実践事例研究

# 旧ユーゴスラビアでトラウマを経験した女性たちへの支援プログラム

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# Practical Case Studies of Intervention Programmes for Sexually Traumatised Women in the Former Yugoslavia

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## 要　旨

1990年から1999年にかけて、ユーゴスラビア戦争が勃発した。「民族浄化」の名の下に、数えきれないほど多くの民間人が虐殺され、女性はレイプされた。ユーゴスラビア戦争では、レイプが「民族浄化」の効果的な武器として用いられた。女性たちの中には、恐怖感と屈辱の下、家族の面前でレイプされた人、また逆に自分の目の前で母親や娘たちがレイプされるのを目撃した人が大勢いる。被害にあった女性たちは自殺をしたり、家族や親戚、さらにはコミュニティからも追い出され、差別されつづけながら生活を送った。女性たちはレイプや性暴力の被害にあっただけではなく、様々な、常軌を逸した状況に、短い期間で一度に遭遇した。家族や親戚、友人の死、そして暴力や殺人の目撃など。

このような状況下では、彼女たちのトラウマのレベルは信じがたいほど高かったと考えられる。多くの女性たちがトラウマに苦しみ、現在においてさえ、過去の記憶・経験に苦しみ悩みつづけている人がいる。彼女達は紛争後、何らかの精神的ケアを受けることができたのだろうか。NGOや国際団体、政府は彼女たちに対策を講じたのだろうか。どんな種類の介入が、紛争下で、性的暴力の被害にあった女性達のトラウマの治癒に有効であったのだろうか。この実践事例研究では、旧ユーゴスラビアで行われている性暴力の被害者に対する支援活動の実践活動を事例として紹介したい。事例は、コソボやクロアチアでトラウマの治療にあたった医師やNGOスタッフへの聞き取り調査、文献・資料をもとに紹介している。多くの課題や達成事項が論じられる。加えて、女性の過酷なトラウマに関連して、本事例研究では、なぜ、性的暴力の被害にあった女性たちだけではなく男性も大きなダメージを受けるのか、ということにも触れている。また、紛争下において、大量レイプが起きる仕組みについても論じている。


**KEYWORD：Trauma, Women, Rape, The Former Yugoslavia, Mental Health Programmes, Future Perspectives**

## 1. Introduction

The Yugoslav wars, which include the Slovenian Independence War, the Croatian War of Independence, the Bosnian War, the Kosova War and the Macedonian War, broke out in the Former Yugoslavia in the 1990s.[1] The Yugoslav wars were notorious for the number of rape victims they produced. It is widely recognised that the mass rape of women occurs during conflicts and that many of these victims consequently suffer from trauma and mental illnesses. In fact, more and more humanitarian organisations worldwide have begun to focus on psycho-social care and the addressing of mental health during and after conflicts.

However, there is very little documentation of the mental health programmes and activities for sexually abused women that were run by governments, NGOs and other international agencies during the Yugoslav wars. Neither is there documentation of the types of psychological symptoms that female victims experienced, or of how much or how long they had to struggle with their trauma. In order to examine the outcome from a long-term perspective and to study the activities of practitioners from the post-war period to the present, the Former Yugoslavia was selected as the target region for this study.

In terms of the structure of this study, the methods used are first explained. Second, the relationship between 'ethnic cleansing' and rape is examined. The practical implementations of the NGOs' intervention programmes for sexually traumatised women then are illustrated. In conclusion, a series of discussions have been summarised.

## 2. Methods

In this study, primary (interviews) and secondary resources were used. In data-gathering, there was a lack of literature and reports documenting either the intervention programmes that tackled the issues of women's trauma caused by war or the present-day situation of these traumatised women. Most of the earlier studies were published in the 1990s and the record kept by practitioners was limited. Thus, to address these problems, interviews were necessary to obtain up-to-date information on the traumatised women, their on-going treatment programmes and the outcome of the intervention programmes that were implemented in the post-war period in the Former Yugoslavia.

Based on the references and notes from the books and journals on the Yugoslav wars, the researcher investigated related organisations and experts' affiliations. In addition, supervisors and advisors in the University of Glasgow, as well as in Japan, introduced some contact people. Firstly, the researcher contacted about 100 experts all over the world via e-mail and telephone. From among these, only three organisations and ten people replied. Due to scheduling, only four people could finally be interviewed. The organisations in which they work/worked are/were all NGOs.[2]

### 2.1. Interviewees and the organisations they belong to

The interviews were taken in Germany (Frankfurt and Cologne) and Croatia (Zagreb and Vukovar) in the interviewees' offices between 22 June and 6 July 2008. Nine main questions were asked during the interview to explore the contents of and the effectiveness of the intervention programmes and to judge how accessible they were to the women (See Appendix 1). Each interview took about two hours. The interviews were taken in English and recorded on a tape recorder.

Ms. Ingeborg Joachim is a trauma-therapist (body-psychotherapeutic approach) and a social educator. She worked for Medica Kosova from 2000 to 2004, partly as the coordinator of the psychosocial department and as a coach for the psychosocial counsellors.[3] Medica Kosova was launched in 1999 by Medica Mondiale with the aim of providing support to traumatised women and girls as soon as possible and to implement the project in the Kosova health system. Medica Kosova provides gynaecological, psychosocial

and juridical support for Kosovar women of all ethnicities; it now works independently as a local NGO.[4]

Ms. Karin Griese is a sociologist employed by Medica Mondiale.[5] Her work has included devising manuals, writing articles and organising seminars and workshops about the women and girls who have been traumatised by war. Medica Mondiale was founded by a gynaecologist, Dr. Monica Hauser, in 1993 and was aimed at providing gynaecological and psychological help to women who had been raped or sexually abused in Bosnia-Herzegovina during the war. Since then Medica Mondiale has been based in Cologne, Germany, mainly working with sexually traumatised women, implementing projects in post-conflict regions and taking a dual approach (that is, both direct aid through gynaecological/psychological support and indirect help through advocacy/fundraising) to support these women.

The third interviewee was Ms. Zdenka Pantic, who works for the International Rehabilitation Centre for Torture Victims in Zagreb (IRCT Zagreb) in Croatia as a psychologist and counsellor for war-traumatised women, children and families.[6] IRCT Zagreb started in 1993 after a large number of refugees fled to Croatia from Bosnia-Herzegovina. IRCT Zagreb gave physical and psychological support to the refugees and other displaced people during the war and in the immediate post-conflict period and, thereafter, to traumatised women, children and families, for free.

The fourth interviewee was Dr. Charles David Tauber, who is a psychiatrist providing counselling services to traumatised people at the Coalition for Work with Psychotrauma and Peace (CWWPP) in Vukovar, Croatia.[7] CWWPP was formed in the Netherlands in 1994 by various experts including physicians, psychologists, social workers, teachers and financial experts. Its main office is located in Vukovar. CWWPP focuses on counselling, education and research activities.

## 3. The relationship between 'ethnic cleansing' and rape

### 3.1. Purpose of rape

#### 3.1.1. Permanent removal

During the conflicts, rape was used by the Serbian army as an effective tactic of 'ethnic cleansing' in order to expand their territory. Hughs, Mladjenović and Mršević [1995: 510] define 'ethnic cleansing' as 'a term used to describe the forceful removal or killing of civilian Croats and Muslims'. They also point out that ethnic cleansing was initiated by the Serbian army. In many cases, the Serbian troops killed all non-Serbian men and boys (including Croatians, Albanians and Muslims) or took them to detention camps where they were tortured or sexually assaulted while the army broke into their houses and communities. The army then raped non-Serbian women, especially Muslim women, often in gangs, using methods of intimidation. Some women were then killed, some were repeatedly raped in the same location and some were taken to detention camps and repeatedly raped there in order to provide sexual gratification for the soldiers or to force them to give birth to 'Serbian babies'.[8] Torture and rape were often carried out in public in order to generate fear among the local people as well as to permanently drive the local population from their villages. Those who had heard stories of rape victims, who had witnessed scenes of rape or torture or who had been victims themselves felt extreme fear and did not want to return to the place where the incident had occurred. Thus, Serbian troops took over the lands and houses that were left behind.

It is widely held, among the international organisations, that rape was used as an effective weapon in the expansion of territories. The European Commission Investigative Mission [1993] concludes, 'a repeated feature of Serbian attacks on Muslim towns and villages was the use of rape, often in public, or the threat of rape, as a weapon of war to force the population to leave their homes'. The European Commission Investigative Mission also regarded rape

as 'a strategic purpose in itself' rather than being 'incidental to the main purpose of the aggression'.[9] The UN General Assembly, in 1996, agreed with this assessment and viewed the rape in Bosnia-Herzegovina as 'a weapon of war and an instrument of ethnic cleansing against women and children'.[10]

#### 3.1.2. Destruction of the enemy's families, communities and cultures

Rape was carried out to destroy the targeted families, communities, societies and cultures as well as to demonstrate male Serbian power.

It is obvious that one of the aims of 'ethnic cleansing' was the destruction of the cultures of other nations. During the conflicts, religious leaders, teachers, community leaders and intellectuals were killed and areas such as mosques, churches, schools and graveyards were destroyed [Stiglmayer 1993: 19]. These people and places were regarded as the symbols and the communicators of the enemies' cultures to the current and the next generations.

In this context, Balkan women were also considered to be cultural representatives and transmitters. They were 'symbols, guardians of home and homeland, women as mothers, reproducers of children and culture' [Cockburn 1998: 162]. Under the household system observed in the area, called 'zadruga', women moved into the homes of their new husbands' parents after marriage and from then were under their authority. Women, especially mothers, were responsible for caring for their family members, bearing and rearing children and engaging in domestic work. Even after the equality of men and women was established under Tito's leadership, patriarchal structures were maintained in various areas of life such as education, employment and politics. The majority of women were still second class civilians in society and were working at home for their families. As nationalism grew in the Former Yugoslavia during the conflict period, the zadruga system was revitalised by nationalists. Women were increasingly expected to bear and rear the next generation of their families, communities and nation. Moreover, a woman's honour became more important in their families, communities, societies, religion and culture.

Folnegovic-Smalc [1993: 175] states that the emotional and physical destruction of the rape victims had a significant negative impact on their families and communities, which was the aim of the Serbian army. There was a Bosnian appeal which stated that Serbian rape was implemented 'to destroy a whole Muslim population, to destroy a society's cultural, traditional and religious integrity' [Brownmiller 1993: 181]. Thus, the treatment of these Balkan women was closely connected with the future of their families, communities and culture. Their honour was an integral part of their families, communities and religion. Their bodies were considered by the Serbian army to be a threat because they were the means of producing another generation of hated enemies. Therefore, the women and their bodies were targeted to be destroyed, conquered and impregnated in order to maximise damage, their families and their communities as well as to eradicate the next generation of the enemy under the name of 'ethnic cleansing'.

#### 3.1.3. Destruction of male enemies

Rape and sexual abuse against women was also used by Serbian soldiers as a tool to defeat male enemies and to demonstrate Serbian power.

The Former Yugoslavia was a patriarchal society in which men held the position of controlling and protecting their female family members. Therefore, fathers and husbands could also be affected when they discovered that their wives and daughters had been raped or sexually abused because they had failed to protect 'their own property' [Zajovic 1993 cited in Kelly 2000: 53]. There were many cases in which women were raped or sexually abused in front of their family members, including their husbands, fathers and brothers [Cockburn 1998: 184].[11] It could be said that the aim of these acts was to humiliate the victims as well as their male family members. Folnegovic-Smalc [1993: 175] suggests that the men were severely demoralised when they realised that they could not defend 'their' women. Male self-esteem was thus completely destroyed when they were made to experience firsthand the rape and sexual abuse of

'their' female family members.

This could explain why the Croatians and Muslims chose to rape Serbian women as a means of revenge, instead of exclusively pursuing their real enemies, the Serbian male soldiers. They seemed to have wanted Serbian men to feel the same abject humiliation that they had experienced when their women were being raped.

Serbian men gained superiority and power over the women and men of the enemy's side by rape. Folnegovic-Smalc [1993: 175] claims that establishing a hierarchy and demonstrating Serbian power over the enemy was the intention of the rapists. Seifert [1996: 41] writes, '*women are raped by men*, which means that the incontestable reality of tortured female bodies is translated into male power'.

### 3.2. Psychological damage to women sexually abused during conflict

The precise number of rape victims is obviously significant, but is not known.[12] Seifert [1996: 35] estimated that about 60,000 women had been raped as of 1993. The Geneva Centre for the Democratic Control of Armed Forces (DCAF) supports this, stating that the number of women who were raped or sexually assaulted during the conflicts in Croatia and Bosnia-Herzegovina has been estimated as between 10,000 and 60,000 [2005: 115]. Many of these women watched their male family members, including their husbands, fathers, sons, brothers and other male relatives and neighbours being murdered and severely tortured before they themselves were raped. Women who were forcibly taken to the internment camps were repeatedly raped by several soldiers (gang rape) almost every night in humiliating, painful and fearful ways.[13] Some women were imprisoned in dark, crowded and unsanitary rooms until they became pregnant and gave birth to 'Serbian babies'. They were not allowed to eat very much, have access to clean water, wash their bodies, or change their clothes until the soldiers ordered them to do so [Stiglmayer 1993: 117]. It seems impossible to imagine to what extent these women were traumatised after being forced into such dreadful situations.

Many of these rape victims committed suicide after escaping or being released because they feared stigmatisation or because they blamed themselves for shaming their family members by becoming 'devalued' women. Many rape survivors experienced marginalisation and stigmatisation by their family members and local people.

In the post-conflict period, a large majority of sexually abused women from the Former Yugoslavia reportedly experienced severe trauma that physically and mentally endangered their everyday lives. They had to struggle with psychological symptoms that included suicidal inclinations, depression and loss of self-confidence [Folnegovic-Smalc 1993: 177].

It is obvious that women who have had such experiences require psychological support. Not only were they sexually abused during the conflicts but they also were exposed to various extreme situations such as losing family members, friends and relatives, being refugees, being physically-abused and being witness to murder and rape, all within a short period. Under these unstable and insecure circumstances, it could be said that their level of trauma was incredibly high. It was difficult for these traumatised women to have survived by themselves without any psychological and social support.

Did these women have access to any mental health services during the post-war period? Did NGOs, international organisations, or the governments try to help them? What types of interventions were provided for the female trauma victims? How did international organisations and NGOs deal with the women's 'multi-layered' trauma?

These questions, which relate to women's mental health programmes in post-conflict periods, have not been fully documented by either academics or agencies, although psychological support could be the key to enhancing peace and sustainable development.

In order to effectively treat trauma to women caused by war, it is vital to focus on the severe mental and physical suffering of the women and to examine their situations of causing these sufferings. It is also

essential to research the intervention programmes for women's mental health from the immediate post-conflict period to the present day. This will contribute to women's sustainable development.

#### 3.2.1. Women's shame and suffering after being raped

According to the reports of those who treated or interviewed rape survivors, raped women felt great shame, disgrace and often had thoughts of suicide after being raped. The majority of these women chose to keep secret any abuse they had faced and they were afraid of being identified. Thomas and Ralph [1994: 89] cite two Yugoslav women's comments to support their arguments. One woman said that if she had been raped she would not be able to face her children and would choose suicide rather than endure the humiliation. Another woman who had been raped by Serbian soldiers said that she knew of many others who had been subjected to the same experience. They kept it secret because they felt shame and they would conceal their daughters' rapes for fear of their daughters' marriages being rejected [90]. Kozaric-Kovacic et al. [1995c: 432] discuss the case of a woman who visited Zagreb Obstetrics and Gynaecological Clinic to obtain approval for a legal abortion. She was raped in front of her daughter and mother-in-law by five Serbian militiamen. After this happened, she asked her family not to tell anybody of the rape. She also remained silent and asked the clinical staff to expunge her record after the examination. Kozaric-Kovacic conclude that her desire to keep the abuse a secret and her feelings of shame were typical of the women who were raped during conflict. According to Folnegovic-Smalc [1993: 176], these reactions stem from the fact that these women want to forget their memories and humiliation and from them not wanting to be labelled as rape victims. Many women chose to conceal their fearful memories and tried to forget the experience.

It is possible to understand why so many women chose to conceal their sexual abuse when one considers the number of women who were expelled, marginalised, or stigmatised by their family members, relatives and communities after they were identified as having been raped, particularly in the rural areas of the Former Yugoslavia [Cockburn 1998: 180]. These women were considered to have defiled their families and communities. Brownmiller says [1993: 181], rape victims in war time are 'evidence of the enemy's bestiality', 'symbols of her nation's defeat', 'pariahs' and 'damaged property'. Thus, many of the raped women were stigmatised as guilty parties. It was not considered how much these women's identities and personalities had been destroyed and how severely they were traumatised as a result of their experiences.

#### 3.2.2. Women's honour

Thomas and Ralph [1994: 90] observed that the concept of a woman's honour resulted in the shame of the rape victims and the attitudes of their families and communities. They also suggest that this shame caused the raped women bury the 'dishonour' and discouraged them from prosecuting the rapists. Most victims were unwilling to obtain suitable physical and psychological treatment for themselves or talk about their situations [Folnegovic-Smalc 1993: 176][Dr. Charles Tauber 2008]. It could be said that their attitudes stemmed from notions of woman's honour as well; they were afraid of identification, felt extreme humiliation and often felt guilty. Moreover, the women's honour seems to have discouraged their families and communities from helping these women, or from seriously pursuing the alleged rapists, since these women were considered to be disgraced and not worthy of help. Conversely, as Thomas and Ralph observe [1994], women's honour increased the Serbian army's motivation to rape as they were not worried about being reported or prosecuted [89].

Article 27 of the Fourth Geneva Convention says, 'Women shall be especially protected against any attack on their honour, in particular against rape, enforced prostitution, or any form of indecent assault'.[14] Thomas and Ralph [1994] argue that this article can lead to the mischaracterisation of rape 'as harm against the community' in terms of law because a woman's honour is often equated with the community's honour. They claim that rape should be recognised 'as harm against the physical integrity of the victim

herself' [92].

As has been discussed, it could be said that women tend to be blamed for being raped and become targets of attack because their honour is seen as the honour of their family and community. Furthermore, perpetrators are not prosecuted because guilt and shame are internalised by the raped women. It might be difficult to eliminate a woman's honour because it is a part of the identity of the women, men, families and communities.

In terms of intervention, it is essential to treat women in a non-stigmatising manner by taking their cultural background into consideration. For example, Medica Kosova offered counselling and treatment support for 'war-traumatised women and girls' because nobody would use their services if they labelled them as being 'for rape victims' [Joachim 2008]. Intervention could be an effective method of empowering women by teaching them that their identities are not composed only of honour and that they are not to blame. Moreover, it is also vital for the locals and people involved in these types of programmes to realise what war rape means to the victims, how physically and mentally damaged they are and how severely they are traumatised. An understanding of these women's suffering is necessary, not only at a logical level but also at the emotional level, to effectively support them. Folnegovic-Smalc [1993: 176] points out that women who receive emotional support from their families and friends tend to recover more quickly than those who talk to professional psychologists. It could be assumed that the emotional support of their families and friends prevents women victims from feeling loneliness and guilt and also relieves them of the burden of their secret.

#### 3.2.3. Rape destroys Women's sexuality and identity

Rape has a significant impact on women. It is powerful enough to destroy their identities, dignity, self-determination and even their lives (by suicide). Referring to this impact, Folnegovic-Smalc et al. [1993: 179] note, 'rape is one of the gravest abuses, with consequences that can last a lifetime'. Seifert [1996: 41] writes that rape is 'forcible entry into the body, severe torture and constitutes the severest attack imaginable on the most intimate self and the dignity of a person'. It could be said that rape destroys women's sexuality (which is connected to their identity) by the abuse of their private parts. For most women, their vagina is the intimate recognition of their sexuality, identity and sex. Therefore, rape is a crime that can devastate women's identities and bring them severe, long-lasting trauma. Seifert [1996: 41) affirms, 'sexual violence is also an assault on the very core of a person's self'. In order to effectively treat sexually abused women, it is essential to consider the impact on them individually, aside from their cultural backgrounds.

#### 3.2.4. Psychological symptoms

The most common psychological reactions of sexually traumatised women are attempted suicide, suicidal thoughts, depression, anxiety, inner agitation, nightmares, sleep disorders, apathy, aggression, loss of self-confidence, fear and repulsion [Folnegovic-Smalc 1993: 175][Seifert 1996: 40]. Seifert [1996: 40] states that among sexually abused women, rape victims in particular tend to lose their identity in addition to these mental symptoms. The psychological symptoms experienced by these women seem to be the most intense during their pregnancies, according to the study by Kozaric-Kovacic et al. [1995c: 428-433].

##### Pregnant women

Kozaric-Kovacic conducted interviews of twenty-five Bosnian and Croatian female rape victims who had visited her gynaecological/obstetrical centre during February 1993. Out of these twenty-five, the numbers of those who were not pregnant, those who were given abortions and those who delivered their infants were 11, 9 and 5, respectively.

All of the five women in this study (who later gave birth at the centre) experienced suicidal thoughts, severe depression and anxiety during their pregnancy. However, after their delivery, their psychological symptoms significantly decreased. All of them abandoned their children; they had no interest in the children and did not want to keep them. These women

rejected further psychiatric treatment and left the hospital soon after their deliveries without providing their addresses.

Kozaric-Kovacic et al. [1995c] conclude that violence against women has a significant negative impact, which can change these women's lives as well as their normal human reactions, by pointing out that the five pregnant women mentioned above experienced severe hypomania (which they had not experienced before) and had no interest in keeping the children they had delivered.[15]

Based on her psychiatric profession, Folnegovic-Smalc [1993: 177] also affirms that it is clear that all women who become pregnant as the outcome of rape experience suicidal thoughts [177].

**After giving testimony**

Many women also experience severe mental symptoms after they have given public testimony. Kozaric-Kovacic et al. [1995c] discuss the case of a woman who deteriorated psychologically and tried to commit suicide after she recounted her rape experience in an interview for a foreign TV programme [430]. It is reported that rape survivors in the Former Yugoslavia experienced severe clinical mental symptoms and tried to kill themselves after their testimonies. By recounting their experiences, these women were vulnerable to flashbacks and their trauma symptoms intensified. Kozaric-Kovacic [1995c: 432] mentions that the level of normalisation achieved after traumatic events is so fragile that current mental symptoms can intensify and new ones can be induced as a result of the recounting of their experiences.

On the other hand, some experts see public testimony as one of the forms of psychological therapy. Agger and Jensen [1993, cited in Kozaric-Kovacic et al., 1995c: 432] recommend women's participation in public testimony as a means of decreasing their grief by sharing their experiences with other people.

The four interviewees in this study had different opinions of public testimony. Dr. Charles Tauber had a positive opinion of public testimony. According to him, public testimony can help achieve public recognition and can be an excellent method of relieving stress for sexual abuse victims. However, he pointed out that the victims' testimonies tend to be political and that this kind of usage should be avoided. Thomas and Ralph [1994: 93] and Dr. Tauber argued that the testimonies of raped women were used to appeal for aid money from international communities by attracting their sympathy. These testimonies were also used as propaganda. Each nation attacked the others' ethnicity and encouraged ethnic hatred by emphasising the enemy's atrocities through mass media. Through these political manipulations, the victims' real stories were sometimes distorted and exaggerated, which led to them losing testimonial credibility.

Ms. Zdenka Pantic also agreed with public testimony because she believed that the sharing of their experiences with others would promote these women's recovery from the trauma. However she insisted that it was important to take into consideration the clients' personalities and the people who would listen to their clients. According to Pantic, female victims tend to tell the truth to people whom they deem trustworthy.

Ms. Griese, Ms. Joachim and Ms. Pantic emphasised the importance of protecting the victims who give public testimony. If their testimonies are aired on TV or are published in newspapers, they may be identified. Ms. Joachim mentioned a Kosovar woman who had gone to the International Criminal Tribunals for the Former Yugoslavia (ICTY), located in The Hague, with much preparation and great courage. Her testimony was aired and the people in her community came to know of her experience. When she came back to Kosova, people isolated her. She could not go back to work, was treated adversely and could not live in her hometown. She finally left Kosova.

Indeed, giving testimony could be of great help in relieving trauma, in sharing their experiences with others and in prosecuting their rapists. However, the women face a high possibility of their trauma recurring, being identified and being ostracised. In terms of interventions, as Thomas and Ralph [1995: 432] note, 'the timing and context of revealing a traumatised person's fragile defence mechanisms must be considered'. Moreover, it is essential to consider the personal traits and cultural backgrounds of clients, the

psychological impact on them, the means of securing confidentiality for them and the establishment of mechanisms to protect them.

To sum up, it is very difficult to conduct intervention programmes for women in the Former Yugoslavia who have been sexually traumatised. They are traumatised in multiple ways through conflicts. They live in communities in which a woman's honour is highly valued. They have difficulty in talking about their experiences although it is obvious that they have deteriorated psychologically and that they require relevant treatment. Their families and communities also either hide them from society or expel them. Although the level of trauma varies between women, most of them are severely damaged. This paper will now examine how these sexually traumatised women have been treated in the intervention programmes.

## 4. NGOs' practical implementation of intervention programmes for sexually traumatised women in the Former Yugoslavia

### 4.1. Accessibility

Could women experiencing trauma after rape or sexual abuse access mental and physical health services in the post-conflict periods? Ms. Ingeborg Joachim answered in the affirmative. In particular, she mentioned the issues of timing and strategy. According to her, the Medica Kosova project for Kosovar Albanian refugees had already started during the war in Albania and successfully reached out to the region of Gjakova shortly after the conflict.

In the early stages of the project, clients/patients were contacted through two working departments: a gynaecological and a psychosocial department. It usually takes time to provide psychosocial care for traumatised women because emergency aid to fulfil basic needs such as food, clothing and housing tends to be prioritised. However, according to Ms. Joachim, psychological support was made available immediately after the war. It seems that Medica Kosova had clear targets in terms of providing mental and physical support to sexually traumatised women at the grass-root level as well as advocating to governments and donors the importance of supporting sexually traumatised women. This facilitated the swift implementation of the psychological scheme.

In terms of strategy, Ms. Joachim asserted the importance of implementing their plans in non-stigmatising ways. In Kosova's conservative culture, rape and sexual matters are taboo. People usually try to hide or deny the incidence and existence of rape and sexual violence. The families of women victims tend to ignore, marginalise and discriminate against sexually abused women because they are considered 'devalued'. Moreover, women victims are often blamed for their rape. In such circumstances, victims are afraid of being identified, devalued and stigmatised by others. Therefore, in the post-conflict period, it was impossible for these women to go to places where they would be recognised as victims of sexual violence.

In light of the above, it is significant to consider the social and cultural aspects of the targeted regions when implementing health care services related to rape and sexual abuse. All the interviewees strongly stated this point. However, how could these marginalised, ignored, sexually abused women receive appropriate services? How did development organisations contact and reach out to these 'hidden' women?

Medica Kosova had an interesting practice that reached out to sexually abused women in Kosova. The organisation ran their centre with the aim of providing women victims with gynaecological and psychosocial support immediately after the conflicts. Fieldwork was conducted by travelling in the 'ambulance' car.[16]

Medica Kosova dispatched staff that included gynaecologists and psychosocial counsellors to villages where significant violation of human rights during the conflicts had been reported. The staff visited these villages in the 'ambulance' car and officially provided the women with gynaecological treatment. According to Ms. Joachim, many women queued up in front of the car for gynaecological examinations. While the gynaecological staff were conducting examinations inside the car, the psychosocial staff were implementing field

research outside by talking with the women waiting in the queue. Once Medica Kosova earned the trust of the local people, they started to bring close relatives and friends who were experiencing severe mental trauma to the centre. In the case that their villages were far from the centre, the counsellors visited them in the ambulance car. Thus, both gynaecological and psychological care was gradually introduced to many women in the region. It could be said that this approach was effective not only in providing services for sexually abused women living in a conservative society but also in making more people aware of the importance of psychosocial treatment. According to Ms. Joachim, the people and even the local doctors in Kosova did not know what psychologists, psychological treatment, or psychosocial counselling was.

The International Rehabilitation Centre for Torture Victims (IRCT) Zagreb carried out effective interventions, similar to those by Medica Kosova, after the Croatian War of Independence. IRCT Zagreb implemented programmes that offered holistic medical treatment from doctors, gynaecologists and dentists as well as special psychological support to people suffering from trauma. IRCT Zagreb also visited refugee camps and villages after the war. To identify these camps and villages, IRCT Zagreb contacted government authorities and used the social networks of other institutions. The ability to locate people who required their services and provide them with physical and mental support, by using strong partnerships with government institutions and NGOs, could be one of the strongest points of IRCT Zagreb's activities.

Dr. Charles David Tauber, however, did not respond to this question on accessibility in the same manner, pointing out two main reasons for his difference of opinion. The first was that women were not willing to go to the health centre to receive mental and physical health services on account of the conservative socio-cultural background in Vukovar, Croatia. The second was that health care in Vukovar was very poor. Dr. Tauber mentioned that the quality and quantity of the health service would not have been adequate even if women could access it in the post-war period.

He also argued that many international organisations came and tried to help victims after the Croatian War of Independence. However, most had no interest in psychological treatment neither did they try to implement it in their intervention programmes. Therefore, many traumatised people could not receive proper treatment in the immediate post-disaster situation in Croatia.

This is not just the case in Croatia. Ms. Karin Griese told the story of Kosova. Medica Mondiale made a questionnaire and disseminated it to other NGOs working with the victims of conflict in Kosova in order to find out whether or not these NGOs were treating raped women. The results indicated that the NGO awareness level of the issues surrounding rape victims in Kosova was very low. Most institutions replied that they did not know if their clients were victims of rape.

Ms. Zdenka Pantic mentioned that it would be impossible to provide immediate psychological services for traumatised women during the war. She suggested that it takes some time to build up mental health service projects for sexually traumatised women. The reason is that it is necessary to carefully research the women's mental health conditions and to consider the cultural and social backgrounds of the targeted regions before implementing projects.

In her opinion, in immediate post-conflict situations, whether or not women could receive psychological and physical treatment would depend on the location in question. If the location is a place where the infrastructure is severely damaged or the political situation is unstable, the service will not be able to reach the women who require it the most.

Indeed, as Ms. Pantic mentions, psychological projects require some time to start up. However, this does not mean that other basic needs should be prioritised. People cannot survive in isolation with only food, especially in devastating post-war situations. Libby Tata Arcel states the following;

> But man does not live on bread alone and people who have experienced war disasters and survived physically also have a fundamental need of being

listened to in order to survive psychically [Libby Tata Arcel 1995: 7].

### 4.2. Treatment

As mentioned above, there are many factors that induce trauma in war and it is impossible to relieve women's mental suffering by removing only one anxiety for them. In addition, the level of trauma that each person experiences is different. How do/did NGO staff or psychologists involved with mental health programmes treat these traumatised women? How do/did practitioners talk with them and consider their cultural contexts in practicing psychological care?

Ms. Joachim explained this in detail. At first, Medica counsellors gave individual support and then gradually started to conduct counselling in small groups such as daughter and mother or refugees from the same village. This is because Ms. Joachim found that sharing similar experiences with familiar people was a great help for decreasing the feeling of loneliness and grief for individuals. She insisted that it is essential for traumatised women to realise that they are not alone and that there is somebody around them who is willing to care for them and to help out in their lives. Not feeling alone is significantly effective in aiding recovery from mental illness. Ms. Pantic also strongly agreed with this idea. She suggested that it is important to have a place where those who have had similar experiences can meet together so that they do not feel alone, are accepted and live with dignity.

Ms. Pantic and Dr. Tauber mainly treat traumatised people individually because the level of trauma that a person experiences and the time taken to overcome it differs from person to person. Lebowitz and Ruth [1994] write, 'maximum attention must be paid to respecting the clients' pace, their level of support and individual needs and differences' [388]. Dr. Tauber insisted on the importance of taking an open-door approach with everyone because traumatised people often regard themselves as crazy and feel acute anxieties about being devalued and discriminated against. According to Ms. Pantic, feeling crazy is a normal reaction of traumatised women; therefore, it is vital for them to have access to psychological services as soon as possible.

Ms. Joachim and Ms. Pantic insist that counsellors should try to research their clients' life situations, backgrounds and cultural contexts when implementing psychological treatment because their clients' environments are deeply connected to their trauma. Ms. Joachim also mentioned that an understanding of cultural contexts is considerably important in gaining the trust of the local people. Counsellors first need to dedicate themselves to building a relationship of trust with their clients and to try not to force them to speak up. The counsellors treat their clients without knowing whether or not they are sexually abused. The counsellors, however, consider the possibility of their clients having been raped so that they can practice the appropriate psychological treatment at the right time. Thus, being with clients and sharing their problems gradually develops trust. This trust helps the clients speak out about their sufferings and leads to more effective counselling.

In terms of psychological care, Ms. Joachim opposes looking at the treatment of war-traumatised women by referring only to Post-traumatic Stress Disorder (PTSD) diagnosis.[17] In her opinion, PTSD treatment tends to examine one significant event that is the cause of the trauma, although the trauma caused by war is provoked by various terrible situations and requires to be looked at within its larger context in order to be effectively treated. She insists that the aims of psychosocial support for sexually traumatised women during war are to help these women live with their experiences in the present day and develop future perspective. These approaches are different from those used to treat PTSD.[18]

Ms. Pantic narrated the story of a refugee mother to emphasize the importance of understanding the clients' environments when implementing psychological treatments. The mother had experienced an extreme level of trauma after she escaped from her hometown and moved to a new place because of war. According to Ms. Pantic, some people, like the mother, have great difficulty in adapting to new places, cultures and

languages. Moreover, these displaced people are in unstable situations in and immediately after the conflicts; they have no idea where to live in the future. It is important to consider these contexts when providing mental health treatment to refugees.

Among various methods, one effective support for women who suffer trauma, according to Ms. Joachim, is body massage. During her work in Kosova, she met many women who suffered discomfort from headaches and backaches. After she did some massages to relieve these aches, her clients said to her, 'I can relax'. She started teaching massages to other counsellors, doctors and nurses who worked in Kosova as well as to their clients. Kosovar women who were taught massage started to use it on their family members and friends. Performing massages on each other was effective not only to decrease their stress but also to strengthen ties between family members and groups of women, according to Ms. Joachim. She also mentioned that people in Kosova, including the local doctors, were often unaware of the extent to which their physical conditions were affected by their stress and mental health problems at the time.

### 4.3. Obstacles

All the interviewees stated that there were many obstacles in implementing mental health intervention programmes for sexually abused women in the context of war and that this was because of a variety of reasons.

Firstly, the discussion of rape and sexual abuse was taboo in the Former Yugoslavia. This prevented women from receiving appropriate treatment and made it hard to identify victims. Ms. Joachim argued that local counsellors in Kosova found it hard at first to talk to their clients about issues of rape and sexual abuse. Some of them found it too difficult and painful to imagine the rape and sexual abuse that their clients had suffered even when there were indicators. Dr. Tauber noted that rape was taboo in Vukovar in Croatia, as well.

Secondly, counsellors and staff were sometimes unable to remove factors causing their clients' extreme trauma, which made them feel like they could not help the traumatised women. According to Ms. Joachim, one of the greatest traumatic conditions was often provoked when people were waiting or searching for missing loved ones. Women experienced the greatest level of stress while they were waiting for their husbands, children, relatives and friends to come back or when they were searching for their dead bodies. However, it was impossible for counsellors and staff to detect missing loved ones and to change their situations.

The third challenge was how to effectively cooperate with other institutions in implementing projects for sexually traumatised women. Ms. Griese mentioned that it is hard to find other organisations that are willing to cooperate. Most organisations do not have a good enough understanding of the serious mental health conditions that women experience during and after conflicts due to being sexually abused or raped.

Fourthly, the lack of qualified staff and doctors is also a serious issue. Dr. Tauber argued that there was a huge growth in the population of traumatised people after the war in Vukovar; however, most doctors could not offer appropriate support for them because of the shortage of their numbers, of hospitals and of low-level health services.[19] He also pointed out that the government has not attempted to improve such situations and has left Vukovar behind because it is a small village with few resources. In these circumstances, qualified doctors tend to leave for work in foreign countries and thus the level of health services provided is still minimal. Many international organisations tried to help these traumatised people by dispatching qualified doctors immediately after the war, but most doctors left Vukovar within a year. There remains little interest in sending doctors back to small villages such as Vukovar when the focus of relief is moved to other conflict areas. Dr. Tauber mentioned that it usually takes at least one year to treat traumatised people and that international organisations do not believe that the requirement of long-term projects is justified. Generally, these organisations try to do things quickly due to their limited mandates. He added that because of this, it is hard to collaborate with international organisa-

tions and to trust their capabilities. Even one decade after a conflict situation, many people still suffer serious trauma. New clients still visit the centre one after another. Ms. Griese and Dr. Tauber insist on the importance of training in order to increase the number of qualified staff, doctors and counsellors, although this will inevitably cost money and will take time to carry out.

The burnout of NGO staff and counsellors is also a problem. Ms. Joachim implied that the psychosocial counsellors got extremely exhausted after the first working period because of an overload of clients and because of the fact that in this period, they had not yet had enough training. Therefore, it is also important to take care of the mental health of the NGO staff and counsellors by supervising and talking with them in order to ensure that they are happy to work in their positions for a longer period of time.

The final and most crucial obstacle preventing the provision of adequate health care is money. All the interviewees affirmed the importance of obtaining enough funds to maintain long-term mental health programmes for sexually abused women. Treating their trauma takes a lot of time. It also takes considerable time and money to train and educate doctors, nurses, staff and non-professionals to enable them to provide suitable physical and psychological services for sexually traumatised women. In these situations, it is important that these services should be provided quickly for people living not only in urban areas but also in rural or war-ruined areas; these services cost money as well. Therefore, it is essential to keep advocating to people for the purpose of raising their awareness and promoting funding for longer time periods. Ms. Griese argued that sustainability is vital because it gives women a chance to get help even after ten or fifteen years. However, raising funds can be difficult as the sensitivity of women's sexual issues and the longevity of the projects do not always appeal to donors. Unlike Afghanistan, Pakistan and Sri Lanka, the Former Yugoslavia, particularly Bosnia-Herzegovina, Serbia and Croatia, is not a 'hot spot' for funding. Ms. Pantic pointed out that people too easily forget to monitor and consider the situation in older conflict zones such as Rwanda and the Former Yugoslavia. She said, 'it does not mean that constant support is necessary, but it is important to know what is happening later on after the wars'. Most donors are not interested in investing in the Former Yugoslavia although there is a significant shortage of doctors, counsellors, NGOs, hospitals and health services.

According to Ms. Griese, the size of an organisation can also affect the level of fundraising it receives. Medica Mondiale became bigger over time because of the huge needs in various regions. She pointed out that bigger organisations have more difficulty in obtaining funds and that once they have grown it is difficult to become smaller again.

### 4.4. Other good and bad practices

In addition to their efforts, what kinds of services did other international organisations and NGOs provide to sexually traumatised women in post-disaster situations? [20] Ms. Joachim stated that some NGOs focused on raped or sexually abused women and helped them in various ways, such as by teaching them to recognise the psychological symptoms caused by trauma or by giving them psycho-education and educating them in PTSD by dividing them into different groups according to marriage status, gender and age. Ms. Joachim and the other staff at Medica Kosova were involved not only with these psychosocial programmes but also with other support programmes including providing clothing, food and income generation opportunities. The clients of Medica Kosova often appealed to the counsellors for aid with their daily problems and the counsellors realised that it was necessary to collaborate with other organisations to fulfil their demands. Ms. Joachim concluded that these activities led to holistic support that effectively helped many traumatised women in Kosova.

Dr. Tauber stated that collaborating and networking with other agencies is important for implementing holistic projects for traumatised people. He also said that projects should be holistic and should take a long-term approach.

According to him, many international organisations came to Croatia immediately after the conflicts and they tried to help traumatised people. Most of the programmes they implemented were to help generate income with the aim of helping to empower and improving the self-confidence of the traumatised people. He argued that the income generation programme itself was good, but the problem was that many organisations practiced their programmes without considering the cultural contexts and mental conditions of the traumatised people. He pointed out that most international organisations considered only the number of people who attended their seminars and participated in their projects; in other words, they considered only 'quantitative' outcomes. He then mentioned an undesirable practice implemented by an international organisation. The aim of the project was to empower war-traumatised men by encouraging them to build houses for themselves. However, the organisation made these men build their houses without providing the men with any psychological support. The outcome of the houses these men had built was fatal, which did not improve the mental condition of the war-traumatised men and lose their self-esteem.

In terms of inappropriate practices, Dr. Tauber and Ms. Griese explained that some international organisations provided traumatised people with medicines, such as sleeping pills and pain killers, in large quantities. They criticised this kind of prescription as not being helpful to clients. It could be important for doctors to consider psychosomatic relations and to try to treat not only the physical problems of their patients but also the psychological ones.

### 4.5. Evaluation of effectiveness

Over the last decade, how have women's situations changed in the Former Yugoslavia? Were efforts that were aimed at helping traumatised women effective?

Dr. Tauber replied, 'No' and he insisted on the necessity for ongoing intervention. On the other hand, Ms. Griese said, 'Yes' for the following two reasons. Firstly, living conditions have improved in Bosnia-Herzegovina and have had a positive impact on women's lives and health. Second, Bosnia-Herzegovina acknowledged in 2006 that raped women were civil victims of war. The government decided that raped women in Bosnia-Herzegovina would be entitled to receive pension, according to the compensation law.[21] Ms. Griese declared this a milestone because it gave women proper recognition of what they had lived through.

It can be said that this decision by the Bosnia-Herzegovinian Government was attributed to lobbying activities by women's NGOs. A film directed by Jasmila Zbanic, titled 'Esma's Secret', was awarded the Golden Bear at the Berlin Film Festival in 2006. The film focused on the issues of rape in the Bosnian War and it attracted the interest of many people to the problems of raped women and their situation in Bosnia-Herzegovina. Annual reports by Medica Mondiale [2006] state that this movie and the signature campaigns led by Medica Mondiale and other women's organisations in Bosnia-Herzegovina succeeded in getting the government to acknowledge raped women as civil victims of war [5-6, 16].

Ms. Joachim thinks that the interventions by Medica Kosova and other organisations helped the traumatised women by improving their situation. She has seen many traumatised women in Kosova gradually gain future perspective and confidence through the programmes and counselling they participated in. She mentioned that it was a kind of taboo for widows and women to earn money and do agricultural work such as keeping cows and driving tractors; however, some women had overcome this taboo and trusted their capabilities and enjoyed their own lives; they said, 'I don't care what others say about me'.[22]

Ms. Pantic said that she wanted to believe that their programmes were as helpful for traumatised women as was suggested by their monitoring reports. Some clients she had treated for almost ten years often said to her, 'If I could not have had this opportunity and could not have joined your programmes, I would have lost the chance to start a new life'.

### 4.6. Current activities and future perspective

A decade after the end of the conflict, what kinds of activities are still in place for traumatised women?

Medica Mondiale is undertaking a 'double approach'; one is direct (psychological, gynaecological and judicial support) and the other is indirect (advocacy and networking). Ms. Joachim and Ms. Griese claimed that raising awareness and getting more funds in order to maintain long-term direct and indirect support is vital.

Ms. Griese told the story of the tremendous impact of a prominent Muslim religious leader on Bosnia-Herzegovinian society. During the war, he said, 'Women who have been raped should be accepted. They are not blamed. They are a kind of hero of the war'.[23]

In light of this story and the Government's decision to pay compensation to women raped during the war, it can be said that advocacy is essential for government and UN officials as well as policy- and law-makers. Their positive, supportive statements and policies have significant impacts that can promote the swift implementation of projects by securing sufficient funds.

In addition, regarding IRCT Zagreb's effective projects, networking between governments and NGOs is crucial. Networking with local and international NGOs as well as raising awareness throughout international society is also significant for continuing intervention programmes and for securing investment in 'cold' spots such as the regions in the Former Yugoslavia.

IRCT Zagreb is now carrying out medical, social and psychological aid programmes for traumatised women for free based on a long-term and holistic approach.

Dr. Tauber believed that organisations should change over time. Coalition for Work with Psychotrauma and Peace (CWWPP) is now providing counselling, training and education and is undertaking research to collect empirical data. He mentioned that when the CWWPP receives more funds he would be interested in doing more research on more effective psychological treatment for men and women who have been sexually abused. He is also planning to open dialogue between academicians, donors and those who support traumatised people after conflict. Through this dialogue, he would like to explore universal principles for supporting war-traumatised people even though there are huge cultural differences between different regions.

## 5. Conclusion

In the Former Yugoslavia, mass rape occurred during the conflicts in the 1990s. Women were sexually abused with the aim of destroying families and culture as well as of humiliating and defeating male enemies. Most raped women experienced severe trauma not only because of the rape but also because of other factors: losing their beloved families, friends, witnessing extreme situations such as torture and murder and moving to places far from their hometowns in the circumstances of war. How had practitioners treated the 'multi-layered' trauma of these women? Through interviewing, it was found out that NGO staff and psychologists had treated them individually or in small groups taking into consideration their personalities and cultural backgrounds. It was also clear that these types of intervention programmes require money and time in order to treat clients, train staff and obtain the trust of clients.

Fundraising is one of the main obstacles faced by these programmes in the beginning, because most donors do not favour interventions that require longevity and that have statistically unclear outcomes. In terms of advocacy, it is important to inform donors from both logical and emotional aspects of the a huge demand for psychological help for women sexually traumatised by war and to inform donors of how much these women are suffering from their mental symptoms. Organisations practising these psychological interventions for sexually traumatised women should provide donors as well as the public with specific information of their current activities and women's status and situation. This will help people and organisations study the various psychological practices in the Former Yugoslavia.

Many women who have been sexually abused feel extreme shame of their experiences. They tend to keep their tragedies secret because these women are

afraid of stigmatisation and discrimination by their families and communities. All the NGOs that the interviewees in this research had/have been working for their clients with considering this cultural context. It can be said that their strategies have been effective in reaching out to and providing suitable services to sexually traumatised women.

Previous studies of the treatment of sexually abused women seem to focus on how to cure raped women as victims rather than on how to empower them as civil participants. Indeed, for effective intervention, it is highly important to understand the women's trauma; however, one should not forget that these women are not just victims but are the prospective co-operators that will establish a sustainable society with men in the Former Yugoslavia. By empowering women, they can gradually build their self-esteem and finally overcome or lessen their trauma. Although it is not an easy task to empower women within their honour-centred, traditional culture, it is vital to boost their self-esteem fully enough for them to be positive about their lives. For their sustainable benefit and development, intervention programmes should focus both on treating women in cultural contexts and on providing future perspective.

## 〈Notes〉

1) In this study, the name 'Kosova' has been used instead of 'Kosovo' because the majority of Kosovar Albanian communities use this name (Corrin, 2003, p.204).
2) The researcher was a Master's student of the University of Glasgow; this paper is a revised version of the author's M.A. dissertation. Therefore, due to a permitted field work period of only two weeks, the places and the number of interviewees were limited. So as to avoid any ethical problems given the author's status as a Master's student, the author could not interview victim-survivors. The researcher has also had a more practical (NGO staff), rather than academic background, as a result of which this paper could have a somewhat journalistic style.
3) The interview took place at her office (Frankfurt, Germany) on 24 June, 2008. http://www.medicamondiale.org/en/projekte-themen/projekte/kosova/ (accessed 20 July, 2009).
4) http://www.medicamondiale.org/en/home/, (accessed 20 July, 2009).
5) The interview took place at Medica Mondiale (Cologne, Germany) on 26 June, 2008.
6) The interview took place at IRCT Zagreb (Zagreb, Croatia) on 1 July, 2008. http://irctzg.org/index.php?lang=en, (accessed 20 July, 2009).
7) The interview took place at CWWPP (Vukovar, Croatia) on 2 July, 2008. http://www.cwwpp.org/What%20and%20How-History.htm, (accessed 20 July, 2009).
8) The Former Yugoslavia is a patriarchal society; therefore children tend to belong to the male authorities.
9) http://www.womenaid.org/press/info/humanrights/warburtonfull.htm#The%20"systematic"%20nature%20of%20the%20rapes, (accessed 20 July, 2009).
10) http://www.un.org/documents/ga/res/51/ares51-115.htm, (accessed 20 July, 2009).
11) Medica Zenica, located in Bosnia-Herzegovina, reported in 1995 that nearly half of its clients had experienced this type of rape (Cockburn, 1998, p.184).
12) Amnesty International concludes that the fear of stigma and shame hinders raped victims from talking about what they have experienced and suffered (cited in Stiglmayer, 1993, p.162).
13) According to the testimonies of women victims, they were forced to urinate on the Koran, pray in the style of the Serbian Orthodox Church, drink the semen and urine of their rapists and sing and dance to Serbian songs. While the women were being raped, the rapists cursed the mothers, husbands and sons of the women. Most women were threatened with knives and beaten during the rape (Stiglmayer, 1993).
14) Convention (IV) relative to the Protection of Civilian Persons in Time of War, Geneva, 12 August,

1949, http://www.icrc.org/ihl.nsf/FULL/380?Open Document, (accessed 20 July, 2009).

15) Many babies born of rape during Bosnia's war were reportedly killed at birth. The number and the origin of those that survived are unknown. Most of these children were pushed into orphanages in Bosnia and Croatia. According to Kada Pandur, who ran one of these orphanages, she had about 700 children (mostly babies) during the years of war although the average number in pre-war times was between 150 and 170 children (ENOC, 2006). Children born of rape are a significant issue in the Former Yugoslavia in the present day; detailed research of this issue is necessary.
16) The car is not used to provide emergency treatment, but the staff of Medica Kosova call this the 'ambulance' car.
17) According to *Encyclopaedia of Rape* (2004, p.153), PTSD ' is a diagnosis used by the American Psychiatric Association (APA) to refer to an anxiety disorder that follows exposure to a traumatic event'.
18) Richters (1998) also points out that trauma in war should be treated with a broader perspective than the PTSD diagnosis (p.121-122).
19) It is impossible to figure out how many people became traumatised after the war in Vukovar because there was no empirical data, according to Dr. Tauber.
20) The NGOs that explicitly provide psychological services for sexually abused women in the Former Yugoslavia are few. According to Ms. Joachim, there were two organisations in Kosova.
21) Unlike Bosnia, where a small pension was paid to women raped during war, Kosova had no such kinds of law, according to Ms. Joachim.
22) Ms. Joachim heard that traumatised symptoms in general diminished under the observation of the counsellors.
23) According to Ms. Joachim, when raped women realise that the rape is not their fault but is a crime against women and should be treated as a crime, it helps them speak out about the rape and what it would have traditionally meant. This also helps in the understanding of the counsellors.

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## Appendix: Interviewing questions

1. Could women who had suffered trauma access any mental health services in the immediate post-conflict period?
2. What kinds of intervention programmes were provided for sexually traumatised women?
3. How did (do) your organisations support for those women?
4. How did international organisations and NGOs deal with women's multiple trauma?
5. Did NGOs international organisations, government policies help women?
6. Did your programmes work out?
7. What kinds of obstacles did you experience when practiced intervention programmes?
8. How has women' s situation of trauma changed from the immediate-post conflict periods to now?
9. What are the good practices and bad practices of intervention programmes in terms of women' s relief and sustainable benefits? Do you know any examples? If you have, could you mention it and why they are good/bad?

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