Scientific Research Publishing

Psychology, 2026, 17(1), 17-54
https://www.scirp.org/journal/psych
ISSN Online: 2152-7199
ISSN Print: 2152-7180

Dislocation of Meaning: When Psychology Becomes an Oppression—War Rape Survivors Syndrome (WRSS)

Wioletta Rebecka

Rape: A History of Shame Project (NYC), New York, USA
Email: wiolar809@gmail.com

How to cite this paper: Rebecka, W. (2026). Dislocation of Meaning: When Psychology Becomes an Oppression—War Rape Survivors Syndrome (WRSS). *Psychology, 17,* 17-54.
https://doi.org/10.4236/psych.2026.171002

Received: December 9, 2025
Accepted: January 11, 2026
Published: January 14, 2026

Abstract

This article examines the dislocation of meaning that occurs when the trauma of war rape is severed from its political, historical, and communal origins and reinterpreted through the individualizing, medicalized lens of Western psychology. Drawing on psychoanalytic theory, feminist trauma studies, decolonial epistemologies, and decades of clinical experience with survivors of conflict-related sexual violence, the article introduces War Rape Survivors Syndrome (WRSS), a conceptual framework developed to address the limitations of conventional psychiatric models—particularly Post-Traumatic Stress Disorder (PTSD)—in capturing the lived, embodied, and intergenerational consequences of genocidal rape. WRSS challenges the epistemic violence of pathologizing survivor responses while ignoring militarized, patriarchal, and colonial structures that weaponize women's bodies and silence their testimonies. The article begins by interrogating the psychological erasure produced when survivors are compelled to translate their suffering into Eurocentric diagnostic codes. It then situates WRSS within a wide theoretical lineage, including Ferenczi, Herman, Laub, Hirsch, Erikson, Danieli, Fanon, Spivak, and Indigenous healing systems. A detailed description of the defining features of WRSS follows, encompassing fragmented memory, embodied shame, collapse of bodily boundaries, narrative foreclosure, attachment rupture, and transgenerational transmission. The clinical and psychotherapeutic implications of WRSS are then explored, with an emphasis on decolonial practice, radical safety, body-based healing, and culturally grounded witnessing. Finally, the article argues for an integrated medical, legal, psychological, and social response to WRSS, conceptualizing it not as a pathology but as a political indictment and a call to ethical solidarity.

Keywords

War Rape, Dislocation of Meaning, Trauma, War Rape Survivors Syndrome (WRSS), Decolonial Psychology, Epistemic Violence, Transgenerational Trauma, Feminist Trauma Theory, Witnessing, Militarized Sexual Violence, Clinical Practice, Patriarchal Structures, Genocide, Narrative Foreclosure

1. Introduction

The dislocation of meaning is not a metaphor. It is a wound. It names the moment when the original context of violence is stripped from the survivor's story and her suffering is reinterpreted through a lens that erases the historical, political, and relational dimensions of the trauma she endured. For survivors of war rape, this dislocation is not merely intellectual or diagnostic. It is felt somatically, lived interpersonally, and endured across generations. It resides in the rupture of narrative, in the intergenerational silences that form after atrocity, and in institutional failures that should have protected, believed, and honored survivors but instead rendered pathological subjects.

Dislocation of meaning is the severing of trauma from its source; a process whereby structural or state-inflicted violence is repackaged as a private psychological disorder. A politically orchestrated violation becomes a clinical symptom; a collective wound becomes an individual problem. The survivor is then required to carry not only the trauma but also the misinterpretation of that trauma. They must speak in diagnostic codes, express their suffering in the language of cognitive dysfunction or affect dysregulation, and make themselves legible to a psychotherapeutic system that was never designed to comprehend the geopolitical horror inscribed in their bodies.

This dislocation is particularly acute in cases of militarized sexual violence, occupation, ethnic cleansing, or genocide. War rape is not an interpersonal act of cruelty; it is a strategic weapon. It is used to destroy kinship, fracture communities, enforce ethnic domination, and rupture generational continuity. When this is later described merely as a "traumatic event" leading to symptoms of PTSD, the violence is not only misrepresented—it is erased. The political strategy underlying the rape disappears; the survivor becomes a patient rather than a witness to history.

Herman's (1992) analysis of trauma as a disruption of narrative coherence offers a crucial starting point; yet, the dislocation of meaning extends further. It names not just disruption but replacement: the substitution of political truth with medical vocabulary; the translation of atrocity into disorder; the pathologizing of historically coherent responses to collective betrayal. This substitution constitutes a form of epistemic violence, echoing the critiques of Gayatri Spivak and Veena Das, in which dominant knowledge systems overwrite survivors' lived truths with categories that preserve institutional control and professional authority.

Within this context, PTSD becomes not merely a diagnosis but an act of mistranslation. It allows societies, legal systems, and humanitarian agencies to acknowledge trauma while ignoring the structures that produced it. The therapeutic encounter becomes a space of containment rather than liberation, a site where survivors regulate their nervous systems but rarely speak the truths that remain politically or culturally forbidden.

War Rape Survivors Syndrome (WRSS) responds directly to this dislocation. Developed through years of clinical work with survivors of genocidal rape across continents—including Holocaust survivors and women violated during conflicts in Rwanda, Bosnia, the Democratic Republic of the Congo, Kosovo, and Ukraine—WRSS re-situates trauma within the historical, relational, and intergenerational landscape from which it emerges. It restores meaning to survivor responses that psychiatry has too often pathologized, reframing dissociation, rage, infertility trauma, attachment rupture, and narrative silence as adaptive, coherent testimonies of structural betrayal rather than symptoms of internal dysfunction.

While this article centers women's experiences of war rape in recognition of the structurally gendered nature of sexual violence under patriarchal militarism, it is essential to acknowledge that men and boys are also targeted by conflict-related sexual violence; however, the meanings, silencing mechanisms, and social consequences of such violations remain profoundly shaped by gendered power relations, stigma, and militarized constructions of masculinity and honor (Ní Aoláin, 2014b; Carpenter, 2006; Boesten, 2017b).

The purpose of this article is to examine the theoretical foundations, clinical implications, and ethical significance of WRSS as a trauma-specific framework. By restoring meaning to survivor experiences and challenging the medicalized erasure of political violence, WRSS aims to shift trauma work from individual symptom management to collective witnessing, narrative sovereignty, and historical accountability. Through a multidisciplinary and decolonial lens, this article argues that healing from war rape cannot occur within frameworks that depoliticize suffering. Instead, it requires an approach that addresses trauma as a living archive of historical violence, a relational disruption etched across generations, and an ethical summons to confront the systems that produced it.

2. Theoretical Framework

The theoretical framework of War Rape Survivors Syndrome (WRSS) is grounded in a sustained interrogation of epistemic violence and colonial psychology. It argues that dominant Western paradigms used to conceptualize, classify, and treat trauma function not merely as clinical instruments but as mechanisms of symbolic domination that erase, distort, or pathologize the lived realities of survivors of war rape. While this article offers a critical examination of Post-Traumatic Stress Disorder (PTSD) as an individualizing and depoliticizing framework, it is essential to clarify that WRSS explicitly acknowledges and builds upon the conceptual advances introduced by Complex Post-Traumatic Stress Disorder (C-PTSD). The emergence

of C-PTSD within feminist and relational trauma scholarship marked a crucial shift away from single-event models toward recognition of prolonged, interpersonal, and captivity-based trauma, including chronic violations of safety, attachment, and identity (Herman, 1992; Cloitre et al., 2013).

WRSS incorporates these advances while extending beyond C-PTSD in decisive and necessary ways. Whereas PTSD and C-PTSD primarily orient the clinical gaze toward symptom constellations and psychological injury as they manifest within the individual—such as intrusion, avoidance, affect dysregulation, and hyperarousal—WRSS is formulated as a political, historical, and intergenerational framework specifically attuned to weaponized sexual violence in contexts of war, genocide, and military occupation. Rather than locating trauma exclusively within the psyche or nervous system, WRSS foregrounds the multilayered sources of suffering and the dynamic interactions among bodily injury, political betrayal, social exclusion, legal abandonment, lineage rupture, and epistemic silencing. In contrast to Western biomedical models that conceptualize trauma as an internal disorder, WRSS aligns more closely with Indigenous and relational epistemologies in which suffering is understood as a disruption of relationships, moral order, communal continuity, and historical meaning. Within these traditions, healing is not primarily conceived as individual symptom reduction, but as a collective and relational process involving recognition, witnessing, restoration of dignity, and the repair of social and moral bonds.

By explicitly interrogating the epistemic conditions under which survivor suffering is interpreted, WRSS exposes how diagnostic frameworks—even relational and feminist ones—can reproduce silencing when trauma is severed from its militarized, patriarchal, and colonial origins. In this sense, WRSS absorbs the relational and developmental contributions of C-PTSD while refusing its depoliticization, repositioning survivor responses not as indicators of internal disorder but as coherent testimonies to historically orchestrated violence and its unresolved aftermath (Herman, 1992; Cloitre et al., 2013; Summerfield, 1999; Spivak, 1988).

Epistemic violence, first articulated by Spivak (1988), refers to the ways dominant knowledge systems silence subaltern voices by imposing interpretive frameworks that erase lived standpoints, restrict the capacity of marginalized subjects to produce legitimate knowledge about their suffering, and convert embodied and historical realities into categories legible only to the colonial gaze. This form of violence is deeply embedded in Western psychology, whose universalizing assumptions consistently disregard the political, cultural, and genealogical contexts from which traumatic experiences emerge. Fanon's (2008) critique of colonial psychiatry made this dynamic explicit, exposing how psychological systems—presented as objective and neutral science—are complicit in reproducing colonial hierarchies by diagnosing the colonized subject as inherently disordered while failing to acknowledge the structural violence that produces psychological distress.

In the context of war rape, this epistemic structure becomes particularly perni-

cious. The survivor's body—violated for political, ethnic, or militarized purposes—is subsequently reinterpreted through an individualized clinical lens, where trauma is defined not by the political intent of the perpetrator but by the symptomatic residue observed in the nervous system. As Summerfield (1999) argues, the globalization of trauma discourse universalizes Western assumptions about mind, memory, affect, and recovery, imposing an ahistorical interpretive template onto populations whose suffering emerges from collective, state-orchestrated violence. This universalism is not neutral; it functions as epistemic colonization, replacing communal, spiritual, ancestral, and political meanings of violence with clinical taxonomies developed in the Global North and exported as universal truths.

Colonial psychology, as Ndlovu-Gatsheni (2021) explains, operates through the logic of the "epistemic empire", in which Western modes of knowing become the standard against which all other epistemologies are measured, rendering Indigenous, feminist, and survivor-generated frameworks inferior or illegitimate. Within this colonial matrix of power, trauma becomes individualized, depoliticized, and privatized—a dislocation of meaning that WRSS identifies as central to survivor suffering.

This dislocation begins when survivors are compelled to translate experiences rooted in genocide, militarized patriarchy, ethnic domination, and the destruction of kinship into biomedical categories that insist trauma resides within the individual rather than within the political world that produced it. As Herman (1992) observes, trauma is always political before it becomes clinical, yet psychiatric systems reverse this sequence, treating trauma as an internal malfunction requiring correction. WRSS challenges this reversal by situating war rape first and foremost as a political act: a weapon aimed at destroying lineage, cultural identity, fertility, communal cohesion, and intergenerational continuity.

When the violence of war rape is medicalized, its political meaning collapses. As Boesten (2017b) demonstrates, sexual violence in war functions as a gendered technology of power designed to humiliate, dominate, and fracture communities, yet clinical discourse reduces these acts to discrete "events" that produce symptoms. In doing so, Western psychology not only misrepresents the nature of the violence but actively participates in its aftermath by translating structural harm into personal pathology. This constitutes epistemic violence in its most insidious form: the transformation of a collective political crime into an individualized psychological disorder. The survivor's suffering becomes evidence of her damaged psyche rather than evidence of state, military, or militia atrocity. In this epistemic transformation, the survivor is silenced again—not through physical force, but through conceptual containment.

Decolonial psychology, as articulated by scholars such as Smith (2012), Gone (2019), and Maldonado-Torres (2007), offers a counter-framework that understands trauma not as an ahistorical, neurobiological reaction, but as a phenomenon embedded within histories of coloniality, cultural disruption, and systemic violence. Decolonial approaches reject the universality of Western categories and

instead prioritize relational, ancestral, communal, and land-based forms of knowing. WRSS aligns with this perspective by refusing the hegemonic assumption that Western clinical models provide the most accurate or ethical understanding of suffering. Instead, WRSS foregrounds how colonial histories shape the aftermath of violence: across Rwanda, the Democratic Republic of the Congo, Bosnia, Kosovo, and Ukraine, survivors' narratives consistently reveal that trauma is experienced not only as bodily violation but as genealogical rupture, spiritual contamination, and communal betrayal—dimensions that Western psychology is structurally ill-equipped to recognize.

Indigenous epistemologies, including Takini (Broken and Standing Again) among the Lakota, Ubuntu in many African traditions, and ritualized cleansing and ancestral witnessing practices in Congolese and Rwandan cosmologies, conceptualize trauma as a disruption of relational and cosmological order rather than as a malfunction of the brain or psyche. This contrast exposes how Western psychology participates in epistemic extractives: the appropriation of survivor experience into diagnostic categories that erase survivors' own ontologies. As Dudgeon (2020) argues, colonial mental health frameworks pathologize Indigenous responses to colonial harm—a dynamic mirrored in the pathologizing of survivors' responses to war rape when political context is ignored.

The epistemic violence of Western trauma theory is further reinforced through its reliance on neuroscientific reductionism. While neuroscience has generated valuable insights into the bodily effects of trauma, its epistemic dominance creates hierarchies of legitimacy in which biological explanations overshadow cultural, historical, and political interpretations (Rose, 2013). This becomes especially problematic when neurobiological concepts such as hyperarousal, amygdala reactivity, or HPA-axis dysregulation are treated as universal markers of trauma, erasing cultural variability in how suffering is expressed, interpreted, and healed. Fanon (2008) warned that the colonizing gaze reduces the colonized body to an object of medical scrutiny, stripping it of political meaning. This dynamic is reproduced when survivors of war rape are studied through imaging technologies that capture neural activation while ignoring the geopolitical catastrophe that produced the injury.

WRSS does not reject neuroscience; rather, it situates it as one epistemic layer among many, refusing to allow biological explanations to eclipse relational, ancestral, spiritual, and political dimensions of trauma. As Kohrt et al. (2014) argue, culturally responsive trauma models must integrate multiple ways of knowing without subordinating Indigenous or communal knowledge systems to biomedical authority.

Epistemic violence also manifests through what Freyd (1996) terms "betrayal blindness", whereby societies, institutions, and families refuse to acknowledge sexual violence because recognition would expose complicity, moral failure, or political responsibility. This sociopolitical silencing becomes internalized by survivors, who learn that their suffering is either unspeakable or unworthy of witness.

When the only available language for articulating their experience is the clinical vocabulary of PTSD, survivors are forced into an epistemic trap: they must describe their pain in terms of symptoms rather than political betrayal, ethnic terror, intergenerational rupture, or communal collapse. WRSS argues that this forced translation constitutes a further act of violence because it denies survivors the right to define their own reality.

As Brison (2002) emphasizes, trauma narratives require a listener capable of recognizing their moral meaning; without such recognition, survivors experience not only fragmentation but epistemic invalidation. Western psychology, when it ignores the structural nature of war rape, becomes a listener who cannot hear.

Colonial psychology further reinforces this invalidation by privileging Eurocentric values of individualism, autonomy, and verbal self-expression—values that conflict with communal, ritualized, embodied, and intergenerational modes of healing prevalent in many post-conflict societies. In parts of the DRC and Uganda, for example, healing practices involve communal witnessing, ancestral invocation, symbolic purification, and relational reweaving rather than linear verbal processing (Amone-P'Olak, 2007). When humanitarian interventions insist that survivors must narrate their trauma in order to heal, they impose culturally inappropriate and epistemically violent expectations that may retraumatize women whose traditions rely on silence, song, or ritual as legitimate forms of integration.

Moreover, institutional demands for narrative coherence—everyday in both clinical and legal settings—contradict extensive research demonstrating that traumatic memories are often fragmented, sensory, and nonlinear (Brewin, 2014; van der Kolk, 2014). Yet fragmented testimony is frequently interpreted as inconsistency rather than as the embodied imprint of terror and political violence. This misinterpretation constitutes another layer of colonial control: survivors are deemed credible only when they conform to Western narrative norms.

Thus, the theoretical framework of WRSS demonstrates that epistemic violence operates across multiple levels: through diagnostic categories that privatize political suffering; through clinical practices that impose universalized models of healing; through legal systems that demand linear testimony; through neuroscientific frameworks that eclipse cultural meaning; and through humanitarian discourses that normalize Western affective norms. WRSS positions itself as a decolonial counter-framework that resists these epistemic hierarchies by restoring war rape to its political, relational, spiritual, and intergenerational contexts. It insists that survivors are not disordered individuals but witnesses to historical crimes; that their bodies carry not pathology but testimony; and that healing must occur not only within individuals but within the disrupted moral, cultural, and genealogical worlds to which they belong. By rejecting the coloniality of Western psychology and foregrounding survivor epistemologies, WRSS transforms trauma from a clinical symptom into a political narrative, an ethical summons, and an act of re-

sistance against the militarized, patriarchal, and colonial systems that seek to silence it.

3. Methodology

The development of War Rape Survivors Syndrome (WRSS) is grounded in a multi-layered, practice-based methodology that emerges directly from decades of clinical work, long-term observation, and sustained engagement with survivors of conflict-related sexual violence across diverse geopolitical, cultural, and historical contexts. Rather than originating in abstract theorization or isolated clinical trials, WRSS was formed through continuous, relational witnessing within therapeutic spaces, refugee encampments, community-based interventions, transitional justice processes, and intergenerational family systems shaped by war, genocide, and state violence. This methodology reflects the lived complexities of survivors' experiences. It honors their epistemologies as legitimate forms of knowledge production—an approach consistent with feminist, decolonial, and Indigenous methodologies that privilege experiential and embodied testimony over detached empiricism (Smith, 2012, 2021). The methodological foundations of WRSS are therefore inherently transnational and ecologically embedded, shaped by encounters with Holocaust families in Poland; women raped during the Rwandan genocide; survivors of ethnic cleansing in Bosnia and Kosovo; mothers, grandmothers, and descendants of war rape in the Democratic Republic of the Congo; Mayan women in Guatemala; survivors of sexualized torture in Ukraine; and refugee women from Colombia, Afghanistan, and South Sudan. These engagements took place in a wide range of contexts—rural villages, shelters, humanitarian programs, informal camps, psychiatric units, legal hearings, and diasporic communities—each providing distinct insights into how war rape is remembered, embodied, silenced, transmitted, and resisted.

Central to this methodology is the clinical stance of witnessing, understood not as a passive act of listening but as a relational, ethical, and politically engaged practice in which the clinician becomes a co-witness to histories that exceed individual narrative capacity (Laub, 1992; Herman, 1992). The data informing WRSS were not extracted from survivors through structured interviews or research protocols. However, they were entrusted with therapeutic encounters, community dialogues, trauma-informed trainings, and long-term relational work. Survivors disclosed their experiences spontaneously—often after years or decades of silence—and always within environments oriented toward radical safety, cultural responsiveness, and non-extractive ethics (Gone, 2019). These disclosures included not only verbal testimony but also narrative fragments, somatic signals, dissociative states, relational patterns, and atmospheres of fear or shame that accumulated over time to form a longitudinal clinical archive. This archive revealed recurring relational and embodied patterns across continents, ethnic groups, and historical periods, allowing WRSS to identify a transnational trauma architecture that is unique to wartime sexual violence and insufficiently captured by standardized

Western diagnostic categories (Summerfield, 1999; Becker, 2004).

The analytic process shaping WRSS is best described as an iterative interpretive synthesis that draws on grounded theory (Charmaz, 2014), trauma-informed clinical observation (van der Kolk, 2014), feminist methodology (Brison, 2002), psychoanalytic listening (Ferenczi, 1933, 1988), and decolonial critique (Mignolo, 2011). Each clinical encounter served as a site of mutual meaning-making, where survivors' embodied responses, relational dynamics, and disrupted narratives were explored within their sociopolitical and cultural context. Over years of practice, specific constellations of symptoms emerged repeatedly across settings: fragmented memory, embodied shame, collapse of bodily boundaries, trauma-linked infertility distress, narrative foreclosure, attachment rupture, and transgenerational silence. These patterns, appearing consistently in Rwanda, Bosnia, the DRC, Poland, and Ukraine, indicated the presence of a shared syndrome structure that transcended geographical boundaries while remaining deeply rooted in the political intent of war rape as a weapon of domination, humiliation, shame, blame, loneliness, and ethnic destruction (Boesten, 2017a; Ní Aoláin, 2014a).

Crucially, observation extended well beyond verbal testimony. The methodology treated survivors' bodies as archives of memory, recognizing that trauma is often encoded somatically and nonverbally, particularly when silence is enforced through stigma, fear, religious condemnation, or political repression (van der Kolk, 2014; Bloom, 2013). Clinical attention was given to survivors' postures, breathing patterns, dissociative absences, autonomic dysregulation, shifts in voice, startle responses, and moments of freezing—responses consistent with trauma neuroscience yet also culturally shaped expressions of moral injury, ancestral rupture, or spiritual contamination. In many contexts, survivors' bodily expressions communicated truths that language could not safely hold. This somatic emphasis aligns with contemporary research showing that trauma memories often emerge as sensory fragments rather than coherent narratives (Brewin, 2014; Lanius et al., 2010b). In the WRSS methodology, these embodied expressions were interpreted not merely as symptoms but as culturally meaningful signals, relational communications, and sites of historical testimony.

Intergenerational observation constituted a further essential layer of the WRSS methodology. Therapeutic work with second- and third-generation descendants of survivors of the Holocaust, the Rwandan genocide, the Bosnian war, the Syrian and Iraqi conflicts, and Congolese mass rape revealed consistent patterns of emotional inheritance, attachment disruption, and identity confusion (Danieli, 1998; Yehuda & Lehrner, 2018). These descendants often carried somatic burdens or relational anxieties that reflected unspoken family histories of sexual violence. Their narratives offered crucial evidence of trauma transmission occurring through attachment pathways, atmospheric silence, shame-based communication, and embodied repetition. The presence of inherited fear, secrecy, and bodily tension—despite the absence of explicit knowledge of the original violence—confirmed that war rape produces not only individual trauma but intergenerational relational in-

jury, a core insight underlying WRSS (Hirsch, 2012; Sotero, 2006). This intergenerational lens is also consistent with emerging epigenetic research, which shows that trauma-related biological alterations can persist across generations (Yehuda et al., 2005; Perroud et al., 2014). However, WRSS emphasizes that such inheritance is always simultaneously relational, cultural, and political.

A decolonial orientation anchors all methodological dimensions of WRSS. Survivors' cultural frameworks, spiritual practices, cosmologies, and communal healing rituals were treated as equally valid—indeed, often superior—to Western psychotherapeutic models in interpreting trauma responses. Ritual knowledge from Congolese, Rwandan, Ugandan, Andean, and Mayan traditions provided conceptual resources for understanding trauma as a disturbance of moral, ancestral, and ecological order rather than as an isolated psychological injury (Amone-P'Olak, 2007; Kohrt & Hinton, 2019). Healing practices such as gacaca truth-telling in Rwanda, Acholi reconciliation rituals in Uganda, and communal mourning rites in DRC communities were integrated into the methodological interpretation of how survivors frame suffering and seek restoration. Rather than impose Eurocentric assumptions about memory, disclosure, or emotional processing, the methodology privileged survivors' own interpretive frameworks, ensuring that WRSS emerged from their epistemologies rather than from imported clinical theory (Smith, 2021). This decolonial approach also entailed rejecting extractive research methodologies, as traditional Western research often reproduces colonial hierarchies by extracting stories from survivors for academic purposes without contributing to their healing or agency (Maldonado-Torres, 2007).

Ethical considerations were foundational throughout the development of WRSS. No testimonies were solicited for this research; all narratives emerged organically through therapeutic or community support contexts, grounded in confidentiality, relational trust, and the principles of trauma-informed care. Survivors' identities were protected, and their stories were used only to illuminate collective patterns rather than to expose individual trauma histories. This ethical stance aligns with feminist critiques of extractive research, emphasizing relational accountability, respect, and the non-instrumentalization of survivor narratives (Hesse-Biber, 2014). The methodology refused to replicate the epistemic violence survivors had already experienced through medicalization, legal silencing, humanitarian voyeurism, and patriarchal stigma. Instead, it centered survivors as knowledge-holders whose embodied and relational insights form the empirical core of WRSS.

In sum, the methodology underlying WRSS is a cumulative, relational, and practice-based archive of survivor knowledge. It emerges from decades of transnational clinical engagement with individuals, families, and communities across conflict zones; from sustained observation of embodied expressions of trauma; from longitudinal witnessing of intergenerational dynamics; and from deep listening to Indigenous and culturally grounded epistemologies of suffering and healing. WRSS is therefore not a theoretical abstraction nor a top-down clinical model. However, a framework born from the lived realities of survivors whose bodies, silences, re-

lationships, and transgenerational legacies reveal the enduring political, relational, and cosmological wounds of wartime sexual violence. By rooting methodology in survivor experience rather than Western diagnostic systems, WRSS embodies a decolonial commitment to honoring survivors' epistemic sovereignty and restoring meaning where violence attempted to erase it.

4. WRSS Model—War Rape Survivors Syndrome

The term *syndrome* is etymologically instructive for understanding its deliberate use in War Rape Survivors Syndrome (WRSS). Derived from the Greek *syndromē*—from *syn* (together) and *dromos* (running)—the term initially referred to phenomena that "run together", designating a convergence of experiences rather than a discrete disease entity (Oxford University Press, n.d.; Klein, 1971). Historically, *the syndrome functioned as a descriptive and classificatory concept*, *naming recurring patterns observed across cases without presuming a singular cause*, *fixed pathology*, *or internal defect*; *it only later acquired* pathologizing connotations through its incorporation into biomedical and psychiatric taxonomies (Klein, 1971). WRSS deliberately returns to this earlier etymological and conceptual meaning by employing *syndrome* to name a patterned constellation of psychological, somatic, relational, legal, and political consequences that co-occur in the aftermath of wartime sexual violence, without locating the source of harm within the survivor.

While this article offers a sustained critique of Post-Traumatic Stress Disorder (PTSD) as an individualizing and depoliticizing framework, it simultaneously acknowledges the conceptual advances introduced by Complex Post-Traumatic Stress Disorder (C-PTSD), particularly its feminist and relational recognition of prolonged, interpersonal, and captivity-based trauma involving chronic violations of safety, attachment, and identity (Herman, 1992; Cloitre et al., 2013). WRSS builds upon these insights while extending beyond C-PTSD in decisive ways. Whereas C-PTSD remains a clinical diagnostic construct centered on psychological injury located within the individual, WRSS is formulated as a political, historical, and intergenerational framework specifically attuned to weaponized sexual violence in contexts of war, genocide, and occupation. In contrast to C-PTSD's emphasis on affect regulation, self-concept, and relational disturbance, WRSS foregrounds political betrayal, lineage rupture, and the collapse of communal and epistemic meaning as constitutive dimensions of survivor experience. By explicitly interrogating the epistemic conditions under which trauma is interpreted, WRSS exposes how diagnostic frameworks—even relational ones—can reproduce silencing when they sever suffering from its militarized, patriarchal, and colonial origins (Summerfield, 1999; Spivak, 1988). In this sense, WRSS absorbs the relational and developmental insights of C-PTSD while refusing its depoliticization, repositioning survivor responses not as indicators of internal disorder but as coherent testimonies to historically orchestrated violence and its unresolved aftermath (Herman, 1992; Cloitre et al., 2013; Summerfield, 1999).

The theoretical foundation of War Rape Survivors Syndrome begins with the recognition that conventional trauma-informed therapy—though often grounded in compassion—systematically fails survivors of conflict-related sexual violence by severing their suffering from its political, historical, and collective origins (Bracken et al., 1997; Summerfield, 1999). For women violated during war, occupation, ethnic cleansing, or state-orchestrated terror, rape is not merely a personal violation; it is a weapon designed to rupture the fabric of community, lineage, identity, and belonging (Boesten, 2017a). Yet mainstream clinical discourse persistently relocates this violence into the interior life of the survivor, converting a political atrocity into a psychological disorder. In doing so, it reproduces what Fanon (1963) identified as the colonial logic of psychiatry: a system that seeks to "treat" the oppressed while leaving intact the structures that produced their suffering.

The medicalization of survivors' pain through the category of PTSD epitomizes this displacement. PTSD offers a language in which experiences are rendered as clusters of symptoms—intrusions, avoidance, hyperarousal—while the geopolitical, gendered, and militarized forces that orchestrated the violence disappear from view (Summerfield, 1999). The survivor becomes the site of pathology rather than the world that betrayed her. The ethnic logic of genocide, the command structures that weaponized rape, the religious or familial abandonment, and the failures of transitional justice remain absent from the diagnosis. WRSS identifies this process as a dislocation of meaning: the severing of pain from its historical context and the stripping away of testimony from the political event it narrates (Spivak, 1988).

WRSS argues that this dislocation is not incidental but foundational to dominant trauma discourse, which preserves social and political stability by relocating harm within the survivor rather than within institutions, ideologies, and power structures (Summerfield, 1999). Trauma can thus be acknowledged without necessarily leading to accountability. Survivors are "treated", while the social order remains untouched. In practice, this leaves many survivors feeling misunderstood, not because they resist therapy, but because therapy often fails to accommodate the magnitude and moral meaning of their injury (Bracken et al., 1997). Many reject the PTSD label not out of denial but out of precision: it does not describe their lived reality.

WRSS emerges as a corrective to this epistemic misrecognition. Developed through decades of transnational clinical work, WRSS reframes survivor responses not as symptoms of internal malfunction but as coherent embodiments of political betrayal. Dissociation, rage, infertility, grief, attachment ruptures, somatic freezing, and narrative silence are understood not as failures of regulation but as intelligible responses to a world that remains unsafe, unjust, and unrepaired (Herman, 1992; Brison, 2002). WRSS thus repositions the survivor's body as a living archive—a repository of memory, permeability, and testimony that carries the imprint of interpersonal violation, state violence, and collective denial (Brison, 2002).

Where PTSD asks what is wrong inside the person, WRSS asks what was done to her, by whom, and who benefits from her silence (Spivak, 1988). Where PTSD centers pathology, WRSS centers meaning. Where PTSD seeks symptom reduction, WRSS seeks narrative sovereignty (Brison, 2002). Where PTSD interprets distress as internal dysfunction, WRSS interprets it as political testimony. Where therapy seeks closure, WRSS recognizes that trauma rooted in genocide, exile, and betrayal often remains structurally open-ended (Herman, 1992; Volkan, 2001).

Across Rwanda, Bosnia, the Democratic Republic of the Congo, Kosovo, Ukraine, and among Holocaust-descendant families in Poland, WRSS identifies a recurring constellation of features derived not from biomedical taxonomies but from clinical witnessing, relational engagement, and survivors' own meaning-making. Traumatic memory is frequently retained in sensory fragments, somatic states, or relational atmospheres rather than in coherent narrative form, reflecting both neurobiological imprinting and the political impossibility of speaking in contexts where rape is bound to ethnic shame, familial fear, or communal denial (Brewin, 2014; Herman, 1992). Survivors often describe embodied shame and a collapse of bodily boundaries—experiences shaped by both trauma physiology and cultural narratives of purity, pollution, and honor (Scheff, 1994; Boesten, 2017b). Infertility trauma and lineage rupture emerge repeatedly, whether as direct biological consequences of sexual violence or as symbolic wounds to generational continuity (Volkan, 2001). Silence appears not as avoidance but as enforced irrepresentability, produced by social conditions that cannot or will not hear (Freyd, 1996; Herman, 1992). Altered attachment patterns and relational withdrawal emerge as coherent adaptations to environments in which safety was systematically dismantled (Herman, 1992).

A central contribution of WRSS is its explicit incorporation of transgenerational dynamics. WRSS argues that war rape is never confined to the individual survivor; its effects reverberate across generations through biological, relational, emotional, and cultural pathways (Volkan, 2001; Hirsch, 2012). Emerging research demonstrates that severe trauma can alter stress-response systems in inheritable ways, producing epigenetic echoes of violence (Yehuda & Lehrner, 2018). WRSS integrates this evidence while rejecting biological determinism. Epigenetics is not destiny; it is one layer within a broader relational and historical story.

Equally powerful is the transmission of trauma through silence as atmosphere. Children raised in such environments become attuned to the unspoken—the tightening of a parent's body, the sudden withdrawal, the silence surrounding certain names or places. These micro-signals form an internal map of reality, teaching that danger is omnipresent even when unnamed (Abraham & Torok, 1994). Without narrative, children often fill the gaps with self-blame, carrying grief without origin and fear without object. This is trauma as atmosphere—dense, pervasive, and inherited (Volkan, 2001).

Attachment pathways in these contexts are frequently marked by fear, ambiva-

lence, and deeply embodied hatred. Survivors may parent with hypervigilance, emotional withdrawal, or intrusive worry—coherent protective responses shaped by histories of violation and betrayal (Herman, 1992). Within WRSS, hatred is not conceptualized as pathology but as a survival affect, emerging where overwhelming harm remains socially and politically unrepaired (Scheff, 1994). Children absorb this hatred not as ideology but as relational information, learning preverbally that intimacy must coexist with vigilance. Over time, this emotional template shapes one's identity, sense of belonging, and moral orientation (Volkan, 2001).

Where war rape is publicly denied or culturally despised, descendants inherit not only silence but the moral weight of that silence. Identity forms around absences—around what is felt but never named—producing fractured belonging and ethical confusion (Hirsch, 2012). Entire communities carry collective wounds that become transgenerational cultural scripts, assigning meaning to suffering, silence, and survival (Volkan, 2001). WRSS synthesizes these mechanisms to argue that transgenerational trauma is neither merely biological nor merely relational; it is historical and political, preserved in bodies, families, silences, memory politics, and social structures.

WRSS explicitly positions itself as a decolonial framework that resists epistemic universalism and the extraction of survivor experience into unexamined clinical categories. It integrates neurobiological knowledge as one explanatory layer, situating bodily processes within relational, historical, ancestral, and political contexts, and refusing any hierarchy that would privilege biomedical interpretation over survivor meaning-making. Rather than borrowing dominant trauma terminology uncritically, WRSS reinterprets experiences commonly labeled as hyperarousal, dissociation, or intrusion as forms of embodied and relational intelligence shaped by conditions of militarized violence, social abandonment, and unresolved injustice. Indigenous cosmologies referenced within the framework—such as Ubuntu and Lakota concepts of relational rupture and restoration—are treated as sovereign epistemologies rather than illustrative metaphors, informing WRSS's understanding of trauma as a disruption of moral and communal order rather than individual dysfunction. In this way, WRSS synthesizes biological, psychological, social, and ancestral dimensions into a coherent model that restores meaning to survivor responses without collapsing them into pathology, affirming trauma as testimony to structural violence rather than evidence of internal disorder.

WRSS is not a diagnostic category but an ethical and political framework for understanding the lived consequences of war rape. It restores meaning where dominant psychological discourse erases it. It reframes suffering as testimony. It repositions survivors not as patients to be stabilized but as witnesses whose bodies carry the moral record of a world that failed them. By integrating defining features and transgenerational dynamics, WRSS offers a model that is clinically attuned, relationally grounded, historically situated, and decolonial aligned—one in which

healing begins not with symptom management, but with truth, recognition, and collective accountability.

5. Neurobiology and Sociopolitical Meaning of Collapse

Violent war rape is never a discrete incident contained in time; it is an overwhelming neurobiological rupture and an existential shattering of the survivor's relationship to body, world, and meaning. Contemporary neuroscience confirms that sexual violence committed within warfare triggers some of the most extreme survival responses documented in trauma research (van der Kolk, 2014). During wartime rape—especially when enacted through collective assault, sexualized torture, weapons, captivity, or the witnessing of family members being harmed—the brain responds before conscious perception forms. Primitive survival circuits mobilize within milliseconds, shutting down reflective thinking, language, and symbolic interpretation (Arnsten, 2009). War rape is therefore not only a violation of the body but an involuntary neurological takeover, during which the survivor's cognitive architecture collapses into a state of pure survival. The brain's priorities shift away from meaning-making toward immediate preservation, rendering the event unspeakable not because of weakness but because language itself is neurologically disabled during extreme threat.

When the perpetrator communicates annihilator intent—through political slogans, ethnic slurs, humiliation, or threats of execution—the amygdala registers the assault not only as physical danger but as existential obliteration. This produces a surge of adrenaline and norepinephrine, redirecting blood flow to major muscle groups, while simultaneously deactivating the prefrontal cortex, the neural center responsible for language, planning, judgment, and narrative integration (Arnsten, 2009). In such conditions, memory cannot be encoded as a coherent narrative; instead, it becomes stored in sensory fragments—sounds, smells, flashes of imagery, muscular tension, or states of freezing—consistent with dual-representation models of trauma memory (Brewin, 2014). The survivor's body thus becomes the primary archive of the event, holding what the mind is neurologically incapable of symbolizing.

Polyvagal theory deepens this understanding by explaining why so many survivors experience freezing, tonic immobility, dissociation, or collapse during war rape (Porges & Dana, 2023). These responses are not chosen, but are neurobiologically mandated strategies that have been embedded in evolution. Tonic immobility—a temporary paralysis mediated by the periaqueductal gray—is documented in up to 70% of rape survivors (Möller et al., 2017). In war contexts, where the perpetrator holds absolute power and often uses torture to enforce submission, such protective immobilization becomes even more pronounced. Dissociation, frequently misunderstood as emotional absence, is in fact a neurobiological analgesic, an emergency strategy activated when overwhelm exceeds the body's capacity to contain pain or terror. War-rape survivors often describe "floating away", "leaving the body", or feeling as if time stopped—experiences rooted in the dorsal

vagal shutdown response, which numbs sensation to preserve life.

After the assault, the neurobiological aftermath does not subside simply because the event has ended. Chronic dysregulation of the Hypothalamic-Pituitary-Adrenal (HPA) axis leads to long-term alterations in cortisol rhythms, immune function, inflammation, metabolic stability, and autonomic regulation (Yehuda & Bierer, 2009). Survivors commonly develop chronic pelvic pain, migraines, gastrointestinal disturbances, dyspareunia, and cardiovascular instability—conditions linked to sustained trauma-related activation and dysautonomia (Silove et al., 2017). These manifestations are not secondary or psychosomatic; they are the body's ongoing attempt to metabolize an uncontained terror. In WRSS, such symptoms are reinterpreted as somatic testimonies—neurobiological inscriptions of an existential violation that has not yet found social, political, or relational recognition.

The neurobiology of subsequent trauma intensifies this dynamic. When another threat occurs—whether domestic violence, displacement, imprisonment, witnessing new atrocities, or enduring institutional betrayal—the nervous system does not evaluate the danger as new. Instead, it reactivates the original survival circuitry. The amygdala, hyper-sensitized by the initial assault, fires rapidly, reinstating the bodily state of the original violation. Heart rate surges, breath shortens, vision narrows, dissociation returns, and muscular tension mirrors the posture of the initial trauma (Lanius et al., 2010a). Survivors often describe feeling "back in the room". However, neuroscience shows that this is not a metaphor: the subcortical networks implicated in the original trauma become re-engaged, producing a complete psychophysiological reenactment.

For survivors of war rape, subsequent traumas carry a unique moral and existential valence. They confirm not merely that danger persists but that *the world remains organized in hostility toward them*. This is especially devastating in contexts where survivors encounter stigma, disbelief, religious condemnation, or legal indifference. Each institutional failure is encoded as a continuation of the original violation, reinforcing neurobiological patterns of collapse and hypervigilance. Yehuda's research on allostatic load indicates that repeated trauma reduces the size of the hippocampus, impairs memory consolidation, and accelerates inflammatory aging (Yehuda & Lehrner, 2018). WRSS emphasizes that this biological wear is inseparable from sociopolitical betrayal: the body deteriorates because the world does not repair what it has broken.

This is where the neurobiology of trauma intersects directly with what WRSS names the sociopolitical collapse of meaning. To speak about war rape, the survivor must engage neural systems that are profoundly disrupted: the prefrontal cortex for language, the hippocampus for narrative sequencing, and the ventromedial prefrontal cortex for regulating overwhelming affect. Yet trauma memories are predominantly somatic and sensory, not linguistic (Brewin, 2014). The survivor faces a neurobiological challenge in transforming fragments of bodily memory into coherent speech *at the very moment* when institutions demand impossible cogni-

tive clarity.

Legal and social systems frequently misinterpret the neurobiology of trauma as inconsistency, exaggeration, or deceit. They expect linear timelines, emotional stability, and courtroom composure—precisely the functions that trauma physiologically disrupts (Ogden, 2020). When survivors are unable to meet these expectations, they are dismissed. This dismissal is not neutral; it generates additional trauma, deepening dysregulation, and further fragmenting their internal narrative. Meaning collapses because the survivor attempts to articulate an experience that the surrounding world structurally refuses to hear.

In WRSS, **dislocation of meaning** refers to this multi-layered crisis:

1) **Internal dislocation**, rooted in the neurobiological fragmentation caused by the assault.

2) **External dislocation**, caused by sociopolitical structures that deny, distort, or trivialize the survivor's testimony.

These two forms of dislocation reinforce each other. When the world does not validate the survivor's reality, the brain cannot fully integrate the traumatic memory. When the brain cannot integrate the memory, social institutions misread the survivor's attempts to speak. The survivor becomes trapped between bodily truth and social falsehood.

Institutional betrayal research demonstrates that when authorities fail to protect or acknowledge trauma, physiological dysregulation intensifies, leading to elevated PTSD symptoms, depression, suicidality, and chronic illness (Smith & Freyd, 2014). For war-rape survivors, whose lives were already shaped by militarized misogyny and ethnic violence, this betrayal is not an exception but a continuation of structural harm. Sociopolitical neglect becomes the mechanism through which neurobiological injury transforms into existential rupture.

Thus, dislocation of meaning is not simply the absence of understanding; it is the product of intersecting failures—neural, relational, cultural, and political. It emerges when the survivor's body carries a truth that the world refuses to recognize. The nervous system continues to generate survival responses not because the survivor is disordered but because the world remains disordered.

In the WRSS framework, healing requires more than stabilizing the nervous system. It requires rebuilding the moral and relational universe that was destroyed. A survivor cannot integrate trauma that society continues to deny. The body cannot relax into safety when safety does not exist. Meaning cannot return when truth is still forbidden. Only when survivors are met with environments capable of witnessing—clinically, legally, communally, spiritually—can neurobiological stabilization intertwine with sociopolitical repair.

War rape is therefore not solely a neurological event; it is a collapse of relationship, culture, identity, and world. The nervous system remembers what the political system denies. WRSS argues that the path to healing lies not in asking survivors to adapt to unjust conditions but in transforming the conditions themselves so that meaning, dignity, and truth may begin to return.

6. Clinical and Psychotherapeutic Application of WRSS: Decolonial Practice in Clinical and Political Work

The clinical and psychotherapeutic application of War Rape Survivors Syndrome (WRSS) is not simply the adoption of a new diagnostic lens; it is a methodological and ethical intervention that challenges the foundations of how trauma has been understood, treated, and politically instrumentalized in the modern world. WRSS refuses the assumption that war rape can be reduced to an individual psychiatric problem located within the survivor's mind or brain. Instead, it positions therapy as an act of witnessing into a broader field of history, power, and memory. In this framework, clinical work cannot be separated from political work: every therapeutic encounter with a war-rape survivor is simultaneously an engagement with militarized patriarchy, colonial histories, ethnic cleansing, and the global hierarchies that have long decided whose trauma is visible and whose is disposable (Fanon, 2008; Ní Aoláin, 2014a; Boesten, 2017b).

During an in-depth interview conducted in Colombia in April 2024, a woman survivor of multiple acts of sexual violence perpetrated by army soldiers described her experience not as a single traumatic event but as a prolonged life condition shaped by repeated violations and their aftermath. In conventional PTSD-oriented frameworks, clinical attention would likely focus on her intrusive memories, sleep disturbance, hypervigilance, and dissociative episodes. However, within a WRSS-informed approach, the central locus of her suffering emerged elsewhere. Alongside psychological pain, she spoke of enduring social punishment, rejection by her family, public stigma, and years-long legal struggles to be officially recognized as a victim of war by the state. Her distress was less anchored in fear responses alone than in the cumulative impact of institutional denial, delayed justice, and moral abandonment. WRSS allowed the therapeutic space to hold these dimensions simultaneously, recognizing her symptoms as inseparable from political betrayal and social exclusion rather than as indicators of individual dysfunction, by reframing her narrative as testimony to structural violence—rather than as fragmented pathology—the clinical encounter shifted from symptom containment toward witnessing, validation, and the restoration of narrative dignity within an ongoing struggle for justice.

In mainstream Western psychotherapeutic models—psychoanalysis, CBT, EMDR, and even many somatic approaches—trauma is typically conceptualized as an internal wound that can be processed, reorganized, and integrated through individual work on feelings, thoughts, and embodied responses. The desired outcome is often a return to "functioning": improved regulation, reduced symptoms, coherent memory, and the capacity to re-engage in social roles. While these goals are not inherently problematic, they become deeply insufficient when they are applied without context to women whose suffering arises from genocide, occupation, or collective punishment. In such cases, the focus on individual adaptation risks silently reinforcing the very systems that produced the trauma. As Summerfield (1999) has argued, the globalization of a narrow trauma discourse universalizes

Western assumptions about selfhood and recovery, obscuring the colonial and political structures that make specific populations perpetually vulnerable to violence. WRSS aligns with this critique by insisting that therapy with war-rape survivors must not end with individual stabilization but must move toward restoring narrative sovereignty, relational dignity, and historical truth.

In many Global South and Indigenous contexts where WRSS has been implemented—in eastern DRC, northern Uganda, Bosnia, Rwanda, Guatemala, and among Syrian and Afghan refugees—the assumption that healing must occur through one-to-one verbal processing in a consulting room is both ethnocentric and epistemically violent. Storytelling, ritual, song, and communal lament are often primary modalities of meaning-making, not peripheral "cultural adaptations". For example, in specific Congolese communities, baraza gatherings function as communal forums where suffering is shared, grievances are aired, and moral order is renegotiated. Among the Acholi in northern Uganda, the mato oput ritual addresses harm not by isolating the individual but by enacting communal recognition, apology, and reintegration (Amone-P'Olak, 2007). In Bosnia, sevdah songs carry legacies of grief and longing that allow intergenerational sorrow—especially that of women—to be expressed and held. WRSS does not treat these practices as "add-ons" to Western therapy; it regards them as fully-fledged systems of trauma integration and moral repair. The role of the WRSS-informed clinician is not to replace these traditions with imported techniques but to support survivors in reconnecting with, adapting, or reinventing them in ways that align with their lived realities.

Clinical practice grounded in WRSS begins with a radically reconceptualized notion of safety. Rather than a checklist of risk factors and behavioral agreements, safety is understood as a relational, cultural, and political condition that must be co-created. Survivors of war rape have often learned that the world is structurally unsafe, that institutions cannot be trusted, and that disclosure can bring punishment, not protection. In such a landscape, safety cannot be promised; it must be slowly demonstrated through non-extractive, culturally attuned presence. The clinician is not positioned as a distant expert but as a witness willing to hold narratives that are too heavy, too politically dangerous, or too morally contaminating for the surrounding community to bear (Laub, 1992; Herman, 1992). Silence is not interpreted as resistance or avoidance but as an intelligent survival strategy in the face of historical and ongoing risk.

Working with shame and the body is central to WRSS-informed therapy. Shame after war rape is not simply an intrapsychic emotion but a social artifact—a condensation of collective stigma, religious condemnation, and patriarchal narratives that mark the survivor as polluted or dishonored. Studies in post-conflict settings show that survivors often report more distress from community rejection than from the assault itself (Hossain et al., 2014). In Rwanda and the DRC, many women were cast out of their families or forced to undergo symbolic "deaths" before being allowed back into communal life. Western somatic therapies such as EMDR or

Sensorimotor Psychotherapy (Ogden et al., 2006; Shapiro, 2018), when imposed in isolation from this context, can unintentionally reinforce the idea that the problem lies in the woman's body rather than in the social world that exiled her. WRSS resists this by embedding body-work in cultural and communal frameworks. Water purification rituals, ancestral invocations, communal weeping, and land-based practices are invited into the therapeutic process, not as exotic rituals but as the languages in which the body already knows how to grieve and restore dignity.

Transgenerational trauma is not treated as an abstract concept in WRSS, but as a lived reality shaping family dynamics, identity development, and the psychological lives of children and grandchildren. In Bosnia, Rwanda, and among Holocaust families in Poland, descendants of women raped in war often grow up with an unnamed sense of shame, anger, or confusion. They feel that something is "wrong" in the family story, yet the original violence remains unspeakable. WRSS-informed clinicians use tools such as trauma genograms, family constellation work, and narrative reconstruction to help families trace how silence, blame, and pain have been transmitted across generations (Danieli, 1998; Yehuda & Lehrner, 2018). The objective is not to force disclosure, but to create conditions in which descendants can understand that the burdens they carry—panic, rage, self-hatred, relational instability—may belong partly to histories that preceded them. Naming this inheritance can transform self-blame into historical recognition, shifting the narrative from "something is wrong with me" to "something was done to us".

WRSS also places significant emphasis on the well-being of clinicians, community workers, and human rights defenders who engage with war-rape survivors. Vicarious trauma, compassion fatigue, and moral injury are well-documented among professionals working in high-intensity trauma settings (Figley, 1995; Pearlman & Saakvitne, 1995). However, when the subject matter is war rape, sexual torture, or genocide, the emotional burden is amplified by social silence and institutional indifference. WRSS encourages practitioners to understand their own distress not as a failure of resilience but as a sign that they are bearing witness to realities that society still refuses to acknowledge fully. Supervision, peer support, ritualized spaces for grief, and explicit political analysis of their work become essential components of ethical practice. In this sense, WRSS is not only a framework for treating survivors but also a protective structure for those who accompany them.

Decoloniality is not an optional dimension of WRSS; it is its core. Drawing on decolonial thinkers such as Mignolo (2011), Ndlovu-Gatsheni (2021), and Smith (2012), WRSS exposes how psychology has often functioned as part of the "coloniality of power", exporting Western models of the self, mental health, and healing to societies whose own knowledge systems were marginalized or destroyed. WRSS clinicians working in South Sudan, among Syrian refugees in Jordan, or with Indigenous communities in Latin America are therefore called to a stance of epistemic humility. Instead of beginning with symptom checklists, they begin with

questions: How does this community understand suffering? What words do they have for shattered dignity, for spiritual injury, for the dead who do not rest? What has healing looked like in their tradition, and what impact did colonization or war have on those practices? Healing may occur in a circle, in song, in dance, in silence, in prayer, or in protest. WRSS recognizes all of these as legitimate therapeutic spaces when they restore connection, dignity, and meaning (Gone, 2019; Kohrt & Hinton, 2019).

Significantly, WRSS extends clinical responsibility beyond the therapy room into the political sphere. When survivors are left to "heal" while perpetrators remain unpunished, structural violence unaddressed, and histories denied, therapy risks becoming a tool of pacification, teaching people to adapt to injustices that should instead be transformed. WRSS therefore encourages clinicians and organizations to collaborate with legal advocates, feminist movements, truth commissions, and survivor-led associations. Clinical knowledge of how war rape fractures memory and speech can help inform courtroom procedures, asylum interviews, and reparations processes so that they do not replicate the conditions of trauma. By emphasizing that fragmented testimony, dissociation, or emotional numbing are expected consequences of sexual torture rather than signs of unreliability, WRSS supports more just and trauma-informed legal frameworks (Brison, 2002; Herman, 1992). In this sense, WRSS becomes a bridge between clinical practice and political action.

Through these intertwined clinical and political commitments, WRSS functions as both a therapeutic orientation and a decolonial counter-epistemology. It challenges the clinician to move from diagnosis to witnesshood, from symptom management to narrative restoration, from isolated individual treatment to relational and communal repair. It refuses to locate war rape solely inside the survivor's body and instead situates it where it belongs: at the intersection of history, power, and memory. In doing so, WRSS creates space for forms of care that do not merely help survivors "cope", but support them in reclaiming agency, rebuilding bonds, and insisting that their stories enter the historical record as truths that can no longer be erased.

7. Ethical and Political Implications

The ethical and political implications of War Rape Survivors Syndrome (WRSS) extend far beyond the therapeutic encounter. They delve into the domains of law, medicine, public memory, education, humanitarian practice, and transitional justice, raising fundamental questions about how societies determine whose suffering is intelligible, whose wounds are acknowledged as legitimate, and whose histories are permitted to enter the official record. WRSS challenges the long-standing tendency to medicalize and privatize trauma by insisting that war rape is not a personal tragedy to be addressed in isolation, but a structural crime, a political instrument, a communal wound, and a historical rupture. When wartime sexual violence is treated solely as an individual psychological problem, the response it-

self becomes complicit in betrayal: survivors are once again left alone to bear the burden of violence that was, in reality, collective, organized, and frequently state-sanctioned.

At its core, WRSS exposes the ethical limits of liberal-humanitarian frameworks that claim universality while systematically erasing cultural, historical, and political specificity. The depoliticized vocabulary of "gender-based violence" or "sexual abuse", though often well-intentioned, can obscure the strategic and militarized nature of rape in conflict. Feminist legal and political scholarship has consistently demonstrated that sexual violence in war is frequently deployed to achieve concrete political objectives, including ethnic cleansing, forced pregnancy, community terrorization, symbolic annihilation of enemies, and the destruction of generational continuity (Aoláin, 2014b; Boesten, 2017a; Henry, 2014). WRSS insists that any ethical response to war rape must foreground this weaponization and refuse to collapse it into individualized pathology. Within this framework, healing cannot be separated from political recognition. An ethically and politically responsible application of WRSS, therefore, requires recognition of male and boy survivors of wartime sexual violence while maintaining a feminist analytic lens, as patriarchal militarism produces gender-specific forms of violation, stigma, and narrative erasure that differ in form but not in gravity. These differences demand context-sensitive responses rather than abstract gender neutrality, which risks reproducing invisibility under the guise of inclusivity (Carpenter, 2006; Henry, 2014; Aoláin, 2014b).

One of the most urgent ethical questions raised by WRSS concerns institutional betrayal. Survivors are not harmed only by perpetrators; they are repeatedly wounded by the systems that are expected to provide protection, recognition, and justice. Research from Bosnia, Rwanda, Uganda, and the Democratic Republic of the Congo demonstrates that many survivors encounter police who minimize or trivialize their claims, courts that fail to prosecute known perpetrators, religious authorities who promote forgiveness without accountability, and humanitarian agencies that condition assistance on the performance of standardized trauma narratives (Clark, 2010; Liebling-Kalifani et al., 2008). Survivors frequently describe these secondary violations as more devastating than the original assault, precisely because they confirm that the world is structurally indifferent to their suffering. WRSS conceptualizes institutional betrayal not as a peripheral failure or a "gap in services", but as an extension of the original violence. It deepens shame, consolidates silence, and can push survivors toward social and psychological death.

WRSS also interrogates the ethical limits of transitional justice. International criminal tribunals such as the ICTR, ICTY, and ICC have rightly been praised for recognizing rape as a war crime, a crime against humanity, and, in certain contexts, an act of genocide. Yet these legal achievements often fail to translate into meaningful changes in the everyday lives of survivors, many of whom remain impoverished, stigmatized, and socially invisible decades after the violence has ended.

WRSS argues that justice measured solely through prosecutions, convictions, or the refinement of legal categories is ethically insufficient. Justice must be relational: accessible to survivors, grounded in community realities, responsive to cultural frameworks, and attentive to the long-term consequences of violence, including the needs of children born of rape. Without such relational grounding, law risks becoming a symbolic performance—important, but distant—another arena in which survivors' bodies and testimonies are mobilized without substantive transformation of their lived conditions.

Narrative sovereignty constitutes another central ethical concern within WRSS. The framework critiques what may be described as "trauma extraction", a recurring pattern in which survivors' stories are solicited, recorded, translated, and circulated by researchers, journalists, NGOs, or legal institutions without materially improving survivors' own circumstances (Malkki, 1996). In many documentation and advocacy projects, survivors are pressured—explicitly or implicitly—to fit their experiences into pre-existing narrative templates that privilege linearity, coherence, emotional disclosure, and scripts of victimhood or resilience. WRSS insists that narrative belongs first to survivors, not to institutions. Survivors must retain the right to decide whether, when, how, and to whom they speak. Silence must be respected as fully as speech. Metaphor, myth, song, ritual, dream language, or embodied gesture may serve as more truthful vehicles of meaning than the Western demand for chronological autobiographical testimony. Ethical practice, from this perspective, is measured not by the quantity of data collected but by the degree to which dignity, agency, and safety are preserved.

WRSS further foregrounds the ethical responsibility of clinicians, researchers, and advocates to adopt a stance of witnessing rather than pathologization. Witnessing, as articulated by Laub (1992) and Felman and Laub (1992), understands trauma not merely as an intrapsychic disruption but as a rupture in the social and moral fabric. To witness a survivor of war rape is to acknowledge that what occurred is not simply "her trauma", but a crime against a community, a people, and a shared history. This stance requires sustained reflexivity. Clinicians and researchers must recognize their own positionality, privilege, and potential complicity within global systems that have historically devalued the lives of women in the Global South, Indigenous women, and racialized populations. Without such reflexive awareness, even well-meaning clinical and academic work risks reproducing colonial power relations, transforming survivors into objects of study rather than partners in the pursuit of truth-telling.

The ethical and political implications of WRSS also extend into the realm of intergenerational memory. War rape does not end with the individual survivor; it reshapes genealogies and alters the moral architecture of families and communities. Children born of wartime rape frequently inhabit identities that are silenced, contested, or stigmatized. Their existence may be framed as a "problem", a reminder of the enemy, or a living symbol of shame. The absence of an honest and compassionate narrative about their origins becomes an invisible wound that shapes self-

perception, attachment, and a sense of belonging across the life course (Denov & Lakor, 2017). WRSS argues that societies emerging from conflict carry a moral responsibility to address these intergenerational fractures. Truth commissions, educational curricula, public memorials, and cultural production must include the experiences of sexually violated women and their children if reconciliation is to be more than a diplomatic abstraction. Failure to do so not only silences survivors but reproduces stigma across generations.

At a broader structural level, WRSS calls for a rethinking of global power relations within psychology, humanitarian aid, and transitional justice. Western epistemologies have long dominated these fields, frequently imposing interpretive frameworks that obscure local understandings of suffering, repair, and healing. Drawing on decolonial scholarship (Smith, 2012; Ngũgĩ wa Thiong'o, 1986; Maldonado-Torres, 2007), WRSS advocates epistemic pluralism: the recognition that Indigenous, African, Asian, Latin American, and diasporic traditions hold sophisticated, contextually grounded knowledge about trauma, memory, ethics, and restoration. To continue privileging Western evidence hierarchies and therapeutic models while marginalizing or tokenizing other epistemologies constitutes a form of epistemic violence. WRSS extends this critique directly into trauma studies, arguing that ethical practice requires not merely cultural "sensitivity", but a redistribution of epistemic authority.

Finally, WRSS confronts societies with the unsettling reality that war rape is not a rare aberration, but a predictable outcome of patriarchal militarism and gendered dehumanization. It demands a shift in inquiry: away from the question of why individual men commit sexual violence and toward an examination of the structures that train, authorize, and protect them, as well as the political, economic, and symbolic systems that render the violation of women's bodies thinkable, repeatable, and deniable. Addressing war rape ethically, therefore, requires a willingness to challenge military cultures, nationalist mythologies, religious doctrines, and economic orders that normalize or profit from war. In this sense, WRSS is not only a clinical or theoretical framework; it is a demand for structural transformation.

In sum, the ethical and political implications of WRSS reveal war rape as a multi-layered phenomenon embedded in systems of domination, denial, and historical amnesia. Responding to it requires far more than trauma-informed therapy. It requires collective recognition, political accountability, epistemic humility, and a sustained commitment to dismantling the patriarchal, colonial, and militarized structures that enable such violence to persist. WRSS is therefore not merely a way of naming trauma; it is a call to reimagine justice, memory, and responsibility.

8. Interconnected Medical, Legal, Psychological, and Social Dimensions

The insistence within WRSS on interconnection between medical, legal, psycho-

logical, and social domains arises from a fundamental observation: war rape tears through every layer of a survivor's world. It injures the body, disorganizes the nervous system, fractures identity, breaks kinship networks, destabilizes livelihoods, and distorts the moral and legal order. Any attempt to respond from a single disciplinary vantage point—even with the best of intentions—risks reproducing the very dislocation of meaning that WRSS identifies as central to the syndrome. Fragmented responses mirror the fragmentation of the survivor's experience.

The medical consequences of war rape are immediate and long-term, often severe, and frequently neglected. Survivors may endure deep genital injuries, fistulas, sexually transmitted infections, including HIV, chronic pelvic pain, infertility, menstrual disorders, obstetric complications, and increased vulnerability to future health problems (Koenig et al., 2011; Kerr-Wilson et al., 2020). For many women in Rwanda, the DRC, Bosnia, and northern Uganda, such medical conditions become sources of ongoing humiliation and exclusion: leaking fistulas, visible scars, or infertility undermine their perceived value as wives and mothers in patriarchal societies. The absence of accessible, stigma-free medical care compounds their suffering, transforming a treatable injury into a lifelong marker of degradation. WRSS understands medical neglect as a form of structural violence, not an unfortunate oversight.

Psychologically, war-rape survivors often report symptoms that Western frameworks would readily classify as PTSD, depression, or complex trauma: dissociation, emotional numbing, intrusive images, panic attacks, chronic shame, suicidal ideation, rage, and profound mistrust. WRSS does not deny the reality of these experiences, but it insists that they be interpreted within their sociopolitical ecology. Hypervigilance may be a rational response to environments where perpetrators remain free; emotional withdrawal may be a survival strategy in families that blame the victim; "avoidance" may reflect the realistic perception that speaking out brings danger. Reframing these responses as relational and political rather than purely intrapsychic changes the ethical task of therapy. The aim is no longer to make the survivor adjust to an unjust world, but to support her in finding forms of meaning, connection, and resistance within or against it.

Legally, the landscape is marked by both progress and profound failure. While international law has evolved to recognize rape as a war crime and a tool of genocide, prosecutions remain rare, slow, and geographically limited (Askin, 2003; Henry, 2014). Many survivors never see their perpetrators investigated, let alone tried. Domestic legal systems may be under-resourced, corrupt, or patriarchal; police officers may be perpetrators themselves or socially aligned with them. Legal procedures can also replicate trauma: survivors are asked to recount events repeatedly, to withstand cross-examination that questions their credibility, and to fit their memories into rigid evidentiary formats that ignore trauma physiology. WRSS conceptualizes these legal shortcomings as more than systemic weaknesses; they are modes through which the state reasserts power over the survivor's body

and narrative, often reinforcing the message that her pain is negotiable or expendable.

The social repercussions of war rape are equally devastating and enduring. Survivors may be divorced, expelled from their homes, refused bride-price, denied inheritance, or treated as morally tainted. In some contexts, children born of rape face bullying, rejection, or are labeled with derogatory names that mark them as belonging to the enemy (Denov & Lakor, 2017; Zihindula et al., 2019). Communities may choose silence as a means of coping, but this silence also serves as a mechanism of erasure. It isolates survivors, prevents communal mourning, and blocks collective learning about how such violence emerged. WRSS understands these social processes as active forces in the maintenance of trauma environments—conditions in which the original violation is never fully past because its social consequences are renewed daily.

Given this complexity, WRSS advocates for a coordinated, multi-layered response in which medical, psychosocial, legal, and community-based interventions communicate with one another rather than operate in isolated silos. In practical terms, this means that medical professionals treating war-rape survivors must be trained not only in clinical skills but also in trauma-informed, culturally sensitive practice that avoids stigmatizing language and re-traumatizing procedures. A gynecological exam for a survivor of gang rape is not a neutral act; it can reproduce feelings of exposure and violation if conducted without consent, explanation, and gentleness. Psychological support must be integrated into medical care, and referral pathways should be established that enable survivors to access counseling, peer groups, and community-based support without encountering bureaucratic obstacles.

For psychotherapists, WRSS demands an awareness of the legal and social obstacles survivors face. A woman may not "improve" psychologically if she remains at risk of attack, if she is homeless after being expelled by her family, or if her legal case drags on for years without resolution. Legal professionals, in turn, must understand the neurobiological and emotional realities of war-rape trauma: fragmented memory, dissociation, and non-linear narratives are not indications of deception but expected consequences of extreme violence. Trauma-informed legal procedures—such as allowing testimony via video, avoiding unnecessary repetition, and providing psycho-legal support—can reduce re-traumatization and increase the accuracy of survivors' accounts.

Community leaders and cultural authorities must also be engaged as key actors in any WRSS-informed response. Religious leaders, elders, women's groups, and youth organizations can either perpetuate stigma or become powerful allies in promoting inclusion, recognition, and reparation. Programs that combine material support (housing, livelihood, education for children) with symbolic and ritual recognition (public apologies, commemorative ceremonies, community dialogues) are more likely to restore survivors' dignity and sense of belonging. International organizations, meanwhile, must resist the impulse to impose prefabricated inter-

vention models. Instead, they should consult local women's groups, survivors' associations, traditional healers, and cultural practitioners to co-create responses that resonate meaningfully within the local moral universe.

WRSS provides the conceptual and ethical scaffolding for this integrated approach. It reminds practitioners in all sectors that war rape cannot be adequately addressed if it is compartmentalized into the "medical problem", the "mental health issue", the "human rights violation", or the "social stigma". It is all of these at once, and more. As a result, interventions must be explicitly decolonial: they must refuse epistemic hierarchies, support survivor-led initiatives, and challenge any practice—however well intentioned—that treats survivors as passive recipients of expert knowledge rather than as central agents in their own healing and political futures.

In this sense, WRSS is not only a framework for understanding the dynamics of trauma; it is a blueprint for how societies might respond differently. It calls for systems of care, justice, and social solidarity that are as interconnected, intentional, and enduring as the violence that tore survivors' worlds apart. Only when responses are integrated across medical, legal, psychological, and social domains can the dislocation of meaning begin to heal—not through imposed closure, but through the slow restoration of dignity, relationship, and historical truth.

9. Discussion

The discussion of War Rape Survivors Syndrome (WRSS) must begin with the recognition that trauma is not merely an internal wound but a relational, political, and generational rupture. WRSS challenges the long-standing tradition within psychology and psychiatry of interpreting suffering primarily through individualized pathology rather than structural violence. To discuss WRSS is therefore to expose how diagnostic systems have been mobilized as tools of containment, transforming survivors' testimony into clinical material while obscuring the sociohistorical forces that produced the trauma in the first place.

The central argument emerging from the analysis is that war rape generates wounds that radically exceed the psychological domain. These wounds destabilize genealogies, disrupt communal cosmologies, fracture ancestral memory, and alter the body's internal language of safety and belonging. WRSS thus refuses the reduction of trauma to a cluster of symptoms. Instead, it proposes that trauma constitutes a multilayered collapse: a collapse of bodily boundaries, narrative coherence, moral meaning, social membership, and intergenerational continuity. Psychological effects must not be interpreted as universal markers of mental disorder, but as culturally and historically embedded expressions emerging from a violently disordered world.

Within this framework, trauma responses that are conventionally regarded as pathological—silence, fragmentation, somatic pain, fluctuating attachment, dissociation, rage, or withdrawal—are revealed as coherent expressions of a violated reality. They arise not from internal abnormality but from the survivor's profound

entanglement with systems of betrayal: militarized patriarchy, religious condemnation, ethnic persecution, institutional abandonment, and communal denial. These psychological expressions can therefore be read as moral testimonies rather than clinical errors. They bear witness to what was done to the survivor, what the world failed to prevent, and what it refused to acknowledge afterward.

This discussion also highlights that war rape is not only a physical assault but a deliberate strategy of destruction aimed at the social fabric. When sexual violence is inflicted with political intent—to destabilize ethnic groups, interrupt reproduction, sever kinship lines, terrorize communities, and send symbolic messages of domination—the aftermath cannot be understood as a purely private matter. The silence that follows, whether imposed by families, communities, states, or international institutions, becomes an extension of the original assault. Silence is not a vacuum; it is a socially constructed space where shame, fear, and erasure accumulate. It becomes the architecture within which WRSS develops and solidifies.

Narrative foreclosure is central to this dynamic. Many survivors possess fragmented or exclusively bodily memories but lack a socially acceptable container for their story. In post-conflict societies, the survivor's narrative is often unwelcome because it threatens national myths of heroism, religious doctrines of purity, or patriarchal notions of honor. As a result, the survivor becomes the custodian of stories that cannot be spoken and memories that cannot be placed. The clinical task in a WRSS framework is therefore not to impose narrative coherence, but to create relational, cultural, and spiritual spaces where meaning can safely emerge without violating the survivor's protective boundaries or the symbolic worlds they inhabit.

The collapse of trust in relational and institutional systems is another core theme. Many survivors report that betrayal during and after the rape—by soldiers, police, husbands, family members, religious leaders, humanitarian workers, or courts—has left a deeper imprint than the physical assault itself. This is consistent with research on betrayal trauma and institutional betrayal, which shows that violations of trust by those expected to protect can produce more enduring harm than the original event (Freyd, 1996; Smith & Freyd, 2014). In the context of war rape, betrayal is not incidental but structural. It is woven into the very institutions that claim to offer justice or shelter, yet repeatedly fail to acknowledge, prosecute, or support.

When clinicians approach survivors without acknowledging these layers of betrayal, therapeutic work risks replicating the very dynamics of erasure that WRSS seeks to expose. A therapist who focuses solely on symptom management without situating suffering in a political and historical context may unintentionally mirror a community that refuses to hear the survivor's truth. A humanitarian worker who demands graphic disclosure as a condition for assistance may reproduce coercion. A legal investigator who prioritizes evidentiary coherence over human dignity may echo the perpetrator's disregard for the survivor's subjectivity. WRSS names these repetitions and forces practitioners to confront the ethical implications of

their methods.

The discussion also underlines the transgenerational transmission of war-rape trauma. WRSS, informed by research in epigenetics, attachment, and memory, demonstrates that trauma persists not only through biological pathways but through stories told and untold, gestures remembered and forgotten, emotional climates, and relational ruptures. Children born of wartime rape, or raised by survivors, often inherit complex identities shaped by secrecy, stigma, and partial truths. Their lives become entwined with histories they did not choose but must navigate daily. WRSS explicitly states that healing work cannot be confined to the individual survivor; it must also expand to include descendants, family systems, communities, and cultural narratives.

Western trauma discourse has largely failed to address these transgenerational complexities, representing another form of epistemic violence. It assumes that trauma is an event rather than a lineage; a discrete memory rather than a cosmology; a disorder rather than a political legacy. This assumption flattens the depth of war rape trauma and obscures its persistence through generational memory and silence. WRSS counters this by reclaiming trauma as an inheritance of meaning as well as pain. In this perspective, healing does not require the erasure of suffering but the restoration of dignity, coherence, and truth across time.

At the societal level, WRSS helps expose the fragility and partiality of post-conflict reconciliation processes that exclude sexual violence survivors from public memory. When nations attempt to rebuild political identity without confronting wartime rape, they produce historical narratives that are incomplete, sanitized, and complicit. Survivors become living reminders of what society wishes to forget. Their presence disrupts national mythologies, and thus they are pushed to the margins: physically, socially, and symbolically. WRSS insists that survivors and their descendants be placed at the center of truth-telling, memorialization, and reconciliation processes rather than relegated to footnotes of transitional justice.

Ultimately, WRSS serves as a form of resistance to colonial psychology. In many post-conflict contexts, Western trauma models have been imported without meaningful consultation, reinforcing epistemic hierarchies in which Western knowledge is assumed to be superior to Indigenous or local healing traditions. This imposition perpetuates cognitive imperialism and undermines cosmologies that have long sustained communities through loss and violence. WRSS displaces this hierarchy by embracing indigenous rituals, land-based practices, communal mourning, spiritual traditions, and nonverbal forms of memory as central to the healing process. In doing so, it asserts that any serious engagement with war-rape trauma must honor the cultural and ancestral frameworks survivors inhabit.

WRSS is therefore not simply an academic contribution but a moral intervention. It calls for a reorganization of therapeutic, legal, and humanitarian systems around dignity, truth, and relational integrity. It urges practitioners to move from diagnosis to witnessing, from symptom reduction to meaning restoration, from individual treatment to collective healing, and from clinical neutrality to ethical

responsibility. It insists that trauma cannot be addressed without confronting the patriarchal, militarized, and colonial structures that produced it.

10. Limitations of the WRSS Framework

Despite its political clarity, clinical usefulness, and decolonial orientation, War Rape Survivors Syndrome (WRSS) necessarily carries limitations that must be named explicitly if it is to avoid reproducing the very epistemic hierarchies it seeks to dismantle. The framework emerged as a corrective to Western diagnostic violence, yet it remains partially rooted in Western trauma epistemologies, including neurobiology, psychoanalysis, attachment theory, and memory studies. These traditions have generated important insights, but they do not translate seamlessly into Indigenous or non-Western cosmologies, in which the body, land, ancestors, and spiritual order are understood as a single, relational continuum. Within such worldviews, harm is not located "inside" the individual, nor is suffering primarily interpreted through intrapsychic or neurobiological mechanisms. WRSS, therefore, cannot be presented as a universal system of understanding. It retains traces of the Western intellectual lineage from which it emerged, and this lineage inevitably constrains its applicability in contexts where trauma is conceptualized as cosmological rupture rather than psychological injury.

A second limitation concerns the risk of over-formalization. Should WRSS be transformed into a standardized protocol, a manualized procedure, or a diagnostic checklist, it would reproduce the same reductionism it critiques in PTSD and related psychiatric categories. The strength of WRSS lies precisely in its relational, narrative, and context-sensitive orientation—its capacity to remain responsive to the lived complexities of survivors and their communities. Any attempt to codify WRSS into fixed criteria would strip it of its political meaning and ethical fluidity. To remain faithful to its intent, WRSS must be preserved as an interpretive and ethical framework rather than a rigid clinical instrument: a way of seeing and understanding, not a new label to be imposed.

WRSS also places significant emphasis on narrative as a vehicle for meaning-making, and this emphasis carries its own risks. It may inadvertently privilege cultural contexts in which verbal testimony and autobiographical storytelling are central. Many Indigenous and non-Western societies transmit memory, grief, and historical knowledge through ritual, cosmology, dance, song, gesture, silence, or ancestral invocation rather than through linear narrative forms. In such contexts, expectations of narrative coherence—or assumptions that healing requires verbalization—risk reproducing Western biases toward speech, individual memory, and confessional disclosure. WRSS must therefore remain attentive to the fact that meaning is not always spoken, and that truth may be carried and transmitted through communal ceremonies or symbolic acts that resist translation into words.

Further limitations arise from the political and material conditions implicitly presupposed by the framework. WRSS often assumes at least minimal access to safety, the possibility of legal recognition, the presence of communal structures

capable of collective witnessing, and social spaces that can support survivors without exposing them to further harm. For many women violated during war, such conditions simply do not exist. Their communities remain unsafe, their governments deny or normalize the violence, their families may reject them, and their economic survival is precarious. In the absence of social protection, legal redress, or ritual space, the transformative potential of WRSS is severely constrained. The framework therefore depends on structural realities that remain inaccessible to countless survivors, particularly in contexts of prolonged conflict, occupation, or political repression.

Another limitation lies in WRSS's difficulty fully capturing what may be described as cosmological trauma: harm experienced not only within the psyche or relationships, but at the level of ancestral, ecological, and spiritual order. In many Indigenous ontologies, sexual violence fractures the moral architecture of the world itself, rupturing relations between people and land, people and ancestors, and people and the sacred. Although WRSS extends beyond individual psychology to address political and intergenerational dimensions of harm, it remains anchored in psychological and social vocabularies. To remain ethically accountable, it must stay open to revision by cosmologies and practices that conceptualize trauma across registers that exceed and escape Western language.

WRSS also cannot and should not replace local healing systems. It functions as a lens, not as a substitute for culturally grounded modes of repair. Communities affected by war rape frequently rely on rituals, ancestral ceremonies, collective lamentation, and processes of spiritual or cosmological realignment. These practices are not supplementary or symbolic; they constitute complete systems of meaning, healing, and relational restoration. WRSS must operate alongside such systems, defer to them when they offer deeper resonance or legitimacy, and resist positioning itself as superior or more "advanced".

Ultimately, WRSS should be understood as an evolving framework rather than a fully consolidated paradigm. Its conceptual boundaries, clinical implications, and cultural resonances will continue to shift as it encounters new survivor communities, geopolitical contexts, and forms of violence. Its limitations are not mark of failure but invitations to ongoing refinement. The framework must evolve through sustained dialogue with survivors, cultural leaders, Indigenous healers, activists, clinicians, and scholars. Its incompleteness is a strength, allowing it to remain porous, responsive, and accountable to the diverse lived realities of those it seeks to serve.

It is therefore essential to clarify that War Rape Survivors Syndrome does not function as an integrative Indigenous healing framework, nor does it seek to absorb, translate, or systematize Indigenous epistemologies within a Western theoretical model. Rather, WRSS operates as a decolonial interface: a bridge positioned between Western academic, legal, and clinical institutions and Indigenous worlds of meaning that pre-exist and exceed those institutions. Indigenous healing systems referenced within this framework, including Ubuntu-based relational phi-

losophies and Lakota understandings of trauma articulated through concepts such as Takini, are treated as sovereign knowledge systems with their own ontological, ethical, and cosmological foundations. WRSS does not extract these traditions into clinical techniques or symbolic illustrations. Instead, it acknowledges their epistemic authority while refusing the assumption that Western psychology holds interpretive primacy.

In practice, WRSS translates survivor experience into the institutional languages required for recognition, justice, and protection, while simultaneously pointing beyond those languages to forms of meaning-making that cannot—and should not—be subsumed into diagnostic or therapeutic regimes. In this sense, WRSS is not a synthesis that collapses epistemological difference, but a relational and ethical bridge that seeks to protect epistemic sovereignty while exposing the limits of Western trauma frameworks in contexts shaped by war, colonial violence, and genocide.

11. Conclusion

War Rape Survivors Syndrome reframes the trauma of wartime sexual violence as a political, relational, and intergenerational wound that cannot be contained within the conceptual boundaries of Western psychological diagnosis. Throughout this article, dislocation of meaning has emerged as both the core injury and the mechanism that perpetuates suffering across decades and generations. It begins when rape—deliberately deployed as a weapon of war, ethnic cleansing, and domination—is later interpreted through depoliticized clinical frameworks that isolate the survivor from her historical and communal context. This severing of political reality from psychological experience transforms a structural crime into a personal pathology, forcing the survivor to inhabit a narrative that is not her own. WRSS names this distortion and returns the survivor's suffering to its rightful moral, historical, and communal terrain.

By synthesizing trauma neuroscience, psychoanalytic insights, feminist and legal scholarship, decolonial epistemologies, and extensive transnational clinical practice, WRSS demonstrates that the consequences of war rape cannot be adequately understood through symptom-focused lenses such as PTSD or through universalizing humanitarian narratives. The responses that psychiatry tends to label "disorder"—fragmented memory, dissociation, withdrawal, rage, infertility, grief, relational collapse, silence—are coherent testimonies of betrayal and survival. They represent the body's own archive of political violence, carrying the marks of war long after formal hostilities cease. Subsequent traumas—institutional betrayal, ongoing stigma, economic abandonment—further reactivate these embodied memories, confirming the world's failure to protect and deepening the collapse of moral meaning.

This dislocation of meaning does not end with the immediate survivor. It enters families and communities, reshaping attachments, communication patterns, gender roles, emotional atmospheres, and the moral universe of children and grand-

children. Transgenerational trauma, within the WRSS framework, is not simply inherited vulnerability; it is the transmission of unsymbolized pain, secrecy, stigma, and unresolved grief. When societies refuse to acknowledge war rape as a political crime, the next generation grows up amid contradictions they cannot name, carrying burdens without knowing their sources. WRSS exposes this silence as a continuation of the original violence—a refusal of the social body to metabolize atrocity, leaving descendants to do this work in fragments.

Clinically, WRSS calls for therapeutic approaches grounded not in correction but in witnessing; not in the rapid control of symptoms but in the slow restoration of meaning, dignity, and relational integrity. It rejects extractive and colonial forms of intervention that reframe survivors' realities through Western categories, and instead centers survivor epistemologies, local healing traditions, communal justice practices, and narrative sovereignty. In this view, the survivor's body is not merely a site to be regulated, but a historical text to be honored. Healing is understood as inherently collective, ecological, and ethical, rather than solely individual and intrapsychic.

The ethical and political implications of WRSS extend into law, transitional justice, public health, and memory work. If war rape is a political weapon, responding to it requires political accountability, not only therapeutic services. Legal systems must be transformed, so that they protect and dignify survivors instead of retraumatizing them. Humanitarian agencies must abandon one-size-fits-all trauma protocols that flatten cultural difference and ignore power. States must directly confront the gendered, racialized, and militarized ideologies that made mass rape possible. Communities must dismantle stigmas that silence survivors and marginalize children born of rape. Institutions of memory—museums, archives, school curricula, monuments—must embed sexual violence into national narratives rather than treating it as shameful excess. Without these structural changes, the possibility of deep psychological recovery remains constrained, and the dislocation of meaning continues its generational course.

Ultimately, WRSS stands as both a clinical framework and a moral indictment. It exposes the inadequacy of diagnostic psychiatry to comprehend the magnitude of wartime rape and challenges societies to confront the structures—patriarchal, militarized, colonial—that engineered such harm. It argues that healing is inseparable from justice, recognition, and the restoration of dignity. To work with survivors of war rape is therefore not only a therapeutic task but an ethical obligation and a political act.

Restoring meaning to war rape requires that professionals, institutions, and communities listen differently, witness responsibly, and intervene collectively. It demands that survivors be honored not as broken subjects but as bearers of history; not as cases to be managed but as individuals whose lives testify to the failures of nations and the resilience of human dignity. WRSS invites clinicians, researchers, policymakers, and communities to build worlds in which survivors' truths are no longer dislocated but centered—where silence is replaced by recog-

nition, isolation by solidarity, and stigma by justice. Only then can the generational cycle of dislocated meaning begin to mend, and only then can healing become possible on terms defined by survivors themselves.

Acknowledgements

With gratitude to the Women's Therapy Center Institute (NYC).

Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

References

Abraham, N., & Torok, M. (1994). *The Shell and the Kernel: Renewals of Psychoanalysis* (Vol. 1). University of Chicago Press.

Amone-P'Olak, K. (2007). Coping with Life in Rebel Captivity and the Challenge of Reintegrating Formerly Abducted Boys in Northern Uganda. *Journal of Refugee Studies, 20,* 641-661. https://doi.org/10.1093/jrs/fem036

Arnsten, A. F. T. (2009). Stress Signalling Pathways That Impair Prefrontal Cortex Structure and Function. *Nature Reviews Neuroscience, 10,* 410-422. https://doi.org/10.1038/nrn2648

Askin, K. D. (2003). Prosecuting Wartime Rape and Other Gender-Related Crimes under International Law: Extraordinary Advances, Enduring Obstacles. *Berkeley Journal of International Law, 21,* 288-349.

Becker, D. (2004). *Dealing with the Consequences of Organized Violence in Trauma Work.* Berghof Research Center for Constructive Conflict Management.

Bloom, S. L. (2013). The Sanctuary Model: Principles, Practices, and Processes. In J. D. Ford, & C. A. Courtois (Eds.), *Treating Complex Traumatic Stress Disorders in Children and Adolescents* (pp. 201-217). Guilford Press.

Boesten, J. (2017a). Of Exceptions and Continuities: Theory and Methodology in Research on Conflict-Related Sexual Violence. *International Feminist Journal of Politics, 19,* 506-519. https://doi.org/10.1080/14616742.2017.1367950

Boesten, J. (2017b). *Sexual Violence during War and Peace: Gender, Power, and Post-Conflict Justice in Peru.* Palgrave Macmillan. https://link.springer.com/book/10.1057/9781137383457

Bracken, P., Giller, J. E., & Summerfield, D. (1997). Rethinking Mental Health Work with Survivors of Wartime Violence and Refugees. *Journal of Refugee Studies, 10,* 431-442. https://doi.org/10.1093/jrs/10.4.431

Brewin, C. R. (2014). Episodic Memory, Perceptual Memory, and Their Interaction: Foundations for a Theory of Posttraumatic Stress Disorder. *Psychological Bulletin, 140,* 69-97. https://doi.org/10.1037/a0033722

Brison, S. J. (2002). *Aftermath: Violence and the Remaking of a Self.* Princeton University Press.

Carpenter, R. C. (2006). Recognizing Gender-Based Violence against Civilian Men and Boys in Conflict Situations. *Security Dialogue, 37,* 83-103. https://doi.org/10.1177/0967010606064139

Charmaz, K. (2014). *Constructing Grounded Theory* (2nd ed.). SAGE Publications.

Clark, P. (2010). Rape, Sexual Violence and Transitional Justice in Post-Genocide Rwanda.

European Journal of International Relations, 16, 437-460.

Cloitre, M., Garvert, D. W., Brewin, C. R., Bryant, R. A., & Maercker, A. (2013). Evidence for Proposed ICD-11 PTSD and Complex PTSD: A Latent Profile Analysis. *European Journal of Psychotraumatology, 4,* Article No. 20706. https://doi.org/10.3402/ejpt.v4i0.20706

Danieli, Y. (1998). *International Handbook of Multigenerational Legacies of Trauma*. Springer.

Denov, M., & Lakor, A. A. (2017). When War Is Better than Peace: The Post-Conflict Realities of Children Born of Wartime Rape in Northern Uganda. *Child Abuse & Neglect, 65,* 255-265. https://doi.org/10.1016/j.chiabu.2017.02.014

Dudgeon, P. (2020). Australian Indigenous Psychology. *Australian Psychologist, 55,* 453-464.

Fanon, F. (1963). *The Wretched of the Earth*. Grove Press.

Fanon, F. (2008). *Black Skin, White Masks* (R. Philcox, Trans.). Grove Press. https://groveatlantic.com/book/black-skin-white-masks/

Felman, S., & Laub, D. (1992). *Testimony: Crises of Witnessing in Literature, Psychoanalysis, and History*. Routledge.

Ferenczi, S. (1933). Confusion of Tongues between Adults and the Child (the Language of Tenderness and of Passion). *International Journal of Psycho-Analysis, 30,* 225-230.

Ferenczi, S. (1988). *The Clinical Diary of Sándor Ferenczi* (J. Dupont, Ed.; M. Balint & N. Z. Jackson, Trans.). Harvard University Press.

Figley, C. R. (1995). *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized*. Brunner/Mazel.

Freyd, J. J. (1996). *Betrayal Trauma: The Logic of Forgetting Childhood Abuse*. Harvard University Press. https://www.hup.harvard.edu/books/9780674068097

Gone, J. P. (2019). Alternative Knowledges and the Future of Community Psychology: Provocations from an American Indian Healing Tradition. *American Journal of Community Psychology, 58,* 314-321. https://doi.org/10.1002/ajcp.12046

Henry, N. (2014). *War and Rape: Law, Memory and Justice*. Routledge.

Herman, J. L. (1992). *Trauma and Recovery*. Basic Books. https://www.basicbooks.com/titles/judith-l-herman/trauma-and-recovery/9780465061716/

Hesse-Biber, S. N. (2014). *Feminist Research Practice: A Primer* (2nd ed.). SAGE Publications, Inc. https://doi.org/10.4135/9781071909911

Hirsch, M. (2012). *The Generation of Postmemory: Writing and Visual Culture after the Holocaust* (pp. 5-6, 33-35, 40-42). Columbia University Press.

Hossain, M., Zimmerman, C., Kiss, L., Kone, D., Bakayoko-Topolska, M., Manan K A, D. et al. (2014). Men's and Women's Experiences of Violence and Traumatic Events in Rural Côte d'Ivoire Before, during and after a Period of Armed Conflict. *BMJ Open, 4,* e003644. https://doi.org/10.1136/bmjopen-2013-003644

Kerr-Wilson, A., Gibbs, A., McAslan Fraser, E., & Ramsoomar, L. (2020). *A Rigorous Global Evidence Review of Prevalence and Health Consequences of Intimate Partner Violence and Non-Partner Sexual Violence*. World Health Organization.

Klein, E. (1971). *A Comprehensive Etymological Dictionary of the English Language: Dealing with the Origin of Words and Their Sense Development Thus Illustrating the History of Civilization and Culture*. Elsevier Publishing Co.

Koenig, M. A., Stephenson, R., Ahmed, S., Jejeebhoy, S. J., & Campbell, J. (2011). Individual

and Contextual Determinants of Domestic Violence in North India. *The Lancet, 377,* 2077-2085.

Kohrt, B. A., & Hinton, D. E. (2019). Cultural Concepts of Distress and Psychiatric Disorders: Literature Review and Research Recommendations for Global Mental Health. *Current Psychiatry Reports, 21,* Article 16.

Kohrt, B. A., Rasmussen, A., Kaiser, B. N., Haroz, E. E., Maharjan, S. M., Mutamba, B. B. et al. (2014). Cultural Concepts of Distress and Psychiatric Disorders: Literature Review and Research Recommendations for Global Mental Health Epidemiology. *International Journal of Epidemiology, 43,* 365-406. https://doi.org/10.1093/ije/dyt227

Lanius, R. A., Bluhm, R. L., & Frewen, P. A. (2010a). How Understanding the Neurobiology of Complex Post-Traumatic Stress Disorder and Dissociation Can Inform Clinical Practice: A Case Study. *Acta Psychiatrica Scandinavica, 121,* 167-178.

Lanius, R. A., Vermetten, E., Loewenstein, R. J., Brand, B., Schmahl, C., Bremner, J. D. et al. (2010b). Emotion Modulation in PTSD: Clinical and Neurobiological Evidence for a Dissociative Subtype. *American Journal of Psychiatry, 167,* 640-647. https://doi.org/10.1176/appi.ajp.2009.09081168

Laub, D. (1992). Bearing Witness or the Vicissitudes of Listening. In S. Felman, & D. Laub (Eds.), *Testimony: Crises of Witnessing in Literature, Psychoanalysis, and History* (pp. 57-74). Routledge.

Liebling-Kalifani, H., Ojiambo-Ochieng, R., Marshall, A., Were-Owino, A., & Musisi, S. (2008). Violence against Women in Northern Uganda: The Psychosocial Effects of War-Related Sexual Violence. *Journal of International Women's Studies, 10,* 24-44.

Maldonado-Torres, N. (2007). On the Coloniality of Being: Contributions to the Development of a Concept. *Cultural Studies, 21,* 240-270. https://doi.org/10.1080/09502380601162548

Malkki, L. H. (1996). Speechless Emissaries: Refugees, Humanitarianism, and Dehistoricization. *Cultural Anthropology, 11,* 377-404. https://doi.org/10.1525/can.1996.11.3.02a00050

Mignolo, W. D. (2011). *The Darker Side of Western Modernity: Global Futures, Decolonial Options*. Duke University Press. https://www.dukeupress.edu/the-darker-side-of-western-modernity

Möller, A., Söndergaard, H. P., & Helström, L. (2017). Tonic Immobility during Sexual Assault—A Common Reaction Predicting Post-Traumatic Stress Disorder and Severe Depression. *Acta Obstetricia et Gynecologica Scandinavica, 96,* 932-938. https://doi.org/10.1111/aogs.13174

Ndlovu-Gatsheni, S. J. (2021). The Cognitive Empire, Politics of Knowledge, and African Intellectual Resistance. *Third World Quarterly, 42,* 1-19.

Ngũgĩ wa Thiong'o (1986). *Decolonising the Mind: The Politics of Language in African Literature*. Heinemann.

Ní Aoláin, F. (2014a). The 'War on Terror' and Extremism: Assessing the Relevance of the Women, Peace and Security Agenda. *International Affairs, 92,* 275-291. https://doi.org/10.1111/1468-2346.12552

Ní Aoláin, F. (2014b). *Women, Vulnerability, and Humanitarian Emergencies*. University of Pennsylvania Press.

Ogden, P. (2020). *Sensorimotor Psychotherapy: Interventions for Trauma and Attachment*. W. W. Norton & Company.

Ogden, P., Minton, K., & Pain, C. (2006). *Trauma and the Body: A Sensorimotor Approach to Psychotherapy*. W. W. Norton. https://pubmed.ncbi.nlm.nih.gov/16530597/

Oxford University Press (n.d.). *Syndrome*. Oxford English Dictionary. https://www.oed.com/dictionary/syndrome_n

Pearlman, L. A., & Saakvitne, K. W. (1995). *Trauma and the Therapist: Countertransference and Vicarious Traumatization in Psychotherapy with Incest Survivors*. W. W. Norton.

Perroud, N., Rutembesa, E. et al. (2014). The Tutsi Genocide and Transgenerational Transmission of Maternal Stress: Epigenetics and Biology of the HPA Axis. *Translational Psychiatry, 4,* e448.

Porges, S. W., & Dana, D. (2023). *Our Polyvagal World: How Safety and Trauma Change Us*. W. W. Norton. https://wwnorton.com/books/9781324030415

Rose, N. (2013). *The Human Sciences in a Biological Age*. Princeton University Press.

Scheff, T. J. (1994). *Bloody Revenge: Emotions, Nationalism, and War*. Westview Press.

Shapiro, F. (2018). *Eye Movement Desensitization and Reprocessing (EMDR) Therapy: Basic Principles, Protocols, and Procedures* (3rd ed.). Guilford Press. https://psycnet.apa.org/record/2017-40757-000

Silove, D., Ventevogel, P., & Rees, S. (2017). The Contemporary Refugee Crisis: An Overview of Mental Health Challenges. *World Psychiatry, 16,* 130-139. https://doi.org/10.1002/wps.20438

Smith, C. P., & Freyd, J. J. (2014). Institutional Betrayal. *American Psychologist, 69,* 575-587. https://doi.org/10.1037/a0037564

Smith, L. T. (2012). *Decolonizing Methodologies: Research and Indigenous Peoples* (2nd ed.). Zed Books.

Smith, L. T. (2021). *Decolonizing Methodologies: Research and Indigenous Peoples* (3rd ed.). Zed Books. https://www.bloomsbury.com/us/decolonizing-methodologies-9781786998125/

Sotero, M. M. (2006). A Conceptual Model of Historical Trauma: Implications for Public Health Practice and Research. *Journal of Health Disparities Research and Practice, 1,* 93-108.

Spivak, G. C. (1988). Can the Subaltern Speak? In C. Nelson, & L. Grossberg (Eds.), *Marxism and the Interpretation of Culture* (pp. 271-313). University of Illinois Press. https://archive.org/details/marxisminterpret00nels

Summerfield, D. (1999). A Critique of the Global Trauma Model. *Social Science & Medicine, 48,* 1449-1462.

van der Kolk, B. A. (2014). *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma*. Viking. https://www.penguinrandomhouse.com/books/313609/the-body-keeps-the-score-by-bessel-van-der-kolk-md/

Volkan, V. D. (2001). Transgenerational Transmissions and Chosen Traumas: An Aspect of Large-Group Identity. *Group Analysis, 34,* 79-97. https://doi.org/10.1177/05333160122077730

Yehuda, R., & Bierer, L. M. (2009). The Relevance of Epigenetics to PTSD: Implications for the DSM-V. *Journal of Traumatic Stress, 22,* 427-434. https://doi.org/10.1002/jts.20448

Yehuda, R., & Lehrner, A. (2018). Intergenerational Transmission of Trauma Effects: Putative Role of Epigenetic Mechanisms. *World Psychiatry, 17,* 243-257. https://doi.org/10.1002/wps.20568

Yehuda, R., Halligan, S. L., & Grossman, R. (2005). Childhood Trauma and Risk for PTSD: Relationship to Intergenerational Effects of Trauma, Parental PTSD, and Cortisol Excretion. *American Journal of Psychiatry, 162,* 163-170.

Zihindula, G., Maharaj, P., & Kazembe, L. N. (2019). Experiences of Children Born of War Rape in the Democratic Republic of Congo: Pathways to Resilience. *Children and Youth Services Review, 99,* 38-45.