"We are still alive"

"We have been harmed but we are brave and strong."

Research on the long-term consequences of war rape and coping st rategies of survi vors in Bosnia and Herzegovina

"RAISE OUR VOICES FOR ALL WOMEN WHO HAVE SPOKEN UP, WHO ARE SILENT AND FOR THOSE WHO WILL NEVER SPEAK UP"

"ONE DAY OF SUFFERING IS TOO MUCH - IMAGINE SUFFERING FOR 22 YEARS"

"RESPECT SURVIVORS, PROSECUTE PERPETRATORS"

"JUSTICE FOR SURVIVORS OF SEXUAL VIOLENCE"

"POINT YOUR FINGER ON THE OTHER SIDE AND NOT AT ME"

"WE ARE NOT 'THOSE POOR WOMEN', WE ARE COURAGEOUS, BRAVE, STRONG AND ACTIVE"

"IT IS IMPORTANT THAT I AM ALIVE"

"YOU ARE ALSO RESPONSIBLE ..."

Bosna i Hercegovina

Bosnia and Herzegovina

“We are still alive”

Research on the long-term consequences of war rape and coping strategies of survivors in Bosnia and Herzegovina

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We have been harmed but we are brave and strong.”

June 2014
Zenica, Bosnia and Herzegovina

Research on the long-term consequences of war rape and coping strategies of survivors in Bosnia and Herzegovina - "We are still alive. We have been harmed but we are brave and strong." Second revised edition.

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Contents

Medica Zenica is the oldest expert non-governmental organisation which has been, since April 1993, continuously providing help, support and care to women and children survivors of war rape and sexual violence. Our approach to women and children, survivors of war rape, sexual violence and trauma, is based on humanistic values. *Medica Zenica* provides education of professionals working with survivors, lobbies and advocates the improvement of the life quality of survivors as well as establishes networks that enable survivors of war rape and sexual violence to know when, where and how to exercise their rights. In the past almost 22 years of active work with survivors of trauma, *Medica Zenica* has provided more than 400,000 various services across Bosnia and Herzegovina.

medica mondiale is a German based feminist women's rights organisation supporting women and girls in war and conflict regions. *medica mondiale* provides psychosocial and legal counselling and trauma sensitive medical consultation, and enhances protection – both through its own projects and in cooperation with local women's organisations. At a political level, *medica mondiale* actively advocates the enforcement of women's rights and interests and demands consistent punishment of crimes as well as effective protection, justice and political ownership for women survivors of sexual and gender based violence.

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This research has been many years in the making, so a complete list of all the people we would like to thank would be prohibitively long. We would therefore like to take this opportunity to extend our deeply-felt appreciation to everyone who has made it possible.

But above all, we know that this research could not have been done without the courage of the women survivors in Bosnia and Herzegovina who took the brave decision to participate in this research. By sharing your experiences with us, we learned a lot from you. Thank you for your trust and time! This research is dedicated to you, and also to the women survivors who remain silent, in the hope that you will be motivated to speak out.

We would like to especially thank the research team in Bosnia and Herzegovina and our experts, consultants and advisors for their commitment and determination. It was both challenging and inspiring to work with you all! We equally want to thank our interview partners in governmental institutions and in non-governmental organisations who shared their valuable insights with us.

We wish to thank our colleagues in *Medica Zenica* and *medica mondiale* who provided us with constant support and encouragement.

We would also like to take this opportunity to thank our families and friends who believed in what we were doing and encouraged and supported us throughout the project because they share the values that underpin our work, our wish that future generations can learn and benefit from this research, and our hope that it will contribute to reaching a day when rape and sexual violence are no longer so prevalent in our society.

And of course, many thanks to our donors who supported our research and helped us to record a part of these survivors' history so we can learn from them how to help others.

This research has had its own history and dynamics; it was a challenge and all of us who were involved in this process feel that we are not the same as in the beginning.

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Foreword

"Point your finger at the perpetrator and not at me."

"Do not underestimate yourself. You are not different from others or worse than them. Appreciate yourself."

"We are not 'those poor women', we are strong, active and courageous."

(Quotes of Bosnian survivors, former clients of *Medica Zenica*)

Over the last twenty years, we have seen a marked increase in awareness of sexual wartime violence and its severe consequences. This is largely due to the worldwide outcry against the mass rapes committed in Bosnia in 1992 and 1993, which in turn was only possible because of the courage of the Bosnian women who spoke out publicly to tell the world what had happened to them. Their courage was followed by the untiring, unflinching efforts of women's rights activists and feminists all over the world to organise support. There was a huge wave of solidarity, from which *Medica Zenica* followed by *medica mondiale*, emerged. The Bosnian organisation *Medica Zenica* was founded in 1993, and is known throughout the country for its tireless work to secure the rights of women who have survived sexual violence, while medica mondiale is a non-governmental organisation based in Germany which supports women and girls in war and crisis zones throughout the world.

Several international achievements have been realised since 1993, including a series of important UN resolutions, the institution of sexual violence as a war crime under international criminal law, and frequent international conferences on the issue. Nonetheless, wartime rape and other forms of gender-specific violence in war-torn and post-war societies still continue – day in and day out.

It is encouraging that, since 2006, survivors in Bosnia and Herzegovina have been able to obtain the ground-breaking status of civilian victims of war in Bosnia and Herzegovina. Disappointingly, however, they have lived in constant fear ever since from the knowledge that they can lose it again if they leave the Federation of Bosnia and Herzegovina and return to their former homes in the Republika Srpska, where this status is not respected.

In October 2013, at a conference held jointly by *Medica Zenica* and *medica mondiale* entitled "Working towards dignity, 20 years of struggle for dignity of survivors of war rape", our conclusion was that most of the survivors are still suffering. The statement "I survived the war, but how can I survive peace?" says everything about the daily fight of those who, despite having gone through hell for two decades, are mobilizing all their efforts in order to go on for a life worth living for themselves and their children.

Although *Medica Zenica* has recorded more than 400,000 instances of supporting women over the last 21 years, violence against women continues to be a huge problem in Bosnian society. Alongside the consequences of the war, reasons for this violence include poverty, unemployment, shattered families, and prevailing patriarchal structures and gender inequality within society.

We are often asked for the "real" figures. But how do you count when some women were raped many times, every day, for weeks on end? How do you count the women and girls who were killed after being raped? And in any case, counting only produces statistics, and we want to shout, as loudly as we are able, that behind each of these statistics there are individuals – survivors – who must often bear the consequences of this violence for the rest of their

lives. Let us try to express that even more clearly: War rape is a severe violation of a woman's human rights, and has extremely detrimental effects on her somatic, psychological and social integrity. The woman is degraded; her most intimate self is deeply injured; and her dignity is trampled upon. Many women suffer for years, even decades, from psychological and physical post-traumatic symptoms such as panic attacks, chronic pain and cancers – and they simply feel homeless in their own lives.

The probability of trauma symptoms becoming chronic is very high for the victims of rape – over 50% in the research. Together with the life-long impairments mentioned above, survivors also suffer social consequences such as stigmatisation and social exclusion, which often jeopardises their ability to support themselves and their families. For this reason, many find it impossible to talk about what happened to them, and this socially-enforced pressure to remain silent then leads to even more suffering. We also have to assume that the majority of survivors remain silent, and so never receive any specific support.

On the other hand, we also know that many survivors want to speak up so that "the world will know what happened to them"[1] – but it is not only up to them alone to break the silence. The reality is that, even 21 years after the war, it is apparent that society, community, politicians are not ready!

The devastating effects of wartime sexual violence are not limited to the individual women themselves. Their families and the whole social environment is also involved. In fact, these long-term consequences persist into the next generations.

How have European post-war societies dealt with their own trauma? In Germany, today's generation of grandchildren are the first to really consider the complex issues of guilt, responsibility and suffering, complicated further by all the destructive and unhealthy effects of their parents' and grandparents' silence and denial.

This research was compiled in the same way that we approach all our work: in a spirit of participation, in order to empower women and girls. We were also clear among ourselves that we wanted to keep editorial ownership. Although this was not easy – we do not want to deny the many arguments and controversies we had over the time – it was very important for the longstanding and earnest partnership between *Medica Zenica* and *medica mondiale* to stick to this common work.

21 years ago, we started our commitment based on clear feelings of solidarity. We were driven by the fact that sexual violence could also happen to us. And we asked ourselves how we would then like to be treated. The answer was clear: with respect and as individuals! And this attitude is still needed. We still need professional and supportive assistance. We still need to share the pain with the survivors, because the consequences of violence are far from over!

In this spirit we want to share the results of this study with like-minded people. With researchers to recognise and fill the gaps in our existing knowledge. With politicians to make them better able to understand their responsibility to act. With donors to continue with their crucial support. With young people to prevent violence.

Whatever function or place we are in – it´s all about dignity. The dignity of the survivors and, at the end of the day, the dignity of ourselves.

Monika Hauser, *founder of Medica Zenica and medica mondiale*

Sabiha Husic, M. Sc., *director of Medica Zenica*

[1] Title of a documentary by medica mondiale about the Foca Trial of the ICTY, 2009.

Summary

International and meta-studies show that war and rape are amongst the most debilitating stressors, producing high rates of Post-Traumatic Stress Disorder (PTSD) and other mental health consequences in survivors. In war rape, this combination of stressors makes their impact even more destructive.

The **aim** of this research and evaluation project was to explore the consequences of war rape on 51 survivors who have used *Medica Zenica's* services since 1993. In the first phase, a number of **psychometric measures and a questionnaire** designed for the purpose of the study were administered to all participants. In the second phase, seven of these participants were selected to give their **life stories** in form of an in-depth interview. Additionally, in view of our **multi-method design**, **focus group discussions** were conducted with non-governmental organisations working in the same field of supporting survivors, and **key informant interviews** were held with governmental institutions to complete our understanding of the situation faced by survivors in contemporary Bosnia and Herzegovina.

The study followed **four main research** questions focussing on 1) the consequences of war rape and sexual violence on survivors' lives, health and relationships; 2) the social acknowledgement of survivors of war rape; 3) the coping strategies and sources of resilience in the past 20 years, and finally 4) the impact of *Medica Zenica's* support on the survivors' lives.

Regarding the **results**, the over-all picture which was revealed calls for special attention: today, almost 20 years after the war, the psychological and health situation of most survivors of war rape participating in our study remains extremely alarming.

The following **key facts** emerged from our analysis of the data:

1) **The mental and general health of survivors of our sample is of grave concern**: 57% of participants are suffering from clinically relevant PTSD symptoms. Their general psychological distress is high and many show psychosomatic problems and anxiety symptoms. 70% of the participants state that the rape experience completely affects their life today. 65% of the participants regularly take drugs; half of them for 20 years. Almost all of the participants take psychopharmacological medicine. Others also take cardio-vascular and hormonal regulation medication, which clearly shows the long-term impact of posttraumatic and post-war stress on women's health. More than 58% of the participants reported the presence of four or more gynaecological problems, and almost 11% reported cancer.

Their relationships with their families, especially husbands and children, are also highly affected: we found clear indications of transgenerational transmission of trauma in the sense that particular patterns of relationships are created around trauma dynamics.

2) Despite the **unique status of civilian victim of war**, which 79% of the women in our sample have obtained, the participants overwhelmingly agree that governmental, cantonal and entity institutions do nothing for survivors. Essential support is perceived as only being provided by NGOs. The presence of **ongoing stigmatisation** in communities, the **lack of protection for witnesses** and **insensitivity** towards survivors of war rape in institutions, and **shortcomings** in the implementation of the law regarding the status clearly outweigh any positive role that

this political mechanism of granting war rape survivors a special status could play.

3) We found that on average the most commonly used coping strategies amongst the participants can be classified as "adaptive". Some aspects of post-traumatic growth were reported by a considerably high number of 68% of the survivors. These positive ways of coping might be attributed to Medica's long-term therapeutic and social support. So, the complexity of these results shows that many participants continue to suffer although, and this is no contradiction, they are also mostly coping as competently as they can. It is the level of destruction implied in war rape, probably exacerbated by other stressors and the ongoing stigmatisation in communities and the society, which makes it almost impossible for many survivors to cope "well".

4) This complex picture is completed by the fact that the participants highly value *Medica Zenica's* services, and mainly point to non-specific factors as playing a major part in their recovery, such as **care** and **availability**, **understanding** and **a safe space for sharing**. They attribute *Medica Zenica* with a key role in their trajectory of coping.

Recommendations centre around **support programmes for survivors** in general, whereby long-term funding for holistic support programmes and networks are recommended as well as strengthening the cooperation between and role of NGOs. Another set of recommendations focuses on the **need for specialised psychosocial and counselling programmes and trauma-sensitivity** in all professional domains of life. It is clear from the research that survivors and their husbands / partners and children need ongoing and tailored support and sensitivity in public institutions, particularly in the health sector. Also, **substantial amendments and improvements are suggested** with regard to the status of civilian victim of war, a significant improvement regarding the protection of survivors when giving their testimonies in national courts, and an ongoing prosecution of perpetrators. A last set of recommendations concerns the **social acknowledgement of survivors in local communities** and the over-all Bosnia and Herzegovina society in order to counteract the discourse of victimisation and stigmatisation and develop a discourse of survival.

1. INTRODUCTION: BACKGROUND TO THE RESEARCH AND EVALUATION PROJECT

1.1. Why conduct research on war rape 20 years after the war in Bosnia and Herzegovina?

During the war in Bosnia and Herzegovina, between 20,000 and 50,000[2] women and girls were systematically raped, sexually assaulted and tortured in concentration camps and while imprisoned in their own homes. Many were forcefully impregnated during this incarceration, and only released when their pregnancy had developed too far for them to have an abortion. Upon delivery, some women kept their children and others gave them up for adoption.

In early 1993, enraged by German media reports about these devastating human rights violations, the gynaecologist and feminist Dr. Monika Hauser together with a group of twenty professionals from Bosnia and Herzegovina began a pioneer project in Zenica to care for and show solidarity with the survivors of this war rape. *Medica Zenica* supported women and girl survivors of war rape and sexual violence by offering them shelter, medical services (particularly gynaecological, internal and general medical services), psychosocial help and logistical support, such as food, hygienic items, clothing, and footwear.

Since those beginnings twenty-one years ago, the project has grown and developed into two independent organisations which continue this commitment to supporting the survivors of war rape and sexual violence. *Medica Zenica* works in Bosnia and Herzegovina, while *medica mondiale e.V.* supports women and girls in war and crisis zones throughout the world. They maintain a close partnership, sharing professional experiences, creating standards for trauma work with survivors of war rape and sexual violence, and sharing lessons learned with other groups around the world.

Most research projects on the consequences of war for different populations in Bosnia and Herzegovina were conducted in the first decade after the war. Their focus was mainly on studying the effects of particular traumatic experiences that happened during the war and how they affected the adjustment and mental health of children, adolescents and adults. Some studies also looked at coping strategies and the potential for posttraumatic growth, identifying various risk and protective factors that influenced the recovery process for survivors from different traumatised groups. A very small number of studies have been conducted on the particularities of war rape in Bosnia and Herzegovina. The most recent of these rare studies of the consequences of war rape on women in Croatia and Bosnia and Herzegovina was carried out by Loncar, Medved, Jovanovic and Hotujac in 2003, eight years after the war, and published in 2006.

A substantial research gap therefore exists, covering both a period of twenty years and a particularly sensitive subject. To date, no studies have been published which reflect

[2] While figures from different reports and sources vary considerably, most are between 20,000-50,000. We have used e.g. the statistic given by the Commission for Gathering Facts on War Crimes in Bosnia and Herzegovina, which set the number at 20,000 (Tokaca, 1999) and the Resolution 1670 of the Parliamentary Assembly of the Council of Europe 2009 as well as other sources.

the consequences of the war on survivors of trauma in Bosnia and Herzegovina twenty years after those events, let alone the specific consequences of war rape on survivors, and the coping strategies they have adopted.[3]

To fill this gap, *Medica Zenica* and *medica mondiale* have collaborated on a research and evaluation project with the following three objectives:

- ☐ Evaluation, Learning, Legitimising
  To contribute to internal evaluation and self-reflective processes within *Medica Zenica* and *medica mondiale* by obtaining valid, objective and scientifically proven feedback on their work.

- ☐ Evidence-based Data
  To provide evidence-based information for service providers and political institutions in Bosnia and Herzegovina and beyond on the long-term consequences of war rape and sexual violence on survivors.

- ☐ Scientific Contribution
  To provide a substantial contribution to the scientific debate on the consequences of war-related sexualized violence and treatment for its survivors.

This research and evaluation report is thus a conscious reflection on the history of twenty years of work with and for survivors of war rape in Bosnia and Herzegovina. It also reflects the experience of those survivors who were supported – and are still supported – during and after the war, allowing testimonies to emerge of their long and complex trajectories of coping and living with war rape and sexual violence, which is known to produce the most destructive outcomes on the mental health of its survivors, for twenty years.

During preparation for the research, the two organisations identified the following questions as central to the endeavour, and used them both to guide the project and provide the structure of the report:

1. How has the war-related sexual violence and rape impacted on the lives of the survivors and their psychological well-being, health, relationships and on family systems?

2. How does Bosnian society treat survivors of war-related sexual violence and rape nowadays? How are they integrated[4] into their society from the legal, social, health and psychosocial point of view?

3. What has helped survivors to get on with their lives after war rape? What has given them the strength to continue their lives? What are their coping mechanisms and how did they evolve in the two decades after their traumatising experiences?

4. What did *Medica Zenica's* work mean for the survivors in their coping process? What were the most important "ingredients" in the help they received that actually made the difference for the women and supported them the most?

[3] We are happy to learn that Amra Delic (Tuzla) is about to finish her Master thesis on the long-term consequences, social support and quality of life of women victims of sexual violence in war, which she conducted from 2011-2013 throughout Bosnia and Herzegovina (100 respondents plus 80 controls) (Personal communication).

[4] In the following report, this aspect of integration / reintegration will be re-framed as social acknowledgement, since in the course of our research preparation we realised that social acknowledgment was a more appropriate term than integration / reintegration (see also 2.3.).

1.2. Values guiding this research and evaluation project

This research and evaluation project was guided by core values that run through the report and have shaped the process from the beginning, and have been translated into a conscious selection of over-all research methodologies, research tools and implementation strategies.

1.2.1. We follow a feminist research paradigm

"One of feminism's central claims is that women's perspectives have often been silenced or ignored; as a result, feminist researchers have been interested in listening for gaps and absences in women's talk, and in considering what meanings might lie beyond explicit speech." (de Vault & Gross, 2012, p. 217)

Our research and evaluation project is fundamentally guided by theories and practices which have been developed over the last twenty years and are identified with the term "feminist research" (see Hesse-Biber, 2012; Reinharz, 1992 for an overview on "feminist research"). The diversity in literature suggests that there is actually no distinct "feminist research" approach as such. Feminist research is as diverse as feminism itself. However, what all feminist research approaches have in common and what could be termed the common denominator of all feminist research theories and methods is that they are clearly committed to changing the status of women. They work for women's emancipation from oppressive structures, including those which exist within male-stream research theories and methodologies. It is research done by women, for women, about women (although not exclusively), and from a woman's perspective.

Although feminist researchers have always used "classical" quantitative methods, they reject a positivist and value-free nature of research and are therefore highly critical of male-dominated social science theories and research practices where women are objectified as research "subjects". In contrast, feminist research clearly emphasises women's experiences, which are considered to be a significant indicator of reality (Harding, 1987) that offers a special form of validity.

In the present research and evaluation project, we chose to offer a variety of methods and follow a mixed-method design (Creswell & Plano Clark, 2010), while keeping to the spirit of the values of feminist research. We use traditional methods such as diagnostic tests and a questionnaire because we believe that it is necessary to be able to compare our results with other scientific research that might not follow a feminist research paradigm. We want to be heard and have our results acknowledged, so that they can have an impact on politics and policies regarding women's lives in the concrete context of Bosnia and Herzegovina, particularly in the various domains of public life that are dominated by male thinking and male practice.

At the same time, we want to move beyond standard methodologies and allow more space for the complexity of women's experiences, their ideas, their hopes, and their struggles in relation to the topic of our research: the lives of women who survived war rape twenty years ago. Mainstream research on coping and mental health issues regarding the traumatic impact of war rape mostly uses psychometric tests, self-report

measures and other statistically normed and more or less culturally validated measurements. Although these are useful and allow comparison between studies, they often fail to adequately depict the complexity of the processes by which women come to terms with the experience of extreme violence. We have therefore opted for the following research methodology:

- Our research methodology – based on the mixed-method design mentioned above – allows participating women to go beyond the response alternatives offered by classical measures and to describe their own unique view on their suffering and their coping processes. By using tools such as a brief test on coping, but at the same time asking a variety of open questions in a questionnaire and providing ample space in the life story interviews for the women to choose for themselves what they actually want to tell us about how they have coped over the last twenty years, we were able to discover a far more complete picture on these highly complex and interacting processes, and gather insights that would not have emerged from tests alone.

- We consciously reflect on the role that *Medica Zenica* and their staff had for the women at the time of their acute suffering. We do not deny that there is a relationship between *Medica Zenica* staff and the participants, who have all used *Medica Zenica's* services, but instead of insinuating that we follow a narrowly focused, positivistic view on "objectivity", we chose to consciously use this relationship to make possible what is so difficult in research on war rape and sexual violence: enabling women to feel accepted and supported in the research environment, and thus enabled to talk about their experiences in emotionally safe ways, leading to responses that "traditional" approaches would be unable to elicit. So, instead of following an ideal of "objectivity" that is based on a pretence of "neutrality" and "non-involvement", our objectivity as feminist researchers is based on consciously reflecting our commitment to the women who are our participants.

- We include the sociopolitical sphere in our research through key informant interviews with relevant public institutions, because we think that the well-being of the survivors who are at the centre of our research is not simply an issue of individual coping behaviour or mental health, but is strongly related to the environment in which these women live. This is again a deeply feminist encounter, and we hope that presenting it here in written form can enhance the political efforts being undertaken to support survivors and allow them to actively participate in changing their social and political environment.

1.2.2. We follow the ethical principle of trauma-sensitivity

The ethical implications of engaging in trauma-focused research has been an issue of growing interest in scientific circles (e.g. Newman & Kaloupek, 2004; Ferrier-Auerbach et al., 2009; Collogan et al., 2004). Ethical codes for research and government regulations in many countries reflect this sensitivity towards the potentially harmful effects of research on respondents. Scholars usually approach the twin nature of trauma-focused research by contrasting the "risks" and "benefits" of participating in a study; a dilemma which respondents also face when they are deciding whether they want to take part or not. The "risks" include things such as emotional distress from answering trauma-related questions, while a "benefit" might be feeling worthwhile

and receiving favourable attention from the research (Newman & Kaloupek, 2004). Most studies show that despite provoking negative emotions in some participants, trauma-focused research actually does not cause undue distress and may be even beneficial: Even those who, for example, feel increased sadness or tension while filling out trauma-related questionnaires report that they do not regret taking part, and that their perceived gains from participation are the same as those who do not report feeling emotionally upset (Ferrier-Auerbach et al., 2009).

However, there are evidently participants who report higher levels of general distress or have experienced multiple traumas, so their participation might actually cause unanticipated distress (Newman & Kaloupek, 2004). According to Powell's research experience in Bosnia, "(g)iving extensive questionnaires on war events to a civilian population after a very recent war is an endeavour which gives rise to ethical concerns, in particular for the well-being of the respondents as well as for the interviewers" (Powell, 2011, p. 32).

Following a principle which we call "trauma-sensitivity", and taking into consideration the principles of ethical research as defined by the World Health Organization in their document "Ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies", we consciously opted for the following procedures to make the research at worst a relatively safe and containable experience, and at best an experience of empowerment, encouraging self-reflection and ongoing support:

- The women were first contacted by phone by a nurse from *Medica Zenica* who they knew from the project and were given time to think about participating in the research. The women were only asked to decide in a second phone call, and those who were still not sure were given more time to think about it;
- We opted for a research team consisting solely of *Medica Zenica* staff to prevent potential reactions of fear or shame that would most probably have occurred if the researchers had been strangers to the women. Survivors of war rape often feel a tremendous sense of shame and a fear of recalling the most terrible experiences in their lives, and such reactions are likely to create response biases in the research;
- The participants could choose whether they wanted to meet the research team at home or at the *Medica Zenica* centre;
- A counsellor was available to the participants during the interviews and tests; participants were able to take breaks whenever they felt they did not want to continue; and where questions were difficult to understand the interviewer gently offered an alternative, simpler explanation to prevent the participants feeling nervous or stressed, which could have biased the results;
- Our study had a clear focus on coping; the life stories in particular concentrated on what the women did in order to get on with their lives, thus providing a space to reflect on the survivors' immense capacity to create and recreate their lives;
- We field-tested the instruments before starting the research to determine the level of emotional strain and distress implied in the procedure. As a result, both to make the research experience less draining for the participants and to ensure that taking part was not so emotionally demanding that it impacted on their family dynamics when they went home (for instance, if they were tired and upset and their family, who

might not know about the rape, wanted to know what was the matter), we shortened the interview guide, and did not use all the tests we had originally planned.

- We opted not to subject our participants to the kind of detailed exploration of war trauma that is normally required when working with PTSD scales, since presenting survivors with a long list of the most horrifying wartime experiences and asking if they were exposed to them or not is likely to be a highly retraumatising experience in itself. The questions were therefore designed to leave the participants in control of how they wanted to answer about what happened to them.

Researchers following a positivistic research paradigm (see above) might argue that taking these measures in order to create a safe and controllable research environment carries a price on "objectivity", and might create biases in the responses of the women that cannot be scientifically controlled. However, our experience suggests that without such an environment it is not possible to have a responsible and ethically conscious way of conducting research on survivors of war rape trauma, while we believe that a research environment which creates fears and may lead to extreme emotional distress will be equally prone to producing a response bias amongst the participants.

1.2.3. We favour a systemic perspective on the consequences of war rape, informed by feminist values

War rape is not the "fate" of individual women; it has perpetrators with names and identities, and it takes place in a historical and regional context in which people hold patriarchically informed values about sexuality and virginity and believe certain myths about rape that contribute to making war rape such a powerful strategy of warfare. War rape also elicits responses from survivors' families, communities, from the larger society, and from the culture in which it takes place. In a globalised world, even the international community's reaction and its media are part of the public response. Women's reactions to their traumatic experiences, therefore, cannot be individualised and psychologised, but must be seen against this complex interplay of systemic responses; a viewpoint that feminist trauma theory has also strongly underlined (Brown, 2004). Coping with one of the most horrifying experiences of violence is thus not done on a psychic level alone; it also happens within the systems of which survivors are part: their relationships with men, with their families, with community and society. And these systems interact with survivors' responses. Therefore, while we give ample space to women's voices, we are aware that the women speak from an experience that also reflects a social and political response.

A thorough review by Campbell et al. (2009) of research concerning the "mental health outcomes of rape" similarly highlighted the fact that handling the impact of sexual violence within a Post-Traumatic Stress Disorder (PTSD) framework alone is limiting, since it risks pathologising victims rather than pointing to the structural conditions which make that violence so pervasive. The authors note the need for so-called ecologically informed trauma models of rape recovery, such as that suggested by Koss & Harvey (1991), which take the systemic nature of sexual violence into account: "Sexual assault does not occur in social and cultural isolation: we live in a rape-prone culture that propagates messages that victims are to blame for the assault, that they caused it and, indeed, deserve it. … Victims are faced with negotiating post assault help seeking

and, ultimately, their pathway to recovery within multiple hostile environments. … If victims turn to formal systems, such as the legal, medical, and mental health systems, they may face disbelief, blame, and refusals of help instead of assistance. The trauma of rape extends far beyond the actual assault, and society's response to this crime can also affect women's well-being" (p. 4).

One key advantage of such an ecological or systemic view is that it can lead to multiple strategies for intervention, since some of the factors that are usually researched in studies on (war) rape – and that will also be presented here – are not easy to modify, for example the level and intensity and the horror inherent to some of the experiences that the women went through. Additionally, psychotherapy is not the only response for changing the concrete reality of women survivors in Bosnian and Herzegovinian context, even though the right to psychotherapy is an essential political claim that we can derive from the still ongoing suffering of war rape survivors. However, societal responses can have a decisive effect on survivors' recovery, and these responses can be shaped. It is our intention to shape them with the results of this research.

1.3. The structure of the evaluation and research report

This research and evaluation report follows the four main research questions as identified in both the theoretical framework of the study (section 2) and the results (section 4). The theoretical background to the study will first present key general issues regarding how to understand and conceptualise war rape and sexual violence in the war in Bosnia and Herzegovina (2.1.), after which we will highlight important research results related to the aftermath of war rape, namely the multiple consequences of war rape on the lives of survivors (2.2.). Section 2.3. will present theoretical background information on what research tells us with respect to social acknowledgement, both in general and specifically for Bosnia and Herzegovina, while 2.4. will explore factors and strategies of coping and resilience-building in survivors of war rape trauma. Finally, 2.5. offers theoretical background information on what helps survivors of war rape in their recovery, both in general and in the light of experiences from the psychosocial assistance provided to Bosnia and Herzegovina and Croatia.

Chapter 3 will highlight the complex methodology of the study, and then describe the main research strategies, instruments and characteristics of the participants in both the quantitative first part of the study (with 51 survivors) and the qualitative life-story methodology (with 7 survivors).

Chapter 4 presents the results of the research and evaluation, again following the four research questions. Results will be presented for each of these questions in turn, using the following format: we will first analyse data from the quantitative study, along with additional information from other relevant sources. We will then present the results from the life stories, and finish by outlining the conclusions that we draw for each research question.

The fifth and final chapter presents the recommendations that we have derived from the results of the study.

Those survivors who used *Medica Zenica's* services and who participated in this research will be called "participants" in this report.

2. THE THEORETICAL FRAMEWORK OF THE STUDY

2.1. War rape and sexual violence in the war in Bosnia and Herzegovina

The war in Bosnia and Herzegovina was one of the most devastating wars in Europe since the end of the Second World War. Bosnia and Herzegovina had a population of approximately 4.3 million people before the war. It is estimated that between 100,000 and 250,000 people, mostly Bosnian Muslims, died between 1992 and 1995 (Rosner & Powell, 2006; Oskam, 2009). Thousands were cruelly held captives in concentration camps, and killed in massacres throughout Bosnia and Herzegovina; the worst being the mass execution of Bosnian Muslim men and boys from Srebrenica on 11th July 1995, which the International Criminal Tribunal for the former Yugoslavia has declared to constitute genocide. The World Bank estimates that about 60% of all houses, half of all schools and a third of the hospitals were damaged or destroyed (World Bank 2004, quoted in Ringdal et al., 2008). Approximately 2.2 million people were displaced (Ringdal et al., 2008), of whom around 1,200,000 became refugees in about 100 countries worldwide (Rosner & Powell, 2006).

In this report, however, we want to focus on one feature of the war which forms the core of our research and has been at the heart of our work for over two decades: war rape and sexual violence.

An estimated 20,000 to 50,000 women and girls from Bosnia and Herzegovina were raped during the war. As early as 1992, a number of reports were published on war rapes in Bosnia and Herzegovina by both journalists and human rights organisations such as Amnesty International and Helsinki Watch, and also by the EU Fact Finding mission of December 1992. While various reports have established that rape took place on all sides of the conflict, by far the largest group of victims were clearly Bosnian Muslim women and girls, while the largest group of perpetrators were Bosnian Serbs.

Although written in some haste twenty years ago, the Final Report of the Commission of Experts[5] still presents the most authoritative and comprehensive investigation of sexual violence during the war in former Yugoslavia. After screening "tens of thousands of allegations of rape and sexual assault", the Commission suggested five different patterns as a first categorisation, regardless of the ethnicity of the perpetrator or the victims (Final report of the United Nations Commission of Experts established pursuant to security council resolution 780 (1992), S/1994/674/Add.2 (Vol. V) 28 December 1994, Annex IX, p.6f.):

a) The first pattern occurs before any widespread or generalized fighting breaks out in a region. This type of rape and sexual assault is accompanied by looting, intimidation, and beatings. Tensions in an area grow, and members of the ethnic group controlling the regional government begin to terrorize their neighbours by intimidation, looting and beatings (…). Some of the reported rapes and sexual assaults are singular and

[5] The Expert Commission, also called the "Bassiouni Commission", prepared its findings in 1993/94 for the International Criminal Tribunal for the former Yugoslavia.

some are multiple. In either case, there is often a gang atmosphere where all the abuses are part of the same event, and all the attackers participate in the event, even if they do not sexually assault the victims. (…)

b) The second pattern of rape and sexual assault occurs in conjunction with widespread or generalized fighting. When forces attack a town or village, the population is gathered and divided by sex and age. Some women are raped and sexually assaulted in their homes as the attacking forces secure the area. Others are selected after the roundup and are then raped and sexually assaulted publicly. The population of the village is then transported to camps.

c) The third pattern of rape and sexual assault occurs in sites of detention or other «collection centres» for refugees. After the population is rounded up in a town or village, men and women are separated. (…) In these custodial situations, soldiers, camp guards, paramilitaries, and even civilians are allowed to enter the camp, pick out women, take them away, rape and sexually assault them, and then either kill them or return them to the site. There is a significant amount of gang-rape and sexual assault reported in this context, and beatings and torture accompany most of the reported rapes and sexual assaults. Survivors report that some women are taken out alone, and some are taken out in groups. The women who are not killed are eventually exchanged. (…) The sexual assault of men in these camps is generally public (…).

d) The fourth pattern of rape and sexual assault occurs in specific types of sites of detention. Survivors of some camps report that they believe that they were detained for the purpose of rape and sexual assault. In these sites, all of the women are raped and sexually assaulted, the raping is quite frequent, and it is often committed in front of other internees. In this context as well, beating and torture accompany rape and sexual assault. Often, the captors state that they are trying to impregnate the women, pregnant women are treated better than their non-pregnant counterparts, and pregnant women are detained until it is too late in the pregnancy to obtain an abortion.

e) The last pattern of rape and sexual assault is detention for the purpose of providing sex. Women are collected from their homes and from camps and taken to hotels or similar facilities where they serve to provide sexual gratification for the armed forces. The women kept in these sites are reportedly killed more often than they are exchanged, unlike the female population in most camps. Additionally, unlike camp detention, the motive for detention of these women seems not to be to cause some reaction in the women detained, but instead to provide sexual services to men.

The Commission concluded that the patterns of rape "suggest that a systematic rape policy existed in certain areas, but it remains to be proven whether such an overall policy existed which was to apply to all non-Serbs" (Annex IX, p. 56).

The International Criminal Tribunal for the former Yugoslavia (ICTY) was founded in May 1993, and its first Chief Prosecutor Richard Goldstone clearly stated that it was his intention to enshrine sexual violence in existing international law. Despite many shortcomings and limitations (see medica mondiale, 2009), it must be acknowledged that the ICTY was the first International Criminal Tribunal to enter convictions for rape as a form of torture and for sexual enslavement as a crime against humanity. The ICTY was also the first International Tribunal based in Europe that passed convictions for rape as a crime against humanity, following a previous case adjudicated by the International Criminal Tribunal for Rwanda.

To date, a number of judgements before the International Criminal Court for the former Yugoslavia (ICTY) and the War Crimes Chamber have confirmed the widespread character and the different patterns of sexual violence during the war, and the organised manner by which sexual violence occurred in the context of forceful expulsion of large parts of the population, particularly Muslims, from their homes and lands. However, it is also safe to say that these judgements represent only a small percentage of the many different forms, patterns and brutal modes of sexual violence used during this war, and there is yet to be a thorough and comprehensive historical research analysing different patterns of sexual violence in different regions, at different times, with different perpetrators, and in different war situations.

Members of both *Medica Zenica* and *medica mondiale* listened to hundreds of stories in which women described their impression of the organised and systematic character of the ways rape and sexual assaults were committed. At the same time, there are also numerous stories of so-called opportunistic rapes, including gang-rapes over a period of time, which were in no way less brutal and had equally traumatic consequences for the survivors. Even the Expert Commission found in their Report that the largest numbers of killings of women and young girls had taken place in so-called "bordellos", that is in detention sites in which women and girls were held to provide sexual services to soldiers and militia men. ICTY's famous "Foca Trial", i.e. the trial against Kunarac et al. that dealt exclusively with rape and sexual enslavement, also threw light on the particular experiences of young girls who were trafficked and sold from one soldier to another.

In many court testimonies women describe how individual perpetrators created situations that are very similar to situations of domestic violence. When we want to understand the widespread character of rapes in this or in other wars, it is not sufficient to focus solely on the possible military strategic character of sexual violence. We also need to analyse the gendered and cultural norms of sexuality and aggression which prompt so many men to obviously enjoy their power to subdue women and female bodies.

We intend to contextualise survivors' suffering and state that, based on reports and particularly on personal testimonies of the survivors with whom we have worked, rape in Bosnia and Herzegovina took place at the intersection of both ethnic-based AND gender-based violence. It thereby creates its own characteristics in the narratives of the survivors and how they try to comprehend the extreme violence they went through.

However, as much as we see the need to recognise that there might be differences regarding the context and symbolic meaning that rape has in a particular historical context – with the context of Bosnia and Herzegovina being our point of reference in this study – we do not intend to create a "hierarchy" of suffering of rape survivors and lose sight of what is common in all rapes: no matter whether they happen in war or in civilian life, whether they occur as a strategy of ethnic cleansing or whether they are perpetrated by civilians in a context of impunity or within marital relationships: Rape is about patriarchy, about the power of men over women in its most physically invasive and destructive form. Patriarchal oppression existed before wars and genocides – and, as Blagojevic proved in the case of the former Yugoslavia (quoted in Seifert, 2001), often aggravates pre-war scenarios of gendered violence. Systematic war rape is only one feature of the way that patriarchal oppression is exacerbated during conflicts. This oppression continues in the form of rape and sexual violence and other forms of direct and structural violence against women after the war, when the actual killing is over, but impunity and militarized gender images continue to exist (Cockburn, 2001).

In her 1993 article relating to war rape in Bosnia and Herzegovina, Rhonda Copelon calls for a re-conceptualisation of crimes against women in time of war which makes gender manifest – and from a feminist perspective, we could add the need to make patriarchal oppression visible. She suggests avoiding any dualistic thinking, stating that: "We must critically examine the claim that rape as a tool of 'ethnic cleansing' is unique, worse than or not comparable to other forms of rape in war or in peace, at the same time as we recognize rape together with genocide inflicts multiple, intersectional harms. This combination of the particular and the general is critical if the horrors experienced by women in Bosnia are to be appreciated and if that experience is to have meaning for women brutalized in less-known theatres of war or in the byways of daily life" (Copelon, 1993, p. 199).

2.2. The aftermath of war rape: the multiple consequences of war rape on the lives of survivors – theoretical background to research question 1

"The politics of rape do not cease when the guns grow cold. The politics of rape may look different, less visible, less outrageous, but they still continue to play themselves out. This is because the politics of rape do not end when the assault itself ends; they do not end when the woman, if she has survived, that woman sees herself in part as a rape survivor, as long as others… see her through the lens of rape; they extend for as long as the power relations between this woman and others are in any way shaped by their respective ideas about men as rapists and women as potential and actual rape victims. […] After the war the politics of rape likely will be played out in such a way that some women will be rewarded for staying silent; others, perhaps, will find themselves in post-war situations in which they will be rewarded for telling their stories – or for telling only sanitized versions of their full stories." (Enloe, 1994, p. 228)

2.2.1. Introductory comments: the paucity of scientific research on the consequences of war rape

Although reports show that rape has been used extensively as a war strategy in many conflicts (Brownmiller, 1975; Mischkowski, 2005; Cohen et al., 2013), there has been little systematic scientific research about its psychosocial effects on rape survivors[6], and even fewer studies on its long-term consequences (Kuwert et. al., 2010).

Similarly, only very few scientific studies have dealt with the *specific* consequences of war rape in Bosnia and Herzegovina. Kozaric-Kovacic et al. (1995) conducted research in 1993 with rape survivors, while Loncar et al. (2006) assessed survivors of war rape from both Bosnia and Herzegovina and Croatia approximately one year after their experience (i.e. between 1993 and 1996). No systematic study on the *specific* consequences of war rape has been undertaken in Bosnia and Herzegovina since then.

This paucity of specialised studies on the psychological consequences of war rape and sexual violence is partly due to the subject matter, since survivors are understandably

[6] This seems, however, to be gradually changing with respect to the rampant war rape and sexual violence in the DR Congo, where a growing body of literature is reflecting on and studying the effects of sexual violence in this area. See e.g. Steiner et al. (2009); Kelly et al. (2011); Hustache et al. (2009).

reluctant to participate openly in research after having been intentionally and strategically subjected to such massive shame and humiliation. More "general" studies on the psychosocial consequences of war on women in Bosnia and Herzegovina (e.g. Agger & Mimica, 1996) have revealed that respondents were more willing to report that they had "witnessed" others being raped, but it is likely that a substantial proportion of these women were in fact choosing to identify themselves as witnesses rather than survivors. It is therefore difficult to assess the specific impact that war rape has on survivors.

While our research focused on a sample of survivors who sought help from *Medica Zenica,* questions about how those women who never seek help feel about and cope with their experiences remain unanswered, which limits the applicability of the results of studies in this area. As Joachim (2005) rightly said in the context of war rape survivors in Kosovo, which can easily be transferred to that of Bosnia and Herzegovina: "We know nothing about the extent of suffering of those women and girls who cannot or do not wish to look for help and lock up their experiences inside themselves. For that reason academic study of the psychological consequences of sexualised violence in war is also limited to the small proportion of survivors who seek some form of help and are prepared to take part in studies and evaluations" (p. 79).

To gain an overview on the current state of scientific research regarding our field of study, we will examine the results of two strands of research that play a role in war rape: the psychosocial consequences of WAR and its multiple forms of traumatisation, and RAPE in both conflict and non-conflict settings.

Epidemiological research and meta-analyses suggest that both war and sexual violence are amongst the most destructive of stressors, and lead to the highest prevalence of post-traumatic disorder (Perkonigg & Wittchen, 1999; Kessler et al., 1995). One can therefore assume that the accumulation of extreme traumatisation – namely undergoing multiple experiences of severe war trauma AND rape and sexual violence as one specific war-related experience – will lead to a significantly high proportion of survivors suffering from post-traumatic problems. In other words: survivors of war rape not only have to deal with one of the most debilitating traumatising experiences, but also undergo other equally devastating experiences such as the death of loved ones, extreme fear, losing their homes, expulsion, etc. Folnegovic-Smalc (1994), based on her psychiatric experience with survivors of war rape in Croatia, clearly describes that the accumulation of other traumatic experiences – in addition to rape and sexual violence – leads to more pronounced symptoms of PTSD in survivors: "In nearly all our patients, the rape is part of a many-layered trauma whose other components may include a stay in a camp, the loss of one or several beloved people, separation from family members, the loss of a home, physical abuse, insults, death threats to the victim or her family, the loss of material goods, and so forth" (p. 177).

While looking at war and sexual violence from a mental health perspective and connecting it to PTSD and other psychiatric disorders, we remain conscious of the continuous and critical debate on PTSD and the justified question as to whether it is appropriate to use psychological diagnostic tools to describe profoundly structural women's rights violations and serious crimes against humanity. It is our wish to keep the survivors of war rape firmly in the centre of our reflections during our analysis of their mental health status, without "de-politicising" and "medicalising" (Bracken et al., 1995; Summerfield, 1999) the suffering caused by concrete historical events and perpetrators.

2.2.2. War and its multiple traumatisation

2.2.2.1. Impact of war experiences on the mental health of its survivors: international experiences and the specific case of Bosnia and Herzegovina

A variety of studies from various regional and historical contexts have identified war as one of the most destructive stressors, and many people who survive war develop post-traumatic problems and disorders of various range and intensity (e.g. Kuwert et al., 2007; de Jong et al., 2001).[7]

The study "Psychological consequences of war trauma and post-war social stressors in Women in Bosnia and Herzegovina" (Klaric et al., 2007) seems particularly useful for establishing the direct impact of exposure to war experiences on mental health. This study compared women from Western Mostar who had been directly exposed to war for four years with a "control group" of women from urban areas in Western Herzegovina who had also experienced war, but had not been directly exposed to war destruction, and analysed their mental health ten years after the war ended. The results of this study showed that even after ten years, women who were directly exposed to long-term and extreme war experiences suffered significantly more serious post-traumatic and general psychological symptoms, with 28.3% of the West Mostar group meeting the criteria for a full PTSD diagnosis, compared to 4.4% of the control group, while a further 7.5% of the highly-affected group showed some posttraumatic symptoms, thus qualifying as having partial PTSD.

In addition to PTSD, the West Mostar group also displayed significantly more general symptoms (such as somatization, depression, anxiety, hostility, obsessive-compulsive symptoms, interpersonal sensitivity, phobic anxiety, paranoid ideation, and psychoticism), and these symptoms were more intense than those of the control group. The latter observation clearly underlines the indication found in many other studies on the after-effects of traumatic experience, namely that PTSD is just ONE psychological consequence of such traumatic events, and is usually accompanied by a number of comorbid disorders, especially depression, somatization and other anxiety disorders. In the context of war, comorbidities especially occur when particularly stressful events are also present, such as the traumatic loss of a loved one or a life-threatening situation (e.g. Momartin et al., 2004).[8]

The prevalence of mental health disorders related to posttraumatic reactions differs greatly across all research in the field. According to Rosner et al. (2003), this is due to different diagnostic criteria, methodological differences in assessing the presence

[7] While it is nowadays a matter of common sense that war has a negative impact on the mental health of survivors, this has not always been the consensus in psychology. Rosner (2003) reports that while earlier psychological studies on war did not find any increase in psychopathology during and after war and armed conflict, most recent studies clearly indicate increased psychological distress and psychopathology during and shortly after war.

[8] Given the variety of symptoms following extreme traumatisation – and rape can undoubtedly be counted as such – various authors and trauma specialists have suggested widening the diagnostic spectrum and introducing diagnoses such as "complex PTSD" (Herman,1992), or DESNOS – the "Disorder of Extreme Stress not otherwise specified" (e.g. Courtois, 2004). The complexity of posttraumatic reactions, particularly given multiple war trauma and rape, often goes beyond a "simple" PTSD diagnosis. However, according to Joachim (2005), in the case of rape, even the concepts of complex PTSD and DESNOS would not cover all the specific symptoms suffered by survivors of sexualised violence in war. It is therefore more important to draw attention to the frequent comorbidities suffered by these survivors, and to explain these comorbidities within the context of their extreme traumatisation.

of mental health disorders, and differences regarding the social and war context. In their study of PTSD three years after the siege of Sarajevo, Rosner et al. (2003) found that 18.6% of respondents in a group of randomly selected residents of the city of Sarajevo were suffering from PTSD; 32.7% of a group in medical treatment could be diagnosed with PTSD; and 38.6% of those in psychological treatment. Women showed a significantly higher risk of developing PTSD than men, which is in accordance with international literature (Kimerling et al., 2002).

Powell (2011) summarises research amongst eight different samples of citizens from Bosnia and Herzegovina who were assessed in 1998 and 1999 and found that the prevalence of PTSD in non-treatment samples ranged from 11% amongst returned refugees[9] to 36% amongst Internally Displaced Persons (IDPs). In addition to PTSD, somatisation, paranoid ideation and aggression were particularly prevalent in the samples. High scores on somatisation were equally found in samples from other war-affected research with citizens from Bosnia and Herzegovina (Klaric et al., 2007; see Powell, 2011 for a summary).

Rosner et al. (2002) compared results from different studies within Bosnia and Herzegovina from two to three years after the end of the war, and concluded that prevalence rates of PTSD vary from 18 to 53%. However, much higher prevalence rates have been established by other studies in Bosnia and Herzegovina; for instance, Bell et al. (2002), quoted in Rosner (2003), showed an extraordinary prevalence of PTSD that reached 85% amongst women who survived Srebrenica. This high prevalence of PTSD amongst survivors of Srebrenica in comparison to other places in Bosnia and Herzegovina was also reported in the study by Hasanovic (2012), who conducted research on 3 different groups of internally displaced and refugee adolescents 3.5 years after the war (in 1999). He found significant statistical differences with regard to the prevalence of PTSD, namely in Srebrenica, where 73.9% of the adolescents were found to suffer from PTSD, while in Zvornik the rate was at 60.8% and in Bijeljina at 47.6%.

In a study conducted by the University Clinical Centre of Tuzla, Avidbegovic et al. (2008) state that the number of traumatised persons seeking help clearly increased after the war. 72.5% of their outpatients were diagnosed with PTSD, in comorbidity with other mental disorders, and 62.5% of their hospitalised patients.

All existing studies on Bosnia and Herzegovina – the most recent of which was conducted in 2005 – indicate that even long after the war was over there are still a substantial number of people there suffering from various degrees of war-related distress (Ringdal et al., 2008; Klaric et al., 2007; Hasanovic, et al., 2005).

[9] Interestingly, PTSD prevalence rates amongst returned refugees are clearly lower than those of refugees who stayed in their host countries and, in the case of Powell's research, lower than all known reports in refugee samples abroad. Powell argues that this could be due to selection effects such as reporting the results for treatment groups and / or different kinds of response bias might have produced a substantial overestimation of current PTSD in refugee samples abroad. However, very high rates of PTSD amongst refugees in resettlement countries have also been reported in other studies: Craig et al. (2008) found a prevalence rate of 67% of Bosnian refugees in the US suffering from PTSD. A similarly high rate of PTSD amongst refugees in the Chicago area – namely 75% – were found in a longitudinal study by Weine et al. (1998).

2.2.2.2. The impact of post-war stressors on mental health: When "war is not over with the last bullet"[10]

As already stated, the concept of "Post-Traumatic Stress Disorder" to describe the effects of traumatic experiences has been widely criticised. One such criticism has been that it does not sufficiently explain the complex long-term processes of traumatisation and recovery once the actual traumatic event is over. Practitioners in the field have begun using a concept called "sequential traumatisation", which was devel-oped by Keilson (1992) in his study on Jewish war orphans in the Netherlands. This concept suggests that there are always three sequences in traumatisation processes, namely the phase prior to the actual traumatic event, the phase of direct traumatisation (e.g. war), and the phase after. It is within the interaction of these three phases – or sequences – that individuals create their potential for recovery. Joachim (2005, referring to Hauser & Joachim, 2003) relates this concept to war rape and sexual violence in Kosovo and points out that "[s]urvivors of sexualised violence in war are almost always in a situation in which their traumatisation process continues in the post-war period and in exile, too" (p. 103).

Post-war stressors therefore increase the traumatic impact of war experiences: Klaric et al.'s 2007 study (quoted above) on the psychological consequences of war trauma and post-war social stressors in women in Bosnia and Herzegovina found that everyday post-war stressors were associated with posttraumatic and general psychological symptoms in both groups (those more affected and those less affected): "The number of recent stressful life events, such as changes in social, working, and economic conditions, in health and behavior of a family member, or separation from family or family breakdown contributed to the intensity of posttraumatic symptoms and the number of general psychological symptoms, possibly by exhausting the remaining coping resources and reducing the feeling of social support" (p. 173f.).

The role that post-war stressors play in the recovery of war-traumatised people – particularly through exacerbating existing symptomatology – has also been underlined by other studies in Bosnia and Herzegovina (Powell & Durakovic-Belko, 2002). For instance, Kleck (2006) conducted a research on women who were expelled from their home villages during the war and found refuge in Tuzla; the respondents showed a significant increase of posttraumatic symptoms between 2002 and 2004. The author relates this to the increasing poverty, being retraumatised through being evicted from their new homes, problems with returning to their original homes, and general increases in domestic violence. Kleck (2006) also found that the commonly-established and well-researched correlation between the number of war events experienced and developing PTSD was weaker in her sample than expected, which supports the hypothesis that current stressors and their importance for existing psychological problems might override this relationship and thus be more significant for a person's mental health status than (only) the number and severity of traumatic events.[11]

[10] This is the title of a report published by Kvinna til Kvinna.

[11] This connection between post-war stress and ongoing trauma was similarly underlined in a study conducted in Afghanistan (Lopes Cardozo et al., 2004), where the authors "did not… find a signifi-

This confirms the belief that typical features of post-war societies such as unemployment, poverty, family problems, broken-down state structures, impunity, etc. pose another serious threat to the mental health of survivors and can even exacerbate post-traumatic reactions. As Mollica (2000) states in an article on "invisible wounds" in Bosnia and Herzegovina, although only a small percentage of survivors of mass violence suffer serious mental illnesses that require acute psychiatric care, the vast majority actually experience low-grade but long-lasting mental health problems, including signs of demoralisation, lack of trust and both physical and mental exhaustion (quoted in Nelson, 2003).

2.2.3. Rape and its consequences for the survivors

We will now approach the second relevant stream of research that contributes to understanding the consequences of war rape on survivors: that which concerns rape.

As already mentioned and proven according to various meta-studies on PTSD prevalence, rape is considered the most noxious of traumatic events. In the following sections, we will explore the field of research on both the mental and physical health consequences of rape in general and of war rape in particular for survivors of this extreme form of traumatisation.

2.2.3.1. What makes rape such a destructive experience? Psychological dynamics and their meaning for survivors

Rape means destruction. Joachim (2005) argues that rape needs to be understood as "the simultaneous transgression of intimate physical and psychological borders; this leads the women and girls to experience the violence they have suffered almost as a destruction of their identity." (p. 66). Seifert describes rape as "a violent invasion into the interior of one's body [that] represents the most severe attack imaginable upon the intimate self and the dignity of a human being: by any measure it is a mark of severe torture" (Seifert, 1994, p .55).

How can the immense destruction inherent to rape be understood from a psychological point of view? Koss & Burkhart (1989) point to two of the most critical factors that make rape such a distinct traumatic experience, namely the interpersonal nature of sexual violence and the pervasive, malevolent social context of rape. "Directed, focused, intentional harm involving the most intimate interpersonal act – that is the nature of rape. Because rape is fundamentally an interpersonal act, victims have to resolve the most central identity questions, 'What will people mean to me and what do I mean to others?'" (p. 31).

Feldmann (1992) similarly describes various core psychological dynamics connected to a survivor's sense of identity that may produce profound changes in them: Rape represents the gravest disrespect of the personal self and self-determination of a woman,

cant association between trauma events and symptom criteria for PTSD in this survey as was found in these other studies. This is surprising in view of the high prevalence of both PTSD symptoms as well as having experienced multiple trauma events. Extreme poverty and concerns for day-to-day survival caused by economic hardship commonly causes stress. In Afghanistan socioeconomic factors may have been more important risk factors than traumatic events for PTSD" (p. 583).

a deliberate humiliation and dehumanisation of the victim that may lead to a crisis of self-worth, often exacerbated by stigmatisation from others. As opposed to other forms of interpersonal violence, rape is characterised by the forced intrusion of a perpetrator into a woman's body. Such a serious violation of self-demarcation and identity is connected with a fear of total annihilation, no matter whether the perpetrator has an intention to kill his victim or not. Rape must furthermore be understood as an act of total loss of control and powerlessness whose dynamics continue to exist and even to generalise to other areas of life in the form of survivors' frequently reported perceived lack of competence, and symptoms of resignation and depression, even long after the rape experience is over. In other words, the massive experience of total loss of control and helplessness vis-à-vis the aggressor can later be felt in other areas of life and lead to a general loss of self-efficacy of survivors. Additionally, rape takes place in that genital space of the body specifically connoted with menstruation, conception, pregnancy and delivery; all areas that are highly significant for women's sense of femininity and identity. And we could add: to that part of women's vital energy which is ingrained in her sexuality.

2.2.3.2. The multiple impact of rape on the mental health of survivors

Sexual violence in general (particularly in respect of childhood sexual assault, although that will not be examined here, since it represents a specific traumatic experience), is a highly pathogenic stressor which produces a range of psychological problems and disorders and a high life-time prevalence of PTSD: meta-analyses suggest that between 50 and 65% (Chivers-Wilson, 2006; Perkonigg & Wittchen, 1999; Kessler et al., 1995), and even up to 80% of survivors (Breslau et al., 1991) suffer from PTSD in their lifetime.

Rape trauma often leads to comorbidities with other mental health disorders and to different psychotraumatic syndromes (Darves-Bornoz, 1996).

An extensive review by Campbell et al. (2009) on research into the impact of sexual assault on women's mental health since the 1990s confirmed that sexual assault is highly detrimental to women's mental health: apart from PTSD, the authors found the following prevalence rates in the different studies on mental health outcomes of rape survivors: 13 to 51% of sexually assaulted women meet the diagnostic criteria for depression; 73 to 82% develop fear and / or anxiety, while 12 to 40% experience generalised anxiety; between 13 and 49% of survivors develop an alcohol addiction, with 28 to 61% using other illicit substances. According to the studies that the authors reviewed, between 23 and 44% report suicidal ideation, with 2 to 19% attempting suicide.

Studies show that survivors of sexual violence also suffer from eating disorders (Laws & Golding, 1996), problems with sleep and nightmares as well as health and somatic problems (Clum et al., 2001), and problems with work and social functioning (e.g. Resick et al., 1981). Drug use is reported, particularly the use of sedatives, tranquilisers and antidepressants as a means of coping with the effects of rape, suggesting the self-medication effects of these psychopharmacological drugs (Sturza & Campbell, 2005).

2.2.3.3. Physical health and rape

Rape has also detrimental effects on survivors' physical health. The consequences of rape on physical health can exacerbate their mental health, since physical problems can function as a constant reminder of the experience, reinforcing the sense of destruction (Joachim, 2005). Thus, physical consequences go beyond merely the direct results of "injuries" or "infections" alone.

Studies on rape survivors from "civilian" settings quote a number of typical signs associated with rape and sexual violence, e.g. gastrointestinal, sexual and reproductive health problems, pain syndromes and eating disorders (Astbury, 2006), as well as pelvic pain, irritable bowel syndrome, chronic diseases such as diabetes, arthritis and headaches (Stein & Barrett-Connor, 2000). Sexually transmitted diseases and particularly the risk of HIV infection are mentioned as physical consequences of rape (Astbury, 2006), as well as unwanted pregnancies. Gynaecological problems such as dysmenorrhea or menorrhagia are also commonly reported (Stein & Barrett-Connor, 2000). While research results on an existing causal relationship between (posttraumatic) stress and cancer are not yet scientifically proven, O'Neill et al. (2013) found an association between a number of mental disorders and the likelihood of reporting a cancer diagnosis following the onset of the mental disorder. The science of psychoneuroimmunology clearly underlines the existence of strong interactions between psychological processes and the nervous and immune systems of the human body.

Sexual problems following rape and sexual violence have been frequently reported. In one analysis of studies (all of which were conducted in non-conflict settings and mostly in the US and Europe) regarding "Problems with sexuality after sexual assault", Van Berlo & Ensink (2000) concluded that although the studies reviewed varied considerably, they showed that the frequency of sexual contact decreases significantly after sexual assaults. For a considerable number of survivors, satisfaction and pleasure in sexual activities also declined for at least one year after the experience of sexual violence. According to the authors, several of the studies under review showed that some survivors develop sexual problems that can persist for many years after the assault. According to Van Berlo & Ensink (2000), certain emotions that are felt during and immediately after the assault, such as anger towards the self, shame, and guilt, can be considered as risk factors for developing more severe and long-lasting sexual problems.

2.2.3.4. Research on war rape with particular focus on war rape in Bosnia and Herzegovina and Croatia

To allow a more systematic comparison between our results and other studies on war rape, particularly those in the context of Bosnia and Herzegovina, we will now present the few studies that exist to date on this subject. In a study conducted on the psychological consequences of rape one year after their experience with 68 rape survivors from Croatia and Bosnia and Herzegovina, Loncar et al. (2006) found that 52 (i.e. **76%**) suffered from **depression**, 51 (i.e. **75%**) from **social phobia** and 21 (i.e. **31%**) from **PTSD**, while 17 (i.e. **25%**) had **sexual dysfunctions**.[12] The authors mention that these disorders were often comorbid with each other.

[12] Sexual problems seem to also be an issue for family members where they had to witness the rapes: Folnegovic-Smalc (1994), in an early article on psychiatric aspects of the rapes in Bosnia and Herzegovina and Croatia, describes that from her clinical experience, all patients who have been primary or secondary victims of sexual violence (i.e. those who have witnessed the rapes of others, particularly relatives) suffer from a strong aversion to sexuality.

Kozaric-Kovacic et al. (1995) conducted a study in 1993 with 25 women refugees from Bosnia and Herzegovina and Croatia who were admitted to the Zagreb Obstetrics and Gynaecological Clinic or associated regional psychiatric centres. They found that all the women exhibited signs of depersonalisation which can be understood as part of the acute reaction to rape, as first described by Burgess & Holmstrom (1974). The women who had been made pregnant through rape came to the psychotherapist either for the psychiatric approval necessary for a legal abortion, for support during their pregnancy, or in one case for the treatment of acute psychiatric symptoms. The authors describe the sense of elation when they delivered the children, which was in sharp contrast to the symptoms of depression and anxiety during their pregnancy.

Findings on war rape in other contexts show marked similarities. E.g. documentation from case studies of *medica mondiale's* project experiences in Albania, Bosnia and Herzegovina and Kosova showed the following common consequences: injuries that included rectal and genital injuries, including bladder and rectum insufficiency and fistulisation; venereal diseases with both acute and long-term and / or chronic consequences, as well as infectious gynaecological processes.

Rape in the context of war may also lead to hormonal dysfunctions, resulting in increased, extremely lengthy and excessive menstruation or even amenorrhoea. Pain during sexual intercourse, chronic pelvic pains, high risk and conflictual pregnancies are often reported, as well as increased reproductive health problems, and even infertility. Health personnel dealing with survivors of war rape have also noted increased pre-cancerous and / or cervical carcinoma, carcinoma of the inner genitals, and breast cancer (Bittenbinder, 1999; Hauser & Griese, 2005; Joachim, 2005; Frljak et al., 1997).

The number and intensity of psychological and physical problems mentioned in both civilian and war rape contexts thus do not seem to differ substantially in the existing literature. However, there might be one particularity with war rape: in war, public service structures and especially medical services usually break down and people have to flee or hide in order not to be killed or taken hostage, so their wounds and injuries and medical problems are often left untreated immediately after the brutalities. This delay might increase the risk of complications and infections that again reinforce the level of future physical health impairment.

2.2.4. The long-term consequences of extreme trauma: Does time heal?

2.2.4.1. Longitudinal aspects for the recovery from trauma in general

General research, as shown in a meta-study conducted in the US by Kessler et al. (1995), suggests that only 20% of traumatised people will have improved psychologically within three years of the initial traumatic experience. Rosner et al. (2003) note that "[a]s these estimates are based on a US American sample, one can assume that the proportion of those improving under the difficult life conditions of the postwar society studied is smaller. In summary, the necessity of treatment for PTSD will exist for a long time in this [sc. Bosnian] society" (p. 52).

There is actually clear evidence that many who suffer from PTSD do not go into remission (Perkonigg et al. 2005; Solomon & Mikulincer, 2006). On the contrary, there is also the possibility of a delayed onset (Andrews et al., 2007; Yehuda et al., 2009).

However, one must acknowledge that research literature regarding the long-term courses and trajectories of PTSD over decades is divergent: Some studies emphasise that PTSD symptoms often diminish over time as people get older (e.g. Zeiss & Dickman, 1989; Fontana & Rosenheck, 1994), and that the percentage of subjects meeting the criteria for PTSD are lower 40 and 50 years after exposure (e.g. Kluznik et al., 1986; Tennant et al., 1997). However, other longitudinal studies highlight the persistence or even exacerbation of PTSD in older people, particularly in Holocaust survivors (e.g. Port et al., 2001; Trappler et al., 2007; Barak et al., 2005).

In a 20-year longitudinal study on Israeli war veterans, respondents were assessed 1, 2, 3 and 17 years after their war experience. While PTSD rates dropped 3 years after the war, they rose again 17 years later in both study groups (Solomon & Mikulincer, 2006). 23% of veterans who did not have a combat stress reaction reported a delayed onset of PTSD. The way that the authors explain this rise is interesting for the context of our study: Whereas the drop in symptoms might be associated with the common-sense wisdom that "time heals", the increase in posttraumatic symptoms 20 years after the war might be an interplay between different factors: "The chronic nature of PTSD renders trauma victims vulnerable for life, and midlife is a particularly high-risk period for either delayed onset or reactivated PTSD. Midlife generally entails some reduction in activity and a shift from planning to reminiscence and from occupation with current events to the review and rethinking of one's life. In the course of this transition, the altered perspective may force the forgotten or suppressed traumatic memories up to the foreground again […] In addition, aging inevitably entails many losses and exit events, from retirement through disease. Such painful events entail loss of structure, routine, self-esteem, status and social interaction and bring down some of the protective shields that trauma survivors have against being flooded by memories" (p. 664). Solomon and Mikulincer (2006) summarise these findings by formulating a call for professional attention to be given to aging individuals who were severely traumatised in their youth.

2.2.4.2. Specific longitudinal aspects of the trauma of (war) rape

Longitudinal studies on the consequences of rape report that most women who recover after a rape experience usually do so within the first 3-6 months; those who do not recover within this period seem to suffer for a longer time with chronified symptoms (Koss & Burkhart, 1989; Harvey & Herman, 1992), particularly in the form of phobias, depression, nonspecific body complaints, mistrust, problems with interpersonal contact, and problems with sexuality (Feldmann, 1992).

Hardly any scientific research has been done on the *long-term* consequences of war rape. One of those very rare studies was authored by Kuwert et al. (2010), who conducted research on women who survived war rape during the Second World War more than 60 years after the war. The researchers found that amongst the 27 women recruited as participants, 19% still reported significant current posttraumatic stress symptoms, indicating a Posttraumatic Stress Disorder at the time of the study. 30% fulfilled the criteria of a current partial Posttraumatic Stress Disorder, and 81% of the women reported a significant impairment in sexuality across their whole lifetime. Since there was no baseline done on this group of survivors at any previous point in their life, it is evidently not possible to know the extent to which their PTSD might have changed over time. The study clearly indicates that for many survivors of war rape trauma, time leads to permanent negative consequences rather than healing their suffering.

2.2.4.3. Looking at the next generation: aspects of transgenerational transmission of trauma

Another longitudinal aspect of trauma that is worthwhile considering in the context of our research and evaluation project is the systemic impact of war rape and its consequences for the generation of the survivors' children – not necessarily on the children born of rape (which constitutes a particular aspect of war trauma), but the children of survivors in general.

Transgenerational transmission of trauma has developed as a concept mostly in relation to research on survivors of the Shoah and the second (and third) generations after them (Danieli, 1998). Most literature has been developed from the work of therapists, and thus deals with a clinical population. More representative research with non-clinical populations has not shown significant differences between children of survivors of the Shoah compared to other children who live under similar circumstances of parents with psychological problems. However, the experience of being a child of a Shoah survivor seems to create a certain vulnerability to posttraumatic stress: A study by Solomon (1995) showed that in a group of Israeli soldiers with PTSD, those who were children of survivors developed significantly more and more chronic symptoms in comparison to children of non-survivors. In addition, the symptoms of the children of non-survivors declined within three years of the traumatic exposure, whereas the children of Shoah survivors suffered beyond three years, even though they were healthy by the time they entered the military (Solomon, 1995).

Children of Shoah survivors who actually sought therapeutic help were typically reported to suffer from depression, apathy and feelings of guilt. Parent-child relationships in survivors' families were often described as emotionally cool, but at the same time over-protective. Feelings of guilt from the children's side were regularly connected with separation and becoming independent because this was perceived by the parents as something ultimately threatening due to the many losses that they had suffered in concentration camps. Many of these children were conceived to replace siblings who had been killed in concentration camps (and are often named after them, functioning like "memory candles", Wardi, 1992), and as a result these children experience emotional pressure since they are not able or allowed to distance themselves from their parents. As the children perceive their parents as suffering and consider them to be powerless victims, they try to protect them from any feelings of rage that they themselves might feel against this strong bonding that is imposed on them (Danieli, 1980; Wardi, 1992; Krell et al., 2004). Similar relational challenges, particularly regarding individuation and feelings of guilt and of responsibility of children towards their parents, have also been reported from other traumatised groups (Beckham et al., 1997; Rosenheck & Fontana, 1998).

These transmissional effects are not only based on social interaction, but most recent research even points to the involvement of biological and endocrinological processes. The research results of the study group around Rachel Yehuda show that significantly more children of mothers who suffered from PTSD also developed PTSD when themselves being exposed to traumatic events. Yehuda et al. found that chronic stress had led to significantly reduced levels of the stress hormone cortisol (a biological marker for PTSD) in babies born to mothers in the US who were traumatised during 9/11 9 months after they were born (Yehuda et al., 2005; 2002). Yehuda's research on biological correlates

to what is termed "transgenerational trauma" has substantially enriched the scientific discussion on epigenetic effects of posttraumatic stress on the next generation.

Although there are no published studies to date in Bosnia and Herzegovina regarding transgenerational effects of trauma, two studies from the region seem of special interest regarding family dynamics in "traumatised families". Franciskovic et al. (2007), researching secondary traumatisation amongst the wives of Croatian war veterans who were diagnosed with PTSD, found that more than half of the women suffered from six or more symptoms of secondary traumatic stress, and only 3 out of the 56 had no symptoms. 22 even met the full diagnostic criteria for secondary traumatic stress. In their study, the authors found women with secondary traumatic stress to have been married longer than those without it. They call for treatment not only of the traumatised patient, but also of the family surrounding them. The authors' conclusions on war veterans can easily be translated into the context of other highly traumatised persons and their families: "In our experience, patients with PTSD often say about themselves that they have changed and become different persons who also behave differently toward others. Their wives also describe them as emotionally distant, irritable, and unable to participate in everyday family life as they had before the war. The wives who knew their husbands before the war had more difficulties accepting their husband's illness and the fact that they had changed" (p. 182).

Another study published by Zalihic et al. (2008) from research conducted in Mostar clearly shows the influence that a father diagnosed with PTSD had on other family members. The authors worked with a control group of families with fathers who were not diagnosed with PTSD and found that more wives from the "PTSD family group" suffered from depression in comparison to the control group. There was no difference between the groups in relation to depression and anxiety frequency of children older than 18, but there were significant differences found in relation to other questions: Mothers of children whose fathers had PTSD reported that their children experienced significantly more stomach pain, eating problems and breathing problems in comparison with their peers from the non-traumatised fathers' group. They also worried more often, and seemed more aggressive towards other children.

2.3. The need for social acknowledgment of war rape survivors - theoretical background to research question 2

2.3.1. Research on the importance of social acknowledgement

War rape is not "just" an extremely brutal act of violence against an individual woman; in many instances it is equally used as a symbolically powerful destructive act against the community and society to which the raped women belongs (Joachim, 2005; Seifert, 1994). It is therefore obvious that individual recovery must be accompanied by mechanisms of social healing that in many psychosocial and other programms aimed at survivors of rape around the world are often referred to by the term "reintegration into the society".[13]

[13] It is debatable whether talking of "reintegration" in relation to survivors of war rape does not ultimately reinforce the cultural idea that woman and girls who have been raped are "cast out of their society". A feminist perspective would argue that no act of violence has the power to remove, or "de-integrate", a rape survivor from their community; rather, this is a cultural stereotype which is employed by per-

Research suggests that a "recovery environment" (Green et al., 1985) is created not only by a survivor's social connections, such as family and friends, but also by the prevailing atmosphere within their wider societal and cultural context. Since cultural norms and social conventions definitely shape the way that survivors perceive their experiences by either reinforcing feelings of shame and / or a sense of bearing some responsibility for what happened (Lebowitz & Roth, 1994), or by supporting them in more functional and empowering interpretations of their experience, it is obvious that reactions within a survivor's wider environment play an important role in how raped women recover.

Most research on social acknowledgement processes to date has concentrated on soldiers and veterans. Butollo et al. (1999) have highlighted the social rejection experienced by American Vietnam veterans (see also Fontana & Rosenheck, 1994) and German soldiers returning from World War II, while Solomon et al. (1989) found similarly strong relations between a lack of social appreciation and posttraumatic symptomatology in soldiers coming home from the Lebanon war.

However, one particularly interesting research on social support (in the sense of social acknowledgement as we use it here) was conducted with German war rape survivors 60 years after World War II, and examined the association between perceived social support and current posttraumatic symptoms. Published by Eichhorn et al. (2012), the authors clearly state in their study results that in comparison to other study populations who survived other traumatic events, the German war rape survivors reported very low perceived levels of social support both then and now, which is attributable to the ongoing strength of the powerful taboo around the subject of war rape amongst the German public.

The authors of the study clearly show a negative relationship between perceived social support in present times and posttraumatic symptoms, while no correlation was found between social support immediately after the war and present PTSD symptoms.

Following their research on the psychological problems experienced by a sample of ex-political prisoners in the former East Germany and in recently-traumatised victims of interpersonal crime, Maercker and Müller (2004) have identified the social acknowledgment of trauma survivors as a major protective factor in the development of Post-Traumatic Stress Disorders.[14] They define this social acknowledgement as "a victim's experience of positive reactions from society that show appreciation for the victim's unique state and acknowledge the victim's current difficult situation" (p. 345).

The unique approach of "social acknowledgement", unlike the more widely known, often quoted and well researched construct of "social support" (e.g. Butollo et al., 1999; Hobfall et al., 1996), is to include significant actors such as local authorities, communities and groups, the media, and public opinion, as well as partners, friends and families. Maercker & Müller (2004) conclude that when trauma survivors sense

petrators when they use rape as a weapon to systematically destroy the enemy's group. Consequently, when helpers label their work as a process of "re-integration", they might involuntarily be strengthening the same negative stereotyping that their programms are designed to work against. Therefore, we use the term "social acknowledgement" rather than "reintegration".

[14] The authors developed an instrument called a "social acknowledgement questionnaire" that predicted comparably better than conventional measures of social support between persons with high and low PTSD severity.

negativity or feel blamed by the way in which people perceive and explain the traumatic event, "the victims' aversive responses to re-experiencing the trauma may be intensified, leading to increased attempts at avoidance" (p. 345). Put simply, posttraumatic symptomatology can be increased by a perceived lack of social acknowledgement for a survivors' suffering.

However, Maercker and Müller also note that negative changes in self-cognition that trauma survivors often experience (e.g. feeling unworthy or "tainted", etc.) sometimes leave survivors feeling "unacknowledged", even in situations where a social environment responds to them in a careful and "acknowledging" manner. Consequently, it is necessary to work on both societal and cultural attitudes and survivors' self-cognitions.

In many post-war countries, measures of social acknowledgement include legal redress (e.g. trials of perpetrators before the International Criminal Tribunal and / or national courts and / or transitional justice mechanisms), psychological support, political or economic measures such as allocating a special status to certain groups of survivors (see below for the case of Bosnia and Herzegovina); special support programmes for economic or educational empowerment, reparations, marking the places of atrocities, public statements from institutions and governments, etc.

2.3.2. Exemplary aspects of social acknowledgement of war rape survivors in Bosnia and Herzegovina: religious messages and the status of the civil victim of war

The following paragraph will be dedicated to describing two particularly interesting and in many respects unique aspects of social acknowledgement of war rape survivors that emerged in Bosnia and Herzegovina.

The first of these forms of social acknowledgement provided to the survivors of war rape relates to the particular commitment of some Muslim religious leaders in both Bosnia and Croatia, where many rape survivors had fled, who issued various statements intended to promote acceptance of rape survivors by considering them to be "martyrs" or "heroines", and fatwas[15] were published in Bosnian Takvim (1994) and Croatian newspapers on, for instance, the right of Muslim women impregnated by rape to have an abortion (quoted in Oskam, 2009). Oskam (2009) reports that e.g. the Muslim leader Dervis Ahmed Nuruddin published a "Message of the Raped Women" in Tuzla in 1993, calling in particular for the husbands of rape survivors "to embrace their wives both in the literal and figurative sense of the word", and for future husbands "to feel proud to marry these girls in order to help them overcome their life's tragedy easier within the valid and honest Islamic marriage" (quoted in Oskam 2009, p.20).

Skjelsbaek (2006) points out that these fatwas were seen as very important by the health workers she interviewed in Bosnia and Herzegovina. Summarising the health workers' views, the author suggests that "[t]he fact that the religious leaders openly addressed the rape issue, and characterized the rape victims as war heroes, may have shifted the way in which the raped women were received and perceived within many families. One result was that the war rape victims were often protected by their families rather than being ostracized" (p. 104). This is important to note in order to contrast

[15] Fatwa, in Islam, is the term for the legal opinion or learned interpretation that a qualified jurist or mufti can give on issues pertaining to the Islamic law.

what happened in these cases with the common perception that raped women are always stigmatised by their families: In many religious families in Bosnia and Herzegovina, these fatwas were in fact a strong entry point for survivors to open up to and be supported and accepted by their families.

Another particular aspect of the social recognition of war rape survivors in Bosnia and Herzegovina is more recent, dating back to 2006 when the amendments and supplements to the Law on Social Protection, Protection of Civilian Victims of War and Protection of Families with Children in 2006, published in the Official Gazette of the Federation of Bosnia and Herzegovina, no.39/06, stated that "persons who have suffered sexual assault and rape are defined as a special category of civilian victims of war" (p. 5).[16] This is unique in the whole world and was lobbied for by many NGOs in Bosnia and Herzegovina, including *Medica Zenica,* along with a number of female parliamentarians and politicians.

The first institution in the Federation of Bosnia and Herzegovina that took action regarding the status of women survivors of war rape as civilian victims of war was the Federal Ministry of Labour and Social Policy, who assumed responsibility for the status after Parliament had passed the relevant amendments and supplements. This status entails the right to a monthly income of 70% of the base amount established by the Federal regulations of rights of war veterans and their families, which is 550 BAM. Besides the financial support, the status guarantees access to the right to special schooling programms, retraining and additional trainings, health and social support, housing support, and employment support.

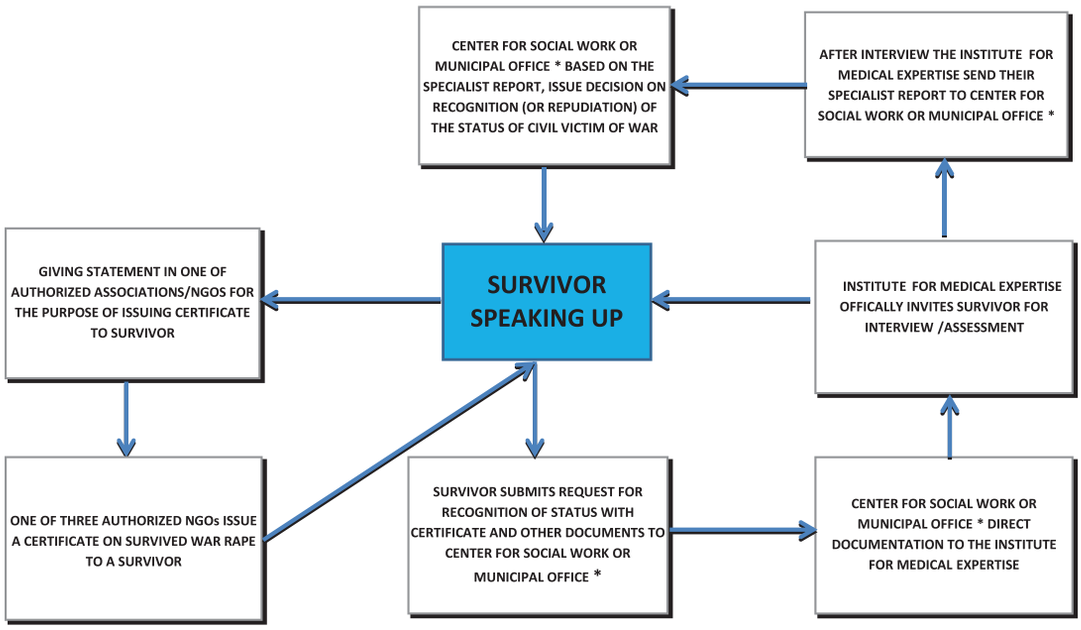
According to legislation in the Federation of Bosnia and Herzegovina, individuals who experienced rape and sexual violence in the war can obtain the status of civilian victim of war by filing a request and the relevant documentation. Besides the identification documents and necessary medical documentation, the applicants need to provide a certificate issued by one of the three non-governmental organisations: the Association "Žena - žrtva rata" Sarajevo, Association of Concentration Camp Torture Survivors BiH and Croatian Association of Camp Detainees in Bosnia and Herzegovina. Their application for the status of civilian victim of war is then submitted to the Centre for Social Work or to a relevant municipal office for social protection services, depending on the applicant's place of residence. There is no time limit for submitting an application.

When reviewing the application and documentation, the municipal office or the Centre for Social Work directs the documentation to the Institute for Medical Expertise for an interview. The Institute for Medical Expertise then sends their specialist report to the municipal office or to Centre for Social Work. The municipal office or the Centre for Social Work issues the Decision on recognition (or repudiation) of the status of civilian victim of war. The Decision on recognition is subject to a revision of the relevant cantonal institution. In the Brčko District the application for the status of civilian victim or war is submitted to the Department for Health and other services, or to the Department for veteran protection and civilian victims of war (with a different list of necessary documents).

[16] See "Guide for Civilian Victims of War", published by the International Commission of Missing Persons in 2007 http://www.ic-mp.org/wp-content/uploads/2008/02/guidebook-wictim-of-war-fbih.pdf.

For an overview of the whole procedure, see the following chart:

GRAPHIC PRESENTATION OF THE PROCEDURE FOR ACHIEVING THE STATUS OF CIVIL VICTIM OF WAR IN THE FEDERATION OF BOSNIA AND HERZEGOVINA



*** In some places where there is no Center for Social Work, Municipal offices for social protection services are authorized for the process of recognition of the status of civil victims of war**

As already pointed out, between 20,000 and 50,000 women and girls were raped and exposed to different kinds of sexual violence during the war in Bosnia and Herzegovina. However, during an interview with the Minister in the Federal Ministry of Labour and Social Policy for the purpose of this research, we learned that in the period from 2006 to 2013 a total of only 779 women had obtained the status of civilian victim of war in Federation of Bosnia and Herzegovina. The ministries, at the date of our interviews, could not provide information about the precise number of applications pending because the legal proceedings go through municipal and cantonal centres for social protection. The information about the exact number of individuals who have the status of civilian victim of war in the Brčko District is also unknown. In praxis it is not known whether there are any individuals who experienced war rape and sexual violence that have the status of civilian victim of war in Republika Srpska.

It must be added here as a serious limitation of this ground-breaking political success of political acknowledgement of survivors of rape that the legislation in Republika Srpska does not recognize a special status for women who survived war rape. Moreover, the Law on the protection of Civilian Victims of War of Republika Srpska only gives the right to this status to those who have 60% invalidity caused by abuse, rape, and other crimes[17], and only if the survivor filed their application before 2007.

In August 2012, the Brčko District passed regulations that recognise the status of civilian victim of war for individuals who suffered permanent psychological damage as a consequence of sexual violence and rape. The law recognises them as individuals with a special status whose damage cannot be specified in percentage terms.[18]

[17] Article 2 of the Law on the Protection of Civilian Victims of War of RS.

[18] Article 2 of the Decision on the protection of civilian victims of war Brcko District.

Related to the civilian status, we discovered during the interviews that the Ministry for Human Rights and Refugees in Bosnia and Herzegovina with the help of the United Nations Population Fund (UNFPA) created a STATE STRATEGY TO ADRESS ISSUES OF SURVIVORS: "The program for improvement of the status of women victims of wartime rape, sexual abuse and torture in Bosnia and Herzegovina for the period 2013 to 2016." Many subjects were included in the making of this program, both relevant government representatives (e.g. Federal Ministry of Labour and Social Policy) and representatives of non-governmental organisations in charge of implementation. The aim was to ensure a complete protection and support to women victims of war rape, sexual violence and torture, and their families, by improving the system of their access to justice, improving programms of rehabilitation, re-socialization and compensation, with active participation of all relevant subjects .[19]

The programm passed the relevant discussion procedures and harmonisation between the relevant subjects in both entities. It was then passed to the Council of Ministers in the form of a bill for further adoption and proposal to the Parliamentary Assembly of Bosnia and Herzegovina. But, as the Minister in Federal Ministry of Labour and Social Policy during our key informant interview pointed out: "*Unfortunately, this process has been stagnating for a year now because of the obstructions from Republika Srpska, in spite of the fact that the non-governmental organizations as well as institutions in Republika Srpska gave positive assessments of the Program valuing it as a necessary framework for praxis in this field"*. With that regard, the Minister Assistant at the Ministry for Human Rights and Refugees BiH underlined: "*In order to begin with the implementation of this Program it is necessary for all levels of government to accept it."*

In the results regarding research question 2, provided in Chapter 4, we will reflect in particular on the impact of the status of civilian war victim on survivors' self-perceptions, and whether the women themselves feel that this status is an important source of social acknowledgment.

2.4. Living with the legacy of war rape: strategies of coping and resilience building in survivors of war rape trauma - theoretical background to research question 3

2.4.1. Why do some survivors recover more easily than others? Introduction to key concepts

It is important to explore the remarkable fact that, while the prevalence of PTSD amongst survivors of extremely pathogenic experiences such as war rape is high, not every survivor suffers from the disorder, or suffers to the same extent as others. To understand why people have different rates of recovery from posttraumatic stress, research in the two decades since the war has focused on what makes people more vulnerable ("risk" factors) or less vulnerable ("protective" factors) to PTSD. These factors are usually grouped into those related to either the survivor's personality, the event, or the social environment (see Joachim, 2005; Butollo et al., 1999; Harvey & Herman, 1992; Brewin et al., 2000). Obviously, these factors interact with each other in a complex way.

[19] Action Plan for Implementation of UNSCR 1325 in Bosnia and Herzegovina for the period 2014-2017.

The ability to recover from post-traumatic stress has recently been associated in trauma psychology with the term "**resilience**". In fact, research on "resilience" and related concepts represents a "paradigm shift [within psychology] from looking at risk factors that led to psychosocial problems to the identification of strengths of an individual (Richardson, 2002, p.309). The word "resilience" originates from the Latin verb "resilire", which literally means "to leap back". It was originally used in physics to describe the quality of certain materials which have the capacity not to break after being strained or deformed, but to 'bounce back' and recover their original size and form (Fletcher & Sarkar, 2013).[20]

Post-traumatic growth is another new concept that is related to posttraumatic adjustment. It was originally conceptualised by Tedeschi and Calhoun (1996), who identified three relevant dimensions of posttraumatic growth: traumatic events can lead to positive changes in self-perception, changes in interpersonal relationships, and a changed philosophy of life.[21]

However, posttraumatic growth should be seen as a self-perceived personality change rather than as a "coping mechanism" or a form of psychological "functioning" and the absence of psychological symptoms. Interestingly, and perhaps contradictory to expectations, studies report either a moderate positive correlation between growth and symptom scores (i.e. more growth correlates with higher symptom scores, Maercker & Langner, 2001; Park et al., 1996) or no significant correlation (i.e. Lehman et al., 1993; Maercker et al., 1999). In other words, it is not contradictory for survivors of trauma to report a number of posttraumatic symptoms, *while at the same time* talking about growth that occurred in their life as a result of the traumatic experience.

Coping, defined by Lazarus & Folkman (1984) as efforts and strategies to deal with difficult external demands, is another concept that is strongly related to overcoming adversity. Lazarus & Folkman developed a "transactional model" of coping, which they defined as "constantly changing cognitive and behavioural efforts to manage specific external and / or internal demands that are appraised as taxing or exceeding the resources of the person" (p. 178). This definition avoids the problem commonly found in literature of confounding coping with its outcome, since coping includes all efforts made to manage demands, regardless of their outcome. From this perspective, one can say that a behaviour such as substance abuse may be a coping strategy if it is used to manage debilitating symptoms following trauma, even though such behaviour is unlikely to help in overcoming those symptoms successfully.

In 1984, Lazarus and Folkman described coping as being either emotion-focussed or problem-focussed. Although this categorisation has been found to be too limiting, it has greatly influenced the literature on coping. They argued that "[c]oping serves two overriding functions: managing or altering the problem with the environment causing distress (problem-focused coping), and regulating the emotional response to the problem (emotion-fo-

[20] Despite the enriching aspects of resilience-related research in trauma psychology, it is important to note that the concept should not be misused or misunderstood to make survivors with posttraumatic problems feel guilty for not being "resilient enough". Resilience research should not insinuate a "moral obligation" to recover through the implication that, because it is possible and people can be trained to do it, they "must" do so, nor should it be seen as synonymous with invulnerability.

[21] Tedeschi & Calhoun (1996) developed the so-called Posttraumatic Growth Inventory that consists of 21 items on five scales: new possibilities, relating to others, personal strength, spiritual change, and life appreciation.

cused coping). […] Problem- and emotion-focused coping influence each other throughout a stressful encounter; they can both facilitate and impede each other." (p. 179).

Many studies on coping after traumatic or adverse events have described coping strategies as either "adaptive", which lead to adjustment and health, or "maladaptive", which lead to negative outcomes, including psychological disorders. However, more recently coping psychology has looked at the contextual suitability and the flexibility of coping. For instance, Chen (2012) identified certain coping strategies as appearing helpful for some people in some situations, but not in others, while Rosner & Powell (2006) found that *all* coping styles were positively correlated with posttraumatic / adversal growth.

Bonanno (2011) introduced another new concept in coping psychology, called "coping flexibility", after finding that having a high Forward Focus (i.e. "getting over it") and a high Trauma Focus (i.e. focusing directly on the traumatic experience in order to process it), both independently and when present in combination were associated with better adjustment.

2.4.2. Risk factors related to war and rape trauma (with special regard to research from Bosnia and Herzegovina)

Brewin et al. (2000) and other meta-studies have shown that whether particular factors predict risk or offer protection is inconsistent across all studies, and things that are protective for some research populations may not be so for others. This is also true for research on protective or risk factors related to rape and sexual violence (Campbell et al., 2009). Whether factors such as age, marital status at the time of the experience, the level of injury inflicted, etc. increase risk or are protective varies.

In 2000, the Sarajevo Symposium gathered scientists and researchers from across the former Yugoslavia to present research results regarding the "psychosocial consequences of the war". Several papers were presented on risk and protective factors that emerged from these studies. For instance, Bell et al. (2002) found that displaced women who were victims of ethnic cleansing were particularly prone to psychopathology and poor social adjustment, because both the intensity of their suffering and the number of traumatic experiences they had undergone were greater. The authors of the study concluded that the most important predictor of both PTSD, poor social functioning, and low self-esteem was witnessing atrocity. Since survivors were usually forced to witness such atrocities, this qualifies as torture. Age seemed a weaker predictor, with younger people being less affected. Good health consistently acted as a protective factor.

Similarly, Savjkak (2002) found that displacement was a potent risk factor for PTSD in the Republika Srpska, since this implied "the accumulation of material, psychological and social losses" (p. 45). The author explained that the death of loved ones retains a strong impact on the frequency of PTSD symptoms three years after the war because current stressors act as "triggers", reactivating the original traumatic experience. In other words: "Frequent post-war difficulties that occurred after displacement and the struggle to meet basic needs act as barriers to processing and coping with past experiences" (p. 46).

Rosner et al. (2002a) conducted research on returnees, displaced and non-displaced persons in Sarajevo and found that almost everyone, but especially displaced persons,

had experienced a huge number of traumatic events involving great personal loss. Stressor variables, including the total number of traumatic events during the war and the total number of current stressors, were accurate predictors of PTSD symptomatology. The severity of traumatic experiences were also found to predict more severe and a higher number of PTSD symptoms in soldiers (Pavlovic & Sinanovic, 2002).

In their 2003 article entitled "Determinants of posttraumatic adjustment in adolescents from Sarajevo who experienced war", Durakovic-Belko, Kulenovic & Drapic looked at risk and protective factors of post-war adjustment in a non-treatment sample in Sarajevo. Female gender and low optimism were found to be common risk factors for both serious depression and PTSD. The trauma experience of loss was found to be the strongest predictor for a posttraumatic stress reaction, while being female served as the strongest predictor for depression.

Coping strategies can serve as either protective or risk factors in posttraumatic symptomatology. Mladina & Huber (2002) studied PTSD and coping strategies amongst different survivors of the war in Bosnia (i.e. soldiers, refugees, land mine victims and persons who survived the war at home), and found that intrinsic religious orientation has a buffering effect on stress: "Especially when stressful conditions are viewed as refractory to change, religious beliefs may provide a basis for meaningful reappraisals" (p.624). Conversely, ruminative thinking, which was particularly prevalent in refugees and soldiers, was connected with more pronounced PTSD symptomatology, and is therefore classified by the authors as a non-adaptive way of coping.

In a study on war experiences and war-related distress in Bosnia and Hercegovina amongst more than 3,000 respondents conducted eight years after the war, Ringdal et al. (2008) found that household size increased war-related distress. These findings are consistent with a similar study conducted in Croatia by Kunovich & Hodson in 1999, who concluded that large households may be a burden rather than a source of social support, particularly in times of economic crisis and unemployment, while overcrowding and being in close contact with family members who might also have been affected by the war can become a source of stress.

Since there are so few studies on war rape in Bosnia and Herzegovina, we cannot easily determine risk factors for this particular context. However, one risk factor that does seem to be specifically connected to war rape is when that rape results in pregnancy. In their 1995 study on rape survivors from Bosnia and Herzegovina and Croatia, Kozaric-Kovacic et al. found that women who got pregnant wanted to "rid" themselves of the pregnancy, and the relief they showed immediately after delivery contrasted strongly with the depression they had suffered from in the months before. In the study by Loncar et al. (2006), most women said that unwanted pregnancy had made their mental recovery more difficult.

2.4.3. Coping strategies associated with severity of PTSD amongst rape survivors

When looking at rape-related risk factors for PTSD severity, particularly with regard to coping strategies, it is apparent that coping strategies do not exist in isolation: They are always related to the specific demands of the stressful situation and the availability of options to cope with it. Coping strategies seem to have a great impact on the ability to recover from stress (Folkman et al., 1986), but the opposite is also true: different types

of psychological distress – and types of traumatic event – seem to motivate specific coping behaviours (Valentiner et al., 1996). In other words, coping with war rape may invoke a different set of coping options to coping with an earthquake or a car accident.

Feldmann (1992) found different coping strategies in his research on 75 survivors of rape in a German sample, such as avoidance and denial of the event, but also more protective mechanisms such as keeping up one's "morale", and feeling an identification and solidarity with other survivors, even supporting them, which helped survivors to develop healthier perspectives on their experience and see it in a societal context, so regaining a sense of competence and control. However, 25.3% of his respondents described feeling unable to detach from what happened and a fixation on their rape experience that took the form of constantly grieving about a loss that can never be overcome. According to Feldmann, maintaining a "positive outlook" to life (meaning that survivors consciously balanced their traumatic experience with a positive attitude towards themselves and the world, and refused to allow the perpetrator to destroy their lives) was a strong predictor of less severe symptoms of PTSD in later life, which is similar to the results found by Lazarus & Launier (1978).

Most studies on rape survivors differentiate between "adaptive" and "maladaptive" strategies, where the former leads to less severe symptoms and faster recovery, while the latter results in more severe symptoms and slower recovery. A number of studies found that not thinking or talking about what happened was related to a blockage in the emotional processing of the traumatic event, which in turn leads to a more severe PTSD (e.g. Janoff-Bulman, 1985; Ehlers & Clark, 2000). Other studies found emotion-focused coping to be positively associated with more severe PTSD symptoms (Solomon et al., 1990). Similarly, in their 2009 systematic review of studies on rape, Campbell, Dworking & Cabral concluded that "maladaptive" strategies involving some level of avoidance, withdrawal and disengagement were associated with a prolonged time for recovery and higher levels of depression, anxiety, fear and PTSD. Many studies suggest that strategies such as expressing emotions, seeking social support, and reducing stress are adaptive. However, one author (Ullman, 1996) noted several studies in which strategies such as joining a support group and going to a therapist were actually related to more distress. Frazier & Burnett (1994) also found that avoidance strategies such as keeping busy and suppressing negative thoughts produced less distress. Campbell et al. (2009) argue that these inconsistencies call for a more detailed examination of the context within which coping strategies are used.

Burgess and Holmstrom were pioneer researchers who first conceptualised the "rape trauma syndrome" in the 1970s. Their classic research, published in 1979, showed that being proactive was clearly associated with faster recovery. For instance, rape survivors who read about, watched television talk shows on, or wrote about the rape experience, changed their residence or telephone number, travelled, worked in rape crisis centres helping other victims and so on recovered much more easily than those who did not. According to Burgess and Holmstrom, "[o]f those victims who used this type of action [i.e. increased action], 70% recovered within months." (p.1281). Regarding quality of life after rape, the researchers found a positive association between recovery and resuming social tasks, i.e. completing an educational programme or restarting work and being promoted. Those survivors who were unable to do this, or who were not in a social support network, felt distressed and unable to regard their lives in a meaningful way, and struggled to recover from their rape experience. Partner-

ship stability was equally associated with recovery length, in that rape survivors "with partnership stability had a faster recovery than victims who did not have partnership stability" (p. 1282).

In one particularly relevant study on war rape survivors in Germany 60 years after the war, Kuwert et al. (2012) found that the coping strategy most frequently adopted was avoidance, which was used by 37% of the survivors; 26% spoke about it, and 19% actively worked through it, e.g. in therapy. 15% of the respondents said that they coped through working, and an equal number mentioned hobbies as coping strategies. Spirituality was an important source of coping for 7%, while an equal number reported anger to be a way of coping. Interestingly, 15% of the survivors said that they did not "need" coping strategies. The authors clearly relate the high level of using avoidance as a coping strategy with the societal position of German war rape survivors, who did not have a space to talk about their experiences. This result underlines the point made above that coping strategies are not only related to the personal preferences or personalities of the survivors, but develop at the place where society responds to certain traumatic events.

2.4.4. What role does "social support" play in buffering war- and rape-related stress?

Social support is a key issue in trauma research, and has been clearly identified in many studies as a protective factor which buffers war-related distress. It plays an important role in the process of recovery from PTSD (e.g. Hobfall et al., 1996), and has been shown to buffer traumatic distress amongst different populations of trauma survivors (Norris et al., 2002). The overall majority of studies regarding rape survivors suggest that social support from family and friends and intimate partners plays a major role in the survivors' recovery process and is correlated with less symptomatology (for an overview, see Campbell et al., 2009). But more than this, studies show that negative social reactions from family, friends, and peers are even more consistently related to increased anxiety, depression and PTSD, leading Campbell et al. (2009) to conclude that apparently "negative social reactions have a stronger detrimental effect on survivors' mental health than positive social reactions have for bolstering well-being […]. It may be that negative social reactions are more salient for survivors' recovery because survivors are more likely to first disclose to family and friends […], and they likely expect sympathetic reactions from these people. If survivors receive unexpected negative reactions from family and friends, it may be particularly upsetting. However, the direction of causality between psycholog-ical distress and social support is unresolved" (p. 13).

The importance of social support is not only limited to the microsystems of families and friends, but may extend to the system of formal social support (e.g. helping organisations). Campbell et al. (2009) evaluated studies which looked at formal social support systems in the United States, particularly those for legal, medical, and mental health support. Evaluating potential risk factors for rape survivors which are related to the responses of these systems, the authors state that "if victims are able to receive the services they need and are treated in an empathetic, supportive manner, then social systems can help facilitate recovery. Conversely, if victims do not receive needed services and are treated insensitively, then these systems can magnify victims' feelings of guilt. Postassault help-seeking from formal social systems can become a 'second rape', that is, a secondary

victimization to the initial trauma. These experiences of secondary victimization can have a negative impact on victims' psychological wellbeing […]" (p.14).

Despite this overwhelming evidence for the importance of social support, some studies mention social support in more differentiated or even critical ways (e.g. Valentiner et al., 1996). Since the partners and family members of rape survivors are usually struggling with their own feelings of powerlessness, blame and shame, which often lead to silence, they can easily reinforce negative effects on the survivors' mental health. For example, Symonds (1975) reports a particularly maladaptive reaction in families of survivors of sexual violence, namely an overprotective and collusive attitude of silence towards the survivor, paired with emotional withdrawal and distractive mechanisms that can be interpreted as both avoidance and over-protectiveness towards the survivor.

How does social support surface in some of the studies regarding war, and war rape in particular? According to Loncar et al. (2006), being married at the time of the war rape provided a certain level of protection and support, while single women or those who were in relationships but not married had significantly more difficulties after the rape and showed more sexual dysfunctions, with Muslim women the most likely to experience sexual dysfunctions. However, according to the same authors, psychogenic amnesia or the inability to recall important aspects of the traumatic experience was more prominent among married women, so marriage seemed to play an ambiguous role as a potential source of social support.

In a study conducted in 2004 on highly and less-highly war-affected women, Klaric et al. (2008) found that social support from "outsiders" was more important than that from family members. Women in the highly-affected study group had significantly lower support from friends and co-workers. *Actual* social support from co-workers predicted the number and intensity of posttraumatic symptoms, while *perceptions* of social support from friends was a significant predictor of PTSD. The authors concluded that "this finding emphasizes the importance of the wider social context for severely traumatized persons, especially ethnic division during and after the war caused disruption of bonds amongst friends and co-workers. Every relationship that was preserved in such circumstances becomes especially important" (p. 471).

Based on these results, Klaric et al. (2008) suggest that rape impacts at more than just the individual level, it also affects the whole structure and functionality of the family, to the extent that "such families are more often the source of a new stressful experience than the source of security and trust for the traumatized member" (p. 472).

Referring to her experience with war rape survivors in Kosovo, Joachim (2005) highlights the (potentially) complicated cultural and shame-related dynamics inherent to the support families provide to war rape survivors: "In a patriarchal context family life is subject to extreme stress if a woman has experienced sexualised violence. As long as the family is not aware of her experience of violence, the survivor will try to protect herself from exclusion and her family from the purported shame. The price to be paid for this is loneliness and even greater suffering if she is unable to cope with the demands of 'normal' life and cannot say why. Constant secrecy and / or suspicion can exacerbate conflicts that already exist within the family. If the family knows about her experience of violence, the woman may be forced not to tell anyone outside the family. In both cases this increases her social isolation" (Joachim, 2005, p. 70).

Against the background of these diverse aspects of social support, we can conclude that while support from family, friends and intimate partners is a very important source of stabilisation, and their absence is an even more potent destabilising factor, social support dynamics might not always be beneficial for survivors. When the dynamics of close relationships are affected by traumatic events, this can lead to complicated interactional patterns, and other alternative social support networks such as peers and support organisations inspired by solidarity might play an especially important role in societies where war has a traumatising impact not just on individual vulnerable groups but on whole family structures, as in Bosnia and Herzegovina.

2.4.5. The special role of self-blame for survivors of rape

Self-blame has been a major feature in the mental health response of rape survivors, particularly and more strongly where it is part of gender socialisation and reinforced by patriarchal structures. Many scholars consider self-blame to function as a coping strategy. Because self-blame is so important in understanding the particular suffering of rape survivors, the following section explores this coping mechanism in more detail.

Several scholars working on rape trauma have analysed self-blame and reached different conclusions as to its function (e.g. Janoff-Bulman, 1979), but most have been unable to demonstrate positive adaptations connected to any type of self-blame (Campbell et al., 2009). Indeed, Burgess & Holmstrom (1979) showed that self-blame actually correlates negatively with adaptation and recovery. In their follow-up study on 81 rape survivors between four and six years after their experience, using open-ended qualitative questions to assess how the survivors estimated their own recovery, they found a clear association between self-esteem and length of recovery. Survivors with positive self-assessments in relation to their rape experience (such as "I am a strong person mentally") had significantly better recoveries than those who made negative self-assessments (such as "I was born with bad luck, something is always happening to me", etc.).

Campbell et al. (2009) consider self-blame as a multilevel meta-construct that develops from and is shaped by the multiple levels within ecological systems. Existing literature clearly shows that self-blame is not an individual factor alone, but is nurtured and reinforced by many different people, social settings and systems and cultures over time, and is related to patriarchal values and assumptions. The authors point to differences in cultures and cultural blame attributions that impact on the mental health outcomes of rape survivors. Certain cultures, for instance collectivistic societies with a strong emphasis on family honour and female virginity, have a strong, negative impact on survivor recovery. The persistence of "rape myths" in a society (e.g. woman who are raped are asking for it, etc.) and rape-prone cultures that condone male violence make it more likely for survivors to blame themselves for the assault and so take responsibility away from the perpetrator. The authors quote various studies showing that those survivors who strongly believed in and accepted rape myths were less likely to acknowledge what happened as sexual assault. In addition, high rape myth acceptance seems to be related with being less willing to disclose the assault and seek support.

2.4.6. Is post-traumatic growth after war and rape possible?

Studies on post-traumatic growth related to war are rare. Most studies on the subject have focussed on people who have survived individual traumatic events, or who suffer from chronic disease (Rosner & Powell, 2006; Linely & Joseph, 2004). This scarcity of studies on post-traumatic growth following war or sexual violence might be related to the subject matter; since such experiences are seen as extremely destructive, it can seem almost unethical to ask whether anything positive evolved from the experience. However, the small number of studies that do exist show that post-traumatic growth after war and rape seems to be possible for some survivors.

Krismanic and Kolesaric (1996) assessed 675 survivors of the war in Bosnia and Herzegovina and in Croatia, and found generally higher positive than negative changes, with the most war-affected sub-groups reporting the greatest amount of positive changes. The authors offered some interesting interpretations of this finding, arguing that refugees and displaced persons in particular wanted to stay healthy out of spite for the enemy, while some respondents may have minimised their traumatic experiences in order to avoid victim status, resulting in high scores on positive changes. However, Rosner & Powell (2006) felt that since this study took place immediately after the war it might reflect short-term expediency rather than long-term outcomes.

Rosner & Powell (2006) looked at aspects of post-traumatic growth after the war in Bosnia and Herzegovina. Interestingly, they found no significant correlation between post-traumatic growth and better living conditions such as employment, income, current accommodation status or being in a stable relationship, contradicting their hypothesis which assumed that post-traumatic growth might be more strongly associated with current living conditions than with events during the war. Their study found a significant positive connection between interpersonal factors (such as those reflecting a change in evaluating the importance of relationships) of the post-traumatic growth inventory (PTGI) and post-traumatic symptoms, general distress and depression, which may indicate that those who suffer more also evaluate positive relationships more highly.

According to another study conducted in Sarajevo by Powell et al. (2003), the overall average scores obtained for post-traumatic growth were considerably lower than those reported in most other studies on other kinds of trauma, with younger people scoring higher than older people. Additionally, there was no significant correlation between the total score for growth on one hand and depression, general symptoms and PTSD on the other, and no connection was found between the number of stressful events and post-traumatic growth. When interpreting these results, the authors pointed out that the relatively low scores for post-traumatic growth in the Bosnian population can be explained by an inverted U-relationship between event severity and growth. According to their analysis of various studies on post-traumatic growth, medium-level severity of events is likely to be associated with the highest post-traumatic growth, while low level stress events and extreme level severity correspond to less post-traumatic growth. The people living in Bosnia and Herzegovina were exposed to an accumulation of stressful events, while the micro- and macrosystems to which they belong were severely shaken, changed and even destroyed, which may explain the low scores for post-traumatic growth.

There are very few studies on the post-traumatic growth of rape survivors. Burt & Katz (1987) studied issues of growth after sexual assault, and in their factor analysis of 29 psychological measures, they found four main growth outcome factors after rape: improved self-concept, self-directed activity, reduced passivity, and less stereotypical

attitudes. 50% of their respondents answered that they felt they had changed in a positive direction, while less than 15% described their personal change as being negative. Positive change was reflected in statements such as "I know myself better", "I value myself more", or "I know who my real friends are".

Veronen & Kilpatrick (1982) suggested three ways in which rape was assimilated as an event that can potentially lead to growth: when survivors described their growth experience as a consciousness-raising experience (in the sense that the rape experience was a trigger to becoming aware of the structural oppression that women live with), as a life appreciation lesson (in the sense of that having survived led them to evaluate life differently and be more grateful for positive experiences), and finally as a challenge to overcome (getting over the experience made survivors feel that they are strong).

Koss & Burkhart (1989) summarise study results showing that traumatic growth after rape reflects "an acceptance and transcendence of the two themes unique to rape trauma" (p. 34); namely the interpersonal nature of sexual violence and the pervasive, malevolent social context of rape. Developing new beliefs from the terror of the rape experience may "allow assimilation of the traumatic experience and function to restore previous meaning, mastery and self-esteem. To the extent that new beliefs were 'born of a trial by fire', they may be more realistic and resilient than those they replaced" (p. 34).

2.5. Helping survivors of war rape in their recovery from trauma: What helps and why? - theoretical background to research question 4

2.5.1. Introductory comments: Do survivors of trauma seek psychosocial support / therapy? And if yes, why?

There is not very much scientifically researched information currently available on when and why survivors of traumatic experiences seek treatment. Gavrilovic et al. (2005), in their meta-analysis of studies which looked at trauma survivors and their readiness to join therapy, concluded that the "most important factors associated with treatment-seeking appear to be a higher level of psychopathology, the type and level of the traumatic event, and socio-demographic characteristics, in particular female gender" (p. 595).

One of the rare studies on survivors of war rape in Bosnia, which was conducted very early during the beginning of the war, reported that all 25 rape survivors in the study refused psychotherapy (Kozaric-Kovacic et al., 1995). Even those left pregnant by war rape who had asked for support during the last phase of pregnancy left the baby at the hospital after delivery, and never came back for psychotherapy. The authors offer two potential explanations for survivors refusing psychotherapy immediately after having survived rape and torture; firstly, it reflects a "phase of denial or depersonalisation" that they observed in all respondents of their study, and which led to a style of narrating the experiences in the third person (similarly Folnegovic-Smalc, 1994), using the phrase "as if"; and secondly, while the war was still ongoing, as was the case during the study quoted above, rape survivors and their families were more concerned with survival. However, the experience particularly of Medica, which started working in

April 1993, contradicts these findings and suggests some additional reasons why some survivors of war rape did not ask for psychotherapy, which are potentially connected to the way that health institutions were organised during the war, and / or staff attitudes.

However, this reluctance to enter psychotherapy or simply to seek help after rape might not only be a problem after war rape; it seems to be a general truth that is also found under "civilian circumstances" and in many Western European countries and the US, that many survivors of rape do not seek help immediately after the event. Many experience considerable post-traumatic stress for several years and try their best "to get over it" before they finally enter therapy (Harvey & Herman,1992; Koss & Burkhart, 1989). This is particularly challenging because most existing treatment concepts for rape sur-vivors primarily deal with the immediate response (Burgess & Holmstrom, 1974), and the increasingly chronic problems of rape survivors due to their ongoing interpersonal problems and challenges with self-worth must be taken into serious consideration in designing treatment concepts (Koss & Burkhart, 1989).

2.5.2. Psychosocial assistance in Bosnia and Herzegovina and Croatia during and after the war: key issues and contextual responses

According to Koic, Delalle-Zebic & Bosnic (1992), PTSD was largely unknown as a diagnosis even to psychologists and psychiatrists in the country, while psychotherapy was a rarity (quoted in Rosner, Powell, Butollo, 2002b).

Similarly, Avidbegovic et al. (2008) point out that when the war started in 1992, both technical knowledge about the psychological consequences of war and therapeutic approaches to PTSD in Bosnia and Herzegovina were very limited. Much depended on each psychiatrist's individual experience with trauma therapy and their access to and also willingness to embrace additional education through specialised literature from other countries, and / or training from international specialists. At the end of the war and immediately afterwards, a number of foreign governmental organisations and NGOs initiated various psychological programmes, including training programmes for treating trauma, in order to support the Bosnian health system in dealing with traumatised people. However, this attracted considerable criticism, with Avidbegovic et al. feeling that the region was "flooded" with different concepts of trauma, claiming "that Bosnia was 'a good marked (sic!) for selling items no matter the quality'. Various psychological and educational programs were used across the differing regions of BiH, often without paying due attention to the given cultural, political and social setting, and often without any evaluation of the programs and their efficacy" (p. 477). The massive presence of mental health professionals during the wars in Bosnia and Herzegovina and Croatia (1991-1995) was described as unprecedented (Arcel, 1998), and heavily criticised (e.g. Summerfield, 1999; Bell et al., 2000; Powell, 2000).

Inger Agger and Jadranka Mimica's evaluation of "Psycho-social assistance to victims of war in Bosnia-Herzegovina and Croatia", published in 1996, looked at the psychosocial problems of 2,291 beneficiaries of psychosocial[22] programmes funded and supported by ECHO in various places in Bosnia and Herzegovina and Croatia. They found that after two years these projects had been able to reach their target population of traumatised

[22] For a critical view on the term psychosocial being overused in programs in Bosnia and Herzegovina, without actually clearly defining what it entails, see Powell, 2002.

women, and that their trauma symptoms had considerably reduced. Interestingly, the two authors found that the thing the beneficiaries most appreciated in the various projects was actually the **contact, care and understanding** created by the staff, while the concrete activities organised within the programmes seemed to be secondary to these more general healing factors: "Socializing with others and talking with staff are non-specific factors which provide contact, warmth, care and acceptance. These factors were encouraged by the creation of a safe space, a room, a centre, in which beneficiaries can feel welcome and where they can meet each other, meet caring staff members and begin re-building trust. These factors are valued most positively by the beneficiaries (82%). However, such non-specific factors are also relevant in organized activities such as group talks, creative, educational and physical activities, and individual therapy. These organized activities were evaluated as considerably less healing by the beneficiaries. It can tenta-tively be concluded that the greatest need of war-traumatized people is to find a space in which trust in fellow human beings can be re-established and where normal human relationships can be formed. The activities offered in this space are less important than the general atmosphere of communal healing" (p. 46).

In her essay on reducing trauma during ethno-political conflict, Agger (2001) used the "problem of the wool" to illustrate the need for cultural adaptations as part of the pro-cess of finding out what would work best with women from Bosnia and Herzegovina. Since people in the region generally considered it shameful to need psychotherapy or psychiatry, and didn't want to be seen as "crazy", it was a problem to motivate people, particularly in rural areas, to participate. As most psychosocial programmes were targeting women, they began inviting them to knitting groups where coffee was served. As Agger explains: "For centuries, during coffee drinking and knitting traditional Bosnian socks, trauma stories have been told, listened to, and acknowledged by a group of female friends and family" (p.14).

Other psychosocial programmes soon started copying this procedure, and started providing wool and needles for their clients. However, this appeared to contradict the accepted belief that clients should pay for psychotherapy. Agger describes how this "problem of the wool" was "gradually solved as staff of psychosocial programs accepted that distribution of wool was not hindering their therapeutic efforts, but was, instead, a practical way of establishing trust and group feeling and of providing useful activities for those who did not want or need more intensive types of interventions" (p.15). Part of this adaptation process was recognising that material support was as much a part and parcel of psychosocial programming as occupational activities, since it encouraged people to access the centre's services "and the need and motivation for psychological help would develop gradually as a trusting relationship was built between the survivor and the staff. […] Providing material aid and occupational activities were important elements in creating a trusting environment" (p. 15).

Cullberg Weston (2002) researched projects that had been funded by Kvinna til Kvinna in Bosnia and Herzegovina and found similar positive outcome to those documented by Agger & Mimica (1996), specifically a reduction in the classical post-traumatic stress symptoms of the women who were the main beneficiaries of these projects. In a study conducted five years after the war amongst 89 women visiting psychosocial programmes (and a control group of women who only recently applied to the psychsocial programmes and hadn't yet begun their treatment), she found that both post-traumatic symptoms and ongoing existential stress seemed to be handled better by those in

treatment, compared to the control group. However, "in spite of the remarkable reduction in posttraumatic stress reactions for the majority of the women, a core group still have a difficult struggle with symptoms initiated by the war" (p. 29). In fact, 23% of the women in the research group still reported strong flashbacks five years after the war, which can be interpreted as a clear indication of an ongoing posttraumatic process.[23] Cullberg Weston suggests that there might be women who were unable to process their trauma in the same way as others, and so might need specific trauma therapy as well as the help on offer at the centre.

In addition, 71% of the women in the quoted study still characterized their life as ongoing suffering and that "life is as bad or even worse than during the war" (p. 54). According to the study, women felt that the war, followed by five years of stressful post-war life, had left them feeling exhausted and vulnerable, particularly given the burden of unemployment and the fact that the old social security system had been severely dismantled. People were in a situation of ongoing existential stress due to mourning lost family members, and feeling the loss of many things such as their old homes and their "pre-war lifestyle", which remained extremely problematic and probably even intensified when people no longer had to concentrate on merely surviving the war.[24]

Cullberg Weston's findings on healing factors at the centres basically mirror those of Agger & Mimica. She states that psychosocial support was a critical part of the healing process for survivors: "It is important with social spaces like women's centres that can promote healing when people's natural support systems are shattered in a society in chaos. […] Women who had access to women's centres and psychosocial support groups expressed how much it has helped them to survive the difficult times through which they have been put during and after the war. It has helped them to rebuild their trust; it has helped them to handle their families better; it has helped them to regain their strength so as to be able to participate in the reconstruction of civil society" (p. 55). According to the study, the women's centres also acted as important settings for empowering women where they could learn something new and acquire new skills, including job training, all of which contributed to rebuilding their strength, self-esteem and hopes for the future. The author finally emphasised that the strong sense of commitment and solidarity amongst the participants also helped them to process their daily problems.

The study finally mentions important limitations of the assistance provided by the centres. There was inadequate support of women to help them get a job and become self-sufficient, which could have substantially reduced post-war economic stress. Another serious failure was that men did not get the same psychosocial support, which might have influenced the post-war rise in domestic violence, since the men were not able to process their traumas and acted out much of their stress and frustration in the form of domestic violence, where women again were especially vulnerable to being targeted.

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[23] Similarly: Mooren, de Jong, Kleber, Ruvic (2003) looked at a brief, structured trauma-therapy method used at projects of MSF and, later, healthnet. Their study showed that only 15.5% of clients who received this very structured and trauma-focused intervention made a full recovery from their posttraumatic problems, while 23% improved and 61% did not improve at all. Regarding their general health status, the study showed that 54.5% improved and 32.7% did not improve, while 12.8% can be considered to have recovered.

[24] The report also mentions post-war stressors such as the weakness of the joint institutions in Bosnia and Herzegovina and the failure to cooperate between entities, as well as corruption which played a role in keeping foreign investors away. In addition, people who had been expelled from the country were beginning to return, which reawakened massive fears and certainly had a negative impact on the mental health of the clients in the programmes.

3. METHODOLOGY OF THE STUDY

3.1. Introduction to the methodological design and main characteristics of the study

This research and evaluation project is based upon a long process of planning of *Medica Zenica* and *medica mondiale*, on various rounds of preparations, implementation of a complex methodological research design and of regular sessions of joint analysis and discussion amongst the members of the *Medica Zenica* research team, the various consultants to the project and between *Medica Zenica* and *medica mondiale*.

Methodologically, the research and evaluation project follows a mixed-methods research design that can be defined as a procedure for collecting, analysing, and combining quantitative and qualitative research and methods in a single study in order to understand a research problem more deeply (Creswell, 2008). These designs are most appropriate when one type of research, either qualitative or quantitative, might not be enough to understand a topic in depth. Obtaining multiple view points on the same research question enables us to understand it more deeply and thus elicit a more holistic view on a complex phenomenon. The consequences of war rape and sexual violence on survivors and how they have coped in the past twenty years is a topic that obviously needs a balanced mixture of methods and cannot be worked upon by one methodological approach alone.

Medica Zenica and *medica mondiale* began planning this joint research and evaluation project in 2012. Realising that even after twenty years the survivors still associate war rape and sexual violence with shame and pain, we consciously decided that the research would be conducted by staff members of *Medica Zenica.* Since the study participants are all clients of *Medica Zenica,* this enabled us to ensure that a relationship of trust and openness remained central to the project.

The research was mainly conducted by four staff members of *Medica Zenica* who are experienced in working with survivors of war rape and trained in using the respective data collection methods. They had technical support from one international and one Bosnian consultant, both specialised in trauma work, and one Bosnian consultant specialised in life story methodology. To ensure maximum objectivity, another Bosnian consultant conducted the focus group discussions and interviews with key informants (for further description, see below).

After pilot-testing the original tests and questionnaire with five survivors, these quantitative instruments were either shortened and / or adjusted to make the procedure less stressful and draining for the participants and to produce more valid results.[25] The first phase of data collection took place in June 2013 with psychometric tests and a ques-

[25] Due to the differences in the content of the instruments used between the pilot and the final version, the number of the participants answering questions or filling in tests varies. The five women who participated in the pilot research did not use the Harvard Trauma questionnaire or the Coping Inventory (so the number of the participants in the analyses of those data is N=46), but they did complete the questionnaire designed for the purposes of the research and the Brief Symptom Inventory. Therefore, the number of participants in the analyses of this data corresponds to the total number of participants who participated in the research (N=51).

tionnaire being administered to the participants, while the second phase in January and February 2014 included qualitative methods such as focus group discussions, key informant interviews and life story interviews with seven selected survivors. The results were thoroughly analysed with respective tools and reviewed between these phases by both *Medica Zenica* and *medica mondiale,* with the support of the consultants. The final draft report of the research was presented to the survivors before final publication.

As already suggested, the methodology for this research was designed in a way that would respect the sensitivity of trauma and comply with the principles of ethical research as defined by the World Health Organization in the document "Ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies". With that regard, it is important to note that all the documentation for this research (participants' informed consent of participating in the research and / or interviews, tests, questionnaires, transcripts of the interviews and documents about researchers' confidentiality and information secrecy) are kept in *Medica Zenica's* archive. Moreover, the names of the participants have been changed to protect their identities and ensure their right to confidentiality.

3.2. Instruments / techniques used in the research (see also annex)

3.2.1. Quantitative measures used for the purpose of the research

The questionnaire designed for the study

A questionnaire consisting of both open-ended and closed questions was specifically designed for this study. It aimed to gather socio-demographic data about the participants and other necessary information covering the main four research questions: (1) questions about traumatic war experiences and their influence on the participants' lives and the lives of their family and children, the relationship with her partner / spouse and other men, and on her general health; (2) questions about the social acknowledgement as perceived by the participants (3) questions about the coping mechanisms which the participants use to overcome their traumatic experiences; and (4) questions about the services provided by *Medica Zenica* and what work of this organisation meant to them.

Harvard trauma questionnaire – a version for Bosnia and Herzegovina

This questionnaire (Harvard Trauma Questionnaire - Bosnia and Herzegovina version, HTQ-BH, Oruč, Kapetanović, Pojskić, Miley et al., 2008) was constructed with the cooperation of experts from The Harvard Association for Mental Health and experts from Bosnia and Herzegovina and Croatia. For the purposes of this research only the fourth part of the questionnaire was used, which consisted of 40 items. The first 16 items were defined using the DSM-IV criteria for PTSD. The remaining 24 items describe the perception of the participants on how trauma impacts their everyday life. The participants were asked to estimate each item and indicate their response using a scale from 1 (not at all) to 4 (very much).

Based on the participants' answers, it is possible to generate three measurements using this questionnaire: *DSM-IV PTSD* results (the higher the result, the greater the number of PTSD symptoms), *the measurement of social dysfunction* (higher results mean less perceived functionality), and *the total result* (the average result of participants to all 40 items). The result for each measurement is calculated by dividing the summation of answers with the total number of answers. The theoretical span of the results in all measurements varies between 1 and 4. According to the original authors (Mollica et al., 1992), a total result ≥2.5 can indicate that the participant is experiencing PTSD, although the authors who validated this scale with the Bosnian population suggested that in this context a result ≥ 2 could indicate PTSD. The alpha coefficients of reliability in this research indicate a satisfactory reliability for the questionnaire (for total HTQ: α=.93, for Social dysfunction: α=.88, and for DSM-IV PTSD result: α=.90).

Brief symptom inventory

This questionnaire (Brief Symptom Inventory, BSI, Derogatis, 1993) was designed to evaluate different symptoms of psychological suffering and discomfort. It was created as a short version of the original scale "Symptom Checklist-90-R" (SCL-90-R; Derogatis, 1993), and consists of 53 items that describe various symptoms. The participant is asked to estimate every item on a scale from 0 (not at all) to 4 (very much). It is possible to calculate results for each participant in nine basic dimensions and three global indexes of psychopathology, and to analyse their answers in four *Additional items* that cannot be classified under any of the primary dimensions of symptoms.

The nine basic dimensions of symptoms are: somatization (SOM), obsessive-compulsive (OC), interpersonal sensitivity (IS), depression (DEP), anxiety (ANX), hostility (HOS), phobia (PHOB), paranoid ideation (PAR) and psychoticism (PSY). The results for each dimension are calculated by dividing the total of answers with the total number of questions.

The three global indexes are Global Severity Index, Positive Symptoms Distress Index, and Positive Symptoms Total. Global Severity Index (GSI) combines information on the number of symptoms with the intensity of discomfort. It is calculated by dividing the total of all answers in all dimensions and additional items with the total number of answers, and is used as a total measurement of perceived discomfort. The Positive Symptoms Distress Index (PSDI) is an indicator of the participants' average level of discomfort, and is interpreted as a measurement of symptom intensity. It is calculated by dividing the total of the value of all items with the total number of present symptoms. The Positive Symptoms Total (PST) indicates the number of symptoms marked by the participant, and is defined as a measurement of the number of symptoms. It is calculated by summing all the answers given by a participant which are not zero.

Alpha coefficients of reliability attained in this research indicate a satisfactory reliability of the inventory.

	SOM	O-C	I-S	DEP	ANX	HOS	PHOB	PAR	PSY
A	.89	.83	.51	.82	.88	.72	.83	.72	.73

Questionnaire on coping strategies

This questionnaire (Brief COPE; & Carver, 1997) is a short version of a questionnaire on coping strategies (COPE Inventory) originally constructed by Carver, Scheier & Weintraub (1989). The short version consists of 28 items for estimating 14 different ways of coping: diverting attention (distraction), active coping, denial, substance use, emotional support, instrumental / practical support, passivation (ceasing to cope), venting, positive reinterpretation, planning, humour, acceptance, religion, and self-blame. Each of these coping strategies is defined by two items, and the participants estimate how often they use each of the coping strategies on a scale from 1 (I have not been doing this at all) to 4 (I have been doing this a lot).

Alpha coefficient of reliability for the 14 ways of coping covered by this research vary from unsatisfactory to very satisfactory.

Distraction	Active coping	Denial	Substance use	Emotional support	Instrumental/practical support	Passivation
.45	.55	.51	-	.59	.55	.32
Venting	Positive reinterpretation	Planning	Humour	Acceptance	Religion	Self-blame
.54	.27	.68	.31	.69	.81	.90

All data obtained were analysed using SPSS 21.[26]

In order to conduct this first, quantitative phase of data collection, the participants were free to choose whether they preferred coming to *Medica Zenica* to participate (25 chose this option) or meeting the research team in their own home or at a neutral lo-cation of their choosing (26 chose this option). All the participants were first informed about the aims of the research and its procedures, and then asked to sign an informed consent for participation in the research. The participants completed the questionnaire independently. Members of the *Medica Zenica* research team explained any uncertainties. If the participant did not want to complete the questionnaires on her own then a *Medica Zenica* research team member would read them the questions and instructions and record their answers. Sometimes participants working independently would leave a question unanswered, resulting in the number of participants varying in some of the analyses. At the end of the interview the participants were asked if they wanted to participate in the second part of the research (the life story interview). Their answers were noted and used for planning the qualitative study.

[26] Since our research sample is not a randomly sampled research population, we exclusively used descriptive statistics and occasionally looked at correlations (Pearson correlation).

3.2.2. Qualitative methods – Part 1: data from governmental institutions and NGOs

The research also aimed to discover more about characteristics of the current social and political environment in which the survivors live. Therefore, we conducted interviews with key informants from relevant governmental institutions (see below). Data was also gathered from focus group discussions with representatives of various Non-Governmental Organisations (NGOs) that provide help and support to female survivors of war rape and sexual violence.

Appropriate guides were developed in advance for all key informant interviews and focus group discussions (see annex).

3.2.2.1. Key informant interviews with governmental institutions

The research team from *Medica Zenica* initially planned to conduct interviews in the Ministry for Human Rights and Refugees of Bosnia and Herzegovina, the Federal Ministry of Labour and Social Policy, the Ministry of Health and Social Protection of Republika Srpska, the Department of Health and other services of the Brčko District, and the Department for Veteran Protection and Civilian Victims of War, who are the key national authorities for supporting survivors. They were included in the research because they were seen as the relevant institutions for solving survivors' problems and passing laws that are relevant to this population group (especially when it comes to obtaining the status of civilian victim of war). These institutions were also included because the research was intended to document the perspective of different regional institutions about the life and reality of the survivors across the whole country around 20 years after the war.

However, only two of the government institutions that we contacted took part in the research: the Ministry for Human Rights and Refugees of Bosnia and Herzegovina (the interview was conducted with the Assistant Minister) and the Federal Ministry of Labour and Social Policy (the interview was conducted with the Minister).

The other two government institutions (the Ministry of Health and Social Protection of Republika Srpska and the Department of Health and other services of the Brčko District – Department for Veteran Protection and Civilian Victims of War) did not participate, even though the relevant persons from these ministries were contacted on several occasions. Initially, the institution from the Brčko District agreed to participate in the research but while the interview was being arranged, the ministry stopped communicating without explanation. The Ministry of Health and Social Protection of Republika Srpska never replied to any of the written or phone call contacts.

3.2.2.2. Key informant interviews and focus group discussions with NGOs

In selecting the relevant NGOs, it was necessary to ensure objectivity by covering the whole of Bosnia and Herzegovina, and including the main NGOs that were dealing with questions of violence against women during and after the war. *Medica Zenica* chose to include the following NGOs: the Association "Žene sa Une" Bihać, the Association "Žene žrtve rata" Sarajevo, Foundation "Udružene žene" Banja Luka, Association "Vive Žene" Tuzla, Association "Budućnost" Modriča, and Association of

Concentration Camp Torture Survivors of the Canton Sarajevo – Section of Women Camp Torture Survivors.

All of the selected NGOs agreed to participate in the research.

3.2.3. Qualitative methods - Part 2: data from survivors through life story interviews

The aim of this type of in-depth interview is to obtain additional information about the long-term impacts of war rape and sexual violence, as well as a longitudinal perspective of the coping process. The interviews consisted of three parts, and were based on the biographical-interpretation method (BI) (Harrison, 2008: xxxV). The first part is centred on the single suggestive question: *Tell us your life story.* Answers to this question form the main narration, and the utmost importance is given to its interpretation.

Participants simply spoke without interruption in this part of the interview, which as a result could vary considerably in length. During the second and third parts of the interview the participants were prompted with two kinds of questions: internal and external. The internal questions were based on the main narrative, and provided additional clarification to better understand the things that the participant disclosed (e.g. "*When you mentioned"... "could you perhaps say something more about that"*). The external questions were not based on the main narrative, but could be used for further reconstruction. These questions were asked in cases where the participant did not refer to the research questions during her narration. A guideline for the interview was created which included 4 main questions and additional sub-questions to monitor the course of the interview and to ensure that all the research questions were fully covered.

Interviews on the basis of life stories are technically very demanding and time-consuming. Besides the fact that it lasts for hours, it was also necessary to make as authentic a transcript of the interview as possible, not only recording the words but also noting non-textual signifiers such as emotions, atmosphere, etc. Thematic reconstruction of the interview (Rosenthal, 1993; Bar-On, 1995), or more precisely coding and parallel analysis, was achieved using the computer coding program MAXQDA Plus.

Using criteria defined after a first analysis of the data obtained in the quantitative part of the study, the *Medica Zenica* research team, together with a specialised consultant, selected seven women for the interview on the basis of their life stories. They were contacted again to verify that they still wanted to share their story, and all seven confirmed that they did. The person from *Medica Zenica* who called them to confirm their participation documented each conversation on a separate form called a "Starting Protocol for the life story". The time and location for the interview were agreed with the participants. They were at liberty to choose where and when the interview should take place (in a mountain hotel, at their home, in *Medica Zenica* or at some other location of their choosing). It was important that they selected the place where they would feel the most comfortable and safe. The intention was to provide each participant with sufficient time and space for reflection. Also, it was necessary to prevent stressful situations or interruptions while they were telling their life stories. Three participants chose to do the life story in *Medica Zenica* and four of them chose a hotel in the mountains. Since the interviews were both long and demanding, the participants were offered the chance to come to the location a day before the interview and stay a day longer so they could be well rested at the day of the interview and could process their feelings in a safe environment after the interview before going back home. All the participants accepted that offer.

The life-story interviews were overseen by two professionals from the *Medica Zenica* team. One of them conducted the actual interview, while the other observed and was in charge of technical aspects (all the interviews were audio recorded). The participants all signed consent forms for the interviews, which were explained to them beforehand. They were also informed about the aim of the interview and the procedure that it would follow.

During the first part of the interview (the main narration), the participants were not interrupted or asked any additional questions so they could tell their stories freely and without any suggestion. The purpose of this approach is to avoid, as far as possible, any suggestion or impact on what the interviewee might say. When they asked where they should begin, they were encouraged to start wherever they wanted. The interviews lasted between three and seven hours, with a break for lunch and any other necessary breaks. Upon the completion of the interview each participant was debriefed by therapists from *Medica Zenica,* and the interviewers were given the opportunity to share their feelings, thoughts and general reactions to the interview.

When the interviews were complete, the audio tapes from each were transcribed by the same person, a *Medica Zenica* associate, to ensure consistency. The para-linguistic symbols to be used in the transcript were agreed beforehand. Transcribing five minutes of audio recording took around an hour to complete. The two members of the *Medica Zenica* research team first analysed the life stories separately, and then analysed them together. A final analysis of the life story data was then performed using the MAXQDA Plus program.

3.3. Characteristics of the participants

3.3.1. Women survivors of war rape and sexual violence (included in the quantitative study)

3.3.1.1. General challenges in the preparatory phase

Medica Zenica has documentation at its disposal for a great number of clients who have been given some form of treatment in the last 20 years. On the basis of information from those documents, it was planned to contact all 119 of *Medica Zenica's* clients who had survived war rape and sexual violence during the war. These survivors fulfilled different criteria that were of interest for us: (1) that there were representatives from all groups (Bosniak, Serb and Croat and others), (2) that survivors were diversified by age and educational status at the time when the rape happened, (3) that survivors were living across the whole of Bosnia and Herzegovina at the time of the research, and (4) that *Medica Zenica* possessed the documentation of their medical examinations and therapy process from the beginning of their treatment.

Medica Zenica had kept contact details for all their beneficiaries, but when the research team started trying to contact survivors it was discovered that some had changed their address or phone number, or had gotten married and changed their family name, so were unavailable for immediate contact. Reaching those women was a challenge on its own, and the research team members used various sources in their quest to reach them. They gathered information from their resources, their family members, friends and colleagues, other survivors who used *Medica Zenica's* services, through field work, from the post office, from social service centres, and from other organisations that work with survivors.

In the end, out of 119 survivors who had used *Medica Zenica's* services, a total of 51 agreed to participate in the research. Their socio-demographic information as well as information about the 68 women who did not to participate in the research are given below.

3.3.1.2. Information about the survivors who used the services of Medica Zenica but did not participate in the research

A total of 68 women survivors of war rape and sexual violence did not participate in the research for a number of different reasons:

- It was impossible to establish any contact with them because their contact information (phone number and address) was incorrect and it was impossible to find accurate data (10 women)
- They had passed away (13 women)
- They did not want to participate in the research (23 women)
- They withdrew their participation, even though they agreed on first contact (5 women)
- They live outside of Bosnia and Herzegovina (17 women)

The following information was available for the 13 former clients who had passed away:

Time of death:

- Died during the war (3 women)
- Died over 5 years ago (3 women)
- Died in the last 5 years (5 women)
- It was impossible to find out (2 women)

Causes of death:

- 3 women died of uterine cancer
- 2 women died in car accidents
- 2 women died of heart attacks
- 6 women died of other diseases or reasons (gastric cancer, liver cancer, lupus, suicide, drowning, unknown)

28 of the women we contacted did not take part in the research (23 declined immediately, while 5 withdrew late). They gave the following reasons:

- They did not want to talk about the past (8 women)
- They did not have time (5 women)
- Other reasons (15 women)
- Sickness, either self of family member
- Fear that their family members would find out about their rape experience
- Fear that talking about it would negatively reflect on their physical or psychological health
- They do not provide a reason

Some of the 17 women living outside Bosnia and Herzegovina live in Austria and some in the USA.

3.3.1.3. Information on participants in the quantitative study

General information gathered for the purposes of this research was very useful in understanding basic socio-demographic characteristics of the participants. The information on age, ethnicity, entity, type of residing settlement, change of residence, is presented in the table below.

The youngest participant when the research was being conducted was 33, and the oldest 81. The average age of the participants was M=50 years (SD=11.81). The table contains three age categories for the participants and a proportional representation of participants between the age groups.

Regarding marital status four are unmarried, 28 married, and one cohabits with a partner. A total of seven participants are divorced, and eleven participants are widows. As the table shows the dominant ethnical group amongst the participants is Bosniak, while a small number of others belong to the other two ethnical categories (two are Serbs and two are Croats). Also, most of the participants (N=46) live within the entity of the Federation of Bosnia and Herzegovina, while a small number (N=5) lives in the entity of Bosnia and Herzegovina-Republika Srpska. Most of the participants are living in cities (almost 60%) while the remainder live in suburban areas or in villages (around 40%). Only eight of the participants did not move home during or after the war. A total of 29 participants moved and are now registered at their current address, and 14 returned to the place where they lived before the war.

Table 3.1. Socio-demographic data (age, ethnicity, entity, place of residence, change of residence, N=51)

		N	%
Age	30 – 40 years	16	31.4
	41 – 55 years	18	35.3
	More than 55 years	17	33.3
Marital status	Married	28	54.9
	Not married	4	7.8
	Living with a partner in a cohabitation	1	2.0
	Divorced	7	13.7
	Widow	11	21.6
Ethnicity	Bosniak	47	92.2
	Serb	2	3.9
	Croat	2	3.9
Entity	Federation of BiH	46	90.2
	Republika Srpska	5	9.8
Type of settlement	Village	11	22.0
	Suburb area	10	20.0
	City	29	58.0
Change of residence	Returned to a place where she lived before the war	14	27.5
	Changed place of residence	29	56.9
	Did not change place of residence	8	15.7

Table 3.2. shows data about the educational status and occupation / employment of the participants before and after the war, as well as the data about their monthly income. The table also shows if the participants have health insurance and the status of civilian victim of the war.

Table 3.2. Data about education, occupation/employment, monthly income, health insurance and civilian victim of war status (N=51)

		N	%
Education	Did not go to school at all	1	2.0
	Few years of elementary school but did not finish	3	5.9
	Finished elementary school	18	35.3
	Finished high school	26	51.0
	Studied on college but did not finish	1	2.0
	Finished college	2	3.9
Occupation/ employment before the war	Employed	21	41.2
	Unemployed	17	33.3
	Student	13	25.5
Occupation/ employment after the war	Employed	13	26.5
	Unemployed	28	54.9
	Retired	10	19.6
Monthly income	Between 100 and 300 BAM	6	12.2
	Between 300 and 550 BAM	16	32.7
	More than 550 BAM	27	55.1
Health insurance	Have	50	98.0
	Do not have	1	2.0
Civilian victim of war status	Obtained	39	76.5
	Did not obtain	12	23.5

The table data shows that a small number of the participants (around 8%) did not finish elementary school. Around 35% finished elementary school and around 50% finished high school. A small number of the participants (around 7%) have also studied at or graduated from college. As for the occupation / employment before the war, 13 were students at elementary or high schools at that time, 17 were unemployed and 21 were employed. Most of the employed participants worked in craft or administrative services (e.g. hair stylist, retailer, restaurateur, typist, administration officer, manager, etc.). At the time of the study a total of 28 participants were unemployed, and 10 of them have retired. Only 13 are currently employed, most of whom work in utility and craft services, while a small number work in administration (one of them is a director, one is a lawyer, and one works in education).

Around 55% of the participants have monthly incomes greater than 550 BAM, around 33% between 300 and 550 BAM, while of the other participants, around 12% have a monthly income of 300 BAM or less. Only one participant does not have health insurance, and 39 (76.5%) of the participants have obtained the status of civilian victim of war. The other 12 participants did not obtain this status.

3.3.2. Selection of participants for the 7 life stories

All the women who took part in the quantitative part of the research were asked if they would also like to participate in the qualitative part, which would mean telling their stories in a life-story interview. While 23 of the original 51 women agreed to take part in the interviews, seven were sufficient for our purposes. It was therefore important to establish some criteria for selecting these seven. The intention was to ensure that the participants who were selected would offer the best representation of the methods the survivors used to cope with their traumatic experiences. The interviewers from *Medica Zenica,* in cooperation with the consultant for the narrative interview, established the following criteria for selecting the participants:

- Age (it was necessary to include those participants who were the youngest at the time when the rape occurred, as well as to include those who were older – up to 40)
- Educational status (it was necessary to include women with different educational status at the time when the rape occurred)
- Economic status (it was necessary to include participants who were both employed and unemployed at the time of the research)
- Current place of residence (it was necessary to include both participants who have returned to places where they lived before the rape as well as those who have not)
- Marital status (it was necessary to include participants who were both married and single)
- Whether they gave birth to a child conceived "through rape" (it was necessary to include those women who decided to give birth to a child conceived through rape as well as those who did not)
- Whether their husbands / partners know about their rape experience (it was necessary to include those women whose husbands / partners know about their rape experience as well as those women whose husbands / partners do not know)

Table 3.3. shows the participants' socio-demographic data and their characteristics on the basis of criteria used for their selection for interview. The data gathered refers to both the time when the rape experience occurred and the time when the research was conducted.

Table 3.3. Socio-demographic data for the participants interviewed and characteristics based on the criteria used for their selection for interview

		At the time of the war trauma	**At the time of research**
Age	The youngest The oldest	13 years 38 years	34 years 58 years
Educational status	Students Finished elementary school Finished high school Finished college	2 1 3 1	- 2 3 2
Economic status / employment	Employed Unemployed	3 4	4 3
Type of settlement	City Village	4 3	6 1
Change of residence	Returned to the place of residence before the war Did not return to the place of residence before the war		4 3
Marital status	Married Not married Divorced Widow	1 6	4 1 1 1
Whether they gave birth to a child conceived "through rape"	Yes No		2 5
Whether their husbands / partners know about their rape experience	Yes No		6 1

In addition to the information displayed in the table above, during the life story interviews, all the participants described surviving multiple rape either by one or more perpetrators in their narratives, and all of them had survived many other traumatic experiences. The participants stated that they were raped in various locations: concentration camps (2 participants), under house arrest (2 participants), in private houses (2 participants), or somewhere else (1 participant).

All of the seven participants have the status of civilian victim of war in Federation of Bosnia and Herzegovina. All the participants have given testimony about their traumatic experiences at various levels of courts and prosecutors' offices in Bosnia and Herzegovina. One of them was a witness at the International Criminal Tribunal for the former Yugoslavia, while one was a witness in Croatia. All seven of the participants used various *Medica Zenica* services, such as shelter, psychological counselling, gynaecological services, general medical examinations, internist, legal aid, economic empowerment and occupational therapy, or services that worked with children. First contacts between all seven participants and *Medica Zenica* occurred when Medica visited their place of residence, which was either their home or a refugee centre.

3.4. Limitations of the study

As with all studies, there are limitations to this research.

One overall limitation is that we cannot easily generalise our findings to the whole group of survivors of war rape and sexual violence living in Bosnia and Herzegovina. The participants in our study had access to *Medica Zenica's* services, and most used them for years. There are many other survivors living in Bosnia and Herzegovina who did not access the services of Medica or any other organisation, whether because of the shame and the pain implied; because they already felt "better" at the end of the war; because they had enough support from others such as family members or friends; because they used other coping strategies, such as emigration; or because they had found other ways to carry on with their lives. Some survivors of war rape may remain too severely challenged by fragile mental health to seek help, even now. Conversely, many survivors who had used Medica's services were unavailable for the study for a number of reasons, such as no longer living in the country, or having died in the intervening years. It is therefore a fact that this research does not tell us whether, for instance, the prevalence of PTSD in our sample, along with other psychological problems, is higher, lower or about the same as for other groups of survivors. We consciously opted NOT to adopt a study design with a so-called "control group", as is often used in scientific research to allow comparison. We felt this was unethical, given the high level of pain that war rape and sexual violence inflicts.

Another methodological limitation to the study design is that we do not have systematically researched data for the prevalence of trauma and other measures for all survivors who participated in the research from the time when they first arrived at *Medica Zenica.* At that time, given the tremendous challenge of taking care of so many survivors, there were other, far more important priorities. However, it would now have been a useful and important source of information to compare the results, e.g. of PTSD prevalence at the time of the war and 20 years later. This current, extensive research may enable a follow up study in 10 or so years to obtain more information on the trajectories of coping with war rape.

An additional limitation shared by all retrospective studies has to do with the subject: 20 years of coping with war rape. Memory effects, i.e. biases, are to be expected in what women remember feeling 20 years ago in comparison to now. Our memory is always shaped by a selection processes of what we remember. So, e.g. being asked whether it was easier to cope with the experience now or 20 years ago, when it had just happened, does not necessarily reflect the "real" feeling of how it actually *was* then and *is* now, but rather how, from today's perspective and with today's experience, they *perceive* their feelings at that time. However, this already gives us some important information about their process of coping.

As will be mentioned in the results, the number of responses per question varies, particularly regarding the questionnaire, since not all participants filled in all the questions. The whole research experience was draining for the participants and some women might not have been used to responding to questions in a written form, even though we created an atmosphere of welcome and acceptance. So, although we tried as far as possible to take care of their needs, some might have gotten tired or emotionally unstable during the procedures of filling in the questionnaire. Others might have ignored

questions that they felt did not apply to them. Although we do not know why some questions went unanswered, as the participants did not record this information, we will always indicate how many responses we got to each question, and present our findings accordingly.

We very consciously decided to implement the study with professional staff members from *Medica Zenica* in order to access information from the women regarding their most painful life experiences; we wanted to avoid a situation where talking about "it" could easily become emotionally overwhelming and lead to either a retraumatisation or to avoiding answering our questions, either of which would make it impossible to obtain authentic responses to the questions. Having professionally trained staff members of an organisation about which the women felt very positive seemed likely to create the safest space for the women to revisit these memories, and the most conducive atmosphere for eliciting valid information. However, while this was an advantage, we also incurred the risk of social desirability bias whereby some answers might have been influenced by the women feeling that they could benefit from services if they portrayed themselves in a certain way. In particular, the questions regarding the impact of *Medica Zenica's* services might have led to a certain bias in responding. On the other hand, as some responses that we transparently quote show, even if the overwhelming majority felt a very positive impact of the services, there were also critical voices. Thus, we believe that even if we expect some response bias because of social desirability issues, these effects do not systematically distort the results.

Despite the fact that our research has such a wide scope and covers four essential areas of concern related to women survivors of war rape, there are, of course, topics that were not included in the research which would have given an even more complete picture, such as how Medica staff themselves perceive their work and how they have been able to cope with the tremendous challenges of supporting survivors of war rape in an environment where almost everyone in Bosnia and Herzegovina has had to come to terms with traumatic war experiences and losses. Equally, we did not include the views and perceptions of the survivors' families, such as husbands / partners and children who know about the woman's experience. Finally, we also did not systematically research community perspectives on the survivors. What is described here always relates to what the survivors *perceive.* Perception, of course, is always something subjective and is influenced by very different mental processes.

We hope that in future research, we might be able to cover some more of these highly relevant topics.

4. RESEARCH RESULTS

The following chapter, which forms the core of our study, presents analyses and results from our four main research questions. The findings will be located against the theoretical background to the study from Chapter 2, and the results obtained from various sources will be highlighted in a triangulated, integrated manner, using the following format for each research question. Firstly, a sub-chapter combining the quantitative results from the tests and questionnaire, along with key informant interviews and focus group discussions with relevant government institutions and NGOs. Secondly, a sub-chapter reflecting the results and summaries from the life stories. As mentioned above, the overall intention is to present the data while also providing a special space in which the survivors' voices can be heard.

4.1. Research question 1: Impact of the experience of war rape and sexual violence on survivors' lives: Results obtained from the psychometric tests, questionnaire and focus group discussions with NGOs

The research looks at three aspects of the impact of war rape and sexual violence on survivors:

- the impact on their psychological health, particularly with regard to PTSD and other measures of distress and psychological suffering;
- the impact on survivors' health in general, and specifically their gynaecological / reproductive health,
- the impact of war rape on survivors' relationship with their family as a whole, with husbands / partners and men in general, and finally with their children.

4.1.1. The multiple traumatisation of war: What do survivors of war rape perceive as (the most) difficult experiences that they went through?

As already mentioned, in most psychometric measures related to PTSD, participants are given a number of typical traumatic experiences (so-called stressors according to DSM-IV), and asked whether they went through them. We wanted to avoid this, since it gives the participants very little control over remembering painful experiences. Secondly, we wanted to assess what the participants themselves remembered as the most stressful experiences after twenty years, thus opening up a space for their unique experiences beyond normed response alternatives. In the questionnaire, therefore, the participants were first asked to name difficult experiences they had during the war, and the various answers they provided were later organised into following categories: rape, witnessing the rape of their mother or daughter, other kinds of physical violence, witnessing physical violence against other people, imprisonment in concentration camps, or at home, imprisonment of family members and close friends, loss of someone close, psychological torture (threats and humiliation), and other (separation, hunger, starvation, etc.). It must be noted that the frequency of the participants' answers in the table

does not mean that the participants did not suffer other forms of violence that may or may not appear on the list; it merely means that in the moment of answering an open question they spontaneously mentioned those specific experiences, usually two or three, that came to mind in that particular moment.

A subsequent question referred to the 'most difficult experience'. The participants provided multiple answers to this open question, since they found it hard to decide on one traumatic experience as the most difficult. Their answers were also organised into the same categories: The numbers in column 'N' show how many participants chose each category as the most difficult experience, with rape being the most commonly chosen (n=30). Throughout the report, most tables will list results according to frequency, with the most frequent responses given first.

Table 4.1.: Traumatic experiences during the war

Difficult traumatic experiences named by participants	N	%	The most difficult traumatic experience	N	%
Rape	33	66.0	Rape	30	60.0
Imprisonment in concentration camps, in house	16	32.0	Other kinds of physical violence	6	12.0
Psychological torture (threats and humiliation)	12	24.0	Imprisonment in concentration camps, in house	6	12.0
Witnessing physical violence against other people	10	20.0	Psychological torture (threats and humiliation)	6	12.0
Other kinds of physical violence	8	16.0	Witnessing rape of their mother, daughter	4	8.0
Imprisonment of family members and close friends	6	12.0	Loss of someone close	4	8.0
Loss of someone close	5	10.0	Witnessing physical violence against other people	2	4.0
Witnessing rape of their mother, daughter	4	8.0	Imprisonment of family members and close friends	2	4.0
Other (separation, hunger, starvation, etc.)	35	70.0	Other (separation, hunger, starvation, ect.)	12	24.0

4.1.2. Impact of war rape on psychological health: Prevalence of PTSD and other measures of psychological distress

As mentioned above, rape (and sexual violence) is one of the most devastating and potentially most pathogenic traumatic experiences. War is another. The survivors who participated in our study went through both.

One of the most frequently researched consequences of traumatic experiences is Post-Traumatic Stress Disorder (PTSD). PTSD is one of the rare diagnostic categories that has a clearly defined etiological factor (namely the traumatic experience), which is the key criterion for its diagnosis. In this research, we used a quantitative approach to collect data on PTSD symptoms from the participants. The main descriptive data was obtained using the Harvard Trauma Questionnaire (HTQ) with a sample of 46 participants, and is shown in Table 4.2.

Table 4.2. Descriptive values of survivors according to the Harvard Trauma Questionnaire (N=46)

	Min	Max	M	SD
DSM-IV PTSD results	1.00	3.94	2.85	.62
Social dysfunction	1.00	3.58	2.39	.54
Final result	1.00	3.73	2.58	.53

As mentioned above, this questionnaire yields three measures. Apart from the final result in the questionnaire, there is also the measurement of PTSD symptoms ("DSM-IV PTSD result") and a measurement of the participants' perceived dysfunction in everyday life ("social dysfunction"). All measures can theoretically assume values between 1 and 4, and the table shows, all average results exceed M=2.3 (the smallest being for perceived dysfunction). The highest average results were M=3.94 for the measure of PTSD symptoms. According to the instructions given by the authors of the scale, higher values for the "*DSM-IV PTSD result"* imply a greater frequency of re-experiencing symptoms, symptoms of avoidance, and hyper-arousal (the three main PTSD symptom clusters).

The average of M=2.58 for the measure "DSM-IV PTSD result" shows the seriousness of participants' PTSD symptoms. The higher the values for the perceived social dysfunction, the more disturbing the traumatic experience is in the everyday life of the participant. The average result obtained from our participants (M=2.39) shows that they also report difficulties in everyday functioning.

The authors of this scale and those of other studies who used this questionnaire state that PTSD can be diagnosed where the final result from the questionnaire exceeds 2.5. In our study, the average result from a sample of 46 participants was M=2.58 (SD=.53). It would, however, be unfounded to claim on the basis of this mean result that, 'on average', the participants in the study have PTSD, since strict clinical procedures require such a diagnosis to be based on diagnostic interviews. Nevertheless one can say that, according to this result, twenty years after they experienced war rape trauma and sexual violence, along with other severely traumatising events, the participants on average show clinically significant results, i.e. results that imply a clinical significance of PTSD symptoms. However, there are studies which assume that participants have PTSD when the final HTQ result is equal to or greater than 2.5. Following this approach, our analyses show that 26 out of 46 participants who completed the questionnaire showed results of ≥2.5, **which means that 57% of our sample of survivors of war rape have PTSD twenty years after the war.**

Prevalence rates for PTSD following sexual violence are variable, but on average stand at 50%, as was said in the theoretical background to research question 1. Studies in Bosnia and Herzegovina that were mostly conducted in the first 10 years after the war have shown that PTSD prevalence in different traumatised populations varies between 18 and 53%, while the highest PTSD prevalence (up to 85%) is found in women who survived the events in Srebrenica (Rosner, 2003). According to Kuwert et al. (2010), who conducted research on the psychological consequences of war rape on women 60 years after the end of the Second World War, 19% of participants reported still having clinically significant current posttraumatic stress symptoms, while 30% fulfilled the criteria of a current partial Post-Traumatic Stress Disorder.

In the study of Loncar et al. (2006) conducted with 68 rape survivors from Croatia and Bosnia and Herzegovina on the psychological consequences of rape one year after their experience, 52 (76%) suffered from depression, 51 (75%) suffered from social phobia and 21 (31%) from PTSD. Although the variance in measures to establish PTSD prevalence make comparisons difficult, we can safely say that 57% of survivors of war rape still suffering from PTSD 20 years after their experience is a considerably alarming result, especially given the fact that the women who participated in the study were provided with psychological and social support by *Medica Zenica* which they greatly appreciated (as will still be seen under research question 4), and felt to be important in their lives.

Two studies which actually used the same instrument (namely the Harvard Trauma Questionnaire) can be cited, allowing a direct comparison with our result. Klarić, Stevanović, Grković and Janovska (2007) compared PTSD symptoms of women from West Mostar who were exposed to war events for four years during the war in Bosnia and Herzegovina and women from the "control group" who lived in Western Herzegovina where there was no direct fighting. The study showed that women from West Mostar showed a significantly higher PTSD prevalence than those in the control group (28.3% compared to 4.4%).

Hasanović (2012) used the HTQ only three and a half years after the war in Bosnia and Herzegovina on a sample of adolescents who were forced to flee Srebrenica, Zvornik and Bijeljina. Their final HTQ results were between M=2.5 (SD=1.3) and M=1.7 (SD=1.2), with youths from Srebrenica scoring the highest results. The PTSD prevalence rate in his sample was between 73.9% (for Srebrenica) and 47.6% (for Bijelina).

Our results for the prevalence of PTSD in survivors of war rape 20 years after the war thus clearly indicate the long-term debilitating effect of war rape on survivors in Bosnia and Herzegovina. Since we cannot determine a base point of PTSD prevalence amongst our sample immediately after the war, we cannot tell if PTSD has increased amongst survivors due to the ongoing stress of living in post-war Bosnia and Herzegovina, or declined over time until it has now reached a point where over half of the women still suffer from PTSD. We might also cautiously suggest, based on the theoretical background to this study, that the women's trajectories could differ over time, with some women having recovered to some extent after the war while others having developed more severe symptoms, possibly due to an aging effect that usually brings about an aggravation of psychological problems, or due to sequentially traumatising effects related to the ongoing post-war stress.

The Brief Symptom Inventory (BSI) standardised psychological test also formed part of the research. This questionnaire (which is a shortened form of the original version SCL-90-R) has been used in clinical studies in Bosnia and Herzegovina and worldwide as a general measure of perceived psychological problems and psychological suffering. Descriptive values obtained in this study's sample of participants (N=51) are shown in Table 4.3.

Table 4.3. Descriptive values of subscales in the short symptom questionnaire (N=51)

	Min	Max	M	SD
Somatisation	.00	3	1.74	.87
Obsessive-compulsiveness	.00	3	1.28	.84
Interpersonal sensitivity	.22	2.75	1.20	.68
Depression	.00	3	1.00	.79
Anxiety	.00	3	1.74	.89
Hostility	.00	3	.92	.66
Phobic anxiety	.00	3	1.39	.97
Paranoid ideation	.00	3	1.15	.79
Psychoticism	.00	3	.75	.66
Global Severity Index (GSI)	.15	2.58	1.27	.39

As shown in the table, the participants mostly reported psychosomatic symptoms and anxiety symptoms (obsessive-compulsiveness, anxiety, and phobic anxiety). It should be remembered that the differences in average values within these nine categories of symptoms are very small, implying that different symptoms of psychological suffering amongst all participants in our research are relatively consistent. These results are expected, and are in line with research about the frequent comorbidities of PTSD in survivors of war and sexual violence.

Finally, Table 4.4. shows the frequency of some of the participants' answers to four additional BSI questionnaire items.

Table 4.4. Participants' answers with additional BSI questionnaire items

		N	%
Bad appetite	Not at all	20	39.2
	Very little	3	5.9
	Moderately	13	25.5
	Quite	6	11.8
	Definitely	9	17.6
Sleep difficulties (falling asleep)	Not at all	4	7.8
	Very little	2	3.9
	Moderately	6	11.8
	Quite	16	31.4
	Definitely	23	45.1
Thoughts about death / dying	Not at all	16	31.4
	Very little	6	11.8
	Moderately	8	15.7
	Quite	10	19.6
	Definitely	11	21.6
Guilt	Not at all	32	62.7
	Very little	5	9.8
	Moderately	4	7.8
	Quite	4	7.8
	Definitely	4	7.8
	Refused to answer	2	3.9

Symptoms displayed in these additional items are significant clinical indicators, and offer professionals important information. In cases where indicative answers with-in these items are "quite" and "definitely", we can say that the biggest percentage of participants who are "quite" or "definitely" distressed are those with difficulties falling asleep (about 76%) and thoughts of death / dying (about 40% of the participants). A smaller number of participants were "quite" or "definitely" distressed due to having a poor appetite (about 30%), and feelings of guilt (about 16%). In other words, it is most common for participants in our study to suffer from clinically significant sleeping difficulties and suicidal thoughts.

For risk factors that serve as a predictor for a more severe posttraumatic symptomatology, we found some interesting associations between the results of the Harvard Trauma Questionnaire and Brief Symptom Inventory, and the participants' occupation / employment, and "civilian war victim" status. Occupation / employment after the war seems to play a protective role: Unemployed participants have a higher global severity index than those who are employed (M = 3.22, SD = 0.68 and M = 2.51, SD = 0.73), meaning that they report more perceived discomfort compared to employed participants. The same applies to the positive symptoms distress index, where unemployed participants had a higher intensity of symptoms compared to those who were employed (M = 0.66, SD = 0.23 and M = 0.35, SD = 0.11). Unemployed participants also report fewer positive current symptoms in relation to employees (M = 36.93, SD = 11.77 and M = 47.08, SD = 8.19). Participants who are employed assess their health as better than those who are unemployed (M = 1.77, SD = 0.44 and M = 1.41, SD = 0.50) and those who have retired (M = 1.77 and M = 1.00, SD = 0.00).

The status of civilian war victims also played a role regarding both PTSD diagnosis and all three indexes of the Brief Symptom Inventory. Participants who have achieved the status of civilian war victims have fewer symptoms of PTSD than those who have not (M = 0.30, SD = 0.12 and M = 0.38, SD = 0.1). They also report a smaller number of general psychological symptoms (result on BSI index: Positive Symptoms Total (PST), M = 38.10, SD = 12.38 and M = 48.08, SD = 4.10.). But it is both interesting and apparently contradictory that survivors who have achieved civilian war victim status report a greater perceived discomfort from, and a greater intensity of, their symptoms (M = 3.14, SD = 0.77 and M=2.41, SD = 0.49; M = 0.61, SD = 0.26 and M = 0.43, SD = 0.12). This underscores the above finding that the number of post-traumatic problems and subjective feelings of suffering do not necessarily correspond with each other.

4.1.3. Participants' perception of the long-term impact of war rape

One of our questions regarding the perceived psychological well-being of survivors of war rape was: Do survivors feel that time heals? Or does the impact of war rape trauma increase over time?

Two questions were asked specifically to find out what participants felt about the impact of war rape over time. One was a closed question ("*When you think about your life now, what do you think, does rape influence your life TODAY, twenty years later?"),* and the other was an open question ("*If yes, or to a certain extent, state the main consequences that impact on your life today, twenty years after the war. Name only one or two things which cross your mind.").* Their answers are shown in Table 4.5 below.

Table 4.5. Participants' answers about the consequences of rape for their life / psychological condition today

Does rape influence your life today, 20 years after?		
	N	%
Not at all	2	4.3
To some extent	12	25.5
Yes, completely	33	70.2
Consequences of rape on a woman's life		
	N	**%**
Memories of rape and distress due to the memories	22	50.0
Emotional issues (fear, nervousness, etc.)	20	43.5
Health / physical difficulties	15	34.1
Relationship with persons who are close	9	20.5
Sleep difficulties	8	18.2

The table shows that of the 47 participants who answered this question, only two reported that the rape trauma no longer has an impact on their life, while all the others self-report a considerable impact on their current psychological functioning. 70.2% even perceive that the rape experience impacts on their lives completely. The participants identified several different issues to describe how they currently perceive the consequences of war rape trauma on their current lives, which were later organised into categories.

As the table below shows, survivors mostly prioritised problems including forced memories of the traumatic experience and the distress they cause, emotional problems, and health difficulties. Some participants also named sleep difficulties and issues in relation to people they were close to. Some of their answers, which reflect the most commonly recognised consequences of rape and show how strong the impact still is on survivors' psychological health, even 20 years after the experiences, are listed below.

Sleeping difficulties

– *"I have nightmares"*
– "*I can't sleep, I dream of guns, soldiers"*
– "*nightmares, I dream I'm always running away, jumping in my sleep"*

Health / physical difficulties

– "*back pain and headaches from beatings"*
– "*had the uterus surgically removed due to consequences of rape"*
– "*3 strokes, diabetes, still-visible scars on the body, thyroid gland issues, blood pressure, angina pectoris", "tuberculosis as a consequence of rape (urinary tract and genitalia)"*

Memories of rape and distress due to those memories

– *"I cannot have my coffee upstairs because the image of being raped repeatedly whenever they wanted comes back", "memories of everything that happened to me"*
– "*no day can go by without me thinking, because every day I see the school where I was taken to"*

– *"the fact that I cannot enjoy everyday activities because different reminders put me back to the events I survived, e.g. watching movies, the news"*

Relationship with close persons

– "*sometimes animosity towards men due to physical abuse"*
– "*being intimate with my husband"*
– "*I have a daughter for whose future I am very afraid"*
– "*towards children – yelling at them"*

Emotional problems

– "*sadness that never goes away, it is always with me"*
– "*fear of seeing some people in the street"*
– *"I cry constantly, I could always cry"*
– "*there come moments when I hate myself"*

In focus group discussions, representatives from NGOs working directly with survivors of war rape confirmed our general findings regarding the consequences of war rape on survivors. They offered some interesting insights which illuminate the way that survivors describe the long-term effects of war rape. A therapist from one association, talking about the influence of trauma on survivors' lives, said: "*They feel they are different from others, incompetent, stigmatised, that they have lost something forever."* Another therapist mentions the negative consequences: "*There is de initely a significant number of women who still haven't spoken out, but they are nervous, they cannot sleep, they have emotional, impulsive reactions, mood swings, and somatically they have high blood pressure, constantly fall ill, pain in the bones, in the legs."*

This confirms our impression that the impact of rape on women's self-worth and sense of identity might have become more chronic with time.

4.1.4. Influence of war rape and sexual violence on the physical health of survivors (health in general, as well as specifically gynaecological / reproductive health)

Rape has a number of consequences for the health of survivors in general and for their gynaecological and reproductive health in particular. The participants were asked several questions to find out on how they assessed their own health situation, starting with "*How would you describe your health condition?"* Their answers are shown in the table below.

Table 4.6. Self-reported health condition

How would you describe your health condition?		
	N	**%**
My health is bad	28	57.1
My health is pretty good	18	36.7
My health is good	3	6.1

Out of 49 participants who answered this question, only 3 stated that their health was good, while the table shows that over half the survivors felt that their health was actually bad.

The second question asked if they regularly saw doctors and, if so, what were their specialisations. Their answers are shown in Table 4.7.

Table 4.7. Information on participants' treatment

Do you see a doctor on a regular basis?		
	N	**%**
No	7	14.6
Yes	41	85.4
Types of doctors visited by the participants		
	N	**%**
Gynaecologist	23	56.1
Psychiatrist, neurologist, psychologist	21	51.2
General practitioner, internal medicine specialist	17	41.5
Other	19	46.3

As shown in the table, 41 of the 48 participants who answered this question reported seeing a doctor regularly. Participants mostly reported seeing gynaecologists, psychiatrists (and psychologists), general practitioners and internal medicine specialists.

Also related to health issues, the participants were asked if they use medicines, which ones, and since when. Their answers are shown in Table 4.8.

Table 4.8. Information on medicines used by the participants

Do you use medicines on a regular basis?		
	N	**%**
No	17	34.7
Yes	32	65.3
If yes, since when?		
	N	**%**
Since the war	14	50.0
Since the last 10 to 15 years	9	32.2
Since 1-2 years	3	10.7
I don't know	2	7.1
If yes, which medicines do you take?		
	N	**%**
Psychopharmacological	30	90.9
Cardio-vascular	17	51.5
Hormone regulators	9	27.3
Other	15	45.5

The table shows that 32 of the 49 participants (65%) who responded to this question use medicines regularly. Almost all (91%) use psychopharmacological medicines and / or 17 (52%) use medicines for cardio-vascular diseases, while a small number reported using medicine to regulate their hormones. Other reasons for using medicine include: "for my veins", "for tuberculosis", "for the stomach", etc. Most of them have used medicine since the war and for the last 15 or so years. The following list shows the type of medicines they use:

- *Lexilium 3mg, trazin, sugeren for allergies, heart medicine, blood pressure, daily 14 pills, since 1995*

- *Tranquilisers, for diabetes, blood pressure, insulin*
- *For blood pressure, pain killers, heart medicine, stomach medicine, tranquilisers – I don't know since when*
- *Tranquilisers, for high blood pressure, heart race anomalies, thyroid gland[...] since 1995*
- *For heart, liver, diabetes, tranquilisers, since the war*
- *I cannot count them all, yellow, white – since the war*

The high levels of cardio-vascular and hormonal medication might be an indicator for the debilitating effects of post-traumatic and ongoing life-related stress on the cardio-vascular and hormonal systems of the body, which would give a clear indication of the severe long-term health consequences of traumatic experiences, aggravating the health situation of survivors over time.

In addition to inquiring about the survivor's health in general, the research wanted to find out more about their gynaecological / reproductive health. Table 4.9. shows their answers.

Table 4.9. Participants' gynaecological problems (grouped along the most frequent problems mentioned)

		N	%
Do you sometime urinate uncontrollably?	No	17	34.7
	Sometimes	6	12.2
	Yes	26	**53.1**
Do you feel pain in the pelvic area (lower part of stomach)?	No	8	16.3
	Sometimes	17	34.7
	Yes	24	**49.0**
Do you suffer sometimes from vaginism, i.e. that your muscles do not allow penetration during sexual intercourse?	No	15	34.9
	Sometimes	9	20.9
	Yes	19	**44.2**
Do you have vaginal discharge?	No	18	37.5
	Sometimes	15	31.3
	Yes	15	**31.3**
Have you had any problems to conceive?	No	29	80.6
	Yes	7	**19.4**
Do you have an itching feeling in the vaginal or rectal area?	No	25	52.1
	Sometimes	15	31.3
	Yes	8	**16.7**
Do you bleed apart from the menstrual cycle?	No	36	75.0
	Sometimes	4	8.3
	Yes	8	**16.7**
Have you had cancer in the last years?	No	42	89.4
	Yes	5	**10.6**

The number of participants who answered those questions related to gynaecological problems varies between 36 and 49. As seen from the table, 5 of the 47 participants (about 11%) reported haven fallen ill from cancer in the years since the war. In addition, we learnt that 7 rape survivors who we tried to contact to participate in research have died from cancer.

A relatively high number of participants (7 out of 36) reported problems with becoming pregnant. These two problems (cancer and getting pregnant) can be seen as the most serious gynaecological / reproductive health problems which the survivors face. Even though it is difficult to separate the influence of trauma from genetic and other risk factors, we can assume that the stress due to their multiple traumatisation and specifically war rape significantly contributed to the development of these grave health problems.

The table shows that the majority of the participants (over 50%) report difficulties such as pelvic pain, uncontrollable urinating, vaginal discharge and vaginism.

The alarmingly high prevalence of gynaecological problems after being raped, despite having access to gynaecological treatment, is further underlined by the numbers of gynaecological problems given per participant: the table below shows that even 20 years after the war, more than 58% suffer from four or more gynaecological problems that are typically associated with the physical consequences of sexual violence.

Table 4.10.: How many different gynaecological problems do the participants report having?

Number of gynaecological problems that participants report having		
Number of problems	**Number of participants**	**%**
0	2	6.5
1	1	3.2
2	6	19.4
3	4	12.9
4	6	19.4
5	8	25.8
6	4	12.9

4.1.5. How did the war rape and sexual violence influence the survivors' relationships with their families as a whole?

The research wanted to find out how rape trauma influenced the survivors' relationships with other people, in particular with partners and husbands, with their families, and finally with children. We were especially interested in finding out whether the women themselves perceive any transmissive effects of their rape trauma on their children.

Two items in the questionnaire were dedicated to the survivors' relationships with their families. One was a closed question ("*When you look at your life now, what do you think: does rape affect the life of your family TODAY, 20 years after?"),* and the other was an open question ("*If yes, or to a certain extent, state the main consequences for your family, today, 20 years after. Name one or two things which cross your mind.").* The table below gives the participants' answers.

Table 4.11. Influence of rape on the participants' family life

Does rape affect the life of your family TODAY, 20 years after?		
	N	%
Not at all	13	27,7
To a certain extent	18	38,3
Yes, completely	16	34,0
Consequences of rape on the woman's family life		
	N	**%**
Relationship with children	12	27.3
Health condition (physical and psychological)	10	22.7
Avoiding speaking / keeping it a secret	7	15.9
Relationship with husband / partner	6	13.6
Relationship with parents	3	6.8
Other	6	13.6

As the table shows, 13 of the 47 participants who answered this question (27.7%) reported that rape trauma does not have any influence on their family life. However, the other 34 participants reported that the trauma of rape influences their families' lives to a greater or lesser degree.

When asked to describe the nature of this influence, they gave various answers which often covered several different aspects (34 participants gave about 44 descriptions). In most cases, the participants reported that rape influenced their relationship with their children (e.g. "*On the anniversary of the horrible events, our son doesn't want to come visit to our town where he was kept in a camp."; "I am overly protective of my children, I don't let them spend time with other people, I don't trust people."),* and on their physical and mental health ("*Nervousness, depression", "My health, especially physical, inability to devote to caring for the family").* More rarely, participants mention avoiding speaking about it and / or keeping the rape a secret (e.g. "*I have never spoken with them openly, it is a taboo topic, they don't know the details."; "We keep quiet, don't talk about it, we fight, but I never speak about it with my family".),* as well as the influence of rape on the relationship with the husband (e.g. "*My husband knew everything, but he never asked me about it until I told him. I had issues with him, he always said he wasn't bothered by it, but I noticed he was, that he was thinking about it."; "My husband doesn't want to contact me, he doesn't let our son contact either. We are still married, we haven't divorced yet.").*

The least commonly mentioned influence of rape was on their relationships with parents (e.g. "*My mother is suffering, she doesn't mention it, but it is hard for her.", "Avoiding seeing parents, they feel sadness and pain.").* Six of the more specific answers were put in the category "other" since they did not fit into any of the other categories (e.g. "*We are all mainly nervous because we were in a camp, except my husband.").*

The way the survivors evaluated the impact of rape on their relationships with family members shows that rape, particularly when it takes place in an environment where other family members also went through traumatising experiences (see last quotation), affects relationships very deeply, and creates traumatic dynamics within them.

4.1.6. How did the war rape and sexual violence impact on the survivors' relationships with husbands / partners and men in general?

As will be described below: 56% of the participants said that their husbands / partners knew of the rape.

In addition, the participants were asked two questions relating to this aspect. One question was closed ("*How do you see your life now, what do you think: does rape influence your relationship with your husband or with men in general TODAY, 20 years after?"),* and the other was an open question ("*If yes, or to a certain extent, state the most important consequences that today, 20 years after, influence your relationship to your husband or men in general? Name only one or two things which cross your mind.").* Table 4.12. gives the participants' answers.

Table 4.12. Participants' answers to questions about the influence of rape trauma on their relationship with their husband and men in general

Does the rape influence your relationship with your husband or with men in general TODAY, 20 years after?		
	N	**%**
Not at all	11	23.9
To a certain extent	14	30.4
Yes, completely	21	45.7
Consequences of the rape for the participants' relationships with men		
Avoiding sexual intercourse or reluctance to have sexual intercourse	11	28.9
Repulsion, anger and distrust towards men	18	47.4
Other	10	26.3

The table shows that 11 of the 46 participants who answered this question (24%) do not feel any effect of the rape trauma on their relationships with their husband / other men today. The remaining 35 participants (76%) reported that trauma affects their relationship with their husband and / or men in general either completely or to a certain extent. Their descriptions of these effects vary and could be categorised into 3 categories: In the majority of cases participants reported that today, as a result of the rape, they feel repulsion, anger and distrust towards their husbands / men in general. Here are some examples:

- *"Men are dead to me."*
- *"I don't trust the male population too much, I try to avoid them but I am not doing very well. I have the feeling that they would do something similar to me, I'm always alert, I am still afraid."*
- *"I don't have a husband, and I don't like men anyway."*

Participants described various ways of avoiding sexual intercourse, or feeling unhappy when agreeing to have intercourse. Some examples include:

- *"I have been avoiding having intercourse with my husband, and even when we did I felt he was thinking the same thing as me. When I have to sleep with him, I would rather cover myself and hibernate."*
- *"I want to kill myself when he is asking to have intercourse."*
- *"I don't have any wish or need for sex, and of course I have never told this to my husband nor could I ever tell him."*

- *"In intimate relations with my husband, some movements remind me of the rape."*
- *"After the rape I was never able to be intimate with my husband again, I am afraid of men."*

4.1.7. How did war rape and sexual violence impact on survivors' relationships with their children?

Two items were included in the questionnaire to find out how war rape influenced the participants' children. One was closed ("*How do you see your life now, what do you think: does rape in luence your children TODAY, 20 years later?"),* and the other was an open question ("*If yes, or to a certain extent, state the most important consequences that today, 20 years later, in luence your children? Name only one or two things which cross your mind.").* Table 4.13 gives the participants' answers.

Table 4.13. Influence of rape on participants' children

Does rape affect your children today, 20 years after?		
	N	**%**
Not at all	18	41.9
To a certain extent	14	32.5
Yes, completely	11	25.6
Consequences of rape on the participants' children		
	N	**%**
Avoiding talking / keeping it a secret	8	27.6
Difficulties being a parent	8	27.6
Concern / fear / sadness with children	7	24.1
Psychological and physical issues (illness) with children	3	10.3
Other (control, adjustment, etc.)	3	10.3

The table shows that a relatively high number of the participants (18 out of 43, i.e. 42%) who answered this question felt that having been subjected to rape during the war does not affect their children today, while about 58% of participants claim that rape has affected their children completely or to a certain extent. When asked to describe this feeling, the participants again gave different answers which were placed in five categories. The majority of the participants described three types of consequences: showing concern / fear with their children, difficulties being a parent, and avoiding talking to their children about rape (keeping a secret). A small number of participants reported having physical or psychological difficulties with their children, or some other consequences that could not be placed in any of the five categories. Some of the participants' responses in each of the categories are given below.

Concern / fear / sadness with children

- *"They become sad and feel bad when I speak about it."*
- *"She is aware that something happened to me and it hurts her."*
- *"My children are wondering why mom is always crying, why everything affects me."*

Personal difficulties being a parent

- *"I cannot show love or emotions towards them. Everything died in me."*
- *"My children are not currently directly affected, they are still small, but I fear for their future, of my indirect influence."*
- *"I raise my voice when I start remembering, I get nervous."*

Avoiding talking with the children about the rape (keeping a secret)

- *"We don't speak about it."*
- *"I never spoke about it with them in detail; they just know what happened to me. Simply they don't want to speak about it either; they don't like to talk about it. My son could not watch Angelina Jolie's movie."*
- *"My daughter knows what happened to me, but I don't want to tell my sons, I hope they never find out."*

Psychological or physical issues (illness) with children

- *"My child is in a psychiatric institution."*
- *"My youngest child's hair fell out, the doctor told me it was due to stress."*

Other

- *"I try not to allow it to influence."*
- *"It all affects my son."*

A therapist with one NGO from the focus group discussions also identified the effects of trauma on children as a problem, which she saw as being in two parts: "*It depends on the age that the survivor had at the time of the rape. If they were older, mature, women, then had children, but if they were younger than 20 they are having completely different reactions now. For instance, now their children are growing, and the daughter is 15 years old, and she was raped when she was 15. We have three women like this from V. They are not enjoying their children getting older, they are not enjoying at all, for them it is danger, a threat. For example if the daughter is just having breasts, if she wears nice clothes or tight clothes... [...] She does not like it, she is afraid, and then aggressive."* One of the NGO representatives spoke about the "silence" and "speaking out": "*The most important thing for them is for their children not to find out. This woman that spoke out recently...'And why now? – Because my daughter has left.' And she decided to speak out now, because she is over there (*daughter moved abroad) *and will never find out. Because no one must know, no-one must find out."*

It is also interesting to note that the presence of PTSD symptoms in participants is associated with their relationship with children. The participants' results on the Harvard Trauma Questionnaire correlate[27] (even if only moderately) with the assessment of the impact of experiencing rape on their relationships with their children. Those participants who reported a larger impact of rape trauma on their relationship with children also report a greater number of symptoms of PTSD ($r = -0.36$), higher total scores on the Harvard Trauma Questionnaire ($r = 0.48$), and lower functionality in everyday life ($r = 0.51$). This can be interpreted in two ways: while the presence of PTSD symptoms has an impact on relationships with children, survivors may also feel that their children are suffering from the experience too, which may exacerbate the symptoms by

[27] We used the Pearson correlation.

reinforcing their sense of having permanently to deal with the negative consequences of the rape experience.

4.2. Research question 1: Impact of the experience of war rape and sexual violence on survivors' lives: Results obtained through the analysis of survivors' life stories

"And the pain? Who is going to take it out of my chest? Who is going to take it out of my head? Who will give me back my tears? And the stigma?" (Elmana)

Influence of trauma on survivors' lives

During the life story interviews, seven survivors talked about the atrocities they had survived during their rape experiences and the consequences for their life and psychological condition. The trauma symptoms they mentioned are typical of those described in the literature, and are in accordance with the results of the quantitative part of the research. Some of them were very young at the time of the rape; the youngest, Elmana, survived war rape at the age of 13. Larisa experienced rape several times during the war, but the first time was also her first sexual experience: "*The worst thing for me was that it was my first time... First, first time I was raped, was in that other hall that I came to. And I had been raped several times during the war. Several times and, so, well, this first time for me was the worst. I mean the most distinct, and I still carry, how to say, some kind of sadness, and I still feel bad."* Berina also said: "*I remember with sadness that I was only eighteen years old when the war started and when I was raped."*

Some talked about a psychological breakdown because they could not terminate a pregnancy after having been raped. Sara said she had hoped to have an abortion when she came to Zenica after being raped. Unfortunately, no one would perform the operation because she was already six months pregnant. The roads had been blocked so she lost contact with her family, who didn't know whether she had been able to have an abortion or even if she was alive. When she arrived at Medica, her pregnancy had left her psychologically and physically broken.

In their life stories participants described feelings of guilt related to this severe trauma. Sara, who was raped while on her way to meet a friend, keeps wondering: "*Why did it have to be me at that moment, why did I have to trust her and go with her. I blame myself for not being smarter."* She also describes feeling guilty for keeping the child "born out of rape": "*I told myself a thousand times that I was selfish for keeping her. I told that to myself a million times, why did I do it? Why didn't I put her up for adoption? Why didn't I give her a life, maybe she would have been better off with someone else?"*

They also described feelings of pain, shame and stigma. Elmana, whose words we used as the title for this section, said*: "And the pain? Who is going to take it out of my chest? Who is going to take it out of my head? Who will give me back my tears? And the stigma?",* while Berina said: *"I see my uncle approaching, crying and hugging me. He knows already. I mean, I'm trying to say, I was the only one everybody knew about in town and have pointed fingers at my whole life."*

Symptoms of avoiding speaking about war rape were also mentioned. Zehra says she always yells: "*Don't speak about that, don't even mention it. I don't like to hear about it."* Elmana says that she doesn't like to listen to things about rape: "*Not because I am not interested, but because I cannot bear to listen."*

When narrating their life stories, the participants also described changes in behaviour. For instance, Zehra talks about a lack of motivation and interest in doing things that can be interpreted as signs of depression: "*I simply don't have any motivation to work, but some things need to be done. I just don't find any pleasure in taking a walk [...]. I do work, it's not that I don't do anything, but not as much as I used to. It's not like I am sick or in pain. Sometimes I am (back pain, kidney), but even when I am not in pain I don't have the will. I wish I were in pain, I wish I could say that, but it's just me. Practically there is nothing wrong with me, and still I can't, that is the worst thing."*

They also mentioned other post-traumatic problems, such as: inability to enjoy life, feeling frozen. Zehra says: "*After the war I simply cannot rejoice, when there is New Year's celebration or my children's birthdays, I prepare something, but there is no happiness."* Želimirka describes how after the rape she wasn't able to cry until she experienced another war trauma (forceful eviction from home): ..."*I experienced it on November 25, 1993, and the other thing was March 2, 1995. It means that my feelings were frozen inside me."*

Some of them talked about a feeling of anxiety that is difficult to control. Emira says: "*It is my story, I am growing old with it and I don't have any more tears, I cannot cry anymore, but there is a ticking bomb inside me, I feel it's going to go off any time now."* Sara says: "*I react impulsively, you can tell me something, I will either cry, or laugh, or scream."*

There has also been mention of traumatic anxiety as a reaction to trauma triggers. Berina says: "*They came to have their hair cut, but they had a bit to drink. This alcohol, combined with uniforms, doesn't matter which uniform it is, that is the moment when it all comes back to me."*

Some spoke about sleep difficulties and suicidal thoughts. Zehra said: "*I simply don't sleep any more as I used to. I wish I could sleep through one night at least."* She also said: "*I start thinking about my children, but for how long do I keep it up, they don't have a father, what will happen if they lose me as well?"* Sara was thinking out loud: "*Maybe my life story should have ended on the twenty-third September when I gave birth to her, to give her away and to disappear? I don't know if its fate, did God want it that way?"*

Feelings of fear and worry about their children's future were brought up strongly by Larisa. She talks about being afraid of something happening to her, meaning becoming disabled because, as she says, "*who would take care of the children then? Then I pray to God, God please wait until my children are old enough."* Berina also states: *"I don't want my daughter to experience what happened to me,"* and so she thinks about the most sensible moment to tell her daughter what she has survived.

Fragmented memories were also mentioned in the interviews: Survivors point out that they can no longer remember all the details, and Zehra said: "*But I cannot remember everything.*" She points out when she goes to Vitez she cannot recognise her school friends,"[…] *and they went to school with me.*"

Influence of rape on the physical health of survivors

During the life story interviews, the participants talked about the influence of rape trauma on their health. Larisa describes the physical injuries inflicted on her during the act of rape and torture in captivity. She says that she and a Roma woman were forced to sit on the floor and lift their legs, and then they beat them and broke their bones. "*They broke my toes. My toes grew back all crooked."* She talks about being hit in the ribs with the butt of a gun, causing an injury that required an operation (which she was too afraid to have). Larisa also had one of the vertebra in her spine broken, which causes her a lot of pain. Emira also describes problems with her thyroid gland and with her heart and that she has to control her hormones: "*And when one takes a look at me, one could say that I am jobless and that I don't want to work."*

Participants also described their gynaecological problems in the interviews. For instance, Želimirka has been struggling with gynaecological problems for years until she finally had a tumour removed on her ovary. Elmana tried for a long time to get pregnant with her husband. When she finally became pregnant they went to the gynaecologist, who told them that the baby's heart was not beating. She said: "*Ooooh, S.* (name of interviewer), *I don't know, nothing ever hurt me that way."*

Influence of rape on the participants' relationships with family members

The narrative interviews with seven survivors complement the overall picture about how rape trauma affects the survivors' families. The text below offers some descriptions from the survivors' life stories.

Sara says: "*It made an impact on my mother, father, sisters, brother, now on my child, on my entire life."* She believes that her trauma has mostly affected her mother: "*She felt so bad, broken, she fell, fell ill and she simply never could put in words that she was also suffering. To me it was enough just to see her crying."* At first Sara blamed herself for trusting people and was taking the painful looks from her parents and others quite badly. She felt responsible for her parents' pain: "*If this hadn't happend to me they wouldn't have worried so much."*

Želimirka describes how it affected her mother who fell ill with angina pectoris: *"[B]ecause one week after I had been raped, her tongue got swallen one night and her mouth, if it weren't for nitro-glycerine, she would have died."*

Elmana describes her time in the camp: "*We were there for two months. Those two months are the worst time in my life. Still I think these two months were harder on my mother and father since they knew nothing about what was happening to us."*

Elmana remembered how hard it was to tell her mother about what had happened to her: "*I didn't want to make her worry."* Elmana says her mother cried, and she comforted her, saying: "*It's alright mother, don't cry, it doesn't matter."* Elmana thinks she coped better than her mother when she found out. Having to see her mother like that was more difficult than the time in the camp.

Berina talks of telling her father about the rape. She didn't tell him the details but only: "*Dad it happened, but let's pretend it didn't."* She remembers her father eventually telling her: "*You know how many people died, martyrs, you are a living martyr for what you survived, for what happened to you."*

Influence of rape on the survivors' relationships with husbands / partners and men in general

The participants also talked about how rape trauma had influenced their relationship with their husbands and / or men in general. In the life stories, we found some touching accounts of women who talked about how supportive their husbands were. For instance Sara said this about her husband's support: "*When I only remember, I couldn't do what he does... If he had rejected me so many times as a husband, after second or third night I would have said enough."* She also says it took her some time to get used to his male presence, moves, and touches: "*[H]is move, his touch could drive me mad, but he endured everything stoically."* She sees her husband as a gift given after a good deed: "*I must have done something good somewhere when I got a husband like that. I don't know what I did to deserve him. The man never married before, he brought me and our child to his family, everybody accepted me so well; it required a lot of strength."* Zehra also mentioned her husband's support: "*When I was raped, I was still a girl, I got married in Z., and my husband was so kind."* Unfortunately, her husband died. She told him about the rape: "*He understood, but I would never tell my children."*

Elmana says she was happy to have a husband like hers: "*No one has a husband like mine, I swear to God."* Berina mentions she works with men and she is proud of herself for not looking at all men in a negative way: "*I didn't let myself."*

However, some participants said that their husbands didn't support them. Emira described how she never "admitted" to her husband that she was raped when he asked her about it after returning from the camp, but later she realised that he knew: "*When I realised that this story is coming out, that people were talking about it, that was the way I was thinking, I said of course, and would do it again. I said it didn't happen, I avoided speaking about it, he didn't pressure me though. But he used to repeat questions, is it true, they say they did take women away? I was categorical in saying that I had never been taken. I wasn't thinking clearly, I was taken in front of twenty or twenty five women. I wasn't alone and I cannot hide it."* She says that before giving birth she went to stay with her mother, where she stayed until the end of her pregnancy, and after she delivered, her husband left her. During the interview she wondered if she was wrong for not telling him the truth, because if she had, he might not have left her.

Larisa talked about her current life and the consequences of her living with a man, a cook in the Serbian army, during the war. She said that this man, Đorđe, offered her a room and promised not to give her away when she ran from the soldiers: "*And this man gave me a key and I went into the room and when I locked myself, I didn't unlock the door until he broke in. So he broke into my room the next night."* She explains that later she got married to him, meaning she started living with Đorđe: "*[B]ecause I had to save myself. The war was about to end. I had no papers. Everyone who was there and was of a different nationality was liquidated, killed, so my only option to survive was to stay with him."* She was married twice more, and each time she was questioned about her past experiences.

Influence of rape on survivors' relationships with their children

The interviews also provided an insight into the consequences of rape on the participants' children and what their relationships with them are like. For example, some of them speak about different difficulties related to parenting. Zehra says: "*I am not going to say I'm crazy, but I'm not fine either... The worst thing, I feel worst about, I have two sons, and I yell at them and transfer my nervousness on them."* Elmana compares her experience to her sister's (who was also raped in the same camp) and says: "*I was always more quiet. Now, she is better than me. She has so much patience with her children, while I am snapping, swearing, yelling, threatening, but no one takes me seriously."* Larisa remembers times when she had no food at home and that her children were hungry. She told them about her hunger experiences (being without food for up to five days), and she tried to keep her children's thoughts occupied with something else. "*But my children also started experiencing distress and hunger because people don't listen. People are deaf to everything."*

Some spoke about avoiding talking with their children and keeping secrets, and expressing concerns about how to tell their children about what happened. Emira said during her interview that her children "partially" know. She never told them about rape, but only mentioned briefly that she was kept in a camp, that there was shooting there, destruction, killings, and that men were taken away never to return again. She assumes her daughter "knows partially" from her grandmother's stories (her mother), and the son knows only that she was in a camp. "*I could never talk to them about things I went through, I don't want to burden them, although all our children have traumas just by looking at us."* Berina has a 12-year-old daughter, and she had spoken to her husband about when and how to tell their daughter about the rape: "*And he said: 'What do you think when will it be the best time to tell her?'"* Berina thinks that it is still too early to talk about this with her daughter and she worries how the child will take it. "*But then I think she will hear about it sometime."* She also explains that the file with her documents about the rape is hidden so the daughter could not find it, because Berina is afraid that her daughter "*will not understand. How to tell her?"* Zehra points out that she did not tell her male children but if they were female children she would have to think about doing so: "*If they were female children, I don't know how it would have been, but I cannot tell that to male children."*

Two participants gave birth to children from rape. Sara says that when the child was born she had no motherly feelings towards the baby, and that it took her a lot of strength to care for and accept it: "*I had no feelings of motherhood, they say motherhood is born. Not really. I didn't have it at all... You believe, dear Allah, I had a feeling I could throw her into the river from a bridge, and she's gone and it's over... I never said I didn't love her or I hate her. But for a long time I didn't feel she was mine."* But in the end she made it: "*The baby is a part of me, regardless of who the father is."* Sara described the moment when her daughter found out the truth about her birth. Her husband gave the girl a lot of support until Sara was able to approach the child: "*When he hugged her and said – do you really need anyone else in your life, apart from me, do you really need another dad, am I not enough... When she hugged him she started crying, I think she let everything out."* Sara's husband accepted the girl as his own child: "*He never broke any promises to her."* Larisa says she has a particularly close relationship with her older son and points out: "*I thought when he was smaller, that I would never be able to tell him anything related to my past, and how I met his father. I thought our*

lives would collapse when the time comes to explain this to your children. I tried so hard all the time for him to love his father." She emphasises how she never wanted to poison her child with hate towards somebody, especially a father, but on the other hand she was afraid of how he will take it and how he will react and "*Maybe he will stop loving me as well?"*

Some participants don't have children. Želimirka says after her failed relationships: "*I have been denied this act of giving birth. I never knew how it felt and I have so much love to give."* On the other hand, she says how important her family is and that she shares her love with the children of her brothers and sister.

Summary gathered from analysing the life stories regarding the impact of war rape on survivors

All the survivors' stories are dominated by feelings of pain, self-blame, shame, and being marked / labelled which remain to this day. It is evident that these feelings occur during interactions in both close and wider social settings – with friends, neighbours, children, and parents. Physical consequences and difficulties also continue to manifest themselves. War rape had a clear impact on their health, and younger women especially pointed out their problems with reproductive health and difficulties in conceiving children and pregnancy.

We noticed that the younger women we interviewed, those who were in school or about to graduate during their war rape experience, were able to think about it as one part of their life which they needed to deal with, while women who were older at the time felt that the war formed a larger part of their life, and that they were less able to start again. Both survivors who have children born of war rape and survivors who gave birth to children after the war have constant, strong feelings of fear and worry about their children's future, which is reflected through their behaviour, and is then transmitted to their children as transgenerational trauma. It is evident from all their stories that survivors ask themselves how their experience impacted on their family members (mother, father, brother, sister, children, etc.), and wonder if they could have done something differently or if that was their destiny. When they speak about their families, survivors mention that they have unconditional and usually unverbalised support from female members, while any support that is given by male family members is important regarding traditional male roles in their cultural and patriarchal beliefes.

Caring for others is another recurring theme in the survivors' life stories, despite their painful experiences. Survivors who were accepted by their partners or husbands, along with their children, describe them as good husbands / partners, while questioning how supportive they would have been had their brothers married a woman in their situation. In this way, women negotiate ways of finding acceptance within the family by nourishing traditional roles on the one hand, while on the other recognising that the men who accept them and their children are acting in a way that is contrary to traditional values and behaviours. A strategy which one survivor employed to save her life during the times of imprisonment and war rape was to "decide" to live with perpetrator. This survival strategy has had long-term consequences on her life, which are deepened by the reactions of men, her family members and society, who question and judge her choices.

Another common problem for survivors who have children is telling them the truth about war rape. Most mothers in this situation have not told their children about their experiences and so lead a kind of double life in which they must constantly adapt their behaviour and emotions to their surroundings, leaving them with an inner conflict which tears them apart. One survivor was forced to tell her daughter against her will because her daughter's friends were gossiping about her and her mother. In similar situations, survivors with children try to find the most suitable moment to speak up about their experience so that they and their children can end this double life. However, the main reason given by survivors for not talking to their children is the fear that they will not be able to understand or accept the truth, and as a result may reject or abandon their mother.

4.3. Conclusions regarding research question 1

Today, almost 20 years after the war, despite the fact that the participants in this study had access to health services at *Medica Zenica* which, as will also be seen under research question 4, they reported as being very helpful in coming to terms with their experiences, the psychological and health situation of most survivors of war rape participating in our study remains extremely alarming.

The following key facts emerged from our analysis of the quantitative data:

- We found that 57% of the participants are suffering from clinically relevant PTSD symptoms. Their general psychological distress is high and they mostly show psychosomatic problems and anxiety symptoms. Around 76% still have difficulty falling asleep, and more than 40% report suicidal thoughts.
- 70% of the participants state that the rape experience completely affects their life today. 57% of the survivors report that their health is bad.
- 85.4% see at least one medical doctor regularly, with 56% of them going to the gynaecologist and / or 51% to a psychiatrist, neurologist or psychologist.
- 65% of the participants regularly take drugs. Half of them stated that they have taken these drugs since the war. Almost all of these participants – 91% – take psychopharmacological medicine.
- Over 50% reporting gynaecological difficulties, such as pelvic pain, uncontrollable urinating, vaginal discharge and vaginism. Almost 20% state that they had problems with conceiving. More than 58% of the participants reported four gynaecological problems or more, and almost 11% reported cancer.
- 76% of the participants said that the rape trauma affects their current relationship with their husband and / or men in general either completely or to some extent, most often in relation to sexual problems.
- 58% of the participants felt that their rape experience also affected the lives of their children either fully or to some extent, and described a number of problems that show difficulties with parenting and with disclosing their experiences to their children.

Apart from these quantitative results, the study gave the participants an opportunity to describe in more detail how rape trauma has affected their lives, and their relationships with family members, men, and children. By telling their life stories and answering open questions in the questionnaire, the participants clearly showed that rape most seriously affected their psychological and physical health, and their relationships with their children. Regarding this relationship, participants talked about problems related to "keeping a secret" and avoiding talking about the rape. 20 years after the war, survivors are still dealing with difficulties in telling children that they survived war rape and / or that the children were born of war rape. Many survivors feel like they are leading double lives through keeping these secrets, which seems to tear them apart.

Furthermore, they say that their children are suffering through watching their mothers suffer, while mothers are finding parenting difficult for numerous reasons; they are too caring and controlling; trauma symptoms make it difficult for them to control im-

pulses and tension, and so mothers behave aggressively and badly with their children; or their ability to bond with and express emotions towards their children is hindered. Survivors who have children conceived due to the war rape, and also survivors who gave birth to children after the war, recognise certain behaviours that negatively impact the relationship with their children and other family members. Feelings of pain, self-blame, shame, being marked / labelled remain to this day, and dominate all the survivors' stories of war rape. It is evident that these feelings occur in their interactions with both close and wider social surroundings; with their friends, neighbours, children, and parents.

All of these signs clearly show transgenerational transmissive effects of trauma that are known from existing literature with other traumatised populations.

4.4. Research question 2: Social acknowledgement: How does Bosnian society treat survivors of war rape today? And how do survivors assess the support and recognition they are given from society? Results obtained from the questionnaire and focus group discussion with NGOs

The theoretical background to research question 2, which is concerned with the importance of social acknowledgement, emphasised the relevance of the post-traumatic environment within which recovery takes place, not only within families and communities, but also at a societal level.

As already mentioned, survivors of war rape in Bosnia and Herzegovina are able to obtain the status of civilian victim of war, which is a unique form of social acknowledgement. In the following presentation of results, we want to look particularly at the actual impact of this status and related support mechanisms that were put in place to support survivors in their recovery. Again, we will first report the answers given by the survivors in the questionnaire and evaluate their perceptions of how they are accepted within society, along with the perceptions of non-governmental organisations on survivors' acknowledgement and the shortcomings of the civilian victim of war mentioned status – and then we will listen to the voices of the women from the life stories.

4.4.1. Participants' perceptions of societal responses towards war rape survivors

The questionnaires administered to the women participating in the study included both open and closed questions.[28] The first was a closed question intended to find out how they perceive the way society cares for women survivors of war rape in general. Their answers are presented in the table below.

Table 4.14.: Perception of the participants on how society in general treats women survivors of war rape (N=51)

Do you feel that survivors of war rape are nowadays well treated by the society in general?		
	N	**%**
Not at all	25	50.0
To some extent	21	42.0
Yes, completely	4	8.0

[28] Sometimes the participants did not answer all the questions, which is why the number varies in some measurements of the final results. There are a number of reasons why the participants did not answer some questions. First, some of the co-participants completed the questionnaire within a structured interview, while others wanted to complete it on their own. It is possible that some of the people working on their own chose not to answer some of the questions. Second, some questions were not relevant to all the participants (e.g. if the question referred to children and they did not have any, or if they were satisfied with something and a question asked about dissatisfaction, etc.). Third, sometimes the participants could not think of the answer in that moment so chose not to reply. This does not mean that they did not have a relevant experience that they could have related, just that they could not call it to mind. And finally the participants provided multiple answers to some of the open-ended questions (i.e. each participant would name three or four different things), and in such cases the total number of responses exceeds the number of participants, since the number given is the sum of the answers analysed, and not the number of participants. Such methodological discrepancies are normal and expected, and do not hamper the reliability or accuracy of the data being presented.

The table shows that 25 (50%) of the participants feel that according to their perceptions "society in general" – and most probably, the participants had different ideas in mind as to what this "society" entailed for them – does not treat women survivors of war rape well. Only 4 (8%) of the 50 participants who answered this question said that society treats women survivors of war rape well. Since this was an open question to encourage the women to spontaneously give their perceptions on societal acknowledgement, more information is needed to analyse what exactly this entails for the women and what and whom they have in mind when being asked about "society in general". This information follows.

The questionnaire aimed to find out what aspects of care female survivors of war rape received and who (outside their family and friends) this support came from. For that purpose, four open-ended questions asked the participants to name the most important things that different NGOs, their local community, local NGOs and international organisations actually did for them. Their answers were analysed and classified into the categories shown in table below.

Table 4.15.: The sources and types of support available to survivors of war rape

What does your canton / entity / state do for survivors of rape? Name the most important things that come to your mind		
	N	**%**
Nothing	29	59.2
Financial support	19	38.8
Shelter	1	2.0
What does your local community do for survivors of rape? Name the most important things that come to your mind		
	N	**%**
Excursions and financial support	2	4.5
Nothing	42	95.5
What do local NGOs do for survivors of rape? Name the most important things that come to your mind		
	N	**%**
Medica Zenica provides help	17	30.9
NGOs do something (without elaborating or identifying the organisations)	10	18.2
NGOs do something (with descriptions or names of organisations other than Medica Zenica)	7	12.7
There are no NGOs in their community	6	10.9
They do not do anything	15	27.3
What do international organisations do for survivors of rape? Name the most important things that come to your mind		
	N	**%**
Nothing	28	62.2
I do not know	11	24.4
Financial support	6	13.3

As the table shows, of the 49 participants who answered to this question, a total of 29 (almost 60%) said that their canton /entity / state does nothing for women survivors of war rape. The remaining 19 participants (around 38%) said that their canton / entity / state provides financial support for the survivors. Only one woman named housing support ("*They support survivors in housing").* It is surprising to note that, although 39 of the participants had gained the status of civilian victim of war, only 19 said that the canton / entity / state provided survivors with financial support.

This finding may be the result of some survivors feeling "forgotten" or "socially unrecognised", and as Maercker & Müller (2004) stated (see theoretical background), sometimes trauma reflects so deeply in a negative self-perception that even though there might be forms of social acknowledgement, survivors of trauma may not be able to recognise them. Another possible explanation of this seeming contradiction could be that although a large number of women participating in this research have obtained the status (76%), compared to less than 800 of the total number of at least 20,000 survivors (4%), they do not see the status as being connected to any sort of social acknowledgement that reinforces their sense of belonging to their society. It is also possible that the negative dynamic generated by their perception of societal attitudes towards them might be stronger than the positive dynamic created by this (largely) political tool. As explained in the theoretical background (Chapter 2), negative social responses towards rape survivors carry a stronger weight than positive responses.

Out of 44 women who answered the question on what their local community does for survivors, 42 answered "nothing". Of the remaining two, one said that their local community organised an excursion for survivors, and the other said that she got a disability pension from her local community. Obviously, the communities of the survivors are mostly perceived as having no real impact on their lives, yet these are the places where the participants live and create relationships and have – or do not have – a sense of belonging.

Participants answered the question "what do local NGOs do for survivors of war rape" in different ways. A total of 55 different answers were given (some participants named more than one thing), and most of the answers (around 31%) included reports related to *Medica Zenica.* Examples of some answers are: "*Medica Zenica – if it was not for Medica me and my child wouldn't be alive, we would be under the ground, food."; "There are no organisations that help me, only Medica helped me."; "Medica is the only one doing something: sheltering, food, medical drugs, clothing, furniture."* Around 18% of answers included reports that local NGOs are doing something for survivors but without saying who the organisations are and what it is that they do (e.g. "*I think they try hard but they don't have much possibility to help us."*). Around 13% of answers provided information about NGOs other than *Medica Zenica* that offer support for survivors, and in what ways (e.g. "*I obtained the status with support of the Association […] 'Žene žrtve rata; Psychotherapy work of […] 'Vive žene.").* The remaining answers included reports that non-governmental organisations do not do anything for survivors (almost 27% of answers), or that there are no NGOs in their community (around 11%).

Regarding international organisations, the participants were mostly unaware whether they did anything to support survivors or not, with only six offering definite reports of financial support. Their answers included: "*Financing projects that provide support to victims / witnesses, financing researches.",* and "*Nothing, they come to take one interview after another, and nothing happens, they just work for their own benefit, they make promises that they don't keep."*

4.4.2. Survivors of war rape and information and access to their rights

As a proxy indicator of their integration into their society, we asked the participants about their rights and the extent to which these rights are connected to their actual needs. First, they were asked if they knew the procedure for obtaining the status of civilian victim of war. Their answers were analysed and are presented in the table 4.16.

Table 4.16.: The level of participants' awareness of their rights regarding the status of civilian victim of war, and other rights which derive from it (N=50)

Do you know / Are you aware of:		**N**	**%**
Procedures that are necessary to get the recognition of your rights as a civilian victim of the war	Yes, I am well informed I know a little bit No, I do not know anything about this	24 14 12	48.0 28.0 24.0
Special programs for schooling, retraining and additional training for war victims?	Yes, I am well informed I know a little bit No, I do not know anything about this	2 8 40	4.0 16.0 80.0
Possibilities to get support for your health and social needs?	Yes, I am well informed I know a little bit No, I do not know anything about this	2 9 39	4.0 18.0 78.0
Possibilities for housing support?	Yes, I am well informed I know a little bit No, I do not know anything about this	4 2 44	8.0 4.0 88.0
Programs of employment?	Yes, I am well informed I know a little bit No, I do not know anything about this	- 6 44	- 12.0 88.0

The table shows that only 50% of the participants who answered these questions appear familiar with the procedures that are necessary to achieve recognition of their rights as civilian victims of war, while the other half know little or nothing about the procedure. As already mentioned, 39 of the 51 participants participating in this research have the status of civilian victim of war and 12 do not. Therefore, the information about the number of participants who have obtained the status and the information on the percentage of participants who actually know the procedure do not match. In other words: 39 of the participants should be familiar with the procedure, because they went through it, but only 24 actually answered this question positively. The reason for this could be that some of the participants who went through the procedure might not have fully understood it. This may suggest that some survivors do not "feel" that the procedure of obtaining the status is an empowering process from which they gain social acknowledgement.

From the previous table it is apparent that the participants knew nothing or very little about the possibilities of accessing other rights to which having the status of civilian victim of war entitles them.

They were then asked to state who had informed them of each of the rights listed that they knew about. The results are displayed in the table 4.17., which shows the actual numbers of participants rather than percentages, since the numbers of participants in most categories were so small.

Table 4.17.: Who informed participants about certain rights?

Who informed you about	NGO	Close persons	The media	State institutions	I do not know
Procedures for obtaining the status	18	7	2	6	3
Education programs	7	-	3	-	-
Healthcare support	7	-	-	2	-
Housing support	4	2	-	-	-
Employment program					

As presented in the table, the participants mostly answered that an NGO (either *Medica Zenica,* the Association "Žene žrtve rata", or the Association of Concentration Camp Torture Survivors) had informed them about the procedures related to obtaining the status of a civilian victim of war, while people close to them, the media and state institutions were rarely named as a source. It is also apparent from the table that it was mostly NGOs who informed them about the other rights that derive from the status, and rarely people close to them, the media or state institutions.

Furthermore, the participants were asked which of the rights mentioned they have access to, and their answers are presented in the table below.

Table 4.18.: Information about the accessed rights

	N	%
I was given the status of a civilian victim of war	39	76.5
I participated in a special program for schooling, retraining and further training	4	8.0
I have got special health or social support	3	6.0
I have got special housing support	4	8.0
I participated in a special job program	0	0.0

Interestingly, some of the 12 participants who do not have the status reported that they used to have the status of civilian victims of war but lost it when they decided to return to live in Republika Srpska. Some of them also said that by obtaining the status their families would find out about their rape experience, which they do not want.

In spite of the fact that the great majority of the participants have the status of civilian victim of war, it is apparent from the table above that in most cases they did not, or only rarely, access the other rights to which they are entitled as individuals with this status (educational programs, retraining, health and social support, housing support, employment programs, etc.).

The participants were also asked if they think that the rights mentioned are compliant with their needs, and if NOT, what is missing. Their answers are presented in the table below.

Table 4.19.: Estimation of the rights

Do you feel that these rights correspond with your actual needs?		
	N	**%**
No	11	24.4
To a certain extent	18	40.0
Yes	16	35.6
If no or to a certain extent, what is missing?		
	N	**%**
Financial support	8	26.7
Healthcare support	3	10.0
Housing support	4	13.3
Child support	2	6.7
Social support	4	13.3
Everything is missing	9	30.0

The table shows that the answers given were quite heterogeneous. It is interesting that out of 45 participants who answered to this question, the minority think that these rights do not match their needs at all, while 75% think that the rights correspond to their needs either fully or to a certain extent. This result may be cautiously interpreted in a way that the participants might derive a certain sense of acknowledgement from the existence of rights to which they are entitled, despite the fact that there are a huge number of deficiencies with them.

The participants gave 30 answers for needs which were not met by these rights. These answers were categorised based on their similarity to other answers in several groups. In most of the answers the participants said that "everything is missing", or many things are missing, e.g. "*Many things, psychologist, doctor, money – sometimes everything is missing; Everything is missing because none of those rights can be accessed, or are not implemented, professional, psychological and legal support."* Some answers suggested that the financial support is the main thing missing: "*The income I have is not sufficient for the needs of my family. After I pay the loans I am left with very little (200 BAM for survival); Everything, I can't provide for my child's education, after I pay the bills I am left with nothing for living."* Other answers suggest a lack of housing support (*housing support – shelter*), social support (*socialising, organised talks for women; Organised trips and social events*), health support (*Health support, exemption from payment of healthcare services; Healthcare support, gynaecological examinations adjusted to women*), and child support (*Children born through rape do not have any rights and are not categorised anywhere; Support for a child*). It is important to note that some of the things which the participants reported as missing are actually guaranteed to them on the basis of their right to the status of civilian victim of war.

The last question relating to the rights of the women was: *What problems did you encounter when you tried to get access to your rights?* The frequency of their answers categorised by similarity in groups is presented in the table 4.20.

Table 4.20.: Problems the participants encountered when they tried to access their rights

	N	%
Did not encounter any problems	21	44.7
Difficulties with administrative procedures	12	25.5
Exposing, shame, uncomfortable about repeating their story	8	17.0
Did not try to access to any rights	6	12.8

As the table shows, six of the 47 participants did not even try to access their rights. Examples of reasons given for this included: "*I don't know what rights I have."; "I didn't even try because here Croatia is in charge."; "I am not in the process of obtaining the status, terrible problems, fought for two years to return to my home."* The percentages of participants who did and who did not have any problems in accessing their rights were almost equal. The problems the participants encountered in accessing their rights were categorised in two groups: "Exposing, shame, feeling uncomfortable about repeating their story" and "Difficulties with administrative procedures". The difficulties with administrative procedures included descriptions such as: *"When I returned to my place of residence in S., I lost my status of civilian victim of war, but I managed to get it again."; "It took too long for the law adoption and implementation."; "They asked for documentation, witnesses, they disputed about what happened."* Exposing, shame and feeling uncomfortable about repeating their story included descriptions such as: "*I encountered the lack of understanding from part of the NGO, they did not have understanding for my psychological state and it was difficult for me to go again through my report."; "The lack of understanding when I gave my statement to one officer, he shared the story with his colleagues who came to the office to see me."; "I felt terrible, I needed to deal with it again and tell the story all over again."*

4.4.3. Do survivors keep silent or talk about their difficult experience with others?

As another proxy indicator of measuring social acknowledgement, we included questions that would measure how open the participants were about their experience. As outlined in the theoretical section, social acknowledgement fundamentally entails the right to speak about what happened during the war and to be listened to without prejudice or stigmatisation.

We measured the degree to which the survivors felt they were part of their society today by asking whether the people around them know about their traumatic experience. The table below shows the answers from the participants to (closed) questions asking who knew about their difficult experience. Of the 51 participants, 45 answered questions on which members of their close family know about their rape experience, 49 answered on whether their friends know about it, and the same number answered on whether anyone else knew. The remaining participants did not answer the questions.

Table 4.21.: Who amongst the people around them knows of the survivors' rape experience?

Question	Offered answers	N	%
Which of your close family members know about your rape experience?	A partner / husband A child / children A mother A father A brother / brothers A sister / sisters A cousin	26 21 21 10 20 25 22	56.5 45.7 45.7 21.7 43.5 54.3 47.8
Do your closest friends know what happened to you during the war?	Yes, they do. Only my best friend does. They don't know everything, but they suspect it. No, they do not know anything.	14 11 14 10	28.6 22.4 28.6 20.4
Is there anybody else in your life who knows about it?	Yes, there are people who know. Some don't know everything, but they suspect it. No, there is no anybody else in my life who knows about it.	28 16 5	57.1 32.7 10.2

The table shows that less than 50% of the total number of the participants (between 44% and 48%) had told their closest family members (i.e. brothers, mother, children and cousins) about their experience of rape. The majority of the participants said that their sisters and / or partners know about their rape experience. The smallest group amongst the participants were those who said that their father knew about their rape experience.

The table also shows that out of 49 participants, around 50% reported that their friends or only their best friend know about their rape experience. The other half of the participants said that their friends do not know, or do not know everything but they suspected it.

It is apparent from the table that the majority of the 49 participants who answered this question (57%) reported that there are other people in their lives who know about their rape experience. Some participants (33%) said that some people suspect but do not know everything and 10% of the participants said that there is nobody else in their lives who know about it.

In the final part of this section we wanted to learn more about the reasons why survivors remain silent. They were asked: *Do you know of other survivors of war rape who never talked with their family or closest friends about what happened?* The table below shows that more than half of the participants know of other women who were raped during the war and never talked about it with their family or friends.

Table 4.22.: Why do survivors keep silent about the rape?

Do you know of other survivors of war rape who never talked with their family or closest friends about what happened?		
	N	**%**
No	21	43.8
Yes	27	56.3
What do you think is the reason they have never talked?		
	N	**%**
Shame and / or feelings of guilt	19	47.5
Fear of rejection	21	52.5

Amongst the reasons given for women not talking about their experience, by far the two most common were fear of stigmatisation and rejection (mentioned by 21 participants) and shame and feelings of guilt (mentioned by 19 participants). Examples of their descriptions of fear are: "*The feeling of fear, because I feel the same, I would have never talked about it if my husband did not talk first. I still feel shame.";* and "*Because of feeling of shame, they blame themselves thinking that they could have prevented it, that they could have put up a struggle.".* Examples of descriptions of stigmatisation and rejection are: "*From fear of reaction of people around them."; "From fear that her husband might leave her, and reaction of people around her."*

These responses suggest that despite the fact that survivors have been acknowledged publicly for what they went through by being granted a special status, this seems to happen on a level that is disconnected from their emotional world and the acknowledgement has not reached the emotional plane at which they are still suffering. We interpret this in two ways, which probably interact with each other. On one hand, the trauma of war rape is so strong that the long-term impact on many of the survivors in Bosnia and Herzegovina might have led to such deep changes in their self-perception that almost no measure of social acknowledgement can actually "heal" their pain. On the other, we might also suggest that granting this status is not a sufficiently powerful method of putting this message of social acknowledgement across. In order to learn more about the deeply-felt lack of social acknowledgement which many survivors mention, we will now present some perceptions of government institutions and more especially the views of NGOs.

4.4.4. Problems interfering with the successful recognition of survivors of war rape in the society (from the perspective of the non-governmental organisations and government institutions)

We have already mentioned that the lack of political will in certain segments of the government of Bosnia and Herzegovina prevents the adoption of the existing strategic plan and a uniform law to regulate the status of civilian victim of war and rights of survivors. During the interviews with the Assistant Minister for Human Rights and Refugees Bosnia and Herzegovina and with the Federal Minister of Labour and Social Policy it was confirmed that there was no uniform law that regulates the status of this population of women.

Aside from this concern, the informants from the two ministries which participated in this research named two other problems that interfere with the successful integration of women who survived war rape into society. One is the lack of information and accurate data. The Assistant Minister in the Ministry for Human Rights and Refugees of Bosnia and Herzegovina said: "*It is impossible to talk about integration without previously creating conditions for that integration, meaning to know who and what exactly that integration involves. It is very important that we work with relevant, verifiable data, gathered in adequate professional way."* The other problem is that the programmes of support are not compliant with the needs of survivors. In that regard the Assistant Minister said: "*That is characteristic for the whole territory of Bosnia and Herzegovina, where the systems of support are inadequate, insufficient and are not compliant with the need of survivors. The main characteristic of all forms of services and help is that they are 'ad hoc' i.e. the support is based on certain rights, or within certain,*

short, timeframe; and that cannot be a method of work with survivors because their trauma is constant."

There are several other NGOs in Bosnia and Herzegovina, apart from *Medica Zenica,* that aim to support women who were systematically raped and sexually assaulted during the war. Six of those organisations participated in this research by taking part in the focus groups that were held to find out what these organisations do for survivors and to gather their experiences.

In analysing the focus group discussions, we learned that two of the NGOs who took part are actually associations of women who survived war rape (the Association of Concentration Camp Torture Survivors of the Canton Sarajevo – Section of Women Camp Torture Survivors and the Association "Žene žrtve rata"). They fight for the rights of survivors, and provide them with help and support in terms of economic and educational empowerment. These two organisations are directly involved in the process of obtaining the status of civilian victim of war. Women can obtain a certificate from these two organisations confirming that they had survived a rape experience, which is necessary for the application. Moreover, these organisations advocate to "stop the silence" and to "speak out".

"Vive žene Tuzla" is an NGO that focusses on providing psychosocial help and support to victims of war, torture and violence (mostly counselling and psychotherapy). They also work on improving the capacity of other organisations and institutions, and advocate for a multidisciplinary, democratic and participative approach in working with traumatised families and individuals.

The remaining three NGOs included in this research (the Association "Žene sa Une" Bihać", the Foundation "Udružene žene Banja Luka" and the Association "Budućnost" Modriča) do not work directly with women who survived being systematically raped and sexually assaulted during the war, but are focussed on combating all forms of violence against women and children. However, this work gives them an insight into the levels of social integration and the general status of war rape survivors in their region.

These representative NGOs named many problems that in their opinion hinder the process of a successful social recognition of survivors. Most often they spoke of the problems related to the issue of the status of civilian victim of war, while almost all the focus groups held with NGOs identified the lack of the uniform law for the status of the survivors in the whole territory of Bosnia and Herzegovina as a key problem. As a member of one NGO said: "*We are under nobody's jurisdiction. It is necessary here in this country to draft amendments to the law […]. That would recognise the victims, not on cantonal level, but on federal or better yet on state level […]. So that a woman in Bihać, Jajce, Brčko, or where ever she might be, has the same rights. Today, if a woman returns back to Republika Srpska, she automatically loses her status."* It is important to mention the recent formation of the Association of Women Victims of War of Republika Srpska, which is a small step towards solving the question of survivors in Republika Srpska.

Another important problem related to the status of civilian victim of war which the NGO representatives pointed out is that the rights of survivors that derive from that status are reduced to a monthly payment (of 550 BAM). The other rights that derive from the status of civilian victim of war (the right to special educational programmes,

retraining and additional trainings, right to healthcare support and social needs, right to housing support and employment support) are not realised in praxis. In addition, this monthly payment is categorised as one of the benefits given to socially handicapped people, which is a problem because these rights should be obtained regardless of someone's social status.

Another problem reported by the members of the focus groups is that the status of civilian victim of war does not necessarily mean that survivors get the right to health insurance. Many survivors (regardless of whether they have the status or not) do not have health insurance. One of the members of an NGO said: "*There are women who do not have the health insurance. If they don't have the insurance they can't get drug proscriptions to get the medical drug without paying for it."* On the other hand, in many cases even when women have the health insurance they still do not have the same rights as other groups traumatised by war who were given much more benefits. With that regard one member an NGO compared the rights given to the women with the rights of war veterans: "*If I would have a card for example of a woman victim of war or a card of concentration camp survivor, whenever I would show the card at the hospital reception I would have a line privilege and I would get to the doctor immediately. Because I am a stressed woman, psychologically ill, and my nerves won't let me wait. It should be in the law, that we the card holders have those privileges that are already given to the war veterans."*

Another important problem interfering with the more successful integration of survivors is the lack of sensitivity of staff at government institutions towards problems related to trauma. A member of one NGO described a situation that shows the macho attitude of a man who was supposed to assist a survivor before she gave testimony at court: "*It should not happen that an employee from the centre for social work comes to you for support of victims and witnesses and [...]. This case happened in I.S., it was terrible, he said to a woman (survivor) on the phone, I will wait for you in one hour, I'll have dark sunglasses on, and he does not know that the person who raped her wore dark glasses."*

The lack of sensitivity within society is portrayed in the fact that the survivors are not truly protected when they are witnesses in court. Members of two NGOs described the following situation: "*If I am a protected witness in a case against this criminal who raped me, why do I receive the written verdict in an envelope to my home address so that my neighbours can read…; Why do they send the verdicts to home addresses… what if my child of 14 years old finds it and read it, and asks… Mom what is this?"*

Three more important things were pointed out by the members of NGOs as interfering with the integration of survivors into society. One is using groups of women who survived war rape for political manipulation. One representative of an NGO stated: "*Everyone is using them, and manipulating with them. I think every political party and government, whenever they don't know what to do for their publicity, use them to draw the attention on them."* The member of another organisation said something similar: "*If there was only a way to depoliticise that problem. So that the politics stays out of it, to make the problem socially acknowledged no matter which side it comes from… a victim is a victim… our politics makes distinction between the victims."* Another is that the perpetrators of these crimes are still free and / or unpunished and in some cases the survivors meet them on a daily basis. A member of one NGO said: "*Every morning*

that chetnik passes by my house. What can I do? I tried to stop him once, I nearly had a breakdown." A third problem is related to the fear of social stigmatisation and labelling the women war rape survivors with the term "victim". That is one of the reasons for their silence about the trauma. A therapist in one NGO said: "*What they bear as their disease is the stigma. We keep calling them victims instead of survivors. Constant reminding on that identity disables complete integration of the trauma. The question is whether the current symptoms are still much related to the rape from over 20 years ago, or to other things that keep the symptoms present."*

4.4.5. General problems experienced in the work of non-government organisations

It emerged from the focus groups that NGOs encounter several problems that interfere with their work with women who survived war rape and sexual violence. The NGOs' representatives agreed that the main problem for them is the lack of political will to begin systematically solving the survivors' problems and the issue of political divisions in Bosnia and Herzegovina. A good example of this problem is an experience of the Foundation "Udružene žene" Banja Luka. This foundation prepared a Protocol for cooperation between government institutions and NGOs in providing support to victims / witnesses in cases of war crimes, sexual violence and other offences of gender based violence. The Protocol was only passed by the city administration of Banja Luka, while there was no political will for it to be passed on other levels of government. With that regard, the representative of one NGO said: "*We turned to the Minister of Justice who supported us in the idea of creating this Protocol for the entity level, and include as many organisations as possible, the concentration camp survivors… […] however, in order to sign the protocol on the entity level of Republika Srpska, it needs to get a necessary agreement from the government, and that's where it stopped."* Another NGO representative reported on the bad cooperation with government institutions: "*If there is no systematic problem solving, there is not much you can do… I can say for my organisation that when we implement a project like that, in order to reach some concrete solutions we send all the reports, conclusions and recommendations to the responsible ministries, but I suspect they end up in the drawers. And that's it, as far as the recovery of the victim concerns."*

Another problem that interferes with work of NGOs with survivors relates to finance. The work of NGOs is mostly funded by the international donors. Therefore, when there is no continuity in financing, there cannot be continuity in work of the organisations or their support of survivors. In order to preserve the continuity of their work some organisations often apply for projects that are completely outside their normal field of their work. For example an employee from one NGO said: "*We have a situation that only the actual projects are followed up, it's the decade of Roma people, so let's all deal with Roma people."*

A significant problem which affects cooperation between the NGOs dealing with survivors, according to the perceptions of NGOs mentioned in the focus group discussions, is the competition between them to secure funding, since the "donor market" usually functions on the basis of project applications which are competing for a limited supply of donor resources. Finally, it was also stated that government institutions which should be offering support to survivors are expecting and indeed relying on the

NGOs to continue their twenty years of work in this field, which covers up for their deficiencies.

4.5. Research question 2: Social acknowledgement: How does Bosnian society treat survivors of war rape today? And how do survivors assess the support and recognition from society? Results obtained through the analysis of survivors' life stories

In their life stories, the seven women who were interviewed also talked about how contemporary Bosnian society supports their recovery from the difficult trauma they experienced.

"Are you one of those raped women?"

Attitude of society in general towards survivors and their rights

In their narratives, the participants described how they experienced the attitudes of society in general towards women who survived war rape and / or members of their family. Some of the seven women talked bitterly about common-place negative and stigmatising attitudes towards survivors amongst both individuals and the community in general. For example, Sara describes a situation when she was enrolling her daughter for school. When she submitted her application and a certificate confirming her status as a civilian victim of war, a school official commented: *"So what, why didn't she take care of herself like I did, why nobody raped me?"* Sara also talked about how hurt her mother felt when she was walking with her granddaughter in the village, and heard some women saying *"Look how proudly she shows off with that 'ustasha' (bastard)."* Berina talked about being the only one in her village who is labelled by her experience, although there are other women living there who survived war rape: "*There are many of us, but it was only I... I don't mean only in our house, there are other houses too, other women and girls. But only I spoke up publically. And that's that, as they say you start wearing that label. It is difficult."* It was so difficult for her to cope with this labelling that two or three years ago she was thinking of moving to a different country.

While telling their stories, the women described measures society has taken for survivors, who takes care of them and how. Želimirka said that support from society came very late: "*This happened in 1993 and the war ended in 1995, and sometime around 2005 they started talking about this, and then in 2006 was something like concrete action."* Sara said that she was supported by Medica, and if she had not known about them she would not have had anyone to turn to. She also said that she knows about the Association "Žene žrtve rata" that can help by providing some material support. Berina said that she went through recovering from her experience alone, but felt that if something similar were to happen to her now she would look for help: "*[S]omeone who would professionally help you, to understand some of those things. And not just some person who doesn't understand these things. But I personally could not find that kind of help in our city. I mean, from anyone."*

In their life stories, the women often spoke of their experiences of the process of obtaining the status of civilian victim of war, and obtaining their rights through being recognised as a special category. All the women who were interviewed had the status of civilian victim of war. They mostly said that the NGOs informed them about pro-

cedures and supported them in accessing their rights. Elmana reported that she did not have any problems obtaining the status of civilian victim of war, and that since then her life has changed for the better. However, she said she is frightened about holding on to this status: "*It is not comfortable when you return to Republika Srpska and your status is obtained in Federation, because it is impossible to obtain the status in RS and you listen every day whether Federation will or will not cancel it."* Larisa said that the survivors had different experiences with the process of obtaining the status: "*There was no one to say – these are the civilian victims of war, they should go here and here for accessing their rights. Everything was from pillar to post. Knock on this door, knock on that door, and so on, and in the end it is what it is."*

Women also spoke of the extent to which this right to the status of civilian victim of war corresponds to their needs. Želimirka pointed out that women often complain about the present situation, but she thinks: "*[T]he amount we receive currently is not small. Considering the situation in our country we can't expect something more."* She also stated that while she is employed, the payment she receives as a civilian victim of war comes in handy: "*I still think this is not a small amount if we compare it with pensions and salaries."* In her narrative, Sara spoke of the rights of children born through the rape: "*[A]nd 20 years later those children do not have their rights."* She thought it would be good to start an association for those children who are now adults, so that they would have someone to turn to in the way that Sara could turn to Medica.

During their narratives the women mentioned problems related to the monthly payment on the basis of their status as civilian victims of war. Larisa talked about irregular monthly incomes that are sometimes all a survivor has to live on: "*The canton does not pay in anything for six, seven months. The Federation owes us for four months I think."* They talked about judgmental and derogatory comments from fellow employees because of their status as civilian victim of war. Emira described being told: "*It happened to you too, and you should be happy that you're recognised here by law and that you receive the money."* Berina experienced something similar: "*[T]hey say you sell yourself for money. But, I wish I didn't have it (the status) if it only had not happened to me."*

Furthermore, the women said that the status of civilian victim of war does not ensure them the same rights as the other groups of people traumatised by the war, who were given more privileges by society. Sara said that her child does not have a scholarship, despite the fact that she submitted the certificate confirming that she is both a civilian victim of war and a member of one association, while the children of fallen soldiers and war veterans have those benefits. She also noted that "Zlatni Ljiljani" or war veterans have more rights than the women who survived rape: "*They even get special place on parking lots because they have the evidence of their wounds.*" Sara wondered how she could prove her wounds to someone: "*Give me a beam scale so I can measure my wounds. My wounds and the wounds of a war veteran… Is there a beam scale that can measure that?"*

In their life stories, the women spoke of experiences which indicate that some employees at government institutions are insensitive when it comes to problems related to trauma. Larisa said: "*That really depends whether that person has enough understanding for you or not. You can find a person who is going to offer you coffee and listen to your problems, but also you find person who says 'Oh I am so tired of you and your*

sufferings.'" Zehra described her experience: "*The worst for me was when SIPA*[29] *came to my house, they stayed for four and a half hours, and I was sickened by them, those were all men. They asked me about everything in detail."* Zehra said that it was difficult to talk about her rape experience in front of two men: "*There were two men, they asked me everything in details, 'when that happened' there were all men, it is different when you talk about it to a woman."* She said that they were very polite but it was just difficult for her to talk to them: "*Those are not pretty things to tell, it's not something I want to shout from the rooftops, and especially not to men."* Emira described one uncomfortable and difficult situation that happened to someone she knew: "*One woman asked her association to send her the membership card in the mail. She was sitting in front of the house with other people, it was summertime. A mailman arrived and shouted: 'Hey, how come you receive an envelope from (*name of the organisation*). Are you one of those raped women?' She told me she froze."*

Some of the women spoke about positive experiences. Berina described going to see a military doctor who told her: "*I know what happened to you. So let's not have me examine you to traumatise you more."* She said "*it was a fortune in the misfortune that she stated the reason for seeing the doctor: rape."* (She explained that the reason why she went to the doctor was documented in the hospital protocols, and that documentation was the only basis on which she could get a certificate a month later confirming she had been raped. She had to ask the hospital to look for the document in the protocols from war period, copy it, and have it signed by the director of the Health Institute.) Sara described the sensitivity of one doctor in the commission for the disability pension who told her: "*Whatever I say to you I know I can't heal your wounds. It is easy for me to examine a person with disability, but how do I examine you? It is very difficult and I don't know how to estimate you. How am I going to estimate the disability to you or to any other woman?"*

Their experiences in schooling and employment also show how society treats women survivors of war rape. Elmana described her experience. Because of the war she was one year behind in her schooling, and she wanted to enrol in a high school in K. where her parents lived: "*I was supposed to go to a high school and I wasn't even finished with my elementary school. I was in seventh grade when the war began."* She remembers she went to school for a month in a basement in M., but had nothing to prove it with: "*My father wouldn't allow me to enrol to the eighth grade again when my generation is entering high school; the schooling must not fall behind he thought."* She believed that with sheer willpower she would be able to pass the eighth grade of elementary school and the first grade of high school together, but she faced a dilemma over which school to enrol with. She quietly said how she felt when she got her official transcript at the end: "*I barely made through. I mean a C, what kind of grade is that? It was a chaos."* But she continued her hard work and her grades improved: "*Later I made it to A grade."* Elmana enrolled at university, successfully completed her degree, and later enrolled for Master studies. She said: "*I went to all the classes like a real geek. I studied and I passed all my exams all in time."* She also worked along with her studies: "*I stretched my studies a little bit; I studied a year longer than it should. I went to work every day, I worked from 8am to 4pm. Then I saw that it won't work and that I don't have time to study."*

[29] The State Investigation and Protection Agency (SIPA) of Bosnia Herzegovina – Državna agencija za istrage i zaštitu, SIPA.

During her studies, Elmana worked at one association, and afterwards got a job in a private firm where she has been working for 10 years. She said she had other job offers but she couldn't quit and say "*Thank you I am not going to work here anymore. I just couldn't do that."* She explained why she did not leave her job in this firm: "*Nowadays if you get pregnant in a private company they immediately look to replace you. In this firm I used three maternity leaves and all three times I received 85% of my salary. The colleagues in the firm follow up on baby showers and celebrations; the director and the colleagues in that firm are very special."*

Sara described that when she returned to her city her father found her a job in a restaurant because they had no money for her to live on. She would leave her child with her family and return home when the child was already asleep. It was difficult to work all day but she had to work and support her child, and smile at everyone when she was working, despite her personal difficulties. Larisa described her struggle to find employment in her city and referred to a lack of understanding and numerous attempts to blackmail her into having sexual intercourse: "*Usually there were such men who did not have understanding, just a bit more civilised than those who raped me*." Emira explained that her situation and poor health prevented her from working full time, while employers do not understand or accept her wanting to work part time, which would be much more suitable for her "*Even if I cannot sleep, my employer does not recognise it.*"

In their interviews, the women talked about their experiences of witnessing and giving statements, and gave their opinion as to whether or not justice had been served. Emira described her upsetting experience when she recognised a man who raped her when she went to visit her mother who lived in the village. She saw him in the grocery store while she was shopping, and recognised a tattoo on his arm. She remembers she looked at his face as he was sitting with some people in front of the café close to the store. Then she sat in her car. She described the situation in these words: "*I turned around once more just to make sure that it was him, and all of them were looking at me."* Emira reported him to SIPA. She went to court and testified.

Želimirka described how the two police officers came for her and took her to the court trial: "*Maybe they wouldn't be on my side, but when they asked around who and what I am, and made sure that I wasn't some kind of humbug, then the people took my side. I stayed in good relations with them. It was published on television and radio too that there was a rape, but they used only initials, so it was properly handled."* Želimirka thinks that her case prevented other possible rapes: "*I think that nobody from our place was raped anymore."*

Most of the participants who were interviewed do not believe in justice in this world, and hoped for God's justice instead. For example, Larisa said: "*After all these years I am so deeply disappointed in justice, that for some time it had a great psychological impact. I found my justice. I found my justice in a spiritual way."* She describes this justice as her hope that all the perpetrators will be punished by God: "*The justice from social institutions, courts, I don't believe in it anymore. It is not a justice for me anymore. For me that is ridiculing the victims. Nothing else. There is no justice there."*

The participants spoke of the problems they had in being witnesses at court. They are not truly protected when they are a court witness. Berina said that her name was pub-

lished in the newspapers after giving her testimony: "*You are meant to be protected, and yet you're published in the newspapers. It is affecting."* She compared the testimony in The Hague with the one in Bosnia and Herzegovina: "*I had an opportunity to go as a witness to The Hague, there is a huge, huge difference. Here, we are unprotected in the court, and everywhere else."* She explained that she was a protected witness, and before the trial her father or husband went to the court to tell them that the media were not allowed to attend. The summons to attend court said that the trial would start at ten, so at that time Berina was sat in the waiting room with her husband and parents. But it was an open space with journalists, lawyers, judges and court police passing by "*and everybody there knew who I was. When all the witnesses are called for then they would call for me, the protected witness. They all saw me. Why couldn't they say for example everyone will be here at 12 so you should come at 9 a.m.? Or at 6 pm so that nobody can see you. Because you are a protected witness."* Berina thinks: "*If I come as a protected witness nobody should be there. If there is a possibility only for the accused, the lawyers and myself. Nobody else. Even the court police should wait outside."*

Finally, the participants talked about reconciliation and attitudes towards people of other ethnicities. Most of the participants believed that they should not make generalisations, that they cannot blame the whole world, and that people should live together regardless of their ethnicity. Emira described how she does not feel hatred towards the Serbs today. In her narrative she said: "*I think that we can't live without each other."* Sara thought so too: "*And should I look away now? Or say I am not going to talk to you because you are that person?"* But some of the participants found it difficult to talk about reconciliation. Elmana answered through tears that she wants to be honest when she talks about reconciliation, what she feels in her heart and soul. She relates it to her war experiences and what she as a girl survived with her family, aunts, cousins and people, Bosnians in the war with Serbs. She remembers the concentration camps, rape, abuse, and an old woman who said: "*Let the little Turk die"* and "*those words still ring in my head"*. Elmana thinks the younger generations can talk about reconciliation: "*New generations that do not know and who have not seen and who have not been told anything, and those who have no one to tell them, they can talk about reconciliation."*

Do survivors speak or keep silent about their difficult experience?

Women who told their life stories also talked about the survivors' silence after the rape. They usually think that the survivors keep silent about their difficult experiences because of shame and fear. Zehra said that it took long time for her to speak up, and that she understands the women who keep silent: "*Women stay silent because of shame; I kept silence because of it. I feel shame. Although many people said I have nothing to feel ashamed for, and the perpetrators should be ashamed. But I am ashamed, I was a girl."* Berina said: "*The women are not ashamed of other women regardless of their age, they are ashamed of men. Such is our petty-bourgeois society it always turns out that a woman asked for it. In the end it turns out that you asked for it literally and that's why you got it. I think that's why they're ashamed. Mostly shame and fear of course."* Emira thinks the same: "*There is no security and that's why women keep silent"*. She said she knew women from where she lived who remain silent and could not bear for people to know about it, adding: "*They know best why they keep silent and don't speak up."*

In the end, it is important to note that in their life stories the survivors emphasise the importance of speaking up and sharing their experiences with others - husbands/partners, children, family members and other women. They think it is important to speak up so that this experience would not happen to others. Emira said: "*The older women told these stories, and we did not believe them then, we were not listening and we tried to silence them. But they were right, it should be told, it should be passed on."* They also emphasised the importance of survivors talking to each other about their experiences so that they realise they are not alone. Berina for example, described how she met another woman who was a catholic, who is her customer in a hairdressing salon, who survived being raped by a soldier from the army. She said she did not know about that woman's experience before "*but she told me, one time when we were alone of what happened to her."* Berina said that they do not talk about it directly, but that they know what they survived and that regardless of their different ethnicity there is a connection between them as survivors, primarily because both are women. "*I mean, we are women and it doesn't matter what our names are, who did it to us, one or another. There is a special connection between us,"* Berina explained that another reason for women not talking about their experiences is that sometimes they made a promise to each other to remain silent: "*It means that nobody must hear what had happened with us there."*

Summary gathered from analysing the life stories regarding the social acknowledgement of war rape survivors

Representatives of the relevant institutions, neighbours, and society in general stigmatise the survivors of war rapes and sexual violence. As a result, survivors are left with feelings of guilt and responsibility for what happened, which leads to re-traumatisation and creates an environment in which it is very difficult for survivors to speak out.

Institutional responses to and concern for the survivors of war rape did not come until at least ten years after the end of the war. Only a small number of organisations, amongst them *Medica Zenica,* showed an interest in developing a comprehensive approach to providing support and assistance to meet their needs before that.

In 2006, female survivors of war rape were finally given the opportunity to apply for the status of "civilian victim of the war". This is the first time anywhere in the world that women have been able to achieve this status, and all of the seven women interviewed for this report have done so. However, numerous obstacles and difficulties remain in place. They cannot exercise this right across the whole of Bosnia and Herzegovina, and live in a state of uncertainty whether they can achieve and retain this status if they return to the Republika Srpska. Difficult prevailing economic conditions mean that survivors are worried that this status might be revoked and their rights abolished, a process for which no clear guidelines have been issued. The reasons women give for applying for this status include a need for existential resources, a desire to have the same benefits as other people, and the wish to ensure that their experiences are recorded for future generations to prevent them happening again.

Some of them recognised that the benefits they receive from having this status are not equal to those in other categories such as war veterans or people with war-related disabilities. Most of them mentioned a lack of sensitivity towards survivors of war rape amongst professionals from government institutions (with certain individual ex-

ceptions), who regard them as a burden on the state budget, and that the state is not providing survivors with other rights they are entitled to under the law, such as employment and education. Conversely, most felt that the state enabled other categories such as war veterans and people with war-related disabilities to enjoy these right fully. Success stories in terms of employment or education come from personal endeavour and family support rather than state intervention on their behalf.

Participants also describe the entire process of testifying in court, starting with having to give their initial statement to male investigators who come to their homes in marked cars and so expose them to stigma from their neighbours, and ending in court appearances where they are exposed to the public and their identity left unprotected, as problematic. Some survivors contrasted this with the positive experience of testifying in The Hague[30].

Negative experiences of testifying to the courts in Bosnia and Herzegovina, and the length of time it takes to prosecute war rapists, have led some survivors to lose faith in the legal system. They all agreed that prosecuting perpetrators would have stopped other war rapes from occurring, and their belief that they would not see justice in this world but hoped for it in the next should be seen as the result of twenty years of disappointment at the failure to bring perpetrators to book.

While most survivors felt that we should talk about the process of reconciliation, and agreed that we shouldn't generalise about people, they still believed that all perpetrators should take responsibility for their actions and be prosecuted for them.

All the women emphasised that they were raped because they belonged to a specific ethnic group, in their case because they were Muslims.

The participants pointed out that many survivors stay silent about surviving war rape because they would feel ashamed in front of male members of their families and communities. Our participants encouraged other survivors not to let shame keep them silent, as it is the perpetrators who should feel ashamed, and not them. However, they understood and supported survivors who decided to keep quiet because they had accepted what happened and wanted to move on. Most of the participants also reported that some groups of survivors make a pact amongst themselves to remain silent, and feel guilty if they break that pact. However, the majority believe that they should speak up about the rape, even if they are elderly, to help prevent future generations from suffering from the same experiences.

[30] See also medica mondiale (2009).

4.6. Conclusions regarding research question 2

Various sources of information provided us with the following picture about the level of perceived social acknowledgement of war rape survivors in our sample:

- Women participating in the research said that governmental, cantonal and entity institutions do not do enough for women who survived war-time rape, apart from securing individual financial benefits. Even those who obtained the status of civilian victims of war do not accept and fully perceive it as a measure of social recognition. It seems that this unique measure of a socio-political recognition of war rape survivors does not outweigh the negative responses that survivors perceive from their surroundings.

- Many participants feel and state that NGOs take most care of survivors and support them in different ways, which offer more social acknowledgement than the support they receive from governmental institutions. The study showed that about 50% of the participants are familiar with the procedures for claiming their right to the status of civilian victim of war, while the other 50% say that they know little or nothing about these procedures, despite the fact that 76,5% actually managed to obtain it. Around 80% of the participants have very limited knowledge about the rights enshrined in the status of civilian victim of war, such as education programs, re-training, additional support for health and social needs, housing, and employment assistance. Around one quarter of the participants feel that the rights they have achieved match their needs, while the rest feel that they are inadequate. The participants state that financial assistance through obtained status of civilian victim of war is not enough as well as that they lack housing, health care, social assistance, and support for their children.

- NGOs whose representatives took part in this research support survivors in different ways, including providing them with professional support and information, legal aid, housing, economic assistance, training, and raising awareness within the society about the issues facing rape survivors. They spoke about various issues related to the status of a civilian victim of war. Their main concerns include the lack of a single law that would have jurisdiction over the entire territory of Bosnia and Herzegovina, the fact that the rights are reduced to mere financial benefits, and the fact that survivors don't have the same rights as other groups of survivors traumatised during the war (such as the association of disabled war veterans, who have been given more privileges). NGO representatives have pointed out that the adequate recognition of survivors and sensitized approach by the professionals in public institutions and agencies on issues related to the survivors' traumas prevent stigmatisation of survivors. Finally, they mention the issue of political manipulation of women who survived rape, and the fact that perpetrators are often living free and / or unpunished.

- NGOs also report financial problems in supporting survivors. Since the work of NGOs in Bosnia and Herzegovina is mainly funded by international donors, they are in constant struggle and stress for fundraising in order to provide continuous support to survivors. This puts NGOs in constant uncertainty because they do not have adequate, continuous financial support from government institutions regarding the support of survivors. Finally, NGOs mentioned inadequate competition of nongovernmental organisations for working with survivors because the trends of donors are that they currently support projects without making an overview of the real capacities, resources and experience of nongovernmental organisations for working with survivors.

- Government representatives talk about a lack of political will in some sections of the government, which hinders the adoption of a unified program and legislation at the state level to regulate the status and rights of survivors. Also they state lack of adequate information and more accurate data on the number of participants who survived rape as a difficulty, and the imbalances between programs by nongovernmental organisations offering support to survivors. It is evident that in Bosnia and Herzegovina there have been no consistent measures to regulate the status of survivors. The Republika Srpska Government makes almost no effort to provide care for women who were systematically raped and assaulted during the war, while since 2006 the Federation of Bosnia and Herzegovina (since 2012 in the Brcko District) has legislation in place that recognise survivors of war rape as a special category of a civilian victims of war and enables them with the opportunity to obtain the status of a civilian victim of war.

- The life stories clearly showed that the participants need protection in trials where they stand as witnesses. Some participants didn't have problems claiming their rights, but some were faced with various administrative problems and issues related to exposure, feeling of shame and unpleasantness for having to repeat their story. Survivors who testified at courts in Bosnia and Herzegovina and at the ICTY in The Hague compared their positive experiences of testifying at the ICTY with the difficulties and obstacles experienced at all levels in Bosnia and Herzegovina. The length of the legal processes of bringing perpetrators to justice, combined with negative experiences of giving testimony, affect survivors' faith and belief in the legal system and decreases their will to testify.

In summary, specifically in the case of women who have the status as a civilian victim of war, we could say that although their status could be a unique and important mechanism of social acknowledgement in the Bosnia and Herzegovinian society, there are many problems related to it which impede whatever positive impact it can have on the survivors' perception of their social acknowledgement. NGOs seem to be perceived as much more important in providing authentic support, and play a major role in fulfilling the need of survivors for social recognition than governmental institutions.

4.7. Research question 3: Coming to terms with war rape: coping strategies and sources of resilience: Results obtained through the coping inventory, questionnaire and focus group discussions with NGOs

As the theoretical background to the study states, research on adjustment to trauma clearly underlines the significance of coping strategies for recovery. Our research therefore also gives special attention to the sources of recovery and resilience and coping mechanisms used by survivors of war rape to carry on with their lives after their extremely painful experiences. Most coping literature, however, is based on coping concepts that are concerned with the immediate or medium-term aftermath of coming to terms with the adverse effects of specific events. There are no instruments for assessing coping processes that stretch over two decades, which would be necessary for this research. We therefore combined standard psychological measuring instruments (namely a questionnaire on the coping mechanisms with war rape) with a variety of questions in the questionnaire that was designed specifically for this research, based on focus group discussions with NGOs working in the same field. Highly relevant information about strategies for coping with rape experiences were also gathered through the life story interviews, and this will be presented after the quantitative data.

4.7.1. What coping strategies are used by the participants?

The participants' coping strategies were assessed using an adapted questionnaire on coping mechanisms (Brief COPE; Carver, 1997), which is an abbreviated version of the questionnaire, the so-called COPE Inventory. This abbreviated version contains 28 statements designed to explore 14 different ways of coping, and assesses how often each coping mechanism was used. Scores on each scale range from 2 to 8 (each scale being defined by two items, ranked from 1 = "I did not do that at all" to 4 = "I did it frequently"). There were 46 participants, and the main descriptive data obtained from questionnaire are given in Table 4.23.

Table 4.23. Mechanisms for coping with the traumatic experience of war rape (N = 46) (the results are presented along their relevance)

	Min	Max	M	SD
Diverting attention	4.00	8.00	6.98	1.26
Acceptance	3.00	8.00	6.39	1.68
Emotional support	3.00	8.00	6.20	1.50
Active coping	2.00	8.00	6.13	1.60
Religion	2.00	8.00	5.65	2.16
Instrumental support	2.00	8.00	5.46	1.75
Planning	2.00	8.00	5.20	1.90
Venting	2.00	8.00	4.31	1.78
Denial	2.00	8.00	4.06	2.06
Self -blame	2.00	8.00	3.59	2.16
Positive reinterpretation	2.00	8.00	3.48	1.39
Passivation	2.00	7.00	3.20	1.24
Humour	2.00	6.00	2.59	1.11
Using substances	2.00	3.00	2.02	.15

Interestingly, the table shows that the least common coping strategy amongst the participants was substance abuse (average response M = 2.02). However, the use of substances in the questionnaire is defined by two items relating to the use of alcohol and drugs. If the items had been further adapted to this research sample and if pharmacological drugs would have been included, this coping strategy would have most probably been reported more frequently by participants, given the data presented above regarding the extremely frequent use of psychopharmacological drugs.

Humour is rarely used as a coping strategy, which is completely congruent with the nature of the experiences they are trying to deal with.

Passivation (i.e. giving up the fight), positive reinterpretation (attempts to see the experience in a positive way) and self -blame (i.e. blaming yourself for what happened) are also rarely used as coping mechanisms (see table above). Bearing in mind that research presented in the theoretical background suggests that self-blame is a maladaptive strategy, this finding is a positive result. The infrequent use of positive reinterpretation makes sense, given that the nature of rape experiences makes it hard for survivors to reframe them in positive ways.

There was a moderate use of venting (i.e. expressing emotions) and denial (i.e. denying what happened). These two strategies are generally considered as risk factors for posttraumatic adjustment. Denial in particular might be more generally associated with the immediate aftermath of war rape, but twenty years of living with the experience and re-experiencing it in everyday life makes it difficult to maintain avoidance.

On average, the participants reported frequent use of emotional support (seeking support from others) and acceptance (attempts to accept and live with what has happened), which is good because these two coping strategies are usually described as protective factors in posttraumatic adaptations. The participants mostly used planning (how to solve problems), support (seeking advice and help from others), religion (prayers and finding consolation in religion) and active coping (taking concrete action to solve the problem). Given the theoretical background, these are coping strategies that produce a better and quicker adjustment.

According to the average results, the participants involved in this research reported that their most common strategy in overcoming the experience of rape is diverting attention to other activities and facilities. The function of diverting attention in general is actually one way of avoiding thinking about what has happened, and the fact that this strategy was the most commonly used is both good and bad. It may be adaptive because it enables the "release" of trauma-related rumination so that survivors can focus on other things in their lives. However, since this is the most frequent kind of strategy used, it can also indicate that the participants are too "immersed" in their trauma, and so redirect their attention to other things in order to overcome it. In any case, the results of the frequency of use of certain coping strategies are generally comprehensible, and in line with what we expected. Although some strategies may be considered more adaptive than others, literature on traumatic stress generally suggests that the best predictor of successful posttraumatic adjustment is the use of a variety of coping strategies, and adopting coping that is sufficiently flexible enough to meet the demands of the situation (Tedeschi and Calhoun, 1995; Duraković; 1998, Bonanno et al., 2011).

We also found interesting results when looking at associations between coping strategies and some socio-demographic variables, particularly regarding the variable "having obtained the civilian victim of war status" and self-blame as a coping strategy. Participants who have achieved the status of civilian victim of war report more frequent self-blame (M = 3.92, SD = 2.28) than participants who have not achieved this right (M = 2.4, SD = 0.97). This result was unexpected, since we had assumed that achieving the status would have a positive impact on ability to cope with trauma. Other results from our research suggest that this self-blame may be related to the negative responses that they perceive from society regarding their obtained status, but it could potentially also be connected with the fact that having the status seems to cement their self-identity as a war rape survivor.

In addition, participants who are informed about the rights of civilian victims of the war are more likely to use active coping strategies (since the whole procedure of obtaining the status requires a range of activities to be done, making it active per se;) than uninformed participants (M = 6.33, SD=1.53 and M = 5.27, SD=1.62), and use less denial (M = 3.70, SD=1.79 and M = 5.00, SD=2.32), since confronting their experiences is unavoidable during the procedure.

When we talk about silence, results show that compared to those whose relatives are unaware and uninformed of their painful experience, participants who shared with their relatives about their experiences more often use active coping (M = 5.52, SD=1.53 and M = 6.68, SD=1.46), instrumental support (M = 4.82, SD=1.80 and M = 6.14, SD=1.49) and acceptance (M = 5.87, SD=1.71 and M = 6.86, SD=1.52). We can assume that just using these adaptive coping strategies helps participants to share this information with relatives, which in turn induces acceptance and encourages and unblocks their potential to cope in more active ways.

This corresponds to another result of our correlational analysis, namely that survivors who tell their closest friends about their experiences are more likely to use both active coping (M = 6.85, SD=0.99 and M = 4.90, SD=1.85) and instrumental coping (M = 6.69, SD=0.95 and M = 4.50, SD=2.01).

These findings highlight the positive connection between being able to share about the experiences – and most probably experiencing support when doing so – and more positive coping strategies that enable survivors to actively deal with their lives. Since correlations are not causal relationships we cannot further establish whether a tendency to use more active coping leads to a greater readiness to share about the experiences with others or, conversely, whether the experience of being able to share what happened with others (which is connected with a positive result of acceptance) enables participants to also use other, more proactive forms of coping.

4.7.2. Does coping get easier or harder with time?

The questionnaire also contained various questions concerning coping. One looked at the difficulties of coping with war rape in relation to the length of time since the experience: "*When you look upon your life now, what do you think: Was it harder for you to cope with your rape experience IMMEDIATELY AFTER THE WAR, OR NOW, 20 YEARS LATER?"* Their answers are shown in the table below.

Table 4.24. When was it more difficult for the participants to cope with the trauma (N = 47)

	N	%
Immediately after the war	19	40.4
Now, 20 years later	13	28
Equal	13	28
Other	2	4

As the table shows, 19 of the participants (40%) who answered this question reported that it was more difficult for them to deal with the experience immediately after the war. 13 (almost 30%) of the participants said that it is harder now, while 13 (almost 30%) said that it was equally difficult to deal with the rape experience immediately after war as now, twenty years later. This result actually leads to the conclusion that besides the 40% who deal more easily with their trauma now, the majority (almost 60 %) either feel no difference, meaning that it does not get easier to cope, or even feel that the difficulties aggravate with time. This might be connected to what was said in the theoretical foundations, namely that there could potentially be different coping trajectories for different survivors.

The following examples of responses offer a clearer picture of the background to these data:

It was more difficult for them to deal with rape experience immediately after the war:

- "*Because I felt helpless because of everything I had to get through. I even tried to commit suicide."*
- *"It was more difficult for me immediately after the war because I didn't know how to move on with my life, but as the time passed in the past 20 years some good things also happened to me."*
- *"It was more difficult for me to cope with war experience immediately after war. I was a child and I did not know how to deal with it."*

It is more difficult now:

- *"It is more difficult now, 20 years later, because I don't have enough strength to cope with and I have to."*
- *"It is even worse now. As a person gets older it is more difficult, it burdens you and it is stronger than you."*
- *"At first I was shocked, but now when it is gone I am aware of everything and it gets worse and worse for me to deal with it."*

It is difficult now just as it was at the time immediately after the war*:*

- *"It was difficult then and it is still difficult to cope with the rape experience."*
- *"Now I have some other – additional fears, I'm more aware of the situation now."*
- *"It is the same. I don't feel any better."*
- *"When I was in Medica I was given a professional help and I felt protected but now I'm all alone."*
- *"It was difficult for me then and now to cope with rape experience, but in different ways. Then I was 17, but now I am older and it is more difficult for me to deal with some things. Then I was young and occupied with the existential but now I am more aware of what had happened to me."*

This again hints at potential risk factors that come with time, such as getting older and becoming more dependent on others, and the fact that ongoing life stresses drain survivors' energy over time. On the other hand, experiencing positive events in one's life can contribute to a better adjustment over time.

4.7.3. Sources of resilience: What helps survivors of war rape?

Other questions were used to find out which strategies survivors have used since the war to overcome their rape experience, and which can be seen as sources of resilience. One question asked the participants to state which five things that helped them the most to move on with their lives after the rape. They were then asked to arrange those five things by importance/significance. For the purposes of this report, only the most significant sources of resilience for the participants (those that were ranked first or second) were analysed.

The table shows how often each response was given by the 50 participants who answered the question.

Table 4.25. Sources of resilience: What has helped participants to continue with their lives despite the war rape experiences (sources of recovery which were ranked first or second according to importance)?

Most important source of resilience	**N**	**Second most important source of resilience**	**N**
Children (and grandchildren)	16	Children (and grandchildren)	16
Husband's support	10	Other people's support (friends, colleagues, who had the same experience)	8
Support from parents and other family members (brother)	9	Work (and focussing on other activities)	8
Other people's support (friends, colleagues, who had the same experience)	4	Support from parents and other family members (brother)	7
Work (and focussing on other activities)	4	Own strength and desire to feel good	4
Support from Medica Zenica	4	Support from Medica Zenica	3
Religion	2	Husband's support	2
Own strength and desire to feel good	1	Religion	2
Avoiding thinking about what had happened	1	Avoiding thinking about what had happened	-

The table shows that the most important source of resilience for the participants were their children or grandchildren, which were most frequently mentioned in both first and second place. Husband's support appears more often in first rather than second place. Obviously support from their husband helped some survivors a lot, which is clearly in accordance with results from research on social support after rape (see theoretical background). Participants also stated family members' support of great importance in their recovery – family support is put in the first and second place. The participants often stated that focussing their attention on work and other activities (for example gardening, listening to the music) and support from other people who had been through the same experience were important sources of resilience, but they were more often ranked in second than first place.

After they had stated which sources of resilience were most helpful to them for carrying on with their lives, the participants were asked to describe *how* these sources gave them strength. Their answers were complex and could not be classified into categories. Here are some examples for sources of resilience ranked first or second to illustrate their way of thinking:

- *"I talk to my mother, she means everything to me. She is my friend, my colleague. Children make me happy."*
- *"When I gave birth to my child, it gave me strength to fight through life."*
- *"The birth of my grandson made me happy. He was my everything, but he was born in the war so it wasn't easy to deal with hunger."*
- *"Love for my children and their love for me kept me in life."*
- *"Work and only work."*
- *"Medica has taught me to appreciate myself. My mother encouraged me."*
- *"Support from women who were placed in Medica and their love for me and my child."*
- *"I talk to my husband. He gives me the strength."*
- *"My husband is the biggest support to me. I search for consolidation in work, it relaxes me. Playing with children also relaxes me."*
- *"I believe it had to happen because God wanted it. My family and my children are my everything."*
- *"My family supported me. Medica provided me with everything and taught me to keep on living."*
- "*I tried not to think about war rape and to have some other things on my mind. It was helpful."*

Finally, the last question about dealing with war rape trauma was framed as follows: "*If a survivor of war rape were to ask you for advice, what would you tell her to do? How would you advise her*?"

Since it was difficult to classify the participants' answers into categories, we simply offer some examples of their answers:

- *"To get help from doctors, psychologists, to turn to an institution NGO and try to obtain the right of the civilian victim of war."*
- *"Do not be silent, talk about it with your family, friends or your psychologist."*
- *"Do not underestimate yourself. You are not different from others nor worse than them. Appreciate yourself."*
- *"Take care of yourself, if you trust someone then talk to him or her. Make life easier for you because you have to live."*
- *"Search for psychologist's help. Talk to someone who is close to you. Talk to those who experienced the same as you did. Bear in mind that it is not your fault. Do creative work."*
- *"Take your life in your hands, go ahead and cry if you are going to feel better but keep in mind that you have to keep on living. Keep in mind that you are not the only woman who had experienced such thing. Find your aims and do not look back."*
- *"Please be strong, do not worry, it is not your fault. Unfortunately, the same happened to me."*

- *"Try to 'bury' your memories. Keep on living your life."*
- *"I would never tell her to forget but to find something that is worth living for. I found it difficult when people told me to forget what had happened. Tell them that they are not alone."*
- *"I do not know. I would tell her not to do what I did. Solitude took my strength. If you ask me she should live a new life."*
- *"I would tell her to occupy her mind with work."*

4.7.4. Speaking up or breaking the silence as particularly important coping strategies after war rape (views from NGOs)

The various data collected from the participants clearly shows the importance of telling their story and thus breaking the silence. The importance of this was equally underscored by representatives of nongovernmental organisations who were asked in focus group discussions what their clients said they found helpful and useful. Members of one association said that they noticed how useful it was to "speak out" instead of remaining silent. One explained that women felt better after speaking about it: "*Each one of them 100% says that 50% of their relief comes even just with entering the association. It means that they found strength to come and to talk about it [...] I think it is crucial for the entire country to raise awareness of women to speak out."* A representative of another association points out that it was a significant support for survivors in Republika Srpska that *Medica Zenica* educated and supported other nongovernmental organisations in Banja Luka, Prijedor by sharing its experience on models of support.

The representative also commended an initiative by *Medica Zenica* to establish a unique institutional network to support those who stand as witnesses in cases of war crimes, sexual violence and other criminal offenses in the territory of Zenica Doboj, Central Bosnia and Una Sana Canton.[31] The establishment of such a network is a step towards improved protection for witnesses, and is expected to lead to greater awareness of the importance of testimony, encourage potential witnesses and give them security during the processes of testifying. The representative pointed out that the experience of testimony is extremely stressful, so the care of witnesses has to have a continuity which includes support before, during and after the trial. She said: *"A woman goes to the testimony, she has no support, and not to mention the time when she returns from the testimony. A woman is only the concern of court up to the moment they get a statement, or woman to testify [...]. [...] Those women need adaption, psychological and medical help, for the woman to adapt afterwards."*

This last statement suggests that breaking the silence by testifying before a court or in other public ways does not work by itself, but only when it is accompanied by social support.

[31] See also Hasanagic, S. (2013). *External evaluation: projects of Medica Zenica funded by medica mondiale 2011-2013. Final report*. Sarajevo.

4.7.5. Is post-traumatic growth possible after war rape?

As mentioned in the theoretical part of the study, Tedeschi and Calhoun (1996) have introduced a construct of post-traumatic growth in the psychology of traumatic stress. They argue that post-traumatic growth manifests itself through changes in three areas: changes in the perception of personal possibilities and personal strength, changes in relationships with other people, and changes in understanding life. Concepts of post-traumatic growth in Bosnia and Herzegovina were studied by Powell, Rosner and Butollo (2003) and Duraković (1998), who both claimed that there are positive influences of trauma in understanding people's adaptation after the war.

There are very few studies regarding post-traumatic growth after rape, so we asked the following question to assess how survivors of war rape evaluate their experiences: "*We have talked a lot about negative consequences of rape that have affected your life. Sometimes people who survive very painful experiences feel that, in spite of the pain, they have learned something positive about their lives. When you look upon the last 20 years, is there something positive that you believe you have learned based on your painful experiences? If yes, can you give a short description?"* The answers were quite different, but they were put into five categories. Table 4.26. contains data on the frequency of answers in each of the categories.

Table 4.26. Positive lessons from trauma

	N	%
Attitude towards life	7	15.9
Attitude towards self	10	22.7
Attitude towards children	4	9.1
Attitude towards other people	9	20.5
No positive lessons	14	31.8

The table shows that about 32% of the participants feel that they haven't learned anything positive about their lives based on their painful experiences. However, a significantly higher portion of answers included descriptions of positive effects of trauma. Here are some examples of their answers in each category.

Attitude towards life

- *"I look at life in a more modern way even though I live in the countryside, my parents were more conservative – work – just keep working – and what will others think."*
- "*Having learned to differentiate: World is not as beautiful as I used to think, people turn into beasts, you have to be careful."*

Attitude towards self

- *"I can take anything (for my children, in order for them to live their lives without the suffering that I experienced)."*
- *"I am resistant, a fighter."*
- *"I became stronger."*
- *"Through therapy work in Medica I realised that what happened to me was not my fault and that I don't have to be ashamed of it and blame myself."*
- *"Perhaps I value myself more now. When I look at people around me, who didn't suffer through anything, and in some way they seem to be suffering more than I am. They don't have anything. I am more proud and coping better, I can manage better*

and I might have not known that before. It is all thanks to people who helped me work on myself, to think positively, and use my experience to help others."

Attitude towards children

- *"I am more open, I talk to my children."*
- *"I recognise the strength that I have to keep going on for my child, if it weren't for my child I think I would kill myself, hang myself, but my child is everything to me and I live for her."*
- *"Will power and fighting for children, they gave me strength and for them I fought and still keep fighting."*

Attitude towards other people

- *"I believe in good people and stay away from the bad ones."*
- *"I became more empathic, I like to listen to people's stories and tell them mine to comfort them."*
- *"Sensibility in working with and contacting other persons with different traumatic experiences."*
- *"I learned that a person hurting needs to be helped, and now I am working with sick people and I want to help them. I help my sisters. I sympathise with them."*

These results show that the majority of participants who took part in the research managed to interpret their trauma in a way that enabled them to integrate their experience into their personal worldview. As suggested in the theoretical introduction, this does not contradict the fact that 57% of the participants still suffer from PTSD and have a great variety of other health problems. Various studies have shown that post-traumatic growth happens even if survivors still suffer from considerable distress.

4.8. Research question 3: Coming to terms with war rape: coping strategies and processes and sources of resilience: Results obtained through the analysis of survivors' life stories

"*I want to live and look to the future…*"

In their life story interviews, participants mentioned different sources of recovery and coping strategies which both illustrate, complement and enrich data from the quantitative approach.

All the participants who have children emphasised that their children gave them the strength to move on. For example, Larisa said: "*My children helped me the most. They are my sense of all. Everything nice I didn´t have, all sufferings I had I forgot about through my children. Through them I fought and had enthusiasm to move on."* Another described how important she found the experience of motherhood: "*I was selfish. I wanted her, because I wanted to know what motherhood was. I wanted her to be mine. She is all I have. I have a husband and a brother but she is all mine. That is the only thing on Earth that is mine."*

Some of them mentioned that support from their husband was a significant source of recovery. Sara described it with the words: "*I don´t know ... I really had luck to have such a husband, who never ever, not with a gesture not even with any glance signified that something bothered him or that he pushed me away. Never, never… he was nothing but a help, never a hindrance."*

They all mentioned the importance of support and approval from the family. For instance, Berina remembers her mother saying *"It is important that you´re alive."* Emira remembered that her biggest help during the wartime when she stayed in a village was her mother, and Elmana sees her father as her special support: "*Whatever bigger life decision I have to make I ask my mother, and I always say in the end that she please ask father what he thinks."*

Participants also said it was very helpful to encourage and support each other instead of feeling sorry for themselves. Larisa, for example, says: "*When I am down I say come on I had worse times and so on. This is how I encourage myself."* Elmana also spoke about how she keeps her spirits up: "*I didn´t want to let myself to focus only on that in life, and to sit and think poor me, look what happened to me ... why me? It happened to me and not just to me …. It happened to many women, not just in Bosnia ... it happens in the whole world in and outside war. And I think ... that it is easier for me that it happened to me and not my mother."* She concludes: "*There are worse cases than mine, I won't complain. I want to live and look into the future."*

One of the women said that it helped her not to hate: "*I think that it saved me that I didn´t hate. Even the people that harmed me, maybe I was furious at the start but I don´t hate them."*

Furthermore, women pointed out that it is helpful to talk about the traumatic experience of rape and not to remain silent. Berina remembers that the morning after the soldiers went away, after all what had happened the previous night, some women said: *"No one must say what happened",* but she said: "*I will."* Zelimirka described how it helped her to speak to the rapists when she confronted them in court, and saw that none could look her in the eyes*: "Come on, look me in the eyes, I can look you in the eyes, you think you harmed my image ... I will walk again with my head held high all over the world [...]. And anyway you weren´t much of men."*

They also state that faith and being religious helped them. For example, Elmana believes that God gives her strength, so she says: "*Dear Allah gave me strength and mind to look at it this way".* She said that she had bad dreams for a while and her grandmother told her "*Take abdest*[32] *before you go to bed and pray until you fall asleep*", and it helped.

Zehra points out how significant it is for her to be able to support other people and help them: "*I will always help if I can, and if I cannot then I would never harm anyone, that´s me. Besides my children this is what makes me happy."*

Zehra also tried to find relief in alcohol: "*Sometimes I tried to calm down with alcohol, but it wouldn´t help."* Elmana chooses to go out with friends and to have a good time rather than take pills: "*I won´t take them now at the age of 35, maybe later for some reason but not now. I won´t think about the past because it is easier for me."*

[32] Abdest is religious washing before the prayer in Islam.

During their stories women also pointed out the importance of social support, such as talking to girlfriends and other women whether or not they had the same experiences. Emira, for example, spends time with women in one association who had similar pasts: "*My private friends are women who survived the same as I [...].*"

Berina pointed out how helpful and encouraging accepting the situation was for overcoming the trauma: "*Recovery, I guess so, is first to accept it. To deal with yourself about what happened. That is and isn´t the worst thing that happened to you. It´s a starting point to accept it, and then comes other support.*" She remembers herself when she accepted she was raped: "*...as it was a dream. In some way I am aware of what happened. Today, still, I know all, but as if it is a bad dream I had. I live with it in the background. I mean, I don´t think about it every day.*"

In her story, Zehra said that there is no hiding from what happened: "*Many years have passed, but you can never forget it. Sometimes that is constantly on my mind, but I think less about it.*" She also said *"You can´t erase it. You can´t take just a rubber and erase it, but you have to think about good things."* All the survivors explained that they do not like the word "victim", or hearing themselves described as "victims". When she talks about herself, Sara says "*I don't like the word victim, for me victims means that I freely and willingly make some sacrifice*", while Elmana describes herself as a fighter, worthy, fair, active and correct, sensible. "*I don't want rape to mark me. I don't want that to be a centre of my life.*" Zehra described herself as a sensitive person who cares for others and would not harm them. Emira sees herself as secure person who has felt positive changes. Berina describes herself as successful: "*After all, I haven't given up on marriage and children*", while Larisa sees herself as a persistent and strong woman who does not give up.

Summary gathered from analysing the life stories regarding coping and sources of resilience in survivors of war rape

In their life stories, most of the survivors emphasised that support from family and friends has helped them to carry on, and also in making decisions to speak up, to keep children born of war rape, to testify, and to accept their experience.

Most also said that accepting what happened and knowing that they were not the only ones, indeed that other people suffered "worse than them", helped them to go on. They saw themselves as survivors. The majority of women said in the life story interviews that religion, their hope and faith in God, helped them to accept their experience, while others valued themselves through helping others to continue with their lives in various ways. It is also evident that some women discovered ways to accept that their experiences are part of their lives which they cannot forget, but they had found methods such as medicine, psychosocial support, and individual / group therapy to put them aside and carry on with their lives. One said that alcohol had helped her temporarily, while several said that they preferred using jokes and humour to taking medicine.

Most of them do not like hearing themselves described as victims, and preferred to see themselves in positive ways such as being strong, active, fighters, sensible, caring, fair, correct, and persistent.

4.9. Conclusions regarding research question 3

We identified the following key issues from our analysis of the data on the coping processes and strategies of war rape survivors:

- On average, the most commonly used coping strategies amongst the participants over the past 20 years have been diverting attention, active coping, and emotional and instrumental support. According to the existing literature on coping, these strategies are all connected with better adjustment to trauma. The participants might have acquired some of these strategies by themselves, but potentially also through the psychosocial and therapeutic support that they got from Medica. In fact, seeking Medica's help after the most terrible human experiences is already a strong indicator that the survivor has an active coping style, and this might have been reinforced by the improvement they felt as a direct result of Medica's interventions, and the general atmosphere there.

- In relation to other coping strategies it was surprising to find an association between having achieved the status of a civilian victim of war and self-blame as a coping strategy. Other results from our research suggest that this may be related to an overall negative response within general society to their achieved status (see research question 2), thus underlining the fact that the existence of negative responses outweighs the potential benefits from positive responses (see theoretical background), or it could be a side-effect of the status, namely that it cements the survivors' identity as a victim.

- There is an association between sharing the experience (as opposed to keeping silent) and using more adaptive strategies of active coping: Participants who have shared about their experiences with significant others, such as relatives and friends, tend to use more active coping strategies. This association can be interpreted in both ways: either active coping as a preferred coping style leads to opening up to others, or having shared about the experience opens the way to more active coping. Speaking out was also identified as a major coping strategy in the focus group discussions run with representatives of NGOs.

- The participants were asked whether it was harder to cope with war-time rape immediately after the war or today, 20 years later. Their responses show that 40% of participants claim that they find it easier to cope with their trauma now than they did right after the war, but there are still about 60% of study participants who reported that coping was either as difficult or more difficult now as it was then. This might hint at differences amongst survivors in their coping trajectories over time. Aging might play a role for aggravating the burden of coping, or at least for it not lessening with time, while posttraumatic growth experiences such as a greater appreciation of life and particularly valuing relationships after the experience might contribute to perceiving coping as becoming easier with time.

- Despite the persistent and enormous level of suffering and psychological distress that was presented in relation to research question 1, the participants reported experiences that can be related to posttraumatic growth: This growth concerned life in general, the self, and their relationships with other people, particularly their children. The importance of relationships were a paramount feature in their responses regarding

their sources of resilience in both the quantitative and qualitative parts of the study. In the life stories, most of them stated that accepting the experience as it is, as well as knowing that they are not the only ones who survived and that there are others who suffered "worse than they did", also helped them to go on.

In fact, based on our current analysis and the role that coping plays in posttraumatic adjustment, we could suggest that the participants in our research show a very complex picture of suffering with regard to their mental and physical health that shows signs of chronification. At the same time, they report strategies of coping that are commonly related to better adjustment and health, as well as posttraumatic growth and resilience. This could lead us to a potential conclusion that the war rape experience is indeed a highly debilitating experience (a finding replicated by international research in many studies on prevalence rates), and even the most "healthy" coping strategies that survivors may also acquire in therapy might not actually be strong enough for many of them to successfully counter this experience. We can therefore say that many participants continue to suffer although, and this is no contradiction, they are also coping as competently as they can – unfortunately, their efforts are simply not enough to counteract the negative impact of the traumatic experience of war rape on their mental health.

4.10. Research question 4: The importance and impact of Medica on survivors' recovery - Results obtained from the questionnaire

Medica Zenica was the first organisation to be founded with the objective of supporting women and girls who survived war rape and sexual violence during the war in Bosnia and Herzegovina. One main objective of this research project were to evaluate our work over the last twenty years, to gain a better understanding of what this work has meant for the beneficiaries of its services in their process of coping with the trauma of war rape and sexual violence, and which aspects of Medica's support and help they found the most valuable and important. The data was gathered through a questionnaire designed especially for the purposes of this research and through life stories, the results of which are presented in the next sub-chapter.

4.10.1. Reasons for using Medica Zenica's services and circumstances of first contact

The participants were asked several questions about when and why they came to Medica, how they found out about the organisation, and how long they continued using its services.

On the question: *When did you first come to Medica, and what was the reason at that time (what need brought you there)?*, approximately 52% of the clients came to Medica for the first time between 1993 and 1995, i.e. during or immediately after the war, while around 48% came between 1996 and 2013. It should be noted that most of the survivors are still using Medica's services today.

Table 4.27.: Time when the participants first came to Medica Zenica

	N	%
Between 1993 and 1995	15	51.8
Between 1996 and 2000	7	24.1
After 2000	7	24.1

It is interesting to note that two participants said that they came to Medica in 2013 through using institutional networks established by *Medica Zenica* and information provided by the cantonal prosecutors.

A total of 47 participants described their initial reason for coming to Medica. Most came because of they felt the need for talk and support (mentioned by 12 participants), health problems (11), rape (10), and psychological problems (7). They also gave many other reasons such as gynaecological problems (4), pregnancy / abortion (4), or a need for accommodation (5). Some of them said that their reason was because they needed help in the process of testifying at court or accessing their rights. Here are some examples of their answers:

- "*Because of a need for conversation and examination, and I did not want to keep silent anymore, I wanted to say what they did and what happened.*"
- "*Because of the accommodation and therapy.*"
- "*In 1993, because of health problems and food.*"

- "*They came from Medica, at my place and they helped, when I recovered I went to Medica to show my gratitude for the package I got.*"
- "*In 1997, because I was beaten up.*"
- "*I came because of pregnancy abortion.*"
- "*Need for medical support, psychological and gynaecological, etc.*"
- "*Because I was beaten up, cut all over my body, with broken bones, and psychologically weak.*"
- "*Safety, accommodation.*"
- "*1994, because of ill psychological state.*"
- "*March 2013, because of rape, I needed help in accessing my rights.*"
- "*In September 1999, I came because I was pregnant, I did not have money to pay for the hospital.*"
- "*In the mid-1994, Medica called me.*"
- "*In 2005, I had to testify in court.*"

On the question: *How did you find out about Medica,* the women's answers were grouped into five categories, as shown in table 4.28.

Table 4.28.: How did the participants find out about Medica? (N=50)

How did you find out about Medica?		
	N	**%**
From friends, other women, family members	26	52.0
Medica Zenica came to me	13	26.0
Government Institutions	5	10.0
The Media	3	6.0
Other non-governmental organisations	3	6.0

As the table shows, 50 participants answered this question. Half of them learnt about *Medica Zenica* through friends, other women, or from family members. A significant number of the participants (26%) said that *Medica Zenica* came to them, while the rest found out about Medica from other organisations or the media.

4.10.2. The duration and kinds of services accessed through Medica

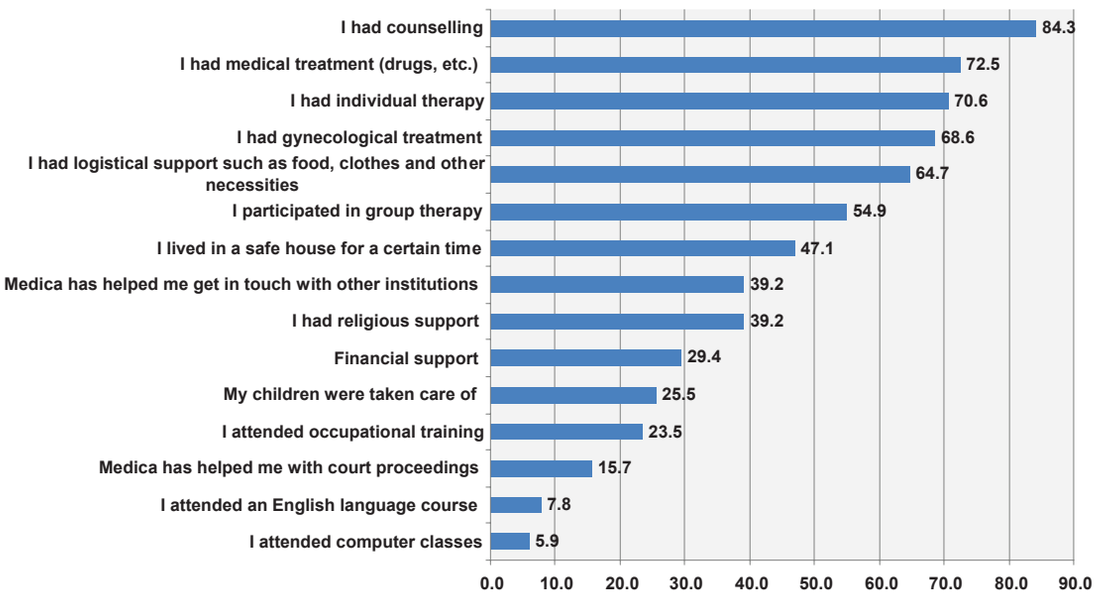
Table 4.29: How long did the participants continue using Medica's services (N=50)?

How long have you been using Medica's services?		
	N	**%**
Up to 3 months	8	16.0
Between 3 months and 1 year	5	10.0
Between 1 and 3 years	11	22.0
Over 3 years	20	40.0
I don't know, I don't remember	6	12.0

Strikingly, of the fifty participants who answered this question, 40% reported that they have used Medica's services for more than three years. This highlights the great need

of war rape survivors for long-term therapy – some might even require this kind of specialised support for the rest of their lives.

The next set of questions examined which services the participants received, and how helpful those services were. The graph below shows a percentage of the participants who used specific Medica services. All participants answered to this question. (N=51) and multiple answers were possible, since all survivors of war rape used various services.



Graph 4.30.

As the graph shows, most participants reported that they received psychological support at Medica. Over 88% received psychological counselling, while many received individual (71%) or group (55%) therapy. The majority received medical examinations and / or gynaecological examinations (more than 70%). Around 66% of the participants received food, clothing and other necessities, while 50% of the participants stayed at the safe house for a certain time. Around 40% of the participants said that Medica helped them to get in touch with other organisations. A significant number of the participants received religious support (40%), financial support (30%), or support with child care (25.5%). 24% attended vocational training programs and a small number attended computer or English language courses (together approximately 14%). Around 16% of the participants said that they received help with their court processes.

Participants' answers to the question: *How helpful were the services?* are displayed in the table 4.31. To understand the answers more clearly, the numbers of participants using each service and how the service is evaluated is shown, rather than percentages.

4.10.3. Which services were useful and what was useful in the services provided?

Table 4.31.: How helpful were certain services (N=51)?

	I used this service	Did not help me at all	Helped me a little bit	Helped me considerably	Helped me very much
I lived at the safe house for some time	24	0	1	4	19
I got medical treatment (drugs etc.)	37	0	0	14	23
I got gynaecological treatment	35	0	2	11	22
I had religious support	20	0	0	6	14
I received individual therapy	36	0	2	5	29
I participated in group therapy	28	1	1	5	21
I got counselling	43	0	2	9	32
I was helped financially	15	0	0	4	11
I got logistical support such as food, clothes and other items	33	0	1	8	24
Medica helped me with the court procedures	8	1	1	0	6
Medica helped me to get in touch with other institutions	20	0	1	4	15
My children were taken care of	13	0	0	1	12
I participated in the vocational training courses -for handicraft (silk work) -for tailoring -for hair-dressing	12	0	0	8	4
I participated in the computer classes	3	0	0	2	1
I participated in the English language course	4	0	0	0	4

The answers, in which the majority of participants reported that Medica's services helped them either "considerably" or "very much" and only a few said that a certain service was not very helpful, confirm the purpose and usefulness of *Medica Zenica's* work.

After this evaluative part of the questionnaire, the participants were asked two open-ended questions.

One was: *What did you not like so much or wished to be different in Medica's services? Please feel free to mention anything that will make our work better in future.* A total of 45 participants answered this question, of whom 35 said "everything was good" or that there were no objections, e.g. "*I liked everything; I liked everything and I thank them very much for everything they do for us, I wouldn't change anything, I wish them all the best; I have no objections, only the words THANK YOU VERY MUCH."* Seven of the participants wrote that the accommodation services and food could be improved, e.g. "*The accommodation in Medica looked like the one from hospitals. It should look more like home. Of course this was my perspective as a child of 15 years old; the food,*

the cheese macaroni." A small number of participants (three) said that they did not like the attitude of staff towards the clients, e.g. "*There were individuals in the personnel that did not understand us because we were 'wildish' because we were young, having survived what we survived. Back at that time we were not even aware what happened to us, and yet you needed to move on and live with it, and accept, although you can never accept."* Three participants suggested ways to improve Medica's work: "*I wish they would open counselling for children; to organise occasional parties or social events for women who used Medica's services. To support women in employment when they need it";* and "*To prepare women and help them for when they leave Medica to be able to handle their trauma and the things I survived."*

The second question was designed to gather information on what kind of support was the most significant for the clients: *If you had to describe in one sentence to other women who have gone through similar experiences what was the most important thing that helped you at Medica, what would you say? What will you remember Medica for?* All of the participants answered this question (N=51), and we decided for this research not to categorise them since their answers usually covered more than one category. However, it was apparent that the most significantly helpful aspects for them were the possibility to talk to someone and share their experiences, to get medical care and support, to feel security, and to find confidence and understanding, acceptance and support.

This confirms experiences from other psychosocial programmes in Bosnia and Herzegovina, as mentioned in the theoretical background to the study: The non-specific factors of contact, care and understanding seem to be the most prevalent in remembering and describing the impact 20 years after the war.

The following text offers some examples of what participants remember Medica for:

- "*Medica was a house that helped me the most, I had all kinds of help I asked for, in other words I was pulled out of the worst state ever, because I thought my life will have no meaning after my release from the concentration camp. Medica is commendable for that, and I thank them that I am capable to support my children today."*
- "*For the conversations, tears and jokes."*
- "*For the therapy, doctors, and the women who were nice."*
- "*It was curative, they gave us courage and security."*
- "*For its efforts, to reach every woman who is a rape victim, to help her psychologically and physically."*
- "*For the help, I found understanding there, I had support, I had a feeling of security. Everyone was nice, polite, and you could talk to anyone. Since this war I have nice memories from Medica, I met nice people, I remember them gladly. In the war, that was the only time I felt safe. Staying in Medica was the only positive thing that happened in that war."*
- "*If it wasn't for Medica I don't know if I would stay alive. I tried to commit suicide a couple of times, but after their treatments it never occurred to me to try again."*
- "*For their warm welcome, and counselling, because food was provided for me, and health support and accommodation in the collective centre."*
- "*I got rid of my trauma and I saw a light in Medica, Medica is the backbone in my life, Medica is my strength and my courage."*

4.11. Research question 4: The importance and impact of Medica on survivors' recovery - Results obtained through the analysis of survivors' life stories

"Someone took care of me. Medica took care of me …"

All the participants talked about the time that they spent with *Medica Zenica.* They remembered how they found out about Medica and described their experiences during their first contact. Berina said that she was surprised that Medica found her, and she did not know how they did it: "*They found me."* She remembers that Medica had only just been founded when two of their employees visited her.

Larisa came to *Medica Zenica* for the first time with her son in 1998, a year and a half after returning to live with her parents. At the time she was 20 or 21 years old, and remembers being terrified when someone suggested going to *Medica Zenica:* "*I remember I cried and I was afraid. There was some, some torture of an inquiry where were you, what did you do, who were you with, how."* Previous experiences had left her afraid that more detailed inquiries would follow, but then she was surprised at how determined the *Medica Zenica* staff were to secure better accommodation for her and her son. Elmana described how she heard of Medica during the war: "*My mother and I were looking for some help, we headed somewhere, we didn't exactly know where, she told someone that her children were in the concentration camp and that someone directed us to Medica Zenica."* She remembers one staff member and her trousers: "*One trouser leg was striped and the other with dots…".* She remembers other war rape survivors, and she remembers knitting with the other women.

Emira remembers her first meeting with women from Medica at a refugee camp which had been set up at a school in Zenica. She remembers how they introduced Medica: "*There is a house, a safe place for women."* She said that she did not accept Medica's offer of help right away, although she saw people leaving the camp and finding other accommodation for themselves, visiting villages, mostly Croat villages because the Croats were then moving away from K. Later, when she started feeling bad, she remembered Medica and decided to ask help for herself, her child and her mother. She stayed with Medica for a year, during which time she began to recover.

In their life stories, women described which Medica services that they found the most useful and the most important. Sara explained that when she came to Medica she was mentally crushed, because her pregnancy was progressing. She found that the care and conversation with the therapists and doctors who worked in Medica were the most important thing for her. She pointed out that Medica took care of her and psychologically cured her: "*Somehow… no, no, someone took care of me. Medica took care of me, I spent so much time there, and they cured me psychologically. The only thing that helped me was Medica."* Berina also explained how much the psychological support had meant: "*During the conversation, questions like 'how do you feel, do you have any more nightmares, how do you react on a uniform' meant a lot to me. It meant a lot, a lot."* Even now when she visits Medica she feels relieved and at ease: "*It is like when you relieve yourself, cry yourself out, something life unburdening."*

Elmana said that the accommodation was very important. She lived with Medica, along with her sister, her aunt and her aunt's children: "*I remember when I came it was like a five star hotel for me. When someone goes through something like we have gone through, and is left with nothing, and all of a sudden they get breakfast, lunch, dinner. There was a masjid too. I remember all that."*

Larisa talked about how material support was of great importance, along with psychological help: "*The most I ever got was Medica. What you did for me, that psychological support. Material support, when people are hungry, is very welcome. And to me, I was hungry at that time, I was hungry for self-confidence, I was hungry for support so I can move on, so I could live. To give me strength, to tell me that what I thought was my fault that it wasn't my fault. When I heard that it was worth to me. It meant everything to me, and it still does."* Želimirka also remembers that *Medica Zenica* gave her and her friend Azemina material support. She described that she came to *Medica Zenica* once with Azemina and when she told a *Medica Zenica* employee that she had come with a friend, they asked where her friend was: "*Where is your friend, she asked and I said she is downstairs waiting for me, in that nursery; well call Azemina she said, and, Azemina and I got those packages from Medica, we put them in the bags."*

Elmana described the importance of religious support. With smile on her face she said she gladly went to the masjid[33] that was in Medica: "*With women who had special stories ..."*

Larisa described the importance of the education, legal support, and referrals to other organisations, etc. "*Medica gave me directions, educations, how to do something, what, when, where, so I addressed to some of those places."* She described that after spending a year with Medica she was ready for a life outside, she got married and gave birth to another child, a girl, and she was again accommodated by *Medica Zenica* because her husband was a violent alcoholic. She said she misses *Medica Zenica* and would like someone to talk to, but the distance makes it difficult.

All the women described what still they remember about Medica, what Medica meant for them at the time and how important it remains today. For example, Sara said that she would turn to Medica if she found herself in a difficult situation: "*You think about things through your life, what if God forbids you get divorced, what if something happens to your child, so who, tell me, who else do you ask for help."* She remembers she called Medica when her daughter had a crisis in school. She was in a city where she didn't know anyone, and couldn't call anyone except Medica: "*The first thing that occurred to me was – there is Medica. I know where I can go. It is the same for those women. You need to have someone by your side. I tell myself, I have the numbers memorised, you have them at all times, and you know who to call even at midnight."* She said Medica has supported her for 20 years in every situation: "*For all these 20 years whatever happens, from psychological side or anything else, every time – Medica. And you know where support is."*

Berina also said she knows she can always come to *Medica Zenica:* "*I know that whenever I come by I am welcome",* and she described *Medica Zenica* as "*very valuable."* Although she doesn't need help at the moment, she knows that she can turn to *Medica Zenica* any time, day or night: "*I don't need it but God forbids if something happens I*

[33] A mosque.

have someone to turn to. At any time day or night, I can call and say – I have snapped I need you!"

Elmana said that organisations like *Medica Zenica* are rare, they support women and really want to help them: "*I think no one else is dealing with it anymore. Maybe they do deal with us for some other interests, but with sole purpose of helping women, to feel good, to help her with employment, and retraining, in scholarship for her child, I don't think there is an organisation that tries to help with all that like Medica Zenica."*

Sara said that she would like Medica to keep going for a long time because many other women need it: "*I would really like because we need something like that. It is necessary for those other women too. I just don't know why they are still afraid of speaking up."* She will remember Medica: "*Thank God and to all the psychotherapists and all the personnel, I managed to move on with my life somehow, although I never, never thought I would survive. I never thought I would live, and live for this long."*

Želimirka said that Medica brought back her faith in people and their goodness. "*I have someone to confide to about what I have gone through, and I know people are benevolent."* She compares the time when Medica came to her and helped with another experience of people she didn't know and had never done anything to coming to her door and raping her: "*Not all people are the same, they helped me and I have someone to turn to. […] [T]here is someone somewhere who thinks about us, women who under the circumstances… we are in the same position so to say… I don't know how to put it. There is someone who sees us as individuals, and not just puts us in the categories of victims."*

Summary gathered from analysing the life stories regarding the importance of Medica's services

All the women who told their life stories emphasised how valuable the comprehensive support and assistance they received from *Medica Zenica* was for them. Women mentioned the following as being the most important aspects of that assistance: unconditional trust from *Medica Zenica* staff, an acceptance which strengthened survivors, shelter, material support, caring for survivors and talking to *Medica Zenica* professionals, opportunities for education, retraining, religious support for those who wanted it, legal aid and training, and referrals to other organisations to access other forms of support. It is noticeable that many found security and a sense of structure in *Medica Zenica* – they know and feel sure that they can call on *Medica Zenica* whenever they need to.

The participants highlighted how important it was that *Medica Zenica* didn't simply wait for survivors to come to them, but they actively searched for the people who needed their help.

Medica Zenica's approach helped survivors to regain their faith in people. Survivors pointed out that *Medica Zenica* was an organisation which is open for everyone, not making any difference between women and girls, but is an organisation which took a stand and provided support and assistance for those women who, especially at the beginning, were not recognised, accepted or supported by anyone else.

4.12. Conclusions regarding research question 4

We were able to derive the following results from the various sources of data available to us:

- Research results show that around half of the participants came to Medica for the first time during the war between 1993 and 1995, and the other half were introduced to Medica's services after the war. Most of the participants are still using Medica's services today. Given what was said in the theoretical background this is rather striking, since there is usually a general reluctance of rape survivors to seek help so soon after the event. Many women who survive rape, including women in non-war settings, suffer for years trying to come to terms by themselves, and only seek help much later. Since about half of participants first heard about Medica from friends, other women who had the same experience or family members, it appears likely that Medica has a growing word-of-mouth credibility and a reputation that women are well treated and get support there, which encourages others to come. A significant number of the participants (26%) reported having been "reached" by *Medica Zenica,* and this was mentioned in the open questions and in the life stories as having been an important experience: somebody cared for them. The long-term support and the special approach to survivors have been evaluated as a source of resilience and most probably a key transmitter of social support that was important for coping, apart from and beyond the social support provided by family members and husbands. Since family bonds might be a source of support, but also sometimes may complicate recovery because of their emotional enmeshment with survivors – as discussed in the theoretical background – other sources of help, such as support organisations and peers, might become extremely important.
- Most participants (from 60% to over 80%) reported having received psychological help, medical assistance, food and clothing, and other supplies. The safe house provided shelter to about 50% of the participants, and approximately 40% stated that Medica helped them to make contact with other organisations. A significant number of participants (from 25% to 40%) received religious support, financial assistance, or help with child care. A small number of participants (around 20%) went through vocational training programmes, computer courses or English language courses. Around 16% reported having received support from *Medica Zenica* in legal procedures.
- The meaning and benefit of *Medica Zenica's* work is most strongly confirmed by the fact that the vast majority of the participants rate Medica's services as "extremely" or "very" helpful. Very rarely do the participants state that the services were not helpful at all or only slightly helpful. When asked to identify the most important thing that they received from Medica, the majority said that it was having the opportunity to speak and share experiences, receive medical treatment, and the fact that they felt safe, were offered trust and understanding, acceptance and support. Survivors also highlighted the provision of comprehensive support, assistance and unconditional trust by *Medica Zenica.* Their responses thus match the results of other studies mentioned in the theoretical background that also pointed to the significance of unspecific therapeutic factors. Apart from taking care of their needs for professional medical care, housing and food, it was crucial to provide them with a space in which they could re-establish trust in human beings and create normal and stimulating inter-personal relations in which they feel accepted and safe. For this research it is an extremely important result to say that women who survived war-time rape, and took part in this study, will remember *Medica Zenica* for this characteristic.

5. RECOMMENDATIONS

In this section, we will formulate a series of recommendations derived from the results of the study. However, in keeping with the overall study discourse, we want to first give voice to the survivors' own recommendations.

During the life stories, all the participants offered recommendations to other survivors and to the public on what could be done to improve the situation of survivors in Bosnia and Herzegovina, so that they would be able to live their lives with dignity. As can be seen below, the survivors' recommendations are mainly focused on a central theme and an overriding dynamic related to war rape and sexual violence, namely speaking up rather than remaining silent.

Survivors' recommendations to the public

"To those who speak on my behalf"

Sara refers to those who speak about women survivors of rape and sexual violence and about children born of rape. She emphasises that she is annoyed when politicians or other people who have never seen a woman who was raped talk about them publically and repeat that they are only victims, victims and victims. **"*They talk a lot about those raped women, those victims*"** but she would like to ask those same people publicly "*[w]ell, man, what do you think that that woman is?*", what do they think the women got from their statements and speeches? Meanwhile, she doesn't want to be in the public eye in order to protect her child. She explains that she wouldn't be so bothered by their speeches and statements if they were helping survivors and asking how they feel, but what irritates her is the fact that some of them abuse the stories of survivors when they need them and when it suits them.

Emira understands that the media have to do their job and to earn their salary, but what she doesn't understand is why they trample over people to reach their goal. Once they have gotten the story they want from a survivor, they never remember to ask how she is, not even after one, two, five years. It would certainly mean a lot to that woman if someone would just ask about her *"**[N]ot even a word to be said, …, hey, I don't need a chewing gum.**"*

Sara also referred to a special group of vulnerable people who still need to learn how to speak up and be helped: the children born of rape. She emphasised that it would be a relief for her if she knew that there is an NGO for children born of rape in Bosnia and Herzegovina, and if there was a phone line for those children, even though they are adults now, that they can call in case of need, or simply for conversation. "***If there is an organisation or phone line for children – maybe it won't be needed but just in case****… Maybe it won't be needed, but just in case. It would be easier that I know that they will direct her to the right way, if something happens to me tomorrow."*

Survivors' recommendations to other survivors: Speak up!

- **Berina** says: "*It is a relief. No matter for how long, but it is some kind of psychological relief for yourself. It is better to admit, then you move on, you turn a new page in your life and continue. You don't have to change your life completely, children, husband, environment, but it is, somehow, to turn the page in order to move on differently. I cannot explain it differently, but it is something like the bright view of life, something what helps me to move on. It is not important who did it, if it is done by a soldier, neighbour, someone else, or husband – it is really not important. That was also something that people were silent about, but I think that it is better for everyone to speak up. It will be easier to continue through life*." After a short break, she adds that when you speak up, "*you always have someone you can address*."

- **Sara** says, "*[I]t doesn't have to be a husband, not even your brother or sister or some professional person; find someone. An unknown person, a girl or woman whom you meet for the first time in your life, tell her at least and you will relieve yourself immediately. Or write at least, or record it yourself and then delete it*."

- **Larisa** asks herself if other survivors had children and if they were afraid for their future. She emphasises: "*I, as a mother, would never have been silent about it because I have a daughter and a son. I wouldn't want my son to deviate or my daughter experience the same as I did. So, I don't see the reason to be silent. Why be silent, so it all could be repeated again*." Larisa recommends to other survivors to speak up, to defend their children, and to protect their future: "*They should tell what tortures them. Let them talk. And in the end, it will be easier for them*." From her personal experience, she emphasises that it is difficult for her when she goes back to the time of the rape, but after, while she talks, it becomes easier: "*And as I talked more about it, all that was getting away from me, as if I talked in third person. As I talked more, it all seemed far, so far from me. In the end, I would like to recommend to survivors to fight for children, their future, that children know, that children learn. If there is no other reason, then because of that*."

- **Želimirka** recommends to all women who survived rape to speak up, and emphasises that they shouldn't be silent for so long a time. Through the example of one of the women who spoke up recently, she says "*if she spoke up before, she would have her psyche saved*." She describes her as being very different before she spoke up: "*She seemed to me much more different after the war than she looks now. It means that it was oppressing her, so she left the job without any explanation when she found out that one man* [who knew about the rape] *will come to work with her. So, during one period, she may have been through and carried with it, but as the time passed by, it seemed more difficult to handle. Even though she found the strength and got married and confessed to her husband, taking into account that she sought help of, she was late. She was supposed to speak up before*."

- **Elmana** thinks about and tries to understand the women who are silent and who don't talk about the rape that they have survived, and she looks at it in two ways. "*If they are silent because they have reconciled with that, no matter what happened, continued with their lives, reconciled with that, decided not to talk, not to return to it, constantly moving on, in that case I encourage them to be silent*." However, "*[i]f they are silent because they are painful, disappointed, I don't think they should be silent*

at all." She continues her explanation with the words. "*So, if they are silent because they have accepted, thank God, let's move on, I love to be silent, here I am silent. But, if someone is silent for any other reason, I don't think that they should keep quiet*."

- **Zehra** knows from her own experience that there is no special medicine that could help women who survived rape to forget, so she says: "*Many years have passed, but that cannot be forgotten, ever. Sometimes it was on my mind all the time, but now I am trying my best to think less.*" She explains further by saying: "*It cannot be deleted. You cannot take the rubber and erase it, but you should think of nice things as well.*"

- **Emira** recommends that women who speak up should be protected: "*If we were protected, if we were given protection, of course we should speak up. There, where we should speak up. And be protected. And that message should be carried and remembered. If it is not remembered, it will happen again ... so women have to speak to save themselves."*

Underlining what the survivors themselves said above, in our function and self-understanding as organisations with more than 20 years of experience in supporting women and girls affected by conflict-related sexual gender-based violence and advocating for the rights of survivors, and keeping in mind the clear commitment of Bosnia and Herzegovina, as stated at the Summit to end sexual violence on Conflict in London 2014[34], that they will protect the survivors, end stigmatisation, and punish the perpetrators:

Medica Zenica and *medica mondiale* call on

- the State of Bosnia and Herzegovina,
- the authorities of the Federation of Bosnia and Herzegovina and the Republika Srpska, Brcko district,
- the NGOs working in Bosnia and Herzegovina,
- the international Donors and Institutions,
- and the society / media in Bosnia and Herzegovina,

to consider the following key recommendations:

5.1. Regarding support programmes for survivors in general:

5.1.1. **Commit to long-term funding for holistic programs to support survivors, including psychosocial and health services, legal aid services, economic benefits and income-generating projects, information networks, and advocacy activities**. The needs for support are still high and with the aging effect, many survivors will need special support programmes. This recommendation includes the long-term funding of NGOs in Bosnia and Herzegovina, including core funding, perhaps through creating a special fund or budget lines to support survivors and their families without singling out survivors of war rape and sexual violence as the only ones who need support.

[34] https://www.youtube.com/watch?v=dTKJXXygaco&index=45&list=PLOHKD7N97aB0jEMdK-L8okWEvkjG--KNEi

5.1.2. **Multiply and replicate the established networks amongst Institutions and non-governmental organisations in Zenica Doboj Canton, Una Sana Canton, Central Bosnia Canton and Banja Luka, and throughout Bosnia and Herzegovina.** The unique networks and the protocols agreed among the stakeholders have proven to be an effective model that provides support for survivors of war violence, while at the same time strengthening the capacities of the institutions involved. This model can be easily transferred to other parts of Bosnia and Herzegovina, and should be adapted where necessary according to the demanding needs of the Bosnian society to take the long-term effects of war trauma into account.

5.1.3. **Strengthen the cooperation between government and non-governmental organisations, and amongst non-governmental organisations.** It is of utmost importance that efforts are combined and synergised in order to achieve the best results and for the survivors to feel that they are actually acknowledged on a broad societal basis.

5.1.4. **Strengthen the position and acknowledgement of NGOs by the State.** Given the need for ongoing support and the fact that family members are also often extremely burdened by the long-term impact of having survived the war, and given the weaknesses and shortcomings related to the status of civilian victim of war, NGOs in Bosnia and Herzegovina have become a strong agent in providing social support and social acknowledgement. Their contribution must be strengthened publically.

5.2. Regarding specialised psychosocial programmes for survivors, and trauma sensitivity in the legal, psychosocial and health professional domains:

5.2.1. **Provide ongoing counselling for survivors of war rape and sexual violence.** The study results clearly show that many of the women who survived war rape and sexual violence are still in great need of support in their trajectories of coping. Rape and sexual violence have led to a general fragility in women's health, psychosocial wellbeing and relationships. However, they still continue their life paths with great courage and try to recreate their lives and relationships with others, while children are of particular importance for the women's coping. Therefore, in order for survivors to be able to lessen the stress in their current lives and support them in rediscovering trust in relationships in general and developing healthy relationship patterns with their children, it is important to continuously offer counselling and psychotherapy. Since we do not have ready-made therapy concepts for these often chronified and complex forms of traumatisation, creativity and the adaption to local contexts will be needed, as proved necessary in the early days of psychosocial work in Bosnia and Herzegovina.

5.2.2. **Provide low-threshold counselling services for families of survivors and for their children.** The findings show signs of a transgenerational transmission of trauma to the next generations, which means to all the children and young people that were born during or after the war. At the same time, the children's well-being and future prospects are very important for stabilising the survivors. Against this background, it is very important to consciously support the younger generation on

several levels. This should include sensitising families, teachers, social workers and educational institutions on the effects of direct and indirect traumatisation, low-threshold counselling, and family-oriented therapeutic approaches. Again, this might require a degree of psychotherapeutic creativity to find ways of using systemic therapeutic methodology in this particular post-war context.

5.2.3. **Provide special counselling on issues of sexuality and married life.** The study clearly indicates that gynaecological and sexual problems are among the most overriding and powerful effects of war rape. This has had grave consequences for the survivors' sexual lives. There is a great need to develop specialised counselling skills on sexuality and marriage therapy amongst trained counsellors working in Bosnia and Herzegovina so that women and men can develop ways of living this part of their life without constantly causing re-traumatisation and frustration.

5.2.4. **Commit to the implementation of a trauma-sensitive approach, based on solidarity, in all support services, including training for all professionals in the area of health and psychosocial professionals, as well as in the educational and legal fields.** Given the alarming evidence that the survivors' health and psychological situations are still very fragile and will most probably become worse as aging and the post-war stressors play their ongoing role, we need awareness in all professional areas which the survivors access for support, particularly (but not exclusively) in the health sector, since health institutions might serve as a primary access strategy for the women to seek help, also for those women who would otherwise never reveal their war rape experiences. Therefore, all health professionals in Bosnia and Herzegovina should receive regular education on the impact of (war rape) trauma on health, and on how to apply a trauma-sensitive approach in their work.

5.2.5. **Pay particular attention to the prevalence of cancer and to the high rate of severe gynaecological and reproductive health problems, as well as to the extremely high rates of psychopharmacological medication that most survivors have used for the last 20 years.** Women and health professionals have to be sensitised about the risk of addiction related to dealing with trauma symptoms. Other ways of trauma-informed diagnosis, treatment and support might help to reduce the use of medications. This will also lead to more empowerment of women, and will encourage positive self- regulation and stabilisation. As one of the women said in her life story: *"I don't want to take medication. I want to laugh!"* As this study shows, war rape trauma effects not only the survivors, but also their relationships with their families. The need for continuous support and special awareness extends to the systemic level, too, where professionals from all levels of society – and in particular health, educational and psychosocial services – need knowledge and good skills for working with these complex effects of traumatisation, not only on the direct survivors, but also on their families.

5.2.6. **Conduct more studies on the long-term effects of the war on women, men and children, with special regard to the transgenerational effects.** Most studies were conducted in the first 10 years after the war; to date, there seems to be no other scientific study that was conducted on the long-term effects of the war, let alone on the long-term effects of war rape. In order to have a good basis for planning, we need scientifically proven data on these issues. Our study therefore hopes to encourage more research in this area.

5.3. Regarding the special state law on the status of civilian victim of war:

5.3.1. Adopt a state law on Victims of Torture in Bosnia and Herzegovina, and amend and improve the application process for the status of civilian victim of war, in particular by:

- Adopting a **uniform state law** on Victims of Torture. To achieve this, it would be necessary to advocate for a single legislation at the state level which would regulate the rights of victims of torture and provide an opportunity for all survivors to exercise equal rights regardless of where they live in Bosnia and Herzegovina.
- In the absence of a uniform state law, **harmonising the existing laws as soon as possible** at entity and cantonal level, and in the Brčko District, which would enable survivors to obtain rights such as the status of civilian victim of war across the whole of Bosnia and Herzegovina, regardless of where they live.
- Ensuring that, in addition to regularly monthly payments, obtaining the status of civilian victim of war enables survivors to obtain all other rights associated with it, such as the **right to special educational, housing and economic empowerment programmes.** It is clear from our study that daily stress factors such as unemployment and unfulfilled existential needs continue to weaken the survivors' general and mental health. Therefore, they need greater access to the special support that the status entails.
- **Improving information** about the survivors' right to apply for the Status of Civilian War Victim and making the procedure and its implications more transparent. It is imperative to make the procedure of claiming the status less complicated and less stressful to avoid retraumatisation.
- **Granting the survivors of war rape equal rights and privileges** to those of other civilian victims of war and war veterans.
- It is therefore necessary to work on sensitisation for the entire post-war Bosnia and Herzegovina environment, in order to tackle the issue of stigmatisation of women who survived war-time rape.
- **Starting an information campaign** on how survivors can apply for and exercise their rights.
- **Sensitising the media** and encouraging them to play a more active and adequate role in promoting survivors' rights.
- **Providing the employees of public administration with specific training on the consequences of trauma** resulting from rape and sexual violence so that these employees and lawyers, as well as doctors, employees of the Institute for Medical Expertise and NGOs involved in the procedure, will become sensitised to the symptoms of PTSD, such as a feeling of shame, guilt, etc. This would prevent survivors from being exposed to unnecessary re-victimisation: As the study clearly shows, applying for the status has the unintended negative effect on survivors of increasing stigmatisation, since anonymity is not assured, and they are not adequately socially acknowledged.

5.3.2. Commission an evaluation in five years' time to evaluate the progress and effects of improvements in the application process and the state law on the Victims of Torture, as well as simplified procedures for excercising the status of civilian victim of war in Bosnia and Herzegovina.

5.4. Regarding protecting survivors of war rape while testifying:

5.4.1. Provide better support and protection of women before and during the process of testifying against perpetrators in the national courts of Bosnia and Herzegovina.

The revelations from participants in this study about the lack of protection and support for women who testify against perpetrators of war rape in the national courts of Bosnia and Herzegovina were astounding. Women need much more support before, during and after trials to avoid endangering their personal safety and risking re-traumatisation, and to enable them to feel safe, respected and empowered. This means that everyone involved at all levels of the legal system should be sensitised by means of a qualification on issues of safety and protection and adopting a trauma-sensitive approach towards survivors and witnesses, and that constant care should be provided for survivors and their families throughout and beyond the process of testifying.

5.4.2. Work for the continuous prosecution of perpetrators. Pursuing legal justice sends an extremely important signal about social acknowledgement to survivors, both those who testify and those who do nor, and even those who have so far chosen not to tell their story. Recognising that there is at least some level of justice being done can have a healing effect beyond therapeutic work.

5.5. Regarding social acknowledgement of survivors (Special recommendations to the society and communities of Bosnia and Herzegovina):

5.5.1. Encourage communities to take positive action towards the social acknowledgement of survivors. Based on the study's findings that stigmatising dynamics in communities are a major reason why survivors keep silent, and given the fact that the participants in the study feel almost no support from their local communities, campaigns and activities need to be derived to redress the balance. Stigma and shame belong to the perpetrators and not to the survivors!

5.5.2. Actively work towards changing the victim discourse into a discourse of survival. The stereotypical "victim" identity that is carried by women who were exposed to this severe trauma needs to be presented in the way

that emphasises the strength and capacity of these women because they have actually "survived" these horrific experiences, and have then succeeded in other roles such as lawyers, artists, mothers, wives, daughters, housewives, etc. It is important that all segments of society adopt this "approach" to their perception of and public discourses about survivors.

5.5.3. Have more men involved in the work against stigmatisation, and provide a space for men to reflect on their roles and attitude towards women and girls, and act as positive role models for young men and boys. The study clearly indicates that women perceive the support of male family members as a crucial coping support. Therefore, it is not only important for the women but also very important for the next generation that more men reflect on their roles and attitudes towards women and girls. Society needs more positive role models for young men and boys. This will help overcome the stigmatisation and devaluation of women that is rooted in patriarchal societies, and contribute to an inclusive, peaceful society and more perceived equality between men and women.

5.5.4. Establish a monitoring mechanism in Bosnia and Herzegovina whereby State representatives, NGOs, survivor organisations, relevant representatives of the media and other organisations from civil society are in constant dialogue about the effects of sexual violence and war trauma.

Questionnaire

Code of the respondent:

A. GENERAL DATA

1. Date of birth:

2. What is your marital status?

☐ single

☐ married

☐ divorced

☐ live with a partner

☐ widowed

☐ If widowed: before, during (due to) or after the war?

3. Do you have children?

☐ YES ☐ NO

If yes, how many:_____ and when were they born?:

1st child _____

2nd child _____

3rd child _____

4th chid _____

4. How many family members live in your household?_____

5. What ethnic group do you belong to?

☐ Bosniak

☐ Serbian

☐ Croatian

☐ Other

6. Where do you live now?

☐ BiH - Federation

☐ BiH - Republika Srpska

☐ BiH – Brcko District

☐ In a village
☐ In a suburban area
☐ In town

7. What is your status regarding your place of residence?

☐ I returned to the place where I lived before the war.
☐ After the war I declared my residence to be where I live now.
☐ I never changed my place of residence.

8. What kind of housing do you have right now?

☐ I live in my own house / flat
☐ I live in the house / flat of my partner / husband
☐ I live in a rented flat or house
☐ I live at a collective centre or refugee centre
☐ I live with other family members
☐ I live at a friends' place
☐ I have a temporary housing
☐ Other .....

9. Do you have health insurance?

☐ Yes
☐ No

10. How far did you progress with your education?

☐ No school at all
☐ Some years at primary school, but did not finish
☐ Finished primary school
☐ Finished secondary School
☐ Studied at university, but did not finish
☐ Graduated from university

11. What was your job before the war?

_____

12. What is your job now after the war?

_____

13. Do you have paid work?

☐ Yes

☐ No

If yes, **how much money can you earn with your work**?

☐ up to 360 KM

☐ from 360 to 800 KM

☐ more than 800 KM

14. Which <u>other</u> sources of family income do you have?

☐ My husband / my partner earns a salary

☐ I receive a personal pension

☐ I receive my husband's pension

☐ I receive a disability pension

☐ I receive social welfare

☐ I have a small business (informal / formal)

☐ I do farming

☐ Family member(s) work on daily allowance without any insurance

☐ Financial help as civil war victim

☐ Other sources of income:

☐ I have no other sources of income

15. How much money do you have at your disposal due to these other sources of income?

☐ up to 100 KM

☐ 100-300 KM

☐ 300-550 KM

☐ more than 550 KM

16. Have you received the status of civil victim of war?

☐ Yes ☐ No

If yes, as what (in what category)?_____

B. INTEGRATION INTO THE SOCIETY

1. Do you feel that survivors of war rape are nowadays treated well by society?

☐ Yes, totally

☐ To some extent

☐ Not at all

2. What does **your canton / your entity / state** do for survivors of rape? Name the most important things that come to your mind.

_____

_____

_____

3. What does **your local community** do for survivors of rape? Name the most important things that come to your mind.

_____

_____

_____

4. What do local **NGOs** do for survivors of rape? Name the most important things that come to your mind.

_____

_____

_____

5. What do **international organisations** do for survivors of rape? Name the most important things that come to your mind.

_____

_____

_____

Please, answer the following questions with

☐ Yes, I am well informed OR

☐ I know a little bit OR

☐ No, I do not know anything about this.

6. Do you know about the procedures that are necessary to get the **recognition of your rights** as a civil victim of the war?

☐ Yes, I am well informed

☐ I know a little bit

☐ No, I do not know anything about this.

If yes or a little bit, who informed you? _____

7. Do you know about **special programmes for schooling, retraining and additional training** for war victims?

☐ Yes, I am well informed

☐ I know a little bit

☐ No, I do not know anything about this.

If yes or a little bit, who informed you? _____

8. Do you know about the **possibility of getting support for your health and social needs**?

☐ Yes, I am well informed

☐ I know a little bit

☐ No, I do not know anything about this.

If yes or a little bit, who informed you? _____

9. Do you know about **possibilities for support for housing**?

☐ Yes, I am well informed

☐ I know a little bit

☐ No, I do not know anything about this.

If yes or a little bit, who informed you? _____

10. Do you know about **job programmes**?

☐ Yes, I am well informed

☐ I know a little bit

☐ No, I do not know anything about this.

If yes or a little bit, who informed you? _____

11. Which of the **following rights** do you have access to?

☐ I was given the status of a civil victim of war

☐ I participate in a special programme for schooling, re-training, or further training

☐ I get special health or social support

☐ I get special housing support

☐ I participate in a special job programme

12. Do you feel that these rights **correspond with your actual needs**?

☐ Yes

☐ To a certain extent.

☐ No

If no or to a certain extent, what is missing? _____

13. What **problems** did you encounter when you tried to get access to your rights?

_____

_____

_____

14. Which **family members** know about your rape experience?

☐ Partner / husband

☐ Children

☐ Mother

☐ Father

☐ Brother(s)

☐ Sisters

☐ Relatives

15. Do your **closest friends** know what happened to you during the war?

☐ Yes, they know.

☐ Only my best friend knows.

☐ They don't know everything, but they suspect it.

☐ No, they do not know anything.

16. Is there **anybody** else in your life who knows about it?

☐ Yes, there are people who know.

☐ Some don't know everything, but they suspect it.

☐ No, there is not anybody else in my life who knows about it.

17. Do you know **other survivors of war rape** who have never talked about it with their family or closest friends about what happened?

☐ Yes.

☐ No.

18. Why do you think they never talked?

_____

_____

_____

19. Do you participate in **community activities or in community groups or other groups**?

☐ Yes

☐ Rarely

☐ No

If yes or rarely, in which groups or activities?

_____

_____

_____

C. THE WAR EXPERIENCES AND THEIR IMPACT

1. When you think back to the war, people went through different painful experiences. For you personally, what were the most difficult experiences you had during the war? You do not have to describe exactly what happened, but just name the events in one or two words.

_____
_____
_____
_____

2. Which of these events that you were telling me about just then do you personally consider the most difficult that you went through during the war?

_____

3. When you look at your life today, do you think that the rape experience **STILL influences your life TODAY**, around 20 years later?

☐ Yes, totally

☐ To some extent

☐ No, not at all

If yes or to some extent, name the most important consequence that your rape experience **still** has for you personally now.

Name only one or two thing which cross your mind.

_____

4. Do you feel that it was more difficult **IMMEDIATELY AFTER THE WAR or NOW 20 YEARS LATER** to cope with your experience?

Why do you think so?

_____

5. When you look at your life today, do you think that the rape experience **STILL influences your families' life TODAY**, 20 years later?

☐ Yes, totally

☐ To some extent

☐ No, not at all

If yes or to some extent, name the most important consequence that your rape experience **still** has for the life of your family now.

Think of one or two points only. What comes to your mind?

_____

_____

6. When you look at your life today, do you think the rape experience **STILL influences your life with your husband or with men in general TODAY**, 20 years later?

☐ Yes, totally

☐ To some extent

☐ No, not at all

If yes or to some extent, name the most important consequence that your rape experience **still** has today on your life with your husband or with men in general?

Think of one or two points only. What comes to your mind?

_____

_____

7. When you look at your life today, do you think the rape **STILL influences your children TODAY**, 20 years later?

☐ Yes, totally

☐ To some extent

☐ No, not at all

If yes or to some extent, name the most important consequence that your rape experience still has on your children.

Think of one or two points only. What comes to your mind?

_____

_____

8. How would you describe your **health**?

☐ My health is in a good state.

☐ My health is fairly okay.

☐ My health is in a bad state.

9. Do you regularly go to **doctors**?

☐ Yes

☐ No

If yes, to which doctors? _____

_____

_____

10. Do you regularly **take drugs**?

☐ Yes

☐ No

- If yes: Which drugs? _____

- If yes: When did you start taking them? _____

11. Many women who survive rape suffer from gynaecological problems. Regarding your gynaecological health at the moment, do you have the following problems?

Do you suffer from vaginal discharge?

☐ YES

☐ A LITTLE

☐ NO

Do you experience itching in your vaginal or rectal area?

☐ YES

☐ A LITTLE

☐ NO

Do you have irregular bleeding outside the menstruation cycle?

☐ YES

☐ A LITTLE

☐ NO

Do you suffer from pain in your pelvic area?

☐ YES

☐ A LITTLE

☐ NO

Do you sometimes have uncontrolled discharge of urine?

☐ YES

☐ A LITTLE

☐ NO

Do you sometimes suffer from vaginism, i.e. that your muscles do not allow penetration during sexual intercourse?

☐ YES

☐ A LITTLE

☐ NO

Have you had problems with getting pregnant?

☐ YES

☐ NO

Did you suffer from cancer in the last years?

☐ YES

☐ NO

12. We have talked a lot about all the negative consequences that the war rape experience had on your life. Sometimes, people who survive very painful events feel that, despite the pain, there are some positive things that they have learnt. When you look back at these past twenty years, is there something positive that you feel you have learnt from these painful experiences you went through? If yes, can you describe this a little bit?

_____

_____

D. STRATEGIES OF COPING / SOURCES OF RESILIENCE

I would now like to invite you to look back at your life in the last 20 years since the rape took place.

1. Name the five things that helped you most to carry on with your life, despite the rape experience. It can be personal qualities that you possess, or other people you know, or other things or events. I will write each thing you think of on a separate piece of paper and, once we have 5 points, I will ask you to please arrange them in an order of importance, then we will write them here, with the most important one at the top, and so on.

1. (most important)
2.
3.
4.
5.

2. How did these things help you? In what ways did they give you strength? Can you describe their specific impact on your life?

_____

_____

_____

3. If a survivor of rape asked you for **advice** about what can help her, what would you tell her what she should do? What would be your advice for her?

_____

_____

_____

E. MEDICA'S IMPACT

1. **When** did you **first** come to Medica and what was the reason at that time (why did you need to come)?

_____

_____

2. **How** did you find out about Medica? _____

_____

3. **For how long have you used Medica's services** from the first time you came until today?

_____

4. What **kinds of services** did you get from Medica? How much did they help you:

Kind of service	Yes, I got this service	Did not help at all	Helped me a little	Helped me considerably	Helped me very much
I lived at the safe house for some time.					
I got medical treatment (drugs etc.)					
I got gynaecological treatment					
I received individual therapy.					
I participated in group therapy.					
I got counselling					
I was helped financially (got money for something I needed)					
I got logistical support such as food, clothes and other items.					
Medica helped me with the court procedures					
Medica helped me to get in touch with other institutions.					

My children were taken care of.					
I participated in the vocational training courses -for handicraft (silk work) -for tailoring -for hair-dressing					
I participated in the computer classes.					
I participated in the English language course.					

5. How did ... (name of the service that helped considerably / a lot)... help you? Can you explain why exactly it was useful for you? How were you able to use what you got?

_____

_____

6. Did you also go to other organisations for such services? If yes, where and for what services?

_____

_____

7. What did you not like so much or wished could be different in Medica's services? Please feel free to mention anything that will help us to make our work better in future.

_____

_____

8. If you had to describe in one sentence to other women who have gone through similar experiences **what was the most important thing that helped you at medica**, what would you say? What will you remember medica for?

_____

Focus Group Discussion Guide for other organisations working with survivors of rape

(Prior explanations: Personal presentation of consultant; over-all objective of the study; thanking participants for participation as colleagues; explanation of framework: how long will the discussion take, what will happen with the data, way of recording the focus group discussion for transcription, sharing of report, etc.)

How long have you been working in this field? When did you start your work?

Approximately how many survivors of war rape and sexual violence have participated in your programmes so far?

What are the main programmes you offer them?

What consequences have you observed, and still observe today, with survivors of war rape?

- on themselves / on their health, both general and psychological
- on their relationships with partners / husbands
- on their children.

In your opinion, which of those consequences are the most important?

How well do you feel that the survivors are integrated into their society? What do you know is being done at local, cantonal, Brcko district's, entities' and state levels for survivors of war rape?

What has helped you as helpers / counsellors to do this work? What were and are your main coping mechanisms to be able to deal with survivors of war rape?

In your opinion, what has your own organisation done that has helped the survivors most? What have you as a professional done that you felt had a positive impact on your clients? How do the clients themselves talk about what has helped them most?

Focus group discussions with nongovernmental organisations in Bosnia and Herzegovina

- Association "Žene sa Une" Bihać, 27.12.2013
- Association "Žene žrtve rata" Sarajevo, 13.01.2014.
- Foundation "Udružene žene" Banja Luka, 16.01.2014.
- Association "Vive Žene" Tuzla, 31.01.2014.
- Association "Budućnost" Modriča, 31.01.2014.
- Association of Concentration Camp Torture Survivors of the Canton Sarajevo –Section of Women Camp Torture Survivors, 07.02.2014.

Key informant interviews for government officials of Ministries

Introduction (Personal presentation; explaining the purpose of the interview – finding out about integration of war rape survivors; explain why you consider the person being interviewed to be a key informant for the research question; recording of interview, sharing of report, etc.)

Thank the person for the time he / she is going to spend on the interview and that you and the whole research team want to learn from her / his views.

1. Can you explain a little bit what your function in the Ministry is? How long have you been working in this position?

2. Many women activists all over the world – and also in Bosnia and Herzegovina - are calling for the **integration** of war rape survivors into their society. How does your Ministry understand "integration into society" with regard to war rape survivors?

3. Can you tell us which specific documents, laws and strategic plans exist in your Ministry that are meant to contribute to the integration of war rape survivors?

4. What does your office do to contribute to this integration of war rape survivors? Can you name some measurements that contribute to this task? Do you have specific programmes for war rape survivors, e.g. in your strategic plan?

5. War rape survivors can apply for the status of a civilian victim of the war. Do you know how many women applied in your entity / in the whole of Bosnia and Herzegovina until the end of 2013? Do you have statistics on this?

6. If there was one thing that you would like to change in your Ministry with respect to the integration of war rape survivors, and if you had power to make it happen, what would it be?

7. Is there anything else that you would like to say regarding the topic of the integration of war rape survivors?

Thanks for your cooperation.

Key informant interviews with government officials of Ministries in Bosnia and Herzegovina

- Vjekoslav Čamber, Minister, Federal Ministry of Labour and Social Policy, 20.12.2013.
- Saliha Đuderija, Minister assistant, Ministry for Human Rights and Refugees of Bosnia and Herzegovina, 23.12.2013.

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