HRFT

Human Rights Foundation of Turkey

Treatment and Rehabilitation Centers Report 2000

Human Rights Foundation of Turkey Publications (25)

Cover Picture: Turhan Selçuk

Cover Design: Levent Kutlu

Printing & Binding: Pelin Matbaası, Ankara

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ISBN 975-7217-30-1

The Human Rights Foundation of Turkey was founded under the Turkish law. It is a nongovernmental and independent foundation. Its statute entered into force upon promulgation in the Official Gazette No. 20741 on 30 December 1990.

HRFT

Human Rights Foundation of Turkey

TREATMENT and REHABILITATION CENTERS REPORT 2000

Ankara, December 2001

This report was prepared and printed

with the financial support of the

European Commission

Turkish version of

the Treatment and Rehabilitation Centers Report - 2000

is available at the HRFT

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STUDIES AND ASSESSMENTS ON TORTURE AND ITS CONSEQUENCES

PREFACE

Metin Bakkalcı*

Since its establishment, one of the main projects of the Human Rights Foundation of Turkey has been the Project for the Treatment and Rehabilitation of Torture Survivors.

The project began in 1990, and by the beginning of 2000 a total of 4696 people had applied to the treatment and rehabilitation centers of the HRFT. This number reached 5719 with a further 1023 people applying to the centers in 2000. Some paid and hundreds of voluntary health professionals work in multidisciplinary teams for the solution of the physical, psychological and social problems of the applicants to the centers.

We started the year 2000 facing court cases and investigations involving our ex-colleagues working in the foundation. In fact, this atmosphere, aimed at hindering our work, continued throughout the year.

This atmosphere itself was turned into a valuable contribution regarding "prevention of torture," led by the very people who themselves were being investigated and tried before the courts. Through this, our Treatment and Rehabilitation project was given greater dimensions. Taking into consideration the power of our work and the strength of our solidarity, it would be fair to state that we will emerge from this process much stronger.

The prison operation, culminating in devastating results at the end of the year 2000, added to the already negative conditions we were facing.

Despite all this, we carried on with our routine projects. After 5 years of constant work the "Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment" (The Istanbul Protocol), which is a very important piece of work in the prevention of torture at an inter-

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national level, began to show positive results. The process of approval as a UN document has moved forward and the translations into the UN official languages has started. The relevant parts of the Turkish version of the Manual have been put into use. Approval of the Istanbul Protocol (IP) by the UN General Council is expected in the fall of 2001. A project for the introduction, education and pilot application of this Manual is being prepared.

Towards the end of last year, hunger strikes were high on the agenda. Our centers have assisted in protecting the health of those who initiated the hunger strikes, and treated those requesting help. A great number of relatives of prisoners and convicts applied to our centers after having been subjected to violence and suppression in their support of prisoners and convicts in F-type prisons.

We were unable to put into practice the projects prepared for establishing a physiotherapy unit in all our centers in the year 2000. However, the new Istanbul center opening in 2001 will have an operational physiotherapy unit.

The preparation of the Social Support Project, which aims to help torture survivors, was completed in 2000 and, of special importance, the Social Support Project for Children was implemented at the beginning of 2001.

The preparation for the Legal Assistance Project for torture survivors has been completed and it is planned to put it into practice in 2001.

Aside from the progress in the above-mentioned areas, concrete programs have been developed regarding the treatment and rehabilitation project in order to improve the work already carried out by the HRFT.

The Treatment and Rehabilitation Centers Project, besides providing medical and rehabilitation for torture survivors includes training, scientific research and scientific activities for improving the quality of services. Within this framework there have been numerous meetings held and attended at both national and international levels.

The project has been carried out in the treatment and rehabilitation centers of the HRFT in Adana, Ankara, Diyarbakır, Istanbul and Izmir. The 5 Cities Project, which covers the provinces where we do not have a center as yet, operated in the provinces of Malatya, Gaziantep, Hatay, Adıyaman and Şanlıurfa in 2000 despite the intensity of human rights violations.

This report, which includes the results derived from the work carried out by the Treatment and Rehabilitation Centers Project in 2000, is published both in Turkish and in English, as in previous years.

In the 2000 Treatment and Rehabilitation Centers Project there is an evaluation of the year 2000 by President Yavuz Önen on behalf of the Executive Board. It is followed by two sections.

The first section includes an outline of the health services provided by the HRFT in 2000 and information and evaluation regarding the applicants to the HRFT Treat-

ment and Rehabilitation Centers in Adana, Ankara, Istanbul, Izmir and Diyarbakır for torture-related problems.

The second section consists of articles on some of the issues that the Treatment and Rehabilitation Centers of the HRFT worked on in 2000.

The first article in this book is by Dr. Deniz Dülgeroğlu and is entitled 'Pathology of the Musculoskeletal System Occurring After Torture.' The article sets out in a systematic way the damage sustained from torture according to the force and the frequency used. We believe that this is a work of importance as it reviews the close relationship between physical and psychological problems.

The second article, 'A Case Report of Rape and Sexual Harassment While Under Arrest', is written by Dr. Şahika Yüksel, who has been studying the subject of rape and sexual harassment for many years, and by Psychologist Dr. Ufuk Sezgin and Dr. Vehbi Kesar. This article presents examples of the importance of reports which are vital if justice is to be achieved. This is of great importance for survivors.

The article by Hıdır Arslan, Önder Özkalıpçı and Şükran İrençin entitled 'Importance of Routine Otoscopic Examination After Beating or Torture' evaluates the cases of people who applied to our İstanbul Center in the years 1998, 1999 and 2000 seeking treatment and documentary proof of the torture and other types of violence that they had been subjected to while in detention and/or in prison. The article assesses the necessity of carrying out an otoscopic examination, taking into consideration the treatment and forensic medical reports. It is stressed that this examination should be carried out routinely even though the person who has been traumatized has no complaints. The importance of carrying out a routine otoscopic examination during the forensic examination is considering the importance of proving torture in the prevention of torture.

During rehabilitation, no clear distinction is made, in terms of the physiotherapy applied or the role of the physiotherapist, between man-made trauma or any other trauma. Nevertheless, in her article entitled Physical Therapy-Rehabilitation of Persons Undergoing Man-Made Trauma, Dr. Mintaze Kerem stresses that there are a number of important points that must be considered in the rehabilitation approaches to man made trauma. She emphasizes the importance of physiotherapy approaches, considering the physical and mental health problems that occur following man-made trauma.

The last article of the report entitled 'Evaluation of Post-Traumatic Stress Disorder Following Earthquakes and Torture', is the summary of the thesis written by Dr. Serpil Doğan. This research compares the Post Traumatic Stress Disorder that occurs following man-made trauma (torture) and that trauma caused by a natural disaster (earthquake). The work also compares the frequency of the PTSD, the progress, a symptom profile and the frequency of the symptoms and their severity.

Today, there is no distinction between the trauma caused by a natural disaster and man-made trauma. This research will help to highlight which type of trauma creates what type of reaction and what symptoms are normal and expected, and it will also help in the development of therapeutical interventions following trauma.

The health personnel working in various cities, who have been working wholeheartedly for a common cause, and hundreds of people sensitive to human rights issues have enabled the HRFT to carry on successfully.

We would like to thank all our friends who have been with us from the very beginning and have contributed to our work and to the Human Rights Association and the Turkish Medical Association, who have always supported us.

HUMAN RIGHTS IN TURKEY IN 2000

Yavuz Önen*

In order to repress the active and growing opposition of the workers to the economic and social policies, the suppression initiated by the government violated mainly the right to live, to organize, to demonstrate, to speak freely to organize politically. These developments forced the HRFT to become more involved in the activities of political parties, non-governmental organizations, labor unions, the general public, media organizations and public authorities. Compared to previous years, the year 2000 created a much more intensive institutional network for the HRFT.

During the course of the year, the violence directed towards public opposition spilled out of the police and security forces headquarters and into the streets. Numerous people have been injured and disabled due to increasing human rights violations. Controversial discussions about the prisons gained pace during the second half of the year. Hunger strikes, which started towards the end of the year drew the attention of human rights organizations as well as various sections of society. The operations conducted by the government in 20 prisons resulting in 32 deaths and transfers to F-type prisons became the most important national issue. Society has been traumatized by the TV broadcasts of unchecked violence and terror in the halls of the prisons carried out by the government security forces numbering as many as ten thousand.

In order to obtain public support, an image was created under the pretense of humanistic help for the prisoners on hunger strike. The media played a special role with biased reporting before and after the operations. With these operations it became obvious that the real intention was the opening of F-type prisons, which had been planned for a long time. The hunger strikes have not stopped after transfers to F-type prisons, on the contrary, the number of participants has increased. The dialog has been cut off with the hunger strikers and nothing has been done about the deaths or the disabled. There have been no investigations initiated against the

* *President of the HRFT*

authorities responsible for the deaths and woundings during the operations. Requests for inspections of the prisons involved in the operations by independent experts have been turned down. The situation created in the prisons has been used by the government to silence active public opposition. Despite the discussions the inmates are presently subject to total isolation as foreseen by Article 16 of the Anti-Terror Law.

Following the operation code-named "Return to Life" during which 32 people lost their lives, organizations that pay particular attention to prisons conditions, such as the Human Rights Association (HRA), the Istanbul Bar Association, the Turkish Medical Association (TMA), the Union of Judicial Employees and Communal Associations, have been oppressed. Six branches of the HRA were closed down, and some executives have been detained. The HRA Headquarters was searched by the police, based on fabricated information that the HRA is being financially supported by the Greek government. Afterwards the prosecution office opened a case against the HRA in order to close it down, based not on financial support but on charges of conducting activities breaching its code of rules. With similar reasoning, several cases have been opened against executives of the four above-mentioned organizations.

On December 12th 2000, during the demonstrations against F-type prisons, the police, in collaboration with ultra-nationalists, terrorized the streets. The family members of prison inmates were attacked in the Freedom and Solidarity Party (ODP) building by the ultra-nationalists. Afterwards police broke into the building and detained the people in the building using force. Many people, including a member of the HRFT Ankara Rehabilitation Center, were detained and some arrested. Based on the Law of Provincial Administration, the provincial governors enforcing crisis management banned freedom of speech, freedom of thought and freedom of demonstration, notifying political parties, unions, non-governmental organizations and foundations. State Security Courts (SSC) restricted the right to organize and the Radio and Television Board (RTUK) restricted the right to obtain information and news.

During 2000, our relationship with the central government increased compared to previous years for example, regional meetings organized by the Ministry of the 57th government in charge of human rights, city and district human rights committee meetings initiated by the publication of rules and regulations of human rights committees on November 2nd 2000, meetings of the HRFT and other organizations with the Minister of Justice during the prison crisis, our invitation from the Ministry of human rights on the occasion of the anniversary of the Universal Declaration of Human Rights. However, the government's approach to resolving the prison crisis by force, the negative experiences in city and district committee meetings and efforts by provincial governors to assign to these committees responsibilities beyond their mandate obliged the HRFT executive board to stop holding city and district committee meetings temporarily.

Our activities in 2000 took place against a background of important developments between Turkey and the rest of the world. Public opinion was shaped by the follow-

ing events: relations of the 57th government with the World Bank and IMF, intensification of the Cyprus issue after the declaration of EU participation on November 9th and the acceptance of Turkish candidacy on December 13th 1999, issues of minorities and discussions about the Kurdish language and broadcasting, and the stir caused by the claims of Armenian genocide in certain European parliaments. These events affected the workload of the HRFT as well. The number and frequency of contacts with the ambassadors, politicians and parliaments of the European Countries, the European Union, the Council of Europe and the United Nations and with the representatives of international human rights associations as well as the foreign media have increased.

Last year, initiatives that will improve the qualitative and quantitative workings of the Foundation have been discussed and necessary decisions have been taken by the executive board. Decisions taken to improve the quality and efficiency of rehabilitation services were implemented.

On the first anniversary of his death, memorial services were held for our founding member Mahmut Tali Ongoren with the participation of the World Communications Foundation, Ankara University Faculty of Communications, Ankara University Graduates of Faculty of Communications Foundation, Gazi University Faculty of Communications, the Progressive Journalists' Association, Turkish Radio and Television Company and Cumhuriyet newspaper. In memory of our beloved friend for his unforgettable contributions in the struggle for human rights in our country, a book has been prepared and is at the publication stage.

During the year 2000, various activities were organized jointly with two entities close to our foundation, namely the Turkish Medical Association (TMA) and the Human Rights Association (HRA). In Izmir, an academic meeting was organized by the TMA, the HRFT and the Federation of International Health and Human Rights Organization (IFHHRO). However, the meeting was cancelled due to police intervention. In addition, I should point out our activities about our Traditional Annual Human Rights Conference and December 10th Week of Human Rights Activities with the HRA. Last year, besides our regular meetings, press releases, official meetings, visits and similar activities, by distributing Universal Human Rights Declaration in Kizilay Square in Ankara for the first time we increased our direct contact with the public.

Our friends from our Izmir Field office, Ms. Gunseli Kaya and Mr. Alp Ayan, were detained during the funeral service of an inmate who has been killed in Ankara Ulucanlar prison. Later they were charged and remained in detention for four months. During this process our Izmir Representative Mr. Veli Lok and Chairman Mr. Yavuz Onen were charged because of their public statements. The cases are still continuing.

The cases against our volunteer physician Dr. Zeki Uzun who has been charged with giving medical treatment to illegal group members has been followed. Dr. Uzun and his son have been subjected to severe torture, and our foundation tried to be supportive in any capacity.

Our founding member and volunteer physician attached to our Istanbul office Prof. Dr. Sebnem Korur Fincanci has been charged with preparing forensic medical reports accusing the security forces. The foundation followed the case and given support. Oppression against foundation personnel and volunteers met with international support, and international representatives observed the court cases in solidarity.

During the prison hunger strikes, defenders of human rights in general, and the TMA and the HRA in particular, were targeted by the media with the purpose of wearing down their resolve.

Some of our activities during the year can be listed as follows:

-Based on our international efforts, we have participated in the preparation of a very important document. This document, the Istanbul Protocol is published in Turkish by the HRFT. The UN translated this document into UN official languages, and following General Assembly approval in September 2001 it will be published as a UN manual. This document has drawn upon the experiences of the HRFT and the TMA to a great extent. In addition, during the five year course of the preparation of this document various national and international persons and institutions have been contacted and collaboration networks have been established in the fields of "Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment".

-We participated both in the General Assemblies of the International Federation of Human Rights (FIDH) in Morocco as observer, and International Rehabilitation Council for Torture Victims (IRCT). Reports have been prepared by participating staff from the headquarters and rep. offices.

-Preparatory work has been completed for the legal support project for torture victims. The project is planned to start in 2001. Also the Social Support Project for children who have witnessed torture has started after many years of preparation.

-The Foundation has participated through its members and volunteers in various meetings and activities involving psychiatry, orthopedics, forensic medicine and social services.

-When the country was preoccupied with the prison crisis, in collaboration with the Yilmaz Guney Foundation, a documentary about the shooting of the movie Duvar (The Wall) was shown in AST theaters.

I would like to thank to all representative offices, staff, members of the board, volunteers and supporting friends for all their contributions.

HRFT
Treatment and Rehabilitation Centers Report

2000
Evaluation Results

HRFT Treatment and Rehabilitation Centers Evaluation Results of 2000

"Torture is a disease where the active pathogen is human." It has been spread to the remote corners of the world, consuming both man and humanity. The HRFT contributes to the fight against torture by trying to solve the health problems related to torture and by its unique studies carried out in the field of documenting torture. The HRFT is determined to continue its work until torture is eradicated and the problems related to torture are solved. The main aim of publishing this report is to share the outcome of the studies with other human rights defenders and health professionals carrying out work against torture.

This report, echoing throughout the world as a cry against torture, will help to counteract the weariness of hundreds of HRFT workers who labor with enormous dedication in a country full of difficulties.

Method

The Human Rights Foundation of Turkey Treatment and Rehabilitation Centers 2000 Report has been prepared retrospectively, based on the information concerning 972 of the 1023 torture survivors who applied to the Treatment and Rehabilitation Centers of the HRFT in Ankara, Istanbul, İzmir, Adana and Diyarbakır in the year 2000. As 36 of the applicants were relatives of torture survivors with no torture or detention history and 15 others had insufficient information, they were excluded from the evaluation.

The questionnaire of 47 items used in order to evaluate the data was prepared to determine the socio-demographic characteristics of the applicants, information on detention and prison stories, which torture methods were inflicted and the sight, and the consequent physical and psychological complaints.

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

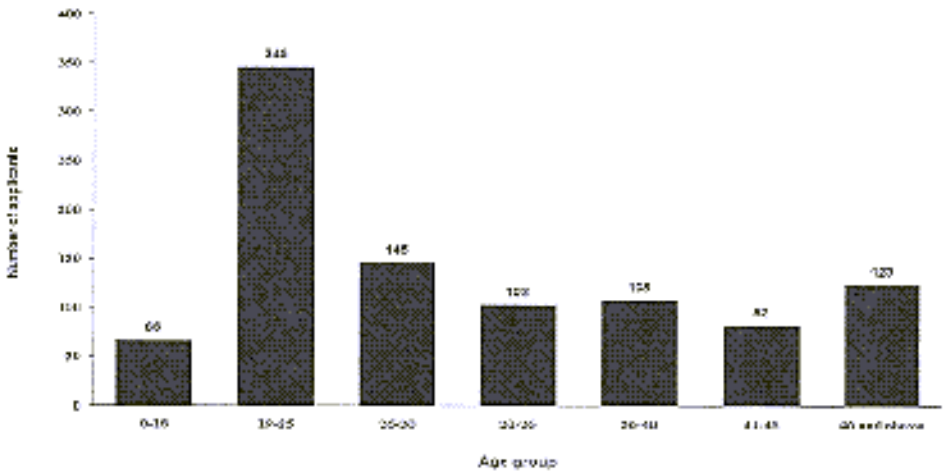
STUDIES OF TREATMENT AND REHABILITATION CENTERS

A. The Social and Demographic Characteristics

When the data of 972 applicants had been evaluated, it was determined that the HRFT Istanbul Representation Office had the highest number of applicants with 419, followed by Adana with 207, Izmir with 120, Ankara with 115 and Diyarbakir with 111. It is striking that the applications to our Istanbul Center increased. The distribution of applicants according to months shows that 393 applicants out of 972 applied in September, October, November and December. One important reason for the increase in applicants in these 4 months (40.4% of the total applicants) was evaluated to be the excessive violence used by the security forces during the F-Type prison protests and the increase in the number of detentions.

It is revealed that the average age is 31.3 ± 12.1 and the ages of our applicants varied between 5 and 81 (Graphic 1). There are 66 people in the 0-18 age group. According to the scientific research carried out, the torture experienced in childhood and adolescence can have greater effects on health when compared to the effects on health in later years. In connection with the demand to eradicate torture it should be a matter of concern that special care is paid to children. The deep effects that torture leaves on their small bodies and souls should not be forgotten.

Graphic 1: The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 2000 according to age groups



Some amendments to Turkish laws have been made in order to protect children. Article 136 of the Code of Criminal Procedures (CMUK) reads, 'The captured person or the defendant, may benefit from the assistance of one or more defenders at any stage and level of the investigation. Thus the detainee can contact a lawyer at all

stages. Again, Article 138 of the CMUK reads, "If the captured person or the defendant is minor (...) a legal counsellor is assigned to him/her without asking for his/her consent". This article makes the assignment of a lawyer by the local bar compulsory for the detainees under the age of 18.

However, if the prosecution is continuing at the State Security Court (SSC), the legal procedures of the SSC are accepted not the CMUK's. The SSC does not give the mentioned rights to the minors in the age group between 11-18. That is to say, minors detained for political reasons does not have a right to access a lawyer while testifying or interrogation.

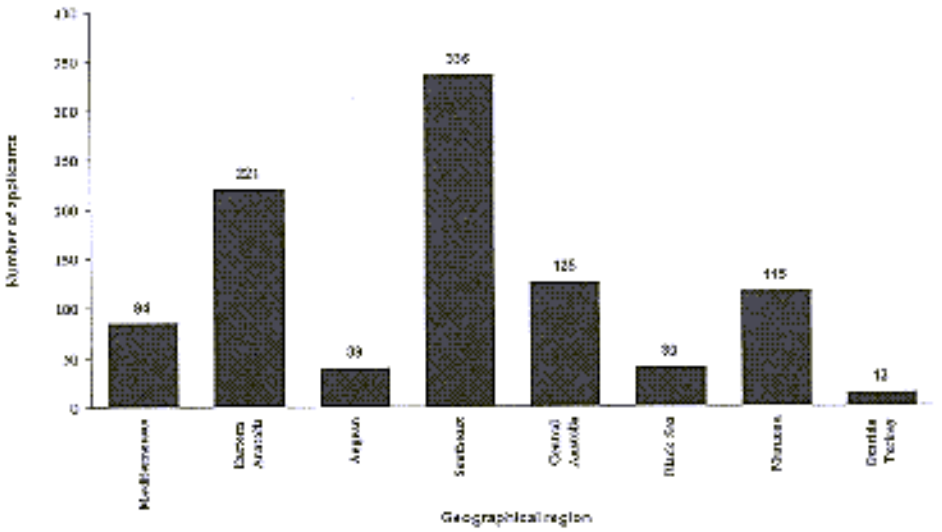
Although there are regulations aiming at protecting children such as Article 19 of the law on Children's Court which reads, "the investigation is set up by the public prosecutor" and regulations which makes the right to remain silent easier, the children prosecuted at the SSC cannot benefit from these rights.

The current regulations facilitates the application of torture for those who are detained for political reasons. While the UN Convention on the Rights of the Child accept the age under 18 as minors, the law on Children's Court accepts the age under 15 as minors. Considering the rights of children, it is essential to make new amendments.

The distribution of applicants according to gender reveals that 374 of them were female and 598 were male.

When the applicants' place of birth is taken into consideration, it can be seen that 336 were born in the Southeast Anatolian Region (Graphic 2). Among the people

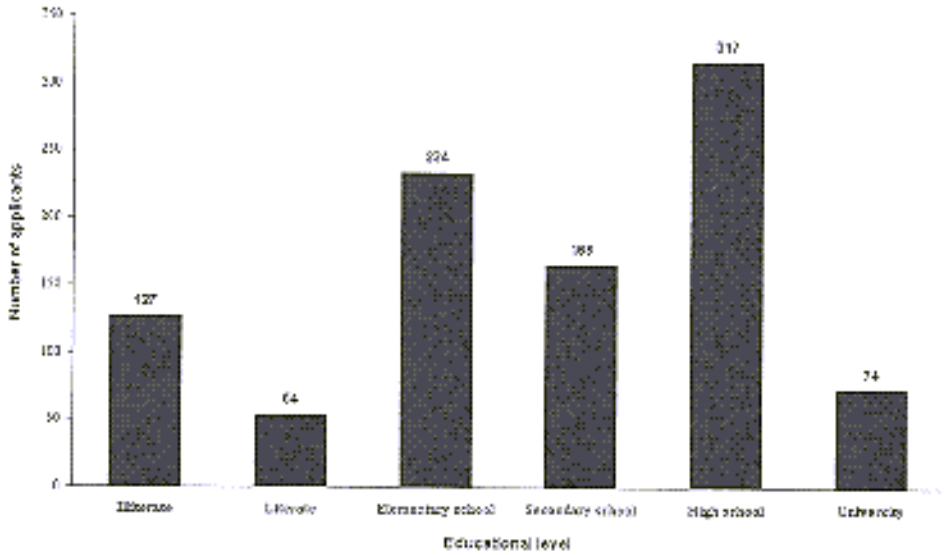
Graphic 2: The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 2000 according to place of birth



who have been tortured for political reasons, the ratio of the Kurdish people is quite high. It is thought that one of the reasons for this could be the density of the Kurdish population living in the region and another could be the pressure to which they are subjected to, whereever they migrate to, due to their ethnic background.

When the education level was evaluated, 317 people were found to be high school graduates. (Graphic 3)

Graphic 3: The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 2000 according to educational level



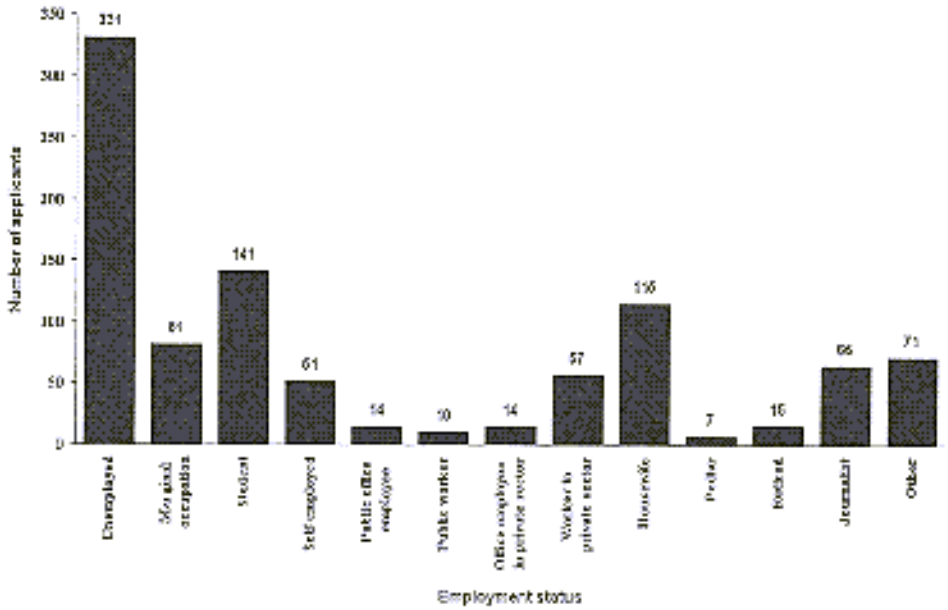
One of the reasons for the high rate of unemployment among applicants is that those who have been detained or imprisoned are dismissed from their place of employment or discontinue their education. When applying for a job, they are rejected because of their criminal records. This is one of the important problems that torture survivors face. (Graphic 4).

Concerning the channels of contact and reference, it is revealed that the Human Rights Association (HRA) is the most important organization (Graphic 5). It is once more put forward with the data given that despite all the pressures and hindrance it faces, HRA is one of the essential application centers in the field of human rights

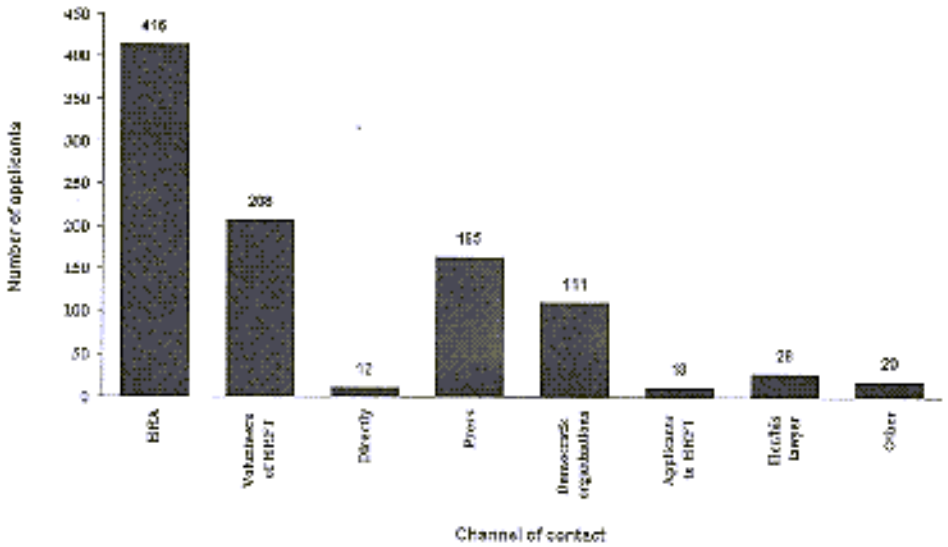
B. Period of Torture

Among the applicants, 540 (55.6%) stated that they had been tortured in the year 2000 (Graphic 6). The period when the applicants were last tortured gives us an objective parameter while evaluating the claim of the use of systematic torture in Turkey. It is significant that among those who have been tortured, only a small group

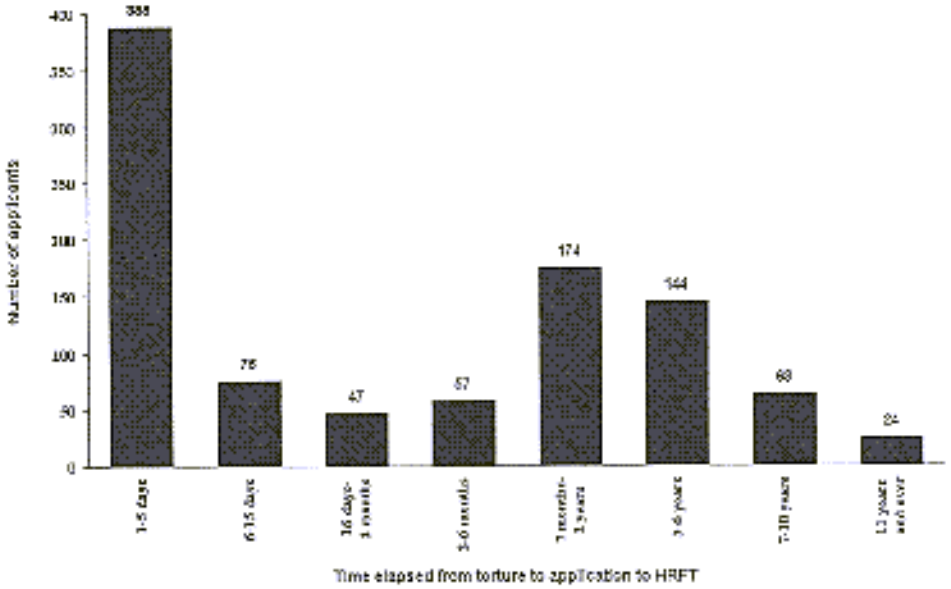
Graphic 4: The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 2000 according to employment status



Graphic 5: The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 2000 according to channel of contact



Graphic 6: The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 2000 according to the period when they were last tortured



apply to our foundation and it is also significant that despite the difficulties faced while trying to prove torture incidents, 540 people applied to our Treatment and Rehabilitation Centers in the year 2000. Contrary to the claims of the authorities, ill-treatment and torture continue to be important human rights issues in Turkey in 2000.

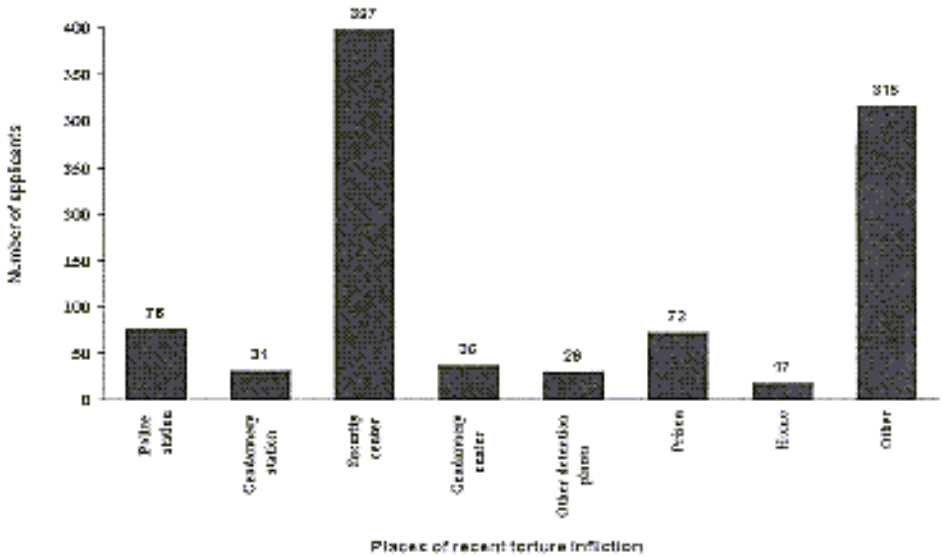
The number of applicants who had been tortured on political grounds was 924 (95.1%) and on non-political grounds was 48 (4.9%). The recognition of the right of access to a lawyer and the shortened period of detention for non-political detainees will help to decrease the application of torture. The low ratio of applicants in the latter group is because they do not know much about the activities of the HRFT and also that they are reluctant to apply to our centers.

Among the applicants, 183 stated that they had been tortured in the State of Emergency Region.

Regarding the institutions where the applicants had been tortured, security centers ranked highest (Graphic 7). According to the information received, among the units where torture is applied, the anti-terror branches of the security centers ranked first. It is notable that "Other" places such as open areas, work places and places such as houses take second place, where 315 people were tortured. The increase in this number was due to the security officers using violence when intervening the demonstrations, when detaining, and in vehicles while transporting people to detention centers.

A considerable number of these 315 people were subjected to torture and ill-treatment during the demonstrations against F-type prisons, which left a mark on human rights in 2000. The incidents such as kidnapping and detention that are not recorded are stated under the heading "Other". Such incidents are not recognized by the authorities. That's why, it is not possible to carry out proceedings against the officials. This situation once more emphasizes the need to discuss the authorization given to the security officers, regarding detention, in the framework of the discussions held to stop torture and amendments should be made to protect the individual. Those who applied to our center within 15 days following their last torture are evaluated as 'early applicants (acute)', and those who applied after 15 days or more, are evaluated as 'later applicants (chronic).' 483 people applied to our centers during the 'acute' period. Most of these applicants were people who had been subjected to ill-treatment and torture during demonstrations against the F-type prisons.

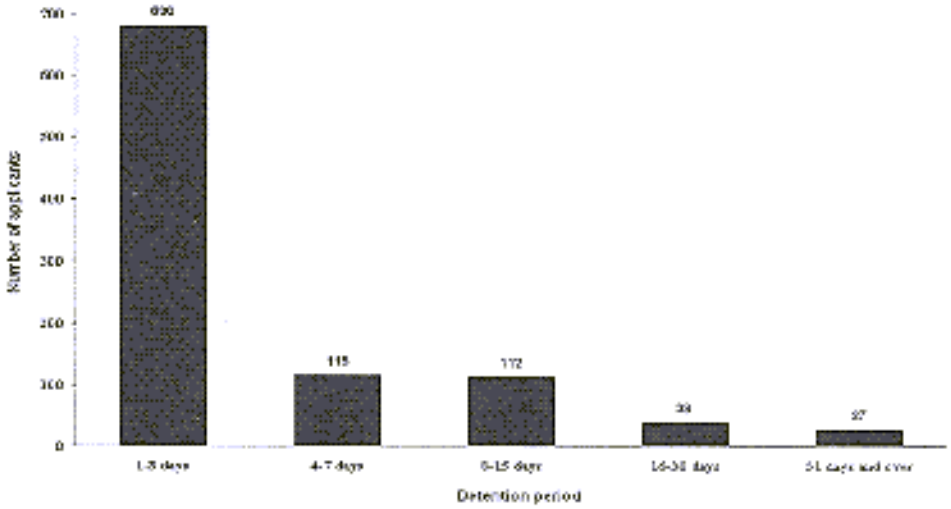
Graphic 7: The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 2000 according to the place of most recent torture



When taking the detention period into consideration, 488 people were kept in detention for one day and the number kept in detention over seven days is 177 (Graphic 8). The numbers indicate that there has been a decrease in the period of detention in the year 2000. However this decrease has not prevented torture from taking place.

Among the applicants, 70.2% (682 people) stated that they were released before appearing before a prosecutor or without any case being opened by the prosecution or that they were prosecuted without remand. In the prosecution process of

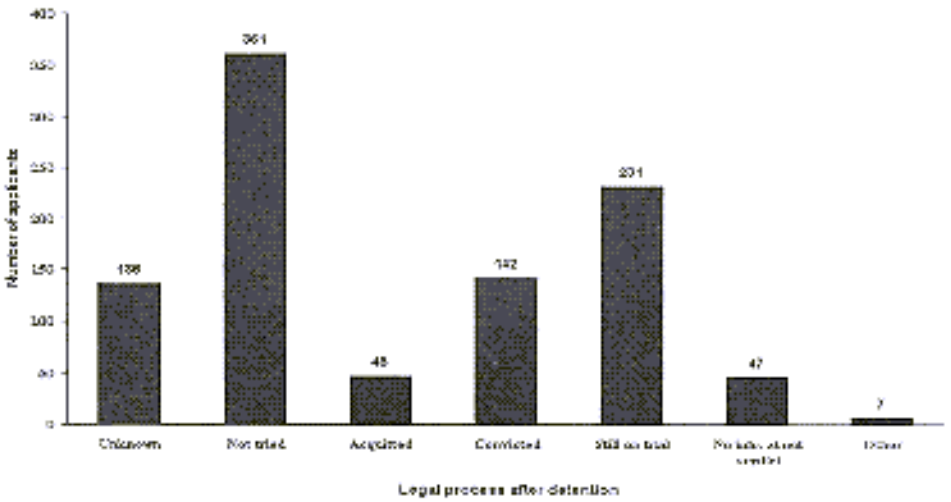
Graphic 8: The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 2000 according to the duration of their most recent detention



the SSC there were complaints as to the methods of collecting evidence not being in accordance with the rules set out by the Code of Criminal Procedures (CMUK) and hindering of the right of defense.

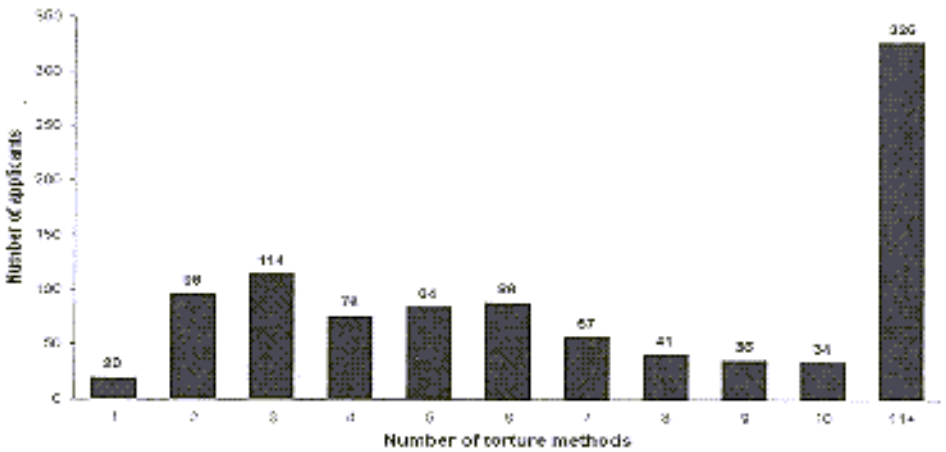
The results of the legal process starting with detention can be evaluated as an important discussion point directed at the justice system (Graphic 9).

Graphic 9 : The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 2000 according to the legal process that followed their last detention period



The torture methods inflicted on the 972 applicants whose data was taken into consideration are presented in Table 1. The numerical assessment reveals that two or more torture methods were inflicted on 952 applicants in one single detention period. Among these applicants, five or more torture methods were inflicted on 68.5% (666 persons) in one single detention period (Graphic 10). This detention process commences the moment that one is deprived of liberty and is subjected to physical and/or mental pain and/or suffering. During this process it is not feasible to differentiate between ill-treatment and torture by looking at the methods individually. The infliction of more than one torture method during a detention period proves that torture is applied systematically.

Graphic 10: The distribution of number of torture methods inflicted on the applicants to the HRFT Treatment and Rehabilitation Centers in 2000.



Of the applicants, 320 of them stated that they had been detained once, 202 twice, and 450 three or more times. Taking into consideration that 70.2% of the applicants were released after detention without appearing before a prosecutor or without any cases being opened against them, it is once again clear that detention is used arbitrarily.

Number of applicants who have been convicted and prisoned and the detained periods of those have been indicated in Graphic 11.

Torture methods inflicted in prison on 429 convicted and prisoners who applied to the HRFT Treatment and Rehabilitation Centers in 2000 have been indicated in Table 2.

The 429 applicants who had spent time in prison were asked to evaluate the prison conditions under the headings, Positive, Satisfactory and Negative. The data collected is presented below in Table 3.

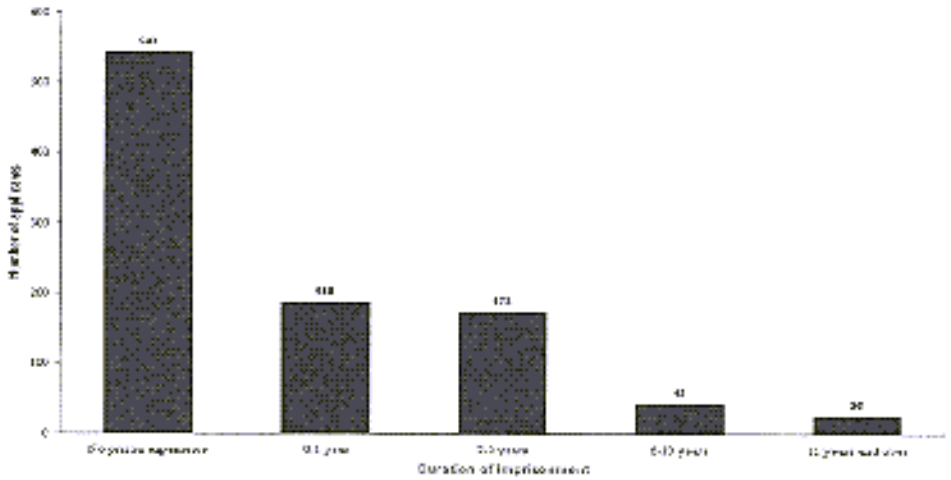
Table 1. Torture methods inflicted on the applicants to the HRFT Treatment and Rehabilitation Centers during their most recent detention in 2000

Torture Method	Number	%
Insulting	754	77.9
Beating	722	74.4
Threats (other than death threats) against the person	549	56.5
Death threat	455	46.9
Blindfolding	383	39.4
Pulling out hair/moustache/beard	382	39.3
Restricting food and water	364	38.4
Forcing to wait on cold floor	348	35.8
Restricting defecation and urination	346	35.6
Cell isolation	313	32.2
Forcing to witness (visual/auditory) torture to others	300	30.9
Stripping naked	264	27.2
Threats against the relatives	260	26.7
Sexual harassment	245	25.3
Forcing to perform extensive physical activity	243	25.0
Forcing to listen to marches or high volume music	238	24.5
Continuously hitting one part of the body	225	23.2
Forcing the person to obey meaningless orders	225	23.2
Pressurized/cold water	223	22.9
Restricting sleep	212	21.8
Electricity	183	18.8
Suspension on a hanger	156	16.1
Squeezing testicles	145	14.9
Torturing in the presence of relatives	127	13.1
Falanga	113	11.6
Asking to serve as an informer	103	10.6
Strangling	87	8.9
Mock execution	75	7.7
Forcing to lie on ice	26	2.7
Burning	18	1.9
Rape	18	1.9
Other	236	24.3

Table 2. Torture methods inflicted in prison on the applicants to the HRFT Treatment and Rehabilitation Centers in 2000 who have spent time in prison

Torture Method	Number	%
Insulting	224	52.2
Beating	152	35.4
Forcing the person to obey meaningless orders	124	28.9
Restricting food and water	120	27.9
Restricting correction and urination	107	24.9
Threats (other than death threats) against chairperson	82	19.1
Death threat	77	17.9
Cell isolation	77	17.9
Forcing to witness (visual/auditory) torture	51	11.9
Forcing to wait on cold floor	46	10.7
Pulling out hair/mustache/beard	45	10.5
Forcing to perform excessive physical activity	41	9.6
Consciously hitting one part of the body	35	8.2
Restricting sleep	31	7.2
Forcing to listen to marches or high volume music	31	7.2
Stripping naked	31	7.2
Pressurized/cold water	28	6.5
Falanga	24	5.6
Sexual harassment	23	5.4
Blindfolding	17	3.9
Threats against relatives	13	3.0
Strangling	13	3.0
Electricity	12	2.8
Suspension on a hanger	11	2.6
Mock execution	8	1.9
Asking to serve as an informer	7	1.6
Torturing in the presence of relatives	7	1.6
Squeezing testicles	7	1.6
Forcing to lie on ice	6	1.4
Burning	5	1.2
Forcing to eat and drink things of which the ingredients are unknown	5	1.2
Rape	1	0.2
Other	169	39.4

Graphic 11: The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 2000 according to the period spent in prison.



It is known that the resources allocated for the nutrition of prisoners has been insufficient for years. Generally the quality of food is not good. The prisoners try to supply their own food as far as possible. With the implementation of the F-type prisons, however, buying food from outside and self-preparation of meals will not actually be possible. It can therefore be expected that sickness due to insufficient nutrition will increase in future.

The reports from applicants reveal that the prison infirmary has insufficient staff and also lacks necessities. Transfers to hospitals can be hindered on the grounds of not having enough security staff. The insistence that gendarmes or prison guards be present in the examination room (the physicians and prisoners could object to this situation, which is a violation of human rights and the ethical principles of the medical profession) usually results in the de facto prevention of the right to examination and treatment.

The problems related to the release of those prisoners who have health problems, especially those who have been on hunger strike and should be treated outside the prison, considered under Article 399 of the Code of Criminal Procedures (CMUK), is still continuing.

The applicants had complained that, in the process of receiving medical reports, the members of the security forces who had inflicted torture on them had not left the examination room, the physicians did not record their complaints in detail, were reluctant to carry out the necessary medical examination and imaging methods and did not write down the findings in the reports objectively.

In most forensic medicine reports, it was seen that neither the standard report forms were used nor were they filled in properly.

Table 3. The evaluation results of the information gathered from the applicants to the HRFT Treatment and Rehabilitation Centers who have spent time in prison regarding prison conditions in 2000

	Positive	Satisfactory	Negative
Nutrition	5	109	315
Accomodation	5	103	321
Hygiene	7	93	329
Communication facilities	5	101	323
Health services	2	59	368
Access to open air and sports facilities	11	133	285
Reaching media	11	123	295
Conditions of transfers	2	32	395

Although there are a few examples of psychological evaluations that took place in the forensic medicine reports, it has not been established as a standard.

C. The Treatment Process

In this section, complaints, diagnosis, treatment methods and treatment processes are evaluated. The 5 options below are taken into consideration while evaluating the relation between the diagnosis and the prison and torture processes.

a) Torture or prison experience is one of the etiologic factors.

b) Torture or prison experience is the only etiologic factor.

c) Torture or prison experience worsened the existing pathology or caused the emergence of the pathology.

d) Not related to torture or prison experience

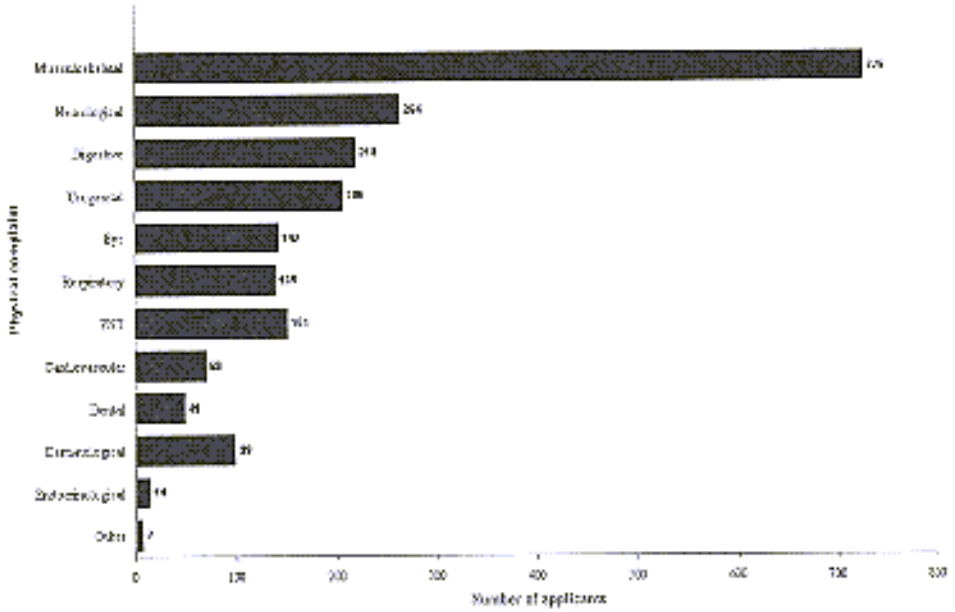
e) Relation could not be established

The diagnoses evaluated within options a, b and c are interpreted as those related to prison and torture processes.

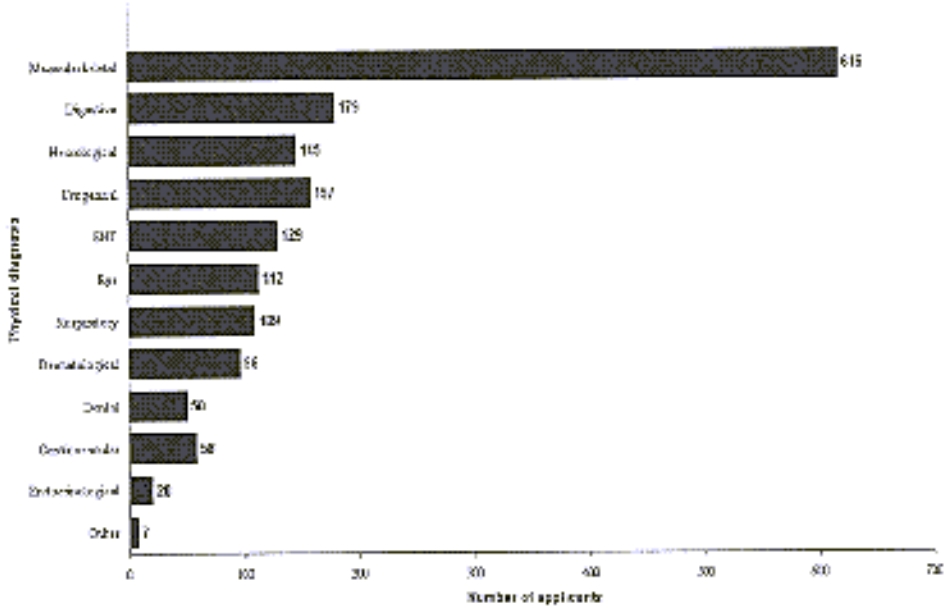
Of the 972 persons who applied to the HRFT Treatment and Rehabilitation Centers in 2000, 538 had only physical complaints, 54 had only psychological complaints, and 380 had both types of complaint. The applicants' growing acceptance of the psychological effects as one of the expected results of torture, helps to establish a rapid and effective therapeutic relation.

If we assess the physical complaints of the applicants in terms of frequency, the ones related to the musculoskeletal system takes first place, as in previous years. (Graphic 12)

Graphic 12: The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 2000 according to their physical complaints.



Graphic 13: The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 2000 according to their physical diagnosis.

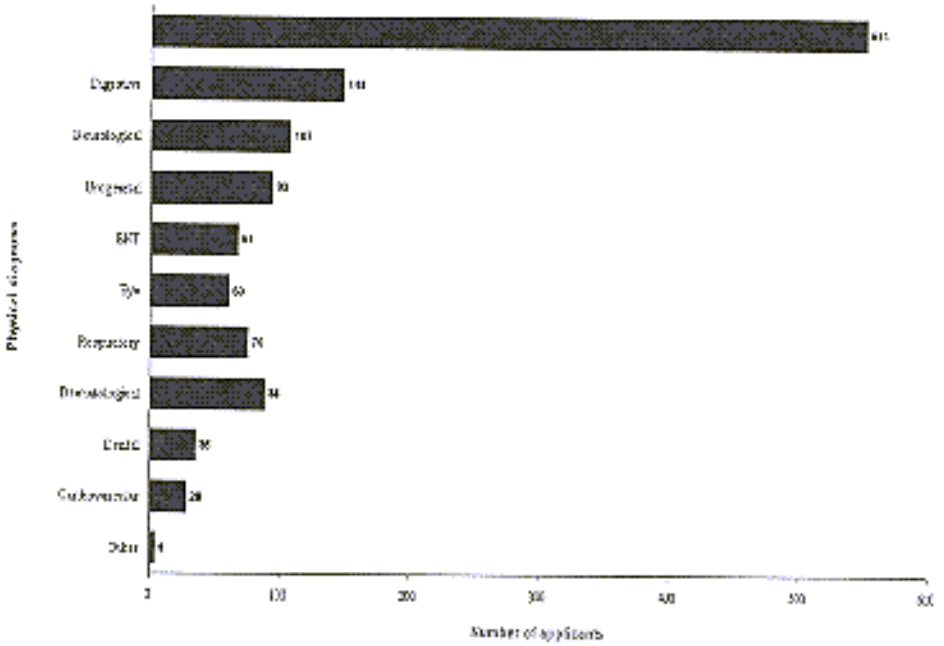


In terms of frequency, the diagnoses related to the musculoskeletal system were again the most common. Six applicants were not diagnosed with any disorder related to their physical complaint (Graphic 13).

No physical disorders were diagnosed for some of the applicants who stated that they had physical complaints. For example, out of 726 applicants who had complaints regarding the musculoskeletal system, no physical disorders were diagnosed in 110 of them. Some of these 110 applicants were not in long contact with our treatment center so we were unable to detect their complaints. In some of them it was determined that the complaints did not have any organic background. Those who have accepted the proposed mental evaluation and the treatment were included in the treatment program.

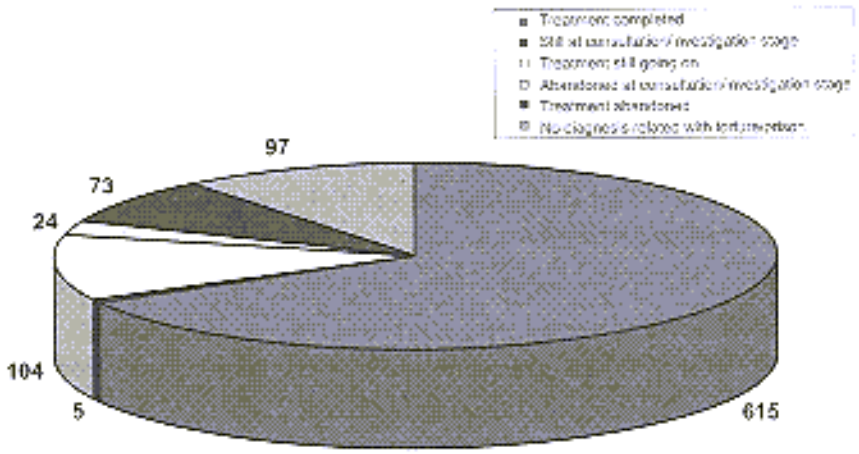
Graphic 14 shows the relation between the physical diagnosis and the torture process.

Graphic 14: The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 2000 according to their physical diagnosis related to torture.



Out of 918 applicants, the treatment of 615 was completed as of 1st January 2001 and the treatment of 104 applicants was continuing at the time of writing. Five of the applicants are at the diagnosis stage. Contact has been lost with 24 applicants before a diagnosis was made and contact was lost with 73 while the treatment was continuing (Graphic 15). One of the main reasons for losing contact with the applicants during the treatment and rehabilitation process is that the applicants do not feel safe in their present environment and feel the need to move to another city.

Graphic 15 : The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 2000 according to course of physical treatment



Another reason could be that the treatment and rehabilitation process takes a long time and for the ones who apply to our Treatment and Rehabilitation Center from other cities it is hard to go back and forth.

It is aimed that applicants to the HRFT meet all the members of the treatment staff. However, those who do not want to have interviews with psychiatrists are not forced to do so and it is pointed out that they can contact our psychiatrists anytime.

The applicants in acute period who do not yet have mental disorders or the signs have not yet appeared are informed about the problems that they might face and that in such cases they could any time see our psychiatrists working in the centers. Out of the total of 972 applicants 434 of them were determined to have mental problems and 414 of them had interviews with psychiatrists.

If we group the complaints of the 434 applicants with psychological problems in terms of frequency, anxiety takes first place and then follows difficulty in falling or staying asleep, concentration difficulties, weakness and fatigue (Table 4).

If we assess the diagnoses related to torture in terms of frequency, Posttraumatic Stress Disorder (PTSD) is found to be the most frequently observed one, as in previous years (Table 5). PTSD was diagnosed in 166 applicants; in 32 of the applicants the PTSD was acute, and in 127 chronic. Late onset PTSD was diagnosed in 7 applicants. Following PTSD, the second most frequent psychological diagnosis was major depressive disorder and acute stress disorder and generalized anxiety disorder, which are anxiety disorders.

The increase in the accumulation of knowledge in our centers regarding the psychological effects of trauma, the PTSD becoming a well known diagnosis and the

Table 4: The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 2000 according to their psychological complaints

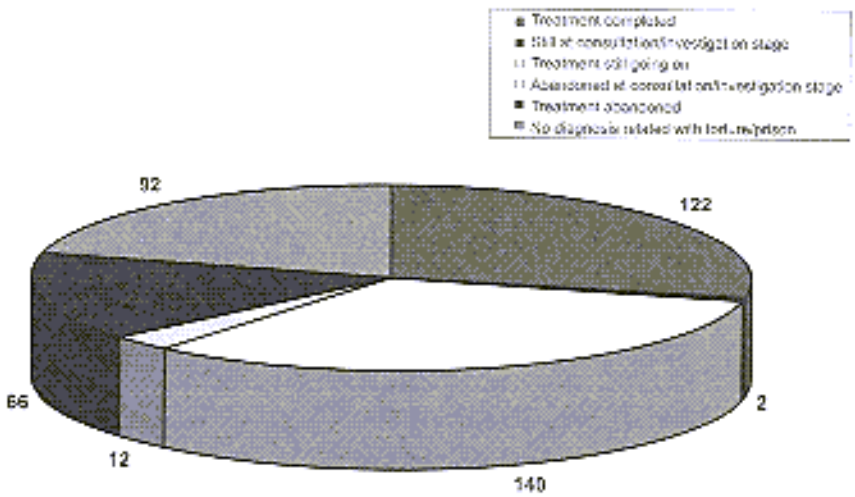
Psychological complaints and symptoms	Number	%
Anxiety	316	72.8
Difficulty in falling or staying asleep	290	66.8
Concentration difficulties	254	58.5
Weakness, fatigue	252	58.1
Irritability or outburst of anger	232	53.5
Intense psychological distress at exposure to internal or external cues that resemble an aspect of the traumatic event	227	52.3
Memory impairment	220	50.7
Depressive mood	208	47.9
Increase or decrease in the duration of sleep	203	46.8
Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event	195	44.9
Feeling of detachment or estrangement from others	179	41.2
Agitation (irritability)	174	40.1
Sense of a foreshortened future	172	39.6
Markedly diminished interest or participation in significant activities	166	38.2
Recurrent and instrusive distressing recollections of the event	162	37.3
Recurrent distressing dreams of the event	155	35.7
Hypervigilance	153	35.2
Exaggerated startle response	148	34.1
Restricted range of affect (blunted affect)	144	33.2
Acting or feeling as if the traumatic event were recurring	142	32.7
Diminished psychomotor activity	139	32.0
Efforts to avoid activities, places, or people that arouse recollections of the trauma	129	29.7
Change in appetite/weight (a decrease or increase)	128	29.5
Dysphoric mood	125	28.8
Response of intense fear, helplessness or horror to the traumatic events witnessed or experienced by others	123	28.3
Efforts to avoid thoughts, feelings or conversations associated with the trauma	112	25.8
Loss of sexual interest	68	15.7
Inability to recall an important aspect of the trauma	64	14.7
Suicidal thoughts or attempt	45	10.5
Obsession	21	4.8
Hallucination (visual, auditory, tactile)	19	4.4
Delusions	18	4.1
Use of alcohol or substance(s)	13	3.0
Compulsion	6	1.4

Table 5: The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 2000 according to their psychiatric diagnosis related to torture.

Psychiatric diagnosis	Number	%
PTSD [Posttraumatic Stress Disorder]	168	38.6
Major depressive disorder	105	24.4
Acute stress disorder	25	5.7
Generalized anxiety disorder	23	5.3
Somatization disorder	17	3.9
Other anxiety disorders	15	3.5
Adjustment disorder	13	3.0
Schizophrenia	8	1.8
Dysthymic disoder	7	1.6
Other mood disorders	6	1.4
Conversion disorder	6	1.4
Other somatoform disorders	5	1.2
Other psychotic disorders	4	1.0
Panic disorder	4	1.0
Other	27	7.4

experiances our psychiatrists gained working with patients who have been tortured, have changed the distribution of the psychiatric diagnosis in terms of frequency compared to the previous years. Among the applicants to the HRFT Treatment and Rehabilitation Centers the frequency of PTSD was determined to be 21.0% in 1997, 27.5% in 1998 and 38.3% in 1999.

Graphic 16 : The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 2000 according to course of psychological treatment

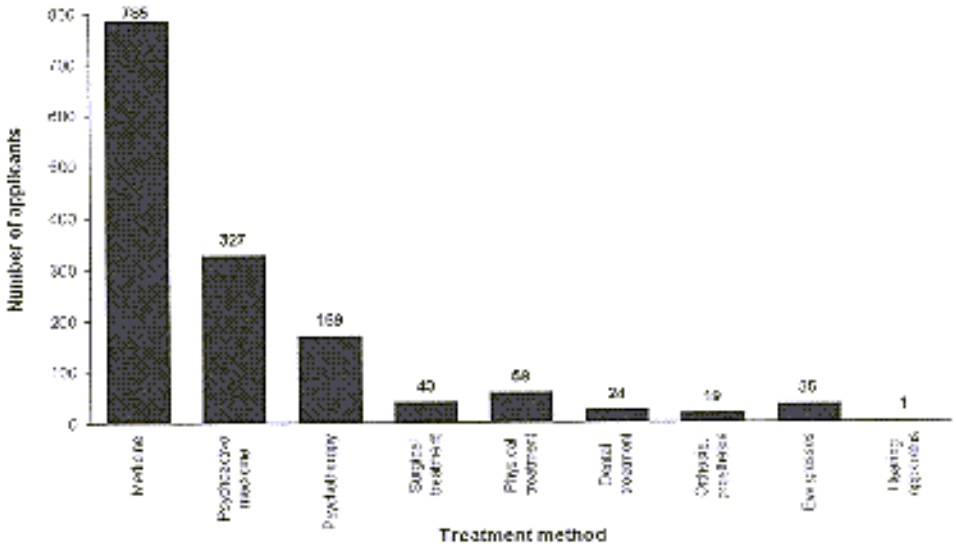


The psychological treatment of 122 applicants was concluded as of 1st January 2001 and it was continuing for 140 applicants. Two applicants abandoned the treatment before receiving any diagnosis and 66 applicants abandoned the psychological treatment before it was finished (Graphic 16). Despite the long course of the psychological treatment, it was found that the continuation to the treatment had increased compared to previous years.

Although abandoning the treatment remains a problem, there has been a decrease compared to previous years.

Graphic 17 shows the distribution of the treatment methods the applicants received.

Graphic 17: The distribution of the applicants to the HRFT Treatment and Rehabilitation Centers in 2000 according to the treatment method they received



CONCLUSION

The HRFT Treatment and Rehabilitation Centers treats those who have been tortured and it has borne witness to only a small proportion of the torture incidents that occur in our country. The data of the work carried out in 2000 by the HRFT Treatment and Rehabilitation Centers once more reveals that torture is applied systematically in our country and continues to be one of the violations against human rights.

No concrete steps have been taken to realize the amendments proposed by various organizations for the prevention of torture. Even the public officials who were proved to have inflicted torture did not receive any punishment. Furthermore they were promoted and the cycle of impunity continued. This is an indication that the political powers are not sincere when making commitments.

Various organizations have pointed out that the judicial processes of the State Security Courts facilitate torture. In order to prevent torture, the jurisdiction of the State Security Courts should be lifted and that a single judicial process should be accepted. With the "Law on Prevention of Torture," new arrangements should be made regarding the officials who inflict torture and the penalties should be increased. In most of the continuing court cases, the officials who have committed the crime of torture are prosecuted under Article 245 of the Turkish Penal Code (TPC) relating to ill-treatment instead of Article 243 of the TPC which relates to torture. It is significant to note that no one has been sentenced for committing a crime of torture in our country where torture is inflicted systematically.

Examples of the political powers encouraging the torturers indirectly continued in the year 2000. During the discussions of Law on reduction of sentences, there were vivid memories of the Security General Director trying to pardon the security officials sentenced for inflicting torture.

With the initiatives of the Ministry of State responsible for Human Rights, Provincial and District Human Rights Councils were established in 2000. Although the human rights defenders were not very hopeful, they attended the councils. The first months went by introducing members to one another and discussing the work areas. The State authorities saw the mission of the council as to show that there were no human rights violations and most members did not have sufficient knowledge about the human rights problem. This made it difficult to continue.

Many people were detained due to the press statements and the demonstrations protesting against the implementation of the F-Type prisons at the end of 2000 and were subjected to violence in detention. These incidents gradually lead to suppression of all democratic activities.

Street fights and the attacks on the demonstrators against F-Type prisons in Ankara by the fascist civilians carrying symbols and shouting slogans of Nationalist Action Party, supported by the security officials, caused anxiety. The security forces instead of neutralizing the attackers during the demonstrations and after the clashes, beat the members and executives of the democratic mass organizations and parties and threw them to the civilian fascists or detained them. The Press has also witnessed the incidents.

Dismissal of Dr. Sema Piskinsüt, the Chairperson of the Parliamentary Human Rights Commission, from her duties has been one of the strokes against expectations. During her time she carried out successful researches on the application of torture and had also prepared reports on the results of her works.

The other example which shows the political powers intention to suppress not the torturers but the people who try to stop torturers, is the dismissal of Prof. Dr. Sebnem Korur Fincanci from her duty at the Forensics by the initiatives of the Ministries of Justice and Interior. She had been under pressure for the work she carried out against torture.

As in previous years an important number of our applicants consisted of Kurdish origin citizens who had been subjected to torture under detention.

Unemployment rate was also high in 2000. Especially those who had cases against them for political reasons kept this rate high and it had negative effects in their treatment process.

Reducing the detention periods partially improved the situation. However the detention period of those who have been detained for political reasons could be extended to 7 days and their right of defense is limited. These implementations give way to torture.

Even though torture has both physical and mental effects on human beings, the forensic reports which are the sole source of detecting torture, only take into consideration the traumatic lesions that are visible. This improper practice of medicine is widely continuing. Although limited, the usage of sophisticated imaging methods or the consideration of the psychological diagnosis within the reports were positive developments realized with the efforts of the Turkish Medical Association, Society of Forensic Medicine Specialists and some psychiatrists.

There is a need for a structural and functional improvement in the Forensic Medicine Institution and the attitude against torture in Medical practice must have a reflection in education of Forensic Medicine Specialists.

As in previous years the HRFT received many letters from prisoners requesting medical assistance. Although many of these complaints were found to be related with torture or ill-treatment they couldn't be accepted as applicants for the difficulties faced in contacting them.

The statements of the applicants and the wide-spread hunger strike protesting against F-Type prisons reveals once again that the prisoners were made to choose hunger striking as a method of seeking their rights. The attitude of the physicians towards hunger strike is discussed ethically and scientifically. During these discussions it is hard to forget the attitude of the media which took sides with the political powers and acted as an authority against the physicians who defended the ethical principles. Moreover following the "Operation Return to Life" they acted as if the hunger strike protests were not continuing.

Following the 1996 hunger strikes the applications made under Article 399 of the Code of Criminal Procedures by a great number of prisoners with sequela is still waiting. Furthermore, due to the hunger strikes which continue into 2001 a great number of hunger strikers suffer from Wernicke-Korsakoff Syndrome or other illness and sequelas which makes the situations in the prisons regarding health and human rights much worse.

Another problem that continued in 2000 was the inhumane treatment that the prisoners and convicts faced when they applied to hospitals for medical treatment. The prisoners had complaints about the physicians and other health personnel, and

the physicians had complaints about the security officials. In Ankara Dr. Aysel Ülker, Dr. Gülay Tomuçin and Dr. Özge Yenier Duman in two different cases asked the gendarmes and the prison warders to take up their security measures outside the examination room. For this, cases have been opened against them. While Dr. Özge Yenier Duman was acquitted in the first hearing with a modal decision, the trials of other two physicians are still continuing.

The implementations that did not give the right to prisoners and convicts to properly and sufficiently benefit from the health institutions continued to be a problem. Prisoners and convicts together with health personnel were attacked in various ways for showing their reaction against the attitudes not conforming to patient's rights and principles of the medical profession.

Wishing to raise our belief in putting torture and human rights violations in a museum of shame.

Studies and Assessments on Torture and Its Consequences

PATHOLOGY OF THE MUSCULOSKELETAL SYSTEM OCCURRING AFTER TORTURE

Dr. Deniz Dülgeroğlu*

Torture results in visible or invisible physical and/or psychological disturbances. These include backache, headaches of undetermined origin, insomnia, recurring nightmares and tiredness, all of which may continue for years. People who have undergone torture usually remember their bad experiences when they wake up in the morning or during the night and become aware of pain [1].

From light to severe damage occurs in the muscles, tendons, joints and connective tissue (ligaments) depending upon the type (hitting, kicking, or suspension) and degree of trauma during torture. The source of the pain in the locomotor system may be nerves, muscles or connective tissue. The pain is classified as neuropathic, myalgic or arthralgic according to the tissues involved.

Neuropathic pain

This may be described as neurogenic inflammation because injuries of the basic tissue of the sensory nerves are followed by inflammation. Pain resulting from injury to nerves remains long after the injury has healed. In some cases, pain may occur without any obvious injury to the nerves (for example, during the period after injury to a joint, reflex sympathetic dystrophy may occur). This results from a reaction between the nociceptors of the C fibrils and the sympathetic system. Continual sensitivity of the nociceptors of the C fibrils results in sympathetic irritation and secretion of norepinephrine. Such symptoms as causalgia and hyperalgia may be added to the description of normal pain. Another example related to this is the involvement of the symmetrical joint, when there is trauma and inflammation in one joint. In neurogenic inflammation, first, neurogenic vasodilatation and axion reflexes are seen, pathophysiologically. Biologically active peptides, such as substance P (SP), neurokinin A (ANKA), a calcitonin gene related peptide (CGRP), and vasoactive intestinal peptide (VIP), play a role in this event.

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Myalgia

This is also referred to as skeletal muscular pain. Trauma or exercise may cause this pain. It is characteristically temporary. The nociceptors of the muscle are A delta nociceptors with thin myelin and C fibril nociceptors without myelin. The fibers of the muscle spindles and the tendons do not transport pain. The receptors of muscular pain are called: 1. Chemonociceptors and 2. Mechanociceptors. Substances that activate these receptors are bradikinin, 5-hydroxitryptamine [5HT], histamine, potassium and hydrogen. Pain originating from the skeletal system is difficult to distinguish from that from tendons, connective tissue, bones, joints and joint capsules. Generally, the pain that originates from the musculoskeletal system increases with use and coercion, and decreases with rest.

Arthralgia

In order to evaluate this type of pain, first the source of the pain must be well established. Later the event is evaluated according to the local and central pathophysiology, and the psychosocial factors affecting the severity of the pain must be kept in mind. In the joints, from an anatomical standpoint: 1. A beta fibers are responsible for deep sensations. 2. The nociceptors of A delta and C fibers are sensitive to harmful stimulation. 3. There are fibers that are sensitive to inflammation but are non-sensitive under normal conditions (mechano-sensitive). In the sympathetic system they affect the joint nerves. However, under normal conditions, the nerves of the joints are not affected by the sympathetic system. In chronic arthritis, the sympathetic activity increases and the sensory fibers of the joints respond, in other words, they become active [2].

During trauma, strain, sprain or laceration of soft tissue causes acute or chronic pain.

According to the length of time the pain occurs, it is classified as acute or chronic. Usually an underlying cause of acute pain can be found and it lasts less than 6 months. Acute pain occurs as a result of real or potential tissue damage and after the destruction of the tissue or its possibility is removed, the pain disappears. Chronic pain is that which continues after the period of recovery.

1-Acute Pain

Distortion of the subcutaneous, perivascular and periarticular nerve plexuses quickly leads to sharp nociceptor pain. Sometimes there may be a period free of pain in serious wounds or crushed tissue if there is a state of shock or mental stimulation.

2-Delayed-Chronic Pain

After various periods of time, deep, irksome and continuous pain begins and increases. This may be due to physical stretching or swelling of the fascial compartments caused by blood or tissue fluid. Increase in pressure in the rigid fascial compartment and the disturbance of secondary flow leads to pain due to chronic ischemia. The development of pain leads to the secretion of transmitter substances as occurs in the activation of kinin and prostoglandins and as a result of tissue distraction [3].

Pressure and coercion due to beating of the head, application of electricity alone or with suspension affects the glenohumeral, acromyoclavicular and sternoclavicular joints, wrists, cervical vertebrae, brachial plexus and peripheral nerves (ulnar, median and radial). Less commonly, hypermobility and subluxation may occur. If the arms are tied behind at the level of the back, dislocation may be seen because of the weakness of the capsule in front of the shoulder joint. After suspension, the most common defect is the thoracic outlet syndrome. Brachial plexus lesions or neuropathy of the ulnar, radial and medial nerves may also develop (4).

Thoracic outlet syndrome (TOS)

Symptoms such as brachial plexus, subclavian artery and venal pressure make up the thoracic outlet syndrome occurring after traction. The structures that bring about this pathological picture may be the clavicle, the transverse process of the 7th cervical vertebra, the fibrotic band, the first costa, or the scalene muscles. Even though it is not found in the same anatomical area, the pectoral minor muscle may be responsible. Neurological, arterial and venal symptoms connected to the base of the vessel nerve sheaf are seen. Ninety percent of the symptoms originate from the nerves and 10% from the arterial or venal base. Neurological symptoms include neck and arm pain, various sensory and motor defects, and numbness and stabbing pain. The arterial symptoms are ischemic pain, claudication and weakness, and chilling and numbness of the extremities. The venal symptoms are pain, swelling, and cyanosis. Pain is seen in 70-90% of TOS cases and appears in connection with brachial plexus pressure. The distribution of neurological symptoms such as pain and numbness in the neck and arm are related to ulnar neuropathy. The reason for this is the frequent involvement of the C8 and T1 roots.

In the diagnosis of TOS, tomography (showing the presence of a fibrotic band) and magnetic resonance (revealing a breakage/avulsion in any area of the brachial plexus) are important. Electroneuromyography (ENMG) is necessary for an exact diagnosis. If surgery is unnecessary, first, analgesic-anti-inflammatory drugs should be given and then posture correction should be performed. Emotional factors that may affect the posture should be kept in mind. Physical agents except for electrical current may be used for inflammation of nerve roots causing spasms in the scalene muscles. The main aim of treatment is to strengthen the muscles of the shoulders. Exercises used for this include: exercises strengthening the trapezium and rhomboid, raising the shoulders, retraction of the shoulders, mobilization of the shoulders, circumduction of the upper extremities, push-ups against a corner, correcting posture and cervical and lumbar extension (5).

Reflex sympathetic dystrophy (RSD) may develop as a result of a lesion in the peripheral nerves. Extreme pain in the arm, hyperesthesia, and vasomotor changes related to the RSD may develop.

Pain in the thorax and dysfunction of the thoracic cage may be seen as a result of vertebral hyperextension due to binding the arms behind the back and stretching of the costal vertebral joints. Tendonitis as a result of coercion in the region of the

joints is most commonly seen in the shoulder joints. If there have been degenerative changes before a sudden stress, tendinous or even muscular ruptures may occur. As a result of repeated trauma of the hyperabduction of the shoulders, impingement syndrome of the teno-periosteal junction may cause a partial or a total rotatory cuff muscle rupture. As a result of hitting the ankle, Achilles tendinitis or ruptures may be seen. Beating the bottom of the feet causes swelling of the soft tissue and plantar fasciitis. Bone scintography with technetium-99, after a period of 2-4 weeks to 12 months, may show breakage and periosteal destruction without breakage, not seen with regular radiography (6).

Generally, coercion of the joints causes a loss of sensory afferent impulses in the mechanoreceptors of the ligaments and the joint capsule, which leads to a feeling of emptiness in the joints by the patients. As a result, there is an increase in the pathology of the joints and a delay in healing due to a loss of proprioception, which plays an important role in the rigidity of the muscles and stability of the joints (3).

The complaints and diagnoses of individuals who had presented at the treatment centers of the Human Rights Foundation of Turkey (HRFT) during the past 5 years were evaluated. The evaluation showed that 84% of those in an early stage (first 15 days) and 60% of those in a late stage (after 15 days) had first degree pathologies of the musculoskeletal system (7). In a study by Peterson evaluating the general health of refugees who had undergone torture, it was found that 29 out of 31 refugees complained of pain in the musculoskeletal system (8). During 1996-2000, individuals in the late stages presented at the HRFT Ankara treatment center and others were referred to us. Examination showed that out of 41 individuals with musculoskeletal complaints, 34.1% had myofascial pain syndrome, 24.3% lumbar strain and 12.1% lumbar discopathy. The evaluation of 55 persons who presented at the Istanbul Treatment Center of the HRFT with musculoskeletal system complaints between 1996 and 1998 showed that 26.8% had lumbar strain 14.6% myofascial pain syndrome and 11.0% lumbar discopathy (9).

Myofascial Pain Syndrome (MPS)

The skeletal system is the most common source of pain that usually occurs in the nape of the neck and the waist and occasionally peripherally. The prevalence in the population has been reported to be 12%. MPS is usually described as pain in the local muscle groups or in a single muscle, sensitive local areas in deep muscle tissue and characteristic areas such as hard bands and trigger points, which are detected by palpation. While the pathogenesis is not completely known, the mechanical nociceptive and primary muscular pathologies are considered to be the cause. Psychopathic pains such as those seen in fibromyalgia are thought to be due to psychoneurosis and personality disturbances. Coercion of the muscles related to torture such as being exposed to cold and dampness leads to psychological problems, depression and anxiety, which lead to the development of MPS. During treatment, if it will not disturb the person who has undergone torture, 1-2 cc of a local

anesthetic, 1% procaine, may be injected into the affected area. Cooling sprays and stretching of the muscle are also helpful. It may be necessary to repeat the treatment over a period of several months. Strong contractions of the affected muscle, either voluntary or involuntary, should be avoided. Relaxing exercises, massage and the use of warm, wet applications may be helpful. Even though the prognosis of MPS is good, there may be cases resistant to treatment.

Back pain (lumbago)

Lumbago is a discomfort that 85% of the entire world population have at least one time during their life. Eighty percent of acute lumbago patients get well without any treatment within 6-8 weeks. Of these, 38% have a second attack within a year. Forty-one percent of those with subacute lumbago and 81% of those with chronic lumbago also have a second attack within a year. Knowledge of the risk factors in the development of lumbago is important in the treatment of acute stage lumbago before it becomes chronic (10).

Risk factors:

- Lifting heavy weights: lifting more than 11.3 kg without bending the knees, lumbar flexion along with rotation while lifting, asymmetric lifting, and repeated lifting.
- Vibration: repeated exposure to high vibration of more than 4.5-5 Hz increases muscular activity leading to muscular weakness. This affects the nourishment of the disks and leads to degeneration of the disks. Studies have shown that this causes an increase in the incidence of disk hernias.
- Sports: Weight-lifting and wrestling.
- Personal factors: such as smoking.
- Psychological factors: Stress, being unsatisfied with occupation. It has been shown that treatment of depression leads to a decrease in back pain and that disability leads to an increase (10,11).

Treatment of acute stage lumbago (0-4 weeks)

- Elimination of serious pathology
- Improvement of posture, exercises for back
- Lumbar support
- Analgesic anti-inflammatory drugs
- Period of rest
- Training in what should be avoided
- Training in proper daily activities
- Unpleasant electrical currents, physical agents with the exception of cold and massage may be used for pain and spasms that were not cured by drugs.

The aim of treatment in chronic lumbago is usually rehabilitation such as:

- ⇨ Control and lessening of pain
- ⇨ Decrease disability
- ⇨ Decrease stress and worry
- ⇨ Lessening of unhealthy activities
- ⇨ Decrease unproductivity, and education of the patient (12).

When the torture victim is held under heavy weights or in a bad position for a long period, lumbago is often seen. When the lumbago becomes chronic, it adds to depression. For this reason, it is helpful to add psychological support to the treatment, to attempt to improve behaviour and to treat with anti-depressants.

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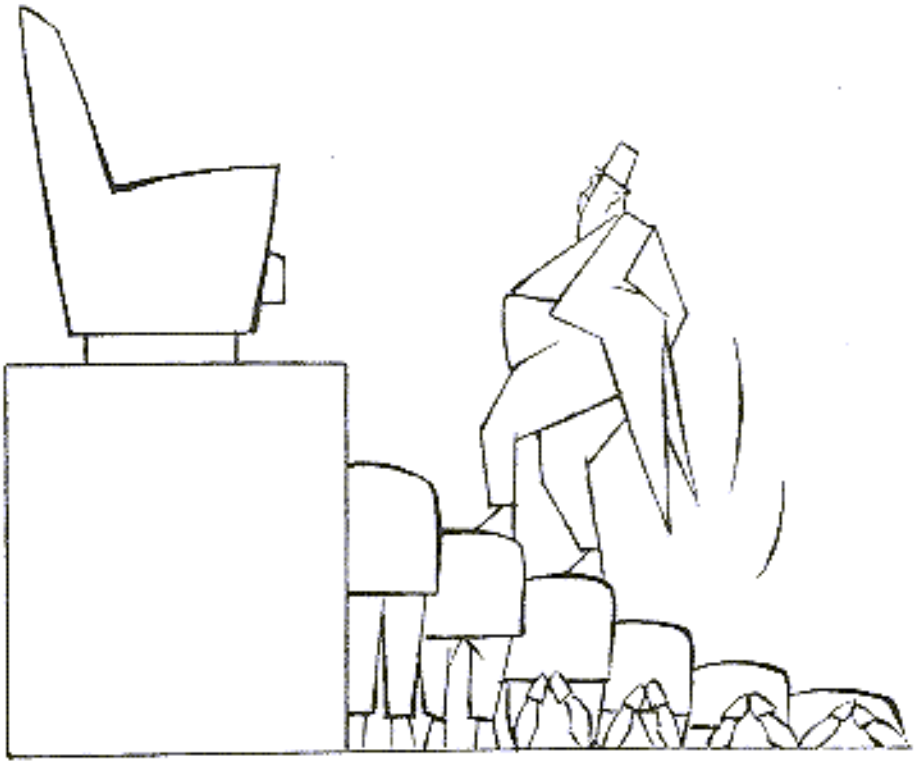

A CASE REPORT OF RAPE AND SEXUAL HARASSMENT WHILE UNDER ARREST

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SUMMARY

Aim: It is difficult to prove that someone has been tortured when new methods of torture that leave no physical signs have been used. At present, the physical and psychological effects of torture on individuals are known. That there may be psychological symptoms related to torture is accepted by forensic medicine and psychological reports are important in cases where there are no physical signs.

Sexual torture is a form of violence based on the difference in strength between strong and weak persons and it is an attack made on the whole person. In this paper, the concept of sexual torture as given above is based on the description by van Willigen: "a harassment which takes place in a political situation". According to this, sexual harassment is not just a sexual activity. It is, at the same time, violence intended to injure a women or men by force and is demeaning. The aim of this paper is to prepare a report of cases of sexual harassment, to make an evaluation from a treatment and psychological perspective from interviews carried out under unsuitable conditions with no privacy and to highlight the work that is being done in spite of such conditions.

Method: This will be a report of sample case. The person in question was treated by the Istanbul Psychosocial Trauma Program and was interviewed in prison.

Result: The effect of torture is the easiest psychological disturbance to prevent. It is a key situation that can be documented while the victim is being helped and these documents can be presented to the court.

Key Words: Torture, Rape, Sexual harassment

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INTRODUCTION

Methods of torture are continually being developed and torturers can apply their methods without leaving any sign. At present, torture can be proved by forensic medical studies on psychological symptoms. When a long period of time has passed since the torture, the fact that the victim was tortured can only be proven psychologically [1].

Definition

Sexual torture is a form of torture that depends upon the difference in strength between the strong and the weak. It may be interpreted as an attack on the individual's whole person. Van Willgen (1984) stated that "sexual torture" is related to the above definition and has political connections [2]. Sexual exploitation is not just sexual, at the same time it is the use of force against women and men. It is a type of violence that is one of the various means of belittling. Without investigating penetration, any sexual activity that involves force may be considered sexual exploitation. Penetration is not an indicator for problems related to sex that occur later.

Torture may be described according to its various forms; the use of torture and its meaning has varied at different times and places. Torture from a psychological viewpoint may be described as a) the use of force to make the individual afraid or confess, or to produce pain; b) producing change by use of psychological pressuring aimed at discrimination in populations. Even though the use of torture is common in Turkey, officials deny that it is being systematically used.

The Turkish Medical Association (TMA) has been preparing alternative reports in regard to the investigation of torture [1]. According to the 6th article of the medical deontology statutes: All physicians who receive a diploma from medical faculties in Turkey and who are Turkish have the right to prepare a report in regard to an individual's physical and mental status [3]. All physicians who have the right by law to prepare a report in regard to an individual's physical and mental status may prepare a report from a professional, scientific and conscientious viewpoint concerning persons who come to them claiming that they have undergone torture. If the subject is not torture, the courts usually accept these reports as evidence. But if the report is about torture, the acceptance of the reports becomes a problem. In addition, the persons preparing the report may face various kinds of pressure.

According to the 33rd article of the TMA's Ethical Rules for the Medical Profession, a physician can not take part in the use of torture or anything similar with his medical knowledge and ability. He can not prepare a report that does not show what really happened. A physician who encounters patients claiming to have been tortured must use his professional knowledge and abilities to find the truth [4].

Reports should be prepared for those under arrest and prisoners should be given treatment in prison hospitals and forensic medical institutions. But if these associations are unable to provide treatment, the patients should be sent to government


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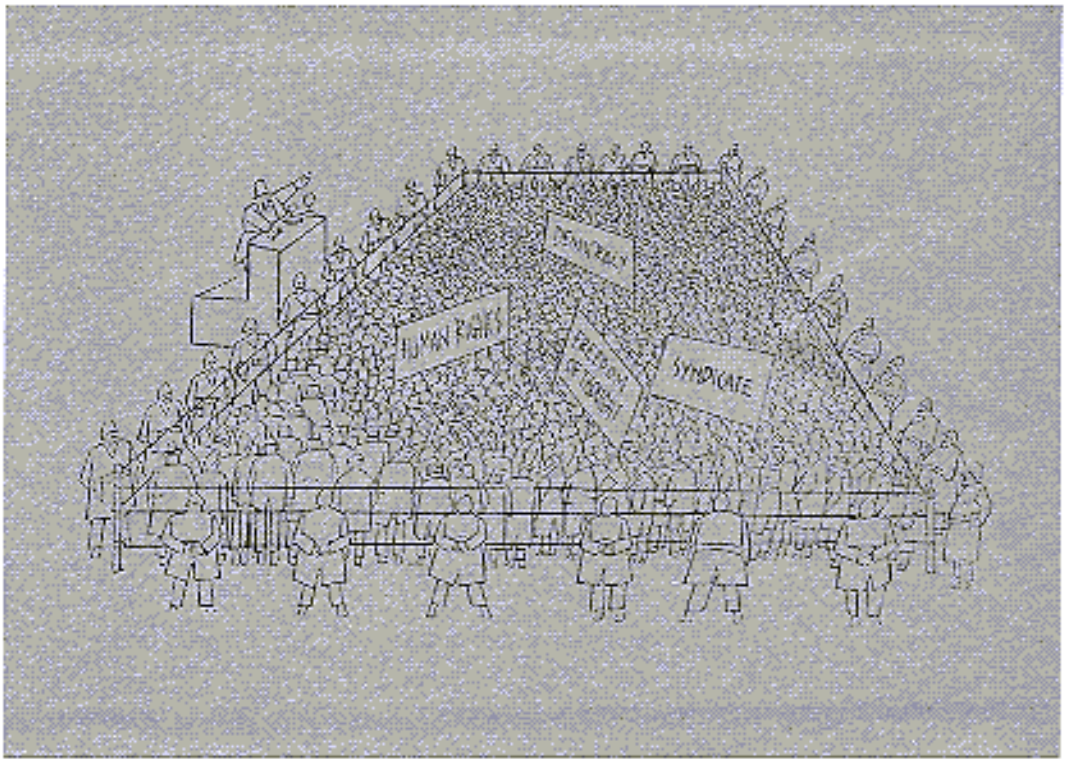
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hospitals or university hospitals. Because of pressure, forensic medical reports usually deny evidence of torture and give false negative results.

The aim of this paper is to present a case using psychological evaluation rather than by medical history and treatment, to show how to prepare a report when there have been unsuitable conditions and privacy is not available, and to present the difficulties faced during these activities, emphasizing the importance of treatment.

Description of sexual exploitation using psychological and medical evidence is under the control of a speciality branch that is developing throughout the world. There are very few specialists in this field in Turkey. Lawyers should refer individuals who are still in prison and have been exploited to an appropriate center. They should be taken to their appointments regularly, the interview should be private and, finally, the court should accept the report that has been prepared. During these procedures, there is a need for specialists who are experienced in scientific clinical information that can be proved. But this procedure is not just medical; it is many-sided. In order for the victim to be at least partially cured, the clinician must have the cooperation of the lawyers.

The case that will be discussed in this paper was sent by the Istanbul Psychosocial Trauma Program through the court to the "Opposition to Rape and Sexual Harassment During Arrest," which is an organization set up by women lawyers.

CASE

Referral: The individual claimed that she could come to terms with the event and that she had no psychological disturbance after the attack. She agreed to come after persuasion by friends and was told about the Istanbul PTP by her lawyers.

History: She was arrested during a raid on her home in 1995, and was raped and tortured. While under arrest she underwent various types of physical torture. She was suspended upright and upside down with her upper body naked. Later she was stripped completely naked. She said that she was blindfolded and recognized the voice of the team's leader, who said, "Put her on the floor." They laid her on the floor. "My arms were numb from the suspension. Someone lay on me and was holding my arms. I can't remember anything else clearly. Later I was dressed and lying on 2 brown armchairs pushed together. It happened once. I don't remember how I got dressed or how they dressed me. Everything is a blank. They took me to a doctor twice to get a health report but there were police officers along with me. The doctor looked at me from a distance and said that I was healthy. The doctors who examined me were from a Government Hospital and the State Security Court. The ones torturing me rubbed cream on the traces from the torture and massaged them to get rid of them".

Personal History: 25 years old, 1 of 4 siblings, married for 5 years with no children. Dropped out of university. Got married when she was 20 years old, of her own free will. No problems in her sexual life.

Accusation: Member of an illegal organization

Punishment: 12 years in prison

Complaints during application: In her own words: "I have difficulty sleeping and have nightmares. I have difficulty remembering and concentrating. I cry often and am very nervous. I keep remembering the things I went through and I can visualize them mentally. I am indifferent, pessimistic, tired and distant from other people. I am uncomfortable around men. I don't talk much with people. Since that event I can't talk.

Sometimes I talk nonsense for 1-2 hours. I tease others in the dormitory and feel strange. I feel as though I am suffocating. I keep trying to forget what happened. I keep trying to think that it wasn't important, it didn't happen. But in some way it keeps coming up. For the last 10 days, I have been having the same nightmare. A man is giving me a knife and I am trying to cut my throat. The same man [someone whose face I recognize, who bothered me at the police station and hit me and I remember hearing his voice while I was being suspended]. He is trying to strangle me. I can't scream; I just freeze. Sometimes when I wake up from a dream, I can't breath. Dead people are calling me. I see myself suspended and swaying there."

Reaction to the rape: She was brought up according to custom. Sex was never mentioned. Her parents learned that she had been raped during the trial. "Why me. Why did they do this to me? They just touched one of my friends and threatened the other. I wish I were blind. I can't stand it. It seems as though my thoughts and feelings about the rape will never go away. I feel as though it will happen again. Sometimes when I see police officers, it seems as though I will be turned over to them again. I can't watch the news about this. When I remember what happened, my hands begin to shake and I start to cry. I don't want to have anything to do with sex. For this reason, I want to divorce my husband. I feel ashamed in front of my husband and everyone else because I was raped. I make different evaluations about the rapists. Sometimes I hate them and think that I can cope with them; sometimes I think its better to ignore and forget what happened".

Psychological examination: She was fully conscious and had no difficulty in orientation. There was nothing unusual about her movements. Her speech is slow and low. She answered questions in a correct manner. She spoke little and has became slow in thinking. She did not speak nonsense. Her abstract thinking was good. She reported that she continually thought of the rape. She was depressed and anxious. She stated that after her disclosure and first interview she became more depressed. Her anxiety was apparent during discussion about the event. She tried to avoid talking about the trauma. She had lost interest in things in which she had formerly been interested. She described the condition of anhedonia. Before the rape she had had no sexual problems. She reported that afterwards she was disgusted with anything that had to do with sex and felt ashamed.

There was no evidence of a lack of understanding, hallucination, confusion, depersonalization or derealization. Clinically, her intelligence level was normal. Her long and short term memory and her determinative memory were normal. She did not describe any difficulty in controlling impulses. She was able to make judgements and to evaluate reality. Her insight about her illness was good. She described early and medium sleeplessness. She described nightmares related to the trauma and of waking in a state of panic.

There was nothing unusual in her past. There was no inherited mental illness in the family.

Clinical observation and treatment: The patient, who was found to be depressive, to take no pleasure in life and who was considering suicide, was given Lustral 2x1. Her situation did not permit systemic and regular psychotherapy. A psychological and informative approach was used. Until that time, except a brief description to her lawyer and friends, she had told no one about the rape and her feelings. Then she was encouraged to talk about it even though it was difficult. She relived the event when she was talking about it during the interviews. While she was reliving the event, she spoke with difficulty about her feelings concerning the trauma she had undergone, and cried. In order to make her face what she had undergone, the informative therapy model was used [5]. The trauma that she had undergone and its effects were brought into focus. After a time the effects of the trauma began to fade and, during this time, the supportive treatment was continued. The situation of the patient was not good and no suitable place for the interviews was available. Because of this, her life before the sexual and physical could not be investigated thoroughly. She cried less during the period of treatment. She stopped visualizing the event. She thought less about the event. She became more social and her sleep improved. Her treatment lasted 8 months. Diagnoses of stress after trauma (SAT) and major depression were made and the patient was given anti-depressive drugs.

Impact of Event Scale (IES)

	Beginning of treatment	End of treatment
Continually reliving the event	27	11
Evasion	32	4
Total	59	11

Example of the Protocol for the Psychological Evaluation of Victims Suspected of Having Been Tortured

The clinical interview and the Istanbul Protocol were the basis for the evaluation [5]. The medical reports and interviews should be standardized. All information concerning the event should be a part of the medical testimony, which should be suitable for defense in court.

In the report, information concerning the personal history, the results of the physical examination and diagnostic tests and the correctness of the testimony should be given. If it is found that the person being examined needs treatment, they should be told and an appointment should be given. Psychological tests such as an intelligence test and the Rorschach test should be used. In addition, whether the patient is psychotic and whether the information he gives is trustworthy should be determined.

Problems that come up during the interview and obstacles to treatment

Privacy. Since torture is carried out in an environment that is generally and extensively connected to politics, the effect of the organized violence can not be evaluated in a simple manner. A basic principle is that the individual should be comfortable and relaxed before the interview. According to the law, it is necessary to ensure privacy for the prisoners undergoing medical examinations. However, the commanders, women guards, and soldiers usually insist on remaining in the examination room during the interview.

Under circumstances where there is no privacy, whether the interview will take place is left up to the prisoner. An interview is not attempted when the prisoner rejects it. Under these circumstances, strategies for carrying out the interview under unsuitable conditions are formulated by the treatment team for those accepting the interview. For example, there were questions concerning the rape, and the prisoners filled in the evaluation criteria for the trauma themselves. After this during the person-to-person interview, questions about the rape were in written form. In this way, we were able to make a diagnosis according to the criteria we used and to communicate about the rape without talking about it.

The provocation of symptoms in a traumatic environment: When individuals have been locked up for a long time, problems that they have tried to ignore come up during the interview. This is a situation in which, during the treatment, there is a recurrence of symptoms in the persons who have undergone trauma. Those giving the treatment are ready to inform the individuals about this and are careful to help them learn to cope. However, the fact that the patients are in prison and are living under the control of those who have attacked them sexually makes things difficult both for the ones giving the treatment and for those receiving it [7,13].

Late application for treatment: Persons who have undergone trauma should be treated early. After six months, if problems related to the traumatic experience remain, a diagnosis of chronic TS is made and the patient is more resistant to treatment. Late application may be due to both internal and external causes. The most basic external cause is that it is very difficult for a lawyer to have the patient transferred from the prison hospital to a civil center. The personal causes are due to the moment of organized violence and sexual harassment and can not be easily brought out. When the victim talks about the attack, they are still under the control of the persons responsible for the attack. The victim is not sure about what may happen to them when they give incriminating information. Revealing the harassment makes them relive the event and symptoms of extreme anxiety related to the event are provocative.

Positive characteristics of the treatment

Despite of insufficient conditions, the victims show advancement in their psychological and social functions at the end of the interviews. There were various contradictions. For example, on one hand it was necessary to bring down a curtain of secrecy around the violence and on the other, every event that became visible meant that the individual had to cope with it. The persons being interviewed were women with a political profile. At the beginning, they thought that the reason for the sexual harassment was political. But after their breakthrough, they were able to come to terms with the difficulties of the personal side of the problem [4,15]

CONCLUSION

Medical reports related to torture have a positive effect on torture victims and the population, and may help to bring about justice. The reports have a curative effect on the victims. After a long period of time has passed, only the psychological evidence of the effects of torture remains. However, in countries where torture is widespread, physicians are put into a delicate situation and accusations are made against them in order to intimidate them. For this reason the medical associations must protect their members.

If we look at this from the viewpoint of forensic psychiatry, the following conclusions are reached:

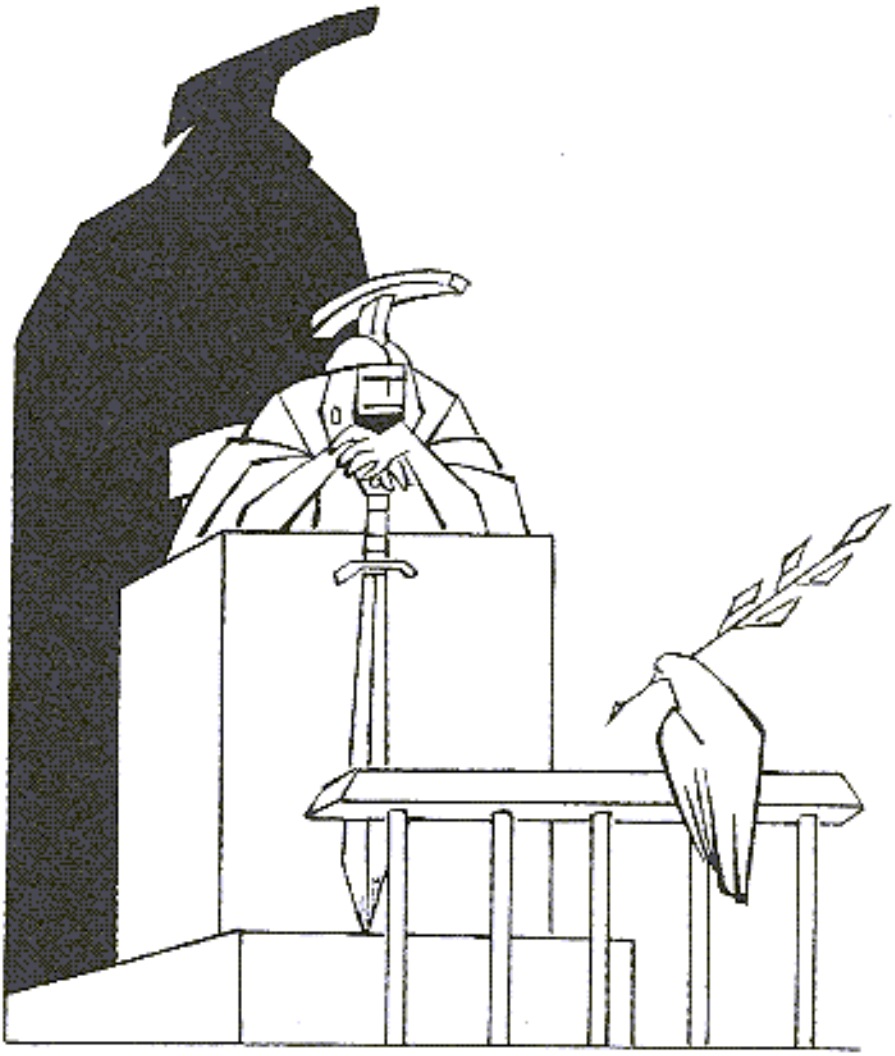
It is necessary to describe the psychological problems related to torture and to legalize this with reports, which make it possible to evaluate this knowledge from a legal standpoint.

Even after a long time, it is possible to show the relationship of TS to torture in a clear way.

Psychological reports are accepted as evidence on an international level.

Even though the surroundings were not suitable or sufficient for treatment, an apparent improvement in the psychological condition of the patients was observed.

In recent years, there has been an increase in studies related to trauma. But there has been no decrease in traumatic events. While we have been trying to be more effective in the treatment of wounds, we have seen no decrease in the incidence of violence man-made or due to natural causes.



EXAMPLE OF A REPORT

No:2000/

Concerning YZYZXhk.

Name of patient:

Date of birth:

Identifying information: YZ 25 years old, high school graduate, married, no children

Reason for referral to our clinic: Because of a request by the lawyers, the court sent her for psychological evaluation related to the sexual harassment and for a report to the court of the results.

History: In 1995, YZ was arrested during a raid on her home. She was raped by the police carrying out the investigation. She was physically tortured while nude.

Contents of the evaluation: On May 13th 1995, as a result of the psychological examination, it was decided that YZ (protocol no: 6768) should be followed-up by the Istanbul Psychosocial Trauma program. From 22nd July 1995 to 30th January 1997, she was interviewed at 15-day intervals for the purpose of diagnosis and treatment. The results are given below.

Psychological examination: She was fully conscious and orientated. Her motor activities had increased due to distress. She spoke slowly and the tone of her voice was low. She answered questions in a meaningful way and her answers were related to the subject at hand. Her emotional state was that of depression. She felt distressed and anxious. Her flow of thought was normal. There was no sign of hallucination. She was preoccupied with the traumatic events (rape) that she had undergone in 1995. During discussion of the event, she showed an increase in anxiety. This was accompanied by efforts to avoid talking about the trauma and she stated that there was an increase in her distress in this situation. She had lost interest in activities in which she had formerly been interested. She described a general loss of interest and anhedonia. There were no signs of any psychopathic symptoms such as hallucinations, confusion, depersonalization or derealization. She complained of frequently visualizing the trauma she had undergone and flashbacks of the event. According to clinical observations she was of normal intelligence. She retained her abstract thinking. Her memory was normal. Her attentiveness and concentration had decreased probably due to her depressed state and extreme occupation with the traumatic event. She reported that she was unable to concentrate or to think deeply on any subject. There was no disturbance in her judgement or the ability to evaluate reality. Her insight was normal. She had difficulty in sleeping because of nightmares related to the event, and woke up in a state of fear.

Diagnosis and differential diagnosis: As has been stated, YZ was helpful to the clinician during the clinical interviews. The patient said that she had undergone physical,

psychological and sexual trauma that threatened her physical integrity. She was preoccupied with the traumatic event and this caused anxiety. Thinking of the event made her try to avoid talking about it. When she was asked to talk about the traumatic events, she did so in a state of anxiety and cried from time to time as she was talking about it. She had lost interest in activities related to daily life. It was difficult for her to go to sleep and to stay asleep. It was difficult for her to concentrate on any subject. The diagnosis, which was made according to the Diagnostic and Digital Handbook of Psychological Disturbances (DSM IV), depended upon the determination of her psychological condition and clinical psychological examination as well as symptoms that had appeared as a result of the trauma she had undergone. A diagnosis of chronic traumatic stress syndrome (TSS) was made.[1] The high value obtained by the evaluation of the diagnostic criterion for stress after traumatic events[2] and the criterion for the evaluation of the effects of the event[3] supported this diagnosis.

Besides this, because of the symptoms of depression shown by pessimism and sorrow, fatigue, exhaustion, decrease in energy, general lack of interest and anhedonia as well as continually thinking of the same subject and feelings of unworthiness, a diagnosis of major depression accompanied by TSS was made.

Diagnosis and Differential Diagnosis (multi-axial evaluation)

Axis I. Post traumatic Stress Disorder (TSSB)

Major Depression

Axis II. None

Axis III. None

Axis IV. Threats of sexual and physical harassment by the security forces

Problems with primary support group

Problems with social environment

Housing problems

Problems in reaching health establishments

Difficulties arising from interactions with the legal system

Other psychosocial and environmental difficulties

Axis V. General Evaluation of Functions GEF : 55

GAF: Serious

A determination of 39 points was made with the criterion for evaluation of the effect of trauma because of the serious symptoms and high rate of functional disability. She received 63 points with the criterion for evaluating the effect of the event, which was a high rate.[3,4]

In conclusion: She was given high points with both criteria that evaluated the psychological effect of the trauma. As described by the DDS-IV, the presence of symptoms seen in persons who have undergone trauma strongly supports the conclusion that the patient in question has had a traumatic experience and a diagnosis of TSS was made.[2]

Lustral tab. 3x1 was given for treatment. In addition, psychotherapy was suggested. But since YZ could not be brought regularly for treatment, psychotherapy was not carried out. She is still receiving treatment.

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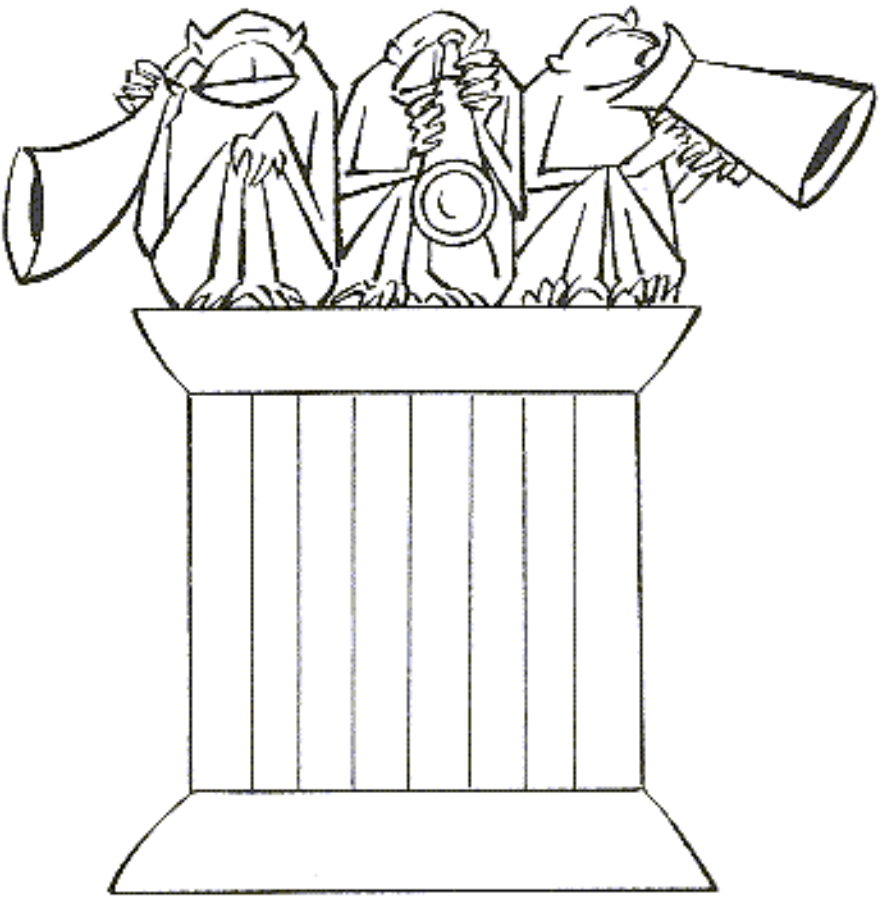

IMPORTANCE OF ROUTINE OTOSCOPIC EXAMINATION AFTER BEATING OR TORTURE*

Hıdır Arslan, Önder Özkalıpçı**, Şükran İrençin****

Introduction

The objective of this presentation is to emphasize the importance of performing an audiological examination to evaluate the tympanic membrane during an initial forensic physical examination.

Cases referred to Istanbul Branch of Human Rights Foundation of Turkey in 1998, 1999 and 2000 for documentation of and treatment of torture and other violent acts during detention or while in prison were assessed in this study.

Discussion

Beating is still the most common method of torture and act of violence. Medical documentation of visible or invisible signs of torture and acts of violence is carried out by branches of the Forensic Medicine Institute, University Departments, emergency rooms of Social Security Institute (SSK) and State hospitals and most commonly by Health Center physicians in our country. In contemporary practice, whether the applicant claims to have been tortured or not, tympanic membrane examination is not routinely performed during forensic examinations after detention, unless there is a specific complaint. However the cases with tympanic membrane perforation make up 35% of the cases with traumatic ENT lesions, even though none of them had an ENT complaint.

According to the literature on tympanic membrane perforations, 36.7% of all ear injuries are tympanic membrane perforations [1]. Although most are simple injuries, occasionally dislocation of bones and fractures are observed as well [6].

** This study was presented verbally to the Annual Forensic Medicine Meeting of the Forensic Medicine Institute of the Ministry of Justice on 25-27 April 2001 in Istanbul*

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Causes of tympanic membrane and ossicular injuries include blast injuries (acoustic trauma) near external auriculae precipitating a sudden increase in pressure, explosions during industrial accidents, some types of radiation, accidents causing thermal burns, hitting the ears (open-handed slaps, sometimes over both ears), careless intraauricular lavage, traffic accidents (head trauma), sporting activities (swimming or diving accidents), putting foreign objects or medical equipment into the internal ear canal (penetrating direct trauma), electrical accidents, sudden changes of pressure in airplanes and even kissing [2].

Common symptoms of traumatic tympanic membrane perforation are hearing loss, tinnitus and pain and, infrequently, dizziness and discharge from the ear, when water or medications penetrate the membrane. Perforation of the tympanic membrane may cause hematoma in the inner ear, cartilage necrosis or infection. Tinnitus and pathognomic audiometric signs of acoustic trauma may be found due to injury in the inner ear in traumatic perforations caused by blasting injuries. Penetrating trauma, especially in the upper quadrants of the tympanic membrane, may cause discontinuity in the ossicular chain, fractures in mallear handle, fistula in the oval or round windows or facial paralysis [2].

The most important short-term and long-term sequelae of traumatic tympanic membrane perforation are hearing loss in the middle or inner ear, vertigo, tinnitus and defects in maintaining balance and, rarely, facial nerve paralysis [3].

Tympanic membrane perforations due to third party violence have been reported to happen frequently in the left tympanic membrane and mostly in the form of small perforations in the lower quadrants. Bone chain dislocations and fractures are reported to be rare. However, although perforations due to blasting injuries are located in the lower quadrants, larger perforations sometimes extend to the upper quadrants, and the upper back quadrant is usually affected1. There is no report of a pars flaccida lesion in the literature. Edge perforations are rarely reported as well. Small bone dislocations and fractures, especially in the incudomalleal joint, are reported in 33% of cases, when the cause is blast injury[4,5].

Traumatic tympanic membrane perforations are usually in the lower quadrants and mostly in the lower back quadrant. The reason for this localization is thought to be the fact that the tympanic membrane is attached to the outer wall of the ear canal obliquely and the pressure caused by the trauma initially affects this area [6].

Sudden pain, ear hemorrhage, tinnitus, dizziness and sudden loss of hearing after trauma indicate that the continuity of the ossicular chain is disrupted or the inner ear has been affected by the trauma [3].

Cholesteatoma is reported to be caused by the edge of the tympanic membrane turning inwards after the blast trauma or small, keratinized squamous epithelia fragments entering the middle ear [4].

Clinical and laboratory examinations

Even the smallest perforations can be found by a simple otoscopic examination and more efficiently by a microscopic examination.

In fresh perforations, the edges of the wound are quite irregular, occasionally hemorrhagic, and sometimes have flap-like extensions. In blast injuries the wound is triangular or star-shaped, while in other types of injury it is shaped like a slit. Thermal or hot liquid perforations are usually quite large, with indistinct edges and atypical localizations [2].

Various types of discharge may come out of the external ear or middle ear of the patient. Otorrhea, if present, must be investigated by laboratory examinations. MRI or CT might help in locating the fracture[3]. The easiest way of identifying temporal bone fractures and discontinuities in the middle ear bone chain is CT scanning, followed by hypocycloidal tomography and linear tomography [6].

In simple hearing loss, an audiogram helps in making the distinction between pathologies in the airway and bone conduction. Hearing loss above 40 dB reflects bone conduction deficit. Sensorineural loss is due to missing cochlea or retrocochlear damage[3]. The audiometry findings after blast injury are pathognomonic; a bowl shape is observed over a frequency of 4000 Hz[2].

Experiences of HRFT Istanbul Branch

In 1998, 159 of the 289 applicants were assessed as emergency cases; 46 of these had ENT complaints, 32 were diagnosed as having ENT lesions associated with trauma and 14 had tympanic membrane perforation. Four of those applicants had not had ear complaints in their initial anamnesis.

In 1999, 130 of the 207 applicants were assessed as emergency cases; 41 had ENT complaints but 24 of them had ENT diagnoses associated with trauma. Although 16 applicants had tympanic membrane perforation, 7 of them had not had ear complaints in their initial anamnesis.

In 2000, 309 of the 429 applicants were assessed as emergency cases; 73 had ENT complaints, while 57 had trauma-associated diagnoses. Of the 21 patients with tympanic membrane perforation, 9 had not had ear complaints in their initial anamnesis.

Another finding of the study was the fact that 14 of the cases examined during the 3 years had tympanic membrane perforation, although there was no mention of ear pathologies in their first forensic examination.

These applicants were referred to ENT specialists, tympanic membrane perforations were confirmed and the reports were given to the applicants themselves or to their lawyers to be put into their official investigation files.

The cause of trauma in our cases was beating; an ENT specialist consulted all of the cases.

Healing does not start in the first 24 hours in traumatic tympanic membrane perforation. If the perforated membrane fragment is not appropriately positioned, the edges of the wound thicken, become inflammated and the chance of closure decreases [3]. However, it is reported that interventions in the first 10 days usually have favorable outcomes[4]. The spontaneous healing rate in traumatic perforation of tympanic membrane is 78% in perforations 2 mm or smaller in size, while the rate is 90% in larger perforations [4]. Surgical repair is indicated for perforations that remain patent for over 3 months. Intermittent hearing loss suggests middle ear bone chain defect, and it should be investigated and surgically repaired[3]. The best approach to patients with uncomplicated perforation might be recommending avoiding getting the ear wet, because even such a precaution might suffice for spontaneous healing [2].

Conclusion and Comments

It is essential to determine and document the tympanic membrane perforation, which translates to 15 days' routine occupation restriction in forensic medicine practice, in routine forensic examinations, considering the time for spontaneous healing. When perforations are not observed in the initial examination or in the first few days after the trauma, they are difficult to observe and determine the origin of in the following days in the second forensic examination or examination in alternative institutions like ours, and the evidence of the trauma is lost.

The finding of tympanic membrane perforation, which translates to 15 days' routine occupation restriction according to forensic medicine institute manuals, is medical evidence that would affect the final verdict in an assault and battery trial, whatever its origin is, and therefore routine otoscopic examination seems to be essential in initial forensic examinations of individuals exposed to trauma.

Steps must be taken by the Ministry of Justice Forensic Medicine Institution, the Association of Forensic Medicine Specialists and the Turkish Physicians Association to ensure routine otoscopic examination of all individuals claiming to be victims of assault and battery, in all medical units that perform forensic examination in primary care settings and forensic medicine centers. The physicians involved in this study are ready to help, in any way, to initiate this practice.

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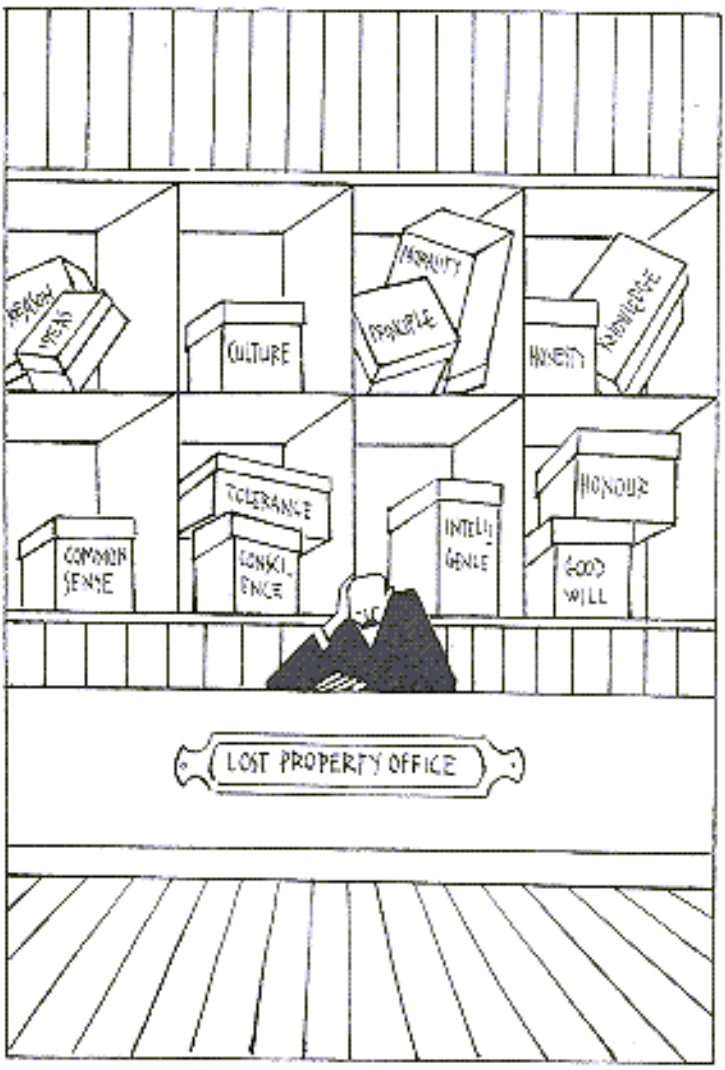

(Kayıp Eşya Bürosu: Akıl, Fikirler, Kültür, Ahlak, Prensip, Dürüstlük, Bilgi, Sağduyu, Hoşgörü, Vicdan, Zeka, Şeref, İyi niyet)

PHYSICAL THERAPY-REHABILATATION OF PERSONS UNDERGOING MAN-MADE TRAUMA

Mintaze Kerem*

The aim of this paper is to emphasize the importance of physical therapy and rehabilitation of persons with physical and psychological problems caused by man-made trauma.

There is no apparent difference in the rehabilitation approach of the physiotherapist or in the use of physical therapy in man-made trauma or any other type of trauma. However there are some important points that should be taken into consideration in the rehabilitation approach in man-made trauma.

In rehabilitation after torture, the most common problem is the "body alienation" syndrome, which is primarily on a psychological level. In order for the rehabilitation to be effective, the problem must be recognized and diagnosed.

Depending upon the severity of traumas such as traffic accidents, home accidents, accidents in the workplace, sporting injuries, falling, collisions or the lifting of heavy weights, the physical integrity of various systems are disturbed. For long or short periods, the individual's physical independence is affected. There is a decrease in functional capacity and their daily activities are limited. In traumatized persons, there may be psychosocial problems, according to the limitation of functions, related to age, gender, socio-economic status, psychological make-up of the individuals etc. Physiotherapy plays an important role in a multi-disciplinary approach to rehabilitation that helps the person to become independent and to regain his functions. There are many aspects to the physiotherapeutic approach. These include the elimination of problems of the musculoskeletal system, pain relief, prevention of muscular weakness occurring after immobility linked to the trauma, regulation of respiratory functions, aiding in the person's mobilization and functions, use of orthoses and prostheses, home rehabilitation and work rehabilitation.

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Even though the physical wounds may be similar after the violence involved in man-made trauma, the psychological status arising after the trauma may differ.

All activities in man-made trauma that lead to disturbances of the psychological integrity of persons who have undergone punishment, bodily pain, application of pain, and personal injury are called *violence*. It has been reported that the most serious and permanent discomfort in persons who have undergone violence is psychological trauma. While the effects of physical violence may be cured in days or months, persons undergoing psychological violence may have very serious health problems that are life long. Physical disturbances that appear in this situation make rehabilitation difficult.

The man-made trauma requiring physiotherapy-rehabilitation can be divided into physical and psychological activities according to the physical or psychological disabilities.

Physical	Psychological
• Beating (severe beating, beating with hard instruments)	• Witnessing of violence in the family by children and others
• Burning	• Isolation
• Pulling out hair, beard, moustache	• Humiliation
• Violence aimed at sexual organs	• Emotional exploitation
• Deprivation of food and water	• Death threats
• Prevention of toilet use.	• Other types of threat
• Rape	• Blindfolding
• Deprivation of sleep	• Sexual harassment
• Forced to wait on a cold surface	• Forced nakedness
• Falanga	

The activities listed above or similar ones are defined by the United Nations Convention against Torture as "Torture means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person, information or confession, punishing him for an act he or a third person has committed or is suspected of having committed...when such pain or suffering is inflicted by or at the instigation of or the consent...of a public official or other person acting in an official capacity."

Rehabilitation approaches for persons undergoing torture are necessary for:

1. Physical disabilities
2. Psychological disabilities
3. Social problems.

A multi-disciplinary team carries out rehabilitation. In the treatment of physical disabilities, the use of physiotherapy and rehabilitation as well as medical treatment is very important. After trauma, the physical problems are usually accompanied by psychological problems. For successful rehabilitation, it is very important for the physiotherapist to recognize and interpret the psychological disabilities. The importance of psychotherapy and social services along with the physiotherapy-rehabilitation must not be forgotten.

Psychological symptoms after torture

- Anxiety
- Difficulty in falling and staying asleep
- Difficulty in concentration
- Tiredness, weakness
- Uneasiness when reminded of trauma
- Nervousness or outbursts of anger, decrease in response threshold
- Reliving trauma or inability to forget
- Extreme degree of decreased or increased amount of sleep
- Memory deficiency
- Occurrence of flashbacks
- Alienation from people or feeling that they are strangers
- Limited future expectation
- Extreme wakefulness (continually on guard)
- Agitation
- Change in appetite (increase or decrease)
- Emotional disabilities
- Decrease in sexual desire
- Thoughts of or attempt at suicide
- Hallucination
- Increased use of alcohol, drugs and cigarettes
- Obsession
- Compulsion
- Severe and untreatable headache

An important syndrome that is seen in patients that have undergone violence is the *Post-Traumatic Stress Disorder* (PTSD). PTSD is a condition characterized by reliving the trauma in various ways, an attempt at escaping from reminders of the trauma or decreased response and increased wakefulness.

Systems most commonly affected by violence: These are the musculoskeletal system, genitourinary system, nervous system and digestive system. Occasionally other organs may be affected.

Physical problems most commonly found in these persons

- Tearing of capsular structures and connective tissue
- Widespread pain in joints and muscle tissues of neck, back, waist and extremities
- Dislocations of shoulder, elbow, wrist, ankle, and chin
- Injuries of disks in the cervical, thoracic and lumbar areas
- Fibrosis and shortening of connective tissue due to a decrease in blood supply to connective tissue surrounding nerves
- Injury to the bottom of the feet and damaging of the arch of the foot
- Disturbances of posture such as kyphosis, lordosis, scoliosis
- Headache
- Paralysis (especially that related to injury of the brachial plexus)
- Widespread paresthesia of the upper and lower extremities
- Breakage of various bones
- Urinary or genital infections
- Irregular menstruation
- Gastric or peptic ulcer
- Disorders of the small and large intestine
- Hemorrhoid
- Ringing in the ears
- Tearing of the ear membrane

Most common diagnoses given for locomotor complaints

- Lumbar, cervical disk hernia
- Lumbar, cervical strain
- Myofascial pain dysfunction syndrome
- Injury of brachial plexus
- Shoulder impingement syndrome
- Lumbar, thoracic, cervical osteoporosis
- Periarthritis of the shoulder
- Scoliosis
- Spondylolysis
- Fracture of the humerus
- Disfunction of the temporomandibular joint
- Burst fractures
- Anterior cruciate ligament rupture

After man-made trauma, the duty of the physiotherapist in the approaches of rehabilitation may be summarized as follows: description of the physical disabilities that occur after trauma with specific evaluations, decreasing the physical disabilities as much as possible, helping the patient become adjusted to the disabilities and limitations, easing pain and provision of sufficient daily activities.

Evaluation in the physiotherapy and rehabilitation program

The evaluation of pain includes the following parameters.

- Analysis of posture
- Evaluation of muscular tonus
- Muscular testing
- Evaluation of respiration
- Evaluation of body perception
- Evaluation of sensory integration
- Evaluation of motility functions
- Evaluation of balance reactions
- Evaluation of reflexes
- Evaluation of daily activities
- It is also necessary to evaluate a specific syndrome, Layer Syndrome in torture victims.

Layer Syndrome: *After trauma, hypotonic and hypertonic areas form in the muscles of the entire back, in particular in the area of the shoulders. This may cause pain in the back and head. The hypertonic and hypotonic muscles should be evaluated. The hypertonic muscles include the cervical erector spinae, upper trapezius, levator scapulae and the thoracolumbar erector spinal muscles. The hypotonhic muscles include the muscles stabilizing the scapulae, the lumbosacral erector spina and the gluteus maximus muscles.*

As we indicated at the beginning of this paper, in rehabilitation after man-made trauma there are specific situations that must be taken into consideration for the rehabilitation to be successful. The most important of these is the feeling of alienation toward his own body and personality.

The general aim of general rehabilitation in this type of patient may be summarized in this way. The approaches to be used should aid the individual in developing his identity and in the restoration of physical and social activities. The approaches should help him in the restoration of self-pride and in recognizing his body and body functions. They should decrease emotional stress, prevent the person from injuring himself and encourage him in the taking up of his role in society. The first step in physical therapy should be to help the patient to accept being touched. Training in

BODY AWARENESS should be used for the purpose of helping in the restoration of personality and body recognition. This training is made up of relaxation, breathing exercises, motivation in movement, touching, massage and dancing. In rehabilitation, improvement of posture is used for the purpose of ridding the person of the feeling of alienation toward his body and the relief of pain. The aim of using the technique of body awareness is to increase the feelings of body completeness, self-respect, and self-trust. For this purpose, at the beginning, in order to increase body awareness, the following steps should be taken.

• Increase in the ability to be aware of the body, recognition of the condition of their posture and able to feel the tension in their muscles,

• Increase in the ability to feel that the body is fine,

• Before any situation gets worse, to recognize the signs that "I don't feel well".

• Increase in the ability to recognize the capacity of the body and to have times they feel "I can do it".

• Recognize the limits and capacity of the body,

• While moving, to attempt to recognize his body type and its capacity.

As knowledge of the body increases, the ability to control the body will increase. Being able to control the body will aid in using less energy for daily activities and to do them in an efficient and balanced manner. In all activities, proper and steady breathing is necessary and they should be trained in this. During this training if they feel an increase in tension of the muscles, attempts at prevention should be made. If certain postures cause pain and muscular tension, that posture should be changed. The person should be taught the limits of the body and not to exceed these limits. Teaching the persons exercises that they are capable of and helping them to realize that they can do them, will help in getting rid of negative thoughts about the body and in becoming free of bad posture.

The most important point in teaching about the body is helping the person to feel joy in and to want the body movements. At the beginning, simple and natural movements are necessary. In this way the person will try to bring out his abilities. The movements that are being taught should be so simple that even the physiotherapist will find them to be overly simple. The treatment sessions are divided into 3 parts.

Relaxation (the person consciously lets himself relax on the bed, and then stiffens and relaxes his muscles)

Exercises from simple to difficult are done lying on back, face down and standing (this includes stepping on the floor with confidence, combining controlled breathing with the exercises and coordinated exercises.)

Massage helps in communication, making contact with the person, decreasing muscular tension and the secretion of endorphins. (This includes touching the body

from the toes to the head as shown by the physiotherapist without removing clothes.)

Treatment should be carried out at least 3 times a week over a long period. Comfortable clothing should be worn during the exercises. The room used should be quiet and free of furniture and painted a restful color. There should be music that the person likes. As the treatment becomes more advanced, tai chi and dance techniques may be used.

Besides this, in the treatment of physical problems arising as a result of trauma, the approach of general physical therapy should include:

Hot/cold pillows, massage, exercises (for correction of posture and strengthening), positions that decrease pain, active and/or passive mobilization, relaxing exercises, respiratory exercises, sensory integration, teaching of balance, if the patient is willing, electrotherapy and bandaging, use of orthesis exercises in a pool, and a home exercise program.

In these patients, an important physical problem that must be taken into consideration is DEPRESSIVE POSTURE. In this postural disability, there is extreme contraction of the flexor muscles and, in particular, the abdominal muscles. The shoulders are elevated and protracted. There is abduction and internal rotation of the upper extremities. There is flexion of the elbow, pronation of the lower arm and the hand is fisted. Flexion of the body, hip and knee is prominent. Stretching of the short muscles and pain relief is important.

There are certain precautions in the rehabilitation approach and evaluation that we may mention. The physiotherapist should not position himself behind the patient. Until the patient has come to trust the physiotherapist, a request that he remove his clothes should not be made. The room should not be brightly lit. When the methods of treatment and agents are being described, anything that reminds the patient of violence should be avoided. Electrotherapy or ice and water treatment should not be used in persons who have undergone torture with these agents. If possible, the treatments should be carried out by a female physiotherapist.

Care should be taken in beginning the treatments on time. Manipulations and traction should not be used in persons who have undergone torture by suspension or by having their teeth extracted. Mirrors should not be used and if possible, a white lab coat should not be worn.

We believe that instead of classic physical therapy and rehabilitation, rehabilitation approaches that include special techniques, which take into consideration the fact that torture has had an effect on the entire personality, should be used.

EVALUATION OF POST-TRAUMATIC STRESS DISORDER FOLLOWING EARTHQUAKES AND TORTURE

Dr. Serpil DOĞAN *

During the present historical period, either the difference between trauma produced by humans or that produced by natural disasters is disappearing or else natural disasters are becoming more violent. For this reason, natural disasters are becoming more of a social disaster. At the same time, political violence and its special version, torture, is becoming a common event. As torture becomes more common, it affects the responses of physicians and psychiatrists both from an individual and organizational standpoint. The approach of the medical profession in simply "binding up the wounds" is not enough in the case of torture and violence, which are some of the most important problems at this time. For this reason these events must be investigated scientifically.

The aim of this study was to determine the rate of appearance of the post-trauma stress disorder (PTSD), its course, the symptomatic profile and the frequency of symptoms as well as a comparison of the violence resulting from earthquakes and torture. At the same time, a comparison was made of the psychological state of the two groups of patients by evaluating their level of depression, anxiety and hopelessness.

In this study, which compares the PTSD appearing as a result of man-made trauma (torture) with that from natural causes (earthquakes), it is necessary to keep certain hypotheses in mind.

1) The difference in the type of trauma affects the rate of appearance of acute and chronic PTSD.

2) The symptomatic profile of PTSD, as well as the frequency and severity of symptoms will vary according to the type of trauma.

* *Psychiatrist.*

3) The difference in the types of trauma will not affect the frequency of accompanying depression and anxiety.

Concept of Trauma and Historical Development

Concept of Trauma

According to the definition of the American Psychiatric Association, traumatic events occur outside ordinary human experiences and are a source of anxiety for almost everyone. For an individual:

- A death threat,
- Severe injury or threat of injury,
- Witnessing the death of someone else or of their being under the threat of death,
- Witnessing the injury of another person or of their being under the threat of injury,
- Unexpected death or death by violence of a family member or of someone also close to them, learning that they have been severely injured, or are under the threat of death or injury.

All of the above are characteristic of trauma. Responses to the event are as important as the characteristics of the event. Responses to a traumatic event include extreme fear, helplessness or being terrified. (APA, 1994)

Categories of Trauma

Trauma may be classified under 3 headings (APA, 1994):

1) Caused by people (war, torture, rape, violence in the family, terrorism, practices in prison and while under arrest)

2) Accidents caused by people (traffic, plane crashes, train wrecks, shipwrecks, accidents in the workplace, fires)

3) Natural disasters (earthquakes, floods, avalanches, hurricanes, tornadoes, forest fires)

There is little difference in the effects of a natural disaster or of trauma caused by people. We can list the factors that make a natural disaster into a social disaster as follows:

1)Early rescue is important. More than half of the deaths due to earthquakes occurs during the first 24 hours. Help that comes on the third day saves only a few of those trapped in the wreckage. Only about 1 out of 10 are saved at this time. Some of these die while they are being taken to medical centers. This is one cause of the mental trauma.

2) It is necessary to take the victims to a safe place, to supply their basic needs and to set up and organize aid. If these are unavailable, it is another source of mental

trauma.

3) It is important to supply suitable places to live and food. A lack of or inequality in any of these is a source of trauma.

4) After the above are achieved, it is necessary to set up a treatment center and to put it into use. A lack of any of the above is a source of mental trauma. This also prevents the mental support of the target group and the attaining of the goal.

Study Groups

The first group included those affected by the Nov. 12 earthquake in Düzce. Sixty persons (33 women and 27 men) who were living in the district of Kaynaşlı agreed to take part in the study.

The second study group included persons who had undergone torture and had presented at the Ankara Treatment Center of the Turkish Human Rights Foundation and the Ankara branch of the Human Rights Association between April and November 2000. A total of 31 persons (16 women and 15 men) agreed to take part in the study. Of these, 14 came from the Foundation and 17, from the Association. Five of these persons were not politically involved but were first degree relatives of persons who had been arrested or convicted for political activities. The criterion for inclusion in the study was being extremely affected by the experience of torture or those who reported that they had been so affected. The criteria for inclusion for both groups are as follows:

* Not less than 18 years of age or more than 44,

* Experience of physical or mental torture or having had experienced the Nov. 12 earthquake,

* No evidence of psychotic disturbances or mental deficiency

* Agreed to take part in the study.

Methods of Data Collection

Social-demographic forms, Pre-trauma information forms, Criteria for evaluating effect of trauma, Clinician-administered PTSD scale (CAPS), Poll form for evaluating torture victims, Hamilton depression evaluation criterion, Spielberg condition-continual anxiety inventory.

Social-Demographic Characteristics

The social-demographic characteristics of the study groups are given below.

Age: The mean age of the first group was 35.2 ±4.8 and that of the second group, 29.1 ±6.5. *Gender:* There were 33 women and 27 men in the first group making a total of 60 persons. The second group included 16 women and 15 men making a total of 31 persons. *Educational status:* Forty-three of the first group could read

and write having completed primary school, 3 had graduated from junior high, 7 from high school, and 7 from university. In the second group, there were 2 who could read and write having completed primary school, 1 had graduated from junior high, 17 from high school, and 10 from university.

Effects of the Earthquake

Thirty-seven (61.7%) persons had lost one or more of their first-degree relatives. The first-degree relatives of 25 (41.7%) persons had been injured. Twenty (33.3%) of the group had been injured themselves and 2 (3.3%) had lost an organ. Fifty-eight (96.7%) had lost possessions and the homes of 37 (63.8%) of these were not fit for occupation. Thirty-nine (65.0%) had seen dead bodies just after the earthquake and 37 (61.7%) had seen severely injured persons. Fifty-two (86.7%) had heard the screams for help of persons trapped under the wreckage. Fifteen (25.0%) had carried wounded persons. Seven (11.7%) had helped in the gathering of the dead. Forty-one (68.3%) persons had not been able to find a place to stay during the first few days. Fifty-three (88.3%) persons stated that the psychological, medical, social and economic aid after the earthquake was sufficient but 7 (11.7%) said it was not. Most of the victims had been helped by volunteers or relatives and considered the support by government agencies to be insufficient. Fifty-eight (96.7%) had previously experienced an earthquake and, of these, 42 had experienced the August 17 Marmara earthquake.

Characteristics of the Torture Victims

Twenty-six persons in our study group had undergone torture for political reasons. The period of time since the last episode of torture was 1-6 months for 13 (41.9%) persons, 7 months-1 year for 7 (22.6%) persons and 1-5 years for 11 (35.5%) persons. The 26 persons had undergone torture for 1-14 times. The period of time that they had been under arrest ranged from 1 to 110 days (mean 11.42 ±3.41). Thirteen out of the 26 had been convicted and imprisoned for 2 months-5 years.

Meaning Given to the Earthquake and Torture by the Victims

Fifteen (25%) out of the 60 in the first group considered the earthquake to be due to fate; 36 (60.0%) to God's will; 11 (18.3%) a punishment of the people sent by God; 23 (38.3%) a natural event and 14 (23.3%) building defects. Five (8.3%) thought this country is unsafe and 2 (3.3%) thought the world to be unjust.

Out of the second group, 3 (9.7%) persons thought that the world is unjust and 31 (100.0%) that this country is unsafe. Twenty-eight (90.3%) persons thought that they would be tortured again. Thirty (96.8%) persons considered torture to be a governmental policy and that it is systematic. It was not just for them, all people might undergo torture.

During this study, in order to determine whether the PTSD symptoms that appeared

after the earthquake and torture traumas would continue during the period that this study was being carried out, an evaluation was made of the frequency of acute and chronic PTSD. During the period after the individuals were affected by the earthquake and the torture until the study begun, no evidence of PTSD was found in 19 (31.7%) of the first group or in 17 (54.8%) of the second group. The criteria for acute PTSD were found in 28 (46.7%) of the first group and in 8 (25.8%) of the second group. There was a higher rate of acute PTSD in the earthquake victims than in the torture victims. While the study was being done, no criteria of PTSD were found in 47 (78.4%) persons in the first group, but the criteria were detected in 13 (21.6%) persons who were given the diagnosis of PTSD. While in the second group, PTSD was not found in 25 (80.6%), 6 (19.4%) persons were given the diagnosis of PTSD. When the groups were evaluated individually, it was found that the rate of chronic PTSD was higher than the acute in the torture group. While the study was being carried out, the patients with the criteria for a PTSD diagnosis were those in which the condition had become chronic. While the study was being done, of those with acute PTSD in the earthquake group, 54% were getting better, but in the torture group, the rate of improvement was a low 25%. Out of the 8 patients with acute PTSD in the torture group, 6 became chronic, while in the earthquake group, 13 out of the 28 patients with acute PTSD became chronic. In the torture group, the rate of 25.8% for PTSD after the trauma, became 19.4% during the study. In other words, the condition had become chronic in most of the patients. In this study, the high rate (75%) of chronic cases in torture victims shows that man-made violence is an important factor in the development of chronic PTSD as was also shown by Breslau et al. (1999).

The high rate of acute PTSD in the earthquake victims may be explained by many factors besides the severity of the trauma, such as the extremely poor living conditions after the trauma, the meaning given to the trauma by the individuals and their negative views as to the cause of the earthquake, the amount of support received after the trauma and whether the victim found this support to be sufficient. On the other hand, the fact that the traumatic experience of the trauma was so recent may be the explanation for the differences in the acute phase. The high rate of PTSD (46.7%) may be due to the severity of the earthquake and the manner in which they were affected. Besides this, there is the question of the difficult living conditions after the earthquake. There are other studies that have obtained similar results in regard to living conditions. For example, in a study of 582 persons 6 months after an earthquake in Armenia (Goenjian, 1993), the frequency of PTSD was found to be 74%. It was suggested that the high rate of PTSD might not be due so much to the severity of the earthquake but rather to the traumatic experiences (seeing dead bodies, hearing screams for help, and seeing the horrified faces of those who were looking for their loved ones).

Similarly, the 26 persons in the torture group had been tortured 1-14 times and expected to be tortured again. There was a similarity in both groups in regard to these characteristics.

Being unable to control either the earthquake or the torture and not knowing when they might happen again leads to unexpected stress. However, the person who has been tortured has no place of safety, no place where he can go. For this reason, in contrast to earthquake victims, he develops a feeling of helplessness. It is to be expected that methods of torture that cause him to lose control and to despair such as suppression of movement, blindfolding and belittling will lead to a higher rate of PTSD. However, the results of the study did not show this. When the person expects he will be tortured, knows about torture and has undergone similar stressful events, he may have developed immunity to such stresses, which has a protective effect. Out of 31 persons who had been tortured, 26 were persons tortured for political reasons. Thus, their being able to overcome the effects of the torture may be due to their being connected to a political group.

In this study, important differences were found in the way persons who had been victims of the earthquake and those victims of torture evaluated the trauma. Out of the 60 persons affected by the earthquake, only 14 (23.3%) thought that the buildings were defective. The remaining 46 (76.7%) thought that the earthquake was caused by God or by uncontrollable nature. All of the torture victims (100%) thought that this country was not safe. Twenty-eight (90.3%) thought that they might be tortured again and 30 (96.8%) persons thought that torture was the policy of the government and that it was systematic. They believe that it is not just aimed at them alone, but that each and everyone may be tortured. One of the most important differences between the torture victims and the earthquake victims is the anger and hostility of the torture victims. During the study it was found that anger and hostility were much higher in the group that had been tortured. All of those who had been tortured were angry but anger was detected in only 22% of the earthquake victims.

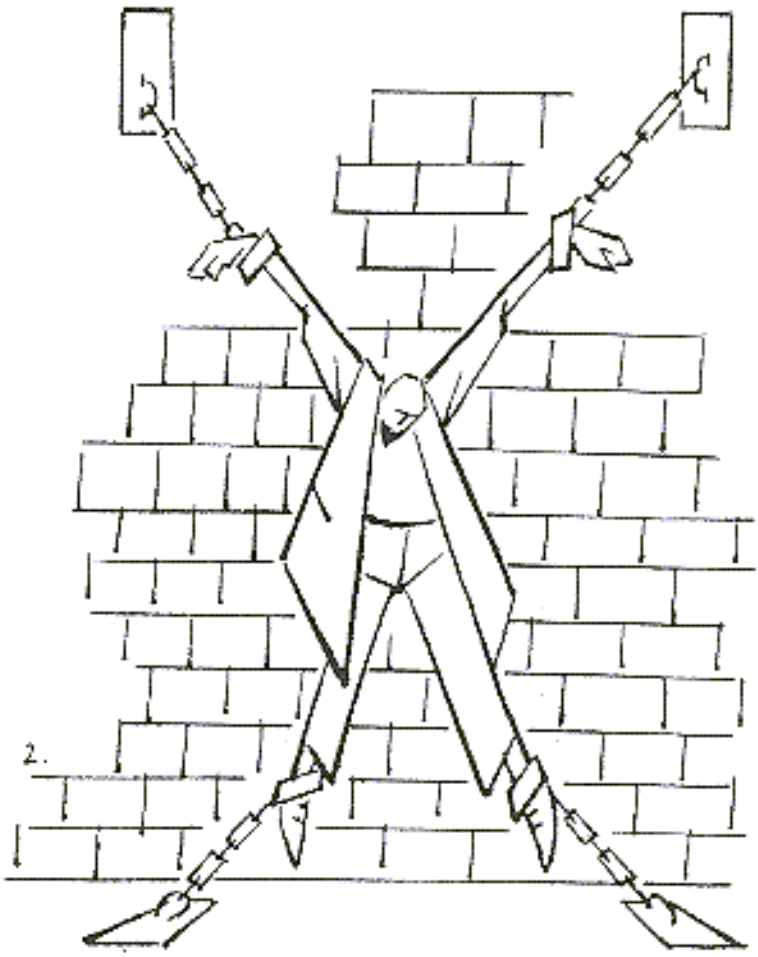
Social support after the trauma has been found to decrease the psychological effects in many studies. (Keane et al., 1985). In particular; close relationships may reduce considerably the psychological disturbances related to stress. The fact that a lack of social support after trauma is related to the development of PTSD was verified by this study. During this study it was found that 53 (88.3%) of the 60 earthquake victims felt that the psychological, medical, social and economic aid had been sufficient, but only 7 thought that it had been insufficient. While there was no statistical significance between the belief that the support they had received was sufficient and the rate of PTSD, the same results were not obtained from the torture group. Of the 19 (61.3%) persons who thought that the psychological, social, political and economic support was sufficient, no PTSD was detected in 13 (68.4%); this finding was statistically significant. In other words, during the study, those per-

sons meeting the criteria for PTSD found the support they received insufficient and this played a role in the development of chronic PTSD.

During the period from the earthquake to the beginning of our study, those who satisfied the criteria of PTSD included 12 (44.4%) men and 16 (48.5%) women. This rate in torture victims was 5 (33.3%) men and 3 (18.8%) women. During the period this study was carried out, the gender of those satisfying the criteria of PTSD in the first group included 3 (11.1%) men and 10 (30.3%) women and in the second group, 1 (7.1%) man and 5 (31.3%) women. According to the findings, during the period following the earthquake, the rate of PTSD was higher in women but the rate in the torture victims was higher in men. However during the period of the study, the rate of the chronic state was higher in women in both groups.

When the symptoms of PTSD were investigated in the period following the trauma, the most common symptoms following the earthquake were related to the difficulty of the trauma and were anxiety producing (93%), psychological difficulties when reminded of the trauma (88%), a loss of interest and no participation in activites (82%), irritability and outbursts of anger (78%), avoidance of thinking, feeling or talking about the trauma (70%), difficulty in falling asleep or staying asleep (67%), avoidance of activities, places and persons related to the trauma (57%), physiological response to stimulation recalling the trauma (55%), exaggerated startle response (55%), increased state of vigilance (53%) and disappearance of future expectations (52%). Other symptoms were found in less than 50%. The most common symptoms in the torture victims included difficulty in falling asleep or staying asleep (74%), forced and anxiety producing thoughts in regard to the trauma (71%), psychological difficulties when forced to remember the trauma (71%), difficulty in concentration (71%) and irritability or outbursts of anger (52%). Other symptoms were found to be less than 50%. While difficulty in sleeping was 6th most common symptom in the earthquake victims it was the most common in the torture victims. Psychological difficulties resulting from intrusive thoughts and reminders of the trauma were the most common symptom in the earthquake victims. Even though a loss of interest in and lack of participation in activities was one of the most common symptoms in the earthquake victims, it was not in the torture victims and the difference was significant.

Restriction of emotions, which was found to be a most common symptom in torture victims by Birkhimer et al. (1985), was found to be the least reported symptom (3%) in this study. In contrast to the earthquake victims, the most common symptom was psychological difficulties when reminded of the trauma. Besides this, the irritability and outbreaks of rage that were thought to be more common in the torture victims was too low to produce any significant difference. This is in contrast to information found in the literature. Even so, this should be discussed in relationship to the exhaustion, destruction and loss naturally experienced by earthquake victims. Besides this, the symptom most commonly reported by earthquake vic-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tims, outbreaks of rage, generally occur in the late stages when the victims are left alone with their losses and are not given the help they need. Another noticeable finding in regard to the torture victims, is a low rate of resolving of the PTSD symptoms. Forty-two percent of the patients in this group had experienced the last torture 1-6 months previously 23% 7 months-1 year previously and 36% 1-5 years previously. In other words, even though in comparison to the earthquake victims, much more time had passed after the experience of torture, the resolving of the PTSD symptoms was much slower. In this study, estrangement from other people was much more common in the torture victims and the difference was significant.

The symptoms of thinking, feeling or talking about the trauma; avoidance of activities, places and people; and displaying a lack of expectation in the future were more common in the earthquake victims than in the torture victim. This may be due to the fact the torture victims were mostly a political group. Besides this, the finding of a lower rate of hopelessness in the torture victims may be due to the fact they are a political group. Since these individuals belong to a political group, they may have more positive expectations for the future. One of the characteristics related to PTSD, feelings of guilt related to what was done or to what was not done during the trauma, was found to be of statistical significance in the torture victims.

When the symptom profile and rate were investigated in the patients fulfilling the diagnostic criteria for PTSD after the trauma, the most common symptoms in the earthquake victims were: coercive and anxiety producing thoughts related to the trauma (93%) and reminders of the trauma producing psychological difficulties (93%). These were followed by such symptoms (in order of frequency) as: avoidance of thinking, feeling or talking about the trauma (86%); lack of interest in and no participation in activities (86%); irritability or outbursts of anger (82%); sleeping problems (79%); no future expectations (64%); flashbacks (57%); physiological response to remainders of the trauma (57%); avoidance of activities, places or people related to the trauma (57%); extreme startle response (53%); and an increased state of being on guard (50%). The other symptoms were found in less than 50% of the patients. The most common symptoms in the torture victims were as follows: difficulty in falling or staying asleep (100%); coercive thoughts leading to anxiety (88%); psychological difficulties in response to reminders of the trauma (88%); avoidance of thinking, feeling or talking about the trauma (88%); avoidance of people and feeling that they are strangers (88%); difficulty in concentration (88%); and no hope for the future (50%). The difference in the rate of the feeling of alienation from other people and difficulty in concentration of the above group as compared to the earthquake victims diagnosed with PTSD was statistically significant. These symptoms were above 50% in the torture victims but they were below 50% in the earthquake victims. While the physiological response to reminders of the trauma (B symptom group), the avoidance of activities, places and persons (C symptom group) and an exaggerated startle response (D symptom group) were above 50% in the earthquake victims, they were below 50% in the torture victims.

During the period of the study, when we considered the profile and rate of the symptoms of patients who fulfilled the criteria of a PTSD diagnosis, we found that there was a similar rate in most of the symptoms and that there was no significant difference between the two groups. However, there was a higher rate of symptoms such as dreams that produced anxiety, decrease in interest and in participation in activities, feeling of having no future, irritability and outbursts of anger, being on guard and an exaggerated startle response in the earthquake victims and there was a significant difference between the 2 groups in terms of those who had been given a diagnosis of PTSD. The symptoms in which differences had been detected were parallel in all of the patients. The most common symptoms in the first group were as follows: decrease in interest and participation in activities (100%); avoidance of thinking, feeling and talking about the trauma (92%); psychological difficulties when reminded of the trauma (85%); difficulty in falling and staying asleep (85%); irritability or outbursts of anger (85%); coercive thinking causing anxiety about trauma (77%), avoidance of activities, places and people recalling the trauma (77%); exaggerated startle response (77%); difficulty in concentration (69%); increase of being on guard (69%);and physiological responses when reminded of the trauma (62%). Other symptoms in patients were less than 50%. The decrease in interest and in participation in activities was higher in the period during which the study was being done than in the period just after the earthquake. In the earthquake victims, the alienation from other people was 4% just after the earthquake but increased to 46% during the study. During the 2 weeks just after a disaster, there was a period known as the "honeymoon stage" during which feeling of closeness and togetherness are prominent. This may be the reason the above symptom was not often reported. Later the feeling of "togetherness" disappears and the individual is left to face his losses and the effect on his life. The reason for the person's avoidance of other people may be due to insufficient help. The increase in the reporting of being on guard and the exegarrated startle response may be due to the repeated earth tremors following the main earthquake so that these symptoms are seen in more than 50% of the patients during the period the study was being done. The most commonly seen symptoms in the torture victims who were given a diagnosis of PTSD are as follows: psychological difficulties when reminded of the trauma (83%); avoidance of thinking, feeling and talking about the trauma (83%); coercive thinking giving anxiety about the trauma (67%); decrease in interest and participation in activities (67%); becoming distant and alienated from people (67%), difficulty in sleeping (67%); difficulty in concentration (67%); physiological response when reminded of the trauma (50%); and avoidance of activities, places and people related to the trauma (50%).Other symptoms were under 50%. As was mentioned before, the alienation from other people was more common in the torture victims. As was shown in other studies of symptoms of extreme response to natural disasters (Madakasira and O'Brien, 1987), in this study, the rate of symptoms was found to be over 50% in the earthquake victims. In the torture victims, only the rate of sleep difficulties and difficulty in concentration were over 50%. Symptoms such as irri-

tability or outbursts of anger, increased being on guard and exeggerated startle response were all under 33% and the difference between the 2 groups was significant.

Many of the symptoms of PTSD were found to be more common in women in both groups

When the frequency and severity scores of the B, C, and D groups of symptoms were compared, it was found that during the study and at any period after the trauma, both the frequency and the severity score were lower in the torture victims and the difference was significant. In any of the periods the C symptom group (avoidance and trapped symptoms) were lower in the torture victims both in frequency and severity and the difference was significant. There was no significant difference in the frequency and severity scores of the two groups in the B (signs of renewed life) and D (increased responses) groups. In a study that compared political violence with earthquakes (Goenjian et al., 1994), the severity score of the PTSD symptoms in the group undergoing violence was significantly higher than those in the earthquake victims. In this study, the fact that the frequency and violence scores of the PTSD symptoms in the torture victims was close to or lower than those of the earthquake group contradicts to the information showing that the PTSD symptoms are more severe in the torture victims. This result may be due to the political leanings of the torture group.

During the study, when the distribution of simultaneous PTSD and depression were compared, it was found that 10 of the 13 patient who met the criteria of PTSD and all of the 6 patients given a diagnosis of PTSD had simultaneous depression. While the co-morbidity of the PTSD and depression in the earthquake victims was 77%, it was 100% in the torture victims. There was no significant difference in depression between the 2 groups. There was a significant difference in depression in those diagnosed with PTSD and those not diagnosed with PTSD between the two groups. When the 2 groups have been followed up for a year, the progress of the depression will become clearer. We think that the frequency of the depression will decrease.

A point that should be considered is that the torture victims represent a special subgroup of trauma victims. Since most of our patients who had been tortured had political ties, they had fewer feelings of helplessness and hopelessness. It must be kept in mind that they had been prepared to be tortured and more care must be taken in adapting these results to other victims of human-produced trauma. It is important to compare other human-made trauma (rape, violence in the family etc.) with victims of natural disasters. In our present world where the difference between natural disasters and human-made trauma is no longer apparent, knowledge of which type of trauma will give what response, what symptoms are normal or what may be expected will aid in the struggle for edification.

In conclusion, the increase in social sensitivity, the development of sufficient physical and social support systems and the fulfilment of urgent and basic needs aimed at all types of traumatic experiences will decrease the long-term results of trauma.

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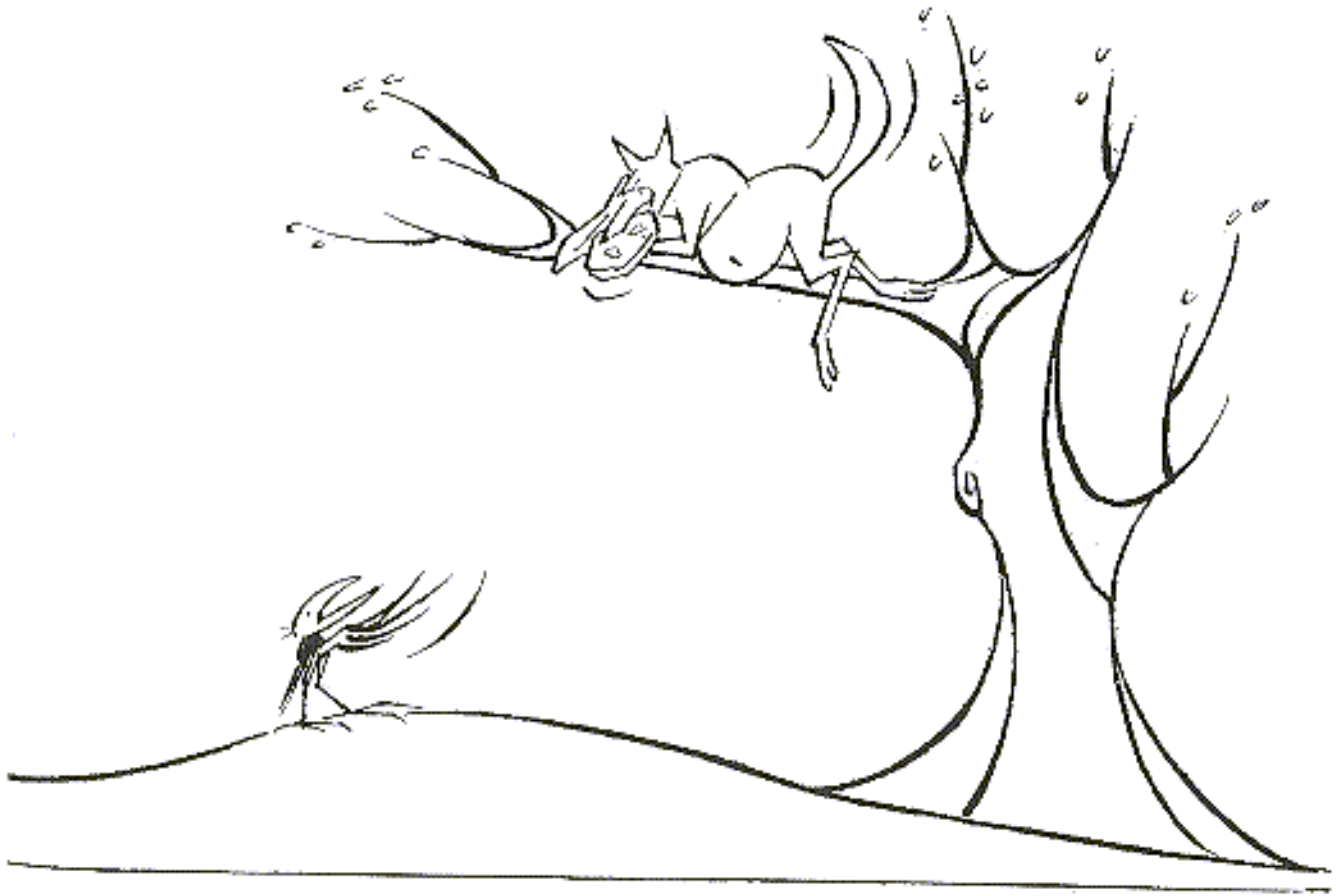

The visual material used in this Report
is from the book of Turhan Selçuk
entitled "Human Rights".

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