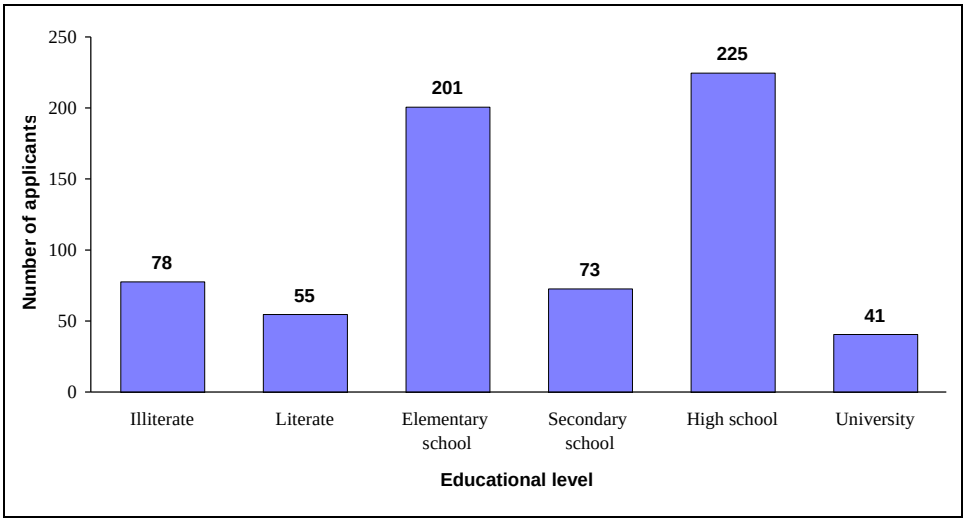


Graphic 2. The classification of applicants to the HRFT Treatment and Rehabilitation Centers in 1998 according to place of birth



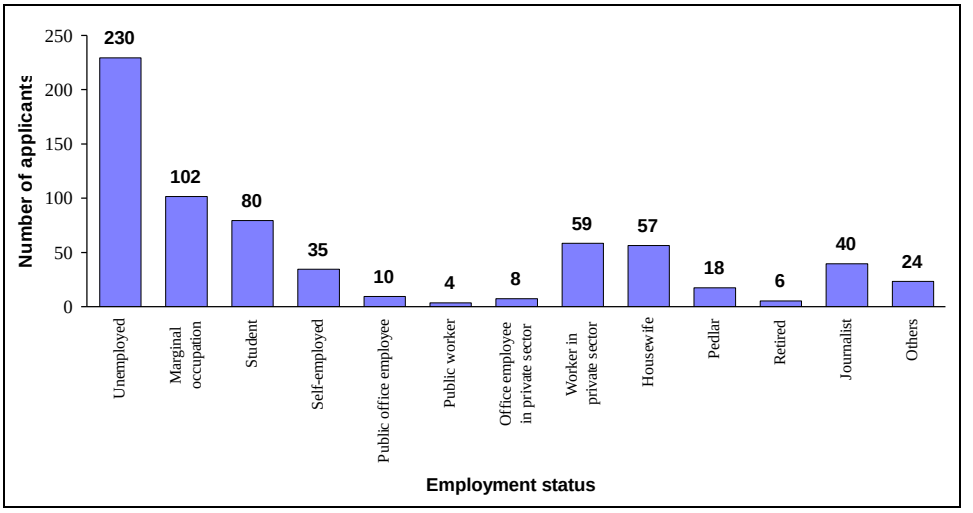
The data on the educational levels of the applicants reveals that high school graduates, who constituted the second largest group in 1997, rank first in 1998 (Graphic 3).

Graphic 3. The classification of applicants to the HRFT Treatment and Rehabilitation Centers in 1998 according to educational level



The high rate of unemployment among applicants prevails as in previous years according to the data on the employment status of applicants (Graphic 4). The problem of unemployment disrupts the integrity of the treatment process while demonstrating the necessity of social projects.

Graphic 4. The classification of applicants to the HRFT Treatment and Rehabilitation Centers in 1998 according to employment status



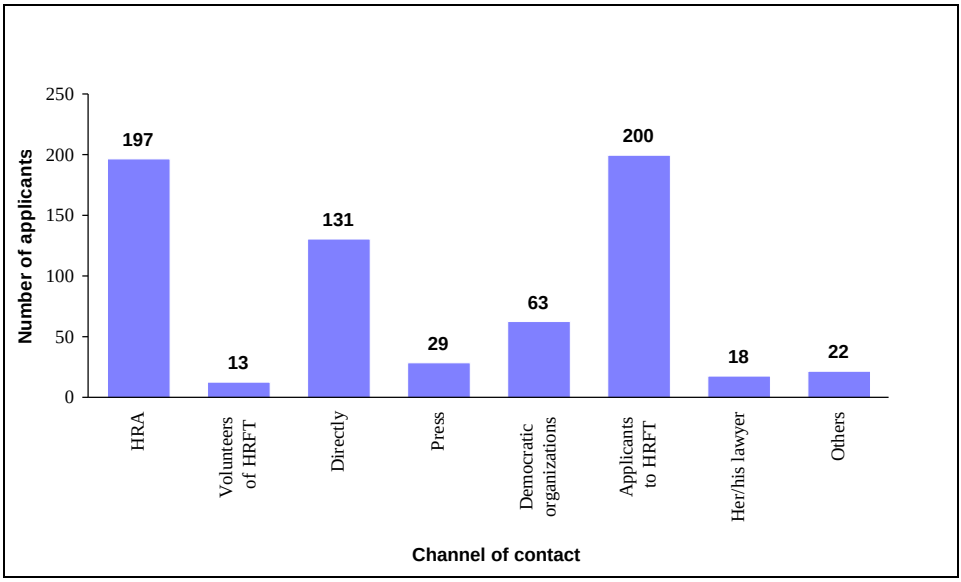
Concerning the channels of contact and reference, it is seen that the ratio of referrals by former applicants is the highest and the second highest is the ratio of referrals by the Human Rights Association but the two ratios are very similar (Graphic 5). This can be considered an indication that the HRFT meets an important demand efficiently and also that the applicants act in solidarity with each other. The active role that the HRA plays in the torture survivors' application to the HRFT reveals the importance of contact and solidarity among organizations.

B. Information Regarding the Period under Torture

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

53.2% of the applicants (358 people) stated that they had last been subjected to torture in 1998. 9.5% of the applicants (64 people) stated they had last been tortured in 1997.

Graphic 5. The classification of applicants to the HRFT Treatment and Rehabilitation Centers in 1998 according to channel of contact



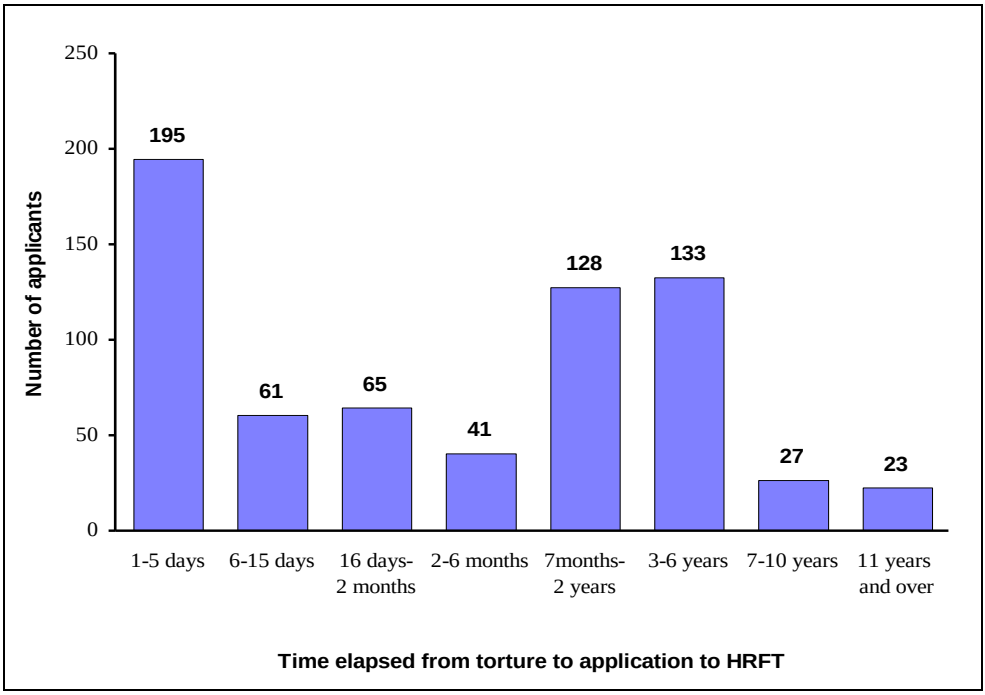
The date the applicants were tortured is informative in approaching the problem of the continuity of systematic application of torture. Even the number of torture survivors applying to the HRFT, despite constituting a relatively small portion of torture claims in Turkey, reveals clearly that torture cases cannot be regarded as exceptional cases. The figures reveal that torture is still applied systematically despite all the promises and claims of reform by the politicians in power. (Graphic 6).

16.0% of the applicants (108 people) stated that they had last been tortured in the State of Emergency Region.

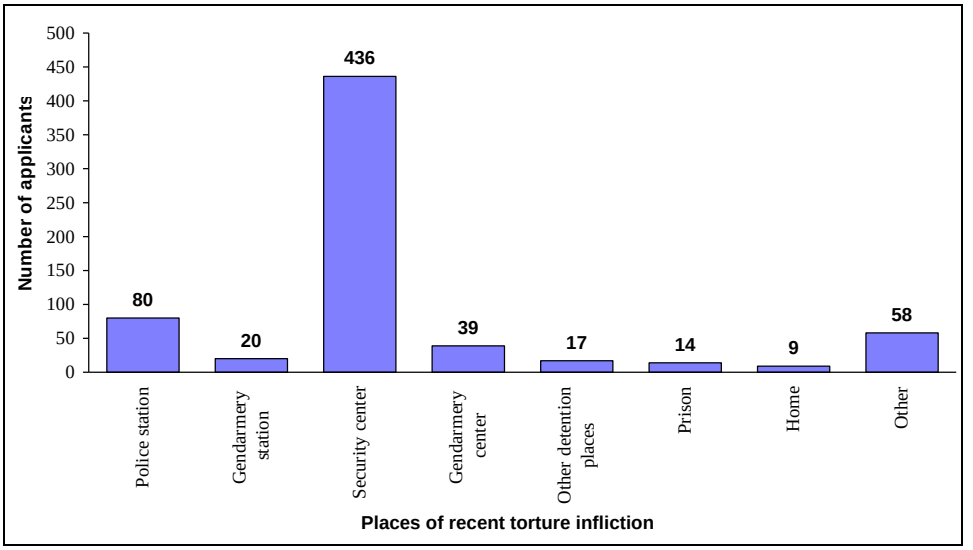
The ratio of applicants who had been tortured on political grounds was 92.0% (619 people) and of those who had been tortured on nonpolitical grounds was 8.0% (54 people). In comparison with the previous year, there was a significant increase in the number of applicants who had been tortured on nonpolitical grounds. The low ratio of applicants who had been tortured on nonpolitical grounds is not because the detention conditions for this group are better but mainly because they are reluctant to seek their rights and they do not know much about the activities of the HRFT.

Regarding the place where the applicants had been most recently tortured, security centers ranked first with 64.8% (436 people) as in previous years (Graphic 7).

Graphic 6. The classification of applicants to the HRFT Treatment and Rehabilitation Centers in 1998 according to the period from the time they had most recently been tortured to their application

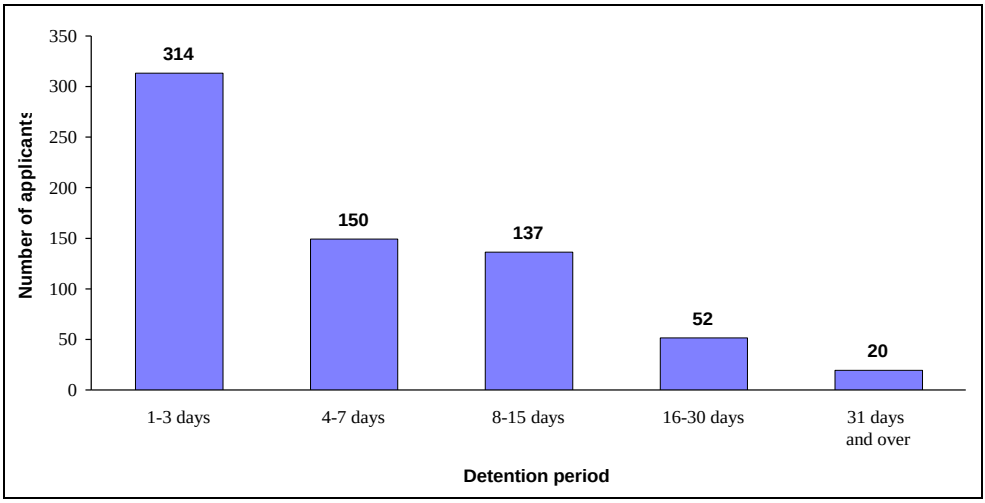


Graphic 7. The classification of applicants to the HRFT Treatment and Rehabilitation Centers in 1998 according to the place of most recent torture



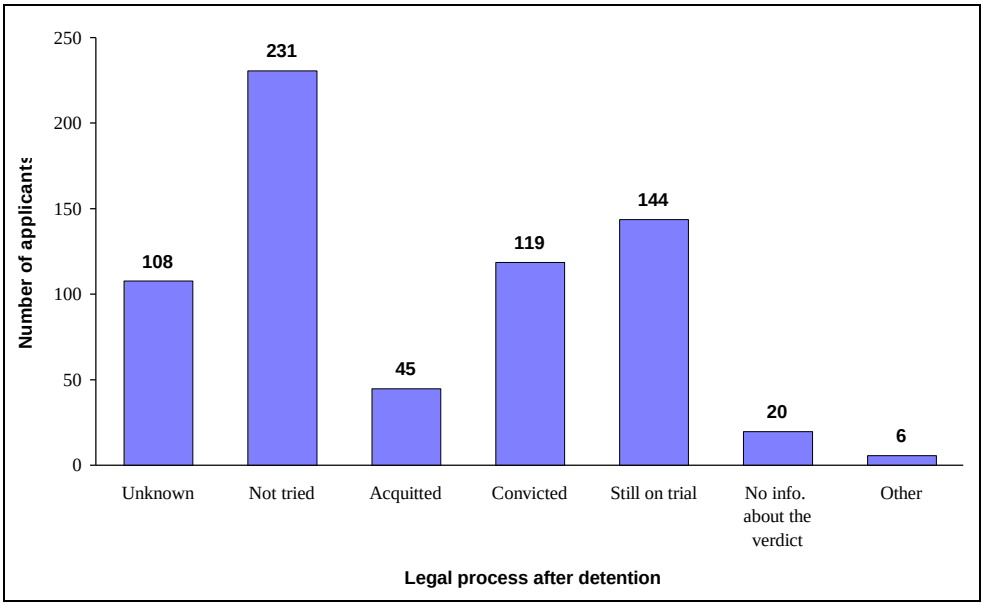
The data on the period of detention and its consequences shows that 31.1% of the applicants (209 people) had been kept in detention for eight days or more during the most recent time they had been detained (Graphic 8).

Graphic 8. The classification of applicants to the HRFT Treatment and Rehabilitation Centers in 1998 according to the duration of their most recent detention



35.2 % of the applicants (237 people) stated that they had been remanded following their most recent detention, 30.8 % (207 people) that they had been released either by the prosecution office or by the court, and 34.0 % (229 people) that they had been released without appearing before the prosecution office. The complaints of the applicants about the judicial process mainly included the use of detention as a means of punishment, interrogations and collection of evidence in ways not abiding by the rules set out by Code of Criminal Procedures (CMUK), and restriction of defence. The legal results of the detention period of applicants yield significant results (Graphic 9).

Graphic 9. The classification of applicants to the HRFT Treatment and Rehabilitation Centers in 1998 according to the legal process that followed their most recent detention period



The torture methods inflicted on the 673 applicants of the HRFT Treatment and Rehabilitation Centers are presented in Table 1.

The torture methods inflicted on 464 people, out of 673 applicants, who had been kept in detention for 1-7 days are given in Table 2

Table 1. Torture methods inflicted on the applicants to the HRFT Treatment and Rehabilitation Centers in 1998.

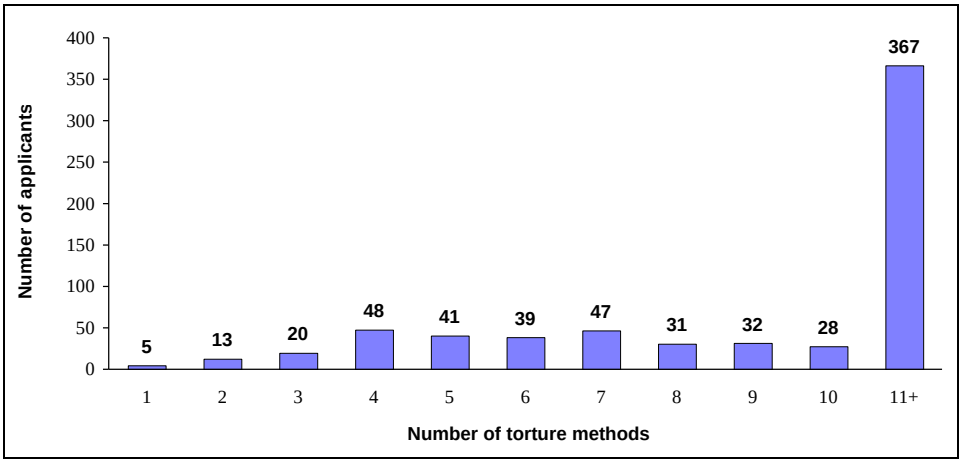
Torture Method	Number	%
Insults	655	97.3
Threats (other than death threats) against the person	605	89.9
Beating	591	87.8
Death threat	527	78.3
Blindfolding	511	75.9
Restricting food and water	387	57.5
Forcing the person to wait on cold floor	383	56.9
Threats against relatives	383	56.9
Restricting defecation and urination	365	54.2
Sexual harassment	335	49.7
Electricity	304	45.2
Solitary confinement	302	44.8
Forcing the person to witness (visual, audial) torture	299	44.4
Stripping the person naked	273	40.6
Sleep deprivation	256	38.1
Pressurized/cold water	245	36.4
Pulling out hair/mustache/beard	232	34.5
Forcing the person to listen to marches or high volume music	221	32.8
Suspension by the arms	206	30.6
Squeezing testicles	176	26.2
Forced extreme physical activity	166	24.7
Suggesting the person serve as an informer	161	23.9
Mock execution	114	16.9
Falanga	110	16.3
Forcing the person to obey meaningless orders	110	16.3
Suffocation	74	11.0
Torturing the person in the presence of relatives	63	9.4
Burning	29	4.3
Rape	19	2.8
Other	148	22.0

Table 2. Torture methods inflicted on applicants to the HRFT Treatment and Rehabilitation Centers in 1998 who stayed in detention for 1-7 days

Torture method	Number	%
Insults	451	97.2
Threats (other than death threats) against the person	411	88.6
Beating	393	84.7
Death threat	337	72.6
Blindfolding	309	66.6
Threats against relatives	242	52.2
Restricting food and water	220	47.4
Forcing the person to wait on cold floor	211	45.5
Restricting defecation and urination	200	43.1
Sexual harassment	198	42.7
Solitary confinement	156	33.6
Forcing the person to witness (visual, audial) torture	153	33.0
Sleep deprivation	124	26.7
Stripping the person naked	121	26.1
Pulling out hair/moustache/beard	116	25.0
Pressurized/cold water	103	22.2
Forcing the person to listen to marches or high volume music	97	20.9
Suggesting the person serve as an informer	88	19.0
Forced extreme physical activity	76	16.4
Electricity	75	16.2
Squeezing testicles	71	15.3
Suspension by the arms	70	15.1
Mock execution	52	11.2
Forcing the person to obey meaningless orders	47	10.1
Falanga	46	9.9
Suffocation	44	9.5
Torturing the person in the presence of relatives	35	7.5
Burning	13	2.8
Rape	7	1.5
Other	90	19.4

The numerical assessment of torture methods inflicted on the applicants to the HRFT during their most recent detention period reveals that more than one torture method was inflicted simultaneously (Graphic 10).

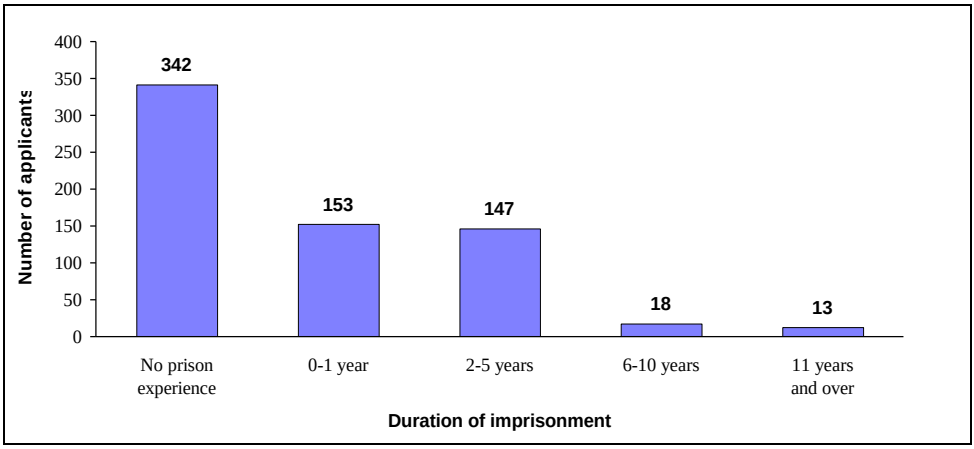
Graphic 10. The classification of number of torture methods inflicted on the applicants to the HRFT Treatment and Rehabilitation Centers in 1998.



Of the 673 torture survivors who applied to the HRFT, 39.3% (265 people) stated that they had been detained once, and 20.0% (134 people) twice. The ratio of those who had been detained three times or more is 40.7% (274 people).

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

Graphic 11. The classification of applicants to the HRFT Treatment and Rehabilitation Centers in 1998 according to the period spent in prison.



331 of the applicants stated that they had spent time in prison. Table 3 shows the torture methods inflicted on these applicants in prison.

Table 3. Torture methods inflicted in prison on applicants to the HRFT Treatment and Rehabilitation Centers in 1998 who have spent time in prison

Torture method	Number	%
Insults	188	56.8
Beating	110	33.2
Forcing the person to obey meaningless orders	80	24.2
Restricting food and water	70	21.1
Restricting defecation and urination	57	17.2
Threats (other than death threats) against the person	49	14.8
Solitary confinement	42	12.7
Death threat	37	11.2
Forcing the person to wait on cold floor	29	8.8
Forcing the person to witness (visual, audial) torture	20	6.0
Threats against relatives	19	5.7
Sleep deprivation	16	4.8
Forcing the person to listen to marches or high volume music	16	4.8
Stripping the person naked	15	4.5
Falanga	15	4.5
Pulling out hair/mustache/beard	14	4.2
Sexual harassment	13	3.9

Pressurized/cold water	12	3.6
Forced extreme physical activity	12	3.6
Suggesting the person serve as an informer	12	3.6
Blindfolding	7	2.1
Suspension by the arms	5	1.5
Squeezing testicles	5	1.5
Mock execution	4	1.2
Suffocation	4	1.2
Electricity	3	0.9
Torturing the person in the presence of relatives	3	0.9
Rape	1	0.3
Other	99	29.9

During the interviews with the 331 applicants who had spent time in prison, they were asked to evaluate the prison conditions. Some of the common points raised are presented below:

A negative/bad evaluation was given for nutrition conditions in prisons by 283 (85.5%) of these applicants, for accommodation by 282 (85.2%), for hygiene by 284 (85.8%), for communication facilities by 261 (78.9%), for health services by 290 (87.6%), for access to open air and sports facilities by 202 (61.1%), for facilities of using printed and visual materials by 246 (74.3%) and for conditions of transfer by 297 (89.7%).

The complaints related with health services included the prevention of access to medical treatment facilities on the pretext of security and the enforcement of medical examinations and treatment under inhumane conditions. However, prisoners should be considered one of the risk groups to whom health services should be provided with special care. The attitude of preventing prisoners from making use of health services as a way of threatening and punishing them, should be challenged.

Another problem in prisons related with health is one which leads indirectly to death or disability of prisoners because although they cannot receive the necessary medical treatment, they are considered under Article 399 of the Code of Criminal Procedures. Article 399 proposes that execution of the sentences given to the convicted prisoners who suffer from vital health problems, be suspended for one year in order for them to receive medical treatment outside the prison.

The stories of applicants reveal that the problem of prevention of prisoners taking salt and sugar while they are on hunger strike has almost been overcome. However, many remanded or convicted prisoners, who have vital health problems because of frequent and long hunger strikes, are still kept in prison.

Of the 673 applicants, 353 stated that they had been taken to a forensic physician, by the initiative of officials, after their recent torture experience and had been able to certify the torture inflicted. 289 applicants stated that they had not been able to prove with a medical report that they had been tortured.

283 (80.2%) of the 353 applicants, who had undergone forensic medical examination, stated that security forces had not left the examination room, 285 (80.7%) of them said that the medical examination had not been carried out properly, and 256 (72.5%) stated that the medical reports had not been issued in accordance with the findings.

It was determined that 110 applicants (16.3%) out of 673, had a permanent trace and/or disability due to torture.

Sixty-two of the applicants, who were given forensic medical reports stating that they had not been tortured, indicated that they had managed to receive medical reports, on their own initiative, certifying that they had been tortured. This fact once again draws attention to the criticisms of forensic medical reports, and reveals that effective use of the Regulation on Patients' Rights issued by the Ministry of Health and of the right to get a second opinion recognized by international documents is extremely important for prevention of torture.

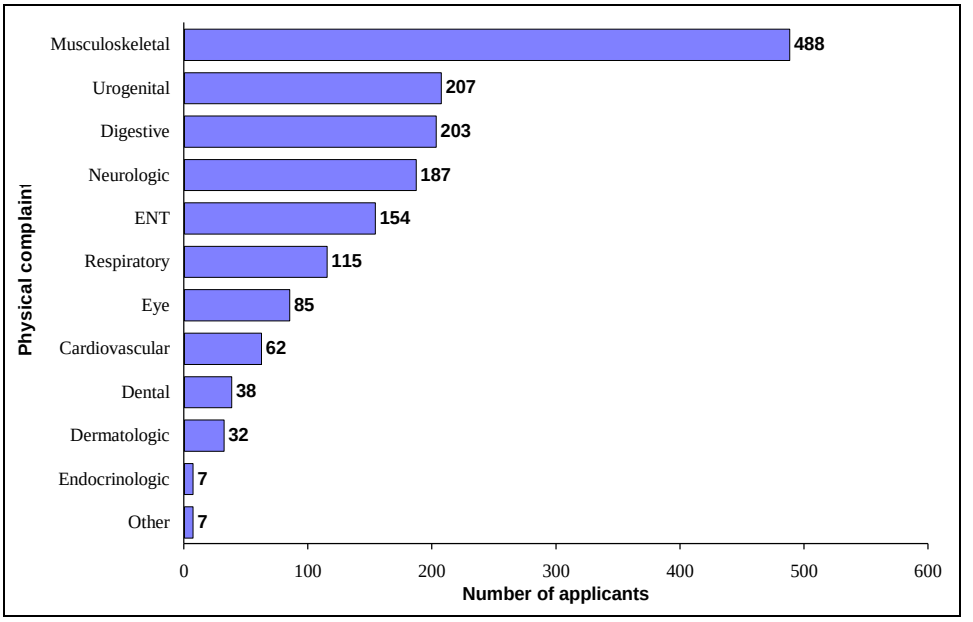
C. The Treatment Process

This section focuses on the complaints, medical and laboratory examinations, diagnosis and treatment of the applicants. 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 established."

Of the 673 people who applied to the HRFT Treatment and Rehabilitation Centers in 1998, 35.2% (237 people) had only physical complaints, 5.1% (34 people) had only psychological complaints, and 59.7% (402 people) sought medical assistance for both physical and psychological complaints.

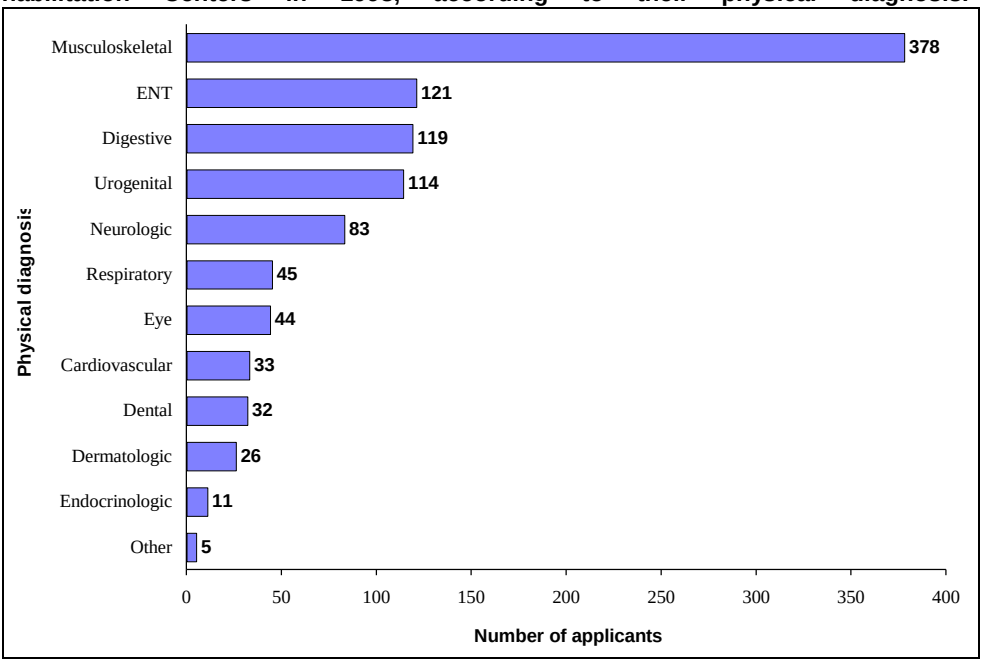
Among the physical complaints, the ones related with the musculoskeletal system were observed most frequently, as in previous years (Graphic 12).

Graphic 12. The classification of applicants to the HRFT Treatment and Rehabilitation Centers in 1998 according to their physical complaints.



85 of the 673 applicants were not diagnosed with any physical complaint. In terms of frequency, the diagnoses related with the musculoskeletal system were the most common (Graphic 13).

Graphic 13. The classification of applicants to the HRFT Treatment and Rehabilitation Centers in 1998, according to their physical diagnosis.



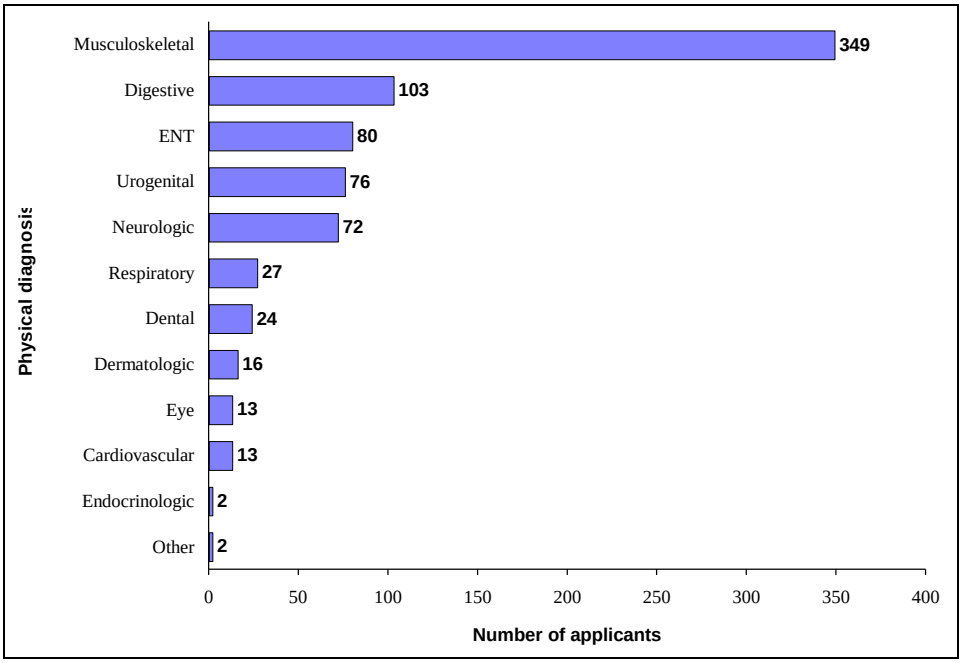
378 of the applicants were diagnosed as having musculoskeletal system disorders and 92.3% of the diagnoses (for 349 applicants) were related with the torture inflicted (Graphic 14).

The applicants to the HRFT are advised to have interviews with psychiatrists working for or in contact with our centers, but they are not forced to do so. In 1998, 340 of the applicants had interviews with psychiatrists; 333 of our applicants did not see a psychiatrist either because they did not need to or did not want to.

Sleep disturbances were the most frequently observed psychological complaint of the applicants as in previous years. The proportions have been determined on the basis of the 436 applicants who had psychological complaints (Table 4).

Posttraumatic Stress Disorder (PTSD) was the most frequently observed diagnosis among the psychological diagnoses related with torture (Table 5). PTSD was diagnosed in 120 applicants; in 33 of the applicants the PTSD was acute, in 80 chronic and in 7 late-term PTSD. Furthermore, 24 of the applicants (5.5%) had acute stress disorder and 14 had generalized anxiety disorder.

Graphic 14. The classification of applicants to the HRFT Treatment and Rehabilitation Centers in 1998, according to their physical diagnosis related to torture.



While the ratio of applicants who were diagnosed with PTSD was 21.0% (109 people) in 1997, it rose to 27.5% (120 people) in 1998. This rise may be connected to the training activities conducted by the HRFT and the experience gained on the subject, along with many other factors.

As the accumulation of knowledge on torture and ill-treatment as traumatic experiences, and on treatment methods increases, the psychological diagnoses become detailed diagnoses rather than more broad diagnoses such as depression, anxiety or psychosis. Thus, it has been observed that the applicants can be assisted more, in terms of treatment, after their problems are understood better.

Table 4. The classification of applicants to the HRFT Treatment and Rehabilitation Centers in 1998 according to their psychological complaints.

Psychological complaints and symptoms	Number	%
Difficulty in falling or staying asleep	276	63.4
Anxiety	262	60.1
Concentration difficulties	223	51.2
Increase or decrease in the duration of sleep	219	50.3
Weakness, fatigue	213	48.9
Irritability or outburst of anger	204	46.8
Memory impairment	203	46.6
Hypervigilance	151	34.7
Feeling of detachment or estrangement from others	140	32.2
Markedly diminished interest or participation in significant activities	130	29.9
Depressive moods	129	29.9
Intense psychological distress at exposure to internal or external cues that resemble an aspect of the traumatic event	119	27.3
Recurrent and intrusive distressing recollections of the traumatic event	112	25.7
Exaggerated startle response	110	25.3
Change in appetite/weight (a decrease or increase)	109	25
Agitation (irritability)	108	24.8
Sense of a foreshortened future	106	24.4
Recurrent distressing dreams of the event	101	23.2
Dysphoric mood	94	21.6
Acting or feeling as if the traumatic event were recurring	93	21.4
Physiological reactivity on exposure to internal or external cues that resemble an aspect of the traumatic event	80	18.4
Response involved intense fear, helplessness or horror to the traumatic events that are experienced, witnessed or confronted by person	78	17.9
Efforts to avoid activities, places or people that arouse recollection of the trauma	77	17.7
Blunted affect	76	17.5
Efforts to avoid thoughts, feelings, or conversations associated with the trauma	64	14.7
Diminished psychomotor activity	62	14.3
Loss of sexual interest	47	10.8
Suicidal thoughts or attempt	25	5.8

Inability to recall an important aspect of the trauma	21	4.9
Delusion	15	3.5
Obsession	14	3.3
Hallucination (visual, auditory, tactile)	14	3.3
Compulsion	9	2.1
Use of alcohol or substance(s)	8	1.9

Table 5. The classification of applicants to the HRFT Treatment and Rehabilitation Centers in 1998 according to their psychiatric diagnosis.

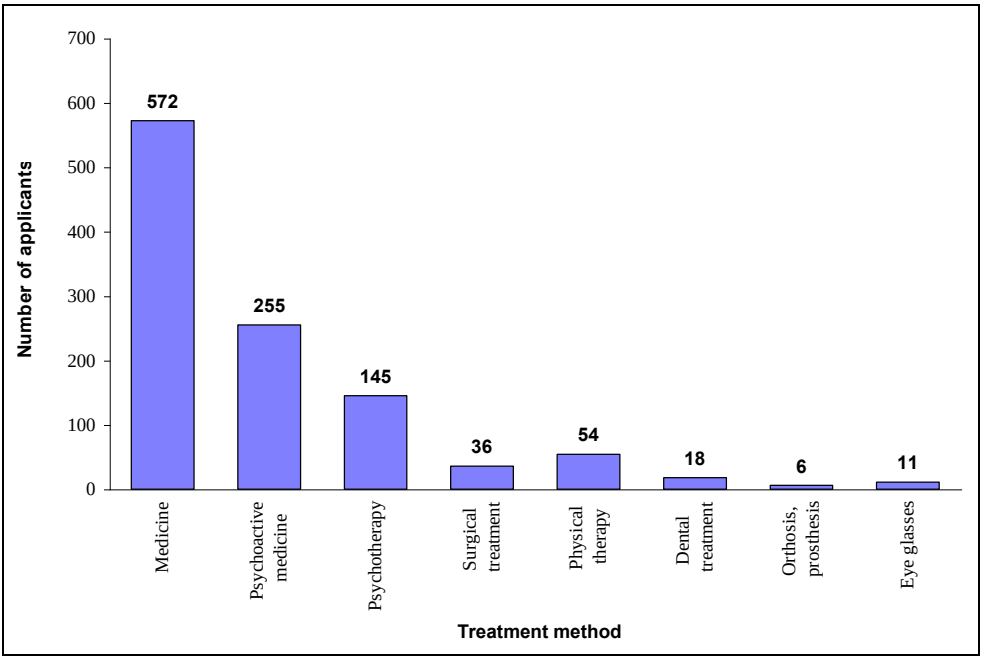
Psychiatric diagnosis	**Number**	**%**
PTSD (Posttraumatic Stress Disorder)	120	27.5
Major depressive disorder	60	13.8
Other anxiety disorders	30	6.9
Acute stress disorder	24	5.5
Generalized anxiety disorder	15	3.4
Other mood disorders	9	2.1
Adjustment disorders	8	1.8
Dysthymic disorder	8	1.8
Other psychotic disorders	6	1.4
Panic disorder	5	1.1
Obsessive-compulsive disorder	5	1.1
Somatization disorder	4	0.9
Conversion disorder	4	0.9
Delusional disorder	4	0.9
Schizophrenia	3	0.7
Sleep disorders	3	0.7
Other	10	2.3

In 1998, the physical treatment of 347 applicants, out of 639 with physical complaints, was concluded, and the physical treatment of 138 applicants was continuing at the time of writing. 78 applicants abandoned the physical treatment and for 26 applicants, no physical diagnosis could be linked with torture or prison experiences. In addition, 50 of the applicants ceased the treatment at the diagnosis stage although they had certain complaints.

The psychological treatment of 123 of the applicants was concluded, and it was continuing for 106 applicants at the time of writing. 57 applicants abandoned the psychological treatment process while 7 applicants obtained a diagnosis unrelated with torture or prison experiences. In addition, 143 applicants ceased coming for treatment usually after the first interview and even without obtaining a psychological diagnosis.

An evaluation of the treatment and rehabilitation methods applied in 1998 reveals that 572 applicants received pharmacological treatment, and 255 applicants received psychopharmocologic treatment. Psychotherapy was applied to 145 applicants. Physiotherapy was applied to 54 applicants, various surgery operations to 36, orthopedic operations to 6 and dental treatment to 16 applicants either alone or in combination with other treatment methods (Graphic 15).

Graphic 15. The classification of applicants to the HRFT Treatment and Rehabilitation Centers in 1998, according to the treatment method they received.



CONCLUSION

In a country where human rights violations are systematic, the Treatment and Rehabilitation Centers Report of the HRFT aims to present a brief account of the generous efforts of hundreds of medical staff from various branches.

In 1998, as in previous years, the security forces resorted to violence during social acts such as demonstrations, marches or meetings. The demonstrators have been subjected to violence while being dispersed or detained by the security forces or during detention.

The fact that 53.2% (358 people) of the 673 applicants to the HRFT Treatment and Rehabilitation Centers in 1998 had been tortured in the same year supports the opinion that torture is systematically applied in Turkey.

The fact that 619 (92.0%) of the 673 applicants in 1998 had been tortured on political grounds should not be taken to mean that ordinary prisoners or detainees are not subjected to systematic torture.

It is worth noting that the place of birth of the majority of applicants was the Southeastern and Eastern Anatolia region and 16% of the applicants had applied to the HRFT due to torture inflicted on them in the State of Emergency Region.

Unemployment, a major factor that negatively affects the treatment and rehabilitation efforts, was again at a significant level in 1998. Projects have been developed concerning supplying work and occupation, and social support to torture survivors. The implementation of these projects will affect the success of the treatment and rehabilitation process directly and in a positive way.

Long periods of detention facilitate infliction of torture. 64.8% of the applicants were released before appearing before a prosecution office, or released by the prosecution office or the court which should be discussed as an indicator of the arbitrary use of detention.

The applicants' statements reveal that psychological torture methods are prominent, but torture methods such as electric shocks and suspension by the arms are also used systematically. These findings should be taken into account in discussions of prevention of torture and recognition of torture findings in medical reports.

The data on the applicants to the Treatment and Rehabilitation Centers of the HRFT in 1998 clearly show that regulations, laws or circulars for prevention of torture and for punishing the torturers in a deterrent manner should urgently be prepared.

In 1998, many convicted or remanded prisoners requested medical assistance through writing letters about their health problems or through their lawyers. Although most of the complaints were found to be related with torture or ill-treatment, effective medical assistance could not be provided due to the difficulties of communication and providing medical services in prisons.

Hunger strikes are still an important method of seeking rights during detention or in prisons as stated by the applicants. The statements of the applicants point out that the attitude of the physicians and their efforts to treat the hunger strikers are extremely important.

Many prisoners who had vital health problems due to insufficient or incorrect medical treatment they received following the widespread hunger strikes and death fasts in 1996 are still kept in prison. Attempts should be made including the implementation of Article 399 of the Code of Criminal Procedures in order to provide medical treatment to these people.

Despite the many symptoms of applicants related with torture, most of them were not reflected in forensic medical reports. This fact should be evaluated taking into account the forensic report procedures, Forensic Medical Institute and the responsibility of the physician in the prevention of torture.

With the hope for a world where torture is banished to the dark pages of history.

Studies and Assessments On Torture and Its Consequences

COMPLEX POSTTRAUMATIC STRESS DISORDER (C PTSD)

Cem Kaptanoğlu*

Even though the condition which has been described as complex posttraumatic stress disorder (C-PTSD) has not yet been accepted generally, many clinicians maintain that it should be included in the group of psychological problems related to trauma. Authors, who have accepted this new syndrome which makes it easier to understand a group of patients that are difficult to diagnose and treat, suggest that PTSD as defined in the DSM (Diagnostic and Statistical Manual of Mental Disorders) should be called simple PTSD[1]. In brief, it appears that in the near future, clinical discussions of PTSD will take the form of complex versus simple PTSD.

The psychological picture resulting from traumatic situations which are chronic or in which there is a possibility that the trauma may be repeated differ from that of simple PTSD. In PTSD posttrauma is defined as an occurrence which took place in the past with it being as likely to be reexperienced as to happen to any member of the general public. Following a traffic accident or a flood, the definition “posttraumatic” might perhaps be used in order to emphasize that an important change occurred in the possibility of a repeat of the trauma. However, the posttrauma resulting from incest, physical and mental mistreatment in childhood, denigration/beating by a spouse, life in a concentration camp, internment in a maximum security prison, forced migration, life during active warfare, and threat of torture differs from that of simple PTSD. The symptomatic characteristics, severity and permanent personality changes that develop in victims of traumas such as those mentioned above are more complex[2-4]. Clinicians who worked with victims

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of the Nazi holocaust or southeastern Asian refugees have indicated that the psychological picture in the groups exceeds the limits of the classical PTSD. Emphasizing that there should be a different approach, they have suggested new names such as “victimization disorder” or “complicated posttraumatic stress disorder” [5]. In particular, some clinicians who have worked with people with a history of childhood abuse have suggested that a single traumatic event and long-term repeated traumatic events should be separated into Type I and Type II. [6] On the other hand, Gilboa et al. emphasize that since traumatic events which cause burns lead to long-term treatment and to sequels, they should be called continuous PTSD instead of just PTSD [7].

“The Psychological and Behavioral Changes Classification” (ICD-10) prepared by the World Health Organization states that long-term life threatening situations (being taken hostage, living under terror or as a prisoner of war who might be killed at any time), life in concentration camps, torture or natural disasters may lead to permanent personality changes. These situations were discussed under the title “Permanent Personality Changes Due to Disastrous Living Conditions”. The diagnostic criteria for these changes are as follows: a) Hostile or distrustful behavior toward other people, b) Social withdrawal c) A feeling of emptiness or hopelessness d) A chronic neurotic feeling that one is continually in danger e) Alienation [8]. Even though there has been much more emphasis on personality changes according to complex PTSD in “Permanent Personality Changes Due to Disastrous Living Conditions” it may be considered that these two diagnoses are complementary.

The DSM-IV working group of the American Psychiatric Association has suggested new diagnoses for psychological changes resulting from long-term, repeated or man-made trauma. Since the criteria of this condition have not yet been sufficiently compared with the PTSD diagnostic criteria, it is still in the form of a rough draft. This condition has been called “Disorder of extreme stress not otherwise specified (DESNOS).” [9] Even though this proposal has not been officially accepted by the DSM-IV, it has caught the attention of many researchers. The diagnostic criteria for DESNOS which have been suggested by the DSM-IV working group of the American Psychiatric Association are shown in Table 1.

I. Table I: Criteria for the Diagnosis of Complex-PTSD

1- History of long term (months, years) subjection to constraint. Examples: Being held hostage, prisoner of war, living in a concentration camp, mistreatment in certain religious orders, pressure in sexuality or home life, (violence in the home, physical or sexual mistreatment during childhood, and organized sexual mistreatment).

2- Undulation in the emotions as given below

Continual dysphoria (dejection, anger)

Chronic suicidal thoughts. Self-inflicted injury

Explosive or extremely suppressed anger (may be interchangeable)

Compulsive or extremely inhibited sexuality (may be interchangeable)

3- Undulation in consciousness as given below

Complete or partial memory loss of trauma

Temporary dissociative episodes

Depersonalization/derealization

Reliving of trauma in a sudden or forced manner or continually thinking of these occurrences as in the symptoms of PTSD

4- Undulation in self-awareness as given below

Despair or feeling of inability

Shame, feeling of guilt or blaming oneself

Loss of innocence, feeling of being in a shameful situation

Feeling of being different from other people

5- Undulation in perception of the aggressor as given below

Continually thinking of the relationship with the aggressor (this includes thoughts of revenge)

An unrealistic view of the aggressor as being very powerful (possibility that the patient is more realistic than the clinician)

Idealizing the aggressor or paradoxically being grateful to the aggressor. A feeling of a special relationship with the aggressor.

Acceptance of the aggressor's system of belief or finding him to be rational

6- Undulation in relationships as given below

Isolation and social withdrawal

Disturbance in close relationships

Continually seeking a savior (this situation may be interchangeable with isolation and withdrawal)

Chronic insecurity

Repeated failure in self-protection

7- Changes in system of values

Loss of beliefs

Loss of hope and feeling of helplessness

As may be determined from Table I, DESNOS or complex PTSD is quite different clinically from simple PTSD. Some researchers have shown that the differences between complex PTSD and simple PTSD may be placed under 3 headings [10].

1- Symptoms: The symptoms of complex PTSD are more variable and show more physical signs. The symptoms may be grouped under 3 headings—somatization, dissociation and affective. Symptoms of somatization usually include complaints of headaches, abdominal pains, back and waist pains, nausea, a feeling of suffocation and digestive discomfort. Dissociation usually appears as multiple personality disturbances in people who have undergone sexual and/or physical mistreatment during childhood. Affective symptoms usually occur as thoughts of suicide accompanied by severe traumatic depression. Physicians often evaluate this situation as depression only and overlook the underlying trauma.

2- Personality changes: Withdrawal from human relationships, feelings of powerlessness, fear of abandonment, passivity, and fearful or rebellious behavior accord in victims of chronic trauma. The victim may develop extreme traumatic bonding with the aggressor.

3- Self-inflicted injury and violent actions: Self-inflicted injuries and attempts at suicide may be seen in victims. Self-inflicted injuries and attempts at suicide are more common in those who have undergone a life of chronic trauma than in those with a single traumatic experience. It has also been reported that people who have undergone chronic trauma in childhood are likely to be violent.

Even though this situation has been given names such as “complex PTSD”, “Disorder of Extreme Stress not Otherwise Specified” or “Permanent Personality Changes after an Experience of Disaster”, we need a diagnostic category which will make it easier to understand victims who have undergone repeated long lasting trauma. In our country, often when individuals come to a physician, their complaints are physical. They are not asked or they are ashamed, do not wish to remember or do not connect the trauma they have undergone with their present complaints. For this reason they rarely mention their depression or symptoms of anxiety. It is not possible to help these people if they do not report the traumas they have undergone.

We may give the following answers to the question “How will the diagnosis--complex PTSD-- be helpful to us in the clinic? In our country where there is considerable violence ranging from that in the home and in traffic to torture and warfare, physicians frequently encounter patients with physical complaints that have

no organic cause. They go from doctor to doctor seeking a “savior”. We could better understand these patients who are usually diagnosed with somatization, conversion disorder or dysthymia within the perimeters of complex PTSD. The problem of a woman patient who complains of nonspecific symptoms such as a feeling of suffocation, backache, headache and dizziness as well as helplessness, sudden anger and thoughts of suicide cannot be explained simply by somatization or depression. We might remember that this could be a syndrome related to chronic trauma, perhaps even complex PTSD. Psychiatrists may find it difficult to diagnose and treat people from the Southeast who have migrated to big cities either willingly or under duress. Perhaps a complex PTSD diagnosis would help us doctors so that we would not have to fall back on drugs as a source of relief for people who act in a hostile and untrusting manner toward other people, who have feelings of helplessness, and who are chronically nervous. Perhaps we could determine why their heads, arms and backs ache as though they have been beaten and why when psychological tests are applied, all emotions except anger can be found. This is a country where for more than 20 years instead of fairy tales there have been stories of warfare, people being killed in the streets and in their homes, torture, kidnapping and disappearances as well as gangs. Perhaps the diagnosis of complex PTSD would help us to understand the present and future behavior, the responses, thoughts and emotions of children growing up in Turkey, many of whom have reached 20 years of age.

REFERENCES

1. Jongedijk RA, Carlier IV, Schreuder BJ, Gersons BP. Complex posttraumatic stress disorder: an exploratory investigation of PTSD and DES NOS among Dutch war veterans. J Trauma Stress, 1996 Jul; 9 (3): 557-86

2. Newman E, Riggs DS, Roth S. Thematic resolution, PTSD and complex PTSD: the relationship between meaning and trauma-related diagnoses. J Trauma Stress 1997 Apr; 10(2):197-213.

3. Roth S, Newman E, Pelcovitz D, van der Kolk B, Mandel FS. Complex PTSD in victims exposed to sexual and physical abuse: results from the DSM-IV Field Trial for Posttraumatic Stress Disorder. J Trauma Stress 1997 Oct; 10(4): 539-55.

4. Dickinson LM, de Gruy FV 3rd, Dickinson WP, Candib LM. Complex posttraumatic stress disorder: evidence from the primary care setting. Gen Hosp Psychiatry 1998 Jul; 20(4): 214-24.

5. Horowitz M. Stress Response Syndromes. Northvale, N.Jersey, London: Jason Aronson, (1986).

6. Terr LC, Childhood traumas: An outline and overview. Am J Psychiatry 1991 Jan;148(1):10-20.

7. Gilboa D, Friedman M, Tsur H. The burn as a continuous traumatic stress: implications for emotional treatment during hospitalization. J Burn Care Rehabil, 1994 Jan-Feb; 15(1): 86-91.

8. Dünya Sağlık Örgütü. ICD-10 Ruhsal ve Davranışsal Bozukluklar Sınıflandırması. Ankara, Türkiye Sinir ve Ruh Sağlığı Derneği Yayını (1993).

9. Herman J L, Trauma and Recovery. New York, Basic Books (1992)

10. Oldham JM, Michelle BR, Tasman A. Review of Psychiatry, Washington, American Psychiatric Press, (1993) Vol:12.

PHYSICAL DISORDERS CONFRONTED IN THE LONG TERM AFTER TORTURE

Ümit Şahin*

Musculoskeletal complaints and disorders are frequent among torture survivors. Different methods of torture, especially those leading to serious trauma such as beating or suspension by the arms, may sometimes cause permanent damage to the musculoskeletal system which constitutes the system of movement of the body. Following torture, certain pathologies consequent to the subjecting of muscles, the spine, peripheral joints and bone structures to direct trauma may develop, as well as painful illnesses and dysfunctioning secondary to the central or peripheral neurologic damage.

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A distinguishing feature of musculoskeletal system disorders consequent to torture is that in addition to acute pathologies, the painful illness may become chronic in many patients and may even appear in the long run, years after the infliction of torture. In the long run, certain disorders such as herniated disk or shoulder periarthritis due to the degeneration of joint systems secondary to the trauma may occur. Sequels due to brachial plexus paralysis consequent to hanging by the arms frequently become chronic.

Changes in perception of pain and psychosomatic processes after the infliction of trauma play a role in painful disorders' becoming chronic. For some patients chronic pain syndrome may be observed which is quite difficult to cure.

Concerning rehabilitation after torture, the approach to disorders causing pain and dysfunction syndromes requires cooperation between physical, psychological and social disciplines. Development of chronic pain and dysfunctioning syndrome may be prevented if a self-disciplined team having a comprehensive approach to the patient applies rehabilitation. Along with physical treatment methods, methods for pain modulation, especially exercises should be used together with psychotherapy.

I will try to make an analysis of physical disorders appearing in the long term with a tendency to become chronic following torture. The information and statistics pertain to the applicants to the Human Rights Foundation of Turkey (HRFT) İstanbul Representation Office who had musculoskeletal system complaints and for whom a physical treatment and rehabilitation consultation was requested, between October 1996 and May 1998.

FINDINGS

1- Age and Sex: Sixty-five people had consultations at the HRFT İstanbul Representation Office between October 1996 and May 1998. Forty-five of them were men and 20 were women, and the average age was 31.4. The statistics on the age and sex of the applicants are given in Table 1.

Table 1: Classification of the applicants according to age and sex

Sex	N	Average Age	Min. age	Max. age	75% percentile
Male	45	32.8	18	68	38.0
Female	20	28.3	18	43	34.7
Total	65	31.4	18	68	37.5

2- The time interval from the date of most recent torture application to the date of physical examination: For 29 of the applicants (45.3%) this time interval was between 1 and 3 years, between 0 and 1 month for 5 of the applicants (7.7%) and more than 5 years for 5 others. Nineteen of the applicants (29.7%) applied within 1 year following the most recent torture application (Table 2)

Table 2: Time interval from the date of most recent torture application to the physical examination for those applicants who had FTR examination

Time interval from the most recent torture application	n	%
0-1 month	5	7.7
1-3 months	5	7.7
3-12 months	9	13.8
1-3 years	29	44.6
3-5 years	11	16.9
More than 5 years	5	7.7
Not definite	1	1.5
Total	65	100

3- Time interval from the date of release from prison to the date of physical examination: Forty-one of the applicants (63.1%) had spent time in prison. The complaints of these applicants can be related both with the torture inflicted on them and the prison process. Only 1 applicant (1.5%) had complaints related only with the prison process. Twenty-nine (70.7%) of the applicants who had been in prison had been released within the last year. Only 4 of these applicants (9.8%) had been released within the last month and 5 (12.2%) had been released more than 5 years previously (Table 3).

Table 3: Time interval from the date of release from prison to the date of physical examination for those applicants who had PTR examination

Time interval after release from prison	n	%
0-1 month	4	6.2
1-3 months	12	18.5
3-12 months	13	20.0
1-3 years	5	7.7
3-5 years	2	3.1
More than 5 years	5	7.7
No prison experience	24	36.9
Total	65	100

4- Time interval from the date of application to the date of physical examination: The period from the application date to the date of physical examination was less than 1 week for 28 (43.1%) of the applicants. For 54 (83.1%) of the applicants, this period was less than 1 month (Table 4).

Table 4: Time interval from the date of application to the HRFT to the date of physical examination for those applicants who had PTR examination

Time	n	%
Less than one week	28	43.1
1-2 weeks	12	18.5
2-3 weeks	6	9.2
3-4 weeks	8	12.3
1-6 months	8	12.3
More than 6 months	3	4.6
Total	65	100

5- Complaints and their location: The 65 applicants applied with 103 different complaints for physical examination. Most of the complaints were related with the axial parts and body such as the waist and neck (66 complaints, 64.1%). The

other frequent complaints were related with the upper extremity (29 complaints, 28.2%) and lower extremity (8 complaints, 7.8%) (Table 5).

Table 5: The location of the complaints related with the Locomotor System

Location	n	%
Upper extremity	29	28.2
Lower extremity	8	7.8
Backbone	66	64.1
Total	103	100

6- Location of complaints: The complaints were analyzed under 11 headings and the most frequently observed complaints were related with the waist and waist-leg region (44 complaints, 42.7%). The second most frequently observed complaints were weakness and numbness in the arms (13 complaints, 12.6%). Eleven complaints (10.7%) were neckache and neck-armaches, and backache and/or restriction in the movement of the arm. Fifty-nine of the complaints were related with the waist, back and neck (Table 6).

Table 6: The classification of complaints related with the Locomotor System

Complaints	**n**	**%**
Low back pain	44	42.7
Neck pain	11	10.7
Back pain	4	3.9
Pain in the shoulder and restriction of movement	11	10.7
Ache in the knee	5	4.9
Ache in the elbow	5	4.9
Weakness in arms	13	12.6

Costal pain	2	1.9
Weakness in legs and difficulty in walking	4	3.9
Ache in the hips	3	2.9
Ache in the jaw bone**	1	1.0
Total	103	100

7- Classification of the diagnoses: The applicants received a total of 82 different diagnoses. The diagnoses were analyzed under 23 headings and lumbar strain was the most frequent diagnosis (22 times, 26.8%). Myofascial pain syndrome was diagnosed 12 times (14.6%) and herniation of the lumbar invertebral disk 9 times (11%). Five applicants (6.1%) were diagnosed as having brachial plexus injury and 4 (4.9%) had sequela due to brachial plexus injury. Around 11% of the applicants received diagnosis related with the brachial plexus (third most frequent diagnosis together with herniation of lumbar intervertebral disk). For 5 applicants (6.1%) the diagnoses were related with fractures. The total number of diagnoses related with muscle pains (lumbar and cervical strain and myofascial pain syndrome) was 39 (47.5%) (Table 7).

Table 7: Classification of the Diagnosis related with Locomotor System complaints

Diagnosis	N	%
Herniation of lumbar intervertebral disk	9	11.0
Herniation of cervicalintervertebral disk	3	3.7
Myofascial pain dysfunction syndrome	12	14.6
Lumbar strain	22	26.8
Cervical strain	5	6.1
Lumbar osteoarthrosis	3	3.7
Cervical osteoarthrosis	1	1.2
Dorsal osteoarthrosis	1	1.2
Brachial plexus injury	5	6.1
Sequela due to brachial plexus injury	4	4.9
Shoulder impingement syndrome	4	4.9
Shoulder periarthritis	1	1.2
Elbow instability	1	1.2
Scoliosis	1	1.2
Scapula fracture	1	1.2
Spondylolysis	1	1.2
Humerus fracture	1	1.2
Lateral epicondylitis	2	2.4
Skin contracture after open fracture	1	1.2
Temporomandibular joint dysfunction synd.	1	1.2
L_1 burst fracture	1	1.2
Rupture of anterior cruciate ligament of knee	1	1.2
Rib fracture	1	1.2
Total	82	100

8- Number and classification of the treatment methods applied: In total, 102 different treatment methods were applied to the applicants. This makes 1.56 treatment methods per applicant. The most common was drug treatment (to 35 applicants, 34.3%), followed by exercise treatment (to 34 applicants, 33.3%). Physical treatment was given to 19 applicants (18.6%).

Table 8: Classification of the treatment methods

Treatment	n	%
Medical	35	34.3
Physical treatment	19	18.6
Exercise	34	33.3
Local Injection	7	6.9
Orthesis	4	3.9
Operation	3	2.9
Total	102	100

9- Proportion of Follow-up: Thirty-five of the applicants (53.8%) did not come for follow-up examinations after the completion of medical treatment.

10- The results of medical treatment for applicants who had a follow-up examination: Since 37 of the applicants did not have follow-up examinations, the result of the medical treatment that they received could not be determined. The medical treatment of 19 (29.2%) of the applicants was concluded in partial or full recovery. The situation of 7 (10.8%) applicants did not change. The medical treatment of 2 (3.1%) applicants is continuing.

Table 9: Treatment procedures and follow-up of the applicants

Current situation	n	%
Recovery	19	29.2
No change	7	10.8
Treatment continuing	2	3.1
Did not come for follow-up	37	56.9
Total	65	100

CONCLUSION

These results reveal that a wide range of musculoskeletal complaints occur related to torture. All of the complaints should be evaluated with a comprehensive rehabilitation approach, which should include physical, psychological and social aspects of rehabilitation.

PROCEDURE FOR REHABILITATION AFTER TORTURE

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According to the Tokyo Report of the World Medical Association, torture is defined as "the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority to force another person to yield information, to make a confession, or for any other reason."

Physical, psychological or psychosomatic problems appear after the trauma, depending upon the level of violence to which the person has been subjected. These problems may limit the person's daily life or cause him or her to lose his or her independence. Rehabilitation procedures are important for the elimination or at least the reduction of these problems [1].

After various methods of torture, disturbances of the musculoskeletal system, chronic pain and poor posture related to these disturbances as well as psychological distress are frequently seen. Just as psychological problems that develop after torture may cause an increase in chronic pain, muscle weakness and posture difficulties, disturbances of the musculoskeletal system may play a role in the increase in psychological problems. In order to eliminate this grievous problem which continues in a vicious circle and affects the individual's independence in his or her daily life, a suitable rehabilitation procedure is necessary [2-4].

According to the report of the Treatment and Rehabilitation Centers of the Human Rights Foundation of Turkey for 1997, the most frequent psychological problems after torture are difficulty in sleeping, a feeling of isolation, loss of trust in oneself and others, orientation difficulties, hallucinations, sleep disturbances such

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as dropping off to sleep, waking up frequently and nightmares as well as chronic headaches and sexual problems [5]. Psychological problems may accompany physical problems. These physical problems include blows to the head, difficulty in jaw movement due to headaches, cardiopulmonary problems, gastrointestinal problems and sexual problems [2].

The function of the physiotherapist in the rehabilitation of people who have undergone torture is to determine the physical inadequacies occurring after torture by using specific evaluations of physiotherapeutic rehabilitation, to eliminate the inadequacies and to prevent, as much as possible, the development of handicaps caused by the inadequacies. For example, the paralysis which occurs due to damage to peripheral nerves as a result of torture by suspension by the arms is such an inadequacy. This inadequacy may handicap the individual in his or her normal activities (such as not being able to work or fulfill his or her role in family life) [1].

In order for physiotherapy to help in the rehabilitation of torture victims, it is important to carry out psychotherapy along with the physiotherapy. Teamwork is necessary in the treatment of symptoms of the musculoskeletal system caused by physical strain during torture and the nervous system as well as in the treatment of psychological problems. The rehabilitation team should include a physician to whom the victim first applies, specialists in related branches, physiotherapists, nurses and social workers [1,6].

Before beginning physiotherapy it is necessary to determine what problems exist in the musculoskeletal system and the nervous system [6].

People who have undergone torture while they were under arrest will have been deprived of normal sensations due to limited movement. This situation leads to a change in the pattern of movement and to the way the body is accepted as well as in the spatial view of the body. These changes result from physical and psychological strains. Being forced to remain in a fixed position during torture will lead to an extraordinary strain of the joints. As a result, there is tissue damage leading to dysfunctions of various joints such as those of the spine, shoulder, wrist, ankle, knee and sacroiliac area. These dysfunctions will affect the entire body. The tonus of the muscles will be disturbed and irritation will result. Hypertonia and tautness of the muscles will lower the level of innervation and will lead to pain. As a result of this, there is a decrease in the elasticity of the muscle which leads to shortening and weak functions as well as to disturbances in posture [1,6].

The physical sequels which are seen after torture occur in the chest, upper or lower extremities depending on the area to which the torture was applied. The most frequent sequels are shown in Table 1.

Table 1. The Physical Sequels Seen Most Often after Torture

Tearing of the capsular structures and supportive connecting tissues
Widespread pain in neck, back, small of back, joints of the extremities and muscular tissue
Dislocation of the joints of the shoulder, elbow, hand or foot
Injury to disks in the cervical, thoracic or lumbar areas
Loss or decrease in movement of all joints
Fibrosis and shortening in connective tissue due to a decrease in the blood flow to the nerves surrounding the connective tissue
Injury to the tissue of the bottom of the feet and disturbance of arch of the foot
Impairment of posture such as kyphosis, lordosis and scoliosis
Headache
Injury to nerves
Paralysis
Difficulty in balance
Widespread paresthesia of the extremities

The physiotherapist should carry out the first consultation with the patient according to the views of the consulting physician and the results of the tests, examination and history taken by the treatment and rehabilitation team. The patient should be made to feel at ease and secure. In order to plan an effective physiotherapeutic rehabilitation program, after the first consultation the patient should be evaluated in detail. The physiotherapist should explain the therapy to be used in detail to the patient and should gain the trust of the patient. The way the evaluation should be carried out is shown in Table 2 [1].

Table 2. Evaluation in the Physiotherapy Rehabilitation Program

Pain evaluation
Posture analysis
Evaluation of muscle tonus
Evaluation of joint mobility
Testing of the muscles
Evaluation of respiration
Integration of sensory reception
Evaluation of walking
Evaluation of balance
Evaluation of reflexes
Evaluation of daily activities
Evaluation of work

In planning the physiotherapy program the first step in the evaluation of problems is to get the patient to accept being touched. Touching is pain relieving as well as being soothing and relaxing. If the patient refuses to be touched, then training in relaxing that does not require touching should be done. Since the primary aim of the treatment is to increase the afferent discharge, the best muscular balance and the most suitable patterns of movement should be obtained by stimulation of the muscle receptors. All or some of the physiotherapy rehabilitation methods given below are used depending upon the needs of the patient.

In order to reduce pain by getting rid of scar tissue and adhesions, hot or cold cushions, massage, exercise, pain relieving positions, active or passive mobilization and relaxing exercises should be used. If there is a history of torture by electricity, no electrotherapy with the exception of ultrasound should be used. In order to restore ability of movement, mobilization methods should be used. Strengthening exercises may be used in order to increase muscular strength. Training in kinetic reception is used for improvement of posture. Balance training may be used in the elimination of balance problems. Training in daily activities and an occupational rehabilitation program should be included in the rehabilitation program. Furthermore, social integration should be emphasized and sports and recreational activities should not be neglected [1-3, 6-8].

Education in "Body Awareness" may be used to help the patient to become reacquainted with his/her body and to restore self-identity. Body awareness is a complex concept. After torture, it is possible to restore abilities such as the total body receptivity which has been disrupted, posture, breathing, spontaneous and controlled body movements and body language by this method. This method which uses a combination of breathing exercises, movement motivation, touch, massage and dance, aids in the relief of pain and improvement of posture, healing of physical wounds and reducing psychological problems as well as increasing the effectiveness of psychology [2,6].

The methods used in the physiotherapeutic rehabilitation of people who have been tortured include those used in physiotherapy carried out in other situations. The treatment program for patients who have undergone torture is set up according to their psychological and physical conditions. Preventive measures in this subject that will be helpful for physiotherapists are as follows:

- The physiotherapist should not position him/herself behind the patient during the first session.
- The patients should not be asked to remove all their clothes until they trust the physiotherapist.
- The lighting in the treatment room should be neither too bright nor too dim. No light should go directly into the patient's eyes.
- When the treatment method is being set up, care should be taken that the exercises and instruments do not remind the patient of violence or torture methods.
- Care should be taken that the appointment of the patient who has undergone torture is not overlooked. The patient should never be kept waiting. It should be kept in mind that waiting may remind the patient of previous experiences and may affect him/her adversely.
- Care should be taken in the use of manipulation and traction. Care should be taken that there is no sudden sound coming from the joints.
- Mirrors should not be used during the first physiotherapy sessions.

There may be resistance to treatment and recurrence of pain and physical complaints related to posttraumatic stress in people who have been tortured. Because of this, there may be an increase in the time required for recovery. It is possible with a good rehabilitation team and suitable treatment along with a social approach to reduce the physical and psychological problems of torture survivors as much as possible and to make them a part of society again. The aim should be to reconnect the mind and body in these patients.

REFERENCES

1. Prip K, Tived L, Holten N. Physiotherapy for Torture Survivors -a Basic Introduction, IRCT, Copenhagen, 1995.

2. Skylv G, Bloch I, Hohne L. Muscle tension and articular dysfunction in torture victims. Journal of Manual Medicine, 1990; 5: 158-161.

3. Somnier FE, Genefke K. Psychotherapy for victims of torture. British Journal of Psychiatry, 1986;149: 323-329.

4. Travell JG, Simons DG. Myofacial Pain and Dysfunction. Baltimore: Williams and Wilkins Company, 1983.

5. Human Rights Foundation of Turkey, Treatment and Rehabilitation Centers Report 1997, HRFT Publications (17) 1997.

6. Hough A. Physiotherapy for Survivors of Torture. Physiotherapy, 1992; 78 (5): 323-328.

7.Bloch I, Moller G. Rehabilitation of torture victims: Physiotherapy as part of the treatment. International Perspectives in Physical Therapy, 1990; 5:121-44.

8. Jacobsen L, Vesti P. Torture Survivors -a New Group of Patients, Danish Nurses Organization, Copenhagen, 1990.

THE DIMENSION OF FORENSIC PSYCHIATRY IN TRAUMA AND PROPOSALS*

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Introduction

Trauma is physical and/or psychological violence that causes changes in the organism. While trauma causes varying effects depending upon the type of application, the severity and the part of the body affected, there is resistance by the individual to trauma physically and psychologically [1-4]. These two components may result in the development of various symptoms in the individual. As a result, trauma is a violence which must be considered in terms of its physical and psychological dimensions. Violence has been described and evaluated in this context from the legal viewpoint. However, while the physical lesions caused by trauma are always investigated, the symptoms of the psychological or psychiatric dimensions are usually not investigated thoroughly or even noticed.

Developments in the field of health have made it easier to detect the physical symptoms of trauma. It is still difficult to determine and evaluate the psychological or psychiatric symptoms. However, the most serious and permanent disturbances or diseases result from mental trauma [5-10]. While the physical trauma may be cured within days or months, the mental trauma may lead to very serious health problems, which can be lifelong. The most striking mental traumas result from traumatic-catastrophic occurrences (natural disasters, death, disappearance, rape, mistreatment of children and violation of human rights, torture etc.). While it

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is impossible to prevent certain catastrophic occurrences, the resulting mental trauma may be lessened greatly.

In order to protect society, legal provisions are made against illegal activities. Violence which leads to trauma is evaluated and punished from a legal standpoint. The Turkish Penal Code (TPC) considers physical and/or violence assault and battery [11,12]. Even though the determination of mental trauma is envisaged legally, applications may be inefficient and incorrect.

Mental trauma complaints made to the courts frequently reflect violations of human rights and torture. The results of physical torture are easily seen. On the other hand, even though mental torture is not so apparent, it takes prominence over physical torture because of the damage to the personality, intimidation and production of fear due to torture and violations of human rights [5-8]. Torture may be a danger that is both individual and general and it leads to mental trauma for the society at large [5-8]. As long as a threat is not broached, proven or punished, its effect will continue to increase.

Trauma according to law

In the laws of the Turkish Republic, any trauma which causes or may cause pain or impairs health or mental functions is called assault and battery. Activities which result in assault and battery include physical means which affect the body partly or totally as well as those causing mental anguish which also may affect the body [11-13].

In Turkish law the words used to describe trauma and violence originate from the Ottoman Empire. Translations of these words include “blow, strike, compulsion, constraint, physical pain, damage to health, interference with mental aptitudes which include personality, emotions, awareness, perception, inclination, memory, intelligence, attention, judgement, abstract thinking, evaluation of reality and willpower.

According to legal principles, disturbance of the individual’s bodily integrity or health may be divided into intentional or negligent actions. Articles of law which are related to assault and battery are found in the 456th, 457th and 459th articles of the TPC.

> **456/1** Any person who gives physical pain to any other person, damages their health or interferes with their mental aptitudes so long as there is no attempt to murder will be imprisoned for 6 months to a year.
>
> **456/2** .... the holding of a person for 20 days or more, or actions involving development of a mental or physical disease, preventing the individual from carrying out his daily occupations during the 20 days,

threatening their life or causing a pregnant woman to give birth prematurely are punished by imprisonment for 2-5 years.

456/3 ... deeds which lead to mental or physical disease which are possibly or absolutely not likely to be cured or causing loss of the senses, hands, feet or ability to speak or a permanent change in appearance or causing a pregnant woman to miscarry are punished by imprisonment for 5-10 years.

456/4 If the assault has not caused any disease or has not prevented the individual from carrying out his daily occupation or the events have not lasted for longer than 10 days, during the legal proceedings, depending upon the complaint of the injured party, the accused may be imprisoned for 2-6 months or be fined.

The 457th article is concerned with events involving instruments and murder attempts and the 459th article with carelessness, a lack of caution or inexperience [12].

The legal evidence of trauma may be described by the following: prevention of the individual's daily activities by trauma, loss or weakening of any of the 5 senses or a loss or weakness of organs (limbs). During criminal proceedings, forensic health is taken into consideration and during legal proceedings, medical health [11,13].

In the description of forensic health, the trauma is classified as light, medium or severe and the level of prevention of daily occupations is determined according to this. In forensic medicine, assault and battery is evaluated according to an apparent lesion. Gök (11) has defined apparent lesions as wounds, ecchymoses, broken or dislocated bones and vessels or nerve injury.

If the assault and battery is carried out by public officials on people on trial (violation of human rights), the offenses are tried under the 243rd and 245th articles of the TPC. In addition, physical and psychological damage is covered by the 452nd and 456th articles of the TPC. Concepts related to human rights were classified according to the 4 April 1983 decision of the Criminal Section of the Supreme Court.

Torture: Action which harms an individual mentally or physically,

Cruel treatment: Any treatment which gives mental or physical pain to a victim.

Inhuman treatment: Actions which severely injure the personality and emotions of a person

Self-respect destroying actions: Actions which affect the honor, reputation or self-respect of the person.

On various occasions the Supreme Court made decisions that mental constraint was to be evaluated as assault and battery.

- All violent actions toward the body or which affected it were to be evaluated as assault and battery. Not only shaking a person but also pushing the person was to be considered assault and battery.
- The fact that the victim does not feel physical pain is not important. Any action such as cutting the hair or beard against the wishes of the individual is an attack against the body and is to be considered assault and battery.
- The assault and battery may be due to neglect. (Such as leaving a child in a cold, damp place so he or she becomes ill).
- Use of mental mistreatment is considered assault and battery.

Physical and/or psychological traumas may be determined medically. In practice, violence is usually considered to be only physical violence. The judge evaluates the trauma according to the opinions expressed by an expert. In addition to reporting the presence of trauma to the judge, medical experts can also give their opinions as to what the final results of the trauma will be. The court considers the request by the public prosecutor or the police for investigation of beatings and mistreatment to be only for physical damage but this is usually erroneous and incomplete. A judge may not find the evidence to be sufficient and require the opinion of a second expert in his or her evaluation of the situation.

Psychological and psychiatric symptoms of trauma

The psychological and psychiatric symptoms of trauma may appear independently of the violence. While psychological or psychiatric symptoms may appear after physical trauma, physical findings may also appear after mental trauma. Physical and mental symptoms in trauma are integral. While physical symptoms may disappear, the psychological or psychiatric symptoms may remain for years, even for life [6,7]. For this reason, psychiatric evaluation should be carried out in all cases of trauma regardless of type.

The following events may cause mental trauma: natural disasters such as earthquakes and floods, being in a life-threatening situation, being in an accident, sudden loss of a relative or a limb, being tortured or threatened with torture, being raped, being attacked by a thief, and having been mentally, physically or sexually mistreated during childhood. The disturbances which occur after mental trauma are classified as acute (psychiatric symptoms occurring within the first six months), delayed (those which occur after 6 months) and chronic (those which continue for longer than 6 months) [14].

In order for psychiatric evaluations to be carried out correctly, suitable conditions must be established and the activities must be carried out according to the principles of medical ethics [6,7]. When the history of the person with psychological and psychiatric symptoms is being taken, first the person's life and personal characteristics must be carefully established and the differences from the present situation evaluated.

Reactions after trauma may vary greatly. The following early symptoms may appear: anxiety; lack of trust; fear; helplessness; hopelessness; no pleasure in living; disturbances in memory, emotions or sleep; difficulty in concentration; reliving the event; symptoms of withdrawal and lifelessness; loss of appetite; severe headaches; impotence; and increase in use of alcohol and drugs [5,8].

Furthermore, it has been reported that the following occur: acute stress disturbances, posttraumatic stress disorder (PTSD), depression, dissociative disturbances, difficulty in adaptation, increase in overuse of alcohol and drugs, temporary psychotic responses, panic attacks, chronic depression, paranoia and psychosomatic diseases [5,7,9,10].

It has been reported that psychological or psychiatric symptoms of trauma may appear long after the occurrence of the trauma. It has been suggested that evaluations made some time after the event may prove that the trauma occurred [5,7].

Evaluation and conclusions

The effects of trauma on the individual have a legal aspect as well as a medical one. It is the duty of medicine and the law to determine the cause of the violence leading to trauma, to prevent it and to eliminate its effects.

It has been reported that in cases of exploitation of children, rape and torture, the more severe and destructive effects of trauma occur on the psychological and psychiatric level [5,7]. It has been pointed out that violence aimed at the body cannot be evaluated only from the physical viewpoint legally and medically. According to the 20.2.1986 decision of the 8th Criminal Section of the Supreme Court, torture of a physical nature which has both mental and physical characteristics is an action which leads to pain and distress. Because of this, it has been stressed that assault and battery cannot be considered only in terms of its physical aspects, but that the mental aspects must also be taken into consideration.

Gök has suggested that the evaluation of the discomfort resulting from mental trauma cannot be evaluated only from a medical viewpoint [11]. Whether or not there is a connection should be left to the discretion of the judge. Hancı indicated that there is a difference of opinion as to whether or not psychological trauma due to stress with no physical effects may be considered assault and battery [13]. As a result there are different evaluations and classifications in psychiatry causing it to be ignored and not to be discussed scientifically. Because of this, when

physical lesions have not been detected, an incorrect decision of no trauma has been made. The determination of the effects of mental trauma and whether or not there is a causative connection can only be made by people trained in this field, therefore this is a subject for forensic psychiatry. The fact that the opinions of people who are not specialists in psychiatry are not acceptable reinforces this view. Since the investigations by experts do not show the causative connection, this makes their reports incomplete. Just as the determination of the effect on the body in a physical event is a medical subject, forensic medicine or forensic psychiatry should evaluate the determination of the psychological effects of trauma. Furthermore, the general committee of the Forensic Medical Institute on several occasions has made decisions stating that "situations which lead to stress are assault and battery and can cause the death of an individual" showing that they have made a causative connection.

It is difficult to establish the connection between findings in an individual after mental trauma, and assault and battery. Whenever an individual applies to a physician after any kind of trauma, a psychiatric evaluation must be made. In the evaluation of trauma, overlooking the psychological or psychiatric dimension is unacceptable. During the examination, in order to establish the mental situation, objective findings must be determined and evaluated by an empathic approach according to the principles of medical ethics. The forensic psychiatric investigation must be detailed and the history of the present event must be compared with the life and characteristics of the person and his or her psychological situation. The psychiatric disturbances caused by the trauma must be evaluated in terms of assault and battery and these findings must be included in the forensic report.

Depending upon the type of violence, even though trauma has a greater physical and mental effect, it also affects the individual's characteristics. Occasionally it has been reported that there was no evidence of mental trauma in the individual [5,6]. However, it is to be expected that mental problems will develop after any extraordinary experience which causes stress [15]. The World Health Organization and the American Medical Association have classified the psychiatric effects and criteria for evaluation of extraordinary circumstances [14]. On this basis, psychiatric findings present objective evidence for the evaluation of trauma.

The length of time which normal life is disrupted still has not been completely defined in regard to the psychiatric findings and diseases. Tables, which have been prepared for physicians for use in determining the length of time that daily life is disrupted, have been prepared for physical lesions [11]. It is apparent that there is a great deficiency here because these tables, which were considered necessary do not contain psychiatric findings or diseases. When physicians and legal organizations use these tables for the determination of the period of normal life disruption, this leads to an erroneous and nonobjective evaluation because signs of mental trauma are ignored. Thus, neither physical nor psychological or

psychiatric symptoms are more important in the determination of trauma. All of the objective findings of trauma (physical and mental) should be determined.

The regulations of the Social Security Administration's Central Directorship for occupational diseases and accidents [16] in the evaluation of various psychiatric disturbances which affect the ability to work, indicate that in cases of personality deficiencies or neurotic depression, there is a 45% decrease in work. Under these conditions, when these syndromes continually prevent work, it is difficult to report that the disruption of normal life by trauma does not do the same. Posttraumatic stress disorder, reactive depression, other psychiatric syndromes, various personality disturbances or neurotic disorders resulting from a mental trauma affect the daily life of the individual and prevent them from working normally.

Proposals

First of all, when the physicians evaluate trauma not only should examination be done for the presence of physical violence but also it is necessary to determine the presence of psychological or psychiatric symptoms. The Ministry of Justice and the Ministry of Health should inform the physicians who prepare forensic reports of the above and should make sure that they pay close attention to this. In order for this subject to be taken into careful consideration, a working group should be set up and conferences should be held.

The findings and the diagnosis which have been objectively evaluated should be recorded in the reports. Psychiatric examinations should be made without fail just after trauma and 1-6 months later. Any investigations and evaluations made later may result in incorrect results because of varying definitions. The Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Classification of Diseases (ICD) evaluations of mental trauma are suitable for use by physicians for common classifications.

It is necessary for those evaluating psychiatric disturbances in the fields of forensic medicine and psychiatry to use a quantitative method in order to be legally objective. The determination of the period of disruption of normal daily life related to psychiatric findings and diseases should be done by cooperation between forensic medical and psychiatric specialists. A table of the legal dimensions should be prepared for use by physicians.

During forensic medical education it should be stressed that trauma does not only cause wounds and similar physical lesions, it also has a mental dimension. Physicians who are examining forensic cases should request psychiatric consultations. The forensic physician who is called in as an expert is obliged to carry out every type of investigation.

Various studies have shown that serious effects appear after an individual has been in a catastrophic traumatic situation. If the mental trauma is detected

early and preventive measures are taken, these kinds of problems may be prevented or lessened.

Certain extraordinary situations are of human origin (such as rape, child abuse and torture). Even though national and international law have forbidden this type of conduct, it still continues. Attempts at prevention have been made in the medical and legal fields but they are not sufficient to eliminate the problem. Since torture is the responsibility of the authorities, it is up to them to solve the problem. Since torture is a violation of human rights and such violent acts affect all actions of the public, it can be eliminated by a coordinated effort.

REFERENCES

1. Di Maio DJ, Di Maio VJ. Forensic Pathology. CRC Press, Inc. 1993:87-90.

2. Gordon I, Shapiro HA, Berson SD. Forensic Medicine. Third Edition, Churchill Livingstone. Edinburgh 1988: 221-6.

3. Gök Ş. Adli Tıp, 6.Baskı. Filiz Kitapevi, İstanbul. 1991.

4. Berger OD, Garnier M, Marc B. Urgences Médico-Judiciare, Doin Editeurs, Paris. 1995; 48-59, 63-78.

5. Yüksel Ş, Olağandışı durumların ruh sağlığına etkisi ve onarılması, Tıp ve İnsan Hakları Sempozyumu, 1-3 Mart 1996, Adana.

6. Rassmussen OV, Medical Aspects of Torture. Danish Medical Bulletin. 1990; 1 (1): 1-88.

7. Tarakçıoğlu B. İşkence Olayı. Belge Yayınları. İnsan Hakları Dizisi:3. Belge Yayıncılık. 1990: 35-49, 145-204.

8. Başoğlu M. Prevention of Torture and Care of Survivors: An Integrated Approach. J. of the American Medical Association 1993; 270: 606-11.

9. Green AH. Child physical abuse. in Textbook of child, adolescent psychiatry. (ed. Wiener JM). American Academy of Child and Adolescent Psychiatry American Psychiatric Press. 1991:477-85.

10. Meadow R. Abc of child abuse. 2nd ed. BMJ. London 1991: 1-4.

11. Gök Ş, Akyol S, Kolusayın RÖ. Kişilerin vücut bütünlüğünde oluşturulan zararların adli tıp açısından değerlendirilmesi, 1987.

12. İçel K, Yenisey F. Karşılaştırmalı ve Uygulamalı Ceza Kanunları, 2. Basım, Beta Basın Yayın Anonim Şirketi, İstanbul 1989.

13. Hancı İH. Hekimin Yasal Sorumlulukları (Tıbbi Hukuk), Egem Tıbbi Yayıncılık, İzmir. 1995: 25-48.

14. DSM IV. Fourth Edition. Washington. APA. 1994.

15. Biçer Ü, Çolak B, Özkalıpçı Ö. Gözaltında Ölüm (Bir Olgu Sunumu), II Ulusal Adli Bilimler Kongresi, 13-16 Mayıs 1996, Bursa.

16. SSK Sağlık İşlemleri Tüzüğü, SSK Genel Müdürlüğü Yayın No: 425 Ankara, 1985, 31-34.

TORTURE AND FORENSIC MEDICAL REPORTS*

SUBJECT. Regarding a forensic medical report given to H. B., which does not reflect the true findings.

REPORTED BY: Lawyers Selçuk Kozağaçlı and N. Betül Vangölü (representing H.B.)

H. B.: son of K. and G, born in K… Occupation: Teacher. Before he gave up teaching he was the head of the K. Branch of the Eğitim Sen (Teachers Union) in the year ... . He is currently under arrest in Ankara Central Closed Prison.

In 1992, between the months of … and…. he was detained during an "illegal organization operation" according to file no. .... of the K. Public Prosecutor. His arm was broken during torture. Then, he was arrested. The trial resulted in his acquittal.

He was prosecuted several times for accusations related to the time he was head of the Branch of the Teachers Union and was acquitted every time (According to law no. 2911 and related to law no. 3713.)[1]

An investigation, which began in regard to the police involved in the torture according to the law on the legal rights of civil servants, was sent first to the Provincial Administrative Board and from there to the Council of State. At present the Council of State has still not reviewed the investigation. This type of file is always delayed until the sentence has elapsed. Only after it is no longer possible to sentence the police involved are these files taken into consideration.

H. B was taken into custody in Ankara on … …1998 accused of activity in an "illegal organization's action". On … … 1998 he was imprisoned at Ankara

* In our country, the systematic use of torture continues regardless of the statements and regulations by government officials for prevention of torture. We present an example of a petition for a torture trial which we think can give an idea about how sincere the politics of preventing torture have been. We leave the interpretation to you.

[1] "The Law on Assembly and Demonstrations" numbered 2911.

Central Prison by order of the Ankara State Security Court (SSC) No.2 where he is now.

At the time he was taken into custody, the Directorate of the Ankara Branch of the Forensic Medicine Institute drew up report no. 40956.7 on December 21, 1998 at 19:30. The report was as follows: "In examinations of individuals sent by the Police Headquarters along with document no. 8508-2 it was found that:

1. There was hyperemia of both wrists of H. B. possibly due to the pressure of the handcuffs. There was nothing showing that he had received any damaging blows." This report was signed by Doctor E. Ç. Ü.. (Appendix 1)

When he was released from custody (in order to be sent to the Public Prosecutor for questioning), report no. 41589 was drawn up by the Directorate of the Ankara Branch of the Forensic Medicine Institute on December 28, 1998 at 00:30. According to this report, "the final report of the examination of H. B. sent with document no. 86-2 on December 28, 1998 by the Anti-Terror Branch Directorate indicates:

That there was no sign of blows or damaging force." The report was signed by Doctor M. K. Ö. (Appendix 2)

On the same day (December 28, 1998) H. B. was taken to the Chief Public Prosecutor's Office of Ankara SSC and was questioned by the Prosecutor A. R. K. (Ank. 1 SSC 1998/18 Basic Series 261). During the questioning when report no. 41589 dated December 28, 1998 was read to him, he stated that the report was wrong. The official report continues in this manner:

"…the accused remained seated and raised his shirt and sweater up over his chest. There were ecchymoses and bruises around his navel of 10-12 cm in diameter. Likewise, when the accused lowered his trousers, so that both legs could be seen, the presence of ecchymoses from the knee to the ankle on his left leg and many ecchymoses about 5 cm in diameter on his right leg were seen…"

"…the injuries you see on my body were made when I was in custody at the police station…" (Appendix 3)

After H. B.'s testimony to the prosecutor, he was arrested, sent to prison by the acting judge of the SSC, and a suit, which was recorded in the Ankara SSC No 1 Basic Series file no. 1999/18. was brought against him.

After returning to prison following his trial, doctors from the Forensic Medicine Institute came to the prison for the purpose of examining him in regard to this incident. At this time, Dr. M. K. Ö. who had signed the 2nd false report noted that he was seeing H. B. for the first time. The person who had been brought to him on Dec. 28. 1998 was not H. B. and for this reason he had reported him to be in good condition.

RESULTS

H. B. was tortured by the chief and police officers of the Ankara Governorship Police Headquarters Anti-Terror Branch Section A/3 (team) and in order to keep this secret:

According to various possibilities,

a. On December 28, 1998 at 00:30, the Directorate of the Ankara Branch of the Forensic Medicine Institute sent another person with H. B.'s papers for a report.[2]

b. H. B. was taken to the Forensic Medicine Institute, where Dr. M. K. Ö. gave him a false report without examining him.

c. The police team prepared a false report dated December 28, 1998 themselves without sending anyone to the Forensic Medicine Institute.

As to the first report dated December 21, 1998, it appears to be a factual report for the following reasons. R. A. who was tried along with H. B. went with him. There was swelling caused by the handcuffs as indicated in the report. H. B. said that he had been taken to the Forensic Medical Department at that time.

[2] After consideration of the testimony of H. B. and Dr. Ö, this seems to be a strong possibility.

T. R.

MINISTRY OF JUSTICE

Directorate of the Forensic Medicine Institute

Directorate of the Ankara …….. Branch

Report No.:41589 Date of Examination: Dec. 28, 1998

To the Public Prosecution Office Time of Examination: 00:30

ANKARA

REPORT

The findings in the examination of the people sent by Directorate of the Anti-Terror Branch on Dec. 21, 1998 with request no. 8508-2 are as follows:

1. There was hyperemia ringing both wrists of H. B. due to the handcuffs. This is a definite report noting that there was no other evidence of damage from blows which would limit activity.

2. There was an ecchymosis 1 cm in diameter lateral to R. A.'s right eyebrow and ecchymotic scratches on the sternocleidomastoid muscle on the right of his throat which may have been caused by fingernails. He complained of a pain in the left side of his chest. This is a definite report noting that normal activity would only be prevented for ONE DAY.

Receipt No.: 70860 Dr. E. Ç. Ü.

T. R.

MINISTRY OF JUSTICE

Directorate of the Forensic Medical Association

Directorate of the Ankara …….. Branch

Report No.:41589 Date of Examination: Dec. 28, 1998

To the Public Prosecution Office Time of Examination: 00:30

ANKARA

REPORT

The findings in the examination of H.B. sent by the Directorate of the Anti-Terror Branch on Dec. 28, 1998 with request no. 8652 are as follows:

This is a definite report that there were no signs of damage to his body by blows.

Receipt No.: 71774 Dr. M. K. Ö.

OFFICIAL REPORT OF TESTIMONY

ANSWERS TO QUESTIONS ABOUT THE EVENT

The accused stated “They did not take me to the Forensic Medicine Institute on the way to the Public Prosecutor”. The doctor’s report of Dec. 28, l998 was read. He said “I don’t accept this”. He lifted his shirt and sweater up over his chest. An ecchymose which surrounded his navel could be seen. Likewise, when he lowered his trousers many ecchymoses could be seen on the legs from the knees to the ankles. He was asked how these symptoms were produced. The accused said “I have a report that I was in healthy condition on Dec. 21, 1998 before I was taken into custody. The wounds that can be seen on my body were brought about while I was in custody at the police station. I was blindfolded the entire time I spent there. This testimony of mine was incorrectly recorded. I was blindfolded whenever I was taken for questioning. The rest of the time, while I was in my cell I was not blindfolded. For this reason, I do not know the identity of the person who beat me. However, I wish to sue all of those on duty during my questioning”.

…

He read and signed his testimony.

28.12.1998

The visual material used in the report is from the book by Selçuk Demirel entitled “İz” which is published by Yapı Kredi Publications.

We extend our thanks to Selçuk Demirel for his kind contribution.