

**Mental Health Outcomes of Trauma in the Central African Republic:
Child Soldiering, Forcible Displacement, Rape and Sexual Violence**

*Situation in the Central African Republic II
ICC-01/14*

ICC Prosecutor v. Alfred Yekatom and Patrice-Edouard Ngaïssona

Report Produced by:
Human Rights in Trauma Mental Health Program
Department of Psychiatry and Behavioral Sciences
Stanford University School of Medicine

I. Introduction

This report was created by the Human Rights in Trauma Mental Health Program (HRTMH Program), an interdisciplinary collaboration based at Stanford University and comprising members of the Department of Psychiatry and Behavioral Sciences, the School of Law, and the Palo Alto University Clinical Psychology graduate program. The program faculty and staff include clinical-academic psychiatrists, professors of medicine, professors of psychology, private treating psychotherapists, social workers, human rights lawyers, law professors, professional research fellows, and graduate and undergraduate students. The members of this program have amassed considerable expertise in trauma mental health, violence, and displacement from a range of disciplinary perspectives that render us qualified to submit this report.

This submission is based on our review of summaries of victim statements, confirmation of charges, and open source documents concerning the Situation in Central African Republic II (ICC – 01/14), along with a comprehensive and comparative literature review on the psycho-social impact of extreme trauma on individuals, their families, and their communities, as well as direct experience with survivors in similar contexts. Special consideration is given to the psychological outcomes of trauma related to the charges of in the case under consideration:

- **war crimes:** rape, the use of children under fifteen in combat, displacement
- **crimes against humanity:** rape, forced displacement, deportation

The co-authors of this report have a history of collaborative research and report writing in the context of The Central African Republic. The HRTMH Program has written an expert report on trauma outcomes in CAR in the cases of the *ICC Prosecutor vs. Jean-Pierre Bemba Gombo* and *ICC Prosecutor vs Dominic Ongwen*. Faculty from the HRTMH Program also recently conducted a series of focus groups, semi-structured interviews, and workshops in Bangui, Central African Republic (USAID RFA-OAA-15-000017). This work was undertaken with an interfaith partnership to develop and evaluate the usefulness of a peer-to-peer mental health intervention to treat trauma, depression, and anxiety, and to promote peace. The qualitative findings exhibit a direct connection between events in the Central African Republic and the professional literature describing the short and long-term consequences of trauma.

This report also relies upon our deep knowledge of empirical research that links trauma exposure with psychophysiological and neurobiological outcomes, thereby elucidating

the mechanisms by which child soldier creation, forced displacement, sexual violence, and other forms of extreme trauma give rise to the psychosocial outcomes documented in the record. The report is furthermore informed by our long experience treating, representing, and working with victims of severe trauma in communities wracked by massive human rights violations. Similar conclusions can be reviewed in our expert testimony about the mental health outcomes of sexual violence presented in *ICC Prosecutor vs Jean Pierre Bemba Gombo* and in *ICC Prosecutor vs Dominic Ongwen*. Attached to this report are the relevant *curricula vitae* of our team (Exhibit A), including publications and relevant forensic activities.

The Office of the Prosecutor is investigating numerous crimes that have documented psychosocial outcomes discussed in further detail below. The ICC has reasonable basis to believe that the Séléka and the Anti-Balaka have committed the following war crimes and crimes against humanity: (i) *Murder, cruel treatment and torture*; (ii) *rape*; (iii) *intentionally directing attacks against the civilian population*; (iv) *attacking protected objects*; (v) *conscripting or enlisting children under the age of fifteen years into armed groups or using them to participate actively in hostilities*; (vi) *outrages upon personal dignity*; (vii) *displacement, deportation and/or forcible transfer of population*; (viii) *persecution*; (ix) *imprisonment and other forms of severe deprivation of physical liberty*; and (x) *destruction of the adversary's property* (Office of the Prosecutor ICC II, 2019).

The documented psychosocial outcomes from these multiple traumatic stressors are summarised as follows. The main psychological outcomes are posttraumatic stress disorder (PTSD); anxiety disorders; mood disorders; dissociation; major depression; phobias; and panic disorders. Survivors will likely experience comorbidity with multiple disorders at once in a single individual. These outcomes occur on a broad spectrum of severity, thus making it likely that a cross-societal analysis will reveal individuals with symptomology without a formal diagnosis. Furthermore, the investigated crimes can cause neurobiological and psychophysiological injuries resulting in long-term memory alteration and response to stressors in individuals, turning short- and mid-term individual outcomes into perpetuated mental and social instability. Conflict participants, displaced populations, and psychologically affected groups and individuals will experience stigmatization and social isolation, principal psychosocial mechanisms giving rise to long-term effects, including negative coping mechanisms which may lead to more harm. A further mechanism underlying perpetuated cycles of violence is the occurrence of negative psychosocial outcomes in children.

II. Methodology

In addition to our members' abundant clinical and professional experience with survivors' psychology, the authors relied upon the vast scientific literature in psychology and psychiatry as well as forced migration, displacement, and violence to reach the major conclusions of this report, as we applied general knowledge from the field to the specific contexts and reports relevant to the current charges in CAR. Other data specifically relevant to CAR and to the case in question are cited throughout the report and carry great weight, including real-time displacement data from the time of the crimes.

First, we performed a comprehensive peer-reviewed literature search in psychological and medical journals using keywords such as "child soldiering," "forced displacement," "posttraumatic stress disorder," "reintegration," etc. The results included single studies, meta-analyses (wherein multiple studies are statistically combined to determine a specific subject matter's effects), and review articles (wherein multiple studies are combined in narrative form to draw conclusions on a specific subject matter). Experts within their respective fields have reviewed all cited material. The literature search also included a focus on published studies examining outcomes from CAR specifically in order to incorporate peer-reviewed qualitative and quantitative data sources and references in the report where possible. Second, we consulted other reports from global health agencies and human rights organizations to place the events within CAR into a global context. Furthermore, we used the expert opinions of Dr. Daryn Reicherter, M.D., and Dr. Ryan Matlow, PhD., and Dr. Lisa Brown, PhD. to supplement the data that exists in the psychological and psychiatric literature. Displacement data from the UN's International Organization for Migration was utilised, via the Displacement Tracking Matrix Tool (DTM). Lastly, this report connects the vast empirical literature that exists with actual victim statements.

III. History of Conflict in Central African Republic in the context of The Prosecutor v. Alfred Yekatom & Patrice-Edouard Ngaïssona

The conflict situation in CAR began in 2012. The current trial focuses on crimes committed since August 1, 2012. Multiple actors are vying for power within the country, including governmental armed forces, formal and recognized armed groups, and village defense groups and Zaraguinas (Potts, Myer, & Roberts, 2011). The two main conflicting parties in the conflict are the Séléka who identify as Muslim (Welz, 2016) and the Anti-Balaka, who identify as Christian or animist.

The Séléka rebel group began to congregate in the northeast beginning in 2012 (Human Rights Watch, 2017a) and took their first town on December 2, 2012 (Kane, 2014). In response to the Séléka displacing and murdering many civilians, the Anti-Balaka emerged mid-2013 (Human Rights Watch, 2017a). After a March 2013 Séléka-led *coup d'état*, political and social instability has resulted in thousands of people being killed, maimed, raped, and displaced both within and outside the country.

The government and the Séléka signed a peace treaty, but fighting recommenced once the government did not fulfill its obligations. Subsequently, in March 2013, the Séléka overthrew the president, Francois Bozize. Michel Djotodia, a Séléka leader, was sworn in as interim president in August 2013 and elections were held in 2015. After the overthrow of Bozize in 2013, however, the Anti-Balaka groups began to organize counterattacks (Welz, 2016). The counterattacks largely comprised coordinated offensives on Muslim communities and attacked Séléka outposts. During the offensives, the Anti-Balaka killed civilians, stole or killed cattle, and burned homes. The Séléka forces then retreated to Boassangoa, where they attacked Christian communities, which they associated with the Anti-Balaka, in revenge.

The attacks perpetrated by these two groups thus target individuals of the opposing religion (Human Rights Watch, 2013). Although the conflict seems to be motivated by religious grievances between the Séléka and the Anti-Balaka, political power, resource accessibility, trade control, and national identity have increasingly become the driving motivations for actors involved in the conflict (Vinck & Pham, 2010). In September 2013, the Séléka was dissolved, but fringe Séléka groups have continued to attack Christian communities. In November 2013, Colonel Saleh, an ex-Séléka commander, ordered farmers accused of being Anti-Balaka to be drowned in a river. These attacks resulted in stretches of land in Bossangoa being abandoned to avoid the Séléka attacks. In December 2013, the Anti-Balaka forces attacked the Muslim community within the city and removed the Séléka forces. In response, Colonel Saleh attacked the Christian side. As the bloodshed continued, African peacekeepers attempted to step in to negotiate agreements that would limit the bloodshed (Human Rights Watch, 2013).

Séléka and Anti-Balaka groups have allegedly committed human rights violations which have resulted in the death of thousands and the displacement of over 450,000 people, across 35 different sites in the country. Estimates of 70,000 asylum seekers have fled to the Democratic Republic of Congo, Cameroon, and other countries to claim asylum (Human Rights Watch, 2013). The International Organization for Migration further documented forced displacement cases into DRC, Chad, Congo, DRC, Sudan, and South Sudan (IOM, 2014). The conflict of 2013 led to the Central African Republic ranking third in global, annual displacement figures (IDMC, 2014); and the country continues to

suffer from protracted displacement, with an estimated 20% of the population remaining displaced to date (IDMC, 2020). The actions of both parties are widely believed to include the war crimes of murder, rape, the use of child soldiers, and displacement. Crimes against humanity include murder, rape, forced displacement, and deportation. These crimes are overlapping within the current conflict. For example, female child recruitment into these armed militia usually begins with the rape and abduction of the child. While armed forces have abducted both sexes, Zaraguinas apparently abducted only boys (Potts, Myer, & Roberts, 2011). Moreover, many schools have been taken over by these forces for military purposes (Human Rights Watch, 2017b). Forced migration for the purpose of exploitation (sexual exploitation, forced recruitment and child soldiers) also meets the international crime of trafficking in persons (UN, 2000).

The conflict continues. After being dismantled by African Union and French armed forces, the Séléka have broken into multiple factions that often shift alliances (Human Rights Watch, 2017a). Djotodia stepped down in January 2014 at the behest of the Economic Community of Central African States (ECCAS), but due to the split nature of the Séléka, Djotodia did not have the power to prevent them from continuing their fight. Catherine Samba-Panza was elected the new president by the National Transitional Council of the CAR in March 2014. CAR was suspended from the African Union in 2013 although it was later reinstated (Welz, 2016).

A Special Criminal Court was enacted into law in CAR in 2015. The goal of this hybrid court is to prosecute international crimes at the national level and to break the cycle of victimization and violence. Towards this end, the Special Criminal Court aims to create an environment of accountability within CAR, initiating prosecutions against crimes that have previously gone unpunished. The Special Criminal Court is a novel endeavor, as it integrates national and international judges, prosecutors, and members of the court (Human Rights Watch, 2018).

IV. Mental Health Experts in Central African Republic uses Global Standards for Psychiatric metrics

Our team seeks to apply international standards and best-practices for capturing and conceptualizing the impact of human rights abuse in various specific contexts. Such standards elucidate the universally-recognized manifestations of traumatic stress. These manifestations are generally represented in psychiatric metrics including DSM-5 and ICD-10, which, as practice standards, provide the basis for understanding psychological outcomes of trauma/HR violation. However, we also consider presentations that may fall outside the diagnostic categories in these manuals. While our team did not conduct direct victim interviews ourselves, we know that the information provided in the report is

consistent and relevant because mental health experts in the Central African Republic use global standards for psychiatric metrics including the DSM-5 and ICD-10. These psychiatric measures for mental health disorders are used around the world, and are the gold standard for diagnosing and structuring case conceptualization and treatment plans. On this basis, our team is confident that the following information is relevant to this case and all the evidence used to support our claims use the DSM-5 and ICD-10. Furthermore, victim testimony offers reports and statements that demonstrate the presence of specific symptoms of mental health conditions, as defined by DSM-5 and ICD-10. Therefore, there is converging information and evidence (i.e., from peer-reviewed literature, local data and reporting, and victim testimony) for the presence of DSM-5 and ICD-10 mental health disorders stemming from the crimes in question.

V. Impact of Trauma on Individual Victims

The crimes at issue in this case give rise to multiple forms of trauma within affected individuals. The science and literature have identified broad, common universal outcomes of severe stress and trauma exposure that are based in human biology and psychology. Individual trauma responses and presentation may vary within these broad domains, based on, for example, the individual's cultural, ethnic, or religious background as well as their being displaced from their place, or country, of origin. Individuals who experience extreme trauma like rape, violence exposure (such as that experienced by child soldiers), and forced displacement commonly experience PTSD, depression, anxiety, stigmatization, and negative developmental consequences. These traumatic events are not mutually exclusive. Research has indicated that exposure to multiple traumatic events leads to more severe psychological outcomes (Betancourt, Borisova, de al Soudiere, & Williamson, 2011; Ertl, Pfeiffer, Shauer-Kaiser, Elbert, & Neuner, 2014). The compounding traumatic effects of rape, child soldiering, and forced displacement only serve to exacerbate the individual's difficulties reintegrating into society and, in many cases, create conditions of social exclusion and lack of social safety and support networks. Further, forced displacement deprived individuals (and communities) of economic stability, access to livelihoods, and access to basic social services including health, nutrition, and sanitation which can lead to acute psychological distress as well as physical harm and resorting to negative coping strategies.

A. Psychological Consequences of Trauma

Extreme trauma is well known to cause psychological harm and physical changes in human brains. This statement is backed by vast amounts of scientific literature. Much of the science can be organized into categories that examine the psychological outcomes on individuals, in groups, and in populations. The psychosocial outcomes resulting from trauma are well described in the literature as well. The expected psychological and psychiatric changes hold up well across cultures, languages, ages, and genders in global samples.

Forced displacement, child soldiering, rape, and other forms of severe trauma and human rights violations have been repeatedly correlated with negative mental health outcomes, including PTSD, depression, anxiety disorders, and many other poor outcomes. These results emphasize the debilitating nature of purposeful and often sustained trauma inflicted in the context of human rights violations.

Witness statements from the case exemplify some of the emotional changes resulting from their traumatic experiences:

“P-2582 is a former child soldier who was forced to join Yekatom’s group. ‘I have headaches at all times, I’m scared...’”

“P-2475 was asked about his current situation, he said: ‘I feel angry frequently. When I see people fighting, or when people shout or beat little girls it makes me angry. When I feel angry I try to go to sleep. I try to avoid taking my anger out on someone else. If it gets too much I pour water on my head to cool myself down.’ (OTP-Prosecution Team)”

1. Posttraumatic Stress Disorder

Posttraumatic stress disorder is a chronic and debilitating mental illness. The DSM-5 (APA, 2013) defines PTSD as a symptom conglomerate that results from experiencing, witnessing, or being exposed to traumatic events. These symptoms are divided into four different symptomatology categories: intrusive thoughts pertaining to the event, stimuli avoidance related to the event, negative changes in thoughts and/or mood regarding the event, and hyper-arousal (APA, 2013). Intrusive thoughts may include memories, dreams, dissociation, flashbacks, and psychological or physiological distress when event reminders trigger individuals. Avoidance symptoms may include attempts to evade internal thoughts or emotions about the event or external people, places, and objects that are related to the event. The negative change in mood and/or cognitions include an inability to

remember events surrounding the trauma; negative views about the self, others, and the world; self-blame; negative feelings such as shame, fear, or guilt; anhedonia (the inability to experience pleasure); feeling detachment from people; and an inability to experience positive mood states. In some cases, this has led to individuals resorting to negative coping mechanisms (i.e. a lack of hope or sense of alternative may force a parent to sell their child into early, forced marriage or child labor; a rape victim may remain in a cycle of sexual violence). The hyper-arousal symptoms may include irritability and/or anger; self-destructive behavior; hypervigilance, or a sense of being on constant alert for external stimuli; an exaggerated startle response; decreased concentration; and sleep problems. In order to meet the diagnosis of PTSD, individuals must have one symptom each from the intrusive and avoidance categories, and two symptoms each from the negative changes in thoughts and/or mood and the hyper-arousal categories (APA, 2013).

PTSD symptoms are required to present for at least one-month per the DSM-5 criteria; however, these symptoms have been known to last longer. For example, Burgess & Hollstrom (1979) report that 63% of their subjects experienced long-term effects due to PTSD, while McCahill, Meyer & Fishman (1979) report 33%. Even individuals who were not directly victimized themselves (e.g., sexual assault, forced displacement, or child soldiering) may suffer from PTSD symptoms due to indirect exposure via their loved ones. Included in the criteria for a PTSD diagnosis are situations in which the individual witnesses a traumatic event (e.g., exposure to the conditions of forced displacement, serious violence of child soldiering, or sexual violation) or learns that the traumatic event occurred to a close family member or friend (DSM-5). An assault to a loved one (especially to a caregiver, in the case of children) is experienced as a threat to the well-being of the individual, and thereby serves as a source of trauma.

PTSD symptoms are often long-lasting. A study of the Bosnian population three years after conflict resolution following the Yugoslavia's dissolution found that 45% of the survivors presenting PTSD, depression, or both, continued to suffer from these disorders, and 16% of previously asymptomatic people had developed PTSD (Mollica et al., 2001). With exposure to multiple instances or forms of trauma (e.g., sexual assault, armed conflict, and associated displacement), the risk for PTSD increases (previous research indicates that PTSD rates can double following exposure to combat and conflict) (Hoge et al., 2004). Multiple studies have found that an increase in the number of traumatic events is associated with increased psychiatric symptoms (Vrana & Lauterbach, 1994; Follette, Polusny, Bechtle & Naugle, 1996; McCauley et al., 1997; Nishith, Mechanic & Reside,

2000). Trauma's psychiatric *sequelae* may extend beyond the classic PTSD symptoms when (1) the victim is a child and still undergoing development (which lasts until approximately age 25), (2) the victim has experienced more than one traumatic event in his or her lifetime, and/or (3) the trauma is experienced within an unsafe and insecure caregiving or support system. Similarly, research with survivors of trafficking in persons conducted in many countries- a crime that often includes forced displacement through transfer, transportation, harboring - demonstrates that, in addition to psychosis, survivors of labor and sex trafficking experience high rates of depression, anxiety, and posttraumatic stress disorder (PTSD), self-harm, and attempted suicide (Stoklosa et al, 2017).

PTSD is one of the most common diagnoses associated with violence exposure (including armed conflict and sexual violence; Holmes & St. Lawrence, 1983). This relationship has gained increased scientific attention since the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III), published in 1980 by the American Psychiatric Association.

2. Anxiety Disorders

Anxiety disorders are common outcomes in the context of forced displacement, child soldiering, and rape. The DSM's previous versions categorized PTSD as an anxiety disorder, and the current research indicates a significant overlap between anxiety symptoms and PTSD symptoms (e.g., Ellis, Atkeson, & Calhoun, 1981; Kilpatrick, Resick & Veronen, 1981). Anxiety symptoms and disorders have numerous debilitating effects and consequences for the individual, involving generalized worry and fear that extend beyond reactions to specific trauma incidents. Fear, avoidance, panic, and uncontrollable arousal are common symptoms of anxiety disorders that can lead to significant functional impairment (DSM-5). These symptoms not only affect the individual but have repercussions for family and community. For example, children whose mothers have panic disorder are 6.8 times more likely to develop the disorder, and children with mothers with phobic disorders are 3.1 times more likely to be diagnosed with the disorder at some point in their life (Merikangas & Pine, 2002). Of note, studies conducted in CAR have indicated a much higher prevalence rate (i.e., 53%) of anxiety symptoms, relative to global standards, with higher rates of anxiety attributed to violence exposure (Vinck & Pham, 2010; WHO, 2017). A 2014 study with IDPs in CAR, conducted by IOM, noted the top reasons for displacement as being insecurity, looting, violent attacks, damaged houses, and physical threats; all of which can have a detrimental impact on anxiety (IOM, 2014). The IOM study noted that "displacement is perceived as a major factor

impacting families' livelihoods and future capacity to provide for themselves by restarting economic activities". The study further found that 65% of IDPs would feel security was reestablished when they no longer heard gunshots.

3. Mood Disorders

Mood disorders are a common outcome for survivors of traumatic experience (Steketee & Foa, 1987). According to the DSM-5, depressive symptoms include depressed mood, suicidal thinking, loss of appetite, weight loss or gain, loss of interest, and hopelessness. Irritability and somatic symptoms may also be present (APA, 2013).

Similar to anxiety disorders, depressive and mood disorders extend beyond the individual victim; research suggests that children with depressed mothers have a lifetime depression prevalence rate between 20% and 41% (Goodman, 2007). Children with depressed mothers also experience mental and motor developmental issues, self-regulation problems, and increased negative affect (Goodman & Gotlib, 1999). As with anxiety, prevalence rates of depression in CAR (55%) are demonstrated to be much higher than global standards (Vinck & Pham, 2010; WHO, 2017).

4. Dissociation

Dissociative symptoms are another common response to extreme trauma, particularly when the survivor is rendered helpless in their ability to protect themselves or their loved ones (DSM-5; Freyd, 1996; van der Kolk, Pelcovitz, Roth, et al., 1996). Previous research indicates that approximately half of individuals who develop PTSD experience significant dissociative symptoms (Breire, Scott, & Weathers, 2005) compared to only 4.4% of adults with no diagnosis. Dissociative symptoms include detachment from one's present state, flashbacks, out-of-body experiences (depersonalization), or feeling as if the world around one is surreal or artificial in some way (derealization). The DSM-5 also defines a dissociative amnesia wherein an individual is unable to remember events from the trauma.

Dissociative responses during traumatic events can be viewed as evolutionarily adaptive as they create cognitive and emotional distance from the horror, terror, and pain; however, the same dissociative experiences that are protective during the trauma are maladaptive when they resurface in individuals' subsequent daily lives and can cause significant impairment in functioning when they become

pathological (Freyd, 1996). Carlson, Dalenberg & McDade-Montez (2012) concluded that dissociative symptoms are related to traumatic experiences and their severity, effects can be long lasting, and high dissociative symptoms increase the likelihood and severity levels of PTSD symptoms.

5. Comorbid Mental Health Disorders

Many other mental health diagnoses are related to trauma and are often seen as co-morbid (i.e., occurring simultaneously) with PTSD. In fact, psychiatric disorder comorbidity is thought to be the rule rather than the exception with interpersonal trauma and abuse. For example, forty percent of children exposed to trauma are diagnosed with at least two psychiatric disorders (Copeland, Keeler, Angold & Costello, 2007). Major depression, dysthymia (chronic but less severe depression), bipolar disorder, generalized anxiety disorder, panic disorder, agoraphobia, social phobia, and obsessive-compulsive disorder have all been linked to PTSD (Creamer, Burgess & McFarlane, 2001).

The 1995 National Comorbidity Study discussed above established a historical precedent for understanding PTSD and comorbid disorder. PTSD was found to be comorbid in 47.9% of individuals with major depression, 21.4% with dysthymia, 16.8% with generalized anxiety disorder, 31.4% with specific phobia, and 27.6% with social phobia (Kessler et al., 1995).

Another common mental health comorbidity involves co-occurrence of substance use disorders with PTSD (Kessler et al., 1995). Alcohol and drug use are a common coping mechanism with the significant distress and posttraumatic reactions that result from sexual assault, violence exposure, and other threats to safety. Kessler et al. (1995) found that among individuals with PTSD, 51.9% were diagnosed with alcohol use or dependence, and 34.5% were diagnosed with drug abuse or dependence.

Witness statements from the case exemplify some of the changes resulting from their forced drug use:

“P-2620 witnessed atrocities committed by the anti-balaka in the camp and described her feelings as follows: ‘

While at the camp, I did not think about the bad things which happened there because they used to give me drugs. When I got home I started thinking about these things and I do not feel good about them.’ (OTP-Prosecution Team)”

6. Psychological Distress Without Formal Diagnosis

Inevitably, there will be survivors of trauma who will not receive one of the discrete diagnoses identified above. People who have experienced significant trauma, but do not meet the diagnostic criteria for PTSD have a subsyndromal or subthreshold presentation. A subsyndromal presentation simply means that they have some but not all of the symptoms present to receive a formal diagnosis.

Not meeting full diagnostic criteria does not imply that the person is not distressed and/or experiencing some type of impaired functioning. For example, almost all survivors of sexual assault or severe violence exposure manifest severe negative psychological consequences in the short-, medium-, or long-term. The psychiatric outcomes that fall outside formal psychiatric diagnoses are still considered marked and unwanted. Furthermore, even if classic psychiatric diagnoses do not emerge as direct sequelae of a specific trauma incident, this experience increases risk for future psychiatric disorder following additional exposure to stress, adversity, or trauma.

7 Suicidality

Suicidality can be thought of as suicide attempts or active thoughts about killing one's self. A lost will to live or wishes for early death are also consistent with suicidality. These symptoms are extremely high in survivors of human rights violations. Thoughts of suicide are increased among individuals who have experienced extreme traumatic events involving significant harm or threat to the individual's - or their loved one's - safety and well-being (FerradaNoli, Asberg, Ormstad, Lundin, & Sundbom, 1998; Lerner, Bonanno, Keatley, Joscelyne, and Keller, 2016). The diagnoses of PTSD and depression are risk factors for suicidal behavior. Ferrada-Noli et al. (1998) indicate that suicidal thoughts are most frequently reported by individuals with a dual diagnosis of PTSD and depression.

8. Negative coping mechanisms

Positive, effective coping strategies are employed by conflict affected populations to ensure their physical and psychological well-being. The impact of forced migration, displacement, sexual violence, or other war crimes and crimes against humanity - the impacts being mental health distress, harm, social exclusion, discrimination, economic devastation - can however force affected individuals and communities to resort to negative coping strategies. This has been most

recently documented in conflicts in Syria, Iraq, and Afghanistan. In a study of the coping strategies of Syrian refugees in Jordan, Alzoubi et al (2017) found that the prevalence of mental disorders among refugees indicates that they have poor coping mechanisms and need professional assistance to be able to cope with their stressful situations in a successful way. The study further noted that individuals exposed to forced migration may adopt negative coping strategies to address the stressors that occur in their daily lives post-migration such as substance abuse, provision of sexual services, early marriage, and gender-based violence. Similarly, the Afghanistan Protection Cluster noted a rise in negative coping strategies leading to protection concerns, including child marriage and worse forms of child labor, following the large scale deportation and return of Afghans from Pakistan and Iran (UN, 2017).

B. Neurobiological and Psychophysiological Responses to Trauma

Extreme stress, trauma, and victimization—including sexual assault, violence exposure, and forced displacement—essentially injure the stress response system, resulting in lasting neurobiological, physiological, and psychological consequences. Extreme stress and trauma impact the brain and central nervous system with an array of physical, psychological, social, and functional impairments that drive the psychiatric disorders described above. These neurobiological injuries to the stress response system are now known to be a universal biological response consistent across individuals, cultures, and mammalian species (Bale, 2015).

1. Stress and the Human Brain

The brain has complex, interconnected regions working in concert, each performing specialized functions to keep the organism alive. Especially relevant to human functioning and the stress response are the prefrontal cortex (PFC) and the limbic system. The PFC commands oversight, regulation, and executive control. It is involved in rational thought, logic, problem-solving, impulse control, self-regulation, and self-awareness. In contrast, the limbic system handles emotional responses and processing. Structures in the limbic system (i.e. the amygdala, hippocampus, and thalamus) participate in emotions, reward, motivation, and memory formation. Known as the “fear circuit,” the limbic system detects threats and activates when potential environmental dangers are perceived, to enable safety and survival responses (such as ‘fight,’ ‘flight,’ or ‘freeze’).

The PFC and limbic system communicate constantly with one another via neural pathways that form a regulatory feedback loop in which cognitive processes (from the PFC) influence emotional responses (in the limbic system), and vice versa. Experience shapes activation and communication between the PFC and limbic system. Hebb's rule, a primary neuroscientific principle, is commonly paraphrased as "neurons that fire together, wire together," meaning that activation becomes mutually reinforced (Hebb, 1949). Two brain regions' connective networks and pathways are in regular communication and co-activation becomes strengthened in order to facilitate learning and adaptation. Through repetition (and Hebb's rule) our life experiences shape activity patterns and interaction among neural systems. Exposure to trauma and traumatic stress results in emotional and instinctual responses prioritization from the limbic system, over the regulatory and intentional process stemming from the PFC.

With limited resources to achieve survival, any perceived environmental stressor (such as that stemming from sexual assault, violence exposure, and forced displacement) requires a resource reallocation in order to address the threat. The brain—which demands a constant blood and oxygen supply—responds to perceived stress, threat, or trauma through "shutting down" the PFC (literally reducing activity in this region) and allocating resources to regions coordinating instinctual survival responses (i.e., the limbic system, in order to trigger the "fight or flight" response), as well as regions regulating respiration, body temperature, and heart rate. Shutting down the PFC in times of danger preserves resources, but it also leaves lower order neural structures (such as the limbic system) unregulated and disorganized (Damasio, Grabowski, Bechara, et al., 2000). The limbic system essentially "hijacks" the brain as the alarm response is triggered and PFC shuts down. A useful analogy is a rider on a horse, where the rider (PFC) exerts control and regulates the system, and the horse (limbic system) responds emotionally and instinctively (van der Kolk, 2014). When the horse (limbic system) is threatened, the rider (PFC) gets temporarily thrown off, as does the capacity for oversight, regulation, and executive control. The limbic system becomes the primary determinant of behavior and function, initiating "fight, flight, or freeze" survival reactions: automatic emotional, cognitive, and physiological responses that prepare an organism to respond to threats with aggression, self-defense, escape, or paralysis. Such responses to threat generally prove adaptive because they eliminate the PFC's slower and deliberative evaluation processes. Even the 'freeze' response (called "tonic immobility"), common in rape and sexual assault, is an adaptive automatic response (seen across all mammals) circumventing increased fight or flight risks (i.e. when escape is impossible, or when flight may incite chase; Fuse et al., 2007; Heidt et

al., 2005). These neurological and physiological response patterns (where a hyperactive limbic system subdues the PFC) can become maladaptive with no genuine danger and turn pervasive after extreme trauma.

The brain's response to stress interacts with the body's physiological functioning via the hypothalamic-pituitary-adrenal (HPA) axis (Southwick, Vythilingam, & Charney, 2005). The limbic alarm response activation releases stress hormones (adrenaline and cortisol) in the brain and the body; these prepare an organism for both short-term and long-term stress exposure. The stress hormones' release activates the sympathetic nervous system (SNS) and triggers the "fight or flight" response: increased heart rate, dilated blood vessels in skeletal muscles, dilated airways in the lungs, and other reactions ensuring an individual's readiness to face imminent threats. The parasympathetic nervous system (PNS) performs opposing functions: decreasing heart rate, constricting lung airways, and constricting blood vessels. The parasympathetic (PNS) response counteracts the sympathetic (SNS) response once danger subsides. Rhythmic, regular fluctuation in SNS and PNS activation helps maintain physiological allostasis. Prolonged SNS activation in times of extreme stress (i.e. during and after sexual assault, and chronic insecurity and instability) disrupts this allostatic balance, leading to pathophysiological states and negative physical and mental health outcomes (McEwen, 1998; McEwen & Wingfield, 2003; Sapolsky et al., 2000; Boyce & Ellis, 2005; Herbert et al., 2006).

Our perceived loss of control during extreme stress becomes a critical factor leading to negative psychological, physical, and functional outcomes. Neuroscience principles illustrate how psychological, physiological, and behavioral responses become engrained through repeated exposure to threat or threat reminders. Our reactions to trauma have lasting impacts on neurobiological structure and function, exemplified through specific 'injuries' to the stress response system and the individual (Bale, 2015; Teicher & Samson, 2013; Van der Kolk, 2006).

2. Sensitization of the Alarm Response

A sensitized alarm response is a long-term consequence to chronic trauma exposure. The alarm response activation during trauma exposure (e.g., violence or loss of home) results in subsequent neural pathway strengthening associated with responses to danger and insecurity, resulting in higher limbic activation baseline levels (Yan et al., 2013) that indicate a chronic alert state (hypervigilance). The threat detection system and HPA axis stress response become chronically active,

primed to identify potential threats and trigger the alarm response. Chronic hypervigilance persistently drains neurological and physiological resources. The amygdala—a central emotion processing region in the limbic system—shows greater activation (exaggerated startle) in response to emotional and ambiguous information in individuals with trauma histories (Teicher & Samson, 2013; Teicher et al., 2016). These findings are paired with decreased structural volume (indicating under-development) and reduced PFC activation in individuals suffering from posttraumatic stress (Teicher & Samson, 2013).

Individuals exposed to trauma and traumatic stress, in result, have a significantly lower threshold for triggering the alarm response (i.e., the limbic system more easily “hijacks” the higher order pre-frontal executive control systems and the PFC is less adept at re-regulating and dampening the alarm response). This is due to trauma’s long-term neurological consequences that result in strengthened bottom-up pathways from an overactive limbic system to the PFC and weakened top-down pathways from the (underactive) PFC to the limbic system (Yan et al., 2013; Teicher et al., 2016). These structural changes affect the ability to regulate cognitive, emotional, and physiological reactions to perceived or potential threats. It becomes natural and automatic for the system to enter “fight, flight, or freeze” survival mode, where executive control and rational decision-making are largely absent. An overactive alarm system may promote survival in a dangerous world, but proves maladaptive in other contexts, as innocuous environmental stimuli frequently summons the “fight, flight, or freeze” alarm response, compromising the ability to re-regulate.

3. Physiological Brain Consequences

As with the short-term stress response, trauma exposure’s long-term neurological consequences mirror long-term physiological consequences to the body’s systems. Long term traumatic stress on physiological systems alters both acute responses to stressors as well as general function (see Teicher & Samson, 2013, for review). Ongoing danger perceptions, helplessness, or control loss result in chronic stress response hyper-activation, stimulating increased and prolonged stress hormones release, which are toxic to psychological and physiological systems when released in excess (Bremner, 2006; Gunnar & Vasquez, 2001, 2006; McEwen, 2007; Sapolsky, 2005, 2012). For example, adrenaline release puts the organism in “fight, flight, or freeze” mode for survival but disrupts homeostasis as the system attempts to maintain a regulated balance.

The PNS, or our physiological “brake,” can either atrophy from underuse or deteriorate with overuse in response to extreme trauma or chronic perceived threat. Individuals with trauma exposure have demonstrated dysregulated cortisol responses to acute stress, showing hypersensitive stress hormone responses in some cases and dampened responses in others (Teicher & Samson, 2013). With general functioning, two-thirds of children and adults exposed to trauma show increased adrenal activity (DeBellis, Keshavan & Clark, 1999; DeBellis, Leterer & Trickett, 1994), but low levels of baseline cortisol (Gunnar & Vasquez, 2001; 2006; Meewise, 2007; Trickett, 2010; Walsh, 2013). This implies these individuals are hypersensitive to threat (more easily triggered into “fight, flight, or freeze” reactions), but otherwise operating at low levels of general activation (i.e., the system operates in a chronically depressed state, often fatigued from compensating for multiple alarm reactions).

Trauma exposure has also been shown to increase cortisol levels at bedtime (Carrion et al., 2010); in other words, individuals are prepared for danger even when the body should be settling down for rest, negatively impacting sleep quality. Such research is consistent with findings that stress and trauma exposure disrupts circadian rhythms (Lupien et al., 2009). This means that individuals experiencing traumatic exposure and stress often struggle with attention, memory, and emotion regulation. To cite again the study by IOM with IDPs in CAR in 2014, 65% stated that they would only feel security had been re-established with the absence of the sound of gun shots (IOM, 2014).

4. Impact on Memory

Neurotransmitters and hormones involved in the stress response alter memory formation through strengthening neural connections and through preserving and enhancing emotional memories and response patterns as adaptation in case the threat returns (McGaugh & Hertz, 1972; Cahill & McGaugh, 1998). Memories formed during traumatic experiences are often more vivid and visceral (due to adrenaline secretion on memory formation), but are also due to disintegrated functioning and communication across neural systems (Southwick et al., 2005). The results are emotionally-laden memories from traumatic experiences that are disorganized and fragmented, affected due to stress-impaired memory consolidation (Roosendaal et al., 2009).

When traumatic experience reminders (images, sounds, sensations) activate the memory trace, the individual returns to the disorganized, dysregulated state that they experienced during the trauma. This state again involves reduced prefrontal

activation, unregulated limbic activity, and stress response system overstimulation. The trauma is often “re-lived” or “re-experienced” repeatedly in the victim’s life, even when they have returned to a relatively safe and stable environment. Even when trauma survivors are safe, their psychophysiological and neuroendocrine responses are conditioned to traumatic experience reminders. The lasting and pervasive neurobiological responses to extreme stress and trauma described above serve as a primary mechanism to increase risk and prevalence of the numerous psychiatric, psychological, social, occupational, and health impairments following experiences of forced displacement, sexual assault, violence exposure, and forced displacement. Studies have found a high prevalence of survivors of trafficking in persons, many of whom have faced forced migration (recruitment, transfer, transportation, receipt, harboring), facing memory impact (Stoklosa, 2017).

Trauma’s relation to memory does not necessarily diminish a witness's ability to recall events and witnesses with PTSD and other trauma related mental health outcomes are very capable of providing accurate and detailed accounts of events. However, a trauma survivor’s presentation of information about the trauma may be disorganized or appear incoherent, due to the emotional dysregulation associated with trauma recall.

C. Consideration of the Impact of Trauma on Child Development

An important factor in understanding the impact of trauma from forced displacement, child soldiering, rape, and sexual assault is the individual’s developmental stage during the assault. Human development occurs iteratively, in stages, in which developing skills in cognition, regulation, coordination, language, and interpersonal functioning inform and interact with one another in an interdependent fashion (Groh et al., 2014). Developmental competencies are learned during specific “sensitive periods” in which the system is more sensitive to specific input, based on increased neuroplasticity in specific brain regions (e.g., Hubel & Wiesel, 1962; Elbert et al., 1995; Siegler, et al., 2014). Although developmental processes and sensitive periods are in many ways ingrained in our genetic code, the code expression is environmentally influenced (Bale, 2015). Trauma (including sexual assault, violence exposure, and home insecurity/displacement) experienced during childhood or adolescence have been shown to have more pervasive and severe consequences than adult exposure due to the negative impact on the cognitive, intellectual, executive functioning, emotion regulation, and interpersonal skills development (National Scientific Council on the Developing Child, 2005; Shonkoff et al., 2012; Teicher & Samson, 2016).

Children's developmental trajectories and skill attainment are environmentally determined including (1) the need for the skill, (2) the resources available to allocate to developing skills, and (3) environmental responses to use of the skill (Shonkoff, 2016). Experiences of trauma and adversity—including threatened death, injury, or sexual violence—alter these factors, thereby impacting the developmental trajectory (Lupien et al., 2009; National Scientific Council on the Developing Child, 2005; Shonkoff et al., 2012; Teicher & Samson, 2016). Trauma alters child development through prioritizing survival tasks and consequently interfering with other developmental tasks (diverting resources away from learning and growth). A child exposed to abuse, violence, and threat will need survival (i.e., fight or flight) skills more than executive control and emotion regulation skills. A child living in chronic fight or flight mode will continue to allocate her resources to survival, rather than to developing skills in language, planning, or creative problem-solving. The child may receive input that their efforts to regulate their emotions do not make the world a safer place and do not effectively remove the threat, so their brain will stop allocating resources to these skills and may instead develop dissociative responses to establish self-preservation.

The dissociative reactions to trauma assault then generalize to other contexts and become engrained across development. Stress response system activation in response to severe or chronic trauma exposure during child development leads to long-term difficulties with emotional and behavioral regulation, with lasting difficulties that extend beyond the hyperarousal and re-experiencing of symptoms that are exhibited in PTSD in adulthood. The dysregulating stress response effect results in a neurological, psychological, and physiological dis-integration (Teicher, et al., 2002), further contributing to experiences of dissociation and dissociative disorders for individuals exposed to sexual assault in childhood (Putnam, 1985; van Ijzendoorn & Schuengel, 1996). The injuries to cognitive, emotional, and behavioral regulatory capacities lead to lasting impairment in self-care, as well as academic and vocational performance, among other difficulty areas.

Difficulties stemming from exposure to trauma in childhood also correspond with lasting alterations in individuals' sense of self, as well as relationships with others. Children begin to internalize their adaptations to trauma exposure (e.g., impulsivity, difficulties with regulation) as personal flaws, leading to poor self-worth and poor self-efficacy (for example, learned helplessness). When untreated or unaddressed, children often assume that they are responsible for the traumas they experienced, leading to lasting feelings of guilt, self-blame, shame, or worthlessness. These self-attributions lead to difficult interactions with others; childhood exposure to violence and abuse has been linked with disrupted attachment, poor social skills, difficulties with trust and security in relationships, and poor interpersonal effectiveness (for review, see D'Andrea et al.,

2012). Trauma exposure in childhood, such as child soldiering or forced displacement, is commonly associated with functional impairment including social isolation, impaired security and stability in relationships, and risk for further trauma or victimization (Finklehor et al., 2007). Past studies have demonstrated significant increases in rates of adulthood victimization among women who were raped as a child compared with women who were adults when they were assaulted (Roodman & Clum, 2001).

As trauma-related development difficulties and skill deficits become engrained over time, childhood trauma becomes a major risk factor for severe mental illnesses (beyond PTSD), including mood disorders, psychotic disorders, and personality disorders (Teicher et al., 2016). Exposure to repeated or multiple traumas specifically during childhood (but not adulthood) is related to increased symptom complexity, psychiatric comorbidity, and difficulty with emotional and interpersonal regulatory functioning in adulthood (Cloitre, et al., 2009; Copeland et al., 2007; D’Andrea, et al., 2012). Even those individuals exposed to childhood trauma who do not exhibit clinically significant psychopathology still demonstrate the alterations in neural structure and function that correspond with childhood trauma, indicating that they are affected, but may have compensatory strategies for the injuries trauma exposure exposed (Teicher et al., 2016).

The Adverse Childhood Experiences (ACE) studies demonstrate how the neurological, physiological, and psychological impact of childhood trauma is linked with long-term functional impairment. An adverse childhood experience is a traumatic event occurring before the age of 18. These large-scale epidemiological investigations highlighted associations between childhood exposure to adversity and trauma and the long-term physical and mental health impairments linked to poor performance outcomes (including financial problems, alcohol and substance abuse, criminal behavior, and poor quality of life) and the leading causes of death in adults (e.g., heart disease, pulmonary disease, suicide) (Felitti, et al. 1998; Dube et al., 2003). The ACE studies found significant risk for negative health and performance outcomes for individuals who had experienced three or more ACEs (with sexual abuse, violence exposure, and instability in the home environment being some of the defined contributing ACEs). Of note, exposure to six or more ACEs was shown to be associated with a 20-year reduction in life expectancy (Brown et al., 2009), indicating that violence and chronic insecurity can contribute to a shortened lifespan for survivors, particularly when such experiences occur within the context of additional life adversities.

E. Intergenerational Transmission of Trauma

Clinicians and physicians have long noted the heightened levels of distress and psychopathology in the children of trauma victims, even when the children themselves were not exposed to traumatic stress. Research has confirmed that parental trauma

exposure corresponds with increased risk for PTSD, mood disorders, and anxiety disorders in children (Yehuda, Halligan, & Bierer, 2001; Yehuda et al., 2015). These observations led scientists to investigate the mechanisms where traumatic distress is transmitted intergenerationally from a traumatized (or trauma-exposed) individual to their children. Intergenerational (or trans-generational) trauma is a trauma that has been directly or indirectly passed down from one generation to another generation (Dass-Brilaford, 2007).

Intergenerational trauma originally developed from studying Jewish Holocaust survivors and their families, resulting in a testable and verified model of the mechanisms by which Holocaust survivors' trauma impacted the functioning and well-being of future generations (Danieli, Norris & Engdahl, 2016). Research has shown that intergenerational trauma transmission not only presents in the second generation (Grunberg & Markert, 2012) but also the third generation (Winship & Knowles, 1996). Besides the study of Holocaust survivors and their families, the study of intergenerational trauma has expanded to other groups' experiences, such as Asian-Pacific Islanders who experienced cultural trauma (Maren Ulriksen De Vinar, 2012) and survivors of South American Political Violence (Bith-Melander et al., 2017), among others.

Traumatization that is incurred through wartime activities can cause intergenerational effects if the traumatization affects the parent's ability to be a caregiver. This can traumatize the child, who observes and copies this behavior through socialization. A parent's PTSD experience has been correlated with increases in internalizing problems and hyperactivity in their children. Children whose parents suffer from depression experience social difficulties and internalize mental health problems due to their caregiver's limited interactional responses and engagements. Children whose parents suffer from PTSD manifest low self-esteem, depression, and antisocial conduct due to their parents' difficulties with relational engagement and emotion dysregulation. A parents' trauma-related heightened emotional reactivity toward their children can increase their child's depression, anxiety, and aggression (East, Gahagan, & Al-Delaimy, 2018). Individuals who were former child soldiers who have physically abused their own children have increased the distress their child experiences through their child's PTSD. An increase in their child's PTSD symptoms was also exhibited in relation to distancing, withdrawal, attachment and intimacy difficulties and psychological absence exhibited by former child soldiers (Song, Tol, & De Jong, 2014).

In addition to the impact of trauma on parenting and family relationships (discussed above), intergenerational transmission of trauma is now also attributed to the trauma-related neurobiological and psychophysiological alterations that are passed from one generation to the next. The neurobiological alterations associated with PTSD and

traumatic distress have also been observed in survivors' children, a finding that has been attributed to trauma exposure impact on an individual's genetic code expression (i.e., epigenetics; Yehuda et al., 2015). Past research has demonstrated that environmental influences such as stress exposure can "reprogram" the genetic blueprint for neural and biological systems development in rats and mice; these changes in the blueprint are subsequently passed onto offspring (Bale et al., 2010; Bale, 2015). These findings have more recently been translated to humans, as parental trauma exposure has been found to alter how the genes that code for the psychophysiological stress response (e.g., release of glucocorticoids) are regulated both in the trauma-exposed individuals and in their children. These findings reveal how exposure to trauma such as sexual assault, violence exposure, and chronic insecurity can alter the victims' and their children's biology, providing a biological explanation for the intergenerational transmission of trauma and traumatic stress. Similarly, protracted conflicts leading to protracted internal displacement and forced migration abroad can significantly impact the broader development of individuals, families, and communities. A study with IDPs in CAR in 2014 noted that their displacement was a longer-term development obstacle with "stability, lack of security, economic vulnerability impacting on the capacity to provide" (IOM, 2014: 16). We can therefore expect that sexual assault, child soldiering, and forced displacement that were committed CAR will correspond with alterations in the biological stress response (which subsequently influences psychopathology and functioning) both in current victims and in future generations, therefore underscoring the pervasive and lasting impact of the crime.

F. Psychological reactions to the destruction of culturally significant property and religious sites

The destruction of culturally significant property and religious sites is weaponized to heighten the burden of intergenerational trauma and prevent societal rebuilding. Currently often overlooked in the trauma psychology literature, the deliberate destruction of important sociocultural infrastructure and symbols is not forgotten by perpetrators; long used as a tactic in warfare, it is particularly prevalent in conflicts with a genocidal turn, such as the inter-communal civil war in CAR, and is covered widely in the social science and history literature.

Specific to the conflict at hand, the targeted destruction of both mosques and churches has been documented throughout the CAR civil war, and is part of the conflict's cycle of increasing Muslim-Christian sectarianization. The cycle of sectarianization plays out through a cycle of inter-communal retribution located in religious sites, for instance in mass shootings of Muslim refugees hiding in churches and their Christian protectors (Associated Press, 2014). Already in 2015, the US ambassador to the United Nations

reported the “chilling” news that 417 of CAR’s 436 mosques had been destroyed (Anna, 2015). One Muslim neighborhood remains in Bangui, the capital, with a “terrified population”; Muslim women interviewed reported fear of leaving the house in their veils, even choosing to give birth at home instead of at hospital to avoid violence (Anna, 2015). In 2003, Bozize’s militia attacked and looted religious institutions in Sibut. Two sisters were shot during this attack at the Sainte-Famille and another was injured at the Petit seminaire. The militia pillaged any valuable goods they could find (MINUSCA, UNDP, United Nations Human Rights, & Violences Sexuelles en Conflit, 2017). Such is the goal and the effect of the destruction of culturally significant property and religious sites, deliberate or not: the visible and marked clearing of the presence, memory, and future of a community through the razing of its sociocultural infrastructure.

The destruction of culturally significant property, sites and artefacts has therefore long been weaponised in war and genocide for exactly its profound psychological effects: “because in recognizing the enemy’s sacred symbols, you are de facto recognizing their humanity, their capacity for pride, unity, and connection to their past and, probably most of all, their capacity for experiencing pain” - and in denying their symbols, you are in turn denying their capacity for pride, unity, past and humanity (Sapolsky, 2017).

The effects of the destruction of the sociocultural infrastructure of a community could be reasonably conceptualised similarly to the destruction of the survivor’s role in the community, but on a far grander scale: preventing the post-conflict societal reintegration of minority communities given the violent cutting of psychological attachment to a space.

The psychological trauma that arises from the razing of physical markers of sociocultural importance is moreover compounded by the permanence of the site or artefact’s loss. The witnessing of destruction or desecration of cultural or religious sites is often tied to the witnessing, participation in, or experience of an atrocity or act of violence - for instance, the church shootings in CAR - and is thus difficult to separate from the general development of PTSD and other trauma psychology as discussed above. However, specific to the experience of loss of a cultural artefact or site is its permanence, adversely contributing to the long-term psychological response of bereavement and complex grief. The connection between PTSD and bereavement and grief after loss from man-made disaster and the experience of injustice has been previously demonstrated in the psychology literature, and thus can be reasonably extrapolated to apply to loss of significant socio-cultural infrastructure due to conflict (Choi H & Cho S., 2019). Further, in CAR, civilians sought refuge in places of worship and cultural significance (IOM, 2014); where these buildings continued to be targeted, this would have led to an accumulation of stress and lack of a sense of safety.

VI. The Broad Impact of Trauma on Interpersonal, Community, and Societal Functioning in the Central African Republic: Destruction of Survivors' Role in their Community

Sexual violence, child soldiering, and forced displacement are human rights violations that disrupt survivors' role in their community. As a result, when large proportions of a given community experience trauma, general community functioning and stability are negatively impacted in severe and lasting fashion. Being displaced often erodes the very fabric of community and societal functioning, with many displaced populations experiencing social isolation and community tensions. The consequences of trauma and extreme stress are manifest in family, community, and social systems, in addition to the psychological, physical, and functional impact that is observed in individual survivors. The systemic manifestation of traumatic stress is understood according to "the parallel process" concept, which states that "when two or more systems (individuals, groups, or organizations) have significant relationships with one another, they tend to develop similar, thoughts, feelings, and behaviors" (Smith, Simmons, & Thames, 1989, p. 13). Just as the trauma can dysregulate, destabilize, and debilitate individuals, communities and social systems suffer similar consequences (Bastick et al., 2007). The shared development of similar trauma-related psychiatric outcomes may occur between two individuals within the same system (e.g., a youth's experience of helplessness or hopelessness following being a child soldier may translate to a parent's sense of inability or powerlessness to help her child), or across different levels of the system (e.g., organizations providing services to victims of child soldiering can often be found to operate in an "alarm state" similar to the psychological state of the individual survivors).

Organizational and societal systems may function in an "alarm state" characterized by emotional reactivity, systemic hyperarousal (e.g., constant crisis), and general lack of safety (including physical and emotional threat, punishment, and blaming/scapegoating); all such reactions parallel individual PTSD symptoms. Organizational and community systems may repeatedly re-enact unsuccessful or unhelpful strategies, a form of re-experiencing trauma also consistent with PTSD. Similar to individual-level disorganization and dissociation, systems exposed to trauma commonly experience dissolution and fragmentation of structures, characterized by blurred organizational/societal boundaries, as well as breakdowns in communication and relationships among individuals within the system. Host communities (of IDPs, asylum seekers, and refugees) in many instances support those suddenly displaced into their community; but in other instances there can be a degree of reaction or tension, further impacting upon the psychological and physical well-being of forced migrants.

The systemic manifestations of traumatic stress engenders understanding the clear and pervasive impact of trauma on the functioning of families, organizations, communities,

and societies affected by the crimes committed in CAR. Societal-wide manifestations of trauma (for example, the impacts on parenting, social functioning, and organizational/institutional supports) have been shown to occur repeatedly in traumatized populations, and there is every indication that communities surviving trauma will manifest systems- and societal-level dysfunction and impairment, consistent with those observed in individual survivors experiencing symptoms of, for example, PTSD and depression. Such societal outcomes have been observed and documented repeatedly in cross-cultural historical and scientific literature (e.g., Van Schaack, Reicherter, Chhang, & Talbott, 2011).

Witness statements from the case exemplify some of the changes resulting from child soldiering:

P-2476 is a child soldier who voluntarily joined the anti-balaka in Mbaiki after his cousin's killing by the Séléka.” “

“P-2511 is a former child soldier, who was 13-years-old when he was recruited by the anti-balaka after his father's death.” “

“P-2475 was taken by the anti-balaka four months after Sélékas arrival in Pissa.”

The children came from all over CAR, they had voluntarily joined the anti-balaka (for food, protection, to avenge the killing of parents), had varying roles within anti-balaka (including cooks, spies, soldiers). It is mentioned that some of the child soldiers spent at least 11 months in the militia; that some of them, after sensitization operations, decided voluntarily to leave the anti-balaka in order to return to their families. (OTP-Prosecution Team)”

A. Parenting and Child Development

The Committee on the Psychosocial Aspects of Child and Family Health and The Task Force on Terrorism of the American Academy of Pediatrics (AAP) concluded that “any effect of trauma on key or trusted adults can result in magnified psychological effects on the children they care for” (Hagan & the Committee on Psychosocial Aspects of Child and Family Health and the Task Force on Terrorism, 2005). In one study, hyperactivity, conduct problems, peer problems, and emotional problems were reported in the children of mothers with a history of child sexual abuse compared to the children of nonabused mothers; these child difficulties were attributed to the parent's mental health and psychological problems stemming from their own experiences of abuse (Roberts et al.,

2004). Parents who are depressed and suffering from PTSD have greater difficulty comforting their children, are more likely to ask children to take on an adult role, are less likely to bond well with their children, and are more likely to abuse and neglect their children (Field, 2011). There is strong evidence that the children's ability to heal from trauma and adversity is closely linked to the mental health of their mother (Smith, Perrin, Yule, Rabe-Hesketh, 2001).

Bowlby (1969) proposes that patterns of early interactions between the individual as a child and their caretaker contributes to individual adult psychopathology. For caregivers who are effectively disturbed by trauma, the provision of sensitive guidance, regulation, and fun during social encounters with their children may be a challenge (Kaitz, 2009). For some parents, pathological trauma reactions may be related to exaggerated responsiveness towards their children in the form of intrusiveness or overprotection (Lyons-Ruth & Block, 1996), reflecting a need to control surroundings, pervasive fears and apprehensions, and a proneness to hyperarousal, which are usually key features of stress disorders, including PTSD (Barlow, 2002).

B. Interruptions to Parent-Child Bonding

Trauma victims may alternatively adopt a withdrawn stance with their children due to their own emotional and physical pain and to protect themselves from further arousal (Lyons-Ruth & Bock, 1996). Withdrawn mothers may avoid interactions with their children if they can; if they cannot, they are likely to have difficulties in focusing on, interpreting, and responding appropriately and consistently to their children's signals (Kaitz, 2009). Children with a history of dysregulated and inconsistent parent-child interactions can develop atypical behavioral patterns toward caregivers, core insecurities, disturbed emotional repertoires, deficient social communication and difficulties in regulating emotions and behavior (Eisenberg et al., 1998). Researchers have related these adverse effects to children's learned helplessness, lack of control, chronic stress, deficits in self-regulation, and felt-insecurity (Weems & Silverman, 2006). Such findings provide further examples of the ways in which outcomes of trauma committed in CAR may continue to perpetuate in parent-child relationships, thereby impacting multiple generations.

Families are less accepting of children born outside of marriage, and the mother often feels the need to protect her children from discrimination in her current home. However, the child may not receive the care they need within the maternal family. Raphael (1986) describes that across many environments, surviving traumatic events frequently begin with high levels of support; however, these support systems tend to weaken as time passes. These inconsistent support systems can be difficult for a vulnerable population

such as young children separated from their mothers. For example, in the DRC, gender-based and sexual violence have been occurring for over a decade in the context of ongoing conflicts. Researchers have investigated the prevalence of PTSD and depression and found that in 2010, the prevalence of depression was 41% and that of PTSD was 50% (Johnson et al., 2010).

Witness statement from the case exemplify the complexity of multiple traumatic experiences co-occurring:

“P-2462 is a victim of rape and forcible transfer. On 5 December 2013, P-2462 was home with her family when the anti-balaka attacked Bossangoa. As they went out of the house to seek refuge at the Imam’s compound, they were attacked by eight anti-balaka fighters. Separated from her family during the escape, P-2462 was taken to an empty school by a group of 5 anti-balaka fighters and raped by the chief of the group named [REDACTED]. The next day she was found by the Fomac and taken to Ecole Liberte with the rest of the Muslim community (OTP-Prosecution Team).”

C. Impact on Relationships and Family Functioning

Exposure to extreme trauma is known to disrupt general family functioning, both when the trauma survivor is a parent or caregiver and/or when the survivor is a child within the family. Sexual assault, violence exposure, forced displacement, and the resulting psychiatric symptoms impact the quality and nature of family relationships through dysregulation in functioning, as well as through disruptions in general family stability and security. Given that humans are social creatures who define themselves through their interactions with others and through their positions within their communities (Bowlby, 1969), extreme trauma can have a devastating impact on individual, family, and community functioning due to violations of trust and security within interpersonal relationships.

VII. Trauma Effects of Displacement; Specific Mental Health Reactions to Forced Displacement

A. Traumatic Effects of Displacement

Forced migration results in the displacement of people within the borders of a country as well as across an international border. 4.2 million people globally are stateless. From an anthropological and social perspective the actual distance an individual moves is irrelevant in the sense that a displacement of even several hundred meters can have devastating consequences on people removing them from religious, ethnic, cultural and

economic support networks. Some people on the move fall into clear legal categories - asylum seekers, refugees, IDPs- while others will comprise 'mixed migration flows'. The legal status of displaced persons - forced migrants - can impact upon their access to basic services, and is thereby important for their physical as well as psychological well-being.

Insecurity and lack of a sense of safety during times of conflict forces individuals to flee from their places of origin; in other instances, war results in civilians being recruited or kidnapped for the purpose of their exploitation or harm also leading to forced mobility. Displaced populations often face a traumatic, stressful, and unsafe journey to reach safety- in the case of CAR, following events of 2013, displaced persons were attacked during their journey and relocation (IOM, 2014).

Refugees, asylum seekers, migrants and IDPs further end up residing in both formal and informal settlements, with differing levels of access to basic social services, employment opportunities, social networks, and freedom of movement.

The definition of a refugee is enshrined in international refugee law (1951 Refugee Convention): "someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion."

The Guiding Principles on Internal Displacement define internally displaced persons (IDPs) as "persons or group of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situation of generalized violence, violation of human rights or natural or human-made disasters, and who have not crossed internationally recognized state border" (UN, 1998).

While there is no formal legal definition of an international migrant, most experts agree that an international migrant is someone who changes his or her country of usual residence, irrespective of the reason for migration or legal status. Generally, a distinction is made between short-term or temporary migration, covering movements with a duration between three and 12 months, and long-term or permanent migration, referring to a change of country of residence for a duration of one year or more (UN, 2018).

In terms of mixed flows, some experts have framed it as 'complex population movements including refugees, asylum seekers, economic migrants and other migrants'.

Unaccompanied minors, environmental migrants, smuggled persons, victims of trafficking and stranded migrants, among others, may also form part of a mixed flow (MHub, 2020).

Not all migration is forced, but where it is - often as a consequence of conflict or natural disaster- the mental health and psychological needs of displaced populations can be acute. Mass disruptions and displacement can bring to several sources of stress for individuals, families and communities involved (IOM, 2019). At least 79.5 million people around the world have been forced to flee their homes. Among them are nearly 26 million refugees, around half of whom are under the age of 18, and 45.7 million IDPs, around 40% of whom are children. 80% of forced migrants reside in countries impacted by food insecurity and malnutrition, and many lack access to basic rights such as education, health care, employment and freedom of movement (UNHCR, 2020). In CAR, displaced persons lost access to their land, crops were damaged, livelihoods were lost, and food insecurity became acute. Citizens of CAR were too displaced to neighboring African countries with acute humanitarian needs as well as their own levels of insecurity.

Individual and communal displacement is a devastating psychological consequence associated with human rights violations (Ertl, Pfeiffer, Shauer-Kaiser, Elbert, & Neuner, 2014; Shultz et al., 2014). Research has found connections between forced displacement and psychopathology development that included depression, posttraumatic stress disorder, generalized anxiety disorder, somatic complaints and increased substance use and abuse (Shultz et al., 2014). Individuals who are internally displaced have been reported to exhibit more severe mental health issues compared to their refugee counterparts (Shultz et al., 2014).

Displacements often occur on the heels of atrocities such as massacres or brutality, compounding the traumatic experience of running from one's home. The compounding effects of trauma and displacement lead to a psychopathology course that ends in increased risk for PTSD, depression, anxiety disorders, somatic issues, increased substance use issues used to cope with the loss and traumatic experiences, and increased suicide risk (Shultz et al., 2014). Victim testimony exhibits displacement. In the Northwest, armed highway bandits attacked Peulh cattle-herding communities, forcing almost 3,000 individuals to flee from the Central African Republic to northern Cameroon. In another instance, armed assailants attacked and killed many people and over 2,000 displaced to Chad. More evidence states that Presidential Guards and *Forces Armées Centrafricaines* (FACA) forced the entire civilian population of Ngaoundaye to flee following, injuring, raping, looting, and setting their town on fire. On 24 January, 2012, another 22,000 civilians were forcibly displaced from the city of Kabo due to warfare (MINUSCA, UNDP, United Nations Human Rights, & Violences Sexuelles en Conflit, 2017).

Displacement's trajectory has been tracked worldwide through various displacement events. Research suggests there are six stages to displacement: pre-expulsion,

departure/expulsion, migration, transition and adaptation during initial relocation, prolonged resettlement, and (rarely) return. During the pre-expulsion phase of displacement, the threat of harm and loss are imminent. Before displacement, individuals experience exposure to traumatic events such as famine, poverty, and religious persecution. Departure/expulsion phase is marked by fear and a quick turn of events as a person is actually forced to physically flee their home. Departure/expulsion events are often set up by various human rights violations. During this phase, family separation and reduction in essential resources is common. The migration phase occurs directly after the departure/expulsion phase. Traumatic events are acutely recalled and re-experienced during this phase as they are newly experienced. Traumas are compounded during this phase because displaced individuals flee and are exposed to other harms, such as familial separation and exposure to combat zones. During the transition and adaptation during the initial relocation phase, displaced individuals are forced to cope with the losses and traumas they have endured while attempting to cope with their new surroundings of which they are not prepared for. Many may face significant barriers to accessing services, including claiming asylum or petitioning as an IDP due to lack of resources, limited humanitarian access, or community tensions and rejection.

The trauma experienced during the displacement - to save life - has been associated with economic, occupational, educational, and familial problems during this phase of relocation. Displaced persons in CAR were faced with a disastrous decision- flee and lose their social and economic stability; stay and face massacre.

During the prolonged relocation phase, displaced individuals are modifying all aspects of their life. Displaced individuals often live in externally unsafe environments characterized by insecurity and lack of privacy- while some IDPs and refugees may live in formal camps, many are forced to take up shelter in informal settlements. Mental health professionals that have worked with these individuals have recorded mental health disorders including PTSD, depression, PTSD-depression comorbid diagnosis, generalized anxiety disorder, panic disorder, somatoform disorder, somatic complaints, alcoholism, sleep disturbances, emotional reactivity, psychological distress, elevated suicide risk, perceived stigmatization, helplessness, and guilt after witnessing violence, and long-term disability associated with mental health problems (Shultz et al., 2014). The (rarely) return portion of these stages is exhibited in the current case. Per victim testimonies, the FACA attacked Sokoumba sometime in February 2009. Over 18,000 civilians and citizens of this town had to flee to Chad to escape the widespread violence and murder occurring in their town, most remaining in Chad until 2012. The village of Sokoumba is still abandoned to this day (MINUSCA, UNDP, United Nations Human Rights, & Violences Sexuelles en Conflit, 2017).

Following the 2013 displacement, a 2014 study with IDPs in 34 (out of the 35) displacement sites in CAR found the main needs to be food security, camp management and shelter, nutrition, health, and access to employment (IOM, 2014). Two thirds of CAR IDPs sampled were forced to resort to negative coping strategies, selling belongings and incurring debt to meet basic food needs; further, 94% of IDPs reported lowering their daily meals and 85% reported spending full days with eating anything. In terms of family separation, which can have a significant impact on mental health, 21% of surveyed CAR IDPs mentioned having had to send their family members elsewhere to ensure their survival and well-being.

In terms of the reasons for displacement, 90% of CAR IDPs surveyed had faced insecurity, 71% had belongings stolen, 55% reported damage to their houses., and 48% reported facing direct physical threats. Not unsurprisingly, the resumption of security was cited as the main precondition for return to their place of origin. The fear of prolonged displacement was mentioned by IDPs as a significant stressor, particularly in meeting the basic needs of the family. Where these basic needs cannot be met, due to limited resources and access issues, there are long-standing ramifications in terms of protracted displacement and physical and psychological well-being.

On the whole, war imposes disastrous effects on the countries that are forced to endure it, and work must be done to heal these countries and their social systems. Widespread displacement of the civilian population, however, can undermine this process (Vindevogel, De Schryver, Broekaert, & Derluyn, 2013). When individuals are displaced from their homes, they not only lose possessions and material items, but they lose the ability to gainful citizens, thus affecting their social status (Shutlz et al., 2014). 20% of the population of CAR remains displaced to this day, facing both protracted as well as multiple instances of displacement (IDMC, 2020).

Witness statements from the case exemplify some of the difficulties associated with displacement and sexual violence:

[REDACTED]

There were four girls who had been “wives” (sex slaves) for Yekatom’s lieutenants.”

[REDACTED]

anti-balaka to identify and release children to remove them from combat and place them with families. He also added that some girls within the anti-balaka were “married” to ComZones (OTP-Prosecution Team).”

B. Internally Displaced Individuals and their Families

An internally displaced citizen is someone who has fled from their home and community of origin for reasons of safety, threat, or insecurity, but remains within the borders of their home country (and thus is not considered a refugee). Individuals who are internally displaced face many barriers to accessing services in their home community but also do not qualify for refugee services. There is often no way to regulate crimes, such as rape and murder. There is a sense of abandonment for individuals who are internally displaced. As well, internally displaced areas support gangs through prostitution and drugs, due to the lawlessness of the space (Shewly, 2013).

Once displaced, individuals are not free from trauma. Internally displaced persons experience physical exhaustion, increased risk for disease, increased exposure to combat zones, food and water deficits, and witnessing harm of loved ones. Individuals may also be coping with injuries sustained during the displacement. There is also risk that these individuals, once displaced, will not be able to find suitable accommodations. They may experience overcrowding which then leads to increased morbidity and mortality (Shultz et al., 2014). Internally displaced individuals may not be protected by the same human rights compared to refugees due to their stay in their home country (Shultz et al., 2014).

When the displacement is quick and forced, the multiple losses experienced at once can be overwhelming. Once an internally displaced person leaves their home, they leave property, assets, the identities they held in their communities and within their countries and thus their social status, and their social support networks. These losses are exhausting alone, but then are exacerbated by trauma experienced during displacement (Shultz et al., 2014).

In addition to the threat of physical harm and the general suffering associated with dislocation, families who are forced to leave their homes may experience dramatic alterations in social roles in their host country, which can lead to negative mental health outcomes and prolonged psychological adjustment (Li, Liddell, & Nickerson, 2016). Individuals who are evicted from their family land can experience exacerbation of their existing mental health issues, including PTSD and psychotic symptoms (Amoné-P'Olak, Otim, Opio, Ovuga, & Meiser-Stedman, 2015). Family separation is one of the most difficult effects of displacement, which exacerbates mental health issues (Cantekin, 2018). Internal displacement spreads families and communities wide, weakening communal strength and support networks. Increased trauma exposure can lead to issues with obtaining employment and economic stability, obtaining educational achievement, and familial adaptation once relocation is obtained (Shultz et al., 2014).

Women and children are disproportionately affected by internal displacement (Shultz et al., 2014). Women face barriers receiving adequate health care, specifically concerning reproductive rights and gynecological care (Shultz et al., 2014). Women are uniquely vulnerable to being internally displaced because of the physical vulnerabilities they hold compared to their male counterparts. Women are at increased risk for sexual violence while living as internally displaced, and living in a space without laws leads to decreased prosecution rates for individuals who rape women. These women are considered unqualified to complain or resist because they are isolated from their home community. Women are also at greater risk for domestic violence and subsequent death because no justice would be provided due to their internally displaced status. Women experience unique stigmatization when they begin to live in an enclave, since enclaves are considered abandoned by their host and home countries. Women who marry within an enclave usually then live their entire lives in that space. The living conditions within internally displaced spaces leads to increased rates of maternal mortality and children born stillborn. Often, hospitals within the host country will not accommodate the maternal needs of pregnant women because these women can not show citizenship documentation (Shewly, 2013).

18 million children have been displaced globally. Children are a vulnerable population when displacement occurs due to their child development. Children will often face social role changes. For instance, a child may become the primary caregiver for younger siblings. If a child is displaced across an international border, they may face challenges that include learning a new language, obtaining an education, and navigating a new culture. This is all occurring at the same time these children must face economic and legal difficulties. Not only are children thrown into this new environment, but the countries that take the most displaced people are low- to-middle income countries who are also facing political, ethnic, and infrastructure issues (Reed et al., 2011). Children must often rely on professional traffickers to get to safer locations, which increases their risk to harm due to their increased vulnerability (Shultz et al., 2014). Children experience the intergenerational transmission of trauma experienced by their families during internal displacement (Shultz et al., 2014). This intergenerational transmission does not only affect mental health as other difficulties are also transmitted such as economic and education problems (Reed et al., 2011).

C. Asylum Seekers, Refugees and their Families

Some individuals who have sought safety in another country will receive formal refugee status, while others may remain asylum seekers (with some having claims eventually rejected). The legal status of an individual will have an impact on their access to basic

services, including access to employment and formal shelter. While many refugees reside in formal camps, it is not uncommon for persons displaced across an international border to reside in informal shelters.

Prolonged detention in camps has been linked to negative mental health outcomes; the longer the detention, the worse the outcome. Individuals who could be considered refugees experience increased rates of PTSD, depression, anxiety, and comorbidity between the three (Li, Liddell, & Nickerson, 2016), as well reported somatic complaints and functional impairment from these symptoms (Riley, Varner, Ventevogel, & Hasan, 2017). These negative mental health outcomes have lasting effects, with some research indicating that depression and PTSD can persist for years (Cantekin, 2018; Li, Liddell, & Nickerson, 2016).

Refugees and asylum seekers report their safety needs are often not met within the camps due to food shortages, shelter shortages, privacy shortages, and fear for their safety (Cantekin, 2018, Riley, Varner, Ventevogel, & Hasan, 2017). In a study comparing traumatic experiences of refugees, Rasmussen et al. (2011) found that traumatic war events were comparatively less correlated with distress compared to basic needs and safety concerns. This state of constant fear also results in refugees being suspicious about social structures as well as concepts of justice and human rights. Refugee camps can exacerbate mental health issues due to status and material loss, insecurity, uncertainty, and family separation (Cantekin, 2018). Together, these stressors can retraumatize the refugee with respect to the harms that caused them to flee in the first place (Cantekin, 2018). In fact, although traumatic war events were the initial stressor for refugees, concerns over daily living mediate psychological distress (Rasmussen et al., 2011, Riley, Varner, Ventevogel, & Hasan, 2017). Therefore, not only are the traumatic experiences of displacement important to consider when discussing the mental health of refugees, but the daily stressors these individuals experience also play an important part in refugees' mental health and psychological well-being (Rasmussen et al., 2011; Riley, Varner, Ventevogel, & Hasan, 2017). Specifically, traumatic events experienced during displacement may be the precipitant for psychological distress; the associated stressors of living in refugee camps mediates the distress experienced (Rasmussen et al., 2011) Another way of looking at this is that exposure to traumatic events makes the stress of daily hassles more unbearable because their stress tolerance has been disrupted, increasing the psychological distress they experienced (Rasmussen & Annan, 2010). This is exhibited in research concluded that families that were having housing difficulties within the refugee camps were twice as likely compared to those families not dealing with housing issues, to report that someone in their family was dealing with some type of illness (Rasmussen & Annan, 2010).

Asylum seekers and refugees often experience financial difficulties related to language difficulties, visa restrictions, and underemployment of individuals with specific skill sets. These financial difficulties can lead to unstable housing in the host country and generate another source of stress (Li, Liddell, & Nickerson, 2016). These refugees do not just face mental health problems within these camps; mass camps are known to spread communicable diseases fast and perpetuate malnutrition due to food shortages (Reed et al., 2011).

Women are labeled as a vulnerable population by humanitarian aid organizations. Women, compared to other individuals, are more likely to experience increased rates of distress when they do not have adequate access to important resources such as water, food, health care, or protective housing within the refugee camp (e.g., living on the borders rather than centrally), generally because it affects their ability to care for children and complete caregiving roles (Rasmussen & Annan, 2010). Due to the women's and mother's experiences of being displaced, there is the potential for women to not be able to give their children adequate physical and emotional support, and thus, may pass their known psychological distress to their children through intergenerational trauma. Mother's stress and ability to cope is associated with her children's psychopathology. If parents are coping well, then the parent's mental health will act as a protective factor against psychological distress for their children (Vossoughi, Jackson, Gusler, & Stone, 2018).

Children are vulnerable to the effects of refugee camps, specifically when it comes to malnutrition, lack of education, cleanliness, and accessing healthcare (Reed et al., 2011; Vossoughi, Jackson, Gusler, & Stone, 2018). Children are vulnerable to the results of political unrest in the host country, especially since they potentially live in an active war zone (Vossoughi, Jackson, Gusler & Stone, 2018). For instance, if a refugee camp begins to take important resources from the surrounding communities, children will begin to experience increased rates of sexual and physical abuse. Children who are unaccompanied are specifically vulnerable within refugee camps. Many children are homeless and others are forced into prostitution to survive (Reed et al., 2011; Vossoughi, Jackson, Gusler, & Stone, 2018). Research indicates that unsanitary latrines and closeness to animals increased the incidence of children contracting bacterial illnesses (Rasmussen & Annan, 2010). Overall, children living in refugee camps experience a multitude of maladjustment problems due to their environment (Vossoughi, Jackson, Gusler, & Stone, 2018). Mental health wise, children are at risk for developing developmental delays, problems interacting socially with others, and difficulty regulating their emotions (Vossoughi, Jackson, Gusler, & Stone, 2018).

VIII. Mental Health Effects of Child Abduction and Soldiering; Specific Psychological Outcomes Attributed to Forced Soldiering in Children

Forced child soldiering involves multiple traumatic events for victims. Each aspect of traumatic experience is a risk factor for unwanted psychiatric outcomes in the survivor. Most survivors are exposed to multiple, complex violent situations. And they are made to violate basic codes of human conduct, altering their psychology toward extreme psychological and societal pathology. Children are dependent on the adults and caregivers around them, therefore, it is often adaptive for them to comply with the directions and influences of those adults providing for their care, supervision, or basic needs, even if this direction violates standard social norms. Throughout the conflict in CAR, the recruitment of children into armed conflict was perpetrated by many sides in the conflict. For instance, Armée Populaire pour la Restauration de la Démocratie (APRD) was recruiting children at its formation in 2005. The APRD used children as young as nine years old to battle in actual fighting. The Union des Forces Démocratiques pour le Rassemblement (UFDR) were also found to forcibly recruit child soldiers at Ouanda-Djalle and force them to fight in armed conflicts. It is estimated that the UFDR recruited about 400 children. The girls were forcibly raped and other children were beaten, forced to work, forced to lift heavy objects, and deprived of their liberty. If they refused to fight, they would be severely beaten and detained (MINUSCA, UNDP, United Nations Human Rights, & Violences Sexuelles en Conflit, 2017).

Witness statements from the case exemplify some of the experiences from their child soldiering:

“P-2476 and the other children were beaten and punished when they did wrong things.”

“P-2511 and the other children were threatened and punished. P-2511 was beaten with a stick and deprived from food for two days (OTP-Prosecution Team)..”

A. Mental Health Harms of Child Soldiering

PTSD has a consistent and high prevalence level in former child soldier populations, predictably between 97-99% (Betancourt, Borisova, Williams, Meyers-Ohki, Rubin-Smith, Annan, Kohrt, 2013). Individuals who were former child soldiers are more likely to develop PTSD compared to their war-affected counterparts who were not child soldiers (Betancourt, Newnham, McBain, & Brennan, 2013; Betancourt, et al., 2019; Ertl, Pfeiffer, Schauer-Kaiser, Elbert, & Neuner, 2014; Brownell & Praetorius, 2017; Kizilhan & Noll-Hussong, 2018; Kohrt, Jordans, Tol, Speckman, Maharjan, Worthman, & Komproe, 2008; Russell & Gozdzia, 2006; Vindevogel, De Schryver, Broekaert, &

Derluyn, 2013; Weierstall, Schalinski, Crombach, Hecker, & Elbert, 2012). Exposure to trauma resulted in increased PTSD, depression symptoms and trauma related disorders (Betancourt, et al., 2019; Ertl, Pfeiffer, Shauer-Kaiser, Elbert, & Neuner, 2014; Hermenau, Hecker, Maedl, Schauer, & Elbert, 2013; Kohrt, Jordans, Tol, Speckman, Maharjan, Worthman, & Komproe, 2008; Russell & Gozdzia, 2006; Vindevogel, De Schryver, Broekaert, & Derluyn, 2013; Weierstall, Schalinski, Crombach, Hecker, & Elbert, 2012).

Increased traumatic exposure resulted in increased PTSD and depression symptoms (Ertl, Pfeiffer, Shauer-Kaiser, Elbert, & Neuner, 2014). Individuals who experienced a conflict environment may become hyper aware of any stimuli that might be considered threatening (Ertl, Pfeiffer, Shauer-Kaiser, Elbert, & Neuner, 2014). This is especially evident in individuals who have developed PTSD (Hermenau, Hecker, Maedl, Schauer, & Elbert, 2013). The “building block effect” reports that continual exposure to traumatic events increases an individual’s risk for PTSD (Hermenau, Hecker, Maedl, Schauer, & Elbert, 2013). Former child soldiers often experienced numerous, chronic, continuous, and prolonged traumatic experiences (Klasen, Reissmann, Voss, & Okello, 2015). Individuals who were former child soldiers experienced thus heightened exposure to traumatic events, which resulted in higher rates of depression, PTSD, psychological difficulties, and functional impairment (Kohrt, Jordans, Tol, Speckman, Maharjan, Worthman, & Komproe, 2008). The cumulative exposure to trauma increases the likelihood of PTSD (Weierstall, Schalinski, Crombach, Hecker, & Elbert, 2012). In addition, low socio-economic status prior to their participation in conflict predicted PTSD in former child soldiers (Klasen, Reissmann, Voss, & Okello, 2015).

Female child soldiers are more likely to be raped and have less adaptive outcomes after leaving armed groups. Girls in this situation are more likely to develop PTSD as compared to boys (Kohrt, Jordans, Tol, Speckman, Maharjan, Worthman, & Komproe, 2008); the same holds true for depression, anxiety, hostility, low self-esteem, and low self-confidence (Betancourt, Borisova, de al Soudiere, & Williamson, 2010). The fact that former child soldiers often commit acts that violate cultural norms can result in reintegration difficulties, especially for girls (Kohrt, Jordans, Tol, Speckman, Maharjan, Worthman, & Komproe, 2008). Young girls who join armed groups often provide various support services, are placed into domestic servitude, and are forced to become “wives.” The girls who are sexually abused or enslaved often exhibit unhealthy sexual behavior afterward (Russell & Gozdzia, 2006).

Witness statements from the case exemplify some of the sexual violations against child abductees in the context of child soldiering:

“P-2620 describes being raped repeatedly by the element who considered her as his ‘wife.’ During her stay at the anti-balaka base, she became pregnant for the anti-balaka who was repeatedly raping her and gave birth to a girl.”

“P-2582 is a former child soldier who was forced to join Yekatom’s group. She was repeatedly raped by anti-balaka subordinates and became pregnant. She had a miscarriage (OTP-Prosecution Team).”

Individuals who were former child soldiers and who also identify as female often have difficulties reintegrating into society due to the effects of stigmatization, relational, and social challenges (Vindevogel, De Schryver, Broekaert, & Derluyn, 2013). Following armed conflict, former female child soldiers may face stigma that affects their ability to be married, because they are considered “sexually tainted,” “unpredictable,” and “aggressive” (despite the fact that experiences of “unpredictability”, irritability, and emotion or behavior dysregulation are normal and expected outcomes of extreme trauma). Female child soldiers have less access to education compared to their male counterparts and are often not included in reintegration programs due to government non-disclosure of female child soldiers. In many reintegration scenarios, female child soldiers were given less access and lower educational investment through their families due to their diminished status (Betancourt et al., 2010; Betancourt, Borisova, de la Soudiere & Williamson, 2010).

Individuals who were child soldiers developed their PTSD in response to different atrocities, many citing their parents’ death, violent exposures, and continuous danger as experiences (Betancourt, Borisova, de al Soudiere, & Williamson, 2011; Kizilhan & Noll-Hussong, 2018). A parent’s death affects all former child soldiers; female child soldiers relied on their caregivers for protection and support, whereas male child soldiers often take on the caregiving role once their parents die, increasing the stress already put on these vulnerable children (Betancourt, Borisova, de al Soudiere, & Williamson, 2011). Individuals who were former child soldiers who have PTSD also experience a worsening of symptoms when they experience the death of a family member or stigma associated with being a child soldier (Betancourt, Newnham, McBain, & Brennan, 2013). Although time can heal some of the traumatic wounds experienced by these individuals, the impact of child soldiering on these individuals has long-lasting consequences, and particularly so for individuals who also lost their parents (Vindevogel, De Schryver, Broekaert, & Derluyn, 2013).

Former child soldiers report an evolving opinion about violence, at first viewing violence as frightening, then normal, then arousing and exciting. This evolution exemplifies

children's malleability within the context of development, and is demonstrative of ways in which children adapt to the environment in which they are reared. Through this evolution, the child eventually labels violent events as "positive" rather than "negative" (Weierstall, Schalinski, Crombach, Hecker, & Elbert, 2012). This type of aggression is called "appetitive aggression" (Hermenau, Hecker, Maedl, Schauer, & Elbert, 2013). Somewhat paradoxically, the more appetitive aggression a former child soldier has developed, the less likely they are to develop PTSD. And, the increased exposure to traumatic experiences leads to increased rates of appetitive aggression (Weierstall, Schalinski, Crombach, Hecker, & Elbert, 2012). Violence is then perpetuated due to increased exposure to violence, which increases former soldiers' appetitive aggression (Weierstall, Schalinski, Crombach, Hecker, & Elbert, 2012). However, if the violent event exposure reaches a certain threshold, then no amount of appetitive aggression acts as a protective factor against PTSD (Weierstall, Schalinski, Crombach, Hecker, & Elbert, 2012). In former child soldiers, the research suggests that other factors will reduce the prevalence of negative psychological outcomes. For example, spirituality and high economic status were found to limit the effects of PTSD (Ertl, Pfeiffer, Shauer-Kaiser, Elbert, & Neuner, 2014).

PTSD in former child soldiers often exists in concurrence with, or is exaggerated by, comorbidity with other symptomatology and disorders. Child soldiers are often given drugs when entering combat in order to "protect them from being killed." This drug use leads to co-occurring addiction problems along with any other mental disorders the children accrue from their experiences (Russell & Gozdzia, 2006).

Forced drug use is pervasive in the use of children used as soldiers. This leads to addictions and other unwanted consequences of exposure to illicit and mind altering substances.

Witness statements from the case exemplify some of the changes resulting from their forced drug use:

"P-2620 became addicted to a drug that the anti-balaka elements were using. Her addiction to the drugs continued after she left the anti-balaka. She stated the following: 'At first when I went back to Pissa I would not feel well if I did not take drugs. I used to get it and hid it so that my uncle would not see it. I stopped taking it after some time.'

"P-2582 is a former child soldier who was forced to join Yekatom's group. She was drugged by the anti-balaka."

“P-2582 is a former child soldier who was forced to join Yekatom’s group. ‘I am no longer myself owing to having taken a lot of drugs’ (OTP-Prosecution Team).”

Children who were former child soldiers have higher rates of suicidal ideation and suicide risk, psychiatric disorders, depression, anxiety, and somatization compared to war-affected counterparts who were not child soldiers (Betancourt, et al., 2019; Ertl, Pfeiffer, Shauer-Kaiser, Elbert, & Neuner, 2014; Kizilhan & Noll-Hussong, 2018). Former child soldiers also commonly experience eating disorders (Van Leeuwen et al., 2018). Former child soldiers have also reported experiencing psychotic symptoms with their PTSD. Wartime experiences such as witnessing violence, death, bereavement, hostility involvement, and sexual abuse predict the development of such symptoms. Psychotic symptoms have also been linked to the co-occurrence of substance use disorder and PTSD, relevant and common mental disorders former child soldiers experience (Amone-P’Olak, Otim, Opio, Ovuga, & Meiser-Stedman, 2015).

Former child soldiers, particularly those who are also rape survivors, also show increased hostility and anxiety toward others (Betancourt et al., 2010). Former child soldiers may frequently resort to violence to solve problems (Van Leeuwen et al., 2018). Low socioeconomic status, traumatic experiences for the victim, and guilt-predicted depression often co-exist in individuals who were formerly child soldiers (Klasen, Reissmann, Voss, & Okello, 2015). Individuals who were former child soldiers exhibited reduced self-esteem due to their exposure to violence and abuse (Kizilhan & Noll-Hussong, 2018). Traumatic experiences for the perpetrator of the atrocity on the child predicts PTSD for that child soldier later in life (Klasen, Reissmann, Voss, & Okello, 2015).

Individuals who *perpetrated* atrocities were more likely to develop symptoms of PTSD themselves (Klasen, Reissmann, Voss, & Okello, 2015). Many former child soldiers were forced to hurt each other or members of their communities in order to sever ties and ensure they would not escape the armed conflict groups (Amone-P’Olak, Otim, Opio, Ovuga, & Meiser-Stedman, 2015). PTSD severity levels and depression elevate with the forced commitment of at least one atrocity during child soldiering (Betancourt, Borisova, de al Soudiere, & Williamson, 2011; Ertl, Pfeiffer, Shauer-Kaiser, Elbert, & Neuner, 2014). There is a relationship between shame, complex trauma, and psychopathology in former child soldiers (Klasen, Reissmann, Voss, & Okello, 2015). In general, personal experiences associated with committing atrocities, moral conflict, and shame and guilt result in a negative impact on mental health (Ertl, Pfeiffer, Shauer-Kaiser, Elbert, & Neuner, 2014).

B. Psychiatric Pathology Acquired from Child Soldiering

Overall, children exposed to trauma in ages 0-5 have an especially robust likelihood in developing both internalizing (sadness, anxiety, loneliness) *and* externalizing (aggression, hyperactivity) symptoms than children of older age groups (Dunn et al., 2020; Keiley et al., 2001). Later onset of trauma proved to attenuate internalizing symptoms; however, externalizing symptoms remain nevertheless persistent, or even more salient (Keiley, et al., 2001; Kaplow & Widom, 2007).

Anxiety sensitivity, including others forms or vulnerabilities to anxiety disorders are associated most strongly with adolescence. Adolescence is a sensitive period in which biopsychosocial alterations due to puberty affect emotional lability and negative affectivity (Brooks-Gunn, Graber, & Paikoff, 1994). Therefore, adolescence is an age range most conducive to anxiety problems, only compounded by the experience of a traumatic event (Leen-Feldner, Reardon, Hayward, & Smith, 2008). Within adolescence, trauma and anxiety sensitivity correlates to ages 14-17, more so than ages 10-13; however, the age period of adolescence nevertheless showed the strongest correlation amongst other developmental age groups (Leen-Feldner et al., 2008; Marshall, 2016). In relation, emotional dysregulation, a primary repercussion of trauma and a predictor of anxiety disorders, (Jazaireri et al., 2015) is most likely to surface if the occurrence of trauma was at school-age (Dunn et al., 2018).

Among mood disorders, depression or major depressive disorder (MDD) is most correlated to trauma before adolescence, as opposed to older age groups (Maercker et al., 2004; Shalinski et al., 2016; Stevens, Rooij, Jovanovic, 2018). The younger childhood period seems to be especially sensitive to the environmental disturbances that can increase the risk of depression; even two times more sensitive (Heim et al., 2010; Dunn, Nishimi, Powers, & Bradley, 2017; Dunn et al., 2013). Political traumatization at age 12, for instance, was most correlated with major depression in adulthood (Maercker et al., 2004); parental loss has higher risk of depression before age 9, compared to adolescents and young adults (Agid, et al., 1999).

Dissociation from emotional trauma is more likely to occur if the traumatic experience was during early childhood, specifically ages 4-5, as opposed to ages 9-10, which are more predictive of depression (Shalinski et al., 2016). Beyond early childhood, up to mid-adolescence (age 14) is also shown to be the window of vulnerability to dissociation upon trauma (Schalinski & Teicher, 2015).

C. Adverse Child Developmental Effects of Child Soldiering

In child development, a ‘sensitive period’ describes a length of time or ages in which particular areas of the brain are undergoing increased plasticity in their stage of development. It is within these sensitive periods that the brain lends itself to external experiences to guide in its formation and organization, which includes skill acquisition. The brain’s normal developmental trajectory and skill acquisition are established by the following environmental considerations—the need for the skill, resources at the child’s disposal to develop the skill, and environmental reception of the child’s usage of the skill (Shonkoff, 2012). In the face of trauma and in the context of war, the child is more in need of skills in relation to survival than skills that are typically included in normal development, such as, planning, language, or affective regulation. Not to mention, circumstances will often not allow for the child to obtain the resources required to develop skills other than the ones for survival. Trauma, thus, interjects the brain’s normal developmental trajectory and rewires the brain’s priorities of skill acquisition resulting in at best, abnormal brain developments (Heim & Binder, 2012).

D. Neurobiological Effects of Child Soldiering on Child Development

Each brain region has a sensitive period in which they have heightened neuroplasticity. Trauma occurring at the sensitive period of a certain brain region, is likely to result in abnormal alterations of that brain region. The neurobiological effects of trauma are shown to most affect the prefrontal cortex and the limbic system, which corresponds to the sensitive periods of these regions—generally starting from early childhood (0-5) to adolescence (12-17). Among the limited research in time-sensitive neurobiological disturbances on brain development, the targeted brain regions show sensitivity primarily in early childhood, school age (ages 6-10/11), with slight divergences including adolescence. These studies that examine the brain’s physical changes as a result of trauma with identification of sensitive periods primarily conclude that early childhood, school-age or adolescence, as opposed to young adulthood, is the period in which trauma is most effective in altering typical brain formation. Those alterations, then, translate to the psychological effects of the relevant trauma.

One developmental disturbance occurs in the amygdala—a component of the limbic system and a critical player in decision-making, memory, and emotional responses. The right amygdala has been shown to grow abnormally large upon trauma exposure. Ages 10-11 is said to be the sensitive period in which the occurrence of trauma strongly correlates with abnormal right amygdala growth. Such change in the region increases vulnerability to stress-related effects (Pechtel, Lyons-Ruth, Anderson, Teicher, 2014; Cunningham, Bhattacharyya, Benes, 2002) and reactivity to stimuli that elicit emotions such as fear (Gloor et al., 1982). Also, hippocampal volume and trauma show significant

negative association and sensitivity at ages 3-5, as well as ages 11-13, with traumatic events likely inhibiting the growth of normal hippocampal development (Rao et al., 2010; Anderson et al., 2008). Such impedance in hippocampal development correlates to interference in normal memory, learning, and emotional development. Additional structural changes within the limbic system that are particularly associated with trauma exposure between the ages of 7 and 13 impact emotion, attention, and memory functions so as to sensitize towards hostile interpretation of what is, in fact, neutral stimuli (Choi et al., 2012). Furthermore, the prefrontal cortex is shown to be maximally sensitive to attenuation in experience of trauma at ages 14-16, with a resulting impact on the development of executive functioning skills (Anderson et al., 2008).

These time-sensitive effects of trauma—psychopathological or neurobiological—present implications for child soldiers and the age in which they are conscripted. A predominant portion of child soldiers range from mid-school age to late adolescence. Correspondingly, in a psychopathological lens, child soldiers in their early childhood are highly susceptible to later depression and dissociation. Adolescent child soldiers are also at the highest risk of dissociation, as well as anxiety disorders amongst all developmental stages. This broad segment of the child soldier population is at heightened risk of vulnerability to stress-related effects and hyper-reactivity to stimuli that evoke fear. It is also likely to face inhibitions in normal memory, learning and emotional development due to limited hippocampal development, and interference in the development of executive control, rational thought, self-regulation, self-awareness due to reductions in the prefrontal cortex. Moreover, more so than their younger and older counterparts, school-age and adolescent child soldiers will likely have increased likelihood to interpret neutral stimuli with inapt hostility. Child soldiers who are recruited as young adults do not suffer to the same degree these neurobiological and psychological consequences. As a child soldier advances in their developmental stages, their brain regions—which at one point were at heightened levels of plasticity—harden, so that their external traumatic experiences are not granted the same degree of influence onto their developmental trajectories and skill acquisition. Therefore, the conscription age of child soldiers and developmental damages of war-related trauma show a roughly negative correlation: the older the child in their traumatic experience, the lower the developmental disturbances.

E. Long-term effects of Child Soldiering

Children forced into child soldiering experience stunted social development, increasingly impaired functioning due to their participation in armed groups, and as compared to their non-abducted counterparts. These children experienced their developmental socialization during sensitive developmental years, increasing their propensity for violent behavior (Russell & Gozdzia, 2006). Indeed, leaders in armed conflicts often prefer younger

soldiers because they have not developed a firm sense of right and wrong and, as a result, are often more willing to commit brutal acts (Russell & Gozdzia, 2006). Research has shown that a possible mechanism for the propensity towards asocial behaviour, such as violence or theft, in former child soldiers lies in the development of “moral disengagement,” in which former child soldiers actively violate their own moral social norms and expect others to do as well due to their exposure to conflict trauma (Wainryb, 2011).

Research indicates that adults who attempt to reintegrate into society do not have difficulty because they were socialized with civilian social norms before participating in armed conflict. Child soldiers lack this socialization, as their important developmental window occurs while they are actively participating in armed conflict, and thus, they learn wartime social norms (Russell & Gozdzia, 2006).

Witness statements from the case exemplify how joining these armed forces changed the trajectory of their lives:

“P-2620 reported, ‘I think that, if I had not joined the anti-balaka, I would have continued my education and got certificates. Right now I think about all the good things that could have happened in my life. I would like to go back to school because I think that is the only way I can improve my life (OTP-Prosecution Team).’”

Former child soldiers who experienced severe and continuous traumatic events and who were denied a normal childhood will be affected by these experiences for the rest of their lives (Kizilhan & Noll-Hussong, 2018). In addition to physical and psychological problems, they can experience heightened levels of hostility and aggression in adulthood and other life-long effects (Betancourt, et al., 2019; Brownell & Praetorius, 2017). Low self-esteem can also have negative effects on their adult mental health and adult personality functioning (Kizilhan & Noll-Hussong, 2018). These mental health issues will affect their overall quality of life (Van Leeuwen et al., 2018). The mental health of former child soldiers can be improved, however, through social inclusion and family interventions.

The harms seen in child soldiers is not simply a function of early exposure to war or violence. Indeed, children who were formerly child soldiers report higher rates of suicidal ideation compared to war-affected but not former child soldier counterparts. There are high rates of depression in child soldiers compared to their non-abducted counterparts (Ertl, Pfeiffer, Shauer-Kaiser, Elbert, & Neuner, 2014; Van Leeuwen et al., 2018). Individuals who were former child soldiers who experienced traumatic events as a victim,

have low socio-economic status, and feel guilty about their behavior are more likely to develop depression than other conflict-affected children (Klasen, Reissmann, Voss, & Okello, 2015).

These harms are not irreversible, however. Providing workforce training and skills will increase former child soldiers' ability to reintegrate successfully into society (Van Leeuwen et al., 2018). A supportive social environment results in easier reintegration for former child soldiers (Klasen, Reissmann, Voss, & Okello, 2015). While former child soldiers exhibit greater wariness and are less initially trusting of out-group members, trust can be reciprocally built if the out-group member initiates a trusting interaction (Trussell, 2018).

F. Impact of Child Soldiering on Survivors' Reintegration and Community Functioning

Child soldiers are usually simultaneously the recipients and perpetrators of violence. They are blamed and stigmatized for the atrocities they committed as child soldiers and as adults, resulting in a challenging psychological recovery and reintegration back into society. Individuals who are war-affected show increases in negative effects on psychosocial well-being, specifically in regard to stigmatization (Betancourt, Newnham, McBain, & Brennan, 2013; Van Leeuwen et al., 2018; Vindevogel, De Schryver, Broekaert, & Derluyn, 2013). Individuals who were former child soldiers are sometimes feared when they return home, and so are socially excluded or become victims of domestic or intimate violence (Klassen, Oettingen, Daniels & Adam, 2010; Kohrt, Jordans, Tol, Speckman, Maharjan, Worthman, & Komproe, 2008; Russell & Gozdzia, 2006). Community acceptance, positive community attitudes, and retention in school all improved mental health outcomes for former child soldiers (Betancourt et al., 2010). The mental health of child soldiers who were currently associated with an armed group was better compared to former child soldiers (Kohrt, Jordans, Tol, Speckman, Maharjan, Worthman, & Komproe, 2008).

Former child soldiers are not just stigmatized for their role in armed conflicts, but also because they are at times perceived as better off than their victims in the post-conflict period. When attempting to integrate former child soldiers into their communities, it is important to not solely focus on their child soldier identity. Former child soldiers who experience psychotic symptoms along with PTSD will experience an exacerbation in these psychotic symptoms due to community and domestic violence, insecurity, stigma, discrimination, and lack of social support. Former child soldiers often face a reduction in their social status following reintegration (Amone-P'Olak, Otim, Opio, Ovuga, & Meiser-Stedman, 2015).

The isolation, stigma, and continued abuse or discrimination against former child soldiers has been demonstrated to be significantly positively associated with continued or worsening PTSD symptomatology years after the conflict. In comparison, family acceptance lowers PTSD symptomatology or severity (Betancourt, Newnham, McBain & Brennan, 2013). The likelihood of post-traumatic resilience is increased with improved socioeconomic status, lower guilt, increased spiritual support and reduced domestic violence (Klasen, Daniels, Oettingen, Post & Hoyer, 2010).

A child's ability to reintegrate back into society is dependent on their level of mental traumatization (Ertl, Pfeiffer, Shauer-Kaiser, Elbert, & Neuner, 2014). Indeed, psychopathology is the strongest predictor of maladjustment when controlling for abduction and trauma exposure and their difficulty reintegrating into society are due to these factors. In addition, behavioral disturbances, suspiciousness, and delayed educational attainment make readjustment difficult. Former child soldiers are affected life-long for their educational delays, which results in them being unlikely to obtain and maintain jobs and results in their increased risk of living in poverty (Brownell & Praetorius, 2017). By contrast, increased access to education leads to increases in prosocial behavior and attitudes (Betancourt, Borisova, de la Soudiere, & Williamson, 2010; Betancourt et al., 2010). Successful social reintegration involves high acceptance, weak continuous associations with the rebel groups, low perceived discrimination, low revenge motivation, and non-acceptance of violent conflict resolution strategies. By contrast, shame, guilt, and moral conflict results in less successful readjustment into society (Betancourt, et al., 2019; Ertl, Pfeiffer, Shauer-Kaiser, Elbert, & Neuner, 2014).

Increased trauma-related disorders and increased aggression may explain why former child soldiers have difficulty reintegrating into society. After experiencing a war-time environment, individuals may be hypersensitive to threatening stimuli (Ertl, Pfeiffer, Shauer-Kaiser, Elbert, & Neuner, 2014). This is especially evident with individuals diagnosed with PTSD. Individuals who were abducted to engage in combat functions also exhibited increased aggression and a high desire for revenge. This may result in higher rates of criminal behavior and retaliation, which the former child soldier may think is appropriate to make their point and cope with their PTSD (Bayer, Klasen, & Adam, 2007). Individuals who were former child soldiers who experienced traumatic events also manifest decreased school performance (Betancourt, et al., 2019). As a result, many child soldiers self-report feeling unequipped to or incapable of contributing productively to their household or family economy (Betancourt, Borisova, Williams, Meyers-Ohki, Rubin-Smith, Annan, Kohrt, 2013).

Former child soldiers experience difficulty maintaining relationships and discovering self-identity. Former child soldiers constantly live in fear of others, and thus, learn to

distrust others (Brownell & Praetorius, 2017). Behavioral disturbances, suspiciousness, and delayed educational attainment all make readjustment difficult (Ertl, Pfeiffer, Shauer-Kaiser, Elbert, & Neuner, 2014). In addition, in the community, there is a level of fear expressed toward the children who return from being child soldiers because of the things they have done (Betancourt et al., 2010; Betancourt, et al., 2019; Ertl, Pfeiffer, Shauer-Kaiser, Elbert, & Neuner, 2014). This can impede reintegration.

Individuals who were former child soldiers have had to deal with toxic stressors involving life threatening experiences with no support from important and significant attachment figures (Betancourt, et al., 2019). They then have difficulty forging meaningful familial bonds. Individuals who were former child soldiers report family difficulties due to familial deaths, familiar incapacitation, or the disappearance of their family members during the conflict (Vindeogel, De Schryver, Broekaert, & Derluyn, 2013). Having difficulty reintegrating into society can lead former child soldiers to voluntarily reenlist into armed groups (Hermenau, Hecker, Maedl, Schauer, & Elbert, 2013). Increased aggression from exposure to violence can lead to more violence, higher military ranks, and higher rates of voluntary recruitment and reenlistments for former child soldiers.

IX. Impact of Sexual Violence on Psychology; Specific Harms of Rape

A. Psychological Outcomes

Sexual violence causes terror and destabilization by undermining victims' feelings of community safety and security (Lee-Koo, 2002). A sense of safety and security dissipates while the individual victim is held captive or is otherwise rendered powerless to control what is happening to them and their body. This effect may become a chronic state with protracted societal destabilization. Safety and security are basic human needs that are essential for individuals to be able to perform their daily functions and to engage in activities that promote growth and development (Maslow, 1943). When an individual does not perceive that they are safe, basic daily activities such as feeding, sleeping, and self-care are undermined and dysregulated. When this occurs, higher-level pursuits—such as taking care of others, gaining employment, and pursuing an education—are also threatened and rendered more challenging, if not impossible. Feelings of danger, threat, and helplessness are not only experienced at the time of the violence itself and in its immediate aftermath, but also resurface in the future, even when objective safety is re-established (DSM-IV; DSM-5). Family members and friends are helpless to assist and are therefore rendered incapable of re-establishing safety and security. As such, even family members are limited in their ability to provide support to the survivor.

When sexual violence occurs, the victim's community and individual members experience reductions in their own safety as well. Indeed, the community's entire social structure is destabilized. Mass violence impacts individuals' and communities' development and functioning across multiple generations (Reid-Cunningham, 2008; Seifert, 1994; Wax, 2004). Individual victim evaluations thus cannot fully capture the damage that massive human rights abuses inflict upon communities. Even crimes of property can damage community functioning. Victim testimony reports widespread sexual and gender based violence that targeted women but also targeted men and boys, anyone ranging from five years-old to 60 and older. This sexual violence involved rape and gang rape. Rape often occurred in the presence of family members, and in at least two cases, more than 20 perpetrators were involved in the rape of one victim. These massive rapes occurred during targeted killings and pillaging, where civilians were killed over a large geographic area. Due to the killing, raping, and pillaging, victims were left fearful, harmed, and with nothing, and often could not even receive medical care (MINUSCA, UNDP, United Nations Human Rights, & Violences Sexuelles en Conflit, 2017).

The psychiatric literature predicts poor functional outcomes for the victims of sexual assault and other forms of extreme violence. The individual consequences include psychiatric disorders such as posttraumatic stress disorder, depression, and anxiety (Heim, Shugart, Craighead & Nemeroff, 2010; DSM-III; DSM-IV; DSM-5; Sadock, Kaplan & Sadock, 2007). Large epidemiological studies have demonstrated that rape and sexual assault are the most commonly identified index traumas associated with PTSD (Kessler et al., 1995). In broad population samples, 45.9% of women exposed to rape and sexual assault developed PTSD at some point in their lifetime (Kessler, et al, 1995). Women exposed to sexual assault are 5.5 times more likely to develop PTSD as compared to other types of trauma victims (Kilpatrick, Edmunds & Seymour, 1992). Within general populations, victims of sexual assault and rape comprised nearly $\frac{3}{4}$ of all individuals who were diagnosed with PTSD (Breslau, Davis, Andreski & Peterson, 1991). In the Tabo Report filed in *Prosecutor vs Jean Pierre Bemba Gombo*, most sexual assault and rape victims in his Central African Republic study likely met at least one, if not all, the criteria for PTSD (Tabo, 2011). Further, research with survivors of trafficking in persons, which in many instances includes forced migration or displacement (through recruitment, transfer, transportation, harboring) are at a heightened risk of PTSD (Stoklosa, 2017).

Rape victims experience a significant increase in anxiety symptoms and specific phobias than other victims (Kilpatrick, Resick & Veronen, 1981; Ellis, Atkeson, and Calhoun, 1981). Major depressive disorder or depressive symptomatology is associated with a

sexual abuse history (Becker-Lausen, Sanders, & Chinsky, 1995; Beitchman, Zucker, Hood, DaCosta, Akman, & Cassiva, 1992; Gold, 1986; Kendall-Tackett, 2007; Morof et al., 2014; Trickett, Noll, & Putnam, 2011). In large general population studies, 22% of women exposed to rape experience a major depressive episode (Zinzow et al., 2012), and 39.3% of female survivors of child sexual abuse developed depression (Molnar, Buka, & Kessler, 2001). Outcomes from sexual assault survivors evaluated at Bangui Hospital reported in the case of *Prosecutor vs Jean Pierre Bemba Gombo* indicated that 36.9% of women suffered from reactive depression and 2.2% suffered from melancholia (characterized by extreme lethargy) (Tabo, 2011b). Female rape survivors are 5.46 times more likely to experience a major depressive episode compared to non-sexual assault victims (Zinzow et al., 2012). In addition, rape and sexual assault are associated with mood instability (including mania) that are linked with the presence of bipolar disorders. Tabo (2011) reported that alcohol and/or substance use disorders were present in 18% of the victims after rape in his population within CAR.

Individuals also suffer from abject feelings of hopelessness (Muhwezi et al., 2011); spiritual degradation (Messina-Dysert, 2013); and heightened suspiciousness, persistent confusion, and fear (Kilpatrick, Resick & Veronen; 1981). Trauma victims see themselves as continually vulnerable, view the world as lacking meaning, and regard themselves as lacking worth (Janoff-Bulman & Frieze, 1983). Negative psychological outcomes have been shown to be long-lasting and pervasive particularly in rape and sexual assault survivors (Cohen and Roth, 1987). For example, a matched pairs study targeting the World War II's long-term effects demonstrated that wartime rape survivors reported greater PTSD symptom severity compared with women who experienced non-sexual war trauma (Kuwert et al., 2014).

Sexual violence in particular severely affects self-esteem and self-efficacy. In fact, a longitudinal study showed decreased self-esteem in rape victims when compared to non-rape victims a full 18 months after the event (Murphy et al., 1988). Evidence shows that human beings' psychological defenses are significantly affected after traumatic experiences (Edmondson et al., 2011). Interpersonal issues, anger, suicidality, and self-identity issues are all associated with sexual assault (Neumann, Houskamp, Pollack, & Briere, 1996) that may or may not be included in a formal diagnosis.

In particular, the guilt and fear amongst rape and other sexual gender-based violence victims is a common phenomenon. Shame and self-blame augment this phenomenon following "tonic immobility," a physical freeze response during the sexual assault. It is estimated that 15-50% of rape victims experience tonic immobility during rape (Campbell, 2012). Although this temporary paralysis is thought to be a natural automatic response to extreme stress or trauma, many victims are unaware of this and, as a result,

are likely to blame themselves for “letting it happen” or “not doing more to stop it.” Victims who undergo such self-deleterious shame in response to sexual mistreatment or violence are at greater risk for trauma-related symptoms and psychological distress. The children of these victims are also at increased risk to develop behavioral problems in their own lives (Babcock-Fenerci & DePrince, 2017).

Furthermore, available evidence points to increased hostility and aggression in adolescents and adult relationships of child sexual abuse survivors (Wekerle et al., 2001). Childhood sexual abuse has been associated with a propensity to perceive partners as uncaring and over-controlling; likewise, people cite poor quality, instability, and difficulties in intimate relationships (Mullen et al., 1994; Hill et al., 2001). These psychological outcomes of sexual abuse impact interpersonal functioning.

Experiences of trauma manifest themselves in multiple ways as discussed above. Particularly forms of trauma, such as sexual violence, leads to certain differentiated responses and psychological sequelae. These include the harms caused by the social stigma and ostracism that may follow the victim of sexual violence.

B. Impact of Rape and Sexual Violence on Survivors’ Reintegration and Community Functioning

Rape can destroy the survivors’ role in their community. Women who have survived sexual assault may be considered indelibly defiled, especially in societies in which the “sexual purity” perception is corrupted through rape stigma (Tabo, 2011; Porter, 2016). The trauma reminder avoidance is a key PTSD component (Zalhić-Kaurin, 1994). Spouses, family members and entire communities may shun, abandon, or even exile the sexual assault victim. Research in refugee camps show that rape victims are at high risk for being ostracized by their communities after they survived sexual violence; some of them consider or commit suicide for the unbearable shame and psychological pain (Friedman, 1992; Kizilhan & Noll-Hussong, 2017). Frederick identifies this extra psychological suffering as secondary or gratuitous psychic trauma, which is the survivor’s response to “perceived harsh stimuli during a vulnerable period” (Frederick, 1987, pp.72). Such outcomes have a pervasive functional impact. For example, Annan et al. (2008) found that women in Uganda who were abducted (and presumably exposed to increased rates of sexual violence) demonstrate lower rates of employment than non-abductee women. Additional studies with formerly abducted women in Northern Uganda have shown that observed impairments in general functioning and performance of daily activities are related to experiences of stigmatization and poor relationships within home communities (Amone-P’Olak et al., 2016). This observed functional impact is also due to physical and psychological impairment (including pain, injury, PTSD, and

depression) that affects an individual's ability to perform basic academic or vocational functions (e.g., due to intrusive overwhelming thoughts, feelings, or memories in PTSD; or to low energy, lack of motivation, and hopelessness associated with depression).

Communities have been known to be responsible for a victim's death as a punishment for being raped (Bastick et al., 2007). This physical or emotional exile may leave women economically vulnerable, left to find their own resources for themselves and their children. As a result of the tendencies towards stigmatization and isolation, mass sexual assault can cause disintegration of the community as survivors flee the area where they were assaulted (Bastick et al., 2007). This, in turn, can lead to a loss of resources, as a campaign of terror prevents people from gathering their possessions and basic items before they leave.

This operates as a direct insult to the individual's sense of safety and comfort. In Bosnia-Herzegovina, for example, where mass rape and assault in public areas led to mass relocation following the disintegration of the former Yugoslavia (Boose, 2002; Reid-Cunningham, 2008), there was an observed reluctance after the conflict ended to return to the geographic locations where the assaults occurred, even though such locations were once considered home (Zalhić-Kaurin, 1994).

C. Risk of Re-traumatization and Re-victimization

Sexual assault and rape victims not only experience distress related to these traumas but are also at greater risk for future re-victimization (Breitenbecher, 2001; Classen, Palesh & Aggarwal, 2005; Littleton & Decker, 2017; Relyea & Ullman, 2017). A report from a Dutch assault center shows that one-third of sexual violence victims had experienced prior abuse (Zijlstra et al., 2017). The inability to focus, function in daily living activities, and care for oneself as seen in survivors with PTSD, depression, and other extreme mental anguish instances is often exploited in the aftermath of the assault. Experiences of stigmatization and rejection compound psychological consequences, as well as economic and societal destabilization common in post-conflict settings, to increase risk of future re-victimization for sexual assault survivors, such as those affected by CAR violence. Strong predictors for sexual re-victimization include social environment hostile to survivors, race, and childhood sexual abuse (Relyea & Ullman, 2017). In addition to inducing PTSD and other forms of psychological distress, sexual assault can lead to increased suicide rates for affected individuals. At study on re-trafficking, further found that survivors of trafficking in persons were at increased risk of being re-trafficked, domestically and internationally (IOM, 2010).

D. X. Physical Health Problems Associated with Crimes in the Central African Republic Context

In addition to the psychological impacts of international crimes, survivors of sexual violence, child soldiering, and forced displacement experience a wide range of physical harms. These negative health outcomes further complicate the life of the impacted individual, often exacerbating comorbid mental health issues, as well as community reintegration and employment prospects. Furthermore, the socioeconomically insecure circumstances in which victims find themselves makes treatment for physical as well as psychological disorders more difficult, with stigma, local instability and reduced circumstances limiting access to healthcare (Betancourt, et al., 2019). In totality, these problems impact not only the individual but also their wider community, complicating socioeconomic rebuilding processes.

A. Physical Impacts of Trauma and Multiple Stressors

Childhood psychological trauma has many direct short- and long-term physical outcomes. Individuals who experience negative social interactions in childhood, for instance, have been found to express inflammatory genes and under-express antiviral genes in immune cells. This process, whereby the individual's immune system is compromised, is called "conserved transcriptional response to adversity" (CTRA). CTRA has furthermore been linked to increased PTSD severity, anxiety, and depression and thus these disorders' own psychosomatic symptoms and associated injuries (Kohrt et al., 2016). Child soldiers, then, having been exposed to innumerable traumatic scenarios, can be reasonably expected to have high CTRA influence and the resultant negative physical outcomes.

More generally, the increased risk of psychological disorders experienced by former child soldiers has been shown to negatively influence expected mortality (Hermenau, Hecker, Maedl, Schauer, & Elbert, 2013). Former child soldiers have been found to have higher rates of severe suicidal ideation, physical complaints, aggression, and functional impairment (Ertl, Pfeiffer, Schauer-Kaiser, Elbert, Neuner, 2014). Higher mortality rates are thus due in part to high casualty rates in conflict zones and psychological trauma's negative physical impact, which includes self-harm, attempted suicide, catatonia and the life-long increased inability to take care of oneself (Brownell & Praetorius, 2017).

Former child soldiers exhibit delays in educational attainment, which not only affects immediate reintegration but also future employment prospects (Russell & Gozdzia, 2006; Betancourt, et al., 2019). Lessened employment prospects increase the likelihood of poverty, which has clear detrimental effects on health as well as access to healthcare, both physical and psychological, that could mitigate psychosomatic problems (Brownell

& Praetorius, 2017; Vindevogel, De Schryver, Broekaert, & Derluyn, 2013). Psychosis and other severe symptoms of PTSD, which increase the likelihood of sustained physical injury, have been documented to be exacerbated by poverty and an inability to take care of basic financial needs (Amone-P'Olak, Otim, Opio, Ovuga, & Meiser-Stedman, 2015).

Physical injury is lasting. In combination with multiple stressors and with close links to psychopathology, heavy exposure to violence not only increases contemporary risk of physical injury but cyclical future injury, for both the former child soldier and the communities they may return to. PTSD symptoms in returned child soldiers, for instance, have a positive correlation with a desire for revenge, heightening likelihood of future violence, injury and disruption to social rebuilding (Bayer, Klasen & Adam, 2007).

B. Sexual Assault in the Context of Child Soldiering

Girls who are recruited or abducted into armed forces in CAR largely take on roles of domestic and sexual servitude. These women and girls, who have been abducted and forced into marriage or slavery, report higher levels of exposure to violence and increased rates of sexual violence relative to non-abducted women (Annan et al., 2008).

C. Physical Disability and Permanent Impairment

Finally, child soldiers and abductees, being highly exposed to active conflict in both soldiering and support capacities, are known to have high rates of disability (Johnson, 2017). While research on the area is new and thus not comprehensive, general consensus holds that many former child soldiers carry long-lasting physical injury incurred from both combat and torture (United Nations Security Council, 2005). Injury can include “war-related physical impairments...resulting from poorly healed bones, severe scarring, embedded shrapnel, and bone and muscle deterioration” as well as “a range of permanent physical impairments...including amputation,” from conflict wounds as well as torture (Johnson & Whitman, 2016; Klassman, Reissman, Voss & Okello, 2015).

Furthermore, childhood mental traumatising and socialisation in contexts in which violence is rewarded has been associated with heightened life-long levels of aggression, and even the development of appetitive aggression (Ertl, Pfeiffer, Schauer-Kaiser, Elbert, Neuner, 2014; Hermenau, Hecker, Maedl, Schauer & Elbert, 2013). Former child soldiers are therefore at a higher risk factor for involvement in aggressive behaviour even upon return, increasing likelihood of physical injury and consequent reintegration setback after their return. A 2014 study on the experience of guilt in child soldiers also has demonstrated a positive association between traumatic experiences as perpetrator,

trauma-related guilt, and externalisation of problems that could prove physically injurious, such as aggression or suicidal ideation (Klassen, Reissmann, Voss & Okello, 2014). The risk here is posed not only to the individual who experienced the trauma but to the people around them too: abuse tends to perpetrate a cycle of violence, in which violence fosters lasting appetitive aggression and the abused in turn becomes the abuser or perpetrator of violence to others (Weierstall, Schalinski, Crombach, Hecker & Elbert, 2012).

D. Insecure Post-Conflict Environments

Finally, physical health risks are inherent in post-conflict environments. Former child soldiers not only face unique socio-economic challenges to healthcare access, as outlined above, but also find themselves recovering from trauma and resultant physical injury and psychopathology in wider contexts of unstable ongoing or post-conflict environments. These environments, whether at the site of conflict or in the context of displacement—such as sea and land crossings, refugee camps, exploitative person smuggling, and so on—come with inherently high risk of physical trauma and injury. Unsafe environments are usually coupled with limited access to basic resources such as food, clean water, and shelter, as well as healthcare, and are often therefore high risk environments for the spread of disease (Fino, Mema & Russo, 2019).

Furthermore, physically disabled persons are far more likely to be left behind or abandoned by fleeing communities in case of recurring conflict (UNICEF, 2018). As discussed above, child soldiers, as a veteran population, have a high likelihood of sustaining serious and lasting physical injury, making them a vulnerable population when conflict in unstable areas breaks out again. Indeed, many child soldiers and abductees report both multiple abductions and multiple displacements over the course of conflict (Weierstall, Schalinski, Crombach, Hecker & Elbert, 2012).

XIII. Conclusion

As detailed in the current Report, when left untreated and unaddressed, the consequences of crimes of forced migration and displacement, rape, and child soldiering such as those committed in CAR are devastating, pervasive, and long-lasting for individuals and communities across multiple generations. Civilians remain in a protracted displacement situation, within and outside of a CAR, with escalating humanitarian and development needs. Resilience and social safety nets are weakened and compromised. However, it is also apparent that with intervention, reparation, and redress, the negative impact of the

crimes can be mitigated; individuals and communities can be healed and rehabilitated; and new opportunities for growth can be fostered.

Stanford, California

References

- (2004). The problem of re-acclimating child soldiers into society assuming peacekeeping is successful question & (and) answer session. *Cornell International Law Journal*, 37(3), 527-530.
- Agid, O., Shapira, B., Zislin, J., Ritsner, M., Hanin, B., Murad, H., Troudart, T., Bloch, M., Heresco-Levy, U., Lerer, B. (1999). Environment and vulnerability to major psychiatric illness: a case control study of early parental loss in major depression, bipolar disorder and schizophrenia. *Molecular Psychiatry*, 4, 163-172.
- American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.
- Amone-P'Olak, K., Lekhutlile, T. M., Ovuga, E., Abbott, R. A., Meiser-Stedman, R., Steward, D. G., & Jones, P. B. (2016). Sexual violence and general functioning among formerly abducted girls in Northern Uganda: the mediating roles of stigma and community relations - the WAYS study. *BMC Public Health*, 16(64).
- Amone-P'Olak, K., Otim, B. N., Opio, G., Ovuga, E., Meiser-Stedman, R. (2015). War experiences and psychotic symptoms among former child soldiers in Northern Uganda: The mediating role of post-war hardships - the WAYS study. *South African Journal of Psychology*, 45, 155-167.
- Anna, C. (2015). Almost all 436 Central African Republic mosques destroyed: U.S. diplomat. CTV News. Retrieved from <https://www.ctvnews.ca/mobile/world/almost-all-436-central-african-republic-mosques-destroyed-u-s-diplomat-1.2284619>
- Annan, J., Blattman, C., Carlson, K., & Mazurana, D. (2008). *The State of Female Youth in Northern Uganda: Findings from the Survey of War-Affected Youth (SWAY), Phase II*. Retrieved from <http://www.sway-uganda.org>
- Annan, J., Blattman, C., Carlson, K., & Mazurana, D. (2011). *Civil war, reintegration, and gender in Northern Uganda*. *Journal of Conflict Resolution*, 55(6), 877-908. Retrieved from <http://dx.doi.org/10.1177/0022002711408013>.
- Apio, E. (2007). Uganda's forgotten children of war. In R. C. Carpenter (Ed.), *Born of War. Protecting children of sexual violence survivors in conflict zones* (pp.94-109). Bloomfield, CT: Kumarian Press.
- Associated Press. (2014). Rebels kill 30 in church raid in Central African Republic. LA Times. Retrieved from <https://www.latimes.com/world/africa/la-fg-rebels-kill-30-central-african-republic-20140528-story.html>
- Bale, T. E. (2015). Epigenetic and transgenerational reprogramming of brain development. *Nature Reviews Neuroscience*, 16, 332-344.
- Bale, T.E., Baram, T.Z., Brown, A.S., Goldstein, J.M., Insel, T.R., McCarthy, M.M., Nemeroff, C.B.,.... Nestler, E.J. (2010). Early life programming and neurodevelopmental disorders. *Biological Psychiatry*, 68, 314-319.
- Banyard VL. (1997). The impact of child sexual abuse and family functioning on four dimensions of women's later parenting. *Child Abuse & Neglect*, 21(11), 1095-1107.
- Barlow DH (2002). *Anxiety and its disorders: The nature and treatment of anxiety and panic* (2nd ed.). New York: Guilford Press.
- Barnes, J. E., Noll, J. G., Putnam, F. W., & Trickett, P. K. (2009). Sexual and physical revictimization among victims of severe childhood sexual abuse. *Child Abuse & Neglect*, 33(7), 412-420.
- Bartels, S., Scott, J., Mukwege, D., Lipton, R., VanRooyen, M., & Leaning, J. (2010). Patterns of sexual violence in Eastern Democratic Republic of Congo: Reports from survivors presenting to Panzi Hospital in 2006. *Conflict and Health*, 4(9), 1-10.
- Bastick, M., Grimm, K., & Kunz, R. (2007). *Sexual violence in armed conflict: global overview and implications for the security sector* (Geneva Centre for the Democratic Control of Armed Forces). Retrieved from <http://www.dcaf.ch/Publications/Sexual-Violence-in-Armed-Conflict>
- Bayer C. P., Klasen, F., & Adam, H. (2007). Association of trauma and PTSD symptoms with openness to reconciliation and feelings of revenge among former Ugandan and Congolese child soldiers. *JAMA*, 298, 555-559.
- Becker-Lausen, E., Sanders, B., & Chinsky, J. M. (1995). Mediation of abusive childhood experiences: Depression, dissociation, and negative life outcomes. *American Journal of Orthopsychiatry*, 65(4), 560-573.
- Beitchman, J. H., Zucker, K. J., Hood, J. E., DaCosta, G. A., Akman, D., & Cassavia, E. (1992). A review of the long-term effects of child sexual abuse. *Child Abuse & Neglect*, 16(1), 101-118. doi:10.1016/0145-2134(92)90011-F
- Betancourt, T. S., Borisova, I. I., de la Soudiere, M., & Williamson, J. (2010). Sierra Leone's child soldiers: War exposures and mental health problems by gender. *Journal of Adolescent Health*, 49, 21-28.
- Betancourt, T. S., Borisova, I. I., Williams, T. P., Brennan, R. T., Whitfield, T. H., de al Soudiere...Gilman, S. E. (2010). Sierra Leone's former child soldiers: A follow-up study of psychosocial adjustment and community reintegration. *Child Development*, 81, 1077-1095.

- Betancourt, T. S., Thomson, D. L., Brennan, R. T., Antonaccio, C. M., Gilman, S. E., VanderWeele, T. J. (2019). Stigma and acceptance of Sierra Leone's child soldiers: A prospective longitudinal study of adult mental health and social functioning. *Journal of the American Academy of Child & Adolescent Psychiatry*.
- Bith-Melander, P., Chowdhury, N., Jindal, C., Efrid, J. T. (2017). *Trauma affecting Asian-Pacific Islanders in the San Francisco Bay Area*. International Journal of Environmental Research and Public Health, 2017, 14, 1053. DOI: 10.3390/ijerph14091053.
- Bloom, S. L., and Farragher, B. (2013). *Restoring Sanctuary: A New Operating System for Trauma-informed Systems of Care*. New York. Oxford University Press.
- Boose, L. E. (2002) Crossing the River Drina: Bosnian rape camps, Turkish impalement, and Serb cultural memory. *Signs*, 28(1), 71-99.
- Boscarino, J. A. (2011). Post-traumatic stress disorder and cardiovascular disease link: Time to identify specific pathways and interventions. *The American journal of Cardiology*, 108(7),1052-1053.
- Bowlby, J. (1969). *Attachment and Loss: Volume 1 attachment*. London: The Tavistock Institute of Humans Relations.
- Boyce, W.T., Ellis, B.J. (2005). Biological sensitivity to context: I. An evolutionary-developmental theory of the origins and functions of stress reactivity. *Development and Psychopathology* 17, 271—301.
- Brackman, A. (1987) *The Other Nuremberg: The untold story of the Tokyo war crimes trials*. New York, NY: William Morrow and Company.
- Breitenbecher, K. (2001). Sexual revictimization among women. A review of the literature focusing on empirical investigations. *Aggression and Violent Behavior*, 6, 415-432.
- Bremner, J. D. (2006). Traumatic stress: Effects on the brain. *Dialogues in Clinical Neuroscience*, 8, 445-461.
- Breslau, N., Davis, G., Andreski, P., & Peterson, E. (1991). Traumatic events and posttraumatic stress disorder in an urban population of young adults. *Archives of General Psychiatry*, 48(3), 216–222.
- Brooks-Gunn, J., Graber, J., & Paikoff, R. (1994). Studying links between hormones and negative affect: Models and measures. *Journal of Research on Adolescence*, 4, 469-486.
- Brownell, G., & Praetorius, R. T. (2017). Experiences of former child soldiers in Africa: A qualitative interpretative meta-synthesis. *International Social Work*, 60, 452-469.
- Brownmiller, S. (1975). *Against our will: Men, women and rape*. New York, NY: Ballantine Publishing Group.
- Burgess, A. W., & Holmstrom, L. L. (1979). Adaptive strategies and recovery from rape. *The American Journal of Psychiatry*, 136(10), 1278-82.
- Burkett LP (1991), Parenting Behaviors of Women Who Were Sexually Abused As Children in Their Families of Origin. *Family Process* Vol. 30, Issue 4. pp. 421-434.
- Campbell, R. (2012, December 3). *Neurobiology of Sexual Assault*. Webinar presentation to the National Institute of Justice, Washington, DC. Retrieved from: <https://www.nij.gov/multimedia/presenter/presenter-campbell/Pages/welcome.aspx>
- Cahill, L., & McGaugh, J.L. (1998). Mechanisms of emotional arousal and lasting declarative memory. *Trends in Neurosciences*, 21, 294-299.
- Cantekin, D. (2018). Syrian refugees living on the edge: Policy and practice implications for mental health and psychosocial wellbeing. *International Migration*, 57, 200-220.
- Carlson, E. B., Dalenber, C., & McDade-Montez, E. (2012). Dissociation in posttraumatic stress disorder part I: Definitions and review of research. *Psychological Trauma: Theory, Research, Practice, And Policy*, 4(5), 479-489.
- Chang, I. (1997) *The rape of Nanking: The forgotten holocaust of World War II*. New York, NY: Basic Books.
- Classen, C. C., Palesh, O. G. & Aggarwal, R. (2005). Sexual revictimization: A review of the empirical literature. *Trauma, Violence & Abuse*, 6, 103-129.
- Choi H, Cho S. (2019). Posttraumatic stress disorder and complicated grief in bereaved parents of the Sewol Ferry disaster exposed to injustice following the loss. *International Journal of Social Psychiatry*. 2020;66(2):163-170. doi:[10.1177/0020764019894607](https://doi.org/10.1177/0020764019894607)
- Choi, J., Jeong, B., Polcari, A., Rohan, M. L., Teicher, M. H. (2012). Reduced fractional anisotropy in the visual limbic pathway of young adults witnessing domestic violence in childhood. *NeuroImage*, 59(2), 1071-1079.
- Cloitre, M., Stolbach, B. C., Herman, J. L., van der Kolk, B., et al. (2009). A developmental approach to complex PTSD: Childhood and adult cumulative trauma as predictors of symptoms complexity. *Journal of Traumatic Stress*, 22,399-408.
- Cohen, L. J., & Roth, S. (1987). The psychological aftermath of rape: Long-term effects and individual differences in recovery. *Journal of Social and Clinical Psychology*, 5(4),525-534.
- Coid J, Petruckevitch A, Feder G, et al. Relation between childhood sexual and physical abuse and risk of revictimization in women: a cross-sectional survey. *Lancet* 2001;358:450
- Coker AL, Smith PH, McKeown RE, King MJ. Frequency and correlates of intimate partner violence by type: physical, sexual, and psychological battering. *Am J Public Health* 2000;90:553
- Cole PM, Woolger C, Power TG, and Smith KD (1992). Parenting difficulties among adult survivors of father-daughter incest. *Child Abuse & Neglect*, 16, 239–249.
- Copeland, W. E., Keeler, G., Angold, A., & Costello, E. J. (2007). Traumatic events and posttraumatic stress in childhood. *Archives of General Psychiatry*, 64(5), 577-584. doi:10.1001/archpsyc.64.5.577
- Copeland, W. E., Keeler, G., Angold, A., & Costello, E. J. (2007). Traumatic events and posttraumatic stress in childhood. *Archives of General Psychiatry*, 64(5), 577-584.
- Creamer, M., Burgess, P., & McFarlane, A. C. (2001). Post-traumatic stress disorder: Findings from the Australian national survey of mental health and well-being. *Psychological Medicine*, 31(7), 1237-1247.

- Cunningham, M.G., Bhattacharyya, S., Benes, F. M. (2002). Amygdalo-cortical sprouting continues into early adulthood: Implications for the development of normal and abnormal function during adolescence. *Journal of Comparative Neurology*, 453(2), 116-130.
- Damasio, A.R., Grabowski, T. J., & Bechara, A., et al., (2000). Subcortical and cortical brain activity during the feeling of self-generated emotions. *Nature Neuroscience*, 3, 1049-1056.
- Danieli, Y., Norris, F. H., Engdahl, B. (2016). *Multigenerational legacies of trauma: modeling the what and how of transmission*. American Journal of Orthopsychiatry, 2016, Vol. 86, No. 6, 639-651.
- D'Andrea, W., Ford, J., Stolbach, B., Spinazzola, J., van der Kolk, B. A. (2012). Understanding interpersonal trauma in children: Why we need a developmentally appropriate trauma diagnosis. *American Journal of Orthopsychiatry*, 82, 187-200.
- DeBellis, M. D., Keshavan, M. S., & Clark, D. B., et al. (1999). Developmental traumatology Part II: Brain development. *Biological Psychiatry*, 45,1271-1284.
- DeBellis, M., Lefter, L., Trickett, P., et al., (1994). Urinary catecholamine excretion in sexually-abused girls. *Journal of the American Academy of Child and Adolescent Psychiatry*, 33, 320-327.
- Dunmore, E., Clark, D. M., & Ehlers, A. (1999). Cognitive factors involved in the onset and maintenance of posttraumatic stress disorder (PTSD) after physical or sexual assault. *Behaviour Research and Therapy*, 37(9), 809-829.
- Dunn, E. C., Nishimi, K., Neumann, A., Renaud, A., Cecil, C., Susser, E. S., & Tiemeier, H. (2020). Time-dependent effects of exposure to physical and sexual violence on psychopathological symptoms in late childhood: in search of sensitive periods in development. *Journal of the American Academy of Child and Adolescent Psychiatry*, 59(2), 283-295.
<https://doi.org/10.1016/j.jaac.2019.02.022>
- Dunn, E. C., Nishimi, K., Powers, A., Bradley, B. (2017). Is developmental timing of trauma exposure associated with depressive and post-traumatic stress disorder symptoms in adulthood? *Journal of Psychiatric Research*, 84, 119-127.
- East, P. L., Gahagan, S., & Al-Delaimy, W. K. (2018). The impact of refugee mothers' trauma, posttraumatic stress, and depression on their children's adjustment. *Journal of Immigrant Minority Health*, 20, 271-282.
- Edmondson, D., Chaudoir, S. R., Mills, M. A., Park, C. L., Holub, J., & Bartkowiak, J. M. (2011). From shattered assumptions to weakened worldviews: Trauma symptoms signal anxiety buffer disruption. *Journal Of Loss And Trauma*, 16(4), 358-385.
doi:10.1080/15325024.2011.572030
- Eisenberg N, Cumberland A, and Spinrad TL (1998). Parental socialization of emotion. *Psychological Inquiry*, 9, 241–273.
- Ellis, E. M., Atkeson, B. M., & Calhoun, K. S. (1981). An assessment of long-term reaction to rape. *Journal Of Abnormal Psychology*, 90(3), 263-266. doi:10.1037/0021-843X.90.3.263
- Ertl, V., Pfeiffer, A., Schauer-Kaiser, E., Elbert, T., & Neuner, F. (2014). The challenge of living on: Psychopathology and its mediating influence of the readjustment of former child soldiers. *PLOS ONE*, 9.
- The Extraordinary Chambers in the Courts of Cambodia (2014). Overview of Civil Party Reparation Requests in Case 002/001. Retrieved from <http://www.eccc.gov.kh/sites/default/files/articles/Annex%20Case%20002-01%20ReparationProjects.pdf>
- The Extraordinary Chambers in the Courts of Cambodia (2014b). Case 002/001. Retrieved from <http://www.eccc.gov.kh/en/case/topic/1294>
- Felitti, M. D., Vincent, J., Anda, M. D., Robert, F., Nordenberg, M. D., Williamson, M. S., ... James, S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine*, 14(4),245-258.
- Field N. (2011). Intergenerational transmission of trauma stemming from the Khmer Rouge regime: An attachment perspective. In B. Van Schaack, D. Reicherter, Chhang, Y., & A. Talbott (Eds.), *Cambodia's hidden scars: trauma, psychology in the wake of the Khmer Rouge*. Documentation Center of Cambodia.
- Fiankan-Bokonga, Catherine. (2017). A historic resolution to protect cultural heritage. Unesco Courier, ISSN 2220-2269.
<https://en.unesco.org/courier/2017nian-di-3qi/historic-resolution-protect-cultural-heritage>
- Fino, E., Mema, D. & Russo, P.M. (2019). War trauma exposed refugees and posttraumatic stress disorder: The moderating role of trait resilience. *Journal of Psychosomatic Research*, 129 (2020). DOI: 109905.
- Follette, V.M., Polusny, M., Bechtle, A.E., & Naugle, A.E. (1996). Cumulative trauma: The impact of child sexual abuse, adult sexual assault, and spousal abuse. *Journal of Traumatic Stress*, 9(1),25-35.
- Frederick, C. J. (1987). *Psychic trauma in victims of crime and terrorism*. In Cataclysms, Crises, and Catastrophes: Psychology in Action, edited by G.R. VandenBos and B.D. Bryant, pp.55-108, from <http://dx.doi.org/10.1037/11106-002>
- Freyd, J. J. (1996). Betrayal trauma: The logic of forgetting childhood abuse. Cambridge, MA: Harvard University Press.
- Friedman, A. R. (1992). *Rape and Domestic Violence: The Experience of Refugee Women*. In Cole, E., Espin, O. M., & Rothblum, E. D. (Eds.), *Refugee Women and Their Mental Health: Shattered Societies, Shattered Lives*(sec. II, pp. 65). New York: Harrington Park Press.
- Friedman, L. (1972). *The law of war, A documentary history*(Vol 2). New York, NY: Random House.
- Gloor, P., Olivier, A., Quesney, L.F., Andermann, F., & Horowitz, S. (1982). The role of the limbic system in experiential phenomena of temporal lobe epilepsy. *Annals of Neurology*, 12 (2), 129-144. <https://doi.org/10.1002/ana.410120203>
- Goodman, S. (2007). Depression in mothers. *Annual Review of Clinical Psychology*, 3(1),107-135.
- Goodman, S. H., & Gotlib, I. H. (1999). Risk for psychopathology in the children of depressed mothers: a developmental model for understanding mechanisms of transmission. *Psychological Review*, 106(3), 458.
- Grunberg, K., Markert, F. (2012). *A psychoanalytic grave walk- scenic memory of the Shoah. On the trans-generational transmission of extreme trauma in Germany*.The American Journal of Psychoanalysis, 2012, 72, (207-222).

Gunnar, M.R., Vazquez, D.M., 2001. Low cortisol and a flattening of expected daytime rhythm: potential indices of risk in human development. *Development and Psychopathology* 13, 515–538.

Hagan, JF, Jr., & the Committee on Psychosocial Aspects of Child and Family Health and the Task Force on Terrorism. (2005). Psychosocial implications of disaster or terrorism on children: A guide for the pediatrician. *Pediatrics*, 116, 787–795.

Hagen, K., & Yohani, S. (2010). The nature and psychosocial consequences of war rape for individuals and communities. *International journal of psychological studies*, 2(2), 14.

Heim, C., Shugart, M., Craighead, W. E., & Nemeroff, C. B. (2010). Neurobiological and psychiatric consequences of child abuse and neglect. *Developmental Psychobiology*, 52(7), 671–690.

Heim, C., Binder, E.B. (2012). Current research trends in early life stress and depression: review of human studies on sensitive periods, gene-environment interactions, and epigenetics. *Experimental Neurology*, 233(1), 102–111.

Heit, S. (2003). Waging sexual warfare: Case studies of rape warfare used by the Japanese Imperial Army during World War II. *Women's Studies International Forum*, 32(5), 363–370.

Herbert, J., Goodyer, I.M., Grossman, A.B., Hastings, M.H., de Kloet, E.R., Lightman, S.L., et al., 2006. Do corticosteroids damage the brain? *Journal of Neuroendocrinology* 18, 393–411.

Hermenau, K., Hecker, T., Maedl, A., Schauer, M., & Elbert, T. (2013). Growing up in armed groups: Trauma and aggression among child soldiers in DR Congo. *European Journal of Psychotraumatology*, 4.

Hill J, Pickles A, Burnside E, Byatt M, Rollinson L, Davis R, and Harvey S (2001). Child sexual abuse, poor parental care and adult depression: Evidence for different mechanisms. *British Journal of Psychiatry*, 179, 104–109.

Hinton, D. E., & Lewis-Fernández, R. (2011). The cross-cultural validity of posttraumatic stress disorder: implications for DSM-5. *Depression and Anxiety*, 28(9), 783–801.

Hoge, C.W., Castro, C.A., Messer, S.C., McGurk, D., Cotting, D.I., & Koffman, R.L. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *New England Journal of Medicine*, 351, 13–22.

Holmes, M. R., & St. Lawrence, J. S. (1983). Treatment of rape-induced trauma: Proposed behavioral conceptualization and review of the literature. *Clinical Psychology Review*, 3(4), 417–433. doi:10.1016/0272-7358(83)90022-3

Human Rights Watch. (2013). “They Came to Kill: Escalating Atrocities in the Central African Republic.” Retrieved from <https://www.hrw.org/report/2013/12/18/they-came-kill/escalating-atrocities-central-african-republic>.

Human Rights Watch. (2017). “Central African Republic: Sexual Violence as Weapon of War.” Retrieved from <https://www.hrw.org/news/2017/10/05/central-african-republic-sexual-violence-weapon-war>

Human Rights Watch. (2017a). “They Said We Are Their Slaves.” Retrieved from <https://www.hrw.org/report/2017/10/05/they-said-we-are-their-slaves/sexual-violence-armed-groups-central-african-republic>.

Human Rights Watch. (2017b). “No Class.” Retrieved from <https://www.hrw.org/report/2017/03/23/no-class/when-armed-groups-use-schools-central-african-republic>

Human Rights Watch. (2018). “Looking for Justice.” Retrieved from <https://www.hrw.org/report/2018/05/17/looking-justice/special-criminal-court-new-opportunity-victims-central-african-republic>

Hynes, H.P. (2004). On the battlefield of women's bodies: An overview of the harm of war to women. *Women's Studies International Forum*, 27, 431–445.

The International Criminal Court. “Central African Republic II.” Retrieved from <https://www.icc-cpi.int/carII>.

The International Criminal Court. “The Prosecutor v. Dominic Ongwen: Alleged Crimes (non-exhaustive list). Retrieved from <https://www.icc-cpi.int/uganda/ongwen/pages/alleged-crimes.aspx>.

International Federation of Human Rights. (2003). *War crimes in the Central African Republic: When the elephants fight, the grass suffers*. Retrieved from https://www.fidh.org/IMG/pdf/FIDH_Report_WarCrimes_in_CAR_English_Feb2003.pdf.

Janoff-Bulman, R., & Frieze, I. H. (1983). A theoretical perspective for understanding reactions to victimization. *Journal of Social Issues*, 39(2), 1–17.

Johnson, D. (2017). “Exploring the intersection of Child Soldiering and Disability.” Retrieved from <https://www.childsoldiers.org/exploring-intersection-child-soldiering-disability/>

Johnson, D. & Whitman, S. (2016). Child soldiers and disability: gaps in knowledge and opportunities for change, *Third World Thematics: A TWQ Journal*, 1:3, 307–320, DOI: [10.1080/23802014.2016.1246349](https://doi.org/10.1080/23802014.2016.1246349)

Johnson, K., Scott, J., Rughita, B., Kisielewski, M., Asher, J., Ong, R., & Lawry, L. (2010). Association of sexual violence and human rights violations with physical and mental health in territories of the Eastern Democratic Republic of the Congo. *Journal of the American Medical Association*, 304(5), 553–562.

Kaitz M, Levy M, Ebstein R, Faraone S, Makuta D (2009). The intergenerational effects of trauma from terror: A real possibility. *Infant Mental Health Journal*. Vol. 30(2), 158–179.

Kane, M. (2014). Interreligious violence in the Central African Republic. *African Security Review*, 23, 312–317.

Kaplow, J. B., Widom, C. S. (2007). Age of onset of child maltreatment predicts long-term mental health outcomes. *Journal of Abnormal Psychology*, 116(1), 176–87.

Keiley, M. K., Howe, T. R., Dodge, K. A., Bates, J. E., Petti, G. S. (2001). The timing of child physical maltreatment: a cross-domain growth analysis of impact on adolescent externalizing and internalizing problems. *Development and Psychopathology*, 13(4), 891–912.

Kendall-Tackett, K. A. (2007). Inflammation, cardiovascular disease, and metabolic syndrome as sequelae of violence against women: the role of depression, hostility, and sleep disturbance. *Trauma, Violence, & Abuse*, 8(2), 117–126.

Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry*, 52(12), 1048–1060.

- Kilpatrick, D. G., Resick, P. A., & Veronen, L. J. (1981). Effects of a rape experience: A longitudinal study. *Journal of Social Issues*, 37(4), 105-122.
- Kilpatrick, D.G., Edmunds, C., Seymour, A. (1992). *Rape in America: A report to the nation*. Charleston, SC: National Victim Center & the Crime Victims Research and Treatment Center, Medical University of South Carolina
- Kizilhan, J.L., & Noll-Hussong, M. (2017). *Individual collective, and trans-generational traumatization in the Yazidi*. *BMC Medicine* 15:198, DOI 10.1186/s12916-017-0965-7
- Kizilhan, J. I. & Noll-Hussong, M. (2018). Post-traumatic stress disorder among former Islamic State child soldiers in northern Iraq. *The British Journal of Psychiatry*, 213, 425-429.
- Klasen, F., Reissmann, S., Voss, C., & Okello, J. (2015). The guiltless guilty: Trauma-related guilt and psychopathology in former Ugandan child soldiers. *Child Psychiatry Human Development*, 46, 180-193.
- Kohrt, B. A., Jordans, M. J. D., Tol, W. A., Speckman, R. A., Maharjan, S. M., Worthman, C. M., & Komproe, I. H. (2008). Comparison of mental health between former child soldiers and children never conscripted by armed groups in Nepal. *JAMA*, 300, 691-702.
- Kohrt, B. A., Worthman, C. M., Adhikari, R. P., Luitel, N. P., Arevalo, J. M. G., Ma, J., ... Cole, S. W. (2016). Psychological resilience and the gene regulatory impact of posttraumatic stress in Nepali child soldiers. *Proceedings of the National Academy of Sciences of the United States of America*, 113, 8156-8161.
- Kuwert, P., Glaesmer, H., Eichhorn, S., Grundke, E., Pietrzak, R. H., Freyberger, H. J., Klauer, T. (2014). *Long-term effects of conflict-related sexual violence compared with non-sexual war trauma in female World War II survivors: a matched pairs study*. *Arch Sex Behav* 43: 1059-1064, DOI 10.1007/s10508-014-0272-8
- Leach J. (2016). Psychological factors in exceptional, extreme and torturous environments. *Extreme physiology & medicine*, 5, 7. <https://doi.org/10.1186/s13728-016-0048-y>
- Leen-Feldner, E. W., Reardon, L. E., Hayward, C., Smith, R. (2008). The relation between puberty and adolescent anxiety: Theory and evidence. *Anxiety in Health*
- Lee-Koo, K. (2002). Confronting a disciplinary blindness: Women, war and rape in the international politics of security. *Australian Journal of Political Science*, 37(3), 525-536.
- Lee-Koo, K. (2011). Gender-based violence against civilian women in post-invasion Iraq: (Re) Politicizing George W. Bush's silent legacy. *Violence Against Women*, 17(12), 1619-1634.
- Li, S. S. Y., Liddell, B. J., & Nickerson, A. (2016). The relationship between post-migration stress and psychological disorders in refugees and asylum seekers. *Disaster Psychiatry: Trauma, PTSD, and Related Disorders*, 18.
- Liebling, H., & Slegh, H. (2011). 'I Became a Woman with a Bad Reputation in My Society' gendered responses to women and girl's bearing a child from rape in Eastern Congo. *African Journal of Traumatic Stress*, 2(2), 60-70.
- Liebling, H., Slegh, H., & Ruratotoye, B. (2012). Women and girls bearing children through rape in Goma, Eastern Congo: Stigma, health and justice responses. *Itupale Online Journal of African Studies*, 4, 18-44.
- Lipka, Michael. (2015). The continuing decline of Europe's Jewish population. FactTank: PEW Research Center. Retrieved from <https://www.pewresearch.org/fact-tank/2015/02/09/europes-jewish-population/>
- Littleton, H. & Decker, M. (2017). *Predictors of resistance self-efficacy among rape victims and association with re-victimization risk: a longitudinal study*. *Psychology of Violence*, Vol. 7(4), Oct. 2017, pp. 583-592
- Lukasse, M., Henriksen, L., Vangen, S., & Schei, B. (2012). Sexual violence and pregnancy-related physical symptoms. *BMC Pregnancy and Childbirth*, 12(1), 83.
- Lyons-Ruth, K & Block D. (1996). The disturbed caregiving system: Relations among childhood trauma, maternal caregiving, and infant affect and attachment. *Infant Mental Health Journal*, 17, 257-275.
- Main M (1996). Introduction to the special section on attachment and psychopathology: Part II. Overview of the field of attachment. *Journal of Consulting and Clinical Psychology*, 64(2), 5-7.
- Manion, I. G., McIntyre, J., Firestone, P., Ligezinska, M., Ensom, R., & Wells, G. (1996). Secondary traumatization in parents following the disclosure of extrafamilial child sexual abuse: Initial effects. *Child Abuse & Neglect*, 20(11), 1095-1109.
- Mullen PE, Martin JL, Anderson JE, Romans SE, and Herbison GP (1994). The effect of child sexual abuse on social, interpersonal and sexual function in adult life. *British Journal of Psychiatry*, 165, 35-47.
- Maslow, A. H. (1943). A theory of human motivation. *Psychological Review*, 50(4), 370-396.
- McEwen, BS. (2007). Physiology and neurobiology of stress and adaptation: Central role of the brain. *Physiological Reviews*, 87(3), 837-904.
- McCahill, T. W., Meyer, L. C., & Fischman, A. M. (1979). *The aftermath of rape*. Lexington, MA: Lexington Books.
- McCauley, J., Kern, D.E., Kolodner, K., Dill, L., Schroeder, A.F. DeChant, H.K., ... Bass, E.B. (1997). Clinical characteristics of women with a history of childhood abuse: Unhealed wounds. *Journal of the American Medical Association*, 277(17), 1362-1368.
- McEwen, B.S., 1998. Protective and damaging effects of stress mediators. *New England Journal of Medicine* 338, 171-179.
- McEwen, B.S., & Wingfield, J.C. (2003). The concept of allostasis in biology and biomedicine. *Hormones and Behavior*, 43, 2-15.
- McGaugh, J.L., Herz, M.J., 1972. Memory consolidation. Albion, San Francisco.
- Meewise, M.L., Reitsma, J.B., de Vries, G.J., Gersons, B.P., & Olff, M. (2007). Cortisol and post-traumatic stress disorder in adults: Systematic review and meta-analysis. *British Journal of Psychiatry*, 191, 387-392.
- Merikangas, K. R. & Pine, (2002). Genetic and other vulnerability factors for anxiety and stress disorders. In Davis, K. L., Charney, D., Coyle, T. J., & Nemeroff, C. (Eds.), *Neuropsychopharmacology: the fifth generation of progress* (pp 867-82). Philadelphia, PA: Lippincott, Williams, & Wilkins.
- Messina-Dysert, G. (2013). Rape and Spiritual Death. *Feminist Theology*, 20(2), 120-132.

- MINUSCA, UNDP, United Nations Human Rights, & Violences Sexuelles en Conflit. (2017). Central African Republic 2003-2015. *CAR-OTP-2055-1987*, 1-220.
- Mollica, R., Sarajlic, N., Chernoff, M., Lavelle, J., Vukovic, I., & Massagli, M. (2001). Longitudinal study of psychiatric symptoms, disability, mortality, and emigration among Bosnian refugees. *Journal of the American Medical Association*, 286(5), 546-554.
- Molnar, B. E., Buka, S. L., & Kessler, R. C. (2001). Child sexual abuse and subsequent psychopathology: Results from the National Comorbidity Survey. *American Journal Of Public Health*, 91(5), 753-760.
- Morof, D. F., Sami, S., Mangeni, M., Blanton, C., Cardozo, B. L., & Tomczyk, B. (2014). A cross-sectional survey on gender-based violence and mental health among female urban refugees and asylum seekers in Kampala, Uganda. *International Journal of Gynecology & Obstetrics*, 127(2), 138-143.
- Muhwezi, W. W., Kinyanda, E., Mungherera, M., Onyango, P., Ngabirano, E., Muron, J., ... & Kajungu, R. (2011). Vulnerability to high risk sexual behaviour (HRSB) following exposure to war trauma as seen in post-conflict communities in Eastern Uganda: a qualitative study. *Conflict and Health*, 5(22), 1-15.
- Murphy, S. M., Amick-McMullan, A. E., Kilpatrick, D. G., Haskett, M. E., Veronen, L. J., Best, C. L., & Saunders, B. E. (1988). Rape victims' self-esteem: a longitudinal analysis. *Journal of Interpersonal Violence*, 3(4), 355-370.
- Naimark, Norman M. (2016). *Genocide : A World History*. Oxford University Press, Incorporated, 1-6.
- Neumann, D. A., Houskamp, B. M., Pollock, V. E., & Briere, J. (1996). The long-term sequelae of childhood sexual abuse in women: A meta-analytic review. *Child Maltreatment*, 1(1), 6-16. doi:10.1177/1077559596001001002
- Nishith, P., Mechanic, M., & Reside, P. (2000). Prior interpersonal trauma: The contribution to current PTSD symptoms in female rape victims. *Journal of Abnormal Psychology*, 109(1), 20-25.
- Noack, A., Baraitser, L. (2004). *Groupwork with mothers who have been sexually abused in childhood*. British Journal of Psychotherapy 20(3).
- Office of the High Commissioner, United Nations. (2012). The destruction of cultural and religious sites: a violation of human rights. Retrieved from <https://www.ohchr.org/EN/NewsEvents/Pages/DestructionShrines.aspx>
- Office of the Prosecutor, International Criminal Court. (2019). *Situation in the Central African Republic II Article 14(18) Report*. https://www.icc-cpi.int/RelatedRecords/CR2019_05689.PDF
- OTP - ICC, The Office of the Prosecutor - Letter of Instruction, See Annex A.
- OTP-Prosecution Team. Summaries of Victim Testimonies.
- Potts, A., Myer, K., & Roberts, L. (2011). Measuring human rights violations in a conflict-affected country: Results from a nationwide cluster survey in Central African Republic. *Conflict and Health*, 5(4), 1-14.
- Rao, H., Betancourt, L., Giannetta J. M., Brodsky, N. L., Korczykowski, M., Avants, B. B., Gee, J. C., Wang, J., Hurt, H., Detre, J. A., Farah, M. J. (2010). Early parental care is important for hippocampal maturation: Evidence from brain morphology in humans. *NeuroImage*, 49(1), 1144-1150.
- Rasmussen, A., & Annan, J. (2010). Predicting stress related to basic needs and safety in Darfur refugee camps: A structural and social ecological analysis. *J Refug Stud.*, 23, 23-40.
- Rasmussen, A., Nguyen, L., Wilkinson, J., Vundla, S., Raghavan, S., Miller, K. E., & Keller, A. S. (2011). Rates and impact of trauma and current stressors among Dafuri refugees in Eastern Chad. *Am J Orthopsychiatry*, 80, 227-236.
- Reed, R. V., Fazel, M., Jones, L., Panter-Brick, C., & Stein, A. (2011). Mental health of displaced and refugee children resettled in low-income and middle-income countries: Risk and protective factors. *Lancet*, 379, 250-265.
- Rehn, E., Johnson Sirleaf, E. (2002). Women, war and peace: The independent experts' assessment on the impact of armed conflict on women and women's role in peace-building. UN Women's Headquarters. Retrieved from <http://www.unwomen.org/en/digital-library/publications/2002/1/women-war-peace-the-independent-experts-assessment-on-the-impact-of-armed-conflict-on-women-and-women-s-role-in-peace-building-progress-of-the-world-s-women-2002-vol->
- Reicherter, D., & Aylward, A., (2011). Impact of War and Genocide on Psychiatry and Social Psychology. In B. Van Schaack, D. Reicherter, Y. Chhang, & Talbott, A (Eds.), *Cambodia's Hidden Scars: Trauma, Psychology in the Wake of the Khmer Rouge*. Documentation Center of Cambodia.
- Reid-Cunningham, A.R. (2008). Rape as a weapon of genocide. *Genocide Studies and Prevention Vol 3*(3), 279-296.
- Relyea, M., Ullman, S. E. (2017). *Predicting sexual assault Re-victimization in a longitudinal sample of women survivors: variation by type of assault*. Violence Against Women, Vol. 23(12), pp. 1462-1483, DOI: 10.1177/1077801216661035
- Reparation for Torture—A Survey of Law and Practice in Thirty Selected Countries, The Redress Trust, London, England, April 2003
- Riley, A., Varner, A., Ventevogel, P., & Hasan, M. M. T. (2017). Daily stressors, trauma exposure, and mental health among stateless Rohingya refugees in Bangladesh. *Transcultural Psychiatry*, 54, 304-331.
- Roberts R, O'Connor T, Dunn J, Golding J, and The ALSPAC Study Team (2004), The effects of child sexual abuse in later family life; mental health, parenting and adjustment of offspring. *Child Abuse & Neglect* 28;525-545.
- Robson, T. (2002, Aug. 21). Bosnia: The United Nations, human trafficking and prostitution. *World Socialist Web Site*. Retrieved from <http://www.wsws.org/en/articles/2002/08/bosn-a21.html>.
- Roodman, A. A., & Clum, G. A. (2001). Revictimization rates and method variance: A meta-analysis. *Clinical Psychology Review*, 21(2), 183-204. doi:10.1016/S0272-7358(99)00045-8
- Roosendaal, B., McReynolds, J. R., Van der Zee, E. A., Sangkwan, L., McGaugh, J. L., & McIntyre, C.K. (2009). Glucocorticoid effects on memory consolidation depend on functional interactions between medial prefrontal cortex and basolateral amygdala. *Journal of Neuroscience*, 29(45), 14299-14308.

Weisleder, P. & Rublee, C. (2018). The Neuropsychological Consequences of Armed Conflicts and Torture. *Current Neurology and Neuroscience Reports*, DOI: 10.1007/s11910-018-0818-6

Russell, L., & Gozdiak, E. M. (2006). Coming home whole: Reintegrating Uganda's child soldiers. *Georgetown Journal of International Affairs*, 7, 57-65.

Ryan, G. L., Mengeling, M. A., Booth, B. M., Torner, J. C., Syrop, C. H., & Sadler, A. G. (2014). Voluntary and involuntary childlessness in female veterans: associations with sexual assault. *Fertility & Sterility*, 102(2), 539-547. doi:10.1016/j.fertnstert.2014.04.042

Sadock, B. J., & Sadock, V. A. (2007). *Kaplan & Sadock's synopsis of psychiatry: behavioral sciences/clinical psychiatry*. Philadelphia, PA: Lippincott Williams & Wilkins.

Sapolsky R.M. (2005). The influence of social hierarchy on primate health. *Science*, 308(5722), 648-652.

Sapolsky, R. M. (2012). Importance of a sense of control and the physiological benefits of leadership. *Proceedings of the National Academy of Sciences of the United States of America*, 109(44), 17730–17731.

Sapolsky, R.M. (2017). *Behave: The Biology of Humans at Our Best and Worst.* Penguin Press, 985-1034.

Sapolsky, R.M., Romero, L.M., Munck, A.U., (2000). How do glucocorticoids influence stress responses? Integrating permissive, suppressive, stimulatory, and preparative actions. *Endocrine Reviews* 21, 55—89.

Schore A (2001). The effects of early relational trauma on right brain development, affect regulation, and infant mental health. *Infant Mental Health Journal*, 22, 201-269.

Seifert, R. (1994). War and rape: a preliminary analysis. In A. Stiglmeier (Ed.), *Mass rape: the war against women in Bosnia-Herzegovina*. Lincoln, NB: University of Nebraska Press.

Shewly, H. J. (2013). Abandoned spaces and bare life in the enclaves of the India-Bangladesh border. *Political Geography*, 32, 23-31.

Shonkoff, J. P., Siegel, B.S., Garner, A. S., Dobbins, M. I., Earls, M. F., McGuinn, L., Pascoe, J., & Wood, D. L. (2012). The lifelong effects of early childhood adversity and toxic stress. *Pediatrics*, 129(1).

Shultz, J. M., Garfin, D. R., Espinel, Z., Araya, R., Oquedo, M. A., Wainberg, M. L., Neria, Y. (2014). Internally displaced "victims of armed conflict" in Columbia: The trajectory and trauma signature of forced migration. *Current Psychiatry Rep.*, 16.

Smith, K. K., Simmons, V. M., & Thames, T. B. (1989). "Fix the Women": An intervention into an organizational conflict based on parallel process thinking. *The Journal of Applied Behavioral Science*, 25 (1), 11- 29.

Smith, P., Perrin, S., Yule, W., & Rabe-Hesketh, S. (2001). War exposure and maternal reactions in the psychological adjustment of children from Bosnia-Herzegovina. *Journal of Child Psychology and Psychiatry*, 42(3), 395-404.

Song, S. J., Tol, W., & De Jong, J. (2014). Indero: Intergenerational trauma and resilience between Burundian former child soldiers and their children. *Family Process*, 53, 239-251.

Southwick, S.M., Vythilingam, M., & Charney, D.S. (2005). The psychobiology of depression and resilience to stress: Implications for prevention and treatment. *Annual Reviews of Clinical Psychology*, 1, 255-291.

Steketee, G., & Foa, E. B. (1987). Rape victims: Post-traumatic stress responses and their treatment:: A review of the literature. *Journal of Anxiety Disorders*, 1(1), 69-86.

Tabo, A. (2011). *Expert Report*. International Criminal Court. Case No. ICC-01/05-01/08.

Tabo, A. (2011b). *Expert Testimony*. International Criminal Court. Case No. ICC-01/05-01/08.

Tedeschi, R. G., & Calhoun, L. G. (2004). Posttraumatic Growth: Conceptual Foundations and Empirical Evidence. *Psychological Inquiry*, 15, 1-18.

Tedeschi, R. G., & Calhoun, L. G. (1995). *Trauma and transformation: Growing in the aftermath of suffering*. Thousand Oaks, CA: Sage.

Teicher, M.H., & Samson, J.A. (2013). Child maltreatment and psychopathology: A case for ecophenotypic variants as clinically and neurobiologically distinct subtypes. *American Journal of Psychiatry*, 170, 1114-1133.

Tomoda, A., Polcari, A., Anderson, C. M., Teicher, M. H. (2012). Reduced Visual Cortex Gray Matter Volume and Thickness in Young Adults Who Witnessed Domestic Violence during Childhood. *PLoS One*, 7(12).

Trickett, P. K., Noll, J. G., & Putnam, F. W. (2011). The impact of sexual abuse on female development: Lessons from a multigenerational, longitudinal research study. *Development and Psychopathology*, 23(02), 453-476.

Trickett, P.K., Noll, J.G., Susman, E.J., Shenk, C.E., Putnam, F.W. (2010). Attenuation of cortisol across development for victims of sexual abuse. *Developmental Psychopathology*, 22(1), 165-175.

Turku, Helga. (2018). When Cultural Property Becomes a Tool of Warfare: Law, Politics, and International Security. *Intergentes: The McGill Journal of International Law and Legal Pluralism*.
<https://intergentes.com/cultural-property-becomes-tool-warfare-law-politics-international-security/>

UNICEF. (2018). *CHILDREN WITH DISABILITIES IN SITUATIONS OF ARMED CONFLICT: Discussion Paper*.

UNDP Policy Paper on Reparations for Croatian Victims of War Related Sexual Violence, December 2013.

United Nations Assistance Mission for Iraq. (2008). *Human Rights Report, 1 July-31 December*. Retrieved from http://www.ohchr.org/Documents/Countries/IQ/UNAMI_Human_Rights_Report_July_December_2008_EN.pdf.

United Nations Disarmament, Demobilization and Reintegration Resource Centre. (2014). *Integrated Disarmament, Demobilization and Reintegration Standards*. New York: United Nations.

United Nations Security Council, July 26 2005. *Resolution 1612 (2005)*, S/RES/1612. Retrieved from <https://documents-dds-ny-un-org.stanford.idm.oclc.org/doc/UNDOC/GEN/N05/439/59/PDF/N0543959.pdf?OpenElement>.

van der Kolk, B. (2006). Clinical implications of neuroscience research in PTSD. *Annals of the New York Academy of Science*, 1071, 277-293.

- van der Kolk, B.A., Pelcovitz, D., Roth, S., Mandel, F.S., MacFarlane, A., & Herman, J.L. (1996). Dissociation, somatization, and affect dysregulation: the complexity of adaptation to trauma. *American Journal of Psychiatry*, 153, (7), pp. 83-93.
- Van Leeuwen, J., Miller, L., Zamir, M. Grundy, R., Amanya, J., Chen, C. & Feinberg, M. (2018). Community reintegrating former child soldiers in Northern Uganda: A qualitative study on the road to recovery. *Journal of Psychology in Africa*, 28, 105-109.
- Van Schaack, B., Reicherter, D., Chhang, Y., & Talbott, A. (2011). *Cambodia's hidden scars: trauma, psychology in the wake of the Khmer Rouge*. Documentation Center of Cambodia.
- Verelst, A., Schryver, M., Broekaert, E., & Derluyn, I. (2014). Mental health of victims of sexual violence in Eastern Congo: Associations with daily stressors, stigma, and labeling. *BMC Women's Health*, 14, 106.
- Vinck P, Pham PN. Association of Exposure to Violence and Potential Traumatic Events With Self-reported Physical and Mental Health Status in the Central African Republic. *JAMA*. 2010;304(5):544–552. doi:10.1001/jama.2010.1065
- Vindevogel, S., De Schryver, M., Broekaert, E., & Derluyn, I. (2013). Challenges faced by former child soldiers in the aftermath of war in Uganda. *Journal of Adolescent Health*, 52, 757-764.
- Vossoughi, N., Jackson, Y., Gusler, S., and Stone, K. (2018). Mental health outcomes for youth living in refugee camps: A review. *Trauma, Violence & Abuse*, 19, 528-542.
- Vrana, S., & Lauterbach, D. (1994). Prevalence of traumatic events and post-traumatic psychological symptoms in a nonclinical sample of college students. *Journal of Traumatic Stress*, 7(2), 289-302.
- Walsh, K., Nugent, N.R., Kotte, A., Amstadter, A.B., Wang, S., Guille, C.,... Resnick, H.S. (2013). Cortisol at the emergency room rape visit as a predictor of PTSD and depression over time. *Psychoneuroendocrinology*, 38(11), 2520-2528.
- Wax, E. (2004, June 6). "We Want to Make a Light Baby" Arab militiamen in Sudan said to use rape as weapon of ethnic cleansing. *Washington Post Foreign Service*. Retrieved from <http://www.washingtonpost.com/wp-dyn/articles/A16001-2004Jun29.html>.
- Weems CF & Silverman WK (2006). An integrative model of control: Implications for understanding emotion regulation and dysregulation in childhood anxiety. *Journal of Affective Disorders*, 91, 113–124.
- Wekerle C, Wolfe DA, Hawkins DL, Pittman AL, Glickman A, and Lovaal BE (2001), Childhood maltreatment, posttraumatic stress symptomatology, and adolescent dating violence: Considering the value of adolescent perceptions of abuse and a trauma mediation model. *Development & Psychopathology*. Col. 13, Issue 4, pp. 847-871.
- Weierstall, R., Schalinski, I., Crombach, A., Hecker, T., & Elbert, T. (2012). When combat prevents PTSD symptoms - results from a survey with former child soldiers in Northern Uganda. *BMC Psychiatry*, 12.
- Welz, C. (2016). Trauma, memory, testimony: Phenomenological, psychological, and ethical perspectives. *Jewish Studies in the Nordic Countries Today Scripta Instituti Donneriani Aboensis*, 27, 104-133.
- Wilson, D. R. (2011). Preparing Adult Survivors of Childhood Sexual Abuse for Pregnancy, Labor, and Delivery. *International Journal Of Childbirth Education*, 26(2), 7-8.
- Widom CS, Czaja SJ, and DuMont KA (2015), Intergenerational transmission of child abuse and neglect: Real or detection bias? *Science*. Vol. 3347 Issue 6229, pp. 1480-1485.
- Winship, G., Knowles, J. (1996). *The trans-generational impact of cultural trauma: linking phenomena in treatment of third generation survivors of the Holocaust*. *British Journal of Psychotherapy*, Vol. 13(2).
- Wirtz, A., Pham, K., Glass, N., Loochkartt, S., Kidane, T., Cuspoca, D.,...Vu, A. (2014). Gender-based violence in conflict and displacement: Qualitative findings from displaced women in Colombia. *Conflict and Health*, 8(10), 1-14.
- World Health Organization (2017). *Depression and Other Common Mental Disorders: Global Health Estimates*. Geneva: World Health Organization;. Licence: CC BY-NC-SA 3.0 IGO.
- Yan, X., Brown, A.D., Lazar, M., Cressman, V.L., Henn-Haase, C., Neylan, T.C., ... Marmar, C.R. (2013). Spontaneous brain activity in combat related PTSD. *Neuroscience Letters*, 547, 1-5.
- Yehuda, R., Daskalakis, N.P., Bierer, L.M., Bader, H.N., Klengel, T., Holsboer, F., & Binder, E.B. (2015, Aug 12). Holocaust exposure induced intergenerational effects on FKBP5 methylation. *Biological Psychiatry*. <http://dx.doi.org/10.1016/j.biopsych.2015.08.005>.
- Yehuda, R., Halligan, S. L., & Bierer, L.M. (2001). Relationship of parental trauma exposure and PTSD to PTSD, depressive and anxiety disorders in offspring. *Journal of Psychiatric Research*, 35, 261-270.
- Zalilic-Kaurin, A. (1994) "The Muslim Women", in *Mass Rape: The War against Women in Bosnia-Herzegovina*, ed. Alexandra Stiglmeier, Lincoln, NB, University of Nebraska Press, p. 170.
- Zijlstra, E., Esselink, G., Moors M. L., LoFoWong, S., Hutschemaekers, G., & Lagro-Janssen, A. (2017). *Vulnerability and re-victimization: Victim characteristics in a Dutch assault center*. *Journal of Forensic and Legal Medicine [J Forensic Leg Med]* 2017 Nov; Bol. 52, pp. 199-207
- Zinzow, H. M., Resnick, H. S., McCauley, J. L., Amstadter, A. B., Ruggiero, K. J., & Kilpatrick, D. G. (2012). Prevalence and risk of psychiatric disorders as a function of variant rape histories: Results from a national survey of women. *Social Psychiatry And Psychiatric Epidemiology*, 47(6), 893-902. doi:10.1007/s00127-011-0397-1

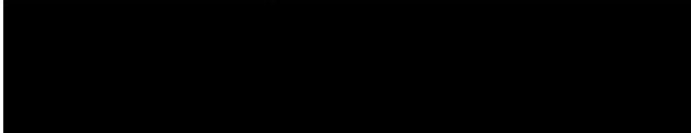
Annex

Annex A - Letter of Instruction



Confidential

Dr. Daryn Reicherter, M.D.
Director
Human Rights in Trauma Mental Health Program
Department of Psychiatry and Behavioral Sciences
Stanford University School of Medicine



Date: 20 August 2020

Re.: The case of The Prosecutor v. Alfred YEKATOM and Patrice-Edouard NGAÏSSONA (ICC-01/14-01/18) - Expert Report

Dear Dr. Reicherter,

The Office of the Prosecutor would like to engage you as expert concerning the proceedings against Alfred YEKATOM and Patrice-Edouard NGAÏSSONA.

Request for Expert Report

We request that you prepare a written report addressing the following:

1. *Immediate and long-term traumatic effects of forcible displacement on a population, including intergenerational and transgenerational effects*
 - a. Traumatic effects of general displacement
 - i. Impact on the displaced persons and their family members
 - ii. If there are specific effects on women or children, what are they?
 - b. Traumatic effects of being enclaved
 - i. Impact on the enclaved persons and their family members;
 - ii. If there are specific effects on women or children, what are they?
 - c. Traumatic effects of being held in refugee camps
 - i. Impact on refugees and their family members
 - ii. If there are specific effects on women or children, what are they?
 - d. Traumatic effects of deportation (removal from the country of residence or origin) on the deported persons and their family members

- i. From the point of view of a separation from the home country, including loss of family ties, property, etc.
 - ii. From the point of view of insecurity in the host country
- 2. *Traumatic issues arising from the phenomenon of child soldiers, including*
 - a. The occurrence of post-traumatic stress disorder ("PTSD") or of any other psychiatric conditions in child soldiers
 - b. Intergenerational effects of child soldiering
 - c. Transgenerational effects of child soldiering
- 3. *Immediate and long-term traumatic effects of rape and sexual violence on victims, including intergenerational and transgenerational effects*
 - a. Impact of rape and sexual violence on individual victims, including direct and indirect victims
 - b. Impact of rape and sexual violence on relationships, family and societal functioning
 - c. Intergenerational and transgenerational impact of rape and sexual violence

Your Expert Report should also include the following information:

- (a) *Professional background and expertise*: a summary of your relevant background, especially in relation to assessing the issues discussed in the Expert Report. In particular, please describe your relevant academic or professional qualifications, prior publications and work (including field) experience.
- (b) *Methodology of the Expert Report*: Please describe the methodology you used in preparing the Expert Report, such as the following:
 - a. Data collection: Describe the methods used in collecting the data, including the method you used to identify sources of data, the sources you were able to identify, and the reliability of the sources you were able to identify.
 - b. Data analysis: Describe the methods you used in analysing the data, including how you processed and computed the data. In addition:
 - 1. to the extent that you relied upon data analysed by others, please describe the method used by the source to analyse the data and the reliability of their methodology.
 - 2. to the extent that your report is subject to peer review by a third person or persons, please provide their name, professional background and

expertise, why you consulted that individual, and their evaluation of your analysis.

- c. Limitations: Describe any limitations in the data collection and/or data analysis process.

You are also requested to attach the following to your Expert Report:

1. The present letter of instructions;
2. Copies of any professional/academic qualifications and certificates, including your most recent *curriculum vitae*;
3. A list of all sources upon which you relied for your Expert Report; and
4. Any photographs, maps, charts and tables which might help illustrate your methodology or your findings.

Remuneration for the Expert Report

It is understood and agreed that you will produce the requested Expert Report on a *pro bono* basis by **15 October 2020**.

Communications with the OTP

Your point of contact will be Assistant Trial Attorney, [REDACTED] All communications should be directed to her. Please note that these instructions will eventually be filed with the Court, which also means that your name will be made public. Please let us know if you have any concerns.

Be assured that we highly appreciate your preparedness to be instructed and to be called as an expert witness.

Kind regards,

[REDACTED]

Kweku Vanderpuye
Senior Trial Lawyer